Medi-Cal Behavioral Health Corrective Action Plan (CAP)

Trinity

Compliance Review Date: 7/25/2023

Corrective Action Plan Fiscal Year: FY 2023-24

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction	DHCS Response
SMHS				
1.2.1 Assessment of ICC and IHBS Services **Finding:** The Plan did not ensure to determine the need for ICC and IHBS services in children and youth who met SMHS criteria. The verification study included the review of 40 children's medical records, of which 14 children who received an initial assessment were found to have indicators for	The plan made a change to its Single Accountable Individual (SAI) to include indicators for ICC and/or IHBS. Additionally, revisions were made to Policy 3312 to address the assessment requirement for determining if ICC or IHBS services were needed. Monitoring mechanism is to ensure that the task is completed is by the EHR.	8/1/23	Please see new SAI form as uploaded into the EHR	

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consideration for ICC and/or IHBS. However, there was no evidence that a determination for needed services was made. The Plan did not maintain an adequate process to ensure all children that met beneficiary access criteria for SMHS were assessed for ICC or IHBS determination. The Plan policy *3312* did not clearly address the assessment requirement to determine if ICC or IHBS services were needed. Although the Plan stated in an interview that staff utilize clinical team meetings to determine if ICC and IHBS services would be appropriate, the Plan could not verify whether these services were actually considered for every child. When the Plan does not				

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determine the need for ICC and IHBS services, this may impact the Plan's ability to adequately meet the mental health needs of children and youth beneficiaries.				
1.2.2 Assessment of Need for TCF Services **Finding:** The Plan did not ensure to assess the need for TFC services to children and youth who met beneficiary access and medical necessity criteria for SMHS. The Plan did not maintain a system to ensure children were assessed for the need of TFC services. The Plan's policy *3312* did not clearly address the assessment requirement to determine if TFC services were needed. In addition,	The plan made a change to its Single Accountable Individual (SAI) to include indicators for TFC. Additionally, revisions were made to Policy 3312 to address the assessment requirement for determining if TFC services were needed. Monitoring mechanism is to ensure that the task is completed is by the EHR	8/1/23	Please see new SAI form as uploaded into the EHR	

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the Plan confirmed in an interview that determinations for TFC were not conducted due to a limited number of foster children within the County. Failure to make determinations for children who might be considered for TFC services may impact the Plan's ability to adequately meet the mental health needs of youth beneficiaries. **This is a repeat finding of the prior review (Fiscal Year 2019/2020) – A.III.G – Assessment of Need for TFC Services**				
1.2.3 Provision of TFC Services **Finding:** The Plan did not ensure the provision of	Revisions were made to Policy 3312 to address the steps to be taken if TFC services were determined a need. The monitoring mechanism will	3/1/24	Policy 3312	

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TFC services by contracting with TFC providers. The Plan did not furnish requested evidence of subcontracts with TFC providers. The Plan confirmed in an interview that TFC services were not provided due to the lack of a TFC providers within the County. The Plan also stated that due to a limited number of foster children within the County, the Plan did not perceive a need to contract with outside agencies for coordinated care. When the Plan does not contract with TFC providers, it cannot ensure the provision of medically necessary TFC services for children and youth in need of such services.	be a contract should the need for TFC arise.			

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1.2.4 ICC Strengths and Needs Reassessments **Finding:** The Plan did not ensure ICC and CFT strengths and needs reassessments were conducted every 90 days. Plan policy *3312 Consumer Care – ICC, IHBS and TFC Services* (*revised June 2023*), states that the Plan will collaborate with other agencies to provide coordinated care to beneficiaries and will ensure a CFT meeting is held; however, there is no statement if this meeting is held every 90 days, and as needed. Additionally, this policy does not state if the Plan's ICC coordinator and CFT conducts a reassessment of strengths and needs every 90 days	Revisions were made to Policy 3312 to address the assessment requirements every 90 days. Monitoring mechanism is to ensure that the task is completed is by the EHR.	3/1/24	Policy 3312	

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for beneficiaries receiving ICC services. The Plan stated in an interview that its staff participated in CFT meetings for children who received ICC services. These meetings were coordinated by an outside agency but there was minimal coordination to ensure compliance with the required timeframe for ICC reassessments. The Plan could not confirm if these CFT meetings were held every 90 days, and as needed. Failure to conduct reassessment meetings every 90 days may impact the Plan's ability to address children and youths' changing needs in a timely manner such as safety concerns, risk of placement				

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disruption, or ineffective support services.				
2.1.1 Referrals and Coordination of Care **Finding:** The Plan did not ensure to coordinate services furnished to beneficiaries with services the beneficiary receives from any other MCO. The Plan lacked written policies and procedures regarding intake, processing, and monitoring of referrals received from the MCO. Although the MOU addressed requirements for program oversight and referral procedures, the Plan did not implement its responsibility to coordinate care for referrals received from the MCO. The Plan	The Plan is currently working on a referral and coordination of care policy and procedure. Currently the Plan is using the Screening Tool to make referrals to the MCO and the Plan has only received 1 referral from the MCO which occurred after the date of the engagement.	6/30/24	Screening Tool Adult 2.1.1 and Screening Tool Child 2.1.1	

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did not maintain a log of referrals from the MCO. There was no evidence that the Plan conducted meetings with the MCO to conduct oversight and review the effectiveness of the MOU, that includes ensuring referrals are processed for medically necessary services. In an interview, the Plan explained that small staff size and staffing shortages contributed to difficulties in fully implementing the MOU. The Plan explained that its attempts to arrange for joint meetings with the MCO was unsuccessful and that there were no joint meetings held during the audit period. The Plan also expressed a lack of understanding regarding the referral of beneficiaries to the MCO for lower levels				

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of care and ongoing services when medical necessity criteria for SMHS were no longer met. When the Plan does not fully implement its MOU by not processing and tracking MCO referrals, this can lead to poor coordination of care that may result in poor health outcomes if the provision of behavioral health services is missed or delayed.				
4.2.1 SMHS Access Information **Finding**: The Plan did not ensure its 24/7 access line system provided information on how to access SMHS and information on services needed to treat a	The Plan has provided Corrective Action Plans to the 24/7 Access Line provider. In addition, the Plan now monitors the internal line by reviewing the phone line bill and the calls that were entered into the 24/7 access log.	10/1/23	2309 24.7 Access Line-Toll Free Number and Tracking	

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beneficiary's urgent condition. DHCS conducted seven test calls to the Plan's statewide 24/7 toll-free number. Of the seven test calls made, three calls did not provide information about how to access SMHS, and two calls did not provide information needed to treat a beneficiary's urgent condition. Although the Plan's policy *2309* required that its 24/7 access line system inform beneficiaries with the obligatory SMHS access information, the Plan did not have an adequate monitoring system to ensure beneficiaries received the necessary SMHS access information. The Plan maintained its 24/7 access line internally				

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during normal business hours and utilized a contracted provider for after-hour services. The Plan conducted internal test calls monthly and utilized the result data for staff training; however, the Plan did not have a process to monitor its after-hours contracted provider. In an interview, the Plan acknowledged it did not have a process to monitor its after-hours contracted provider to ensure that required access information was provided to beneficiaries calling the 24/7 access line. When the Plan does not monitor to ensure the provision of information for access to care, beneficiaries may not receive necessary details to make informed decisions. This can result				

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in poor mental health outcomes due to missed or delayed access to necessary behavioral health services. **This is a repeat finding of the prior review (Fiscal Year 2019/2020) – D.VI.B1-4 – 24/7 Access Line Information**				
4.2.2 Access Call Log **Finding:** The Plan did not log nor include all required log data for beneficiary calls requesting information on SMHS access. In a verification study, seven test calls were made to the Plan's 24/7 access line. Calls were made requesting information on SMHS access. Subsequent	The Plan has provided Corrective Action Plans to the 24/7 Access Line provider. In addition, the Plan now monitors the internal line by reviewing the phone line bill and the calls that were entered into the 24/7 access log.	10/1/23	2309 24.7 Access Line-Toll Free Number and Tracking	

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to the calls made, a review of the log showed that five of seven required test calls were not recorded in the Plan's written log for initial SMHS requests. The verification study also revealed that the written log did not include all required log data such as the beneficiary's name, request date, and the initial disposition of the request. Although the Plan's Policy *2309* addresses the contractual requirement to maintain a written inquiry log, it did not delineate all the required log data. In an interview, the Plan stated that it lacked oversight and monitoring to ensure adherence to written log requirements for initial SMHS requests. An inaccurate log of initial information requests for				

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SMHS can result in the Plan's inability to effectively monitor and track the request in order to provide timely access to behavioral health services. **This is a repeat finding of the prior review (Fiscal Year 2019/2020) – D.VI.C2. – SMHS Information Inquiry Log**				
6.1.1 Written Grievance Submission **Finding:** The Plan did not maintain processes to collect and accurately track grievances to meet timeframes for written log entries and acknowledgment letters. The timeframe for logging grievance entries and sending out of grievance	The Plan has implemented checking and tracking grievances on a daily basis.	8/15/23	Trinity SMHS FY 23-24 Evidence Tracker Triennial (Snippet of log)	

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acknowledgement letters is based on the grievance receipt date. In view of this premise, the Plan did not ensure timely grievance log entries and grievance acknowledgement letters due to inaccurate recording of the grievance receipt date and incomplete entries in the tracking log. Review of the Plan's grievance monitoring and tracking log revealed incomplete entries that lacked the date when grievances were received. Grievances from a submission box were retrieved once a week resulting in non-implementation of the Plan's policy to log grievances within one business day of the grievance receipt date.				

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In an interview, the Plan explained that because of the low number of grievances submitted by beneficiaries, the Plan checks and logs retrieved grievances from the submission box approximately once a week. In addition, the Plan acknowledged that it incorrectly interpreted the grievance receipt date as the collection date and not the date when the grievance was received by or submitted to the Plan. When the Plan does not accurately track grievances, this can cause a delay in the grievance process which can lead to delays in beneficiary access to necessary services				

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7.2.1 Provider Payment Suspension **Finding:** The Plan did not maintain procedures to ensure suspension of payments to network providers when there is a credible allegation of fraud. Although the Plan's policy *1004* addresses the commitment to comply with all applicable laws and regulations specific to program integrity and FWA, the policy did not delineate the process to identify providers with a credible allegation of fraud and how the Plan suspends payments to these providers. In an interview, the Plan confirmed it had no policies and procedures on how the Plan will suspend providers with	The Plan created policy 1010 to address FWA.	10/5/23	Policy 1010	

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credible allegations of fraud. When there are no processes to identify and suspend payments to network providers for which there are credible allegations of fraud, this could lead to financial losses to the Medi-Cal program that may impact the quality of health care.				
7.2.2 Whistleblower Protection Policy **Finding:** The Plan did not maintain policies that detailed information regarding the False Claims Act and employees' rights to be protected as whistleblowers. In an interview, the Plan acknowledged it does not	The Plan created policy 1011 for Whistleblower Protection	10/5/23	Policy 1011	

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maintain policies that outline the requirement regarding employee rights to protection as whistleblowers. The Plan provided multiple policies throughout its system of care specific to program integrity and FWA; however, the polices did not delineate the False Claims Act and protection of whistleblowers. Failure to implement policies about the False Claims Act and employee whistleblower protection may result in FWA going unreported or limit employee whistleblowing due to fear of retaliation.				
7.2.3 Recovery of FWA Overpayment **Finding:** The Plan did not maintain a process for	The Plan has written into its provider contracts that "If the Contractor identifies an issue or receives notification of a compliant concerning an	10/5/23	Policy 1010	

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identifying and recovering overpayments due to FWA. Although, the Plan's policy *1008* ensures the reporting of suspected fraud, it did not delineate the requirement to identify and recover overpayments due to FWA. In addition, the Plan acknowledged in an interview that it does not have policies or procedures outlining this requirement. Failure to implement a system designed to identifying and recover overpayments due to FWA may result in misuse of state funding towards fraudulent services.	incident of potential fraud, waste, or abuse, in addition to notifying the County, the Contractor shall conduct an internal investigation to determine the validity of the issue/compliant, and develop and implement corrective action, if needed." The Plan created policy 1010 to address FWA.			

Submitted by: [Plan's Signature on File]

Title: [Insert Name], [Insert Title]

Date: Click or tap to enter a date.