MEDICAL REVIEW - SOUTHERN SECTION II
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

Ventura County Medi-Cal
Managed Care Commission
dba: Gold Coast Health Plan

Contract Number: 10-87128

Audit Period: April 1, 2016
Through
March 31, 2017

Report Issued: March 23, 2018

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I. INTRODUCTION

The audit report represents the findings from the medical audit of Gold Coast Health Plan and their establishment of a County Organized Health Care System (COHS) Managed Care contract for Ventura County with the State of California.

The Medical Review Branch conducted a full scope review of the requirements in Gold Coast's Medi-Cal contract (10-87128). The purpose of the review was to determine if the Plan was in compliance with the Medi-Cal contract, other applicable laws, and regulations. Evaluation of the Plan's compliance were performed with the contract and regulations in the area of Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

In April 2010, the Ventura County Medi-Cal Managed Care Commission (Governing Body) was established as an independent oversight entity to provide health care services to Medi-Cal recipients under the business name of Gold Coast Health Plan (Plan). A contract between the COHS and the Department of Health Care Services (DHCS) was approved on June 20, 2011. The Plan began serving local Members as a Managed Care Plan on July 1, 2011.

Medi-Cal is the Plan's only line of business. As of July 2017, the Plan served approximately 207,000 Members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical review audit for the review period April 1, 2016 through March 31, 2017. The on-site review was conducted from Monday, June 5, 2017 through Friday, June 16, 2017. The audit consisted of document review, verification studies, and interviews with the Plan's personnel.

An Exit conference was held on February 22, 2018 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted supplemental information after the Exit Conference which is reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Members' Rights, Quality Management, and Administrative and Organizational Capacity.

The summary of the findings by category is as follows:

Category 1 – Utilization Management

No findings.

Category 2 – Case Management and Coordination of Care

The Plan is required to monitor and ensure the coordination of services and joint case management between its primary care providers, the California Children's Services (CCS) specialty providers, and local CCS programs. The Plan did not ensure the coordination of services for their medical home teams. In some instances, the Plan identified the wrong Primary Care Provider assigned to the Medical Home team in their CCS Service Authorization Requests (SAR's) which can cause possible delay in providing needed services to members. The PCP coordinates all medical care with the team with the common goal of the Member's good health.

The Plan is responsible for the provision of Behavior Health Treatment (BHT) services as a managed care benefit, including the coordination of the Member's care with their Regional Center and BHT provider. The Plan did not ensure the appropriate access, coordination of care and collaboration of Behavioral Health Treatment (BHT) program services. There was no documentation to demonstrate the coordination and provision of services with other entities and/or healthcare professionals to ensure that covered services and support are provided to Members of the program, as well as avoid any duplicative services.

Category 3 – Access and Availability of Care

No findings.

Category 4 – Member's Rights

No findings.

Category 5 – Quality Management

During the 2015-2016 audits, DHCS made a recommendation to develop an effective monitoring system of Provider training. We verified the Plan has developed and implemented a new system to track training, ensuring the training is initiated within 10 days after the execution of the new Provider contract and completed within 30 days from the onset of the training. Based on our review, it appears that Plan's new system successfully addresses the 2015-2016 finding. No repeat findings were identified for the 2016-2017 audit.

Category 6 – Administrative and Organizational Capacity

No findings.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The Department of Health Care Services, (DHCS) Medical Review Branch conducted this audit to ascertain that the medical services provided to Plan Members comply with Federal and State laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

The on-site review was conducted from June 5, 2017 through June 16, 2017. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Interviews were conducted with the Plan's administrators and staff, as well as review of documentations.

The following verification studies were performed:

Category 1 – Utilization Management

Prior Authorization: Ten (10) medical and ten (10) pharmacy prior authorization requests were reviewed appropriately for medical necessity, consistent application of criteria, and timeliness.

Appeal Procedures: Ten (10) prior authorization appeals were reviewed to ensure that required timeframes are met and appeals are appropriately routed and adjudicated.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): Ten (10) medical records were reviewed for evidence of Coordination of Care between the Plan and CCS Providers.

Initial Health Assessment: Twenty (20) medical records were reviewed for completeness and timely completion.

Behavioral Health Treatment (BHT): Ten (10) medical records were reviewed for evidence of Coordination of Care and collaboration between the provider and member.

Category 3 – Access and Availability of Care

Emergency Service Claims: Ten (10) emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: Ten (10) family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: Ten (10) grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

A description of the findings for each category is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS ❖	
AUDIT PERIOD: April 1, 2016 through March 31, 2017	DATE OF ONSITE AUDIT: June 5, 2017 through June 16, 2017

CATEGORY 2 –CASE MANAGEMENT AND COORDINATION OF CARE	
2.2	CALIFORNIA CHILDREN'S SERVICES

California Children's Services (CCS):

A. Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS eligible conditions to the local CCS program…. (as required by Contract)
   1) Ensure that Contractor's Providers perform appropriate baseline health assessments and diagnostic evaluations which provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS-eligible medical condition;
   2) Assure that contracting Providers understand that CCS reimburses only CCS-paneled Providers and CCS-approved hospitals within Contractor's network; and only from the date of referral;
   3) Enable initial referrals of Member's with CCS-eligible conditions to be made to the local CCS program by telephone, same-day mail or FAX, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.
   4) Ensure that Contractor continues to provide all Medically Necessary Covered Services to the Member until CCS eligibility is confirmed.
   5) Ensure that, once eligibility for the CCS program is established for a Member, Contractor shall continue to provide all Medically Necessary Covered Services that are not authorized by CCS and shall ensure the coordination of services and joint case management between its Primary Care Providers, the CCS specialty Providers, and the local CCS program.
   6) If the local CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary Covered Services to the Member. If the local CCS program denies authorization for any service, Contractor remains responsible for obtaining the service, if it is Medically Necessary, and paying for the service if it has been provided.

B. Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program…for the coordination of CCS services to Members.

COHS Contract A.11.10.A, B

SUMMARY OF FINDINGS:

2.2.1 Coordination of services and joint case management between its Primary Care Providers, CCS Specialty Providers and local CCS program.

The Plan shall monitor and ensure the coordination of services and joint case management between its Primary Care Providers, the California Children's Services (CCS) Specialty Providers, and the local CCS program. *Contract, Exhibit A, Attachment 11.10.A (5).*

The Plan's manual, Care Management Coordination of Care-Matching the Medical Home, outlines and recognizes the importance of Member assignments to their Medical Home and Primary Care Provider (PCP). Medical Home is the Plan's description of the team-based approach they use for Member care. The PCP coordinates all medical care with the team, usually consisting of the Member, family, Primary Physician, and Specialists who all work toward the common goal of the Member's good health.

Samples of California Children's Services (CCS) eligible Members' medical records were reviewed in a verification study. The study revealed that seven (7) of the ten (10) medical records revealed different Primary Care Providers (PCP) listed by the Plan from their medical homes as identified in their Service Authorization Request (SAR). The Plan stated that if discrepancies were noted during their CCS review for eligibility, steps are taken by staff to correctly match the Medical Home. The Plan does not verify that the updated information of Member's Primary Care Provider is documented on the Service Authorization Request.

If a member's PCP documented in the Plan's system is different from the Medical Home in the Service Authorization Request, it can cause potential problems in collaboration for joint case management and communications in reaching the intended provider. The confusion can negatively affect team communication, referrals, and create system barriers to needed services.

RECOMMENDATION:

2.2.1 Develop monitoring to ensure consistency in the identification of the Primary Care Provider and Medical Home team for efficient provision of services and case management of Members.

2.6	BEHAVIORAL HEALTH TREATMENT (BHT)

Provision of Behavioral Health Treatment (BHT) services for individuals under 21 years of age:

EPSDT Services for Members under Twenty-One (21) Years of Age
Contractor shall cover and ensure the provision of screening, preventive, and Medically Necessary diagnostic and treatment services for Members under 21 years of age, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services. Contractor shall ensure appropriate EPSDT services are initiated as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.
COHS Contract A.10.5

Comprehensive Case Management Including Coordination of Care Services
Basic Case Management Services are provided by the Primary Care Provider, in collaboration with the Contractor and shall include Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies.
COHS Contract A.11.2(A)(6)

Responsibilities for BHT Coverage for Children diagnosed with ASD.
The Plan is responsible for the provision of EPSDT services to include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavior Analysis (ABA) and other evidence-based interventions, professional services, and treatment programs that help prevent or minimize the adverse effects of Autism Spectrum Disorder (ASD), and promote, to the maximum extent practicable, the functioning of a Member with ASD.

All children must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. When a screening exam indicates the need for further evaluation of a child’s health, the child must be referred for medically necessary diagnosis and treatment without delay.

❖ COMPLIANCE AUDIT FINDINGS ❖	
PLAN: GOLD COAST HEALTH PLAN	
AUDIT PERIOD: April 1, 2016 through March 31, 2017	DATE OF ONSITE AUDIT: June 5, 2017 through June 16, 2017

In accordance with existing Medi-Cal contracts, MCPs are responsible for the provision of EPSDT services for beneficiaries under 21 years of age (see APL 14-017). To conform to the federal EPSDT requirements, MCPs must:

1) Inform Members that EPSDT services are available for Members under 21 years of age;
2) Provide access to comprehensive screening and prevention services in accordance with the most current Bright Futures periodicity schedule including, but not limited to, a health and developmental history, a comprehensive unclothed physical examination, appropriate immunizations, lab tests, and lead toxicity screening, at designated intervals or as necessary if circumstances suggest variations from normal development.
3) Provider access to Comprehensive Diagnostic Evaluation (CDE) based upon recommendation of a licensed physician and surgeon or a licensed psychologist for treatment of ASD including all medically necessary services, including but not limited to, BHT services.

All Plan Letter 15-025

SUMMARY OF FINDINGS:

2.6.1 Requirements of Ensuring Coordination of Care, per APL 15-025 and the Memorandum of Understanding.

The Contract requires that the Plan cover and ensure the provision of screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 year of age, including EPSDT supplemental services.

The Plan is also responsible for the provision of Behavior Health Treatment (BHT) services as a managed care benefit, including the coordination of the Member's care with their Regional Center and BHT provider. Tri-Counties Regional Center will support the Plan's care coordination by providing necessary Member information to the Plan and its subcontracted providers and vendors (Memorandum of Understanding with Tri-Counties Regional Center). The Memorandum of Understanding sets forth the structure for the sharing of Member information to promote shared understanding of the medically necessary Behavior Health Treatment (BHT) services and ensure appropriate access.

In accordance with existing Medi-Cal contracts, the Plan is responsible for the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for beneficiaries under 21 years of age. To conform to the federal EPSDT requirements, the Plan must provide access to comprehensive diagnostic evaluation based upon a recommendation of a licensed physician and surgeon or a licensed psychologist for the treatment of Autism Spectrum Disorder including all medically necessary services, including but not limited to, BHT services (All Plan Letter 15-025).

Ten (10) of ten (10) Members' medical records were reviewed in a verification study. The study found insufficient documentation demonstrating the coordination of care between Primary Care Providers (PCP), Specialist, BHT Providers and Members. Onsite interviews with Plan providers found they had referred Members to BHT Providers and/or Specialist to assess, diagnose and recommend an appropriate treatment plan designed specifically for the Member. However, the PCP and Member did not receive any information from the Plan, BHT providers, or Specialist communicating the outcome/decisions of referrals. The Plan failed to demonstrate the collaboration and coordination of medically necessary BHT services.

Coordination of care between everyone involved in the patient's care is important to help promote a healthy and active lifestyle in order to treat the core symptoms of Autism and strive for the best outcomes.

The lack of documented care coordination between the PCPs, Specialists and BHT Providers may cause potential risk to Member care. The sharing of Member data, reports and intervention plans are critical to coordinating care and assisting Providers and Members to make informed health decisions.

RECOMMENDATIONS:

2.6.1 Ensure that there is coordination of care and collaboration communicated between the different Providers of the Members for efficient coordination of rendered services.

MEDICAL REVIEW - SOUTHERN SECTION II
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

Ventura County Medi-Cal Managed Care Commission dba: Gold Coast Health Plan

Contract Number: 10-87129
State Supported Services

Audit Period: April 1, 2016
Through
March 31, 2017

Report Issued: March 23, 2018

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II. COMPLIANCE AUDIT FINDINGS 2

INTRODUCTION

The audit report presents the findings of the contract compliance audit of Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan and its implementation of the State Supported Services contract No. 10-87129 with the State of California. The State Supported Services contract covers abortion services for Gold Coast Health Plan.

The onsite audit of the Plan was conducted from Monday, June 5, 2017 through Friday, June 16, 2017. The audit covered the review period from April 1, 2016 through March 31, 2017 and consisted of a document review of materials provided by the Plan.

□ COMPLIANCE AUDIT FINDINGS (CAF) □	
PLAN: Gold Coast Health Plan	
AUDIT PERIOD: April 1, 2016 through March 31, 2017	DATE OF AUDIT: June 5, 2017 through June 16, 2017

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS
Abortion *Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:* *Current Procedural Coding System Codes*: 59840 through 59857* *HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336* **These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.* *State Supported Services Contract Exhibit E.1*

SUMMARY OF FINDINGS:

Plan Policy # CL-007, states Gold Coast Health Plan (GCHP) will reimburse providers for Abortion services without the requirement of an authorization when the services are performed on an outpatient basis. Inpatient hospitalization for the performance of an abortion requires prior authorization under the same criteria as other medical procedures. All the required billing procedure codes are included in the policy.

Processing Guidelines states that a claim billed with a sensitive service diagnosis code may not be subject to normal authorization guidelines.

Member Handbook indicates that family planning and sensitive services are a benefit provided to members. PCPs and OB/GYN specialists are available to assist members in obtaining these services.

The Plan is in compliance to meet the contractual requirements.