

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: December 1, 2013
Through
November 30, 2014

Report Issued: September 25, 2015

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I. INTRODUCTION

On June 2, 2009, the Ventura County Board of Supervisors authorized the establishment of a County Organized Health Care System (COHS). This action began the transition of the County's Medi-Cal delivery system from the Fee for Service model to a managed care health plan model by approving a County Organized Health Care System (COHS).

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 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 February 2015, the Plan served approximately 183,129 Members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period December 1, 2013 through November 30, 2014. The on-site review was conducted from February 17 through 27, 2015. The audit consisted of a documents review, verification studies, and interviews with the Plan's personnel.

An Exit Conference was held on July 8, 2015 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 finding. 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 are as follows:

Category 1 – Utilization Management

Notices of Action letters for Prior Authorization were not sent to all Members.

The Plan's Policy does not specify that the written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Plan's group needs assessment and approved by DHCS.

Category 2 – Case Management and Coordination of Care

The Plan lacked a monitoring system to ensure that Members who are eligible for Case Management receive these services and that coordination of care occurs between the Primary Care Providers and Specialty Providers. In addition, the Plan lacked a monitoring system to ensure that there is Continuity of Care for Members with their Primary Care Providers.

The Plan lacked an effective monitoring and tracking system to ensure that all Members eligible for California Children's Services receive Case Management. In addition, there was no effective system to monitor coordination of care between Primary Care Providers and specialty providers.

The title and purpose of the Plan's Policy on Early Intervention/Developmental Disabilities lacked consistency with the language. In addition, the Plan lacked a monitoring system to ensure that the Early Intervention/Developmental Disabilities Members receive primary care services and coordination of care between Primary Care

Providers and specialists.

The Plan did not perform oversight for Initial Health Assessment compliance. In addition, the medical records lacked documentation of repeated attempts to reach the Member for completion of the Initial Health Assessment

Category 3 – Access and Availability of Care

The Plan did not develop procedures to monitor Member waiting times in the providers' offices and did not include the procedures in the Plan's Policies. In addition, the Plan's Policy did not state that Members should not be required to travel more than 10 miles or 30 minutes from the Members' residence for an appointment. Also, the Member Handbook did not indicate the timeframe of the initial prenatal care appointment as stated in the Plan Policy. Furthermore, the Provider Directory includes outdated provider contact information.

Provider Manual and Member Handbook does not indicate that Members needing Urgent Care Services are seen within 24 hours upon request.

The Plan does not follow their Policies which require a Corrective Action Plan from the Health Networks for deficiencies or non-compliance.

The Plan did not monitor the subcontractor to ensure timely and proper payment of claims. The Plan's Policies for Emergency Services and Family Planning claims do not indicate that the Plan pay 90 percent of all clean claims within 30 days of the date of receipt and 99 percent of all clean claims within 90 days as required by the Contract. In addition, the Plan's Policy does not indicate that misdirected Emergency Services and Family Planning claims received by the Plan will be re-directed to the appropriate payer of service within ten (10) working days.

The Plan did not implement an effective monitoring system to ensure Member access to at least a 72-hour supply of medically necessary drugs in an emergency situation.

Category 4 – Member's Rights

The Plan does not follow its policies and procedures which require the Plan to maintain and process grievances in a timely manner.

The Plan's Policy does not indicate that the discovery of a security incident and investigation of a security incident or breach be submitted to the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer within the required timeframe as required by the Contract. In addition, the Plan did not submit such notifications to required DHCS personnel in a timely manner.

Category 5 – Quality Management

The Governing Body did not exercise its responsibility for the QI Program. There were no regular QI reports sent to the Governing Body; and the QI Committee did not report directly to the Governing Body. The Plan did not regularly revise its QI Policies to reflect current practices and policies.

The Plan lacked oversight of credentialing activity and review of credentialing policies by all committees tasked with their responsibility.

The Plan's Program Description lacked its QI Services activities as required by the Contract. In addition, the Plan lacked adequate accountability between the QI system and its Governing Body.

The Plan did not maintain a system to ensure accountability for delegated Quality Improvement activities as required by the Contract.

The Plan's Policy does not include the contractual requirements of internal monitoring procedures and the Plan's implementation of the written procedures of securing medical records at each site. In addition, the Plan lacked an effective system of assigning and tracking Members to their Primary Care Providers.

Category 6 – Administrative and Organizational Capacity

The Plan's Policy does not include the contractual requirement to conduct training to all new providers within the timeframe. In addition, the Plan did not develop a monitoring system to ensure that the newly contracted provider initiate the training within ten (10) working days of being placed on active status and shall complete the training within 30 calendar days.

The Plan did not report suspected fraud and abuse cases to DHCS within the required timeframe.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS) Medical Review Branch 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 February 17 through 27, 2015. 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. Documents were reviewed and interviews were conducted with the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 26 medical and 20 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review by the Plan.

Appeal Procedures: 33 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): 5 medical records were reviewed for evidence of Coordination of Care between the Plan and CCS Providers.

Individual Health Assessment: 19 medical records were reviewed for completeness and timely completion.

Category 3 – Access and Availability of Care

Emergency Service Claims: 65 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 30 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member’s Rights

Grievance Procedures: 54 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Category 5 – Quality Management

Medical Records: 8 providers were interviewed to ensure that the providers are delegated the responsibility of securing and maintaining medical records at each site. Also the Plan’s policies and procedures were reviewed for completeness.

Category 6 – Administrative and Organizational Capacity

New Provider Training: 15 new provider training records were reviewed for timely Medi-Cal Managed Care program training.

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

❖ COMPLIANCE AUDIT FINDINGS ❖

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CATEGORY 1 - UTILIZATION MANAGEMENT

1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures:

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements... (as required by Contract)

COHS Contract A.5.2

Exceptions to Prior Authorization:

Prior Authorization requirements are not applied to Emergency Services, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

COHS Contract A.5.2.G

Timeframes for Medical Authorization:

Pharmaceuticals: 24 hours or one (1) business day on all drugs that requires prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1).

COHS Contract A.5.3(F)

Notification of Prior Authorization Denial, Deferral, or Modification:

Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative... This notification must be provided as specified in Title 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.

COHS Contract A.13.8.A

SUMMARY OF FINDINGS:

Gold Coast Health Plan (Plan) has a well-described system for processing Prior Authorizations with the appropriate staffing for front-line and supervisory functions. Services such as emergency care and family planning are provided without need for authorization according to the contract. The Plan use well-described and accepted clinical guidelines for the determination of medical necessity. The Plan regularly performs Inter Rater Reliability studies. The appropriate medical professionals render decisions on all cases reviewed.

The Plan's Policy # HS-001, Prior-Authorization Requests, defines the process by which the Plan performs pre-authorization activities. Denials or modifications to Prior Authorization requests were made by a Medical Director or Licensed Pharmacist. Reasons for decisions were clearly documented. Decisions and resolutions of appeals are timely and not unduly delayed for medical conditions requiring time sensitive services. In addition, the Policy states that the Plan notifies the Members through written Notice of Action letters. Furthermore, the Policy states that the decisions are made within 24 hours on all drugs that require Prior Authorization.

The Plan complied with written Member notifications of denied, deferred, or modified Prior Authorization requests as specified in CCR, Title 22, sections 51014.1, 51014.2, and 53894, and Health and Safety Code section 1367.01.

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A verification study was performed on a total of forty-six (46) Prior Authorizations which included twenty-six (26) medical services and twenty (20) pharmacy Prior Authorizations. Based on the review, two (2) medical Prior Authorizations lacked a Notice of Action Letter.

RECOMMENDATION:

Verify that all Members receive written Notice of Action letters for Prior Authorizations.

❖ COMPLIANCE AUDIT FINDINGS ❖

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1.4

PRIOR AUTHORIZATION APPEAL PROCESS

Appeal Procedures:

There shall be a well-publicized appeals procedure for both providers and patients.

COHS Contract A.5.2.D

Written Member Information:

Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Contractor's group needs assessment and approved by DHCS.

COHS Contract A.13.4.C

SUMMARY OF FINDINGS:

The Plan has a well-organized process for logging and resolving appeals which is in accordance with contractual requirements.

The Plan's Policy # GA-002, Member Appeal Process, describes the Plan's timeframes for appeals processing: 45 days to process, acknowledgement notice to the Member of the appeal within 5 calendar days with extensions of up to 14 days if needed. The Plan's timeframe for expedited appeals: 45 days to process, resolve the appeals within 3 working days with extensions of up to 14 days if needed. However, the Policy does not include the language that the written information is provided to Members at a sixth grade reading level or as determined appropriately through the Plan's group needs assessment and approved by DHCS. [COHS Contract Reference: A.13.4.C]

A total of thirty-three (33) appeals were reviewed. The review disclosed that appeals were processed within the appropriate timeframes by a physician using evidence based guidelines. However, six (6) resolution letters contained languages that were either vague or too high at a literacy level. [COHS Contract Reference: A.13.4.C]

RECOMMENDATIONS:

1. Update Policy # GA-002, Member Appeal Process, to include the language that written information is provided to Members at a sixth grade reading level or as determined appropriately through the Plan's group needs assessment and approved by Department of Health Care Services.
2. Verify that resolution letters are at the appropriate literacy level.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1

CASE MANAGEMENT AND COORDINATION OF CARE: WITHIN AND OUT-OF-PLAN

Case Management and Coordination of Services:

Contractor shall ensure contracted providers provide basic comprehensive Medical Case Management to each Member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the member.
COHS Contract A.11.1

Out-of-Plan Case Management and Coordination of Services:

Contractor shall implement procedures to identify individuals who may need or who are receiving services from out-of-plan providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services...

COHS Contract A.11.4

SUMMARY OF FINDINGS:

The Plan has policies and procedures for the Coordination and Continuity of Care for the Members. The Plan is required to ensure the provision of Comprehensive Medical Case Management Services to each Member. These services are provided through either Basic or Complex Case Management activities, based on the medical needs of the Member.

The Plan Policy # HS-013, Coordination of Care, describes the Plan's Coordination of Care responsibilities and implementation plan. In addition, this Policy describes that the Plan's PCPs understand the importance of their role in care coordination, provider training and provider bulletins, and other means of communication.

The Plan Policy # HS-037, Tracking Referrals to Specialists, describes the Plan's process for monitoring specialty utilization both in and out of network.

The Plan conducts Facility Site Reviews (FSR) with their providers. Although, the FSRs determine if there is documentation for Coordination and Continuity of Care for Members, this function could not be confirmed at the Provider level. Interviews with the providers disclosed that there is lack of Continuity of Care. When a Member disenrolls and then re-enrolls or if they change their Health Plan, there is no system in place to enroll the Members back with their prior or current Primary Care Providers. In addition, previous referrals and consultations with specialists could not be followed through. Therefore, this leads to a lack of Coordination of Care for Members that are not re-assigned back to the providers.

Although the Plan has written policies and procedures for provision of Case Management and Coordination of Care both within and outside the network, the Plan lacks documentation for monitoring and tracking Members who receive these services.

❖ COMPLIANCE AUDIT FINDINGS ❖

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RECOMMENDATIONS:

1. Develop a monitoring and tracking system to ensure that accessibility and Coordination of Care occur between the Primary Care Providers and Specialists.
2. Strengthen the Plan's system to ensure that there is Continuity of Care for Members with their Primary Care Providers. This implementation includes the development of an effective process in the assignment of new Members, so that established Members can be re-directed to their own Primary Care Providers.

❖ COMPLIANCE AUDIT FINDINGS ❖

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2.2

CALIFORNIA CHILDREN'S SERVICES

California Children's Services (CCS):

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)

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

COHS Contract A.11.8.A, B

SUMMARY OF FINDINGS:

The Plan's Policy # HS-039, California Children's Services Coordination, defines guidelines for coordination of care between the Plan and California Children Services (CCS). The Care Management Coordination Job Aid Manual (JAM) defines guidelines and processes for Coordination of Care activities included within the Care Management process. It also describes the process of facilitating the transition of Members from CCS paneled pediatric providers to the Plan's adult providers. In addition, the CCS Workflow defines the process on how children identified with potential CCS eligible conditions will be referred to CCS by the facility or provider and that the Plan will assist with the referral process as necessary.

A Memorandum of Understanding (MOU) between California Children Services (CCS) Program and the Plan is in place. The parties agree and understand that the responsibility for performance of certain services under the Agreement will be shared by both parties. The MOA addresses each party's responsibility.

A review of five (5) medical records disclosed a lack of documentation which includes:

- All 5 Members were not included on the Complex Case Managed Members List. No documentation that Case Management notes were reviewed. In addition, they lacked documentation of Coordination of Care between the PCP, CCS specialty providers and the local CCS program
- One (1) medical record lacked documentation for follow-up or results of referrals
- One (1) medical record had no documentation after the enrollment date
- One (1) medical record documented multiple re-assignment dates to different providers and therefore, IHA was not completed within the timeframe.
- One (1) Member had no IHA documentation. The Member was more than 21 years old, but still included on the CCS eligible member list. No documentation for a CCS eligible condition was found in the medical record.

The Plan has the responsibility to ensure that Members with CCS-eligible conditions are referred in a timely manner to the CCS program, continue to provide medically necessary covered services not authorized by CCS and document Coordination of Care and Case Management between the Member's Primary Care Providers, CCS specialty providers, and the local CCS program.

RECOMMENDATION:

Verify that all CCS-eligible Members are monitored and tracked for Case Management and that Coordination of Care between Primary Care Providers and specialty providers occur and is documented.

❖ COMPLIANCE AUDIT FINDINGS ❖

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2.3

EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITIES

Services for Persons with Developmental Disabilities:

Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.

Contractor shall provide all screening, preventive, Medically Necessary, and therapeutic Covered Services to Members with developmental disabilities. Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall monitor and coordinate all medical services with the Regional Center staff, which includes identification of all appropriate services, which need to be provided to the Member.

Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers...for the coordination of services for Members with developmental disabilities.

COHS Contract A.11.9.A, B, D

Early Intervention Services:

Contractor shall develop and implement systems to identify children under three (3) years of age who may be eligible to receive services from the Early Start Program and refer them to the local Early Start Program

Contractor shall collaborate with the local Regional Center or local Early Start Program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start Program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start Program, with Primary Care Provider participation.

COHS Contract A.11.10

SUMMARY OF FINDINGS:

The Plan's Policy # HS-015, Case Management for Members under 21, states that the purpose is to define the process of referral for Members under the age of 21 years that require Regional Center services. It only outlines the process of referral for Members less than 3 years of age identified as with or at risk for developmental delay or disabilities. The title and the purpose should be modified to adapt to the meaning or content of the Policy.

In addition, the Policy # HS-015, Case Management for Members under 21, made reference to MMCD Letter 97-02. Letter 97-02 from Department of Health Services (DHS) refers to Participation of Foster Care and Adoption Assistance Program for Children in Medi-Cal Managed Care. Use of DHS Letters and APLs are encouraged as guidance in the development of policies and procedures for contracted Health Plans, but the Plan needs to ensure that the correct document is referenced.

Furthermore, this Policy # HS-015, Case Management for Members under 21, also states that the Plan will develop a plan for notification of Primary Care Provider for Members receiving services for Developmentally Disabled Members pending reports from the Regional Center. However, based on the interview with the Providers, the assessment and referral of Members to the Tri-County Regional Center (TCRC) is conducted through a vendor. The providers did not receive notification from the Plan of Members receiving services for the Developmentally Disabled.

❖ COMPLIANCE AUDIT FINDINGS ❖

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The Memorandum of Understanding between the Plan and TCRC delineates the responsibilities of the Plan and the Regional Center in the coordination of services for Members with Developmental Disabilities.

Interview with TCRC revealed that there was only one Mental Health Provider in Ventura County who is no longer available. There are no other providers to take care of their Members. The providers also acknowledged during the interview that referrals from the Plan's Delegated Entity takes at least three months and when the provider or Member attempts to schedule an appointment, it takes additional time or the specialist is unavailable for new Members.

The Plan lacked a monitoring system with their Primary Care Providers for Coordination of Care and provision of medically necessary covered diagnostic, preventive and treatment services for its Members with EI/DD conditions.

RECOMMENDATIONS:

1. Update Policy # HS-015, Case Management for Members under 21, to ensure that it defines the meaning or content of the policy.
2. Use the correct DHCS Letters and APLs as references for guidance in the development of policies and procedures.
3. Review and strengthen procedures for the identification of EI/DD eligible Members and develop a monitoring system to ensure that the EI/DD eligible Members receive primary care services and that coordination of care occurs between Primary Care Providers and EI/DD specialists.
4. Ensure that EI/DD eligible Members receive referrals and consultation services including treatments in an efficient and timely manner.

❖ COMPLIANCE AUDIT FINDINGS ❖

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2.4

INITIAL HEALTH ASSESSMENT

Provision of Initial Health Assessment:

Contractor shall cover and ensure the provision of an IHA (complete history and physical examination)...to each new Member within 120 days of enrollment.

COHS Contract A.10.3.A

Contractor shall make repeated attempts, if necessary, to contact a Member and schedule an IHA.....(as required by Contract)

COHS Contract A.10.3.E

Provision of IHAs for Members under Age 21:

- 1) For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 120 calendar days following the date of enrollment or within the most recent periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two (2) and younger, whichever is less.
- 2) For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

COHS Contract A.10.4

Services for Adults Twenty-One (21) Years of Age and Older:

Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

COHS Contract A.10.5

SUMMARY OF FINDINGS:

The COHS Contract requires the provision of an Initial Health Assessment (IHA) for each new Member within stipulated timelines and reasonable attempts to contact a Member to schedule an IHA be made and that all attempts be documented.

The Plan Policy # HE/CI-004, Initial Health Assessment and Individual Health Education Behavioral Assessment, describes the procedure that requires the provision of an IHA for each new Member. The Policy also describes that all Members receive an Initial Health Assessment (IHA) and an Individual Health Education Behavioral Assessment (IHEBA) within 120 calendar days of the effective date of enrollment in the Plan. The Policy further states that the Plan makes at least three attempts and document all attempts to perform an IHA at subsequent office visit(s) until all components of the IHA are completed.

The Plan provided an IHA Monitoring Report for the fourth quarter of 2014. The report indicated that Medical Record Review audits were performed to ensure that IHA's are being conducted within 120 days of the effective date as required by DHCS.

Based on interviews conducted with the providers at their provider sites, it was disclosed that the Plan lacked a monitoring and tracking system to confirm whether the IHAs were performed for the Members. In addition, the medical records lacked documentation of follow-up attempts to improve completion of the IHA. The Plan did not comply with IHA time requirements according to the contract. [COHS Contract Reference: A.10.3.E]

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The Plan monitored compliance for the timely provision of the IHA during the Facility Site Review (FSR). However, other than FSR, no other efforts were made to monitor IHA completion or evaluate completion rates.

Nineteen (19) Members medical records were sampled from the FSR and were reviewed for compliance with the IHA requirements. Based on this verification review, the following was disclosed:

- Five (5) medical records had the IHA completed within 120 days
- Two (2) medical records were not reviewed. One medical record did not belong to the Member selected and one record had no documentation post enrollment.
- Eleven (11) medical records had no documentation of the enrollment date
- Seventeen (17) medical records documented a comprehensive IHA

RECOMMENDATIONS:

1. Develop a process to effectively monitor completion of the Initial Health Assessment within the required timeframe.
2. Develop a system to ensure that repeated attempts to reach the Member for completion of the Initial Health Assessments are made and documented.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1

APPOINTMENT PROCEDURES AND WAITING TIMES

Appointment Procedures:

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, children’s preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

COHS Contract A.9.3.A

Prenatal Care:

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.

COHS Contract A.9.3.B

Waiting Times:

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers’ offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in Subprovision A, Appointments, above.

COHS Contract A.9.3.C

Time and Distance Standard:

Contractor shall maintain a network of Primary Care Physicians that are located within 30 minutes or ten (10) miles of a Member’s residence unless the Contractor has a DHCS approved alternative time and distance standard.

COHS Contract A.6.7

Written Member Information:

Compliance with the following may be met through distribution of a provider directory:

The name, National Provider Identifier (NPI) number, address and telephone number of each Service Location....

COHS Contract A.13.4.D.3

SUMMARY OF FINDINGS:

The Plan’s Policy # AA-001, Access and Availability Standards, addresses access and availability standards for appointment procedures, prenatal care visits, and waiting times. The Policy states that the appointment for the first prenatal visit must be scheduled within two weeks of Member’s request. Primary Care Providers are requested to monitor waiting times and adhere to standards in this Policy. However, the Plan did not monitor the Primary Care Providers for compliance with this Policy and Contract requirements. The Plan Policy # AA-004, After Hour Calls and Waiting Times, states that the Plan will periodically conduct office visits and/or telephone surveys to evaluate performance against access standards. The Plan did not monitor appointment procedures, prenatal care, or waiting times to ensure access standards were met.

According to the Plan personnel, the Plan monitors the wait time for Members at provider’s offices through Customer Service when a Member calls with issues, during Member orientation, Facility Site Reviews, the Grievance process, Health Services Department, and Provider Relations Department. The Plan does not have an effective system and procedures to ensure the monitoring of Member wait times in the providers’ offices as required by the Contract. [COHS Contract Reference: A.9.3.C]

❖ COMPLIANCE AUDIT FINDINGS ❖

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The Plan's Policy # AA-001, Access and Availability Standards, does not include the requirements to comply with the Contract which states, "The Plan shall maintain a network of Primary Care Physicians that are located within 30 minutes or ten (10) miles of a Member's residence unless the Contractor has a DHCS approved alternative time and distance standard." [COHS Contract Reference: A.6.7]

Member Handbook does not indicate that the appointment for the first prenatal visit must be scheduled within two weeks of Member's request as stated in the Plan Policy.

Fifteen providers were selected from the Plan's Provider Directory for the Access Verification Study. It was noted that the Provider Directory had improper contact information for six tested providers. According to the Plan personnel, the Provider Directory is updated monthly and posted on their website. As per the Contract, "Compliance with the following may be met through distribution of a Provider Directory: the name, National Provider Identifier (NPI) number, address and telephone number of each Service Location". [COHS Contract Reference: A.13.4.D.3]

RECOMMENDATIONS:

1. Follow the Plan Policies and implement an effective tracking system of appointment procedures, prenatal care visits, and waiting times to ensure the monitoring of Member wait times in provider offices.
2. Update Policy # AA-001, Access and Availability Standards, to ensure Members are not required to travel more than 10 miles or 30 minutes from the Members' residence.
3. Update Member Handbook to indicate that the appointment for the first prenatal visit must be scheduled within two weeks of Member's request.
4. Update the Provider Directory to ensure that Members have the correct contact information of their providers.

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3.2

URGENT CARE / EMERGENCY CARE

Urgent Care:

Contractor shall ensure that a Member needing Urgent Care is seen within 24 hours upon request.
COHS Contract A.9.3.E

Emergency Care:

Contractor shall ensure that a Member with an Emergency Condition will be seen on an emergency basis and that Emergency Services will be available and accessible within the Service Area 24-hours a day, 7-days a week.
COHS Contract A.9.6

Contractor shall have as a minimum a designated emergency service facility within the Service Area, providing care on a 24-hours a day, 7-days a week basis. This designated emergency service facility will have one or more Physicians and one (1) Nurse on duty in the facility at all times.
COHS Contract A.6.4

SUMMARY OF FINDINGS:

The Plan's Policy # AA-001, Access and Availability Standards, include criteria and standards for Urgent Care Services. The Policy states that urgent appointments should be available to Members the same day or within 24 hours of the call for an appointment. The requests are evaluated and the urgency is assessed based on the Member's medical problem and the need for urgent treatment. The Policy further indicates that Access and Availability standards are monitored through the Plan's Access and Availability studies.

The Provider Manual informs providers about the Plan's accessibility standards for Urgent Care services; however, the language for Urgent Care Services describes Urgent Care Services within 48 hours rather than within 24 hours as stated in the Plan Policy # AA-001.

The Member Handbook does not inform the Member needing Urgent Care is seen within 24 hours as stated in the Plan Policy # AA-001.

The Provider Manual and Member Handbook languages do not match their Policy.

RECOMMENDATION:

Update the Provider Manual and Member Handbook to state that Members needing Urgent Care Appointments should be seen within 24 hours.

❖ COMPLIANCE AUDIT FINDINGS ❖

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3.3

TELEPHONE PROCEDURES / AFTER HOURS CALLS

Telephone Procedures:

Contractor shall require providers to maintain a procedure for triaging Members' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

COHS Contract A.9.3.D

After Hours Calls:

At a minimum, Contractor shall ensure that a Physician or an appropriate licensed professional under his/her supervision is available for after-hours calls.

COHS Contract A.9.3.F

SUMMARY OF FINDINGS:

The Plan Policy # AA-001, Access and Availability Standards, describes the implementation of the any necessary Corrective Action Plans and follow-up when deficiencies were found.

The Plan Policy # AA-004, After Hour Calls and Waiting Times, establishes access standards and monitoring procedures for telephone procedures and after-hours calls. This Policy states the Plan will periodically conduct office visits and/or telephone surveys to evaluate performance against access standards. If deviation from the standard is found, the problem will be investigated with proper follow-up. The Policy further describes the implementation of Corrective Action Plan and follow-up when deficiencies were found. The Plan did not perform monitoring procedures as outlined in its Policy.

According to the Plan personnel, the Plan monitors non-compliant providers for further non-compliance and issues a formal Corrective Action Plan, if necessary. The results of the Provider Access Survey showed that letters were sent to each Health Network with deficiencies noted. The letter informed the networks that results were for information only, no corrective action was required.

The results of the Provider Access Survey were documented in the Quality Improvement Committee (QIC) meeting minutes. Based on QIC, Provider Relations monitors non-compliant providers for further non-compliance and will result in the issuance of a formal Corrective Action Plan.

RECOMMENDATION:

Ensure that the Plan follows their Policies which require a Corrective Action Plan from the Health Networks for deficiencies or non-compliance.

❖ **COMPLIANCE AUDIT FINDINGS** ❖

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3.5

EMERGENCY SERVICE PROVIDERS (CLAIMS)

Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization: (Claims)

Contractor is responsible for coverage and payment of emergency services and post stabilization care services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the plan....

COHS Contract A.8.12.A,C,D

For all non-contracting providers, reimbursement by Contractor or by a subcontractor who is at risk for out-of-plan Emergency Services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with provision 4, Claims Processing, above, and 42 USC Section 1396u-2(b)(2)(D).

COHS Contract A.8.12.E

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this provision, unless the contracting provider and Contractor have agreed in writing to an alternate payment schedule.

- A. Contractor shall comply with 42 USC Section 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39.
- B. Contractor shall pay 90 percent of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99 percent of all clean claims within 90 days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment.
- C. Contractor shall maintain procedures for prepayment and post payment claims review, including review of data related to provider, Member and Covered Services for which payment is claimed.
- D. Contractor shall maintain sufficient claims processing/tracking/payment systems capability to: comply with applicable State and Federal law, regulations and Contract requirements, determine the status of received claims, and calculate the estimate for incurred and unreported claims.
- E. Contractor shall submit claims payment summary reports to DHCS on a quarterly basis as specified in Exhibit A, Attachment 2, Provision 2. Financial Audit Reports Paragraph B. 2.

COHS Contract A.8.4

Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR Section 1300.67(g)(1).

COHS Contract A.9.6.A

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).

CCR, Title 28, Section 1300.71(g)

Claim Filing Deadline: For a provider claim involving emergency service and care, the plan shall forward the claim to the appropriate capitated provider within ten (10) working days of the receipt of the claim that was incorrectly sent to the plan.

CCR, Title 28, Section 1300.71(b)(A)

❖ COMPLIANCE AUDIT FINDINGS ❖

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SUMMARY OF FINDINGS:

The Plan's claims processing is subcontracted to the Xerox Company. The subcontractor submits weekly claim reports to the Plan.

The Plan's Policy # CL-005, Urgent/Emergency Services Claims Reimbursement, outlines the procedure for the clean claims containing all required information will be processed within 45 working days of receipt. Any claim that does not contain all the necessary information will be returned to the provider for correction. However, the Policy does not include that the Plan shall pay 90 percent of all clean claims are paid within 30 days of the date of receipt and 99 percent of all clean claims within 90 days as required by the Contract. [COHS Contract Reference: A.8.4]

The Plan's Policy # CL-005, Urgent/Emergency Services Claims Reimbursement, does not indicate how the payers are informed of any misdirected Emergency Services claims as required by California Code of Regulations, Title 28, section 1300.71(b)(A).

Sixty-five (65) Emergency Services claims were reviewed for appropriate and timely payment. Based on the review, forty-five (45) claims were processed outside the timeframe which includes: 12 claims that were incorrectly paid, 28 claims that were adjusted, and 5 claims that were initially denied. The Plan was not in compliance with the requirements as stated in COHS Contract Reference: A.8.4 and California Code of Regulations, Title 28, section 1300.71(g). **This is an ongoing finding.**

According to the Plan personnel, the processing of the claims is monitored by the review of the weekly claim report from the subcontractor. The review occurs after the claims are processed and adjustments are made to previously processed claims.

The Plan did not have proper monitoring mechanisms in place to detect an error for out-of network emergency services as required by the Contract. [COHS Contract Reference: A.8.4]

RECOMMENDATIONS:

1. Update Policy # CL-005, Urgent/Emergency Services Claims Reimbursement, to indicate that:
 - The Plan shall pay 90 percent of all clean claims are paid within 30 days of the date of receipt and 99 percent of all clean claims within 90 days as required by the Contract.
 - The misdirected Emergency Services claims are forwarded to the appropriate payer within ten (10) working days of receipt.
2. Verify that claims for Emergency Services are paid within the timeframe after the date of receipt by the Plan.
3. Improve monitoring claims processing to ensure out-of-network Emergency Services claims are paid in timely manner

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Gold Coast Health Plan

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3.6

FAMILY PLANNING (PAYMENTS)

Family Planning: (Payment)

Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate.... (as required by Contract)

COHS Contract A.8.8

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this provision, unless the contracting provider and Contractor have agreed in writing to an alternate payment schedule.

- A. Contractor shall comply with 42 USC Section 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39.
- B. Contractor shall pay 90 percent of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99 percent of all clean claims within 90 days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment.

COHS Contract A.8.4

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).

CCR, Title 28, Section 1300.71(g)

Claim Filing Deadline: (ii)...The plan within ten (10) working days of the receipt of the claim incorrectly sent to the plan shall forward the claim to the appropriate capitated provider.

CCR, Title 28, Section 1300.71(b)(B)

SUMMARY OF FINDINGS:

The Plan's claims processing is subcontracted to the Xerox Company. The subcontractor submits weekly claim reports to the Plan.

The Plan's Policy # CL-006, Sensitive Services and Family Planning Claims Reimbursement, outlines the procedure for the clean claims containing all required information will be processed within 45 working days of receipt. Any claim that does not contain all necessary information will be returned to the provider for correction. However, the Policy does not include that the Plan shall pay 90 percent of all clean claims are paid within 30 days of the date of receipt and 99 percent of all clean claims within 90 days as required by the Contract. [COHS Contract Reference: A.8.4]

The Plan's Policy # CL-006, Sensitive Services and Family Planning Claims Reimbursement, does not indicate how the payers are informed of any misdirected Family Planning claims as required by California Code of Regulations, Title 28, section 1300.71(b)(B).

❖ COMPLIANCE AUDIT FINDINGS ❖

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Thirty (30) Family Planning Services claims were reviewed for appropriate and timely payment. Based on the review, eight (8) claims were processed outside the timeframe as required by the contract. [COHS Contract Reference: A.8.4 and California Code of Regulations, Title 28, section 1300.71(g)]. **This is an ongoing finding.**

According to the Plan personnel, the processing of the claims is monitored by the review of the weekly claim report from the subcontractor. The review occurs after the claims are processed and adjustments are made to previously processed claims.

The Plan did not have proper monitoring mechanisms in place to detect an error for out-of network Family Planning claims as required by the Contract. [COHS Contract Reference: A.8.4]

RECOMMENDATIONS:

1. Update Policy # CL-006, Sensitive Services and Family Planning Claims Reimbursement, to indicate that:
 - The Plan shall pay 90 percent of all clean claims are paid within 30 days of the date of receipt and 99 percent of all clean claims within 90 days as required by the Contract.
 - The misdirected Family Planning services claims are forwarded to the appropriate payer within ten (10) working days of receipt.
2. Verify that claims for Family Planning Services are paid within the timeframe after the date of receipt by the Plan.
3. Improve monitoring of claims processing to ensure out-of-network Family Planning claims are paid in timely manner.

❖ COMPLIANCE AUDIT FINDINGS ❖

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3.7

ACCESS TO PHARMACEUTICAL SERVICES

Pharmaceutical Services and Prescribed Drugs:

Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations...

Contractor shall arrange for pharmaceutical services to be available, at a minimum, during regular business hours. Contractor shall develop and implement effective drug utilization reviews and treatment outcomes systems to optimize the quality of pharmacy services.

Contractor shall ensure access to at least a 72-hour supply of a covered outpatient drug in an emergency situation. Contractor shall meet this requirement by doing all of the following: ... (as required by Contract). COHS Contract A.10.7.F.1

SUMMARY OF FINDINGS:

The Plan contracts with Script Care to provide pharmacy claims and network services.

The Plan's Policy PH-001, Standards and Guidelines for the Provision of Pharmaceutical Services and Prescribed Drugs, describes the requirement to provide a 72-hour supply of the drugs to a Member or up to a 10-day supply of medication(s). The Policy also describes the emergency medication supply procedures.

Hospital Contract states the language that Provider shall ensure Member access to a 72-hour supply of a Medically Necessary Covered outpatient drug as part of Emergency Services by either providing a 72-hour supply of the drug to the Member or providing an initial dose of medication and a prescription for additional medication, which together cover the Member for the 72-hour period.

The Plan UM/QI Committee monitors pharmacy operation metrics including prior authorization, turn-around-time compliance, provider service metrics, and Inter-Rater Reliability study results.

Furthermore, per interview with the Plan personnel, the Plan does not have readily available 24-hour pharmacies in all of its service areas. There are only two 24-hour pharmacy in-networks to access. After-hours drugs may be problematic if the Member is not able to obtain the drugs from the Emergency Room Department.

Based on the interview with the Plan personnel, the Plan monitors access to a 72-hour supply of a covered outpatient drug in an emergency situation by reviewing the Daily Reports, Monthly Oversight audits conducted by the Pharmacy Benefit Manager, Quarterly Meetings with P&T Committee, Yearly Reports from Providers Relations, and through pharmacy grievances and appeals. However, the Plan lacked an effective monitoring mechanism to ensure Member access to at least a 72-hour supply of medically necessary drugs in an emergency situation. [COHS Contract Reference: A.10.7.F.1]

RECOMMENDATION:

Verify Member access to at least a 72-hour supply of a covered outpatient drug in an emergency situation.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Gold Coast Health Plan

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CATEGORY 4 – MEMBER’S RIGHTS

4.1

GRIEVANCE SYSTEM

Member Grievance System and Oversight:

Contractor shall implement and maintain a Member Grievance system in accordance with Title 28 CCR Section 1300.68 (except Subdivision 1300.68(c)(g) and (h)), 1300.68.01(except Subdivision 1300.68.01(b) and (c)), Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, paragraph D.12, and 42 CFR 438.420(a)(b) and (c).

COHS Contract A.14.1

Contractor shall implement and maintain procedures...to monitor the Member’s Grievance system and the expedited review of grievances required under Title 28 CCR Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858.... (as required by Contract)

COHS Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any sub-contracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).

COHS Contract A.14.3.A

SUMMARY OF FINDINGS:

The audit report issued in June 2013 cited the Plan for deficiencies with their grievance system. The Plan has made numerous changes to its appeals and grievances process in the last year. Only recently the Plan separated the Grievances and Appeals Department from its Member Services Department. There is an involvement of the Associate Chief Medical Officer in the current process, which is now directly performed by the Plan.

A total of fifty-four (54) grievance files (33 clinical and 21 administrative) were reviewed with the following deficiencies:

- Fifteen (15) grievances (6 clinical and 9 administrative) were resolved outside of the thirty (30) day turnaround time required by the Contract.
- Eight (8) grievances were either not clearly classified as administrative or clinical grievances or were administrative grievances that should have been evaluated as clinical.
- For four (4) clinical grievances, a complete medical record review could not be verified from the grievance file.

A review of all 359 grievances on the log submitted by the plan for the audit period found 16% of clinical grievances and 48% of administrative grievances were resolved outside of 30 days, confirming a persistent issue with delay.

Per Plan Policy # GA-003, Member Grievance Process, grievances will be resolved within thirty (30) calendar days from the date received, with a 14-day extension letter sent to the Members if additional time is required to resolve the grievance. The Plan needs to be in compliance with the Contractual requirement for timely resolution and needs medical record review of grievances. [COHS Contract Reference: A.14.2]

❖ COMPLIANCE AUDIT FINDINGS ❖

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RECOMMENDATIONS:

1. Resolve grievances within 30 days as required by the Contract.
2. Verify complete medical record review of grievance cases and make sure this review is documented in the case file.
3. Verify consistency in the distinction between clinical and non-clinical grievance cases.

❖ COMPLIANCE AUDIT FINDINGS ❖

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4.3

CONFIDENTIALITY RIGHTS

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:

Contractor agrees:

- B. Safeguards—To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains or transmits on behalf of DHCS; and to prevent use or disclosure of PHI other than as provided for by this Contract.
- K. Notification of Breach During the term of this Contract:
 - 1. Discovery of Breach. To notify DHCS immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI in computerized form if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Contract, or potential loss of confidential data affecting this Contract Notification shall be provided to the DHCS Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer and the DHCS Information Security Officer.. ...
 - 2. Investigation of Breach. To immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within five (5) working days of the discovery, to notify the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer of:...
 - 3. a. Notice of Privacy Practices. To produce a Notice of Privacy Practices (NPP) in accordance with standards and requirements of HIPAA, the HIPAA regulations, applicable State and Federal laws and regulations, and Section 2.A. of this Exhibit. ...

COHS Contract G.3.B and K

SUMMARY OF FINDINGS:

The Plan's Policy # HI-006, Incident Response and Reporting, describes the internal process for responding to and reporting security incidents. However, the Policy does not indicate the language stated in the Contract which is as follows:

- 1) For Discovery of Breach: The Plan shall notify DHCS immediately by telephone call plus e-mail or fax upon the discovery of breach of security within 24 hours. The notification shall be provided to the DHCS Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer and the DHCS Information Security Officer. [COHS Contract Reference: G.3.K]
- 2) For Investigation of Breach: The Plan shall immediately investigate such security incident and within five (5) working days of the discovery notify to the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer [COHS Contract Reference: G.3.K]

Fifteen (15) HIPAA breach cases were reviewed for this Verification Study. Based on the review, four (4) were not submitted to DHCS personnel within 24-hours, eight (8) were missing email confirmation of notification of breach to the DHCS personnel, and seven (7) were notified to only the DHCS Privacy Officer.

❖ COMPLIANCE AUDIT FINDINGS ❖

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RECOMMENDATIONS:

1. Update Policy # HI-006, Incident Response and Reporting, to include the contractual stipulation that:
 - For discovery of breach, notify DHCS within 24 hours of any suspected security incident and to be submitted to the DHCS Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer and the DHCS Information Security Officer.
 - The investigation of security incident of a HIPAA breach within five (5) working days be submitted to the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer
2. Ensure that Initial Notification of Breach is submitted to the required DHCS personnel within the required 24 hour timeframe.

❖ COMPLIANCE AUDIT FINDINGS ❖

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CATEGORY 5 – QUALITY MANAGEMENT

5.1

QUALITY IMPROVEMENT SYSTEM

General Requirements:

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28 CCR Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider.

COHS Contract A.4.1

SUMMARY OF FINDINGS:

The Plan has an established Quality Improvement (QI) program led by the CMO and QI Departments. There is a committee with the appropriate membership that meets quarterly. Ongoing quality improvement initiatives are reported to the QI committee and the Governing Body. Based on a review of the Governing Body meeting minutes, it does not appear that the QI Program Description or Work Plan was reviewed and approved by the Governing Body.

Review of six Quality Improvement-related Policies shows that only two of these Policies have been updated since October 2011. Policy # QI-016, Contract Compliance Monitoring – Site Audits and Medical Records Review, states that Utilization Management is not a delegated service; however, that is no longer the case. Also, Policy # QI-002, External Accountability Set (EAS) Performance Measures, Quality Improvement Projects (QIPs) and Consumer Satisfaction Survey Requirements, describes the list of clinical measures collected to satisfy the DHCS EAS measures; however, these measures no longer reflect what is currently collected and reported in the QI reports.

The Plan has not regularly revised their policies on Quality Improvement to reflect current practices and policies. They should revise them annually and as needed whenever changes are implemented to ensure accurate reflection of current plan policies and procedures.

RECOMMENDATIONS:

1. Ensure the Governing Body reviews and approves the Quality Improvement Program Description and Work Plan at least annually.
2. Perform regular revision of Quality Improvement Policies to ensure they reflect current practices and policies.

❖ COMPLIANCE AUDIT FINDINGS ❖

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5.2

PROVIDER QUALIFICATIONS

Credentialing and Re-credentialing:

Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD, Credentialing and Recredentialing Policy Letter, MMCD Policy Letter 02-03. Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

COHS Contract A.4.12

Provider Qualifications:

All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered....Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.

COHS Contract A.4.12.A

Delegated Credentialing:

Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6. Delegation of Quality Improvement Activities...

COHS Contract A.4.12.B

Disciplinary Actions:

Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process.

COHS Contract A.4.12.D

SUMMARY OF FINDINGS:

The Plan has written policies detailing their credentialing process. The plan utilizes Gemini Diversified Services as their Credentialing Verification Organization. Gemini is certified by the NCQA for primary verification services.

There is a process in place for providers to be directly credentialed by the plan. The process was verified by selecting credentialing files. Credentialing activity and Plan Policy review is adequately described in the Credentialing/Peer Review Committee meetings, but not in Quality Improvement Committee or Governing Body meetings. There were no approved policies by the Governing Body during the audit period, although there is a draft Credentialing Policy that is expected to be finalized outside the audit review period.

In addition to its Credentialing/Peer Review Committee, the Plan shall perform summary reporting of credentialing activity to its Quality Improvement Committee and written policy review by the Governing Body to demonstrate adequate oversight of credentialing activity as required by the Contract [COHS Contract Reference: A.4.12].

RECOMMENDATION:

Verify appropriate oversight of credentialing activity and review of credentialing policies by all committees tasked with this responsibility.

❖ COMPLIANCE AUDIT FINDINGS ❖

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5.3

QUALITY IMPROVEMENT PROGRAM DESCRIPTION AND STRUCTURE

Written Description:

Contractor shall implement and maintain a written description of its QIS that shall include the following:

- A. Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.
- B. Organizational chart showing the key staff and the committees and bodies responsible for Quality Improvement activities including reporting relationships of QIS committee(s), and staff within the Contractor's organization.
- C. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.
- D. A description of the system for provider review of QIS findings, which at a minimum, demonstrates physician and other appropriate professional involvement and includes provisions for providing feedback to staff and providers, regarding QIS study outcomes.
- E. The role, structure, and function of the quality improvement committee.
- F. The processes and procedures designed to ensure that all Medically Necessary Covered Services are available and accessible to all Members...and that all Covered Services are provided in a culturally and linguistically appropriate manner.
- G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that members are able to obtain appointments within established standards.
- H. Description of the quality of clinical care services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services.
- I. Description of the activities, including activities used by Members that are Seniors and Persons with Disabilities or persons with chronic conditions, designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management.

COHS Contract A.4.7.A-I

Accountability: Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the Medical Director, and the inclusion of contracting Physicians and Contracting Providers in the process of QIS development and performance review. Participation of non-contracting providers is at the Contractor's discretion.

COHS Contract A.4.2

Provider Participation: Contractor shall ensure that contracting Physicians and other providers from the community shall be involved as an integral part of the QIS. Contractor shall maintain and implement appropriate procedures to keep contracting providers informed of the written QIS, its activities, and outcomes.

COHS Contract A.4.5

Governing Body: Contractor shall implement and maintain policies that specify the responsibilities of the governing body including at a minimum the following...

COHS Contract A.4.3.A-D

❖ COMPLIANCE AUDIT FINDINGS ❖

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SUMMARY OF FINDINGS:

With regard to the written description and overall structure of its Quality Improvement (QI) program, the Plan has made some interim improvements since the 2013 prior audit. They revised their Program Description in 2013, and there is evidence of sub-committee reporting during their QI Committee meetings and improved reporting of their Quality Improvement metrics and project results.

Review of the Plan's current Program Description shows some elements required by the Contract are still missing: 1) Mechanisms to ensure access and availability of service appointments within contractual timelines, 2) Description of activities to ensure Case Management and Care Coordination, and 3) Description of the system for provider review of QI system findings and study outcomes. [COHS Contract Reference: A.4.7.A-I]

In addition, there was no evidence that the Governing Body made recommendations regarding the QI system or performed their yearly approval of the QI Program Description and QI Work Plan. This yearly review is described in Plan QI Policy # QI-019, Quality Improvement Systems, and the Plan should ensure it is performed in accordance with their policy. The DHCS Contract requires a system of accountability between the QI program and its Governing Body (among other entities). The Plan should exhibit evidence that this occurs [COHS Contract Reference: A.4.2 and A.4.3.A-D].

RECOMMENDATIONS:

1. Verify the written QI Program Description contains all elements required by the Contract, including description of activities regarding Access and Availability, Case Management and Care Coordination, and provider review of the QI system.
2. Make sure adequate accountability between the QI system and the Governing Body, including annual review of QI documents and QI system improvement recommendations.

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5.4

DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

Delegation of Quality Improvement Activities:

- A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their Subcontract, at minimum:
 - 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.
 - 2) Contractor's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes.
 - 3) Contractor's reporting requirements and approval processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.
 - 4) Contractor's actions/remedies if subcontractor's obligations are not met.
- B. Contractor shall maintain a system to ensure accountability for delegated Quality Improvement activities, that at a minimum:
 - 1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
 - 2) Ensures subcontractor meets standards set forth by the Contractor and DHCS.
 - 3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

COHS Contract A.4.6

SUMMARY OF FINDINGS:

The Plan delegates selected functions related to Quality Improvement to five subcontractors – three are delegated for credentialing and two for Quality Improvement and Member Services. There is a well-described process for delegation audits, which was performed for all five subcontractors during the audit period, with Corrective Action Plans for each one. However, for groups with delegated Quality Improvement, there did not appear to be a review of any collected metrics or QI reports, or significant involvement of a Plan Medical Director in their review.

The Plan Policy # QI-008, Delegation of Credentialing and Re-credentialing Activities, describes the audit procedures for contractors with delegated credentialing. However, since the policy's last revision in 2011, the Plan has modified their audit procedures and has not updated their written policy to reflect the changes.

Review of committee meeting minutes for Credentialing/Peer Review, Quality Improvement, and the Governing Body shows inconsistent reporting of either delegated credentialing activity, reports of ongoing monitoring, or results of delegation audits. According to DHCS Contract, the Plan "shall maintain a system to ensure accountability for delegated Quality Improvement activities" [COHS Contract Reference A.4.6]. To ensure accountability, there should be adequate communication between the Compliance Department and the committees tasked with delegated QI oversight and a more systematic approach to reporting.

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RECOMMENDATIONS:

1. Verify all relevant information to evaluate a delegate's capacity for Quality Improvement is collected and make sure adequate involvement of the Plan's Medical Director in evaluation of health care quality.
2. Update and revise Quality Improvement policies annually or as needed to reflect current Plan procedures.
3. Verify adequate reporting to oversight committees for Delegated Quality Improvement activities.

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5.5

MEDICAL RECORDS

Medical Records

- A. General Requirement
Contractor shall ensure that appropriate Medical Records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4), Title 42 USC Section 1396a(w), shall be available to health care providers at each Encounter in accordance with Title 28, CCR Section 1300.67.1(c).
- B. Medical Records
Contractor shall develop, implement and maintain written procedures pertaining to any form of medical records:
 - 1) Initial Health Assessment within 120 days of enrollment.
 - 2) For storage and filing of medical records including: collection, processing, maintenance, storage, retrieval identification, and distribution.
 - 3) To ensure that medical records are protected and confidential in accordance with all Federal and State law.
 - 4) For the release of information and obtaining consent for treatment.
 - 5) To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).
- C. On-Site Medical Records
Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site.
- D. Member Medical Record
Contractor shall ensure that a complete medical record is maintained for each Member that reflects all aspects of patient care, including ancillary services, and at a minimum includes:
 - 1) Member identification on each page; personal/biographical data in the record.
 - 2) Initial Health Assessment within 120 days of enrollment in accordance with MMCD Policy Letter 08-003.
 - 3) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.
 - 4) All entries dated and author identified; for Member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.
 - 5) The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.
 - 6) Allergies and adverse reactions are prominently noted in the record.
 - 7) All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.
 - 8) Reports of emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions.
 - 9) Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.
 - 10) For medical records of adults, documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.
 - 11) Health education behavioral assessment and referrals to health education services.

COHS Contract A.4.13.A, B, C, D

SUMMARY OF FINDINGS:

The Plan did not have policies and procedures regarding Medical Records review during the audit period. There is a newly developed draft pending approval Policy # QI-024, Medical Records Requirements with effective date of

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12/16/14. The Policy states that all providers and practitioner offices must maintain procedures consistent with the Plan standards for maintenance of Member medical records. However, the Policy lacked the Plan's internal monitoring procedures of Practitioner's compliance with the medical record requirements as required by the Contract. [COHS Contract Reference: A.4.13.A.B.C.D].

In addition, the Policy # QI-024, Medical Records Requirements, states that each Practitioner/Provider site will ensure that an individual is delegated the responsibility of securing and maintaining medical records whereas the Contract requirements states that "Contractor" shall develop, implement, and maintain written procedures of securing and maintaining medical records at each site. [COHS Contract Reference: A.4.13.B].

Based on the interviews conducted with the eight (8) Providers at their provider sites, it was found that the Members medical records were properly secured both for hard copy and electronic health records; however, the Plan lacked tracking and monitoring system of automated assignment of its Members.

RECOMMENDATIONS:

1. Update Policy # QI-024, Medical Records Requirements, to include the following:
 - Implement an internal monitoring procedure including medical record reviews to ensure that the Providers are compliant with documentation requirements.
 - Gold Coast Health Plan shall develop, implement, and maintain written procedures of securing and maintaining medical records at each site.
2. Ensure an effective system of assigning and tracking of members to their Primary Care Providers.

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.4

PROVIDER TRAINING

Medi-Cal Managed Care Provider Training:

Contractor shall ensure that all Primary Care Providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Contractor shall conduct training for all providers no later than 10 (ten) working days after the Contractor places a newly contracted provider on active status and shall complete the training within 30 calendar days of placing on active status....
COHS Contract A.7.5

SUMMARY OF FINDINGS:

The Plan's Policy # PR-017, Provider Site Visit, indicates that "the Plan will contact new providers within ten working days of contract execution to arrange orientation". The Contract requirements states that "Contractor shall conduct training for all providers no later than 10 (ten) working days after the Contractor places a newly contracted provider on active status and shall complete the training within 30 calendar days of placing on active status". [COHS Contract Reference: A.7.5]

A sample of fifteen (15) newly contracted providers which includes 13 providers from medical groups and 2 independent providers were selected for review during the audit period to ensure that training was provided in accordance with Contractual requirements. Based on the review, the following were disclosed:

- For the 13 newly contracted providers from the medical groups, the Plan was unable to provide the requested training documentation and did not track them to ensure that the providers received the trainings within 10 working days of being placed on active status and completed the training within 30 calendar days as required by the Contract. [COHS Contract Reference: A.7.5]
- 2 independent providers had the training initiated within 10 working days of being placed on active status.

According to the interview with the Plan personnel, the medical groups are responsible to provide training to a newly contracted provider. The Plan does not have a system in place to track if a newly contracted provider has initiated the training and completed it within the required timeframe. The Plan's only method of monitoring is through Facility Site Reviews.

The Plan does not have a monitoring mechanism to ensure that the newly contracted providers initiate the training within ten (10) working days of being placed on active status and complete the training within 30 calendar days.

RECOMMENDATIONS:

1. Update Policy # PR-017, Provider Site Visit, to indicate that the Plan shall conduct training for all providers no later than 10 (ten) working days after the Plan places a newly contracted provider on active status and shall complete the training within 30 calendar days of being placed on active status.

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2. Develop a tracking system to ensure that the newly contracted provider initiate the training within ten (10) working days of being placed on active status and complete the training within 30 calendar days.

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6.5

FRAUD AND ABUSE

Fraud and Abuse Reporting

B. Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse....

4) Fraud and Abuse Reporting

Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten (10) working days of the date Contractor first becomes aware of, or is on notice of, such activity.

COHS Contract E.2.24.B

SUMMARY OF FINDINGS:

The Plan's Compliance Program is responsible for providing regular training and information sessions for all Plan employees, contractors, temporary staff, Network Providers, and practitioners regarding the Plan's fraud, waste and abuse policies and procedures.

The Plan's Policy # FWA-001, Fraud, Waste, and Abuse Identification Reporting and Investigation, indicates that cases of suspected, potential or actual fraud and abuse cases be reported to the Department of Health Care Services (DHCS), using form MC 609 within 10 working days from the date of discovery.

The Plan's Policy # 4H, Monitoring and other Credentialing Quality Issues, indicates the monitoring sources procedures for tracking Suspended Providers. The Plan complies with the Contractual requirements.

A sample of eighteen (18) Fraud and Abuse cases for the audit period were selected for review. Based on the review, four (4) cases did not meet contractual requirements as follows:

- One (1) case was not reported to the Department of Health Care Services
- Two (2) cases were reported to the Department of Health Care Services outside the required timeframe
- One (1) case was missing the email confirmation to the Department of Health Care Services with the attached MC609.

Based on the review, the Plan did not report the four suspected fraud and abuse cases to the Department of Health Care Services within the timeframe of ten (10) working days in order to comply with the contractual requirements.

[COHS Contract Reference: E.2.24.B]

RECOMMENDATION:

Verify that all the cases of suspected Fraud or Abuse are reported to the Department of Health Care Services within the required timeframe of ten (10) working days.

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: December 1, 2013
Through
November 30, 2014

Report Issued: September 25, 2015

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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 February 17 through 27, 2015. The audit covered the review period from December 1, 2013 through November 30, 2014 and consisted of a document review of materials provided by the Plan.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Gold Coast Health Plan

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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 A.1*

SUMMARY OF FINDINGS:

The Plan Policy CL-007, Abortion Services Claims Reimbursement, states that the Plan reimburses for Abortion services without the requirement of an authorization for an outpatient service. Inpatient hospitalization for the performance of an abortion requires prior authorization under the same criteria as other medical procedures. The qualified providers licensed to furnish abortion services render services to GCHP Members.

The Member Handbook and the Provider Manual informs the Members that no medical justification or prior authorization is required for Abortion services unless inpatient hospitalization is required.

The Members Handbook states that the Plan PCP's and OB/GYN specialists are available to assist the Members in obtaining the services.

The Provider Manual states that the GCHP Medi-Cal members may self-Refer to any willing Medi-Cal Provider for family planning and sensitive services without prior authorization.

The billing procedure codes are included in the Plan's Policies. In addition, the Plan has guidelines to provide instructions for the billing of abortion services for participating Providers and for claims processors when paying or denying a claim with updated billing codes. The Plan is in compliance with the Contractual requirement.