REPORT ON THE MEDICAL AUDIT OF VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION DBA GOLD COAST HEALTH PLAN 2025

DHCS Audits and Investigations
Contract and Enrollment Review Division
Los Angeles Section

Contract Number: 23-30242
Audit Period: July 1, 2024 — December 31, 2025
Dates of Audit: February 9, 2026 — February 20, 2026
Report Issued: July 28, 2026

DHCS

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I. INTRODUCTION

The Ventura County Board of Supervisors authorized the establishment of a County Organized Health System on June 2, 2009. This action began the transition of the county's Medi-Cal delivery system from Fee-For-Service to a managed care health plan model.

In April 2010, Ventura County Medi-Cal Managed Care Commission was established as an independent oversight entity to provide health care services to Medi-Cal members as Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan (Plan). A Contract between the County Organized Health System 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.

As of February 2026, the Plan had 230,027 Medi-Cal members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of July 1, 2024, through December 31, 2025. The audit was conducted from February 9, 2026, through February 20, 2026. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on July 14, 2026. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On July 22, 2026, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management Program, Population Health Management and Coordination of Care, Network and Access to Care, Grievances, Appeals, and Member Rights, Quality Improvement and Health Equity Transformation Program, Plan Administration and Organization.

The prior DHCS medical audit for the period of July 1, 2023, through June 30, 2024, was issued on March 12, 2025. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation of the 2024 Corrective Action Plan.

The summary of the findings by category follows:

Category 1 – Utilization Management Program

The Plan is required to base authorization decisions on the medical necessity of requested covered services. Finding 1.2.1: The Plan did not ensure that its authorization decisions were based on the medical necessity of requested covered services.

Category 2 – Population Health Management and Coordination of Care

There were no findings noted for this category during the audit period.

Category 3 – Network and Access to Care

There were no findings noted for this category during the audit period.

Category 4 – Grievances, Appeals, and Member Rights

The Plan must ensure that all grievances related to medical quality of care issues be immediately submitted to the Plan's Medical Director for action. Finding 4.1.1: The Plan did not ensure that grievances related to medical quality of care issues were immediately submitted to the Plan's Medical Director for action.

The Plan must ensure the timely written acknowledgement of each grievance or appeal and provide a notice of resolution to the member as quickly as the member's health condition requires. Finding 4.1.2: The Plan did not ensure the written acknowledgement and notice of resolution required timeframes were met.

The Plan must adopt and implement written policies and procedures to ensure prompt and equitable resolution of discrimination grievances and maintain a Grievance and Appeal (G&A) system that meets required acknowledgment and resolution timeframes. Finding 4.3.1: The Plan failed to ensure the prompt resolution of discrimination grievances.

The Plan must submit information regarding discrimination grievances to the DHCS' Office of Civil Rights (OCR) within 10 calendar days of mailing a Discrimination Grievance Resolution letter. Finding 4.3.2: The Plan did not submit the required information to the DHCS' OCR.

Category 5 – Quality Improvement and Health Equity Transformation Program

There were no findings noted for this category during the audit period.

Category 6 – Plan Administration and Organization

The Plan must submit quarterly Fraud, Waste, and Abuse (FWA) reports to DHCS' Program Integrity Unit (PIU) within 10 working days after each quarter ends. Finding 6.13.1: The Plan did not submit all reports required during the audit period.

The Plan must have a regular method to verify that services reported as delivered by network providers were received by members. Finding 6.13.2: The Plan did not perform this verification on a consistent basis.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

DHCS conducted an audit of the Plan from February 9, 2026, through February 20, 2026, for the audit period of July 1, 2024, through December 31, 2025. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, 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 Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management Program

Service Requests: Twenty-five medical services requests (5 approved and 20 denied) were reviewed for timeliness, consistent application of criteria, and appropriate review.

Delegated Prior Authorization Requests: Fifteen medical prior authorization requests were reviewed for appropriate and timely adjudication. Of the 15 requests, 8 were pre-service requests and 7 were concurrent review requests.

Category 2 – Population Health Management and Coordination of Care

Enhanced Care Management: Twenty-eight files were reviewed for care coordination and completeness to evaluate service performance.

Category 3 – Network and Access to Care

Emergency Services and Family Planning Claims: A total of 30 (15 emergency services and 15 family planning) claims were reviewed for appropriate and timely adjudication.

Category 4 – Grievances, Appeals, and Member Rights

Appeal Procedures: Fifteen appeals related to medical services were reviewed for appropriateness and timeliness of decision-making.

Grievance Procedures: Thirty-two standard grievances, seven expedited grievances, nine exempted grievances, and nine inquiries were reviewed for timely resolutions, response to complainant, and submission to the appropriate level for review. The 32 standard grievance cases included 20 quality of care and 12 quality of service grievances.

Confidentiality Rights: Eleven Protected Health Information breach and security incidents were reviewed for processing and timeliness requirements.

Category 5 – Quality Improvement and Health Equity Transformation Program

Potential Quality Issues: Eight potential quality issues cases were reviewed for appropriate evaluation, investigation, and effective action taken to address improvements and remediation.

Category 6 – Plan Administration and Organization

FWA: Twelve FWA were reviewed for appropriate reporting and processing.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management Program

1.2 Prior Authorizations and Review Procedures

1.2.1 Authorization Decisions Based on Medical Necessity

The Plan must ensure that policies and procedures for authorization decisions are based on the medical necessity of a requested covered service and are consistent with criteria or guidelines supported by sound clinical principles and evidence-based practice. *(Contract, Exhibit A, Attachment III, section 2.3.K.1)*

Unless otherwise specified in this Contract, the Plan must comply with all current and applicable provisions of the Medi-Cal Provider Manual. *(Contract, Exhibit E, section 1.1.2.C)*

Plan policy, *HS-001 Prior Authorization Requests* (revised 09/22/2025), states that the Plan's utilization management staff, comprised of qualified and licensed clinical professionals, will use evidence-based guidelines to evaluate medical necessity for pre-service requests.

Plan policy, *HS-004 Utilization Review Criteria* (revised 09/22/2025), states that the Plan shall utilize written clinical criteria based on sound medical evidence to determine the appropriateness of requested medical services. Approved criteria include the DHCS Medi-Cal Provider Manual criteria.

Finding: The Plan did not ensure that its authorization decisions were based on the medical necessity of requested covered services.

Verification studies revealed 6 out of 25 prior authorization request samples and 1 out of 15 appeal samples where the Plan did not base its authorization decision on the medical necessity of the requested covered service.

The Plan approved three prior authorization requests for Durable Medical Equipment without reviewing for medical necessity.

- In one sample, a request for a power wheelchair was approved without reviewing submitted documentation for medical necessity. The wheelchair mobility evaluation that was submitted to the Plan was performed by a healthcare

professional employed by the Durable Medical Equipment supplier instead of an independent healthcare professional.

- The Medi-Cal Provider Manual states that records from suppliers/vendors or healthcare professionals (physical therapist, occupational therapist or practitioner) with a financial relationship or conflict of interest in the claim or outcome are not considered sufficient by themselves for determining medical necessity.
- In two additional samples, the Plan approved the purchase of Continuous Positive Airway Pressure machines without reviewing medical necessity and without verifying documentation of an initial three-month trial.
- The Medi-Cal Provider Manual states that authorization for purchase of a Continuous Positive Airway Pressure machine may be granted only after an initial three-month rental if reauthorization documentation requirements for medical necessity are met.

In a written narrative, the Plan confirmed that the three sample requests were approved without a medical necessity review. The Plan explained that in the second quarter of 2024, the Plan adopted an administrative approval process to facilitate its transition to a new medical management software system effective July 1, 2024. Under the administrative approval process, the Plan allowed its utilization management staff to approve outpatient Medi-Cal covered services rendered by in-network providers without medical necessity review. The approach was designed to support staff training while ensuring continued compliance with regulatory decision timeliness requirements.

During the interview the Plan stated that this practice currently remained in effect.

The Plan's practice was not documented in a written policy or procedure, and an end-date for the practice was not set. As a result, the Plan did not follow its policies HS-001 and HS-004 to utilize clinical criteria to determine appropriateness of the requested services and approved these three requests even though they did not meet the medical necessity criteria outlined in the Medi-Cal Provider Manual.

The Plan denied covered services in three prior authorization requests and in one member appeal without a review for medical necessity. The Plan stated during the interview that its reviewers determined that the requested services were excluded from coverage based on not having a reimbursement rate set in the Medi-Cal Fee-for-Service rates schedule and therefore did not review the requests for medical necessity.

However, the Medi-Cal Provider Manual states that the requested services may be covered as a Medi-Cal benefit if medical necessity is demonstrated. The Plan reviewers' inappropriate use of the Medi-Cal Fee for Service rates schedule as the source for determining coverage status is not described in the Plan's policies and procedures. The Plan's Chief Medical Officer acknowledged during the interview that this practice was incorrect and that staff retraining was needed. As a result, a request for a medically necessary injectable drug for diabetic retinal swelling was incorrectly denied as an excluded benefit with no review of the submitted clinical information that demonstrated medical necessity.

When the Plan does not ensure that authorization decisions are based on medical necessity and in compliance with applicable provisions of the Medi-Cal Provider Manual, medically unnecessary services may be approved which increases the risk of FWA, or services which are medically necessary may be unduly denied resulting in negative impacts to members' health.

Recommendation: Implement Plan policies and procedures to ensure that authorization approval and denial decisions are based on the medical necessity of requested covered services.

COMPLIANCE AUDIT FINDINGS

Category 4 – Grievances, Appeals, and Member Rights

4.1 Grievance and Appeal Program Requirements

4.1.1 Submission of Quality of Care Grievances to Medical Director

The Plan must ensure that all grievances related to medical quality of care issues be immediately submitted to the Plan's Medical Director for action. The Plan must ensure that the person making the decision on a grievance has clinical expertise in treating a member's condition or disease when deciding any grievance involving clinical issues. *(Contract, Exhibit A, Attachment III, section 4.6.1.D)*

Plan policy, *GA-001 Member Grievance Appeals System* (effective 02/23/2025), states that the G&A Manager ensures any grievance that relates to medical quality of care issues are referred to the Chief Medical Officer or Associate Chief Medical Officer for review.

Plan desktop procedure, *Grievance and Appeal Vision Service Plan (VSP) Case Workflow*, states if a grievance regarding vision care services requires follow up from VSP, the Plan's G&A Specialist will send an email to the VSP Complaint and Appeals Team. The VSP team will research and follow up with a response to the grievance.

Finding: The Plan did not ensure that grievances related to medical quality of care issues were immediately submitted to the Plan's Medical Director for action.

A verification study revealed that 2 out of 20 grievance samples related to medical quality of care issues were not submitted to the Medical Director for action. They were decided by Registered Nurses (RNs).

- In one quality of care grievance, the Plan's RN determined that the member's issue with prescribed eyeglasses involved a clinical quality component. However, the grievance was not forwarded to the Medical Director as required.
- In a second quality of care grievance, the member filed a grievance about their new glasses causing headaches. The Grievances RN decided the case. The grievance was not forwarded to the Medical Director as required.

The Plan has a desktop procedure, *Grievance and Appeal Vision Service Plan (VSP) Case Workflow*, outlining the process for resolving grievances related to vision care services. The Plan's delegate, VSP, is responsible for researching the grievance and giving

recommendations. The Plan is responsible for completing the grievance process and sending out the Grievance Resolution letter. The Plan's desktop procedure does not include a process to refer any grievances involving clinical quality of care issues to the Plan's Medical Director for action.

The Plan confirmed during the interview that it did not follow its written policies and procedures that required grievances involving any quality of care issues to be referred to a Medical Director when grievances were related to vision care services administered by VSP.

When the Plan does not ensure that grievances involving quality of care issues are submitted to the Medical Director for action, it may result in delays in the involvement of the Medical Director in the grievance process. Substandard or poor-quality medical care by providers may go unnoticed, inadequately investigated, or unresolved, potentially leading to medical harm to members.

Recommendation: Implement Plan policies and procedures and revise desktop procedures to ensure that any grievance involving medical quality of care issues is submitted to the Plan's Medical Director for action.

4.1.2 Grievances and Appeals Acknowledgement and Resolution Timeframes

The Plan must ensure that its G&A system meets the following requirement: ensures timely written acknowledgement of each grievance or appeal and provides a notice of resolution to the member as quickly as the member's health condition requires. This should not exceed 30 calendar days from the date the member makes an oral or written request to the Plan for a standard grievance or appeal, or 72 hours for an expedited grievance or appeal. *(Contract, Exhibit A, Attachment III, section 4.6.1.B)*

The Plan must have a policy and procedure to provide written acknowledgement to the member within five calendar days of receipt of the grievance. *(Contract, Exhibit A, Attachment III, section 4.6.2.E)*

Plan policy, *GA-001 Member Grievance Appeals System* (effective 02/23/2025), states that the Plan will send a written acknowledgment to the member within five calendar days of receiving their grievance or appeal. The Plan will resolve and send a written resolution letter to the member within 30 calendar days of receipt for standard grievances or appeals, or within 72 hours of receipt for expedited grievances or appeals.

Plan desktop procedure, *Provider Response Process* (revised 08/01/2025), states that in the event documentation is not provided timely or not provided at all, the G&A staff will escalate to the Provider Relations Team for assistance in working with the provider for a response. If the documentation is received it will be uploaded to the Plan's data management platform. If the case is already closed and a decision has been made, this information will not be considered part of the research or resolution.

Finding: The Plan did not ensure written acknowledgement and notice of resolution of G&As were sent to members within the required timeframes.

Verification studies revealed 4 out of 15 appeals, 8 out of 20 quality of care grievances, and 10 out of 12 quality of service grievances where the Plan did not send written acknowledgments and/or notices of resolution to members within the required timeframes.

During the interview the Plan explained that several factors contributed to the delay in processing G&As. In July 2024, the Plan transitioned to a new software system and moved its member services call center functions in-house. This caused cases to be misrouted by the call center and within the G&A Department as the new system was launched and staff were trained. In June 2025, the Plan transitioned its handling of paper mail from an outside vendor to an in-house digital mailroom. The Plan identified delays in the transfer of correspondence from the legacy system to the new system. This led to delays in G&As getting forwarded from the mailroom to the G&A Department.

In a written narrative the Plan stated that another factor that contributed to delays was providers' failure to promptly submit their response as part of the grievance investigation process. The Plan's desktop procedure, *Provider Response Process*, outlines the steps for escalation to Provider Relations when providers do not respond to requests. However, the procedure does not specify what actions should be taken if a grievance case is approaching the required resolution timeframe.

Plan policy, *GA-001 Member Grievance Appeals System* (effective 02/23/2025), states that the G&A Manager is responsible for reviewing data on the timeliness of acknowledgments and resolutions, but it does not specify how often these reviews should occur, nor does it address the monitoring of timely and proper routing of G&As from the Plan's call center and mail room to the G&A Department. During the interview, the Plan explained that G&A aging reports are generated once a month.

Delays in resolving G&As may prevent members from receiving needed services or timely responses to their care quality concerns.

Recommendation: Implement policies and procedures to ensure the Plan sends written acknowledgement and notice of resolution of G&As to members within the required timeframes.

4.3 Discrimination Grievances

4.3.1 Prompt Resolution of Discrimination Grievances

The Plan must adopt and implement written policies and procedures to ensure the prompt and equitable resolution of discrimination grievances. *(Contract, Exhibit A, Attachment III, 4.6.3.B)*

The Plan must have in place a member G&A system that complies with California Code of Regulations, title 28, section 1300.68. The Plan must ensure that its G&A system meets the following requirement: ensures timely written acknowledgement of each grievance or appeal and provides a notice of resolution to the member as quickly as the member's health condition requires. This should not exceed 30 calendar days from the date the member makes an oral or written request to the Plan for a standard grievance or appeal, or 72 hours for an expedited grievance or appeal. *(Contract, Exhibit A, Attachment III, 4.6.1.B)*

Plan policy, *GA-001 Member Grievance Appeals System* (effective 02/23/2025), states that the Plan will send a written acknowledgment to the member within five calendar days of receiving their grievance or appeal. The Plan will resolve and send a written resolution letter to the member within 30 calendar days of receipt for standard grievances.

Plan policy, *GA-008 Member Discrimination Grievance* (effective 10/14/2021), states that the Plan's Civil Rights Coordinator will be responsible for forwarding all grievances alleging discrimination based on any characteristic protected by federal or state nondiscrimination law to DHCS.

Plan desktop procedure, *Provider Response Process* (revised 08/01/2024), states the Health Services Clinical Operations Assistant will reach out to the physician's office within five calendar days from the date the response was sent. The Health Services Clinical Operations Assistant contacts the physician to follow up with the provider to ensure they have received the Provider Response Form and will be sending the response back to the Plan within the requested time. In the event, this documentation is not provided timely or not provided at all, the G&A staff will escalate the issue to the Provider Relations Team for assistance in working with provider for a response.

Finding: The Plan did not ensure the prompt resolution of discrimination grievances.

The verification study revealed that six of six discrimination grievance notices of resolution were not sent to members within the required timeframes. The following are examples of the deficiencies:

- One discrimination grievance was resolved 112 days after it was received. The staff responsible for monitoring the aging report did not ensure that the discrimination grievance was resolved timely. In a written statement the Plan acknowledged that the discrimination grievance was not resolved within the required time frame.
- In another discrimination grievance the case was resolved 36 days after it was received. In a written narrative the Plan stated the delay was due to a new system configuration which resulted in the grievance being misrouted to an incorrect queue. The Plan marked the grievance as closed. Plan staff failed to ensure the grievance was resolved timely.
- Two discrimination grievances cases were resolved 47 and 78 days after they were received. In a written narrative the Plan stated the provider's failure to respond to and submit requested documentation caused the delay. The Plan provided its G&As desktop procedures, *Provider Response Process*. The procedure describes the steps the Plan takes when a provider does not respond. However, the procedure does not specify what actions should be taken if the grievance case is approaching the resolution timeframe.
- Two discrimination grievances were resolved 66 and 79 days after they were received. In a written narrative the Plan stated that the grievance was assigned to the discrimination grievance queue, however staff failed to access and resolve the grievance within the required timeframe.

During the interview the Plan explained that it transitioned to a new software system and brought its member services call center in-house as of July 2024. This contributed to cases getting misrouted from the call center and within the G&A Department as the new system went live and staff were trained. In June 2025, the Plan transitioned its handling of paper mail from an outside vendor to an in-house digital mailroom. The Plan identified delays in the transfer of correspondence from the legacy system to the new system which also led to delays in G&As getting forwarded from the mailroom to the G&A Department.

The Plan further stated that aging reports were generated monthly. However, the Plan's policy GA-001 does not specify how frequently the timeliness of cases should be

monitored by the G&A Manager, nor does it address the monitoring of timely and proper routing of G&As from the Plan's call center and mail room to the G&A Department.

During the interview the Plan confirmed that according to its policy GA-008, discrimination grievances are placed and handled in a separate queue from standard grievances. The staff responsible for monitoring the discrimination grievance queue did not ensure the discrimination grievances were resolved timely.

When grievances are not resolved within the required timeframe, members are not provided with the information they need to make informed decisions about exercising their rights.

Recommendation: Revise and implement policies and procedures to ensure discrimination grievance processing meets the required timeframes.

4.3.2 Discrimination Grievances

The Plan must submit information regarding discrimination grievances to the DHCS' OCR within 10 calendar days of mailing a Discrimination Grievance Resolution letter, as specified in All Plan Letter (APL) 21-004. *(Contract, Exhibit A, Attachment III, section 4.6.3.C)*

Within 10 calendar days of mailing a Discrimination Grievance Resolution letter to a member, Managed Care Plans must submit detailed information regarding the grievance to DHCS OCR's designated discrimination grievance email inbox. *(APL 25-005, Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, and Alternative Formats)*

Plan policy, *GA-008 Member Discrimination Grievance* (effective 10/14/2021), stated that the Plan's Civil Rights Coordinator will send the DHCS OCR the detailed grievance information within 10 calendar days of mailing a Discrimination Grievance Resolution letter to a member.

Finding: The Plan did not submit information regarding discrimination grievances to the DHCS OCR after mailing a Discrimination Grievance Resolution letter to members.

A verification study of discrimination grievances revealed that in all six samples reviewed the Plan did not send detailed information regarding the discrimination grievances to the DHCS OCR.

The Plan's policy, *GA-008 Member Discrimination Grievance*, states that the Plan's Civil Rights Coordinator will send to DHCS the detailed grievance information within 10 calendar days of mailing a Discrimination Grievance Resolution letter to a member. However, the Plan did not follow its policy. In addition, the policy lacked procedures on how the Plan's Civil Rights Coordinator would meet submission deadlines and monitor for compliance.

In a written response the Plan acknowledged that its grievance system did not include a trigger mechanism to alert staff of OCR submission deadlines. The Plan informed the DHCS team that its staff manually tracked the OCR deadlines.

When the Plan does not submit grievances alleging discrimination in a timely manner to the DHCS' OCR, it hinders the DHCS' ability to investigate and mitigate discrimination cases. As a result, members may face prolonged lack of access to civil rights protections and enforcement for potential discrimination incidents.

Recommendation: Revise policies and procedures to ensure timely submission of detailed information regarding discrimination grievances to the DHCS OCR.

COMPLIANCE AUDIT FINDINGS

Category 6 – Plan Administration and Organization

6.13 Fraud Prevention Program

6.13.1 Quarterly Fraud, Waste, and Abuse Status Report

The Plan must submit a quarterly report to DHCS' PIU on all FWA investigative activities 10 working days after the close of every calendar quarter. *(Contract, Exhibit A, Attachment III, section 1.3.2.D.3)*

Plan's policy, *FWA 001 Fraud Waste and Abuse Identification Reporting and Investigation* (revised 05/01/2025), stated the Plan will submit a quarterly report to DHCS' PIU on all FWA investigative activities 10 working days after the close of every calendar quarter. The quarterly report will contain the status of all preliminary, active, and completed investigations and will include both Plan and DHCS-initiated referrals.

Finding: The Plan did not ensure that all quarterly FWA reports were submitted to DHCS' PIU during the audit period.

The audit period was from July 01, 2024, through December 31, 2025, and the Plan was required to submit six FWA quarterly status reports to DHCS' PIU. The Plan did not submit three of the six quarterly status reports from July 1, 2024, to March 31, 2025.

During the interview, the Plan acknowledged the Plan staff responsible did not submit the required quarterly reports. There was a change in Privacy Officer during the audit period. In a written response, the Plan stated the new Privacy Officer began submitting the quarterly reports during Q2 of 2025.

Although the Plan policy delineated the requirement to submit quarterly reports to the DHCS' PIU the Plan did not adhere to its policy.

When the Plan does not ensure all FWA quarterly reports are submitted to DHCS' PIU, it hinders DHCS' ability to investigate and mitigate potential FWA activities.

Recommendation: Implement policies and procedures to ensure timely submission of the quarterly FWA status reports.

6.13.2 Method to Verify Services Delivered

The Plan must have a regular method to verify, by sampling or other methods, confirming that services that have been represented to have been delivered by network providers were received by members. *(Contract, Exhibit A, Attachment III, section 1.3.2.C)*

The Plan is required to implement and maintain arrangements or procedures that are designed to detect and prevent FWA. The procedures must include the following: provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members, and the application of this verification process on a regular basis. *(Code of Federal Regulations, title 42, section 438.608(a)(5))*

Finding: The Plan did not have a regular method to verify that services delivered were received by members.

A review of the service verification log showed that the Plan did not verify services were rendered to members in 15 out of the 18 months during the audit period.

During the interview, the Plan explained that it contracts with its claim's vendor to conduct sampling of the member population as part of the Plan's service verification process. During the audit period the Plan's claims vendor conducted sampling for three months, from April 2025 through June 2025.

In a written statement the Plan confirmed that they do not have policies and procedures in place to verify that services delivered were received by members.

When the Plan does not consistently verify services rendered, the Plan is not able to identify potential FWA issues.

Recommendation: Develop policies and procedures to verify that services delivered were received by members.

REPORT ON THE MEDICAL AUDIT OF VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION DBA GOLD COAST HEALTH PLAN 2025

DHCS Audits and Investigations
Contract and Enrollment Review Division
Los Angeles Section

Contract Number: 23-30274
Contract Type: State Supported Services
Audit Period: July 1, 2024 — December 31, 2025
Dates of Audit: February 9, 2026 — February 20, 2026
Report Issued: July 28, 2026

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I. INTRODUCTION

This report presents the results of the audit of Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan (Plan) compliance and implementation of the State Supported Services contract number 23-30274 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of July 1, 2024, through December 31, 2025. The audit was conducted from February 9, 2026, through February 20, 2026, which consisted of a document review and a verification study with the Plan administration and staff.

An Exit Conference with the Plan was held on July 14, 2026. No deficiencies were noted during the review of the State Supported Services Contract.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Terminology (CPT) codes 59840 through 59857. These codes are subject to change upon the Department of Health Care Services' implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. *(State Supported Services Contract, Exhibit A, sections 1.2.1 and 1.2.2)*

Plans must cover abortion services, as well as the medical services and supplies incidental or preliminary to an abortion, consistent with the requirements outlined in the Medi-Cal Provider Manual. Plans and their network providers and subcontractors are prohibited from requiring medical justification or imposing any utilization management or utilization review requirements, including prior authorization and annual or lifetime limits, on the coverage of outpatient abortion services. *(All Plan Letter 24-003, Abortions and Directly Related Medical Services and Supplied)*

Plan policy, *CL-007 Abortion Services Claims Reimbursements* (revised 07/11/2024), stated that the Plan will reimburse out of plan providers for abortion services without the requirement of an authorization when the services are performed on an outpatient basis. Providers will be reimbursed at the prevailing Medi-Cal rate based on the services provided and are identified upon the CPT, Healthcare Common Procedure Coding System, and/or diagnosis codes for abortion related services. Abortion procedure codes are delineated in the Plan's policy. CPT codes include 59840, 59841, 59850 through 59852, and 59855 through 59857. Healthcare Common Procedure Coding System codes include A4649, S0199, S0190, and S0191.

The verification study revealed the Plan appropriately processed abortion claims for payment and did not demonstrate any deficiencies related to State Supported Services.

Findings: Based on the review of the Plan's documents, there were no deficiencies noted for the audit period.

Recommendation: None.