CONTRACT AND ENROLLMENT REVIEW DIVISION
RANCHO CUCAMONGA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION DBA: GOLD COAST HEALTH PLAN

2022

Contract Number:	10-87128
Audit Period:	June 1, 2021 Through May 31, 2022
Dates of Audit:	July 25, 2022 Through August 5, 2022
Report Issued:	January 4, 2023

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I. INTRODUCTION

The Ventura County Board of Supervisors authorized the establishment of a County Organized Health System (COHS) 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 recipients as Gold Coast Health Plan (Plan). A Contract between the COHS and the Department of Health Care Services (DHCS) was approved on June 20, 2011. The Plan began serving local members as a managed care plan on July 1, 2011.

The Plan's provider network consists of approximately 427 primary care, 4,565 specialists, 352 behavioral health, and 414 other service providers. The Plan contracts with 24 hospitals, 19 acute care, and five tertiary hospitals.

Medi-Cal is the Plan's only line of business. As of May 31, 2022, the Plan served approximately 236,281 members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period June 1, 2021 through May 31, 2022. The audit was conducted from July 25, 2022 through August 5, 2022. The audit consisted of document reviews, verification studies, and interviews with Plan representatives and a delegate entity.

An Exit Conference was held on December 6, 2022. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. The Plan submitted a response to address the audit findings. The results of the DHCS evaluation of the Plan's response are reflected in this report.

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

The prior DHCS medical audit report issued on October 29, 2021 (audit period April 1, 2019 through May 31, 2021), identified deficiencies incorporated in the Corrective Action Plan (CAP) dated March 2, 2022. This year's audit included review of documents to determine implementation and the effectiveness of the Plan's CAP.

The summary of findings follows:

Category 1 – Utilization Management

Review of prior authorization and appeal requests for appropriate and timely adjudication yielded no findings.

Category 2 – Case Management and Coordination of Care

The Plan is required to ensure the provision of a Blood Lead Screening (BLS) test to members at ages one and two. The Plan did not ensure the provision of BLS tests to age appropriate members.

The Plan is required to ensure their network providers provide verbal or written anticipatory guidance to parents or guardians of child members regarding exposure to lead starting at six months of age and continuing until 72 months of age. The Plan did not ensure this guidance was provided to parents or guardians of child members.

Category 3 – Access and Availability of Care

The Plan is required to use a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of Non-Emergency Medical Transportation

(NEMT) service for Medi-Cal members. The Plan did not ensure NEMT providers used the required DHCS approved PCS form.

The Plan is required to ensure providers are enrolled in the Medi-Cal program. The Plan did not ensure its transportation providers were enrolled in the Medi-Cal program.

Category 4 – Member's Rights

During the prior year audit, the Plan did not maintain a system to ensure accountability for delegated activities that includes the continuous monitoring, evaluation, and approval of delegated functions. The Plan also did not monitor its subcontractor's call center for classification and routing of member grievances. In response to the CAP, the Plan revised its grievance and appeals training schedule from annually to quarterly, and assigned a Member Services team member to perform weekly call center audits. The Plan updated Policy *MS-013* to include monitoring of the grievance process and the call center's quality audit scorecard to include additional elements. Review of the Plan's response to the CAP yielded no findings.

Category 5 – Quality Management

The Plan is required to conduct training for newly contracted network providers within ten working days after placing them on active status and shall complete the training within 30 calendar days. The Plan did not conduct and complete provider training within the required timeframe.

Category 6 – Administrative and Organizational Capacity

Review of the Plan's organizational capacity to guard against fraud and abuse yielded no findings.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The audit period was June 1, 2021 through May 31, 2022. The audit was conducted from July 25, 2022 through August 5, 2022. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine that policies were implemented and effective. Documents were reviewed and interviews were conducted with Plan representatives and a delegated network provider.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 26 medical prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeal Process: 25 medical prior authorization appeal requests were reviewed for appropriate and timely adjudication.

Delegation of Utilization Management: 12 prior authorization requests from a delegate entity were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Initial Health Assessment (IHA): 12 medical records were reviewed to confirm completion of IHAs and 12 were reviewed for completion of BLS tests.

Behavioral Health Treatment: Ten medical records were reviewed for compliance with behavioral health treatment requirements.

Category 3 – Access and Availability of Care

Emergency Service and Family Planning Claims: 31 emergency service claims and 20 family planning claims were reviewed for appropriate and timely adjudication.

NEMT: 24 records were reviewed to confirm compliance with NEMT requirements.

Non-Medical Transportation (NMT): 28 NMT records were reviewed to confirm compliance with NMT requirements.

Category 4 – Member's Rights

Grievance Procedures: 34 quality of service and 25 quality of care grievance cases were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review. Fifteen exempt grievances were reviewed for proper classification and routing to the appropriate level for review.

Confidentiality Rights: 14 cases were reviewed for reporting of privacy incidents to DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within the required timeframes.

Category 5 – Quality Management

Quality Improvement System: Eight potential quality issue cases were reviewed for timely evaluation and effective action taken to address improvements.

Provider Training: 15 newly contracted provider records were reviewed to determine if providers received Medi-Cal Managed Care program training within the required timeframe.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse: 14 fraud and abuse cases were reviewed for proper reporting of suspected fraud, waste, or abuse to DHCS within the required timeframe.

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

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	INITIAL HEALTH ASSESSMENT

2.1.1 Blood Lead Screening Tests

The Plan shall cover and ensure the provision of a BLS test to members at ages one and two. The Plan shall also document and appropriately follow up on BLS test results. *(Contract, Exhibit A, Attachment 10(5)(D)(1-2))*

The Plan must ensure that network providers order or perform BLS tests on all child members at 12 and 24 months of age or when the network provider performing a Periodic Health Assessment (PHA) becomes aware that a child member 12 months to 24 months of age or members 24 to 72 months of age has no documented evidence of a BLS test taken. *(All Plan Letter (APL) 20-016, Blood Lead Screening of Young Children)*

Plan policy QI-029, *Blood Lead Screening of Young Children (revised 12/01/2021)*, stated that the Plan's providers are required to perform BLS testing on all children at 12 months and at 24 months of age, and during a health assessment when the network provider performing a PHA becomes aware that a child member who is 12 to 24 months of age has no documented evidence of a BLS test taken. Blood lead testing for children ages 12 months to six years is also monitored by the Facility Site Review (FSR) medical record review conducted once every three years.

Finding: The Plan did not ensure the provision of BLS tests to child members at ages one and two.

Plan policy *QI-029* stated Plan providers are required to perform BLS testing on all children at 12 months and 24 months of age. However, the Plan did not ensure the provision of BLS tests to age appropriate members.

The verification study revealed nine medical records did not have the provision of a BLS test to child members at ages one and two.

The Plan conducts a FSR of provider sites as part of its initial credentialing process to ensure providers meet certain minimum state required standards. During the interview, the Plan stated that they monitor the completion of BLS tests once every three years for each provider during their FSR. However, since providers are not reviewed annually, the Plan acknowledged the need to improve their oversight to meet contractual requirements.

If age-appropriate BLS tests are not provided in a timely manner, at-risk children may not be identified, which may result in lead poisoning that can cause brain damage; slow growth and development; as well as learning, behavioral, hearing, and speech problems.

Recommendation: Revise and implement procedures to ensure the provision of BLS tests to child members at ages one and two.

2.1.2 Anticipatory Guidance for Lead Exposure

The Plan is required to comply with all existing final Policy Letters and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2.1.D))*

The Plan must ensure that their network providers provide verbal or written anticipatory guidance to the parents or guardians of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. This anticipatory guidance must be provided to the parent or guardian at each PHA, starting at six months of age and continuing until 72 months of age. *(APL 20-016, Blood Lead Screening of Young Children)*

Every healthcare provider who performs a PHA of a child shall provide written or verbal anticipatory guidance to a parent or guardian of the child with regards to harmful exposure to lead. The anticipatory guidance must be provided at each PHA, starting at six months of age and continuing until 72 months of age. *(California Code of Regulations (CCR), Title 17, section 37100 (a)(1))*

Plan policy QI-029, *Blood Lead Screening of Young Children (revised 12/01/2021)*, stated that the Plan's providers are required to provide verbal or written anticipatory guidance to the parents or guardians of a child member during each PHA, about exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. Compliance in providing BLS anticipatory guidance will be monitored through ongoing IHA medical record reviews and FSR.

Finding: The Plan did not ensure anticipatory guidance was provided to parents or guardians of age appropriate members.

Plan policy *QI-029* stated that a provider's compliance in providing BLS anticipatory guidance will be monitored by use of the Plan's audit tool. However, the DHCS audit found the Plan did not ensure verbal or written anticipatory guidance was provided to the parents or guardians of child members six to 72 months of age.

The verification study revealed 11 medical records did not contain documentation that verbal or written anticipatory guidance was provided to the child's parent or guardian.

During the interview, the Plan stated that it monitors the completion of BLS tests once every three years for each provider during their FSR medical record review. However, since providers are not reviewed annually, the Plan acknowledged the need to improve their oversight process to ensure BLS anticipatory guidance are provided.

If lead poisoning anticipatory guidance is not given to parents or guardians in a timely manner, at-risk children may not be identified and can result in further lead exposure and poisoning.

Recommendation: Revise and implement procedures to ensure the provision of verbal and written lead poisoning anticipatory guidance is provided to parents or guardians of child members.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	**NON-EMERGENCY MEDICAL TRANSPORTATION AND NON-MEDICAL TRANSPORTATION**

3.8.1 Physician Certification Statement Form

The Plan is required to comply with all existing final APLs issued by DHCS. All APLs issued by DHCS subsequent to the effective date and during the term of this Contract shall provide clarification of Plan's obligation pursuant to this Contract, and/or inform and provide clarification to the Plan regarding mandated changes in state or federal law or regulations, or pursuant to judicial interpretation. *(Contract Amendment A30, Exhibit E, Attachment 2 (1)(D))*

The Plan is required to use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. All NEMT PCS forms must include, at a minimum, the following components: function limitations justification, dates of service needed, mode of transportation that is to be used when receiving these services, and PCS of medical necessity. NEMT services may be authorized for a maximum of 12 months. *(APL 17-010, Non-Emergency Medical and Non-Medical Transportation Services, revised 9/8/2020)*

Plan policy HS-047, *Non-Emergency Medical and Non-Medical Transportation Services (revised 04/2021),* stated that members must request NEMT services through their provider. Plan providers are required to complete the NEMT prescription/attestation of medical necessity form. The form must be completed and submitted to the Plan for authorization prior to services being rendered. NEMT requests originated by the medical home that meet criteria will be valid for all NEMT for up to one year.

Finding: The Plan did not ensure NEMT providers use the required DHCS approved PCS form.

Plan policy *HS-047* stated that Plan providers are required to complete the NEMT prescription of medical necessity form. However, the Plan did not ensure providers used the current approved PCS form that contains transportation modality and medical necessity.

The verification study identified 13 NEMT services provided that did not have current PCS forms with transportation modality and medical necessity. Additionally, eight NEMT services did not have PCS forms for services rendered.

During the interview, the Plan stated providers are instructed to use the most current PCS

form available on the Plan's website, provider's operation manual, and bulletin. However, the Plan acknowledged they were unaware some providers were using an outdated PCS form. Therefore, the Plan did not have an effective monitoring system to ensure providers use the most current DHCS approved PCS form.

If the Plan does not utilize the current DHCS approved PCS form, members may not receive the appropriate level of transportation service necessary for their medical condition, which can potentially result in patient harm.

Recommendation: Revise and implement procedures to ensure NEMT providers use the required DHCS approved PCS form for services rendered.

3.8.2 Medi-Cal Enrollment of Transportation Providers

The Plan is required to evaluate the prospective subcontractor's ability to perform the requested services, shall oversee, and remain responsible and accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements as stated in Code of Federal Regulations (CFR) Title 42 438.230, Title 22 CCR Sections 53867 and 53250, and APL 17-004, as well as those specified in this Contract. The Plan is required to remain accountable for all functions and responsibilities that are delegated to subcontractor. *(Contract Amendment A34, Exhibit A, Attachment 6 (13))*

The Plan is required to ensure all network providers must be screened and enrolled in accordance with CFR, Title 42 438.602(b), and APL 19-004. *(Contract Amendment A35, Exhibit A, Attachment 6 (17))*

The Plan is also required to ensure that their subcontractors and delegated entities comply with all applicable state and federal laws and regulations; Contract requirements; reporting requirements; and other DHCS guidance including, but not limited to APLs. The Plan must have in place policies and procedures to communicate these requirements to all subcontractor and delegated entities. *(APL 17-004, Subcontractual Relationships and Delegation, issued 4/18/2017)*

Plan policy NO-013, *Screening and Enrollment of New Providers (revised 6/30/2020),* stated that when a provider is non-Medi-Cal certified, they are required to enroll in the Medi-Cal program and must submit a Provider Enrollment Agreement to DHCS.

Finding: The Plan did not ensure its transportation providers were enrolled in the Medi-Cal program.

Plan's policy *NO-103* required that its providers enroll in the Medi-Cal program. However, the

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Plan did not ensure their transportation providers were enrolled in the Medi-Cal program. The Plan contracted with a transportation provider-broker that subcontracted with other transportation providers to render NEMT and NMT services to Medi-Cal members. The verification study found that four transportation providers not enrolled in the Medi-Cal program provided services to Medi-Cal members.

During the interview, the Plan acknowledged they were unaware their contracted provider-broker utilized non-Medi-Cal providers to transport members. The DHCS audit found the Plan lacked oversight of their subcontracted transportation provider to ensure its transportation providers were enrolled in the Medi-Cal program.

When the Plan does not ensure all its transportation providers are enrolled in Medi-Cal, the Plan cannot ensure members receive adequate and safe transportation services.

Recommendation: Revise and implement procedures to ensure transportation providers are enrolled in the Medi-Cal program.

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CATEGORY 5 – QUALITY MANAGEMENT

5.1	PROVIDER TRAINING

5.3.1 Provider Training

The Plan is required to ensure that all network 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. The Plan is required to conduct training for all network providers no later than ten working days after contractor places a newly contracted network provider on active status and shall complete the training within 30 calendar days of placing on active status. *(Contract, Exhibit A, Attachment 7 (5))*

Plan policy NO-001*, New Provider Orientations (revision date 06/30/2020),* stated that Provider Relations will initiate contact and begin orientation training to new providers within ten working days of contract execution and shall complete all training within 30 working days of being contracted.

Finding: The Plan did not ensure newly contracted providers received training within ten working days after placing providers on active status and did not complete the training within 30 calendar days.

Plan's policy *NO-001* stated the Plan will begin orientation training to new providers within ten working days and complete all training within 30 calendar days. However, the Plan did not implement its policy to train new providers within the required timeframes.

The verification study revealed the Plan did not conduct training for ten newly contracted providers within ten working days. In addition, for seven of the ten providers the Plan did not complete the training within 30 calendar days from placing the providers on active status.

During the interview, the Plan acknowledged it did not have enough resources to effectively monitor timely training of newly contracted providers.

Without ensuring that newly contracted providers receive timely training regarding the Medi-Cal program, the Plan cannot ensure providers operate in full compliance with program requirements. This can also lead to misinformation about member's rights, available resources, and provider's responsibilities.

Recommendation: Implement policy and procedures to ensure newly contracted providers receive and complete training within the required timeframes.

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REPORT ON THE MEDICAL AUDIT OF

VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION DBA: GOLD COAST HEALTH PLAN

2022

Contract Number:	10-87129 State Supported Services
Audit Period:	June 1, 2021 Through May 31, 2022
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I. INTRODUCTION

This report represents the audit of Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan's (Plan) compliance and implementation of the State Supported Services Contract No. 10-87129. The Contract covers contracted abortion services with the Plan.

The audit period was June 1, 2021 through May 31, 2022. The audit was conducted from July 25, 2022 through August 5, 2022.

An Exit Conference with the Plan was held on December 6, 2022. There were no deficiencies found.

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PLAN: Gold Coast Health Plan

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STATE SUPPORTED SERVICES

SUMMARY OF FINDING:

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Coding System Codes: 59840 through 59857 and Health Care Financing Administration Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, and Z0336. 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. Such changes shall not require an amendment to this Contract. *(Contract, Exhibit A, (4))*

Plan policy CL-007, *Abortion Services Claims Reimbursement* stated, "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. Inpatient hospitalization for the performance of an abortion requires prior authorization under the same criteria as other medical procedures. All qualified providers licensed to furnish abortion services may render services to Plan members."

The Plan's Member Handbook stated, if you are under 18 years of age, you can go to a doctor without permission from your parents or guardian for family planning and abortion services. You may choose any provider and go to them for these services without a referral or pre-approval (prior authorization). Additionally, the Provider Manual stated that Plan members may self-refer without prior authorization to any willing Medi-Cal provider for abortion services.

A review of the Plan's State Supported Services claims processing system and procedure codes used to bill for abortion services yielded no findings.

RECOMMENDATION:

None