

MEDICAL REVIEW – RANCHO CUCAMONGA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

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

Contract Number: **10-87128**

Audit Period: April 1, 2017
Through
March 31, 2018

Report Issued: **September 28, 2018**

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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 fee-for-service model to a managed care health plan model.

In April 2010, 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 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.

Medi-Cal is the Plan's only line of business. As of April 2018, the Plan served approximately 197,270 members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical review audit for the period April 1, 2017 through March 31, 2018. The onsite review was conducted from Monday, June 4, 2018 through Thursday, June 14, 2018. The audit consisted of document review, verification studies, and interviews with the Plan's personnel.

An Exit conference was held on August 30, 2018 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the preliminary audit findings. The Plan submitted supplemental information after the Exit Conference, which is reflected in this report.

The audit evaluated six categories of performance: Utilization Management, 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 March 23, 2018 (audit period April 1, 2016 through March 31, 2017) identified deficiencies that were addressed in the Corrective Action Plan (CAP). The CAP dated May 24, 2018 noted that previous audit findings were closed.

The summary of the findings by category are as follows:

Category 1 – Utilization Management

No findings were noted during this audit period.

Category 2 – Case Management and Coordination of Care

The Plan had two prior year audit findings that involved problems with coordination of services/care between the Plan and California Children's Services (CCS), and between the Plan, Behavioral Health Treatment (BHT) providers, and Primary Care Provider (PCP). The Plan submitted CAPs for the prior year audit findings.

To correct the prior year audit findings, the Plan implemented a monthly review of all active CCS cases for consistency of member information between the Plan and CCS to ensure efficient provision of services. The Plan also amended their UM policy for BHT to include members, PCP, and the requesting BHT provider for all Notice of Actions related to the approval, denial, or modification of BHT services.

No findings were noted during this audit period.

Category 3 – Access and Availability of Care

No findings were noted during this audit period.

Category 4 – Member’s Rights

The Plan did not submit privacy incident reports to all required DHCS entities within 10 working days. The Plan did not properly monitor its contractor to comply with privacy incident reporting.

Category 5 – Quality Management

No findings were noted during this audit period.

Category 6 – Administrative and Organizational Capacity

The Plan did not have policies and procedures to notify the Medi-Cal Managed Care Program/Program Integrity Unit (MMCP/PIU) within 10 working days of removing a suspended, excluded, or terminated provider from its provider network. Also, the Plan did not have procedures to confirm suspended, excluded, or terminated providers are no longer receiving Medicaid payments, and to ensure the safe transition of Medi-Cal members to a new provider.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The onsite review was conducted from June 4, 2018 through June 14, 2018. 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 administrators, staff, and network providers.

The following verification studies were conducted:

Category 1 – Utilization Management

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

Appeal Procedures: Ten prior authorization appeals were reviewed to ensure that required time frames were met and appeals were appropriately routed and adjudicated.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): 13 medical records were reviewed for coordination of care between the Plan and CCS providers.

Complex Case Management: 12 medical records were reviewed for continuous tracking, monitoring, and coordination of resources to members who received complex case management services.

Initial Health Assessment (IHA): 15 adults and ten children medical records were reviewed to confirm required elements for IHA were completed within 120 days of enrollment in the health plan.

Behavioral Health Treatment (BHT): Ten BHT charts were reviewed for compliance with BHT provision requirements.

Category 3 – Access and Availability of Care

Appointment Availability: 15 contracted providers from the Provider’s Directory were reviewed to determine if appointments were accurate, complete, and available. The third next available appointment was used to measure access to care.

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

Category 4 – Member’s Rights

Grievance Procedures: Ten quality of service and ten quality of care grievance cases were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review.

Confidentiality Rights: Ten cases were reviewed for proper reporting of suspected or actual breaches of privacy incidents to the appropriate entities within the required time frames.

Category 5 – Quality Management

Provider Qualifications: Ten contracted providers were reviewed to determine if they received Medi-Cal Managed Care program training within the required time frame.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse: Ten cases were reviewed for proper reporting of suspected fraud and/or abuse to the appropriate entities within the required time frame.

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

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Gold Coast Health Plan

AUDIT PERIOD: April 1, 2017 - March 31, 2018

DATE OF ONSITE AUDIT: June 4, 2018 -
June 14, 2018

CATEGORY 4 – MEMBER’S RIGHTS

4.3

CONFIDENTIALITY RIGHTS

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:

A. Responsibilities of Business Associate.

Business Associate agrees:

2. **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, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316....(as required by Contract)

J. Breaches and Security Incidents. During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. **Notice to DHCS.** (1) To notify DHCS immediately by telephone call plus email or fax upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. (2) To notify DHCS within 24 hours by email or fax of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate....

COHS Contract G.III.C, J

❖ COMPLIANCE AUDIT FINDINGS ❖

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2. **Investigation and Investigation Report.** Too immediately, investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated “DHCS Privacy Incident Report” containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:
3. **Complete Report.** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure....

COHS Contract G.III.C, J

SUMMARY OF FINDING:

4.3.1 Timely submission of privacy incident reports

The Plan is required to provide a complete report of the investigation to DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within 10 working days of the discovery of the breach or unauthorized use or disclosure. The report shall be submitted on the “DHCS Privacy Incident Report” form...*(Contract, Exhibit G, III (J)(3))*

The Plan did not submit privacy incident reports to all required DHCS entities and did not submit these reports within 10 working days. Although the Plan has policies and procedures on privacy incident reporting, the Plan did not properly monitor its contractor to comply with privacy incident reporting. The verification study revealed a case was not reported to DHCS Program Contract Manager and DHCS Information Security Officer; another case exceeded the reporting time frame by 54 working days.

Without timely submission of privacy incident reports to DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer, the Department will not be able to take immediate corrective actions to mitigate any risk or damage to the members’ protected health information.

❖ COMPLIANCE AUDIT FINDINGS ❖

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June 14, 2018

RECOMMENDATIONS:

4.3.1 Adhere to the Plan's privacy incident reporting policies and procedures to ensure timely submission of privacy incident reports to the required DHCS entities.

Improve the Plan's monitoring process to ensure its contractor complies with privacy incident reporting.

❖ COMPLIANCE AUDIT FINDINGS ❖

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.3

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. These requirements shall be met through the following:

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....

5. Tracking Suspended Providers

Contractor shall comply with Title 42 CFR Section 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with Physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. A list of suspended and ineligible providers is maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal website (www.medi-cal.ca.gov) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (<http://oig/hhs.gov>). Contractor is deemed to have knowledge of any providers on these lists. Contractor must notify the Medi-Cal Managed Care Program/Program Integrity Unit within ten (10) State working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program.

COHS Contract E.2.27.B

SUMMARY OF FINDINGS:

6.3.1 Notification of Suspended, Excluded, or Terminated Providers

The Plan must "notify the Medi-Cal Managed Care Program (MMCP)/Program Integrity Unit (PIU) within 10 State working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving

❖ COMPLIANCE AUDIT FINDINGS ❖

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payments in connection with the Medicaid program." (*Contract, Exhibit E, Attachment 2, (27)(B)(5)*)

Title 42, Code of Federal Regulations, section 438.608 requires the Plan to implement and maintain procedures that are designed to detect and prevent fraud, waste, and abuse. A compliance program that includes, at a minimum, the following elements: "...Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements."

The All Plan Letter (APL) 16-001 states the Plan is required to "communicate the notification to all related downstream entities including subcontractors and delegated entities; ensure the provider receives no payment for Medi-Cal services provided on or after the effective date of action; and maintain ongoing communication with DHCS about the transition of any affected beneficiaries." The Plan also "must take steps to ensure the safe transition of Medi-Cal beneficiaries to a new provider."

Although the Plan has a process to track and monitor suspended or terminated provider through their Credentialing and Provider Network departments, the Plan did not have specific policies and procedures to notify the MMCP/PIU within 10 working days of removing a suspended, excluded, or terminated provider from its provider network and confirm the provider is no longer receiving Medicaid payments. In addition, the Plan acknowledged they did not have policies and procedures to ensure the safe transition of Medi-Cal members to a new provider.

Lack of policies and procedures to report and stop payment to suspended, excluded, or terminated providers from the Plan's network, may result in unnecessary costs to the Medicaid program. Also, lack of policies and procedures to ensure safe transition of members to new providers may lead to delays in members receiving medically necessary services.

RECOMMENDATIONS:

6.3.1 Develop and implement policies and procedures to notify Medi-Cal Managed Care Program/Program Integrity Unit within 10 working days of removing a suspended, excluded or terminated provider from its network and to confirm these providers are no longer receiving Medicaid payments.

Develop and implement policies and procedures to ensure the safe transition of Medi-Cal members to a new provider.

MEDICAL REVIEW SECTION – RANCHO CUCAMONGA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

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

Contract Number: 10-87129
State Supported Services

Audit Period: April 1, 2017
Through
March 31, 2018

Report Issued: September 28, 2018

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INTRODUCTION

This report presents audit findings of the Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan (GCHP) State Supported Services Contract No. 10-87129. The State Supported Services contract covers contracted abortion services with GCHP.

The audit period was April 1, 2017 through March 31, 2018. The onsite audit was conducted from June 4, 2018 through June 14, 2018.

An exit conference was held on August 30, 2018 with the Plan.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Gold Coast Health Plan

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DATE OF ONSITE AUDIT: June 4, 2018 -
June 14, 2018

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 Care Services (DHCS) 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.*

(Contract Exhibit A, (4))

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 Finance Administration (HCFA) Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, and 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. *(Contract, Exhibit A, (4))*

Policy# CL-007: *Abortion Services Claims Reimbursement* states, Gold Coast Health Plan (GCHP) "will reimburse providers for Abortion services without the requirement of an authorization when the services are performed on an outpatient basis. Inpatient hospitalization for the performance of an abortion requires prior authorization under the same criteria as other medical procedures. All qualified providers licensed to furnish Abortion Services may render services to GCHP members."

All required State Supported Services procedure codes were verified within the Plan's billing system.

There were no deficiencies noted during this audit period.

RECOMMENDATION:

None