DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

LOS ANGELES SECTION

REPORT ON THE MEDICAL AUDIT OF VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION DBA GOLD COAST HEALTH PLAN FISCAL YEAR 2024-25

Contract Number: 23-30242

Audit Period: July 1, 2023 — June 30, 2024

Dates of Audit: September 23, 2024 — October 4, 2024

Report Issued: March 12, 2025

TABLE OF CONTENTS

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 (FFS) 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 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.

As of September 2024, the Plan had 245,613 Medi-Cal members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of July 1, 2023, through June 30, 2024. The audit was conducted from September 23, 2024, through October 4, 2024. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on February 19, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On March 6, 2025, 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 (UM), 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 for the period of July 1, 2022, through June 30, 2023, was issued on November 30, 2023. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation of the 2022 and 2023, Corrective Action Plans.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan is required to ensure the UM program has a specialty referral system to track and monitor authorized, denied, deferred, or modified referrals, including out-of-network referrals, and the timeliness of the referrals. The Plan did not ensure there was a UM program with a specialty referral system to track and monitor authorized, denied, deferred, or modified referrals, including out-of-network referrals, and the timeliness of the referrals. The Plan's specialty referral systems must include information on requested out-of-network services. The Plan must ensure that all network providers are aware of the specialty referral processes and tracking procedures. The Plan did not ensure the UM program included a specialty referral system to track and monitor authorized, denied, deferred, or modified referrals, including out-of-network referrals, and the timeliness of the referrals.

The Plan is required to ensure that prior authorizations, concurrent review, and retrospective review authorization procedures meet the minimum requirements.

Prior authorization requirements must not be applied to preventive services. The Plan did not ensure that prior authorization requirements were not applied to preventive services.

Category 2 – Case Management and Coordination of Care

The Plan must cover and ensure that Initial Health Appointments (IHA) are performed within 120 calendar days of enrollment with the Plan. The Plan did not provide IHAs to members within 120 calendar days of enrollment with the Plan.

The Plan must make reasonable attempts to contact a member to schedule an IHA. The Plan did not make reasonable attempts to contact members and document all attempts to schedule an IHA.

The Plan must cover and provide blood lead screening tests to members up to six years of age and in intervals as specified in *All Plan Letter (APL) 20-016, Blood Lead Screening of Young Children*. The Plan did not ensure the provision of blood lead screening tests to members at one and two years of age, including up to six years of age.

The Plan must provide oral or written anticipatory guidance that includes information that children can be harmed by exposure to lead. The Plan did not provide oral or written blood lead anticipatory guidance to the parent or guardian of members starting at six months to six years of age.

The Plan must accept Continuity of Care (COC) requests over the telephone and must not require the requester to complete and submit a paper or online form if the requester prefers to make the request by telephone. The Plan did not implement policies and procedures to accept COC requests from providers over the telephone.

The Plan is required to attempt to notify member of the COC decision via the member's preferred method of communication or by telephone. The Plan must also send a notice by mail to the member within seven calendar days of the COC decision. The Plan did not send the member notification by mail within seven calendar days of the COC decision.

The Plan must include in the notice for COC requests that are denied a statement of the Plan's decision, a clear and concise explanation of the reason for denial, and the member's right to file a grievance or appeal. The Plan's notification of denial for COC requests did not include the required information as specified in *APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023*.

The Plan must include in the notice for COC requests that are approved a statement of the decision, the duration of the COC arrangement, the process that will occur to transition the member's care at the end of the COC period, and the member's right to choose a different network provider. The Plan's member notification of approval for COC requests did not include the required information as specified in APL 23-022.

The Plan must develop, implement, maintain, and periodically update the Quality Improvement and Health Equity Transformation Program policies and procedures to include, at a minimum, mechanisms to continuously monitor, review, evaluate, and improve coordination and COC services to all members. The Plan's policies and procedures did not include mechanisms to continuously monitor, review, and evaluate COC services for all members.

Category 3 – Access and Availability of Care

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

Category 4 – Member's Rights

The Plan is required to have a grievance system that allows the DHCS to contact the Plan regarding urgent grievances 24 hours a day, 7 days a week. The Plan's policy did not include written procedures to allow the DHCS to contact the Plan regarding urgent grievances.

The Plan is required to submit a written record of grievances and appeals to the governing body, the public policy body, and an officer or designee for periodic review and the review must be thoroughly documented. The Plan's written grievance log was not reviewed by the board of directors, public policy body, and a designated officer.

Category 5 – Quality Management

The Plan must ensure that all network providers complete training within 30 working days after placing a newly contracted network provider on active status. The Plan did not provide training to newly contracted providers within the required timeframes.

Category 6 – Administrative and Organizational Capacity

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

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 September 23, 2024, through October 4, 2024, for the audit period of July 1, 2023, through June 30, 2024. 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

Service Requests: 25 medical services requests (4 approved, 16 denied, and 5 deferred) were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: 25 appeals related to medical services were reviewed for appropriateness and timeliness of decision-making.

Delegated Prior Authorization Requests: 11 medical prior authorization requests were reviewed for appropriate and timely adjudication. Of the 11 requests, 5 were pre-service requests and 6 were concurrent review requests.

Category 2 – Case Management and Coordination of Care

IHA: 30 medical records were reviewed for appropriate documentation, timely completion, and fulfillment of all required IHA components.

Complex Case Management: 20 medical records were reviewed for continuous tracking, monitoring, and coordination of services.

COC: 25 medical records were reviewed to evaluate the process used for COC approval and notification of services.

Category 3 – Access and Availability of Care

Non-Emergency Medical Transportation (NEMT): 20 records were reviewed to confirm compliance with NEMT requirements.

Non-Medical Transportation (NMT): 20 records were reviewed to confirm compliance with NMT requirements.

Category 4 – Member's Rights

Grievance Procedures: 40 standard grievances, 7 expedited grievances, 20 exempted grievances, and 20 inquiries were reviewed for timely resolutions, response to complainant, and submission to the appropriate level for review. The 40 standard grievance cases included 20 quality of care and 20 quality of service grievances.

Category 5 – Quality Management

Potential Quality Issues (PQI): Five PQI cases were reviewed for appropriate evaluation, investigation, and effective action taken to address improvements and remediation.

New Provider Training: 15 newly contracted providers were reviewed for timely provision of Medi-Cal Managed Care Program training.

Category 6 – Administrative and Organizational Capacity

Encounter Data Review: Five records were reviewed to verify the Plan's claims process and supporting documentation.

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

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.1 Referral Tracking

1.1.1 Referral Tracking System

The Plan must ensure that the UM program has a specialty referral system to track and monitor referrals requiring prior authorization. When prior authorization is delegated, the Plan must ensure that subcontractors have systems in place to track and monitor referrals requiring prior authorization. The Plan's specialty referral systems must include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. The Plan's specialty referral systems must include information on requested out-of-network services. The Plan must ensure that all network providers are aware of the specialty referral processes and tracking procedures. *(Contract Exhibit A, Attachment III 2.3(H))*

The Plan's policy, *HS-037 Tracking Referrals to Specialist* (revised 07/27/2023), stated that only out-of-network and out-of-area specialty referrals require prior authorization. These specialty referrals are tracked and trended through quarterly reports and presented annually to the UM and Medical Advisory Committees for review and recommendations.

Finding: The Plan did not ensure the UM program included a specialty referral system to track and monitor authorized, denied, deferred, or modified referrals, including out-of-network referrals, and the timeliness of the referrals.

The Plan's policy, HS-037 stated that out-of-network and out-of-area specialty referrals are tracked and trended through quarterly reports. However, review of the Plan's quarterly reports showed that although the Plan tracked authorized referrals, the Plan did not track denied, deferred, or modified referrals, and referral timeliness. Furthermore, the Plan did not demonstrate oversight to ensure the delegate Carelon had systems in place to track and monitor referrals requiring prior authorization. The Plan delegated Carelon to perform prior authorizations for behavioral health services.

Review of the delegation agreement between the Plan and Carelon revealed no description of the Plan's oversight process to ensure that Carelon tracks and monitors authorized, denied, deferred, or modified referrals, including out-of-network referrals, and the timeliness of the referrals. In an interview, the Plan stated that the annual

review of Carelon included a random sampling of specialty referrals. Although requested from the Plan, the Plan did not submit documentary evidence demonstrating that its oversight of Carelon tracked and monitored all authorized, denied, deferred, or modified referrals, including out-of-network referrals, and the timeliness of the referrals. Without a specialty referral tracking system, the Plan is not able to monitor access to care and perform interventions to improve the timeliness for the delivery of the services.

Recommendation: Revise and implement policies and procedures to ensure the Plan's UM program includes a specialty referral system to track and monitor authorized, denied, deferred, or modified referrals, including out-of-network referrals; and the timeliness of the referrals.

1.2 Prior Authorization Review Requirements

1.2.1 Preventive Services

The Plan must ensure that prior authorizations, concurrent review, and retrospective review authorization procedures meet the minimum requirements, in accordance with California Health and Safety Code, section 1367.01. Prior authorization requirements must not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease (STD) services, human immunodeficiency virus (HIV) testing, or initial mental health and substance use disorder assessments. *(Contract, Exhibit A, Attachment III, 2.3.1(H))*

Plan policy, *HS-001 Prior Authorization Requests* (revised 01/23/2024), stated that the Plan's pre-authorization review procedures must meet the minimum requirements, and prior authorization requirements should not be applied to emergency services, minor consent services, family planning services, preventive services, primary care services, basic prenatal care, mild to moderate mental health assessments or treatments.

Finding: The Plan did not ensure that prior authorization requirements were not applied to preventive services.

Although Plan policy HS-001, stated that the prior authorization requirements should not be applied to preventive services, prior authorizations were required for low-dose Computed Tomography (CT) scans for lung cancer screening.

Review of the Plan's prior authorization log identified 56 prior authorization requests for low-dose CT for lung cancer screening. In addition, review of the Plan's Prior

Authorization Grid indicated that CT scans required prior authorization but did not differentiate that low-dose CT scans used for lung cancer screening did not require prior authorization.

During the interview, the Plan stated that it educates providers of the Plan's prior authorization process through the Plan's website, provider manual, provider operation bulletin, and during new provider training. However, the Plan's Prior Authorization Grid incorrectly included preventive services. The UM Department is responsible for reviewing and updating the Prior Authorization Grid on an annual basis.

When the Plan requires prior authorizations for preventive services, this may cause a delay and possible denials for medically necessary services.

Recommendation: Implement policies and procedures and revise the Prior Authorization Grid to remove prior authorization for preventive services.

COMPLIANCE AUDIT FINDINGS

Category 2 – Case Management and Coordination of Care

2.1 Initial Health Appointment

2.1.1 Initial Health Appointment Timeliness

The Plan must ensure the provision of an IHA in accordance with California Code of Regulations (CCR), Title 22, sections 53851(b)(1), and 53910.5(a)(1), and *APL 22-030*, *Initial Health Appointment*. An IHA at a minimum must include a history of the member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, a physical examination, and the diagnosis and plan for treatment of any diseases, unless the member's Primary Care Provider (PCP) determines that the member's medical record contains complete information, updated within the previous 12 months, consistent with the assessment requirements. The Plan must ensure that a member's completed IHA is documented in their medical record and that appropriate assessments from the IHA are available during subsequent health visits. *(Contract, Exhibit A, Attachment III, 5.3.3)*

The Plan must cover and ensure that IHAs are performed within 120 calendar days of enrollment with the Plan. *(Contract, Exhibit A, Attachment III, 5.3.4 (A) and 5.3.5 (A)(1))*

Plan policy, *QI-034 Initial Health Appointment* (revised 03/26/2024), stated that Plan providers must conduct the IHA within 120 days of member enrollment. The Plan distributes monthly lists of new members to contracted PCPs to assess IHA needs and conduct outreach. Providers are required to make two phone calls and send an outreach letter to schedule the IHA. The providers are required to record the outreach efforts and send the documentation back to the Plan. Additionally, the Plan has an established process to monitor for IHA timeliness by using a combination of monthly lists provided to PCPs to track members needing IHAs, quarterly Medical Record Reviews (MRRs) to evaluate compliance with IHA requirements, and the use of primary care visits as proxy measures for IHA completion. The Plan also leverages Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System codes from claims to indicate whether an IHA has been conducted and tracks various childhood screenings, including those for adverse childhood experiences, developmental issues, and substance use disorders, to ensure comprehensive preventive care.

Finding: The Plan did not provide IHAs to members within 120 calendar days of enrollment with the Plan.

In a verification study, 6 of 25 members experienced delays in IHAs. Delays ranged from 5 days to 179 days beyond the 120 days of enrollment with the Plan.

During the interview, the Plan stated that there is no process in place to track members who are nearing the 120-day deadline for completing the IHAs. Instead, the Plan reviews this retrospectively. The Plan explained that the process involves providing a list of new members to providers to make two required phone calls and send one outreach letter to schedule the IHA. The providers then submit the outreach information to the Plan. Additionally, the Plan monitors IHA completion through billing claims data, but acknowledged that there is typically a three-month delay in receiving and processing this information. This deficiency stems from the lack of a proactive tracking mechanism for members nearing the 120-day deadline. The Plan's reliance on retrospective reviews and delayed claims data prevents timely intervention and may have led to missed or delayed IHAs.

When the Plan does not provide timely IHAs, this can lead to delays in assessment and management of the acute, chronic, and preventative health needs of the member.

Recommendation: Revise and implement policies and procedures to ensure IHAs are completed within 120 calendar days of enrollment with the Plan.

2.1.2 Initial Health Appointment Outreach

The Plan must make reasonable attempts to contact a member to schedule an IHA. The Plan must document all attempts to contact a member. Documented attempts that demonstrate the Plan's efforts to unsuccessfully contact a member and schedule an IHA will be considered evidence in meeting this requirement. *(Contract, Exhibit A, Attachment III, 5.3.3)*

The Plan's desktop procedure, *IHA Steps for Outreach,* documents that providers are directed to perform outreach to members for scheduling an IHA. Providers receive a list of new members monthly and are instructed to send outreach letters and make two phone call attempts if necessary. The outreach attempts, including letters and calls, are documented in a spreadsheet with specific codes indicating the outcome of each contact. Once the outreach process is complete, the spreadsheet must be emailed back to the Plan's Quality Improvement (QI) team to ensure that all efforts are tracked and logged as required.

Finding: The Plan did not make reasonable attempts to contact members and document all attempts to schedule an IHA.

An IHA verification study identified eight member records that revealed non-timely IHA completion, six of which did not show documentation of outreach.

In an interview, the Plan stated that outreach responsibilities are delegated to providers, with specific instructions to complete a log documenting the outreach efforts. The logs are then returned to the Plan, where, according to the QI Registered Nurse Manager, are stored and reviewed for completeness. However, the QI Registered Nurse Manager confirmed that no further follow-up or oversight actions are taken on the logs. The only additional oversight related to IHA outreach is conducted through the quarterly MRR audit process.

Failure to document outreach efforts can result in members not receiving timely notifications about important health assessments, screenings, or services, leading to potential gaps in care.

Recommendation: Implement policies and procedures to ensure the Plan makes and documents reasonable attempts to contact members to schedule an IHA.

2.1.3 Blood Lead Screening Test

The Plan must cover and ensure the provision of blood lead screening tests to members at the ages and intervals specified in accordance with *APL 20-016, Blood Lead Screening of Young Children. (Contract, Exhibit A, Attachment III, 5.3.4 (D))*

Plans must ensure that the network providers order or perform blood lead screening tests on all children in accordance with the following: 1) At 12 months and at 24 months of age; 2) When the health care provider performing a Periodic Health Assessment (PHA) becomes aware that a child 12 to 24 months of age has no documented evidence of blood lead screening test taken at 12 months of age or thereafter; 3) When the network provider performing a PHA becomes aware that a child member 24 to 72 months of age has no documented evidence of a blood lead screening test taken; 4) At any time, a change in circumstances has, in the professional judgement of the network provider, put the child member at risk; and 5) If requested by the parent or guardian. *(APL 20-016)*

Plan policy, *QI-029 Blood Lead Screening of Young Children* (revised 02/28/2023), mandates Blood Lead Level (BLL) testing for all children at one and two years of age, as well as for children aged one through six without prior documented testing. The

Plan ensures compliance by identifying children under six who missed the required testing and notifying network providers of incomplete documentation.

Finding: The Plan did not ensure the provision of blood lead screening tests to members at one and two years of age, including up to six years of age as specified in APL 20-016.

In a verification study of IHA documentation for members aged two through four years old, 4 of 13 member records revealed that Plan providers did not perform BLL testing nor document whether a child member had a previous blood lead test taken. If the Plan does not have an established process to inquire and document previous BLL tests, it cannot determine the need to perform BLL tests.

During interviews, when asked if the Plan has an established process to inquire about previous BLL testing before deciding whether testing is needed, the Plan referenced the quarterly lead reporting, which is based on specific BLL testing CPT codes (absence of which warrants testing), and the DHCS' data on lead testing results. This information is used to inform providers about members who still require testing. However, when asked if the Plan has an established process for documenting inquiries into previous BLL testing in members' charts, since no such documentation was found in the BLL samples reviewed, the Plan did not confirm the existence of such a process but instead stated that this is an area of improvement that the Plan is addressing with the providers.

Failing to provide blood lead screening tests at the required ages and intervals may result in missed opportunities to detect elevated BBLs in children. This could delay early intervention and treatment, potentially leading to prolonged lead exposure, which can cause serious developmental, cognitive, and behavioral health issues in affected children.

Recommendation: Implement policies and procedures to provide blood lead screening tests to members at the ages and intervals specified in APL 20-016.

2.1.4 Blood Lead Level Anticipatory Guidance

The Plan must comply with all DHCS' guidance, including but not limited APLs, Policy Letters (PLs), the California Medicaid State Plan, and the Medi-Cal Provider Manual. *(Contract, Exhibit E, 1.1.2)*

The Plan is required to provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child that at a minimum, includes information that children can be

harmed by exposure to lead. This anticipatory guidance must be provided to the parent or guardian at each PHA, starting at 6 months of age and continuing until 72 months of age. *(APL 20-016, Blood Lead Screening of Young Children)*

Plan policy, *QI-029 Blood Lead Screening of Young Children* (revised 02/28/2023), stated that Plan providers offer oral or written anticipatory guidance to the parent(s) or guardian(s) of a child during each PHA. This guidance must address the risks of lead exposure emphasizing that children are especially vulnerable to lead poisoning from the time they begin crawling at six months until they reach six years of age.

Finding: The Plan did not provide oral or written blood lead anticipatory guidance to the parent or guardian of members starting at six months to six years of age.

A verification study of IHA documentation for members aged two through four years old was conducted to review for compliance with BLL requirements. Ten of 13 member records revealed the Plan did not document BLL related anticipatory guidance to the parent or guardian of members starting at six months to six years of age.

In an interview, the Plan acknowledged that compliance for anticipatory guidance requirements was reviewed for a limited age group and not for all children ages six months to six years. The Plan's MRR tool only reviewed documentation of anticipatory guidance compliance for children at six and twelve months of age. However, the Plan updated the MRR tool and implemented usage in July 2024 to address the gap.

Failing to provide anticipatory guidance to patients may result in the Plan missing opportunities to inform parents or guardians about the risks of lead exposure. This communication gap could lead to reduced awareness of preventive measures, potentially increasing the risk of lead poisoning in children.

Recommendation: Implement policies and procedures to provide oral or written blood lead anticipatory guidance to the parent or guardian of members starting at six months to six years of age.

2.4 Continuity of Care

2.4.1 Continuity of Care Requests by Telephone

The Plan must accept COC requests from the member, authorized representative, or a provider over the telephone, according to the requester's preference, and must not require the requester to complete and submit a paper or online form if the requester

prefers to make the request by telephone. To complete a telephone request, the Plan may take any necessary information from the requester over the telephone. *(APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023)*

Plan policy, *HS-049 Continuity of Care* (revised 02/20/2024), described the COC process and stated that members, authorized representatives, or providers may request COC with an out of network provider. The request may be submitted over the phone or in writing to the Plan and submitted to the UM Department for review.

The Plan informs members of their COC rights, and the member services telephone number is listed in the member handbook.

Finding: The Plan did not implement its policies and procedures to accept COC requests from providers over the telephone.

During the interview, the Plan stated the COC requests submitted by providers are handled by the UM Department. Currently, the UM Department processes the requests as out-of-network requests. Providers do not have the option to submit the requests over the phone. Instead, providers are instructed to follow the out-of-network requirements, which involves completing the request through the designated portal or via fax.

In a written response, the Plan confirmed that COC requests are completed using a Pre-Authorization Treatment Request Form. The Plan did not state that it accepts or completes COC requests over the telephone.

Without a procedure in place to allow providers to submit COC requests over the telephone, the members' care may be delayed or impacted.

Recommendation: Implement policies and procedures to accept providers' COC requests over the telephone.

2.4.2 Member Notification for Continuity of Care Requests

A COC request is considered complete when the Plan notifies the member of the decision. The Plan must attempt to notify the member of the COC decision via the member's preferred method of communication or by telephone. The Plan must also send a notice by mail to the member within seven calendar days of the COC decision. *(APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023)*

Plan policy, *HS-049 Continuity of Care* (revised 02/20/2024), stated that for denials the Plan will notify the member via member's preferred method of communication or by telephone within 48 hours of the decision, for one of the following reasons: 1) COC criteria is not met; 2) Plan and the out-of-network Medi-Cal FFS provider are unable to agree to a rate; 3) Plan has documented quality of care issues with the Medi-Cal FFS provider; and 4) The Plan makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days. The notice to the member will include: 1) A statement of the decision; 2) A clear and concise explanation of the denial reason; and 3) The member's right to file a grievance or appeal.

According to the Plan's *Job Aid Manual Continuity of Care Process* (revised 03/06/23), for denied COC requests, the Care Management Coordinator (CMC) will call the member within 72 hours to assist with transitioning the member to an in-network provider and follow the Care Management process.

Finding: The Plan did not send the member notification by mail within seven calendar days of the COC decision.

In a verification study, nine of ten COC requests were denied by the Plan. Although the Plan documented attempts to notify members, it did not send a notice of the COC decision by mail within seven calendar days of the Plan's decision.

Plan policy HS-049, states the Plan's process for providing COC and the elements of a COC notification letter. However, this policy does not state that notification letters will be mailed to members within seven calendar days of the COC decision.

The absence of specific guidelines regarding mailing notices may delay effective communication with the member about the decision on COC, potentially leading to delays in receiving timely and appropriate services.

Recommendation: Revise and implement policy and procedures to send notices by mail to members within seven days of the COC decision.

2.4.3 Member Notification Letter of Continuity of Care Denial

The Plan must include in the notice for COC requests that are denied the following information: 1) A statement of the Plan's decision; 2) A clear and concise explanation of the reason for denial; and 3)

The member's right to file a grievance or appeal. *(APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023)*

Plan policy, *HS-049 Continuity of Care* (revised 02/20/2024), stated that for COC requests that are denied, the notice to the member will include: 1) A statement of the decision; 2) A clear and concise explanation of the denial reason; and 3) the member's right to file a grievance or appeal.

Finding: The Plan's notification of denial for COC requests did not include the required information as specified in APL 23-022.

In a verification study, nine of ten COC requests were denied, and the Plan did not send denial letters to members with the following information:

- A statement of the Plan's decision.
- A clear and concise explanation of the reason for denial.
- The member's right to file a grievance or appeal.

The Plan sent Unable To Reach letters to members instead of the notice of denial for COC requests.

During the interview, the Plan explained that COC requests are treated as out-of-network prior authorizations and are handled through the UM Department. As a result, the Plan utilizes the NOA template, released under *APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*, that is used for out-of-network prior authorizations and has not been modified to integrate the required information for denials of COC requests. The Plan stated that the Health Services Leadership Team is responsible for updating and developing letters to members in accordance with new regulations as well as distributing and implementing to its respective departments. The Plan also recognized the deficiency alluded to a misinterpretation of the original instructions which led to a delay in implementing regulations.

Without the required information on the denial notice, members will be unaware of the status of their COC request, reason for the denial, and may not be able to exercise their appeal rights.

Recommendation: Develop notification letter for denied COC requests to include the required information as specified in APL 23-022.

2.4.4 Member Notification Letter of Continuity of Care Approval

For COC requests that are approved the Plan must include the following information: 1) A statement of the decision; 2) The duration of the COC arrangement; 3) The

process that will occur to transition the member's care at the end of the COC period; and 4) The member's right to choose a different network provider. *(APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023)*

Plan policy, *HS-049 Continuity of Care* (revised 02/20/2024), stated that COC requests that are approved, the notice to the member will include: 1) A statement of the decision; 2) The duration of the COC arrangement; 3) The process that will occur to transition the member's care at the end of the COC period; and 4) The member's right to choose a different provider from the Plan's provider network.

According to the Plan's *Job Aid Manual Continuity of Care Process* (updated 03/06/23), for COC requests approved for 12 months, CMC will send the COC approval letter "CM PR MBR COC Approval LTR CC PCP" to the member and PCP.

Finding: The Plan's member notification letters regarding approvals for COC requests did not include the required information as specified in APL 23-022.

In a verification study, one of ten COC requests was approved. Although the Plan sent an approval notification letter, this letter did not contain the following information:

- A statement of the decision
- The process that will occur to transition the member's care at the end of the COC period.
- The member's right to choose a different network provider.

The Plan sent the UM letter intended for out-of-network authorization instead of the notice of approval for COC requests.

During the interview, the Plan explained that COC requests are treated as out-of-network prior authorizations and are handled through the UM Department. As a result, the Plan is currently using a letter template intended for out-of-network authorizations and has not modified the template to integrate the required information for approvals of COC requests in accordance with APL 23-022.
The Plan acknowledged the deficiency occurred due to a misunderstanding of the regulations governing the member notification process for COC requests.

Without the required information on the approval notice, members will be unaware of the status of their COC request, decision for plan of care, and treatment.

Recommendation: Develop notification letter for approved COC requests to include the required information as specified in APL 23-022.

2.4.5 Tracking and Monitoring of Continuity of Care Services

The Plan must develop, implement, maintain, and periodically update the Quality Improvement and Health Equity Transformation Program policies and procedures that include, at a minimum, mechanisms to continuously monitor, review, evaluate, and improve coordination and COC services to all members. (*Contract, Exhibit A, Attachment III, 2.6.6 (F))*

The Plan must continue to report on existing metrics related to any COC provisions outlined in state law and regulations, or other state guidance documents. DHCS may request additional reporting on COC at any time and in a manner determined by the DHCS. (*APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023)*

Finding: The Plan's policies and procedures did not include mechanisms to continuously monitor, review, and evaluate COC services for all members.

The Plan's policy, HS-049 did not include a process to monitor, track, and evaluate COC services.

During the interview, the Plan stated that the COC log provided for the audit was specifically extracted for the DHCS' request. The Plan stated there was a misinterpretation of the original instructions which led to a delay in implementing changes.

Without a process in place to continuously monitor, review, and evaluate COC services, members may not receive medically necessary services in a timely manner.

Recommendation: Revise policies and procedures to include mechanisms to continuously monitor, review, evaluate, and improve COC services to members.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member's Rights

4.1 Grievance System

4.1.1 Urgent Grievances

The Plan's policies and procedures must include all required information set for grievances and expedited review of grievances as required under the Code of Federal Regulations (CFR), Title 42, sections 438.402, 438.406, and 438.408; CCR, Title 28, sections 1300.68 and 1300.68.01, and CCR, Title 22, section 53858. *(Contract, Exhibit A, Attachment III, 4.6.2)*

The Plan is required to include in the grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of a member, including, but not limited to, severe pain, potential loss of life, limb or major bodily function ("urgent grievances"). *(CCR, Title 28, section 1300.68.01(a))*

The Plan is required to have a grievance system that allows DHCS to contact the Plan regarding urgent grievances 24 hours a day, 7 days a week. During normal work hours, the Plan shall respond to DHCS within 30 minutes after initial contact from DHCS. During non-work hours, the Plan shall respond to DHCS within one hour after initial contact from DHCS. The Plan is required to provide DHCS a description of the system established by the Plan to resolve urgent grievances and how DHCS may access the Plan's grievance system. *(CCR, Title 28, section 1300.68.01(b))*

Plan policy, *GA-001 Member Grievance & Appeals System* (revised 03/14/2024), stated that a member can request an expedited grievance for cases that may involve an imminent and serious threat to their health, including, but not limited to, severe pain or potential loss of life, limb or major bodily function. The Plan will resolve these cases that meet criteria within 72 hours of receipt of the request.

Finding: The Plan's policy does not include written procedures to allow DHCS to contact the Plan regarding urgent grievances.

Plan policy GA-001, addresses the Plan's policy to process expedited grievances. However, this policy lacks a description on how the Plan allows DHCS to contact the Plan regarding urgent grievances 24 hours a day, 7 days a week.

In an interview, the Plan's staff gave conflicting information that DHCS can contact the Plan regarding urgent grievances 24 hours a day, 7 days a week. The Plan stated that a process exists; however, no written procedures are in place in the Plan's policies and procedures.

The Plan did not submit additional documents to demonstrate that a process is in place to allow DHCS to contact the Plan regarding urgent grievances 24 hours a day, 7 days a week.

Without written procedures in place, urgent grievances may not be processed in a timely manner which may cause harm to members.

Recommendation: Revise and implement policies and procedures to allow DHCS to contact the Plan regarding urgent grievances.

4.1.2 Written Record

The Plan is required to have in place a member grievance and appeal system that complies with CFR, Title 42, sections 438.228 and 438.400 – 424, CCR, Title 28, sections 1300.68 and 1300.68.01, and CCR, Title 22, section 53858 for covered services including contractor's selected community supports under CFR, Title 42, section 438.3(e)(2). The Plan is required to follow grievance and appeal requirements, and use all notice templates included in *APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*.

A written record shall be made for each grievance received by the Plan, including the date received, the Plan representative recording the grievance, a summary or other documents describing the grievance, and the disposition. The written record of grievances shall be reviewed periodically by the governing body of the Plan, the public policy body created pursuant to CCR, Title 28, section 1300.69, and by an officer of the Plan or their designee. The review shall be thoroughly documented. (*CCR, Title 28, section 1300.68 (b)(5)*)

The written record of grievances and appeals must be reviewed periodically by the governing body of the Plan, the public policy body, and by an officer or designee. The review must be thoroughly documented. *(APL 21-011)*

Plan policy, *GA-001 Member Grievance & Appeals System* (revised 03/14/2024), stated that the recording of grievances, either verbally or in writing is documented in the grievance log. The Plan tracks member grievances and appeals and submits monthly

and quarterly reports to the DHCS outlining all member grievances and appeals received.

Finding: The Plan's written grievance log was not periodically reviewed by the board of directors, public policy body, and a designated officer.

Although the Plan's policy GA-001, stated that a grievance log will be maintained, the policy does not mention that the grievance log will be reviewed periodically by the Plan's governing body, the public policy body, and an officer or designee.

During the interview, the Plan stated that Grievance and Appeals Department reports the total number of grievances to the Consumer Advisory Committee, but these reports did not include the required components outlined in APL 21-011. Furthermore, the Plan stated that the governing board and advisory committee does not periodically review the written grievance log.

If the Plan's governing body, public policy body and the designated officer or designee does not document and attest to a review of the written record of grievances, the Plan's ability to make timely interventions to remedy problems identified and provide quality of care and services to its members can be negatively affected.

Recommendation: Update policies and procedures and develop and implement a process to include the periodic review of the grievance record by the Plan's governing body, public policy body, and by an officer of the Plan or their designee.

COMPLIANCE AUDIT FINDINGS

Category 5 – Quality Management

5.1 Provider Qualifications

5.1.1 New Provider Training

The Plan must ensure that all network providers receive training regarding the Medi-Cal Managed Care program to ensure the network providers operate in full compliance with the Contract and all applicable federal and state statutes, regulations, APLs, and PLs. The Plan must start training within ten working days and complete training within 30 working days after placing a newly contracted network provider on active status. The Plan may conduct network provider training online or in-person. The Plan or must maintain records of attendance to validate that network providers received training on a bi-annual basis. *(Contract, Exhibit A, Attachment III, 3.2.5)*

Plan policy, *NO-001 New Provider Orientation* (revised 09/13/2023), stated that Provider Relations will initiate contact and begin orientation training for new providers within 10 business days of contract execution and shall complete all training within 30 days of being contracted. The Provider Relations representative meets with the provider or designated staff for education and training and the new provider attests to receiving the orientation by signing the New Provider Orientation Form.

Finding: The Plan's newly contracted providers did not complete training within 30 working days of active status.

The verification study revealed that 7 of 15 newly contracted providers did not complete the training within 30 working days of being placed on active status. The provider training was delayed between one and nine months.

During the interview, the Plan stated that additional columns were added to the Provider Orientation Tracking log for timely tracking of provider training. However, the Plan's tracking system for provider training continues to be ineffective.

Without proper training of newly contracted providers, the plan cannot ensure providers have the necessary information to provide proper care to meet members' needs.

Recommendation: Implement policies and procedures to have all newly contracted providers complete training within 30 working days of being placed in active status.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

LOS ANGELES SECTION

REPORT ON THE MEDICAL AUDIT OF VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION DBA GOLD COAST HEALTH PLAN FISCAL YEAR 2024-25

Contract Number: 23-30274

Contract Type: State Supported Services

Audit Period: July 1, 2023 — June 30, 2024

Dates of Audit: September 23, 2024 — October 4, 2024

Report Issued: March 12, 2025

TABLE OF CONTENTS

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, 2023, through June 30, 2024. The audit was conducted from September 23, 2024, through October 4, 2024, 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 February 19, 2025. There were no deficiencies found for the audit period.

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 23-30274, Exhibit A, Section 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. *(APL 24-003, Abortion Services)*

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 (HCPCS) and/or diagnosis codes for abortion related services. Abortion procedure codes are delineated in the Plan's policy. CPT codes include 59840, 59841, 59850-59852 and 59855-59857. HCPCS 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