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

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

2021

Contract Number: 10-87128

Audit Period: April 1, 2019 Through May 31, 2021

Report Issued: October 29, 2021

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I. INTRODUCTION

On June 2, 2009, the Ventura County Board of Supervisors authorized the establishment of a County Organized Health System (COHS). 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 (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.

The Plan's provider network consists of approximately 438 primary care, 3,408 specialists, 303 behavioral health, 514 pharmacy, and 372 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 1, 2021, the Plan served approximately 221,504 members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of April 1, 2019 through May 31, 2021. The review was conducted from August 2, 2021 through August 6, 2021. The audit consisted of document reviews, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on October 5, 2021. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the preliminary audit finding. On October 20, 2021, the Plan submitted a response to address the audit finding. The results of the DHCS evaluation of the Plan's response are reflected in this report.

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

The prior DHCS medical audit report issued on September 12, 2019 (audit period April 1, 2018 through March 31, 2019) identified deficiencies incorporated in the Corrective Action Plan (CAP) dated February 19, 2020. This year's audit included review of documents to determine implementation and the effectiveness of the Plan's CAP.

The summary of findings are as follow:

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

Review of the Plan's case management and coordination of care program yielded no findings.

Category 3 – Access and Availability of Care

Review of the Plan's access and availability of care for specialists and specialty services yielded no findings.

Review of the Plan's access and availability of pharmaceutical services yielded no findings.

Category 4 – Member's Rights

During the prior year audit, the Plan's written grievance responses to members did not contain a clear explanation of the Plan's decision. In response to the CAP, the Plan updated, revised, and implemented its policies and procedures. The policies and procedures include measures for additional audits and reviews of grievance resolution letters, and training of Plan staff. Review of the Plan's response to the CAP yielded no findings.

During the prior year audit, the Plan did not provide fully translated written informing material on their Grievance Resolution and Notice of Appeal Resolution letters to all members that speak the identified threshold language. In response to the CAP, the Plan engaged with its vendor to ensure they provided fully translated letters to members. The Plan tested the process and provided "Test Script" samples as evidence that the new process passed its testing phase. Review of the Plan's response to the CAP yielded no findings.

During the prior year audit, the Plan did not submit privacy incident reports to DHCS within ten working days. The Plan also did not monitor its subcontractor for compliance with privacy incident reporting. In response to the CAP, the Plan updated its policies and procedures to establish reporting requirements. The Plan's Privacy Incident Tracking Log was also updated to incorporate oversight of the Plan's business associates reporting timeframes. Review of the Plan's response to the CAP yielded no findings.

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 did not monitor its subcontractor's call center for classification and routing of member grievances. Therefore, member grievances were not directed to, addressed, and resolved by the Plan's grievance system.

Category 5 – Quality Management

Review of the Plan's quality improvement system yielded no findings.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The 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 audit period was April 1, 2019 through May 31, 2021. The review was conducted from August 2, 2021 through August 6, 2021. 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 and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 20 medical and 20 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Prior Authorization Appeal Process: 21 medical and 15 pharmacy prior authorization appeal requests were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Complex Case Management: 11 medical records were reviewed for continuous tracking, monitoring, and coordination of services provided to members.

Continuity of Care: 11 member files were reviewed to confirm members received continuity of care and fulfillment of requirements.

Category 3 – Access and Availability of Care

Appointment Availability: 12 contracted providers from the provider’s directory were reviewed to determine appointment availability, accuracy, and completeness of the directory listings.

Category 4 – Member's Rights

Grievance Procedures: 20 quality of service and 15 quality of care grievance cases were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review. 20 member calls were reviewed for appropriate classification and submission to the appropriate level for review.

Confidentiality Rights: 15 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

Potential Quality Issues: Ten cases were reviewed for timely evaluation and effective action taken to address improvements.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Gold Coast Health Plan

AUDIT PERIOD: April 1, 2019 – May 31, 2021
DATE OF AUDIT: August 2, 2021 – August 6, 2021

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Oversight of Subcontractor

According to Contract, Exhibit A, Attachment 4 (6) (B) (1), (2), and (3), the Plan is required to maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum: 1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities 2) Ensures subcontractor meets standards set forth by the Contractor and DHCS, and 3) Includes the continuous monitoring, evaluation, and approval of delegated functions.

All Plan Letter (APL) 17-004 states Medi-Cal Managed Care Health Plans are ultimately responsible for ensuring 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.

Finding: 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 did not monitor its subcontractor's classification and routing of member grievances.

The Plan entered into a Contract with a subcontractor and delegated the function of maintaining a call center for its members to file a grievance at any time about any matter. If a member calls expressing any form of dissatisfaction with a Plan provider, the subcontractor is responsible for educating the member about the grievance process and routing the event to the Plan's appropriate member grievance queue. According to the state Contract and APL, the Plan is to maintain a system that ensures accountability for delegated functions. However, the Plan did not monitor its subcontractor's call center for compliance in classifying and routing member's grievances.

The verification study revealed that the subcontractor did not classify the member's expression of dissatisfaction as grievances on 20 occasions from July 2019 to December 2019. Consequently, the subcontractor did not route these events to the Plan's member grievance queue. Therefore, the member's complaints were not directed to, addressed, and resolved by the Plan's grievance system.

Although the Plan provides its subcontractor's with grievance and appeal training annually, it did not ensure its subcontractor met the standards as outlined within their subcontract and

supporting Member Grievance Job Aide Manual. The Job Aide Manual states, if a member expresses dissatisfaction concerning an experience with the Plan's provider but does not wish to file a grievance, the subcontractor is still required to route the grievance appropriately. As a result, the Plan did not meet the standards set forth within their state Contract and maintain a system to ensure accountability for delegated functions.

According to Policy Number: MS-013, Call Center Service Level Agreement Oversight, the Plan will perform oversight of its subcontractor's call center. However, the service level agreement did not include procedures on how the Plan will monitor the subcontractor's compliance in classifying and routing member grievances. The Plan also confirmed during the interview, that they did not monitor the subcontractor.

Without having proper oversight of delegated functions, the Plan cannot ensure grievances are properly classified by its subcontractor. Therefore, a member's expression of dissatisfaction is not routed to the Plan's member grievance work queue, which may lead to unresolved complaints, a lack of tracking and trending of grievances**,** and potential quality of care issues for members.

Recommendation: Revise and implement policies and procedures to ensure continuous monitoring, evaluation, and approval of its subcontractor's classification and routing of member grievances.

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2021

Contract Number: 10-87129
State Supported Services

Audit Period: April 1, 2019
Through
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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 April 1, 2019 through May 31, 2021. The audit was conducted from August 2, 2021 through August 6, 2021.

An Exit Conference with the Plan was held on October 5, 2021. There were no deficiencies found.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Gold Coast Health Plan

AUDIT PERIOD: April 1, 2019 – May 31, 2021
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STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

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))*

Policy #CL-007: Abortion Services Claims Reimbursement states, "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."

The Plan Member Handbook states, 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).

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

RECOMMENDATION:

None