

Performance Evaluation Report
Gold Coast Health Plan
July 1, 2013–June 30, 2014

Managed Care Quality and
Monitoring Division
California Department of
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Performance Evaluation Report – Gold Coast Health Plan

July 1, 2013 – June 30, 2014

1. INTRODUCTION

Purpose of Report

The Department of Health Care Services (DHCS) administers California’s Medicaid program (Medi-Cal), which provides managed health care services to more than 7.7 million beneficiaries (as of June 2014)¹ in the State of California through a combination of contracted full-scope and specialty managed care health plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364² requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services provided by the states’ Medicaid MCPs. The EQRO’s performance evaluation centers on federal and state-specified criteria that fall into the domains of quality, access, and timeliness and includes designation of one or more domains of care for each area reviewed as part of the compliance review process, each performance measure, and each quality improvement project (QIP). The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on the Medi-Cal Managed Care program (MCMC). Due to the large number of contracted MCPs and evaluative text, HSAG produced an aggregate technical report and MCP-specific reports separately. The reports are issued in tandem as follows:

- ◆ The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs’ performance through organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and

¹ *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>.

² Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- ◆ MCP-specific evaluation reports (July 1, 2013–June 30, 2014). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS’s contracted MCP, Gold Coast Health Plan (“Gold Coast” or “the MCP”), for the review period July 1, 2013, through June 30, 2014. Actions taken by the MCP subsequent to June 30, 2014, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Health Plan Overview

Gold Coast is a full-scope MCP delivering services to its MCMC members as a County Organized Health System (COHS). A COHS is a nonprofit, independent public agency that contracts with DHCS to administer Medi-Cal benefits through a wide network of health care providers. Each COHS MCP is established by the County Board of Supervisors and governed by an independent commission.

Gold Coast became operational to provide MCMC services in Ventura County in July 2011. As of June 30, 2014, Gold Coast had 160,077 MCMC members.³

³ *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at:
<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>

Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP's compliance with standards established by the state related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. DHCS conducts this review activity through an extensive monitoring process that assesses MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers review activities for DHCS's joint medical audit and its Seniors and Persons with Disabilities (SPD) medical survey. These reviews often occur independently, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's medical audit/SPD medical survey reviews to draw conclusions about each MCP's performance in providing quality, accessible, and timely health care and services to its MCMC members. For this report, HSAG reviewed the most current joint medical audits/SPD medical survey reports available as of June 30, 2014. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to evaluate key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS's MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes prior to the commencement of MCP operations, during MCP expansion into new counties, upon contract renewal, and when MCPs revise their policies and procedures.

Medical Audits and SPD Medical Surveys

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical audits of Medi-Cal MCPs. In some instances, however, these audits were

conducted solely by DHCS or DMHC. These medical audits, which are conducted for each Medi-Cal MCP approximately once every three years, assess MCPs' compliance with contract requirements and State and federal regulations.

DHCS received authorization "1115 Waiver" from the federal government to conduct mandatory enrollment of SPDs into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes in non-County Organized Health System (COHS) counties. DHCS entered into an Interagency Agreement with DMHC to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California's strong patients' rights laws. Mandatory enrollment for these beneficiaries began in June 2011.

During this review period, DHCS began a transition of medical monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical audit frequency from once every three years to once a year. These reviews were replaced with the A&I annual medical audit and DMHC's SPD medical survey every three years.

Under DHCS's new monitoring protocols, any deficiencies identified in either A&I medical audits or DMHC SPD medical surveys and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under the new protocols include identifying root causes of MCP issues, augmented by DHCS technical assistance to MCPs; imposing a corrective action plan (CAP) to address any deficiencies; and imposing sanctions and/or penalties, when necessary.

Audits and Investigations Division Medical Performance Audit

The most recent medical performance audit for Gold Coast was conducted December 10, 2012, through December 14, 2012, covering the review period of November 1, 2011, through October 31, 2012. HSAG provided a detailed summary of the findings from the audit in Gold Coast's 2012–13 MCP-specific evaluation report. A&I identified findings in all audited areas. The MCP was required to submit a CAP to DHCS in response to the findings.

In a letter to Gold Coast dated September 18, 2013, DHCS referenced the CAP for the medical performance audit, along with a CAP DHCS established to address the MCP's financial condition and critical contract compliance issues in the areas of staffing, claims processing, financial controls, and having a management information system capable of performing the functions required pursuant to the MCP's contract with DHCS. The letter indicated that the two CAPs would be consolidated into one.

In a letter to Gold Coast dated May 8, 2014, DHCS indicated that the MCP provided DHCS with a response to the CAP for the medical performance audit. The letter stated that DHCS

determined that Gold Coast was in compliance with all requirements and the CAP was therefore closed.

Strengths

Gold Coast fully resolved all outstanding findings from the December 2012 A&I medical performance audit.

Opportunities for Improvement

Since Gold Coast fully resolved all outstanding findings from the December 2012 A&I medical performance audit, HSAG has no recommendations for the MCP in the area of compliance reviews.

Conducting the EQRO Review

DHCS annually selects a set of performance measures for the Medi-Cal full-scope MCPs to evaluate the quality of care delivered by the contracted MCPs to Medi-Cal Managed Care program (MCMC) beneficiaries. DHCS consults with contracted MCPs, the EQRO, and stakeholders to determine what measures the MCPs will be required to report. The DHCS-selected measures are referred to as the External Accountability Set. DHCS requires that MCPs collect and report External Accountability Set rates, which provides a standardized method for objectively evaluating MCPs' delivery of services.

HSAG conducts validation of the External Accountability Set performance measures as required by DHCS to evaluate the accuracy of the MCPs' reported results. Validation determines the extent to which MCPs followed specifications established by DHCS for its External Accountability Set-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

The Centers for Medicare & Medicaid Services (CMS) requires that states conduct performance measure validation of their contracted health plans to ensure that plans calculate performance measure rates according to state specifications. CMS also requires that states assess the extent to which the plans' information systems (IS) provide accurate and complete information.

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.⁴ This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

⁴ The CMS EQR Protocols can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Performance Measure Validation

DHCS's 2014 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS[®])⁵ measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 32. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance AuditsTM⁶ of all Medi-Cal MCPs in 2014 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2014 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2014 Compliance Audit Final Report of Findings for Gold Coast Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that Gold Coast followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A brief summary of the findings and opportunities for improvement is included below.

- ◆ Gold Coast had sufficient practices in place to process medical data.
- ◆ Gold Coast had appropriate data security and control procedures in place to minimize potential data loss.
- ◆ The auditor recommended that Gold Coast reconcile its data to ensure enrollment data integrity.

⁵ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

⁶ NCQA HEDIS Compliance AuditTM is a trademark of the National Committee for Quality Assurance (NCQA).

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 presents a summary of Gold Coast's performance measure results for 2011–14. Note that data may not be available for all four years.

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specification changes impacting comparability. In addition to the performance measure results from 2011–14, Table 3.1 shows the MCP's performance compared to the DHCS-established MPLs and HPLs for each year. Rates below the MPLs are **bolded**, and rates above the HPLs are shaded in gray.

DHCS based the MPLs and HPLs on the NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *CDC–H9 (>9.0 percent)* measure. For the *CDC–H9 (>9.0 percent)* measure, a low rate indicates better performance, and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

The reader should note the following regarding Table 3.1:

- ◆ HEDIS 2014 was the first year that DHCS held Gold Coast accountable to meet the MPLs for any performance measures. Since 2013 was the first year Gold Coast reported rates, DHCS did not hold the MCP accountable to meet the MPLs in 2013.
- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure used for the ACR collaborative QIP; therefore, no MPL or HPL is established for this measure.
- ◆ For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ The *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures. No MPL or HPL is established for a utilization measure. Additionally, HSAG did not compare performance for these measures.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for 2014:
 - All four *Children and Adolescents' Access to Primary Care* measures.
 - *Cervical Cancer Screening*. Note: MCPs have reported a rate for the *Cervical Cancer Screening* measure since 2008; however, due to NCQA's HEDIS 2014 specification changes to reflect the new screening guidelines, this measure was considered to be a first-year measure in 2014.

Consequently, HSAG did not include or make comparisons to previous years' rates in this report.

- *Comprehensive Diabetes Care—LDL-C Control.* (This measure is being eliminated for HEDIS 2015.)
- *Comprehensive Diabetes Care—LDL-C Screening.* (This measure is being eliminated for HEDIS 2015.)

**Table 3.1—Performance Measure Results
Gold Coast—Ventura County**

Measure ¹	Domain of Care ²	2011 ³	2012 ⁴	2013 ⁵	2014 ⁶	2013–14 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	19.17%	13.08%	▲
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	‡	—	—	49.21	38.12	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	‡	—	—	317.16	205.78	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	86.73%	88.47%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	88.46%	93.33%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	86.28%	89.51%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	13.87%	18.24%	↔
Cervical Cancer Screening	Q,A	—	—	—	60.58%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	80.05%	75.43%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	82.51%	97.37%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	63.09%	86.27%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	NA	82.26%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	NA	79.18%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	62.29%	61.31%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	42.58%	45.74%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	81.75%	85.16%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	37.96%	45.50%	↑
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	—	—	33.58%	28.47%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	—	—	78.83%	79.56%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	79.81%	78.10%	↔

Measure ¹	Domain of Care ²	2011 ³	2012 ⁴	2013 ⁵	2014 ⁶	2013–14 Rate Difference ⁷
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	Q	—	—	56.20%	45.50%	▲
<i>Controlling High Blood Pressure</i>	Q	—	—	61.56%	54.01%	▼
<i>Immunizations for Adolescents—Combination 1</i>	Q,A,T	—	—	65.21%	60.34%	↔
<i>Medication Management for People with Asthma—Medication Compliance 50% Total</i>	Q	—	—	NA	48.92%	Not Comparable
<i>Medication Management for People with Asthma—Medication Compliance 75% Total</i>	Q	—	—	NA	28.03%	Not Comparable
<i>Prenatal and Postpartum Care—Postpartum Care</i>	Q,A,T	—	—	63.99%	59.37%	↔
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	Q,A,T	—	—	80.78%	83.94%	↔
<i>Use of Imaging Studies for Low Back Pain</i>	Q	—	—	76.95%	77.07%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	—	42.09%	43.80%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	—	42.09%	43.31%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	—	30.41%	28.71%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	—	61.80%	64.23%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.

⁴ 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.

⁵ 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.

⁶ 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.

⁷ Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

▼ = Statistically significant decline.

↔ = No statistically significant change.

▲ = Statistically significant improvement.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant decline in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant improvement in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),⁷ DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The selection team considered conditions seen frequently in the senior population and reflected in measures such as *All-Cause Readmissions*, *Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures that could reflect possible access issues which could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

The final selected SPD measures are listed below. Following the list of measures are Table 3.2 and Table 3.3, which present a summary of Gold Coast's 2014 SPD measure results. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁸ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures. Appendices A and B include tables displaying the two-year trending information for the SPD and non-SPD populations for all measures that DHCS required the MCPs to stratify for the SPD population. The SPD trending information is included in Appendix A and the non-SPD trending information is included in Appendix B.

- ◆ *All-Cause Readmissions—Statewide Collaborative QIP*
- ◆ *Ambulatory Care—Outpatient Visits*
- ◆ *Ambulatory Care—Emergency Department Visits*
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*

⁷ Senate Bill 208 (Steinberg et al, Chapter 714, Statutes of 2010) added W&I Code 14182(b)(17), which provides that DHCS shall develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the subset of enrollees who are seniors and persons with disabilities. Managed care health plan performance measures may include measures from HEDIS; measures indicative of performance in serving special needs populations, such as the NCQA Structure and Process measures; or both.

⁸ HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.2.

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- ◆ *Comprehensive Diabetes Care—LDL-C Screening*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Table 3.2—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Gold Coast—Ventura County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	9.53%	15.06%	▼	13.08%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.52%	89.11%	↔	88.47%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	92.50%	Not Comparable	93.33%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.58%	90.10%	↔	89.51%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	97.46%	89.74%	↓	97.37%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.35%	83.61%	↔	86.27%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	82.53%	77.69%	↓	82.26%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	79.68%	72.72%	↓	79.18%
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	60.83%	59.85%	↔	61.31%
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	42.34%	44.04%	↔	45.74%
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	84.43%	85.16%	↔	85.16%
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	45.01%	49.88%	↔	45.50%
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	25.30%	34.79%	↑	28.47%

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
Comprehensive Diabetes Care—LDL-C Screening	77.37%	80.05%	↔	79.56%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	75.67%	81.51%	↑	78.10%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	46.47%	42.34%	↔	45.50%

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

**Table 3.3—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
Gold Coast—Ventura County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
189.20	35.36	361.16	64.02

*Member months are a member's "contribution" to the total yearly membership.

Performance Measure Result Findings

The rates improved significantly from 2013 to 2014 for the following measures:

- ◆ *All-Cause Readmissions.*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics.*
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners—12 to 24 Months*, resulting in the rate moving from below the MPL in 2013 to above the MPL in 2014.
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners—25 Months to 6 Years*; however, the rate remained below the MPL.
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*, resulting in the rate moving from below the MPL in 2013 to above the MPL in 2014.
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*, resulting in the rate moving from not meeting the MPL in 2013 to exceeding the MPL in 2014.

The rates improved from 2013 to 2014 for the following measures. Although not statistically significant, the improvement resulted in the rates moving from below the MPLs in 2013 to above the MPLs in 2014:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

In addition to the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* measure, the rates were below the MPLs for the following measures:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rate declined significantly from 2013 to 2014 for the *Controlling High Blood Pressure* measure; however, the rate remained above the MPL.

Seniors and Persons with Disabilities Findings

The SPD rates were significantly better than the non-SPD rates for two measures, and the SPD rates were significantly worse than the non-SPD rates for the following measures:

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

The *Ambulatory Care* measures are utilization measures, which can be helpful in reviewing patterns of suspected under- and overutilization of services; however rates should be interpreted with caution as high and low rates do not necessarily indicate better or worse performance. For this reason, DHCS does not establish performance thresholds for these measures and HSAG does not provide comparative analysis.

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve the MCP's performance for the particular measure. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the highest priority barriers; the steps the MCP will take to improve care and the measure's rate; and the specific, measurable target for the next Plan-Do-Study-Act cycle. DHCS reviews each IP for soundness of design and anticipated effectiveness of the interventions. To avoid redundancy, if an MCP has an active QIP which addresses a measure with a 2014 rate below the MPL, DHCS allows the MCP to combine its QIP and IP.

For the 2013–14 MCP-specific reports, DHCS reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2013 (measurement year 2012). DHCS also reviewed the HEDIS 2014 rates (measurement year 2013) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. Additionally, throughout the reporting year, DHCS engaged in monitoring activities with MCPs to assess if the MCPs were regularly assessing progress (at least quarterly) toward achieving desired IP outcomes. Finally, DHCS assessed whether the MCPs would need to continue existing IPs and/or to develop new IPs.

For MCPs with existing IPs and those needing to submit new IPs, DHCS provided HSAG with a summary of each IP that included the barriers the MCP experienced which led to the measure's rate being below the MPL, the interventions the MCP implemented to address the barriers, and outcome information. HSAG provides a summary of each IP below, along with strengths and opportunities for improvement.

Note: DHCS and the MCPs are engaging in new efforts to improve the quality of care for Medi-Cal managed care beneficiaries. These efforts include targeting key quality improvement areas as outlined in California's Medi-Cal Managed Care Quality Strategy Annual Assessment (i.e., immunization, diabetes care, controlling hypertension, tobacco cessation, and postpartum care). MCPs are using a rapid cycle approach (including the Plan-Do-Study-Act cycle) to strengthen these key quality improvement areas and have structured quality improvement resources accordingly. As a result, DHCS may not require an MCP to submit IPs for all measures with rates below the MPLs. MCPs continue to be contractually required to meet MPLs for all External Accountability Set measures.

Assessment of MCP's Improvement Plans

Since 2013 was the first year Gold Coast reported performance measure rates, DHCS did not hold the MCP accountable to meet the MPLs and therefore did not require the MCP to submit any IPs. Based on 2014 rates, the MCP will be required to submit IPs for the following measures in 2014:

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Although the rates were below the MPLs for three of the *Children and Adolescents' Access to Primary Care Practitioners* measures, Gold Coast will not be required to submit IPs for these measures. DHCS elected not to require the MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures for the 2013 and 2014 reporting years. This decision was made to prioritize DHCS and MCP efforts in other areas of poor performance that have clear improvement paths and direct population health impact.

Strengths

HSAG auditors determined that Gold Coast followed the appropriate specifications to produce valid performance measure rates, and no issues of concern were identified.

The rates improved significantly from 2013 to 2014 for six measures, resulting in the rates for three of the measures moving from not meeting the MPLs in 2013 to exceeding the MPLs in 2014. The rates for two additional measures improved from not meeting the MPLs in 2013 to exceeding the MPLs in 2014.

Opportunities for Improvement

Gold Coast has the opportunity to improve the HEDIS audit process by reconciling its data to ensure enrollment data integrity.

To improve performance on required measures, Gold Coast has the opportunity to assess the factors leading to the rates being below the MPLs for six measures and identify strategies to improve the rates. Additionally, the MCP has the opportunity to assess the factors leading to the rate declining significantly from 2013 to 2014 for the *Controlling High Blood Pressure* measure to ensure that the rate remains above the MPL. Finally, for the measures with SPD rates significantly worse than the non-SPD rates, Gold Coast has the opportunity to assess the factors leading to the significantly worse SPD rates to ensure that the MCP is meeting the SPD population's needs.

Note: Gold Coast reported on actions the MCP has taken to address the SPD rate being significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure (See Appendix D). Although the MCP's efforts resulted in significantly fewer SPD readmissions from 2013 to 2014 (See Appendix A), the SPD rate continued to be significantly worse than the non-SPD rate for this measure in 2014.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol⁹ to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

Full-scope MCPs must conduct a minimum of two QIPs. They must participate in the DHCS-led statewide collaborative QIP and conduct an MCP-specific (internal) QIP or an MCP-led small group collaborative QIP. MCPs that hold multiple MCMC contracts or that have a contract that covers multiple counties must conduct two QIPs for each county.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of MCPs' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the MCP's QIP objectives (QIP results).

Beginning July 1, 2012, HSAG began using a revised QIP methodology and scoring tool to validate the QIPs. HSAG updated the methodology and tool to place greater emphasis on health care outcomes by ensuring that statistically significant improvement has been achieved before it assesses for sustained improvement. Additionally, HSAG streamlined some aspects of the scoring to make the process more efficient. With greater emphasis on improving QIP outcomes, member health, functional status, and/or satisfaction will be positively affected.

HSAG organized, aggregated, and analyzed Gold Coast's validated QIP data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

⁹ The CMS Protocols can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Quality Improvement Project Objectives

Gold Coast participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2013–June 30, 2014.

Table 4.1 below lists Gold Coast’s QIPs and indicates whether the QIP is clinical or nonclinical and the domains of care (i.e., quality, access, timeliness) the QIP addresses.

**Table 4.1—Quality Improvement Projects for Gold Coast
July 1, 2013, through June 30, 2014**

QIP	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Clinical	Q, A
<i>Increasing the Rate of Annual Diabetic Eye Exam</i>	Clinical	Q, A

The *All-Cause Readmissions* statewide collaborative QIP focused on reducing readmissions due to all causes within 30 days of an inpatient discharge for beneficiaries aged 21 years and older. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members, leading to improved health outcomes.

The *Increasing the Rate of Annual Diabetic Eye Exam* QIP targeted the MCP’s members with diabetes and focused on increasing retinal eye exams. Ongoing management of members with diabetes is critical both to preventing complications and to ensuring optimal health for these members.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across CMS protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
Gold Coast—Ventura County
July 1, 2013, through June 30, 2014**

Name of Project/Study	Type of Review ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Overall Validation Status ⁴
Statewide Collaborative QIP				
<i>All-Cause Readmissions</i>	Annual Submission	63%	100%	<i>Partially Met</i>
	Annual Resubmission 1	88%	100%	<i>Met</i>
Internal QIPs				
<i>Increasing the Rate of Annual Diabetic Eye Exam</i>	Annual Submission	64%	70%	<i>Partially Met</i>
	Annual Resubmission 1	92%	100%	<i>Met</i>

¹**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG’s validation criteria to receive an overall *Met* validation status.

²**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

⁴**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Validation results during the review period of July 1, 2013, through June 30, 2014, showed that Gold Coast’s annual submission of its *All-Cause Readmissions* QIP received an overall validation status of *Partially Met*. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on HSAG’s validation feedback, Gold Coast resubmitted the QIP and achieved an overall *Met* validation status, with 88 percent of the evaluation elements and 100 percent of the critical elements receiving a met score. The *Increasing the Rate of Annual Diabetic Eye Exam* QIP annual submission received an overall validation status of *Partially Met*. Gold Coast resubmitted the QIP and achieved an overall *Met* validation status, with 92 percent of the evaluation elements and 100 percent of the critical elements receiving a met score.

Table 4.3 summarizes the aggregated validation results for Gold Coast’s QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
Gold Coast—Ventura County
(Number = 4 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)**	88%	13%	0%
	IV: Correctly Identified Study Population	75%	25%	0%
	V: Valid Sampling Techniques (if sampling is used)	83%	17%	0%
	VI: Accurate/Complete Data Collection	45%	35%	20%
Design Total		73%	20%	7%
Implementation	VII: Sufficient Data Analysis and Interpretation	83%	6%	11%
	VIII: Appropriate Improvement Strategies**	88%	13%	0%
Implementation Total**		85%	8%	8%
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		Not Assessed	Not Assessed	Not Assessed

*The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

**The stage and/or activity totals may not equal 100 percent due to rounding.

HSAG validated Activities I through VIII for Gold Coast’s *All-Cause Readmissions* and *Increasing the Rate of Annual Diabetic Eye Exam* QIPs annual submissions.

Gold Coast demonstrated an adequate application of the Design stage, meeting 73 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The *All-Cause Readmissions* and *Increasing the Rate of Annual Diabetic Eye Exam* QIPs had multiple design issues, resulting in lower scores for Activities III through VI. Gold Coast corrected the deficiencies in the resubmissions.

Both QIPs progressed to the Implementation stage during the reporting period. Gold Coast demonstrated an adequate application of the Implementation stage for both QIPs, meeting 85 percent of the requirements for all applicable evaluation elements within the study stage. In the initial submission of the *All-Cause Readmissions* QIP, Gold Coast did not fully describe the data analysis plan and did not document if there were any factors that threatened the internal or external validity of the findings, resulting in a lower score for Activity VII. Gold Coast corrected the deficiencies in the resubmission, resulting in the QIP achieving an overall *Met* validation status.

For the *Increasing the Rate of Annual Diabetic Eye Exam* QIP, Gold Coast did not fully describe the data analysis plan, did not document the process used to determine the barriers, and did not include an evaluation plan for each intervention, resulting in lower scores for Activities VII and VIII. Gold Coast corrected the deficiencies in the resubmission, resulting in the QIP achieving an overall *Met* validation status.

Quality Improvement Project Outcomes and Interventions

The *All-Cause Readmissions* and *Increasing the Rate of Annual Diabetic Eye Exam* QIPs did not progress to the Outcomes stage during the reporting period; therefore, no outcome information is included in this report. Following is a summary of the MCP's interventions for each QIP:

All-Cause Readmissions QIP

- ◆ MCP staff members called members 48–72 hours after discharge to:
 - Ensure the members made and kept their follow-up appointment.
 - Ask if discharge instructions were understood and explain the discharge instructions further.
 - Ask if the members filled their prescriptions.
 - Ask how medications were taken to see if members understood and complied.
 - Send and provide additional educational material if needed or requested.
 - Provide education in a way that addressed language or educational barriers.

Increasing the Rate of Annual Diabetic Eye Exam QIP

- ◆ Sent letters to providers indicating which members with diabetes had completed or were pending diabetic screening tests.
- ◆ Provided educational materials in both English and Spanish to members with diabetes.
- ◆ Worked with a claims vendor to provide membership files to providers.
- ◆ Collected more detailed and complete medical and vision claims data to improve capture of vision services provided to members with diabetes.
- ◆ Increased members' awareness of available transportation services.
- ◆ Increased members' awareness of vision coverage.

Outcome information for each QIP will be included in Gold Coast's 2014–15 MCP-specific evaluation report.

Strengths

Gold Coast demonstrated an adequate application of the QIP process for both the *All-Cause Readmissions* and *Increasing the Rate of Annual Diabetic Eye Exam* QIPs.

Opportunities for Improvement

In response to HSAG's recommendations in Gold Coast's 2012–13 MCP-specific evaluation report, Gold Coast received technical assistance on three multiple occasions to help the MCP improve documentation in the QIP Summary Form (see Appendix D). Since Gold Coast had to resubmit both QIPs due to incomplete or inaccurate documentation, the MCP demonstrates continued opportunities for improving QIP documentation. The MCP should continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.

Conducting the EQRO Review

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, MCMC requires its contracted MCPs to submit high-quality encounter data. DHCS relies on the quality of these MCP encounter data submissions to accurately and effectively monitor and improve MCMC's quality of care, establish appropriate performance metrics, generate accurate and reliable reports, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of DHCS's overall management and oversight of MCMC.

Beginning in State Fiscal Year (SFY) 2012–13, DHCS contracted with HSAG to conduct an Encounter Data Validation (EDV) study. During the first contract year, the EDV study focused on an information systems review and a comparative analysis between the encounter data in the DHCS data warehouse and the data in the MCPs' data systems. For SFY 2013–14, the goal of the EDV study was to examine the completeness and accuracy of the encounter data submitted to DHCS by the MCPs through a review of the medical records.

Although the medical record review activities occurred during the review period for this report, their results and analyses were not available at the time this report was written. Individual MCP medical record review results and analyses will be included in each MCP's 2014–15 evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each MCP in the three domains of care—quality, access, and timeliness. A numerical score is calculated for each domain of care for performance measure rates, QIP validation, and QIP outcomes (measured by statistical significance and sustained improvement). A final numeric score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care and converted to a rating of above average, average, or below average. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the MCPs' medical audit/SPD medical survey reviews and assessment of the accuracy and completeness of encounter data to determine overall performance within each domain of care, as applicable. A more detailed description of HSAG's scoring process is included in Appendix C.

Please note that when a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care.

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.¹⁰

DHCS uses the results of performance measures and QIPs to assess care delivered to beneficiaries by an MCP in areas such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, DHCS monitors aspects of an MCP's operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems. DHCS also uses the results

¹⁰ This definition of quality is included in Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction: An Introduction to the External Quality Review (EQR) Protocols*, Version 1.0, September 2012. The definition is in the context of Medicaid/Children's Health Insurance Program MCOs, and was adapted from the IOM definition of quality. The CMS Protocols can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

of member satisfaction surveys to assess beneficiaries' satisfaction with the quality of the health care they receive from the MCPs.

Gold Coast's quality improvement program description includes details about the MCPs organizational structure, which supports the provision of quality care to the MCP's MCMC members.

The rates improved significantly from 2013 to 2014 for the following quality performance measures:

- ◆ *All-Cause Readmissions*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*, resulting in the rate moving from below the MPL in 2013 to above the MPL in 2014
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*, resulting in the rate moving from not meeting the MPL in 2013 to exceeding the MPL in 2014

The rates improved from 2013 to 2014 for the following quality measures. Although not statistically significant, the improvement resulted in the rates moving from below the MPLs in 2013 to above the MPLs in 2014:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

The rates were below the MPLs for the following quality measures:

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rate declined significantly from 2013 to 2014 for the *Controlling High Blood Pressure* measure, which falls into the quality domain of care; however, the rate remained above the MPL.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and the SPD rates were significantly better than the non-SPD rates for two of the measures. The SPD rate was significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure, which falls into the quality domain of care. This means that significantly more SPD members (aged 21 years and older) were readmitted within 30 days of an inpatient discharge than were non-SPD members.

Both of the MCP's QIPs fell into the quality domain of care. Since neither QIP progressed to the Outcomes stage, HSAG was not able to assess the QIPs' success at improving the quality of care delivered to the MCP's MCMC members.

Overall, Gold Coast showed below-average performance related to the quality domain of care.

Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

Gold Coast's quality improvement program description includes objectives related to ensuring access to care for the MCP's members.

The rates improved significantly from 2013 to 2014 for the following access performance measures:

- ◆ *All-Cause Readmissions.*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, resulting in the rate moving from below the MPL in 2013 to above the MPL in 2014.
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*; however, the rate remained below the MPL.

The rate improved from 2013 to 2014 for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure, which falls into the access domain of care. Although not statistically significant, the improvement resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014.

In addition to the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* measure, the rates were below the MPLs for the following access measures:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Nine of the measures stratified for the SPD population fall into the access domain of care and the SPD rate was significantly better than the non-SPD rate for one of these measures. The SPD rates were significantly worse than the non-SPD rates for the following access measures:

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

Both of the MCP's QIPs fell into the access domain of care. Since neither QIP progressed to the Outcomes stage, HSAG was not able to assess the QIPs' success at improving access to care for the MCP's MCMC members.

Overall, Gold Coast showed below-average performance related to the access domain of care.

Timeliness

The timeliness domain of care relates to an MCP's ability to make timely utilization decisions based on the clinical urgency of the situation, to minimize any disruptions to care, and to provide a health care service quickly after a need is identified.

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

Gold Coast's quality improvement program description includes information about the MCP's structure related to member rights, grievances and appeals, coordination and continuity of care, and utilization management, which can all affect the timeliness of care delivered to members.

The rate was below the MPL for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, which falls into the timeliness domain of care. The rates were above the MPLs for the four remaining timeliness performance measures.

Overall, Gold Coast showed average performance related to the timeliness domain of care.

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2012–13 MCP-specific evaluation report. Gold Coast’s self-reported responses are included in Appendix D.

Recommendations

Based on the overall assessment of Gold Coast in the areas of quality, timeliness, and accessibility of care, HSAG recommends the following to the MCP:

- ◆ To improve the HEDIS audit process, reconcile the MCP’s data to ensure enrollment data integrity.
- ◆ Assess the factors leading to the rates being below the MPLs for six measures, and identify strategies to improve the rates. Given DHCS and MCP priorities, the MCP may want to initially focus efforts on the following measures:
 - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*
 - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- ◆ Assess the factors leading to the rate declining significantly from 2013 to 2014 for the *Controlling High Blood Pressure* measure to ensure that the rate remains above the MPL.
- ◆ For the following measures with SPD rates significantly worse than the non-SPD rates, assess the factors leading to the significantly worse SPD rates to ensure that the MCP is meeting the SPD population’s needs:
 - *All-Cause Readmissions*—Note that the SPD rate for this measure improved significantly from 2013 to 2014 (see Appendix A). The MCP should continue to implement the strategies that resulted in improvement on the SPD rate for this measure.
 - *Children and Adolescents’ Access to Primary Care Practitioners—12 to 24 Months*
 - *Children and Adolescents’ Access to Primary Care Practitioners—7 to 11 Years*
 - *Children and Adolescents’ Access to Primary Care Practitioners—12 to 19 Years*

- ◆ Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.

In the next annual review, HSAG will evaluate Gold Coast's progress with these recommendations along with its continued successes.

Table A.1 provides two-year trending information for the SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the “2013–14 Rate Difference” column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲ ▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table A.1—HEDIS 2014 SPD Trend Table
Gold Coast—Ventura County**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	23.16%	15.06%	▲
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	70.16	64.02	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	493.66	361.16	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	88.46%	89.11%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	88.37%	92.50%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.97%	90.10%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	75.00%	89.74%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	61.92%	83.61%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	NA	77.69%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	NA	72.72%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	57.66%	59.85%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	44.53%	44.04%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	85.16%	85.16%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	35.04%	49.88%	↑
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	36.25%	34.79%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	79.08%	80.05%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	86.13%	81.51%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	58.64%	42.34%	▲

*Member months are a member's "contribution" to the total yearly membership.

Table B.1 provides two-year trending information for the non-SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the “2013–14 Rate Difference” column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲ ▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table B.1—HEDIS 2014 Non-SPD Trend Table
Gold Coast—Ventura County**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	11.32%	9.53%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	46.49	35.36	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	294.22	189.20	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.26%	87.52%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.15%	88.58%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	82.60%	97.46%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	63.12%	86.35%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	NA	82.53%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	NA	79.68%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	65.69%	60.83%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	44.04%	42.34%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	82.73%	84.43%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	37.71%	45.01%	↑
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	33.82%	25.30%	↓
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	77.37%	77.37%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	80.78%	75.67%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	54.99%	46.47%	▲

*Member months are a member's "contribution" to the total yearly membership.

Quality, Access, and Timeliness Scoring Process

Scale

2.5–3.0 = Above Average

1.5–2.4 = Average

1.0–1.4 = Below Average

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.¹¹ This process allows HSAG to evaluate each MCP's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.1)

Quality Domain

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
 - ◆ If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than three.
 - ◆ If there are **three or more** measures below the MPLs, the number of measures below the MPLs minus the number of measures above the HPLs must be less than three.
3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

¹¹ The CMS protocols specify that the EQRO must include an assessment of each MCP's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients in its detailed technical report. The report must also document procedures used by the EQRO to analyze the data collected and how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
 - ◆ If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than two.
 - ◆ If there are **three or more** measures below the MPLs, then the number of measures below the MPLs minus the number of measures above the HPLs must be less than two.
3. To be considered **Below Average**, the MCP will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects (QIPs)

Validation (Table 4.2): For each QIP submission and subsequent resubmission(s), if applicable.

1. **Above Average** is not applicable.
2. **Average** = *Met* validation status.
3. **Below Average** = *Partially Met* or *Not Met* validation status.

Outcomes (Table 4.4): Activity IX, Element 4—Real Improvement

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

Sustained Improvement (Table 4.4): Activity X—Achieved Sustained Improvement

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care.

For each **QIP**, the Validation score (1 or 2), the Outcomes score (1, 2, or 3), and the Sustained Improvement score (1, 2, or 3) are entered for each applicable domain of care (Q, A, T). The scores are automatically calculated by adding the scores under each domain of care and dividing by the number of applicable elements.

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

APPENDIX D. **MCP'S SELF-REPORTED FOLLOW-UP ON EXTERNAL QUALITY REVIEW RECOMMENDATIONS FROM THE JULY 1, 2012–JUNE 30, 2013 PERFORMANCE EVALUATION REPORT**

for Gold Coast Health Plan

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with Gold Coast's self-reported actions taken through June 30, 2014, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table D.1—Gold Coast's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report

2012–13 External Quality Review Recommendation Directed to Gold Coast	Actions Taken by Gold Coast During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
1. Ensure that the MCP fully resolves all findings from the December 2012 A&I medical performance audit through the DHCS CAP process.	On May 8, 2014, the medical performance audit corrective action plan was closed out by DHCS. DHCS issued a formal close-out letter to the Plan. Please refer to the attached letter issued by DHCS. Note: HSAG reviewed the referenced document and confirmed that it is a close-out letter.
2. Engage in the following efforts to improve the HEDIS audit process:	
a. Create a monthly volume report by provider or develop tracking reports for claims/encounters submitted by the MCP's vendors to improve effectiveness on monitoring claims/encounter data completeness.	The Plan tracks MCP encounter data monthly and is in the process of developing reports for all vendors scheduled to be completed by October 1, 2014.
b. Investigate a way to link baby claims previously billed under the mother's identification number to the baby's identification number once the baby receives his/her own Medicaid identification number to help capture immunizations and well-child visit data administratively that occur during the first 60 days of life.	The Plan will undertake a project in Quarter 2 of fiscal year 2014–15 to determine the feasibility of developing and implementing a report that links newborn charges billed under the mother's identification number with the baby's own Medi-Cal ID number in order to capture and track well-child visit data that occurs during the first 60 days of life.
3. Since Gold Coast had 10 measures with rates below the MPLs in 2013, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than attempting to improve performance on all measures at once.	GCHP did not meet the minimum performance level for 10 submeasures in 7 of the HEDIS required measures. Since 2013 was the first HEDIS data submission for the Plan, the <i>Medication Management for People with Asthma</i> measure could not be reported since this measure requires two years of data. The Plan reported on 13 required measures meeting MPL on 15 submeasures. For the 2014 HEDIS reporting, the Plan reported on 14 measures with only 6 submeasures not making the MPL. Therefore, the Plan improved from 10 to 6 submeasures not meeting MPL while reporting an additional measure in 2014.

2012–13 External Quality Review Recommendation Directed to Gold Coast	Actions Taken by Gold Coast During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation															
	<p>The Plan worked with DHCS as evidenced by the following:</p> <ul style="list-style-type: none"> On July 16, 2013, GCHP attended DHCS' and HSAG's Statewide Technical Assistance call to review HSAG's updated validation process and DHCS' revised QIP Summary Forms and updates to the Quality Improvement Assessment Guide for Medi-Cal Managed Care Plans. After review of all the HEDIS rates below the MPL, GCHP decided to focus the internal QIP on increasing the rate of diabetic retinal eye exams and on July 25, 2013, GCHP submitted to DHCS the QIP Topic Proposal Form. On August 8, 2013, the Quality Improvement and Health Education Departments met to strategize action plans to improve the Plan's HEDIS measures below the MPL; and the Quality Improvement Department developed an Intervention Spreadsheet, which was sent to DHCS and HSAG on September 10, 2013. On August 19, DHCS requested rationale for selecting <i>CDC-Eye</i> over <i>CDC-H8/H9</i>, and the plan responded on August 21. That same day, DHCS approved the QIP topic. On August 26, GCHP contacted DHCS to request additional guidance on timeline and delivery method for internal QIP submission, and DHCS responded the same day. On September 10, 2013, DHCS, HSAG, and GCHP met for a second Technical Assistance call to discuss GCHP's QIP and HEDIS rates and to review GCHP's performance improvement plans to increase the HEDIS measures that fell below the MPL. The Internal QIP on increasing diabetic retinal eye exams was submitted on November 19, 2013, and the QIP was approved on January 17, 2014. <p>The <i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i> measure met the MPL for the 2014 HEDIS survey, demonstrating improvement. A key intervention was the creation of clinic level "report cards" for HEDIS and another was meeting with the major clinic groups to review results, discuss barriers, and assist improvement efforts.</p> <p>Additional efforts made beyond the Internal QIP included identifying the top providers overusing antibiotics for coded viral bronchitis and sending them a letter from the chief medical officer informing them of this and mailing reminder letters to our members who had not had a cervical cancer screening within the last year.</p>															
<p>4. Assess the factors leading to the SPD rates for the <i>All-Cause Readmissions and Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)</i> measures being significantly worse than the non-SPD rates and identify strategies to ensure the MCP is meeting the SPD</p>	<table border="1" data-bbox="695 1667 1422 1843"> <thead> <tr> <th></th> <th>SPD Rate_2012</th> <th>Non-SPD Rate_2012</th> <th>SPD Rate_2013</th> <th>Non-SPD Rate_2013</th> </tr> </thead> <tbody> <tr> <td>ACR</td> <td>23.16</td> <td>11.32</td> <td>15.06</td> <td>9.53</td> </tr> <tr> <td>CDC_BP</td> <td>57.66</td> <td>65.69</td> <td>59.85</td> <td>60.83</td> </tr> </tbody> </table> <p>During the 2012 data stratification between SPD and non-SPD, the Plan realized it had four times as many SPD as non-SPD members in</p>		SPD Rate_2012	Non-SPD Rate_2012	SPD Rate_2013	Non-SPD Rate_2013	ACR	23.16	11.32	15.06	9.53	CDC_BP	57.66	65.69	59.85	60.83
	SPD Rate_2012	Non-SPD Rate_2012	SPD Rate_2013	Non-SPD Rate_2013												
ACR	23.16	11.32	15.06	9.53												
CDC_BP	57.66	65.69	59.85	60.83												

2012–13 External Quality Review Recommendation Directed to Gold Coast	Actions Taken by Gold Coast During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
population's needs.	the readmission population. The Plan began an effort to make a transition telephone call to heart failure and congestive heart failure members discharged to ensure medication compliance, follow-up provider appointment, and understanding of discharge instructions. Continued planning has resulted in a hospital-based health plan nurse at the Plan's largest admitting hospital and further development of case management. The 2012–13 comparison table above demonstrates a significant decrease in the gap between SPD and non-SPD.
5. Review the QIP Completion Instructions prior to submitting QIPs to ensure all required documentation is included in the QIP Summary Form.	The Plan attended statewide Technical Assistance call on July 16, 2013. The call covered the revised QIP submission form and submission process, and the Plan requested further clarification from DHCS via e-mail on August 26, 2014. The Plan also attended Technical Assistance call with only GCHP, HSAG, and DHCS present on September 10, 2013.
6. Review the 2013 MCP-specific CAHPS® ¹² results report and develop strategies to address the <i>Rating of Health Plan</i> , <i>Getting Care Quickly</i> , and <i>Rating of All Health Care</i> priority areas.	The CAHPS results were presented in a PowerPoint presentation format at GCHP Senior Leadership Meeting in April 2014 and at the Quality Improvement Meeting in June 2014. Currently, efforts are being made to contract with The Myers Group to perform a CAHPS-like survey this year and collect data enabling the Plan to pinpoint providers and/or areas with access issues so that attempts to resolve these issues will be targeted. Since the CAHPS survey was done in 2013 for 2012 membership and GCHP was a new plan, we considered doing another survey more indicative of the Plan's current level of service.
7. Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.	GCHP is currently engaged in an encounter data improvement project (EDIP) designed to improve the completeness, accuracy, reliability, and timeliness of the encounter data we capture and submit to DHCS. We have hired a Manager to oversee the process, and we are actively recruiting for an analyst who will be the liaison between the delegated groups and the Plan. The three recommendations listed in the 2012–13 MCP-Specific Encounter Data Validation Study Report are included within the process improvement goals for this project. Specifically, we will include the recommendations and track as deliverables the following: <ol style="list-style-type: none"> 1. Examine the policies and contracts that detail the providers' claims and encounter data submission to ensure timeliness, completeness, and accuracy of the claims data. 2. Review and refine the policies and procedures for creating the encounter data file for DHCS and enhance the data reconciliation processes to include more than a comparison of the total paid dollars. 3. Develop operational policies and procedures for correcting and resubmitting encounter data to DHCS.

¹² CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).