Performance Evaluation Report

Gold Coast Health Plan

July 1, 2011–June 30, 2012

Medi-Cal Managed Care Division
California Department of
Health Care Services

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Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal program, which provides managed care services to approximately 4.9 million beneficiaries (as of June 2012)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] 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 plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO designates each compliance review standard, performance measure, and quality improvement project (QIP) to one or more domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

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

- The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.

[1] *Medi-Cal Managed Care Enrollment Report—June 2012.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: January 17, 2013.
[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.

- Plan-specific evaluation reports include findings for each plan regarding its organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

This report is specific to DHCS's contracted plan, Gold Coast Health Plan ("Gold Coast" or "the plan"), which delivers care in Ventura County, for the review period July 1, 2011, through June 30, 2012. Actions taken by the plan subsequent to June 30, 2012, regarding findings identified in this report, will be included in the next annual plan-specific evaluation report.

Plan Overview

In July 2005, the governor signed the 2005–2006 Budget Act that called for the expansion of Medi-Cal managed care in 13 counties, including Ventura County. The Ventura County Medi-Cal Managed Care Commission was established in January 2010 to administer health care services to Medi-Cal members in Ventura County. Gold Coast was created under the County of Ventura. Gold Coast is a full-scope managed care plan operating in Ventura County. The plan delivers care to members as a County Organized Health System (COHS) model.

In a COHS model, DHCS initiates contracts with county-organized and county-operated plans to provide managed care services to beneficiaries with designated, mandatory aid codes. In a COHS plan, beneficiaries can choose from a wide network of managed care providers. These beneficiaries do not have the option of enrolling in fee-for-service Medi-Cal unless authorized by the plan.

Gold Coast became operational to provide MCMC services in Ventura County in July 2011. As of June 30, 2012, it had 105,368 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2012*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specify that the State or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid managed care plan'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 plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers DHCS's medical performance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing Structure and Operations

HSAG organized, aggregated, and analyzed results from DHCS's compliance monitoring reviews to draw conclusions about Gold Coast's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of DHCS's Medi-Cal Managed Care Division (MMCD) have historically worked in conjunction with the Department of Managed Health Care to conduct joint audits of Medi-Cal managed care plans. In some instances, however, medical performance audits have been conducted solely by DHCS or the Department of Managed Health Care. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each Medi-Cal managed care plan approximately once every three years.

DHCS requires that the plan meet all State and federal requirements as part of its readiness review before becoming operational. MMCD evaluated the following areas to determine Gold Coast's compliance with the State's requirements for providing services to MCMC members. Areas evaluated and reviewed included:

- Provider Network
- Primary Care Physician Network
- Hospital Network
- Pharmacy Network
- Laboratory Network
- Geographic Accessibility
- Member and Provider Outreach
- Formulary
- Coordination of Care
- Policies and Procedures
- Plan Operation Descriptions
- Transition of Care

Gold Coast was found to be compliant with DHCS's plan readiness requirements in July 2011. No medical performance review was conducted during the review period for Gold Coast, as the plan just became operational in July 2011.

Member Rights and Program Integrity Review

MMCD's Member Rights/Program Integrity Unit (MR/PIU) is responsible for monitoring plan compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to member rights and program integrity. The MR/PIU aids plan readiness through review and approval of plans' written policies and procedures that include the areas of member grievances and appeals; prior-authorization request notifications; marketing (for non-COHS plans); Seniors and Persons with Disabilities Sensitivity training; facility site accessibility assessment; cultural and linguistic services; and program integrity (fraud and abuse prevention and detection). The MR/PIU reviews and approves processes over these areas prior to the commencement of plan operations, during plan expansion, upon contract renewal, and upon the plan's change in policy and procedures. The MR/PIU aids and monitors plan compliance through biennial on-site health plan monitoring visits that include the issuance of formal

monitoring reports, provision of technical assistance, and follow-up as needed for the resolution of compliance observations and findings.

For this report, HSAG reviewed the most current medical performance reviews and MR/PIU plan monitoring reports available as of June 30, 2012. In addition, HSAG reviewed each plan's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews.

MR/PIU conducted an on-site review of Gold Coast in March 2012, covering the review period of July 1, 2011, through February 29, 2012. The scope of the review included Member Grievances, Prior Authorization Notifications, Cultural and Linguistic Services, the False Claims Act, and Program Integrity.

The MR/PIU report, dated June 13, 2012, summarized the findings and observations from the March 2012 review. MR/PIU noted the following:

- Although Gold Coast was not required to conduct physical accessibility assessments until November 2012, the plan had taken the initiative to begin conducting physical accessibility assessments of its provider network.
- Gold Coast was in the process of implementing its Seniors and Persons with Disabilities (SPD) Sensitivity Training, and MR/PIU provided guidance and technical assistance to the plan.
- The plan's Fraud and Abuse Program policies and procedures were recently approved by DHCS. Gold Coast was engaging in efforts to begin reporting suspected fraud and/or abuse cases to MR/PIU.

MR/PIU noted findings in the categories of Member Grievances and Prior Authorization Notifications and provided technical assistance observations in the areas of Member Grievances and Cultural and Linguistic Services. Gold Coast was not required to respond to the findings or the technical assistance observations. MR/PIU will follow up with the plan on the findings and recommendations during its next review. Listed below are the findings and technical assistance observations:

Member Grievances

Findings

Of 50 grievance files reviewed:

- Twenty-four had been resolved beyond the maximum allowed 30-calendar-day time frame.
- Eleven contained an acknowledgement letter that was sent to the member after the maximum allowed 5-calendar-day time frame.

- None contained the required telephone number of the plan representative in the acknowledgement letter.

Technical Assistance Areas

- The 24 grievances cases that were resolved beyond the maximum 30-day time frame were missing evidence that written notification had been provided to the member regarding the status of the grievance and the estimated date when the grievance would be resolved. MR/PIU instructed the plan to make the necessary control adjustments to ensure the member is notified in writing of the status of the grievance and provided with an estimated date of resolution.
- The date and time the grievance was filed with the plan or provider was not clearly identified in all 50 grievance files reviewed. MR/PIU instructed the plan to take the necessary steps to ensure that Gold Coast's grievance logs contain uniform record elements, including the date and time each grievance is filed, and that this information is readily accessible for tracking and monitoring.

Prior Authorization Notifications

Findings

Of 50 prior authorization notification files reviewed:

- All contained a notice of action (NOA) letter that did not provide sufficient clarity of the specific regulation or plan authorization procedure supporting the plan's action.
- One contained an inaccurate decision date, one was missing a decision date, and one contained a decision date that exceeded the required 14-calendar-day time frame.
- Six contained an NOA letter that was mailed past the 3-working-day requirement.
- Two files were missing the NOA letter.

Cultural and Linguistic Services/Provider Office Visit

Technical Assistance Area

- The staff members at one of five provider offices visited indicated that they were not aware of Gold Coast's 24-hour language line that is available to members. MR/PIU instructed the plan to take the necessary steps to ensure that Gold Coast provides cultural and linguistic education to the providers' front office staff members.

Strengths

The MR/PIU review determined that the plan was fully compliant in the areas of Cultural and Linguistic Services, the False Claims Act, and Program Integrity. MR/PIU noted that Gold Coast has started taking steps to ensure provider offices are physically accessible to members and implementing the plan's SPD Sensitivity Training. Additionally, the plan has engaged in efforts to begin reporting suspected fraud and/or abuse cases to MR/PIU.

Opportunities for Improvement

Gold Coast has the opportunity to make improvements in the areas of Member Grievances and Prior Authorization Notifications to ensure full compliance with all contract requirements in these areas.

Conducting the Review

DHCS annually selects a set of performance measures—in consultation with contracted plans, the EQRO, and stakeholders—to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members. These DHCS-selected measures are referred to as the External Accountability Set (EAS). DHCS requires that plans collect and report EAS rates, which provide a standardized method for objectively evaluating plans' delivery of services.

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

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

HSAG evaluates two aspects of performance measures for each plan. First, HSAG assesses the validity of each plan's data using protocols required by the Centers for Medicare & Medicaid Services (CMS). This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the plan's performance in providing quality, accessible, and timely care and services to its MCMC members.

Performance Measure Validation

DHCS's 2012 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[4] measures and an internally developed measure for the statewide collaborative QIP that fell under all three domains of care—quality, access, and timeliness. In order to report these HEDIS measure rates, plans must first have members meet continuous enrollment requirements for each measure being reported, which typically means members need to be enrolled in the plan for 11 of 12 months during the measurement year. Gold Coast's members did not have continuous enrollment during 2011 because the plan began Medi-Cal operations in July 2011. Consequently, HSAG did not conduct a HEDIS Compliance Audit™ of Gold Coast in 2012.

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

Performance Measure Validation Findings

There were no performance measure validation findings to report for the review period.

Performance Measure Results

As stated above, Gold Coast was not required to report performance measure validation results during the review period. DHCS requires the plan to submit performance measure results in 2013 for the 2012 measurement period. HSAG will include these results in Gold Coast's next plan-specific evaluation report.

Strengths

While Gold Coast did not submit EAS rates in 2012, the plan appears to have awareness of the importance of meeting DHCS requirements for reporting performance measurement results, as evidenced by the plan's 2012 Quality Improvement Work Plan including an objective and tasks related to HEDIS measure reporting. Additionally, the plan's quality improvement program description includes processes for assessing and analyzing performance on HEDIS measures and developing activities, when needed, to improve the care provided to members.

Opportunities for Improvement

Gold Coast should begin making plans for reporting performance measures beginning in 2013. The plan should work with DHCS and the EQRO to hold an introductory meeting on performance measures to ensure that the plan understands DHCS's requirements and has an operational plan for reporting valid and reliable rates.

Conducting the 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 Centers for Medicare & Medicaid Services' (CMS') validating protocol to ensure that plans 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.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012* 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 plans' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using the CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the plan's QIP objectives (QIP results). HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about Gold Coast's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Project Objectives

Gold Coast had one clinical QIP proposal in progress during the review period of July 1, 2011–June 30, 2012. The plan participated in the new statewide *All-Cause Readmissions* collaborative which focused on reducing readmissions for members aged 21 years and older due to all causes within 30 days of an inpatient discharge. 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 QIP fell under the quality and access domains of care.

For its second QIP, the plan submitted a proposal outlining work to reduce avoidable emergency room visits; however, after review of the QIP, the EQRO recommended that DHCS provide the plan with an extension for selecting and submitting a QIP proposal until data are available for a full year and reported as part of the HEDIS 2013 measurement set, covering the 2012 calendar

year. In the interim, the EQRO recommended having technical assistance calls with Gold Coast in preparation for the plan's internal QIP. DHCS agreed with the EQRO's recommendations, and the plan's second QIP will be due to DHCS in July 2013.

Quality Improvement Project Validation Findings

The table below summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Gold Coast Health Plan—Ventura County July 1, 2011, through June 30, 2012

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
*All-Cause Readmissions**	Proposal	Not Applicable	Not Applicable	*Pass*

[1] **Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the plan 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*.

*During the review period, the *All-Cause Readmissions* QIP was reviewed as a *Pass/Fail* only, since the project was in its study design phase.

Validation results during the review period of July 1, 2011, through June 30, 2012, showed that Gold Coast appropriately submitted the common language developed for the study design phase and received a *Pass* score for the *All-Cause Readmissions* proposal.

Due to unique one-time validation scoring used for the initial submission of the study design stage for the *All-Cause Readmissions* statewide collaborative proposal, HSAG did not conduct detailed scoring. The plan will submit its internal QIP beginning in 2013. For this review period, there are no additional QIP validation scores to report.

Quality Improvement Project Outcomes and Interventions

Since the *All-Cause Readmissions* QIP did not progress to the implementation stage during the review period, HSAG did not include outcome or intervention information in this report. HSAG will include details of outcomes and interventions for the *All-Cause Readmissions* QIP in Gold Coast's 2012–2013 plan-specific evaluation report.

Gold Coast's contract with DHCS began in July 2011. The plan will submit its internal QIP beginning in 2013. For this review period, there are no QIP validation scores, interventions, or outcomes to report for internal QIPs.

Strengths

There were no significant strengths noted for Gold Coast related to QIPs.

Opportunities for Improvement

As the plan progresses through the QIP process, it should refer to the QIP Completion Instructions and contact HSAG for technical assistance as needed. In addition, the plan should work with the EQRO in preparation for its internal QIP submission due to DHCS in July 2013.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of above average, average, or below average in the areas of quality, access, and timeliness domains of care. A score is calculated for performance measure rates, QIP validation, and QIP outcomes as measured by statistical significance and sustained improvement for each domain of care. A final score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the plans' medical performance and MR/PIU reviews, when applicable, to determine overall performance within each domain of care.

HSAG did not apply its standardized scoring process to Gold Coast during the review period given that the plan was newly contracted as of July 1, 2011, and did not have data available for reporting QIPs or performance measures.

Quality

The quality domain of care relates to a plan's ability to increase desired health outcomes for its MCMC members through the provision of health care services and the plan's structural and operational characteristics.

DHCS uses the results of performance measures and quality improvement projects (QIPs) to assess care delivered to beneficiaries by a plan 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 a plan'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.

The plan met all of the program and structural requirements during the readiness review period to becoming operational in July 2011. Gold Coast's 2012 Quality Improvement Program Description and 2012 Quality Improvement Work Plan include descriptions of processes and objectives to ensure quality care is provided to MCMC members.

The plan did not have performance measure results to assess quality of care across the EAS, and there are no QIP outcomes to report for this reporting period.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC members. DHCS has contract requirements for plans to ensure access to and the availability of services to beneficiaries and uses monitoring processes, including audits, to assess a plan'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. Medical performance reviews, MR/PIU reviews, performance measures, and QIP outcomes are used 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.

The plan did not have performance measure results to assess access of care across the EAS, and there are no QIP outcomes to report for this reporting period. Gold Coast's 2012 Quality Improvement Program Description and 2012 Quality Improvement Work Plan include descriptions of processes and objectives to ensure MCMC members have access to services. The readiness review found the plan's network adequate to provide services to members in Ventura County.

Timeliness

The timeliness domain of care relates to a plan'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 plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' 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.

The plan did not have performance measure results to assess timeliness of care across the EAS, and there are no QIP outcomes to report for this reporting period. The MR/PIU review noted several areas in need of improvement related to member grievances and prior authorizations. Gold

Coast's 2012 Quality Improvement Program Description includes an objective to respond timely to all grievances and describes that the Utilization/Case Management Committee has a responsibility to review the timeliness of medical necessity reviews; however, there was no information regarding the monitoring mechanism for ensuring members' access to timely care or for resolving these deficiencies within the plan's work plan.

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 plan:

- Resolve all deficiencies from the March 2012 MR/PIU review. Specifically:
  - Provide documentation of a process to ensure grievances are resolved within the required time frame.
  - Provide documentation of a process to ensure that acknowledgement letters are sent within the required time frame.
  - Provide documentation that the required telephone number of the plan representative is included in all acknowledgement letters.
  - Provide documentation that NOA letters include the specific regulation or plan authorization procedure supporting the plan's action.
  - Provide documentation of a process to ensure that NOA letters are sent within the required time frame and applicable and accurate dates are included in the letter. Additionally, ensure NOA letters are included in the member's case file, when applicable.
- Work with DHCS and the EQRO to hold an introductory meeting on performance measures to ensure that the plan understands DHCS's requirements and has an operational plan for reporting valid and reliable rates.
- Refer to the QIP Completion Instructions and contact the EQRO for technical assistance as needed.
- Work with the EQRO in preparation for the plan's internal QIP submission due to DHCS in July 2013.

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