Performance Evaluation Report

Gold Coast Health Plan

July 1, 2012–June 30, 2013

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 California's Medicaid program (Medi-Cal), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[1] in the State of California through a combination of contracted full-scope and specialty managed care 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 §438.364[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 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 Program Technical Report, July 1, 2012–June 30, 2013*. 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

[1] *Medi-Cal Managed Care Enrollment Report—June 2013*. 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.

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.

- MCP-specific evaluation reports (July 1, 2012–June 30, 2013). 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, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care 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 managed care providers. Each COHS MCP is sanctioned 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, 2013, Gold Coast had 106,190 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2013*. 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 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, 2012–June 30, 2013*, 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 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.

For this report, HSAG reviewed the most current member rights reviews, medical performance audits, and monitoring reports available as of June 30, 2013. 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 review 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 MCP contracts reflect federal and State requirements. DHCS reviews and

approves MCP processes in these areas prior to the commencement of MCP operations, during MCP expansion into new counties, upon contract renewal, and upon the MCP's changes in policies and procedures.

Medical Performance Audits and Member Rights Reviews

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical performance audits of Medi-Cal MCPs. In some instances, however, these audits were conducted solely by DHCS or DMHC. These medical performance audits assess MCPs' compliance with contract requirements and State and federal regulations. These audits were conducted for each Medi-Cal MCP approximately once every three years.

During this review period, DHCS began a transition of medical performance monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical performance audit frequency from once every three years to once each year. The second change, which occurred late in this report's review period (March 2013), was the phasing out of DHCS's biennial member rights/program integrity on-site reviews.[4] The biennial member rights/program integrity on-site reviews were replaced with an expanded continuous review process.

Under DHCS's new monitoring protocols, findings identified in annual A&I Medical Audits, DMHC Seniors and Persons with Disabilities (SPD) Enrollment Surveys, and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under these new protocols include follow-up communications and meetings with MCPs, augmented by DHCS technical assistance for MCPs to develop meaningful corrective action plans (CAPs) that address findings.

Since DHCS was transitioning to new monitoring protocols during this reporting period, HSAG reviewed the most recent monitoring reports available as of June 30, 2013. In some cases, the most recent monitoring report available was the earlier DHCS or DMHC medical audit report (once every three-years) and/or the biennial member rights/program integrity review report. For some of the MCP-specific evaluation reports, HSAG assessed the MCP using materials produced under the new monitoring protocols.

[4] These reviews were conducted by DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit to monitor MCP 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 the follow areas: member grievances and appeals, prior-authorization request notifications, marketing (for non-COHS MCPs), cultural and linguistic services, and program integrity (fraud and abuse prevention and detection).

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. A&I evaluated Gold Coast's compliance with its DHCS contract and regulations in these areas:

- Utilization Management
- Continuity of Care
- Availability and Accessibility
- Member's Rights
- Quality Management
- Administrative and Organizational Capacity

A&I issued the audit report to Gold Coast on June 6, 2013. The report indicated that A&I identified several findings in each of the review areas, and A&I provided multiple recommendations to the MCP related to each area. Gold Coast is required to submit a CAP to A&I in response to the findings. HSAG will provide information about the CAP and A&I's assessment of the CAP in Gold Coast's 2013–14 MCP-specific evaluation report. Following is a summary of the identified deficiencies within each of the review areas:

Utilization Management

During the Utilization Management (UM) portion of the review, Gold Coast was found to have deficiencies in the Utilization Management Program, Prior Authorization Review Requirements, Referral Tracking System, and Delegation of Utilization Management categories. Findings included:

- Gold Coast's Governing Body, UM Committee, and Quality Improvement (QI) Committee did not conduct monitoring or oversight of UM policies, procedures, or practices to ensure appropriate review and approval of medically necessary covered services.
  - The UM system did not generate reports for evaluation of providers' utilization, performance, or costs that allow integration with the MCP's QI plan.
  - There were no mechanisms to ensure that guidelines were consistently applied with methods such as interrater reliability.
  - Systems were not in place to detect or manage under- or overutilization of medical services.
- Gold Coast's Pharmacy and Therapeutics (P & T) Committee did not document consideration of medical benefit, clinical justification, or comparisons to existing therapies in the same category or class when new drugs were added to the formulary.

- Gold Coast does not conduct adequate oversight of the pharmacy prior authorization (PA) process, and the pharmacy PA process allows inappropriate therapies.
- Computer-generated pharmacy denial letters contained a range of errors from spelling and syntax to unclear and/or illogical language.
- Gold Coast did not track and monitor services requiring prior authorization.

Continuity of Care

During the Continuity of Care portion of the review, Gold Coast was found to have deficiencies in the Coordination of Care: Within and Out-of-Plan, California Children's Services, Early Intervention Services/Developmental Disabilities, and Initial Health Assessment categories. Findings included:

- Gold Coast did not budget for case management nurses and was unable to perform case management coordination of services both in and out of network.
- The MCP did not produce data reports to monitor coordination of care.
- Gold Coast did not coordinate care for eligible California Children's Services members.
- Gold Coast did not monitor if Early Start and developmentally disabled members received preventive care and did not coordinate members' care with the MCP, Regional Center, and primary care provider (PCP).
- Gold Coast did not use the monthly Medi-Cal Managed Care Division data file to identify eligible members receiving Developmental Disabilities and Early Start services.
- Gold Coast did not perform oversight for initial health assessment (IHA) compliance.
  - IHA completion rates were not available and provider compliance with follow-up on missed or broken appointments was not enforced.
  - IHA data were not reported to the UM or QI committees.

Availability and Accessibility

During the Availability and Accessibility portion of the review, Gold Coast was found to have deficiencies in the Appointment Procedures and Waiting Times, Urgent Care/Emergency Care, Telephone Procedures/After Hours Calls, Specialists and Specialty Services, Emergency Service Providers (Claims), Family Planning (Payments), and Access to Pharmaceutical Services categories. Findings included:

- Gold Coast did not monitor appointment procedures, prenatal care, waiting times, urgent care, or emergency care to determine if access standards were met.

- Gold Coast did not monitor telephone procedures, after-hours calls, or specialists and specialty services for compliance with access standards.
- The MCP did not monitor the claims-processing subcontractor to ensure timely and proper payment of claims was performed.
  - Gold Coast paid emergency services claims late.
  - The MCP erroneously denied claims for lack of prior authorization for services provided by out-of-network providers.
  - Gold Coast denied out-of-network family planning claims for lack of prior authorization from out-of-network providers when no prior authorization was required.
- Gold Coast did not monitor member access to a 72-hour supply of medically necessary drugs in an emergency situation.

Member's Rights

During the Member's Rights portion of the review, Gold Coast was found to have deficiencies in the Grievance System, Cultural and Linguistic Services, and Confidentiality Rights categories. Findings included:

- Gold Coast did not monitor the subcontractor who operated the MCP's call-in center.
  - Staff members were poorly trained, calls were dropped, and call-in center backlogs were not monitored.
  - Grievances were misclassified in the system, lost, and not recovered for months.
  - Grievance processing was untimely and clinical grievances were not properly reviewed.
  - Letters did not have clear explanations of how the grievance was resolved and were not always translated in the member's designated language.
- Gold Coast's Grievance and Appeals Committee did not meet regularly and did not report to the QI Committee for discussion and improvement recommendations.
- Gold Coast hired consultants without written contracts containing confidentiality agreements prior to access of DHCS protected health information.
- Gold Coast did not have an employee training program for privacy practices.

Quality Management

During the Quality Management portion of the review, Gold Coast was found to have deficiencies in the Quality Improvement System, Provider Qualifications, and Quality Improvement Program Description and Structure categories. Findings included:

- The Governing Body did not exercise responsibility for the QI Program.
  - There were no regular QI reports sent to the Governing Body.
  - The QI Committee did not report directly to the Governing Body.
  - There was no formal process to identify aspects of care, prioritize topics, or perform barrier analysis for QI.
- The Governing Body did not oversee the function of the QI Committee and the activities of the Credentialing Committee.
  - Gold Coast approved the credentialing audits of two delegated medical groups even though the audit found numerous areas of noncompliance, and neither delegated medical group was required to complete a corrective action plan.
- The Pharmacy Benefits Manager (PBM) was responsible for performing credentialing and recredentialing of network pharmacies but did not perform the tasks.

Administrative and Organizational Capacity

During the Administrative and Organizational Capacity portion of the review, Gold Coast was found to have deficiencies in the Medical Director, Medical Decisions, Provider Training, Fraud and Abuse, and Contract Performance categories. Findings included:

- Gold Coast's chief medical officer (CMO) and medical director did not ensure QI activities were defined and implemented.
  - The CMO's involvement in clinical grievances was not present or documented.
  - The CMO was responsible for overseeing pharmacy management, but CMO involvement was not evident in the prior authorization denial process.
- Gold Coast did not have policies and procedures for new provider training, and new provider training was not conducted within the required 10 days of active status of the provider.
- Gold Coast did not have an employee training program for fraud, waste, and abuse and did not implement procedures to monitor and identify potential or suspected fraud and abuse committed by members or providers.
- Many procedures performed at Gold Coast were not formalized in the MCP's policies, and written policies and procedures were often not followed.

- Committees did not sufficiently address issues brought up in prior minutes or the follow-up actions.
- Governing Body decisions in the early development stage of the MCP contributed to subsequent management problems.
  - Selection of subcontractors for major MCP functions such as UM, claims payment, and member services was done without conducting a thorough evaluation, resulting in subcontractors that were unable to customize services to the MCP's needs.
  - The decision to outsource significant operational control of core elements of a managed care system, together with a lack of vendor oversight, constituted a failure of the Governing Body to provide the necessary resources to ensure full contract performance.
- The Governing Body did not participate in a system of accountability by its failure to approve or monitor the QI system. The MCP's decisions were made in spite of conflicts of interest. These actions did not demonstrate an accountable body responsible for carrying out the contract and making member services a high priority.

Follow-up from Outstanding Findings and Deficiencies Noted in 2011–12 MCP-specific Evaluation Report

Although HSAG did not receive follow-up information from DHCS on the outstanding findings from the MCP's March 2012 Member Rights/Program Integrity Unit (MR/PIU) on-site review, the MCP's self-reported actions regarding the findings are included in Appendix B of this report. HSAG reviewed Gold Coast's self-report of actions the MCP has taken to resolve the outstanding issues, along with submitted policies and documentation, and it appears that the MCP has addressed the outstanding findings from the MR/PIU review. It should be noted that HSAG did not receive documentation from the MCP regarding whether the information was submitted to MR/PIU.

Strengths

It appears Gold Coast addressed the findings from the March 2012 MR/PIU review in the areas of Member Grievances and Prior Authorization Notifications.

Opportunities for Improvement

Gold Coast has the opportunity to make improvements in the areas of Utilization Management, Continuity of Care, Availability and Accessibility, Member's Rights, Quality Management, and Administrative and Organizational Capacity to ensure full compliance with all contract requirements in these areas, which span all domains of care.

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, 2012–June 30, 2013*, 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.[5] 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.

[5] 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 2013 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[6] 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 31. 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 Audits™[7] of all Medi-Cal MCPs in 2013 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2013 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 2013 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 review of the MCP's HEDIS audit report revealed the following observations:

- To improve effectiveness on monitoring claims/encounter data completeness, the auditor recommended that Gold Coast create a monthly volume report by provider or develop tracking reports for claims/encounters submitted by its vendors.
- Gold Coast's processes allowed for effective monitoring of successful file loads into its database.
- The auditor recommended that Gold Coast 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. This will help to capture immunizations and well-child visit data administratively that occur during the first 60 days of life.

[6] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[7] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

- Gold Coast conducted a comprehensive member-level audit in November 2012 to identify and correct any potential eligibility errors. This process strengthened the MCP's control on the completeness and accuracy of the enrollment data.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 displays a performance measure name key with abbreviations for reporting year 2013.

Table 3.1—Name Key for Performance Measures in External Accountability Set

Performance Measure Abbreviation	Full Name of 2013 Reporting Year† Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions* ‡
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient Visits*
CAP–1224	*Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
CAP–256	*Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
CAP–711	*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
CAP–1219	*Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
CBP	*Controlling High Blood Pressure*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
IMA–1	*Immunizations for Adolescents—Combination 1*
LBP	*Use of Imaging Studies for Low Back Pain*
MMA–50	*Medication Management for People with Asthma—Medication Compliance 50% Total*
MMA–75	*Medication Management for People with Asthma—Medication Compliance 75% Total*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*
MPM–DIG	*Annual Monitoring for Patients on Persistent Medications—Digoxin*
MPM–DIU	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
W-34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Table 3.1—Name Key for Performance Measures in External Accountability Set

Performance Measure Abbreviation	Full Name of 2013 Reporting Year† Performance Measure
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

† The reporting year represents the year the measure rate is reported and generally represents the previous calendar year's data.
‡ The ACR measure is a DHCS-developed measure for use in the All-Cause Readmissions Statewide Collaborative Quality Improvement Project.

Table 3.2 below presents a summary of Gold Coast's 2013 performance measure results (based on calendar year 2012 data) compared to 2012 performance measure results (based on calendar year 2011 data).

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 specifications changes impacting comparability. Table 3.2 shows the MCP's 2013 performance compared to the DHCS-established MPLs and HPLs.

DHCS based the MPLs and HPLs on the National Committee for Quality Assurance's (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.

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
Gold Coast—Ventura County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	--	13.87%	★	Not Comparable	18.98%	33.33%
ACR	Q, A	--	19.17%	--	Not Comparable	--	--
AMB–ED	‡	--	49.21	‡	Not Comparable	‡	‡
AMB–OP	‡	--	317.16	‡	Not Comparable	‡	‡
CAP–1224	A	--	82.51%	★	Not Comparable	95.56%	98.39%
CAP–256	A	--	63.09%	★	Not Comparable	86.62%	92.63%
CAP–711	A	--	NA	NA	Not Comparable	87.56%	94.51%
CAP–1219	A	--	NA	NA	Not Comparable	86.04%	93.01%
CBP	Q	--	61.56%	--	Not Comparable	--	--
CCS	Q,A	--	57.66%	★	Not Comparable	61.81%	78.51%
CDC–BP	Q	--	62.29%	★★	Not Comparable	54.48%	75.44%
CDC–E	Q,A	--	42.58%	★	Not Comparable	45.03%	69.72%
CDC–H8 (<8.0%)	Q	--	37.96%	★	Not Comparable	42.09%	59.37%
CDC–H9 (>9.0%)	Q	--	56.20%	★	Not Comparable	50.31%	28.95%
CDC–HT	Q,A	--	81.75%	★★	Not Comparable	78.54%	91.13%
CDC–LC (<100)	Q	--	33.58%	★★	Not Comparable	28.47%	46.44%
CDC–LS	Q,A	--	78.83%	★★	Not Comparable	70.34%	83.45%
CDC–N	Q,A	--	79.81%	★★	Not Comparable	73.48%	86.93%
CIS–3	Q,A,T	--	80.05%	★★	Not Comparable	64.72%	82.48%
IMA–1	Q,A,T	--	65.21%	★★	Not Comparable	50.36%	80.91%
LBP	Q	--	76.95%	★★	Not Comparable	72.04%	82.04%
MMA–50	Q	--	NA	--	Not Comparable	--	--
MMA–75	Q	--	NA	--	Not Comparable	--	--
MPM–ACE	Q	--	86.73%	★★	Not Comparable	83.72%	91.33%
MPM–DIG	Q	--	88.46%	★★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	--	86.28%	★★	Not Comparable	83.19%	91.30%
PPC–Pre	Q,A,T	--	80.78%	★★	Not Comparable	80.54%	93.33%
PPC–Pst	Q,A,T	--	63.99%	★★	Not Comparable	58.70%	74.73%
W-34	Q,A,T	--	61.80%	★	Not Comparable	65.51%	83.04%

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
Gold Coast—Ventura County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
WCC–BMI	Q	--	42.09%	★★	Not Comparable	29.20%	77.13%
WCC–N	Q	--	42.09%	★	Not Comparable	42.82%	77.61%
WCC–PA	Q	--	30.41%	★	Not Comparable	31.63%	64.87%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
‡ This is a utilization measure, which is not assigned a domain of care. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
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),[8] 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

[8] 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 plan and for the subset of enrollees who are seniors and persons with disabilities. Managed care 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.

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 Tables 3.3 and 3.4, which present a summary of Gold Coast's 2013 SPD measure results. Table 3.3 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[9] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.4 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department (ED) Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (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*

[9] 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 3.3.

Table 3.3—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Gold Coast—Ventura County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	11.32%	23.16%	▼	19.17%
CAP–1224	82.60%	75.00%	↔	82.51%
CAP–256	63.12%	61.92%	↔	63.09%
CAP–711	NA	NA	Not Comparable	NA
CAP–1219	NA	NA	Not Comparable	NA
CDC–BP	65.69%	57.66%	↓	62.29%
CDC–E	44.04%	44.53%	↔	42.58%
CDC–H8 (<8.0%)	37.71%	35.04%	↔	37.96%
CDC–H9 (>9.0%)	54.99%	58.64%	↔	56.20%
CDC–HT	82.73%	85.16%	↔	81.75%
CDC–LC (<100)	33.82%	36.25%	↔	33.58%
CDC–LS	77.37%	79.08%	↔	78.83%
CDC–N	80.78%	86.13%	↑	79.81%
MPM–ACE	84.26%	88.46%	↑	86.73%
MPM–DIG	NA	88.37%	Not Comparable	88.46%
MPM–DIU	85.15%	86.97%	↔	86.28%

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

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 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.

Table 3.4—2013 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
294.22	46.49	493.66	70.16

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

Performance Measure Result Findings

Since 2013 was the first year Gold Coast reported performance measure rates, no comparison to prior years' performance can be made. Overall, Gold Coast performed below average on its measures in 2013. No measures had rates above the HPLs, and 10 measures had rates below the MPLs.

Seniors and Persons with Disabilities Findings

The following measures had SPD rates that were significantly higher than the non-SPD rates:

- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Annual Monitoring for Patients on Persistent Medications—ACE*

The SPD rate for the *All-Cause Readmissions* measure was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had significantly more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population. Additionally, the SPD rate for the *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* measure was significantly lower than the non-SPD rate, meaning that significantly fewer SPD members with diabetes had controlled blood pressure when compared to non-SPD members with diabetes.

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 quality, access, and timeliness associated with the low-performing measure and positively impact the measure's rate. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the steps it will take to improve care and the measure's rate. DHCS reviews each IP for soundness of design and potential efficacy. DHCS requires MCPs to correct and resubmit any IP that fails to meet DHCS's IP standards.

For the 2012–13 MCP-specific reports, HSAG reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2012 (measurement year 2011). HSAG then reviewed the HEDIS 2013 rates (measurement year 2012) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. In addition, HSAG assessed the MCP's need to continue existing IPs and/or to develop new IPs.

Since 2013 was the first year Gold Coast was required to report performance measure rates, the MCP will not be required to develop IPs for measures with rates below the MPLs. While no IPs are required, the MCP is encouraged to conduct barrier analyses and identify strategies to improve performance measure rates that were below the MPLs in 2013.

Strengths

During the HEDIS audit process, the following was noted by the auditor:

- Gold Coast's processes allowed for effective monitoring of successful file loads into the MCP's database.
- Gold Coast conducted a comprehensive member-level audit in November 2012 to identify and correct any potential eligibility errors. This process strengthened the MCP's control on the completeness and accuracy of the enrollment data.

Opportunities for Improvement

Gold Coast has the opportunity to make improvements related to the HEDIS audit process, including:

- Creating a monthly volume report by provider or developing tracking reports for claims/encounters submitted by the MCP's vendors to improve effectiveness on monitoring claims/encounter data completeness.
- Investigating 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.

Gold Coast also has the opportunity to make improvements on several measures that had rates below the MPLs in 2013. The MCP is encouraged to conduct barrier analyses and identify strategies to improve the rates on these measures. Additionally, Gold Coast has the opportunity to assess the factors leading to the SPD rates for the *All-Cause Readmissions* and *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* measures being significantly worse than the non-SPD rates and identify strategies to ensure the MCP is meeting the SPD population's needs.

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 protocol[10] 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, 2012–June 30, 2013,* 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.

[10] 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 was working with DHCS and HSAG on identifying an appropriate internal QIP topic during the review period of July 1, 2012–June 30, 2013.

Table 4.1 below displays information about the *All-Cause Readmissions* QIP, including 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, 2012, through June 30, 2013

QIP	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	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.

Prior to initiation of the statewide collaborative QIP, Gold Coast had a 30-day readmission rate of 14.7 percent among Medi-Cal beneficiaries. Gold Coast also found that the readmission rate for the SPD population was 15.7 percent, which was higher than the 9.9 percent rate for the non-SPD population.

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, 2012, through June 30, 2013

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	Study Design Submission	80%	100%	*Met*

[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, 2012, through June 30, 2013, showed that the study design submission by Gold Coast of its *All-Cause Readmissions* QIP received an overall validation status of *Met* with 100 percent of critical elements and 80 percent of evaluation elements met. Table 4.3 shows the validation results for Gold Coast's *All-Cause Readmissions* QIP across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
Gold Coast—Ventura County
(Number = 1 QIP Submissions, 1 QIP Topics)
July 1, 2012, through June 30, 2013

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)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	50%	25%	25%
Design Total		**80%**	**10%**	**10%**
Implementation	VII: Sufficient Data Analysis and Interpretation	Not Assessed	Not Assessed	Not Assessed
	VIII: Appropriate Improvement Strategies	Not Assessed	Not Assessed	Not Assessed
Implementation Total		**0%**	**0%**	**0%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**0%**	**0%**	**0%**

*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.

HSAG validated Activities I through VI for Gold Coast's *All-Cause Readmissions* study design submission.

Gold Coast demonstrated an adequate application of the Design stage for the *All-Cause Readmissions* QIP, meeting 80 percent of the requirements for all applicable evaluation elements within the study stage. Gold Coast met 100 percent of the requirements for Activities I through V; however, the MCP struggled with Activity VI, meeting only 50 percent of the requirements for all applicable evaluation elements for this activity. The lower score for Activity VI was due to Gold Coast not including a clearly defined and systematic process for collecting baseline and remeasurement data and not describing the MCP's data analysis plan for the QIP.

Activities VII through X were not assessed since the *All-Cause Readmissions* QIP did not progress to the Implementation or Outcomes stage.

Quality Improvement Project Outcomes and Interventions

The *All-Cause Readmissions* QIP did not progress to the Implementation or Outcomes stage during the reporting period; therefore, no intervention or outcome information is included in this report.

Strengths

Gold Coast successfully submitted most of the required information for the *All-Cause Readmissions* QIP and worked with DHCS and HSAG to identify an appropriate internal QIP topic.

Opportunities for Improvement

Gold Coast has the opportunity to ensure all required documentation is included in the QIP Summary Form to ensure the MCP meets all QIP requirements.

Conducting the EQRO Review

In addition to conducting mandatory federal activities, CMS provides for the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[11] survey as an optional Medicaid external quality review activity to assess MCMC beneficiaries' satisfaction with their health care services. DHCS periodically assesses the perceptions and experiences of MCMC beneficiaries as part of its process for evaluating the quality of health care services.

To assist with this assessment, DHCS contracted with HSAG to administer the CAHPS Health Plan Surveys in 2013. DHCS requires that the CAHPS survey be administered to both adult beneficiaries and the parents or caretakers of child beneficiaries at the MCP level. In 2013, HSAG administered standardized survey instruments, CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with HEDIS supplemental item sets, to members of all full-scope MCPs.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Gold Coast's 2013 CAHPS MCP-Specific Report contains the detailed findings and recommendations from the 2013 survey. A brief summary of the findings, strengths, and opportunities for improvement is included below.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about Gold Coast's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures. The global measures (also referred to as global ratings) reflect overall member satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., getting needed care, getting care quickly).

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

CAHPS Global Rating Measures:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

CAHPS Composite Measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*

Table 5.1 shows the domains of care (quality, access, timeliness) for each of the CAHPS measures.

Table 5.1—CAHPS Measures Domains of Care

Measure	Domains of Care
Rating of Health Plan	Q
Rating of All Health Care	Q
Rating of Personal Doctor	Q
Rating of Specialist Seen Most Often	Q
Getting Needed Care	Q, A
Getting Care Quickly	Q, T
How Well Doctors Communicate	Q
Customer Service	Q
Shared Decision Making	Q

National Comparisons

To assess the overall performance of the MCPs, HSAG calculated MCP-level results with county-level analysis, when the MCP provided services in more than one county, and compared the results to the NCQA HEDIS Benchmarks and Thresholds for Accreditation.[12] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).[13]

Star ratings were determined for each CAHPS measure (except the *Shared Decision Making* measure)[14] using the following percentile distributions in Table 5.2.

Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures

Star Rating	Adult and Child Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or above the 75th and below the 90th percentiles
★★★ Good	At or above the 50th and below the 75th percentiles
★★ Fair	At or above the 25th and below the 50th percentiles
★ Poor	Below the 25th percentile

Table 5.3 and Table 5.4 present the star ratings for the global ratings and composite measures for Gold Coast's adult and child Medicaid populations.[15]

Table 5.3—Medi-Cal Managed Care County-Level Global Ratings
Gold Coast—Ventura County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★★	★★★	★★★★★	★★★★★
Child	★	★	★★★	★★

[12] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.
[13] NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.
[14] Since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating.
[15] Due to the changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure.

Table 5.4—Medi-Cal Managed Care County-Level Composite Measures
Gold Coast—Ventura County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★★★	★	★★★	★★★
Child	★	★	★	★

Strengths

Gold Coast received *Excellent* ratings for the adult *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often* measures and *Good* ratings for the following adult measures:

- *Rating of All Health Care*
- *Getting Needed Care*
- *How Well Doctors Communicate*
- *Customer Service*

Additionally, the MCP received a *Good* rating on the child *Rating of Personal Doctor* measure.

Since 2013 was the first year Gold Coast participated in the CAHPS survey, HSAG could not make any comparisons to prior years' surveys.

Opportunities for Improvement

Overall, Gold Coast's CAHPS results showed average performance. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the MCP's CAHPS results. The purpose of the analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as Gold Coast's highest priorities: *Rating of Health Plan, Getting Care Quickly,* and *Rating of All Health Care*. The MCP should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2013 Gold Coast CAHPS MCP-Specific Report.* Areas for improvement spanned the quality and timeliness domains of care.

Conducting the EQRO Review

Accurate and complete encounter data are critical to the success of managed care programs. The completeness and accuracy of these data are essential in DHCS's overall management and oversight of its Medi-Cal MCPs. In order to examine the extent to which encounters submitted to DHCS by MCPs are complete and accurate, DHCS contracted with HSAG to conduct an encounter data validation (EDV) study.

Methodology

During the reporting period, HSAG evaluated two aspects of the encounter data for each MCP. First, HSAG evaluated the information systems and processes of each MCP. Secondly, HSAG performed a comparative analysis between the encounter data housed in the DHCS data warehouse and the encounter data submitted to HSAG from each MCP's data processing system.

In the first EDV activity, HSAG conducted a desk review of the MCPs' information systems and encounter data processing and submission. HSAG obtained the HEDIS Record of Administration, Data Management, and Processes (Roadmap)[16] completed by the MCPs during their NCQA HEDIS Compliance Audit™. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse.

Concurrent with the review of the MCP information systems and processes, HSAG used the administrative records (claims/encounters) in each MCP's claims processing system to evaluate the extent to which the encounters submitted to DHCS were complete and accurate. HSAG evaluated the encounters submitted to DHCS with a date of service between July 1, 2010, and June 30, 2011, and submitted to DHCS on or before October 31, 2012, for the following four types of encounters:

- Medical/Outpatient
- Hospital/Inpatient
- Pharmacy
- Long-Term Care

[16] The Roadmap is a tool used by MCPs to communicate information to the HEDIS auditor about the MCPs' systems for collecting and processing data for HEDIS.

All encounters submitted to HSAG by the MCPs underwent a preliminary file review. The preliminary file review determined whether any potential data issues identified in the data files would warrant a resubmission. The comparative analyses evaluated the extent to which specified key data elements in DHCS's data warehouse are matched with the MCP's files in the following categories:

- Record Completeness
- Element-Level Completeness
- Element-Level Accuracy

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Gold Coast's 2012–13 MCP-Specific Encounter Data Validation Study Report contains the detailed findings and recommendations from the EDV study. A brief summary of the findings and opportunities for improvement is included below.

Please note that since Gold Coast did not have claims and encounter data available from the time period for the study, HSAG was only able to conduct a review of the MCP's encounter systems and processes.

Encounter Data Validation Findings

Since Gold Coast did not have any encounters in the study period for the comparative analysis, findings from this study were limited to review of the MCP's encounter systems and processes only.

Review of Encounter Systems and Processes

The information provided in Gold Coast's Roadmap and supplemental questionnaire indicated that while the MCP had new processes in place for receiving, processing, and submitting encounter data, the policies and procedures may not have been robust enough to ensure complete and consistent encounter data submissions. The information provided in the supplemental questionnaire appeared to have some gaps and inconsistencies in detailing Gold Coast's processes for the receipt, processing, and correction of claims and encounter data submissions to DHCS. Without the detailed claims and encounter data to review for the encounter data validation period of July 2010 through June 2011, it is not feasible for HSAG to assume that Gold Coast's limited policies and procedures for encounter data reporting ensured consistent and complete encounter data reporting to DHCS.

Recommendations

Based on its review, HSAG recommends the following:

- The MCP should examine the policies and contracts that detail the providers' claims and encounter data submission requirements to ensure timeliness, completeness, and accuracy of the claims data.
- The MCP should 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.
- The MCP should develop its operational policies and procedures for correcting and resubmitting encounter data to DHCS.

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, CAHPS survey measure ratings, QIP validation, and QIP outcomes (measured by statistical significance and sustained improvement). A final numeric score, combining the performance measures scores, CAHPS survey measure ratings 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, CAHPS survey measures, and QIPs, HSAG uses results from the MCPs' medical performance and Medi-Cal Managed Care Division 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 A.

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.[17]

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

[17] 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.

HSAG reviewed the quality documents Gold Coast submitted as part of the process for developing this report, and they describe an organizational structure that supports the provision of quality care to the MCP's members.

Gold Coast has findings from the December 2012 A&I medical performance audit in the areas of Quality Management and Administrative and Organizational Capacity that could impact the quality of care delivered to the MCP's members.

The rates for eight measures falling into the quality domain of care were below the MPLs, and all other quality measures had average rates.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and two of these measures had SPD rates that were significantly better than the non-SPD rates:

- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Annual Monitoring for Patients on Persistent Medications—ACE*

The SPD rate for the *All-Cause Readmissions* measure, which falls into the quality domain of care, was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had significantly more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population. Additionally, the SPD rate for the *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* measure was significantly lower than the non-SPD rate, meaning that significantly fewer SPD members with diabetes had controlled blood pressure when compared to non-SPD members with diabetes.

All CAHPS measures fall into the quality domain of care. Overall, the MCP had better ratings for the adult population, with two measures receiving an *Excellent* rating and four measures receiving a *Good* rating. Seven of the eight child measures received below-average ratings.

The *All-Cause Readmissions* QIP falls into the quality domain of care. Since the QIP did not progress to the Outcomes stage, HSAG was not able to assess the QIP's success at improving the quality of care delivered to the MCP's 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.

HSAG reviewed the quality documents Gold Coast submitted as part of the process for developing this report, and they describe processes to ensure members' access to needed health care services.

Gold Coast has findings from the December 2012 A&I medical performance audit in the areas of Continuity of Care, and Availability and Accessibility, which could impact members' access to needed health care services.

The rates for five measures falling into the access domain of care were below the MPLs. All other access measures had average rates.

Nine of the performance measures stratified for the SPD population fall into the access domain of care, and the SPD rate for one of these measures, *Comprehensive Diabetes Care—Medical Attention for Nephropathy*, was significantly better than the non-SPD rate. The *All-Cause Readmissions* measure falls into the access domain of care and as indicated above, the SPD rate for this measure was significantly higher than the non-SPD rate, which suggests that SPD members may not have adequate access to follow-up and care management services.

The *Getting Needed Care* CAHPS measure falls into the access domain of care. The MCP received a *Good* rating on this measure for the adult population and a *Poor* rating for the child population.

The *All-Cause Readmissions* QIP falls into the access domain of care. As indicated above, this QIP did not progress to the Outcomes stage; therefore, HSAG was not able to assess the QIP's success at improving members' access to needed services.

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 has findings from the December 2012 A&I medical performance audit in the areas of Utilization Management and Member's Rights, which could impact the timeliness of services delivered to members.

One of the five measures falling into the timeliness domain of care, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, had a rate below the MPL in 2013, and the other four timeliness measures had average rates.

One CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care. This measure received a *Poor* rating for both the adult and child populations, suggesting that members are not satisfied with the time it takes to receive needed health care services.

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 2011–12 MCP-specific evaluation report. Gold Coast's self-reported responses are included in Appendix B.

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:

- Ensure that the MCP fully resolves all findings from the December 2012 A&I medical performance audit through the DHCS CAP process.
- Engage in the following efforts to improve the HEDIS audit process:
  - 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.
  - 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.
- 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.
- Assess the factors leading to the SPD rates for the *All-Cause Readmissions* and *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* measures being significantly worse than the non-SPD rates and identify strategies to ensure the MCP is meeting the SPD population's needs.
- Review the QIP Completion Instructions prior to submitting QIPs to ensure all required documentation is included in the QIP Summary Form.
- Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Rating of Health Plan, Getting Care Quickly,* and *Rating of All Health Care* priority areas.
- 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.

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

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.[18] This process allows HSAG to evaluate each MCP's performance measure rates (including CAHPS survey measures) 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 3.2)

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.

[18] 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.

3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

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.

CAHPS Survey Measures

(Refer to Tables 5.3 through 5.4)

1. A score of 3 is given for each measure receiving an Excellent or Very Good Star rating.
2. A score of 2 is given for each measure receiving a Good Star rating.
3. A score of 1 is given for each measure receiving a Fair or Poor Star rating.

Quality Domain

(Note: Although the *Shared Decision Making* measure falls into the quality domain of care, since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating and is therefore not included in this calculation.)

1. To be considered **Above Average**, the average score for all quality measures must be 2.5–3.0.
2. To be considered **Average**, the average score for all quality measures must be 1.5–2.4.
3. To be considered **Below Average**, the average score for all quality measures must be 1.0–1.4.

Access Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Needed Care* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Needed Care* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Needed Care* measure.

Timeliness Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Care Quickly* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Care Quickly* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Care Quickly* measure.

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** = 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 =** 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.

For each **CAHPS** measure, a score of 3 is given for each measure receiving a Star rating of Excellent or Very Good and the total score is entered for each domain of care (Q, A, T). A score of 2 is given for each measure receiving a Star rating of Good, and the total score is entered for each domain of care (Q, A, T). A score of 1 is given for each measure receiving a Star rating of Fair or Poor, and the total score is entered for each domain of care (Q, A, T). The average score for each domain of care is used to determine the CAHPS measure performance for each domain of care.

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 performance and Medi-Cal Managed Care Division 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, CAHPS measures, and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the encounter data validation (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 B. MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

for Gold Coast Health Plan

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with Gold Coast's self-reported actions taken through June 30, 2013, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table B.1—Gold Coast's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

2011–12 External Quality Review Recommendation	Gold Coast's Self-Reported Actions Taken Through June 30, 2013, that Address the External Quality Review Recommendation
1. Resolve all deficiencies from the March 2012 MR/PIU review. Specifically:	
a. Provide documentation of a process to ensure grievances are resolved within the required time frame.	GCHP submitted the following in response to item 4.1, Member Grievance System and Oversight, of the Corrective Action Plan: Policy Number GA-003, Member Grievance (attachment #1) Policy Number MS-012, Member Services Grievance Process (attachment #2) Member Services Grievance Process Flowchart (attachment #3) Policy Number MS-012, Grievance and Appeals Internal Audit Process (attachment #4) Grievance & Appeals Audit Sheet (attachment #5) **NOTE:** HSAG reviewed the policies referenced above, and it appears they meet the requirements.
b. Provide documentation of a process to ensure that acknowledgement letters are sent within the required time frame.	GCHP submitted the following in response to item 4.1, Member Grievance System and Oversight, of the Corrective Action Plan: Policy Number GA-003, Member Grievance (attachment #1) Policy Number MS-012, Member Services Grievance Process (attachment #2) Member Services Grievance Process Flowchart (attachment #3) Policy Number MS-011, Grievance and Appeals Internal Audit Process (attachment #4) Grievance & Appeals Audit Sheet (attachment #5) **NOTE:** HSAG reviewed the policies referenced above, and it appears they meet the requirements.
c. Provide documentation that the required telephone number of the plan representative is included in all acknowledgement letters.	Please see attached sample acknowledgement letters (attachments #6 & #7) **NOTE:** HSAG reviewed the documents referenced above, and it appears they meet the requirements.

2011–12 External Quality Review Recommendation	Gold Coast's Self-Reported Actions Taken Through June 30, 2013, that Address the External Quality Review Recommendation
d. Provide documentation that notice of action (NOA) letters include the specific regulation or plan authorization procedure supporting the plan's action.	Gold Coast Health Plan Health Services Department provides a summary of the reasons a service cannot be approved. The Health Services department uses Milliman Care Guide QI for review of medical necessity. In cases where there is no Milliman criterion, policies from national medical organizations are utilized (e.g., American College of Obstetricians and Gynecologists, Advisory Committee on Immunization Practices). The member and provider are given the opportunity to receive a copy of the criteria if they so choose. Additionally, if the service is a carve-out or not a covered benefit, the member is given that information. Several denial letters are attached. **NOTE:** HSAG reviewed the documentation provided by the MCP and did not find denial letters with the information indicated above.
e. 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.	Gold Coast Health Plan has revised Policy HS-001 (attachment #8) and HS-002 (attachment #9) to reflect the current process for issuing denials and for notifying the appropriate parties. The policies are included as attachments. Letters are automatically generated as soon as a case has been decisioned. Letters will be provided in case files when requested. **NOTE:** HSAG reviewed the policies referenced above, and it appears they meet the requirements.
2. 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.	On June 20, 2013, e-mail received re: TA-HSAG's Updated Validation Process & Revised QIP Submission Forms. GCHP responded on June 20, 2013, with an attendees list and participated on a call on July 16, 2013. Received e-mail of 7/25/13 on "TA Call Updates" and 8/7/13 e-mail on "Summary of 7/16/13 TA Call." E-mails are attached (attachment #10). **NOTE:** HSAG reviewed the e-mails referenced above and confirmed they contain the information indicated.
3. Refer to the QIP Completion Instructions and contact the EQRO for technical assistance as needed.	After reviewing the QIP Summary Form and QIP completion instructions, GCHP e-mailed for TA on 6/25/13 and received responses on 6/25/13 and 7/5/13. The TA call was also attended on 7/16/13. See attached e-mails (attachment #11) **NOTE:** HSAG reviewed the e-mails referenced above and confirmed they contain the information indicated.

2011–12 External Quality Review Recommendation	Gold Coast's Self-Reported Actions Taken Through June 30, 2013, that Address the External Quality Review Recommendation
4. Work with the EQRO in preparation for the plan's internal QIP submission due to DHCS in July 2013.	Email of 7/11/13 confirmed 8/13/13 call for TA on baseline submission. GCHP attended. GCHP e-mailed request for TA- Word version of QIP form on 7/19/13 and received response the same day. On 7/25/13, GCHP submitted its internal QIP on 7/25/13. On 8/19/13, GCHP received an e-mail requesting additional information and responded on 8/21/13. On 8/21/13, the internal QIP topic was approved. On 8/30/13, GCHP confirmed attendance for the 9/10/13 DHCS recommended TA call. See attached e-mails (attachment #12). **NOTE:** HSAG reviewed the e-mails referenced above and confirmed they contain the information indicated.