Performance Evaluation Report

CalViva Health

July 1, 2013–June 30, 2014

Managed Care Quality and Monitoring Division
California Department of Health Care Services

April 2015

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July 1, 2013 – June 30, 2014

Purpose of Report

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

The Code of Federal Regulations (CFR) at 42 CFR §438.364[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 Technical Report, July 1, 2013–June 30, 2014*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and operations,

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

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

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

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

Managed Care Health Plan Overview

CalViva is a full-scope MCP delivering services to its MCMC members as a "Local Initiative" (LI) MCP under the Two-Plan Model (TPM). In TPM counties, MCMC beneficiaries may choose between two MCPs; typically, one MCP is an LI and the other a Commercial Plan (CP). DHCS contracts with both plans. The LI is established under authority of the local government with input from State and federal agencies, local community groups, and health care providers to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. MCMC beneficiaries in Fresno, Kings, and Madera counties may choose to enroll in CalViva, the LI MCP; or in Anthem Blue Cross Partnership Plan, the alternative CP.

CalViva became operational in all three counties to provide MCMC services effective March 2011. As of June 30, 2014, CalViva had 219,812 MCMC members in Fresno County, 19,615 in Kings County, and 27,313 members in Madera County—for a total of 266,740 MCMC members.[3]

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

Conducting the EQRO Review

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

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

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

Assessing the State's Compliance Review Activities

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

Readiness Reviews

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

Medical Audits and SPD Medical Surveys

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

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

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

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

Audits and Investigation Division Audit

The most recent A&I medical audit for CalViva was conducted March 11, 2013, through March 22, 2013, covering the review period of January 1, 2012, through December 31, 2012. HSAG provided a summary of the findings from the audit in CalViva's 2012–13 MCP-specific evaluation report. As indicated in the 2012–13 report, the MCP was required to submit a CAP describing the actions taken to correct each finding and the results of each action.

In a letter dated June 24, 2014, DHCS indicated that on May 13, 2014, the MCP provided DHCS with an update to its CAP (originally issued on September 16, 2013). The update included actions the MCP had taken to address audit findings in the following areas:

- Utilization Management
- Continuity of Care

- Access and Availability
- Member's Rights and Responsibilities
- Quality Improvement System
- Organization and Administration of Plan

The letter stated that DHCS's review of the CAP determined that CalViva was in compliance and that the CAP was therefore closed.

Department of Managed Health Care Seniors and Persons with Disabilities Medical Survey

The most recent DMHC SPD medical survey for CalViva was conducted March 11, 2013, through March 13, 2013, covering the review period of January 1, 2011, through December 31, 2012. In CalViva's 2012–13 MCP-specific evaluation report, HSAG provided a summary of two potential deficiencies DMHC identified from the audit. The potential deficiencies were in the areas of Member Rights and Quality Management.

In a letter dated March 12, 2014, DMHC indicated that on September 16, 2013, CalViva provided DHCS with a response to its CAP, which addressed both potential deficiencies and, as a result, DMHC deemed the SPD medical survey closed.

Strengths

CalViva fully resolved all outstanding findings from the A&I medical audit and DMHC SPD medical survey.

Opportunities for Improvement

Since CalViva resolved all areas of concern identified through the most recent audit and survey, HSAG has no recommendations for opportunities for improvement related to compliance reviews.

Conducting the EQRO Review

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

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

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

Validating Performance Measures and Assessing Results

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

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

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

Performance Measure Validation

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

HSAG performed NCQA HEDIS Compliance Audits™[6] of all Medi-Cal MCPs in 2014 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2014 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

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

- CalViva utilized a three-tier verification cycle to ensure that accurate and complete data were entered into its database.
- CalViva successfully transitioned its Healthy Families Program population into MCMC with no impact on member operations (i.e., processes related to enrollment, customer service, member outreach, etc.).

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 through Table 3.3 present a summary of CalViva's performance measure results for 2011–14. Note that data may not be available for all four years.

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specification changes impacting comparability. In addition to the performance measure results from 2011–14, Table 3.1 through Table 3.3 show the MCP's performance compared to the DHCS-established MPLs and HPLs for each year. Rates below the MPLs are **bolded**, and rates above the HPLs are shaded in gray.

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

The reader should note the following regarding Table 3.1 through Table 3.3.

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

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

Table 3.1—Performance Measure Results
CalViva—Fresno County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	10.64%	13.10%	▼
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	45.57	50.13	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	448.77	469.48	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	**82.27%**	84.64%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	**86.60%**	**80.77%**	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	**83.02%**	84.96%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	38.41%	38.66%	↔
Cervical Cancer Screening	Q,A	—	—	—	64.34%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	76.89%	71.80%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	97.82%	96.60%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	91.50%	91.08%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	91.74%	91.42%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	90.68%	87.51%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	**48.66%**	54.26%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	48.91%	48.42%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	82.97%	79.81%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	43.80%	**38.20%**	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	—	—	36.74%	32.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	—	—	76.64%	72.99%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	75.67%	76.89%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	47.45%	**54.74%**	▼
Controlling High Blood Pressure	Q	—	—	58.88%	53.12%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	76.89%	72.46%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	70.53%	**44.11%**	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	43.01%	24.31%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	63.75%	61.20%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	90.02%	88.02%	↔
Use of Imaging Studies for Low Back Pain	Q	—	—	82.11%	79.90%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	69.10%	64.96%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	71.29%	74.94%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	44.53%	52.55%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	81.51%	82.69%	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.

Table 3.2—Performance Measure Results
CalViva—Kings County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	10.31%	7.92%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	60.31	62.09	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	452.56	430.69	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	**80.23%**	87.21%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	**78.03%**	84.25%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	32.14%	**17.24%**	↔
Cervical Cancer Screening	Q,A	—	—	—	**57.18%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	69.83%	70.06%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	96.98%	**94.68%**	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	89.73%	**83.58%**	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	NA	**87.06%**	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	NA	**84.62%**	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	**50.36%**	**45.50%**	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	**42.82%**	48.42%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	80.54%	**78.59%**	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	**41.85%**	**39.66%**	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	—	—	**27.98%**	32.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	—	—	74.94%	74.21%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	78.35%	78.10%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	**50.85%**	52.07%	↔
Controlling High Blood Pressure	Q	—	—	55.23%	**41.03%**	↓
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	73.59%	73.20%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	NA	48.59%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	NA	30.51%	Not Comparable

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	**57.46%**	**52.84%**	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	89.93%	82.67%	↓
Use of Imaging Studies for Low Back Pain	Q	—	—	75.50%	80.23%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	48.42%	**37.47%**	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	53.28%	**45.99%**	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	41.36%	36.98%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	67.40%	**59.29%**	↓

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
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▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.3—Performance Measure Results
CalViva—Madera County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	10.81%	13.40%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	50.89	52.05	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	444.01	482.26	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	**80.80%**	**83.06%**	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	**81.88%**	85.94%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	25.61%	**16.67%**	↔
Cervical Cancer Screening	Q,A	—	—	—	64.44%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	71.29%	66.96%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	98.53%	98.08%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	91.75%	93.49%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	NA	92.88%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	NA	90.68%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	59.37%	64.96%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	55.72%	60.34%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	85.89%	88.32%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	46.47%	43.07%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	—	—	33.09%	34.31%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	—	—	**70.32%**	74.45%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	81.27%	82.00%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	43.31%	49.39%	↔
Controlling High Blood Pressure	Q	—	—	56.69%	52.10%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	65.66%	69.68%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	NA	**42.78%**	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	NA	24.23%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	65.90%	**50.27%**	↓

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	93.35%	80.05%	↓
Use of Imaging Studies for Low Back Pain	Q	—	—	77.17%	**70.68%**	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	62.29%	59.28%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	73.72%	68.81%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	64.72%	60.82%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	84.43%	87.34%	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

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

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

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

The final selected SPD measures are listed below. Following the list of measures are Table 3.4 through Table 3.9, which present a summary of CalViva's 2014 SPD measure results. Table 3.4 through Table 3.6 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,8 and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.7 through Table 3.9 present the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures. Appendices A and B include tables displaying the two-year trending information for the SPD and non-SPD populations for all measures that DHCS required the MCPs to stratify for the SPD population. The SPD trending information is included in Appendix A and the non-SPD trending information is included in Appendix B.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

[8] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.4 through Table 3.6.

Table 3.4—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CalViva—Fresno County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.78%	15.39%	▼	13.10%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.64%	85.27%	↔	84.64%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	82.26%	Not Comparable	80.77%
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.23%	86.97%	↑	84.96%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.57%	100.00%	↔	96.60%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.06%	91.65%	↔	91.08%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	91.33%	93.33%	↑	91.42%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.45%	88.51%	↔	87.51%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	52.07%	55.47%	↔	54.26%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	43.80%	54.01%	↑	48.42%
Comprehensive Diabetes Care—HbA1c Testing	79.32%	81.75%	↔	79.81%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	36.50%	39.17%	↔	38.20%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	26.28%	34.79%	↑	32.12%
Comprehensive Diabetes Care—LDL-C Screening	66.42%	74.45%	↑	72.99%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	69.83%	81.27%	↑	76.89%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	57.18%	54.50%	↔	54.74%

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

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

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

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

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

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

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

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

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

Table 3.5—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CalViva—Kings County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	S	8.57%	↔	7.92%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	81.71%	91.32%	↑	87.21%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	74.56%	92.14%	↑	84.25%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	94.85%	NA	Not Comparable	94.68%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	83.44%	87.65%	↔	83.58%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	86.92%	90.00%	↔	87.06%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.55%	85.71%	↔	84.62%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	39.91%	46.98%	↔	45.50%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	37.22%	52.68%	↑	48.42%
Comprehensive Diabetes Care—HbA1c Testing	78.92%	80.87%	↔	78.59%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	37.22%	39.26%	↔	39.66%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	28.25%	34.56%	↔	32.12%
Comprehensive Diabetes Care—LDL-C Screening	73.54%	76.51%	↔	74.21%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.68%	80.20%	↔	78.10%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	55.61%	50.34%	↔	52.07%

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

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

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

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

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

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

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

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

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table 3.6—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CalViva—Madera County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	S	16.36%	▼	13.40%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.41%	85.77%	↔	83.06%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.42%	89.71%	↔	85.94%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	98.06%	NA	Not Comparable	98.08%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	93.38%	97.17%	↔	93.49%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	92.84%	94.29%	↔	92.88%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	90.76%	88.42%	↔	90.68%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	68.31%	57.53%	↓	64.96%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	59.08%	55.52%	↔	60.34%
Comprehensive Diabetes Care—HbA1c Testing	88.00%	89.63%	↔	88.32%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	44.62%	43.81%	↔	43.07%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.23%	36.12%	↔	34.31%
Comprehensive Diabetes Care—LDL-C Screening	74.46%	74.58%	↔	74.45%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.08%	87.63%	↑	82.00%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	47.69%	49.16%	↔	49.39%

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

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

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

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

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

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

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

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

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table 3.7—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
CalViva—Fresno County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
458.67	47.62	555.25	70.05

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

Table 3.8—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
CalViva—Kings County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
403.24	55.66	651.69	113.80

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

Table 3.9—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
CalViva—Madera County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
464.83	49.54	665.45	78.44

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

Performance Measure Result Findings

Across all counties, the rates for three measures were above the HPLs and the rates for 23 measures were below the MPLs. The rates for five measures improved significantly from 2013 to 2014, and the rates for 14 measures declined significantly from 2013 to 2014.

The following measures had rates above the HPLs for the second consecutive year:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Fresno County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Madera County

Fresno and Madera counties performed similarly, with Fresno County having two measures with rates above the HPLs and four measures with rates below the MPLs and Madera County having one measure with a rate above the HPL and five measures with rates below the MPLs. Kings

County was the lowest performing county, with no measures with rates above the HPLs and 14 measures with rates below the MPLs.

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

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Fresno and Kings counties, resulting in the rates moving from below the MPL in 2013 to above the MPL in 2014
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Fresno County, resulting in the rate moving from below the MPL in 2013 to above the MPL in 2014
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* in Madera County
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total* in Fresno County

The rates for the following measures improved from 2013 to 2014; and although the improvement was not statistically significant, the change resulted in the rates moving from below the MPLs in 2013 to above the MPLs in 2014:

- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Kings and Madera counties
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in Fresno County
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Kings County
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* in Kings County
- *Comprehensive Diabetes Care—LDL-C Screening* in Madera County

Additionally, the rate for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure in Kings County moved from higher than the MPL in 2013 (i.e., worse) to lower than the MPL (i.e., better) in 2014.

Across all counties, 14 rates representing 13 measures were significantly worse in 2014 when compared to 2013, resulting in eight rates moving from above the MPLs in 2013 to below the MPLs in 2014. Six additional rates declined from 2013 to 2014 and although the decline was not statistically significant, the decline resulted in the rates moving from above the MPLs in 2013 to below the MPLs in 2014.

Seniors and Persons with Disabilities Findings

Across all counties, the SPD rates were significantly better than the non-SPD rates for the following measures:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Kings County

- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Fresno and Kings counties
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* in Fresno County
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Fresno and Kings counties
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* in Fresno County
- *Comprehensive Diabetes Care—LDL-C Screening* in Fresno County
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Fresno and Madera counties

Across all counties, the SPD rates were significantly worse than the non-SPD rates for the following measures:

- *All-Cause Readmissions* in Fresno and Madera counties
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm/Hg)* in Madera County

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

Improvement Plans

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

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

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

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

Assessment of MCP's Improvement Plans

Since 2013 was the first year CalViva was required to report performance measure rates, the MCP was not required to develop IPs for measures with rates below the MPLs in 2013. Based on the 2014 reporting year rates, CalViva will work with DHCS to prioritize quality improvement activities and interventions utilizing a rapid cycle approach (including Plan-Do-Study-Act) to address measures with rates below the MPLs. Following is a list of the measures with rates below the MPLs in 2014:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Madera County
- *Annual Monitoring for Patients on Persistent Medications—Digoxin* in Fresno County
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Kings and Madera counties
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in Kings County
- *Comprehensive Diabetes Care—HbA1c Testing* in Kings County
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* in Fresno and Kings counties
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in Fresno County
- *Controlling High Blood Pressure* in Kings County
- *Medication Management for People with Asthma—Medication Compliance 50% Total* in Fresno and Madera counties
- *Prenatal and Postpartum Care—Postpartum Care* in Kings and Madera counties
- *Use of Imaging Studies for Low Back Pain* in Madera County

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

Strengths

CalViva followed the appropriate specifications to produce valid performance measure rates and had processes in place to ensure accurate and complete data were entered into its database. Additionally, the MCP successfully transitioned its Healthy Families Program population into MCMC.

Across all counties, CalViva had three measures with rates above the HPLs. The rates for three measures in Fresno County improved significantly from 2013 to 2014, and Kings and Madera counties each had one measure with a rate that improved significantly from 2013 to 2014. Additionally, the rates for 10 measures moved from below the MPLs in 2013 to above the MPLs in 2014.

CalViva provided documentation of actions the MCP has taken to improve rates on measures and acknowledged the importance of prioritizing areas for improvement (See Appendix D).

Opportunities for Improvement

CalViva has the opportunity to assess the factors leading to several measures having rates below the MPLs and several measures having rates that declined significantly from 2013 to 2014. Additionally, the MCP has the opportunity to identify the factors contributing to Kings County performing worse than Fresno and Madera counties and then duplicate strategies being used in Fresno and Madera counties, as appropriate, to improve performance measure rates in Kings County. For measures with SPD rates that are significantly worse than the non-SPD rates, CalViva has the opportunity to assess the factors leading to the SPD rates being significantly worse to ensure that the MCP is meeting the needs of the SPD population.

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[9] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

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

Validating Quality Improvement Projects and Assessing Results

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

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

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

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

Quality Improvement Project Objectives

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

Table 4.1 below lists CalViva's QIPs and indicates the county in which the QIP is being conducted, 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 CalViva
July 1, 2013, through June 30, 2014

QIP	Counties	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Fresno, Kings, Madera	Clinical	Q, A
Retinal Eye Exams	Fresno, Kings, Madera	Clinical	Q, A

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

The *Retinal Eye Exams* QIP targeted the MCP's diabetic members and focused on increasing retinal eye exams. Ongoing management of members with diabetes is critical to preventing complications and ensuring optimal health for these members.

Quality Improvement Project Validation Findings

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

Table 4.2—Quality Improvement Project Validation Activity
CalViva—Fresno, Kings, and Madera Counties
July 1, 2013, through June 30, 2014

Name of Project/Study	Counties	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	All counties received the same score	Annual Submission	100%	100%	*Met*
Internal QIPs					
Retinal Eye Exams	Fresno	Annual Submission	72%	80%	*Not Met*
		Annual Resubmission 1	100%	100%	*Met*
	Kings	Annual Submission	76%	80%	*Not Met*
		Annual Resubmission 1	100%	100%	*Met*
	Madera	Annual Submission	76%	80%	*Not Met*
		Annual Resubmission 1	100%	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, 2013, through June 30, 2014, showed that CalViva's annual submission of its *All-Cause Readmissions* QIP received an overall validation status of *Met*, with 100 percent of the evaluation elements (critical and noncritical) receiving a met score. The *Retinal Eye Exams* QIP annual submission received a *Not Met* validation status. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on HSAG's validation feedback, CalViva resubmitted the QIP; and upon subsequent validation, the QIP achieved an overall *Met* validation status, with 100 percent of the evaluation elements (critical and noncritical) receiving a met score.

Table 4.3 summarizes the aggregated validation results for CalViva's QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
CalViva—Fresno, Kings, and Madera Counties
(Number = 9 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	89%	3%	8%
	VI: Accurate/Complete Data Collection	94%	0%	6%
Design Total		**95%**	**1%**	**4%**
Implementation	VII: Sufficient Data Analysis and Interpretation	79%	7%	14%
	VIII: Appropriate Improvement Strategies	83%	17%	0%
Implementation Total		**80%**	**10%**	**10%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**Not Assessed**	**Not Assessed**	**Not Assessed**

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

HSAG validated Activities I through VIII for both CalViva's *All-Cause Readmissions* and *Retinal Eye Exams* QIP annual submissions.

CalViva demonstrated a strong application of the Design stage, meeting 95 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. CalViva met all requirements for all applicable evaluation elements within the Design stage for its *All-Cause Readmissions* QIP. The MCP did not document the correct population size, the margin of error, or the qualifications of staff members for the *Retinal Eye Exams* QIP, resulting in lower scores for Activities V and VI.

The MCP demonstrated an adequate application of the Implementation stage, meeting 80 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. CalViva met all requirements for all applicable evaluation elements within the Implementation stage for its *All-Cause Readmissions* QIP. For the *Retinal Eye Exams* QIP, CalViva provided the

MCP-level rate and interpretation of findings instead of individual county rates and interpretations, resulting in a lower score for Activity VII. In Activity VIII, CalViva identified three barriers for the *Retinal Eye Exam* QIP; however, the MCP did not prioritize those barriers. The incomplete documentation led to a lowered score for Activity VIII.

Quality Improvement Project Outcomes and Interventions

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

All-Cause Readmissions QIP

- Implement a transitional care model program using the Coleman Care Transitions Intervention as the underlying foundation.
- Implement an ambulatory case management program to focus on transition of care and continuity of care.
- Make interactive voice response (IVR) calls to members hospitalized for any condition to encourage them to call their providers and/or the Nurse Advice Line for any questions about their care and to set up follow-up appointments with their primary care providers.
- Place on-site case managers at high-volume hospitals.
- Provide the Agency for Healthcare Research and Quality (AHRQ) *Taking Care of Myself Guide* to hospitals and providers to distribute to patients prior to discharge.
- Expand the disease management program and education to include other chronic conditions.

Retinal Eye Exams QIP

- The MCP's medical management team will visit each clinic and conduct a presentation outlining the project goals, barriers identified to date, clinic-specific rates, documentation requirements, recommendations for improvement, and plans for remeasurement.
- Compare the quarterly provider profile of noncompliant cases with a claims report to evaluate improvements in both clinical procedures and billing procedures, and share this information with the clinics.
- Audit 10 percent of eligible members per clinic quarterly to concurrently evaluate the complete process, including exam results in the clinic record and compliance with overall improvement strategy implementation.
- Distribute an educational flyer to communicate the importance of an annual retinal eye exam and the process for obtaining the exam.

- Include an article on retinal eye exams for members with diabetes in the MCP's spring 2014 newsletter.

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

Strengths

CalViva demonstrated an excellent application of the QIP Design stage. The MCP was able to achieve a *Met* validation status for the *All-Cause Readmissions* QIP on the first submission.

In response to HSAG's recommendation in CalViva's 2012–13 MCP-specific evaluation report, the MCP documented evaluation plans for each intervention and performed an annual barrier analysis for each QIP.

Opportunities for Improvement

CalViva has the opportunity to ensure that all required documentation is included in the QIP Summary Form since the MCP had several instances of incomplete data. The MCP should reference the QIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed prior to submission.

Conducting the EQRO Review

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

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

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

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

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

Quality

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

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

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

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

HSAG reviewed CalViva's quality improvement program description and found detailed documentation of processes the MCP uses to ensure that quality care is provided to its MCMC members.

The following quality performance measures had rates above the HPL for the second consecutive year:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Fresno County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Madera County

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

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Fresno and Kings counties
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Fresno County
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total* in Fresno County

Across all counties, 11 rates for measures in the quality domain of care were significantly worse in 2014 when compared to 2013 and 19 rates were below the MPLs.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care. Across all counties, nine SPD rates were significantly better than the non-SPD rates. Three SPD rates were significantly worse than the non-SPD rates:

- *All-Cause Readmissions* in Fresno and Madera counties
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in Madera County

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

Overall, CalViva 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 CalViva's available quality improvement information and found that the MCP included processes in its quality improvement program description designed to ensure members' access to needed health care services. Additionally, the MCP included activities in its 2014 Quality Improvement Work Plan to assess and monitor members' access to services. CalViva's evaluation of the MCP's work plan activities showed that the overall goals for access to care measures were met; however, the denominator was <30, so the results should be viewed with caution. The evaluation also showed that the after-hours access standards were not met. In response to the standards not being met, CalViva indicated that a CAP will be implemented to ensure that providers comply with the standards. Lastly, the MCP indicated that it did not meet its goals related to member satisfaction with access to care and that the MCP will continue to focus on enhancing the members' experiences and improving their satisfaction with access.

The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure falls into the access domain of care, and the rate for this measure in Madera County was above the HPL for the second consecutive year.

The *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* measure falls into the access domain of care, and the rate for this measure in Madera County improved significantly from 2013 to 2014.

Across all counties, eight rates for measures in the access domain of care were significantly worse in 2014 when compared to 2013 and nine rates were below the MPLs.

Nine of the performance measures stratified for the SPD population fall into the access domain of care. Across all counties, six SPD rates were significantly better than the non-SPD rates. The *All-Cause Readmissions* measure falls into the access domain of care and the SPD rates for this measure in Fresno and Madera counties were significantly worse than the non-SPD rates.

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

Overall, CalViva 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.

CalViva's quality improvement program description provides details of activities related to member rights and protections, grievances, continuity and coordination of care, and utilization management. The program description includes a summary of the MCP's processes to assess and monitor timeliness of care.

The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure falls into the timeliness domain of care, and the rate for this measure in Madera County was above the HPL for the second consecutive year.

The rates for the following timeliness measures were below the MPLs in 2014:

- *Prenatal and Postpartum Care—Postpartum Care* in Kings and Madera counties
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Kings County

Additionally, the rate in Madera County for the *Prenatal and Postpartum Care—Postpartum Care* measure and the rate in Kings County for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure declined significantly from 2013 to 2014.

Overall, CalViva showed average performance in the timeliness domain of care.

Follow-Up on Prior Year Recommendations

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

Recommendations

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

- Since across all counties CalViva had 23 measures with rates below the MPLs and 14 measures with rates that were significantly worse in 2014 when compared to 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.
- Identify the factors contributing to Kings County performing worse than Fresno and Madera counties and then duplicate strategies being used in Fresno and Madera counties, as appropriate, to improve performance measure rates in Kings County.
- For measures with SPD rates that are significantly worse than the non-SPD rates, assess the factors leading to the SPD rates being significantly worse to ensure that the MCP is meeting the needs of the SPD population.
- Reference the QIP Completion Instructions to ensure that all required documentation for each activity has been addressed prior to submission.

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

Table A.1 through Table A.3 provide two-year trending information for the SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the tables:

– = A year that data were not collected.

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

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

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

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

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

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

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

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

Table A.1—HEDIS 2014 SPD Trend Table
CalViva—Fresno County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	12.30%	15.39%	▼
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	66.02	70.05	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	551.16	555.25	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.76%	85.27%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	89.61%	82.26%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.44%	86.97%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	91.46%	100.0%	↑
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	90.62%	91.65%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	93.76%	93.33%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	90.79%	88.51%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	49.39%	55.47%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	50.12%	54.01%	↔
Comprehensive Diabetes Care—HbA1c Testing	86.62%	81.75%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	45.50%	39.17%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	38.20%	34.79%	↔
Comprehensive Diabetes Care—LDL-C Screening	82.00%	74.45%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.27%	81.27%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	42.09%	54.50%	▼

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

Table A.2—HEDIS 2014 SPD Trend Table
CalViva—Kings County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	12.69%	8.57%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	115.90	113.80	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	737.46	651.69	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.71%	91.32%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.11%	92.14%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	89.47%	87.65%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	90.00%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	85.71%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	49.53%	46.98%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.59%	52.68%	↑
Comprehensive Diabetes Care—HbA1c Testing	49.07%	80.87%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	37.85%	39.26%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	28.50%	34.56%	↔
Comprehensive Diabetes Care—LDL-C Screening	49.07%	76.51%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.24%	80.20%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	34.11%	50.34%	▼

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

Table A.3—HEDIS 2014 SPD Trend Table
CalViva—Madera County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	14.04%	16.36%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	72.47	78.44	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	648.89	665.45	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.11%	85.77%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.55%	89.71%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months	NA	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years	90.79%	97.17%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years	NA	94.29%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years	NA	88.42%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	51.85%	57.53%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	59.26%	55.52%	↔
Comprehensive Diabetes Care—HbA1c Testing	89.35%	89.63%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	48.61%	43.81%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	32.87%	36.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	74.54%	74.58%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	84.26%	87.63%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	43.98%	49.16%	↔

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

Table B.1 through Table B.3 provide two-year trending information for the non-SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the tables:

– = A year that data were not collected.

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

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

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

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

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

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

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

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table B.1—HEDIS 2014 Non-SPD Trend Table
CalViva—Fresno County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.69%	7.78%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	42.99	47.62	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	435.84	458.67	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.26%	83.64%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	79.47%	81.23%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.90%	96.57%	↓
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.52%	91.06%	↓
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	91.65%	91.33%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	90.67%	87.45%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	53.16%	52.07%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	43.20%	43.80%	↔
Comprehensive Diabetes Care—HbA1c Testing	78.64%	79.32%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	44.17%	36.50%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.98%	26.28%	↓
Comprehensive Diabetes Care—LDL-C Screening	71.60%	66.42%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	68.20%	69.83%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	49.76%	57.18%	▼

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

Table B.2—HEDIS 2014 Non-SPD Trend Table
CalViva—Kings County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	5.00%	S	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	53.80	55.66	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	419.16	403.24	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	74.65%	81.71%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	71.18%	74.56%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.94%	94.85%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	89.73%	83.44%	↓
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	86.92%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	84.55%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	48.28%	39.91%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.87%	37.22%	↔
Comprehensive Diabetes Care—HbA1c Testing	55.17%	78.92%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	32.02%	37.22%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	16.75%	28.25%	↑
Comprehensive Diabetes Care—LDL-C Screening	53.69%	73.54%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.41%	76.68%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	40.89%	55.61%	▼

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

Table B.3—HEDIS 2014 Non-SPD Trend Table
CalViva—Madera County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.41%	S	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	48.98	49.54	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	425.90	464.83	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	76.08%	80.41%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	75.86%	81.42%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	98.67%	98.06%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.77%	93.38%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	92.84%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	90.76%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.78%	68.31%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	50.81%	59.08%	↑
Comprehensive Diabetes Care—HbA1c Testing	82.52%	88.00%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	44.98%	44.62%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.66%	33.23%	↔
Comprehensive Diabetes Care—LDL-C Screening	69.26%	74.46%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.35%	79.08%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	44.01%	47.69%	↔

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

Quality, Access, and Timeliness Scoring Process

Scale
2.5–3.0 = Above Average
1.5–2.4 = Average
1.0–1.4 = Below Average

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

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.1 through 3.3)

Quality Domain

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

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

Access and Timeliness Domains

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

Quality Improvement Projects (QIPs)

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

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

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

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

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

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

Calculating Final Quality, Access, and Timeliness Scores

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

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

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

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

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

for CalViva Health

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

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

2012–13 External Quality Review Recommendation Directed to CalViva	Actions Taken by CalViva During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
1. Ensure all findings from the March 11, 2013, through March 22, 2013, A&I Medical Audit are addressed and resolved.	All findings from the March 11, 2013, through March 22, 2013, Department of Health Care Services (DHCS) A&I Medical Audit were addressed and resolved. CalViva Health (the "plan") received a June 24, 2014, DHCS closeout letter accepting the corrective actions implemented by the plan for the medical audit findings. Per the closeout letter received from the DHCS on June 24, the final report is a public document and will be made available on the DHCS website and to the public upon request. Please refer to the public DHCS closeout letter for a detailed description of activities implemented by the plan.
2. Ensure all deficiencies from the March 11, 2013, through March 13, 2013, DMHC SPD Medical Survey are addressed and resolved. Specifically:	
a. Ensure that the MCP is conducting sufficient monitoring of its delegated exempt grievance process.	All findings from the March 11, 2013, through March 13, 2013, Department of Managed Health Care (DMHC) SPD Medical Survey were addressed and resolved. The plan received a March 12, 2014, closeout letter accepting the corrective actions implemented by the plan for the DMHC SPD medical Survey findings. a. The plan provided DHCS with supporting documentation indicating that it took the necessary steps to correct this deficiency with the revision of the Monthly Appeals and Grievances Dashboard, the revision of the quarterly Appeals and Grievances Executive Summary, and the creation of Policy and Procedure AG-006.
b. Ensure an appropriate range of specialist providers are included on the MCP's Quality Improvement/Utilization Management Committee.	b. The plan provided DHCS with supporting documentation demonstrating it has taken the necessary steps to address this by adding three specialists to the Quality Improvement (QI)/Utilization Management (UM) Committee. The plan also indicated that it would continue its efforts to add/retain specialists to its QI/UM Committee in order to remain in compliance with the recommendation.

2012–13 External Quality Review Recommendation Directed to CalViva	Actions Taken by CalViva During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
3. Since CalViva had 17 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.	Reporting year (RY) 2013 was the first full year of reporting HEDIS data for CalViva Health. As a new plan, the All Plan Letter on Quality and Performance Improvement Program Requirement for 2014 (APL 14-003) states: *First year for New Plans or New Counties. A new MCP or MCP expanded into a new county need not to submit a HEDIS IP if the MCPs first year reported rate is below the MPL* (Section 9.a.i.). RY2013 was used as the baseline year for the various HEDIS measures. Overall, although there were 17 measures in the three counties below the MPL, these were categorized by 4 overarching measures including: 1) CCS – Cervical Cancer Screening—Interventions have included a provider online news article on well-woman screenings (July 2013) and a member newsletter article in the fall 2013 issue (in homes November 2013). 2) CDC – Comprehensive Diabetes Control—CDC-E is part of the plan's individual QIP that has various interventions. CDC interventions included provider online news articles, "Improving Diabetes Outcomes through Diagnosis and Management" (November 2013)and "Improving Quality of Care for Adult Patients with Diabetes" (May 2014), initiation of quarterly provider mailings in 2013 with reminders of various CDC check-ups that must be conducted, and a member newsletter article in the summer 2014 issue (in homes May 2014). 3) MPM – Monitoring Persistent Medications—Initial interventions included a member newsletter article on medication compliance in the spring 2014 issue (in homes March 2014) and distribution of the "Improving the Patient Experience Toolkit" to providers which includes a medication card for members to use to keep track of all current medications they take. Development and distribution of the toolkit started in mid-2013, has continued on an ongoing basis, and was updated in June 2014. 4) PPC – Post Partum Care—A preconception provider toolkit was developed in April 2014 that has information for providers to discuss inter-conception care and the importance of the postpartum visit. In addition, interventions included a member newsletter article in the fall 2013 issue (in homes November 2013) and pregnancy packet mailings that include information on postpartum care. The plan acknowledges HSAG's recommendation and will work with DHCS to identify priority areas for improvement rather than attempting to improve performance on all measures at once.

2012–13 External Quality Review Recommendation Directed to CalViva	Actions Taken by CalViva During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
4. Assess the factors that are leading to the SPD rates for the *All-Cause Readmissions* and *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)* measures in Fresno County and the *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg*) measure in Madera County being significantly worse than the non-SPD rates to ensure the MCP is meeting the needs of the SPD population.	RY2013 was the first full year of reporting HEDIS® data for CalViva Health; thus, it was the baseline year for many of the measures. ACR measure in Fresno County: RY2013: Overall rate= 10.6; SPD rate = 12.3; non-SPD=7.7. This is part of the Statewide collaborative QIP in which CalViva Health started implementing an intervention in November 2013 around a transitional care management (TCM) program that utilizes the Coleman Care Transitions Intervention as the underlying foundation. The TCM program is focused in Fresno County and specifically on the SPD population with the goal to improve transitional care by providing patients with tools and support which promotes knowledge and self-management of their conditions as they move from the acute care setting. CAP (12–24 months) in Fresno County: RY2013: Overall rate= 97.82 (above the MPL of 95.56); SPD rate=91.46; non-SPD rate= 97.9. Overall, met the measure at above the MPL, but the SPD rate was lower than non-SPD rate. Have developed tools for providers to use to improve access including "Improving the Patient Experience Toolkit" that also includes an access scheduling tip sheet as a quick reference guide for providers. The plan will monitor rates and adjust interventions accordingly. CDC-BP (<140/90 mm Hg) in Madera County: RY2013: Overall rate= 59.37 (above the MPL of 54.48); SPD rate=51.85; non-SPD rate=62.78. Overall rate in Madera County was above the MPL, but the SPD rate was lower than the non-SPD rate. The plan currently has an internal QIP for the CDC-E measure and includes quarterly provider mailings of reminders of various CDC check-ups that must be conducted. In addition, diabetes is part of the plan's disease management program that includes the following ongoing interventions: reminder letters to members regarding medication adherence and need for annual eye exam, pre and post disease management program enrollment mailings, and calls to high risk diabetics. CalViva Health will monitor rates and adjust interventions accordingly.

2012–13 External Quality Review Recommendation Directed to CalViva	Actions Taken by CalViva During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
5. Engage in the following efforts to improve performance on QIPs:	
a. Reference the QIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed prior to submission.	During this review period, CalViva Health has submitted two QIPs: 1) *Comprehensive Diabetes Care–Diabetic Retinal Eye Exam* was submitted in August 2013, revised in October 2013, and the plan received a "met" HSAG validation requirement on November 7, 2013. 2) *All Cause Readmissions* was submitted in September 2013 and received a "Met" HSAG validation requirements as of October 10, 2013. The QIP Completion Instructions were followed for each submission.
b. Consider, at minimum, conducting an annual barrier analysis for each QIP, and ensure that the MCP thoroughly documents the barrier analysis process including providing the data; the identified barriers; and the rationale for how the barriers are prioritized.	CalViva Health conducts a formal barrier analysis for each QIP annually. This barrier analysis includes a review of the data, details regarding barriers encountered, and prioritization of interventions to address identified barriers based upon rationale provided by team members. This evaluation is presented to the QI/UM Committee for input and approval. Additionally, each QIP team performs a less formal barrier analysis quarterly with an analysis of the most recent quarterly data, barrier identification, and development of strategies to address the most significant barriers encountered.
c. Ensure that each QIP intervention includes an evaluation plan.	Each QIP intervention includes an evaluation plan. The plan has created a quarterly data tracking summary of all interventions to capture the quarterly trends in a snapshot. In addition, the plan will include Plan-Do-Study-Act (PDSA) evaluations of interventions planned for the *Diabetic Retinal Eye Exam* IQIP which will be included with the re-measurement submission in August 2014 and for the *All-Cause Readmissions* QIP in September 2014.
6. Review the 2013 MCP-specific CAHPS®[12] results report and develop strategies to address the *How Well Doctors Communicate*, *Rating of All Health Care*, and *Getting Care Quickly* priority areas.	The plan has reviewed the 2013 MCP-specific CAHPS results report that was received on February 27, 2014. The report is being distributed to stakeholders in different functional areas to take action on the identified opportunities for improvement. The plan's quality improvement workgroup and access workgroup are two main avenues wherein key participant stakeholders will identify barriers and take supportive action where necessary. The plan is focused on conducting a full analysis of the CAHPS survey results (as is documented in the 2014 QI work plan) and distributing resources and tools to providers such as the "Improving the Patient Experience Toolkit" and Appointment Access Schedule Tip sheet to enhance provider-patient communication. The toolkit includes the following information: • Tips for improving access to care • Tips for improving care coordination • Tips for improving provider-patient communication

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

2012–13 External Quality Review Recommendation Directed to CalViva	Actions Taken by CalViva During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	• Additional tips—mental health care • Cultural and linguistic interpreter services • Online resources