Performance Evaluation Report

CalViva Health

July 1, 2011–June 30, 2012

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

June 2013

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Purpose of Report

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

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

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

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

[1] *Medi-Cal Managed Care Enrollment Report—June 2012.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: January 17, 2013.
[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

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

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

Plan Overview

CalViva is a full-scope managed care plan operating in Fresno, Kings, and Madera counties. CalViva serves members in all three counties as a Local Initiative (LI) plan under the Two-Plan Model. In a Two-Plan Model county, DHCS contracts with two managed care plans to provide medical services to Medi-Cal beneficiaries. Most Two-Plan Model counties offer an LI plan and a nongovernmental, commercial health plan.

MCMC beneficiaries in Fresno, Kings, and Madera counties may enroll in CalViva, the LI plan, or in the alternative commercial plan. CalViva became operational in all three counties to provide MCMC services in March 2011. CalViva contracts with Health Net Community Solutions, a National Committee for Quality Assurance (NCQA)-Accredited MCMC plan, for capitated provider, network, and administrative services. As of June 30, 2012, CalViva had 190,067 MCMC members in Fresno, Kings, and Madera counties, collectively.[3]

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

Conducting the Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specify that the State or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

DHCS conducts this review activity through an extensive monitoring process that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

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

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

Assessing Structure and Operations

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

Medical Performance Review

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

No medical performance review was conducted during the review period for CalViva as the plan just became operational in March 2011. DHCS requires that the plan meet all State and federal requirements as part of its readiness review before becoming operational. The plan was fully compliant with all DHCS requirements as of March 2011. A joint medical audit (A&I and Department of Managed Health Care) will be conducted in March 2013. Results from that audit will be reported in CalViva's next plan-specific evaluation report.

Member Rights and Program Integrity Review

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

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

MR/PIU conducted an on-site review of CalViva in June 2012. The review period covered July 1, 2011, through June 1, 2012. MR/PIU noted findings in the areas of prior authorization notifications, cultural and linguistic services, SPD sensitivity training, and physical accessibility. CalViva was not required to respond to the findings. MR/PIU will follow up with the plan on the findings during its next review. Listed below are the findings:

Prior Authorization Notifications

- Eleven of fifty prior authorization notification case files reviewed were missing the required citation supporting the plan's decision on the denial letter.

- Two of fifty prior authorization notification case files contained a health plan name other than CalViva.

Cultural and Linguistic Services

- The staff in two out of five CalViva provider offices visited indicated that they do not discourage the use of family, friends, or minors as interpreters.

SPD Sensitivity Training

- The staff at three out of five CalViva provider offices indicated that they were unsure of having received SPD sensitivity training.

Physical Accessibility

- Two out of five CalViva provider offices visited were not aware if the Facility Site Review (FSR) Attachment C—Accessibility Survey was conducted on their facility.

No findings were identified in the areas of marketing and program integrity (fraud and abuse prevention and detection). In the next reporting period, CalViva will provide documentation to HSAG regarding how the plan addressed the identified findings since the MR/PIU review was conducted during the last month of the review period for which this report is written.

Strengths

Although MR/PIU noted findings in most areas reviewed, the plan had no findings in the areas of marketing and program integrity. Additionally, while there were findings in several areas reviewed, there were not multiple findings within each of the areas.

Opportunities for Improvement

The plan has an opportunity to improve in the area of prior authorizations and cultural and linguistic services. These areas can have an impact on quality, access, and timeliness of care provided to plan members. CalViva should document how the plan will address each of the findings identified during the MR/PIU review and how the plan will monitor the progress on resolving the findings.

Conducting the Review

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

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

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

Validating Performance Measures and Assessing Results

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

Performance Measure Validation

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

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

Performance Measure Validation Findings

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

Performance Measure Results

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

Strengths

While CalViva did not submit EAS rates in 2012, the plan appears to have awareness of the importance of monitoring performance and making improvements where needed to ensure quality, accessible, and timely health care for MCMC members, as evidenced in the plan's internal work plan.

Opportunities for Improvement

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

Conducting the Review

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

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

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of plans' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using the CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the plan's QIP objectives (QIP results). HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about CalViva's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Project Objectives

CalViva had two clinical QIP proposals in progress during the review period of July 1, 2011–June 30, 2012. CalViva's first project, an internal QIP, aimed to increase the number of retinal eye exams for its diabetic members aged 18 to 75 years. Additionally, the plan participated in the new statewide *All-Cause Readmissions* collaborative which focused on reducing readmissions for members aged 21 years and older. Both QIPs fell under the quality and access domains of care.

The new statewide collaborative proposal focused on reducing readmissions due to all causes within 30 days of an inpatient discharge. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members leading to improved health outcomes.

The *Retinal Eye Exam* QIP proposal targeted diabetic members and focused on increasing retinal eye exams. Ongoing management of diabetic members is critical to preventing complications and ensuring optimal health for these members.

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for CalViva Health—Fresno, Kings, and Madera Counties July 1, 2011, through June 30, 2012

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
*All-Cause Readmissions** (All counties received the same score)	Proposal	Not Applicable	Not Applicable	*Pass*
Internal QIP				
Retinal Eye Exams (All counties received the same score)	Proposal	94%	88%	*Partially Met*
	Resubmission	100%	100%	*Met*

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

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

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

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

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

Validation results during the review period of July 1, 2011, through June 30, 2012, showed that CalViva's proposal submission of its *Retinal Eye Exams* QIP received an overall validation status of *Partially Met*. As of July 1, 2009, DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, CalViva resubmitted the proposal and upon subsequent validation, achieved an overall *Met* validation status. For the *All-Cause Readmissions* proposal, the plan appropriately submitted the common language developed for the study design phase and received a *Pass* score.

Due to unique one-time validation scoring used for the initial submission of the study design stage for the *All-Cause Readmissions* statewide collaborative proposal, this QIP will not be included in the following QIP validation table. Additionally, since the QIP had not progressed to the implementation stage, it will not be included in the outcomes table or discussion.

Table 4.2 summarizes the aggregate validation results for CalViva's QIPs across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for CalViva Health— Fresno, Kings, and Madera Counties (Number = 6 QIP Submissions, 1 QIP Topic) July 1, 2011, through June 30, 2012

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)	92%	8%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**97%**	**3%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	Not Assessed	Not Assessed	Not Assessed
	VII: Appropriate Improvement Strategies	Not Assessed	Not Assessed	Not Assessed
Implementation Total		Not Assessed	Not Assessed	Not Assessed
Outcomes	VIII: Sufficient Data Analysis and Interpretation	Not Assessed	Not Assessed	Not Assessed
	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total				

*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.

CalViva demonstrated an appropriate application of the design stage, scoring 100 percent on all applicable evaluation elements for three of the four activities. In Activity III of the *Retinal Eye Exam* QIP, the plan initially documented that the baseline measurement period would be calendar year (CY) 2011 and that it would report administrative data. HSAG provided technical assistance and instructed the plan to use (1) the HEDIS retinal eye exam measure as the project outcome, (2) the HEDIS hybrid methodology for data collection to align with DHCS's HEDIS reporting requirements, (3) data gathered beginning March 1, 2011, through December 31, 2011, as

historical data since CalViva's contract did not begin until March 2011, and (4) CY 2012 as the baseline measurement period. The plan adjusted its study design in the proposal resubmission according to the recommendations. Since CalViva had not conducted sampling yet, Activity V was scored *Not Applicable* for the proposal submission.

Quality Improvement Project Outcomes and Interventions

Table 4.3 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods.

Table 4.3—Quality Improvement Project Outcomes for CalViva Health— Fresno, Kings, and Madera Counties July 1, 2011, through June 30, 2012

QIP #1—Retinal Eye Exam					
QIP Study Indicator	**County**	**Baseline Period 1/1/12–12/31/12**	**Remeasurement 1 1/1/13–12/31/13**	**Remeasurement 2 1/1/14–12/31/14**	**Sustained Improvement¥**
The percentage of eligible diabetic members who received a retinal eye exam in the measurement year	Fresno	‡	‡	‡	‡
	Kings	‡	‡	‡	‡
	Madera	‡	‡	‡	‡

¥ Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.
‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

CalViva had not progressed to the point of reporting baseline data or improvement strategies.

Strengths

CalViva accurately documented the QIP process as evidenced by a *Met* validation status for the proposal resubmission of its *Retinal Eye Exam* QIP. Although the plan achieved this score with the benefit of resubmission, the scores demonstrated compliance with the recommendations provided in the QIP validation tool.

Opportunities for Improvement

There were no significant deficiencies in CalViva's QIP proposals. As the plan progresses through the QIP process, it should refer to the QIP Completion Instructions and contact HSAG for technical assistance as needed.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Quality

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

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

Based on review of CalViva's available quality improvement information, the plan showed overall average performance related to the quality domain of care. The plan demonstrated appropriate application of the QIP design stage, receiving 100 percent on all applicable evaluation elements for three of the four activities. CalViva's 2012 Quality Improvement (QI) Program Description includes descriptions of the processes the plan uses to ensure quality care is provided to MCMC members.

The plan met all of the program and structural requirements during the readiness review period to becoming operational in March 2011.

The plan did not have performance measure results to assess quality of care across the EAS.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for plans to ensure access to and the availability of services to members and uses monitoring processes, including audits, to assess a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services.

Medical performance reviews, MR/PIU reviews, performance measures, and QIP outcomes are used to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

Overall, CalViva showed average performance related to the access domain of care. The plan's 2011 Quality Improvement Work Plan Evaluation documents activities to monitor access to care and indicates that CalViva is on target with meeting access-related goals.

The plan did, however, have findings in the MR/PIU review. One finding was related to cultural and linguistic requirements not being met, as some provider offices did not discourage the use of family and friends for language translation services. Another finding involved several providers' offices not completing sensitivity training for the SPD population. These findings can have an impact on members' access to services.

Timeliness

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

DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified.

CalViva's 2012 Quality Improvement (QI) Program Description outlines the plan's activities related to enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. The plan appears to have processes in place to assess the timeliness of utilization decisions and ensure that services are timely provided. The plan did, however, have findings identified in the MR/PIU review in the area of prior authorizations; and the plan has an opportunity to improve these deficient areas.

Follow-Up on Prior Year Recommendations

DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2010–2011 plan-specific evaluation report. Since this is the first year an evaluation report is being produced for CalViva, no recommendations were made in 2010–11 and therefore, no responses to recommendations were submitted by the plan.

Recommendations

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

- Ensure that all findings identified during the June 2012 MR/PIU review are addressed. Specifically:
  - Implement a process to ensure that all denial letters issued include a citation of the specific regulation or plan authorization procedure supporting the action.
  - Implement a quality control process to ensure that all prior authorization notifications sent to members contain the proper health plan name.
  - Identify and implement a process to ensure that established policies and procedures are consistently applied so that limited English proficient (LEP) members are discouraged from using family, friends, or minors as interpreters.
  - Ensure that the required SPD sensitivity training is consistently conducted.
  - Continue to conduct facility site accessibility assessments and ensure results are made available to members through CalViva's Web site and provider directory in accordance with MMCD contract and policy letter guidelines.
- Initiate technical assistance with MMCD and the EQRO to discuss the requirements for performance measure validation to ensure the plan is able to report valid and reliable rates in 2013.
- Refer to the QIP Completion Instructions and contact HSAG for technical assistance as needed while progressing through the QIP process.

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

Quality, Access, and Timeliness

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

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in the areas of quality, access, and timeliness domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

Quality Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) greater than negative three, if there are two or less measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than three.
3. To be considered ***Below Average***, a plan will have three or more measures below the MPLs than it has above the HPLs.

Access Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus and the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Timeliness Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects (QIPs)

(Refer to Tables 4.1 and 4.3)

- **Validation** *(Table 4.1)*: For each QIP submission and subsequent resubmission(s), if applicable.
  - **Above Average** is not applicable.
  - **Average** = *Met* validation status.
  - **Below Average** = *Partially Met* or *Not Met* validation status.
- **Outcomes** *(Table 4.3)*: Activity IX, Element 4—**Real Improvement**
  - **Above Average** = All study indicators demonstrated statistically significant improvement.
  - **Average** = Not all study indicators demonstrated statistically significant improvement.
  - **Below Average** = No study indicators demonstrated statistically significant improvement.

- **Sustained Improvement** *(Table 4.3)*: Activity X—**Achieved Sustained Improvement**
  - **Above Average =** All study indicators achieved sustained improvement.
  - **Average =** Not all study indicators achieved sustained improvement.
  - **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 performance reviews and MR/PIUs did not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of this activity 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.