Performance Evaluation Report

CalViva Health

July 1, 2012–June 30, 2013

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

April 2014

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1. INTRODUCTION

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

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

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

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and

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

operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- MCP-specific evaluation reports (July 1, 2012–June 30, 2013). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, CalViva Health ("CalViva" or "the MCP"), for the review period July 1, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Plan Overview

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 most TPM counties, there is an LI and a "commercial plan" (CP). DHCS contracts with both plans. The LI is designed—with the input of local government, 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, 2013, CalViva had 177,715 MCMC members in Fresno County, 15,245 in Kings County, and 21,503 members in Madera County—for a total of 214,463 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

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

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

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

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's compliance monitoring reviews to draw conclusions about 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.

For this report, HSAG reviewed the most current member rights reviews, medical performance audits, and monitoring reports available as of June 30, 2013. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes in these areas prior to the commencement of MCP operations, during

MCP expansion into new counties, upon contract renewal, and upon the MCP's changes in policies and procedures.

Medical Performance Audits and Member Rights Reviews

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

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

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

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

Audits & 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. Although the report was issued on July 15, 2013, which is outside the review period for this report, HSAG

[4] These reviews were conducted by DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit to monitor MCP compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to the follow areas: member grievances and appeals, prior-authorization request notifications, marketing (for non-COHS MCPs), cultural and linguistic services, and program integrity (fraud and abuse prevention and detection).

includes the information since the audit was conducted within the review period. The following categories were reviewed:

- Utilization Management
- Continuity of Care
- Access and Availability
- Member's Rights and Responsibilities
- Quality Improvement System
- Organization and Administration of Plan
- State Supported Services (Abortion Services)

CalViva was fully compliant with the State Supported Services requirements; however, findings were identified in all other review areas. Details of each finding can be found in the report issued by A&I on July 15, 2013.

The MCP was required to submit a corrective action plan (CAP) describing the actions taken to correct each finding and the results of each action. The CAP was submitted to DHCS outside the review period for this report. HSAG will provide a summary of the CAP and DHCS's assessment of the CAP in CalViva's 2013–14 MCP-specific evaluation report.

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

The most recent DMHC SPD Enrollment Survey for CalViva was conducted March 11, 2013, through March 13, 2013, covering the review period of January 1, 2011, through December 31, 2012. Although the report was issued on July 12, 2013, which is outside the review period for this report, HSAG includes the information since the review was conducted within the review period.

The survey evaluated the following elements specifically related to CalViva's delivery of care to the SPD population to determine if the MCP was in compliance with DHCS contract and Knox-Keene Health Care Service Plan Act of 1975 requirements:

- Utilization Management
- Continuity of Care
- Availability and Accessibility
- Member Rights
- Quality Management

The DMHC survey report, issued July 12, 2013, noted two potential deficiencies:

- In the area of Member Rights, DMHC noted that CalViva is not conducting sufficient monitoring of its delegated exempt grievance process.
- In the area of Quality Management, DMHC noted that CalViva's Quality Improvement/Utilization Management Committee lacks an appropriate range of specialist providers and is not representative of the composition of the MCP's contracted provider network.

Since CalViva's response to the identified potential deficiencies occurred outside of the review period for this report, HSAG will provide follow-up information on the MCP's efforts to address the potential deficiencies in the MCP's 2013–14 MCP-specific evaluation report.

Strengths

CalViva was fully compliant with the State Supported Services requirements that were assessed during the A&I Medical Audit. For the SPD Enrollment Survey, DMHC did not identify any potential deficiencies in the areas of Utilization Management, Continuity of Care, and Access and Availability.

Opportunities for Improvement

For overall MCP Medi-Cal services, CalViva has the opportunity to improve in the areas of Utilization Management, Continuity of Care, Access and Availability, Member's Rights and Responsibilities, Quality Improvement System, and Organization and Administration of Plan. Specific to meeting the health care needs of the SPD population, CalViva also has the opportunity to improve in the areas of Member Rights and Quality Management. The areas with opportunities for improvement impact the quality and timeliness of and access to the health care provided to MCP members. CalViva should document how the MCP will address each of the findings identified during the A&I Medical Audit and DMHC SPD Enrollment Survey and how the MCP will monitor progress on resolving the findings.

Conducting the EQRO Review

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

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

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

Validating Performance Measures and Assessing Results

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

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[5] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

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

Performance Measure Validation

DHCS's 2013 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 31. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[7] of all Medi-Cal MCPs in 2013 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2013 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2013 Compliance Audit Final Report of Findings for 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. For the 2013 HEDIS audit process, CalViva used a new NCQA-certified vendor, Verisk Health, for data integration and HEDIS reporting. As a result, an extensive amount of parallel testing was conducted to ensure that HEDIS measure rates matched previous results. The conversion between vendors resulted in MCP staff members who were much more knowledgeable of the file preparation, transfer, and verification processes.

Performance Measure Results

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

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

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

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

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

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

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability. Table 3.2 shows the MCP's 2013 performance compared to the DHCS-established MPLs and HPLs.

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

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
CalViva—Fresno County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	--	38.41%	★★★	Not Comparable	18.98%	33.33%
ACR	Q, A	--	10.64%	--	Not Comparable	--	--
AMB–ED	‡	--	45.57	‡	Not Comparable	‡	‡
AMB–OP	‡	--	448.77	‡	Not Comparable	‡	‡
CAP–1224	A	--	97.82%	★★	Not Comparable	95.56%	98.39%
CAP–256	A	--	91.50%	★★	Not Comparable	86.62%	92.63%
CAP–711	A	--	91.74%	★★	Not Comparable	87.56%	94.51%
CAP–1219	A	--	90.68%	★★	Not Comparable	86.04%	93.01%
CBP	Q	--	58.88%	--	Not Comparable	--	--
CCS	Q,A	--	70.07%	★★	Not Comparable	61.81%	78.51%
CDC–BP	Q	--	48.66%	★	Not Comparable	54.48%	75.44%
CDC–E	Q,A	--	48.91%	★★	Not Comparable	45.03%	69.72%
CDC–H8 (<8.0%)	Q	--	43.80%	★★	Not Comparable	42.09%	59.37%
CDC–H9 (>9.0%)	Q	--	47.45%	★★	Not Comparable	50.31%	28.95%
CDC–HT	Q,A	--	82.97%	★★	Not Comparable	78.54%	91.13%
CDC–LC (<100)	Q	--	36.74%	★★	Not Comparable	28.47%	46.44%
CDC–LS	Q,A	--	76.64%	★★	Not Comparable	70.34%	83.45%
CDC–N	Q,A	--	75.67%	★★	Not Comparable	73.48%	86.93%

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
CalViva—Fresno County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
CIS–3	Q,A,T	--	76.89%	★★	Not Comparable	64.72%	82.48%
IMA–1	Q,A,T	--	76.89%	★★	Not Comparable	50.36%	80.91%
LBP	Q	--	82.11%	★★★	Not Comparable	72.04%	82.04%
MMA–50	Q	--	70.53%	--	Not Comparable	--	--
MMA–75	Q	--	43.01%	--	Not Comparable	--	--
MPM–ACE	Q	--	82.27%	★	Not Comparable	83.72%	91.33%
MPM–DIG	Q	--	86.60%	★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	--	83.02%	★	Not Comparable	83.19%	91.30%
PPC–Pre	Q,A,T	--	90.02%	★★	Not Comparable	80.54%	93.33%
PPC–Pst	Q,A,T	--	63.75%	★★	Not Comparable	58.70%	74.73%
W-34	Q,A,T	--	81.51%	★★	Not Comparable	65.51%	83.04%
WCC–BMI	Q	--	69.10%	★★	Not Comparable	29.20%	77.13%
WCC–N	Q	--	71.29%	★★	Not Comparable	42.82%	77.61%
WCC–PA	Q	--	44.53%	★★	Not Comparable	31.63%	64.87%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
‡ This is a utilization measure, which is not assigned a domain of care. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.3—Comparison of 2012 and 2013 Performance Measure Results
CalViva—Kings County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	--	32.14%	★★	Not Comparable	18.98%	33.33%
ACR	Q, A	--	10.31%	--	Not Comparable	--	--
AMB–ED	‡	--	60.31	‡	Not Comparable	‡	‡
AMB–OP	‡	--	452.56	‡	Not Comparable	‡	‡
CAP–1224	A	--	96.98%	★★	Not Comparable	95.56%	98.39%
CAP–256	A	--	89.73%	★★	Not Comparable	86.62%	92.63%
CAP–711	A	--	NA	NA	Not Comparable	87.56%	94.51%
CAP–1219	A	--	NA	NA	Not Comparable	86.04%	93.01%
CBP	Q	--	55.23%	--	Not Comparable	--	--
CCS	Q,A	--	61.56%	★	Not Comparable	61.81%	78.51%
CDC–BP	Q	--	50.36%	★	Not Comparable	54.48%	75.44%
CDC–E	Q,A	--	42.82%	★	Not Comparable	45.03%	69.72%
CDC–H8 (<8.0%)	Q	--	41.85%	★	Not Comparable	42.09%	59.37%
CDC–H9 (>9.0%)	Q	--	50.85%	★	Not Comparable	50.31%	28.95%
CDC–HT	Q,A	--	80.54%	★★	Not Comparable	78.54%	91.13%
CDC–LC (<100)	Q	--	27.98%	★	Not Comparable	28.47%	46.44%
CDC–LS	Q,A	--	74.94%	★★	Not Comparable	70.34%	83.45%
CDC–N	Q,A	--	78.35%	★★	Not Comparable	73.48%	86.93%
CIS–3	Q,A,T	--	69.83%	★★	Not Comparable	64.72%	82.48%
IMA–1	Q,A,T	--	73.59%	★★	Not Comparable	50.36%	80.91%
LBP	Q	--	75.50%	★★	Not Comparable	72.04%	82.04%
MMA–50	Q	--	NA	--	Not Comparable	--	--
MMA–75	Q	--	NA	--	Not Comparable	--	--
MPM–ACE	Q	--	80.23%	★	Not Comparable	83.72%	91.33%
MPM–DIG	Q	--	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	--	78.03%	★	Not Comparable	83.19%	91.30%
PPC–Pre	Q,A,T	--	89.93%	★★	Not Comparable	80.54%	93.33%
PPC–Pst	Q,A,T	--	57.46%	★	Not Comparable	58.70%	74.73%
W-34	Q,A,T	--	67.40%	★★	Not Comparable	65.51%	83.04%

Table 3.3—Comparison of 2012 and 2013 Performance Measure Results
CalViva—Kings County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
WCC–BMI	Q	--	48.42%	★★	Not Comparable	29.20%	77.13%
WCC–N	Q	--	53.28%	★★	Not Comparable	42.82%	77.61%
WCC–PA	Q	--	41.36%	★★	Not Comparable	31.63%	64.87%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
‡ This is a utilization measure, which is not assigned a domain of care. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.4—Comparison of 2012 and 2013 Performance Measure Results
CalViva—Madera County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	--	25.61%	★★	Not Comparable	18.98%	33.33%
ACR	Q, A	--	10.81%	--	Not Comparable	--	--
AMB–ED	‡	--	50.89	‡	Not Comparable	‡	‡
AMB–OP	‡	--	444.01	‡	Not Comparable	‡	‡
CAP–1224	A	--	98.53%	★★★	Not Comparable	95.56%	98.39%
CAP–256	A	--	91.75%	★★	Not Comparable	86.62%	92.63%
CAP–711	A	--	NA	NA	Not Comparable	87.56%	94.51%
CAP–1219	A	--	NA	NA	Not Comparable	86.04%	93.01%
CBP	Q	--	56.69%	--	Not Comparable	--	--
CCS	Q,A	--	60.83%	★	Not Comparable	61.81%	78.51%
CDC–BP	Q	--	59.37%	★★	Not Comparable	54.48%	75.44%
CDC–E	Q,A	--	55.72%	★★	Not Comparable	45.03%	69.72%
CDC–H8 (<8.0%)	Q	--	46.47%	★★	Not Comparable	42.09%	59.37%
CDC–H9 (>9.0%)	Q	--	43.31%	★★	Not Comparable	50.31%	28.95%
CDC–HT	Q,A	--	85.89%	★★	Not Comparable	78.54%	91.13%
CDC–LC (<100)	Q	--	33.09%	★★	Not Comparable	28.47%	46.44%
CDC–LS	Q,A	--	70.32%	★	Not Comparable	70.34%	83.45%
CDC–N	Q,A	--	81.27%	★★	Not Comparable	73.48%	86.93%
CIS–3	Q,A,T	--	71.29%	★★	Not Comparable	64.72%	82.48%
IMA–1	Q,A,T	--	65.66%	★★	Not Comparable	50.36%	80.91%
LBP	Q	--	77.17%	★★	Not Comparable	72.04%	82.04%
MMA–50	Q	--	NA	--	Not Comparable	--	--
MMA–75	Q	--	NA	--	Not Comparable	--	--
MPM–ACE	Q	--	80.80%	★	Not Comparable	83.72%	91.33%
MPM–DIG	Q	--	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	--	81.88%	★	Not Comparable	83.19%	91.30%
PPC–Pre	Q,A,T	--	93.35%	★★★	Not Comparable	80.54%	93.33%
PPC–Pst	Q,A,T	--	65.90%	★★	Not Comparable	58.70%	74.73%
W-34	Q,A,T	--	84.43%	★★★	Not Comparable	65.51%	83.04%

Table 3.4—Comparison of 2012 and 2013 Performance Measure Results
CalViva—Madera County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
WCC–BMI	Q	--	62.29%	★★	Not Comparable	29.20%	77.13%
WCC–N	Q	--	73.72%	★★	Not Comparable	42.82%	77.61%
WCC–PA	Q	--	64.72%	★★	Not Comparable	31.63%	64.87%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
‡ This is a utilization measure, which is not assigned a domain of care. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[8] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The selection team considered conditions seen frequently in the senior population and reflected in

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

measures such as *All-Cause Readmissions, Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures that could reflect possible access issues which could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

The final selected SPD measures are listed below. Following the list of measures are Tables 3.3 and 3.4, which present a summary of CalViva's 2013 SPD measure results. Table 3.5 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[9] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.6 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department (ED) Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*
- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

[9] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Tables 3.5, 3.7, and 3.9.

Table 3.5—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
CalViva—Fresno County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	7.69%	12.30%	▼	10.64%
CAP–1224	97.90%	91.46%	↓	97.82%
CAP–256	91.52%	90.62%	↔	91.50%
CAP–711	91.65%	93.76%	↔	91.74%
CAP–1219	90.67%	90.79%	↔	90.68%
CDC–BP	53.16%	49.39%	↔	48.66%
CDC–E	43.20%	50.12%	↑	48.91%
CDC–H8 (<8.0%)	44.17%	45.50%	↔	43.80%
CDC–H9 (>9.0%)	49.76%	42.09%	▲	47.45%
CDC–HT	78.64%	86.62%	↑	82.97%
CDC–LC (<100)	33.98%	38.20%	↔	36.74%
CDC–LS	71.60%	82.00%	↑	76.64%
CDC–N	68.20%	81.27%	↑	75.67%
MPM–ACE	80.26%	83.76%	↑	82.27%
MPM–DIG	NA	89.61%	Not Comparable	86.60%
MPM–DIU	79.47%	85.44%	↑	83.02%

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

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

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

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

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

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

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

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

Table 3.6—2013 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
435.84	42.99	551.16	66.02

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

Table 3.7—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
CalViva—Kings County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	5.00%	12.69%	↔	10.31%
CAP–1224	96.94%	NA	Not Comparable	96.98%
CAP–256	89.73%	89.47%	↔	89.73%
CAP–711	NA	NA	Not Comparable	NA
CAP–1219	NA	NA	Not Comparable	NA
CDC–BP	48.28%	49.53%	↔	50.36%
CDC–E	41.87%	41.59%	↔	42.82%
CDC–H8 (<8.0%)	32.02%	37.85%	↔	41.85%
CDC–H9 (>9.0%)	40.89%	34.11%	↔	50.85%
CDC–HT	55.17%	49.07%	↔	80.54%
CDC–LC (<100)	16.75%	28.50%	↑	27.98%
CDC–LS	53.69%	49.07%	↔	74.94%
CDC–N	72.41%	82.24%	↑	78.35%
MPM–ACE	74.65%	85.71%	↑	80.23%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	71.18%	86.11%	↑	78.03%

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

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

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

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

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

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

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

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

Table 3.8—2013 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
419.16	53.80	737.46	115.90

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

Table 3.9—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
CalViva—Madera County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	7.41%	14.04%	↔	10.81%
CAP–1224	98.67%	NA	Not Comparable	98.53%
CAP–256	91.77%	90.79%	↔	91.75%
CAP–711	NA	NA	Not Comparable	NA
CAP–1219	NA	NA	Not Comparable	NA
CDC–BP	62.78%	51.85%	↓	59.37%
CDC–E	50.81%	59.26%	↔	55.72%
CDC–H8 (<8.0%)	44.98%	48.61%	↔	46.47%
CDC–H9 (>9.0%)	44.01%	43.98%	↔	43.31%
CDC–HT	82.52%	89.35%	↑	85.89%
CDC–LC (<100)	33.66%	32.87%	↔	33.09%
CDC–LS	69.26%	74.54%	↔	70.32%
CDC–N	77.35%	84.26%	↔	81.27%
MPM–ACE	76.08%	87.11%	↑	80.80%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	75.86%	88.55%	↑	81.88%

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

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

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

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

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

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

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

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

Table 3.10—2013 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
425.90	48.98	648.89	72.47

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

Performance Measure Result Findings

Since 2013 was the first year CalViva reported performance measure rates, no comparison to prior years' performance can be made. Across all counties, five measures had rates above the HPLs and 17 measures had rates below the MPLs.

The following measures had rates above the HPLs:

Fresno County

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Use of Imaging Studies for Low Back Pain*

Madera County

- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rates for the following measures were below the MPLs in all three counties:

- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

The *Cervical Cancer Screening* measure had rates below the MPLs in Kings and Madera counties and the *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* measure had rates below the MPL in Fresno and Kings counties.

Overall, Madera County performed better than Fresno and Kings counties, with three measures above the HPLs and four measures below the MPLs. Fresno County had two measures above the HPLs and four measures below the MPLs, and Kings County had no measures above the HPLs and nine measures below the MPLs.

Seniors and Persons with Disabilities Findings

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

- *Annual Monitoring for Patients on Persistent Medications—ACE* in Fresno, Kings, and Madera counties
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Fresno, Kings, and Madera counties
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Fresno County

- *Comprehensive Diabetes Care—HbA1c poor Control (>9.0 Percent)* in Fresno County
- *Comprehensive Diabetes Care—HbA1c Testing* in Fresno and Madera counties
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* in Kings County
- *Comprehensive Diabetes Care—LDL-C Screening* in Fresno County
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Fresno and Kings counties

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

- *All-Cause Readmissions* in Fresno County
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)* in Fresno County
- *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 quality, access, and timeliness associated with the low-performing measure and positively impact the measure's rate. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the steps it will take to improve care and the measure's rate. DHCS reviews each IP for soundness of design and potential efficacy. DHCS requires MCPs to correct and resubmit any IP that fails to meet DHCS's IP standards.

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

Since 2013 was the first year CalViva was required to report performance measure rates, the MCP will not be required to develop IPs for measures with rates below the MPLs. While no IPs are

required, DHCS encouraged CalViva to conduct barrier analyses and identify strategies to improve performance measure rates that were below the MPLs in 2013.

Strengths

CalViva's staff members demonstrated knowledge of the file preparation, transfer, and verification processes for the HEDIS audit process. Across all counties, five measures performed above the HPLs. Additionally, CalViva's 2012 Quality Improvement Work Plan: Year End Evaluation indicated that during 2012, the MCP implemented outreach initiatives to improve postpartum visits.

Opportunities for Improvement

CalViva has opportunities to make improvements on several measures that had rates below the MPLs. Kings County has the most opportunities for improvement since this county performed below the MPLs on nine measures. Additionally, CalViva has the opportunity to assess the factors that led to the SPD rates for two measures in Fresno County and one measure in Madera County being worse than the non-SPD rates.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[10] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

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

Validating Quality Improvement Projects and Assessing Results

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

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

HSAG organized, aggregated, and analyzed 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.

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

Quality Improvement Project Objectives

CalViva participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2012–June 30, 2013.

Table 4.1 below lists CalViva's QIPs and indicates the counties 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, 2012, through June 30, 2013

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

Prior to initiation of the statewide collaborative QIP, CalViva had a 30-day readmission rate of 9.8 percent among Medi-Cal beneficiaries. CalViva also found that the readmission rate for the SPD population was 13.0 percent, which was higher than the 7.61 percent rate for the non-SPD population.

The *Retinal Eye Exams* QIP targeted the MCP's 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

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, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	89%	100%	*Met*
Internal QIPs				
Retinal Eye Exams	Study Design Submission	75%	83%	*Not Met*
	Study Design Resubmission 1	90%	100%	*Met*

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

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

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

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

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that CalViva's study design submission of its *All-Cause Readmissions* QIP received an overall validation status of *Met*, with 100 percent of critical elements and 89 percent of evaluation elements met. CalViva received a *Not Met* validation status for its *Retinal Eye Exams* annual submission. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on the validation feedback, CalViva resubmitted the QIP and upon subsequent validation, achieved an overall *Met* validation status with 100 percent of critical elements and 90 percent of evaluation elements being met.

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 = 3 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	62%	15%	23%
Design Total		**84%**	**6%**	**10%**
Implementation	VII: Sufficient Data Analysis and Interpretation	Not Assessed	Not Assessed	Not Assessed
	VIII: Appropriate Improvement Strategies	Not Assessed	Not Assessed	Not Assessed
Implementation Total		**0%**	**0%**	**0%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**0%**	**0%**	**0%**

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

HSAG validated Activities I through VI for CalViva's *All-Cause Readmissions* QIP study design submission and *Retinal Eye Exams* QIP annual submission.

CalViva demonstrated a strong application of Activities I through IV as evidenced by the MCP receiving *Met* scores for 100 percent of the elements in these activities for both QIPs; however, CalViva struggled with Activity VI for both QIPs. CalViva did not describe the MCP's data analysis plan for the *All-Cause Readmissions* QIP, which resulted in a lower score for Activity VI. Activity VI received a lower score for the *Retinal Eye Exams* QIP because CalViva did not provide information regarding the staff members who would be responsible for the data collection or the data collection tool. Also, CalViva did not provide a full description of the data analysis plan for this QIP. CalViva corrected these deficiencies in the *Retinal Eye Exams* QIP resubmission, and the QIP received an overall *Met* validation status.

HSAG did not score either QIP for the implementation and outcomes stages since neither QIP progressed to these stages.

Quality Improvement Project Outcomes and Interventions

Since the *All-Cause Readmissions* and *Retinal Eye Exams* QIPs did not progress to the implementation or outcomes stage during the reporting period, no intervention or outcome information is included in this report.

Strengths

CalViva excelled at defining the study questions, clearly defining the study indicator, and correctly identifying the study population for both the *All-Cause Readmissions* and *Retinal Eye Exams* QIPs.

Opportunities for Improvement

CalViva struggled with providing documentation for the data collection portion of both QIPs. The MCP should reference the QIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed prior to submission to avoid incomplete documentation of the various elements.

Going forward, CalViva should consider, at minimum, conducting an annual barrier analysis. The MCP has opportunities to improve in the area of documenting the barrier analysis process, including providing the data, the identified barriers, and the rationale for how the barriers are prioritized. More frequent analyses may allow CalViva to identify changes or trends that are not evident from an annual analysis.

CalViva should ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the MCP cannot determine whether to modify or discontinue existing interventions, or implement new ones, thereby reducing the likelihood of achieving the project objectives and improving performance.

Conducting the EQRO Review

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

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

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

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

Findings

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

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

CAHPS Global Rating Measures:

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

CAHPS Composite Measures:

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

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

Table 5.1—CAHPS Measures Domains of Care

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

National Comparisons

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

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

Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures

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

Tables 5.3 through 5.6 present the star ratings for the global ratings and composite measures for CalViva's adult and child Medicaid populations.[15]

Table 5.3—Medi-Cal Managed Care Adult County-Level Global Ratings CalViva—Fresno, Kings, and Madera Counties

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Fresno	★	★	★	★+
Kings	★★	★★★+	★★★★★+	★★★★★+
Madera	★	★+	★+	★★★+

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

[12] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.

[13] NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.

[14] Since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating.

[15] Due to the changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure.

Table 5.4—Medi-Cal Managed Care Child County-Level Global Ratings
CalViva—Fresno, Kings, and Madera Counties

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Fresno	★★	★	★	★★★★★+
Kings	★★	★+	★★★★★+	★+
Madera	★★★★	★★★+	★★★	★★★★★+

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Table 5.5—Medi-Cal Managed Care Adult County-Level Composite Measures
CalViva—Fresno, Kings, and Madera Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Fresno	★	★	★	★★+
Kings	★★+	★★+	★+	★+
Madera	★+	★+	★+	★★+

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Table 5.6—Medi-Cal Managed Care Child County-Level Composite Measures
CalViva—Fresno, Kings, and Madera Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Fresno	★★	★	★	★★
Kings	★+	★+	★★+	★★★★★+
Madera	★★★+	★+	★+	★★★★+

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Strengths

Overall, Kings County received the highest marks for the adult global ratings. Kings County received three or more stars for *Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Specialist Seen Most Often*.

As for the child global ratings, Madera County excelled at member satisfaction. Madera County received three or more stars for all four categories: *Rating of Health Plan, Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. Also, both Kings and Madera counties received five and four stars respectively for the child *Customer Service* measure.

Please note that the MCP had fewer than 100 respondents for most of the measures across all counties, so caution should be exercised when evaluating these results.

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

Opportunities for Improvement

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

Conducting the EQRO Review

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

Methodology

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

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

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

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

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

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

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

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

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

Encounter Data Validation Findings

Review of Encounter Systems and Processes

CalViva's processes for aggregating and submitting claims and encounter data files adhere to industry best practices; however, it is important to note that CalViva is largely dependent on delegated entities. Health Net Community Solutions, Inc. (Health Net) manages the claims processing activities for CalViva. Vision and pharmacy claims are similarly managed by external providers. These service providers perform their own claims processing activities and submit the data to CalViva. Health Net also subcontracts the claims processing to Cognizant Technology Solutions. Each level of claims administration involves some degree of oversight, although the details were not provided to HSAG. CalViva stated that monthly reports are generated to measure the timeliness and completeness of the capitated encounter data submissions; however, it is not clear which entity is responsible for this oversight. Once the claims processing entities complete their respective validation, oversight, and claims submission, CalViva then aggregates and submits all the claims data to DHCS. CalViva's encounter team is responsible for resolving any encounter data rejections. CalViva reported that less than 0.1 percent of claims/encounters were rejected by DHCS for all encounter types, as evidenced by the data and supported by stable claims processing and oversight methods.

Record Completeness

Overall, CalViva had very low record omission and record surplus rates, indicating relatively complete data when comparing DHCS's data and the encounter data extracted from CalViva's

data system for this study. These rates performed better than the statewide rates for all claim types except for one. The record omission rate of 13.8 percent for long-term care (LTC) encounters was above the statewide record omission rate of 1.1 percent. However, this only indicated that 25 LTC records were omitted from the DHCS data warehouse. Fresno, Kings, and Madera counties had consistent record omission and record surplus rates for the Medical/Outpatient and Pharmacy claim types. For the Hospital/Inpatient claim type, Madera County had high record omission and record surplus rates of 27.1 percent and 75.2 percent, respectively. The high record omission rates for Madera County may be related to the duplicated records in the data CalViva submitted to HSAG. The high record surplus rate was because the Hospital/Inpatient data submitted to HSAG by CalViva only contained the original records, and the data in the DHCS data warehouse contained both the original and adjustment records.

Data Element Completeness

CalViva had perfect data element completeness results with element omission and element surplus rates of 0.0 percent for all key data elements in the Medical/Outpatient, Hospital/Inpatient, Pharmacy, or LTC encounters.

Data Element Accuracy

CalViva had very high data element accuracy with complete accuracy (100.0 percent) for most of the key data elements. The *Billing/Reporting Provider Number* had lower data element accuracy rates of 98.6 percent and 89.7 percent for Medical/Outpatient and LTC encounters, respectively, due to truncation of the provider ID number in the DHCS data warehouse. The data element *Revenue Code* for Hospital/Inpatient encounters had a lower accuracy rate of 90.3 percent because the two data sources displayed the revenue codes in a different order on the claim lines for some of the encounters. Overall, CalViva had very good all-element accuracy by exceeding the statewide all-element accuracy rate for all claim types by more than 20 percentage points.

Recommendations

Based on its review, HSAG recommends the following:

- CalViva's accuracy of claims and encounter data is driven by the third party entities that process the claims (e.g., Health Net). While each entity is responsible for the timeliness and completeness of the data submissions, the oversight details were not requested as part of the supplemental questionnaire. As such, HSAG initially recommended ensuring that CalViva's claims processing oversight be examined to ensure the claims data that CalViva receives are as accurate as possible. CalViva has subsequently stated that there are policies and procedures in place for the oversight of claims and encounters.

- Although there were numerous adjustment records in the DHCS data warehouse, all of them were submitted to correct a data error caused by Health Net's system. Based on CalViva's responses to the questionnaire, if retrospective adjustments were applied after the records were submitted to DHCS, the modified records were not submitted to DHCS. To ensure the data in the DHCS data warehouse are complete and accurate, CalViva should modify its processes so that it receives and can distinguish modified records from its delegated claims processing entities and CalViva could then submit the subsequent claims adjustments to DHCS after the original submission.
- For data element *Billing/Reporting Provider Number*, the field length is 12 characters based on the Encounter Data Element Dictionary. However, this data element was saved as a 10-character field in the DHCS data warehouse. DHCS should consider increasing the length of this data field to 12 characters in the data warehouse. In the meantime, CalViva should try to submit the providers' 10-digit National Provider Identifier (NPI) whenever possible for this data element.
- The high record omission and record surplus rates from Madera County were most likely related to how data were extracted/prepared for this study. However, CalViva should investigate the reasons these rates were so high to ensure potential issues related to the data submissions to DHCS can be addressed earlier. The two items to investigate are (1) why there were duplicated records for the submission date of August 22, 2011, and (2) why there were no adjustment records for the Hospital/Inpatient encounter data that were submitted to HSAG.
- For the low accuracy rate from data element *Revenue Code* for Hospital/Inpatient encounters, CalViva should investigate why the orders of populating the revenue codes were different for some of the encounters that existed in both sources. CalViva needs to populate the revenue code in a consistent way for future data submissions.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[17]

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

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

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

HSAG reviewed CalViva's 2013 Quality Improvement (QI) Program Description, which includes descriptions of the processes the MCP uses to ensure quality care is provided to its MCMC members.

The A&I Medical Audit conducted in March 2013 identified findings in the areas that could impact the quality of care delivered to the MCP's members. Additionally, when conducting the SPD Enrollment Survey with CalViva, DMHC noted that the MCP's Quality Improvement/Utilization Management Committee lacked representation of specialist providers reflective of the MCP's contracted provider network, which could impact efforts to ensure quality of care for the SPD population.

The following quality performance measures had rates above the HPLs in Fresno County:

- *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*
- *Use of Imaging Studies for Low Back Pain*

The following quality performance measures had rates above the HPLs in Madera County:

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

Across all counties, 17 performance measures falling into the quality domain of care had rates below the MPLs.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and eight of these measures had SPD rates that were significantly better than the non-SPD rates. The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in members in the SPD population being seen more regularly by providers and leading to better monitoring of care. Two quality measures had SPD rates that were significantly worse than the non-SPD rates:

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

All CAHPS measures fall into the quality domain of care. Across all counties, most of the measures had a *Fair* or *Poor* rating. In Kings County, four measures received an *Excellent* rating:

- *Rating of Personal Doctor*—adult and child populations
- *Rating of Specialist Seen Most Often*—adult population

- *Customer Service*—child population

The *Rating of Specialist Seen Most Often* measure for the child population in Fresno and Madera Counties received an *Excellent* rating. Madera County also had two measures for the child population that received a *Very Good* rating—*Rating of Health Plan* and *Customer Service*.

Both of CalViva's QIPs fell into the quality domain of care. Neither of the QIPs progressed to the implementation or outcomes stage, so HSAG was not able to assess the QIPs' success at improving the quality of care delivered to the MCP's 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 activities in its 2013 Quality Improvement Work Plan to monitor members' access to care. CalViva's 2012 Quality Improvement Work Plan: Year End Evaluation showed that providers in all counties are complying with many of the access standards. Some of the counties did not meet all access-related goals, and CalViva documented actions the MCP will take to assist providers with improving performance.

The A&I Medical Audit conducted in March 2013 identified findings in the areas of Continuity of Care and Access and Availability, which both fall into the access domain of care. DMHC's SPD Enrollment Survey, however, did not note any deficiencies in these areas.

Madera County was the only county that had access performance measures with rates above the HPLs. The measures with rates above the HPLs were:

- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*

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

The following access performance measures had rates below the MPLs:

- *Cervical Cancer Screening* in Kings and Madera counties
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Kings County
- *Comprehensive Diabetes Care—LDL-C Screening* in Madera County
- *Prenatal and Postpartum Care—Postpartum Care* in Kings County

Nine of the performance measures stratified for the SPD population fall into the access domain of care, and four of these measures had SPD rates that were significantly better than the non-SPD rates. As indicated above, the better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in members in the SPD population being seen more regularly by providers and leading to better monitoring of care. Two access measures in Fresno County had SPD rates that were significantly worse than the non-SPD rates:

- *All-Cause Readmissions*
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*

Overall, CalViva performed below average on the access-related CAHPS measure, *Getting Needed Care,* for both the adult and child populations.

Both of CalViva's QIPs fell into the access domain of care. Since neither of the QIPs progressed to the implementation or outcomes stage, HSAG was not able to assess the QIPs' success at improving access to needed services or the impact of the QIPs' interventions on the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure in Kings County, which, as indicated above, had a rate below the MPL in 2013.

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 2013 Quality Improvement (QI) Program Description provides descriptions of activities related to member rights and protections, grievances, continuity and coordination of care, and utilization management.

The A&I Medical Audit conducted in March 2013 identified findings in areas falling into the timeliness domain of care; however, DMHC's SPD Enrollment Survey did not note any deficiencies in timeliness-related areas.

Madera County was the only county that had timeliness performance measures with rates above the HPLs. The measures with rates above the HPLs were:

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

The *Prenatal and Postpartum Care—Postpartum Care* measure, which falls into the timeliness domain of care, had a rate below the MPL in Kings County.

One CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care. This measure received a *Poor* rating in all counties except Kings County, which received a *Fair* rating.

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

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:

- Ensure all findings from the March 11, 2013, through March 22, 2013, A&I Medical Audit are addressed and resolved.

- Ensure all deficiencies from the March 11, 2013, through March 13, 2013, DMHC SPD Enrollment Survey are addressed and resolved. Specifically:
  - Ensure that the MCP is conducting sufficient monitoring of its delegated exempt grievance process.
  - Ensure an appropriate range of specialist providers are included on the MCP's Quality Improvement/Utilization Management Committee.
- 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.
- 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.
- Engage in the following efforts to improve performance on QIPs:
  - Reference the QIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed prior to submission.
  - 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.
  - Ensure each QIP intervention includes an evaluation plan.
- Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *How Well Doctors Communicate*, *Rating of All Health Care*, and *Getting Care Quickly* priority areas.
- Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.

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

Quality, Access, and Timeliness Scoring Process

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

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[18] This process allows HSAG to evaluate each MCP's performance measure rates (including CAHPS survey measures) and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Tables 3.2 through 3.4)

Quality Domain

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

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

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

Access and Timeliness Domains

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

CAHPS Survey Measures

(Refer to Tables 5.3 through 5.6)

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

Quality Domain

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

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

Access Domain

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

Timeliness Domain

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

Quality Improvement Projects (QIPs)

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Not all study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Not all study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

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

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

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

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

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

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

for CalViva Health

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

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

2011–12 External Quality Review Recommendation	CalViva's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
Ensure that all findings identified during the June 2012 MR/PIU review are addressed. Specifically:	
1. Implement a process to ensure that all denial letters issued include a citation of the specific regulation or plan authorization procedure supporting the action.	The plan has implemented processes to ensure that all denial letters issued include a citation of the specific regulation or plan authorization procedure supporting the action. • The plan delegates precertification and prior authorization functions to its administrative contractor. The plan notified its administrative contractor on July 24, 2012, about the findings and corrective action needed and held a follow-up meeting on November 16, 2012, with the administrative contractor to discuss the findings and actions implemented. • The administrative contractor arranged for medical director training on September 27, 2012, for the medical directors and registered nurses who regularly review the plan's cases. The medical director training included training to ensure that all denial letters include a citation of the specific regulation or plan authorization procedure supporting the action. • The plan's chief medical officer and director of medical management approved the training and materials used. • The plan submitted to the DHCS Member Rights/Program Integrity Unit (MR/PIU) on March 15, 2013, an example of a denial notice letter after the MR/PIU monitoring review visit, which included a citation of the specific regulation or plan authorization procedure supporting the action. • The plan's oversight audit was completed on January 22, 2013. The oversight audit included ensuring denial letters issued include a citation of the specific regulation or plan authorization procedure supporting the action. The plan did not note any concerns. The plan will review denial letters again during the next regularly scheduled oversight audit.

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

2011–12 External Quality Review Recommendation	CalViva's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
2. Implement a quality control process to ensure that all prior authorization notifications sent to members contain the proper health plan name.	The plan has implemented processes to ensure that all prior authorization notifications sent to members contain the proper health plan name. • The plan delegates precertification and prior authorization functions to its administrative contractor. The plan notified its administrative contractor on July 24, 2012, about the findings and corrective action needed and held a follow-up meeting on November 16, 2012, with the administrative contractor to discuss the findings and actions implemented. • The administrative contractor advised the plan on November 16, 2012, that it had pulled all letter templates and re-reviewed them to ensure the correct health plan name is used in the letter. • The plan's oversight audit was completed on January 22, 2013. The oversight audit included ensuring the correct health plan name was used. The plan did not note any concerns. The plan will review notification letters again during the next regularly scheduled oversight audit. • The plan submitted to the DHCS Member Rights/Program Integrity Unit (MR/PIU) on March 15, 2013, an example of a denial notice letter after the MR/PIU monitoring review visit which included the correct health plan name.
3. 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.	• The plan on October 23, 2012, met with its administrative contractor to discuss the current interventions in place to ensure LEP members are discouraged from using family, friends, or minors as interpreters. • The current interventions in place and discussed included: 1. Facility Site Reviews (FSRs) which occur at the provider site once every three years. The FSR nurses who conduct the review inform the provider site of the plan's cultural and linguistics (C&L) policies and procedures and the availability of interpreter services for LEP members. The FSR nurses also leave a manual at the provider site which includes C&L-related information. 2. Ad-hoc and annual provider in-service trainings by the plan's Provider Relations Department. The provider sites are made aware of the plan's C&L policies and procedures and the availability of interpreter services for LEP members through a presentation and handouts. The presentation and handouts are left with the provider. 3. Targeted workshops (by request) from the plan's C&L Department to assist the providers with accessing interpreter services for LEP members and other C&L areas where the provider requests additional assistance.

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

2011–12 External Quality Review Recommendation	CalViva's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	Handouts and materials are presented during the workshop. 4. Interpreter reference cards, posters, and provider updates which are given out and/or sent directly to the provider site notifying the provider site of the plan's C&L policies and procedures and the availability of interpreter services for LEP members. • The plan believes the interventions above were sufficient; however, in response to the finding, the plan's Community Relations Department now includes cultural and linguistic service awareness as part of its monthly provider visits.
4. Ensure that the required SPD sensitivity training is consistently conducted.	• The plan on October 23, 2012, met with the administrative contractor to discuss the current interventions in place to ensure that the required SPD sensitivity training is consistently conducted. • The plan utilizes a training module entitled, "Quality Services for People with Disabilities and Activity Limitations" produced by the Harris Family Center for Disability and Health Policy. The training is available online to contracted providers. Contracted providers are made aware of the training and the importance of completing the training through these current interventions: 1. Facility Site Reviews (FSRs) which occur at the provider site once every three years. The FSR nurses who conduct the review inform the provider site of the availability of SPD sensitivity training online and the importance of the provider site completing the required training. 2. Ad-hoc and annual provider in-service trainings by the plan's Provider Relations Department. The provider sites are made aware of the availability of SPD sensitivity training and how to access the training online. 3. Provider updates which are sent to contracted providers. The provider updates introduce SPD sensitivity training and provide step-by-step instructions on how to access the training online. 4. New Provider Welcome Packets, which are sent within 10 days to all newly contracted providers. The welcome packet includes information to newly contracted providers about the availability of SPD sensitivity training online. • The plan on June 16, 2013, revised its Medi-Cal Operations Training Presentation. Information was added to the presentation about SPD provider training.

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

2011–12 External Quality Review Recommendation	CalViva's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
5. 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.	The plan continues to perform physical accessibility site reviews (PARS) and ensures results are made available to members via the following mechanisms: • Physical accessibility results are made available through the plan's printed provider directory which is updated twice a year. The printed provider directory is available on the plan's Web site, included in new member welcome kits, the annual mailing, and available upon request. • Beginning in Quarter 1, 2013, the plan implemented a searchable provider database on the plan's Web site located at http://www.calvivahealth.org. The provider information in the database also includes physical accessibility information. • The plan provided an update on the facility site accessibility assessments to the plan's Public Policy Committee on March 6, 2013. The Public Policy Committee includes plan members as part of the committee. • On March 22, 2013, the plan submitted to the DHCS MR/PIU a spreadsheet of PARS assigned to the plan and completed as of March 2013.
Additional Recommendations:	
1. 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.	The plan has discussed and obtained technical assistance from MMCD and the EQRO related to the requirements for performance measure validation to ensure the plan is able to report valid and reliable rates in 2013. These meetings include: • On October 22, 2012, 2:00–3:00 p.m., CalViva Health Medical Management staff (chief medical officer, director of medical management, and quality specialist) met with representatives from HSAG (Jennifer Lenz, Nicholas Zimmerman) and DHCS (Erin Toyama) to discuss HEDIS requirements for CalViva Health in 2013. At the conclusion of the call, CalViva was determined to be ready to proceed with HEDIS submission and validation. • On January 23, 2013, 1:00–2:00 p.m., CalViva Health Medical Management staff participated in the HSAG 2012 HEDIS Improvement Plans Technical Assistance Call for Medi-Cal Health Plans. • On January 30, 2013, 3:00–4:00 p.m., CalViva Health participated in the HEDIS 2013 Pre-On-site Kick-off Call with Charlie Chapin, Lead Auditor, HSAG, and Marilea Rose, Medical Record Reviewer, HSAG. • On January 31, 2013, the CalViva Health 2013 HEDIS Roadmap was submitted to HSAG. • On February 15, 2013, 2:00–3:00 p.m., CalViva Health Medical Management staff participated in the HSAG—California Plan All-Cause Readmissions (PCR) Measure Review.

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

2011–12 External Quality Review Recommendation	CalViva's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	• On March 5–6, 2013, CalViva Health Medical Management staff participated in the NCQA HEDIS 2013 On-site Compliance Audit for the California DHCS Medi-Cal Managed Care Program lead by Charlie Chapin, HSAG Auditor. At the closing conference, Mr. Chapin reported no surprises or significant areas of concern. HEDIS reporting for CalViva Health is a high-quality product. All issues identified on the audit report from this review were resolved before the data submission deadline. • On May 22, 2013, CalViva Health passed the medical record validation by HSAG. • On June 17, 2013, all CalViva Health 2012 HEDIS submission files were finalized and locked by the auditor for final submission to meet the reporting deadline. All measures were reportable.
2. Refer to the QIP Completion Instructions and contact HSAG for technical assistance as needed while progressing through the QIP process.	The plan has followed the QIP Completion Instructions and contacted HSAG for technical assistance as needed while progressing through the QIP process. These contacts include: **<u>All-Cause Readmissions (ACR) QIP</u>** • On September 28, 2012, CalViva Health submitted the All-Cause Readmissions QIP Study Design Phase Sections I–VI to DHCS and HSAG for approval according to the instructions provided in the QIP Instructions. • On October 18, 2012, 10:30–11:30 a.m., CalViva Health participated in the DHCS Medi-Cal Managed Care Program QIP Call Discussion (Technical Assistance Call). • On November 2, 2012, CalViva Health received notification from HSAG that the ACR submission for CalViva Health was validated with an overall "Met" validation status. • On November 8, 2012, 10:30–11:30 a.m., CalViva Health participated in DHCS Medi-Cal Managed Care Program ACR All-Plan Call. • On January 31, 2013, CalViva Health submitted the Barrier Analysis and Interventions grid to DHCS and HSAG for approval. • On February 11, 2013, 1:00–1:30 p.m. CalViva Health Medical Management staff met with Jolene Rasmussen, Jennifer Lenz, and Patty Ferry from HSAG and KA Corley from DHCS regarding ACR Barrier Analysis and Intervention Technical Assistance for the January 31 submission. • On March 12, 2013, a follow-up e-mail was received from Jolene Rasmussen regarding the 2/11/2013 CalViva Health ACR Barrier Analysis and Intervention Technical Assistance Call which included recommendations for inclusion of specific information for the next ACR QIP submission due September 30, 2013.

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

2011–12 External Quality Review Recommendation	CalViva's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
#2. Continued	**Individual QIP Diabetic Retinal Eye Exams** • On August 31, 2012, CalViva Health submitted the Individual QIP Diabetic Retinal Eye Exam Study Design Phase Sections I–VI to DHCS and HSAG for approval according to the instructions provided in the QIP Instructions. • On October 26, 2012, received notification from HSAG that the Diabetic Retinal Eye Exam QIP submission for CalViva Health was validated and required further modifications for final approval. • On November 7, 2012, CalViva Health Medical Management staff participated in a technical assistance call with HSAG (Christi Melendez and Donald Grostic) to clarify requested modifications. • On November 8, 2012, CalViva Health resubmitted the revised Diabetic Retinal Eye Exam QIP based on recommendations from the technical assistance call. • On November 20, 2012, received notification from HSAG that the Diabetic Retinal Eye Exam QIP submission for CalViva Health was validated with an overall "Met" validation status. Next submission due date is August 30 2013.