2024 QUALITY IMPROVEMENT & HEALTH EQUITY PROGRAM ANNUAL EVALUATION

Reviewed by QIHE Committee March 20, 2025.

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CONTENTS

1. INTRODUCTION

This program evaluation provides a comprehensive overview of quality improvement activities conducted in Calendar Year 2024(CY2024).

The content of this evaluation includes:

- Descriptions of completed and ongoing QI activities
- Trending of QI measures to assess performance.
- Analysis and evaluation of the overall effectiveness of the QI program.

2. HEDIS OVERVIEW

In 2024, HPSM was required to collect and report HEDIS measures for the Medi-Cal, CareAdvantage and HealthWorks populations. The 2024 reporting year (RY2024) HEDIS results are an analysis of services provided in the 2023 measurement year (MY2023). Individual HEDIS measures are selected by the Centers for Medicare and Medicaid Services (CMS) for CareAdvantage and the Department of Health Care Services Medi-Cal Managed Care Division (DHCS-MMCD) for Medi-Cal. In addition, HPSM collects and reports HEDIS measures for NCQA Health Plan Accreditation for the Medi-Cal population as determined by NCQA Medicaid measure set. Starting in 2024, the California Department of Managed Healthcare required reporting of certain HEDIS measures for the Medi-Cal and HealthWorx populations.

DHCS sets a Minimum Performance Level (MPL) and a High Performance Level (HPL) for each required measure. Performance levels are based on prior year's HEDIS reporting from all National Committee of Quality Assurance (NCQA) national Medicaid plans. The MPL and HPL are the 50th and 90th percentiles, respectively. Results for all HEDIS measures can be found in APPENDIX A. MANAGED CARE ACCOUNTABILITY SET (MCAS) RESULTS TRENDED.

CMS provides a STARS bonus program for D-SNP plans. Select HEDIS measures are used for Part C STARs rating. "Cut-points" for Star rating for each measure set with CMS's comparative methodology across all Medicare Advantage plans for the current year HEDIS reporting.
DHCS assigns improvement projects for required measures not meeting the MPL. There were no assigned improvement activities in 2024 as no measures were below the MPL.

Included are the results for each of HPSM's key areas of focus compared over the last several years.

It should be noted that based on the HEDIS data collection and reporting schedule, HEDIS results discussed for reporting year 2024 are of services provided to members enrolled in 2023.

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2024 MEDI-CAL SUMMARY HIGHLIGHTS* :

For Reporting Year (RY) 2024/Measurement Year (MY) 2023,

- **6 measures above HPL (above 90th percentile):**
  - Childhood Immunization Status –combination 10
  - Immunizations for Adolescents –combination 2
  - Breast Cancer Screening
  - Chlamydia Screening in Women
  - Prenatal and Postpartum Care – Postpartum Care
  - Prenatal and Postpartum Care – Timely Prenatal Care
- **No measures below MPL (50th percentile)**

* RY2024 and trended results for all Medi-Cal HEDIS measures can be found in APPENDIX A. MANAGED CARE ACCOUNTABILITY SET (MCAS) RESULTS TRENDED

2024 CAREADVANTAGE SUMMARY HIGHLIGHTS *:

In RY2024/MY2023, HPSM successfully reported on all measures required by CMS for D-SNP Plans. The STAR ratings for Part C HEDIS measures were

Medicare STAR HEDIS Summary

Measure Information					MY2023 Medicare Star Cut Points						
ID	Indicator	MY 2021	MY 2022	MY2023	Star	1 Star	2 Stars	3 Stars	4 Stars	5 Stars	Notes
BCS	Breast Cancer Screening	58.40	67.51	71.51	3	< 52 %	>= 53 % to <67 %	>= 67 % to < 75 %	>= 75 % to < 82 %	>= 82 %	
CBP	Controlling High Blood Pressure	69.81	64.12	70.79	2	< 69 %	>= 69 % to < 74 %	>= 74 % to < 80 %	>= 80 % to < 85 %	>= 85 %	3x weight
COA	Care of Older Adults: Medication Review	80.74	83.42	87.07	3	< 53 %	>= 53 % to < 80 %	>= 80 % to < 92 %	>= 92 % to < 96 %	>= 96 %	
COA	Care of Older Adults:Pain Assessment	82.96	81.38	93.66	4	< 60 %	>= 60 % to < 81 %	>= 81 % to < 92 %	>= 92 % to < 96 %	>= 96 %	
COL	Colorectal Cancer Screening		67.15	66.6	3	< 53 %	>= 53 % to < 65 %	>= 65 % to < 75 %	>= 75 % to < 83 %	>= 83 %	
EED	Eye Exam for Patients with Diabetes	72.32	71.97	70.48	3	< 57 %	>= 57 % to < 70 %	>= 70 % to < 77 %	>= 77 % to < 83 %	>= 83 %	
HBD	HbA1c poor control >9.0% (reverse score)	78.05	73.85	76.33	3	< 49 %	>= 49 % to < 72 %	>= 72 % to < 84 %	>= 84 % to <90 %	>= 90 %	3x weight
OMW	Osteoporosis Management in Women who had a Fracture	24.24	NA	14.89	1	< 27 %	>= 27 % to <39 %	>= 39 % to < 52 %	>= 52 % to < 71 %	>= 71 %	
SPC	Statin Therapy for Patients with Cardiovascular Disease	85.71	85.31	86.09	3	< 81 %	>=81 % to < 85 %	>= 85 % to < 88 %	>= 88 % to < 92 %	>= 92 %	
TRC	Transitions of Care: Medication Reconciliation	63.50	39.66	60.34	3	< 42 %	>= 42 % to < 57%	>= 57 % to < 73 %	>= 73 % to < 87 %	>= 87 %	
TRC	Transitions of Care:average of 4 rates		40.09	48.91	2	< 44 %	>= 44 % to < 52 %	>= 52 % to < 63 %	>= 63 % to < 77 %	>= 77 %	
PCR	Plan All-Cause Readmissions		10.46	12.64	2	>14 %	>12 % to <=14 %	>10 % to <=12 %	>8 % to <=10 %	<=8 %	3x weight, Lower is better
FMC	Follow-Up after ED for People with Multiple Chronic Conditions		60.41	62.92	4	< 39 %	>= 39 % to < 53 %	>= 53 % to < 60 %	>= 60 % to < 69 %	>= 69 %	7 day rate

2024 QUALITY AND PERFORMANCE IMPROVEMENT

There were no DHCS required quality improvement projects for 2024 based on RY2024 HEDIS results but the Plan did have several areas of focus for improvement.

There were 2 required Performance Improvement Projects (PIP's) based of Statewide results in 2024. The PIP's focused on the following HEDIS Measures:

- W30-Well Child Visits in the first 30 months of life
- FUM/FUA-Follow Up after Emergency Department for Mental Health or Substance Abuse.

The W30 PIP is a Health Equity PIP focused on the Hispanic population and the FUM/FUA PIP is Non-Clinical. The intervention for the W30 PIP was implemented in February 2024. The intervention for FUH/FUA was implemented in December 2024. The impact of the 2024 interventions will be reported in 2025.

3. QUALITY OF CLINICAL CARE

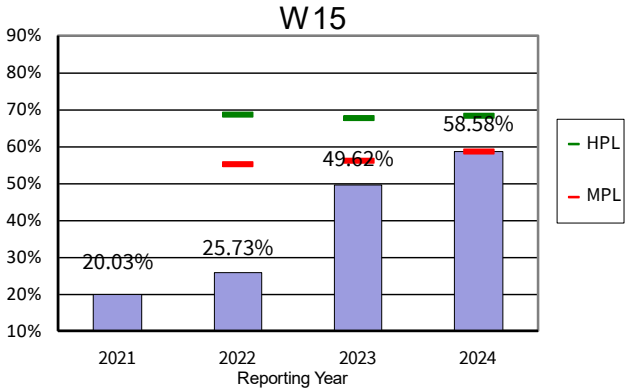
3.1 AREAS OF FOCUS FOR IMPROVEMENT

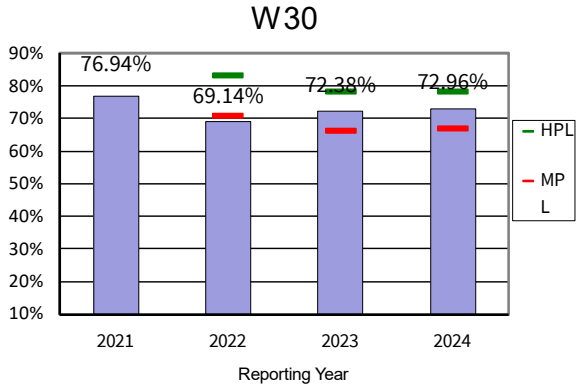
HEDIS MEASURES AND RESULTS

Well-Child Visits in First 30 Months of Life

The percentage of members who had the following number of well-child visits with a PCP. Two rates are reported:

1. W15: Six or more well-child visits in the *first 15 Months* Children who turned 15 months old during the measurement year.
2. W30: Two or more well-child visits *Age 15 Months–30 Months*. Children who turned 30 months old during the measurement year.



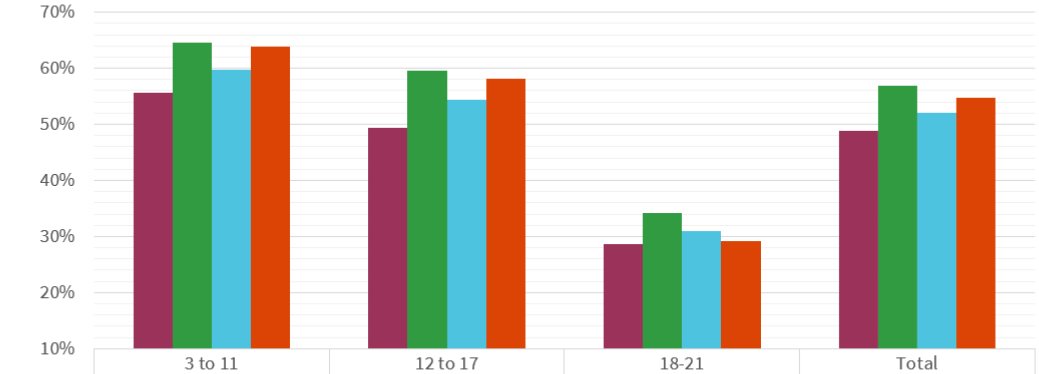


Area of Focus for 2023 and 2024

- MC benchmark P4P payment measure and included in Care Gaps P4P program
- Continue to investigate potential data gaps and procure additional data capture
- Engaging Family Health Services to assist with member barriers to visits
- DHCS Clinical PIP topic -reducing disparity for the Hispanic/Latino population
- DHCS Collaborative Sprint lead by Institute for Healthcare Improvement (IHI) to focus on improving child well visits

Child & Adolescent Well Care Visits

Percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.



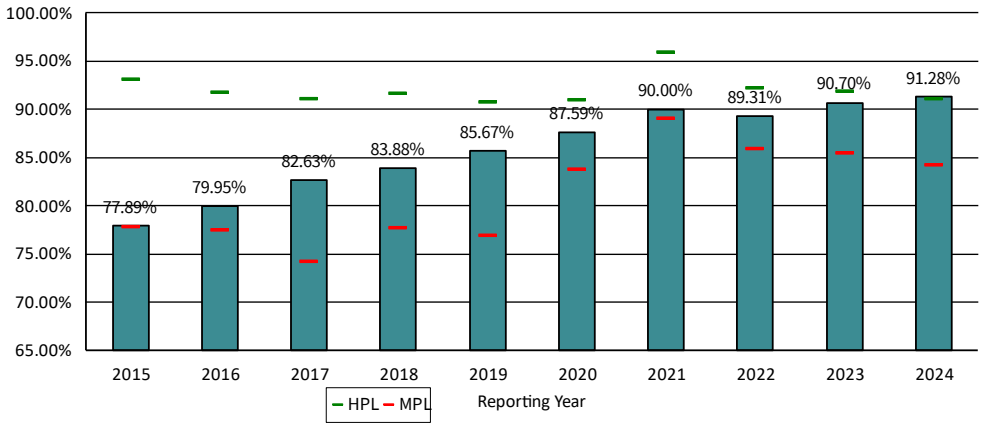
	3 to 11	12 to 17	18-21	Total
MY2020	55.64%	49.35%	28.66%	48.80%
MY2021	64.56%	59.51%	34.12%	56.92%
MY2022	59.67%	54.38%	30.93%	52.00%
MY2023	63.92%	58.10%	29.19%	54.81%

Area of Focus for 2023 and 2024

- MC benchmark P4P payment measure and included in Care Gaps P4P program
- DHCS Collaborative Sprint lead by Institute for Healthcare Improvement (IHI) to focus on improving child well visits

Prenatal Care

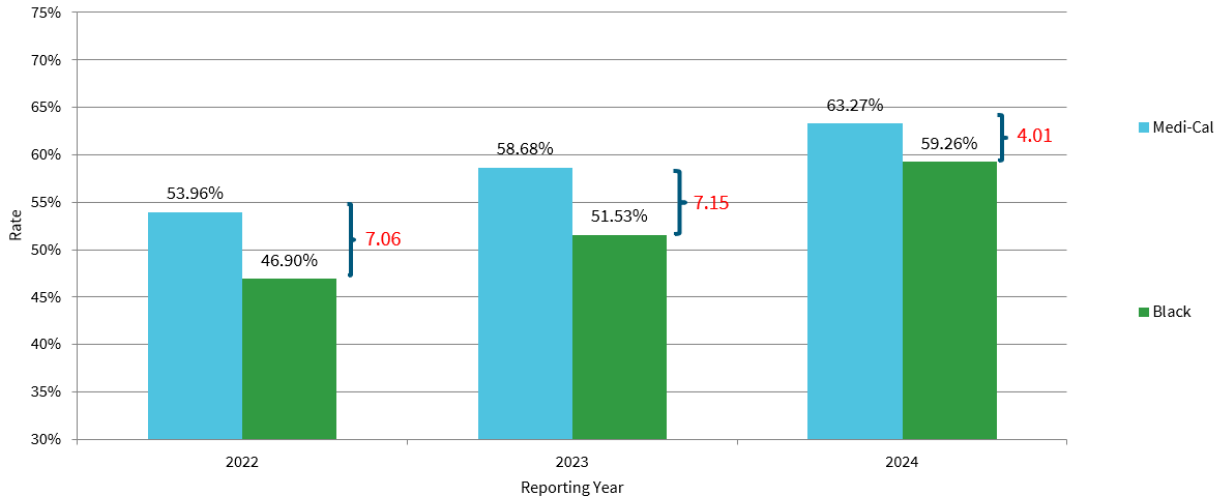
Percentage of Medi-Cal deliveries that received a prenatal care visit within the first trimester or 42 days of enrollment if the member became enrolled after the first trimester



- Baby+Me Program: Member incentives and outreach for timely initial prenatal care

Breast Cancer Screening

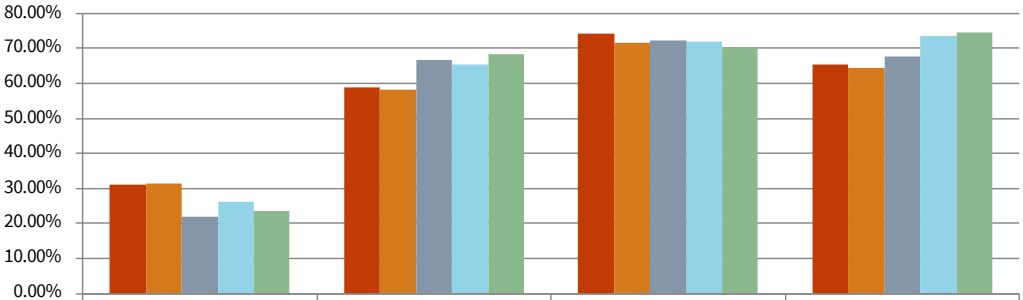
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.



- Performance improvement project (PIP) in 2022 with direct member outreach calls to Black identifying women who had not had a screening in the last two years to decrease the disparity among Black/African American identifying Medi-Cal members.
- Multiple ongoing interventions to improve cancer screening rates for adult members in 2023 and continuing in 2024

Diabetes Care

Percentage of **Medicare** members 18 - 75 years of age with diabetes who had each of the following tests or results within the measurement year (Rates by reporting year):

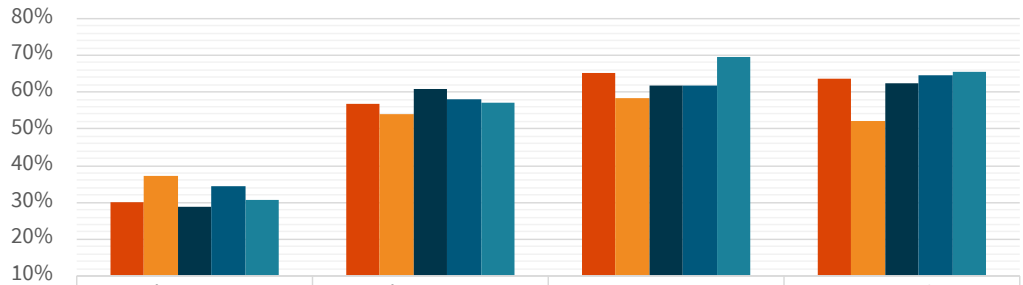


	HbA1C >9%	HbA1C <8%	Eye Exam	BP<140/90
2020	31.11%	58.77%	74.32%	65.43%
2021	31.42%	58.10%	71.57%	64.34%
2022	21.95%	66.58%	72.32%	67.83%
2023	26.15%	65.50%	71.97%	73.58%
2024	23.67%	68.35%	70.48%	74.47%

- P4P incentives to PCPs for ensuring that diabetic members have their HbA1c monitored & achieve control
- Leveraging other encounters with Medicare members to collect & monitor HbA1c and BP through home -based assessments and HomeAdvantage programs

Diabetes Care

Percentage of **Medi-Cal** members 18 - 75 years of age with diabetes who had each of the following tests or results within the measurement year (rates by reporting year):

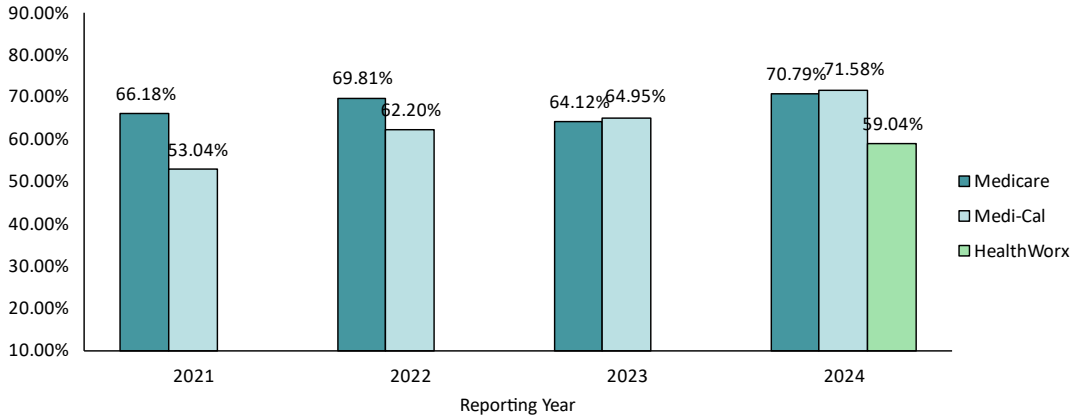


	HbA1C >9%	HbA1C <8%	Eye Exam	BP<140/90
2020	30.17%	56.69%	65.21%	63.75%
2021	37.23%	54.01%	58.39%	52.07%
2022	28.78%	60.98%	61.71%	62.44%
2023	34.43%	57.97%	61.77%	64.56%
2024	30.77%	57.07%	69.48%	65.51%

- P4P incentives to PCPs for ensuring that diabetic members have their HbA1c monitored & achieve good control, and receive an eye exam
- Current interventions with diabetes med adherence, self -management programs, and transitions of care support

Controlling High Blood Pressure

Percentage of members 18 -85 years of age with hypertension whose blood pressure was controlled (<140/90 mm Hg) during the measurement year, using latest BP value in the measurement year



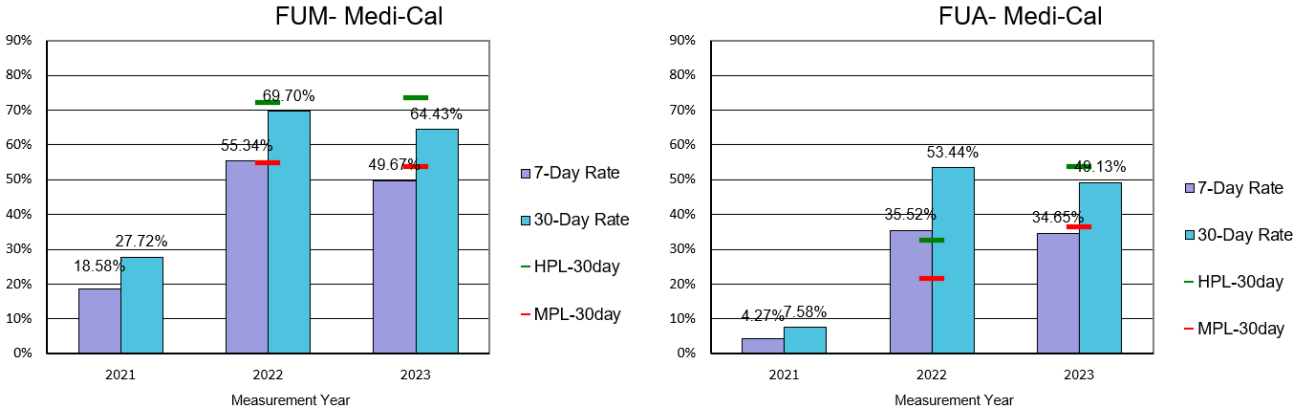
- With RY2021, BP measured with digital monitor by member can be used. Home digital BP monitors CMC formulary in 2021, and Medi -Cal Rx June 1, 2022
- Hypertension control in all PCP P4P programs

Follow-up after ED visit for Mental Health (FUM) or Substance Use (FUA)

FUM: The percentage of emergency department (ED) visits for members **6** years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

FUA : The percentage of emergency department (ED) visits among members age **13** years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

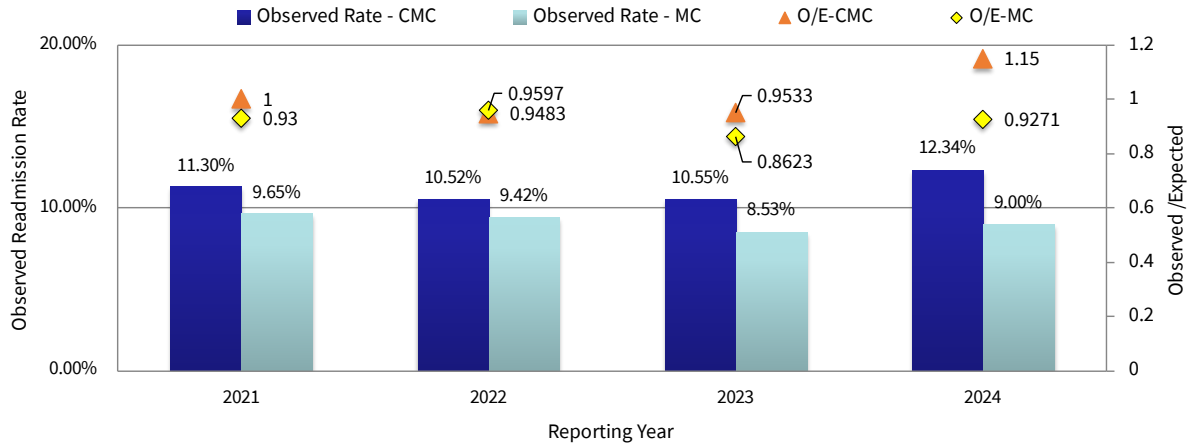
1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).



- Received encounter data from BHRS to more accurately measure report follow-up services provided to Medi-Cal members

Plan All-Cause Readmissions

Percentage of acute inpatient and observation stays with an unplanned acute inpatient and observation stay for any diagnosis within 30 days of the initial hospital discharge for members ages 18 -64 for Medi-Cal or 18+ for Medicare. All admissions from "outlier members" (4+ admissions) are excluded



- Lower rates are better

3.2 PERFORMANCE IMPROVEMENT PROJECTS (PIP'S)

PIP'S OVERVIEW

All California Medi-Cal Plans are required to participate in DHCS designated Performance Improvement Projects(PIP's). A PIP is a three year project whose purpose is to make measured improvement in a deficient area identified in Statewide HEDIS measure results. PIP's are either Clinical or Non Clinical in nature and may include an Equity component. PIP's include a baseline measurement year and two re measurement years. PIP's must include a Project Aim statement and targeted interventions to make improvement. Annual submissions to document improvement results and measure the impact of the interventions from year to year are done in the Fall of every year.

Starting in 2024, the Quality Improvement Department implemented a disparity performance improvement project (PIP) on the Well-Child Visits in the First 15 Months of Life measure which requires six or more well-child visits in the first 0 to 15 months of life. (W30 6+). In 2024, the Plan reported 2023 Baseline Year rates and implemented the intervention.

PIP Topic: Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) measure rates for the Hispanic American population.

Program Area Goal: Implement targeted interventions to improve the percentage of Hispanic members who complete 6 or more well child visits in the first 15 months of life.

Measure/Program	W30 Health Equity Clinical PIP
Program Description	Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) measure rates for the Hispanic American population.
Aim Statement:	Do targeted interventions improve the percentage of Hispanic members who complete 6 or more well child visits in the first 15 months of life?
Numerator Description	From the eligible population the number of Hispanic members who had 6 or more well-child visits with a PCP within the first 15 months of life.
Denominator Description	The eligible Hispanic population based on applicable specifications for the Measurement Year.
Baseline year and Rate	01/01/2023-12/31/2023 **61.95%**
MY 2024 Intervention	Stellar Care Gap Program Incentive
Barriers addressed	Providers not incentivized for completed outreach/scheduling/claim submission efforts in current Benchmark incentive program, only for visit completion.
MY 2024 Progress	The intervention was implemented in 02/2024. MY 2024 rate will be reported in September 2025.

Starting in 2024, the Quality Improvement Department implement a 3 year non-clinical performance improvement project (PIP) on the Follow Up after Mental Health(FUM) and /Follow Up After Substance Abuse(FUA) HEDIS Measures. In 2024, the Plan reported 2023 Baseline Year rates and implemented the intervention.

PIP Topic: Provider notifications for members with SUD/SMH diagnoses following or within 7 days of emergency department (ED) visit.

Program Area Goal: Implement a process and improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 7 days of emergency department (ED) visit.

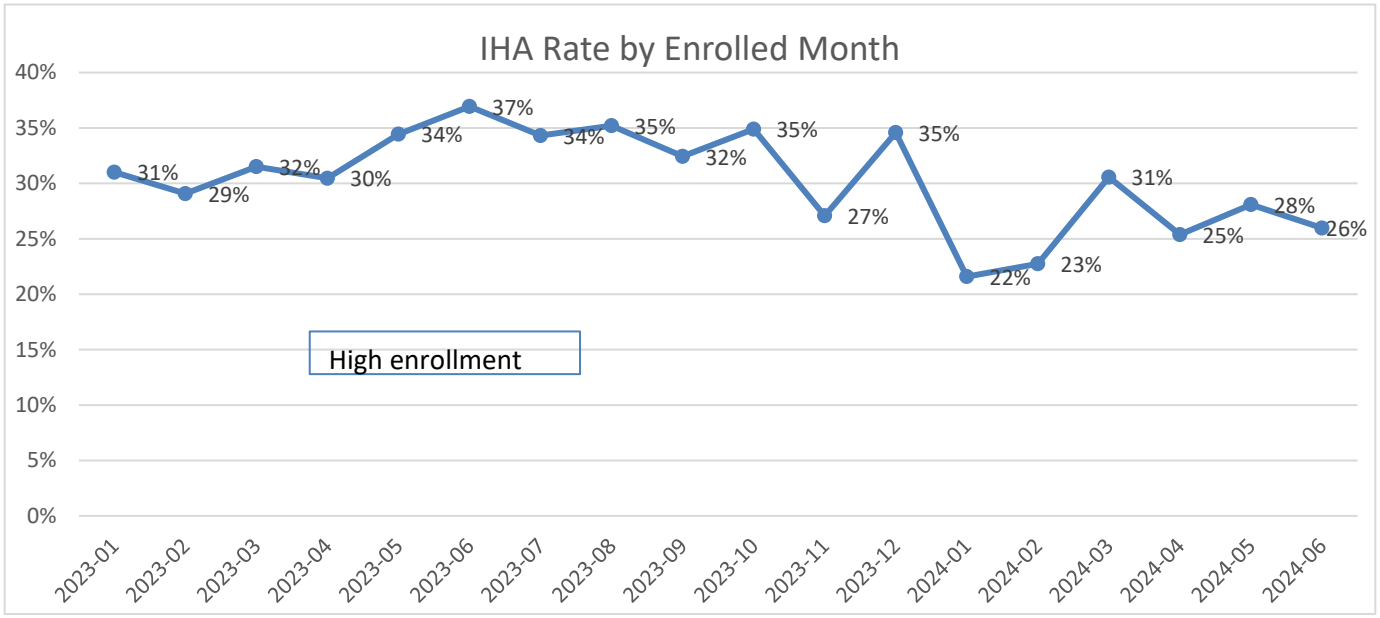
Measure/Program	FUH/FUA Non-Clinical PIP
Program Description	Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 7 days of emergency department (ED) visit.
Aim Statement:	During the measurement year, do targeted interventions improve the percentage of provider notifications, for members 6 years and older for SMH diagnosis and for members 13 years and older for substance use disorder diagnoses, following or within 7 days of emergency department (ED) visit?
Numerator Description	Notification to the PCP or BH provider of members 6 years and older for SMH diagnosis and for members 13 years and older for substance use disorder diagnoses **with** an emergency department (ED) visit with a principal diagnosis of SUD or SMH diagnoses within 7 days of the ED visit.
Denominator Description	Emergency department (ED) visits with a principal diagnosis of SUD or SMH by members 6 years and older for SMH diagnosis and for members 13 years and older for substance use disorder diagnoses in the PIP Population.
Baseline year and Rate	01/01/2023-12/31/2023- **0%**
MY 2024 Intervention	Pilot Provider notifications for members seen in one of the project Pilot Hospitals, and documented in the Point Click Software program, following or within 7 days of an emergency department (ED) visits.
Barriers addressed	No HPSM process for notification to Providers of Emergency Department Visits.
MY 2024 Progress	Intervention was implemented on 12/31/2024. 2024 rates will be reported in September 2025.

3.3 INITIAL HEALTH ASSESSMENT (IHA)

IHA OUTREACH PROGRAM DESCRIPTION

Completion of the Initial Health Appointment (IHA) is a high priority area for HPSM because receiving primary care and preventative services is important for the Medi-Cal population due to the high incidence of chronic and/or preventable illnesses found in this population. The purpose of the IHA is to enable a provider to comprehensively assess the member's chronic, acute and preventative needs and to identify patients whose needs require coordination with additional resources. The All Plan Letter (APL 22-030) requires all primary care providers to conduct an IHA to all Medi-Cal managed care patients as part of their initial and well care visits. It is required that the Health Plan reach a 100% compliance rate ensuring every member enrolled is seen by their primary care physician within the first 120 days of enrollment. HPSM measured the percentage of members with a completed IHA monthly to determine the compliance rate and to look for improvement opportunities.
The Plan did not obtain 100% compliance in 2024 and therefore performed many actions in an effort to improve the rate.

MONTHLY IHA COMPLIANCE RATES 2023-2024 GRAPH



IHA PROVIDER EDUCATION

The training manual for HPSM's provider network educated providers on the IHA requirement and the benefit of doing outreach to their new members to get them in to be seen as soon as possible. The Health Plan of San Mateo made the providers aware of the requirement of the IHA through three programs in 2024.

1. **Provider Services Outreach:** Periodic visits were done by provider service personnel to provide updates on changes to existing programs, introduce new programs, and reinforce on-going programs.

2. **Pay for Performance Program:** Monthly reports were sent to the providers detailing gaps in IHA completion rates.
3. **Medical Record Review as part of the FSR audit process:** Any deficient IHA documentation was addressed at the time of the Facility Site Review by site review nurses. Providers noncompliant or mostly noncompliant with consistent IHA completion were placed on a Corrective Action Plan.

IHA BARRIERS

In 2024 some network PCPs appeared to continue to lack awareness of the IHA requirement, particularly if they do not regularly gain many new members. From feedback from PCPs and review of medical records we discovered that providers did not create a medical record until a new patient presents for care and thus did not have a medical record to document IHA outreach attempts. Some PCPs often used other systems to track and document IHA outreach attempts that HPSM does not review to assess compliance of IHA. Other PCPs did not record their outreach attempts in a way that is readily traceable to a specific member.

IHA OUTREACH PROGRAM ACTIONS FOR 2024

HPSM struggled to increase the completion and timeliness of IHAs in 2024 and so therefore completed the following actions to improve IHA rates.

- Ensured HPSM's website contained updated information for Providers and the correct IHA training document for providers to utilize.
- Used IHA requirement attestations to be used to educate providers during Site Reviews.
- Continued pay-for-performance(P4P) monetary incentive for PCPs for timely IHA completion in 2024. Under the Benchmark P4P, IHA remained a payment metric for Family Practice and Adult track providers and reporting-only for Pediatric providers. This was based on prioritization in assigned quality metric sets. As part of P4P, monthly reports were sent to PCPs detailing level of performance.
- Incentivized three separate components: the outreach, scheduling of the IHA and timely completion of the IHA in its new Care Gap P4P Program.
- Allowed PCPs to readily view and filter for their assigned members in need of an IHA utilizing the new Care GAP P4P platform.
- Continued PCP compliance monitoring during the MRR process and issued provider correction action plans when deficiencies were found.
- Continued to include IHA reminder in new Medi-Cal member packets

4. SAFETY OF CARE & QUALITY OF SERVICES

4.1 CLINICAL GUIDELINES ANNUAL REVIEW

HPSM's Quality department lead an annual review of the clinical guidelines posted on the HPSM website. The review process ensured the posted guidelines were evidenced-based, current, and relevant to the plan's member population. The Quality Improvement team checked the date of the most recent published update for each guideline, posted by the source organizations. We prepared an annual summary of the posted guidelines for presentation to the Quality Improvement & Health Equity Committee (QIHEC) in the Fall. The summary

provided the last published date of each guideline, and included progress notes on the update status for any guideline that had not been updated within the last 5 years.

2024-2025 Clinical Guidelines and Resources were posted on our website: https://www.hpsm.org/provider/resources/guidelines.

CLINICAL GUIDELINES ANNUAL REVIEW UPDATE

Annual review and approval by Quality Improvement & Health Equity Committee (QIHEC)

The Quality department presented the annual summary of the posted guidelines to the Quality Improvement Committee at its quarterly meeting in September 2024. All additional and updated guidelines were reviewed and approved by the QIHEC.

ACTIONS FOR 2024

HPSM Quality continued to check the websites for the source organizations for updates to the guidelines posted on the HPSM website. Quality ensured that the Provider Manual maintained a hyperlink to the Clinical Guidelines page on the HPSM website. Provider Services promoted awareness of the clinical guidelines posted on the HPSM website to the provider network through news alert or article in the provider newsletter.

4.2 FACILITY SITE REVIEW (FSR) AND MEDICAL RECORD REVIEW

On September 22, 2022, the Department of Health Care Services released a new All-Plan Letter 22-017, that supersedes Policy Letters 20-006. This new APL greatly increased and changed the requirements for Facility Site Reviews (FSR) program. As stated in this letter: "The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of updates to the Department of Health Care Services' (DHCS)Primary Care Provider (PCP) site review process, which includes Facility Site Review (FSR) and Medical Record Review (MRR) policies. This APL includes changes made to the criteria and scoring of DHCS' FSR and MRR tools and standards. This APL supersedes Policy Letters (PL) 20-006 . MCPs were expected to implement updated FSR and MRR tool requirements effective July 1, 2022.

Credentialing is part of the comprehensive quality improvement system included in all Medi-Cal managed care contracts as mandated by the California Code of Regulations (CCR) Title 22, sections 53100 and 53280 and Title 10 of the California Administrative Code, beginning with section 1300.43. As one element of the QI process, credentialing ensures that physician and non-physician medical practitioners are licensed and certified in accordance with State and Federal requirements. Full scope site reviews are conducted initially during the pre-credentialing period and triennially thereafter, for primary care providers, including pediatricians, and obstetricians. These reviews are done as a requirement of participation in the California State Medi-Cal Managed Care Program, regardless of the status of other accreditation and/or certifications to assure providers are in compliance with applicable local, state, federal and HPSM standards.

HPSM conducts full scope reviews utilizing the criteria and guidelines of California Department of Health Care Services Medi-Cal Managed Care (MMCD Policy Letter 22-017 dated September 22, 2022 or any superseding Policy Letter). HPSM may also address additional requirements as appropriate for quality studies. A passing Site

Review Survey shall be considered “current” if it is dated within the last 3 years and need not be repeated until the due date of the next scheduled site review survey or when determined necessary through monitoring activities by the plan.

The schedule for performing facility site review is determined by the Quality Management staff and the prospective provider. It is based on the prospective credentialing date, as well as provider availability and preference. Site reviews for continuing providers are scheduled and performed within three years of the provider’s last site review in compliance with criteria and guidelines of a full scope review is conducted utilizing the criteria and guidelines of California Department of Health Care Services Medi-Cal Managed Care (MMCD Policy Letter 22-017 Dated September 22, 2022 , or superseding Policy Letter) Full Scope Site Review Survey 2022 and Medical Record Survey Tool 22022

Providers who move to a new site must undergo a full scope site review unless the site has been reviewed with a passing score within the last three years (MMCD PL 22-017). The site review must be completed as soon as possible after the provider’s move to the site or the provider’s notice to HPSM (whichever is later), and not later than 30 calendar days after the date the new site was opened for business or HPSM’s notification date. A minimum passing score of 80% on both the site review and medical record review survey is required for a provider to continue as an HPSM provider in good standing. If critical elements of deficiencies are identified, a score in any section of the site or medical record review scores below 90%, or there is a deficiency in pharmacy or infection control, or an overall score below 90%, then a corrective action plan (CAP) is required to be completed by the provider as part of compliance with their HPSM contract.

HPSM reviews sites more frequently when determined necessary based on monitoring, evaluation or corrective action plan (CAP) follow-up needs. Additional site reviews may be performed at the discretion of the CMO or designated Medical Director, using input from the certified site review nurses, if patient safety or compliance with applicable standards is in question. The same audit criteria applicable for initial full scope site reviews are applicable for subsequent site reviews. Deficiencies identified during the review may be referred to provider services for action and follow up.

In 2024, HPSM completed 17 FSRs and 24 MRRs, which eliminated the backlog from prior years due to the public health emergency in 2020-2022. Following the Site Reviews, 7 of the providers/sites received a CAP for either the MRR or FSR, or both. Six (6) CAPs were closed successfully and timely according to regulatory requirements; one (1) provider/site CAP is pending closure within the timeframe standards

Common Deficiencies identified in Facility Site Review:

- **Expired Medications and Medical Equipment:** Expired medications and medical equipment were observed on-site, including but not limited to oxygen tubing, irrigation equipment, gauze, syringes, and lab equipment. Additionally, written policies or procedures for documenting medication expiration were not available.
- **Outdated or Expired Scope of Practice Agreement for Physician Assistants:** The Scope of Practice agreement for Physician Assistants was either outdated or had expired. Furthermore, there was no evidence to indicate that the Scope of Services/Practice had been reviewed or updated as required.
- **Incomplete/Unsigned Employee Training Documentation:** Employee training documentation was found to be incomplete or unsigned in several instances, indicating a lack of thorough recordkeeping and potential gaps in employee training verification.

- **Non-Compliant Drug/Vaccine Storage Units:** Drug and vaccine storage units were found to be non-compliant with the required standards, which could potentially compromise the safety and effectiveness of the stored medications.

Critical Elements in the Facility Site Review identified were the following:

- **Missing Staff Training Documentation:** There was a lack of documented staff training, indicating insufficient evidence that site personnel are properly qualified and trained for their assigned responsibilities.
- **Missing Sterilization Logs for Reusable Medical Instruments:** There were no available logs or documentation to verify that reusable medical instruments are properly sterilized after each use, raising concerns about infection control practices.
- **Infrequent Spore Testing of Autoclave/Steam Sterilizer:** Spore testing of the autoclave/steam sterilizer, including documented results, is not being conducted at least on a monthly basis as required for ensuring proper sterilization and infection control.
- **Inconsistent Mask Seal Checks During Emergency Medication and Equipment Inspections:** The condition of the seals on both adult and pediatric masks is not being checked on a monthly basis as part of the Emergency Medication and Equipment checks, which could potentially compromise the effectiveness of these emergency supplies.

Common Deficiencies identified in Medical Record Review

- **Documentation of Primary Language and Linguistic Needs:** The primary language and linguistic needs of patients were not consistently documented. Additionally, there was missing documentation regarding the offering of interpreter services and the identification of the interpreter when necessary.
- **Advance Care Directives:** There was no documentation indicating that Advance Care Directives were offered or discussed with patients. Furthermore, these directives were not completed by members, nor were they updated every five years as required.
- **Adult Immunizations Not Administered According to Guidelines:** Adult immunizations were not consistently administered in accordance with established guidelines, potentially leading to gaps in patient care and preventative health.
- **Missing Required Screenings:** Several required screenings were either not performed or not properly documented. These screenings include, but are not limited to: Tuberculosis, Hepatitis B/C Virus, Breast Cancer, Cervical Cancer, Colorectal Cancer, Osteoporosis, Blood Lead, Sudden Cardiac Arrest and Cardiac Death, HIV Infection, and Sexually Transmitted Infection screenings.
- **Fluoride Varnish and Supplementation:** Fluoride varnish was neither performed nor documented for eligible patients, and fluoride supplementation was inconsistently documented.
- **Missing Documentation of Folic Acid Supplementation:** There was missing documentation indicating that folic acid supplementation was provided to women of reproductive age.
- **Skin Cancer Behavioral Counseling:** There was a lack of documentation regarding Skin Cancer Behavioral Counseling for parents aged 24 and below with young children, as recommended.
- **Use of Validated Screening Tools:** Required validated screening tools were not used for the following screenings:
    - **Alcohol Use Disorder and Behavioral Counseling:** CAGE, CRAFFT, AUDIT, DAST, DAST-20, ASSIST, NM-ASSIST, NIDA, TAPS

- **Depression Screening:** PHQ, Hospital and Anxiety Depression Scales in Adults, Geriatric Depression Scale in Older Adults, Edinburgh Postnatal Depression Scale (EPDS)
- **Drug Use Disorder and Behavioral Counseling:** CAGE, CRAFFT, AUDIT, DAST, DAST-20, ASSIST, NM-ASSIST, NIDA, TAPS
- **Intimate Partner Violence Screening for Women of Reproductive Age (12-49 years):** HARK, HITS, E-HITS, PVS, WAST

FSR ACTIONS FOR 2024

- **Ongoing Compliance with FSR/MRR Completion and Regulatory Changes**: Continued with the established processes for completing FSR (Facility Site Reviews) and MRR (Medical Record Reviews). Additionally, implemented new processes necessary to comply with regulatory changes affecting the Site Review tools and standards.
- **Development and Distribution of Educational Materials:** Created additional educational materials to be posted on the FSR page of HPSM's website and distributed to providers. These materials included, but were not limited to, a Required Staff Trainings Packet, Adult Screenings, and Pediatric Screenings (with a focus on new DHCS-required screenings). Additionally, they guided providers to access resources on the HPSM website for information on FSR/MRR completion and Corrective Action Plans. This initiative will assist in reducing deficiencies in future FSRs and MRRs and ensure providers maintain full compliance.
- **Collaboration with Managed Care Health Plans:** Continued collaborating with other managed care health plans to enhance site review operations. Exchanged site review results for shared providers to promote consistency, improve quality assurance, and facilitate continuous improvement across all participating health plans.
- **Provider Education on Validated Screening Tools and New Survey Requirements:** Educated providers on the required validated screening tools and the new survey standards. Ensured the distribution of educational materials to providers prior to the scheduled site review to support their preparedness and success in meeting the requirements.
- **Facility Site Review Data Management System:** Brought on a Facility Site Review (FSR) Data Management vendor that offered an organized and integrated system for the collection, management, and analysis of data related to Site Review Surveys of our Primary Care Provider (PCP) facilities. The vendor's system supported our ongoing efforts to ensure compliance with regulatory standards and quality assurance practices.
- **Filled Open Positions and Completed Certification Trainings**: Ensured the timely filling of open positions and completion of the required Certification in Site Review (CSR) for relevant staff

4.3 PHYSICAL ACCESSIBILITY REVIEW (PAR)

Department of Health Care Services Policy Letter 12-006 and All Plan Letter 15-023 requires Medi-Cal managed care health plans to use PAR attachments C, D and E appropriate to their provider type in line with the three-year cycle requirement of FSR attachments A and B.

Attachment C is used for physical accessibility review of PCP's, typically conducted concurrently with the FSR and MRR. Once the initial PARS for the PCP has been conducted, the next 2 triennial PARS can be assessed via attestation indicating no changes have occurred, or noting any additions, such as height adjustable exam table.

If the provider has moved to a new location since the initial PARS was performed, a full PARS would be initiated within 30 days of the relocation, in conjunction with the Facility Site Review.

Attachment D documents accessibility requirements for providers of ancillary services,: free-standing facilities that provide diagnostic and therapeutic services. Examples include, but are not limited to, centers for dialysis, radiology, imaging, cardiac testing, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, and pulmonary testing.

Lastly, attachment E is for community-based adult services (CBAS) and includes all facilities that provide bundle CBAS services but does not include licensed only adult daily health care center and programs.

Attachment C, D and E have accessibility indicator symbols that determine the level of accessibility. If a provider's office or site meets all critical elements (CE), they will have "Basic Access." If they miss one or more CE then they will have "Limited Access." If they meet all medical equipment guidelines then they will have "Medical Equipment Access." Accessibility indicator symbols are the following:

Accessibility Indicator Symbols
P= Parking
EB= Exterior Building
IB= Interior Building
R= Restroom
E= Exam Table
T=Medical Equipment
PD=Patient Diagnostic and Treatment Use
PA= Participant Areas

A total of 19 PCP Physical Accessibility Reviews (PAR) were done for 2024

Below is the break down for 2024 :

Level of Access:	**# of PCP/Hospital**
Basic Access	7
Basic Access/ Medical Equipment	2
Limited Access	9
Limited Access/Medical Equipment	1
No Access	0

A total of 4 CBAS Physical Accessibility Reviews (PAR) were done for 2024

Level of Access:	**# of CBAS**
Basic Access	4
Limited Access	0

The plan did not encounter barriers or issues meeting the PAR policy objectives. No corrective action plan was required for providers/facilities that did not meet the level of access. Recommendations may be made to meet the highest level of accessibility, but it was not a requirement.

The goal was to continue to provide the PAR results of access level and the accessibility indicators so that our SPD members can identify, by using the provider directory, a facility that best fits their physical needs. The focus was continued to keep all providers sites, ancillary and CBAS up to date with any physical changes to the parking, exterior building, interior building, restroom, exam room, medical equipment, participant areas, patient diagnostic and treatment use.

4.4 POTENTIAL QUALITY ISSUE (PQI) MONITORING

A Potential Quality Issue (PQI) is a suspected deviation from expected provider performance or clinical care, as well as issues with the outcome of care which requires further investigation to determine whether an actual quality issue or opportunity for improvement exists. The PQI process is employed to determine opportunities for improvement in the provision of care and services for HPSM members and to initiate appropriate actions for improvement based upon outcome, risk, frequency, and severity.

92 PQI/Quality of Care Reviews were adjudicated in 2024
Final counts by PQI Level

Row Labels	Count
P0/S0	42
P0/S1	18
P0/S2	7
P1/S0	10
P1/S1	7
P2/S0	5
P2/S1	1
P3/S0	1
P3/S2	1
Grand Total	**92**

4.5 QUALITY MONITORING ACTIVITIES

In accordance with regulatory requirements and guidance, the QI team maintains quality oversight for services provided to HPSM Medi-Cal members at the following Medi-Cal contracted facilities:

1. Skilled Nursing Facilities/Long Term Care Facilities including Intermediate Care Facilities/Home For Individuals With Developmental Disabilities
2. Regional Centers
3. Subacute Facilities

In 2024 the following activities were completed:

- The PQIs received for the aforementioned facilities were cross-referenced with data from the California Department of Public Health (CDPH) using the California Health Facility Information Database (Cal Health Find). This database includes various information, such as performance history, complaints, facility-reported incidents, state enforcement actions, and audit deficiencies. After analyzing the data, no significant trends were found between the information received from the CDPH and the nature of the PQIs. These findings were shared with the CQC for further review.
- The Quality Improvement (QI) Team met with the SMC Ombudsman to address quality of care concerns for members residing in Skilled Nursing Facilities (SNFs) and Long-Term Care (LTC) settings. As a result, a workgroup was established to begin meeting in January 2025. The workgroup's focus will be on identifying and reporting quality of care concerns via various channels such as PQIs, grievances, and other mechanisms. The group will convene quarterly and will include representatives from QI, G&A, Provider Services (PS), Utilization Management (UM), as well as the SMC Ombudsman.

5. MEMBER EXPERIENCE & HEALTH OUTCOMES

5.1 HEALTH OUTCOMES SURVEY (HOS)

This Healthcare Effectiveness Data and Information Set (HEDIS®) a Health Outcomes Survey (HOS) Effectiveness of Care Report (HEDIS HOS Report) presents the HEDIS HOS results for HPSM based on data from the HOS Round 26 survey (Cohort 26 Baseline) collected in 2023 (MY2023/RY 2024)).

If a Plan does not achieve a denominator of at least 100 responses, the rates are reported as not applicable (NA) in their tables.

The Cohort 26 Baseline HOS survey was fielded from July through November 2023 and there are no previous year data(Follow-Up) available for year to year comparisons as this is the first report available for HPSM's Medicare Advantage plan.

HPSM participated in the Medicare Health Outcomes Survey (HOS) to gather valid, reliable, and clinically meaningful health status data for the CareAdvantage program to use in quality improvement activities, pay for performance, program oversight, public reporting, and to improve health (https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HOS/).

This self-report survey of plan members was conducted in English, Spanish, & Chinese. Baseline results of HOS are intended to help plans identify potential areas for improvement and evaluate the physical and mental

health of members. The reporting is done within specific cohorts with a follow-up 2 years later. This was the first HOS report for HPSM's Medicare Advantage Plan (CareAdvantage).

The following topics were covered in the survey:

- Health Status Measures
  - Physical (PCS) & Mental (MCS)Component Summary Scores
- Effectiveness of Care (HEDIS) measures
  - Fall Risk Management (FRM)
    - Discussing Fall Risk: 65+ with visit in past 12 months, discussed falls or problems with balance or walking with their current practitioner.
    - Managing Fall Risk: 65+ who had a fall or had problems with balance or walking in the past 12 mos, who were seen by a practitioner is past 12 mos and who received a recommendation for how to prevent falls or treat problems with balance or walking.
  - Physical Activity in Older Adults (PAO)
    - Discussing Physical Activity: 65+ with visit in past 12 months, spoke with doctor/health provider about their level of exercise or physical activity.
    - Advising Physical Activity: 65+ with visit in past 12 months, received advice to start, increase or maintain their level of exercise or physical activity.
  - Management of Urinary Incontinence in Older Adults (MUI)
    - Discussing Urinary Incontinence: 65+ reported having urine leakage in the past 6 months who discussed their urinary leakage problem with a health care provider.
    - Treatment of Urinary Incontinence : Discussed treatment options for urinary incontinence with healthcare provider.
    - Impact of Urinary Incontinence: Reported that urine leakage made them change their daily activities or interfered with their sleep a lot.

HOS included the following in HEDIS results:

- Monitoring Physical Activity
- Reducing the Risk Of Falling
- Improving Bladder Control

The following were used for Star Measures:

Measure	***Type***
Monitoring Physical Activity (HEDIS HOS)	Star Ratings
Reducing the Risk of Falling (HEDIS HOS)	Star Ratings
Improving Bladder Control (HEDIS HOS)	Star Ratings
Improving or Maintaining Mental Health (HOS)	Display Only
Improving or Maintaining Physical Health (HOS)	Display Only
Physical Functioning Activities of Daily Living (HOS)	Display Only

Cohort 26-Star Cut Points for 2023

	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MUI	< 39 %	>= 39 % to < 44 %	>= 44 % to < 48 %	>= 48 % to < 52 %	>= 52 %
PAO	< 41 %	>= 41 % to < 47 %	>= 47 % to < 52 %	>= 52 % to < 60 %	>= 60 %
FRM	< 50 %	>= 50 % to < 56 %	>= 56 % to < 63 %	>= 63 % to < 73 %	>= 73 %

Cohort 26-Results for 2023

Plan Score Comparisons against State/Region/National Rates

Table 1: 2023 HEDIS HOS Rates for MAO H6019, California, CMS Region 9, and HOS Total†

	MUI Discuss Rate	MUI Treat Rate*	MUI Impact Rate	PAO Discuss Rate	PAO Advise Rate*	FRM Discuss Rate	FRM Manage Rate*
H6019	NA	49.00%	30.69%	63.24%	65.28%	31.63%	76.52%
California	57.43%	44.48%	18.19%	58.79%	53.74%	25.73%	58.36%
CMS Region 9	58.49%	44.48%	17.99%	57.74%	51.53%	26.27%	57.14%
HOS Total	59.90%	45.03%	15.35%	55.85%	49.37%	27.60%	56.76%

†See Table 3 results for all MAOs in the state.

* Measures incorporated into the 2025 Medicare Star Ratings include the MAO 2023 *Improving Bladder Control* (MUI Treat Rate), *Monitoring Physical Activity* (PAO Advise Rate), and *Reducing the Risk of Falling* (FRM Manage Rate).

Plan Score Year to Year Comparisons (TBD-No previous year data)

Table 2: Trends in HEDIS HOS Rates over Three Rounds of Data for MAO H6019

	MUI Discuss Rate	MUI Treat Rate*	MUI Impact Rate	PAO Discuss Rate	PAO Advise Rate*	FRM Discuss Rate	FRM Manage Rate*
2023 Round 26	NA	49.00%	30.69%	63.24%	65.28%	31.63%	76.52%
2022 Round 25	NA	NA	NA	NA	NA	NA	NA
2021 Round 24	NA	NA	NA	NA	NA	NA	NA

* Measures incorporated into the 2025 Medicare Star Ratings include the MAO 2023 *Improving Bladder Control* (MUI Treat Rate), *Monitoring Physical Activity* (PAO Advise Rate), and *Reducing the Risk of Falling* (FRM Manage Rate).

Plan Historical Scores(As Medi-Medi Plan)

Table 2: Trends in HEDIS HOS Rates over Three Rounds of Data for MAO H7885

	MUI Discuss Rate	MUI Treat Rate*	MUI Impact Rate	PAO Discuss Rate	PAO Advise Rate*	FRM Discuss Rate	FRM Manage Rate*
2022 Round 25	64.71%	48.08%	30.10%	64.16%	61.86%	34.93%	76.97%
2021 Round 24	64.38%	51.25%	32.70%	68.36%	66.58%	36.13%	74.32%
2020 Round 23	62.70%	44.53%	31.20%	57.35%	63.44%	31.65%	77.65%

* Measures incorporated into the 2024 Medicare Star Ratings include the MAO 2022 *Improving Bladder Control* (MUI Treat Rate), *Monitoring Physical Activity* (PAO Advise Rate), and *Reducing the Risk of Falling* (FRM Manage Rate).

Improving or Maintaining Physical Health (PCS) and Improving or Maintaining Mental Health (MCS) 2023 scores

Table 1: 2023 Cohort 26 Baseline Mean Unadjusted and Adjusted PCS and MCS Scores for MAO H6019, California, and HOS Total†

	Unadjusted PCS Score (SD)	Adjusted PCS Score (SD)	Unadjusted MCS Score (SD)	Adjusted MCS Score (SD)
H6019	35.8 (11.6)	37.4 (5.8)	49.2 (12.3)	49.7 (5.3)
California	39.8 (12.2)	39.7 (5.8)	51.8 (11.1)	52.1 (5.3)
HOS Total	39.4 (12.5)	39.4 (6.1)	52.9 (10.8)	52.9 (5.4)

The baseline PCS and MCS scores are case-mix adjusted to allow for equitable comparisons across all MAOs. For the 2023 HOS national sample, a mean PCS score of 39.4 and a mean MCS score of 52.9 were calculated.

PFADL Scale 2023 Scores

The PFADL scale combines two VR-12 physical functioning questions (limitations in moderate activities and climbing stairs) with the six ADL questions to create a Likert-type scale, which ranges from 0-16. The unadjusted PFADL scale score is the sum of the points from the 8 items; the score ranges from 0 to 16, where a higher score is better.

Table 10: 2023 Cohort 26 Baseline Mean PFADL Scale Scores for MAO H6019, California, and HOS Total

	Mean PFADL Scale Score
H6019	12.05
California	13.25
HOS Total	13.27

Table 11: 2023 Cohort 26 Baseline Distribution of Mean PFADL Scale Scores for MAO H6019, California, and HOS Total

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
H6019	12.05	3.56	6.00	10.00	13.00	15.00	16.00	0.00	16.00
California	13.25	3.05	9.00	12.00	14.00	16.00	16.00	0.00	16.00
HOS Total	13.27	2.99	9.00	12.00	14.00	16.00	16.00	0.00	16.00

Note: If no members reported for this measure, the result is *not applicable* (NA). If there was only one MAO in the state, the standard deviation (SD) for the state was *not calculated* (NC).

Table 10: *2020-2022 Cohort 23 Performance Measurement* Mean PFADL Scale at Baseline and Follow Up and Change Score Measure Results for MAOs in the state, California and HOS Total

	Mean PFADL Scale at Baseline	Mean PFADL Scale at Follow Up	PFADL Change Score
H7885	12.57	12.07	89.17
California	13.50	13.09	93.09
HOS Total	13.71	13.39	94.43

Note: If no members reported for these measures, the results are *not applicable* (NA).

- The PFADL scale combines two VR-12 physical functioning questions (limitations in moderate activities and climbing stairs) with the six ADL questions to create a Likert-type scale, which ranges from 0-16.
- Measure of percent of function retained by member over two years
- Higher score is better, indicating little decline in function
- At the national level, the mean PFADL change score is 94.43, with a minimum of 70.76 and maximum of 100. The top 25% of MAOs had scores of 96.84 or greater, while 25% had scores of 92.84 or lower. Ten percent of MAOs had scores of 98.15 or higher, and 10% had scores of 89.91 or lower.

➢ **HPSM's PFADL Change Score ranks in the lower 10th percentile**

MUI 2023 Scores

Table 5: Discussing Urinary Incontinence Rate for California, CMS Region 9, and HOS Total

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
California	57.43	5.03	51.47	53.38	57.76	61.45	63.64	47.37	65.05
CMS Region 9	58.49	5.61	51.02	53.40	59.93	62.56	65.08	47.37	68.69
HOS Total	59.90	5.68	53.15	56.31	59.81	63.06	67.06	41.82	81.76

Note: If there was only one MAO in the state, the standard deviation (SD) for the state was *not calculated* (NC); and the 10th (P10), the 25th (P25), 50th (Median), 75th (P75), and 90th (P90) percentiles, and minimum and maximum rates will equal the MAO's rate. If the number of responses in the denominator for the MAO rate was less than 100, the HEDIS HOS rate was *not applicable* (NA). If the rates for all MAOs in a state were NA, the HEDIS HOS rate was also NA for the state. Statistics for State and Region were *not applicable* (NA) for Regional Preferred Provider Organizations (RPPO) and Private Fee-for-Service (PFFS) contracts.

Table 6: Treatment of Urinary Incontinence Rate for California, CMS Region 9, and HOS Total

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
California	44.48	4.82	37.88	40.41	45.50	47.59	49.48	31.55	52.54
CMS Region 9	44.48	5.02	37.84	41.75	45.39	48.11	50.58	31.55	52.69
HOS Total	45.03	5.03	38.46	41.98	45.12	48.31	51.30	30.07	63.13

Please see the note accompanying HEDIS Table 5 above for the meaning of NC and NA.

Table 7: Impact of Urinary Incontinence Rate for California, CMS Region 9, and HOS Total

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
California	18.19	6.86	10.96	13.33	16.10	21.24	30.69	9.59	33.33
CMS Region 9	17.99	6.44	10.79	12.74	17.19	21.49	27.88	8.50	33.33
HOS Total	15.35	6.98	8.15	10.38	13.36	19.35	25.85	4.06	42.68

Please see the note accompanying HEDIS Table 5 above for the meaning of NC and NA.

PAO 2023 Scores

Table 9: Advising Physical Activity Rate for California, CMS Region 9, and HOS Total

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
California	53.74	5.37	46.34	50.93	53.50	57.72	60.85	44.16	65.28
CMS Region 9	51.53	5.37	45.21	46.87	51.67	54.93	58.74	39.02	65.28
HOS Total	49.37	6.25	41.54	45.40	49.62	53.46	56.47	30.13	72.57

Table 8: Discussing Physical Activity Rate for California, CMS Region 9, and HOS Total

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
California	58.79	7.57	49.13	54.45	59.11	63.44	68.97	43.78	76.39
CMS Region 9	57.74	6.72	49.13	53.01	57.24	62.76	67.54	43.78	76.39
HOS Total	55.85	7.21	46.34	51.25	55.75	60.76	65.05	34.64	76.66

Please see the note accompanying HEDIS Table 5 for the meaning of NC and NA.

FRM 2023 Scores

Table 11: Managing Fall Risk Rate for California, CMS Region 9, and HOS Total

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
California	58.36	8.17	47.91	50.49	57.01	63.64	70.10	47.57	76.80
CMS Region 9	57.14	7.26	49.38	51.35	55.64	60.68	65.36	46.73	76.80
HOS Total	56.76	8.51	47.57	50.71	55.59	61.22	67.97	37.14	88.98

Please see the note accompanying HEDIS Table 5 for the meaning of NC and NA.

Table 10: Discussing Fall Risk Rate for California, CMS Region 9, and HOS Total

	Mean	SD	P10	P25	Median	P75	P90	Min	Max
California	25.73	4.69	21.50	22.55	25.34	27.46	29.18	17.65	44.86
CMS Region 9	26.27	4.61	21.89	22.67	25.69	28.85	32.18	17.65	44.86
HOS Total	27.60	5.40	22.24	24.07	26.67	29.88	34.84	14.01	52.36

Please see the note accompanying HEDIS Table 5 for the meaning of NC and NA.

HOS HEDIS 2023 Scores

Table 4: 2023 HEDIS HOS Performance Measures for MAO H6019

HEDIS HOS Measure	Numerator	Denominator	Percentage
MUI			
Discussing Urinary Incontinence	65	98	NA
Treatment of Urinary Incontinence*	49	100	49.00%
Impact of Urinary Incontinence	31	101	30.69%
PAO			
Discussing Physical Activity	172	272	63.24%
Advising Physical Activity*	188	288	65.28%
FRM			
Discussing Fall Risk	93	294	31.63%
Managing Fall Risk*	101	132	76.52%

* Measures incorporated into the 2025 Medicare Star Ratings include the MAO 2023 *Improving Bladder Control* (MUI Treat Rate), *Monitoring Physical Activity* (PAO Advise Rate) and *Reducing the Risk of Falling* (FRM Manage Rate).
Values are provided to the second decimal place for the Star Ratings. HEDIS names are abbreviated in this table. If the denominator for the MAO was less than 100 responses, NCQA assigned a result of *not applicable* (NA).

5.2 CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS) SURVEY

The CAHPS survey is a member experience survey conducted annually for CMC and Medi-Cal members and is conducted in the first half of the year and measures member experiences in the previous 6 months. The Medicare survey sample is drawn from all members who have been enrolled for at least 6 months, living the U.S. and not in an institutional setting. The Medi-Cal 2024 survey includes both adult and child members. HSPM conducts separate annual CAHPS surveys for its Medicare members. The surveys are mailed in English and Spanish with a follow up telephone call.

2024 Medicare CAHPS SURVEY SUMMARY

The response rate was 39.2%, which is a slight increase when compared to the 2023 response rate of 35%. Most questions are answered using a 0 (worst) to 10 (best) scale **or** a “never, sometimes, usually, always” scale.

CAHPS MEDICARE SURVEY RESULTS

Member Experience with Health Plan Measures	Mean Score	Base Group	Statistical Significance	Reliability	Number of Stars	Star Rating
Domain Rating: Member Experience with Health Plan	Data Not Available	Data Not Available	Data Not Available	Data Not Available	2	★★
Getting Needed Care	75	1	Below Average	Good	1	★
Getting Appointments and Care Quickly	74	1	Below Average	Good	1	★
Rating of Health Care Quality	85	3	No Discernible Difference	Good	3	★★★
Rating of Health Plan	86	3	Below Average	Good	2	★★

Member Experience with Health Plan Measures	Mean Score	Base Group	Statistical Significance	Reliability	Number of Stars	Star Rating
Customer Service	88	2	Below Average	Good	2	★★
Care Coordination	82	1	Below Average	Good	1	★

Member Experience with Drug Plan Measures	Mean Score	Base Group	Statistical Significance	Reliability	Number of Stars	Star Rating
Domain Rating: Member Experience with Drug Plan	Data Not Available	Data Not Available	Data Not Available	Data Not Available	3	★★★
Getting Needed Prescription Drugs	86	1	Below Average	Good	1	★
Rating of Drug Plan	87	4	No Discernible Difference	Good	4	★★★★

For this response, survey participants were asked whether they received a flu vaccination recently (yes or no). The table below shows HPSM's percentage of "yes" responses, and the national average for all MA contracts. HPSM scored well on the flu vaccine measure well above the National CMS average.

Vaccine Measure	Mean Score	Base Group	Statistical Significance	Reliability	Number of Stars	Star Rating
Annual Flu Vaccine	83	5	Above Average	Good	5	★★★★★

2024 Medi-Cal CAHPS SURVEY SUMMARY

See APPENDIX B: RY2024/MY2023 MEDI-CAL CAHPS SURVEY RESULTS

5.3 GRIEVANCES AND APPEALS

The Grievances & Appeals Report representing data from 2023, was presented to the HPSM Consumer Advisory Committee. The report provided Health Plan of San Mateo's (HPSM) Consumer Advisory Committee with an overview of the volume and type of complaints received from HPSM members, as well as whether the Grievance and Appeals (G&A) Unit is addressing these complaints in a timely manner. Throughout this report, the term "complaints" refers to both grievances and appeals. Specifics regarding the following areas can be found in the attached report:

- Methodology
- Rates of Complaints per 1,000 Members
- Timeliness of Complaint Resolution

- Results, Analysis, Barriers and Proposed Actions by LOB
    - CareAdvantage/Cal-Mediconnect (CA-CMC)
    - Medi-Cal (MC)
    - Healthy Kids, HealthWorx, ACE & CCS
- Primary Care Provider (PCP Changes by Provider)

See Appendix C. HPSM Consumer Advisory Committee Grievance & Appeals Report

6. SUMMARY OF EFFECTIVENESS 2024

Adequacy of QI Program Resources	Securing adequate resources to support QI activities remained a focus in 2024. It was a challenge to retain adequate staff in the QI RN roll, and it remained open at the close of 2024. HPSM continues to actively recruit for this role in 2025. QI Department staff focus on clinical quality monitoring, evaluation and reporting functions and may lead quality improvement initiatives across organizational teams. However, quality improvement program implementation and ongoing administration continues to be integrated through the various operational units of HPSM. This allows for a more robust and sustainable QIHE Program that will lead to substantial improvement in health outcomes for our members.
QIHE Committee Structure	The QIHE committee structure was not significantly changed in 2024. The Quality Improvement & Health Equity Committee (QIHEC) continues to provide a forum for HPSM to report out program activities. The committee continues to serve as an advisory role in our QI programming in 2024 and actively participates in discussions regarding opportunities for improvement, data analysis, intervention planning and evaluation. The QIHEC met quarterly in 2024. The QIHEC met quorum for each meeting, and total committee membership increased to 6 members. HPSM is actively recruiting additional members to the QIHEC to include up to 8 total committee members. The QIHE Committee Structure itself has been successful at achieving its purpose and will continue.
Practitioner Participation and Leadership Involvement	The CMO has direct oversight of the Quality Improvement Department in addition to Utilization Management, Pharmacy, and Dental units and Medical Directors. In addition to the practitioners that sit on the QIHE Committee and HPSM's CMO, HPSM has three Medical Directors with differing areas of expertise including Obstetrics & Gynecology, Gerontology and Primary Care, and a Dental Director. This structure continued throughout 2024. Our CMO and Dental and Medical Directors are heavily involved with QIHE Program activities and provide their clinical expertise throughout our intervention planning and evaluation process as well as ongoing clinical quality and patient safety monitoring. They also provide very valuable feedback and suggestions for improvement from the provider perspective on various initiatives. This is done both through their individual participation in various project meetings as well as the Clinical Quality Committee.

	Similarly, leadership involvement in the QIHE Program happens both from individual's participation in various QIHE activities as well as through the QIHE Committees including the Quality Improvement & Health Equity Committee (QIHEC) and Clinical Quality Committee (CQC). Management participation from several HPSM Departments participate in these committees and include representation from the following departments: • Pharmacy • Utilization Management • Population Health • Integrated Care Management • Behavioral Health • Provider Services • Quality Improvement • Dental This current structure supports practitioner participation and leadership involvement in QIHE Program Activities and will continue in 2025.
Summary	The current level of resources for quality improvement, leadership and practitioner involvement and committee structure supports the Quality Improvement & Health Equity Program in meeting its objectives. Expanding the current membership of the QIHEC is recommended to enhance and diversify its advisory capacity particularly in addressing health equity.

APPENDIX A. MANAGED CARE ACCOUNTABILITY SET (MCAS) RESULTS TRENDED

MEASURES HELD TO THE MINIMUM PERFORMANCE LEVEL (50TH PERCENTILE)

MY2023/RY2023 MCAS – MPL

HealthPlan OF SAN MATEO
Healthy is for everyone

Abrev	Measure	50th Percentile MPL	MY2023	MY2022	MY2021	MY 2020
CBP	Controlling High Blood Pressure*	61.31	71.48	64.95	62.20	53.04
HBD>9	Hemoglobin A1c Control for Patients with Diabetes: Poor Control (>9.0%)* (lower is better)	37.96	30.77	34.43	28.78	37.23
AMR	Asthma Medication Ratio	65.61	75.18	77.44	69.56	70.06
CIS-10	Childhood Immunization Status –Combo 10*	30.90	54.03	54.50	54.85	61.56
IMA -2	Immunizations for Adolescents –Combo 2*	34.31	50.85	49.39	51.58	50.61
BCSE	Breast Cancer Screening	52.60	63.27	58.68	53.96	59.20
CCS	Cervical Cancer Screening*	57.11	61.22	61.69	57.61	58.91
CHL	Chlamydia Screening in Women	56.04	69.07	67.39	68.71	63.98
PPC -Post	Prenatal and Postpartum Care– Postpartum Care*	78.10	86.63	89.53	92.45	92.59
PPC-Pre	Prenatal and Postpartum Care– Timeliness of Prenatal Care*	84.23	91.28	90.70	89.31	90.0
WCV	Child and Adolescent Well -Care Visits (3-21 yrs)	48.07	54.81	52.00	56.92	48.80
LSC	Lead Screening in Children*	62.79	70.66	67.88	N/A	N/A
DEV^	Developmental Screening in the First Three Years of Life	34.70	56.07	53.15	43.02	24.24
FUM	Follow-Up After Emergency Department Visit for Mental Illness (30 -Day Follow-Up)	54.87	64.43	69.70	27.72	N/A
FUA	Follow-Up After Emergency Department Visit for Substance Use (30-Day Follow-Up)	36.34	49.13	53.44	7.58	N/A
TFL-CH^	Topical Fluoride for Children	19.30	23.00	20.32	N/A	N/A
W30	Well-Child Visits in the First 30 Months of Life • 6 or more well-child visits in first 15 months of life • 2 or more well -child visits in 15 to 30 months of life	 58.38 66.76	 58.58 72.96	 49.62 72.38	 25.73 69.14	 20.03 76.94

*Hybrid measure (chart review + admin & sup data)
^Non-HEDIS measure

Under MPL (50th Percentile/CMS FFY 2022 state medians for non -HEDIS)
Above HPL (90th Percentile)

MY2023/RY2023 MCAS – no MPL

Abbrev.	Measure	MY2023	MY 2022	MY 2021	MY 2020
FUA	Follow-Up After Emergency Department Visit for Substance Use (7 -Day Follow-Up)	34.65	35.52	4.27	N/A
FUM	Follow-Up After Emergency Department Visit for Mental Illness (7 -Day Follow-Up)	49.67	55.34	18.58	N/A
AAP	Adults' Access to Preventive/Ambulatory Health Services	68.76	67.59	N/A	N/A
POD	Pharmacotherapy for Opioid Use Disorder	18.62	26.03	N/A	N/A
PRS-E	Prenatal Immunization Status: Flu + Tdap	52.01	49.67	N/A	N/A
PDS-E	Postpartum Depression Screening and Follow Up • Screening • Follow-up	8.67 66.67	10.75 86.67	N/A	N/A
PND-E	Prenatal Depression Screening and Follow Up • Screening • Follow-up	9.65 64.71	11.91 47.06	N/A	N/A
DSF-E	Depression Screening and Follow-up for Adolescents and Adults • Screening • Follow-up	8.29 68.45	4.31 80.81	N/A	N/A
DRR-E	Depression Remission or Response for Adolescents and Adults • Follow-up • Remission • Response	37.97 7.17 16.03	0 0 0	N/A	N/A
CCP^	Contraceptive Care: Postpartum Women Ages 15 -44 Most or moderately effective contraception – 90 days	57.16	48.92	52.41	50.17
CCW^	Contraceptive Care: All Women Ages 15 -44 Most or moderately effective contraception	22.07	23.07	25.26	24.34

^Non-HEDIS measure All administratively collected measures;

MY2023/RY2024 MCAS – no MPL

Abbrev.	Measure	MY2023	MY 2022	MY 2021	MY 2020
AMB-ED	Ambulatory Care: Emergency Department (ED) Visits per 1,000 member months	43.33	44.76	38.63	36.99
ADD-Init	Follow-Up Care for Children Prescribed Attention -Deficit/Hyperactivity Disorder (ADHD) Medications – Initiation Phase	52.59	50.82	24.35	22.88
ADD-C/M	Follow-Up Care for Children Prescribed Attention -Deficit/Hyperactivity Disorder (ADHD) Medications – Continuation and Maintenance Phase	46.51	N/A	N/A	N/A
PCR	Plan All-Cause Readmissions (18-64 yr olds) • Observed rate (lower is better) • Observed to expected ratio	9.00 0.9271	8.53 0.8623	9.42 0.9597	9.64 0.9322
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing	37.35	31.51	42.55	35.64
AMM -AP	Antidepressant Medication Management - Effective Acute Phase Treatment	69.20	69.55	67.59	66.47
AMM -CP	Antidepressant Medication Management - Effective Continuation Phase Treatment	50.09	53.26	51.48	51.09
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.89	81.26	80.19	78.15
COLE	Colorectal Cancer Screening	49.91	47.82	N/A	N/A

All administratively collected measures;

10

MY2023/RY2023 DMHC HEQMS

Abrev	Measure	50th Percentile MY2022	MC MY2023	HW MY2023
CBP	Controlling High Blood Pressure*	61.31	71.48	59.04
HBD >9	Hemoglobin A1c Control for Patients with Diabetes: Poor Control (>9.0%)* (lower is better)	37.96	30.77	23.78
HBD <8	Hemoglobin A1c Control for Patients with Diabetes: Control (<8%)*	52.31	57.07	69.19
CIS-10	Childhood Immunization Status –Combo 10*	30.90	54.03	NA
IMA -2	Immunizations for Adolescents –Combo 2*	34.31	50.85	NA
BCSE	Breast Cancer Screening	52.60	63.27	70.78
AMR	Asthma Medication Ratio	65.61	75.18	NA
PPC -Post	Prenatal and Postpartum Care– Postpartum Care*	78.10	86.63	NA
PPC-Pre	Prenatal and Postpartum Care– Timeliness of Prenatal Care*	84.23	91.28	NA
COL	Colorectal Cancer Screening**	NA	49.91	63.59
WCV	Child and Adolescent Well -Care Visits (3-21 yrs)	48.07	54.81	NA
W30	Well-Child Visits in the First 30 Months of Life • 6 or more well -child visits in first 15 months of life • 2 or more well -child visits in 15 to 30 months of life	 58.38 66.76	 58.58 72.96	 NA
PCR	Plan All-Cause Readmissions (18-64 yr olds) • Observed rate (lower is better) • Observed to expected ratio	 NA 0.9853	 9.00 0.9271	 9.09 1.3535
DSF-E	Depression Screening and Follow -up for Adolescents and Adults • Screening • Follow-up	NA	8.29 68.45	0.10 NA

*Hybrid measure (chart review + admin & sup data), **hybrid for Commercial and Medicare only

Medi-Cal CAHPS Survey Results & Analysis MY2023/RY2024

October 2024

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1. OVERVIEW

Medi-Cal CAHPS results are available every year, using NCQA CAHPS and certified vendors. 2020 CAHPS was not conducted for the Medi-Cal population due to the response and impact of the Covid-19 pandemic. Results are trended across collection years when questions and composite items are consistent. Supplemental questions varied across collection year depending on state reporting requirements, and thus trending across collection years is not possible.

As Table 1 shows above, there is a consistent decrease in response rate for both Adult and Child surveys for more recent collection years. However, response rates remained sufficient for valid result reporting for 2023.

1.1 TABLE 1: CAHPS RESPONSE RATE TENDS

	2016		2019		2021		2022		2023	
CAHPS Data	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Child**
Sample size (includes oversampling)	1384	1731	1917	1659	1850	1799	1350	1650	1350	1650
Patient Level Records Used: Complete & Valid	344	511	423	381	392	379	277	211	220	178
Total Response Rate: Complete/(sample-Ineligible)	**26.58 %**	**31.56 %**	**23.35 %**	**23.06 %**	**21.71%**	**21.34 %**	**21.0 %**	**13.1 %**	**16.8 %**	**11.0%**

2. ADULT SURVEY RESULTS

Table 2 below shows trends in "Top box" ("Always" or "Usually") responses for composite items and supplemental items for the adult survey across collection years. Comparison to 2022 shows that every composite section saw an increase in scores, though three still did not meet the goal rate:

1.Rating of Personal Doctor

- 2023 Top-Box Score: 67.7%
- Goal Percent Rate: 71.1% (Goal Not Met)
- 2022 to 2023 Change: +9%
- Analysis: The score improved by 9% from 2022 to 2023, but still fell short of the goal by 3.4%. While there was notable improvement, the difference in the goal suggests a need for further focus on areas that contribute to patient satisfaction with personal doctors, such as availability, communication, or personalized care.

2. Getting Needed Care

- 2023 Top-Box Score: 82.2%
- Goal Percent Rate: 84.6% (Goal Not Met)
- 2022 to 2023 Change: +2.3%
- Analysis: The score only increased by 2.3% between 2022 and 2023, falling short by 2.4%. This small growth indicates possible ongoing challenges in access to care, perhaps due to long wait times, limited availability of services, or difficulties in navigating the system.

3. Getting Care Quickly

- 2023 Top-Box Score: 78.0%
- Goal Percent Rate: 83.8% (Goal Not Met)
- 2022 to 2023 Change: +4.6%
- Analysis: Despite a 4.6% improvement from 2022, the goal was missed by 5.8%. The larger gap suggests persistent issues with wait times for appointments or the speed of receiving care, which need to be addressed to meet expectations.

The *Rating of Personal Doctor, How Doctors Communicate, and Customer Service* were all identified during the last survey cycles as focus areas of improvement. In these sections we saw significant increases (see below) though *Rating of Personal Doctor* still did not meet the goal rate.

The goal rate was met for *Rating of a Health Plan, Rating of all Health Care,* and *Getting Needed Care, How Well Doctor's Communicate, and Customer Service.* There were no decreases in composite scoring.

2.1 TABLE 2: ADULT SURVEY RESULTS TRENDS AND COMPARISONS – PATIENT EXPERIENCE MEASURES

Measure	2013 Top-Box Scores	2016 Top-Box Scores	2019 Top-Box Scores	2021 Top-Box Scores	2022 Top-Box Scores	2023 Top-Box Scores	2022 to 2023 change	All Other Medicaid Health Plans 2022 Top-Box Scores	NCQA HPR Estimated Rating	Goal Percent Rate**	Goal Met
Rating of Health Plan	56.50%	59.20%	58.23%	63.06%	63.8%	67.0%	+3.2%	60%	4	64.9%	Yes
Rating of All Health Care	52.70%	52.00%	50.18%	60.27%	56.3%	60.7%	+4.4%	54%	4	58.7%	Yes

Rating of Personal Doctor	64.60 %	66.50 %	68.65 %	65.27%	58.7 %	67.7%	+9 %	67%	3	71.1%	No
Rating of Specialist Seen Most Often	68.50 %	71.6% +	71.20 %	71.54%	64.5 %	71.2%	+6.7%	66%	N/A	N/A	N/A
Getting Needed Care	81.20 %	73.60 %	77.60 %	80.45%	79.9 %	82.2%	+2.3%	50%	3	84.6%	No
Getting Care Quickly	75.80 %	69.00 %	79.30 %	80.15%	73.4 %	78.0%	+4.6%	54%	3	83.8%	No
How Well Doctors Communicate	87.40 %	88.30 %	93.10 %	91.99%	88.9 %	91.8%	+2.9%	75%	N/A	N/A	N/A
Customer Service	82.90 %	88.8% +	88.70 %	86.39%	82.9 %	91 %	+8.1%	68%	N/A	N/A	N/A

For the trend results, measures with less than 100 responses are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents.

***Goal Rate is set by health plan ratings (HPR) by evaluating plans in three categories: consumer satisfaction, clinical quality (includes prevention and treatment) and NCQA Accreditation Standards score.*

*

Below, Table 3 shows:

There were increases in all individual scores except three questions. The largest increase came from questions, *Q.24. Customer Service Provided Information and Help (+17.83%), Q.6. Got Check Up/Routine Appointment As Soon As Needed (+13.49%),* and *Q.13 Personal Doctor Listened Carefully (+6.14%).*

This year, there were three decreases in the composite and individual items for the adult survey. These include composite score for *How Well Doctor's Communicate (-.22%),* and individual scores of *Coordination of Care (-7.66%),* and *Health Plan Forms Were Easy to Fill Out (-5.22%).*

2.2 TABLE 3: TREND OF COMPOSITE AND INDIVIDUAL ITEMS FOR ADULT SURVEY

N/A response rates to item were too low to render a valid result

3. CHILD SURVEY RESULTS

Table 4 below shows trends in “Top box” (“Always” or “Usually”) responses for composite items and supplement items for the Child survey across collection years. One goal rate was met during this survey cycle, Rating of Personal Doctor. No Goal Rates were met during this survey cycle though all but two scores saw increases. The Rating of All Health Care saw the largest increase at +14.7% bust still fell short of the goal rate by 2.2%. See the scores below that did not meet the goal rate:

1. Rating of All Health Care

- 2023 Top-Box Score: 70.7%
- Goal Percent Rate: 73.1% (Goal Not Met)
- 2022 to 2023 Change: +14.7%
- Analysis: Despite a significant improvement of 14.7% from 2022 to 2023, the score still fell short of the goal by 2.4%. The drastic increase suggests substantial progress in areas of healthcare quality or availability, but lingering challenges, perhaps related to overall patient experience, remain and prevented the goal from being met.

2. Getting Needed Care/Care Easily

- 2023 Top-Box Score: 76.2%
- Goal Percent Rate: 86.6% (Goal Not Met)
- 2022 to 2023 Change: -0.5%
- Analysis: The score decreased by 0.5% from 2022 to 2023, falling 10.4% short of the goal. This is a concerning trend, indicating ongoing or worsening difficulties with accessing necessary care. Barriers to care, such as long wait times, insufficient provider networks, or complexities in the referral process, could be contributing factors.

3. Getting Care Quickly

- 2023 Top-Box Score: 76.0%
- Goal Percent Rate: 89.3% (Goal Not Met)
- 2022 to 2023 Change: +0.6%
- Analysis: The score only increased by a marginal 0.6%, leaving a significant gap of 13.3% between the 2023 score and the goal. The minimal improvement suggests that efforts to reduce wait times or improve the speed of care delivery have not been effective enough. This could point to issues such as delays in appointment scheduling or long wait times in clinics.

Overall Challenges:

- Access to care, both in terms of getting the needed care easily and getting care quickly, remains a significant issue. The minor or negative changes in these areas reflect potential systemic barriers that need addressing to meet the set goals.

- For future improvements, focus should be placed on addressing the obstacles that patients face in receiving timely and necessary care, along with exploring ways to enhance overall patient satisfaction with healthcare services.

3.1 TABLE 4: CHILD SURVEY RESULTS TRENDS AND COMPARISONS

Measure	2016 Top-Box Scores	2019 Top-Box Scores	2021 Top-Box Scores	2022 Top-Box Scores	2023 Top-Box Scores	2022 to 2023 change	All Other Medicaid Health Plans 2019 Top-Box Scores	NCQA HPR Percentile	Goal Percent Rate**	Goal Met
Rating of Health Plan	69.90%	78.30%	76.84%	72.5%	74.9%	+2.4%	69%	4	74.4%	Yes
Rating of All Health Care	68.00%	70.30%	77.93%	56.0%	70.7%	+14.7	66%	3	73.1%	No
Rating of Personal Doctor	76.10%	79.30%	81.31%	76.7%	80.7%	+4.0%	75%	4	79.30%	Yes
Rating of Specialist Seen Most Often	71.6%+	81.4%+	N/A	73.3%	76.5%	+3.2%	71%	N/A	N/A	N/A
Getting Needed Care/Care Easily	77.80%	78.60%	82.66%	76.7%	76.2%	-.5%	56%	4	86.6%	No
Getting Care Quickly	77.40%	81.10%	81.14%	75.4%	76.0%	+.6%	67%	4	89.3%	No
How Well Doctors Communicate	92.30%	93.20%	93.98%	91.1%	87.9%	-3.2%	77%	N/A	N/A	N/A
Customer Service	89.40%	94.30%	86.35%	86.5%	88.0%	+1.5%	67%	N/A	N/A	N/A

For the trend results, measures with less than 100 responses are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents. N/A response rates to item were too low to render a valid result
***Goal Rate is set by health plan ratings (HPR) by evaluating plans in three categories: consumer satisfaction, clinical quality (includes prevention and treatment) and NCQA Accreditation Standards score.*

Table 5 shows the composite and Individual Item's "Top box" ("Always" or "Usually") responses. Increases were seen in *Got Care As Soon As Needed When Care Was Needed Right Away (3.61%), Got Appointment With Specialist as Soon As Needed (.14%), Customer Service Provided Information or Help (10.25%).*

There were decreases in all other scores for the Children's Individual and Composite Children's Survey. The largest decreases were seen in *Coordination of Care (-8.36%), Personal Doctor Showed Respect (-5.61),* and *Personal Doctor Listened Carefully (-5.25%).*

3.2 TABLE 5: TREND OF COMPOSITE AND INDIVIDUAL ITEMS FOR CHILD SURVEY

N/A response rates to item were too low to render a valid result

4. ANALYSIS, BARRIERS, AND ACTION PLAN FOR UNMET GOALS (ADULT & CHILD)

4.1 RATING OF ALL HEALTH CARE

The "Rating of All Health Care" measure for the children's survey shows a score of 70.7%, indicating a slight improvement but still falling short of the established goal of 73.1%. This score reflects an opportunity for enhancement, as efforts are needed to ensure a higher level of satisfaction among pediatric members.

4.2 QUALITATIVE ANALYSIS

The qualitative data from the children's survey suggests that while there is a notable level of satisfaction, there remains room for improvement in how families perceive the overall quality of healthcare received. Parents' feedback highlights key aspects such as accessibility, coordination of care, and the quality of interactions with healthcare providers.

Key themes in the feedback include:

- Access to Care: Parents report that timely access to care significantly influences their overall rating. Delays in appointments or difficulty in reaching providers can lead to lower satisfaction scores.

- Quality of Interaction: Effective communication between healthcare providers and patients is crucial. Parents value when providers listen to their concerns, explain treatment options clearly, and involve them in decision-making regarding their children's health.

Although the score indicates some level of satisfaction, the feedback suggests that improving these areas could lead to a higher overall rating of healthcare experiences for children.

4.3 BARRIERS

Several barriers may hinder improvements in the "Rating of All Health Care" for the children's survey:

- **Communication Gaps**: Parents sometimes report that they feel inadequately informed about their child's treatment plans or that their concerns are not fully addressed. This gap can lead to feelings of disconnect from the healthcare process.
- **Cultural and Language Barriers**: Diverse families may face challenges in understanding medical information or expressing their needs due to language differences or cultural misunderstandings, further complicating the healthcare experience.

These barriers, if unaddressed, can contribute to a lower rating of overall healthcare experiences for pediatric members.

4.4 ACTION PLAN

Cultural Competency Initiatives and Training: HPSM' Health Equity Team will enhance cultural competency training for providers to ensure they are equipped to address the diverse needs of the families they serve. This training will focus on understanding cultural differences, overcoming language barriers, and fostering an inclusive environment, active listening, clear explanations, and involving parents in their children's care decisions to foster trust and satisfaction.

By implementing these action items, HPSM aims to enhance the overall healthcare experience for children, ultimately improvingGet satisfaction scores and achieving better health outcomes for pediatric members.

4.5 GETTING NEEDED CARE/CARE QUICKLY

Both measures fell significantly short of their goals, with "Getting Needed Care" missing the target by 10.4% and "Getting Care Quickly" by 13.3%. Although there was minimal improvement in "Getting Care Quickly" (+0.6%) from 2022 to 2023, "Getting Needed Care" saw a slight decline (-0.5%).

4.6 QUALITATIVE ANALYSIS

The shortfall in both measures suggests systemic issues in access to care. The slight decline in the Getting Needed Care/Care Quickly measure suggests that while some progress has been made, significant barriers still exist that prevent patients from obtaining care as easily as they should. Feedback from patients indicates challenges such as difficulty in securing appointments with specialists, delays in getting referrals approved, and limited availability of providers in certain areas. Additionally, administrative complexities, such as insurance authorizations and lengthy processing times, contribute to the difficulty patients experience when trying to access needed care.

Despite efforts to improve care coordination and streamline processes, the current system may still fall short of patient expectations in terms of speed and ease of access, which affects overall satisfaction with healthcare services.

4.7 BARRIERS

Key barriers contributing to the underperformance in "Getting Needed Care" and "Getting Care Quickly" include:

1. **Complex Scheduling Processes**: Difficulty in booking timely appointments due to overloaded healthcare systems or lack of available appointment slots leads to patient dissatisfaction and unmet care needs.
2. **Patient Awareness**: Some patients may not fully understand how to navigate the healthcare system to get the care they need, including being unaware of available resources or services

4.8 ACTION PLAN

1. **Primary Care Investment Strategy**: In 2024 HPSM launched its company initiative, headed by Medical Directors and Provider Services, the Primary Care Investment Strategy. This Strategy addresses the primary care crisis (financial neglect and workforce shortages) and promotes Advanced Primary Care, in order to achieve better and more equitable health outcomes for our members. Through interviews from within the primary care network and experts in the field, opportunities of improvement were decided upon but most relating to this measure is the focus on improving care experience. Within the 'better care experience' aim, the goals include uplifting member voices, enhancing community partnerships, improving access, and increasing engagement. This project is a multi-year initiative and will likely include much of our network
2. **Enhance Patient Education and Outreach**: To enhance member knowledge and improve their ability to navigate the healthcare system, HPSM Health Education and Marketing Team will continue to include guides and educational content in our newsletters and other communication channels. These guides will focus on simplifying key processes. Additionally, we will provide condition-specific resources to help members manage their health effectively,

including self-care tips and advice on when to seek professional care. By distributing this information through a variety of channels—such as newsletters, mailers, and social media—we aim to reach a broader audience and ensure that all members have easy access to the tools and knowledge they need. This initiative is part of our ongoing commitment to empowering members, improving their healthcare experience, and addressing barriers to accessing needed care.

4.9 RATING OF PERSONAL DOCTOR

The "Rating of Personal Doctor" measure showed significant improvement from the previous cycle, with the adult survey increasing by 9 points and the children's survey increasing by 4 points. Despite this improvement, the adult Medicaid score still falls short of the goal, while the children's Medicaid score has met the goal but remains at the lower end of the percentile rating.

For the adult survey, reaching the next percentile threshold is seen as an opportunity due to its proximity to the goal. In contrast, the children's survey score was targeted for retention, aiming to maintain or improve its current standing.

4.10 QUALITATIVE ANALYSIS

2023 scores for *Rating of Personal Doctor* are 67.7% (top-box) for adult Medicaid and 80.7% (top-box) for children's Medicaid. This measure has been seen as an opportunity to move to the next percentile for the adult survey, due to being close to the next percentile threshold. For the children's survey the *Rating of Personal Doctor* measure was selected to retain the score, it currently sits at the lower end of the percentile rating.

Though this measure continues from the last cycle to be a measure, we did see significant improvement from the previous cycle. The adult survey increased by 4 points for the children's survey and 9.0 points for the adult. The adult survey still falls short of the goal HPR Rate.

When looking at communities that scored this rating low, there are some differences between the adult and child populations. For the adult survey, results show that those with fair/poor mental health and fair/poor overall health rate this measure negatively. To contrast, those 55 or older and those other in race/ethnicity category rate their personal doctor strongly. Within the children's survey, those who rate the personal doctor strongly are those in age rage of 5-8 and those who are Hispanic/Latino. Lower rating groups include 14 and older, those with 'good' mental health, and our Asian population.

4.11 BARRIERS

A potential barrier to the success of the Primary Care Investment Strategy in improving the "Rating of Personal Doctor" measure lies in addressing the disparities in perception among different demographic groups. For the adult Medicaid population, individuals with fair or poor mental and overall health rated their personal doctors negatively, suggesting that improvements in care experience may not fully reach or resonate with these vulnerable groups without targeted interventions. Similarly, in the children's Medicaid survey, groups like adolescents, those with "good" mental health, and the Asian population rated their personal doctors lower, indicating that a one-size-fits-all approach may not be effective. Additionally, the primary care workforce shortages and financial neglect being addressed by the initiative are long-term issues, which may delay immediate improvements in member satisfaction, particularly in communities that are already underserved.

4.12 ACTION PLAN

Primary Care Investment Strategy: In 2024 HPSM launched its company initiative, headed by Medical Directors and Provider Services, the Primary Care Investment Strategy. This Strategy addresses the primary care crisis (financial neglect and workforce shortages) and promotes Advanced Primary Care, in order to achieve better and more equitable health outcomes for our members. Through interviews from within the primary care network and experts in the field, opportunities of improvement were decided upon but most relating to this measure is the focus on improving care experience. Within the 'better care experience' aim, the goals include uplifting member voices, enhancing community partnerships, improving access, and increasing engagement. This project is a multi-year initiative and will likely include much of our network.

5. ANALYSIS, BARRIERS, AND ACTION PLAN FOR KEY IMPROVEMENT AREAS (ADULT & CHILD)

5.1 HEALTH PLAN FORMS WERE EASY TO FILL OUT

Both the adult and children's surveys saw decreases in scores from the previous cycle, with a decline of 3 to 5 points. The children's survey in particular was identified as an opportunity to increase the percentile rating. The decreases suggest that members are facing greater challenges with health plan forms compared to previous years.

5.2 QUALITATIVE ANALYSIS

2023 scores for the children's survey were 80.7% (top-box) and 90.7% (top-box). For the child's survey this measure was identified as an opportunity to increase our percentile rating. Both saw decreases from the previous cycle in scores between 3 and 5 points.

When looking at communities that scored this rating low, there are some differences between the adult and child populations. For the children's survey, results show that those with good mental health rate this measure negatively. To contrast, those who identify as white rate the *Ease of Filling Out Forms* positively. Within the adult's survey, those who rate *Ease of Filling Out Forms* strongly are those with excellent/very good mental health. Lower rating groups those with 'good' mental health, and our white population.

5.3 BARRIERS

Barriers described by HPSM call center staff that are mentioned by members include access to a printer or computer applications that allow for online forms to be completed. Additionally, in early 2024, health plan forms on the website were edited to be 'fillable' online, though member is unable to submit them online.

A further barrier to this metric could be the digital divide among members, as not all may have access to the necessary devices or applications required to complete fillable forms online. Additionally, members with limited digital literacy may struggle to navigate the website or member portal, despite efforts to simplify the process. Finally, technical issues such as website glitches or compatibility problems with certain devices could hinder the effectiveness of these changes and frustrate users.

5.4 ACTION PLAN

1) **WEBSITE CHANGES:** IN EARLY 2024, HEALTH PLAN FORMS WERE EDITED ON THE WEBSITE TO BECOME 'FILLABLE' FOR MEMBERS. MEANING THAT IF A MEMBER HAS ACCESS TO THE APPROPRIATE APPLICATIONS ON THEIR DEVICE, THEY ARE ABLE TO FILL OUT THE FORM ONLINE RATHER THAN PRINTING FORMS, FILLING THEM OUT, AND MAILING THEM IN. ADDITIONALLY, THERE WILL BE EDITS TO THE DIRECTIONS ON THE HPSM WEBSITE TO BETTER DESCRIBE THE PURPOSE AND DIRECTIONS FOR EACH FORM THAT A MEMBER MAY NEED. EDITS WILL ALSO BE MADE ON HOW TO RETURN THE FORMS.

2) **MEMBER PORTAL:** CURRENTLY HPSM'S POPULATION HEALTH MANAGEMENT TEAM IS PILOTING A FORM IN THE MEMBER PORTAL TO GATHER SOGI (SEXUAL

ORIENTATION AND GENDER IDENTITY) DATA FROM MEMBERS. AFTER THIS PILOT PHASE, THERE ARE GOALS THE OTHER FORMS CAN BE TRANSITIONED TO FORMS THAT CAN BE DIRECTLY SUBMITTED ON THE PORTAL. THIS CHANGE WOULD ALLOW MEMBERS WITH LIMITED DIGITAL LITERACY TO EASE THE PROCESS. BY REMOVING THE NEED TO SAVE THE DOCUMENT AND EMAIL TO NECESSARY TEAMS THE EASE OF FILLING OUT FORMS WILL BE IMPROVED.

5.5 HOW WELL DOCTOR'S COMMUNICATE

The communication scores reflect a decrease for pediatric members and an increase for adult members. The adult survey shows potential for improvement as it is close to moving into the next percentile rating. In contrast, for the children's survey, only one question, Q13 (Dr. listened carefully), has been identified as an opportunity for enhancement.

5.6 QUALITATIVE ANALYSIS

The rates of this composite score decreased for pediatric members and increased for adult members. Parents of children reported rates from 87.9% and adults reported rates from 91.8%. Opportunity to move into the next percentile rating has been identified for much of the composite scoring to *How Well Doctor's Communicate* for the adult survey. Whereas only one area of the children's survey has been identified as an opportunity, Q13. Dr. listened carefully.

Patients frequently emphasize the importance of feeling heard and understood during medical appointments. When doctors actively listen, show empathy, and explain medical information in clear, non-technical language, patients report feeling more comfortable and confident in their care. Effective communication also includes giving patients adequate time to ask questions and ensuring that doctors address their concerns thoroughly, rather than rushing through appointments.

However, breakdowns in communication can occur when doctors rely too heavily on medical jargon, appear distracted (e.g., focusing on electronic health records), or fail to explain the reasoning behind treatment options. Cultural and language barriers can further impede effective communication, particularly when patients feel their values or concerns are not adequately acknowledged. Consistency in follow-up communication, such as explaining test results and treatment plans clearly, is another area where some patients express dissatisfaction.

Overall, patients tend to rate communication highly when doctors foster an open, patient-centered approach that is respectful, informative, and attentive, but inconsistencies in these practices can negatively impact patient trust and care outcomes.

5.7 BARRIERS

Effective communication between doctors and patients in large healthcare systems can face several barriers. One key challenge is time constraints; doctors often have limited time during appointments due to high patient volumes, which can hinder thorough discussions. Additionally, the complexity of healthcare information can make it difficult for doctors to convey medical details in a way that patients easily understand. Language differences and cultural barriers further complicate communication, especially in diverse populations. In large systems, the use of electronic health records (EHRs), while valuable, can also divert doctors' attention away from face-to-face interactions, as they may spend more time inputting data than engaging with patients directly. These factors together can lead to reduced patient satisfaction and potential misunderstandings in care.

5.8 ACTION PLAN

HPSM continues to investigate factors that may impact the quality of communication between providers and members. Current activities include:

3) **CAHPS communication planning**: HPSM's Learning and Development and Member Experience Team plans to begin building an infrastructure in 2025 for increased provider knowledge of CAHPS and its scorings. This work will assist providers in recognizing the importance of communications and how HPSM prioritizes member experience. Barriers include engaging providers in review of CAHPS results that cannot be tailored to them due to the deidentified nature of the survey. When providers are unable to see their practice-specific assessments of the member experience, their role in the improvement process of the network's overall performance may be less evident. Providers may also deprioritize subjective assessments of their quality of care in favor of health or financially based outcomes that are more objective in measurement.
3) **Diversity, Equity, and Inclusion Training**: Doctors participating in Diversity, Equity, and Inclusion (DEI) training can greatly enhance the care they provide to patients. DEI training helps physicians become more aware of cultural differences, biases, and inequities that may impact patient outcomes. By improving their cultural competence, doctors can build stronger, more trusting relationships with patients from diverse backgrounds. This leads to more personalized care, better communication, and ultimately, improved patient satisfaction and health outcomes.
3) **Provider-based learning:** HPSM is currently expanding its Learning & Development team to support provider learning. In partnership with HPSM's provider-facing unit, this work includes the development of provider training and education resources to support member experience and health outcomes. Providers will be trained on topics relating to survey and CAHPS results and

internal discussions with providers on high need areas, this discovery is not yet available at the time of this report.

6. 2023/2024 GOAL RATES

CAHPS Top-Box Area	2022 Score	2024 Goal Score	Comments
How Well Doctors Communicate	88.9% (adult) 91.1% (child)	90.9% (adult) 93.1% (child)	HPSM will aim to increase this area by at least 2 percentage points in the next year. There are many strategies to improve this factor happening over the next year.
Rating of Personal Doctor	80.15% (adult) 76.7% (child)	81.15% (adult) 77.7% (child)	HPSM will aim to increase this area by at least 1 percentage point in the next year.
Customer Service	82.9% (adult) 86.5% (child)	83.9% (adult) 87.5% (child)	We will also aim to increase these rates by at least 1%.

7. SMOKING AND TOBACCO USE TRENDS

Medical Assistance with Smoking and Tobacco Use Cessation

HPSM is committed to strengthening tobacco cessation interventions by tracking tobacco cessation intervention utilization data and assessing results to inform future tobacco cessation intervention strategies. This is in alignment with tobacco cessation intervention utilization tracking requirements set in section 8 of the Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries All Plan Letter: APL 16-014 (ca.gov).

	2019	2022	**2023**	**Change**
Q32.Advising Smokers and Tobacco Users to Quit	N/A	71.4%	**60.9%**	**-10.5%**
Q33.Discussing Cessation Medications	N/A	57.1%	**58.7%**	**+1.6%**
Q34.Discussing Cessation Strategies	N/A	53.6%	**52.2%**	**-1.4%**

*Under 100 results in a N/A score

ANALYSIS AND ACTION PLAN

HPSM's Population Health Management Team is conducting a comprehensive review of all the requirements outlined in the Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries, APL, focusing on tobacco cessation interventions and tracking. This review evaluates how we will meet the established guidelines, particularly in tracking the utilization of tobacco cessation interventions and assessing their results. We are conducting a gap analysis to determine where we are compliant and where improvements are needed. The primary goal is to enhance the effectiveness of our tobacco cessation efforts by using data to guide future strategies, ensuring we provide the best support possible.

One key area of improvement we have identified is ensuring that providers meet the requirement for advising tobacco users to quit. To address this, we will work closely with providers services to understand the gaps and come up with actionable solutions. This may include offering provider training, refining providers resources, and implementing more robust assessment tools to monitor when and how advice is given. These efforts will help providers deliver effective tobacco cessation interventions that meet both regulatory standards and the needs of their patients.

Another important area is ensuring providers educate members on tobacco cessation strategies. This can include giving the providers the tools and information they need to help members quit successfully. To support these efforts, we may set up a system to regularly monitor the effectiveness of the intervention and track providers' performance and provide educational materials. This system will help ensure we meet the required standards and improve member satisfaction.

MEMBER EXPERIENCE COMMITTEE

GRIEVANCE & APPEALS NCQA REPORT

REPORTING PERIOD: Q1 2023-Q4 2023 DATE: 08/01/2024

1. DATA METHODOLOGY AND GOAL SETTING

1.1.1 DATA METHODOLOGY

For all Medi-Cal members, including those covered under CCS, the National Committee for Quality Assurance (NCQA) requires specific data collection and grouping standards, which we are including for Medi-Cal and CCS members only.

In the tables below, grievances and appeals are separated based on whether they are related to Behavioral Health services, and further broken down in the categories NCQA requires. Behavioral Health includes services provided by Health Plan of San Mateo to treat mild- moderate/non-specialty mental health diagnoses, as well as services provided by Magellan Health to treat members with autism spectrum disorder and related diagnoses.

We have calculated the rate of behavioral health complaints per 1,000 members using the number of members who received services from HPSM or Magellan as the denominator. In this way, members who are not utilizing behavioral health services are not included in the rate, making it a more accurate reflection of member experience.

For non-behavioral health complaints, the rate is calculated based on member eligibility, not utilization, since any eligible member can make a complaint about any of HPSM's covered benefits at any time.

1.1.2 GOAL RATES

HPSM's quarterly G&A reports use a methodology that calculates a complaint rate using the number of complaints received during a quarter divided by the average eligibility during that quarter. As such, the volume of complaints increases quarter to quarter, while eligibility continues to be averaged. This does not allow for comparison of quarterly and annual rates. For this report, the complaint rate is calculated in a similar fashion, but takes into account the number of months during which the complaints were received. As a result, quarterly rates and yearly rates can be compared on the same scale.

Goals were based on the data gathered during 2022.

The G&A Unit set the following goal rates for all non-behavioral health grievances and appeals for 2023:

	Min Rate per 1,000 members per Month (2023)	Max Monthly Rate per 1,000 Members per Month (2023)	Goal 2023
Non-Behavioral Health: Grievances	0.46	0.53	**0.99**
Non-Behavioral Health: Appeals	0.06	0.11	**0.14**

For behavioral health services, the rate of complaints during 2023 was calculated using the number of members utilizing behavioral health services in 2019:

	Min Rate per 1,000 Utilizing Members per Month (2023)	Max Rate per 1,000 Utilizing Members per Month (2023)	Goal 2023
Behavioral Health: Grievances	0.37	0.60	**0.55**
Behavioral Health: Appeals	0.00	0.15	**0.03**

Complaint rates from 2023 were based on the date the grievance or appeal was *received.* In late 2019 HPSM's Consumer Advisory Committee changed its meeting schedule to receive more timely data from several of HPSM's operational areas. To comply with this decision, the G&A Unit changed their quarterly reports to reflect the G&A volumes based on the date the complaints were *closed*, allowing for all necessary data to be available by the report deadline.

2.1.1 MEDI-CAL AND CCS BEHAVIORAL HEALTH GRIEVANCES

The following table contains the number of behavioral health grievances received during calendar year 2023.

Category	Q1 2023	Q2 2023	Q3 2023	Q4 2023
	# Complaints	# Complaints	# Complaints	# Complaints
Access	10	13	11	9
Attitude and Service	1	1	1	1
Quality of Care	0	5	2	3
Billing and Financial Issues	1	0	0	0
Quality of Practitioner Office Site	0	0	0	0
Total Grievances	**12**	**19**	**14**	**13**

The following table contains the complaint rate for behavioral health grievances received throughout the calendar year 2023.

Category	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Goal Rate	2023 Rate
	Complaints per 1000 members per month	Complaints per 1000 members per month	Complaints per 1000 members per month	Complaints per 1000 members per month		
Access	0.32	0.41	0.34	0.25		
Attitude and Service	0.03	0.03	0.03	0.03		
Billing and Financial Issues	0.03	0.00	0.00	0.00		
Quality of Care	0.00	0.16	0.06	0.08		

Category	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Goal Rate	2023 Rate
	Complaints per 1000 members per month	Complaints per 1000 members per month	Complaints per 1000 members per month	Complaints per 1000 members per month		
Quality of Practitioner Office Site	0.00	0.00	0.00	0.00		
Total Grievances	**0.38**	**0.60**	**0.43**	**0.36**	**0.55**	**0.44**

2.1.2 MEDI-CAL AND CCS BEHAVIORAL HEALTH APPEALS

The table below contains the number of behavioral health appeals received during calendar year 2023.

Category	Q1 2023	Q2 2023	Q3 2023	Q4 2023
	# Complaints	# Complaints	# Complaints	# Complaints
Access	1	3	0	0
Attitude and Service	0	0	0	0
Billing and Financial Issues	0	0	0	0
Quality of Care	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0
Total Appeals	**1**	**3**	**0**	**0**

The following table contains the complaint rate for behavioral health appeals received throughout the calendar year 2023.

Category	Q1 2023 Complaints per 1000 members per month	Q2 2023 Complaints per 1000 members per month	Q3 2023 Complaints per 1000 members per month	Q4 2023 Complaints per 1000 members per month	Goal Rate	2023 Rate
Access	0.06	0.28	0.0	0.00		
Attitude and Service	0.00	0.00	0.00	0.00		
Billing and Financial Issues	0.00	0.00	0.00	0.00		
Quality of Care	0.00	0.00	0.00	0.00		
Quality of Practitioner Office Site	0.00	0.00	0.00	0.00		
Total Appeals	**0.06**	**0.28**	**0.00**	**0.00**	**0.03**	**0.09**

2.1.3 MEDI-CAL AND CCS NON-BEHAVIORAL HEALTH GRIEVANCES

The following table contains the number of non-behavioral health grievances received during calendar year 2023.

Category	Q1 2023 # Complaints	Q2 2023 # Complaints	Q3 2023 # Complaints	Q4 2023 # Complaints
Access	43	41	28	26
Attitude and Service	84	73	93	89
Billing and Financial Issues	25	28	29	16
Quality of Care	43	62	72	55
Quality of Practitioner Office Site	0	3	2	0
Total Grievances	**195**	**207**	**224**	**186**

The following table contains the complaint rate for non-behavioral health grievances received throughout the calendar year 2023.

	Q1 2023	Q2 2023	Q3 2023	Q4 2023		
Category	**Complaints per 1000 members per month**	**Complaints per 1000 members per month**	**Complaints per 1000 members per month**	**Complaints per 1000 members per month**	**Goal Rate**	**2023 Rate**
Access	0.10	0.10	0.06	0.06		
Attitude and Service	0.20	0.17	0.21	0.22		
Billing and Financial Issues	0.06	0.07	0.06	0.04		
Quality of Care	0.10	0.15	0.16	0.14		
Quality of Practitioner Office Site	0.00	0.01	0.00	0.00		
Total Grievances	**0.47**	**0.48**	**0.49**	**0.46**	**0.99**	**0.48**

2.1.4 MEDI-CAL AND CCS NON-BEHAVIORAL HEALTH APPEALS

The following table contains the number of non-behavioral health appeals received during calendar year 2023.

Category	**Q1 2023**	**Q2 2023**	**Q3 2023**	**Q4 2023**
	Complaints Total	**Complaints Total**	**Complaints Total**	**Complaints Total**
Access	28	22	32	26
Attitude and Service	0	0	0	0
Billing and Financial Issues	0	0	0	0
Quality of Care	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0
Total Appeals	**28**	**22**	**32**	**26**

The following table contains the complaint rate for non-behavioral health appeals received throughout the calendar year 2023.

	Q1 2023	Q2 2023	Q3 2023	Q4 2023		
Category	**Complaints per 1000 members per month**	**Complaints per 1000 members per month**	**Complaints per 1000 members per month**	**Complaints per 1000 members per month**	**Goal Rate**	**2023 Rate**
Access	0.07	0.05	0.07	0.06		
Attitude and Service	0.00	0.00	0.00	0.00		
Billing and Financial Issues	0.00	0.00	0.00	0.00		
Quality of Care	0.00	0.00	0.00	0.00		
Quality of Practitioner Office Site	0.00	0.00	0.00	0.00		
Total Appeals	**0.07**	**0.05**	**0.07**	**0.06**	**0.14**	**0.06**

3. ANALYSIS, BARRIERS, AND PROPOSED ACTIONS

3.1.1 ANALYSIS OF GRIEVANCE AND APPEAL VOLUMES, RATES, AND TRENDS

During this review period, the rate of non-behavioral health grievances and appeals and non-behavioral health appeals met the yearly goal; however, this was not the case for behavioral health appeals.

The behavioral health appeals failed to meet the established goal rate for two of the quarters as well as for the year-end goal. This indicates that the rate of behavioral health appeals filed in 2023 was higher than in 2022.

Behavioral Health Appeals

BH Type	BH Count
BHRS - Mild/Moderate	3
BHT/ ABA Therapy	1
Grand Total	**4**

For last year's report HPSM did not meet the goal for behavioral health grievances. To address this, Q4 2022 and Q1 2023 HPSM implemented a process improvement to address the provider-member matching process grievances. Magellan began offering a first available appointment for members to avoid a waitlist. This allowed members to choose if they wanted to take the appointment to receive a service, even if it wasn't a perfect scheduling match. To address the gaps in follow-through and care management, HPSM approved, recruited for, and hired a new BHT program manager and clinical care manager to provide care management and coordination services. The program manager was hired in October 2022 and the clinical care manager was hired in May 2023. This year the behavioral health grievances did meet goal, showing improvement over last year's rates.

3.1.2 Barriers:

While behavioral health grievances saw a decrease from 2022 data, perceived access delays continue to be the reason for access appeals related to BHRS. While the appeals were only seen in Q1 and Q2 of 2023, it is important to review to determine root cause and identify trends. As seen in the chart above, most of the increase in behavioral health appeal volume in 2023 is the result of a perceived delay in obtaining a provider, resulting in the member going out of network for services and then requesting reimbursement from HPSM. In three of the four appeals the members went out of network, even when the services were available in network and were not considered emergency services.

No other barriers were identified since grievances and non-behavioral appeals are within the goal.

3.1.3 PROPOSED ACTION:

(i) In order to help address these issues HPSM will educate members on these services. Education around when to call the ACCESS Call Center and when they should be calling HPSM. Also, where to call when looking for an in-network provider or looking to switch providers.