2022 QUALITY IMPROVEMENT PROGRAM ANNUAL EVALUATION

Prepared in February 2023

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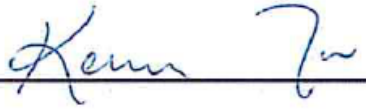
X 

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1. INTRODUCTION

This program evaluation provides a comprehensive overview of quality improvement activities conducted in 2022.

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 RESULTS

In 2022, HPSM was required to collect and report HEDIS measures for the Medi-Cal and CareAdvantage populations. The 2022 reporting year HEDIS results are an analysis of services provided in 2021 (measurement year). 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.

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.

CMS sets a rate for each quality withhold measure. Plans must meet this benchmark or achieve gap improvement (10% improvement or at least 1% rate change) for a prior score below the benchmark to "pass" the quality withhold measure and earn back withheld funds.

Results from each specific HEDIS measure can be found in the Quality of Clinical Care Activities Section of this evaluation to align with associated interventions. Included are the results for each of HPSM's key areas of focus for quality improvement interventions 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 2022 are of services provided to members enrolled in 2021.

2022 MEDI-CAL SUMMARY:

For Reporting Year (RY) 2022,

- 4 measures above HPL (above 90th percentile):
  - Childhood Immunization Status –combination 10
  - Immunizations for Adolescents –combination 2
  - Prenatal and Postpartum Care – Postpartum Care
  - Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)
- 3 measures below MPL (50th percentile):

- Cervical Cancer Screening
- 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

CAREADVANTAGE/CAL-MEDICONNECT (CA-CMC) SUMMARY:

In 2022, HPSM successfully reported on all 55 measures required by CMS for Medicare-Medicaid Plans. In addition, all three CMS Core Quality Withhold HEDIS measure passed the performance requirement, significantly improving from 2021. These measures are Controlling High Blood Pressure (CBP), and Follow-up after Hospitalization for Mental Illness (FUH).

2022 PERFORMANCE IMPROVEMENT

The following areas represented opportunities for improvement and key areas of focus for 2022:
Adolescent Well-Care Visits (WCV)
Breast Cancer Screening (BCS)
Cervical Cancer Screening (CCS)
Comprehensive Diabetes Care (CDC)
- A1c Testing
- Poor A1c Control

Controlling High Blood Pressure (CBP)

3. QUALITY OF CLINICAL CARE ACTIVITIES

3.1 ADOLESCENT WELLCARE VISITS (WCV)

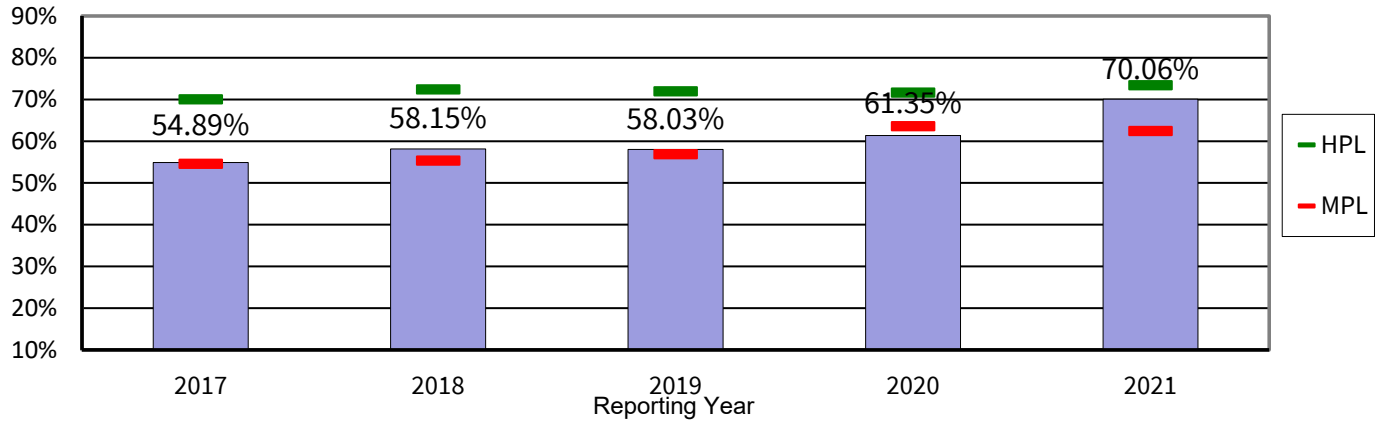
Abrev	Measure	MY2021	50th Percentile	MY 2021 Rate	MY 2019 Rate
WCV	Child and Adolescent Well-Care Visits (3-21 yrs)	56.92	45.31	48.8	N/A

Measure/Program	Adolescent WCV PIP Program
Objective:	By June 30, 2022, increase the percentage of adolescent well visits among 18 to 21 year olds assigned to Daly City Youth Clinic, from 11% to 15%.
Program Description	**Incentive Program –** HPSM had initiated a Performance Improvement Project (PIP) focused on improving AWC for young adults aged 18-21 years of age. However, due the COVID-19 pandemic, no real developments in the plan could take place and the PIP had to be put on hold. HPSM reinitiated this PIP in 2021. HPSM will offer a $25 Target incentive gift card for all teen members aged 18-21, who participate in a well visit at Daly City Youth Clinic
Trend:	Our rates have been lower for this age group than the average.

Goal Met/Not Met	The rate for MY2021 was 56.92 and did meet the MPL for this measure.
Barriers identified	Although we met the goals for this measure, we have identified some barriers in the past that continue to affect this measure. These are as follows: 1. High number of no shows at well child visits even after appointments have been made. 2. Members don't have the full information on the importance of well visits.
Recommended interventions for barriers	Incentive program developed to ensure that members attend their well visit after appointment has been made
Whether yearly planned activities were met	Finalized internal process with BSI team on checking well visits for teens and ensuring they met well visit criteria. Finalized process with Daly City Clinic on how well visits would be checked and submitted by the clinic. As of January 2022, incentive program was launched and gift cards sent out to teens on a weekly basis
Any changes to the program	Provider site was also changed from Seqouia Youth Clinic to Daly City Youth Clinic due to resource constraints.

3.2 ASTHMA MEDICATION RATIO (AMR)

AMR HEDIS RESULTS

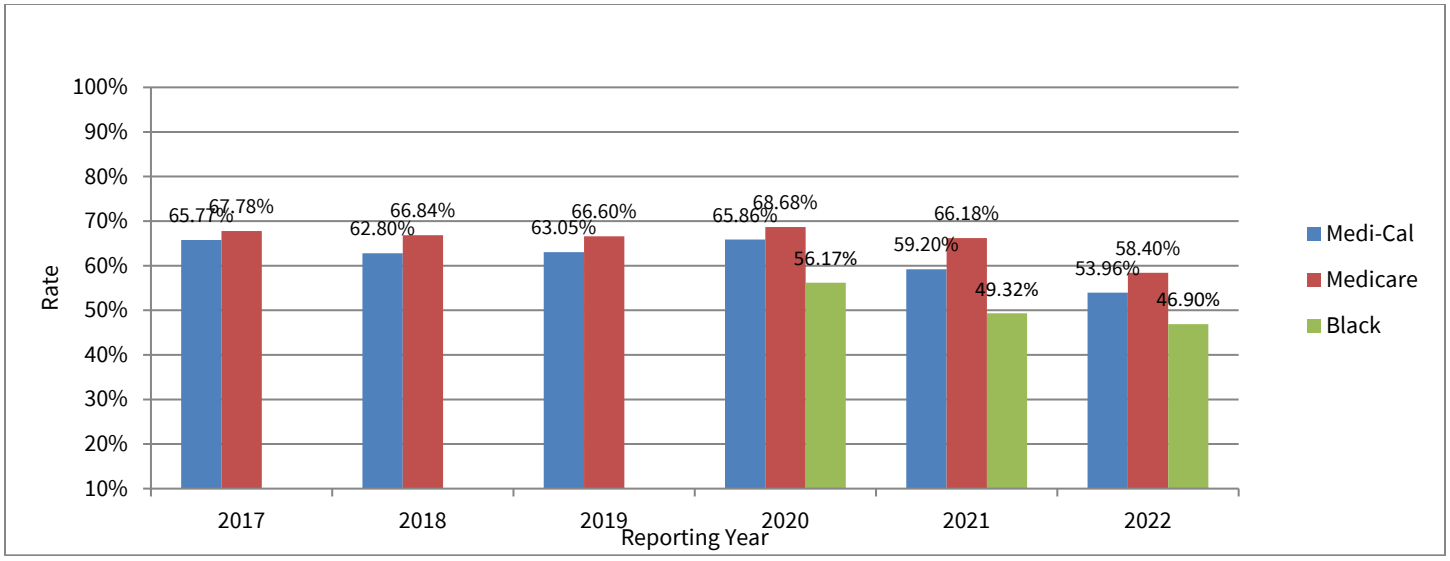


AMR has improved in recent years and no longer active improvement project in 2023. HPSM will continue to monitor AMR annually.

3.3 BREAST CANCER SCREENING (BCS)

BCS HEDIS RESULTS

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



For BCS Medi-Cal RY2022 MPL (50th percentile) was 53.93% and HPL (90th percentile) was 61.97%.

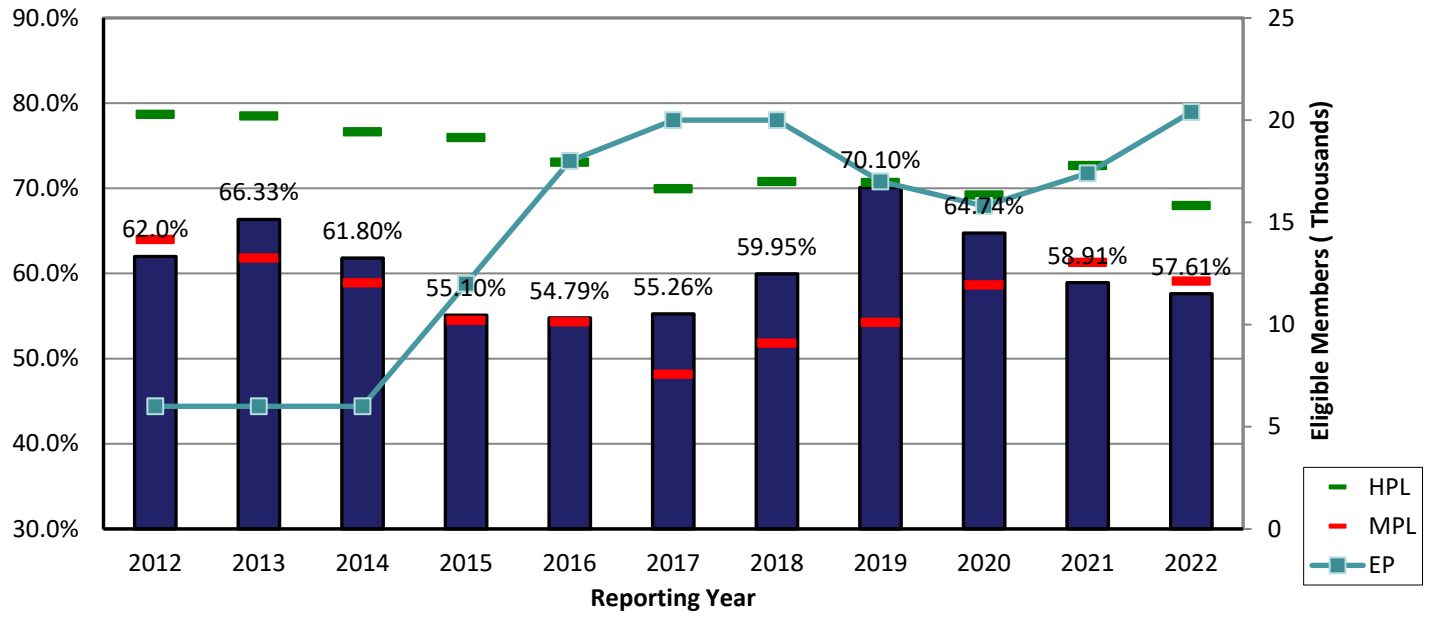
Measure/Program	BCS METRIC
Objective:	By December 31, 2022, increase the percentage of mammography screenings among continuously enrolled African American Medi-Cal members, ages 52 - 74 from 46.43% to 55.8%.
Program Description	1. **BCS/ ICM Outreach Program:** Direct outreach to non-compliant members through phone calls, discussing the importance of talking to their PCP about breast cancer screening. 2. **BCS Monthly Mailer:** HPSM will mail a postcard to eligible non-compliant members reminding them to talk to their PCP about whether a screening is right for them. This mailer also includes a link to our updated health tips page, which provides more information and resources on breast cancer. 3. **BCS Member Incentive Pilot:** In partnership with Ravenswood Family Health Clinic, HPSM will offer members assigned to the clinic incentive opportunities: 1) $10 Target gift card for discussing BCS with a Health Coach at the clinic; 2) $25 Target gift card for getting a breast cancer screening mammography.
Trend:	Our rate for BCS decreased from the prior year from 49.32% to 46.90%.
Goal Met/Not Met	The goal was not met for 2022.
Barriers identified	Because we did not meet the goal for this measure, and we see a disparity in the African American population, we want to increase rates in this population. Planned activities to understand barriers are as follows:

	1. Integrated care management team will reach out to African American members to understand barriers to mammography. 2. Ravenswood Family Health Center will share identified barriers discovered in health coaching sessions.
Recommended interventions for barriers	The BCS measure was added to the 2022 P4P Program. PCPs have access to P4P reports for their assigned members. Annual incentive payment was implemented. We conducted an outreach program to African American women aged 52-74 who are eligible and due for BCS. We asked them about barriers and facilitators to getting a screening. We field tested and edited the Staying Healthy mailer.
Whether yearly planned activities were met	Planned yearly activities were met.

3.4 CERVICAL CANCER SCREENING (CCS)

CCS HEDIS RESULTS

Percentage of women ages 21-64 with Medi-Cal who received a pap test in the last 3 years, or a pap test and HPV test within the last 5 years if 30+ years of age OR a HPV test within last 5 years if 30+ years of age :

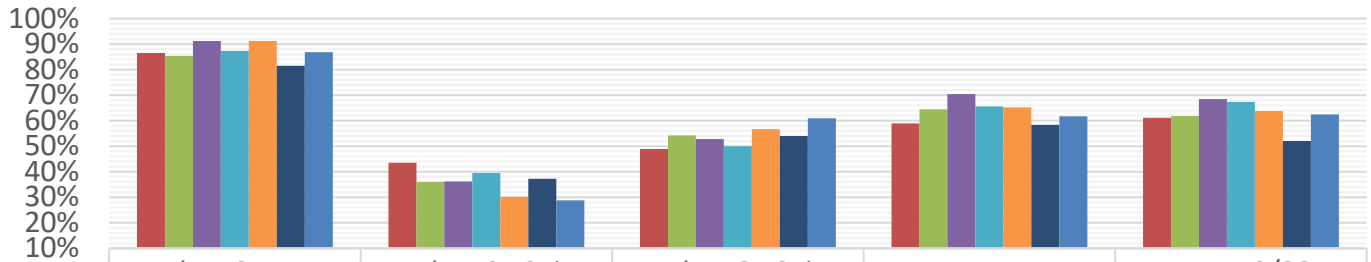


Measure/Program	CCS METRIC
Objective:	By December 31, 2022, increase CCS rate among women, ages 24 to 64, who are continuously enrolled in Medi-Cal from 58.94% (MY2020) to 59.12% (MY2021 MPL).
Program Description	**Staying Healthy Mailer:** Mailers will encourage members to ask PCP about recommended preventive care and screenings for women in their age group, promote benefits of recommended preventive screenings and tests for women, and encourage contacting PCP via telehealth to inquire about when next routine Pap test is due, and encourage members to adopt a healthy lifestyle which includes getting regular cancer screenings to detect early signs of changes, before developing symptoms. CCS Measure added to the P4P Program.
Trend:	Our rate for CCS decreased from the prior year from 58.91% to 57.61%.
Goal Met/Not Met	The goal was not met for 2022.
Barriers identified	Prior conversation with PCPs and an analysis of HPSM resources have identified the following barriers: 1. Due to competing priorities and limited staffing resources, solo PCP practices primarily use “in reach methods” rather than proactive member outreach efforts which require planning and additional dedicated staff time. 2. COVID related issues have prevented members from visiting their PCPs, and during the pandemic, HPSM staff resources have been limited.
Recommended interventions for barriers	To address the lack of time and resources that solo PCPs are experiencing, HPSM will conduct targeted proactive member outreach through mailers, member newsletters, and health information on our member website and social media. HPSM will also conduct scripted interviews with willing members to better understand barriers on the member level as well as explore other barriers to sexual and reproductive health.
Whether yearly planned activities were met	Planned yearly activities were met and will continue in 2023.
Any changes to the program	HPSM will partner with Clincs to validate data on reports.

3.5 COMPREHENSIVE DIABETES CARE (CDC)

CDC HEDIS RESULTS

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:

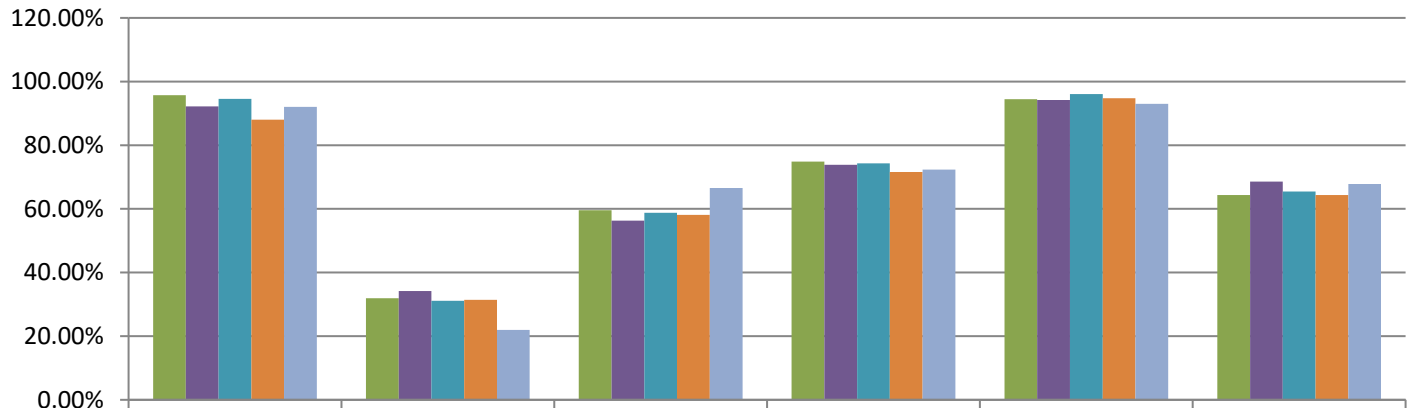


	HbA1C Test	HbA1C >9%	HbA1C <8%	Eye Exam	BP<140/90
2016	86.55%	43.52%	48.90%	58.92%	61.12%
2017	85.40%	36.01%	54.26%	64.48%	61.80%
2018	91.20%	36.19%	52.81%	70.42%	68.46%
2019	87.32%	39.51%	50.00%	65.61%	67.32%
2020	91.24%	30.17%	56.69%	65.21%	63.75%
2021	81.51%	37.23%	54.01%	58.39%	52.07%
2022	86.83%	28.78%	60.98%	61.71%	62.44%

Comprehensive Diabetes Care (CDC) 2021 MPLs & HPLs:

HEDIS Measure	Medicaid 50th Percentile*	Medicaid 90th Percentile*
Eye Exam (Retinal) Performed	51.36%	63.02%
HbA1c Testing	82.97%	88.08%
HbA1c Poor Control (>9.0%)	37.47%	27.98%
HbA1c Control (<8.0%)	46.83%	55.23%
Blood Pressure Control (<140/90 mm Hg)	58.52%	71.23%

Percentage of **CMC** members 18 - 75 years of age with diabetes who had each of the following tests or results within the measurement year:



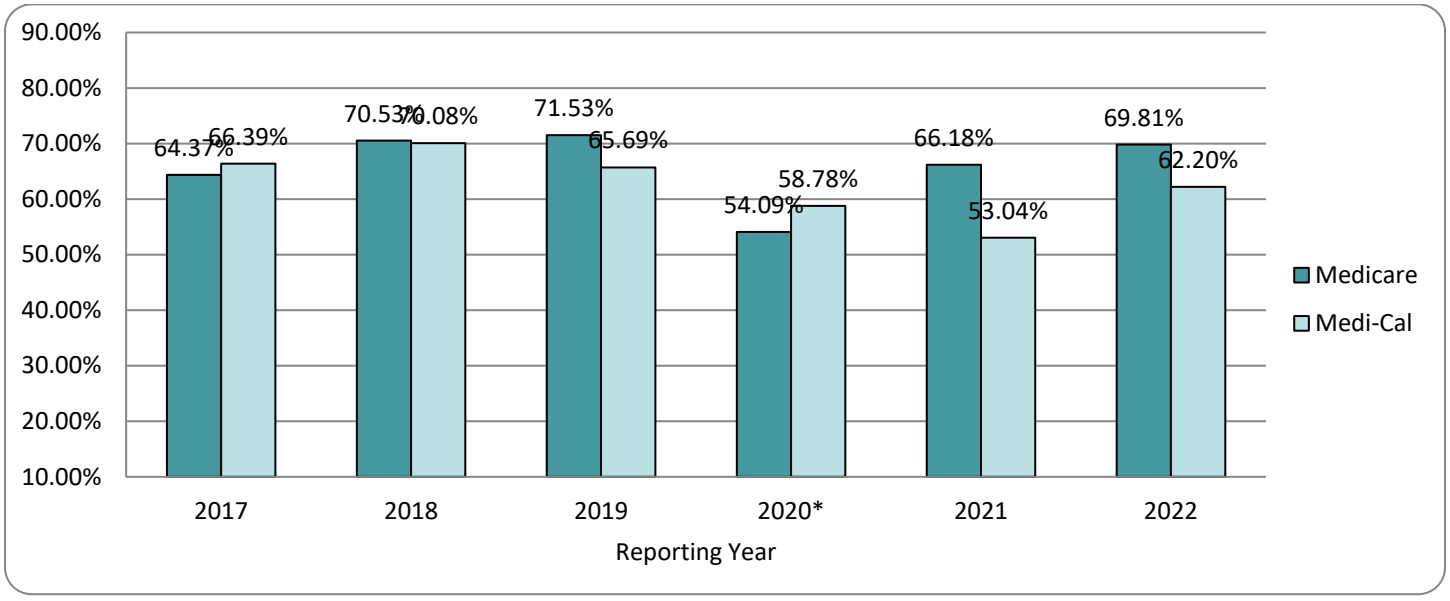
	HbA1C Test	HbA1C >9%	HbA1C <8%	Eye Exam	Nephropathy Scn	BP<140/90
2018	95.73%	31.91%	59.55%	74.87%	94.47%	64.32%
2019	92.21%	34.17%	56.28%	73.87%	94.22%	68.59%
2020	94.57%	31.11%	58.77%	74.32%	96.05%	65.43%
2021	88.03%	31.42%	58.10%	71.57%	94.76%	64.34%
2022	92.02%	21.95%	66.58%	72.32%	93.02%	67.83%

Measure/Program	Comprehensive Diabetes Care (CDC)
Objective:	For *Medicare* By Dec 31, 2022 reduce the number of CMC diabetics with a Hba1c in poor control from 31.24% (HEDIS MY2020) to less than 30%.
Program Description	Hba1c poor control (>9%) was maintained as payment measure for CMC benchmarking P4P for 2022. Care gap reports were included with monthly P4P reports so Provider offices could prioritize appointment outreach efforts.
Goal Met/Not Met	The HEDIS MY2021 final results for Hba1c poor control (>9) = 21.95%. Goal was met.

3.6 CONTROLLING HIGH BLOOD PRESSURE (CBP)

CBP HEDIS RESULTS

Percentage of members 18-85 years of age with hypertension whose blood pressure was controlled during the measurement year



For CBP Medi-Cal RY2022 MPL (50th percentile) was 55.35% and HPL (90th percentile) was 66.79%.

Measure/Program	Controlling Blood Pressure (CBP)
Objective:	By Dec 31, 2022, increase the rate of controlled blood pressure in Medi-Cal members diagnosed with hypertension from HEDIS MY2020 53.04% to 55.35% (MY2021 MPL rate) and in CMC members with hypertension from 66.18% to 71% (quality withhold benchmark).
Program Description	The Quality Team worked with the Provider Communications Team and developed targeted messaging for 10 identified Clinics. In the targeted messaging, which was sent via email, we encouraged the Clinics to reach out to all patients in the provided care-gap reports, including those known to have blood pressure monitoring devices , to schedule an encounter and/or to develop a tailored care plan for regularly reporting BP results to their PCP.
Trend:	The *Medicare* rate for CBP increased from 66.18% to 69.81%. The *Medi-Cal* rate for CBP increased from 53.04% to 62.20%.
Goal Met/Not Met	For 2022, HPSM did meet the MPL goal for Medi-Cal but did not meet the Quality Withhold benchmark rate for Medicare. However, the measure still passed for the Quality Withhold as over a 10% gap improvement was achieved. • The *Medicare* rate for CBP was 69.81% • The *Medi-Cal* rate for CBP was 62.20%

Whether yearly planned activities were met	Planned yearly activities were met.

3.7 INITIAL HEALTH ASSESSMENT (IHA)

IHA OUTREACH PROGRAM DESCRIPTION

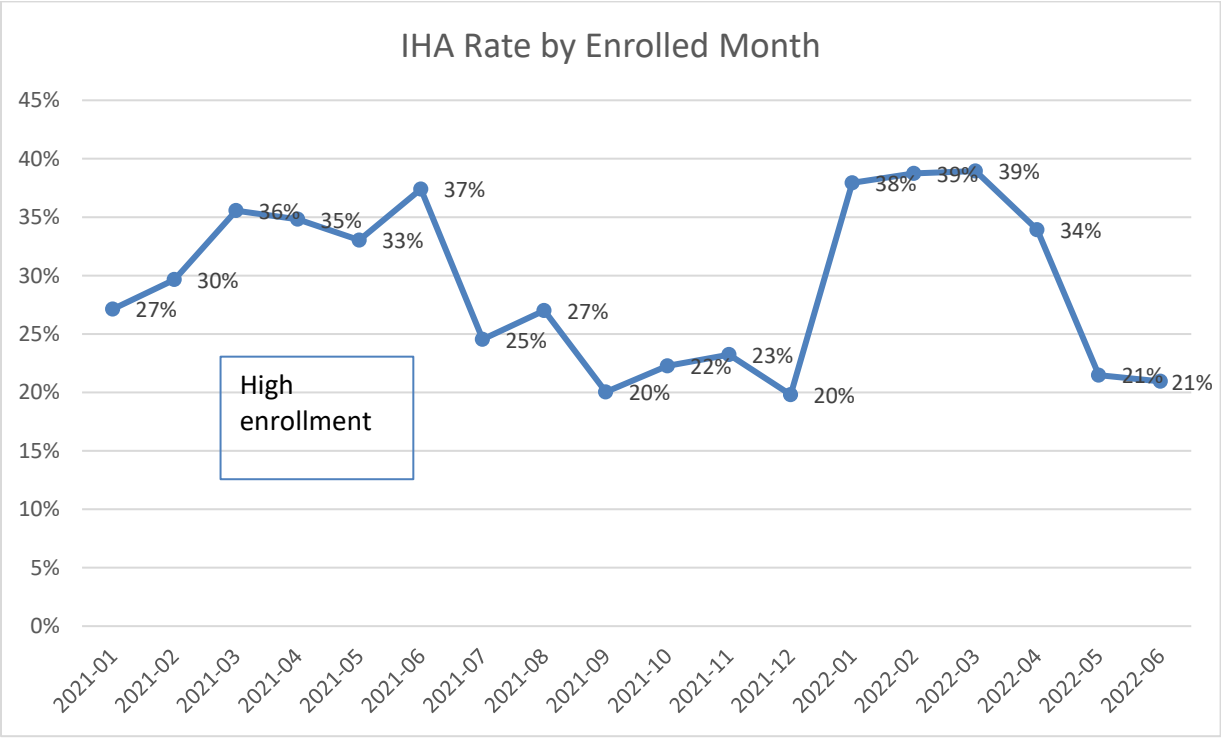
The Initial Health Assessment (IHA) has become an increasingly higher priority in health plans across California. Focus has also increased on primary care and preventative services as the Medi-Cal population has a higher incidence of chronic and/or preventable illnesses, many of which could be modified through appropriate health behavior change and early detection to promote lifestyle changes. 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 08-003) requires all primary care providers to administer an IHA to all Medi-Cal managed care patients as part of their initial and well care visits. It is required that health plan's reach a 100% compliance rate ensuring every member enrolled is seen by their primary care physician.

IHA OUTREACH PROGRAM UPDATES

A letter is sent out to new HPSM members on a monthly basis in conjunction with a flyer in their welcome packet, urging members to set an appointment with their provider as soon as they are able. A training manual for HPSM's provider network was created to educate providers on the requirement and benefit to outreach to their new members to get them in to be seen.

While the information about the importance of scheduling an IHA with their providers continued in new member packet, other member outreach efforts were suspended during the public health emergency (PHE). Upon lifting of PHE, in July of 2021, the IHA reminder flyer was revised to emphasize the safety of seeing their provider during the Covid-19 pandemic and the importance of wearing a mask.

MONTHLY IHA COMPLIANCE RATES 2021-2022



IHA PROVIDER EDUCATION

The Health Plan of San Mateo makes the providers aware of the requirement of the IHA and SHA/IHEBA through three programs.

1. **Provider Services Outreach:** Periodic visits updating changes to existing programs, introducing new programs, and reinforcing on-going programs by provider service personnel.
2. **Pay for Performance Program:** Monthly reports sent to the provider detailing level of participation. Including Provider Services Pay for Performance promotion visits.
3. **Medical Record Review as part of the FSR audit process:** Any deficient IHA and SHA/IHEBA documentation is addressed at the time of the Facility Site Review by site review nurses. Providers noncompliant or mostly noncompliant with consistent IHA completion will be asked to complete a Corrective Action Plan. Providers are given copies of the Staying Healthy Assessments for all age groups and appropriate languages for the practice population.

IHA BARRIERS

The SHA continues to be the greatest hurdle to higher compliance rates. With the increased emphasis on use of Electronic Health Records, the paper-based SHA has become more cumbersome for the provider and the office staff. Providers consistently ask about the availability of an electronic version of the SHA. Providers have asked for acceptable alternatives to the SHA.

The Quality Improvement Department continues to review new avenues to increase IHA compliance.

IHA OUTREACH PROGRAM ACTION PLAN FOR 2023

Starting in 2023, the IHA was modified. The Initial Health Appointment still needs to occur within the first 120 days of enrollment, however, the SHA/IHEBA component is no longer required. HPSM has struggled to increase the timeliness of IHAs and will be implementing the following in 2023 to improve IHA rates.

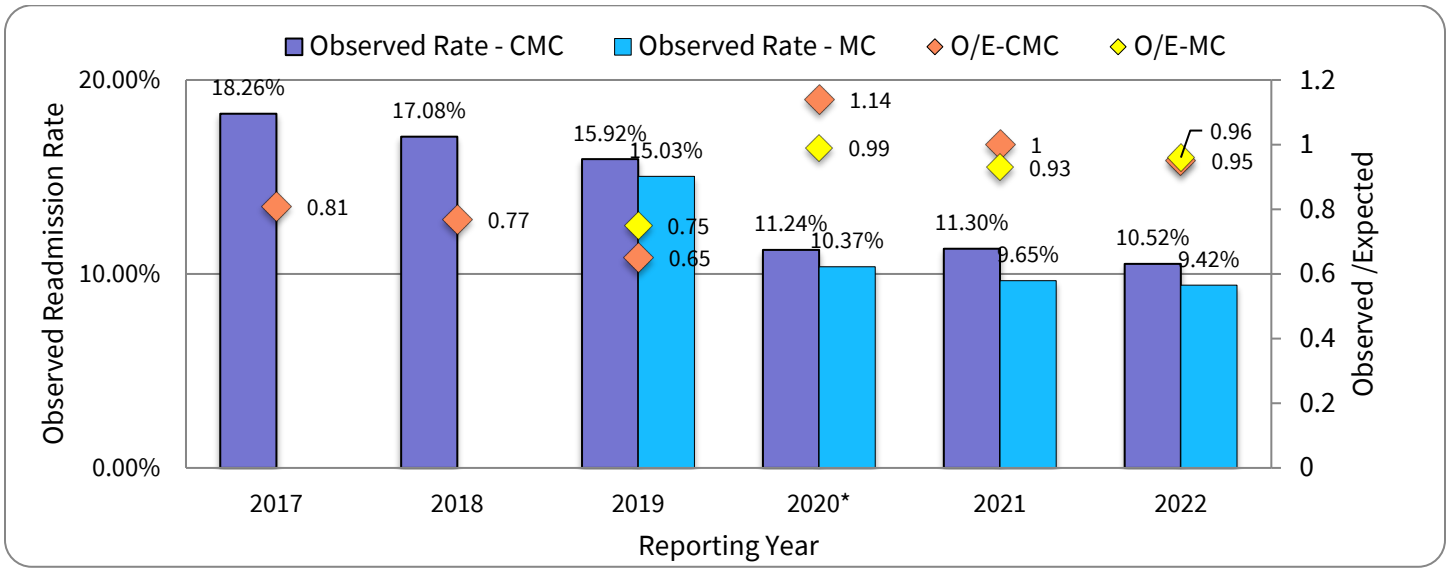
IHA completion will continue to be incentivized for Medi-Cal PCPs under HPSM Pay for Performance (P4P) program. As part of P4P, monthly reports sent to PCPs detailing level of performance.

- Provider notification of changes to IHA requirement
- Continue pay-for-performance(P4P) monetary incentive for PCPs for timely IHA completion in 2023
- Conduct training webinars with providers on IHA requirements and reporting for the P4P incentive
- Revise PCP monthly member engagement/assigned patient report to enable PCPs to more readily identify new Medi-Cal members in need of an IHA and deadline/date for completion to meet the timeliness requirement
- Include an article in the provider newsletter on IHA requirements and resources
- Continue monitoring IHA compliance on a quarterly basis, identifying trends in PCP compliance
- Continue PCP compliance monitoring and correction action activities.
- Continue IHA reminder insert in new Medi-Cal member welcome packets.

3.8 PLAN ALL-CAUSE READMISSIONS (PCR)

PCR HEDIS RESULTS

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 CMC.



Measure/Program	PCR Metric
Objective:	Objective: Reduce 30-day readmissions so that the observed readmissions to the expected readmissions, based on member level of risk and acuity, is less than 1 for both Medicare and Medi-Cal populations.
Program Description	The Care Transition program is available to all HPSM members that are discharged from an in-patient hospital stay at any of our contracted facilities and are identified to have complex post discharge support needs. Working collaboratively with the facility staff, the Inpatient Review Nurse provides support for the members discharge back home. The Inpatient Review Nurse assesses the members in need of Care Transitions support using a complex needs assessment tool and refers members to the Integrated Care Management team (ICM).
Trend:	PCR measurement methodology changed in reporting year 2020 where members with 4 or more inpatient admissions were removed as outliers from the PCR observed readmission rate calculation. Because of this change in the measure calculation, observed readmission rates and ratios are not comparable to prior reporting years. However, from reporting years 2021 to 2022 for both Medi-Cal (from 9.65% to 9.42%) and CMC (from 11.30% to 10.52) populations indicate improvement. The observed to expected readmission ratio (O/E) for Medi-Cal increased from 0.93 to 0.96, but decreased for CMC from 1 to 0.95.

Goal Met/Not Met	While there was increase in O/E for Medi-Cal, PCR O/E were under 1 for both Medi-Cal and CMC populations. Goal was met.
Barriers identified	Lack of timely PCP follow up visits by members after discharge. This occurs because hospitals do not have a process in place or the necessary staff resources to communicate to the PCP that a discharge has happened. Also, members being discharged are unaware they need to follow up with their PCP because Hospital's lack resources to fully educate members at time of discharge on the importance of scheduling a timely PCP follow up visit. These factors prevent successful continuity of care for the member.
Recommended interventions for barriers	The care transitions program was restructured allowing availability of the program for members not only discharged from an in-patient stay at Seton, Mills, SMMC and Stanford but from all discharging facilities including but not limited to discharges from other hospitals, acute care facilities and SNFs. In collaboration with the Utilization Management's Inpatient Nurse team, all members identified for discharge are provided care transitions by the Inpatient Nurse assigned to a facility and referred to the Integrated Care Management (ICM) when identified to have a complex case need providing opportunity for members already engaged with their ICM Care Manager to continue being supported by that ICM Care Manager or assigned to an ICM Care Manager for care transitions. Members who are engaged with Enhanced Care Management (ECM) or HPSM's HomeAdvantage program are directed to the ECM or HomeAdvantage provider for care transitions and post discharge support.
Whether yearly planned activities were met	Yes
Any changes to the program	HPSM will continue to utilize the CT Team to bridge the gap in providing care transitions management to the members after discharge as described above. In 2023, CT program will also focus on engaging members to have lower rates of 14-day ED visits post discharge as well as higher rates of engagement with their PCPs post discharge.

4. SAFETY OF CARE & QUALITY OF SERVICES

4.1 CLINICAL GUIDELINES ANNUAL REVIEW

HPSM's Quality department leads an annual review of the clinical guidelines posted on the HPSM website. The review process ensures the posted guidelines are evidenced-based, current, and relevant to the plan's member population. The Quality Improvement team goes online to check the date of the most recent published update for each guideline, posted by the source organizations. We prepare an annual summary of the posted guidelines for presentation to the Quality Improvement Committee (QIC) in the Fall. The summary provides the last published date of each guideline,and includes progress notes on the update status for any guideline that has not been updated within the last 5 years.

2022 Clinical Guidelines and Resources listed by Topic
New:
1. Primary Care Guidelines on Prescribing Controlled Substances

2. The CDC Guideline for Prescribing Opioids for Chronic Pain-(CDC 2016)
3. The CDC Guidelines for Treatment of Latent Tuberculosis-(CDC 2020)

Asthma

1. Asthma Management Guidelines - Clinician's Guide (NHLBI Dec 2020)
2. Global Initiative for Asthma (GINA) 2020 Guidelines
3. Asthma Care - Quick Reference Guide (NHLBI -revised 2012)
4. Asthma Medication Ratio Tip Sheet
5. Asthma Action Plan

Behavioral Health

1. ADHD Parents Medication Guide (APA 2013)
2. Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts (APA 2019)
3. Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescent (AAP 2019)
4. Developmental Services Referral Guide
5. Depression in adults: recognition and management (NICE Updated June 2022)
6. Depression in children and young people: identification and management (NICE 2019)
7. Guidelines for Assessment of and Intervention With Persons With Disabilities (APA Updated Feb 2022)
8. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management (AAP 2018)
9. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part II. Treatment and Ongoing Management (AAP 2018)
10. Guidelines for Psychological Practice for People with Low-Income and Economic Marginalization (AAP 2019)
11. Guidelines for Psychological Practice with Lesbian, Gay & Bisexual Clients (renamed APA GUIDELINES for Psychological Practice with Sexual Minority Persons) (APA 2021)
12. Guidelines for Psychological Practice with Older Adults (APA 2014)
13. Guidelines for Treatment of Patients with Substance Use Disorders (APA 2010)
14. PCP Referral Form for Behavioral Health and Recovery Services
15. Pharmacological Treatment of Patients with Alcohol Use Disorder (APA 2018)
16. Treating Depression in the Primary Care Setting

Cancer Screening

1. Breast Cancer Screening
2. Colorectal Cancer Screening (USPSTF 2021)
3. Cervical Cancer Screening Guidelines
4. Lung Cancer Screening (USPSTF 2021)
5. Grade Definitions for United States Preventive Services Task Force Recommendations
6. USPSTF Grade A and B Recommendations

Cardiovascular and Circulatory Guidelines

1. Guidelines for Management of Heart Failure (ACC - 2017)
2. CDC Guide to Effective High Blood Pressure, Cholesterol, and Cardiovascular Disease Prevention Programs, Including Pharmacists on the Care Team

Diabetes

1. Diabetes Prevention Program
2. Standards of Medical Care in Diabetes (ADA -2021)
3. Self Management Sessions (for patients at SMMC Clinic)
   Immunization Schedules

Schedules for Health Care Professionals

1. Birth to 18 years and Catch Up schedules (CDC 2022
2. Adult Immunization Schedule (CDC 2022)
3. Combination Vaccines

Easy-to-Read Schedules For Patients and Parents
1. Recommended for Babies and Children (birth to age 6)
2. Recommended for Children and Teens (age 7 to 18)
3. Recommended for Adults
4. Combination Vaccines – Information for Parents

Obesity
1. Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults (USPSTF- 2018)
2. Child or Teen Obesity Screening (USPSTF - 2017)
3. Adults Body Mass Index Calculator
4. Adult Body Mass Index Table

Pediatrics
1. ASD and ABA Referral Guidelines
2. Blood Lead Screening Guideline (CDPH 2019)
3. Blood Lead Poisoning Testing and Management (CDPH 2017)
4. Bright Futures Clinical Guidelines and Resources
5. Bright Futures Preventive Care Periodicity Schedule
6. Pediatric Therapy Eligibility Guidelines
7. Pediatric Care Coordination Supportive Services Referral Guide
8. Pocket Guide: Guidelines for Health Supervision of Infants, Children and Adolescents

STD Guidelines
1. CDC Sexually Transmitted Disease Treatment Guidelines (CDC 2021)
2. Chlamydia Screening (USPSTF 2014)
3. Disease Reporting Form – San Mateo County
4. HPV vaccine for child/teen (scroll to 18 months to 18 years on schedule or Birth-18 Years Immunization Schedule | Syndicated | CDC)
5. HPV vaccine information for parents

Source organization and websites for evidence-based guidelines posted on HPSM's website.
American Academy of Pediatrics (AAP)
American College of Cardiology (ACC)
American Diabetes Association (ADA)
American Psychiatric Association (APA)
Centers for Disease Control (CDC)
California Department of Public Health (CDPH)
National Heart Lung and Blood Institute (NHLBI)
National Institute for Health and Care Excellence (NICE)
U.S Preventive Services Task Force (USPSTF)

CLINICAL GUIDELINES ANNUAL REVIEW UPDATE

Annual review and approval by Quality Improvement Committee (QIC)

The Quality department presented the annual summary of the posted guidelines to the Quality Improvement Committee at its quarterly meeting in September 2022. All additional and updated guidelines were reviewed and approved by the QIC.

ACTION PLAN FOR 2023

HPSM Quality will continue to check the websites for the source organizations for updates to the guidelines posted on the HPSM website. Quality will also ensure that the Provider Manual maintains a hyperlink to the Clinical Guidelines page on the HPSM website. Provider Services will promote 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.

Due to staffing shortages and lack of certified site review (CSR) nurse (s), HPSM was only able to conduct one (1) site review in 2022.

- Of the 1 facility site review completed in 2022, the FSR score was 73 %.
- Of the 1 medical record review completed in 2022 , the MRR score was 93% %.

Following the Site Review, the provider abovementioned was issued a corrective action plan (CAP), which was closed May 11, 2022.

Common Deficiencies identified in Facility Site Review:

- Written policies of documenting medication expiration were not available and expired medications present. Documentation of cleaning schedule for janitorial services including a list of cleaning products used was not readily available.
- Documentation of employee trainings were often incomplete
- All stored and dispensed prescription drugs were not always labeled appropriately

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

Site personnel are qualified and trained for assigned responsibilities. No evidence that a qualified/trained personnel retrieve, prepare or administer medications. Site is compliant with OSHA Bloodborne Standard and Waste Management Act. Needle stick safety precautions are not practiced on site. Blood, other potentially infectious material and regulated wastes are not placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping. Re-usable medical instruments are properly sterilized after each use Spore testing of autoclave/steam sterilizer with documented results is not done at least monthly.

Common Deficiencies identified in Adult Medical Record Review

- Primary language and linguistic needs were not documented.
- Evidence of tuberculosis screenings absent in medical record.
- Staying Healthy Assessments as part of the Initial Health Assessment (IHA) as well as subsequent Staying Health Assessments were not completed.
- Advance Care Directives were not documented as offered or discussed nor was it filled out by member.
- Adult immunizations were not given according to guidelines
- No evidence of site personnel receiving safety/training information in various topics (i.e. Bloodborne pathogens exposure prevention, infection control/universal precautions, biohazardous waste handling, and etc.)
- Drugs are not handled safely and stored appropriately

FSR ACTION PLAN FOR 2023

- Continue with our processes with completing FSR/MRRs in efforts to reduce backlog as result of the PHE and reduced staffing in 2022
    - Reduce backlog by 10 by end of 2023
- Create additional new educational materials, for posting on the FSR page of HPSM's website and distribute to providers. Among these: Required Staff Trainings Packet; Adult Screenings, Pediatric Screenings (with emphasis on new DHCS-required screenings. Direct our providers towards obtaining information about FSR/MRRs and completing Corrective Action Plans from the resources on our HPSM Website. This will help reduce deficiencies in future FSRs and MRRs and help providers to maintain full compliance.
- We will continue to collaborate with other MC Health Plans to obtain results of site reviews prevent duplicate site reviews of the same provider.
- Put together a plan to educate providers on the new survey and assure their success. Focus on distribution of material prior to the scheduled site review
- Fill open QI Nurse position and begin the CSR process for respective candidate

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
PA= Participant Areas

A total of 8 Physical Accessibility Reviews (PAR) were done for 2022.

Below is the break down for 2022:

Level of Access:	# of PCP/Hospital
Basic Access	2
Basic Access/ Medical Equipment	0
Limited Access	6
Limited Access/Medical Equipment	0
No Access	0

Two facilities met all CE receiving "Basic Access." 6 sites received" Limited Access."
The plan did not encounter barriers or issues meeting the PAR policy objectives. No corrective action plan is required for providers/facilities that do not meet the level of access. Recommendations may be made to meet the highest level of accessibility, but it is not a requirement.

The goal is 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 will be to continue 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.

4.5 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.

We completed 42 PQI/Quality of Care Reviews from 1/1/2022 to 12/31/2022.

Final counts by PQI Level

Row Labels	Count
P0/S0	13
P0/S1	9
P0/S2	6
P1/S0	4
P1/S1	3
P2/S2	3
Grand Total	**38**

5.0 MEMBER EXPERIENCE & HEALTH OUTCOMES

5.1 HEALTH OUTCOMES SURVEY (HOS)

HPSM participates in the Medicare Health Outcomes Survey (HOS) to gather valid, reliable, and clinically meaningful health status data from the CareAdvantage Cal-Mediconnect 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 is 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. The following topics are covered

- Health Status Measures
  - Physical (PCS) & Mental (MCS)Component Summary Scores
- Chronic medical conditions
- Functional status (ADLs)
- Clinical measures
- Effectiveness of Care (HEDIS) measures
  - Fall Risk Management (FRM)
  - Osteoporosis Testing in Older Adults (OTO)

- Physical Activity in Older Adults (PAO)
- Management of Urinary Incontinence in Older Adults (MUI)

REQUIREMENTS AND TIMEFRAMES:

In 2021, MAOs with Medicare contracts in effect on or before 1/1/2018 participated in the survey. Plans must also have had a minimum enrollment of 500 with 6 months of continuous enrollment to participate. Surveys are fielded annually in August through November 2021 and summary reports are available the following July. The baseline for HPSM's Cohort 22 was collected in 2019 and the follow up survey for that population was collected in 2020. The baseline conducted for HPSM's Cohort 21 was collected in 2018 and the follow-up survey for that population was collected in 2019. The baseline conducted for HPSM's Cohort 20 was collected in 2017 and the follow-up survey for that population was collected in 2018 and the merged results are available in a report from CMS.

For Cohort 22 the original baseline sample size for was 1,200; however, 920 members were not included in the analytic sample because they did not complete the baseline survey, were not seniors, or were determined to be ineligible beneficiaries at baseline. Therefore, the analytic sample size was 280. Of the 280 members in the analytic sample, 47 voluntarily disenrolled from HPSM and 23 died between baseline and follow up. Of the 210 members sent a follow up survey, 4 were determined to be ineligible. Of the remaining 206 members, there were 55 who did not complete the survey and 151 who returned a completed follow up survey. This represented an overall follow up response rate of 73.3% for HPSM, as compared with the National HOS follow up response rate of 63%.

HOS COHORT 22 FOLLOW-UP RESULTS:

Improving or Maintaining Physical Health Score Results Trended over Three Cohorts

Table 1: Trends in Physical Health Results over Three Cohorts for MAO H7885

	Percent Better*	Percent Same*	Percent Worse*	Percent Better+Same*	Performance Results**
2019-2021 Cohort 22	18.05%	54.63%	27.32%	72.68%	⇔
2018-2020 Cohort 21	15.86%	60.92%	23.22%	76.78%	⇔
2017-2019 Cohort 20	21.12%	51.05%	27.83%	72.17%	⇔

NA indicates that the MAO did not have results for the specified cohort.

* The percent better, same, worse, or better+same refers to member health status within an MAO.

** The statistical significance of each performance result for the MAO is indicated by one of the following symbols:

⬆ MAO performed significantly better than expected (higher than the national average)

⬇ MAO performed significantly worse than expected (lower than the national average)

⇔ MAO performed as expected (the same as the national average)

In the category for improving or maintaining their physical health score, HPSM results were as expected, the same as the national average

Improving or Maintaining Mental Health Score Results Trended over Three Cohorts

Table 2: Trends in Mental Health Results over Three Cohorts for MAO H7885

	Percent Better*	Percent Same*	Percent Worse*	Percent Better+Same*	Performance Results**
2019-2021 Cohort 22	14.68%	70.88%	14.44%	85.56%	⇔
2018-2020 Cohort 21	14.02%	67.05%	18.93%	81.07%	⇔
2017-2019 Cohort 20	15.29%	68.73%	15.98%	84.02%	⇔

NA indicates that the MAO did not have results for the specified cohort.

* The percent better, same, worse, or better+same refers to member health status within an MAO.

** The statistical significance of each performance result for the MAO is indicated by one of the following symbols:

- ⬆ MAO performed significantly better than expected (higher than the national average)
- ⬇ MAO performed significantly worse than expected (lower than the national average)
- ⇔ MAO performed as expected (the same as the national average)

Our results also suggest that in the category for maintaining or improving the mental health score, HPSM results were as expected, the same as the national average

Distribution of Members with Worse Self-Rated General and Comparative Health Status HPSM (H7885), CA and National Total

Table 3: *2019-2021 Cohort 22 Performance Measurement* Distributions of Members with Worse Self-Rated General and Comparative Health Status for MAO H7885, California, and HOS Total

	Fair or Poor		Comparative Physical Slightly Worse or Much Worse		Comparative Mental Slightly Worse or Much Worse	
	Baseline	Follow Up	Baseline	Follow Up	Baseline	Follow Up
H7885	43.2%	49.3%	35.4%	35.4%	19.7%	30.8%
California	29.3%	32.2%	25.8%	30.6%	13.4%	18.2%
HOS Total	21.6%	24.9%	22.6%	27.8%	9.9%	13.6%

HPSM has seen an increase in the baseline versus follow up cohorts for this measure and especially in the mental health related response.

2021 HEDIS HOS MEASURES

The HEDIS HOS results measure Plan performance in the following four measures: Management of Urinary Incontinence in Older Adults (MUI), Physical Activity in Older Adults (PAO), Fall Risk Management (FRM), and Osteoporosis Testing in Older Women (OTO). Three components of the HEDIS HOS measures are used in the Medicare Star Ratings: Improving Bladder Control, Monitoring Physical Activity, and Reducing the Risk of Falling.

HEDIS HOS results are based on data from the HOS Round 24 surveys (combined *Cohort 24 Baseline* and *Cohort 23 Follow Up* data) collected in 2021. Prior rounds also combined baseline and follow-up surveys administered the calendar year.

Trending of over the last Three Survey Years:

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*
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%
2019 Round 22	68.67%	50.34%	32.67%	62.80%	65.82%	37.97%	80.68%

* Measures incorporated into the 2023 Medicare Star Ratings include the MAO 2021 *Improving Bladder Control* (MUI Treat Rate), and *Reducing the Risk of Falling* (FRM Manage Rate).

HPSM rates increased across all measures from prior survey year, except FRM Manage Rate.

HPSM 2021 HEDIS HOS Rates Compared to California, CMS Region 9 and National HOS Total:
Table 1: 2021 HEDIS HOS Rates for MAO H7885, 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*
H7885	64.38%	51.25%	32.70%	68.36%	66.58%	36.13%	74.32%
California	57.98%	45.65%	19.23%	58.36%	55.18%	24.58%	60.14%
CMS Region 9	57.89%	45.20%	17.75%	56.56%	52.13%	24.49%	57.84%
HOS Total	59.30%	45.19%	15.76%	55.28%	49.92%	26.11%	55.63%

†See Table 3 results for all MAOs in the state.
* Measures incorporated into the 2023 Medicare Star Ratings include the MAO 2021 *Improving Bladder Control* (MUI Treat Rate), and *Reducing the Risk of Falling* (FRM Manage Rate).

HPSM performed well in all ratings.

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 2022 survey includes only child members. The HSPM conducts separate annual CAHPS surveys for its members with Medicare and child members with Medi-Cal. The surveys are mailed in English and Spanish with a follow up telephone call.

2022 Medicare CAHPS SURVEY SUMMARY

The response rate was 35.6%, which is an increase when compared to the 2021 response rate of 35.3%, Most questions are answered using a 0 (worst) to 10 (best) scale **or** a “never, sometimes, usually, always” scale.

CAHPS MEDICARE SURVEY RESULTS

Health Plan Overall Ratings Measure Results:
For this survey measure, respondents used a 0-10 scale to rate their health plan, care received from their plan overall, their personal doctor, and the specialist (if any) they had seen most frequently in the past 6 months. The questions for each of the items are as follows:

Overall Ratings	Survey Item
Rating of Health Plan	Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?
Rating of Health Care Quality	Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?
Rating of Personal Doctor	Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?
Rating of Specialist	We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

For each measure, the table below shows the national average for all MA contracts, the national average for all MMP contracts. This provides HPSM's case-mix adjusted mean score, over time, on a 0-10 scale. Statistical Significance indicates whether HPSM's rating was significantly above, below than or no difference to the national MA average. A score of N/A indicates that response rates to those items were not sufficiently high to render a reliable, comparable rate. As shown HSPM's rating on the composite items are below average across contract types.

Overall Health Plan Ratings	Primary MA State (CA) Score	National MA Score	Primary MMP State (CA) Score	National MMP Score	Your Contract's Score	Statistical Significance (Your Contract Versus National)	Reliability of Your Contract's Score
Rating of Health Plan	8.8	8.8	8.6	8.6	8.4	Below Average	Good
Rating of Health Care Quality	8.6	8.7	8.4	8.5	8.2	Below Average	Good
Personal Doctor	9.1	9.2	9.0	9.0	N/A	N/A	Very Low
Specialist	8.9	9.0	8.9	8.9	N/A	N/A	Very Low

MEDICARE-SPECIFIC AND HEDIS MEASURE RESULTS:

For this response, survey participants were asked whether they received a flu vaccination recently and whether they had ever received a pneumonia vaccination (yes or no). The table below shows HPSM's percentage of "yes" responses for these two items, the national average for all MA contracts, the national average for all MMP contracts, and whether the score was significantly greater than, less than, or equal to the national MA average. These items are not adjusted for case mix. HPSM scored well on the flu vaccine measure above the National MA and MMP average and is comparable to the National MA percentages for the pneumonia vaccine.

Medicare-Specific and HEDIS Measures	Primary MA State (CA) Score	National MA Score	Primary MMP State (CA) Score	National MMP Score	Your Contract's Score	Statistical Significance (Your Contract Versus National)	Reliability of Your Contract's Score
Annual Flu Vaccine	81%	75%	74%	69%	86%	Above Average	Good
Pneumonia Vaccine	76%	73%	61%	56%	67%	No Difference	Good

HEALTH PLAN COMPOSITE MEASURES RESULTS:

Responses to individual survey questions were combined to form five composite (summary) measures of members' experiences with their health plans. For each measure, the table below shows the national average for all MA contracts, the national average for all MMP contracts, the plan's case-mix adjusted mean score on a 1-4 scale, and whether the plan's score was significantly above, below than or no difference to the national MA average. A score of N/A indicates that response rates to those items were not sufficiently high to render a reliable, comparable rate.

CAHPS Health Plan Composite Measure Questions

Table 1. MA-PD CAHPS Survey Composites

Composite Measures	Survey Items Included in the Composite
Getting Needed Care	In the last 6 months, how often was it easy to get the care, tests or treatment you needed? In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
Getting Appointments and Care Quickly	In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic? Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

Composite Measures	Survey Items Included in the Composite
Doctors Who Communicate Well	In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand? In the last 6 months, how often did your personal doctor listen carefully to you? In the last 6 months, how often did your personal doctor show respect for what you had to say? In the last 6 months, how often did your personal doctor spend enough time with you?
Customer Service	In the last 6 months, how often did your health plan's customer service give you the information or help you needed? In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect? In the last 6 months, how often were the forms for your health plan easy to fill out?
Care Coordination	In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results? In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them? In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

Medicare Health Plan Composite Measure Results

Health Plan Composite Measures	Primary MA State (CA) Score	National MA Score	Primary MMP State (CA) Score	National MMP Score	Your Contract's Score	Statistical Significance (Your Contract Versus National)	Reliability of Your Contract's Score
Getting Needed Care	3.39	3.45	3.31	3.38	3.26	Below Average	Good
Getting Appointments and Care Quickly	3.31	3.33	3.20	3.28	3.22	Below Average	Good
Doctors Who Communicate Well	3.71	3.75	3.69	3.72	N/A	N/A	Very Low
Customer Service	3.68	3.71	3.63	3.68	N/A	N/A	Very Low
Care Coordination	3.52	3.59	3.50	3.55	3.54	No Difference	Good

HPSM performed below average across contract types for the composite measures with a reliable result, and equivalent to other contract types for the Care Coordination measure.

2022 Medi-Cal CAHPS SURVEY SUMMARY

See APPENDIX B: 2022 MEDI-CAL CAHPS SURVEY RESULTS

5.3 GRIEVANCES AND APPEALS

The Grievances & Appeals Report representing data from 2022, 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

9. SUMMARY OF EFFECTIVENESS 2022

Adequacy of QI Program Resources	Securing adequate resources to support QI activities continued to be a challenge in 2022. In the beginning of 2021, the QI Department underwent a reorganization where staff that focused on the quality improvement initiatives were redeployed to focus on population health management and health equity efforts. These changes left vacancies in the department. As a result, QI staffing was spread thin and we had to assess priorities and transition responsibilities to remaining department staff to ensure coverage of high priority projects, especially for continued COVID-19 response and vaccination efforts. By mid-2022, three staff members were hired including, QI Specialist, QI Clinical Manager and a QI Nurse. The open positions remained unfilled at the end of 2022. The reorganization of the QI Department also initiated a transformation of how the quality improvement initiatives and programs are administered within HPSM. QI Department staff will retain the clinical quality monitoring, evaluation and reporting functions and may lead quality improvement initiatives across organizational teams. However, quality improvement program implementation and ongoing administration will be more integrated through the various operational units of HPSM. This allows for a more robust and sustainable QI Program that will lead to substantial improvement in health outcomes for our members.
QI Committee Structure	The QIC committee structure remained the same in 2022. The committee continues to provide a forum for QI to report out of program activities. The committee continues to serve as an advisory role in our QI programming in 2022 and actively participate in discussions regarding opportunities for improvement, data analysis, intervention planning and evaluation. The QI 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 and Pharmacy units and Medical Directors. In addition to the practitioners that sit on the QI Committee and HPSM's CMO, HPSM has three medical directors with differing areas of expertise including Obstetrics & Gynecology, Gerontology and Primary Care. This structure continued throughout 2022. Our CMO and Medical Directors are heavily involved with QI 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 QI Program happens both from individual's participation in various QI activities as well as through the QI Committees including the Quality Improvement Committee (QIC) 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 QI Program Activities and will continue in 2023.

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

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

Abrev	Measure	MY2021	50th Percentile	MY 2020 Rate	MY 2019 Rate
CBP	Controlling High Blood Pressure*	62.20	55.35	53.04	(58.78)^
CDC >9	Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)* (lower is better)	28.78	43.19	37.23	30.17
CIS-10	Childhood Immunization Status –Combo 10*	54.85	38.20	61.56	51.58
IMA -2	Immunizations for Adolescents –Combo 2*	51.58	36.74	50.61	55.12
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents BMI Percentile Documentation* Counseling for Nutrition* Counseling for Physical Activity*	83.78 78.46 76.60	76.64 70.11 66.18	75.18 74.7 65.94	73.97
BCS	Breast Cancer Screening	53.96	53.93	59.20	65.86
CCS	Cervical Cancer Screening*	57.61	59.12	58.91	(64.72)^
CHL	Chlamydia Screening in Women	68.71	54.91	63.98	67.49
PPC -Post	Prenatal and Postpartum Care – Postpartum Care*	92.45	76.40	92.59	84.18
PPC-Pre	Prenatal and Postpartum Care – Timeliness of Prenatal Care*	89.31	85.89	90.0	87.59
WCV	Child and Adolescent Well-Care Visits (3-21 yrs)	56.92	45.31	48.80	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	25.73 69.14	54.92 70.67	20.03 76.94	N/A

New MPL = 50th Percentile
*Hybrid measure (chart review + admin & sup data)
^Rotated measure: MY 2018 rate reported (MY2019 measured rate)
Under MPL
Above HPL

ALL OTHER MCAS MEASURES

Measure Abbrev.	Measure	MY 2021 Rate	MY 2020 Rate	MY 2019 Rate
AMB-ED	Ambulatory Care: Emergency Department (ED) Visits per 1,000 member months	38.63	36.99	49.88
ADD-Init	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications – Initiation Phase	24.35	22.88	22.70
ADD-C/M	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications – Continuation and Maintenance Phase	N/A	N/A	N/A
PCR	Plan All-Cause Readmissions • Observed rate (lower is better) • Observed to expected ratio	9.42 0.9597	9.64 0.9322	10.37 0.9926
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing	42.55	35.64	N/A
AMR	Asthma Medication Ratio	69.56	70.06	61.35
AMM -AP	Antidepressant Medication Management - Effective Acute Phase Treatment	67.59	66.47	67.02
AMM -CP	Antidepressant Medication Management - Effective Continuation Phase Treatment	51.48	51.09	49.37
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.19	78.15	N/A
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence •7-Day Follow-up •30-Day Follow-up	4.27 7.58	N/A	N/A
FUM	Follow-Up After Emergency Department Visit for Mental Illness •7-Day Follow-up •30-Day Follow-up	18.58 27.72	N/A	N/A

All administratively collected measures; Measure new to MCAS for MY2021

Measure Abbrev.	Measure	MY 2021 Rate	MY 2020 Rate	MY 2019 Rate
DEV^	Developmental Screening	43.02	24.24	45.28
COB^	Concurrent Use of Opioids and Benzodiazepines (lower is better)	15.91	18.56	18.46
OHD^	Use of Opioids at High Dosage in Persons Without Cancer (lower is better)	8.56	9.38	10.19
CDF^	Screening for Depression and Follow-Up Plan: Age 12 and Older	36.17	28.45	27.03
CCW^	Contraceptive Care: All Women Ages 15-44: •Most or moderately effective contraception •Long Acting Reversible Contraception (LARC)	25.26 5.25	24.34 4.99	24.38 5.17
CCP^	Contraceptive Care: Postpartum Women Ages 15-44: •Most or moderately effective contraception – 3 days •Most or moderately effective contraception – 60 days •LARC – 3 days •LARC – 60 days	26.91 52.41 14.88 25.93	25.75 50.17 13.89 23.97	15.79 42.34 7.54 22.73

All administratively collected measures
^Non-HEDIS measure

APPENDIX B: 2022 MEDI-CAL CAHPS SURVEY RESULTS

OVERVIEW

Medi-Cal CAHPS results were available every three years, using NCQA CAHPS and certified vendors prior to HPSM's NCQA Accreditation. 2020 CAHPS was not conducted for the Medi-Cal population due to the response and impact of the Covid-19 pandemic. NCQA CAHPS is now conducted annually. 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. In 2022, only the Child Survey was conducted for accreditation because the Adult and Child survey is conducted only every other year; therefore, no response rate is available for adults in 2022.

Table 1: CAHPS 2022 Response Rate Trends

	2016		2019		2021		2022
CAHPS Data	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Child**	**Child**
Sample size (includes oversampling)	1384	1731	1917	1659	1850	1799	1635
Patient Level Records Used: Complete & Valid	344	511	423	381	392	379	222
Total Response Rate: Complete/(sample-Ineligible)	**26.58%**	**31.56%**	**23.35%**	**23.06%**	**21.71%**	**21.34%**	**13.6%**

As Table 1 above shows, there were 222 completed surveys which is a decrease from 379 child responses in 2021. Although the response rate of 13.6 is low, it is sufficient for valid result reporting for 2022.

CHILD SURVEY RESULTS

Table 2 below shows trends in "Top box" ("Always" or "Usually") responses for composite items for the Child survey across collection years. Also included are the 2022 Top Box Scores for all plans in the SPH Book of Business(BOB) for comparison, and the Plan's NCQA Health Plan Rating (HPR). Comparing 2021 results shows improvement in the rating of the ***Getting Needed Care, Getting Care Quickly*** and ***Customer Service*** composite items and a decrease in ***Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor,*** and ***How Well Doctors Communicate***.

HPSM staff set 2022 Plan goals for ***How Well Doctors Communicate***, ***Getting Needed Care***, ***Getting Care Quickly*** and ***Customer Service*** based on Plan desired improvement percentile . The goal rates for ***Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor,*** and ***Rating of Specialist*** were set to match NCQA Quality Compass results.

The 2022 performance goal rates were not met for ***Rating of Personal Doctor, How Well Doctor's Communicate*** or ***Customer Service,*** but were met for ***Rating of Health Plan, Rating of All Health Care, Rating of Specialist, Getting Needed Care*** **and** ***Getting Care Quickly***.

There was a significant decrease in the ***Rating of Personal Doctor*** compared to the 2021 results, but a significant increase in the ***Getting Needed Care*** and ***Customer Service*** *measures*.

Table 2: Child Survey Results 2022 Trends and Comparisons

Measure	2016 Top-Box Scores	2019 Top-Box Scores	2021 Top-Box Scores	2022 Top-Box Scores	2021 to 2022 change	SPH BOB 2022 Top-Box Scores	NCQA HPR 2022	2022 Goal Rate	Goal Met
Rating of Health Plan	69.90%	78.30%	76.84%	74.80%	-2.04%	72.50%	66.67th	72.20%	Yes
Rating of All Health Care	68.00%	70.30%	77.93%	76.00%	-1.93%	71.20%	66.67th	74.30%	Yes
Rating of Personal Doctor	76.10%	79.30%	81.31%	74.70%	-6.61%	77.40%	10th	78%	No
Rating of Specialist Seen Most Often	71.6%+	81.4%+	N/A	88.40%	NA	73.90%	NA	73.80%	Yes
Getting Needed Care	77.80%	78.60%	82.66%	87.80%	5.14%	84.40%	NA	84.66%	Yes
Getting Care Quickly	77.40%	81.10%	81.14%	83.30%	2.16%	86.70%	NA	82.14%	Yes
How Well Doctors Communicate	92.30%	93.20%	93.98%	93.90%	-0.08%	94.40%	Not Measured	93.98%	No
Customer Service	89.40%	94.30%	86.35%	91.40%	5.05%	88.30%	Not Measured	95%	No

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.

Table 3 below shows trends in the responses to individual questions. Increases in ***Customer service provided information or help, Got check-up/routine appointment as soon as needed,*** and ***Ease of getting care, tests or treatment*** *were* significant. ***Personal doctor explained things, Personal doctor listened carefully,*** and ***Health plan forms were easy to fill,*** also increased in 2022.

Small decreases in ratings occurred for ***Personal doctor showed respect, Personal doctor spent enough time,*** and ***Customer service treated member with courtesy and respect.***

Table 3: 2022 Trend of Individual Items for Child Survey

	2016	2019	2021	2022	**Change 2021 to 2022**
Composites and Individual Items (2022)		**Always + Usually**	**Always + Usually**	**Always + Usually**	
Getting Care Quickly					
Q4. Got care as soon as needed when care was needed right away	75.83%	NA	NA	84.2%	**NA**
Q6. Got check-up/routine appointment as soon as needed	79.03%	82.66%	75.61%	82.40%	**6.79%**
Getting Needed Care					
Q9. Ease of getting care, tests or treatment	82.62%	84.17%	82.46%	87.40%	**4.94%**
Q23. Got appointment with specialist as soon as needed	NA	NA	NA	88.2	**NA**
How Well Doctors Communicate					
Q12. Personal doctor explained things	94.44%	92.89%	94.12%	95.10%	**0.98%**
Q13. Personal doctor listened carefully	94.06%	94.17%	95.59%	96.00%	**0.41%**
Q14. Personal doctor showed respect	95.44%	97.48%	98.03%	96.80%	**-1.23%**
Q17. Personal doctor spent enough time	85.21%	88.14%	88.18%	87.80%	**-0.38%**
Customer Service Composite					
Q27. Customer service provided information or help	85.53%	90.24%	77.88%	88.50%	**10.62%**
Q28. Customer service treated member with courtesy and respect	93.21%	98.35%	94.83%	94.30%	**-0.53%**
Forms Were Easy to Fill Out					
Q30. Health plan forms were easy to fill	93.11%	93.02%	94.63%	96.20%	**1.57%**

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

Table 4 below shows the Plan's NCQA HPR percentile results for 2022. The Plan scored in the 66.67th percentile for ***Rating of Health Plan*** and ***Rating of All Health Care*** and in the 10th percentile for ***Rating of Personal Doctor***. The measures ***Rating of Specialist, Getting Needed Care,*** and ***Getting Care Quickly*** did not generate enough responses to render a valid result. The measures ***How Well Doctors Communicate*** and ***Customer Service*** were not measured for NCQA.

Table 4-NCQA HPR percentiles with ranges

Measure	2016 Top-Box Scores	2019 Top-Box Scores	2021 Top-Box Scores	2022 Top-Box Scores	2021 to 2022 change	SPH BOB 2022 Top-Box Scores	NCQA HPR 2022
Rating of Health Plan	69.90%	78.30%	76.84%	**74.80%**	-2.04%	72.50%	**66.67th** (74.4-78.6%)
Rating of All Health Care	68.00%	70.30%	77.93%	**76.00%**	-1.93%	71.20%	**66.67th** (73.1-77.1%)
Rating of Personal Doctor	76.10%	79.30%	81.31%	**74.70%**	-6.61%	77.40%	**10th** (71.8-75.4%)
Rating of Specialist Seen Most Often	71.6%+	81.4%+	N/A	**88.40%**	NA	73.90%	**NA**
Getting Needed Care	77.80%	78.60%	82.66%	**87.80%**	5.14%	84.40%	**NA**
Getting Care Quickly	77.40%	81.10%	81.14%	**83.30%**	2.16%	86.70%	**NA**
How Well Doctors Communicate	92.30%	93.20%	93.98%	**93.90%**	-0.08%	94.40%	**Not Measured**
Customer Service	89.40%	94.30%	86.35%	**91.40%**	5.05%	88.30%	**Not Measured**

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

APPENDIX C: 2022 HPSM CONSUMER ADVISORY COMMITTEE GRIEVANCE & APPEALS REPORT

APPENDIX C 2022 HPSM CONSUMER ADVISORY COMMITTEE GRIEVANCE & APPEALS REPORT

HPSM Consumer Advisory Committee

Grievance & Appeals Report

Reporting Period:

Q4 2022 (Oct – Dec 2022)

Presented 01/17/2023

Table of Contents

1. Overview

1.1 Purpose

This report provides 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.

1.2 Methodology

The data for this report comes from three sources:

1. MedHOK: system of record for appeals and grievances
2. HEALTHsuite: system of record for authorizations, claims, and member eligibility
3. HPMS System (for CTM data)

All complaints closed during the reporting period were analyzed by line of business and type of complaint. For Medi-Cal and CCS, additional information is included in accordance with guidelines from the National Committee for Quality Assurance (NCQA).

Previously, complaints were reported based on the receive date. Starting in 2020, we are reporting cases by closure date, which allows the G&A unit to provide the data as soon as the quarter is over, without having to wait for all cases to close to determine timeliness and appropriate classification.

Please note that members assigned to Kaiser Permanente file their complaints directly with Kaiser, not with HPSM, since Kaiser is delegated for all grievance and appeals functions. Kaiser provides HPSM with quarterly data on the grievances and appeals filed with them by HPSM members; this data is included separately in this report.

Case data is pulled from MedHOK based on the date HPSM closed the case. If it is filed by a member's representative (e.g. family member, friend, attorney), the receive date is based on the date the member authorized that person to represent them, and the complaint timeliness is calculated using this receive date as the start date of the complaint.

By tracking and trending complaints filed with HPSM, the Grievance and Appeals (G&A) Unit hopes to identify and address the root causes leading to member dissatisfaction.

2. Rate of Complaints per 1,000 Members

The rate of complaints per 1,000 members allows the G&A Unit to compare complaint rates while accounting for the differences in enrollment numbers across different lines of business. Below are average enrollment numbers by line of business for Q4 2022.

Line of Business	Average Enrollment for Q4
CareAdvantage CMC	8,799
Medi-Cal Only (Excluding CCS)	135,914
HealthWorx	1,211
ACE	22,295
CCS/WCM	1,411
TOTAL	**169,630**

2.1 Goal Rate, by Line of Business

Complaint rates differ significantly by line of business in large part because each line of business serves a different population. For example, CareAdvantage CMC (CA CMC) members are older and/or have at least one disabling condition, which leads them to interact more frequently with the healthcare system. HPSM's assumption is that increased interaction leads to increased opportunity for member dissatisfaction. In contrast, Medi-Cal members, many of whom are healthy children or young adults, have a lower rate of complaints in part because these members do not need as many services and therefore have fewer interactions with HPSM and its providers.

Please note that HPSM is unable to quantify how much of the difference in complaint rates can be attributed to differences in members' level of interaction with the healthcare system versus other factors, such as differences in the way members are treated by providers or differences in access to care.

The G&A Unit reviewed the rate of complaints for each quarter since 2019. Given the low utilization rates during 2020 and early 2021, when vaccines were not available, the first two quarters of 2019 and the last two quarters of 2021 were used as a realistic reflection of what the grievance rate should look like. From this historical review, the G&A Unit identified the minimum and maximum rate of complaints per 1,000 members per month (previously reported per quarter) and set a goal for each line of business.

For Medi-Cal and CCS, Pharmacy benefits are no longer available through HPSM as of 1/1/2022. For that reason, pharmacy appeals were excluded from the complaint rate calculation for 2022. Grievances about pharmacy or prescription drug issues were included as these are still worked on by HPSM's G&A team. Most pharmacy grievances were resolved over the phone within one business day.

Line of Business	Min	Max	Goal
CareAdvantage CMC	5.60	6.76	6.18
Medi-Cal Only (Excluding CCS)	0.46	0.95	0.70
HealthWorx	1.44	2.75	2.10
ACE	0.09	0.20	0.14
CCS	0.24	2.62	1.43
TOTAL	**0.96**	**1.35**	**1.16**

2.2 Rate of Complaints per 1,000 members per month for 2022

Line of Business	Q1	Q2	Q3	Q4	Goal
CareAdvantage CMC	6.80	7.60	9.24	7.01	6.18
Medi-Cal Only (Excluding CCS)	0.62	0.68	0.64	0.52	0.70
HealthWorx	3.68	3.59	2.24	1.93	2.10
ACE	0.34	0.12	0.07	0.12	0.14
CCS	0.98	0.49	0.95	0.95	1.43
TOTAL	**0.91**	**0.99**	**1.03**	**0.82**	**1.16**

2.3 Analysis, Barriers, and Proposed Action

The rate of complaints per 1,000 members was above the goal for CareAdvantage CMC, which decreased slightly from Q3 and similar to the Q2 level. While we see a slight decrease, we are still investigating why these high numbers have been above the threshold all year. We will continue to track, especially as we move into the D-SNP in 2023.

The rate of complaints per 1,000 members was within the goal of Medi-Cal, HWx, CCS, and ACE. There are no proposed actions for these lines of business.

3. Timeliness of Complaint Resolution

3.1 Timeliness Rates for Complaint Resolution

The G&A Unit's goal, as mandated by the Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS), and the Department of Managed Health Care (DMHC), is to resolve at least 95% of grievances and appeals within the required regulatory timeframe. Below are the timeliness rates across all lines of business. This table excludes cases resolved within 24 hours of receipt.

Type of Complaint	# Received (all LOBs)	# Resolved Timely	Goal	% Resolved Timely (Q4 2022)
Grievances	318	316	95%	99.37%
Medical Appeals	67	64	95%	95.52%
Pharmacy Appeals	32	31	95%	96.88%

3.2 Analysis, Barriers, and Proposed Actions

The G&A Unit met the goal of 95% and processed 98.75% of all completed case investigations and case reviews for grievances timely. The Pharmacy Unit processed 96.88% of pharmacy appeals timely. For medical appeals processing, the G&A Unit met the goal, resolving 96.88% of

medical appeals timely. This quarter, despite staffing challenges, worked hard to meet and exceeded the goals.

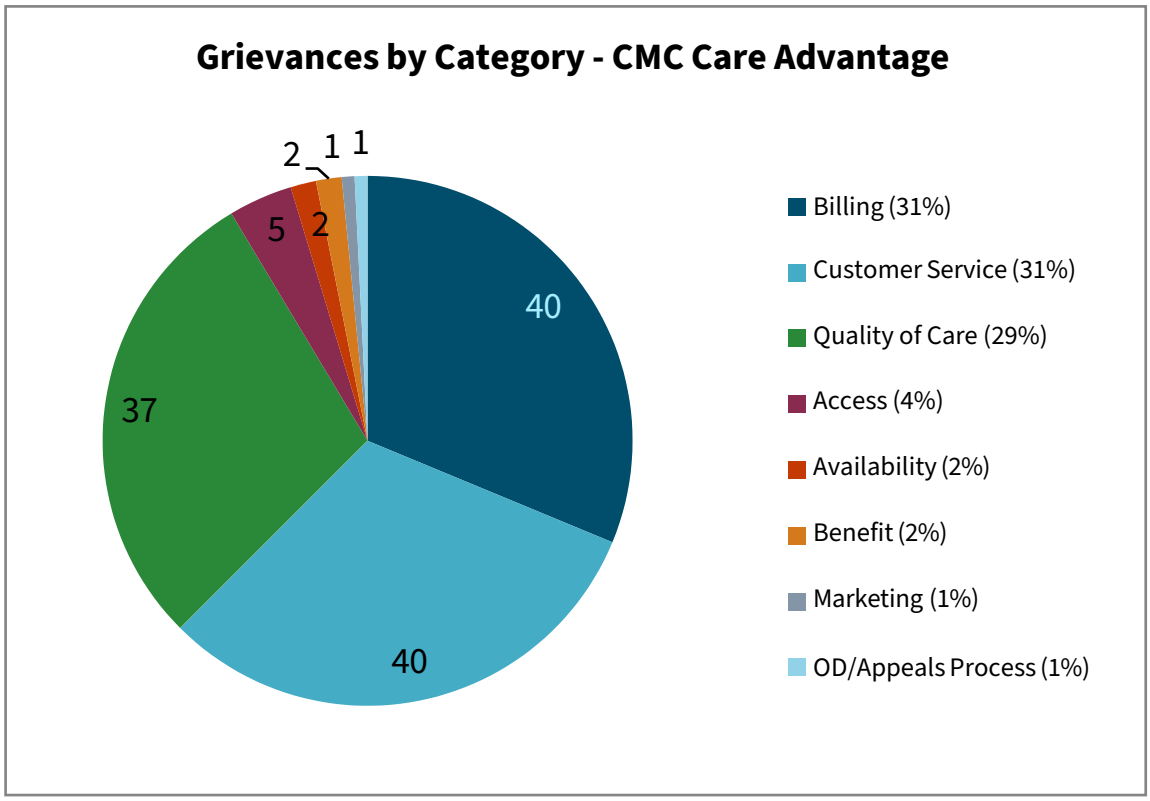
4. CareAdvantage Cal-MediConnect (CA CMC)

4.1 Number of Appeals and Grievances (Complaints) Received

LINE OF BUSINESS			Q1	Q2	Q3	Q4	TOTA
CareAdvantage CMC							
Appeals	**Part C**	**Expedited**	5	4	2	3	14
		Standard	14	21	20	23	78
	Part D	**Expedited**	12	7	17	9	45
		Standard	25	37	27	22	111
	Total Appeals		**56**	**69**	**66**	**57**	**248**
Grievances	**Part C**	**Expedited**	1	0	0	0	1
		Standard	99	115	156	114	484
	Part D	**Expedited**	0	0	0	0	0
		Standard	23	17	22	14	76
	Total Grievances		**123**	**132**	**178**	**128**	**561**
CareAdvantage CMC Total			**179**	**201**	**244**	**185**	**809**

4.2 Types of Grievances Received, by Category

The following graph shows the types of grievances received from CareAdvantage CMC members. A breakdown of subcategories is available as an addendum upon request.



4.3 Resolutions Within 24 Hours of Receipt

The following reflects complaints that were resolved by HPSM's staff within 24 hours of the member informing HPSM of the complaint. These complaints are not included in the count of grievances in the tables above and do not enter the formal grievance process.

- **24 - Hour Resolutions, by Type of Service**

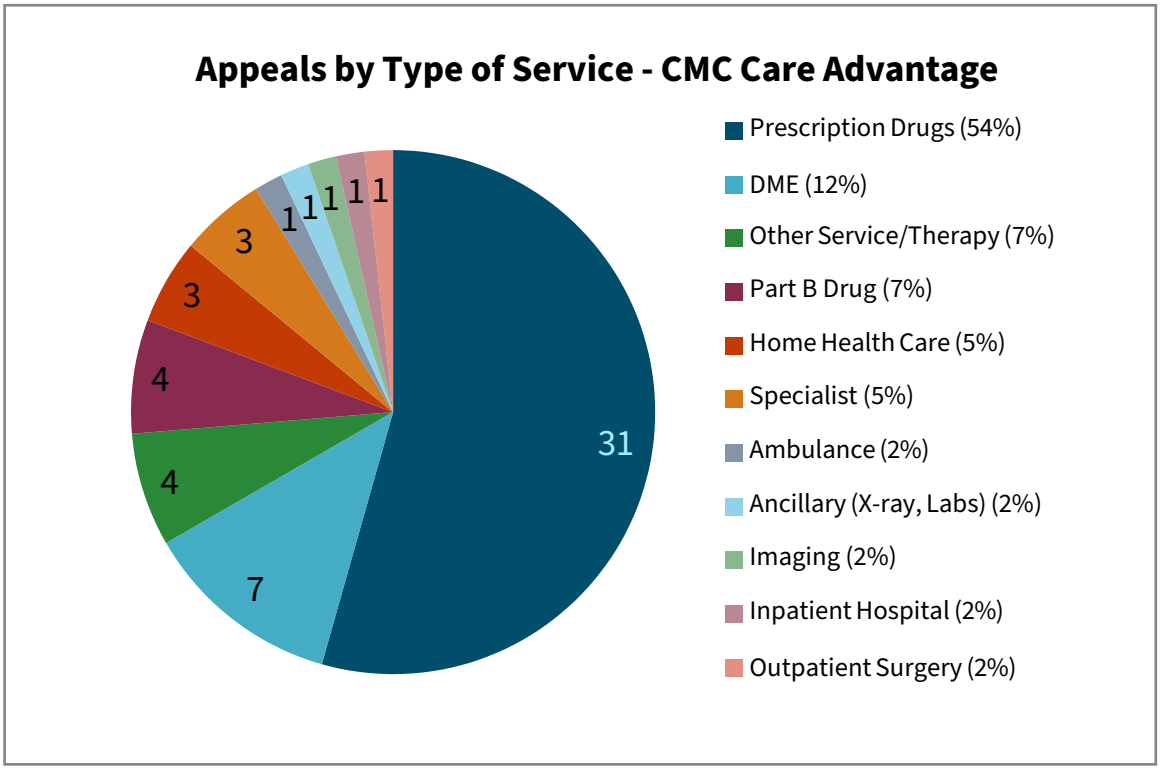
Types of Service	Q1	Q2	Q3	Q4	Total
Medical Services/Supplies	9	11	7	4	31
Prescription Drugs	40	28	28	10	106
Total	**49**	**39**	**35**	**14**	**137**

- **24 - Hour Resolutions, by Category**

Category	Part C Grievance	Part D Grievance
Access	1	9
Benefit	0	1

Category	Part C Grievance	Part D Grievance
Customer Service	3	0
Grand Total	**4**	**10**

4.4 Types of Appeals Received



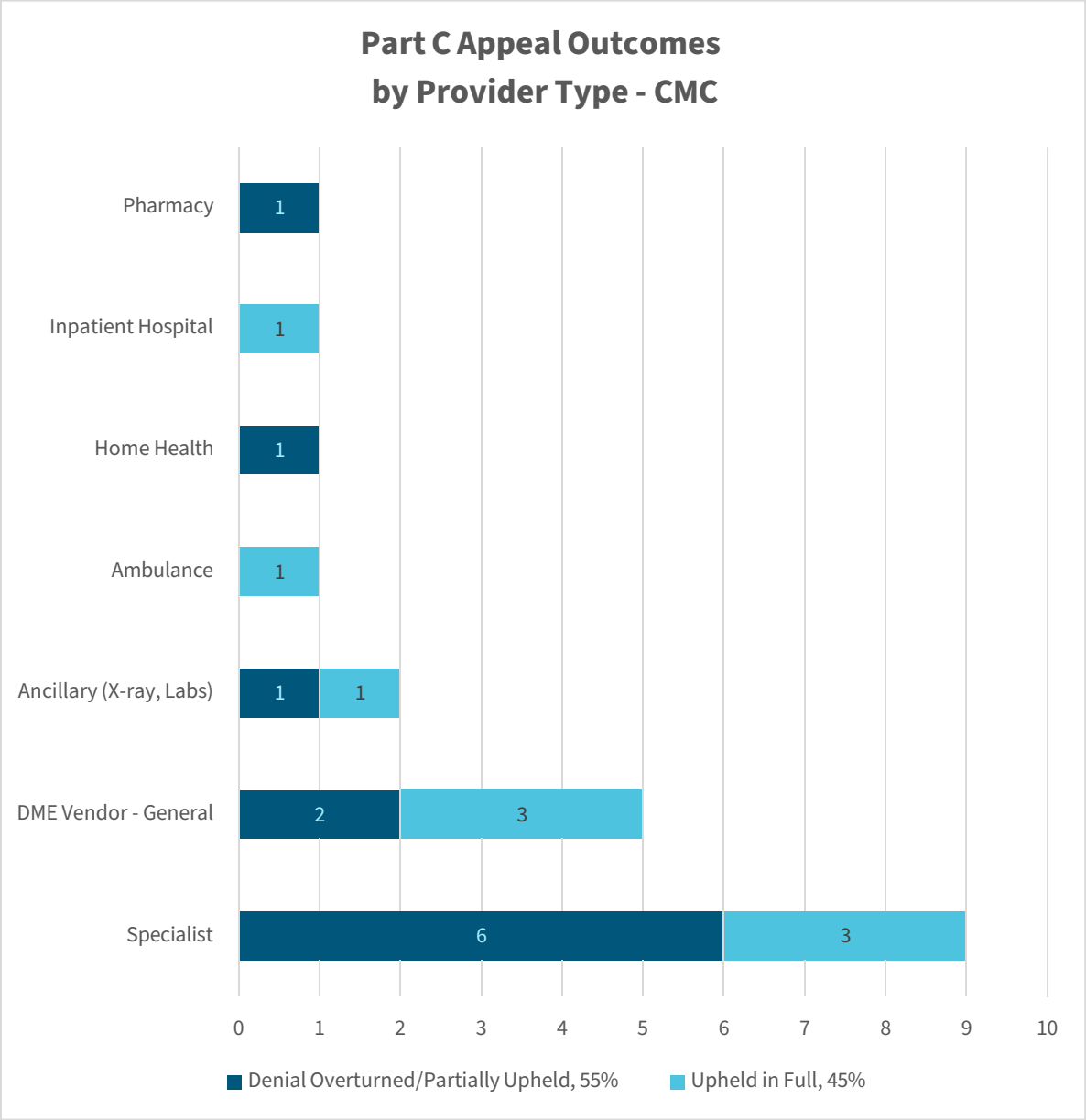
4.5 Rate of Overturned Appeals

The table below shows appeal outcomes depending on whether the benefit requested was a prescription drug (Medicare Part C) or a medical service or supply (Medicare Part D).

Type of Denial	Total Appeals	Overturned	Upheld in Part	Upheld in Full	Withdrawn or Dismissed
Part C- Medical	25	10	1	8	6
Part D - Prescription Drugs	31	16	0	12	3

Prescription drug appeals were overturned in full or in part **57.14%** of the time. For all other appeals, the overturn rate is **52.63%**. This is something HPSM is reviewing to determine root cause for overturned appeals.

Below is a breakdown of the number of Part C (medical) appeals by the type of provider:



4.6 Analysis, Barriers, and Proposed Actions/Solutions (CA CMC)

Grievances:

- The **volume of grievances has decreased from Q3 to Q4 2022.** The volume has increased from 123 grievances filed in Q1 to 132 filed in Q2 and finally, to 178 filed in Q3 2022, but dropped down to near Q1 levels for Q4 at 128.
- Grievances related to **Customer Service** remained stable and continued to be in the top spot, from 31% in Q1 to 39% in Q2 to 39% in Q3 and 31% in Q4.
- Grievances related to **Billing issues** increased to 31% in Q4 from 29% in Q1 to 20% in Q2 to 20% in Q3 2022.
- Grievances related to **Quality of Care** increased this quarter to 29%, rounding out the top 3.

Appeals:

- The **volume of appeals** decreased to near Q1 levels at 57 after 2 quarters of increases. Most appeals continue to be related to prescription drugs (54%), which decreased slightly, but has remained relatively stable. Durable Medical Equipment also decreased slightly at 12% of appeals. The third largest category shifted from Other Service/Therapy (13%) in Q2 to Specialist (11%) in Q3 back to Other Service/Therapy (7%) in Q4.
- The **overturn rate** for drug appeals has increased after decreasing last quarter from 50% in Q1, to 53% in Q2, to 41% in Q3 and up to 57% in Q4. Part C appeals had decreased in Q3 (34%), but jumped back up to 52.9% in Q4. This is slightly lower than the high in Q1. The most common overturn reason is additional clinical information being provided on appeal.

Proposed Action:

- HPSM will discuss trends on overturned appeals with UM and Medical Directors to determine if **additional provider education** is needed.
  HPSM will **monitor quality of care grievances** going forward to determine if this is an ongoing issue or not.

4.7 CTM Complaints

The CMS Complaint Tracking Module (CTM) tracks complaints filed by CareAdvantage CMC members directly with 1-800-MEDICARE. Since the inception of CareAdvantage CMC, HPSM has received very few CTM complaints. No CTM complaints have been received so far this year.

Parameter	2014	2015	2016	2017	2018	2019	2020	2021	2022
Total CTM Complaints	0	2	1	3	0	1	5	0	1
Rate Per 1000 Enrollees	0	0.02	0.01	0.03	0	0.02	0.57	0	0.02

Other MMP Plans Aggregate Rate	0.16	0.09	1.1	0.1	0.11	0.14	N/A	N/A	N/A

4.8 CTM Complaint Analysis & Proposed Action Plan

There are no proposed actions given that HPSM received one CTM complaint in 2022 from a provider who filed with HPSM and did not like the decision.

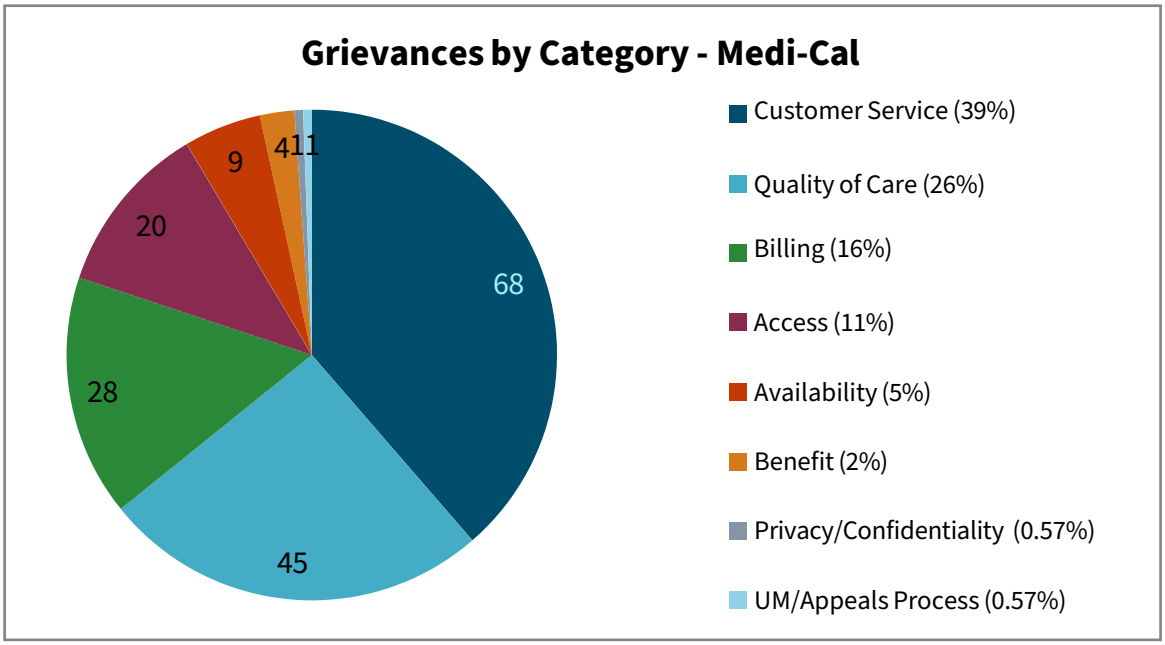
Medi-Cal (MC)

4.9 Number of Appeals and Grievances (Complaints) Received

LINE OF BUSINESS			Q1	Q2	Q3	Q4	TOTAL
Medi-Cal							
Appeals	**Medical Services**	**Expedited**	4	8	5	2	19
		Standard	25	38	24	35	122
	Drugs	**Expedited**	0	0	0	0	0
		Standard	2	0	0	0	2
	Total Appeals		**31**	**46**	**29**	**37**	
Grievances	**Medical Services**	**Expedited**	2	0	0	0	2
		Standard	182	188	210	170	750
	Drugs	**Expedited**	0	0	0	0	0
		Standard	10	19	15	6	50
	Total Grievances		**194**	**207**	**225**	**170**	**796**
Medi-Cal			**225**	**253**	**254**	**213**	**945**

4.10 Types of Grievances Received, by Category

The following graph shows the types of grievances received. A breakdown of subcategories is available as an addendum upon request.



4.11 Regulatory Grievances (DMHC Consumer Complaints)

Regulatory grievances are complaints that are escalated to the Department of Managed Health Care (DMHC) for secondary review. These complaints may be escalated by a member or a member's authorized representative, such as a family member or attorney. During Q4 of 2022, eleven regulatory grievances were filed:

- The majority were related to access/availability of BHT resources for youth.

4.12 Resolutions Within 24 Hours of Receipt

The following reflect complaints that were resolved by HPSM staff within 24 hours of the member informing HPSM of the complaint. These complaints are not included in the count of grievances in the tables above, and do not enter the formal grievance process.

- **24 - Hour Resolutions, by Type of Service**

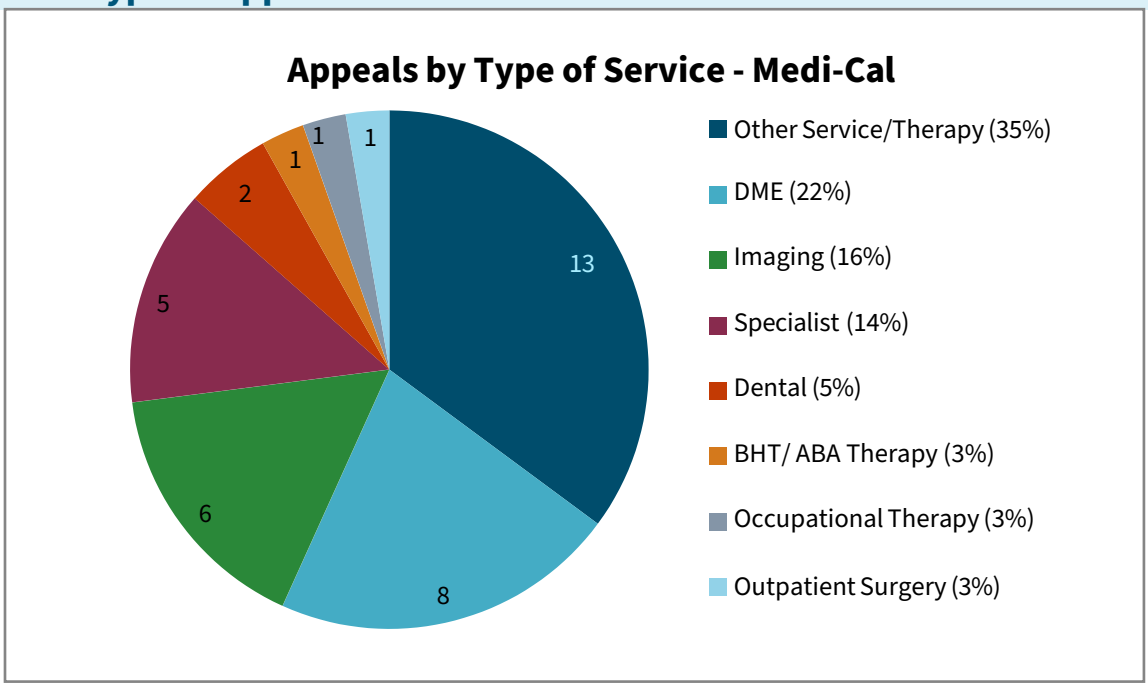
Types of Service	Q1	Q2	Q3	Q4	Total
Medical Services/Supplies	22	21	48	36	127
Prescription Drugs	6	0	9	6	21
Total	**28**	**21**	**57**	**42**	**148**

- **24 - Hour Resolutions, by Category**

Category	Medical Grievance	Pharmacy/Drug Grievance
Access	11	3
Availability	0	0
Benefit	7	1
Billing	3	1
Customer Service	12	1
Enrollment/Disenrollment	2	0
Marketing	1	0
Total	**36**	**6**

Note: We do not expect further pharmacy/drug grievances from MC members, but we will keep tracking them through this quarter.

4.13 Type of Appeals Received



4.14 Regulatory Appeals (Independent Medical Reviews & State Fair Hearings)

Regulatory appeals are appeals that are escalated to either the Department of Managed Health Care or the Department of Social Services for external review. Medi-Cal members have the right to escalate their appeals with either agency.

- The Department of Managed Health Care (DMHC) conducts an Independent Medical Review by an external physician and renders a decision to uphold or overturn the denial from HPSM.
- The Department of Social Services (DSS) conducts a State Hearing with an Administrative Law Judge, who renders a decision based on the member's legal rights.

During Q4, there were six cases filed for State Fair Hearing:

- One was dismissed, one was pending at the time of this report, and four were completed.

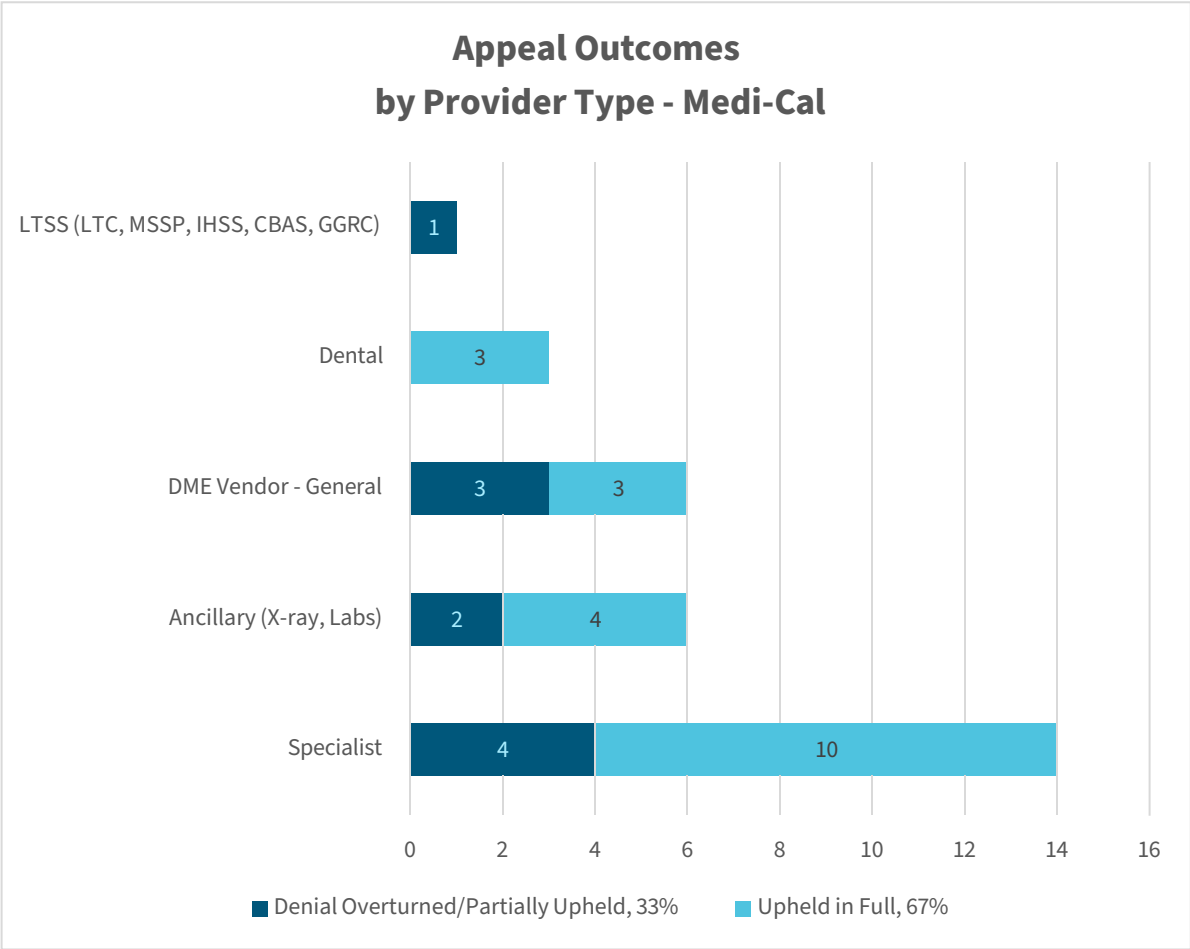
4.15 Rate of Overturned Appeals

The table below shows appeal outcomes depending on whether the benefit requested was a prescription drug or a medical service/supply.

Type of Denial	Total Appeals	Overturned	Upheld in Part	Upheld in Full	Withdrawn or Dismissed
Medical/Services	37	11	2	20	4

The Prescription drug benefit is no longer covered by HPSM Medi-Cal. For medical appeals, the overturn rate is **33.33%**.

Below is the breakdown of medical appeals by Provider Type:



4.16 Analysis, Barriers, and Proposed Actions/Solutions (MC)

Grievances:

- The **volume of grievances** remained consistent and saw the first decrease of the year in Q4 among Medi-Cal members with 194 grievances filed in Q1, 207 in Q2 and 225 in Q3, and 170 in Q4.
- The distribution of the **types of grievances** continued on a similar trend from Q3 to Q4, with Customer Service (39% this quarter) and Quality of Care (26% this quarter) as the highest type.
- HPSM received eleven **DMHC complaints,** which is an increase from prior quarters. The majority of these complaints were related to BHT treatment Access/Availability.

- **Grievances resolved in 24 hours** saw a slight decrease from Q3 but continued to be higher than in Q1 and Q2. Of note, all of these are now related to medical issues since pharmacy issues are now forwarded to the State Medi-Cal Rx program.

Appeals:

- The **volume of appeals** decreased from 31 appeals in Q1 to 46 in Q2 and down to 29 appeals in Q3, but went up slightly in Q4 to 37. By **type of service**, the largest areas again this quarter were Other Service/Therapy (35%), Specialist care (14%), and Durable Medical Equipment (22%). Additionally, there was a new category of imaging that received 16% of the appeals in Q4.
- The **rate of overturned medical appeals** has decreased from prior quarters to 33% in Q4 (from 40% in Q2 and 43% in Q3).
- There was a decrease in **Independent Medical Reviews** filed, though the small case numbers do not necessarily indicate a trend.

Proposed Action:

- **To address the increase in grievances against provider offices related to Quality of Care and Customer Service** HPSM's Provider Grievance Subcommittee will continue to meet regularly to review grievances by provider, identify problematic trends, and take action as appropriate. This is an inter-departmental effort between HPSM's Provider Services Department, Quality Department, Medical Directors, and Grievance and Appeals Unit.

4.17 NCQA Data Collection and Grouping

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 San Mateo County Behavioral Health and Recovery Services (BHRS) to treat mild-moderate mental health diagnoses, as well as services provided by Magellan Health to treat members with autism spectrum disorder and related diagnoses.

Note: For this report, we have calculated the rate of complaints per 1,000 members using the number of members who received services from BHRS.

Previously, we included children receiving ABA therapy in the total amount of behavioral health utilizing members. This data was received late in the quarter, so this caused a delay in reporting. Beginning in 2022, these children's complaints will continue to be part of the total complaint count, but the number of children serviced will not be added to the number of members receiving behavioral health services. The reported complaint rate will be slightly higher than if we were able to count all members serviced within the quarter, but the increase is not expected to be significant. The real rate can be calculated and provided upon request once the ABA utilization data is received.

Goal Rates

In general, the goal rate of complaints per 1,000 Medi-Cal members per month is set at **0.70** and the goal rate per 1,000 CCS members per month is set at **1.43**. These goal rates include all grievances and appeals for all services, not only those related to behavioral health; they are also calculated based on enrollment, not utilization of services.

In separating out behavioral versus non-behavioral health complaints, the G&A Unit has established separate goal rates in order to account for the more limited denominators in each of the data sets below.

Based on the data gathered for Q1 and Q2 of 2019, as well as Q3 and Q3 of 2021, the G&A Unit has set the following goal rates for all non-behavioral health grievances and appeals for 2022.

All goals were re-calculated after excluding Rx appeals. The new rates are also calculated as complaints per 1,000 members per month.

	Min	Max	Current goal
Non-Behavioral Health: Grievances	0.60	1.38	**0.99**
Non-Behavioral Health: Appeals	0.08	0.20	**0.14**

For behavioral health services, the rate of complaints was also calculated using Q1 and Q2 of 2019, and Q3 and Q3 of 2021. The rate is based on utilization (Behavioral Health and ABA therapy users).

	Min	Max	Current goal
Behavioral Health: Grievances	0.10	0.33	**0.22**
Behavioral Health: Appeals	0.00	0.06	**0.03**

4.17.1 Medi-Cal and CCS Behavioral Health Grievances

For 2022, as explained above, the grievance rate is calculated without the quarterly count of children utilizing ABA therapy, due to report timing. Their grievances are still part of the total. The complaint rates are expected to be comparable even if calculated differently. Here is Q1 of 2022 compared to Q4 of 2022, and the new goal set for 2022.

	Q1 2022		Q4 2022		Goal
	Complaints Total	**Complaints per 1000 members per month**	**Complaints Total**	**Complaints per 1000 members per month**	
Access	10	0.32	14	0.44	N/A
Attitude and Service	1	0.03	2	0.63	N/A
Billing and Financial Issues	0	0.00	0	0.00	N/A
Quality of Care	9	0.28	1	0.03	N/A
Quality of Practitioner Office Site	0	0.00	0	0.00	N/A
Total Grievances	**20**	**0.63**	**17**	**0.55**	**0.22**

4.17.2 Medi-Cal and CCS Behavioral Health Appeals

Here is Q4 2022 compared to Q1 2022 and the new goal set for 2022.

	Q1 2022		Q4 2022		Goal
	Complaints Total	Complaints per 1000 members per month	Complaints Total	Complaints per 1000 members per month	
Access	0	0	0	0.00	N/A
Attitude and Service	0	0	0	0.00	N/A
Billing and Financial Issues	0	0	0	0.00	N/A
Quality of Care	0	0	1	0.03	N/A
Quality of Practitioner Office Site	0	0	0	0.00	N/A
Total Appeals	**0**	**0.00**	**1**	**0.03**	**0.03**

4.17.3 Medi-Cal and CCS Non-Behavioral Health Grievances

	Q1 2022		Q4 2022		Goal
	Complaints, Total	Complaints, Total	Complaints, Total	Complaints per 1000 members per month	
Access	45	0.12	41	0.09	N/A
Attitude and Service	78	0.21	79	0.47	N/A
Billing and Financial Issues	13	0.04	28	0.17	N/A
Quality of Care	45	0.12	41	0.24	N/A
Quality of Practitioner Office Site	0	0.00	0	0	N/A
Total Grievances	**181**	**0.50**	**189**	**0.46**	**0.99**

4.17.4 Medi-Cal and CCS Non-Behavioral Health Appeals

	Q1 2022		Q4 2022		Goal
	Complaints, Total	Complaints, Total	Complaints, Total	Complaints per 1000 members per month	
Access	29	0.08	33	0.01	N/A
Attitude and Service	3	0.01	3	0.01	N/A
Billing and Financial Issues	0	0.00	2	0.00	N/A
Quality of Care	5	0.01	1	0.00	N/A
Quality of Practitioner Office Site	1	0.00	0	0.00	N/A
Total Appeals	**38**	**0.10**	**39**	**0.09**	**0.14**

4.17.5 Analysis, Barriers, and Proposed Action:

(i) Behavioral Health complaint rates for Q4 2022, calculated as complaints per 1,000 members per month:

- The *rate of grievances* related to behavioral health services did not meet the goal of no more than 0.22 grievances per 1,000 utilizing members. The rate for Q1 (0.63) and for Q2 (0.50) and Q3 (.50) and Q4 (.55) were all above the goal. As a result, these grievances will be shared with HPSM's Behavioral Health team for further analysis to identify trends and potential actions. HPSM continues to notice an uptick in grievances regarding Behavioral Health Therapy (BHT) against HPSM and the delegate, Magellan.
- The *rate of appeals* related to behavioral health services met the goal in Q1, Q2 and Q3 2022, with both quarters being below the goal rate of no more than 0.03 appeals per utilizing member. Therefore, no action is proposed.

(ii) Non-Behavioral Health complaints for Q2 2022, calculated as complaints per 1,000 members *per month*:

- The *rate of non-behavioral health related grievances* met the goal in all quarters of 2022. The goal of no more than 0.99 grievances per 1,000 members per month was met with rates of 0.50 in Q1, 0.53 in Q2 2022, .63 in Q3 2022 and .46 in Q4. No action is proposed.

- The *rate of non-behavioral health appeals* was also within the goal of no more than 0.14 appeals per 1,000 members per month, with a rate of 0.10 in Q1, a rate of 0.12 in Q2 2022, a rate of .08 in Q3 2022 and a rate of .09 in Q4 2022. No action is proposed.

HealthWorx, ACE, and CCS

4.18 Number of Appeals and Grievances (Complaints) Received for Other Lines of Business

LINE OF BUSINESS	Q1	Q2	Q3	Q4	TOTAL
HEALTHWORX					
Appeals	1	3	6	2	12
Grievances	12	10	2	5	29
HealthWorx	**13**	**13**	**8**	**7**	**41**
ACE					
Appeals	2	1	2	3	8
Grievances	7	8	3	5	23
ACE Subtotal	**9**	**9**	**5**	**8**	**31**
CCS					
Appeals	1	1	1	0	3
Grievances	3	1	3	4	11
CCS Subtotal	**4**	**2**	**4**	**4**	**14**

4.19 Types of Grievances for HealthWorx, ACE, and California Children's Services (CCS)

CATEGORY	HW	ACE	CCS	TOTAL
Access	0	0	1	1
Billing	4	1	0	5
Customer Service	1	2	2	5
Enrollment/Disenrollment	0	1	0	1
Quality of Care	0	1	1	2
TOTAL	**5**	**5**	**4**	**14**

4.20 Resolutions Within 24 Hours of Receipt

The following reflect complaints that were resolved by HPSM staff within 24 hours of the member informing HPSM of the complaint. These complaints are not included in the count of grievances in the tables above, and do not enter the formal grievance process.

- **24 - Hour Resolutions, by Type of Service**

Types of Service	Q1	Q2	Q3	Q4	Total
Medical Services/Supplies	0	0	3	3	6
Prescription Drugs	36	14	5	7	62
Total	**36**	**14**	**8**	**10**	**68**

- **24 - Hour Resolutions, by Category**

Category	Medical Grievance	Pharmacy/Drug Grievance
Access	0	6
Billing	1	1
Customer Service	1	0
UM/Appeals Process	1	0
Grand Total	**3**	**7**

4.21 Analysis, Barriers, and Proposed Action

The number of grievances and appeals received from **HealthWorx** members decreased significantly over the year from a high of thirteen complaints received each quarter this year, to five in Q4. Similarly, complaints from **ACE** participants also decreased slightly to nine complaints received each quarter (Q1 and Q2) and five in Q3 and Q4. The number of complaints from **CCS** members remained stable from four complaints filed in Q1 to two complaints filed in Q2 2022 and back to four complaints in Q3 and Q4 2022.

Among these lines of business, the **types of grievances** received remained similar to past quarters. The largest area continues to be Quality of Care and billing, with a shift from Access & Availability to Customer Service in Q4.

Grievances resolved within 24 hours were related to prescription drug issues and medical services and supplies, which represented a significant decrease in prescription drugs in past quarters and the added grievances of medical services and supplies for the second quarter this year. The **overall number of grievances resolved within 24 hours decreased** from a high of 36 in Q1 to 10 in Q4 (with 8 in Q3 as the lowest).

No concerning trends are identified from this data, particularly given the small size of the data, and therefore no action is recommended.

5. Kaiser Permanente

This section includes data on grievances and appeals filed by HPSM members assigned to Kaiser Permanente as their primary care provider. Kaiser is delegated to intake, investigate, and resolve all complaints filed by or on behalf of HPSM members assigned to Kaiser.

5.1 Number of Appeals and Grievances (Complaints) Received by Kaiser

	Q1	Q2	Q3	Q4
Appeals	2	1	1	3
Grievances	42	56	34	56
Kaiser Total	**44**	**57**	**35**	**59**

5.1 Types of Kaiser Grievances and Appeals

Each grievance can have different grievance types, but only the primary reason is selected for each of the grievances reported in the next table.

Grievance Types	Q4
Authorization	1
Case Management / Care Coordination	28

Grievance Types	Q4
Discrimination	1
Member Informing Materials	5
Out-of-Network	1
PHI / Confidentiality / HIPAA	3
Plan Customer Service	1
Provider / Staff Attitude	3
Provider Availability	1
Referral	1
Technology / Telephone	3
Timely Access	8
Total Number of Grievances	**56**

For Kaiser Q4 appeals, this is the breakdown by benefit type:

Appeal Benefit Types	Q4
Case Management / Care Coordination	3
Total Number of Appeals	**3**

5.2 Analysis, Barriers, and Proposed Action

The number of ***appeals*** filed with Kaiser by HPSM members remained stable, with two appeals filed in Q1, only one appeal filed in both Q2 and Q3, and increased slightly to 3 appeals in Q4 2022.

The number of ***grievances*** filed with Kaiser by HPSM members increased from forty-four grievances in Q1 to fifty-seven in Q2, dropped back down in Q3 to thirty-four and increased in Q4 to fifty-six, which was similar to the Q2 2022 rate. Case Management/ Care Coordination continues to be the highest category of grievances. The other categories have remained stable. HPSM has requested a response regarding these increases from Kaiser and will work with Kaiser to identify if there is a need for further action on these trends.

6. Primary Care Provider (PCP) Changes by Provider

Reason for PCP Change	Number of Changes in Q4 2022
Difficulty Obtaining an Appointment.	31
Poor Service	23
Provider and Patient Incompatible	1
Total	**55**

A total of 55 members requested to change their assigned PCP effective Q4 of 2022 due to dissatisfaction. This is a decrease from the 93 members who requested to switch in Q1; 88 who requested to switch in Q2 and 73 who requested to switch in Q3.

In Q4, members switched away from a total of 21 different PCPs, which a slight decrease from Q1, Q2, and Q3. Of those, 17 were clinics and 4 were individual providers. One individual provider had four or more members switching away from their practice. With clinics, there were three that had four or more members choosing a different provider.

This data is shared with HPSM's Provider Services team quarterly for additional action as needed. These trends are similar to the past quarters.