



2025 QUALITY IMPROVEMENT & HEALTH EQUITY PROGRAM ANNUAL EVALUATION

Reviewed by QIHE Committee March 19, 2026.

2025 QUALITY IMPROVEMENT & HEALTH EQUITY PROGRAM ANNUAL EVALUATION

X

Chris Esguerra, MD
Chief Medical Officer
Health Plan of San Mateo

X

Amy Scribner
Chief Health Officer
Health Plan of San Mateo

X

Kenneth Tai, M.D.
Quality Improvement Committee Co -Chairperson
San Mateo Health Commission

X

Jeanette Aviles, M.D.
Quality Improvement Committee Co-Chairperson

CONTENTS

1. INTRODUCTION	4
2. HEDIS OVERVIEW.....	4
3. QUALITY OF CLINICAL CARE	6
3.1 Areas of Focus for Improvement	6
HEDIS Measures and Results.....	6
3.2 Performance Improvement Projects (PIP's)	10
PIP's Overview.....	10
3.3 Initial Health Assessment (IHA)	12
IHA Outreach Program Description.....	12
3.4 NCQA Q13 Continuity & Coordination of Medical Care Standard(2025-2028)	14
Standard Description.....	14
4. SAFETY OF CARE & QUALITY OF SERVICES	15
4.1 Clinical Guidelines Annual Review.....	15
4.2 Facility Site Review (FSR) and Medical Record Review.....	16
4.3 Physical Accessibility Review (PAR)	18
4.4 Potential Quality Issue (PQI) Monitoring.....	20
4.5 Quality Monitoring Activities.....	20
5. MEMBER EXPERIENCE & HEALTH OUTCOMES.....	21
5.1 Health Outcomes Survey (HOS).....	21
5.2 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.....	24
5.3 Grievances and Appeals.....	26
6. SUMMARY OF EFFECTIVENESS 2025	26
APPENDIX A. MANAGED CARE ACCOUNTABILITY SET (MCAS) RESULTS TRENDED	28
APPENDIX B. MEDI-CAL CAHPS.....	31
APPENDIX C: 2025 HPSM CONSUMER ADVISORY COMMITTEE GRIEVANCE & APPEALS REPORT	44

1. INTRODUCTION

This program evaluation provides a comprehensive overview of quality improvement activities conducted in Calendar Year 2025(CY2025).

The content of this evaluation includes:

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

2. HEDIS OVERVIEW

In 2025, HPSM was required to collect and report Health Effectiveness Data Information Set (HEDIS) measures for the Medi-Cal, CareAdvantage and HealthWorks populations. The 2025 reporting year (RY2025) HEDIS results are an analysis of services provided in the 2024 measurement year (MY2024). 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 the National Committee of Quality Assurance (NCQA) Health Plan Accreditation for the Medi-Cal population as determined by NCQA Medicaid measure set. Starting in 2024, the California Department of Managed Healthcare required reporting of certain HEDIS measures for the Medi-Cal and HealthWorx populations.

CMS provides a STARS bonus program for D-SNP plans. Select HEDIS measures are used for Part C STARS rating. “Cut-points” for Star rating for each measure set with CMS’s comparative methodology across all Medicare Advantage plans for the current year HEDIS reporting.

DHCS 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 NCQA national Medicaid plans. The MPL and HPL are the 50th and 90th percentiles, respectively. Results for all HEDIS measures can be found in APPENDIX A. MANAGED CARE ACCOUNTABILITY SET (MCAS) RESULTS TRENDED.

DHCS assigns improvement projects for required measures not meeting the MPL. There were no assigned improvement activities in 2025 as no measures were below the MPL for MCAS reporting year 2025.

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

It should be noted that based on the HEDIS data collection and reporting schedule, HEDIS results discussed for reporting year 2025 are of services provided to members enrolled in 2024.

2025 MEDI-CAL SUMMARY HIGHLIGHTS* :

For Reporting Year (RY) 2025/Measurement Year (MY) 2024,

- **6 measures above HPL (above 90th percentile):**
- Childhood Immunization Status –combination 10
- Immunizations for Adolescents –combination 2
- Breast Cancer Screening
- Chlamydia Screening in Women
- Prenatal and Postpartum Care – Postpartum Care

- Glycemic Status Assessment for Patients with Diabetes (>9%)
- **No measures below MPL (50th percentile)**

* RY2025 and trended results for all Medi-Cal HEDIS measures can be found in APPENDIX A. MANAGED CARE ACCOUNTABILITY SET (MCAS) RESULTS TRENDED

2025 CAREADVANTAGE SUMMARY HIGHLIGHTS *:

In RY2025/MY2024, HPSM successfully reported on all measures required by CMS for D-SNP Plans. The STAR ratings for Part C HEDIS measures were

MY24/SY26 Measurements and Weights	MY23/SY25 Rate	MY24/SY26 Rate	MY24/SY26 Star	1 Star Final SY26 Cutpoint	2 Stars Final SY26 Cutpoint	3 Stars Final SY26 Cutpoint	4 Stars Final SY26 Cutpoint	5 Stars Final SY26 Cutpoint
C01: Breast Cancer Screening (1x)	72%	71%	3	< 58 %	>= 58 % to < 71 %	>= 71 % to < 76 %	>= 76 % to < 84 %	>= 84 %
C02: Colorectal Cancer Screening (1x)	68%	73%	4	< 48 %	>= 48 % to < 60 %	>= 60 % to < 70 %	>= 70 % to < 78 %	>= 78 %
C08: Care for Older Adults - Medication Review (1x)	87%	88%	3	< 58 %	>= 58 % to < 85 %	>= 85 % to < 93 %	>= 93 % to < 98 %	>= 98 %
C10: Osteoporosis Mgt in Women who had a Fracture (1x)	15%	22%	1	< 32 %	>= 32 % to < 41 %	>= 41 % to < 53 %	>= 53 % to < 68 %	>= 68 %
C11: Diabetes Care – Eye Exam (1x)	70%	77%	3	< 60 %	>= 60 % to < 72 %	>= 72 % to < 80 %	>= 80 % to < 86 %	>= 86 %
C12: Diabetes Care – Blood Sugar Controlled (3x)	76%	78%	3	< 54 %	>= 54 % to < 77 %	>= 77 % to < 87 %	>= 87 % to < 91 %	>= 91 %
C13: Kidney Health Eval. for Patients with Diabetes (1x)	54%	57%	3	< 34 %	>= 34 % to < 51 %	>= 51 % to < 62 %	>= 62 % to < 74 %	>= 74 %
C14: Controlling Blood Pressure (3x)	71%	69%	2	< 67 %	>= 67 % to < 75 %	>= 75 % to < 80 %	>= 80 % to < 86 %	>= 86 %
C18: Plan All-Cause Readmissions (3x)	13%	12%	2	> 12 %	> 10 % to <= 12 %	> 9 % to <= 10 %	> 7 % to <= 9 %	<= 7 %
C19: Statin Therapy for Patients w/Cardio. Disease (1x)	86%	86%	3	< 81 %	>= 81 % to < 85 %	>= 85 % to < 88 %	>= 88 % to < 91 %	>= 91 %
C20: Transitions of Care (1x)	49%	53%	2	< 44 %	>= 44 % to < 56 %	>= 56 % to < 69 %	>= 69 % to < 79 %	>= 79 %
C21: Follow-up after ED visit t for People with Multiple High-Risk Chronic Conditions (1x)	63%	59%	3	< 50 %	>= 50 % to < 59 %	>= 59 % to < 67 %	>= 67 % to < 78 %	>= 78 %

2025 QUALITY AND PERFORMANCE IMPROVEMENT

There were no DHCS required quality improvement projects in 2025 based on MY2024 HEDIS results but the Plan did have several areas of focus for improvement.

There were 2 required 3 year Performance Improvement Projects (PIP's) based on Statewide results. The PIP's focused on the following HEDIS Measures:

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

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

RY2025 is year 2 of the 3 year cycle and results are submitted in the Fall of the reporting year. See section 3.2 Performance Improvement Project for full description and results of PIPs.

3. QUALITY OF CLINICAL CARE

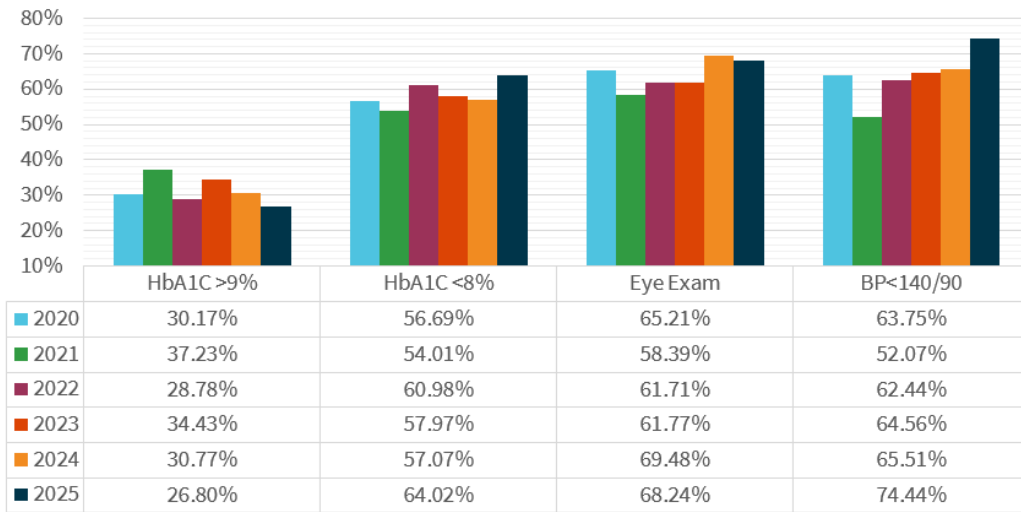
3.1 AREAS OF FOCUS FOR IMPROVEMENT

HEDIS MEASURES AND RESULTS

Diabetes Care

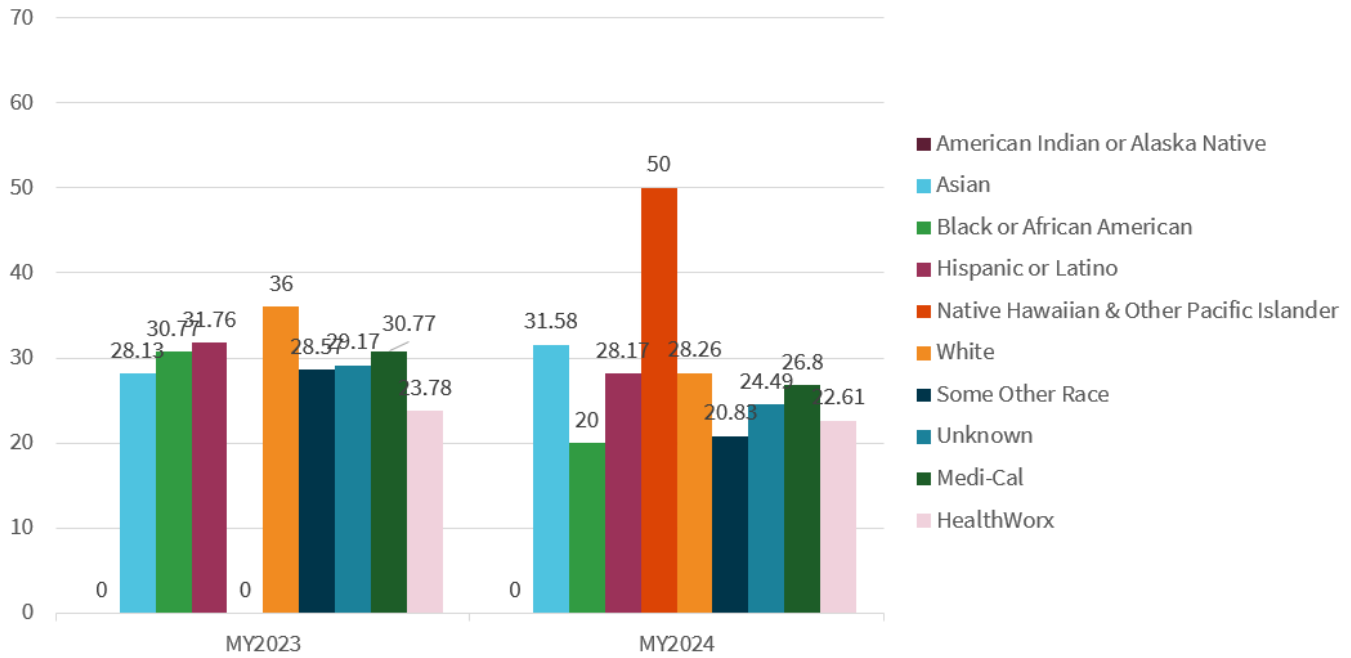


Percentage of **Medi-Cal** members 18 - 75 years of age with diabetes who had each of the following tests or results within the measurement year (rates by reporting year):



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

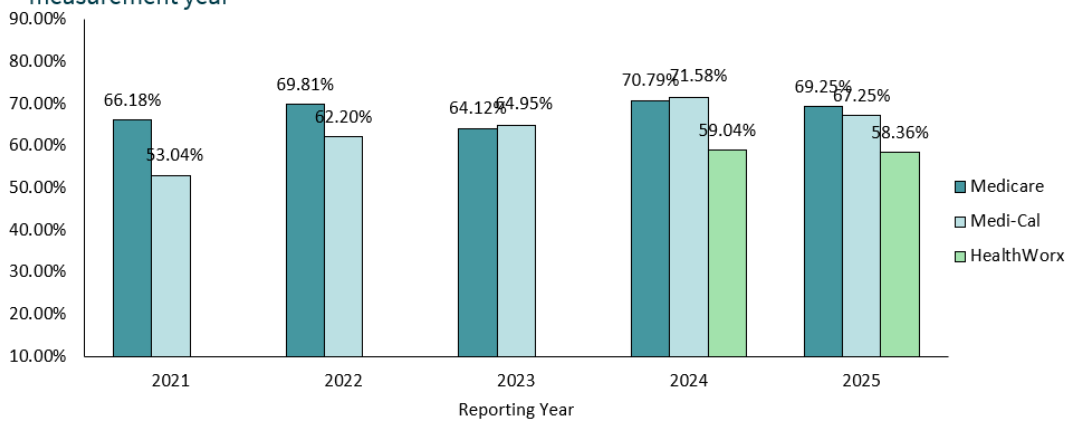
HbA1c >9% HW, MC Race/Ethnicity Stratification



Controlling High Blood Pressure

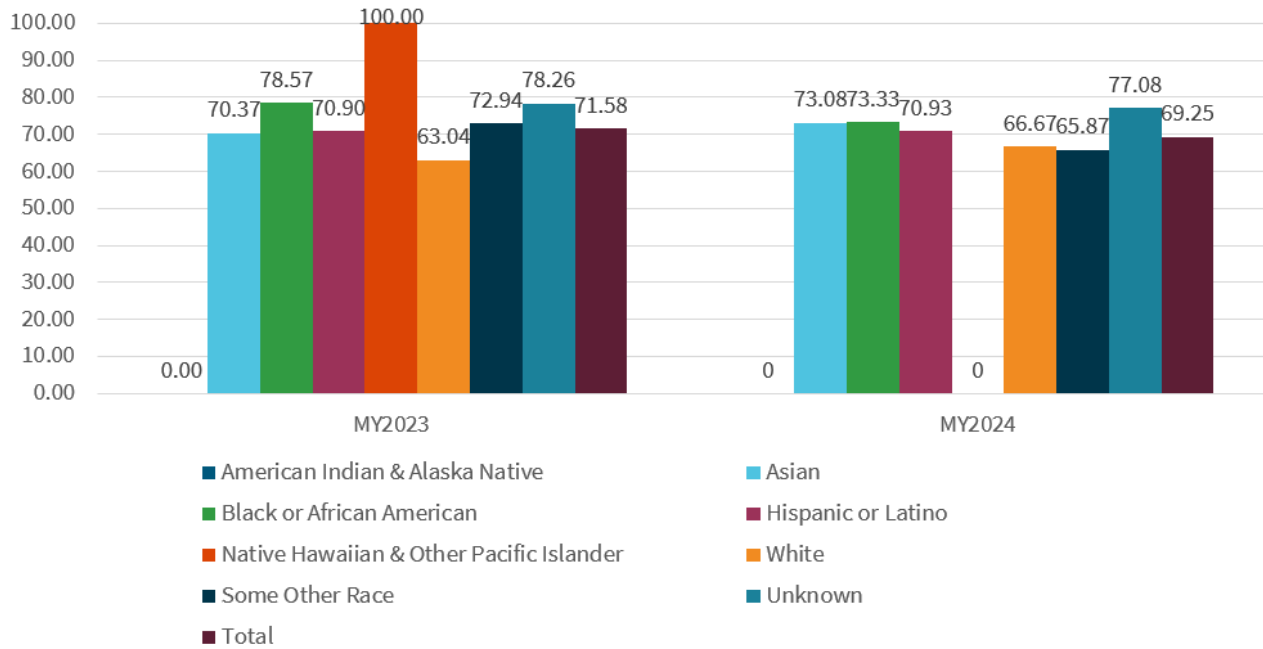


Percentage of members 18-85 years of age with hypertension whose blood pressure was controlled (<140/90 mm Hg) during the measurement year, using latest BP value in the measurement year



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

MC CBP Race/Ethnicity Stratification

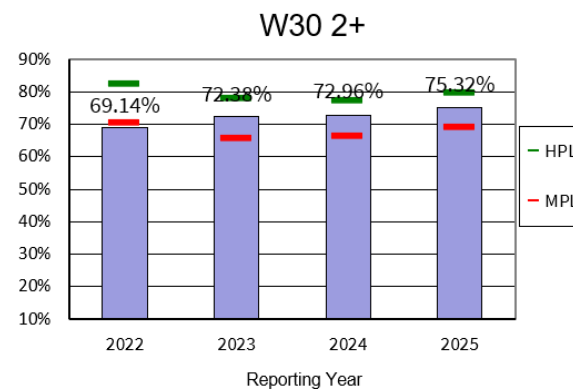
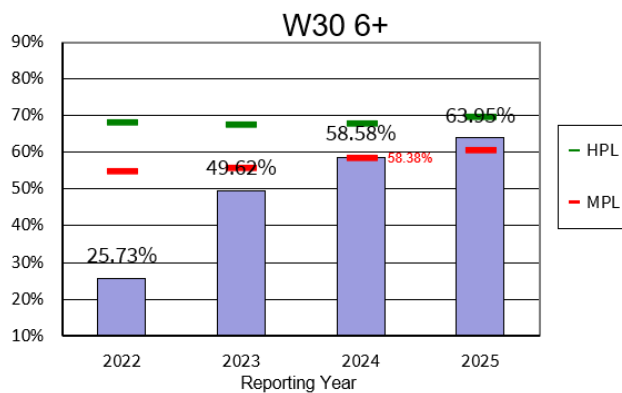


Well-Child Visits in First 30 Months of Life



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

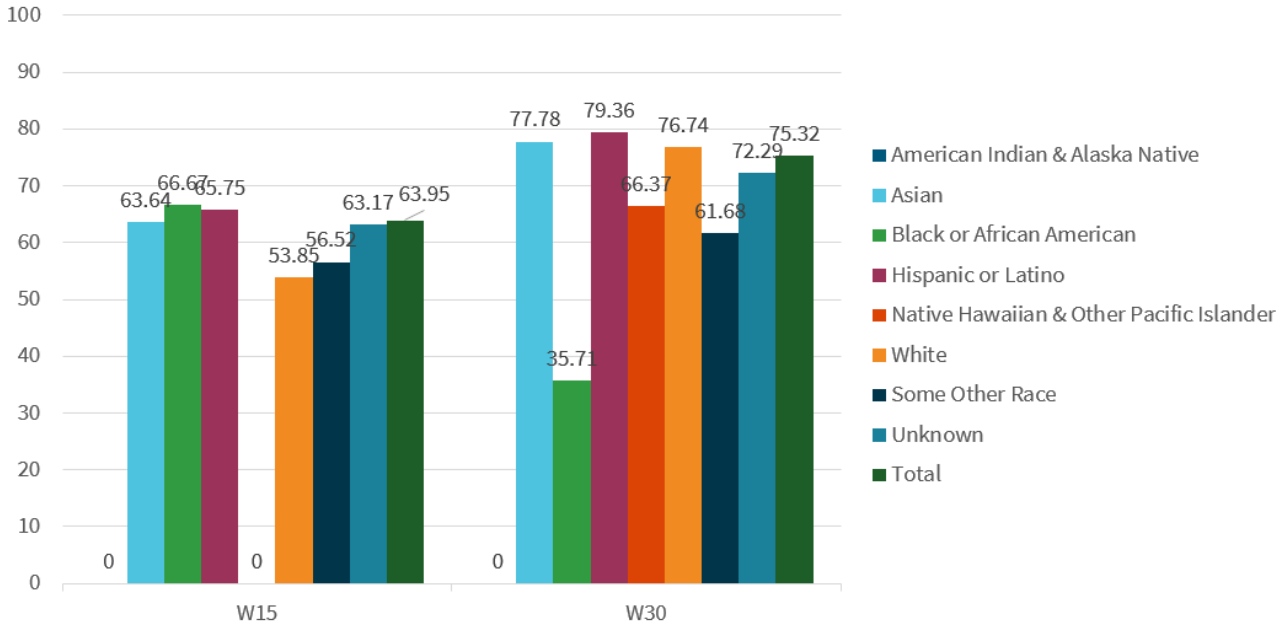
1. W30 6+ : Six or more well-child visits in the *first 15 Months*. Children who turned 15 months old during the measurement year.
2. W30 2+ : Two or more well-child visits *Age 15 Months–30 Months*. Children who turned 30 months old during the measurement year.



Area of Focus for 2024 and 2025

- MC benchmark P4P payment measure and included in Care Gaps P4P program
- DHCS Clinical PIP topic -reducing disparity for the Hispanic/Latino population
- DHCS Collaborative Sprint lead by Institute for Healthcare Improvement (IHI) to focus on improving child well visits

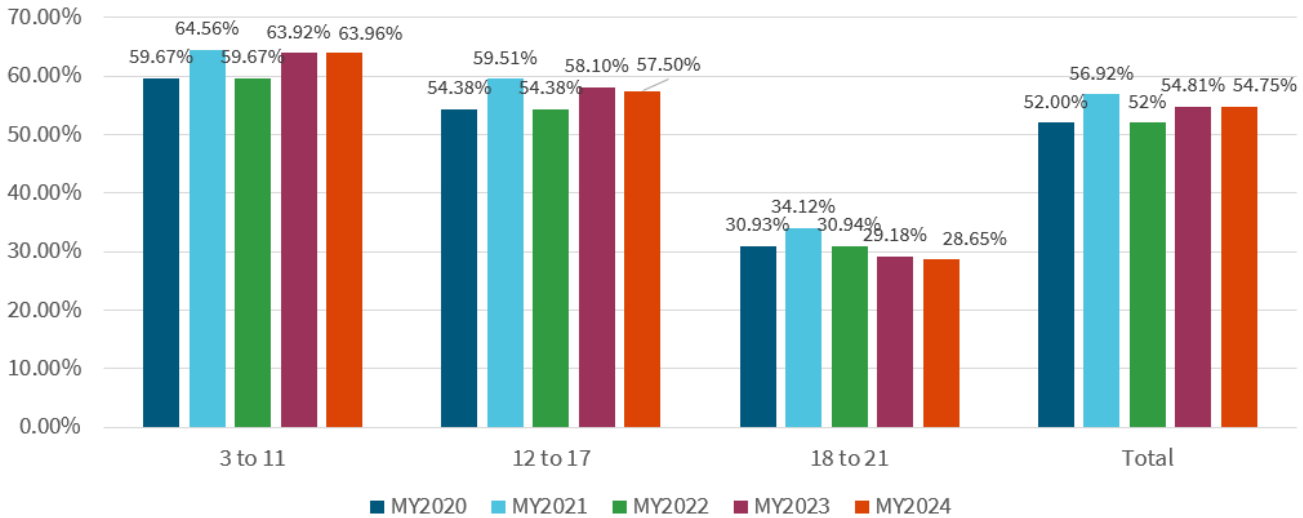
W30 Race/Ethnicity Stratification



Child & Adolescent Well Care Visits



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



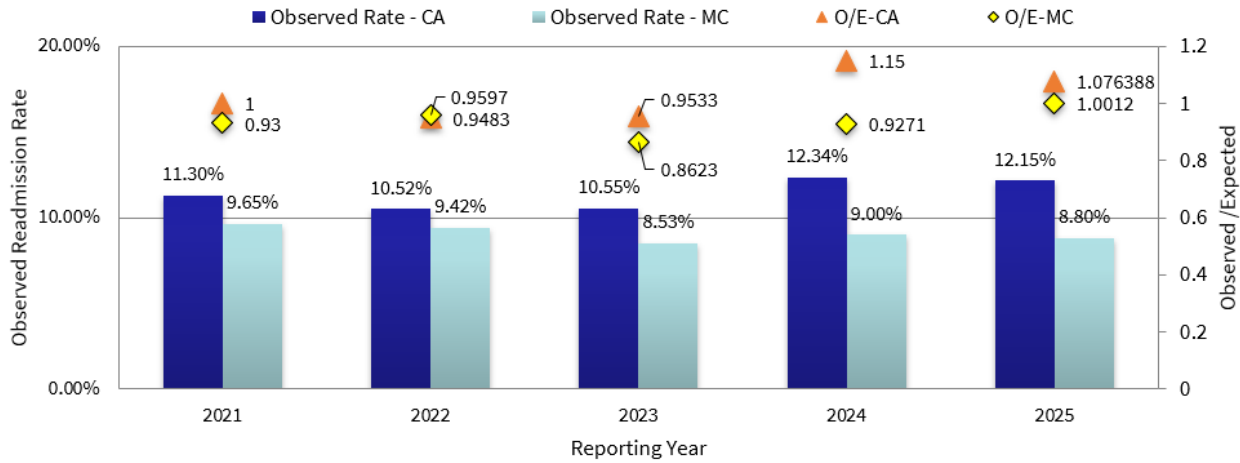
Area of Focus for 2024 and 2025

- MC benchmark P4P payment measure and included in Care Gaps P4P program
- Member incentive for Teen Well Visit, pilot to members assigned to SMMC clinics for primary care

Plan All-Cause Readmissions



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



- Lower rates are better

3.2 PERFORMANCE IMPROVEMENT PROJECTS (PIPS)

PIPS OVERVIEW

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

Starting in 2024, the Quality Improvement Department implemented a disparity performance improvement project (PIP) on the Well-Child Visits in the First 15 Months of Life measure which requires six or more well-child visits in the first 0 to 15 months of life. (W30 6+). In 2024, the Plan reported 2023 Baseline Year rates and implemented the intervention. In 2025 the Plan reported Year 1 rates.

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

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

Measure/Program	W30 Health Equity Clinical PIP
-----------------	--------------------------------

Program Description	Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) measure rates for the Hispanic American population.
Aim Statement:	Do targeted interventions improve the percentage of Hispanic members who complete 6 or more well child visits in the first 15 months of life?
Numerator Description	From the eligible population the number of Hispanic members who had 6 or more well-child visits with a PCP within the first 15 months of life.
Denominator Description	The eligible Hispanic population based on applicable specifications for the Measurement Year.
Baseline year and Rate	01/01/2023-12/31/2023 61.95%
MY 2025 Intervention	Stellar Care Gap Program Incentive
Barriers addressed	Providers not incentivized for completed outreach/scheduling/claim submission efforts in current Benchmark incentive program, only for visit completion.
Year one and Rate	01/01/2024-12/31/2024 65.75%
Improvement	Yes, but not statistically significant improvement

Starting in 2024, the Quality Improvement Department implement a 3 year non-clinical performance improvement project (PIP) on the Follow Up after Mental Health(FUM) and /Follow Up After Substance Abuse(FUA) HEDIS Measures. In 2024, the Plan reported 2023 Baseline Year rates and implemented the intervention. In 2025 the Plan reported Year 1 rates.

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

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

Measure/Program	FUH/FUA Non-Clinical PIP
Program Description	Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 7 days of emergency department (ED) visit.

Aim Statement:	During the measurement year, do targeted interventions improve the percentage of provider notifications, for members 6 years and older for SMH diagnosis and for members 13 years and older for substance use disorder diagnoses, following or within 7 days of emergency department (ED) visit?
Numerator Description	Notification to the PCP or BH provider of members 6 years and older for SMH diagnosis and for members 13 years and older for substance use disorder diagnoses with an emergency department (ED) visit with a principal diagnosis of SUD or SMH diagnoses within 7 days of the ED visit.
Denominator Description	Emergency department (ED) visits with a principal diagnosis of SUD or SMH by members 6 years and older for SMH diagnosis and for members 13 years and older for substance use disorder diagnoses in the PIP Population.
Baseline year and Rate	01/01/2023-12/31/2023 0%
MY 2025 Intervention	Pilot Provider notifications for members seen in one of the project Pilot Hospitals, and documented in the Point Click Software program, following or within 7 days of an emergency department (ED) visits.
Barriers addressed	No HPSM process for notification to Providers of Emergency Department Visits.
Year one and Rate	01/01/2024-12/31/2024 0.27%
Improvement	Yes. Improvement was achieved but was minimal because the process was not fully implemented until 12/31/2024, therefore the intervention was not implemented soon enough in MY2024 for significant improvement.

3.3 INITIAL HEALTH ASSESSMENT (IHA)

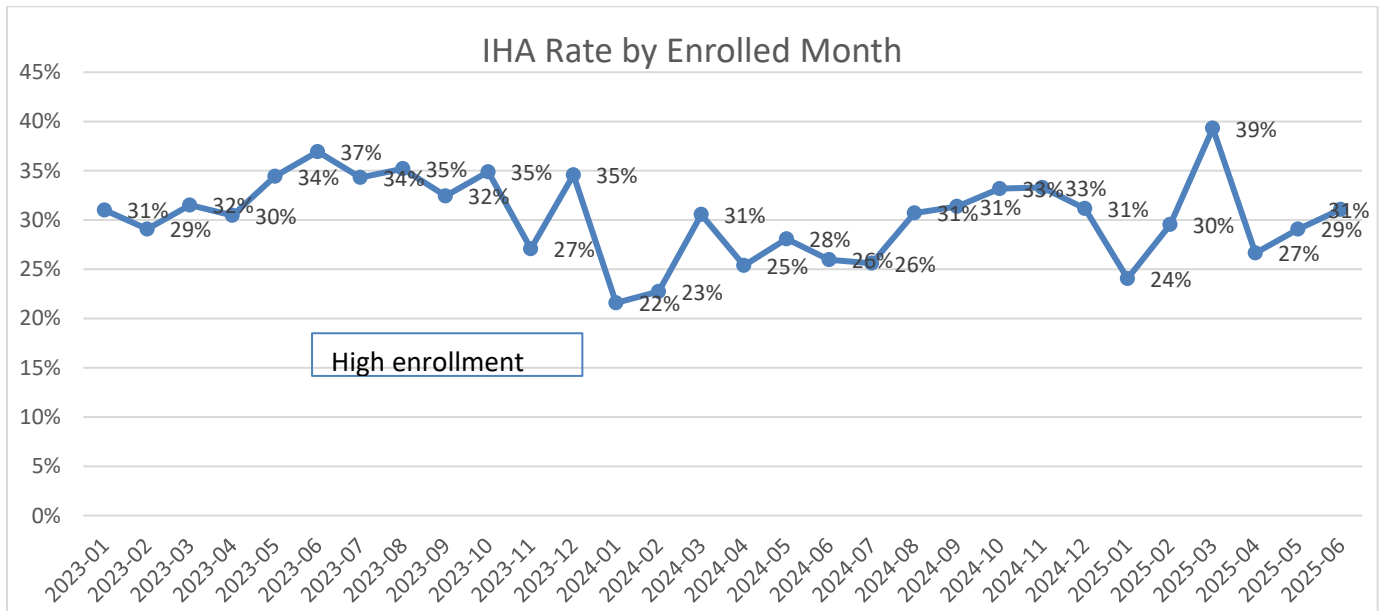
IHA OUTREACH PROGRAM DESCRIPTION

Completion of the Initial Health Appointment (IHA) is a high priority area for HPSM because receiving primary care and preventative services is important for the Medi-Cal population due to the high incidence of chronic and/or preventable illnesses found in this population. The purpose of the IHA is to enable a provider to comprehensively assess the member's chronic, acute and preventative needs and to identify patients whose needs require coordination with additional resources. The All Plan Letter (APL 22-030) requires all primary care providers to conduct an IHA to all Medi-Cal managed care patients as part of their initial and well care visits. It is required that the Health Plan reach a 100% compliance rate ensuring every member enrolled is seen by their primary care physician within the

first 120 days of enrollment. HPSM measured the percentage of members with a completed IHA monthly to determine the compliance rate and to look for improvement opportunities.

The Plan did not obtain 100% compliance and received a CAP from DHCS for improvement and therefore performed many actions in 2025 in an effort to improve the rate and close the CAP.

MONTHLY IHA COMPLIANCE RATES 2023-2025 GRAPH



IHA PROVIDER EDUCATION

The training manual for HPSM’s provider network educated providers on the IHA requirement and the benefit of doing outreach to their new members to get them in to be seen as soon as possible. The Health Plan of San Mateo made the providers aware of the requirement of the IHA through three programs in 2025.

- Provider Services Outreach:** Periodic visits were done by provider service personnel to provide updates on changes to existing programs, introduce new programs, and reinforce on-going programs.
- Pay for Performance Program:** Monthly reports were sent to the providers detailing gaps in IHA completion rates.
- Medical Record Review as part of the FSR audit process:** Any deficient IHA documentation was addressed at the time of the Facility Site Review by site review nurses. Providers noncompliant or mostly noncompliant with consistent IHA completion were placed on a Corrective Action Plan.

IHA BARRIERS

In 2025 some network PCPs appeared to continue to lack awareness of the IHA requirement, particularly if they do not regularly gain many new members. From feedback from PCPs and review of medical records we discovered that providers did not create a medical record until a new patient presents for care and thus did not have a medical record to document IHA outreach attempts. Some PCPs often used other systems to track and document IHA outreach attempts that HPSM does not review to assess compliance of IHA. Other PCPs did not record their outreach attempts in a way that is readily traceable to a specific member. In addition, many members are unaware of the need for and importance of completing an IHA with their PCP after enrollment with the Plan.

IHA OUTREACH PROGRAM ACTIONS FOR 2025

HPSM struggled to increase the completion and timeliness of IHAs in 2025 and so therefore completed the following actions to improve IHA rates.

- Ensured HPSM’s website contained updated information for Providers and the correct IHA training document for providers to utilize.
- Used IHA requirement attestations to be used to educate providers during Site Reviews.
- Continued pay-for-performance(P4P) monetary incentive for PCPs for timely IHA completion in 2025. Under the Benchmark P4P, IHA remained a payment metric for Family Practice and Adult track providers and reporting-only for Pediatric providers. This was based on prioritization in assigned quality metric sets. As part of P4P, monthly reports were sent to PCPs detailing level of performance.
- Incentivized three separate components: the outreach, scheduling of the IHA and timely completion of the IHA in its new Care Gap P4P Program.
- Allowed PCPs to readily view and filter for their assigned members in need of an IHA utilizing the new Care GAP P4P platform.
- Continued PCP compliance monitoring during the MRR process and issued provider correction action plans when deficiencies were found.
- The Plan is making new member outreach calls as of 02/2025. The script for this process includes a reminder to schedule an IHA.
- The Plan also sends an IHA flyer to all new members as part of the new member packet.

3.4 NCQA Q13 CONTINUITY & COORDINATION OF MEDICAL CARE STANDARD (2025-2028)

STANDARD DESCRIPTION

NCQA released a new Q13 standard in 2024 for the period covering 2025-2028. The standard states that the Plan must demonstrate continuity and coordination of care across the health care network, and between medical and behavioral healthcare, through performance on Health Plan Ratings for stated HEDIS measures. The organization annually monitors performance and acts, in the form of an improvement plan, on one required HEDIS measure for which it received a rating of “1” or “0.”

The 8 measures applicable to HPSM are:

- EED-Eye Exam for Patients with Diabetes
- PPC-Prenatal and Postpartum Care (Prenatal and Postpartum rates)
- APP-Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.
- FUM and FUA -Follow-Up After ED visit for Mental Illness or for Substance Use (7 days rate)
- FI - Follow-up After High-Intensity Care for Substance Use Disorder (7 days rate)
- SSD-Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

In 2025, the Plan had an average NCQA Health Plan rating score of 3.75 for these measures, with no measures below a rating of “2”. Individual measure rate and rating scores are below. No new improvement project plans were thus required. Establish improvement programs were effective in achieving comparatively high ratings for these measures. The Plan will continue to monitor the rates for reporting year 2026.

HPSM 2025 Ratings Measure Name	HEDIS Rate	Measure Rating Score Compared to Percentiles
Prenatal and Postpartum Care—Timeliness of Prenatal Care	0.908	4
Prenatal and Postpartum Care—Postpartum Care	0.937	5
Eye Exam for Patients With Diabetes	0.682	4
Follow-up After Emergency Department Visit For Mental Illness—7 days	0.468	4
Follow-up After Emergency Department Visit For Substance Use Disorder—7 days	0.306	4
Follow-up After High-Intensity Care for Substance Use Disorder—7 days	0.214	2
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	0.84	3
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotic	0.742	4
Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment	N/A-No Benefit	N/A-No Benefit
Follow-up After Hospitalization For Mental Illness—7 days	N/A-No Benefit	N/A-No Benefit
	Total	30
	AVERAGE (Total/8)	3.75

4. SAFETY OF CARE & QUALITY OF SERVICES

4.1 CLINICAL GUIDELINES ANNUAL REVIEW

HPSM’s Quality department lead an annual review of the clinical guidelines posted on the HPSM website. The review process ensured the posted guidelines were evidenced-based, current, and relevant to the plan’s member population. The Quality Improvement team checked the date of the most recent published update for each guideline, posted by the source organizations. We prepared an annual summary of the posted guidelines for presentation to the Quality Improvement & Health Equity Committee (QIHEC) in the Fall. The summary provided the last published date of each guideline, and included progress notes on the update status for any guideline that had not been updated within the last 5 years.

2025-2026 Clinical Guidelines and Resources were posted on our website:
<https://www.hpsm.org/provider/resources/guidelines>.

CLINICAL GUIDELINES ANNUAL REVIEW UPDATE

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

The Quality department presented the annual summary of the posted guidelines to the Quality Improvement Committee at its quarterly meeting in September 2025. All additional and updated guidelines were reviewed and approved by the QIHEC.

ACTIONS FOR 2025

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

4.2 FACILITY SITE REVIEW (FSR) AND MEDICAL RECORD REVIEW

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 2022

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

below 90%, then a corrective action plan (CAP) is required to be completed by the provider as part of compliance with their HPSM contract.

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

In 2025, HPSM completed 9 FSRs and 9 MRRs. Following the Site Reviews, 3 of the providers/sites received a CAP for either the MRR or FSR, or both. Both CAPs were closed successfully and timely according to regulatory requirements.

Common Deficiencies identified in Facility Site Review:

- **Expired Medications and Medical Equipment/Supplies:** Expired medications and medical equipment were observed on-site, including but not limited to oxygen tubing, irrigation equipment, gauze, syringes, and lab equipment. Additionally, written policies or procedures for documenting medication expiration.
- **Inadequate Maintenance of Medical Equipment:** Improper documentation to demonstrate medical equipment requiring annual service and/or calibration was performed.
- **Non-Compliant Drug/Vaccine Storage Units:** Drug and vaccine storage units were found to be non-compliant with the required standards (e.g. appropriate vaccine refrigerator, daily temperature logs), which could potentially compromise the safety and effectiveness of the stored medications.
- **Inappropriate Drug and Hazardous Substance Disposal:** Lack of proper biohazardous waste containers; no written policy or procedure for the appropriate handling and disposal of biohazardous waste.

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

- .
- **Expired Emergency Medication and Medical Equipment:** Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia were not replaced prior to expiration. The potency and effectiveness of expired medications decline, potentially failing to treat life-threatening conditions. Additionally, written policies or procedures for documenting medication expiration were not available.

Common Deficiencies identified in Medical Record Review

- **Notice of Privacy:** Missing signed copy of Notice of Privacy within the member's health record.
- **Advance Care Directives:** There was no documentation indicating that Advance Care Directives were offered or discussed with patients. Furthermore, these directives were not completed by members, nor were they updated every five years as required.
- **Adult and Pediatric Immunizations Not Administered According to Guidelines:** Adult and Pediatric immunizations were not consistently administered in accordance with established guidelines, potentially leading to gaps in patient care and preventative health.
- **Missing Required Screenings:** Several required screenings were either not performed or not properly documented. These screenings include, but are not limited to: Tuberculosis, Hepatitis B/C Virus, Breast Cancer, Cervical Cancer, Colorectal Cancer, Osteoporosis, Blood Lead, Sudden Cardiac Arrest and Cardiac Death, HIV Infection, and Sexually Transmitted Infection screenings.
- **Fluoride Varnish and Supplementation:** Fluoride varnish was neither performed nor documented for eligible patients, and fluoride supplementation was inconsistently documented.

- **Missing Documentation of Folic Acid Supplementation:** There was missing documentation indicating that folic acid supplementation was provided to women of reproductive age.
- **Skin Cancer Behavioral Counseling:** There was a lack of documentation regarding Skin Cancer Behavioral Counseling for parents aged 24 and below with young children, as recommended.
- **Use of Validated Screening Tools:** Required validated screening tools were not used for the following screenings:
 - **Alcohol Use Disorder and Behavioral Counseling:** CAGE, CRAFFT, AUDIT, DAST, DAST-20, ASSIST, NM-ASSIST, NIDA, TAPS
 - **Depression Screening:** PHQ, Hospital and Anxiety Depression Scales in Adults, Geriatric Depression Scale in Older Adults, Edinburgh Postnatal Depression Scale (EPDS)
 - **Drug Use Disorder and Behavioral Counseling:** CAGE, CRAFFT, AUDIT, DAST, DAST-20, ASSIST, NM-ASSIST, NIDA, TAPS
 - **Intimate Partner Violence Screening for Women of Reproductive Age (12-49 years):** HARK, HITS, E-HITS, PVS, WAST

FSR ACTIONS FOR 2025

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

4.3 PHYSICAL ACCESSIBILITY REVIEW (PAR)

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

Attachment C is used for physical accessibility review of PCP’s, typically conducted concurrently with the FSR and MRR. Once the initial PARS for the PCP has been conducted, the next 2 triennial PARS can be assessed via attestation indicating no changes have occurred, or noting any additions, such as height adjustable exam table. If the provider has moved to a new location since the initial PARS was performed, a full PARS would be initiated within 30 days of the relocation, in conjunction with the Facility Site Review.

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

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

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

Accessibility Indicator Symbols

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

A total of 9 PCP Physical Accessibility Reviews (PAR) were done for 2025 :

Level of Access:	# of PCP/Hospital
Basic Access	3
Basic Access/ Medical Equipment	2
Limited Access	4
Limited Access/Medical Equipment	0
No Access	0

A total of 4 Ancillary/Specialty Physical Accessibility Reviews (PAR) were done for 2025

Level of Access:	# of Ancillary/Specialty
Basic Access	0
Basic Access/ Medical Equipment	4
Limited Access	0

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

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

4.4 POTENTIAL QUALITY ISSUE (PQI) MONITORING

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

27 PQI/Quality of Care Reviews were adjudicated in 2025
 Final counts by PQI Level

Row Labels	Count
P0/S0	11
P0/S1	5
P1/S1	1
P1/S2	2
P2/S1	2
P2/S2	4
P3/S0	2
Grand Total	27

4.5 QUALITY MONITORING ACTIVITIES

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

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

In 2025 the following activities were completed:

- The PQIs received for the aforementioned facilities were cross-referenced with data from the California Department of Public Health (CDPH) using the California Health Facility Information Database (Cal Health Find). This database includes various information, such as performance history, complaints, facility-reported

incidents, state enforcement actions, and audit deficiencies. After analyzing the data, no significant trends were found between the information received from the CDPH and the nature of the PQIs. These findings were shared with the CQC for further review.

- The Quality Improvement (QI) Team met with the SMC Ombudsman to address quality of care concerns for members residing in Skilled Nursing Facilities (SNFs) and Long-Term Care (LTC) settings. As a result, a workgroup was established and began meeting in January 2025. The workgroup's focus is on identifying and reporting quality of care concerns via various channels such as PQIs, grievances, and other mechanisms. The group convenes quarterly and includes representatives from QI, G&A, Provider Services (PS), Utilization Management (UM), as well as the SMC Ombudsman.

5. MEMBER EXPERIENCE & HEALTH OUTCOMES

5.1 HEALTH OUTCOMES SURVEY (HOS)

This Healthcare Effectiveness Data and Information Set (HEDIS®) a Health Outcomes Survey (HOS) Effectiveness of Care Report (HEDIS HOS Report) measures the change in health status for Medicare beneficiaries over time. It is a Cohort study of a baseline survey with initial sample of 1,200 and follow-up two years later.

The 2025 report presents the HEDIS HOS results for HPSM based on data from the HOS Round 27 survey (Cohort 27 Baseline) collected in 2024 (MY2024/RX 2025) and Cohort 26 trending data. There is only a single year of prior data (Follow-Up) available for year-to-year comparisons as Cohort 26 was the first year of data available for HPSM's Medicare Advantage plan.

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

The Cohort 27 Baseline HOS survey was fielded from July through November 2024.

Medicare HOS Survey Administration and Star Ratings Timeline							
	Data Collection		HOS Reports		Medicare Part C Star Ratings		
	Baseline	Follow Up	Baseline	Follow Up	2-yr PCS/MCS Change/ PFADL Change	HEDIS HOS Measures	Rating Year
2026	Cohort 29	Cohort 27	Cohort 28	Cohort 26	2022-2024 Cohort 25	2024 Cohort 27 Baseline & 2024 Cohort 25 Follow-up	2026
2025	Cohort 28	Cohort 26	Cohort 27	Cohort 25	2021-2023 Cohort 24	2023 Cohort 26 Baseline & 2023 Cohort 24 Follow-up	2025
2024	Cohort 27	Cohort 25	Cohort 26	Cohort 24	2020-2022 Cohort 23	2022 Cohort 25 Baseline & 2022 Cohort 23 Follow-up	2024
2023	Cohort 26	Cohort 24	Cohort 25	Cohort 23	2019-2021 Cohort 22	2021 Cohort 24 Baseline & 2021 Cohort 22 Follow-up	2023
2022	Cohort 25	Cohort 23	Cohort 24	Cohort 22	2018-2020 Cohort 21	2020 Cohort 23 Baseline & 2020 Cohort 21 Follow-up	2022

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

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

The following topics were covered in the survey:

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

COHORT 27-RESULTS FOR 2025

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

Table 1: 2024 HEDIS HOS Rates for MAO H6019, California, CMS Region 9, and HOS Total

	MUI Discuss Rate	MUI Treat Rate	MUI Impact Rate	PAO Discuss Rate	PAO Advise Rate	FRM Discuss Rate	FRM Manage Rate
H6019	NA	NA	NA	62.06%	59.78%	29.81%	77.86%
California	57.72%	45.02%	17.82%	59.43%	54.96%	25.17%	60.89%
CMS Region 9	58.66%	45.10%	16.74%	58.57%	53.04%	26.20%	58.81%
HOS Total	60.24%	45.30%	15.23%	56.65%	49.98%	27.77%	58.02%

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

	MUI Discuss Rate	MUI Treat Rate	MUI Impact Rate	PAO Discuss Rate	PAO Advise Rate	FRM Discuss Rate	FRM Manage Rate
2024 Round 27	NA	NA	NA	62.06%	59.78%	29.81%	77.86%
2023 Round 26	NA	49.00%	30.69%	63.24%	65.28%	31.63%	76.52%
2022 Round 25	NA	NA	NA	NA	NA	NA	NA

Star Cut Points for 2024 Round 27

	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MUI Treat	Less than 41 %	Greater than or equal to 41 % to less than 45 %	Greater than or equal to 45 % to less than 49 %	Greater than or equal to 49 % to less than 53 %	Greater than or equal to 53 %
PAO Advise	Less than 41 %	Greater than or equal to 41 % to less than 47 %	Greater than or equal to 47 % to less than 53 %	Greater than or equal to 53 % to less than 59 %	Greater than or equal to 59 %
FRM Mange	Less than 51 %	Greater than or equal to 51 % to less than 57 %	Greater than or equal to 57 % to less than 62 %	Greater than or equal to 62 % to less than 71 %	Greater than or equal to 71 %

Physical and Mental Health Status



Table 3: 2024 Cohort 27 Baseline Self-Rated General and Comparative Health Status for MAO H6019, California, and HOS Total

	General Health Excellent to Good*	General Health Fair or Poor	Comparative Physical Health Much Better to About the Same*	Comparative Physical Health Slightly Worse or Much Worse	Comparative Mental Health Much Better to About the Same*	Comparative Mental Health Slightly Worse or Much Worse
H6019	56.6%	43.4%	66.6%	33.4%	82.4%	17.6%
California	69.0%	31.0%	71.6%	28.4%	84.8%	15.2%
HOS Total	72.2%	27.8%	72.0%	28.0%	86.3%	13.7%

*Categories for general health included "Excellent," "Very good," or "Good." Categories for comparative health included "Much better," "Slightly better," or "About the same."

Physical and Mental Health Status



Table 4: Trends in Self-Rated General and Comparative Health Status Over Three Baseline Cohorts for MAO H6019

	General Health Excellent to Good*	General Health Fair or Poor	Comparative Physical Health Much Better to About the Same*	Comparative Physical Health Slightly Worse or Much Worse	Comparative Mental Health Much Better to About the Same*	Comparative Mental Health Slightly Worse or Much Worse
2024 Cohort 27	56.6%	43.4%	66.6%	33.4%	82.4%	17.6%
2023 Cohort 26	56.6%	43.4%	66.4%	33.6%	76.9%	23.1%
2022 Cohort 25	NA	NA	NA	NA	NA	NA

*Categories for general health included "Excellent," "Very good," or "Good." Categories for comparative health included "Much better," "Slightly better," or "About the same."
 NA in a row indicates that the MAO did not have results for that cohort.

Physical Health

Cut Points:	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
	Less than 66 %	Greater than or equal to 66 % to less than 70 %	Greater than or equal to 70 % to less than 72 %	Greater than or equal to 72 % to less than 75 %	Greater than or equal to 75 %

Mental Health

Cut Points:	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
	Less than 81 %	Greater than or equal to 81 % to less than 83 %	Greater than or equal to 83 % to less than 85 %	Greater than or equal to 85 % to less than 88 %	Greater than or equal to 88 %

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 2025 survey includes both adult and child members. HSPM conducts separate annual CAHPS surveys for its Medicare members. The surveys are mailed in English and Spanish with a follow up telephone call.

2025 Medicare CAHPS SURVEY SUMMARY

The response rate was 37.5%, which is a slight decrease when compared to the 2024 response rate of 39.2%. Most questions are answered using a 0 (worst) to 10 (best) scale or a "never, sometimes, usually, always" scale.

CAHPS MEDICARE SURVEY RESULTS

Table 4. Results for Contract H6019

Member Experience with Health Plan Measures	Mean Score	Base Group	Statistical Significance	Reliability	Number of Stars	Star Rating
Getting Needed Care	77	1	Below Average	Good	1	★
Getting Appointments and Care Quickly	77	1	Below Average	Good	1	★
Rating of Health Care Quality	84	2	Below Average	Good	2	★★
Rating of Health Plan	86	3	No Discernible Difference	Good	3	★★★
Customer Service	86	1	Below Average	Good	1	★
Care Coordination	84	1	Below Average	Good	1	★

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



Vaccine Measure	Mean Score	Base Group	Statistical Significance	Reliability	Number of Stars	Star Rating
Annual Flu Vaccine	80	5	Above Average	Good	5	★★★★★

Member Experience with Drug Plan Measures	Mean Score	Base Group	Statistical Significance	Reliability	Number of Stars	Star Rating
Getting Needed Prescription Drugs	85	1	Below Average	Good	1	★
Rating of Drug Plan	86	3	No Discernible Difference	Good	3	★★★

2025 Medi-Cal CAHPS SURVEY SUMMARY

See APPENDIX B: 2025/24 CAHPS Results and Analysis

5.3 GRIEVANCES AND APPEALS

The Grievances & Appeals Report representing data from 2024, 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-Medicconnect (CA-CMC)
 - Medi-Cal (MC)
 - Healthy Kids, HealthWorx, ACE & CCS
- Primary Care Provider (PCP Changes by Provider)

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

6. SUMMARY OF EFFECTIVENESS 2025

Adequacy of QI Program Resources	Securing adequate resources to support QI activities remained a focus in 2025. HPSM filled the open QI RN role in August of 2025. As of the writing of this report, all Quality Improvement department positions are filled. QI Department staff focus on clinical quality monitoring, evaluation and reporting functions and may lead quality improvement initiatives across organizational teams. However, quality improvement program implementation and ongoing administration continues to be integrated through the various operational units of HPSM. This allows for a more robust and
---	--

	sustainable QIHE Program that will lead to substantial improvement in health outcomes for our members.
QIHE Committee Structure	The QIHE committee structure was not significantly changed in 2025. The Quality Improvement & Health Equity Committee (QIHEC) continues to provide a forum for HPSM to report out program activities. The committee continues to serve as an advisory role in our QI programming in 2025 and actively participates in discussions regarding opportunities for improvement, data analysis, intervention planning and evaluation. The QIHEC met quarterly in 2025. The QIHEC met quorum for each meeting, and total committee membership increased to 7 members. HPSM is actively recruiting additional members to the QIHEC to include up to 8 total committee members. The QIHE Committee Structure itself has been successful at achieving its purpose and will continue.
Practitioner Participation and Leadership Involvement	<p>The CMO has direct oversight of the Quality Improvement Department in addition to Utilization Management, Pharmacy, and Dental units and Medical Directors. In addition to the practitioners that sit on the QIHE Committee and HPSM's CMO and Chief Health Officer (CHO), HPSM has three Medical Directors with differing areas of expertise including Obstetrics & Gynecology, Gerontology and Primary Care, and a Dental Director. This structure continued throughout 2025. Our CMO, CHO and Dental and Medical Directors are heavily involved with QIHE Program activities and provide their clinical expertise throughout our intervention planning and evaluation process as well as ongoing clinical quality and patient safety monitoring. They also provide very valuable feedback and suggestions for improvement from the provider perspective on various initiatives. This is done both through their individual participation in various project meetings as well as the Clinical Quality Committee.</p> <p>Similarly, leadership involvement in the QIHE Program happens both from individual's participation in various QIHE activities as well as through the QIHE Committees including the Quality Improvement & Health Equity Committee (QIHEC) and Clinical Quality Committee (CQC). Management participation from several HPSM Departments participate in these committees and include representation from the following departments:</p> <ul style="list-style-type: none"> • Pharmacy • Utilization Management • Population Health • Integrated Care Management • Behavioral Health • Provider Services • Quality Improvement • Dental <p>This current structure supports practitioner participation and leadership involvement in QIHE Program Activities and will continue in 2026.</p>
Summary	The current level of resources for quality improvement, leadership and practitioner involvement and committee structure supports the Quality Improvement & Health Equity Program in meeting its objectives. Expanding the current membership of the QIHEC is recommended to enhance and diversify its advisory capacity particularly in addressing health equity.

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

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

MY2024/RY2025 MCAS – MPL



Abrev	Measure	50th Percentile MPL	MY2024	MY2023	MY2022	MY2021	MY 2020
CBP	Controlling High Blood Pressure*	64.48%	67.25%	71.48	64.95	62.20	53.04
GSD	Glycemic Status for Patients with Diabetes: Poor Control (>9.0%)* (lower is better)	33.33%	26.80%	30.77	34.43	28.78	37.23
AMR	Asthma Medication Ratio	66.24%	69.48%	75.18	77.44	69.56	70.06
CIS-10	Childhood Immunization Status –Combo 10*	27.49%	45.23%	54.03	54.50	54.85	61.56
IMA -2	Immunizations for Adolescents –Combo 2*	34.3%	48.91%	50.85	49.39	51.58	50.61
BCSE	Breast Cancer Screening	52.68%	65.02%	63.27	58.68	53.96	59.20
CCS	Cervical Cancer Screening*	57.18%	63.01%	61.22	61.69	57.61	58.91
CHL	Chlamydia Screening in Women	55.95%	72.93%	69.07	67.39	68.71	63.98
PPC-Post	Prenatal and Postpartum Care – Postpartum Care*	80.23%	93.72%	86.63	89.53	92.45	92.59
PPC-Pre	Prenatal and Postpartum Care – Timeliness of Prenatal Care*	84.55%	90.82%	91.28	90.70	89.31	90.0
WCV	Child and Adolescent Well-Care Visits (3-21 yrs)	51.81%	54.75%	54.81	52.00	56.92	48.80
LSC	Lead Screening in Children*	63.84%	78.97%	70.66	67.88	N/A	N/A
DEV^	Developmental Screening in the First Three Years of Life	35.7%	66.05	56.07	53.15	43.02	24.24
FUM	Follow-Up After Emergency Department Visit for Mental Illness (30-Day Follow-Up)	53.82%	61.21	64.43	69.70	27.72	N/A
FUA	Follow-Up After Emergency Department Visit for Substance Use (30-Day Follow-Up)	36.18%	47.30	49.13	53.44	7.58	N/A
TFL-CH^	Topical Fluoride for Children	19%	28.05	23.00	20.32	N/A	N/A
W30	Well-Child Visits in the First 30 Months of Life • 6 or more well-child visits in first 15 months of life • 2 or more well-child visits in 15 to 30 months of life	60.38%	63.95%	58.58	49.62	25.73	20.03
		69.43%	75.32%	72.96	72.38	69.14	76.94

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

Under MPL (50th Percentile/CMS FFY 2023 state medians for non-HEDIS)
Above HPL (90th Percentile)

MY2024/RY2025 MCAS – no MPL



Abbrev.	Measure	MY2024	MY2023	MY 2022	MY 2021	MY 2020
FUA	Follow-Up After Emergency Department Visit for Substance Use (7-Day Follow-Up)	30.63%	34.65%	35.52%	4.27%	N/A
FUM	Follow-Up After Emergency Department Visit for Mental Illness (7-Day Follow-Up)	46.88%	49.67%	55.34%	18.58%	N/A
AAP	Adults' Access to Preventive/Ambulatory Health Services	66.22%	68.76%	67.59%	N/A	N/A
POD	Pharmacotherapy for Opioid Use Disorder	14.89%	18.62%	26.03%	N/A	N/A
PRS-E	Prenatal Immunization Status: Flu + Tdap	45.78%	52.01%	49.67%	N/A	N/A
PDS-E	Postpartum Depression Screening and Follow Up	1.28%	8.67%	10.75%	N/A	N/A
	• Screening	N/A	66.67%	86.67%		
PND-E	Prenatal Depression Screening and Follow Up	2.55%	9.65%	11.91%	N/A	N/A
	• Screening	80.00%	64.71%	47.06%		
DSF-E	Depression Screening and Follow-up for Adolescents and Adults	9.86%	8.29%	4.31%	N/A	N/A
	• Screening	39.31%	68.45%	80.81%		
DRR-E	Depression Remission or Response for Adolescents and Adults	17.39%	37.97	0	N/A	N/A
	• Follow-up	2.17%	7.17%	0		
	• Remission	3.26%	16.03%	0		
CCP^	Contraceptive Care: Postpartum Women Ages 15-44 Most or moderately effective contraception – 90 days	63.49%	57.16%	48.92%	52.41%	50.17%
CCW^	Contraceptive Care: All Women Ages 15-44 Most or moderately effective contraception	21.92%	22.07%	23.07%	25.26%	24.34%

^Non-HEDIS measure All administratively collected measures;

MY2024/RY2025 MCAS – no MPL



Abbrev.	Measure	MY2024	MY2023	MY 2022	MY 2021	MY 2020
ADDE-Init	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications – Initiation Phase	59.83%	52.59%	50.82%	24.35%	22.88%
ADDE-C/M	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications – Continuation and Maintenance Phase	N/A	46.51%	N/A	N/A	N/A
PCR	Plan All-Cause Readmissions (18-64 yr olds) <ul style="list-style-type: none"> Observed rate (lower is better) Observed to expected ratio 	8.80% 1.0012	9.00% 0.9271	8.53% 0.8623	9.42% 0.9597	9.64% 0.9322
APME	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing	37.84%	37.35%	31.51%	42.55	35.64
AMM -AP	Antidepressant Medication Management - Effective Acute Phase Treatment	69.43%	69.20	69.55%	67.59%	66.47%
AMM -CP	Antidepressant Medication Management - Effective Continuation Phase Treatment	48.77%	50.09	53.26	51.48	51.09%
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	84.05%	81.89%	81.26%	80.19%	78.15%
COLE	Colorectal Cancer Screening	51.55%	49.91%	47.82%	N/A	N/A

All administratively collected measures;



October 2025

Mackenzie Moniz, MSW
 Member Experience Program Manager
Mackenzie.Moniz@hpsm.org

Contents

Overview	32
Table 1: CAHPS Response Rate Trends.....	32
Table 2: CAHPS Domains	33
2024 Adult Survey Results (Medi-Cal).....	33
Table 3: Adult Medi-Cal – Results Trends and Comparisons	33
Table 4: Composite Scores.....	34
2024 Child Survey Results (Medi-Cal).....	36
Table 5: Child Medi-Cal – Results Trends and Comparisons	36
Table 6: Composite Scores.....	37
2024 Commercial Adult Results.....	38
Table 7: Commercial Adult – Results Trends and Comparisons	39
Table 8: Composite Scores.....	39
Analysis, Barriers, and Action Plan.....	40
Overview	40
Access to Care.....	41
Analysis	41
Barriers.....	41
Action Plan 2026.....	41

Customer Service & Navigation	41
Analysis	41
Barriers	41
Action Plan 2026	41
Care Coordination	42
Analysis	42
Barriers	42
Action Plan 2026	42
2024–2025 Goal Rates and Focus Areas	42
Smoking and Tobacco Use Trends	43

Overview

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results for 2024 reflect member-reported experiences across Medi-Cal (Adult and Child), and Commercial Adult. Results provide insight into member satisfaction, highlight barriers, and inform Health Plan of San Mateo’s (HPSM) strategies to improve equity, access, and quality of care.

Table 1: CAHPS Response Rate Trends

Response rates have fluctuated over recent years, with Medi-Cal populations showing the greatest challenges in maintaining participation, while Medicare members remain the most consistently engaged. Commercial survey response rates have been relatively stable. These patterns reflect ongoing barriers in engaging Medi-Cal families, alongside stronger and more reliable participation among older adult members.

	2022		2023			2024		
CAHPS Data	Adult	Child	Adult	Child	Commercial	Adult	Child	Commercial
Sample size (includes oversampling)	1350	1650	1350	1650	925	1320	1625	890

Patient Level Records Used:								
Complete & Valid	277	211	220	178	222	242	257	222
Total Response Rate:								
Complete/(sample-Ineligible)	21%	13.1%	16.8%	11%	24%	18%	15.8%	25%

Table 2: CAHPS Domains

The table outlines the key domains measured in the CAHPS survey. It highlights the three categories of evaluation: Global Ratings (overall impressions of health care, health plans, and providers), Composite Measures (specific experiences with access, timeliness, communication, and service), and Effectiveness of Care Measures (focused on tobacco cessation counseling in the adult population). Together, these domains capture both the breadth and depth of member experience and inform targeted improvement strategies.

Global Ratings	Composite Measures	Effectiveness of Care Measures (adult population only)
<i>Rating of Health Plan</i>	<i>Getting Needed Care</i>	<i>Advising Smokers and Tobacco Users to Quit</i>
<i>Rating of All Health Care</i>	<i>Getting Care Quickly</i>	<i>Discussing Cessation Medications</i>
<i>Rating of Personal Doctor</i>	<i>How Well Doctors Communicate</i>	<i>Discussing Cessation Strategies</i>
<i>Rating of Specialist Seen Most Often</i>	<i>Customer Service</i>	

2024 Adult Survey Results (Medi-Cal)

Response Rate: 18.3% (242 completes)

Key Improvements: Getting Needed Care (+2.3%), Customer Service (+8.1%)

Challenges: Rating of Personal Doctor (67.7%, below goal), Coordination of Care (-7.7%)

Health Plan Rating: 67.0% top-box

Table 3: Adult Medi-Cal – Results Trends and Comparisons

The 2024 Adult Medi-Cal CAHPS survey results show mixed performance, with progress in some areas but notable declines in others. The rating of personal doctor improved to 69.9%, a 2.3 percentage point increase from 2023, though it remains slightly below the goal threshold of 71.1%. Communication with doctors also remains a strong area, increasing to 93.6% and maintaining consistently high performance above 90%.

In contrast, several measures showed declines compared to the prior year. The rating of health plan decreased by three points to 63.9%, falling just short of the 64.9% goal. Ratings of overall health care also

declined by 2.4 percentage points to 58.4%, missing the goal rate. Access-related measures continue to present challenges: “getting needed care” fell by 4.4 points to 77.8%, and “getting care quickly” dropped by 3.9 points to 74.0%, with both remaining below their respective goal thresholds. The rating of specialists also declined by more than four points, underscoring persistent concerns in access to specialty services.

Customer service performance declined slightly to 89.8% but continues to reflect an overall area of strength, with scores remaining well above 85%.

Overall, the 2024 Adult Medi-Cal results highlight strong provider communication and stable customer service as key strengths. However, declines across ratings of health plan, health care, and access to needed or timely care point to critical areas for improvement to meet member expectations and goal thresholds.

Measure	2021	2022	2023	2024	2023→2024 Change	Goal Rate	Goal Met
Rating of Health Plan	63.1%	63.8%	67.0%	63.9%	-3.0%	64.9%	No
Rating of All Health Care	60.3%	56.3%	60.7%	58.4%	-2.4%	58.7%	No
Rating of Personal Doctor	65.3%	58.7%	67.7%	69.9%	+2.3%	71.1%	No
Rating of Specialist seen most often	71.6%	64.5%	71.2%	67.0%	-4.2%	N/A	N/A
Getting Needed Care	80.5%	79.9%	82.2%	77.8%	-4.4%	84.6%	No
Getting Care Quickly	80.1%	73.4%	78.0%	74.0%	-3.9%	83.8%	No
How Well Doctors Communicate	92.0%	88.9%	91.8%	93.6%	+1.8%	N/A	N/A
Customer Service	86.4%	82.9%	91.0%	89.8%	-1.2%	N/A	N/A

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

Table 4: Composite Scores

The 2024 Adult CAHPS survey results demonstrate a combination of progress and areas requiring continued focus. Ratings of the health plan and health care showed modest improvement over 2023,

though both measures remain below NCQA Quality Compass benchmarks. The rating of personal doctors increased slightly to 81.0%, meeting the plan’s internal goal rate, while the rating of specialists remained steady.

Measures related to access continue to present challenges. “Getting needed care” held at 77.0%, while “getting care quickly” improved slightly to 77.5%; however, both remained below benchmark thresholds. These findings suggest ongoing barriers to timely access that directly impact member experience.

Communication and provider interaction remain strengths. The composite “How Well Doctors Communicate” rose to 88.5%, maintaining performance well above comparison benchmarks. Within this composite, measures such as doctors explaining things clearly and spending enough time with patients continue to reflect high levels of satisfaction, although some areas, such as listening carefully, declined slightly.

Customer service measures also performed strongly. Scores for “Customer service provided information and help” improved to 89.0%, showing continued upward movement and surpassing internal goals. Similarly, members reported consistently high satisfaction with courtesy and respect from plan representatives.

Areas of concern include “Coordination of Care,” which remained below benchmarks, and “Health plan forms were easy to fill out,” which declined slightly to 90.7%. These measures suggest opportunities to streamline administrative processes and strengthen integration of services.

Overall, the 2024 Adult survey results highlight stability in provider communication and customer service, but persistent gaps in access and care coordination continue to influence overall member experience. These findings will guide targeted improvement efforts in the upcoming year.

	2025 Valid n	2023	2024	2025	2025 Press Ganey BOB	2024 Quality Compass
Rating Questions (% 9 or 10)						
Q28. Rating of Health Plan	233	63.8%	67.0%	63.9%	63.8%	61.5%
Q8. Rating of Health Care	149	56.3%	60.7%	58.4%	58.0%	56.8%
Q18. Rating of Personal Doctor	173	58.7%	67.7%	69.9% ↑	71.4%	69.2%
Q22. Rating of Specialist	100	64.5%	71.2%	67.0%	68.9%	67.7%
Rating Questions (% 8, 9 or 10)						
Q28. Rating of Health Plan	233	77.2%	86.8%	81.5%	79.1%	77.7%
Q8. Rating of Health Care	149	73.7%	79.3%	79.2%	76.7%	75.8%
Q18. Rating of Personal Doctor	173	77.1%	86.8%	86.1% ↑	84.9%	83.3%
Q22. Rating of Specialist	100	86.9%	88.5%	87.0%	83.5%	82.5%
Getting Needed Care (% Usually or Always)						
Q9. Getting care, tests, or treatment	148	85.0%	85.7%	80.4%	85.5% ▼	84.6%
Q20. Getting specialist appointment	109	74.8%	78.7%	75.2%	79.4%	78.8%
Getting Care Quickly (% Usually or Always)						
Q4. Getting urgent care	75 ^A	77.0%	76.8%	82.7%	83.9%	82.8%
Q6. Getting routine care	156	69.7%	79.1%	65.4% ↓	80.1% ▼	78.7% ▼
Effectiveness of Care (% Sometimes, Usually, or Always)						
Q32. Advised to Quit Smoking: 2YR	39 ^A	71.4%	60.9%	61.5%	74.4% ▼	73.5% ▼
Q33. Discussing Cessation Meds: 2YR	40 ^A	57.1%	58.7%	52.5%	55.1%	52.8%
Q34. Discussing Cessation Strategies: 2YR	39 ^A	53.6%	52.2%	43.6%	48.5%	46.6%
Customer Service (% Usually or Always)						
Q24. Provided information or help	107	82.9%	91.0%	89.8%	89.9%	89.1%
Q25. Treated with courtesy and respect	108	74.6%	87.9%	84.3%	84.7%	83.8%
Q25. Treated with courtesy and respect	107	91.2%	94.1%	95.3%	95.0%	94.3%
How Well Doctors Communicate (% Usually or Always)						
Q12. Dr. explained things	136	88.9%	91.8%	93.6%	93.6%	93.0%
Q13. Dr. listened carefully	137	89.2%	89.0%	92.7%	93.5%	92.7%
Q13. Dr. listened carefully	136	88.0%	93.4%	95.6% ↑	93.8%	93.2%
Q14. Dr. showed respect	136	92.1%	95.6%	96.3%	95.3%	94.8%
Q15. Dr. spent enough time	137	86.1%	89.1%	89.8%	91.8%	91.0%
Q17. Coordination of Care	88 ^A	88.8%	82.0%	87.5%	86.3%	85.6%
Q27. Ease of Filling Out Forms (% Usually or Always)	230	95.7%	90.7%	94.3%	95.0%	94.8%

**Although this data reflects the 2024 CAHPS survey collection year, the reporting materials produced by Press Ganey and NCQA label them as “2025” because they are published and applied to the 2025 measurement and accreditation cycle. For clarity, these results represent member experiences in 2024 but are referenced as 2025 results in vendor reporting and benchmarking tools.*

2024 Child Survey Results (Medi-Cal)

Response Rate: 15.8% (257 completes)

Key Improvements: Rating of All Health Care (+14.7%), Rating of Personal Doctor (+4.0%)

Challenges: Decline in How Well Doctors Communicate (-3.2%), Coordination of Care (-8.4%)

Health Plan Rating: 74.9%, exceeding NCQA benchmarks

The 2024 Child Medi-Cal CAHPS results show improvement in several key measures compared to 2023. The rating of the health plan increased by 2.8 percentage points to 77.0%, exceeding the goal rate of 74.4%. The rating of all health care also improved to 71.4%, though it remains below the goal threshold of 73.1%. The rating of personal doctor declined slightly by 1.1 points to 79.6% but still surpassed the goal rate of 79.3%.

Access to care showed notable progress. “Getting needed care” rose by nearly seven points to 83.1%, though this result remains below the goal rate of 86.6%. “Getting care quickly” improved by 5.8 points to 81.8% but similarly fell short of the 89.3% goal. These gains indicate progress in addressing access challenges, though further efforts are needed to meet benchmark expectations.

Provider communication continues to be a strong area. “How well doctors communicate” improved to 92.5%, nearly a five-point increase from the prior year. Customer service also advanced to 90.6%, demonstrating consistent satisfaction with plan representatives.

Overall, the 2024 child survey results highlight meaningful improvements in access and satisfaction with the health plan, as well as continued strength in communication and customer service. However, key access measures remain below goals, signaling an ongoing need for targeted initiatives to ensure children and families can obtain care easily and in a timely manner.

Table 5: Child Medi-Cal – Results Trends and Comparisons

Measure	2021	2022	2023	2024	2023→2024 Change	Goal Rate	Goal Met
Rating of Health Plan	72.5%	72.5%	74.9%	77.0%	+2.8%	74.4%	Yes
Rating of All Health Care	56.0%	56.0%	70.7%	71.4%	+7.7%	73.1%	No
Rating of Personal Doctor	76.7%	76.7%	80.7%	79.6%	-1.1%	79.3%	Yes
Getting Needed Care	76.7%	76.7%	76.2%	83.1%	+6.9%	86.6%	No

Getting Care Quickly	75.4%	75.4%	76.0%	81.8%	+5.8%	89.3%	No
How Well Doctors Communicate	91.1%	91.1%	87.9%	92.5%	+4.7%	N/A	—
Customer Service	86.5%	86.5%	88.0%	90.6%	+2.6%	N/A	—

Table 6: Composite Scores

The 2024 Medicaid Child CAHPS survey results reflect both stability and areas of concern across key composites. Ratings of the health plan and overall health care showed modest improvement compared to the prior year, with scores approaching benchmark levels but still falling short of national averages. The rating of personal doctor remained a relative strength, exceeding internal goal thresholds and demonstrating consistency across survey cycles.

Access-related measures continued to present challenges. Both “Getting needed care” and “Getting care quickly” remained below benchmarks, with only marginal changes from 2023. These findings highlight ongoing barriers for children and their caregivers in securing timely services, an area that has consistently impacted satisfaction.

Communication between doctors and families declined slightly in 2024, falling from prior-year levels. Although historically a strong measure, this downward shift signals the need to reinforce provider engagement, particularly in listening carefully and spending enough time with patients. Customer service performance remained stable, with scores aligning to prior year trends but leaving limited room for further improvement.

Overall, the 2024 Child CAHPS survey results demonstrate that while satisfaction with personal doctors remains high, access and communication are persistent areas for improvement. These findings underscore the importance of targeted strategies to improve timely care, strengthen provider-family communication, and ensure that administrative processes support a positive member experience for children and their caregivers.

	2025 Valid n	2023	2024	2025	Press Ganey BOB	Quality Compass
Rating Questions (% 9 or 10)						
Q31. Rating of Health Plan	251	72.5%	74.9%	77.7%	72.7% ▲	71.3% ▲
Q8. Rating of Health Care	161	56.0%	70.7%	71.4% †	72.1%	69.6%
Q21. Rating of Personal Doctor	206	76.7%	80.7%	79.6%	78.4%	76.5%
Q25. Rating of Specialist	60^	73.3%	76.5%	90.0% †	74.9% ▲	72.8% ▲
Rating Questions (% 8, 9 or 10)						
Q31. Rating of Health Plan	251	86.8%	87.7%	90.0%	86.8%	86.3% ▲
Q8. Rating of Health Care	161	78.0%	84.6%	86.3%	88.0%	86.9%
Q21. Rating of Personal Doctor	206	87.3%	88.6%	93.2%	90.8%	89.7% ▲
Q25. Rating of Specialist	60^	95.6%	85.3%	95.0%	88.0% ▲	87.2% ▲
Getting Needed Care (% Usually or Always)						
Q9. Getting care, tests, or treatment	113	76.7%	76.2%	83.1%	84.6%	83.3%
Q23. Getting specialist appointment	159	81.3%	80.4%	81.1%	90.4% ▼	89.6% ▼
Q23. Getting specialist appointment	67^	72.0%	72.1%	85.1%	78.8%	77.7%
Getting Care Quickly (% Usually or Always)						
Q4. Getting urgent care	110	75.4%	76.0%	81.8%	86.7% ▼	86.3% ▼
Q6. Getting routine care	66^	80.4%	83.3%	89.4%	90.5%	90.5%
Q20. Coordination of Care	155	70.3%	68.6%	74.2%	83.0% ▼	82.5% ▼
Q20. Coordination of Care	72^	83.7%	76.7%	94.4% †	86.4% ▲	83.5% ▲
Customer Service (% Usually or Always)						
Q27. Provided information or help	100	86.5%	88.0%	90.6%	88.9%	88.3%
Q28. Treated with courtesy and respect	101	76.1%	83.9%	83.2%	83.3%	82.7%
Q28. Treated with courtesy and respect	100	96.9%	92.1%	98.0%	94.5%	93.8% ▲
How Well Doctors Communicate (% Usually or Always)						
Q12. Dr. explained things	150	91.1%	87.9%	92.5%	94.4%	93.8%
Q13. Dr. listened carefully	151	88.3%	87.2%	91.4%	94.7% ▼	94.3%
Q14. Dr. showed respect	151	93.3%	88.4%	92.7%	95.9% ▼	95.2%
Q17. Dr. spent enough time	152	98.1%	92.6%	96.1%	97.2%	96.7%
Q30. Ease of Filling Out Forms (% Usually or Always)	149	84.5%	83.2%	89.9%	89.7%	89.1%
Q30. Ease of Filling Out Forms (% Usually or Always)	238	94.6%	91.3%	91.2%	95.1% ▼	94.9% ▼

**Although this data reflects the 2024 CAHPS survey collection year, the reporting materials produced by Press Ganey and NCQA label them as “2025” because they are published and applied to the 2025 measurement and accreditation cycle. For clarity, these results represent member experiences in 2024 but are referenced as 2025 results in vendor reporting and benchmarking tools.*

2024 Commercial Adult Results

Response Rate: 25.0% (222 completes)

Strengths: Above 67th percentile in Customer Service and Access to Care

Challenges: Coordination of Care, Consistency in Provider Communication

Overall Ratings: Comparable to NCQA Quality Compass averages

The 2025 CAHPS results for the HealthWorx commercial population reflect areas of improvement alongside persistent challenges. Within the Health Plan domain, the rating of the health plan increased by 3.5 percentage points to 59.9%, reflecting progress though still leaving room for growth relative to benchmarks. Customer service and claims processing both improved, with scores rising to 89.7% and 89.6% respectively, demonstrating continued member satisfaction with plan operations. Ease of filling out forms remained stable at 94.2%, reflecting a strong and consistent strength. In contrast, “getting needed care” declined slightly to 72.7%, indicating continued challenges in access to services.

In the Health Care domain, several measures showed meaningful gains. The rating of health care rose by 4.5 points to 58.3%, while ratings of specialists and personal doctors also improved, increasing by 6.3 and 10.1 points respectively. These gains suggest members are experiencing better interactions with providers overall. However, coordination of care declined sharply by 11.5 points to 80.9%, representing a significant gap that warrants attention. Communication with doctors remained relatively strong at 91.5%,

though slightly decreased compared to 2024. Getting care quickly remained stable at 71.8%, indicating little change in timely access.

Overall, the 2025 HealthWorx results highlight notable progress in provider ratings and plan services, particularly in customer service, claims processing, and ratings of personal doctor. At the same time, declines in coordination of care and access to needed care underscore the importance of targeted interventions to address care delivery challenges.

Table 7: Commercial Adult – Results Trends and Comparisons

Measure	Summary Rate Score		
	2024	2025	Change
Health Plan Domain			
Q31. Rating of Health Plan	56.4%	59.9%	3.5%
Getting Needed Care	74.4%	72.7%	-1.7%
Customer Service	87.3%	89.7%	2.3%
Claims Processing	84.9%	89.6%	4.7%
Q27. Ease of Filling Out Forms	93.9%	94.2%	0.2%
Health Care Domain			
Q8. Rating of Health Care	53.8%	58.3%	4.5%
Getting Care Quickly	71.3%	71.8%	0.5%
How Well Doctors Communicate	92.3%	91.5%	-0.8%
Q17. Coordination of Care	92.4%	80.9% ↓	-11.5%
Q18. Rating of Personal Doctor	61.3%	71.3% ↑	10.1%
Q22. Rating of Specialist	65.5%	71.8%	6.3%

Table 8: Composite Scores

The 2025 CAHPS results for the HealthWorx Commercial Adult population show progress in several key domains, while also highlighting ongoing access and coordination challenges.

Ratings of care demonstrated improvement compared to prior years. The rating of the health plan increased to 59.7%, with the rating of health care rising to 58.3%. The rating of personal doctor improved significantly to 71.3%, and the rating of specialists reached 71.8%, both reflecting stronger satisfaction with provider relationships. Despite these gains, ratings of the health plan and overall health care remain below NCQA Quality Compass benchmarks.

Access to care continues to be a mixed area. Getting needed care and getting care quickly remained stable in the mid-70s, but both measures fell below the Quality Compass thresholds, indicating persistent barriers in timely and reliable access. Coordination of care declined, mirroring challenges seen across other product lines, and remains an area requiring targeted improvement.

Member experience with plan operations continues to be a relative strength. Customer service remained high at 89.7%, claims processing improved to 89.6%, and ease of filling out forms remained above 94%.

These results indicate that administrative functions and member support are consistently meeting member expectations.

Communication between members and providers remained a strong area at 91.5%, although slightly down from the previous year. Scores for doctors explaining things, listening carefully, showing respect, and spending enough time all continue to exceed 90%, reflecting sustained positive provider interactions.

Overall, the 2025 Commercial Adult results highlight consistent strengths in provider communication, customer service, and administrative processes. However, ratings of the health plan and access to care remain below benchmark levels, underscoring the need for continued focus on improving care coordination and reducing barriers to timely services.

	2025 Valid n	2023	2024	2025	2025 Non-PPO Press Ganey BOB	2025 Non-PPO Quality Compass	2025 All LOB Quality Compass
Rating Questions (% 7 or 10)							
Q31. Rating of Health Plan	212	--	56.4%	59.9%	43.6% ▲	42.7% ▲	42.4% ▲
Q8. Rating of Health Care	151	--	53.8%	58.3%	49.7% ▲	48.8% ▲	48.7% ▲
Q18. Rating of Personal Doctor	171	--	61.3%	71.3% ↑	68.6%	68.0%	68.1%
Q22. Rating of Specialist	117	--	65.5%	71.8%	66.3%	66.3%	66.1%
Rating Questions (% 8, 9 or 10)							
Q31. Rating of Health Plan	212	--	77.0%	80.2%	64.3% ▲	64.9% ▲	64.7% ▲
Q8. Rating of Health Care	151	--	76.6%	79.5%	74.3%	74.2%	73.8%
Q18. Rating of Personal Doctor	171	--	78.6%	84.5%	85.0%	84.8%	84.9%
Q22. Rating of Specialist	117	--	84.1%	85.6%	83.5%	83.8%	83.7%
Getting Needed Care (% Usually or Always)							
Q9. Getting care, tests, or treatment	153	--	80.1%	79.7%	83.9%	84.7%	85.1%
Q20. Getting specialist appointment	122	--	68.6%	65.6%	76.5%	77.8%	78.4%
Getting Care Quickly (% Usually or Always)							
Q4. Getting urgent care	77^	--	73.5%	75.3%	81.6%	80.1%	81.7%
Q6. Getting routine care	145	--	69.0%	68.3%	76.3%	77.1%	78.0%
Q17. Coordination of Care	94^	--	92.4%	80.9% ↓	83.4%	84.1%	83.9%
Effectiveness of Care (% Sometimes, Usually, or Always)							
Q35. Advised to Quit Smoking: 2YR	22^	--	83.3%	77.3%	73.7%	--	--
Q36. Discussing Cessation Meds: 2YR	22^	--	58.3%	63.6%	48.7%	--	--
Q37. Discussing Cessation Strategies: 2YR	22^	--	66.7%	59.1%	45.7%	--	--
	2025 Valid n	2023	2024	2025	2025 Non-PPO Press Ganey BOB	2025 Non-PPO Quality Compass	2025 All LOB Quality Compass
Claims Processing (% Usually or Always)							
Q29. Handled claims quickly	29^	--	84.9%	89.6%	84.9%	88.7%	89.4%
Q30. Handled claims correctly	30^	--	82.4%	90.0%	83.3%	87.2%	87.8%
Customer Service (% Usually or Always)							
Q24. Provided information or help	87^	--	87.5%	89.3%	86.5%	89.9%	90.7%
Q25. Treated with courtesy and respect	87^	--	87.3%	89.7%	85.6%	88.5%	88.9%
How Well Doctors Communicate (% Usually or Always)							
Q12. Dr. explained things	143	--	80.7%	85.1%	78.5%	81.7%	82.3%
Q13. Dr. listened carefully	144	--	94.0%	94.3%	92.7%	95.2%	95.5%
Q14. Dr. showed respect	143	--	92.3%	91.5%	94.8%	94.9%	95.0%
Q15. Dr. spent enough time	144	--	91.8%	88.9%	95.5%	95.7%	95.9%
Q13. Dr. listened carefully	144	--	95.0%	89.6%	94.6%	94.6%	94.8%
Q14. Dr. showed respect	143	--	95.0%	95.8%	96.3%	96.3%	96.3%
Q15. Dr. spent enough time	143	--	87.4%	91.6%	92.8%	92.9%	93.0%
Ease of Filling Out Forms (% Usually or Always)							
Q13. Dr. listened carefully	206	--	93.9%	94.2%	96.2%	96.4%	96.4%

Analysis, Barriers, and Action Plan

Overview

HPSM continues to build on lessons from prior CAHPS cycles, aligning action plans to emerging challenges and opportunities across the Medi-Cal populations. The 2026 strategy is organized into three primary focus areas:

- **Access to Care**
- **Customer Service & Navigation**
- **Care Coordination**

This report summarizes key findings from the most recent results, outlines persistent barriers, and describes the multi-year action plan designed to improve member experience and performance across lines of business.

Access to Care

Analysis

Access to care continues to show variation across product lines. For Medi-Cal, adults reported declines in 2024, with *Getting Needed Care* decreasing by 4.4 points and *Getting Care Quickly* by 3.9 points. Children, however, showed strong improvements, gaining 6.9 points in needed care and 5.8 points in timely care. These differences suggest that while certain access initiatives are resonating with families, adults continue to face more barriers in navigating timely appointments.

Barriers

For Medi-Cal, capacity constraints and uneven distribution of providers influence how consistently members experience timely care. Children's results show improvement, though pediatric specialty access may remain variable across the network.

Action Plan 2026

To support Medi-Cal, HPSM is expanding Welcome Calls to orient new members and clarify expectations for care navigation. The 59 IVR system will add functionality for common requests, such as replacement ID cards, reducing the need for live-agent interactions. We're evaluating enhancements to our Five9 phone system to introduce IVR self-service features, like requesting an ID card replacement, to improve efficiency, reduce call volume, and limit the need for live agent interaction. Mailings will be refined in frequency and format, with QR codes to make resources easier to access.

Customer Service & Navigation

Analysis

Customer service and navigation produced different results across Medi-Cal populations. Adults experienced a slight decline in overall customer service, while children reported improvements of 2.6 points in customer service and 2.8 points in health plan ratings. This reflects some progress in family-facing supports, while adults continue to report difficulties with forms and navigation.

Barriers

For Medi-Cal, digital literacy, form completion, and navigation supports are not experienced uniformly across the membership, contributing to variability in results.

Action Plan 2026

For Medi-Cal, staff training and availability will be expanded, and forms will continue to be made fillable. Work is underway to determine whether forms can also be made submittable directly through the member portal, and this capability is being actively explored with IT partners. HPSM is also exploring additional capabilities to strengthen member feedback and digital engagement. These include after-call surveys to provide more timely insights, as well as secure messaging, chat features, and texting

campaigns through the Digital Engagement Strategy. Alongside these innovations, expanded digital literacy supports and outreach in provider offices and community locations will help ensure all members can access these tools effectively.

Care Coordination

Analysis

Communication scores improved in 2024, with Medi-Cal adults rising by 1.8 points and children by 4.7 points. These results show that communication-focused initiatives are gaining traction, though broader care coordination remains an opportunity.

Barriers

For Medi-Cal, care coordination is influenced by how data is shared across providers and how consistently care management systems interact. These differences can create uneven experiences for members with complex needs.

Action Plan 2026

For Medi-Cal, priorities include improving provider data sharing and exploring the use of AI functionality for call center agents to support consistent communication and flag care coordination needs in real time. Equity-focused survey follow-up will also be piloted to better understand disparities and guide targeted interventions.

2024–2025 Goal Rates and Focus Areas

Rating of Personal Doctor (Adult & Child)

Last year, this measure was identified as a dual focus: adults were near the next percentile threshold, while children were at the lower end of their percentile band. In 2024, adult scores increased by +2.3 points (67.7% → 69.9%), though they remain below the goal rate of 71.1%. For children, the measure declined slightly by -1.1 points (80.7% → 79.6%), though it still met the goal rate of 79.3%. This split highlights that while adults are slowly improving, children’s experiences require renewed attention to prevent further erosion. The Primary Care Investment Strategy, launched in 2024, has begun addressing this area by focusing on improving member voice, community partnerships, and overall care experience. The adult gains suggest this work is having early impact, but the decline in children’s results indicates the need for more targeted interventions, particularly for adolescents and Asian populations who continue to report lower satisfaction.

Health Plan Forms Were Easy to Fill Out (Adult & Child)

Ease of completing forms was selected last year as an improvement area due to prior declines and their importance for overall member experience. In 2024, scores remained challenged: adults continued to show low satisfaction, and children’s results declined slightly, despite targeted changes. Key steps from the action plan were implemented in 2024, including making forms fillable online, simplifying instructions, and piloting direct submission through the member portal. These align directly with barriers identified last year, such as lack of printer access and unclear return instructions. While these efforts

have not yet resulted in measurable score improvements, they represent foundational changes. The next phase, expanding portal-based submissions and ensuring members with limited digital literacy can navigate forms, will be critical to reversing declines and achieving meaningful progress.

How Well Doctors Communicate (Adult & Child)

This measure was a retention focus last year, with adults already scoring high and children showing opportunity for improvement. In 2024, adults improved further by +1.8 points (91.8% → 93.6%), while children rebounded strongly with a +4.7-point increase (87.9% → 92.5%). For adults, this represents the strongest result in the past four years, and for children, it reverses the previous year's dip, particularly in the "listening carefully" item. These gains align with action plan priorities implemented in 2024: expanded CAHPS communication planning, DEI training to strengthen cultural responsiveness, and new provider learning resources through HPSM's Learning & Development team. Last year's challenge was that plans were still in early stages. This year, execution has begun, and results show that members are already experiencing improvement. The focus moving forward will be to sustain these gains, while paying continued attention to adolescent populations and culturally diverse families to ensure progress is equitable.

Smoking and Tobacco Use Trends

The 2025 results for Medicaid Adults show a mixed picture in the effectiveness of care related to smoking cessation. The measure *Advised to Quit Smoking (G32)* improved slightly, increasing by **0.7 percentage points** from 60.9% in 2024 to 61.5% in 2025. This suggests that providers are maintaining consistency in offering advice to quit, keeping the plan close to benchmark performance and demonstrating stability in this area.

In contrast, both *Discussing Cessation Medications (G33)* and *Discussing Cessation Strategies (G34)* declined notably. Cessation medication discussions dropped by **6.2 percentage points**, from 58.7% in 2024 to 52.5% in 2025, while cessation strategy discussions fell by **8.6 percentage points**, from 52.2% to 43.6%. These declines place the plan in the lower percentiles nationally and highlight a widening gap in more detailed counseling conversations.

The overall trend indicates that while providers are continuing to advise members to quit, fewer conversations are occurring about the practical support that help members succeed, such as medications or behavioral strategies. This imbalance may reduce the effectiveness of smoking cessation efforts, as advice alone has limited impact without follow-up support and resources.

Going forward, this represents an opportunity for targeted provider engagement and member outreach. Reinforcing provider training on cessation counseling, integrating prompts into clinical workflows, and continuing to implement exploring member-facing educational tools could help shift the focus from advice alone to comprehensive cessation support. With smoking cessation directly tied to improved long-term health outcomes, addressing these gaps is critical to advancing member well-being and overall plan performance.

Key Metric Performance

Health Plan of San Mateo

Medicaid Adult

Measure	Summary Rate Score			2025 Press Ganey BOB Benchmark						Plan Percentile Rank	PG BOB
	2024	2025	Change	Percentile Distribution							
Effectiveness of Care											
Q32. Advised to Quit Smoking: 2YR	60.9%	61.5%	0.7%							89 th	74.4% ▼
Q33. Discussing Cessation Meds: 2YR	58.7%	52.5%	-6.2%							42 nd	55.1%
Q34. Discussing Cessation Strategies: 2YR	52.2%	43.6%	-8.6%							28 th	48.5%

Summary Rate Scores

Health Plan of San Mateo

Medicaid Adult

	2025 Valid n	2023	2024	2025	2025 Press Ganey BOB	2024 Quality Compass
Rating Questions (% 9 or 10)						
Q28. Rating of Health Plan	233	63.8%	67.0%	63.9%	63.8%	61.5%
Q8. Rating of Health Care	149	56.3%	60.7%	58.4%	58.0%	56.8%
Q18. Rating of Personal Doctor	173	58.7%	67.7%	69.9% ↑	71.4%	69.2%
Q22. Rating of Specialist	100	64.5%	71.2%	67.0%	68.9%	67.7%
Rating Questions (% 8, 9 or 10)						
Q28. Rating of Health Plan	233	77.2%	86.8%	81.5%	79.1%	77.7%
Q8. Rating of Health Care	149	73.7%	79.3%	79.2%	76.7%	75.8%
Q18. Rating of Personal Doctor	173	77.1%	86.8%	86.1% ↑	84.9%	83.3%
Q22. Rating of Specialist	100	86.9%	88.5%	87.0%	83.5%	82.5%
Getting Needed Care (% Usually or Always)						
Q9. Getting care, tests, or treatment	148	79.9%	82.2%	77.8%	82.4%	81.5%
Q20. Getting specialist appointment	109	74.8%	78.7%	75.2%	79.4%	78.8%
Getting Care Quickly (% Usually or Always)						
Q4. Getting urgent care	115	73.4%	78.0%	74.0%	82.0%	80.4% ▼
Q6. Getting routine care	156	77.0%	76.8%	82.7%	83.9%	82.8%
Effectiveness of Care (% Sometimes, Usually, or Always)						
Q32. Advised to Quit Smoking: 2YR	39 th	71.4%	60.9%	61.5%	74.4%	73.5% ▼
Q33. Discussing Cessation Meds: 2YR	40 th	57.1%	58.7%	52.5%	55.1%	52.8%
Q34. Discussing Cessation Strategies: 2YR	39 th	53.6%	52.2%	43.6%	48.5%	46.6%

APPENDIX C: 2025 HPSM CONSUMER ADVISORY COMMITTEE GRIEVANCE & APPEALS REPORT



Member Experience Committee Grievance & Appeals NCQA

Report Reporting Period: Q1 2024-Q4 2024

Date: 08/01/2025

DATA METHODOLOGY AND GOAL SETTING

1.1.1 DATA METHODOLOGY

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

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

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

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

1.1.2 GOAL RATES

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

Goals were based on the data gathered during 2022.

The G&A Unit set the following goal rates for all non-behavioral health grievances and appeals for 2024

	Min Rate per 1,000 members per Month (2024)	Max Monthly Rate per 1,000 Members per Month (2024)	Goal 2024
Non-Behavioral Health: Grievances	0.60	1.38	0.99
Non-Behavioral Health: Appeals	0.08	0.20	0.14

SUMMARY: 2024 goals for Non-Behavioral Health are set at 0.99 for grievances and 0.14 for appeals per 1,000 members per month.

For behavioral health services, the rate of complaints during 2024 was calculated using the number of members utilizing behavioral health services in 2019:

	Min Rate per 1,000 Utilizing Members per Month (2024)	Max Rate per 1,000 Utilizing Members per Month (2024)	Goal 2024
Behavioral Health: Grievances	0.37	0.60	0.55
Behavioral Health: Appeals	0.00	0.15	0.03

SUMMARY: 2024 goals are 0.55 for behavioral health grievances and 0.03 for appeals per 1,000 utilizing members per month.

Complaint rates from 2024 were based on the date the grievance or appeal was *received*. In late 2019 HPSM’s Consumer Advisory Committee changed its meeting schedule to receive more timely data from several of HPSM’s operational areas. To comply with this decision, the G&A Unit changed their quarterly reports to reflect the G&A volumes based on the date the complaints were *closed*, allowing for all necessary data to be available by the report deadline.

2.1.1 MEDI-CAL AND CCS BEHAVIORAL HEALTH GRIEVANCES

The following table contains the number of behavioral health grievances received during calendar year 2024.

Category	Q1 2024	Q2 2024	Q3 2024	Q4 2024
	# Grievances	# Grievances	# Grievances	# Grievances
Access	4	8	12	18
Attitude and Service	1	6	8	6
Quality of Care	5	5	5	10
Billing and Financial Issues	1	1	0	0
Quality of Practitioner Office Site	0	0	0	0
Total Grievances	11	20	25	34
Standard Met/ Not Met	Standard Met	Standard Met	NOT MET	NOT MET

SUMMARY: Behavioral health grievances rose steadily in 2024, increasing from 11 in Q1 to 34 in Q4, with most of the growth tied to access and quality of care issues.

The following table contains the complaint rate for behavioral health grievances

Category	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Goal Rate	2024 Rate
	Grievances per 1000 members per month	Grievances per 1000 members per month	Grievances per 1000 members per month	Grievances per 1000 members per month		
Access	0.11	0.21	0.29	0.43		
Attitude and Service	0.03	0.16	0.19	0.14		
Billing and Financial Issues	0.03	0.03	0.00	0.00		
Quality of Care	0.14	0.13	0.12	0.24		
Quality of Practitioner Office Site	0.00	0.00	0.00	0.00		
Total Grievances	0.31	0.53	0.60	0.81	0.55	0.56
Standard Met/ Not Met	Standard Met	Standard Met	NOT MET	NOT MET		NOT MET

received throughout the calendar year 2024.

SUMMARY: Rates climbed each quarter, starting at 0.31 in Q1 and peaking at 0.81 in Q4; the annual rate of 0.56 slightly exceeded the 0.55 goal, mainly due to access

and quality of care concerns.

2.1.2 MEDI-CAL AND CCS BEHAVIORAL HEALTH APPEALS

The table below contains the number of behavioral health appeals received during calendar year 2024.

Category	Q1 2024	Q2 2024	Q3 2024	Q4 2024
	# Appeals	# Appeals	# Appeals	# Appeals
Access	1	2	0	0
Attitude and Service	0	0	0	0
Billing and Financial Issues	0	0	0	0
Quality of Care	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0
Total Appeals	1	2	0	0
Standard Met/ Not Met	Standard Met	Standard Met	Standard Met	Standard Met

SUMMARY: Only three behavioral health appeals were reported in 2024, all related to access, with one in Q1 and two in Q2; no appeals were recorded in the second half of the year.

The following table contains the complaint rate for behavioral health appeals received throughout the calendar year 2024.

Category	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Goal Rate	2024 Rate
	Appeals per 1000 members per month	Appeals per 1000 members per month	Appeals per 1000 members per month	Appeals per 1000 members per month		
Access	0.03	0.05	0.00	0.00		
Attitude and Service	0.00	0.00	0.00	0.00		
Billing and Financial Issues	0.00	0.00	0.00	0.00		
Quality of Care	0.00	0.00	0.00	0.00		
Quality of Practitioner Office Site	0.00	0.00	0.00	0.00		

Total Appeals	0.03	0.05	0.00	0.00	0.03	0.02
Standard Met/ Not Met	Standard Met	Standard Met	Standard Met	Standard Met		Met

SUMMARY: Appeal rates stayed minimal across 2024, peaking at 0.05 in Q2 and finishing the year at 0.02 overall, remaining below the 0.03 goal rate.

2.1.3 MEDI-CAL AND CCS NON-BEHAVIORAL HEALTH GRIEVANCES

The following table contains the number of non-behavioral health grievances received during calendar year 2024.

Category	Q1 2024	Q2 2024	Q3 2024	Q4 2024
	# Grievances	# Grievances	# Grievances	# Grievances
Access	27	35	33	21
Attitude and Service	44	101	111	74
Billing and Financial Issues	18	18	36	26
Quality of Care	61	79	57	52
Quality of Practitioner Office Site	2	2	3	1
Total Grievances	152	235	240	174
Standard Met/ Not Met	Standard Met	NOT MET	NOT MET	Standard Met

SUMMARY: Grievances increased through Q3 2024, reaching 240 cases, before dropping to 174 in Q4, with most related to attitude/service and quality of care.

The following table contains the complaint rate for non-behavioral health grievances received throughout the calendar year 2024.

Category	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Goal Rate	2024 Rate
	Grievances per 1000 members per month	Grievances per 1000 members per month	Grievances per 1000 members per month	Grievances per 1000 members per month		
Access	0.07	0.08	0.08	0.04		
Attitude and Service	0.11	0.23	0.27	0.16		
Billing and Financial Issues	0.04	0.04	0.08	0.05		
Quality of Care	0.14	0.16	0.13	0.12		
Quality of Practitioner Office Site	0.00	0.00	0.01	0.00		

Total Grievances	0.36	0.51	0.56	0.37	0.99	0.45
Standard Met/ Not Met	Standard Met	NOT MET	NOT MET	Standard Met		Met

SUMMARY: Rates rose from 0.36 in Q1 to a peak of 0.56 in Q3, then declined to 0.37 in Q4, finishing the year at 0.45 well below the 0.99 goal.

2.1.4 MEDI-CAL AND CCS NON-BEHAVIORAL HEALTH APPEALS

The following table contains the number of non-behavioral health appeals received during calendar year 2024.

Category	Q1 2024	Q2 2024	Q3 2024	Q4 2024
	Appeals Total	Appeals Total	Appeals Total	Appeals Total
Access	24	37	33	17
Attitude and Service	0	5	0	0
Billing and Financial Issues	0	0	0	0
Quality of Care	0	10	0	0
Quality of Practitioner Office Site	0	0	0	0
Total Appeals	24	52	33	17
Standard Met/ Not Met	Standard Met	Standard Met	Standard Met	Standard Met

SUMMARY: Non-behavioral health appeals totaled 126 in 2024, peaking at 52 in Q2 before declining to 17 in Q4; most were related to access and quality of care.

The following table contains the complaint rate for non-behavioral health appeals received throughout the calendar year 2024.

Category	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Goal Rate	2024 Rate
	Appeals per 1000 members per month	Appeals per 1000 members per month	Appeals per 1000 members per month	Appeals per 1000 members per month		
Access	0.06	0.08	0.08	0.04		
Attitude and Service	0.00	0.01	0.00	0.00		
Billing and Financial Issues	0.00	0.01	0.00	0.00		
Quality of Care	0.00	0.02	0.00	0.00		

Quality of Practitioner Office Site	0.00	0.00	0.00	0.00		
Total Appeals	0.06	0.12	0.08	0.04	0.14	0.08
Standard Met/ Not Met	Standard Met	Standard Met	Standard Met	Standard Met		Met

SUMMARY: Appeal rates ranged from 0.06 in Q1 to a high of 0.12 in Q2, ending the year at 0.08—well below the 0.14 goal rate.

3. ANALYSIS, BARRIERS, AND PROPOSED ACTIONS

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

In 2024, Behavioral Health Grievances did not meet the annual goal rate of 0.55, closing the year at 0.56 per 1,000 members per month. During the 2024 review period, behavioral health appeals (0.02), non-behavioral health grievances (0.45), and non-behavioral health appeals (0.08) all met their respective annual goal rates of 0.03, 0.99, and 0.14 per 1,000 members per month.

While behavioral health appeals met the annual goal, they exceeded the target in Q1 (0.03) and Q2 (0.05) before dropping to zero in Q3 and Q4. Behavioral health grievances, however, increased steadily across all four quarters. Both trends were driven by access-related issues within BHRS, where members reported delays in connecting with in-network providers, leading members to seek out-of-network care and request reimbursement. Additional grievance drivers included attitude and service concerns, as well as quality of care issues.

The de-delegation from Magellan on October 1, 2024, is expected to help address access-related barriers by allowing HPSM to directly oversee provider network performance and service delivery. Continued monitoring will be essential to determine whether this operational change will reduce grievance volumes and improves member experience over time.

Behavioral Health Grievances

BH Type	BH Count
---------	----------

BHRS - Mild/Moderate	45
BHT/ ABA Therapy	45
Grand Total	90

SUMMARY: In 2024, a total of 90 behavioral health grievances were reported, split evenly between BHRS Mild/Moderate (45) and BHT/ABA Therapy (45).

3.1.2 Barriers:

- (i) In 2024, Behavioral Health Grievances did not meet the annual goal rate of 0.55, closing the year at 0.56 per 1,000 members per month. This slightly higher than target rate was driven by persistent access-related problems, including an insufficient number of available providers, appointment scheduling delays, and prolonged waiting times for in-network care. Member feedback also highlighted recurring issues with staff attitude, service interactions, and the quality of care received. These combined factors contributed to consistently elevated grievance volumes across all four quarters, indicating that the underlying barriers were systemic and not limited to isolated incidents.

3.1.3 PROPOSED ACTION:

- (i) We will Continue monitoring following the de-delegation from Magellan on October 1, 2024, we anticipate grievance volumes will decline due to improved direct oversight.
- (ii) Quarterly check-ins with providers with top issues, requiring corrective action plans with clear and measurable timelines for improvement regarding reported concerns.
- (iii) Implement a monthly review process to track Medi-Cal and CCS behavioral health grievances by category, provider, and root cause. Analyze emerging trends to enable early identification of systemic issues and use these insights to drive targeted provider interventions and strategic process improvements.