American Specialty Health

2022 Quality Improvement (QI) Annual
Evaluation Executive Summary

(4Q 2021 - 3Q 2022)

AMERICAN SPECIALTY HEALTH, INC.

American Specialty Health Plans of California, Inc.

American Specialty Health Group, Inc.

American Specialty Health Insurance Company

TABLE OF CONTENTS

VISION OF THE QUALITY IMPROVEMENT (QI) PROGRAM

The core vision of American Specialty Health (ASH) is to empower individuals to live healthier, longer lives. To achieve the vision of transforming healthcare through the delivery of quality healthcare services through collaboration with providers, practitioners and client partners, ASH will:

- Positively impact the delivery of healthcare by broadening the understanding and acceptance of specialty healthcare practitioners within the established healthcare community and third-party reimbursement system.
- Facilitate the integration of specialty healthcare, health improvement, population health, and integrative health care services into traditional health care management products.
- Promote evidence-based decision assist tools to support the delivery and management of specialty therapies to improve the health care choices made by members, practitioners, and client partners in the selection and delivery of clinically effective, cost-efficient healthcare services and products.

PURPOSE OF THE QI PROGRAM

The purpose of American Specialty Health's annual Quality Improvement Evaluation is to measure the effectiveness and summarize the accomplishments of the Quality Improvement Program related to the quality of care, service, and safety provided to patients and identify opportunities for future improvements. The annual QI Evaluation reviews various aspects of the QI Program, the Clinical Services Utilization Management (UM) Program, the Credentialing Program, and the Clinical Performance Program captured through the QI Workplan activities. The annual QI Evaluation process reviews and documents the overall effectiveness of the QI program, addresses the quality of clinical care and service, operational improvements, and summarizes the program activities and improvements that were accomplished throughout the year. The annual QI Evaluation process identifies barriers encountered during the QI process in an effort to aid in identifying priorities, resources and/or modified methodologies necessary for obtaining established goals.

PHILOSOPHY OF THE QI PROGRAM

The QI Program defines the process for monitoring member quality of care and service. To achieve the goal of improved member clinical outcomes, pertinent data (aggregate and practitioner-specific data) are collected and analyzed by clinical committees to identify improvement opportunities, develop interventions, and measure outcomes. Data are collected through methods such as member surveys, medical record evaluations, clinical care studies, practitioner surveys, member appeals and grievances, and internal performance measurements extracted from ASH databases. To achieve the goals of service quality, data are collected and monitored by integrated committees against standardized internal and external performance standards. Quality improvement initiatives and priorities focus on areas where members have the greatest need and where the greatest potential to positively impact quality of service and healthcare service delivery to ASH members, providers, practitioners, and clients are identified.

The QI Program incorporates the scope of benefits, services, and activities provided by ASH. It is comprehensive, fully operational, and includes a description of the program, company mission, goals, and objectives throughout all operational areas, and reports on ASH's progress in meeting its goals and objectives.

ASH is committed to continuous quality improvement of the programs and services it offers to individuals. This purpose influences the quality improvement program throughout ASH and incorporates cross-functional activities to monitor, review, and analyze outcomes of programs and policies that impact the quality of care and the quality of service including, but not limited to, the prevention, recognition, and management of adverse outcomes; patient safety; practitioner accessibility; and clinical and administrative services provided to members. The Quality Improvement Program (QI

Program) describes components of the clinical performance program designed to evaluate compliance by credentialed practitioners with ASH's standards of professional care and professional recognized standards of practice related to services provided under the practitioner's scope of professional licensure and acceptable to ASH and its Quality Oversight Committee. The QI program supports and defines the mechanisms to improve the organization administrative processes, clinical services, and clinical activities in accordance with the corporate vision and mission.

Systems within the QI Program are designed to objectively measure, evaluate, monitor, and improve the processes related to the practitioner-member interaction, clinical services provided to members, and internal processes. The QI Program integrates clinical and operational management systems that support consistent compliance with protection of patient health and welfare, privacy and confidentiality of member information, and peer review information. These management systems meet state and federal security standards, meet, or exceed accreditation standards, and meet client delegation requirements. Areas in need of improvement are identified, appropriate interventions are implemented, and improvement results are documented. The goal of these interventions is continuous quality improvement in clinical and administrative operations and the delivery of clinical services.

The ASH philosophy is based on the following quality improvement principles:
- Member-Centric;
- Outcomes-Based;
- Evidence-Based;
- Safe;
- Technology enabled;
- Virtual services enabled;
- Excellent service delivery;
- Integrity;
- Competency of staff;
- Caring;
- QI focused leadership;
- Monitoring accuracy and consistency;
- Measurement accuracy and reporting quality;
- Auditing for QI identification;
- Teamwork;
- Creativity; and
- Change management affinity.

Quality is defined by ASH as meeting or exceeding internal or external customer (e.g., member, client, accreditation entities, state, and federal regulators) expectations and specifications at a cost that represents value to all applicable customers. ASH is committed to continuously improving the quality of member care and service through organization-wide collaborative planning in the oversight of clinical care, services, products, relevant measurement, and assessment of exiting processes to improve clinical outcomes.

The QI Program is designed to:
- Consistently meet or exceed the expectations of customers.
- Measure performance relative to industry standards, internal standards, and customer expectations.
- Identify and implement changes in processes and organizational structure based on gained experience; and
- Continually improve the support of client, industry, and internally defined standards.

- Objectively and systematically measure and monitor services offered by ASH and implement quality improvement activities based upon the findings.

GOALS OF THE QI PROGRAM

The goals of ASH's QI Program are to:
- Maintain and improve upon managed care operations, quality systems, and continuous quality improvement initiatives in support of ASH members, practitioners, and providers. The outcome of these activities will result in improved member health, high member satisfaction, and high quality clinical and service delivery.
- Facilitate effective health improvement outcomes for the members who access services from an ASH credentialed practitioner.
- Deliver effective, evidence-based clinical decision making through the credentialing, medical necessity review, and quality management functions of the organization for the benefit of the member seeking covered health services.
- Improve consumer health by facilitating the integration of evidence-based specialty healthcare products, benefits, and services with conventional evidence-based healthcare in the support of health plans and third-party reimbursement.
- Continue expansion of education initiatives; teaching consumers, clients, practitioners, and staff regarding clinical aspects and benefits of specialty healthcare and evidence-based practices.
- Ensure appropriate member access and availability to practitioners that agree to ASH terms and conditions including, but not limited to, ASH clinical services program, administrative requirements, adherence to ASH policies, and that have been credentialed according to ASH's Credentialing Program.
- Make timely, responsive, clinically appropriate, and/or operationally accurate decisions to support quality assurance and medical necessity review, credentialing, clinical performance (quality) management, medical record documentation review, practitioner facility criteria, preventive health services, customer services, appeals and grievances management, claims management, and contract services.
- Provide quality management and improvement support related to clinical and operational processes, policy development, research, reporting, regulatory compliance, accreditation maintenance, and delegation audit management, including management of the interface between clinical quality and administrative operations.
- Serve our culturally and linguistically diverse membership or customers as mutually agreed upon and delegated by our health plan partners.
- Provides educational support to employers, health plans, employee benefit consultants, and others on evidence-based healthcare for the efficacy, patient safety, and cost-effectiveness of services/interventions which are provided.
- Improves consumer access to and availability of evidence-based services provided by practitioners of chiropractic, physical therapy, occupational therapy, speech therapy, acupuncture, therapeutic massage, naturopathy, nutritional services, podiatry, and other healthcare services added to ASH programs.
- Maintains accreditation and licenses, for clinical services and operations;
- Maintains delegated status by clients for services contracted from ASH;
- Continually promotes measurable, value-added improvement in the clinical and operational quality of services and products;
- Maintains high customer satisfaction through operational and service excellence, including maintaining at least 90% patient satisfaction;
- Maintains practitioner satisfaction and network stability through operational and service excellence;
- Develops and disseminates evidence-based clinical practice guidelines and best clinical practices and assists practitioners with implementation to continually improve the quality and safety of clinical services delivered by ASH practitioners;
- Supports activities and programs that facilitate integration with allopathic medicine;
- Conducts research initiatives that are focused on the ASH vision and mission;
- Continues to enhance the consistency and reliability of the ASH specialty healthcare model; and
- Monitors information received from practitioners and practitioners and takes appropriate action when suspicions of inappropriate or potentially fraudulent practices are discovered.

The annual Quality Improvement (QI) Evaluation describes the overall effectiveness of the QI Program including the activities and projects initiated during the prior year and their results. The evaluation contains a written description of completed and ongoing quality improvement activities that address quality and safety of clinical care and quality of service. Measures are trended to assess performance in the quality and safety of clinical care and service with analysis of the results of quality initiatives, including barrier analysis.

OVERVIEW OF AMERICAN SPECIALTY HEALTH COMMITTEE STRUCTURE

The Quality Improvement (QI) program (QI program) has been established with input and active participation of key staff and management. The ASH Committees, Key Process Teams (KPTs), and clinical peer committees effectively managed the activities included in the 2022 QI Workplan. The committees meet on a regular basis to review Routine Indicators, Routine Monitoring, QI Activities, and QI Studies.

The Quality Oversight Committee (QOC) has responsibility for the development and oversight of the QI program. The QOC includes, among others, the Chief Health Services Officer (CHSO), Vice President of Clinical Services (VPCS), Vice President of Health Services, and at least one credentialed practitioner.

The QI program is reviewed, assessed, and approved annually. The responsibility for assessing and monitoring the quality of care and clinical services provided to members is delegated by the Board of Directors (BOD) to QOC. The QI program is approved by QOC, monitored by American Specialty Health – Specialty (ASH) senior management, and the outcomes are reported to QOC and the BOD at least annually.

OVERALL EFFECTIVENESS OF THE QI PROGRAM

American Specialty Health has made signification improvements to its clinical and administrative operational infrastructure to provide high quality service to its customers. Continuous advancements to technology and process improvements resulted in measurable improvements to performance and strengthened the operational capabilities for future growth. ASH consistently monitors and measures its performance, meeting or exceeding **97%** of the performance standards from 4Q 2021 to 3Q 2022. To strengthen the efficiency and quality of internal processes and operations in support of our health care delivery systems, ASH continues to build alliances with clients, educational institutions, accreditation agencies, regulatory bodies, practitioner organizations, and other external customers in the managed care and health care industries.

ASH believes that being accredited, supporting our accredited health plan partners, and working with accrediting organizations in the development of standards is evidence that our quality program has enhanced and strengthened the patient and practitioner encounter while positively influencing clinical outcomes. Obtaining national accreditation through URAC and the National Committee for Quality Assurance (NCQA) demonstrates ASH's commitment to compliance with industry standards and regulators, and high-quality care and services to members, practitioners, and other customers. ASH has continued its fully accredited status since 1998.

Dedicated staff, analytical capabilities, and data resources are allocated by the Board of Directors to support the corporate-wide QI Program. All employees are responsible for service excellence and improving the quality of assigned tasks and responsibilities.

The following summaries provide an overview of the Quality Improvement Studies in progress, as well as key accomplishments, barriers, and recommendations relating to the QI Workplan activities for 2022.

CONFIDENTIALITY

The Quality Improvement Evaluation and all documents related to it are confidential and subject to all confidentiality policies.

RESULTS SUMMARY

The Results Summary details the quarter and year-to-date outcomes that were monitored throughout the 2022 Quality Improvement year. For any activity that missed a review or a quarterly goal, the activity is analyzed for identification of potential barriers. The summary of the analysis can be found in the Barrier Analysis section of the Quality Improvement Evaluation.

🟢 = All goals met   🟡 = Goal Partially Met   🔴 =Missed goal or review   ⚫ = N/A

Activity #	QI Activity Title and Goal	4Q21	1Q22	2Q22	3Q22
1	**QI Program**				
1.1	Total Quality Management System				
1.1.1	Track Implementation of all Recommendations from Previous Year's Evaluation	🟢	🟢	🟢	🟢
1.1.2	Business Owners to complete and Present New NCQA QIA Form Section I: Activity Selection and Methodology to Committee/Team	🟢	⚫	⚫	⚫
2	**QIA Admin**				
2.1	Service				
2.1.1	Increase Electronic Claim Auto-Adjudication Rates [Goal: ASHLink Auto-Adjudication = 75%; Clearinghouse Auto-Adjudication = 55%]	🟢	🟢	⚫	🟢
3	**Clinical QI Study**				
3.1	Clinical Care				
3.1.1	Monitoring X-Ray utilization (Over Utilization) [Goal: GA, TN, TX - ≤ 10% (consistent with ASH averages and national benchmarks)]	⚫	🟢	🟢	⚫
3.1.2	Encouraging Practitioners to Support Tobacco Cessation with Patients [Goals: 1) ≥85% Practitioners "Always or Often" Ask about tobacco use; 2) ≤5% Practitioners "Never" Ask About Tobacco Use; 3) ≥60% of "Always or Often Ask" Instruct those who use tobacco to quit]	⚫	🟢	🟢	🟢
3.1.3	Encouraging Practitioners to Promote Physical Activity	⚫	🟢	🟢	⚫
4	**Routine Indicator**				
4.1	Service				
4.1.1a	Monitor Practitioner Inquiry Telephone Responsiveness [Goal: 30 seconds = 75%]	🟢	🟢	🟢	🔴
4.1.1b	Monitor Practitioner Inquiry Telephone Responsiveness [Goal: 60 seconds = 85%]	🟢	🔴	🟢	🔴
4.1.1c	Monitor Practitioner Inquiry Telephone Responsiveness [Goal: Avg speed = 30 secs.]	🟢	🔴	🟢	🔴
4.1.1d	Monitor Practitioner Inquiry Telephone Responsiveness [Goal: Abandonment rate = 5%]	🟢	🟢	🟢	🟢

Activity #	QI Activity Title and Goal	4Q21	1Q22	2Q22	3Q22
4.1.1e	Monitor Practitioner Inquiry Telephone Responsiveness [Goal: Call blockage = 2%]	●	●	●	●
4.1.1f	Monitor Practitioner Inquiry Telephone Responsiveness (Unanswered Calls > 10 Minutes) [Goal: Report Wait Times ≥10 Minutes]	●	●	●	●
4.1.2a	Monitor Member Inquiry Telephone Responsiveness [Goal: 30 seconds = 80%]	●	●	●	●
4.1.2b	Monitor Member Inquiry Telephone Responsiveness [Goal: 60 seconds = 85%]	●	●	●	●
4.1.2c	Monitor Member Inquiry Telephone Responsiveness [Goal: Avg speed = 30 secs.]	●	●	●	●
4.1.2d	Monitor Member Inquiry Telephone Responsiveness [Goal Abandonment rate = 5%]	●	●	●	●
4.1.2e	Monitor Member Inquiry Telephone Responsiveness [Goal: Call blockage = 2%]	●	●	●	●
4.1.2f	Monitor Member Inquiry Telephone Responsiveness (Unanswered Calls > 10 Minutes) [Goal: Report Wait Times ≥10 Minutes]	●	●	●	●
4.1.3	Monitor Practitioner Inquiry Types to Identify Trends	●	●	●	●
4.1.4	Monitor Member Inquiry Types to Identify Trends	●	●	●	●
4.1.5a	Monitor Practitioner Inquiry Resolution Timeliness [Goal: Immediately = 75%]	●	●	●	●
4.1.5b	Monitor Practitioner Inquiry Resolution Timeliness [Goal: Within 1 Business Day = 80%]	●	●	●	●
4.1.5c	Monitor Practitioner Inquiry Resolution Timeliness [Goal: Within 2 Business Days = 85%]	●	●	●	●
4.1.5d	Monitor Practitioner Inquiry Resolution Timeliness [Goal: Within 5 Business Days = 90%]	●	●	●	●
4.1.6a	Monitor Member Inquiry Resolution Timeliness [Goal: Immediately = 80%]	●	●	●	●
4.1.6b	Monitor Member Inquiry Resolution Timeliness [Goal: Within 1 Business Day = 85%]	●	●	●	●
4.1.6c	Monitor Member Inquiry Resolution Timeliness [Goal: Within 2 Business Days = 90%]	●	●	●	●
4.1.6d	Monitor Member Inquiry Resolution Timeliness [Goal: Within 5 Business Days = 95%]	●	●	●	●
4.1.7	Monitor Member Administrative and Clinical Appeals Trends	●	●	●	●
4.1.8	Monitor Member Appeal Uphold Rate	●	●	●	●
4.1.9	Monitor Member Grievance Trends	●	●	●	●
4.1.10a	Monitor Timeliness of Member Grievance Acknowledgements and Resolution [Goal: Acknowledged within 5 calendar days = 90%]	●	●	●	●

Activity #	QI Activity Title and Goal	4Q21	1Q22	2Q22	3Q22
4.1.10b	Monitor Timeliness of Member Grievance Acknowledgements and Resolution [Goal: Resolved within 30 calendar days = 90%]	🟢	🟢	🟢	🟢
4.1.11a	Monitor Timeliness of Member Appeals Acknowledgement and Resolution [Goal: Commercial & Medicare - Acknowledged within 5 calendar days = 90%]	🟢	🟢	🟢	🟢
4.1.11b	Monitor Timeliness of Member Appeals Acknowledgement and Resolution [Goal: Urgent (Commercial) & Expedited (Medicare) Appeals Resolved within 72 hours = 90%]	🟢	🟢	🟢	🟢
4.1.11c	Monitor Timeliness of Member Appeals Acknowledgement and Resolution [Goal: Pre-service Resolved within 15 calendar days = 90%]	🟢	🟢	🟡	🟢
4.1.11d	Monitor Timeliness of Member Appeals Acknowledgement and Resolution [Goal: Post-service (Commercial) & Routine (Medicare) Resolved within 30 calendar days = 90%]	🟢	🟢	🟢	🟢
4.1.12	Monitor Practitioner Administrative Appeal Trends	🟢	🟢	🟢	🟢
4.1.13	Monitor Timeliness of Practitioner Acknowledgement of Practitioner Appeals - ASHP [Goal: Acknowledged within 15 calendar days = 90%]	🟢	🟢	🟢	🟢
4.1.14a	Monitor Timeliness of Resolution of Practitioner Appeals [Goal: Pre-Service (Clinical) Resolved within 15 days = 90%	🟢	🟢	🟡	🟢
4.1.14b	Monitor Timeliness of Resolution of Practitioner Appeals Goal: Post-Service (Admin & Clinical) Resolved within 30 calendar days = 90%]	🟢	🟢	🟢	🟢
4.1.15a	Monitor MNR Form Decision-making Timeliness and TAT [Goal: Clinical decision making (Commercial): pre-service within 2 business days = 93%]	🟢	🔴	🟡	🟢
4.1.15b	Monitor MNR Form Decision-making Timeliness and TAT [Goal: Clinical decision making (Commercial): post-service within 30 calendar days = 95%]	🟢	🟢	🟡	🟢
4.1.15c	Monitor MNR Form Decision-making Timeliness and TAT [Goal: Clinical decision making (Medicare): pre-service within 14 calendar days = 95%]	🟢	🟢	🟡	🟢
4.1.15d	Monitor MNR Form Decision-making Timeliness and TAT [Goal: Clinical decision making (Medicare): post-service within 14 calendar days = 95%]	🟢	🟢	🟢	🟢
4.1.16a	Monitor MNR Form Member Notification Timeliness and TAT [Goal: Member notification (Commercial & Medicare): pre-service within 2 business days = 95%]	🟢	🟢	🟢	🟢
4.1.16b	Monitor MNR Form Member Notification Timeliness and TAT [Goal: Member notification (Commercial & Medicare): post-service within 5 business days = 95%]	🟢	🟢	🟢	🟢

Activity #	QI Activity Title and Goal	4Q21	1Q22	2Q22	3Q22
4.1.17a	Monitor MNR Form Practitioner Notification Timeliness and TAT [Goal: practitioner notification (Commercial & Medicare): pre-service within 1 business day = 95%]	🟢	🟢	🟢	🟢
4.1.17b	Monitor MNR Form Practitioner Notification Timeliness and TAT [Goal: practitioner notification (Commercial & Medicare): post-service within 1 business day = 95%]	🟢	🟢	🟢	🟢
4.1.18a	Monitor MNR Form Processing Timeliness for Priority States/Clients [Goal: processing = 90% Client]	🟢	🟢	🟡	🟢
4.1.18b	Monitor MNR Form Processing Timeliness for Priority States/Clients [Goal: processing = 100% Priority States]	🟢	🟢	🟢	🟢
4.1.19a	Monitor Claims Processing Timeliness [Goal: commercial within 15 calendar days = 80%]	🟢	🟢	🟢	🟢
4.1.19b	Monitor Claims Processing Timeliness [Goal: commercial within 25 calendar days = 95%]	🟢	🟢	🟢	🟢
4.1.19c	Monitor Claims Processing Timeliness [Goal: commercial within 30 calendar days = 99%]	🟢	🟢	🟢	🟢
4.1.19d	Monitor Claims Processing Timeliness [Goal: Medicare (unaffiliated) within 30 calendar days = 97%]	🟢	🟢	🟢	🟢
4.1.19e	Monitor Claims Processing Timeliness [Goal: Medicare (all other) within 60 calendar days = 97%]	🟢	🟢	🟢	🟢
4.1.20a	Monitor CBR Claims Processing Timeliness [Goal: Received to Post within 9 Days = 90%]	🟢	🟢	🔴	🟢
4.1.20b	Monitor CBR Claims Processing Timeliness [Goal: Received to Paid within 30 Days = 96%]	🟢	🟢	🔴	🔴
4.1.20c	Monitor CBR Claims Processing Timeliness [Goal: Post to 837 File Sent within 1 Business Day = 95%]	🟢	🟢	🟢	🟢
4.1.20d	Monitor CBR Claims Processing Timeliness [Goal: Last Receipt to Date Paid in 7 Days = 90%]	🟢	🟢	🟢	🟢
4.1.20e	Monitor 2-Step Claims Processing Timeliness [Goal: Received to Post within 9 Days = 90%]	🟢	🟢	🔴	🟢
4.1.20f	Monitor 2-Step Claims Processing Timeliness [Goal: Received to Paid within 30 Days = 96%]	🟢	🟢	🟢	🔴
4.1.20g	Monitor 2-Step Claims Processing Timeliness [Goal: Post to 837 File Sent within 1 Business Day = 95%]	🟢	🟢	🟢	🟢
4.1.20h	Monitor 2-Step Claims Processing Timeliness [Goal: Last Receipt to Date Paid in 7 Days = 90%]	🟢	🟢	🟢	🟢
4.1.21	Monitor Claims Re-pricing Timeliness [Goal: Commercial & Medicare within 7 business days = 90%]	🟢	🟢	🟢	🟢
4.1.22a	Monitor Claims Processing Denial Letter Timeliness [Goal: Commercial within 30 calendar days = 99%]	🟢	🟢	🟢	🟢
4.1.22b	Monitor Claims Processing Denial Letter Timeliness [Goal: Medicare within 60 calendar days = 98%]	🟢	🟢	🟢	🟢
4.1.23a	Monitor Claims Processing Accuracy [Goal: coding accuracy = 98%]	🟢	🟢	🟢	🟢
4.1.23b	Monitor Claims Processing Accuracy [Goal: payment accuracy = 95%]	🟢	🟢	🟢	🟢

Activity #	QI Activity Title and Goal	4Q21	1Q22	2Q22	3Q22
4.1.23c	Monitor Claims Processing Accuracy [Goal: financial accuracy = 99%]	🟢	🟢	🟢	🟢
4.1.24	Monitor Complaints Regarding the Website for ASHLink.com	🟢	🟢	🟢	🟢
4.1.25	Monitor Website Performance Indicators for ASHLink.com	🟢	🟢	🟢	🟢
4.1.26	Evaluate Appropriateness of External Website Links for ASHLink.com	🟢	🟢	🟢	🟢
4.1.27	Evaluate Functionality of Website Links for ASHLink.com	🟢	🟢	🟢	🟢
4.1.28	Quarterly Complete National Verification of Practitioner Data to Ensure Accuracy	🟢	🟢	🟢	🟢
4.1.29	Perform Assessment of On-Line Provider Listings to Ensure Usability and Usefulness Every Three Years (Assessment most recently performed in 2020)	⚫	⚫	⚫	⚫
4.1.30	Review ASHLink Terms & Conditions and Privacy Statement	🟢	🟢	🟢	🟢
4.1.31	Review Choosehealthy Terms & Conditions and Privacy Statement	🟢	🟢	🟢	🟢
4.2	Practitioner Contracting/Communications				
4.2.1a	Monitor Geographic Availability of Practitioners [Goal = 90% Members with Desired Access - Suburban/Urban -	🟢	🟢	🟢	🟢
4.2.1b	Monitor Geographic Availability of Practitioners [Goal = 90% Members with Desired Access -Rural - Chiropratic]	🟢	🟢	🟢	🟢
4.2.1c	Monitor Geographic Availability of Practitioners [Goal = 90% Members with Desired Access - Suburban/Urban -	🟢	🟢	🟢	🟢
4.2.1d	Monitor Geographic Availability of Practitioners [Goal = 90% Members with Desired Access -Rural - Acupuncture]	🟢	🔴	🔴	🔴
4.2.1e	Monitor Geographic Availability of Practitioners [Goal = 90% Members with Desired Access - Suburban/Urban -	🟢	🟢	🟢	🟢
4.2.1f	Monitor Geographic Availability of Practitioners [Goal = 90% Members with Desired Access -Rural - Naturopathy]	🟢	🟢	🟢	🟢
4.2.1g	Monitor Geographic Availability of Practitioners [Goal = 90% Members with Desired Access - Suburban/Urban - Nutrition	🟢	🟢	🟢	🟢
4.2.1h	Monitor Geographic Availability of Practitioners [Goal = 90% Members with Desired Access -Rural - Nutrition Services]	🟢	🟢	🟢	🟢
4.2.1i	Monitor Geographic Availability of Practitioners [Goal = 90% Members with Desired Access - Suburban/Urban - Physical Therapy/Occupational Therapy]	🟢	🟢	🟢	🟢
4.2.1j	Monitor Geographic Availability of Practitioners [Goal = 90% Members with Desired Access -Rural - Physical Therpay/Occupational Therapy]	🟢	🟢	🟢	🟢
4.2.1k	Monitor Geographic Availability of Practitioners [Goal = 90% Members with Desired Access - Suburban/Urban -	🟢	🟢	🟢	🟢
4.2.1l	Monitor Geographic Availability of Practitioners [Goal = 90% Members with Desired Access -Rural - Therapeutic Massage]	🟢	🟢	🟢	🟢

Activity #	QI Activity Title and Goal	4Q21	1Q22	2Q22	3Q22
4.2.2a	Monitor Credentialing and Re-credentialing Approval Rates - Aggregate	🟢	🟢	🟢	🟢
4.2.2b	Monitor Credentialing and Re-credentialing Approval Rates - Chiropractic	🟢	🟢	🟢	🟢
4.2.2c	Monitor Credentialing and Re-credentialing Approval Rates - Acupuncture	🟢	🟢	🟢	🟢
4.2.2d	Monitor Credentialing and Re-credentialing Approval Rates - Therapeutic Massage	🟢	🟢	🟢	🟢
4.2.2e	Monitor Credentialing and Re-credentialing Approval Rates - Nutrition Services	🟢	🟢	🟢	🟢
4.2.2f	Monitor Credentialing and Re-credentialing Approval Rates - Naturopathy	🟢	🟢	🟢	🟢
4.2.2g	Monitor Credentialing and Re-credentialing Approval Rates - Occupational Therapy	🟢	🟢	🟢	🟢
4.2.2h	Monitor Credentialing and Re-credentialing Approval Rates - Physical Therapy	🟢	🟢	🟢	🟢
4.2.2i	Monitor Credentialing and Re-credentialing Approval Rates - Speech Therapy	🟢	🟢	🟢	🟢
4.2.3a	Monitor Credentialing Timeliness by Specialty [Goal: Primary verifications completed in 180 calendar days = 98%]	🟢	🟢	🟢	🟢
4.2.3b	Monitor Credentialing Timeliness by Specialty [Goal: Attestations completed in 180 calendar days = 97%]	🟢	🟢	🟢	🟢
4.2.3c	Monitor Credentialing Timeliness by Specialty [Goal: Notifications completed in 90 calendar days = 95%]	🟢	🔴	🟢	🟢
4.2.4a	Monitor Recredentialing Timeliness by Specialty - Chiropractic [Goal: % completed within TAT = 95%]	🟢	🟢	🟢	🟢
4.2.4b	Monitor Recredentialing Timeliness by Specialty - Acuputncture [Goal: % completed within TAT = 95%]	🟢	🟢	🟢	🟢
4.2.4c	Monitor Recredentialing Timeliness by Specialty - Therapeutic Massage [Goal: % completed within TAT = 95%]	🟢	🔴	🟢	🟢
4.2.4d	Monitor Recredentialing Timeliness by Specialty - Nutrition Services [Goal: % completed within TAT = 95%]	🟢	🔴	🟢	🟢
4.2.4e	Monitor Recredentialing Timeliness by Specialty - Naturopathy [Goal: % completed within TAT = 95%]	🟢	🟢	🟢	🟢
4.2.4f	Monitor Recredentialing Timeliness by Specialty - Occupational Therapy [Goal: % completed within TAT = 95%]	🟢	🔴	🟢	🟢
4.2.4g	Monitor Recredentialing Timeliness by Specialty - Physical Therapy [Goal: % completed within TAT = 95%]	🟢	🔴	🟢	🟢
4.2.4h	Monitor Recredentialing Timeliness by Specialty - Speech Therapy [Goal: % completed within TAT = 95%]	🟢	🔴	🟢	🟢
4.2.5	Monitor Mid-cycle Verification Outcomes	🟢	🟢	🟢	🟢
4.2.6a	Monitor Practitioners Administrative Corrective Action Plans (CAPs) Trends by Specialty - Chiropractic	🟢	🟢	🟢	🟢

Activity #	QI Activity Title and Goal	4Q21	1Q22	2Q22	3Q22
4.2.6b	Monitor Practitioners Administrative Corrective Action Plans (CAPs) Trends by Specialty - Acupuncture	🟢	🟢	🟢	🟢
4.2.6c	Monitor Practitioners Administrative Corrective Action Plans (CAPs) Trends by Specialty - Therapeutic Massage	🟢	🟢	🟢	🟢
4.2.6d	Monitor Practitioners Administrative Corrective Action Plans (CAPs) Trends by Specialty - Nutrition Services	🟢	🟢	🟢	🟢
4.2.6e	Monitor Practitioners Administrative Corrective Action Plans (CAPs) Trends by Specialty - Naturopathy	🟢	🟢	🟢	🟢
4.2.6g	Monitor Practitioners Administrative Corrective Action Plans (CAPs) Trends by Specialty - Occupational Therapy	🟢	🟢	🟢	🟢
4.2.6h	Monitor Practitioners Administrative Corrective Action Plans (CAPs) Trends by Specialty - Physical Therapy	🟢	🟢	🟢	🟢
4.2.6i	Monitor Practitioners Administrative Corrective Action Plans (CAPs) Trends by Specialty - Podiatry	🟢	🟢	🟢	🟢
4.2.7a	Monitor Practitioners Turnover Rate For All Specialties [Goal: YTD Turnover ≤ 15% DC]	🟢	🟢	🟢	🟢
4.2.7b	Monitor Practitioners Turnover Rate For All Specialties [Goal: YTD Turnover ≤ 15% LAc]	🟢	🟢	🟢	🟢
4.2.7c	Monitor Practitioners Turnover Rate For All Specialties [Goal: YTD Turnover ≤ 15% ND]	🟢	🟢	🟢	🔴
4.2.7d	Monitor Practitioners Turnover Rate For All Specialties [Goal: YTD Turnover ≤ 15% NS]	🟢	🟢	🟢	🔴
4.2.7e	Monitor Practitioners Turnover Rate For All Specialties [Goal: YTD Turnover ≤ 15% PT-OT]	🟢	🟢	🟢	🟢
4.2.7f	Monitor Practitioners Turnover Rate For All Specialties [Goal: YTD Turnover ≤ 20% MT]	🟢	🟢	🟢	🟢
4.2.8a	Monitor Practitioner Compliance with Member Access Standards for Appointments (Secret Shopper) - ASHG [Goal: Practitioners Compliant with Member Access Standards for	🟢	🟢	🟢	🟢
4.2.8b	Monitor Practitioner Compliance with Member Access Standards for Appointments (Secret Shopper) - ASHP [Goal: Practitioners Compliant with Member Access Standards for	🟢	🟢	🟢	🔴
4.2.9	Monitor Member Grievances for Access to Appointments [Goal = ≤3 Complaints per 1,000 Members]	🟢	🟢	🟢	🟢
4.2.10	Review Practitioner Availability and Accessibility Results with ASH Client Services and Regulatory Compliance teams to determine need for regulatory filings and health plan notifications (ASHP and ASHG)	🟢	🟢	🟢	🟢
4.2.11	Monitor Requests for MOU and Out of Network Services	🟢	🟢	🟢	🟢
4.2.12	Evaluation of member access complaints, requests for out of network services, and member experience (Annual CAHPS survey)	🟢	🟢	🟢	🟢
4.3	Care and Service				
4.3.1a	Monitor Patient Satisfaction using CAHPS/ASH tool [Goal: 90% Patient Satisfaction - Chiropractic - California]	⚫	⚫	⚫	🟢

Activity #	QI Activity Title and Goal	4Q21	1Q22	2Q22	3Q22
4.3.1b	Monitor Patient Satisfaction using CAHPS/ASH tool [Goal: 90% Patient Satisfaction - Chiropractic - National]	●	●	●	◐
4.3.1c	Monitor Patient Satisfaction using CAHPS/ASH tool [Goal: 90% Patient Satisfaction - Acupuncture - California]	●	●	●	◐
4.3.1d	Monitor Patient Satisfaction using CAHPS/ASH tool [Goal: 90% Patient Satisfaction - Acupuncture - National]	●	●	●	◐
4.3.1e	Monitor Patient Satisfaction using CAHPS/ASH tool [Goal: 90% Patient Satisfaction - Naturopathy]	●	●	●	◐
4.3.1f	Monitor Patient Satisfaction using CAHPS/ASH tool [Goal: 90% Patient Satisfaction - Therapeutic Massage	●	●	●	◐
4.3.2	Monitor Practitioner Satisfaction	●	●	●	◐
4.3.3a	Monitor Practitioner Satisfaction with UM processes [Goal: 70% Practitioner Satisfaction - Chiropractic - California]	●	●	●	◐
4.3.3b	Monitor Practitioner Satisfaction with UM processes [Goal: 70% Practitioner Satisfaction - Chiropractic - National]	●	●	●	◐
4.3.3c	Monitor Practitioner Satisfaction with UM processes [Goal: 70% Practitioner Satisfaction - Acupuncture - California]	●	●	●	◐
4.3.3d	Monitor Practitioner Satisfaction with UM processes [Goal: 70% Practitioner Satisfaction - Acupuncture - National]	●	●	●	◐
4.3.3e	Monitor Practitioner Satisfaction with UM processes [Goal: 70% Practitioner Satisfaction - Naturopathy]	●	●	●	◐
4.3.3f	Monitor Practitioner Satisfaction with UM processes [Goal: 70% Practitioner Satisfaction - Therapeutic Massage]	●	●	●	●
4.3.3g	Monitor Practitioner Satisfaction with Physical Therapy/Occupational Therapy	●	●	●	●
4.4	Clinical Care				
4.4.1a	Monitor Patient Satisfaction with UM Processes [Goal: 90% Patient Satisfaction - Chiropractic - California]	●	●	●	◐
4.4.1b	Monitor Patient Satisfaction with UM Processes [Goal: 90% Patient Satisfaction - Chiropractic - National]	●	●	●	◐
4.4.1c	Monitor Patient Satisfaction with UM Processes [Goal: 90% Patient Satisfaction - Acpuncture - California]	●	●	●	◐
4.4.1d	Monitor Patient Satisfaction with UM Processes [Goal: 90% Patient Satisfaction - Acpuncture - National]	●	●	●	◐
4.4.1e	Monitor Patient Satisfaction with UM Processes [Goal: 90% Patient Satisfaction - Naturopathy]	●	●	●	◐
4.4.1f	Monitor Patient Satisfaction with UM Processes [Goal: 90% Patient Satisfaction - Therapeutic Massage]	●	●	●	◐
4.4.2a	Monitor Consistency of Applying Medical Necessity Review Criteria and the Evaluation of Inter-rater Reliability (IRR) - Step One [Goal: Step One	●	●	●	◐
4.4.2b	Monitor Consistency of Applying Medical Necessity Review Criteria and the Evaluation of Inter-rater Reliability (IRR) - Step One [Goal: Step One Clean Cases = 90% - Acupuncture]	●	●	●	◐

,

Activity #	QI Activity Title and Goal	4Q21	1Q22	2Q22	3Q22
4.4.2c	Monitor Consistency of Applying Medical Necessity Review Criteria and the Evaluation of Inter-rater Reliability (IRR) - Step One [Goal: Step One Clean Cases = 90% - Therapeutic Massage]	⚫	⚫	⚫	🟢
4.4.2d	Monitor Consistency of Applying Medical Necessity Review Criteria and the Evaluation of Inter-rater Reliability (IRR) - Step One [Goal: Step One Clean Cases = 90% - Naturopathy]	⚫	⚫	⚫	🟢
4.4.2e	Monitor Consistency of Applying Medical Necessity Review Criteria and the Evaluation of Inter-rater Reliability (IRR) - Step One [Goal: Step One Clean Cases = 90% - PT/OT]	⚫	⚫	⚫	🟢
4.4.2f	Monitor Consistency of Applying Medical Necessity Review Criteria and the Evaluation of Inter-rater Reliability (IRR) - Step One [Goal: Step One Clean Cases = 90% - Podiatry]	⚫	⚫	⚫	⚫
4.4.2g	Monitor Consistency of Applying Medical Necessity Review Criteria and the Evaluation of Inter-rater Reliability (IRR) - Step One [Goal: Step One Clean Cases = 90% - Speech]	⚫	⚫	⚫	⚫
4.4.3a	Monitor Consistency of Applying Medical Necessity Review Criteria and the Evaluation of Inter-rater Reliability (IRR) - Step Two [Goal: Step Two Clean Cases = 90% - Chiropractic]	⚫	🟢	🟢	🟢
4.4.3b	Monitor Consistency of Applying Medical Necessity Review Criteria and the Evaluation of Inter-rater Reliability (IRR) - Step Two [Goal: Step Two Clean Cases = 90%-Acupuncture]	⚫	🟢	🟢	🟢
4.4.3c	Monitor Consistency of Applying Medical Necessity Review Criteria and the Evaluation of Inter-rater Reliability (IRR) [Goal: Step Two Clean Cases = 90%-Therapeutic Massage]	⚫	🟢	🟢	🟢
4.4.3d	Monitor Consistency of Applying Medical Necessity Review Criteria and the Evaluation of Inter-rater Reliability (IRR) - Step Two [Goal: Step Two Clean Cases = 90% - Naturopathy]	⚫	🟢	🟢	🟢
4.4.3e	Monitor Consistency of Applying Medical Necessity Review Criteria and the Evaluation of Inter-rater Reliability (IRR) - Step Two [Goal: Step Two Clean Cases = 90% - PT/OT]	⚫	🟢	🟢	🟢
4.4.3f	Monitor Consistency of Applying Medical Necessity Review Criteria and the Evaluation of Inter-rater Reliability (IRR) - Step Two [Goal: Step Two Clean Cases = 90% -Podiatry]	⚫	🟢	⚫	⚫
4.4.3g	Monitor Consistency of Applying Medical Necessity Review Criteria and the Evaluation of Inter-rater Reliability (IRR) - Step Two [Goal: Step Two Clean Cases = 90% - Speech]	⚫	🟢	⚫	⚫
4.4.4	Monitor Trends in Practitioner Clinical Corrective Action Plans (CAPs)	🟢	🟢	🟢	🟢
4.4.5	Monitor Trends in Member Clinical Grievances Issues	🟢	🟢	🟢	🟢
4.4.6	Monitor Trends in Practitioner Clinical Appeals	🟢	🟢	🟢	🟢
4.4.7	Monitor Impact of CPS on Average Office Visit and X-ray Utilization Rates	🟢	🟢	🟢	🟢
4.4.8	Monitor CPS Criteria and Tier Participation	⚫	⚫	🟢	🟢
4.4.9	Monitor MNR Form Clinical Non-Approval (Denial) & Partial Approval Rates	🟢	🟢	🟢	🟢
4.5	**Delegation**				
4.5.1	Monitor Timeliness of Claims Processing monthly Reports to Clients [Goal: % reported within timeline = 95%]	🟢	🟢	🟢	🟢
4.5.2	Monitor Timeliness of Eligibility File Loading [Goal: % clean files loaded within 3 business days = 95%]	🟢	🟢	🟢	🟢
4.5.3	Monitor Mission-critical System Availability [Goal: % available = 99.5%]	🟢	🟢	🟢	🟢
4.5.4	Monitor Website Availability for ASHLink [Goal = 99.5% Uptime]	🟢	🟢	🟢	🟢

Activity #	QI Activity Title and Goal	4Q21	1Q22	2Q22	3Q22
4.5.5a	Report Quality of Care Immediate Terminations to Health Plan Clients [Goal = 90% in 2 business days]	🟢	🟢	🔴	🟢
4.5.5b	Report Quality of Care Immediate Terminations to Health Plan Clients [Goal = 100% in 5 business days]	🟢	🟢	🟢	🟢
4.5.6	Ensure Timely Response to Delegation CAPs and Recommendations [Goal: 95% responded to within the agreed upon timeframes]	🟢	🟢	🟢	🟢
4.6	**Regulatory**				
4.6.1	Confirm Completion of Staff by Entity Analysis and Coordinate Staffing Adjustments Accordingly	⚫	⚫	⚫	⚫
5	**Routine Monitoring**				
5.1	**Service**				
5.1.1	Monitor Language Assistance Service for Compliance and Effectiveness - California (Delegated Business) • Staff Training [Goal: 100% ≤ 30 days] • Practitioner Communications • Volume and languages utilized for interpretation services • Volume, languages requested, and turnaround time for translation services [Goal: 100% TAT <21 days] • Language assistance related complaints and grievances	🟢	🟢	🟢	🟢
5.1.2	Monitor Language Assistance Service for Compliance and Effectiveness- Non-CA (ACA) • Staff Training [Goal: 100% ≤ 30 days] • Practitioner Communications • Volume and languages utilized for interpretation services • Volume, languages requested, and turnaround time for translation services [Goal: 100% TAT <21 days]	🟢	🟢	🟢	🟢
5.1.3	Educate Practitioners and Staff on Serving a Culturally and Linguistically Diverse Membership Population.	⚫	⚫	⚫	⚫
5.1.4	Monitor ASHLink Network Search Accessibility (Goal: Monitor and Remediate Issues Timely)	⬛	🟢	⚫	🟢
5.1.5	Monitor Choosehealthy Network Search Accessibility (Goal: Monitor and Remediate Issues Timely)	⬛	🟢	⚫	🟢
5.1.6	Monitor PTRx (ASH Specialty Networks and EmD!) Accessibility (Goal: Monitor and Remediate Issues Timely)	⬛	🟢	⚫	🟢
5.2	**Practitioner Contracting/Communications**				
5.2.1	Obtain Letters Verifying State Licensing Entities Perform Education Verification Prior to Licensing	⚫	⚫	⚫	⚫
5.2.2	PCC KPT Review of QI activity, including the Practitioner Satisfaction Survey Results to Identify QI activities	🟢	🟢	⚫	🟢
5.2.3	Monitor Practitioner Involvement in Education Activities	🟢	🟢	🟢	🟢
5.3	**Clinical Care**				
5.3.1	Report Evidence Evaluation Committee Review of Techniques or Procedures	⚫	⚫	⚫	⚫
5.3.2	Conduct PAHAC Meetings [Goal: Schedule Semi-annual meetings (2 Chiropractic; 2 PTOT)]	🟢	🟢	🟢	🟢

Activity #	QI Activity Title and Goal	4Q21	1Q22	2Q22	3Q22
5.3.3	Report Coordination of Patient Care (Medical Co-Management/Patient	🟢	🟢	🟢	🟢
5.3.4	Over-utilization -- Monitor and Report Potential Over-Utilization	🟢	🟢	🟢	🟢
5.3.5	Under-Utilization -- Monitor Potential Under-Utilization Annually Through a Member Functional Outcome Survey	⚫	⚫	⚫	🟢
5.3.6	Under-Utilization -- Monitor Potential Under-Utilization Annually Through a Focused Survey	🟢	🟢	⚫	🟢
5.3.7	Monitor Timely Completion of Annual Review of All Policies [Goal: 98% within established timeframes]	🟢	🟢	🟢	🟢
5.3.8	Monitor Scope of Practice Regulations for all Contracted Practitioner Types and Implement Applicable Updates as Necessary	🟢	🟢	🟢	🟢
5.3.9	Monitor and Report Clinical Quality Trends to BoD	🟢	🟢	🟢	🟢
5.3.10	Monitor Appropriateness of Acupuncture Services through Medical Physician Review	🟢	🟢	🟢	🟢
5.3.11	Monitor Practitioners with a Specific Radiological Quality Assurance Review	⚫	⚫	⚫	⚫
5.3.12	Present CAHPA & CPM Reports to QIC	🟢	🟢	🟢	🟢
5.3.13	Review and report CPT, HCPC and ICD-10 Annual Code updates	🟢	🟢	⚫	🟢
5.3.14	Update CPT, ICD and HCPC codes in policy (per Annual revisions)	🟢	🟢	🟢	🟢
5.4	**Accreditation**				
5.4.1	Obtain Re-accreditation from URAC for Health Network, Health UM	⚫	⚫	🟢	🟢
5.4.2	Obtain Re-accreditation for UM from NCQA	⚫	⚫	⚫	🟢
5.4.3	Obtain Re-accreditation for Credentialing from NCQA	⚫	⚫	⚫	🟢
5.4.4	Complete and Report Annual QI Evaluation	🟢	🟢	⚫	⚫
5.4.5	Complete and Report Annual QI Workplan	🟢	🟢	⚫	⚫
5.4.6	Complete Annual Review of the Quality Improvement (QI) Program	🟢	🟢	🟢	🟢
5.4.7	Complete Annual Review of the Clinical Services (UM) Program	🟢	🟢	🟢	🟢
5.4.8	Complete Annual Review of the Credentialing Program	🟢	🟢	⚫	⚫
5.4.9	Review Compliance with applicable URAC Standards as Released	🟢	🟢	🟢	🟢
5.4.10	Review Compliance with CR & UM, and HP Standards as released	🟢	🟢	🟢	🟢
5.4.11	Complete Accreditation Communication Requirements - Practitioners	🟢	🟢	🟢	🟢
5.4.12	Prepare Accreditation for URAC Telehealth, Virtual Physical Therapy (VPT); [Goal: Complete desktop application prepare for validation audit]	⬛	⬛	🟢	🟢
5.5	**Delegation**				
5.5.1	Performance Standards and Clinical Indicators Reported to Clients [Goal = 90% within Stipulated Calendar Days from Close of Quarter (30, 45, 60, or 90)]	🟢	🟠	🟢	🟢

Activity #	QI Activity Title and Goal	4Q21	1Q22	2Q22	3Q22
5.5.2	Current UM, QI and Credentialing Programs Reported to Clients	🟢	🟢	🟢	🟢
5.5.3	Post QI Evaluation Summary on ASHLink (pre-login) and FLASH	🟢	🟢	⚫	⚫
5.5.4	Review Compliance with NCQA HPA Standards	🟢	🟢	🟢	⚫
5.5.5	Report California UM and Clinical Quality Reports to Health Plan Clients	🟢	🟢	⚫	🟢
5.5.6	Perform Annual Delegation Oversight Review Audit of any CVO or Entity in Which All or Part of Credentialing has been Delegated	⚫	⚫	⚫	⚫
5.5.7	Monitor Process of Delegation Agreement Review and Execution [Annual Goal: Delegation Agreements Executed within 90 days of effective date (independent of client delays): 90%]	🟢	🟢	🟢	🟢
5.5.8	Perform Random Quality Assurance Audits of Medical Doctor Files to Verify Accuracy of Data via NPDB Query	🟢	🟢	🟢	🟢
5.6	**Regulatory**				
5.6.1	Monitor Training Completion and Compliance for Staff (ASH Employees. Temporary Employees, Seasonal Employees, Interns, Volunteers & Board of Directors) for: 1) Fraud, Waste and Abuse Training; 2) Privacy and Security Training; and	🟢	🟢	🟢	🟢
5.6.2	Monitor Training Completion and Compliance for Practitioners/Providers & Delegatees for: 1) Exclusion Checks 2) CMS Required Training—General Compliance and Fraud, Waste and Abuse; and 3) Code of Conduct/Conflict of Interest.	⚫	⚫	🟢	⚫
5.6.3	Track and Report Regulatory Complaints and Non-Routine Inquiries	🟢	🟢	🟢	🟢
5.6.4	Monitor and Report on all Required Federal Exclusion Lists and State Medicaid Lists Tracking for Staff (ASH Employees, Temporary Employees, Seasonal Employees, Interns, Volunteers, Consultants, & Board of Directors & Shareholders)	🟢	🟢	🟢	🟢
5.6.5	Monitor and Report on all Required Federal Exclusion List and State Medicaid Lists Tracking for Government Program Affilates (Contracted Practitioners, Delegatees & Vendors, as applicable) [Goal = Complete Monthly Check]	🟢	🟢	🟢	🟢
5.6.6	Monitor and Report on Quarterly Compliance Office Reports Sent to the Board of Directors [Goal: Quarterly Submission of Reports]	🟢	🟢	🟢	🟢
5.6.7	Monitor and Report on Quarterly Compliance Reports Sent to the Ethics & Integrity Committee [Goal: Quarterly Submission of Reports]	🟢	🟢	🟢	🟢
5.6.8	Review Exhibit J for Material Changes (California) [Goal: Bi-Annual Review of Ex. J.]	⚫	⚫	⚫	⚫
5.6.9	Monitor California Department of Insurance Sufficiency Standards of California Practitioners to Determine Recruitment Needs to Support the California Department of Insurance (CDI) Access Standards	🟢	🟢	🟢	🟢

Activity #	QI Activity Title and Goal	4Q21	1Q22	2Q22	3Q22
5.6.10	Monitor Member Grievances Related to Caltrans Road Closures To Determine Recruitment Needs to Support the California Department of	🟢	🟢	🟢	🟢
5.6.11	Review Federal and State Language Assistance Program Requirements for Changes	🟢	🟢	🟢	🟢
5.6.12	Complete annual review of the ASH Language Assistance Training Program (ASH Employees and Contracted Practitioners)	🟢	🟢	⚫	🟢
6	Virtual Physical Therapy (VPT)				
6.1	Virtual Physical Therapy (VPT) Network Buildout [Goal: At least 2 credentialed and appropriately licensed VPT providers for all 50 states]			🟢	🟢
6.2	VPT Patient Experience Monitor VPT Patient Service Quality [Goal: To build survey tool(s) and methodology for future survey			⚫	🟢
6.2.1	VPT Patient Experience Monitor VPT Patient Care [Goal: To build survey tool(s) and methodology for future survey			⚫	🟢
6.3	VPT Provider Experience Survey [Goal: To build survey tool(s) and methodology for future survey			⚫	🟢
6.4	Client Satisfaction Assessment [Goal: To build survey tool(s) and methodology for future survey			⚫	🟢
6.5	Monitoring Quality of Care (Adverse events, complaints, and grievances [Goal: To build the reporting and methodology]			⚫	🟢
6.6	Develop Reporting for VPT Performance Measures [Goal: [Goal: To build the reporting and methodology]			⚫	🟠

QUALITY IMPROVEMENT ACTIVITY (QIA) STUDIES

The following is a high-level summary of the Quality Improvement Activity (QIA) studies that were scheduled for review based on the 2022 Quality Improvement Workplan. Please refer to the subsequent QI sections which describe the Quality Improvement Activities in further detail.

QUALITY IMPROVEMENT STUDIES IN PROGRESS

SERVICE

2.1.1   INCREASE ELECTRONIC CLAIM AUTO-ADJUDICATION RATES

[Goal: ASHLink Auto-Adjudication = 75%; Clearinghouse = 55%]

Both internal and external customer satisfaction, as well as a reduction in operating costs can be achieved by increasing the electronic claims auto-adjudication rate. To meet the established goals, system issues such as claims processing for services rendered by a non-participating practitioner, referral research, and eligibility/benefit research will need to be addressed to result in more efficient claims processing.

Summary:
Barring the missed ASHLink target in 1st Quarter 2022, auto-adjudication results consistently exceed stated goals in both categories. Overall data integrity has improved due to EDI involvement and partnership with client health plans to improve the quality of eligibility data loaded into the ASH system.

Due to the largest national client's contract conversions effective 01/01/2022, several claims could not auto-adjudicate and resulted in unnecessary pends requiring human review. Claims and IT partnered to deploy contract conversion updates to eliminate unnecessary pends in late February 2022. Auto-adjudication rates were expected to (and did) exceed goals in 2Q 2022 and beyond.

CLINICAL CARE

3.1.1   MONITORING X-RAY UTILIZATION (OVER-UTILIZATION)

[Goal: Georgia; Tennessee; Texas, Florida]

Summary
For the purposes of this quality improvement activity (QIA), a target range goal of total patient x-ray utilization for a practitioner geographic region has been identified as within the range of 9.4% (average of California, ASH's most mature network) and 12.2% (the national performance level). Since its implementation in 2003, states identified with significant member/patient populations and x-ray utilization above the established goal have been flagged for potential intervention to help contracted chiropractors align their radiographic use with their peers nationally and an evidence-based approach. Practitioners within the states of Texas (TX), Tennessee (TN), Georgia (GA) and Florida (FL) have been identified for intervention for this QIA.

It is estimated that the current focus states will meet goal by December 31,2023. Thereafter, this study will continue with a different cohort of high-utilization users. Close out the current QIA and develop a new focused study to reduce inappropriate x-ray utilization among contracted practitioners.

3.1.2   ENCOURAGING PRACTITIONERS TO SUPPORT TOBACCO CESSATION WITH PATIENTS

[Goal: ≥85% Practitioners "Always or Often" Ask about tobacco use; ≤5% Practitioners "Never" Ask About Tobacco Use; ≥60% of Practitioners to "Advise" those who use tobacco to quit]

ASH aims to educate and encourage its practitioner network to deliver tobacco cessation best practices by consistently asking members about tobacco use and advising those who use tobacco to quit (ASK and ADVISE) during clinical encounters. This initiative follows the U.S. Preventative Services Task Force's recommendations and other long-standing guidelines that clinicians ask all adults about tobacco use and advise them to stop using tobacco to thwart the well-established health consequences of tobacco use including premature mortality, cardiovascular disease, and cancer. Study completion date: the anticipated completion will be determined when the goals are achieved.

Summary:
In 2022, 78.9% of chiropractic practitioners reported that they "always" (67.5%) or "often" (11.4%) ASK new clients if they smoke or use tobacco products (compared to 79.8% in 2021); 8.8% reported that they "never" ask about tobacco usage (compared to 10.1% in 2021); and 49.9% responded that they "always" ADVISE tobacco users to quit (compared to 49.7% in 2021). ADVISE was the lowest performing metric and farthest from the goal of > 60% at 49.9% in 2022 for Chiropractic.

In 2022, 75.3% of acupuncture practitioners reported that they "always" (59.2%) or "often" (16.1%) ASK new clients if they smoke or use tobacco products (compared to 75.6% in 2021); 8.8% reported that they "never" ask about tobacco usage (compared to 8.9% in 2021); and 55.3% responded that they "always" ADVISE tobacco users to quit (compared to 57.2% in 2021). ASK was the lowest performing metric and farthest from the goal of > 85% at 59.2% in 2022 for acupuncture. The results for chiropractic and acupuncture practitioners indicate the areas of focus for this QIA and the need to continue this activity, bringing forth interventions and further opportunities to advocate for tobacco cessation with patients.

3.1.3 ENCOURAGING PRACTITIONERS TO PROMOTE PHYSICAL ACTIVITY

[Goal: practitioners who always ASSESS new patients' level of physical activity ≥ 85%; Practitioners to always ADVISE to start, increase, or maintain their level of exercise or physical activity as appropriate ≥ 65%]

This study is focused on ASH's network chiropractors and acupuncturists and the intent is twofold: to improve the percentage of practitioners who always ASSESS new patients' level of physical activity; and to improve the percentage of practitioners to always ADVISE to start, increase, or maintain their level of exercise or physical activity as appropriate.

This study is projected to be completed when the performance goal > 85% of practitioners who always ASSESS new patients' level of physical activity is met; and when the performance goal > 65% percentage of practitioners to always ADVISE to start, increase, or maintain their level of exercise or physical activity as appropriate is met. Both performance goals must be met in order to consider the study successful and no longer needed.

Summary:
The 2022 survey responses indicated small improvements in "Always" ASSESS for acupuncture practitioners (55.9% compared to 55.7% last year) and "Always" ADVISE for chiropractic practitioners (62.0% compared to 61.1% last year), but there was a decrease in percentage of practitioners that "Always" ADVISE for acupuncture (60.1% compared to 60.8% last year) and "Always" ASSESS for chiropractic (58.5% compared to 59.8% last year).

During 2022, ASSESS for Acupuncture practitioners and ADVISE for Chiropractic practitioners improved while ADVISE for Acupuncture and ASSESS for Chiropractic decreased compared to 2021 performance. Neither the ASSESS or ADVISE goal (85% and 65% respectively) has been met for either specialty, indicating the opportunity to continue this QIA to develop interventions to promote and facilitate incorporating physical activity assessment and advisal into daily practice.

BARRIERS IDENTIFIED IN 2022

Quality Improvement activities are monitored throughout the year. When a quality improvement initiative, routine indicator, or routine monitoring activity does not meet its expected goal, the project is analyzed for identification of potential barriers. Barrier resolution focus on variables such as alternate or improved processes, modifications in policy or process, member and/or practitioner education, or other methods to obtain improved performance.

Summaries

The following is a summary of the barriers identified and actions taken during the implementation of the 2022 Quality Improvement Workplan.

QUALITY IMPROVEMENT STUDIES

CLINICAL CARE

Please reference write-up in the "Quality Improvement Studies in Progress" section of the Quality Improvement Executive Summary.

QUALITY IMPROVEMENT ACTIVITY (QIA) - ADMINISTRATIVE

2.1.1   INCREASE ELECTRONIC CLAIM AUTO-ADJUDICATION RATES

[Goal: ASHLink Auto-Adjudication = 75%; Clearinghouse = 55%]

Summary:
Barring the missed ASHLink target in 1st Quarter 2022, auto-adjudication results consistently exceed stated goals in both categories. Overall data integrity has improved due to EDI involvement and partnership with client health plans to improve the quality of eligibility data loaded into the ASH system.

Actions Taken:
Due to the largest national client's contract conversions effective 01/01/2022, several claims could not auto-adjudicate and resulted in unnecessary pends requiring human review. Claims and IT partnered to deploy contract conversion updates to eliminate unnecessary pends in late February 2022. Auto-adjudication rates were expected to (and did) exceed goals in 2Q 2022 and beyond.

ROUTINE INDICATORS

SERVICE

4.1.1A   MONITOR PRACTITIONER INQUIRY TELEPHONE RESPONSIVENESS

[Goal: 30 seconds = 75%]

Summary:
The goal was missed for 4Q 2021 – 2Q 2022. The department struggled at the beginning of the month to meet stats but had staffing strategies in place to try and recover throughout the month. Unfortunately, the department experienced significantly higher volume than anticipated immediately following the Juneteenth holiday which put the department in a position where they did not meet for the rest of the month. Total volume was 1% higher than last month. Provider volume was 1% higher.

Actions Taken:

Strategically pulled some resources back to focus on auxiliary work for the remainder of the month knowing the resources would need to pull them back to the phones starting July 1st in an effort to meet for the new month and quarter.

4.1.1B   MONITOR PRACTITIONER INQUIRY TELEPHONE RESPONSIVENESS
[Goal: 60 seconds = 85%]

Summary:

The goal was missed for 4Q 2021 – 2Q2022. The department struggled at the beginning of the month to meet stats but had staffing strategies in place to try and recover throughout the month. Unfortunately, the department experienced significantly higher volume than anticipated immediately following the Juneteenth holiday which put the department in a position where they did not meet for the rest of the month. Total volume was 1% higher than last month. Provider volume was 1% higher.

Actions Taken:

The department struggled at the beginning of the month to meet stats but had staffing strategies in place to try and recover throughout the month. Unfortunately, the department experienced significantly higher volume than anticipated immediately following the Juneteenth holiday which put the department in a position where they did not meet for the rest of the month. Total volume was 1% higher than last month. Provider volume was 1% higher.

4.1.1C   MONITOR PRACTITIONER INQUIRY TELEPHONE RESPONSIVENESS
[Goal: Avg speed = 30 secs]

Summary: The goal was missed for 4Q 2021 – 2Q 2022. The department struggled at the beginning of the month to meet stats but had staffing strategies in place to try and recover throughout the month. Unfortunately, the department experienced significantly higher volume than anticipated immediately following the Juneteenth holiday which put the department in a position where they did not meet for the rest of the month. Total volume was 1% higher than last month. Provider volume was 1% higher.

Actions Taken:

Strategically pulled some resources back to focus on auxiliary work for the remainder of the month knowing the resources would need to pull them back to the phones starting July 1st in an effort to meet for the new month and quarter.

4.1.15A MONITOR MNR FORM DECISION-MAKING TIMELINESS AND TURNAROUND TIME
[Goal: Pre-Service (Commercial) Resolved within 2 business days (Goal = 93%)]

Summary:

For 4Q 2021 and 1Q 2022, the goals were missed. Due to increased receipts, federal holidays, and ASH holidays in the months of November, December and the beginning of January, ASH TATs were impacted adversely affecting the ability to meet the requirements and performance levels required. The receipts in these months exceeded the timely processing capacity as a result of staffing challenges related to the national staffing shortages, existing staff on Leaves of Absence, and impact from unexpected call outs due to COVID related circumstances.

Actions Taken:

In January, two additional staff returned from LOA and five additional staff members were hired. This was aided by a change to the compensation package in the department that was made in December to attract and retain talent. By the end of January and through February the work had stabilized with a seasonal reduction in receipts and staffing has

returned to a capacity commensurate with receipts. Recovery in turnaround times and inventories was seen in the last week of January and through February.

4.1.20 (A, B, E,F &G)   MONITOR CBR CLAIMS PROCESSING TIMELINESS

Summary:
4.1.20a – Received to Post within 9 days [Goal = 90%]
The received to post missed 3 months of the year due to increased volumes of pended claims.

4.1.20b – Received to Paid within 30 days [Goal = 96%]
The Received to Paid within 30 days missed 4 months of the year due to a combination of up-front pended claim delays and missed 835 files.

4.1.20e – 2-Step - Received to Post within 9 days [Goal = 90%]
The received to post missed 3 months of the year due to increased volumes of pended claims.

4.1.20f – 2-Step - Received to Paid within 30 days [Goal = 96]
The received to paid was missed for 2 months of the year due to a delay in claims being returned on the 835-claim file.

4.1.20g –2-Step - Post to 837 File Sent within 1 business day [Goal = 95%]
The post to 837 file sent within 1 business day missed 1 month this year due to a bug that caused claims to reject incorrectly.

Actions Taken:
Per 2021 QI Workplan Recommendation: Increased goal for Received to Post within 9 days for CBR claims from 85% to 90% in 2022 QI Workplan to align with Key Performance Indicator reporting. ASH continued to partner with the 2-step clients on reviewing monthly aged claim files. This included alerting clients when an 835 file has not been received by ASH. Claims and IT partnered to update contract conversions to eliminate unnecessary pends.

CARE AND SERVICE

4.2.1D   MONITOR GEOGRAPHIC AVAILABILITY OF PRACTITIONERS

[Goal: 90% Members with Desired Access – Rural – Acupuncture]

Summary:
Achieved 83.3% of the 90% Goal in 1Q 2022. PCC runs quarterly geo access reports based on ASH Standards. In Q1 2022, 30 states were identified as underserved. Licensed providers in underserved counties within these states have been identified and added to the underserved recruitment campaign.

ROUTINE MONITORING

DELEGATION

4.5.5A   REPORT QUALITY OF CARE IMMEDIATE TERMINATIONS TO HEALTH PLAN CLIENTS

[Goal: 90% in 2 business days]

Summary:
The goal was missed for 1Q 2022. The two-day notification missed the 90% goal with 84% being sent within two business days. The goal was missed due to one practitioner who was contracted for chiropractic, acupuncture, and massage therapy, was recommended for immediate termination for all contracts. Initially only the chiropractic contract was termed.

Notifications for the chiropractic contract were sent within one business day from termination decision date. Notifications for the acupuncture contract were sent three business days after the termination decision date, no notifications were needed for the massage therapy contract. The aggregate year-to-date TAT is exceeding the 90% TAT at 92%.

4.5.6   ENSURE TIMELY RESPONSE TO DELEGATION CAPS AND RECOMMENDATIONS

[Goal: 95% responded to within the agreed upon timeframes]

Summary:
ASH missed delivering five delegation audit corrective action plans (CAPs) and/or audit recommendations timely to applicable health plans from 4Q 2021-3Q 2022. Due to staff oversight, five delegation audit CAPs were not sent timely to one health plans.

Actions Taken:
Applicable staff was coached and retrained to support timely submission of delegation audit CAPs to health plans moving forward.

Upon evaluation of the 2021 Workplan activities, including barriers and opportunities for improvement, the following recommendations made by the Committees and Key Process Teams were conducted in 2022 to further enhance the effectiveness of the quality improvement system results.

The following is a summary of the barriers/opportunities for improvement identified and action taken during the implementation of the 2022 Quality Improvement Workplan.

A total of **42** recommendations were made in 2022, of which **39** were completed (93%), **2** are in progress, and **1** not completed. Recommendations in progress and not completed will be continued in the 2023 QI year.

CLINICAL QI STUDY

3.1.1 MONITORING X-RAY UTILIZATION (OVER UTILIZATION)

Summary:

Continue reviewing x-ray utilization among all states to include as appropriate within the intervention group.

Actions Taken:

Review of x-ray utilization of all states identified the same four states (GA, TN, TX, and FL) with the highest number of practitioners with high utilization in calendar year 2021 qualifying as cohorts for the 2022 QIA.
Recommendation completed.

3.1.2 ENCOURAGING PRACTITIONERS TO SUPPORT TOBACCO CESSATION WITH PATIENTS

Summary:

1. *Continue the Tobacco Cessation QIA and continue to promote the ASK and ADVISE tobacco cessation best practices by retaining the newsletter articles, patient education resources, recurring newsletter blurb highlighting the patient education resources, and developing flyers and handouts for practitioners for the Great American Smokeout in 2022.*
2. *Explore additional educational opportunities for practitioners on Tobacco Cessation.*

Actions Taken:

1. Collaborated with the American Cancer Society (ACS) to co-brand with American Specialty Health (ASH) on existing evidence-based literature developed by ACS for quitting smoking and the health benefits of staying quit. ACS has approved the use of an existing flyer for use by ASH. Co-branding agreement was approved by the ASH Vendor Oversight Committee.
Recommendation completed.
2. ASH researched continuing educational opportunities on the topic of Smoking and Health Benefits of quitting, which would provide CE credits for ASH practitioners.
Recommendation completed.

3.1.3 ENCOURAGING PRACTITIONERS TO PROMOTE PHYSICAL ACTIVITY

Summary:

1. *Continue the practitioner and patient educational interventions in 2022.*
2. *Review and refine the educational resources with clinical input to ensure relevance and impact among practitioners and patients.*

Actions Taken:

1. The newsletter article titled *Promoting Physical Activity* was reviewed and republished in May/June newsletter. **Recommendation completed.**
2. CHI team reviewed content in 3Q to ensure it was accurate and relevant. **Recommendation completed.**

ROUTINE INDICATORS

SERVICE

4.1.1   MONITOR PRACTITIONER INQUIRY TELEPHONE RESPONSIVENESS

Summary:

Customer service leadership should continue to monitor staffing levels monthly and work with ASH Human Resources team to ensure hiring forecasts stay on target.

Actions Taken:

Customer service leadership worked closely with HR to create and implement a nationwide recruitment strategy to ensure staff is not focused in one area of the country. Customer service leadership also worked in parallel with the Executive leadership team to enhance the compensation package to attract qualified candidates.
Recommendation completed.

4.1.2   MONITOR MEMBER INQUIRY TELEPHONE RESPONSIVENESS

Summary:

Customer service leadership should continue to monitor staffing levels monthly and work with ASH Human Resources team to ensure hiring forecasts stay on target.

Actions Taken:

Customer service leadership worked closely with HR to create and implement a nationwide recruitment strategy to ensure staff is not focused in one area of the country. Customer service leadership also worked in parallel with the Executive leadership team to enhance the compensation package to attract qualified candidates.
Recommendation completed.

4.1.5   MONITOR PRACTITIONER INQUIRY RESOLUTION TIMELINESS

Summary:

Continue to identify ways to improve timeliness of log resolution.

Actions Taken:

Created health plan specific teams to monitor and manage call logs to ensure timely resolution.
Recommendation completed.

4.1.7   MONITOR MEMBER ADMINISTRATIVE AND CLINICAL APPEALS TRENDS

Summary:

Beginning in 2022, APG Leadership recommends including all member appeals handled by ASH for clients that have requested both the delegated and non-delegated workflows in this activity. This will provide a more accurate indicator of member appeal trends.

Actions Taken:

As a carry-over recommendation from 2022, APG will continue to partner with IMD on revised reporting. While it will fall outside the purview of 4.1.7, member appeal trends can be better identified through examination of all member appeals (including those handled by ASH in the non-delegated model). **Recommendation completed.**

4.1.9 MONITOR MEMBER GRIEVANCE TRENDS

Summary:

Beginning in 2022, APG Leadership recommends including all member grievances handled by ASH for clients that have requested both the delegated and non-delegated workflows. This will provide a more accurate indicator of member grievance trends.

Actions Taken:

As a carry-over recommendation from 2022, APG will continue to partner with IMD on revised reporting. While it will fall outside the purview of 4.1.8, member grievance trends can be better identified through examination of all member grievances (including those handled by ASH in the non-delegated model).
Recommendation in progress. *Carryover to 2023 QI Work Plan.*

4.1.20 MONITOR CBR CLAIMS PROCESSING TIMELINESS

Summary:

1. *ASH will continue to run aged claim reports for all 2 step clients and identify areas of opportunity for both the client and ASH.*
2. *ASH Claims team will update KPI Reports to track claims turnaround time for Received to Paid metric for Fully Insured and Self-Funded business separately.*

Actions Taken:

1. ASH continued to partner with the 2-step clients on reviewing monthly aged claim files. This included alerting clients when an 835 file has not been received by ASH.
   Recommendation completed.
2. **Per 2021 QI Workplan Recommendation**: Increased goal for Received to Post within 9 days for CBR claims from 85% to 90% in 2022 QI Workplan to align with Key Performance Indicator reporting. Claims and IT partnered to update contract conversions to eliminate unnecessary pends.
   Recommendation completed.

4.1.28 QUARTERLY COMPLETE NATIONAL VERIFICATION OF PRACTITIONER DATA TO ENSURE ACCURACY

Summary:

To increase overall validation rates across the ASH network, in 2022 ASH will begin directory suppression in all states and for all specialties. Directory suppression has shown to be an effective tool to increase the overall validation rates, while removing potentially outdated and inaccurate information from the provider directory. Beginning in 2022, APG Leadership recommends including all member grievances managed by ASH for clients that have requested both the delegated and non-delegated workflows. This will provide a more accurate indicator of member grievance trends.

Actions Taken:

In 2022 ASH increased staffing in support of the 2021 QI recommendation to begin directory suppression within all states and specialties. Additional staffing allowed ASH to increase direct phone outreach to contracted practitioners who failed to complete their quarterly validation. The increased outreach resulted in higher validation rates across all specialties and in all states.

During the first month of each quarter, all practitioners receive notification within ASHLink to verify their demographic listing data. Additionally, every quarter, practitioners are reminded of the validation requirement and process in the practitioner newsletters. ASH continually monitors the overall validation status of the provider network. Where appropriate, ASH will utilize additional validation outreach and reminder methods including the use of automated interactive voice response (IVR) phone technology, mail, email, and live phone outreach. Practitioner communications

educate the practitioners on the regulatory requirements for validation, while directing them to ASHLink to complete their quarterly validation.
Recommendation completed.

PRACTITIONER CONTRACTING/COMMUNICATION

4.2.4   MONITOR RECREDENTIALING TIMELINESS BY SPECIALTY

Summary:

Continue to implement corrective actions in recredentialing processes and procedures.

Actions Taken:

There was marked improvement in 2021 - 2022 through improved oversight, especially via reporting, of providers due for recredentialing. The stabilized performance achieved in $2^{nd} – 4^{th}$ Quarters is expected through 2023.
Recommendation completed.

4.2.8   MONITOR PRACTITIONER COMPLIANCE WITH MEMBER ACCESS STANDARDS FOR APPOINTMENTS (SECRET SHOPPER)

Summary:

1. *ASH PCS team will continue to call practitioners found to be non-compliant upon initial ASHP After Hours survey to educate them on compliance requirements before the follow up on the resurvey call, which will be completed at a minimum three weeks after the initial call.*

    Action Taken: Secret shopper procedure document updated to include process for (PCS) team member to conduct a phone training regarding the access guidelines prior to receiving the re-survey evaluation.
    Recommendation completed.

2. *To help increase the overall performance for 2022 ASHP and ASHG Urgent/ Non-Urgent Appointment Surveys, practitioners that fail the initial survey related to ASH contractual agreements will continue to be referred to the Practitioner Contract Services (PCS) team for outreach to conduct a phone training regarding the guidelines prior to receiving the re-survey evaluation as well as an educational letter (documenting the identified deficiencies) and attestation form to sign and return to ASH acknowledging their understanding and agreement to comply with all member accessibility.*

    Actions Taken:
    Secret shopper procedure document updated to include process for (PCS) team member to conduct a phone training regarding the access guidelines prior to receiving the re-survey evaluation. The provider will be required to sign and return and attestation acknowledging their understanding and agreement to comply with all member accessibility standards.
    Recommendation completed.

CARE AND SERVICE

4.3.3   MONITOR PRACTITIONER SATISFACTION WITH UM PROCESSES

Summary:

Present the 2021 Provider and Practitioner Satisfaction Survey results to the Provider Orientation Workgroup to solicit any feedback on opportunities to improve provider and practitioner satisfaction with the UM process.

Actions Taken:

The 2021 Provider and Practitioner Satisfaction Survey results were presented to the Provider Orientation Workgroup on August 11, 2022, to solicit feedback on opportunities to improve provider and practitioner satisfaction with the UM process.

In addition, the following actions were taken to improve practitioner satisfaction with the UM process:
- ASH continues to use the ASHSeminars.Splashthat.com website, which provides details on upcoming webinars/seminars and allows practitioners to RSVP. Topics covered in the webinars/seminars include claims process, operations manual, MNR process, client summaries, and more.
- ASH is working on a Provider Education Library (PEL) project designed with the primary objective to review, revise, perform a gap analysis, add as needed, update, to provide consistency across specialties to the articles/resources available in the ASHLink PEL.
- ASH continues to program ASHLink modifications to enhance communication on ASHLink and increase provider awareness.
- ASH held Acupuncture, Chiropractic, and Rehabilitation Services Professional Affairs Healthcare Advisory Committee meetings to solicit input, feedback, and recommendations from the professional associations, academic institutions, and other professional representatives to assist ASH in assessing quality improvement opportunities. Additional meetings will be held in 2023.

Recommendation completed.

CLINICAL CARE

4.4.2   MONITOR CONSISTENCY OF APPLYING MEDICAL NECESSITY REVIEW CRITERIA AND THE EVALUATION OF INTER-RATER RELIABILITY (IRR) - STEP ONE

Summary:

4.4.2a – Step One Clean Cases – Chiropractic:

1. *(Chiropractic) CQE ARF team to complete ARF job aid and have the CQE ARF team conduct additional training addressing best practices for clearly outlining adverse determination rationale while minimizing duplicative communications.*

    Actions Taken:
    - A refresher training was conducted addressing the proper application of ARF Code 116 (Complete Denial of Passive Therapies), tips were also shared on the best options to clearly explain rationale while preventing Duplicate/Double rationale for a denied service.
    - A refresher training was conducted for all specialties about utilizing contributing factors (Denial Rationale) effectively for member communication.
    - A workgroup was formed 2Q22 to complete a Job Aid (For Chiropractic and Acupuncture specialties) that will act as a guide for Clinical Quality Evaluators (CQEs) to select the best ARF code(s) for clearly outlining adverse determination rationale while minimizing duplicative communications. During the process of developing various versions of the Job Aid and discussing associated processes, New Interactive ARF Codes and contributing factors (For Chiropractic and Acupuncture specialties) have been developed and efforts are being made to retire various Interactive ARF codes to simplify the Interactive ARF selection and application process by the CQEs, while improving the rationale messaging for the members and providers.
    - Actions have been taken to complete CQE sub-group beta testing, staff training and implementation of a New Interactive ARF Code system by the end of 4Q2022. This system / process improvement effort has streamlined possible code options, where possible, it is expected to reduce the instances of "Double Denials" (Addressing a Denied Service more than once), as well as improve the clarity of adverse determination rationale.

    Recommendation completed.

2. *(Chiropractic; Acupuncture; Physical Therapy/Occupational Therapy) Continue to assess for opportunities that will enhance interface during future Step One IRR testing to better approximate day-to-day working conditions.*

Actions Taken:
- All the necessary data that CQEs would normally have access to render an MNR determination was provided for this testing. (Chiropractic, Therapeutic Massage)
- Current CQE Manual Worksheets that CQEs occasionally utilize during their day-to-day work were used for this testing. (Chiropractic, Therapeutic Massage)
- Microsoft Forms was utilized for CQEs to submit their cases responses, mirroring some day-to-day system prompts and allowing electronic submission of reviews. (Rehab Services)

Recommendation completed.

4.4.2b – Step One Clean Cases – (Acupuncture, Chiropractic, Physical Therapy/Occupational Therapy)

1. Continue to assess for opportunities that will enhance interface during future Step One IRR testing to better approximate day-to-day working conditions.

Actions Taken:
- All the necessary data that CQEs would normally have access to render an MNR determination was provided for this testing. (Chiropractic, Therapeutic Massage)
- Current CQE Manual Worksheets that CQEs occasionally utilize during their day-to-day work were used for this testing. (Chiropractic, Therapeutic Massage)
- Microsoft Forms was utilized for CQEs to submit their cases responses, mirroring some day-to-day system prompts and allowing electronic submission of reviews. (Rehab Services)

Recommendation completed.

2. Continue to discuss and establish parameters for medical necessity decision making involving issues noted on this audit including provider outreach calls and selecting appropriate interactive denial codes.

Actions Taken:
This was incorrectly categorized as a recommendation, as this is a standard part of the process and CQI efforts.
Recommendation completed.

4.4.2e – Step One Clean Cases – Physical Therapy / Occupational Therapy

Continue to assess for opportunities that will enhance interface during future Step One IRR testing to better approximate day-to-day working conditions.

Actions Taken:
- All the necessary data that CQEs would normally have access to render an MNR determination was provided for this testing. (Chiropractic, Therapeutic Massage)
- Current CQE Manual Worksheets that CQEs occasionally utilize during their day-to-day work were used for this testing. (Chiropractic, Therapeutic Massage)
- Microsoft Forms was utilized for CQEs to submit their cases responses, mirroring some day-to-day system prompts and allowing electronic submission of reviews. (Rehab Services)

Recommendation completed.

4.4.3   MONITOR CONSISTENCY OF APPLYING MEDICAL NECESSITY REVIEW CRITERIA AND THE EVALUATION OF INTER-RATER RELIABILITY (IRR) - STEP ONE

Summary:

4.4.3a – Step Two Clean Cases – Chiropractic

Outline remediation / training actions within ASH's Clinical Quality Evaluation IRR Process and Procedure document for when a CQE does Not meet the target performance threshold of 90%.

Actions Taken:

Remediation / training actions were outlined within the IRR Process and Procedure UMG 11 in 4Q 2021. **Recommendation completed 4Q 2021.**

4.4.3b – Step Two Clean Cases – Acupuncture

Outline remediation / training actions within ASH's Clinical Quality Evaluation IRR Process and Procedure document for when a CQE does Not meet the target performance threshold of 90%.

Actions Taken:

Remediation / training actions were outlined within the IRR Process and Procedure UMG 11 in 4Q 2021. **Recommendation completed 4Q 2021.**

4.4.3c – Step Two Clean Cases – Therapeutic Massage

Outline remediation / training actions within ASH's Clinical Quality Evaluation IRR Process and Procedure document for when a CQE does Not meet the target performance threshold of 90%.

Actions Taken:

Remediation / training actions were outlined within the IRR Process and Procedure UMG 11 in 4Q 2021. **Recommendation completed 4Q 2021.**

4.4.3d – Step Two Clean Cases – Naturopathy

Outline remediation / training actions within ASH's Clinical Quality Evaluation IRR Process and Procedure document for when a CQE does Not meet the target performance threshold of 90%.

Actions Taken:

Remediation / training actions were outlined within the IRR Process and Procedure UMG 11 in 4Q 2021. **Recommendation completed 4Q 2021.**

4.4.3e – Step Two Clean Cases – Physical Therapy / Occupational Therapy

Continue to assess for opportunities that will enhance interface during future Step One IRR testing to better approximate day-to-day working conditions.

Actions Taken:

Remediation / training actions were outlined within the IRR Process and Procedure UMG 11 in 4Q 2021. **Recommendation completed 4Q 2021.**

4.4.8   MONITOR CPS CRITERIA AND TIER PARTICIPATION

Summary:

1. *Continue to review the data sources, code, requirements to work with Information Management (IMD) to improve data analytics to streamline the QA process.*

   Actions Taken:
   Collaborated with IMD team to evaluate existing requirements and code in preparation for redesign process. Discussions have begun to create quality screens to allow CPS team to ensure clean data prior to CPS annual review process. Work has begun to rewrite the CPS process to better align with requirements and criteria, as well as add in new data and functionality needed to support Rehab Services recalibration and flag-based logic for letter generation process. **Recommendation completed.**

2. *Continue to work with the Clinical Quality Administration (CQA) and Administrative committees to identify opportunities to more closely manage Quality and Admin Issue decisions processed, documentation, and data entry into PROMIS to improve automation and reduce the QA processes.*

Actions Taken:
CPS team collaborated with CQA team to ensure that CQA tier impact determinations are correctly reflected within CPS decisions. CPS team worked with clinical and operational leadership to reevaluate and refine the tier impacts for Administrative CAPs. Discussions were initiated regarding streamlining the process of assigning tier impact for Admin CAPs to ensure that both CDC (issues CAPs) and PRC (typically assigns impact for clinical issues) have well defined process to document and address Admin CAPs. May consider new recommendation in next QI year to track work specifically related to Admin CAPs and tier impact.
Recommendation completed.

ROUTINE MONITORING

PRACTITIONER CONTRACTING/COMMUNICATIONS (PCC)

5.2.3   MONITOR PRACTITIONER INVOLVEMENT IN EDUCATION ACTIVITIES

Summary:
ASH will continue the utilization of hosted Webinars, while continuing to monitor the COVID – 19 pandemic for an opportunity to host in person seminars in 2022.

Actions Taken:
Q1 2022: As part of our larger project for provider education we have conducted a survey of internal staff to solicit input on recommended topics and have engaged IT, OPS, and Marketing to brainstorm innovative ways of communicating information.

Q2 2022: Shared results from the internal ASH clinical staff survey (conducted 1Q2022) with the Chiropractic and Acupuncture PAHACs. Observations from the survey and internal discussions included but were not limited to feedback received about useful Educational Topics. Next steps, primarily related to ideas and the value of conducting a Voice of Customer External Survey of Providers and various ASH Clinical Committee members, were also presented. The purpose for this survey would be to engage them in the process, so that ASH delivers upon the Providers' needs and their knowledge transfer preferences. Similar presentations with other ASH clinical committees are planned during 3rd - 4th Quarter. Monthly meetings with the Provider Education Workgroup continued, primarily to share details concerning the needs of ASH's CQE and CQA clinical staff, to discuss ideas for knowledge transfer, and to assist with the development of resources. A sub-group of the Provider Education Workgroup was formed in June to assist with developing tools and a SharePoint library that will be utilized to support content development, content approval, and appropriate maintenance of resources. This sub-group will also suggest the initial topics to consider for development based upon feedback received from the internal ASH clinical staff survey.
Recommendation completed.

CLINICAL CARE

5.3.1   REPORT EVIDENCE EVALUATION COMMITTEE REVIEW OF TECHNIQUES OR PROCEDURES
Assess and prioritize potential agenda topics for EEEC/IEEC in 2022.

Summary:
ASH evaluates health-related information and evidence for all lines of business. ASH did not hold an Internal Evidence Committee (IEEC) or External Evidence Evaluation Committee (EEEC) meetings in 2022.

Actions Taken:
ASH is interested in evaluating the current state of evidence for acupuncture coverage opportunities. An external consultant (Dr. Groessl's research team - UCSD) was contracted to perform a literature search and provide summaries of the conclusions, bias, harms, and quality of evidence. Areas of further interest were identified. Research is expected to be complete by January 1, 2023, with the goal of an IEEC in the first quarter of 2023.

ASH is interested in evaluating specific diet trends (intermittent fasting, keto, etc.) with the intention of developing a White Paper in 2023 and an IEEC in 2023 when the document is complete.
Recommendation completed.

5.3.2   CONDUCT PAHAC MEETINGS

1.   ASH Clinical Services team will engage the PAHAC committees in 2022 to solicit topics of interest and to learn more about how the PAHAC want to access information.

2022 PAHAC Meetings Held
Chiropractic: 03-10-2022 and 10-28-2022
Rehabilitation: 05-25-2022 (Scheduled October meeting cancelled)
Acupuncture: 05-12-2022 and 10-19-2022

Summary:
ASH Clinical Services team will engage the PAHAC committees in 2022 to solicit topics of interest and to learn more about how the PAHAC want to access information.

Actions Taken:
The recommendation from the 2021 Quality Improvement Program (ASH Clinical Services team will engage the PAHAC committees in 2022 to solicit topics of interest and to learn more about how the PAHAC wants to access information) was completed. The Provider Education project continued throughout 2022 and included a survey of the CQE staff regarding topics frequently encountered in interactions with providers. The CQE staff's suggestions were shared with the PAHACs, and ASH solicited PAHAC input regarding topics and methods of information sharing. The Chiropractic PAHAC expressed that the PAHAC were being brought into the process later in the project development than the PAHAC would have preferred. It was explained to the PAHAC that ASH did describe the project and solicited input during the 2021 PAHAC meeting and that, while significant evaluation of needs and current resources has been completed in 2022, the project is still in its infancy and that this is a good time to solicit PAHAC input. In response to this concern, the Chiropractic Provider Satisfaction survey was reviewed to determine the broader provider network community's satisfaction with the ability to provide input to ASH on Process and policy and ASH's implementation of suggestions. Approximately two-thirds of chiropractic providers were satisfied or very satisfied with their ability to provide input and ASH implementation of their suggestions. In addition, ASH senior management engaged some of the most experienced and outspoken members of the Chiropractic PAHAC to further identify their concerns and discuss solutions and changes that may make the PAHAC more relevant to their constituencies in the future. These conversations included the Chief Health Services Officer who brought the concerns to the CET for defining and implementing improvements.
Recommendation completed.

5.3.11   MONITOR PRACTITIONERS WITH A SPECIFIC RADIOLOGICAL QUALITY ASSURANCE REVIEW

Summary:
The CPS team will review data from practitioners with repeated failures of the X-ray criteria and work with CQA leadership if any additional interventions are needed.

Actions Taken:

CQA monitored the CPS annual tier x-ray MNR assignments to determine whether the revised process (continuing to send x-ray education letters but not refer to CSIT those who remained in X-ray MNR for three annual reviews) would result in those practitioners complying with the ASH X-ray Guidelines.

In order to effectively address the increase in chiropractors assigned x-ray MNR whose radiographic use at annual CPS review qualified them for CSIT referral, the process for the management of this population was reviewed. Practitioners identified as high x-ray utilizers are assigned x-ray MNR at each annual CPS review. This cohort of high x-ray utilizers is also monitored quarterly. A review of their collective x-ray use over time documents their increase in utilization at each annual CPS review where high utilizers are assigned to this cohort (x-ray MNR requirement). Typically, x-ray utilization decreases significantly in subsequent quarters as practitioners in this group align their x-ray utilization to comply with an evidence-based approach and their peers over time. This trend repeats with newly identified high utilizers assigned to this cohort while those who have reduced radiographic utilization are removed at each annual CPS review.

The number of chiropractors who failed the X-ray MNR requirement for 3 consecutive review cycles and would have historically qualified for CSIT referral declined in 2019 to 155 and to 143 in 2020, then increased in 2021 to 156, followed by a decrease to 101 in 2022. Despite the fluctuations, the number remains low relative to the total number of practitioners.

The CPS team analyzed the data for those practitioners with repeated failures of the X-ray criteria and reviewed this data with CQA leadership. Due to the low numbers, no additional interventions will occur at this time, but the CPS team will continue to monitor the data to determine if additional interventions may be needed for a subset of this group.
Recommendation completed.

5.3.13   REVIEW AND REPORT CPT, HCPC AND ICD-10 ANNUAL CODE UPDATES

Summary:

1. *Continue to identify opportunities to access information quicker such as alternative vendors or sources for information.*

    Actions Taken:

    CQA continues to use authoritative sources for accessing and reviewing annual CPT codes. Optum was contacted to see if CQA could purchase an electronic copy of HCPC and ICD-10 coding updates. CQA has been gaining early access to ICD codes by subscribing to and receiving email notification when CMS releases ICD-10 code updates. This information is accessed via the CMS website sometimes weeks in advance of receipt of codebooks and posting of updates through EncoderPro (Optum). Once the CMS information is reviewed, the information is subsequently compared to either information from the codebook and/or EncoderPro. ICD-10 codes become effective annually on 10/1. For 10/1/22 ICD code updates, proposed codes were presented to KPT on 8/10/22. Updates for ICD codes related to Low Back Pain were identified as having significant operational impact and were separately presented to KPT on 7/14/21 while the remaining ICD updates were presented on 8/10/22.
    Recommendation in progress. *Carryover to 2023 QI Work Plan.*

2. *Ensure Health Services Policy Team and Health Services Associate Manager are receiving information to review and update policies, as needed. The CQA P & P will be updated to include language that agenda submission emails to CCC/KPT agendas will include a cc: to Health Services Policy Team and Health Services Associate Manager when coding updates are presented.*

Actions Taken:

Additional staffing has been approved and filled with a new FTE being added to the CQA Scope Team in Q4 2022. In an effort to ensure coding changes are known timely throughout the company, code updates are also being presented to CQT. Presentation directly to CQT allows for clinicians and subject matter experts to be informed of the code changes which may impact CPGs; and to ask questions and/or clarify the coding changes. Coding information from CMS websites and EncoderPro is utilized to research and compile information before coding books are available. This allows for early evaluation of coding changes which are confirmed with coding books once they are accessible either through e-books or printed versions.

The CQA P&P will be updated to include language that quarterly and annual coding changes will be presented to CQT. (This edit has been added to the 2023 draft).
Recommendation completed.

DELEGATION

5.5.1   PERFORMANCE STANDARDS AND CLINICAL INDICATORS REPORTED TO CLIENTS

Summary:

1. *Q1 2021 delivery delay may have been due to closure in DFW. Client Services to work with IMD leadership to carry out root cause analysis for delayed reporting to identify potential resolution for reporting delays.*
2. *CTS will continue to execute the annual training which covers the delivery and tracking process for Performance Standards reports. The training presentation includes the critical nature of timely delivery as well.*
3. *All CSMs will be required to add client specific Outlook tasks in their calendars.*
4. *CTS recommends PSTDs reports be delivered automatically from IMD to health plans. This would be similar to other reports that go directly from IMD to clients. CTS would be able to assist with delivery changes immediately.*

Actions Taken:

1. LD: disaster recovery for PSTDs generation was not addressed in standing IMD/CTC meetings. This can be revisited in 2023 as CTC leadership will continue to meet with IMD leadership to improve delivery to CTC.
   Recommendation not completed, add to 2023 recommendations.
2. Annual CTC Training completed 1Q2022. **Recommendation completed.**
3. CSMs have been advised due dates need to be documented in calendars. **Recommendation completed.**
4. Ongoing discussions to get automated directly from IMD to SPN clients. CTC had a conversation with IMD leadership and CTC was advised that the lift would be too heavy for completion.
   Recommendation completed.

REGULATORY

5.6.1   MONITOR TRAINING COMPLETION AND COMPLIANCE FOR STAFF (ASH EMPLOYEES. TEMPORARY EMPLOYEES, SEASONAL EMPLOYEES, INTERNS, VOLUNTEERS & BOARD OF DIRECTORS) FOR: 1) FRAUD, WASTE AND ABUSE TRAINING; 2) PRIVACY AND SECURITY TRAINING; AND 3) CODE OF CONDUCT AND GENERAL COMPLIANCE/CONFLICT OF INTEREST TRAINING

Summary:

Expand the definition of ASH Staff in Activity 5.6.1 to include temporary employees, seasonal employees, interns, and volunteers to align with ASH's Compliance Program.

Actions Taken:

Updated to include temporary employees, seasonal employees, interns, volunteers, consultants, and shareholders.
Recommendation completed 1Q 2022.

5.6.3   TRACK AND REPORT REGULATORY COMPLAINTS AND NON-ROUTINE INQUIRIES

Summary:

Continue monitoring to confirm the baseline volume of <15 inquiries per quarter.

Actions Taken:

ASH continues to monitor to confirm the baseline volume of < 15 inquiries per quarter. The first two quarters of 2022 followed the baseline at approximately 15 or less inquiries per quarter. 2nd and 3rd Quarters have increased over 40% from this baseline but are still at manageable levels with no discernible trends. 4th Quarter appears to have returned to the expected baseline.

Recommendation completed.

5.6.4   MONITOR AND REPORT ON ALL REQUIRED FEDERAL EXCLUSION LISTS AND STATE MEDICAID LISTS TRACKING FOR STAFF (ASH EMPLOYEES, TEMPORARY EMPLOYEES, SEASONAL EMPLOYEES, INTERNS, VOLUNTEERS, CONSULTANTS, & BOARD OF DIRECTORS & SHAREHOLDERS)

Summary:

Expand the definition of ASH Staff in Activity 5.6.4 to include temporary employees, seasonal employees, interns, volunteers, consultants & shareholder to align with RC 29_Exclusion Screenings.

Actions Taken:

Updated to include temporary employees, seasonal employees, interns, volunteers, consultants, and shareholders.

Recommendation completed.

Upon evaluation of the 2022 Workplan activities, including key accomplishments and barriers, the following are recommendations made by the committees and Key Process Teams to further enhance the effectiveness of the quality improvement system results.

Following is a summary of the recommendations /opportunities for improvement identified which will be carried out during the implementation of the 2023 Quality Improvement Workplan. Recommendations in progress from the 2022 QI Work Plan will continue to be worked on in 2023.

CLINICAL QI STUDIES

CLINICAL CARE

3.1.1   MONITORING X-RAY UTILIZATION (OVERUTILIZATION)

- Close out the current QIA and develop a new focused study to reduce inappropriate x-ray utilization among contracted practitioners.

3.1.2   ENCOURAGING PRACTITIONERS TO SUPPORT TOBACCO CESSATION WITH PATIENTS

- Continue the Tobacco Cessation QIA and continue to promote the ASK and ADVISE tobacco cessation best practices by retaining the newsletter articles, patient education resources, recurring newsletter blurb and pop-ups highlighting the patient education resources and developing flyers and handouts for practitioners for the Great American Smokeout in 2023.
- Explore additional educational opportunities for practitioners on Tobacco Cessation.

3.1.3   ENCOURAGING PRACTITIONERS TO PROMOTE PHYSICAL ACTIVITY

- Continue the practitioner and patient educational interventions in 2023.
- Review and refine the educational resources with clinical input to ensure relevance and impact among practitioners and patients.

ROUTINE INDICATOR

SERVICE

4.1.1A – 4.1.1F   MONITOR PRACTITIONER INQUIRY TELEPHONE RESPONSIVENESS

- Customer service leadership should continue to monitor staffing levels monthly and work with ASH Human Resources to ensure hiring forecasts stay on target.

4.1.2A – 4.1.2F MONITOR MEMBER INQUIRY TELEPHONE RESPONSIVENESS

- The department will project volumes in accordance with historical Juneteenth holiday volumes.

4.1.5A – 4.1.5D MONITOR PRACTITIONER INQUIRY RESOLUTION TIMELINESS

- Continue to identify ways to drive down log resolution.

4.1.14A – 4.1.14B MONITOR TIMELINESS OF RESOLUTION OF PRACTITIONER APPEALS

- APG Leadership will work with IMD to revise the criteria so that cases that do not require committee review (and therefore are not upheld or overturned) are properly excluded removed from the approval rate metrics.

4.1.20A – 4.1.20H MONITOR CBR CLAIMS PROCESSING TIMELINESS

- ASH will continue to run aged claim reports for all 2 step clients and identify areas of opportunity for both the client and ASH.

- Exclude CGHB claims from counting towards the received to paid turnaround time for 4.1.20b.

PRACTITIONER CONTRACTING/COMMUNICATIONS

4.1.28   QUARTERLY COMPLETE NATIONAL VERIFICATION OF PRACTITIONER DATA TO ENSURE ACCURACY

- In 2023 ASH recommends enhanced practitioner communications reminding practitioners of the quarterly validation requirements.

4.2.1A – 4.2.1L   MONITOR GEOGRAPHIC AVAILABILITY OF PRACTITIONERS

- ASH recommends recalculating network adequacy results for areas where there are no providers available to recruit. This will provide an analysis and results for member access where licensed providers are available.

4.2.3A – 4.2.3C MONITOR CREDENTIALING TIMELINESS BY SPECIALTY

- The notification timeliness metric does not correspond to Performance Standard Reports, which were revised in 3rd Quarter 2022 to align with accreditation standards. This metric should be revised to measure the timeliness from the committee review date and when the provider notification letter is sent.

4.2.8A – 4.2.8B   MONITOR PRACTITIONER COMPLIANCE WITH MEMBER ACCESS STANDARDS FOR APPOINTMENTS (SECRET SHOPPER) - ASHP & ASHG

- ASH PCS team will continue to call practitioners found to be non-compliant upon initial ASHP After Hours survey to educate them on compliance requirements before the follow up on the resurvey call, which will be completed at a minimum three weeks after the initial call.
- To help increase the overall performance for 2023 ASHP and ASHG Urgent/ Non-Urgent Appointment Surveys, practitioners that fail the initial survey related to ASH contractual agreements will continue to be referred to the PCS team for outreach to conduct a phone training regarding the guidelines prior to receiving the re-survey evaluation as well as an educational letter (documenting the identified deficiencies) and attestation form to sign and return to ASH acknowledging their understanding and agreement to comply with all member accessibility

4.2.12 EVALUATION OF MEMBER ACCESS COMPLAINTS, REQUESTS FOR OUT OF NETWORK SERVICES, AND MEMBER EXPERIENCE (ANNUAL CAHPS SURVEY)

- ASH will continue monitoring member access complaints and requests for out of network services on a quarterly basis.

CLINICAL CARE

4.4.2A – 4.4.2G   MONITOR CONSISTENCY OF APPLYING MEDICAL NECESSITY REVIEW CRITERIA AND THE EVALUATION OF INTER-RATER RELIABILITY (IRR) – STEP ONE

4.4.2a – Step One – Chiropractic
- Continue to assess for opportunities that will enhance interface during future Step One IRR testing to better approximate day-to-day working conditions.

4.4.2b – Step One – Acupuncture
- Continue to assess for opportunities that will enhance interface during future Step One IRR testing to better approximate day-to-day working conditions.
- Continue current audit processes to evaluate the consistency with which ASH CQEs involved in rendering Medical Necessity Review determinations, apply guidelines in clinical decision making and assess for opportunities to improve consistency and performance.

4.4.2c – Step One – Therapeutic Massage
- Continue to assess for opportunities that will enhance interface during future Step One IRR testing to better approximate day-to-day working conditions.

4.4.2e – Step One – Physical Therapy / Occupational Therapy

- Continue to assess for opportunities that will enhance interface during future Step One IRR testing to better approximate day-to-day working conditions.

4.4.4   MONITOR TRENDS IN PRACTITIONER CLINICAL CORRECTIVE ACTIONS PLANS (CAPS)

- Continue to observe, track, and assess Practitioner CAP compliance rates to identify trends and potential barriers to achieving higher CAP compliance rates. Consider whether a higher CAP compliance rate is a desirable outcome for ASH to the extent that it influences the cost-benefit analysis to favor permanent implementation of such increased communication efforts to Practitioners. However, the extra burden placed on CQA staff would be a formidable barrier and should be carefully weighed.

4.4.8   MONITOR CLINICAL PERFORMANCE SYSTEM CRITERIA AND TIER PARTICIPATION

- Work with CQA and PCS teams to develop and implement process for Administrative CAPs to make tier impact decisions during committee, include tier impact determination in CAP letter and apply impact to practitioner/provider at time of CAP.

ROUTINE MONITORING

SERVICE

5.2.3   MONITOR PRACTITIONER INVOLVEMENT IN EDUCATION ACTIVITIES

- For 2023, we are in the process of creating and addressing additional webinars that focused on practitioner questions related to ASHLink. As needed, ASH will implement educational webinars based on questions received during clinical and recruitment Q and A sessions.

CLINICAL CARE

5.3.1   REPORT EVIDENCE EVALUATION COMMITTEE REVIEW OF TECHNIQUES OR PROCEDURES

- Assess and prioritize potential agenda topics for EEEC/IEEC in 2023.

5.3.2   CONDUCT PAHAC MEETINGS

- Evaluate ways to further engage the PAHAC members in order to enhance their value to ASH and the Associations. Re-engage PAHAC in CPG review.
- In 2023 hold 6 PAHAC meetings; 2 Chiropractic, 2 Acupuncture, 2 Rehabilitative Services.

5.3.11   MONITOR PRACTITIONERS WITH A SPECIFIC RADIOLOGICAL QUALITY ASSURANCE REVIEW

- The CPS team will review data from practitioners with repeated failures of the X-ray criteria and work with CQA leadership if any additional interventions are needed.

5.3.13   REVIEW AND REPORT CPT, HCPC AND ICD-10 ANNUAL CODE UPDATES

- Continue to search for opportunities to access information quicker such as alternative vendors or sources for information.
- The CQA P&P will be updated to include language that quarterly and annual coding changes will be presented to CQT.

REGULATORY

5.6.3   TRACK AND REPORT REGULATORY COMPLAINTS AND NON-ROUTINE INQUIRIES

- Continue monitoring to confirm the baseline volume of <15 inquiries per quarter.

5.6.9 MONITOR CALIFORNIA DEPARTMENT OF INSURANCE SUFFICIENCY STANDARDS OF CALIFORNIA PRACTITIONERS TO DETERMINE RECRUITMENT NEEDS TO SUPPORT THE CALIFORNIA DEPARTMENT OF INSURANCE (CDI) ACCESS STANDARDS

- Evaluation of counties where there are no licensed providers available to recruit is recommended to be added to the analysis. Identification of these areas would provide insight into where providers are available for recruitment focus.