QUALITY IMPROVEMENT HEALTH AND EQUITY IMPROVEMENT COMMITTEE

June 20, 2024, 6:00 p.m. – 7:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd.
South San Francisco CA 94080

Voting Committee Members	Specialty	Present (Yes or Excused)
Kenneth Tai, M.D.	PCP (Internal Medicine)	Excused
Jaime Chavarria, M.D.	PCP (Family Medicine)	Yes
Maria Osmena, M.D.	PCP (Pediatric)	Yes
Jeanette Aviles, M.D.	SMMC Physician (Internal Medicine)	Yes
Alpa Sanghavi, M.D.	SMMC Physician (Chief of Quality and Patient Experience)	Yes
Non-voting HPSM Staff	**Title**	**Present (Yes or Excused)**
Chris Esguerra, M.D.	CMO	Yes
Nicole Ford	QI Director	Yes
Janet Davidson	UM Manager	Yes
Samareen Shami	PHM Manager	Yes

1. Call to Order
   The meeting was called to order by Dr. Jeanette Aviles.

2. Public Comment/Communication
   No public comment received.

3. Approval of Agenda
   Motion to approve. Approved by the Committee members.

4. Consent Agenda:
   4.1 QIHEC Minutes from March 21, 2024
   4.2 UMC Minutes from April 22, 2024
   4.3 CQC Minutes from May 20, 2024
   4.4 CCS Minutes from December 14, 2023
   4.5 Dental Advisory Group minutes from
      4.5.1 March 15, 2024
      4.5.2 April 19, 2024
      4.5.3 May 17, 2024
   4.6 P&T minutes from March 26, 2024
   4.7 Peer Review Committee minutes from February 13, 2024 and April 9, 2024

   Approval of Consent Agenda
   Motion to approve. Approved by the Committee members.

5. Prior Authorization (PA) List Search Tool and PA List updates

HPSM previously met with a vendor who had developed a prior authorization code tool for any codes requiring prior authorization for medical necessity review. The purpose is to update the list for functionality accuracy as well as NCQA requirement. The list is member/provider user-friendly. The prior authorization code tool will search the code with the date the code was updated to reflect the changes that were made to the prior authorization list.

Feedback from this committee is needed with the prior authorization list/search tool.

A comment from Dr. Esguerra with the existing version is a spreadsheet that is downloaded to be posted for medical necessity review. The tool does not request prior authorization other than indicating a prior authorization is required or not. The list is updated on a quarterly basis. In addition, there was a significant amount of clean up required on the spreadsheet. For example, there were some inconsistencies with codes for specific prior authorizations that required prior authorizations or not. What other items should be included on the list that makes sense such as from a service perspective (likely ordered by a primary care) on a claim. Additional work is still needed for electronic integration for CMS guidelines requirement by 2027.

A comment from Dr. Chavarria where the title of the prior authorization result is confusing and should be removed from the list. What is the timeframe to approve the authorization? Dr. Esguerra commented that the process is typically within 5 days and/or less for all LOB. Ms. Davidson commented that typically for routine authorizations is 5 business days and urgent authorization is within 72-hours. The average turnaround time is 3 days. Dr. Chavarria suggested adding the turnabout timeframe would be helpful.

A comment from Dr. Aviles if the prior authorization code list is the same for members and providers? Ms. Davidson commented that the list is slightly different for members and providers. The member list will be reviewed by Compliance for any recommendations. The list will be available on the HPSM website.

A comment from Ms. Davidson, the member/provider, could be put in the key word description to populate the code. In addition to build through the prior authorization list to review what codes providers have been requesting with the volume.

Action items:

- Add to the code list tool the turnaround timeframe, routine, and urgent authorizations.
- Follow up with Pharmacy related to programming issues for electronic integration.

6. HEDIS Measurement Year 2023/Reporting Year 2024 Results

- Health (H) Effectiveness E Data (D) Information (I) set
- Performance metrics that assess the effectiveness and access/availability of care
- Measured and reported annually: submitted mid-June for prior calendar year's membership and services.
- All submissions require passing NCQA audit prior to reporting.
- Compared across health plans annually.
- Most measures based on claims, and pharmacy data (Administrative) require the use of medical record review as well (Hybrid). Plans can also use supplemental data sources (e.g. laboratory, EMR, registry, case management system, and HIE data feeds) with auditor approval to measure evidence of care.

- Benchmarks
    - Medicare

    - Medi-Cal MCAS
    - DMHC HEQMS
- HEDIS MY2023/Ry2024
    - Added 2 new supplemental data sources in addition to established immunization registry, laboratory and EMR feeds from large volume PCPs.
    - Collected and reviewed 4,000 medical records.
    - Reused charts collected from Risk Adjustment Project.
    - Vendor for data analytics and medical record abstraction, HPSM staffed oversight and project management.
- Medi-Cal MCAS
    - 6 measures above HPL (above 90th percentile)
    - Childhood Immunization Status – combination 10
    - Immunizations for Adolescents – combination 2
    - Breast Cancer Screening
    - Chlamydia Screening in Women
    - Prenatal and postpartum care – postpartum care
    - Prenatal and postpartum care – timely prenatal care
    - No measure between MPL (50th percentile)
- Medicare and DMHC HEQMS
    - Successfully measured and reported all required measures.
- CMS STAR Ratings Estimate
    - Cut points released in October of reporting year
    - Changes in TRC - HomeAdvantage vendor change
    - OMW: The percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.
- MY2023/RY2023 MCAS – MPL
- MY2023/RY2023 MCAS – no MPL
- MY2023/RY2023 DMHC HEQMS
- Well-Child Visits in First 30 Months of Life
    - Area of Focus for 2023 and 2024
    - MC benchmark P4P payment measure and included in Care Gaps P4P program
    - Continue to investigate potential data gaps and procure additional data capture
    - Engaging Family Health Services to assist with member barriers to visits
    - DHCS Clinical PIP topic -reducing disparity for the Hispanic/Latino population
    - DHCS Collaborative Sprint lead by Institute for Healthcare Improvement (IHI) to focus on improving child well visits
- W30 Race/Ethnicity Stratification
    - State-wide PIP to reduce the disparity with Black/African American population, but HPSM's EP for this population is small (N=9 for W15 and 22 for W30), so Hispanic/Latino chosen as target population (N =465)
    - Keep in mind small N for some populations
- Breast Cancer Screening
    - Performance improvement project (PIP) in 2022 with direct member outreach calls to Black women who had not had a screening in the last two years to decrease the disparity among Black/African American Medi-Cal members.
    - Multiple ongoing interventions to improve cancer screening rates for adult members in 2023 and continuing in 2024

- Diabetes Care
    - P4P incentives to PCPs for ensuring that diabetic members have their HbA1c monitored & achieve control
    - Leveraging other encounters with Medicare members to collect & monitor HbA1c and BP through home-based assessments and HomeAdvantage programs
- HbA1c HW, MC Race/Ethnicity Stratification
    - State-wide PIP to reduce the disparity with Black/African American population, but HPSM's EP for this population is small (N=9 for W15 and 22 for W30), so Hispanic/Latino chosen as target population (N =465)
    - Keep in mind small N for some populations
- Controlling High Blood Pressure
    - With RY2021, BP measured with digital monitor by member can be used. Home digital BP monitors CMC formulary in 2021, and Medi-Cal Rx June 1, 2022
    - Hypertension control in all PCP P4P programs
- MC CBP Race/Ethnicity Stratification
- Plan All-Cause Readmissions
    - Percentage of acute inpatient and observation stays with an unplanned acute inpatient and observation stay for any diagnosis within 30 days of the initial hospital discharge for members ages 18-64 for Medi-Cal or 18+ for Medicare. All admissions from "outlier members" (4+ admissions) are excluded
    - Lower rates are better

Comments from Dr. Aviles concerning the immunization registry where providers are not using the data registry. Ms. Ford commented that HPSM will conduct a medical record review. Another comment from Dr. Aviles if providers were not allowed to use the care system. Meanwhile, SMMC uses the care system whereas not all providers, pharmacies, will use the care system. Ms. Ford commented that claims data is allowed but immunization is not always reimbursed versus administration by the Plan.

A comment from Dr. Aviles if there a HEDIS measure screening for syphilis and other measures? Ms. Ford confirmed, Chlamydia Screening for Women only.

A comment from Ms. Ford explained Prenatal and Postpartum Care – timely prenatal care is within the first trimester and/or within 42 days enrollment with the Plan.

A comment from Dr. Esguerra where there is high level volume of performance measures within the 90th percentile. Whereas many Plans have struggled with meeting the immunizations and breast cancer screening measures. In addition, the State has incentivized high performance levels with rates for measurement year 2024 for 1) care for our members and 2) a quality withholds.

Comments from Ms. Davidson for women who have been screened for multiple STI's if the data is available in the system? Dr. Esguerra commented, probably. Ms. Ford asked if we could identify the codes for those screenings. Ms. Ford asked if there was a procedure code from the lab. Dr. Aviles commented that not all screenings for STI's are incentivized as Chlamydia screening under Performance for Payment. A recommendation by Public Health as universal for Chlamydia for routine screening.

A comment from Ms. Davidson concerning the CMS STAR Ratings Estimate under HbA1c rate is high? Ms. Ford stated the rate should be lower whereas HPSM has reported around 23% where lower is better. Dr. Esguerra stated the context for Medicare CMS STAR Ratings not only for the Duals population compared to all other Duals population for Medicare.

A comment from Dr. Aviles concerning HbA1c for members who scored 9% and higher are in this specific group? Ms. Ford stated the members are placed in the controlled group. In addition, there is

one measure with one STAR rating for osteoporosis management (fracture) is not always reported due to requiring 30 eligible members during the measurement year. A member with a fracture would be tested for bone marrow density within the six-month timeframe, after-the-fact.

A comment from Ms. Ford with other areas of low performance under transition of care metrics and Plan All-Cause Readmission. For transition of care, the notification of patient, admission, discharge notice must be documented in the outpatient medical record by the primary care provider. The notification would need to be documented/acknowledged in the patient's medical chart.

A comment from Dr. Aviles concerning depression screening under prenatal/postpartum data. Ms. Ford stated the prenatal/postpartum as well as for the general population are categorized for multiple depression screening measures by NCQA.

A comment from Ms. Shami where the Population Health Management team has recently released data on health disparity across the board. The Population Needs Assessment data will be available to this committee soon.

Action item: Ms. Ford will inquire with our team about Chlamydia screening as well as other STI screenings, and report back to the committee.

7. Adjournment: **next meeting September 19, 2024**