HealthPlan OF SAN MATEO
Healthy is for everyone

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THE SAN MATEO HEALTH COMMISSION
Regular Meeting
August 22, 2024 - 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., Boardroom
South San Francisco, CA 94080

This meeting of the San Mateo Health Commission will be held in the Boardroom at 801 Gateway Blvd., South San Francisco. Members of the public wishing to view this meeting remotely may access the meeting via YouTube Live Stream using this link: https://youtube.com/live/UbDfEx71tCo?feature=share
Please note that while there will be an opportunity to provide public comment in person, there is no means for doing so via the Live Stream link

AGENDA

1. **Call to Order/Roll Call**
2. **Public Comment/Communication**
3. **Approval of Agenda**
4. **Consent Agenda***
   - 4.1 Quality Improvement and Health Equity Committee Minutes, March 2024
   - 4.2 Waive Request for Proposal and Approval of Amendment to Agreements with MedHOK, Inc.
   - 4.3 Approval of Amended Conflict of Interest Code, Biennial Review
   - 4.4 Approval of Quality Improvement (QI) Documents: 2023 QI Program Evaluation; 2024 QI Program Description; and 2024 QI Work Plan
   - 4.5 Approval of Amendment to Agreement with County of San Mateo for ACE Third Party Administrator Agreement
   - 4.6 Waive Request for Proposal and Approval of an Agreement with Air Systems Service & Construction.
   - 4.7 Approval of Amendment to Agreement with Compliance Strategies
   - 4.8 Approval of San Mateo Health Commission Meeting Minutes from June 12, 2024
5. **Specific Discussion/Action Items**
   - 5.1 Quality Update
   - 5.2 Compliance Program Update
6. **Report from Chief Executive Officer**
7. **Other Business**
8. **Adjournment**

**Items for which Commission action is requested.*

Government Code §54957.5 requires that public records related to items on the open session agenda for a regular commission meeting be made available for public inspection. Records distributed less than 72 hours prior to the meeting are available for public inspection at the same time they are distributed to all members, or a majority of the members of the Commission. The Commission has designated the Clerk of the San Mateo Health Commission located at 801 Gateway Boulevard, Suite 100, South San Francisco, CA 94080, for the purpose of making those public records available for inspection. Meetings are accessible to people with disabilities. Individuals who need special assistance or a disability-related modification or accommodation (including auxiliary aids or services) to participate in this meeting, or who have a disability and wish to request an alternative format for the agenda, meeting notice, agenda packet or other writings that may be distributed at the meeting, should contact the Clerk of the Commission at least two (2) working days before the meeting at (650) 616-0050. Notification in advance of the meeting will enable the Commission to make reasonable arrangements to ensure accessibility to this meeting and the materials related to it.

AGENDA ITEM: 4.1

DATE: August 14, 2024

QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE
March 21, 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)	**Excused**
Jeanette Aviles, M.D.	SMMC Physician (Internal Medicine)	**Yes**
Non-voting HPSM Members	**Title**	**Present (Yes or Excused)**
Chris Esguerra, M.D.	CMO	**Yes**
Nicole Ford	QI Director	**Yes**
Richard Moore, M.D.	Medical Director, Senior	**Yes (Virtual)**
Samareen Shami	PHM, Manager	**Yes (Virtual)**
Talie Cloud	PH Program Specialist	**Yes**

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

2. Public Comment/Communication
No public comment or communication for discussion at this meeting.

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

4. Consent Agenda:
4.1 QIHEC Minutes from December 21, 2023
4.2 UMC Minutes from January 22, 2024
4.3 CQC Minutes from February 20, 2024
4.5 Dental Advisory Group minutes from
  4.5.1 December 15, 2023
  4.5.2 January 19, 2024
  4.5.3 February 16, 2024
4.6 P&T minutes from October 24, 2023
4.7 Peer Review Committee minutes from 12/12/2023

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

5. Utilization Management Review

Dr. Esguerra reported we will need input from this committee going forward with the Utilization Management Committee meetings. The Utilization Management Committee meetings have been established on a quarterly basis. Previously, we identified inconsistencies with certain groups of services where there were some services requiring prior authorization. There was a high volume of inconsistencies with services not requiring prior authorization. The majority of clean up required to remove prior authorizations from the list.

The plan for this year is a broader review for all requiring prior authorizations from a standpoint 1) how is it useful, 2) preventative care, and 3) a prior authorization might not necessarily be the solution. The last Utilization Management meeting from January 2024 focused on the cleanup of the prior authorization list. There have been alignment issues with DHCS requiring prior authorization, but the Plan would not require prior authorization for certain services. From a primary care perspective on current routine services, might not require prior authorization. The driver of costs is not primary care but mostly with hospitals, emergency room visits, post-acute care, high costs durable medical equipment, and perhaps high costs of drugs administered by physicians.

<u>Recommended actions</u>

- Feedback and input from this committee to work through the process in the frequency, the analysis work, and a more explicit discussion from a quality perspective.
- Review nutritional supplements that are under Medi-Cal Pharmacy Benefits.

Comments from Dr. Esguerra where DHCS for Medi-Cal has required prior authorization for some services where there were audit findings for the Plan due to removing prior authorization for the service. A few services are under federal statue and/or are a state regulatory letter requirement. For example, two specific services 1) NEMT and 2) Dental and Anesthesia require prior authorization. In addition, how to streamline efficiency and remove these barriers while requiring prior authorization for better support/purpose versus being the gatekeeper for prior authorizations.

6. Approval of the 2023 QI Program Evaluation, 2024 QIHE Program Description, & 2024 QI Work Plan

2023 QI Evaluation Summary – Clinical Quality Measures (HEDIS/MCAS – MY2022/RY2023)
Medi-Cal
3 measures above HPL (above 90th percentile)

- Childhood immunization status – combination 10
- Immunization for adolescents – combination 2
- Prenatal postpartum care – Postpartum care

1 measure below MPL (50th percentile)

- Well-child visits in the 1st 30 months of life
- 6 or more well-child visits in the 1st 15 months of life

CareAdvantage Cal-MediConnect (CMC)

- Plan All Cause Readmission (PCR) and follow-up after hospitalization for mental illness (FUH) met quality withhold benchmarks.

- Controlling High Blood Pressure under quality withhold benchmark.

Performance measurement system change from quality withhold benchmarks to CMS STARS for MY2023/RY2024.

- Health Outcomes Survey (HOS) – 2022 collection (Cohort 23/Round 25)
    - Trends in improving or maintaining physical health and mental health scores were as expected, the same as or higher than the national average.
    - Measures incorporated into Medicare Star Ratings include the Improving Bladder Control (MUI Treat Rate), physical activities, and Reducing the Risk of Falling (FRM Manage Rate). HPSM performed well in these measures, at the 4- and 5-Star rate.
- Member Experience (CAHPS)
    - Collected for both Child and Adult Medi-Cal members as well as CareAdvantage members in 2023.
    - Performed well for flu vaccine measure.
    - Identified areas of focus for improvement are How Well Doctors Communicate, Rating of Personal Doctor, Customer Service.
- Patient Safety and Quality of Care Monitoring
    - Potential Quality Issue (PQI) Monitoring.
    - Facility Site Reviews & Physical Accessibility Reviews.

2024 Program Changes – greater emphasis and integration of Health Equity

- Stratification of HEDIS/MCAS results by race and ethnicity of membership to more readily identify and trend disparities where DHCS has asked to integrate within the Quality Improvement program.
- NCQA also incorporates race and ethnicity stratification with the HEDIS quality metrics.
- Ongoing efforts to collect sexual orientation and gender identity of membership. Collecting data from providers, members, and other surveys.

Areas of focus for 2023

- Well-Child Visits (W30) 6+ visits in 1st 15 months of life
    - Benchmark and Care Gap P4P payment measure.
    - Continued to investigate potential data gaps and procure additional data capture.
    - Engaging Family Health Services to assist with member barriers to child-well visits.
    - DHCS Clinical PIP topic – reducing disparity for the Hispanic population.
    - State-wide MCP Collaborative Sprint Rapid Cycle Intervention to improve on all child well visits.
- Behavioral Health measure data capture and coordination
    - DHCS Nonclinical PIP topic – building an infrastructure that links members to county mental health and providers for coordinated services.
    - Notifications to PCPs and BH providers after ED visit for mental illness or substance use.
    - Depression screening data capture – PHQ-9
- Cancer Screenings and Chronic Conditions Management
    - Benchmark and Care Gap P4P payment measures.
    - CA member incentive for breast and colorectal cancer screenings.

    - Cologuard pilot.
    - Exploring primary care engagement strategies.
    - Communication of disease management programs and resources for members and providers.
- Cancer Screening Initiative
    - Cancer screening reminder letter to members due for least one cancer screening receive a mailed reminder letter and scheduled screenings in available languages. Approx. 28,000 letters mailed Q1 2024 and Q2 2024 letters will be mailed within a week.
    - Cologuard Pilot for CA members assigned, receive a mailed Cologuard. 234 kits mailed with 15% completion rate. Another 429 kits are in the process to be sent out in the mail.
    - Cancer screening incentive for CA members who complete a breast and/or colorectal cancer screening, receive a $25 Target gift card.
- Primary Care Engagement – goal to increase the number of members who visit their primary care provider annually by 5%. Ongoing/planned work:
    - Call campaign planned for CA members who have not visited a PCP in the past 12 months. Planned implementation mid-April 2024.
    - Assessing root causes and opportunities for Medi-Cal population.
    - Ensuring the importance of preventive care is discussed in any interaction a member has with HPSM.
- Chronic Condition Management – conducted analysis of members with diabetes and hypertension & surveyed 21 provider groups and identified 3 buckets of work:
    - Staff awareness building
    - Provider communications
    - Targeted network improvements.
- YMCA Fitness Membership Program – YMCA membership is available to CA members at no cost.
- To learn more: https://www.hpsm.org/member/my-health-plan/careadvantage-2024/fitness-membership-program

Comment from Dr. Aviles with the well-child visits in the missed visits. Ms. Ford stated the analysis report does not provide the actual visits other than the metric counts of 6 visits. Continue to work on this measure and there have been improvements over the last year. Basically, all California health plans struggle with this measure. Currently working statewide to help improve on this measure.

Comment from Dr. Aviles if there is a measurement for Reducing the Risk of Falling and is there an expected tool/standard documentation? Ms. Ford reported that the provider should ask specifically to risk of falling. There is no documentation or a tool, which is a member-based survey (HOS).

Comment from Dr. Esguerra where HPSM could help by providing the forms to providers as well as helping remind members what was discussed at the appointment. The challenge with the survey is whether members remembered the fall and remembered to enter in the survey. There are opportunities for care coordinators/providers to ask members about the risk assessment/survey, which might motivate the member.

Comment from Ms. Ford with the surveillance of the PQI monitoring where most issues are grievance related as well through our case management for other recorded incidents. We are reviewing the PQI processes in how to streamline, timely investigation, and outcomes within our internal operations for improvement. Meanwhile, the FSR was placed on hold during the public health emergency (PHE) from 2021 – 2022 with our contracted primary care clinics. During the PHE, there was a backlog of reviews as well as staffing turnovers. As of February 2024, we have two, full-certified quality review nurses for site reviews.

Comment from Dr. Chavarria when members receive the Cologuard letter, should members go to their providers? Ms. Cloud reported the letter states to contact their primary care provider to schedule the appointment and there is a contact at HPSM for their PCP.

Comment from Dr. Chavarria what is the next step if the Cologuard test is positive? Ms. Cloud stated some of the kits tested positive where the results are faxed to the provider lab along with the spreadsheet with the results on a bi-weekly basis to SMMC. SMMC will follow up to schedule the colonoscopy.

Comments from Dr. Aviles, SMMC does not notify for normal cancer screening results. Also, why a call campaign for the CA population with the primary care engagement? Ms. Cloud stated the data performance in relation to Stars on several measures showed care gaps for those members who have not visited their PCP in the past year. Also, we proactively look for any members who have not visited their PCP where 10% of members have not visited their assigned PCP.

Comment from Dr. Aviles concerning the gift card for the CA population is eligible for anyone and is there an age limit cap? Ms. Cloud stated the general mailer went out to all members with the explanation of benefits.

Comments from Dr. Esguerra where 94% of the CA members qualify for the healthy foods supplemental benefit due to a chronic condition diagnosis. A healthy foods card is issued once confirmed on the encounter data.
The YMCA Fitness Membership Program is specifically a supplemental benefit for the CA population, which was communicated to many healthcare partnerships who work with CA members.

Motion to approve. Approved by the Committee members.

6. Adjournment: **next meeting June 20, 2024**

MEMORANDUM

AGENDA ITEM:	**4.2**
DATE:	**August 14, 2024**

DATE: July 15, 2024

TO: San Mateo Health Commission

FROM: Pat Curran, Chief Executive Officer
Eben Yong, Chief Information Officer
Chris Baughman, Chief Performance Officer

RE: Waive Request for Proposal and Approval of Amendment to Agreement with MedHOK

Recommendation:

Approve a waiver of the Request for Proposal (RFP) process and authorize the Chief Executive Officer to execute an amendment to extend the current software subscription agreement with MedHOK, Inc. for an additional five years, with an option of a one-year renewal beyond the five-year term. This amendment increases the contract maximum by an additional $6,781,847 for the five year period. The five-year term of the agreement remains the same and is scheduled to expire on August 31, 2029 (or 2030 if the additional year is implemented).

Background and Discussion:

The Commission approved funding for a software subscription agreement with MedHOK in July 2014 for the implementation of the Care Management Module (Phase 1). The Care Management module was successfully implemented on January 1, 2015 with the users primarily being the care coordination staff of HPSM. The Commission approved Phases 2 and 3 (Grievances, Medical Appeals, Provider Dispute Resolution and Pharmacy Prior Authorizations, and Pharmacy Appeals) in March 2015. Phase 2 was implemented on January 1, 2016, and Phase 3 was implemented on November 1, 2016. Additional components for Disease Management and California Children's Services were added in 2017. The current agreement with MedHOK expires on August 31, 2024.

MedHOK has become a critical application for HPSM operations, continually evolving to meet the changing of needs of the Plan. MedHOK has been a valuable business partner throughout the past ten years.

Given the extensive resources and time invested in the implementation and ongoing maintenance, as well as the organization’s satisfaction with the application, staff request that the RFP process be waived and the subscription agreement with MedHOK be approved for an additional five years with the option to extend an additional year. The increase covers an annual per member per month fee paid to MedHOK, Inc., based on HPSM's membership count and a 5% Cost of Living Adjustment (COLA) increase per year. Included in this request is the additional cost to cover increased Plan membership.

Fiscal Impact:

The amendment increases the contract by $6,781,847 for five years, this includes the additional cost to cover increased Plan membership. The current contract is $6,100,000. Please note that MedHOK, Inc. did not increase cost for HPSM on the last renewal.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF WAIVING THE RFP PROCESS AND APPROVE AN AMENDMENT TO SUBSCRIPTION AGREEMENT WITH MEDHOK INC.

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission successfully implemented the Care Management Module of the MedHOK system on January 1, 2015, the Grievance and Appeals/ Provider Dispute Resolution Modules on January 1, 2016, and the Pharmacy Modules on November 1, 2016;
B. The San Mateo Health Commission has an ongoing need for the application and services provided by MedHOK;
C. The San Mateo Health Commission has previously agreed to a five-year subscription agreement that is due to expire on August 31, 2024; and
D. Both parties wish to extend the subscription agreement for an additional five years with an optional sixth year

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the RFP requirement and approves the amendment to the agreement with MedHOK to extend the term for an additional five years through August 31, 2029 (or 2030 if the additional year is implemented) at a cost of $6,781,847 for software and services related to MedHOK services and software; and
2. Authorizes the Chief Executive Officer to execute said amendment

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 14th day of August, 2024 by the following votes:

AYES:
NOES:
ABSTAINED:
ABSENT:

_____
George Pon, Chair

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

MEMORANDUM

AGENDA ITEM: 4.3

DATE: August 22, 2024

DATE: July 15, 2024

TO: San Mateo Health Commission

FROM: Pat Curran, CEO

RE: Approval of Revised Conflict of Interest Code – Biennial Review

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Recommendation

Adopt revisions to the Health Plan of San Mateo conflict of interest code to update the position titles on the designated filer list.

Background and Discussion

The San Mateo Health Commission has previously adopted a conflict of interest code for HPSM which includes a list of designated filers who must complete California Form 700, Statement of Economic Interests, upon assuming a position, annually, and when leaving the position.

The County Assessor's Office requires a biennial review and update of the code. Since the last biennial review in 2022, a number of position titles have changed and new positions have been created, requiring an update of this list of designated filers. Attached is a redlined version of the conflict of interest code indicating the changes required.

Fiscal Impact

There is no fiscal impact related to this action.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF A REVISED CONFLICT OF INTEREST CODE

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has adopted a conflict of interest code (COI) for the Health Plan of San Mateo; and

B. The appendix to the code designates the positions required to complete the California Form 700 – Statement of Economic Interests when assuming office, annually, and when leaving office; and

C. Changes to position titles, deletion of positions, and additions of newly formed positions requires updates to the list of designated filers.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves the revised Conflict of Interest Code as attached, to be submitted for approval to the San Mateo County Board of Supervisors.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 14th day of August 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

CONFLICT OF INTEREST CODE OF THE
SAN MATEO HEALTH COMMISSION
COUNTY OF SAN MATEO, STATE OF CALIFORNIA

Approved by the Code Reviewing Body on the (_____)

The Political Reform Act, Government Code Section 81000, et seq., requires state and local government agencies to adopt promulgated Conflict of Interest Codes. The Fair Political Practices Commission has adopted a regulation, 2 Cal. Adm. Code Section 18730, which contains the terms of a standard Conflict of Interest Code, which can be incorporated by reference, and which may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act after public notice and hearings. Therefore, the term of 2 Cal. Adm. Code Section 18730 and any amendments to it, duly adopted by the Fair Political Practices Commission are hereby incorporated by reference and, along with the attached Appendix in which officials and employees are designated and disclosure categories are set forth, constitute the Conflict of Interest Code of the SAN MATEO HEALTH COMMISSION (hereafter "Agency").

Pursuant to Section 18730 (b) (4) (B) of the Standard Code, all designated employees shall file statements of economic interests with the agency, which shall make and retain a copy and forward the originals to the code reviewing body, which shall be the filing officer.

As directed by Government Code Section 82011, the code reviewing body is the Board of Supervisors for the County of San Mateo. Pursuant to Title 2, division 6 of the California Administrative Code, Section 18227, the County Clerk for the County of San Mateo shall be the official responsible for receiving and retaining statements of economic interests filed with the Board of Supervisors.

APPENDIXDESIGNATED OFFICIALS AND EMPLOYEES

Designated Positions	Disclosure Category
~~Chief Compliance Officer~~	~~1, 2, 3, 4~~
Chief Executive Officer	1, 2, 3, 4
Chief Health Officer	1, 2, 3, 4
Chief Financial Officer	1, 2, 3, 4
Chief Government Affairs and Compliance Officer	1, 2, 3, 4
Chief Information Officer	1, 2, 3, 4
Chief Operating Officer	1, 2, 3, 4
Chief Medical Officer	1, 2, 3, 4
Chief Performance Officer	1, 2, 3, 4
~~Claims Director~~	~~1, 2, 3, 4~~
Commissioners	1, 2, 3, 4
Controller	1, 2, 3, 4
Dental Director	1, 2, 3, 4
Director of Claims and Payment Integrity	1, 2, 3, 4
Director of Compliance	1, 2, 3, 4
Director of Financial Planning & Analysis	1, 2, 3, 4
Director of Health Analytics	1, 2, 3, 4
Director of Human Resources	1, 2, 3, 4
Director of Medicare	1, 2, 3, 4
Director of Pharmacy	1, 2, 3, 4
Director of Population Health	1, 2, 3, 4
Director of Provider Services	1, 2, 3, 4
Director of Quality Improvement	1, 2, 3, 4
~~Facilities Director~~	~~1, 2, 3, 4~~
Facilities Manager	1, 2, 3, 4
Government and Regulatory Affairs Manager	1, 2, 3, 4
IT Applications Manager	1, 2, 3, 4
IT Operations Manager	1, 2, 3, 4
Legal Counsel	1, 2, 3, 4
Marketing and Communications Manager	1, 2, 3, 4
Medical Director	1, 2, 3, 4
Senior Medical Director	1, 2, 3, 4
Utilization Review Manager	1, 2, 3, 4
Consultants*	1, 2, 3, 4

* Consultants shall be included in the list of designated employees and shall disclose pursuant to the broadest disclosure category in the code subject to the following limitation:

The Chief Executive Officer may determine in writing that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to comply fully with the disclosure requirements described in this section. Such determination shall include a description of the consultant's duties, and, based upon that description, a statement of the extent of disclosure requirements. The Chief Executive Officer's determination is a public record and shall be retained for public inspection in the same manner and location as this conflict of interest code and shall forward a copy of this determination to the San Mateo County Board of Supervisors. Nothing herein excuses any such consultant from any other provisions of the Conflict of Interest Code.

MEMORANDUM

AGENDA ITEM: 4.4

DATE: August 14, 2024

DATE: July 8, 2024

TO: San Mateo Health Commission

FROM: Chris Esguerra, M.D., Chief Medical Officer
Nicole Ford, Director of Quality Improvement

RE: Quality Improvement & Health Equity Program Documents: 2023 Quality Improvement Program Evaluation, 2024 Quality Improvement & Health Equity Program Description, and 2024 Quality Improvement Work Plan

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Recommendation:

Approve the attached HPSM quality documents for submission to the California Department of Health Care Services (DHCS): 2023 Quality Improvement Program Evaluation; 2024 Quality Improvement & Health Equity (QIHE) Program Description; and 2024 Quality Improvement Work Plan.

Background and Discussion:

The following summarizes the 2023 Quality Improvement Program Evaluation and the changes to the Quality Improvement & Health Equity Program Description and Work Plan attached. These documents are presented to the Commission for review as part of HPSM's standard quality oversight process and as required by the Plan's contract with the California Department of Health Care Services.

Quality Improvement Program Evaluation

The 2023 Quality Improvement (QI) Program Evaluation analyzes core clinical and service indicators to determine if the QI Program has achieved its key performance goals during the year. It is based on the 2023 QI Program activities and provides guidance for the 2023 QIHE Program and Work Plan.

Trending and analysis of our clinical quality metrics reported in 2023 indicated that many preventative care services and screenings improved in 2022. Most notably, cervical and breast cancer screening rates increased from prior year rates, likely impacted by the performance improvement interventions implemented in 2022. There was improvement in chronic disease monitoring and management, as indicated by increases in blood pressure control and comprehensive diabetes care measure rates from the prior year. There was also significant increase in well-child visit rates for infants. While rates have improved, well-child visits are still under DHCS required performance benchmarks. A Performance Improvement Project (PIP) to improve the rate of early well-child visits for Hispanic/Latino identifying members is in development, as are interventions to improve well-child visits for all pediatric members.

Quality Improvement & Health Equity Program Description

The QIHE Program description details the structure, membership, and responsibilities of the Quality Improvement & Health Equity committee as well as the operational committees that report to the Quality Improvement & Health Equity committees for oversight. It also outlines HPSM's process for monitoring and improving member safety, including procedures for identifying, researching, and resolving quality of care issues.

The 2023 QI Program Evaluation indicates that the QI Program is effective in meeting many of its quality of clinical service objectives as well as dynamic in meeting the emergent and continuing healthcare needs of HPSM members. The 2024 QIHE Program has a greater focus on integrating health equity in quality metrics and addressing health disparities identified for racial or ethnic groups within HPSM's membership. There are ongoing efforts to collect sexual orientation and gender identity of our members to enable stratification of quality and health outcome measures across member populations of sexual orientation and gender groups.

Quality Improvement Work Plan

The QI Work Plan is the operational and functional component of the QIHE Program that outlines the key activities for the upcoming year. It provides detailed objectives, scope, timeline, deliverables, and person or operational unit responsible for each activity.

Quality improvement efforts in 2024 are focused on promoting the maintenance or establishment of preventative care services and regular chronic disease monitoring and management. Targeted interventions have been developed to improve preventative care and screenings for member populations that have disparately low rates of these services. Multiple diabetes management and prevention interventions that include diabetes medication adherence, self-management programs, and transitions of care support are being implemented.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF
2023 QUALITY IMPROVEMENT PROGRAM EVALUATION
2024 QUALITY IMPROVEMENT & HEALTH EQUTIY PROGRAM DESCRIPTION
2024 QUALITY IMPROVEMENT WORK PLAN

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission is required by the State to review and approve , the Quality Improvement Program Evaluation, the Quality Improvement & Health Equity Program Description; and Quality Improvement Work Plan on an annual basis; and
B. These documents have been prepared by the Quality Staff and reviewed by the Quality Improvement & Health Equity Committee to be submitted to the Commission for approval.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission adopts the following documents as attached:
    a. 2023 Quality Improvement Program Evaluation
    b. 2024 Quality Improvement & Health Equity Program Description
    c. 2024 Quality Improvement Work Plan

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 14th day of August, 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

2023 QUALITY IMPROVEMENT PROGRAM ANNUAL EVALUATION

Reviewed by QIHE Committee March 2024.

X

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

X

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

X

Jeanette Aviles, M.D.
Quality Improvement Committee Co-Chairperson
San Mateo Health Commission

TABLE OF CONTENTS

1. INTRODUCTION

This program evaluation provides a comprehensive overview of quality improvement activities conducted in Calendar Year 2023(CY2023).

The content of this evaluation includes:

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

2. HEDIS RESULTS

In 2023, HPSM was required to collect and report HEDIS measures for the Medi-Cal and CareAdvantage populations. The 2023 reporting year (RY2023) HEDIS results are an analysis of services provided in the 2022 measurement year (MY2022). Individual HEDIS measures are selected by the Centers for Medicare and Medicaid Services (CMS) for CareAdvantage and the Department of Health Care Services Medi-Cal Managed Care Division (DHCS-MMCD) for Medi-Cal. In addition, HPSM collects and reports HEDIS measures for NCQA Health Plan Accreditation for the Medi-Cal population as determined by NCQA Medicaid measure set.

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

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

DHCS assigns improvement projects for required measures not meeting the MPL. Improvement efforts and results for each specific HEDIS measure targeted for improvement in CY2023 can be found in the Quality of Clinical Care Activities Section of this evaluation to align with associated interventions. Included are the results for each of HPSM's key areas of focus for quality improvement interventions compared over the last several years.

It should be noted that based on the HEDIS data collection and reporting schedule, HEDIS results discussed for reporting year 2023 are of services provided to members enrolled in 2022.

2023 MEDI-CAL SUMMARY HIGHLIGHTS*:

For Reporting Year (RY) 2023/Measurement Year (MY) 2022,

- 3 measures above HPL (above 90th percentile):
  - Childhood Immunization Status –combination 10
  - Immunizations for Adolescents –combination 2
  - Prenatal and Postpartum Care – Postpartum Care
- 1 measure below MPL (50th percentile):
  - Well-Child Visits in the First 15 Months of Life:
    - 6 or more well-child visits in first 15 months of life

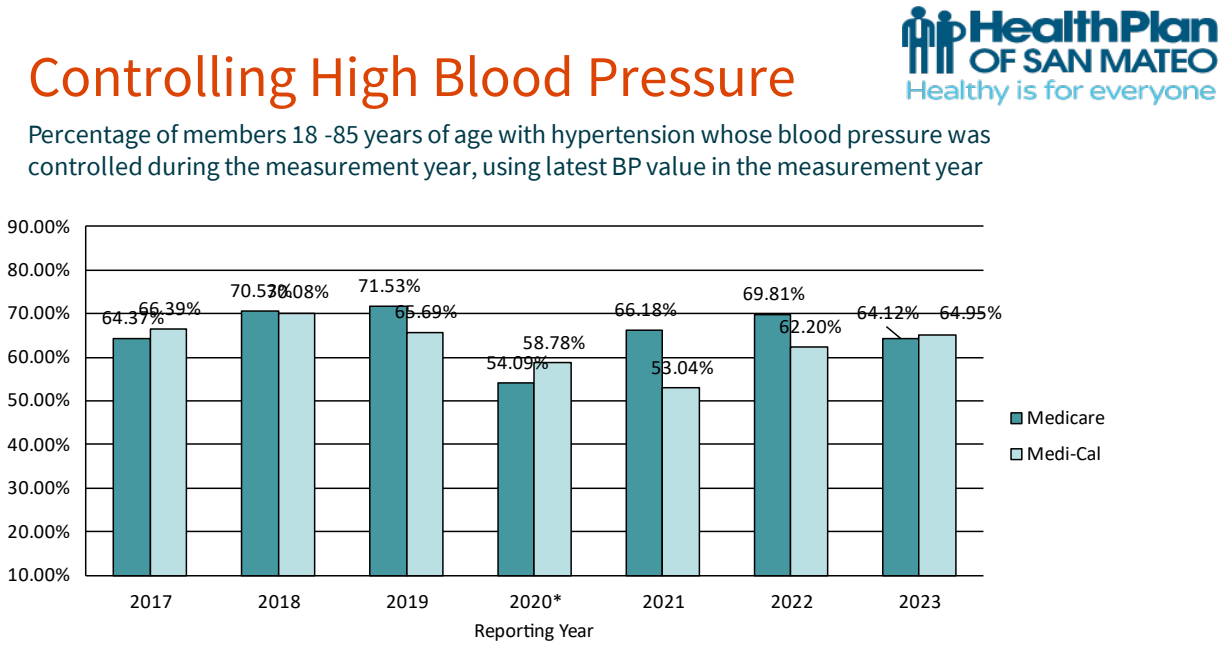
* RY2023 and trended results for all Medi-Cal HEDIS measures can be found in APPENDIX A. MANAGED CARE ACCOUNTABILITY SET (MCAS) RESULTS TRENDED

2023 CAREADVANTAGE/CAL-MEDICONNECT (CA-CMC) SUMMARY HIGHLIGHTS *:

In RY2023/MY2022, HPSM successfully reported on all 55 measures required by CMS for Medicare-Medicaid Plans. In addition, HPSM passed 2 of 3 HEDIS quality withhold measures. The quality withhold measures and results are:

1. Controlling Blood Pressure(CBP)-did not pass
2. Follow-up after Hospitalization for Mental Illness(FUM)-passed
3. Plan All-Cause Readmissions(PCR)-passed

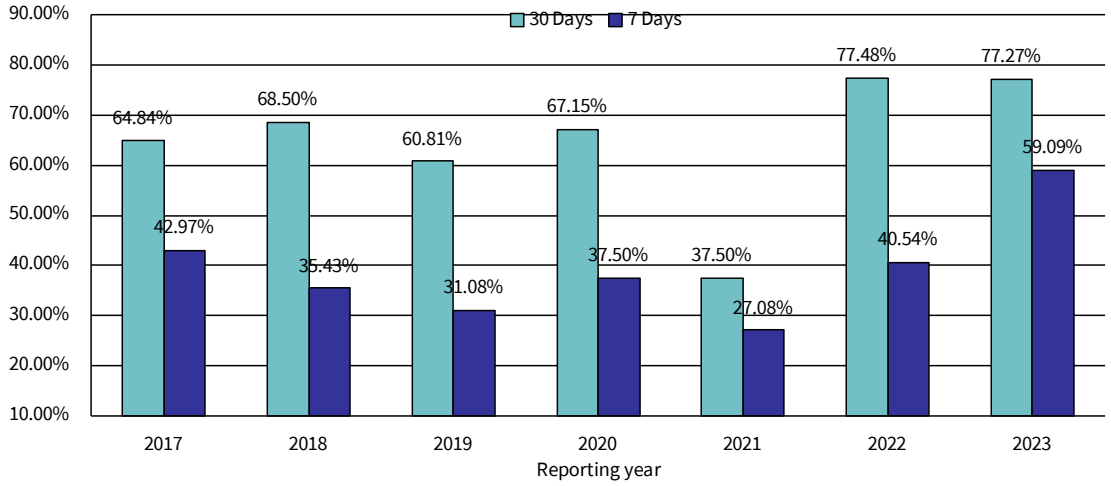
* RY2023 trended results for all CMS HEDIS measures can be found in APPENDIX A. MANAGED CARE ACCOUNTABILITY SET (MCAS) RESULTS TRENDED



- CMS Core Measure Benchmark = 71% starting RY2021 (56% prior years)
- *Measure rotated: 2020 measured rated, 2019 rate reported for 2020 submission due to COVID -19 response
- 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

Follow-up after Hospitalization for Mental Illness

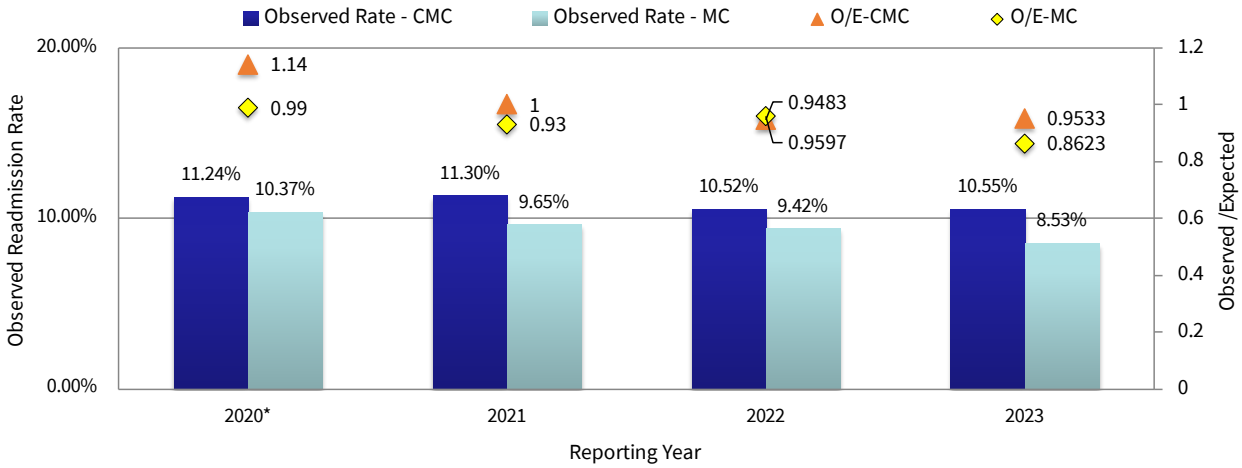
Percentage of **CareAdvantage CMC** mental health discharges with subsequent outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner



- CMS Core Measure Benchmark for follow-up within 30 Days = 56%
- Worked with BHRS to report qualifying follow -up services to include in HEDIS reporting

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 CMC.



- Lower rates are better
- *Measure changes for RY2020: admissions from “outlier members” (4+ admissions) excluded
- CMS Core Measure Benchmark = Observed to Expected Ratio (O/E) < 1. 0 (risk adjusted)

The following areas represented opportunities for improvement and key areas of focus for CY2023 based on MY2022 HEDIS results and were a focus of quality improvement activities in 2023:

- Well-Child Visits in the First 30 Months of Life(W30)
- Cervical Cancer Screening (CCS)

3. QUALITY OF CLINICAL CARE IMPROVEMENT ACTIVITIES

3.1 WELL CHILD VISITS (W30)

W30 HEDIS RESULTS

Percentage of children who receive 6 we1l child visits from 0-15 months of age and who receive 2 well child visits from 15-30 months of age.:

Abrev	Measure	MY2022	50th Percentile	MY 2021 Rate	MY 2020 Rate
W30	Well Child Visits(0-15 Months)	49.62	55.72	25.73	20.03
	Well Child Visits(15-30 Months)	72.38	65.83	69.14	76.94

Measure/Program	W30 Strengths, Weaknesses, Opportunities, Threats (SWOT) Project
Objective:	By June 30, 2023, increase the percentage of well child visits among children 0-15 months from 25.73% to 54.92% and from 69.14% to 70.67% for those 15-30 months.
Program Description	Identifying HPSM's Strengths, Weaknesses, Opportunities, and Threats and implementing strategies and action items under each category to improve outcomes.
Trend:	Our rates have been lower for this age group than the average.
Goal Met/Not Met	The rate for MY2022 was 49.62 for 0-15 months and did not meet the MPL for this measure. The rate for MY2022 was 72.38 for 15-30 months and did meet the MPL for this measure
Barriers identified	We identified barriers that affect the measure. These are as follows: 1. High number of no shows at well child visits even after appointments have been made. 2. Members don't have full information on the importance of well visits.

	3. Billing issues caused by newborns not having a Medi-Cal ID for claims submission of initial well child visits.
Recommended interventions for barriers	The County Home Visiting Program was updated to include discussion on importance of well child visits to HPSM members they visit.
Whether yearly planned activities were met	The implementation of inclusion of well child visits education to the County Home Visiting Proem was completed.
Any changes to the program	The SWOT is now completed and will not continue in 2024. A DHCS Performance Improvement Project(PIP) will be implemented in 2024 for the 0-15 months portion of the measure instead.

3.2 CERVICAL CANCER SCREENING (CCS)

CCS HEDIS RESULTS

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

Abrev	Measure	MY2022	50th Percentile	MY 2021 Rate	MY 2020 Rate
CCS	Cervical Cancer Screening	61.69	57.64	57.61	58.91

Measure/Program	CCS METRIC
Objective:	By July 7th, 2023, increase the HPSM CCS rate from 57.61% (MY2021) to the MPL of 59.12% by conducting member outreach calls.
Program Description	ICT member outreach calls to members living in San Mateo County and who are Black/African American identifying and/or have development disabilities and are managed by Golden Gate Regional Center
Trend:	Our rate for CCS increased from the prior reporting year from 57.61% to 61.69%.

Goal Met/Not Met	The goal was met for RY2023.
Barriers identified	Prior conversation with PCPs and an analysis of HPSM resources have identified the following barriers: 1. Due to competing priorities and limited staffing resources, solo PCP practices primarily use "in reach methods" rather than proactive member outreach efforts which require planning and additional dedicated staff time. 2. COVID related issues have prevented members from visiting their PCPs, and during the pandemic, HPSM staff resources have been limited.
Recommended interventions for barriers	To address the lack of time and resources that solo PCPs are experiencing, HPSM targeted proactive member outreach calls.
Whether yearly planned activities were met	Planned yearly activities were met.
Any changes to the program	The PDSA is completed and will not continue in 2024 because the MPL goal was achieved for RY2023.

3.3 INITIAL HEALTH ASSESSMENT (IHA)

IHA OUTREACH PROGRAM DESCRIPTION

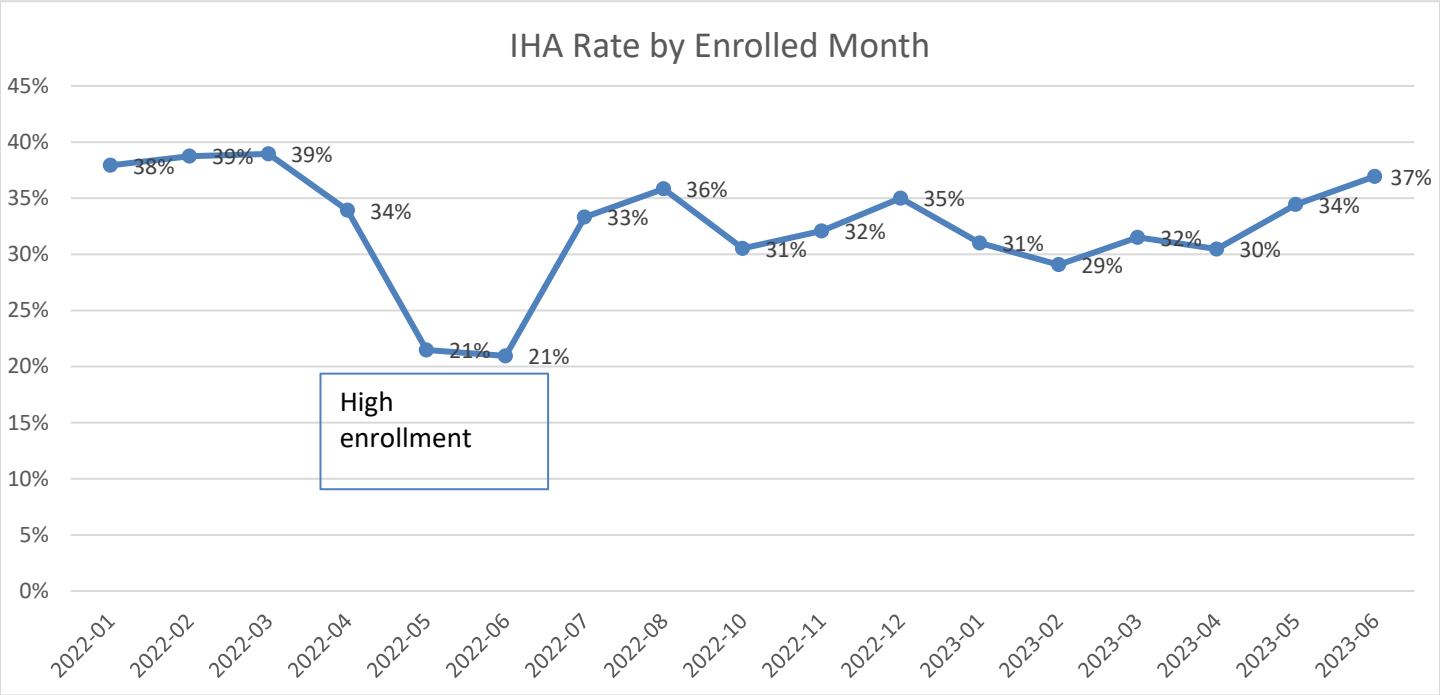
The Initial Health Appointment (IHA) has become an increasingly higher priority in health plans across California. Focus has also increased on primary care and preventative services as the Medi-Cal population has a higher incidence of chronic and/or preventable illnesses, many of which could be modified through appropriate health behavior change and early detection to promote lifestyle changes. The purpose of the IHA is to enable a provider to comprehensively assess the member's chronic, acute and preventative needs and to identify patients whose needs require coordination with additional resources. The All Plan Letter (APL 22-030) requires all primary care providers to conduct an IHA to all Medi-Cal managed care patients as part of their initial and well care visits. It is required that health plan reach a 100% compliance rate ensuring every member enrolled is seen by their primary care physician within the first 120 days of enrollment.

IHA OUTREACH PROGRAM UPDATES

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

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

MONTHLY IHA COMPLIANCE RATES 2022-2023 GRAPH



IHA PROVIDER EDUCATION

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

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

IHA BARRIERS

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

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

IHA OUTREACH PROGRAM ACTION PLAN FOR 2024

HPSM has struggled to increase the timeliness of IHAs and will be implementing the following in 2024 to improve IHA rates.

- Updating HPSM's website to contain updated information for Providers and revising the IHA training document for providers
- Create IHA requirement attestations to be used to educate providers during Site Reviews.
- Continue pay-for-performance(P4P) monetary incentive for PCPs for timely IHA completion in 2024. Under the Benchmark P4P IHA remains a payment metric for Family Practice and Adult track providers and reporting-only for Pediatric providers. This is based on prioritization in assigned quality metric sets. As part of P4P, monthly reports are sent to PCPs detailing level of performance.
- HPSM is also incentivizing both the scheduling of the IHA and timely completion with inclusion of the IHA in its new Care Gap P4P. Care Gap P4P utilizes an interactive platform that allows PCPs to readily view and filter for their assigned members in need of an IHA. Continue monitoring IHA compliance on a quarterly basis, identifying trends in PCP compliance
- Continue PCP compliance monitoring and correction action activities.

Continue IHA reminder insert in new Medi-Cal member welcome packets.

4. SAFETY OF CARE & QUALITY OF SERVICES

4.1 CLINICAL GUIDELINES ANNUAL REVIEW

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

2023-2024 Clinical Guidelines and Resources can be found on our website:
https://www.hpsm.org/provider/resources/guidelines.

CLINICAL GUIDELINES ANNUAL REVIEW UPDATE

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

The Quality department presented the annual summary of the posted guidelines to the Quality Improvement Committee at its quarterly meeting in September 2023. All additional and updated guidelines were reviewed and approved by the QIHEC.

ACTION PLAN FOR 2024

HPSM Quality will continue to check the websites for the source organizations for updates to the guidelines posted on the HPSM website. Quality will also ensure that the Provider Manual maintains a hyperlink to the Clinical Guidelines page on the HPSM website. Provider Services will promote awareness of the clinical guidelines posted on the HPSM website to the provider network through news alert or article in the provider newsletter.

4.2 FACILITY SITE REVIEW (FSR) AND MEDICAL RECORD REVIEW

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

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

HPSM conducts full scope reviews utilizing the criteria and guidelines of California Department of Health Care Services Medi-Cal Managed Care (MMCD Policy Letter 22-017 dated September 22, 2022 or any superseding Policy Letter). HPSM may also address additional requirements as appropriate for quality studies. A passing Site Review Survey shall be considered "current" if it is dated within the last 3 years and need not be repeated until the due date of the next scheduled site review survey or when determined necessary through monitoring activities by the plan.

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

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

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

In 2023, HPSM completed 35 FSRs and 32 MRRs . Following the Site Reviews, 9 of the providers/sites received a CAP for either the MRR or FSR, or both. All CAPs were closed successfully and timely according to regulatory requirements.

Common Deficiencies identified in Facility Site Review:

- Written policies of documenting medication expiration were not available and expired medications present. Documentation of cleaning schedule for janitorial services including a list of cleaning products used was not readily available.
- Documentation of employee trainings were often incomplete
- Documentation of checking of emergency equipment/supplies for expiration and operating status was not done at least monthly.

- Site did not utilize drugs/vaccine storage units that are able to maintain required temperature.
- Lack of approved eye charts (literate and illiterate)
- All stored and dispensed prescription drugs were not always labeled appropriately

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

- Site personnel are qualified and trained for assigned responsibilities.
- No evidence that a qualified/trained personnel retrieve, prepare or administer medications.
- Site is compliant with OSHA Bloodborne Standard and Waste Management Act.
- Needle stick safety precautions are not practiced on site.
- Blood, other potentially infectious material and regulated wastes are not placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping.
- Re-usable medical instruments are properly sterilized after each use Spore testing of autoclave/steam sterilizer with documented results is not done at least monthly.
- Lack of Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag; lack of oxygen tank being 2/3 full

Common Deficiencies identified in Medical Record Review

- Primary language and linguistic needs were not documented.
- Evidence of tuberculosis screenings absent in medical record.
- Advance Care Directives were not documented as offered or discussed nor was it filled out by member.
- Adult immunizations were not given according to guidelines
- Required Screenings were not performed or documented, including but not limited to: Hepatitis B/C Virus, Breast Cancer Screening, Cervical Cancer Screening, Colorectal Cancer Screening, Osteoporosis Screening, Blood Lead Screening, Sudden Cardiac Arrest and Cardiac Death Screening.
- Fluoride Varnish was not performed or documented;
- Dental Oral Health Assessment not performed or documented
- Lack of interpreter being identified in provider notes

FSR ACTION PLAN FOR 2024

- Continue with our processes with completing FSR/MRRs in efforts to reduce backlog as result of the PHE and reduced staffing in 2022
    - Reduce backlog to 0 by end of 2024
- Create additional new educational materials, for posting on the FSR page of HPSM's website and distribute to providers. Among these: Required Staff Trainings Packet; Adult Screenings, Pediatric Screenings (with emphasis on new DHCS-required screenings. Direct our providers towards obtaining information about FSR/MRRs and completing Corrective Action Plans from the resources on our HPSM Website. This will help reduce deficiencies in future FSRs and MRRs and help providers to maintain full compliance.
- We will continue to collaborate with other MC Health Plans to obtain results of site reviews and prevent duplicate site reviews of the same provider.
- Put together a plan to educate providers on the new survey and assure their success. Focus on distribution of material prior to the scheduled site review.
- Train QI Nurse for Site Review Certification

4.3 PHYSICAL ACCESSIBILITY REVIEW (PAR)

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

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

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

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

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

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

A total of 43 Physical Accessibility Reviews (PAR) were done for 2023

Below is the break down for 2023 :

Level of Access:	# of PCP/Hospital
Basic Access	9
Basic Access/ Medical Equipment	13
Limited Access	20
Limited Access/Medical Equipment	1
No Access	0

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

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

4.5 POTENTIAL QUALITY ISSUE (PQI) MONITORING

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

41 PQI/Quality of Care Reviews were adjudicated in 2023

Final counts by PQI Level

Row Labels	Count
P0/S0	18
P0/S1	11
P0/S2	4
P1/S0	5
P1/S1	1
P1/S2	1
P2/S2	1
Grand Total	**41**

5. MEMBER EXPERIENCE & HEALTH OUTCOMES

5.1 HEALTH OUTCOMES SURVEY (HOS)

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

This self-report survey of plan members is conducted in English, Spanish, & Chinese. Baseline results of HOS are intended to help plans identify potential areas for improvement and evaluate the physical and mental health of members. The reporting is done within specific cohorts with a follow-up 2 years later. The following topics are covered

- Health Status Measures: Physical (PCS) & Mental (MCS)Component Summary Scores
- Chronic medical conditions
- Functional status (ADLs)
- Clinical measures
- Effectiveness of Care (HEDIS) measures
  - Fall Risk Management (FRM)
  - Physical Activity in Older Adults (PAO)
  - Management of Urinary Incontinence in Older Adults (MUI)

REQUIREMENTS AND TIMEFRAMES:

MAOs with Medicare contracts in effect on or before 1/1/2018 participated in the survey. Plans must also have had a minimum enrollment of 500 with 6 months of continuous enrollment to participate. Surveys are fielded annually in August through November and summary reports are available the following July. Results are trended over three years(2020-2022 for Cohort 23). The baseline for HPSM's Cohort 23 was collected in 2020 and the follow up survey for that population was collected in 2021. The baseline conducted for HPSM's Cohort 22 was collected in 2019 and the follow-up survey for that population was collected in 2021 -2020. The baseline conducted for HPSM's Cohort 21 was collected in 2018 and the follow-up survey for that population was collected in 2019-2020 and the merged results were made available in a report from CMS.

For Cohort 23 the original baseline sample size was 1,200; however, 909 members were not included in the analytic sample because they did not complete the baseline survey, were not seniors, or were determined to be ineligible beneficiaries at baseline. Therefore, the analytic sample size was 291. Of the 291 members in the analytic sample, 29 voluntarily disenrolled from HPSM and 27 died between baseline and follow up. Of the 235 members sent a follow up survey, 3 were determined to be ineligible. Of the remaining 232 members, there were 111 who did not complete the survey and 121 who returned a completed follow up survey. This represented an overall follow up response rate of 57.3% for HPSM, as compared with the National HOS follow up response rate of 52.2%.

HOS COHORT 23 FOLLOW-UP RESULTS:

Improving or Maintaining Physical Health Score Results Trended over Three Cohorts

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

	Percent Better*	Percent Same*	Percent Worse*	Percent Better+Same*	Performance Results**
2020-2022 Cohort 23	17.05%	52.17%	30.78%	69.22%	⇔
2019-2021 Cohort 22	18.05%	54.63%	27.32%	72.68%	⇔
2018-2020 Cohort 21	15.86%	60.92%	23.22%	76.78%	⇔

Note: See Appendix 1 for a description of changes to the case-mix that may affect comparability of trending results.
NA indicates that the MAO did not have results for the specified cohort.

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

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

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

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

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

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

Improving or Maintaining Mental Health Score Results Trended over Three Cohorts

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

	Percent Better*	Percent Same*	Percent Worse*	Percent Better+Same*	Performance Results**
2020-2022 Cohort 23	22.45%	67.14%	10.41%	89.59%	⬆
2019-2021 Cohort 22	14.68%	70.88%	14.44%	85.56%	⇔
2018-2020 Cohort 21	14.02%	67.05%	18.93%	81.07%	⇔

Note: See Appendix 1 for a description of changes to the case-mix that may affect comparability of trending results.
NA indicates that the MAO did not have results for the specified cohort.
* The percent better, same, worse, or better+same refers to member health status within an MAO.
** The statistical significance of each performance result for the MAO is indicated by one of the following symbols:
⬆ MAO performed significantly better than expected (higher than the national average)
⬇ MAO performed significantly worse than expected (lower than the national average)
⇔ MAO performed as expected (the same as the national average)

Our results also suggest that in the category for maintaining or improving the mental health score, HPSM results were significantly better and higher than the national average.

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

Table 3: *2020-2022 Cohort 23 Performance Measurement* Distributions of Members with Worse Self-Rated General and Comparative Health Status for MAO H7885, California, and HOS Total

	General Health Fair or Poor		Comparative Physical Slightly Worse or Much Worse		Comparative Mental Slightly Worse or Much Worse	
	Baseline	Follow Up	Baseline	Follow Up	Baseline	Follow Up
H7885	40.7%	42.0%	27.5%	37.0%	23.1%	18.6%
California	27.1%	30.8%	26.8%	29.7%	18.3%	16.2%
HOS Total	21.9%	24.5%	24.6%	27.3%	15.6%	12.8%

HPSM has seen an increase from the baseline versus follow up cohorts for General Health and Comparative Physical but a decrease in Comparative Mental for this measure.

Table 4: *2020-2022 Cohort 23 Performance Measurement* Distribution of Members with Multiple Chronic Medical Conditions§ for MAO H7885, California, and HOS Total

	Multiple Chronic Medical Conditions§	
	Baseline	Follow Up
H7885	76.3%	70.0%
California	74.1%	61.6%
HOS Total	76.1%	63.0%

§ Multiple chronic medical conditions are defined as having two or more conditions.
Note: Removal of three conditions in 2022 will affect comparability between the baseline and follow up results in this report and reports from prior years.

HPSM is performing better than State and National results.

Table 5: *2020-2022 Cohort 23 Performance Measurement* Distribution of Members with Worse Health for the Healthy Days Measures for MAO H7885, California, and HOS Total

	14 or More Days of Poor Physical Health		14 or More Days of Poor Mental Health		14 or More Days of Activity Limitations	
	Baseline	Follow Up	Baseline	Follow Up	Baseline	Follow Up
H7885	22.7%	27.4%	15.4%	17.2%	18.3%	20.0%
California	17.5%	20.6%	12.7%	12.9%	13.4%	15.0%
HOS Total	16.0%	18.4%	9.7%	10.1%	10.9%	13.0%

HPSM is performing better than State and National results.

Table 6: *2020-2022 Cohort 23 Performance Measurement* Distribution of Members in Extreme Categories of the BMI Measures for MAO H7885, California, and HOS Total

	Underweight (BMI < 18.5)		Overweight (BMI 25 to 29.99)		Obese (BMI ≥ 30)	
	Baseline	Follow Up	Baseline	Follow Up	Baseline	Follow Up
H7885	5.3%	4.4%	34.2%	30.1%	23.7%	24.8%
California	3.3%	3.4%	36.4%	35.9%	24.6%	22.8%
HOS Total	1.9%	2.3%	36.8%	36.5%	31.7%	30.2%

Note: BMI categories were modified beginning with the *2017 Cohort 20 Baseline* Report. Underweight was changed from "<20" to "<18.5."

HPSM is performing better than State and National results.

HEDIS HOS MEASURES

The HEDIS HOS results measure Plan performance in the following three measures: Management of Urinary Incontinence in Older Adults (MUI), Physical Activity in Older Adults (PAO), and Fall Risk Management (FRM). These three components of the HEDIS HOS measures are also used in the Medicare Star Ratings.

HEDIS HOS results are based on data from Cohort 25 Baseline and Cohort 23 Follow Up data collected in 2022. Prior rounds also combined baseline and follow-up surveys administered the calendar year.

Table 1: 2022 HEDIS HOS Rates for MAO H7885, California, CMS Region 9, and HOS Total†

	MUI Discuss Rate	MUI Treat Rate*	MUI Impact Rate	PAO Discuss Rate	PAO Advise Rate*	FRM Discuss Rate	FRM Manage Rate*
H7885	64.71%	48.08%	30.10%	64.16%	61.86%	34.93%	76.97%
California	57.75%	44.53%	17.51%	58.19%	54.78%	25.32%	61.59%
CMS Region 9	57.75%	44.63%	16.23%	57.72%	52.34%	25.43%	59.55%
HOS Total	59.43%	44.75%	14.89%	55.55%	49.71%	27.10%	56.50%

† See Table 3 results for all MAOs in the state.
* Measures incorporated into the 2024 Medicare Star Ratings include the MAO 2022 *Improving Bladder Control* (MUI Treat Rate), *Monitoring Physical Activity* (PAO Advise Rate), and *Reducing the Risk of Falling* (FRM Manage Rate).

HPSM performed comparatively well in all ratings.

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

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

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

HPSM rates decreased across most measures from prior survey year.

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

The CAHPS survey is a member experience survey conducted annually for CMC and Medi-Cal members and is conducted in the first half of the year and measures member experiences in the previous 6 months. The Medicare survey sample is drawn from all members who have been enrolled for at least 6 months, living the U.S. and not in an institutional setting. The Medi-Cal 2023 survey includes both adult and child members. HSPM conducts separate annual CAHPS surveys for its Medicare members. The surveys are mailed in English and Spanish with a follow up telephone call.

2023 Medicare CAHPS SURVEY SUMMARY

The response rate was 35%, which is a slight decrease when compared to the 2022 response rate of 35.6%. Most questions are answered using a 0 (worst) to 10 (best) scale **or** a "never, sometimes, usually, always" scale.

CAHPS MEDICARE SURVEY RESULTS

Health Plan Overall Ratings Measure Results:

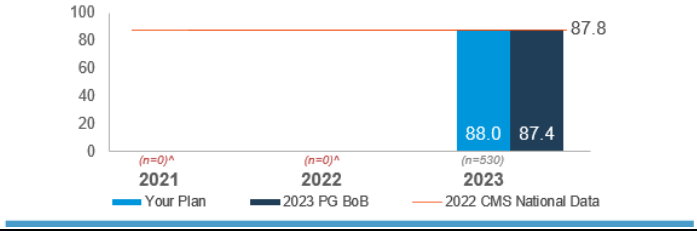
The 2023 Medicare CAHPS survey was a voluntary survey for our first year as an D-SNP Plan. There are no previous year results to compare against. For this survey measure, respondents used a 0-10 scale to rate their health plan, care received from their plan overall, their personal doctor, and the specialist (if any) they had seen most frequently in the past 6 months. The questions for each of the items are as follows:

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

For each measure, the table below shows the HPSM results for 2023 and the national average for all MA contracts. As shown HSPM's rating on the composite items is above the national average for ***Rating of Health Plan*** but below average for the other scores.

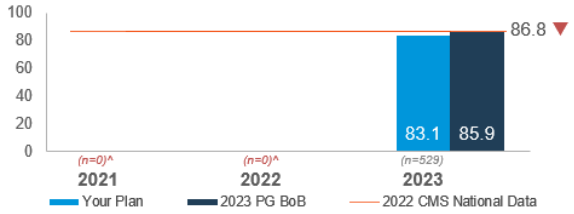
RATING OF HEALTH PLAN

PG %tile Rank	SMS
65th	88.0



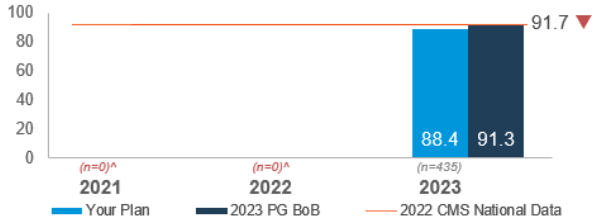
RATING OF HEALTH CARE QUALITY

PG %tile Rank	SMS
21st	83.1



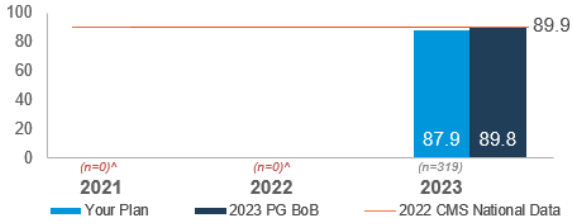
RATING OF PERSONAL DOCTOR +

PG %tile Rank	SMS
8th	88.4



RATING OF SPECIALIST +

PG %tile Rank	SMS
21st	87.9

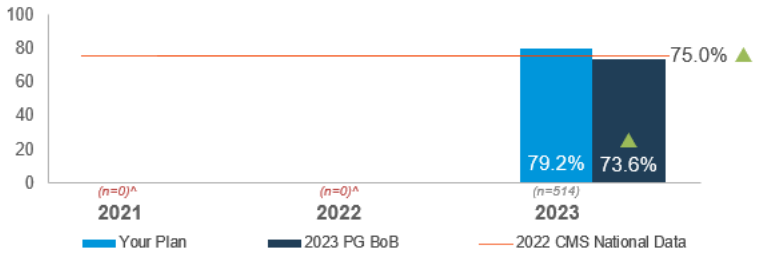


MEDICARE-SPECIFIC AND HEDIS MEASURE RESULTS:

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

ANNUAL FLU VACCINE

PG %tile Rank	% Yes
80th	79.2%



HEALTH PLAN COMPOSITE MEASURES RESULTS:

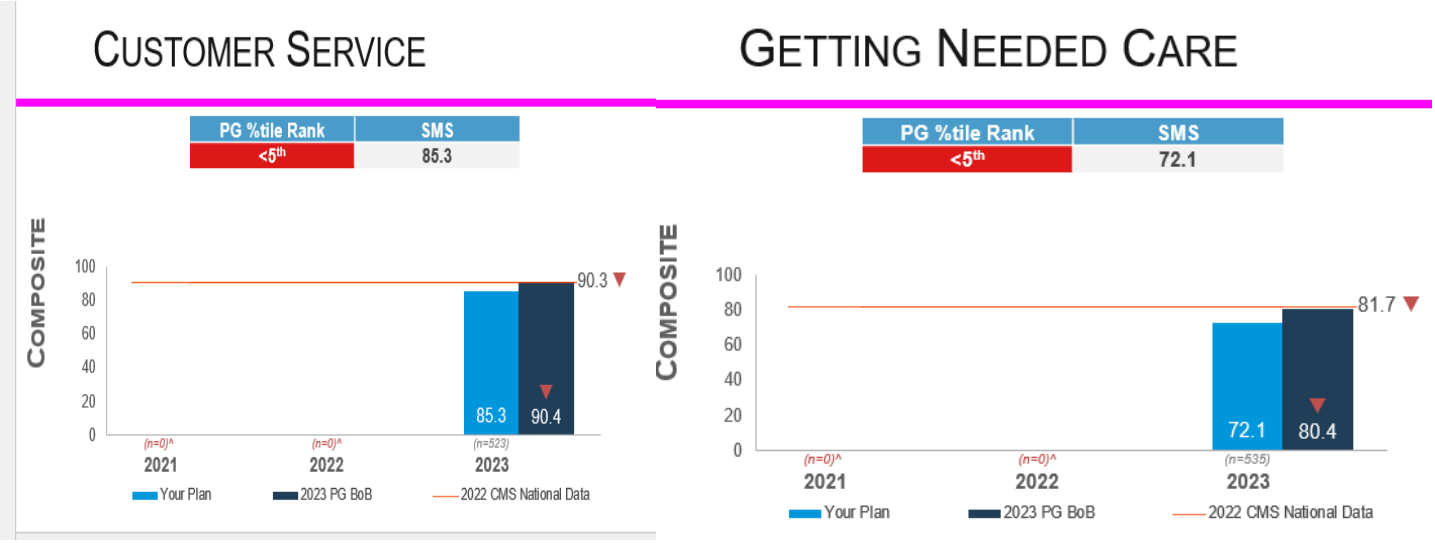
Responses to individual survey questions were combined to form five composite (summary) measures of members' experiences with their health plans. For each measure, the table below shows the HPSM result and the national average for all MMP contracts.

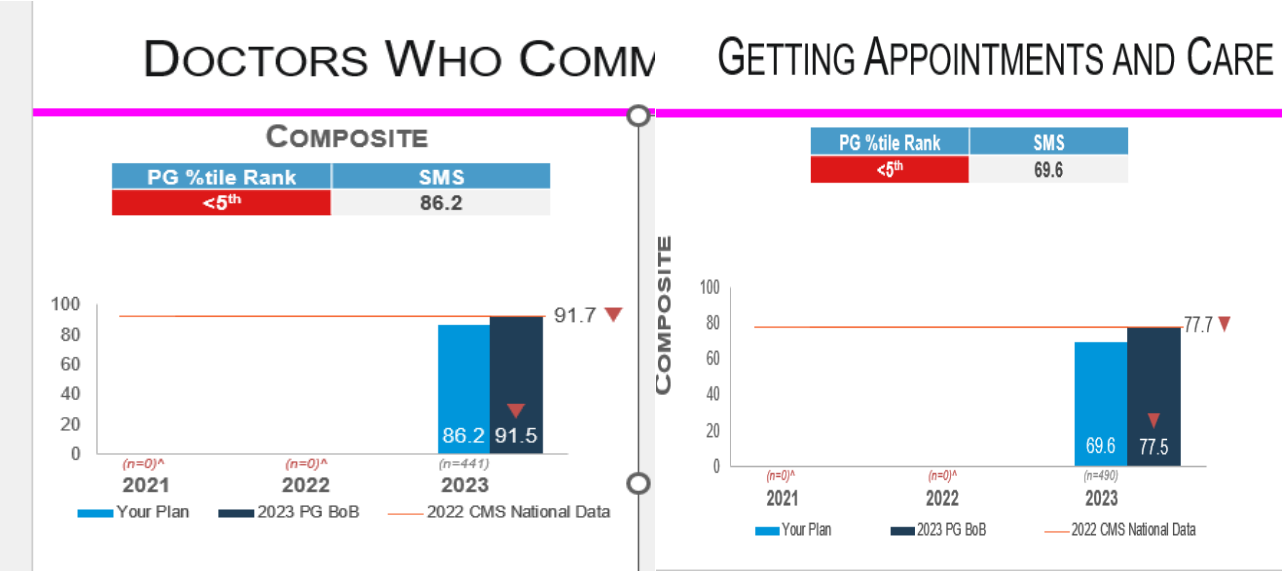
CAHPS Health Plan Composite Measure Questions

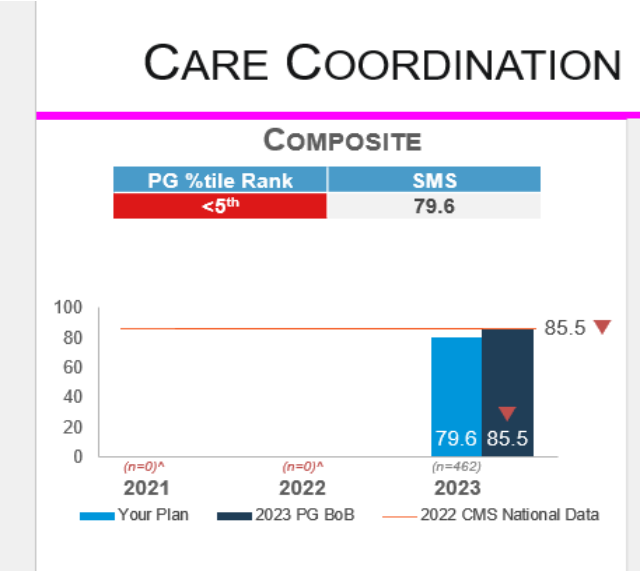
Table 1. MA-PD CAHPS Survey Composites

Composite Measures	Survey Items Included in the Composite
Getting Needed Care	In the last 6 months, how often was it easy to get the care, tests or treatment you needed? In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
Getting Appointments and Care Quickly	In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic? Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
Doctors Who Communicate Well	In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand? In the last 6 months, how often did your personal doctor listen carefully to you? In the last 6 months, how often did your personal doctor show respect for what you had to say? In the last 6 months, how often did your personal doctor spend enough time with you?
Customer Service	In the last 6 months, how often did your health plan's customer service give you the information or help you needed? In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect? In the last 6 months, how often were the forms for your health plan easy to fill out?

Composite Measures	Survey Items Included in the Composite
Care Coordination	In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results? In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them? In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?







Medicare Health Plan Composite Measure Results

HPSM performed below the national average on all the composite measures.

2023 Medi-Cal CAHPS SURVEY SUMMARY

See APPENDIX B: 2023 MEDI-CAL CAHPS SURVEY RESULTS

5.3 GRIEVANCES AND APPEALS

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

- Methodology
- Rates of Complaints per 1,000 Members
- Timeliness of Complaint Resolution
- Results, Analysis, Barriers and Proposed Actions by LOB
    - CareAdvantage/Cal-Mediconnect (CA-CMC)
    - Medi-Cal (MC)
    - Healthy Kids, HealthWorx, ACE & CCS
- Primary Care Provider (PCP Changes by Provider)

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

6. SUMMARY OF EFFECTIVENESS 2023

Adequacy of QI Program Resources	Securing adequate resources to support QI activities improved in 2023. Two additional staff members were hired in 2023, including a QI Nurse and QI Program Manager. All open positions were filled by the end of 2023. QI Department staff focus on the clinical quality monitoring, evaluation and reporting functions and may lead quality improvement initiatives across organizational teams. However, quality improvement program implementation and ongoing administration continues to be integrated through the various operational units of HPSM. This allows for a more robust and sustainable QI Program that will lead to substantial improvement in health outcomes for our members.
QI Committee Structure	The QI committee structure expanded in 2023. The Quality Improvement Committee (QIC) expanded it functions to include health equity and provide oversight of our dental services. The QIC was renamed to the Quality Improvement & Health Equity Committee (QIHEC).The committee continues to provide a forum for HPSM to report out program activities. The committee continues to serve as an advisory role in our QI programming in 2023 and members actively participate in discussions regarding opportunities for improvement, data analysis, intervention planning and evaluation. The QIHEC met quarterly in 2023 as planned. While the QIHEC met quorum for each meeting, total committee membership declined to 4 members. HPSM is actively recruiting additional members to the QIHEC to include up to 8 total committee members, to expand and diversify its advisory capacity. The QI Committee Structure itself has been successful at achieving its purpose and will continue.
Practitioner Participation and Leadership Involvement	The CMO has direct oversight of the Quality Improvement Department in addition to Utilization Management, Pharmacy, and Dental units and Medical Directors. In addition to the practitioners that sit on the QI Committee and HPSM's CMO, HPSM has three Medical Directors with differing areas of expertise including Obstetrics & Gynecology, Gerontology and Primary Care, and a Dental Director. This structure continued throughout 2023. Our CMO, Chief Health Officer (CHO), Dental and Medical Directors are

	heavily involved with QI Program activities and provide their clinical expertise throughout our intervention planning and evaluation process as well as ongoing clinical quality and patient safety monitoring. They also provide very valuable feedback and suggestions for improvement from the provider perspective on various initiatives. This is done both through their individual participation in various project meetings as well as the Clinical Quality Committee. Similarly, leadership involvement in the QI Program happens both from individual's participation in various QI activities as well as through the QI Committees including the Quality Improvement & Health Equity Committee (QIHEC) and Clinical Quality Committee (CQC), Management participation from several HPSM Departments participate in these committees and include representation from the following departments: • Pharmacy • Utilization Management • Population Health • Integrated Care Management • Behavioral Health • Provider Services • Quality Improvement • Dental This current structure supports practitioner participation and leadership involvement in QI Program Activities and will continue in 2024.
Summary	The current level of resources for quality improvement, leadership and practitioner involvement and committee structure supports the Quality Improvement Program in meeting its objectives. Expanding the current membership of the QIEC is recommended to enhance and diversify its advisory capacity, particularly in addressing health equity.

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

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

MY2022/RY2023 MCAS – MPL

HealthPlan OF SAN MATEO
Healthy is for everyone

Abrev	Measure	MY2022	50th Percentile	MY2021	MY 2020 Rate
CBP	Controlling High Blood Pressure*	64.95	59.85	62.20	53.04
CDC >9	Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)* (lower is better)	34.43	39.90	28.78	37.23
CIS-10	Childhood Immunization Status –Combo 10*	54.50	34.79	54.85	61.56
IMA -2	Immunizations for Adolescents –Combo 2*	49.39	35.04	51.58	50.61
BCS	Breast Cancer Screening	58.68	50.93	53.96	59.20
CCS	Cervical Cancer Screening*	61.69	57.64	57.61	58.91
CHL	Chlamydia Screening in Women	67.39	55.32	68.71	63.98
PPC -Post	Prenatal and Postpartum Care– Postpartum Care*	89.53	77.37	92.45	92.59
PPC-Pre	Prenatal and Postpartum Care– Timeliness of Prenatal Care*	90.70	85.40	89.31	90.0
WCV	Child and Adolescent Well -Care Visits (3-21 yrs)	52.00	48.93	56.92	48.80
LSC	Lead Screening in Children*	67.88	63.99	N/A	N/A
W30	Well-Child Visits in the First 30 Months of Life				
	• 6 or more well-child visits in first 15 months of life	49.62	55.72	25.73	20.03
	• 2 or more well -child visits in 15 to 30 months of life	72.38	65.83	69.14	76.94

New MPL = 50th Percentile
*Hybrid measure (chart review + admin & sup data)
Measure new to MCAS for MY2022

Under MPL
Above HPL

MY2022/RY2023 MCAS – no MPL

Measure Abbrev.	Measure	MY2022 Rate	MY 2021 Rate	MY 2020 Rate
AMB-ED	Ambulatory Care: Emergency Department (ED) Visits per 1,000 member months	44.76	38.63	36.99
ADD-Init	Follow-Up Care for Children Prescribed Attention -Deficit/Hyperactivity Disorder (ADHD) Medications – Initiation Phase	50.82	24.35	22.88
ADD-C/M	Follow-Up Care for Children Prescribed Attention -Deficit/Hyperactivity Disorder (ADHD) Medications – Continuation and Maintenance Phase	N/A	N/A	N/A
PCR	Plan All-Cause Readmissions • Observed rate (lower is better) • Observed to expected ratio	8.53 0.8623	9.42 0.9597	9.64 0.9322
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing	31.51	42.55	35.64
AMR	Asthma Medication Ratio	77.44	69.56	70.06
AMM -AP	Antidepressant Medication Management - Effective Acute Phase Treatment	69.55	67.59	66.47
AMM -CP	Antidepressant Medication Management - Effective Continuation Phase Treatment	53.26	51.48	51.09
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.26	80.19	78.15
COL	Colorectal Cancer Screening	47.82	N/A	N/A

All administratively collected measures; Measure new to MCAS for MY2022

MY2022/RY2023 MCAS – no MPL

Measure Abbrev.	Measure	MY 2022 Rate	MY 2021 Rate	MY 2020 Rate
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence • 7-Day Follow-up • 30-Day Follow-up	 35.52 53.44	 4.27 7.58	N/A
FUM	Follow-Up After Emergency Department Visit for Mental Illness • 7-Day Follow-up • 30-Day Follow-up	55.34 69.70	18.58 27.72	N/A
AAP	Adults' Access to Preventive/Ambulatory Health Services	67.59	N/A	N/A
POD	Pharmacotherapy for Opioid Use Disorder	26.03	N/A	N/A
PRS-E	Prenatal Immunization Status: Flu + Tdap	49.67	N/A	N/A
PDS-E	Postpartum Depression Screening and Follow Up • Screening • Follow-up	10.75 86.67	N/A	N/A
PND-E	Prenatal Depression Screening and Follow Up • Screening • Follow-up	11.91 47.06	N/A	N/A
DSF-E	Depression Screening and Follow-up for Adolescents and Adults • Screening • Follow-up	4.31 80.81	N/A	N/A
DRR-E	Depression Remission or Response for Adolescents and Adults	0	N/A	N/A

All administratively collected measures; Measure new to MCAS for MY2022

MY2022/RY2023 MCAS – no MPL

Measure Abbrev.	Measure	MY 2022 Rate	MY 2021 Rate	MY 2020 Rate	MY 2019 Rate
DEV^	Developmental Screening (ages 1 -3 yrs)	53.15	43.02	24.24	45.28
CCP^	Contraceptive Care: Postpartum Women Ages 15 -44 Most or moderately effective contraception – 60 days	48.92	52.41	50.17	42.34
CCW^	Contraceptive Care: All Women Ages 15 -44 Most or moderately effective contraception	23.07	25.26	24.34	24.38
TFL-CH^	Topical Fluoride for Children (1 – 20 yrs) • Dental or Oral Health Services • Dental Services • Oral Health Services	20.32 17.52 2.78	N/A	N/A	N/A

All administratively collected measures
^Non-HEDIS measure

Child measure specifications
Adult measure specifications

MY2022/RY2023 MCAS – no MPL

Measure Abbrev.	Measure	MY 2022 Rate	MY 2021 Rate	MY 2020 Rate
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence • 7-Day Follow-up • 30-Day Follow-up	 35.52 53.44	 4.27 7.58	 N/A
FUM	Follow-Up After Emergency Department Visit for Mental Illness • 7-Day Follow-up • 30-Day Follow-up	55.34 69.70	18.58 27.72	N/A
AAP	Adults' Access to Preventive/Ambulatory Health Services	67.59	N/A	N/A
POD	Pharmacotherapy for Opioid Use Disorder	26.03	N/A	N/A
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DSF-E	Depression Screening and Follow-up for Adolescents and Adults • Screening • Follow-up	4.31 80.81	N/A	N/A
DRR-E	Depression Remission or Response for Adolescents and Adults	0	N/A	N/A

All administratively collected measures; Measure new to MCAS for MY2022

APPENDIX B. MEDI-CAL CAHPS

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Overview

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

Table 1: CAHPS Response Rate Tends

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

As Table 1 shows above there is a consistent decrease in response rate for both Adult and Child surveys for more recent collection years. However, response rates remained sufficient for valid result reporting for 2022.

Adult Survey Results

Table 2 below shows trends in "Top box" ("Always" or "Usually") responses for composite items and supplemental items for the Adult survey across collection years. Comparison to 2021 results shows improvement in *Rating of Health Plan* where the goal rate was met.

Getting Needed Care/Quickly, How Doctors Communicate, and Customer Service were all identified during the last survey cycles as focus areas of improvement. Of these goal areas, there were slight decreases in scores of *Getting Needed Care, How Doctors Communicate, and Customer Service.* There was a more significant decrease *in Getting Need Care Quickly.* Despite the decrease, the goal rate was met for *Getting Needed Care.*

The goal rate was met for *Rating of a Health Plan, Rating of all Health Care,* and *Getting Needed Care.* The largest decreases in points were *Getting Care Quickly, Rating of Personal Doctor, Rating of All Health Care, and How Well Doctors Communicate*.

Table 2: Adult Survey Results Trends and Comparisons

Measure	2013 Top-Box Scores	2016 Top-Box Scores	2019 Top-Box Scores	2021 Top-Box Scores	2022 Top-Box Scores	2021 to 2022 change	All Other Medicaid Health Plans 2022 Top-Box Scores	NCQA HPR Percentile	Goal Rate	Goal Met
Rating of Health Plan	56.50%	59.20%	58.23%	63.06%	63.8%	.0074	62%	33rd – 66th Percentile	63.00%	Yes
Rating of All Health Care	52.70%	52.00%	50.18%	60.27%	56.3%	-.0397	56%	33rd – 66th Percentile	52.80%	Yes
Rating of Personal Doctor	64.60%	66.50%	68.65%	65.27%	58.7%	-.0657	68%	<10th Percentile	69.80%	No
Rating of Specialist Seen Most Often	68.50%	71.6%+	71.20%	71.54%	64.5%	-.0070	67%	N/A	71.70%	No
Getting Needed Care	81.20%	73.60%	77.60%	80.45%	79.9%	-.0055	52%	10th – 32nd Percentile	78.20%	Yes
Getting Care Quickly	75.80%	69.00%	79.30%	80.15%	73.4%	-.0675	56%	10th – 32nd Percentile	80.09%	No
How Well Doctors Communicate	87.40%	88.30%	93.10%	91.99%	88.9%	-.0309	76%	N/A	90.20%	No
Customer Service	82.90%	88.8%+	88.70%	86.39%	82.9%	-0.023	69%	N/A	86.50%	No

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

https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/cahps-database/2022-hp-chartbook.pdf

Table 3: Trend of Composite and Individual Items for Adult Survey

Composite and Individual Items (2022)	Top-Box scores 2016	2019	2021	2022	Change 2021 to 2022
Getting Care Quickly					
Q4. Got care as soon as needed when care was needed right away	NA	86.40%	NA	77.00%	
Q6. Got check-up/routine appointment as soon as needed	65.63%	72.14%	73.64%	69.70%	-3.94%
Getting Needed Care					
Q9. Ease of getting care, tests or treatment	75.00%	82.85%	82.96%	85.00%	2.04%
Q20. Got appointment with specialist as soon as needed	72.28%	72.41%	77.94%	74.80%	-3.14%
How Well Doctors Communicate					
Q12. Personal doctor explained things	85.56%	91.90%	89.38%	89.20%	-0.18%
Q13. Personal doctor listened carefully	87.64%	94.67%	93.75%	88.00%	-5.75%
Q14. Personal doctor showed respect	92.22%	95.16%	95.11%	92.10%	-3.01%
Q15. Personal doctor spent enough time	87.78%	90.65%	89.73%	86.10%	-3.63%
Coordination of Care					
Q17. Coordination of Care	NA	85.31%	86.67%	88.80%	2.13%
Customer Service					
Q24. Customer service provided information or help	NA	81.02%	80.86%	74.60%	-6.26%
Q25. Customer service treated member with courtesy and respect	NA	96.35%	91.93%	91.20%	-0.73%

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

There were positive changes for two top-box score questions in 2022, being *Q9. Ease of Getting Care, Tests, or Treatment* and *Q17. Coordination of Care*.

The largest negative score changes were found under *Customer service, Q24. Customer Service Provided Information or Help*, and under *Getting Care Quickly Q6. Got Checkup/Routine Appointment as Soon as Needed*. These are important factors to keep in mind as we plan the improvement process for the upcoming years.

Child Survey Results

Table 4 below shows trends in “Top box” (“Always” or “Usually”) responses for composite items and supplement items for the Child survey across collection years. No Goal Rates were met during this survey cycle though the Customer Service Measure was the only score to increase closer to its goal rate.

Table 4: Child Survey Results Trends and Comparisons

Measure	2016 Top-Box Scores	2019 Top-Box Scores	2021 Top-Box Scores	2022 Top-Box Scores	2019 to 2021 change	All Other Medicaid Health Plans 2019 Top-Box Scores	NCQA HPR Percentile	Goal Rate	Goal Met
Rating of Health Plan	69.90%	78.30%	76.84%	72.5%	-0.0434	70%	33rd – 66th Percentile	78.20%	No
Rating of All Health Care	68.00%	70.30%	77.93%	56.0%	-0.2193	69%	<10th Percentile	72.90%	No
Rating of Personal Doctor	76.10%	79.30%	81.31%	76.7%	-0.0461	76%	33rd – 66th Percentile	79.30%	No
Rating of Specialist Seen Most Often	71.6%+	81.4%+	N/A	73.3%	N/A	73%	N/A	81.40%	N/A
Getting Needed Care/Care Easily	77.80%	78.60%	82.66%	76.7%	-0.0596	60%	10th – 32nd Percentile	80.50%	No
Getting Care Quickly	77.40%	81.10%	81.14%	75.4%	-0.0574	70%	<10th Percentile	84.90%	No
How Well Doctors Communicate	92.30%	93.20%	93.98%	91.1%	-0.0288	80%	N/A	91.80%	No
Customer Service	89.40%	94.30%	86.35%	86.5%	0.0015	69%	N/A	88.50%	No

For the trend results, measures with less than 100 responses are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents. N/A response rates to item were too low to render a valid result

Table 5: Trend of Composite and Individual Items for Child Survey

Composite and Individual Items (2022)	Top-Box Scores				Change 2019 to 2021
	2016	2019	2021	2022	
Getting Care Quickly					
Q4. Got care as soon as needed when care was needed right away	75.83%	NA	NA	80.40%	
Q6. Got check-up/routine appointment as soon as needed	79.03%	82.66%	75.61%	70.30%	-5.31%
Getting Needed Care					
Q9. Ease of getting care, tests or treatment	82.62%	84.17%	82.46%	81.30%	-1.16%
Q23. Got appointment with specialist as soon as needed	NA	NA	NA	72.00%	
How Well Doctors Communicate					
Q12. Personal doctor explained things	94.44%	92.89%	94.12%	88.30%	-5.82%
Q13. Personal doctor listened carefully	94.06%	94.17%	95.59%	93.30%	-2.29%
Q14. Personal doctor showed respect	95.44%	97.48%	98.03%	98.10%	0.07%
Q17. Personal doctor spent enough time	85.21%	88.14%	88.18%	84.50%	-3.68%
Coordination of Care					
Q20. Coordination of Care	NA	NA	NA	83.70%	
Customer Service Composite					
Q27. Customer service provided information or help	85.53%	90.24%	77.88%	76.10%	-1.78%
Q28. Customer service treated member with courtesy and respect	93.21%	98.35%	94.83%	96.90%	2.07%
Forms Were Easy to Fill Out					
Q30. Health plan forms were easy to fill	93.11%	93.02%	94.63%	94.60%	-0.03%

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

While there was improvement significant in Q.28 Treating a Member with Courtesy and Respect, many of the other measures fell and did not meet the goal rates. Each year, three sections are selected for a deeper look relating to the scores given. The criterion for selection is based on improvement strategies, organizational initiatives, and need of membership. In the following analysis document, please find a focus on sections *How Well Doctor's Communicate, Rating of Personal Doctor, and Customer Services* as areas of opportunity listed with barriers and action plans responding to the questions above.

Analysis, Barriers, and Action Plan for Key Improvement Areas (Adult & Child)

How Well Doctors Communicate

Related CAHPS Questions: Q12. Personal doctor explained things, Q13. Personal doctor listened carefully, Q14. Personal doctor showed respect, Q15. Dr. spent enough time

Qualitative Analysis

The rates of this composite score increased for pediatric members and stayed relatively stable for adult members. Parents of children reported rates from 91% - 93% and adults reported rates from 87% - 95%. The past survey cycle showed a slight decline in both children's and adult's scores. This deviation is something to continue to monitor and create educational opportunities for our provider network.

Barriers and Action Plan

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

1) **CAHPS communication planning**: HPSM plans to begin building an infrastructure in 2023 for increased provider knowledge of CAHPS and its scorings. This work will assist providers in recognizing the importance of communications and how HPSM prioritizes member experience. Barriers include engaging providers in review of CAHPS results that cannot be tailored to them due to the deidentified nature of the survey. When providers are unable to see their practice-specific assessments of the member experience, their role in the improvement process of the network's overall performance may be less evident. Providers may also deprioritize subjective assessments of their quality of care in favor of health or financially based outcomes that are more objective in measurement.

2) **Provider grievance trending**: To maintain these high scores and work toward improvement, HPSM will continue the work described above related to grievance trending by provider. Other than CAHPS, HPSM's primary inputs for member feedback related to provider communication are grievances filed against providers. Many customer service grievances filed against providers are fundamentally issues of miscommunication between the provider and the member. As such, HPSM will continue its work tracking and trending grievances by provider and reviewing this information at HPSM's Provider Grievance Subcommittee for action as appropriate.

3) **Provider-based learning:** HPSM is currently expanding its Learning & Development team to support provider learning. In partnership with HPSM's provider-facing unit, this work includes the development of provider training and education resources to support member experience and health outcomes. Providers will be trained on topics relating to survey and CAHPS results and internal discussions with providers on high need areas, this discovery is not yet available at the time of this report.

4) **Data transparency:** HPSM posits that the quality of provider interactions between one another may also impact the member perception of how well doctors communicate. HPSM continues to iterate upon its data-sharing processes with providers, including how to improve the completeness of member referrals and utilization in PCP-facing patient monitoring reports. By providing the PCP with information on member utilization elsewhere in the managed care ecosystem (e.g. Enhance Care Management and Community Supports, behavioral health, hospital), PCPs are better equipped to communicate with the member with more preparedness and understanding of their care holistically. Barriers include the timeliness and completeness of member utilization data and limitations on the mechanisms by which HPSM may securely share patient health information.

Rating of Personal Doctor

Related CAHPS Questions: Q18. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor, Q14 Dr. showed respect, Q12 Dr. explained things, Q13 Dr. listened carefully, Q15 Dr. spent enough time

Qualitative Analysis

As stated above, adult members reported improved scores in *Getting Needed Care* and *Getting Care Quickly*. Similarly, the parents of pediatric members reported improved scores in *Getting Needed Care*, though the scores for *Getting Care Quickly* remained stable. This increase may be in part the result of efforts led by HPSM's Provider Services Department at addressing access to care barriers. These efforts include the following:

Targeted Member Reassignment: Beginning in late 2021, HPSM resurrected a member reassignment process temporarily paused during the onset of the public health emergency that reassigns members for primary care based on their utilization patterns. If HPSM receives a billable primary care encounter from a non-assigned, in-network primary care clinic for two consecutive visits over a rolling 12 months, HPSM will initiate a process to reassign that member to the clinic where they are seeking care. This intervention supports member choice of their personal doctor and other factors such as aligning the population for whom each primary care provider (PCP) must assume responsibility for quality monitoring and care.

Trending of member grievances: HPSM monitors member grievances filed against providers through recurring grievance reports that categorize critical pieces of information describing the member experience and summarize Plan resolution. Providers with a rate of grievances that trend at or above a certain standard deviation above the mean are forwarded for review by the Provider Grievance Subcommittee, a group of key subject mater experts across multiple business units whose scope includes identifying opportunities for improvement to the member/provider relationship. Providers may be identified for follow-up or corrective action based on an in-depth review of the nature of the member grievances filed against them.

Barriers

Access to Primary Care: When HPSM observes access and availability challenges in the primary care network, HPSM pivots its strategic planning to improve specific provider relationships that may mitigate the challenges. HPSM's primary care network cannot often expand with net new contracts due to already having business relationships with all practices in the service area and a lack of new practices emerging. These trends are the result of several phenomena. Firstly, San Mateo County is subject to the national primary care shortage as population growth and aging outpaces the number of people entering the physician profession and primary care specialty. Secondly, the regional landscape follows national trends of consolidation of primary care and other health care services into large healthcare systems. Since 2020, HPSM has observed higher rates of primary care physician retirement and independent practice closure due to factors partially exacerbated by the public health emergency. As a result, HPSM instead prioritizes capacity-building initiatives within existing primary care contracts with both small, independent practices and large health systems. The empanelment capacity lost since 2020 has been largely replaced by increases to remaining contracts, and HPSM has not observed true capacity constraints when assigning members to a best fit primary care provider considering factors such as geographic location, provider specialty and age range, spoken language(s), and others. Steps to increase access to primary care include:

HPSM will continue to implement corrective action based on a cross-referencing of timely access results of appointment availability and member access grievances. Provider groups for whom indications of noncompliance or access challenges exist across multiple data sources are subject to formal notification of noncompliance, discussion and planning in join operations or one-on-one meetings with HPSM, and responding to punitive actions including sanctions and termination from the network as needed. HPSM will continue to engage in network expansion efforts by conducting outreach to new PCPs to join the network as they are identified.

Beginning 2023, HPSM will begin to allocate $30 million over five years toward targeted capacity-building and practice transformation initiatives to improve both the quality and sustainability of primary care. HPSM's investment in a Quadruple Aim, where provider experience is a fourth arm of theoretical improvement of quality health care, will improve the member experience by improving the provider experience upstream.

Access to Specialty Care: In 2022, HPSM's high volume provider types and high impact provider types met the goal of fewer than two complaints per 1,000 paid claims. Nonetheless, HPSM continues to closely monitor access to specialty care, given the following known barriers: limitations of certain specialist provider types in the market and/or geographic area, the perception among certain providers that Medi-Cal members are a more challenging and complex patient population, and some providers' unwillingness to accept Medi-Cal payment rates. Additionally, some providers are contracted with the HPSM Medi-Cal network but limit the number of Medi-Cal patients they will see or limit their panel to only Medi-Cal patients

with whom they have a prior relationship, further limiting timely access for new members who need to see these provider types. This is especially prominent among large health systems that control the specialty provider market in the service area, including Stanford Health Care, Sutter Health, and the University of California at San Francsico. To mitigate these barriers:

1) Similar to primary care, HPSM will cross-reference practitioner-level data on noncompliance with the point-in-time analysis of provider timely access standards with access and availability member grievance data to identify any providers with multiple indications of access issues. HPSM will tailor corrective actions based on the circumstances of the noncompliance and characteristics of the provider group. Corrective actions may include sending a notice of corrective action which describes patterns of noncompliance and prescribes timelines for monitoring remediation; delivering report out to network provider or provider group in a joint operations meeting or other convening with discussion on corrective action opportunities; sanctioning network provider or provider group by restricting member assignment or utilization of the provider's services until corrective actions are met; or ultimately terminating from the network.

2) HPSM will continue to hold joint operations meetings and expand business relationships with large health systems representing a majority of member specialty utilization in order to improve access in critical provider groups that control the specialty market. Recently, HPSM leveraged a joint operations meeting to enter negotiations for a standalone specialty agreement with our highest volume specialty partner, Stanford Health Care, in order to expand capacity beyond hospital-based specialty providers and negotiate mutually agreed upon competitive rates that will guarantee HPSM member access to high-impact and high-volume specialty services. Additionally, HPSM leads standing strategic planning meetings with high volume FQHC partners, including our County system, to identify specialty types prioritized for recruitment.

3) HPSM will continue to engage in network expansion efforts by conducting outreach to new specialists to join the network. The state of specialty availability in San Mateo County follows a similarly trend of consolidation, though new practices entering the service area are less uncommon than in primary care. For example, in response to an identified geoaccess deficiency in ophthalmology in 2021-2022, HPSM added two new independent ophthalmologists to the provider network through prioritized outreach and networking. Customer Service

Customer Service

Related CAHPS Questions: Q24. Provided information or help, Q25. Treated with courtesy and respect.

Qualitative analysis

As noted above, Member Services scores for *Customer Service provided information or help* changed from 80.86% in 2021 to 74.60% in 2022, resulting in -6.26%. Scores for *Customer Service treated member with courtesy and respect* changed from 91.93% in 2021 to 91.20% in 2022, resulting in -0.73%. The past survey data showed a decline in customer experience. First call resolution continues to be a priority for the Member Services Department.

Barriers

HPSM Member Services Department experienced barriers with staffing promotions and backfilling positions during the peak of the closing of the Public Health Emergency, leading to an increase of calls from members, non-members, and community partnering agencies. The amount of time Member Services staff spent on incoming calls increased due to an upsurge in education requests from members and non-members, following mailings sent by DHCS and county offices. Member Services team received back-to-back calls on top of meeting the mandatory return calls within one business day, while managing projects in-between calls. During this period, Member Services experienced technical difficulties with our current phone

system leading to an increase in missed calls, therefore pulling staff out of the incoming call queue to return member calls within one business day.

4.3.3 Analysis and Action Plan

HPSM is committed to increasing its *Customer Service* ratings in 2023. Although we expect ratings to naturally improve given that the stressors of the pandemic are subsiding, the Member Services Department will also implement the following interventions:

Steps to Increase Providing Accurate and Helpful Service

The MS Department continues to conduct monthly refresher training on Medi-Cal and other LOB benefits, eligibility and services to ensure that staff remain up to date. The MS Department administers an annual skills and knowledge test, to measure MS Representative's knowledge levels related to benefits, services and processes.

The MS Department performs quality monitoring per MS Representative each month. Effective June 2023, quality monitoring analysis increased from three to six calls per MS Representative. Quality monitoring analysis measures performance related to the accuracy and understandability of the information provided, and the Representative's demeanor and level of respect. Each Representative has an objective of achieving a score of at least 95% per quarter on their monitored calls. MS Leadership tracks performance across quarters and acts as needed to address performance issues.

Steps to Increase Treating Members with Courtesy and Respect

The MS Department performs regular training and resources that focus on active listening and handling calls with empathy, dignity, and respect. MS staff are also assigned training modules through LinkedIn Learning. The MS team attended a de-escalation training in 2023 that included topics for empathy, active listening and reactions. The team continues to practice techniques learned during the training session.

MS Leadership will continue to monitor and evaluate calls as previously identified and will act as needed to address performance issues and deficiencies.

Steps to Increase Resources during High Call Volumes

The MS Department will carefully consider its current policies and procedures to identify areas for increased efficiency, thereby maximizing staff available to answer the phones.

The MS Department will be moving to a cloud-based call center system in September 2021. With this new system, the MS team will have easier access to real-time data on call volumes, hold times, and other key measures. Additionally, using a cloud-based system should decrease connectivity issues previously experienced throughout 2020 and 2021 because of staff working from home.

2023/2024 Goal Rates

HPSM is committed to maintaining its scores for *How Well Doctors Communicate*. It is also committed to increasing its scores for *Getting Needed Care, Getting Care Quickly,* and *Customer Service*. By implementing the strategies described above, HPSM aims to reach the following goals by August 2024:

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

Smoking and Tobacco Use Trends

Medical Assistance with Smoking and Tobacco Use Cessation

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

	2019	Numerator	Denominator	**2022**	**Numerator**	**Denominator**
Advising Smokers and Tobacco Users to Quit	N/A	34	0	**71.4%**	**28**	**<100***
Discussing Cessation Medications	N/A	2	0	**57.1%**	**28**	**<100***
Discussing Cessation Strategies	N/A	22	0	**53.6%**	**28**	**<100***

*Under 100 results in a N/A score

Group is performing...

- Above the plan score by 5 or more points
- Above the plan score
- Below the plan score
- Below the plan score by 5 or more points
- Above/blow plan score but has low base (<30)

Accreditation measure

Other measure

HealthPlan OF SAN MATEO
Healthy is for everyone

	Response Rate	Rating of Health Plan	Rating of Health Care	Getting Needed Care	Getting Care Quickly	Flu Vaccine	Rating of Personal Doctor	Rating of Specialist	Customer Service	How Well Doctors Communicate	Care Coordination	Ease of Filling Out Forms
Plan Score		63.8%	56.3%	79.9%	73.4%	59.7%	58.7%	64.5%	82.9%	88.9%	88.8%	95.7%
18-34 age group	17.2%	46.8%	45.3%	70.9%	68.4%	58.7%	32.7%	68.5%	70.9%	91.9%	10.8%	97.7%
35-44 age group	6.2%	29.8%	30.3%	59.9%	77.4%	64.7%	42.7%	59.5%	49.9%	70.9%	19.8%	99.7%
45-54 age group	12.4%	58.8%	45.3%	75.9%	77.4%	45.7%	49.7%	58.5%	90.9%	83.9%	81.8%	99.7%
55+ age group	64.2%	72.8%	45.3%	83.9%	73.4%	64.7%	66.7%	64.5%	85.9%	90.9%	88.8%	93.7%
HS grad or less	48.7%	66.8%	61.3%	82.9%	72.4%	62.7%	57.7%	69.5%	79.9%	88.9%	87.8%	94.7%
Some college or more	51.4%	60.8%	51.3%	77.9%	74.4%	55.7%	57.7%	60.5%	84.9%	88.9%	90.8%	96.7%
White	39.1%	67.8%	70.3%	81.9%	78.4%	66.7%	63.7%	58.5%	84.9%	91.9%	87.8%	95.7%
Hispanic/ Latino	31.2%	68.8%	65.3%	82.9%	77.4%	47.7%	64.7%	59.5%	85.9%	87.9%	78.8%	94.7%
Asian	40.6%	54.8%	44.3%	77.9%	64.4%	65.7%	50.7%	71.5%	75.9%	83.9%	84.8%	95.7%
Other	15.6%	74.8%	58.3%	67.9%	69.4%	37.6%	61.7%	61.5%	79.9%	86.9%	85.8%	94.7%
Black/African American	6.3%	62.8%	50.3%	82.9%	75.4%	61.7%	61.7%	66.5%	99.9%	99.9%	99.8%	99.7%
Native Hawaiian/PI	4.3%	89.8%	40.3%	79.9%	73.4%	74.7%	74.7%	80.5%	82.9%	99.9%	99.8%	79.7%
American Indian or Alaska Native	2%	79.8%	50.3%	54.9%	75.4%	49.7%	66.7%	100%	82.9%	66.9%	NA	99.7%

APPENDIX C: 2023 HPSM CONSUMER ADVISORY COMMITTEE GRIEVANCE & APPEALS REPORT

MEMBER EXPERIENCE COMMITTEE GRIEVANCE & APPEALS NCQA REPORT REPORTING PERIOD: Q1 2022-Q4 2022 DATE: 08/31/2023

1. DATA METHODOLOGY AND GOAL SETTING

1.1.1 DATA METHODOLOGY

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

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

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

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

1.1.2 GOAL RATES

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

Goals were based on the data gathered during 2021.

The G&A Unit set the following goal rates for all non-behavioral health grievances and appeals for 2022:

	Min Rate per 1,000 members per Month (2021)	Max Monthly Rate per 1,000 Members per Month (2021)	Goal 2022
Non-Behavioral Health: Grievances	0.60	1.38	**0.99**
Non-Behavioral Health: Appeals	0.08	0.20	**0.14**

For behavioral health services, the rate of complaints during 2022 was calculated using the number of members utilizing behavioral health services in 2019:

	Min Rate per 1,000 Utilizing Members per Month (2021)	Max Rate per 1,000 Utilizing Members per Month (2021)	Goal 2022
Behavioral Health: Grievances	0.10	0.33	**0.22**
Behavioral Health: Appeals	0.00	0.06	**0.03**

Complaint rates from 2022 were based on the date the grievance or appeal was *received.* In late 2019 HPSM's Consumer Advisory Committee changed its meeting schedule to receive more timely data from several of HPSM's operational areas. To comply with this decision, the G&A Unit changed their quarterly reports to reflect the G&A volumes based on the date the complaints were *closed*, allowing for all necessary data to be available by the report deadline.

2.1.1 MEDI-CAL AND CCS BEHAVIORAL HEALTH GRIEVANCES

The following table contains the number of behavioral health grievances received during calendar year 2022.

Category	Q1 2022	Q2 2022	Q3 2022	Q4 2022
	# Complaints	# Complaints	# Complaints	# Complaints
Access	10	9	9	14
Attitude and Service	1	2	2	2
Billing and Financial Issues				
Quality of Care	9	5	5	1
Quality of Practitioner Office Site				
Total Grievances	**20**	**16**	**16**	**17**

The following table contains the complaint rate for behavioral health grievances received throughout the calendar year 2022.

Category	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Goal Rate	2022 Rate
	Complaints per 1000 members per month	Complaints per 1000 members per month	Complaints per 1000 members per month	Complaints per 1000 members per month		
Access	0.32	0.28	0.28	0.44		
Attitude and Service	0.03	0.06	0.06	0.06		
Billing and Financial Issues	0.00	0.00	0.00	0.00		
Quality of Care	0.28	0.16	0.16	0.03		

Category	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Goal Rate	2022 Rate
	Complaints per 1000 members per month	Complaints per 1000 members per month	Complaints per 1000 members per month	Complaints per 1000 members per month		
Quality of Practitioner Office Site	0.00	0.00	0.00	0.00		
Total Grievances	**0.63**	**0.50**	**0.50**	**0.55**	**0.22**	**0.545**

2.1.2 MEDI-CAL AND CCS BEHAVIORAL HEALTH APPEALS

The table below contains the number of behavioral health appeals received during calendar year 2022.

Category	Q1 2022	Q2 2022	Q3 2022	Q4 2022
	# Complaints	# Complaints	# Complaints	# Complaints
Access		1		0
Attitude and Service				
Billing and Financial Issues				
Quality of Care				1
Quality of Practitioner Office Site				
Total Appeals	**0**	**1**	**0**	**1**

The following table contains the complaint rate for behavioral health appeals received throughout the calendar year 2022.

Category	Q1 2022 Complaints per 1000 members per month	Q2 2022 Complaints per 1000 members per month	Q3 2022 Complaints per 1000 members per month	Q4 2022 Complaints per 1000 members per month	Goal Rate	2022 Rate
Access	0.00	0.03	0.0	0.00		
Attitude and Service	0.00	0.00	0.00	0.00		
Billing and Financial Issues	0.00	0.00	0.00	0.00		
Quality of Care	0.00	0.00	0.00	0.03		
Quality of Practitioner Office Site	0.00	0.00	0.00	0.00		
Total Grievances	**0.00**	**0.03**	**0.00**	**0.03**	**0.03**	**0.015**

2.1.3 MEDI-CAL AND CCS NON-BEHAVIORAL HEALTH GRIEVANCES

The following table contains the number of non-behavioral health grievances received during calendar year 2022.

Category	Q1 2022 # Complaints	Q2 2022 # Complaints	Q3 2022 # Complaints	Q4 2022 # Complaints
Access	45	22	75	41
Attitude and Service	78	96	90	79
Billing and Financial Issues	13	16	18	28
Quality of Care	45	64	66	41
Quality of Practitioner Office Site		0	2	0
Total Grievances	**181**	**198**	**251**	**189**

The following table contains the complaint rate for non-behavioral health grievances received throughout the calendar year 2022.

Category	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Goal Rate	2022 Rate
	Complaints per 1000 members per month	Complaints per 1000 members per month	Complaints per 1000 members per month	Complaints per 1000 members per month		
Access	0.12	0.06	0.19	0.09		
Attitude and Service	0.21	0.25	0.23	0.47		
Billing and Financial Issues	0.04	0.04	0.05	0.17		
Quality of Care	0.12	0.17	0.17	0.24		
Quality of Practitioner Office Site	0.00	0.00	0.01	0.00		
Total Grievances	**0.50**	**0.53**	**0.63**	**0.46**	**0.99**	**0.53**

2.1.4 MEDI-CAL AND CCS NON-BEHAVIORAL HEALTH APPEALS

The following table contains the number of non-behavioral health appeals received during calendar year 2022.

Category	Q1 2022	Q2 2022	Q3 2022	Q4 2022
	Complaints Total	Complaints Total	Complaints Total	Complaints Total
Access	29	40	27	33
Attitude and Service	3	1	1	3
Billing and Financial Issues		2	2	2
Quality of Care	5	1	3	1
Quality of Practitioner Office Site	1			
Total Appeals	**38**	**44**	**33**	**39**

The following table contains the complaint rate for non-behavioral health appeals received throughout the calendar year 2022.

Category	Q1 2022 Complaints per 1000 members per month	Q2 2022 Complaints per 1000 members per month	Q3 2022 Complaints per 1000 members per month	Q4 2022 Complaints per 1000 members per month	Goal Rate	2022 Rate
Access	0.08	0.11	0.07	0.01		
Attitude and Service	0.01	0.00	0.00	0.01		
Billing and Financial Issues	0.00	0.01	0.02	0.01		
Quality of Care	0.01	0.00	0.01	0.00		
Quality of Practitioner Office Site	0.00	0.00	0.00	0.00		
Total Appeals	0.10	0.12	0.08	0.09	**0.14**	**0.10**

3. ANALYSIS, BARRIERS, AND PROPOSED ACTIONS

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

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

The behavioral health grievances failed to meet the established goal rate for all quarters as well as for the year-end total. This indicates that the rate of grievances filed in 2022 was higher than in 2021.

As seen in the charts below, most of the increase in behavioral health grievance volume in 2022 is the result of a significant increase in grievances for behavioral health therapy (BHT) services.

Behavioral Health Grievances

BH Type	BH Count
BHRS - Mild/Moderate	26
BHT/ ABA Therapy	44
Grand Total	**70**

Other than BHT, the only type of service that saw an increase in volume from 2021 to 2022 was grievances related to mild to moderate behavioral health services, both therapy and medication management.

- Whereas in 2021, the G&A Unit received 942 grievances, in 2022, the G&A Unit received 889.
- Additionally, the total number of appeals filed decreased from 450 to 156.
- Total membership increased in 2022, as well.
- The appeal trend indicates that outreach to providers has been successful. During 2022, HPSM's Medical Directors and Provider Services department worked closely with the provider group (Stanford), who generated the highest appeals per assigned member. The work centered required information for the utilization review process and also a peer-to-peer process for the MDs at Stanford to speak with the MDs at HPSM. This intervention received positive response and providers at Stanford are more consistently submitting appropriate medical necessity documentation during the prior authorization process and using the peer-to-peer process more consistently, resulting in less appeals overall.
- Prior authorization requirements were removed from most non-specialty and behavioral health services.

3.1.2 Barriers:

(i) During the review process, HPSM discovered that the root cause of the BHT related BH grievances was related to Magellan's provider-member matching process. Members were being asked for scheduling preference and being put on a waitlist until there was a perfect scheduling match for an appointment.

(ii) Additionally, it was discovered that Magellan did not have appropriate follow-through on care management activities and lacked ability and knowledge of local resources to connect members to.

(iii) No other barriers were identified since appeals for all types of service decreased and the rate of non-BH grievances were within the goal.

3.1.3 PROPOSED ACTION:

(i) To address the provider-member matching process, HPSM implemented a process improvement in Q4 2022 and Q1 2023. As a result of the process improvement, Magellan began offering a first available appointment for members to avoid a waitlist. This allowed members to choose if they wanted to take the appointment to receive a service, even if it wasn't a perfect scheduling match.

(ii) To address the gaps in follow-through and care management, HPSM approved, recruited for, and hired a new BHT program manager and clinical care manager to provide care management and coordination services. The program manager was hired in October 2022 and the clinical care manager was hired in May 2023.

(iii) Anticipating that these changes may take some time to show impact, so recommend increasing the goal amount for BH grievances to 0.55 for 2023.

2024 QUALITY IMPROVEMENT AND HEALTH EQUITY (QIHE) PROGRAM DESCRIPTION

QIHEC Review Date: March 2024

2024 Quality Improvement and Health Equity Program Description Approval Form

X

Chris Esguerra, M.D.
Chief Medical Officer
Health Plan of San Mateo

X

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

X

Jeanette Aviles, M.D.
Quality Improvement Committee Co-Chairperson
San Mateo Health Commission

CONTENTS

HPSM MISSION STATEMENT

The Health Plan of San Mateo provides San Mateo County's vulnerable and underserved residents access to high quality care services and supports that help them live the healthiest lives possible.

We have a vision, that healthy is for everyone.

VALUES

***Health** care that puts members at the center of everything we do.*

***Equitable** access to quality services and supports for all members.*

***Advocacy** for members disproportionally impacted by health inequities.*

***Local** health care based in San Mateo county provided in partnership with community resources.*

***Transparency** and accountability achieved through local governance.*

***Honesty** is the core of our service to members, providers, business partners and the community.*

***You** - because HEALTHY is for everyone!*

1. INTRODUCTION

1.1 BACKGROUND

The Health Plan of San Mateo (HPSM) was created in 1987 by a coalition of local elected officials, hospitals, physicians, and community advocates to serve the needs of Medi-Cal eligible beneficiaries. As a County Organized Health System (COHS), HPSM is authorized by state and federal law to administer Medi-Cal (Medicaid) benefits in San Mateo County. Based within the community it serves, HPSM is sensitive to, and its operation reflects, the unique health care environment and needs of San Mateo County's Medi-Cal beneficiaries. Beginning April 2014, HPSM began its Cal MediConnect (CMC) Medicare-Medicaid Plan to further serve dually eligible individuals with the goal of providing members with access to high quality services delivered in a cost-effective and compassionate manner. The Cal MediConnect plan ended on 12/31/2022. Beginning on January 1, 2023, in alignment with DHCS, HPSM transitioned the CalMediconnect plan to a D-SNP Plan named CareAdvantage. CareAdvantage Dual Eligible Special Needs Plan (D-SNP) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to for HPSM Medi-Cal members who have Medicare Parts A & B.

Consistent with its mission, HPSM operates additional product lines in response to community needs. These include Access and Care for Everyone (ACE) Program and HealthWorx. By taking on these additional groups and a state-licensed Medicare program under a competitive, risk-based contract with the Centers for Medicare and Medicaid Services (CMS), HPSM has expanded and reaffirmed its commitment to providing health care to San Mateo County's most vulnerable residents.

Effective February 2010, HPSM expanded its service contract with the Department of Health Care Services (DHCS), to include Long Term Care (LTC). This expansion includes facility charges in LTC facilities, sub-acute and intermediate care facilities (ICFs). In July 2012, Community-Based Adult Services (CBAS) was added to HPSM's DHCS' contract.

In January 2022, HPSM expanded its service contract with DHCS to include a dental services benefit with the goal of medical and dental service integration.

As of January 2024, HPSM serves approximately 173,000 members or participants under the following lines of business: Medi-Cal, CareAdvantage (D-SNP), HealthWorx, California Children's Services (CCS), and San Mateo County ACE Program (HPSM serves as the third-party administrator).

As of January 2024, HPSM is integrating Health Equity into the QI Program as required by the 2024 DHCS Contract.

1.2 HPSM'S DELIVERY SYSTEM

HPSM can fulfill its mission in San Mateo County because of its successful partnership with its outstanding healthcare delivery partners. Medical services are delivered to our members through our directly contracted provider network. HPSM's network includes over 800 primary care providers and over 2,000 specialists. In addition, HPSM's network includes 8 hospitals and medical centers located in San Mateo County and in neighboring San Francisco. All medical service authorizations under HPSM's scope of service for each line of business are performed by HPSM licensed clinical staff.

1.3 SCOPE OF SERVICES

HPSM provides a comprehensive scope of acute and preventive care services for its members through its Medi-Cal, HealthWorx, CCS, and CareAdvantage (D-SNP) lines of business. Certain services are not covered by HPSM or may be provided by a different agency:

- Specialty Mental Health services and substance abuse services are administered by the San Mateo County Behavioral Health and Recovery Services (BHRS) for all lines of business but Medi-Cal behavioral health is managed by HPSM and is not delegated. Behavioral Health Treatment (BHT) is administered by Magellan Health Services.
- California Children's Services (CCS) is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS authorizes care and in San Mateo County, HPSM pays for the specific medical services and equipment provided by CCS-approved specialists. The CCS program is funded with State, County, and Federal tax monies, along with some fees paid by parents or guardians.
- Health Plan of San Mateo works with community programs to ensure that members with special health care needs, high risk or complex medical and developmental conditions receive additional services that enhance their medical benefits. These partnerships are established through special programs and specific Memorandums of Understanding (MOUs) with certain community agencies including the San Mateo County Health Services Agency (HSA), California Children's Services (CCS), and the Golden Gate Regional Center (GGRC).
- Beginning January 1, 2022, outpatient pharmacy benefits for HPSM Medi-Cal members were transitioned from HPSM to fee-for-service (FFS) Medi-Cal. As of that date, these services were no longer managed by HPSM. Instead, they are administered by the California Department of Health Care Services (DHCS) in partnership with its contracted pharmacy benefits manager (PBM), Magellan.

2. QUALITY IMPROVEMENT AND HEALTH EQUITY PROGRAM

2.1 PURPOSE

The Quality Improvement and Health Equity (QIHE) Program provides a formal process to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety, equity, and effectiveness of care and service utilizing a multidimensional approach. This approach enables HPSM to focus on opportunities for improving operational processes and health outcomes and high levels of member and practitioner/provider satisfaction. The QIHE Program promotes the accountability of all employees and affiliated health personnel for the quality and equity of care and services provided to our members. HPSM communicates the standards and norms included in this program through a variety of methods, including but not limited to provider training, direct outreach to individual or groups of providers, HPSM's website, the Provider Manual, and provider newsletters.

2.2 GOALS

The goals of the QIHE Program are to:

- Provide timely access to high-quality healthcare for all members, through a cost-effective, safe, equitable, linguistically, and culturally appropriate health care delivery system that objectively and systemically monitors and evaluates quality and appropriateness of health care and services.
- Pursue opportunities to improve health care, services, health equity, and safety; and
- Resolve identified problems in a timely manner.

2.3 OBJECTIVES

- Design and maintain the quality improvement and health equity structure and processes that support continuous quality improvement and health equity, including measurement, trending, analysis, intervention and re-measurement.
- Meet the cultural and linguistic needs of the membership.
- Comply, communicate, and coordinate with all governmental agency requirements.
- Support practitioners with participation in quality improvement and health equity initiatives of HPSM and all governing regulatory agencies.
- Establish clinical and service indicators that reflect demographic and epidemiological characteristics of the membership, including benchmarks and performance goals for continuous and or periodic monitoring and evaluation.
- Maintain an on-going up-to-date credentialing and re-credentialing system that compiles with HPSM standards, including primary verification, the use of quality improvement, and other performance indicators in the re-credentialing process.
- Measure availability and accessibility to clinical care and service.
- Measure member satisfaction, identify and address areas of dissatisfaction in a timely manner through:
    - quarterly analysis of trended member complaint data; and
    - member satisfaction surveys; and
    - solicitation of member suggestions to improve clinical care and service.
- Continue to develop, adopt, and adapt practice guidelines (including preventive health) reflective of the membership.

- Measure the conformance of contracted practitioners' medical records against HPSM medical record standards at least once every three years. Take steps to improve performance and re-measure to determine organization-wide and practitioner specific performance.
- Develop studies or quality activities for member populations using demographic data. Studies and/or activities are designed to identify barriers to improved performance and/or validate a problem or measure conformance to standards.
- Oversee full delegated subcontractor and downstream fully delegated subcontractor activities by:
    - establishing performance standards consistent with the QIHE Program,
    - monitoring performance through regular reporting, and
    - evaluating performance and addressing deficiencies regularly.
- Evaluate under and over-utilization, continuity, and coordination of care through a variety of methods and frequencies based upon members' needs. These methods include but are not limited to an annual evaluation of:
    - Medical/dental record review
    - utilization of physical and behavioral health care
    - rates of referral to specialists
    - hospital discharge summaries in office charts
    - communication between referring and referred-to physicians
    - quarterly analysis of member complaints regarding difficulty obtaining referrals
    - encounter data
    - identification and follow-up of non-utilizing members
    - profiles of physicians, and
    - measurement of compliance with practice guidelines
    - reports on the number and type of services, denials, deferrals, and modifications, appeals and grievances
- Uses the methods above for equity-focused interventions
- Coordinate QIHE activities with all other activities, including, but not limited to, the identification and reporting of risk situations, the identification and reporting of adverse occurrences from UM activities, and the identification and reporting of quality of care concerns through complaints and grievances collected through the Grievance and Appeals Department.
- Implement and maintain health promotion activities and disease management programs linked to QIHE initiatives to improve performance. These activities include, at a minimum, identification of high-risk and/or chronically ill members, the education of practitioners, and outreach campaigns to members.
- Create and maintain the infrastructure to achieve accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting body for HPSM, fully delegated subcontractors and downstream fully delegated subcontractors, including the annual reporting with copies of reports, accreditation status, survey type, level, results, recommended actions/improvements, corrective action plans, summaries and accreditation expiration dates, as appropriate.
- Methods to address EQRO technical reports and evaluation report recommendations.
- Ensure community engagement with commitment to member and family focused care, and uses consumer advisory committee (CAC) findings, member listening sessions, focus groups/surveys, and uses that information to inform policies.
- Utilization of performance improvement plan (PIP) findings and outcomes, consumer satisfaction surveys, and collaborative initiatives.
- Perform disease surveillance pursuant to California state regulation Title 17 CCR 2500 et seq. including the reporting of diseases and conditions to local and state public health authorities and ensure directives from local and state public health authorities are implemented across HPSM

through coordination with the Chief Medical Officer and Chief Health Officer, and other Leadership Team members.

2.4 EVALUATION OF THE QIHE PROGRAM

The QIHE Program is evaluated on an annual basis. Findings from the annual evaluation are used to make modifications to the QIHE Program Description and QIHE Work Plan as necessary.

The annual QIHE Program Evaluation includes:

- A description of completed and going QIHE activities that address the quality, health equity, and safety of clinical care and quality of services
- Trending of measures to assess performance in quality, health equity, and safety of clinical and the quality of service indicator data
- Analysis of the results of the QIHE initiatives, including barrier analysis that evaluates the effectiveness of QIHE interventions for the previous year (demonstrated improvements in the quality, health equity, and safety of clinical care and in the quality service)
- An evaluation of the overall effectiveness of the QIHE program, including progress toward influencing safe clinical practices throughout the network that determines the appropriateness of the program structure, processes, and objectives

2.4.1 MONITORING OF PREVIOUSLY IDENTIFIED ISSUES

Recommendations that are used to re-establish a Work Plan for the upcoming year which includes a schedule of activities for the year, measurable objectives, and monitoring of previously identified issues, explanation of barriers to completion of unmet goals and assessments of goals.

2.5 SCOPE OF QUALITY IMPROVEMENT AND HEALTH EQUITY PROGRAM

The QIHE Program provides for review and evaluation of all aspects of health care, encompassing clinical care, health equity, and services provided to external and internal customers. External and internal customers are defined as members, practitioners, governmental agencies, and Health Plan of San Mateo employees.

All departments participate in the quality improvement process. The Chief Medical Officer and Chief Health Officer integrate the review and evaluation of components to demonstrate the process is effective in improving health care. Measuring clinical and service outcomes, health equity, and member satisfaction is used to monitor the effectiveness of the process.

- The scope of quality review will be reflective of the health care delivery systems, including quality of clinical care, health equity, and quality of service.
- All activities will reflect the member population in terms of age groups, disease categories and special risk status including those members with particularly complex needs.

The scope of services include, but are not limited to, services provided in institutional settings including acute inpatient, long term care, skilled nursing, ambulatory care, home care and behavioral health (as provided by product line); and services provided by primary care, specialty care and other practitioners including dentists. The scope also includes coordination and cooperation with the External Quality Review Organization as designated by DHCS, and detailed in policy QI-120 Coordination with the EQRO.

2.6 QIHE PROGRAM STRUCTURE

Oversight of the Quality Improvement and Health Equity Program is provided through a committee structure, which allows for the flow of information to and from the San Mateo Health Commission.

2.6.1 QIHE PROGRAM FUNCTIONAL AREAS AND RESPONSIBILITIES (QI 1.A.1)

The Quality Improvement and Health Equity Departments are responsible for implementing a multidimensional and multi-disciplinary QIHE Program that effectively and systematically monitors and evaluates the quality and safety of clinical care, health equity, and service rendered to members.

The Quality Improvement and Health Equity Program functions include, but are not limited to:

- Improve health outcomes for all members by incorporating health promotion programs and preventive medicine services into all the primary care delivery sites.
- Ensure effectiveness of continuous quality improvement and health equity activities across the organization.
- Evaluate the standards of clinical care and promote the most effective use of medical resources while maintaining acceptable and high standards. This includes an annual evaluation of the Quality Improvement Program.
- Ensure care is not withheld or delayed for any reason, including potential financial gain or incentives to HPSM providers. This includes ensuring HPSM does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, and pressure health care providers or institutions to render care beyond the scope of their training or expertise.
- Improve health care delivery and health equity by monitoring and implementing corrective action, as necessary, for access and availability of provider services to members.
- Conduct effective oversight of fully delegated and downstream fully delegated providers.
- Ensure strong collaboration between QI, HE, and other HPSM departments, such as Utilization Management, Population Health, Integrated Care Management, Pharmacy, Provider Services, Marketing & Communications, and Customer Support as needed, to ensure the most effective action is being taken on various QI initiatives.

2.6.2 QUALITY IMPROVEMENT DEPARTMENT (QI 1.A.1)

The Quality Improvement Department reports to the Chief Medical Officer. Responsibilities of the department include:

- Provides the systematic monitoring and measurement of health outcomes, patient safety and member satisfaction and identifies areas of improvement.
- Provide staff support to the Quality Improvement and Health Equity Committee (QIHEC) and Clinical Quality Improvement Committee (CQC).
- Develop initial drafts of the QI Program documents for review and approval by the QIHEC.
- Develop a work plan identifying the responsibilities of the operations that support the program implementation.
- Review and evaluate the work plans and quarterly reports of the sub-committees reporting to the CQC
- Assist in the review and evaluation of delegates reports.
- Assist in data collection for selected components of contractual reporting requirements for external review agencies.
- Develop and implement systematic data collection methodologies.
- Assist in the development of research design and methodologies for disease management and health promotion programs.
- Monitor the QI Program to assure compliance with regulatory and accrediting agency requirements.
- Assist in the development of company-wide policies and procedures related to Quality Improvement.

2.7 POPULATION HEALTH MANAGEMENT (PHM) PROGRAM OPERATIONS & OVERSIGHT

The Population Health Management (PHM) team maintains the oversite of the PHM Program Strategy and is responsible for associated reporting. PHM and Health Promotion team leads many PHM initiatives and programs especially those programs aimed at keeping members healthy, managing emerging risk, and improving outcomes across settings/patient safety. The PHM team is also responsible for conducting ongoing population assessments and impact analysis to better inform PHM programming. Several other PHM program operations such as those focused on delivery support systems and complex case management are integrated throughout various HPSM departments. Collectively, PHM Strategy operations and various programs are integrated throughout the following units:

- Health Promotion/Health Education
- Culturally & Linguistically Appropriate Services
- Care Coordination
- Complex Case Management
- Care Transitions
- Behavioral Health & Integrated Services
- Pediatric Health
- Pharmacy Services
- Provider Services

Depending on the topic, PHM reports and program updates are provided regularly to MEC, CQC, QIHEC, committees annually.

Please refer to HPSM's Population Health Management (PHM) Program Strategy for more detailed description of the various programs**.**

2.8 BEHAVIORAL HEALTH SERVICES (QI 1, A, 2)

HPSM's behavioral health management strategy provides behavioral healthcare services to members in order to achieve the best possible clinical outcomes with the most efficient use of resources. Timely, high-quality care, delivered by the appropriate provider in the least restrictive treatment setting is the key to achieving that objective. Behavioral Health Program supports members achieving and maintaining healthy, productive lifestyles.

Behavioral health benefits are structured as follows:

- Members with Serious Mental Illness are served by San Mateo County Behavioral Health and Recovery Services (BHRS) under the carve out of Specialty Mental Health Services.
- Medi-Cal members requiring Applied Behavioral Analysis (ABA) are served by Magellan Health Services which functions as a delegated entity under HPSM. Medi-Cal members under 21 years old receive medically necessary BHT services whether or not the member has an autism diagnosis under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.
- Medi-Cal members under 21 receive even more comprehensive services under the EPSDT benefit including mental health, developmental and specialty services.
- Members covered under other lines of business are also served by BHRS which is a delegated entity under HPSM.
- Addiction treatment services are largely carved out and are managed by BHRS.

HPSM staff work closely with San Mateo County BHRS to oversee and monitor the behavioral health benefit. These activities include but are not limited to assessing member satisfaction with behavioral health services;

ensuring the network is of sufficient size and location for routine behavioral health services (emergency services are carved out); and studying efforts to improve clinical outcomes for members with depression who are screened and treated in the primary care setting. HPSM regularly monitors the continuity and coordination of care between medical and behavioral health practitioners, including facilitating interdisciplinary care teams and conducting case reviews for members with behavioral health conditions and complex medical needs as necessary. HPSM also measures and reviews access to behavioral health services, such as timely follow-up with behavioral health after hospitalization or emergency department visit for mental health condition.

2.9 QIHE PROGRAM AUTHORITY AND RESPONSIBILITY

The San Mateo Health Commission (Commission) assumes ultimate responsibility for the Quality Improvement (QIHE) Program and has established Quality Improvement and Health Equity Committee (QIHEC) to oversee this function. The Commission plays a key role in monitoring the quality of health care services provided to members and improving quality services delivered to our members. The Commission authorizes and designates the Chief Executive Officer (CEO) as the individual responsible for the implementation of the QIP. The CEO has delegated oversight of the day-to-day operations of the QIHE Program to the Chief Medical Officer (CMO) and Chief Health Officer (CHO).

The Quality Improvement and Health Equity Committee (QIHEC), the Chief Medical Officer and Chief Health Officer have the responsibility for planning, designing, implementing, evaluating and coordinating patient care, clinical quality improvement, and health equity activities. The QIHEC reports on QIHE Program activities to the Commission.

Performance accountability of the Commission includes:

- Annual review and approval of the Quality Improvement and Health Equity Program description, Quality Improvement and Health Equity Work Plan and the Quality Improvement and Health Equity Program Evaluation.
- Review status of QIHEP and annual work plan at least quarterly.
- Evaluate effectiveness of QIHE activities and provide feedback to the QIHEC as appropriate.
- Establish direction and strategy for the QIHE Program.

2.9.1 ROLE OF THE CHIEF MEDICAL OFFICER (QI 1.A.3)

The Chief Executive Officer (CEO) has appointed the Chief Medical Officer (CMO) as the designated physician to support the Quality Improvement Committees outlined in this program by providing day-to-day oversight and management of all quality improvement activities. The Chief Medical Officer is responsible for:

- All activities requiring day-to-day physician involvement. The Chief Medical Officer may delegate performance of any of these responsibilities to other physicians within the Health Plan.
- Directing the Health Services Department and the various functions under its umbrella, including Quality Improvement, Credentialing, Utilization Management, Complex Case Management, Behavioral Health Services (as covered by product line) and Pharmacy (as covered by product line). The Chief Medical Officer may consult with a contracted psychiatrist (designated behavioral health care practitioner), as necessary, for behavioral health issues.
- Communicating with the San Mateo Health Commission (Commission) information from the Quality Improvement Committee (QIC), the Clinical Quality Committee (CQC), the Credentialing Sub-Committee, the Utilization Management Committee (UMC), and the Pharmacy and Therapeutics Committee (P&T).
- Communicating feedback from the Commission to the above listed committees.

- Serving as chair for the QIHEC, and the Credentialing/Peer Review/Physician Advisory Committee.
- Providing clinical oversite to the Clinical Quality Committee (CQC)
- Serving as the co-chair for the UMC and P&T.
- Overseeing meeting preparations for the above committees, educating committee members regarding the principals of quality improvement, keeping the committees and organization current with the regulations and standards of the California Department of Health Care Services, Center for Medicare and Medicaid Services (CMS) and NCQA.
- Ensuring that the goals, objectives and scope of the QIHE Program are interrelated in the process of monitoring the quality of clinical care, clinical safety and services to members. The Chief Medical Officer will not be influenced by fiscal motives in making medical policy decisions and establishing medical policies.
- Ensuring that a review and evaluation of the components of the QIHE Program are performed annually in order to demonstrate that the process is effective in improving member care, safety and services.
- Providing oversight to the implementation of the Quality Improvement and Health Equity Program (QIHEP).
- Guiding the formulation of quality indicators and clinical care guidelines in collaboration with network practitioners.
- Providing direct oversight of the credentialing and re-credentialing process.
- Developing or approving policies and procedures for quality improvement, credentialing, preventive health, utilization management, pharmacy management and behavioral health.
- Reviewing aggregated outcomes from member complaints and grievances, member satisfaction surveys and practitioners' satisfaction surveys.
- Overseeing the development of member and practitioner education relation to QIHE Program issues.
- Ensuring that quality of care is a component in all policy development related to health care services.
- Communicating directly with practitioners on any issues of the QIHEP to include quality of care; peer review; credentialing; or clinical care guidelines.
- Assisting the senior management team in the analysis, design and implementation of interventions to improve health care service delivery.
- Communicating information and updates regarding the QIHE Program to HPSM leadership and staff via general staff, senior management team meeting, and other internal meetings.
- Delegating staff from other divisions to perform QIHE Program activities by agreement of appropriate division chief.

2.9.2 ROLE OF PARTICIPATING PRACTITIONERS

Participating practitioners serve on the QIHE Program Committees as necessary to support and provide clinical input. Through these committees' activities, network practitioners:

- Review, evaluate and make recommendations for credentialing and re-credentialing decisions;
- Review individual medical records reflecting adverse occurrences;
- Participate in peer review activities;
- Review and provide feedback on proposed medical/dental guidelines, preventive health guidelines, clinical protocols, disease management programs, quality and HEDIS results, new technology and any other clinical issues regarding policies and procedures;
- Review proposed QIHE study designs; and
- Participate in the development of action plans and interventions to improve levels of care and service.

2.9.3 INVOLVEMENT OF DESIGNATED BEHAVIORAL HEALTH PRACTITIONER (QI 1.A.4)

Health Plan of San Mateo has designated a behavioral health practitioner, a psychiatrist, for the QIHE Program. The designated behavioral health practitioner advises the Quality Improvement Committee (QIHEC) to ensure that the goals, objectives and scope of the QIHEP are interrelated in the process of monitoring the quality of behavioral health care, safety and services to members.

HPSM's current CMO is a board certified psychiatrist. HPSM also employs a Chief Health Officer, a clinical psychologist, who is responsible for leading the clinical and administrative management of HPSM's Behavioral Health Integrated Services programs across all lines of business. Their key functions include, but are not limited to:

- Management and oversight of key delegated relationships with BHRS and the BHT administrator
- Review and guidance in the development and monitoring of quality improvement metrics, studies and interventions for behavioral health and substance use conditions and related services.
- Participation in the Clinical Quality Improvement Committee (CQC);
- Development of behavioral health and substance use clinical criteria;
- Review of potential quality incidences (PQIs) involving behavioral health and substance services, facilities or practitioners;
- Creation and review of quality improvement, care coordination and utilization management policies and procedures for behavioral health and substance use services

2.9.4 RESOURCES AND ANALYTIC SUPPORT (QI 1.A.1)

Quality Improvement is a data driven process. Health Plan of San Mateo maintains an information data system appropriate to provide tracking of multiple data sources for implementing the QIHE Program. These sources include, but are not limited to, the following:

- Encounter data
- Claims data
- Pharmacy data
- Laboratory data
- Medical records
- Dental records
- Utilization data
- Utilization case review data
- Practitioner, provider and member complaint data
- Practitioner, provider and member survey results
- Appeals and grievance information
- Statistical, epidemiological and demographic member information
- Authorization data
- Enrollment data
- HEDIS data
- Behavioral Health data
- Risk Management data

In addition, Health Plan of San Mateo staff and analytical resources include, but are not limited to:

- Quality Improvement
- Health Education/Health Promotion
- Population Health Management
- Utilization Management
- Customer Support
- Case Management

- Provider Services
- Health Information Managment
    - Health Data Analysts
    - Information Systems Analysts
    - Biostatisticians
    - Statistical Analysis System (SAS) software suite – a comprehensive system for analyzing data

The Quality Improvement and Health Equity Committee uses the above data and resources to fully evaluate and develop objectives or quantitative methods in order to define the specific problem. The Committee must proceed to implement a problem solving action based on its findings and the objective parameters measured. After adequate time has been permitted for problem resolution, a re-evaluation is performed using the same quantitative measures. The Committee bases the re-evaluation time frame (1 month, 3 months, 6 months, etc.) on the severity of the problem identified. The steps outlined below must be supported by adequate documentation of a problem-oriented approach to quality improvement:

- Define of specific indicators of performance through monitoring process
- Collect and analysis of appropriate data
- Identify opportunities to improve performance
- Implementation of interventions and/or guidelines to improve performance
- Measure effectiveness of interventions and/or conformance to guidelines
- Re-evaluate for further potential performance improvements with the same quantitative measures

2.9.5 DELEGATED QIHE ACTIVITIES (QI 1.A.1)

Health Plan of San Mateo may delegate Utilization Management, Quality Improvement and Health Equity, Credentialing, Member Rights and Responsibilities, Medical Record and Facility Review, Claims payment and Preventive Health activities to Health Plans, County entities, and/or vendors who meet the requirements as defined in a written delegation agreement and delegation policies and according to NCQA accreditation and regulatory standards.

To ensure that delegates meet required performance standards, HPSM:

- Provides oversight to ensure compliance with federal and state regulatory standards, and NCQA standards for accreditation.
- Reviews and approves program documents, evaluations, and policies and procedures relevant to the delegated activities.
- Conducts required pre-delegation activities
- Conducts annual oversight audits
- Review reports from delegated entities
- Collaborates with delegated entities to continuously improve health service quality

The Delegation Oversight Committee oversees the delegate's compliance with delegation agreements/documents. HPSM monitors delegated compliance through an annual oversight review. Review includes appropriate policies and procedures, programs, reports and files may be reviewed at this time. Should an improvement action plan be required of the delegate, HPSM will review and approve the plan and perform follow-up tracking of compliance in accordance with stated time frames. If the delegated activities are not being carried out in accordance with the terms of the delegation agreement and/or improvement action plan, corrective action (up to and including revocation of delegated status) may be implemented. Delegated oversight review results are reported to the QIHEP committees as appropriate and to the QIHEC.

2.9.6 COLLABORATIVE QIHE ACTIVITIES (QI 1.A.1)

Collaborative activities. If the organization collaborates with other organizations on QIHE activities:

- It includes information about the collaborative and QIHE activities performed in the QIHE program description.
- It has communication and feedback mechanisms between the collaborative group and its internal QIHE Committee.

If the collaborative group has its own QIHE committee for carrying out functions, the organization may consider it to be a subcommittee of the QIHE Committee.

2.9.7 ANNUAL REVIEW AND UPDATE OF QUALITY IMPROVEMENT AND HEALTH EQUITY PROGRAM

The purpose of the annual QIHE Program Evaluation by the QIHEC is to determine if quality improvement and health equity processes and recommendations made throughout the year result in demonstrated quality improvements in health care, health equity, disease prevention and the delivery of health care services to members.

The annual evaluation assesses whether the QIHEP activities are systematically tracking improvement projects, resulting in improved clinical care and services, and providing appropriate follow-up of corrective actions to monitor their effectiveness. The QIHEC is responsible for assessing reports, analyzing study and survey findings, and identifying areas of care, which demonstrate improvement and other areas, which may still require interventions. Once a determination is made, the program plan is evaluated to see if certain processes require modification. A final report, including QIHEP program recommendations is submitted to the Commission for annual approval. The following aspects of the Quality and Health Equity Departments activities are assessed during the annual plan evaluation:

- Ongoing surveillance of quality indicators for the year
- Quality improvement projects (goals and objectives) for the year
- Tracking of previously identified issues requiring continued surveillance
- Quality improvement review of the QIHEP and outcome results from the previous year
- Evaluation and modification, if necessary, of the QIHEP for the upcoming year
- Implementation of the quality improvement strategy
- Promotion of the development of an effective quality improvement program based on quality improvement strategies
- Completion of the work plan in a timely basis
- Determination if additional resources are necessary to accomplish the quality improvement strategy, and
- Recommendations for needed changes in the quality improvement program or administration

Practitioners and members are notified annually that a summary of the QIHEP is available upon request. This summary included information about the QIHEP's goals, processes, and outcomes as they relate to member care and service.

2.9.8 ANNUAL QUALITY IMPROVEMENT AND HEALTH EQUITY WORK PLAN

Annually the QI and HE departments develop QIHE Work Plans for the calendar year. The Work Plans integrates QIHE reporting, studies from all areas of organization (clinical and service) and includes requirements for external reporting. The QIHE Work Plans are based on the results of the annual program evaluation.

The Work Plans include the following elements:

- Measurable objectives for each QIHE activity planned for the year, including patient safety
- Program scope

- Activities planned for the year, the quality, and safety of clinical care and service indicators, benchmarks, performance goals and previous year results
- Timeframe within which each activity is to be completed.
- The person responsible for initiation, implementation, and management of each activity
- Planned monitoring and follow-up activities from previously identified issues
- Time frame for evaluation of the effectiveness of the QIHE Program.

Planned Additions to the QIHE Work Plans include:

- Scheduled reports to the QIHEC and the Commission
- Scheduled reporting to external regulators (i.e. DHCS)
- The oversight of reporting delegated activities
- Schedules of all planned quality activities (i.e. member satisfaction surveys, practitioner compliance surveys)

2.9.10 APPROVAL OF THE QUALITY IMPROVEMENT AND HEALTH EQUITY PROGRAM

Annually, following each review and update, the Quality Improvement and Health Equity Program description and work plan is reviewed and approved by the Quality Improvement and Health Equity Committee, the Chief Medical Officer, the Chief Health Officer, and the San Mateo Health Commission. The approval process includes the authorized signatures at each level of review.

3. QUALITY IMPROVEMENT AND HEALTH EQUITY PROGRAM COMMITTEES

QIHE PROGRAM COMMITTEE MEETINGS

The Quality Improvement and Health Equity Committee (QIHEC) and subcommittees convene at regularly scheduled meetings, or more often is the chairperson deems it necessary; minimum frequency for QIHEC meetings will not extend beyond a quarterly basis.

A quorum consisting of either four members or 50% of the members, whichever is less, must be present for any QIHE Program committee to conduct business. If a quorum cannot be assembled within thirty (30) minutes of the scheduled meeting, those in attendance will select an alternate date and time. The committee members in attendance may decide to continue the meeting for discussion items only, holding all action items or business until a quorum is assembled, or elect to adjourn.

The chairperson, with the assistance of the co-chair, is ultimately responsible for notifying committee members about the meeting schedules. Reminder phone calls will be placed to the committee members a minimum of three (3) days prior to the scheduled meeting to encourage participation. An agenda and any necessary reading materials will be emailed to participants in advance to expedite the meeting time and prepare for discussion.

QIHE PROGRAM COMMITTEE MINUTES

Comprehensive, accurate minutes are prepared and maintained for each QIHE Program regular or ad hoc meetings. Minutes include at a minimum, the name of the committee, date, list of members present, and the names and titles of guests, if applicable. The minutes reflect all decisions and recommendations, including rationale for each, the status of any activities in progress, and a description of the discussions involving

recommended studies, corrective action plans, responsible person, follow-up and due date. Minutes of the QIHE Program committees' meetings are provided for review to the:

- Committee members
- San Mateo Health Commission, and
- Regulatory bodies (as required and applicable).

QIHE PROGRAM COMMITTEE AGENDAS

The QIHE Program Committees agendas shall follow the basic outline:

- Review of Minutes
- Unfinished Business
- Ongoing Reports
- Review of Protocols/Policies
- New Business

Copies of all minutes, reports, data, medical records and other documents used for quality or utilization review purposes, are maintained in a manner that will ensure confidentially of the members and providers involved in each case. Access to these records is restricted to the QIHE Program committees' members and selected administrative personnel as deemed necessary (i.e., CEO, legal staff/counsel, Commission). All sensitive information, medical records and QIHEC findings are maintained in secure files.
QIHE Program reports, minutes, audit results and other Quality Improvement and Health Equity documentation, including a written summary of HPSM's QIHEC activities, findings, recommendations, and actions prepared after each meeting, are distributed for review to the:

- Chief Medical Officer
- Chief Health Officer
- Chief Executive Officer
- San Mateo Health Commission
- QIHEC Committee members
- Regulatory bodies (as requested, required, and applicable)
- Public through HPSM's website on at least a quarterly basis (written summary of QIHEC activities, findings, recommendations, and actions, only; including summaries fully delegated subcontractors and downstream fully delegated subcontractors QIHEC).

All distributed copies are collected and destroyed after review; originals are maintained in secured files by committee chair and/or co-chair.

QIHE PROGRAM COMMITTEE RESPONSIBILITIES AND FUNCTIONS

- Review the QIHE Program Description that establishes strategic direction for HPSM and forward to the Commission for approval.
- Evaluate the Quality and Health Equity Work Plans, which includes providing feedback and recommendations to the appropriate sub-committee department and forward to the Commission for approval.
- Evaluate the effectiveness of the QIHE Program with input from other committees and departments annually.
- Receive, review and analyze status reports on the implementation of Work Plans, including aggregate trend reports and analysis of clinical and service indicators.
- Appoint subcommittees and ad hoc committees as needed.
- Ensure that system-wide trends are identified and analyzed.
- Ensure that quality improvement and health equity efforts are prioritized, resources are appropriate, and resolutions occur.

- Prioritize quality improvement and health equity efforts and assure that resources are allotted.
- Approve Quality Improvement and Health Equity Program policies.
- Ensure appropriate oversight of delegated activities.
- Ensure integration, coordination, and communication among committees reporting to QIHEC.

QIHE PROGRAM COMMITTEE MEMBERS (QI 1.A.1)

For staff participants, qualifications and term of service as a Committee member is determined by the duration of time a staff member holds the position, which initially qualified him/her for Committee membership (i.e. term of service continues as long as the Quality Improvement Director holds his/her position which is also a designated position on the QIHEC).

Selected contracted practitioners and providers are invited to serve as members of a QIHE Committee by the chairperson or co-chair. Selection is based on the following attributes:

- Availability/accessibility
- Board certification
- Communication skill/diplomacy
- Credentials/re-credentials verification
- Interest/enthusiasm
- Knowledge/expertise
- Managed care knowledge/experience
- Medical/surgical experience
- Peer/personal recommendation
- Previous quality committee experience
- QM audit results greater than average
- Reputation/ethical standards
- Specialty type
- Serves one or more of the following member populations:
    - Members affected by health disparities
    - Limited English Proficiency (LEP) members
    - Children with Special Health Care Needs (CSHCN)
    - Seniors and Persons with Disabilities (SPD)
    - Persons with chronic conditions
- *HPSM utilizes findings from the annual population needs assessment (PNA) to ensure that committees reflect varied perspectives across race, ethnicity, language, gender identity, sexual orientation, and disability status. The committee chair will present HPSM member demographic information following the completion of the annual PNA and whenever a committee position becomes available. HPSM will utilize PNA findings to identify and invite diverse candidates to apply for open committee seats, ensuring ongoing diversity within our committees.*

A practitioner representative selected to participate on any QIHE Committee continues to serve as long as he/she continues to qualify as a contracted practitioner whose specialty is required on the Committee panel and meets acceptable standards of behavior, with the following exceptions:

- Practitioner requests voluntary removal or
- Involuntary request for removal may be made when a provider:
    - Is no longer qualified
    - Is repeatedly unavailable (unexcused absences from three consecutive meetings)
    - Develops a conflict of interest

- Behavior is disruptive and not conducive to effective, professional discussions and performance of business
- Fails to meet QIHEP expectations

REPORTING RELATIONSHIPS OF QIHE STAFF, FULLY DELEGATED SUBCONTRACTORS AND DOWNSTREAM FULLY DELEGATED SUBCONTRACTORS, AND THE QIHE PROGRAM COMMITTEES (QI 1.A.1)

Methods of communication include, but are not limited to, quality improvement and health equity reports, oral presentations and discussions, memorandums, policies and procedures and meeting minutes. HPSM monitors providers through quality monitoring and on-site inspections and audits. The Quality Improvement Director and Population Health Director are the focal points for convergence of quality improvement and health equity related activities and information.

The QI Director and PH Director are responsible for the coordination and distribution of all QIHE Program related data and information, including that of any fully delegated subcontractors and downstream fully delegated subcontractors. The Quality Improvement and Health Equity Committee (QIHEC) reviews, analyzes, makes recommendations, initiates actions, and/or recommends follow-up based on the data collected and presented. The Chief Medical Officer and Chief Health Officer communicates the QIHEC's activity to the Commission. The Commission reviews QIHE activities. Any concerns of the Commission are communicated back to the source for clarification or resolution.

Fully delegated subcontractors and downstream fully delegated subcontractors are required to maintain a QIHEC in compliance with DHCS contract section Exhibit A, Attachment III, Section 2.2.3.E, and to report to HPSM's QIHEC on at least a quarterly basis.

CONFLICT OF INTEREST

Health care providers serving on any QIHE Program Committee, who are/were involved in the care of a member under review by the committee, are not allowed to participate in discussions and determinations regarding the case. In addition, committee members cannot review cases involving family members, providers with whom they have a financial or contractual affiliation or other similar conflict of interest issues. Prior to participating in any QIHE Program activities, committee members are required to sign a Conflict of Interest statement, which is maintained on file in the Quality Department.

CONFIDENTIALITY

Because of the goals and objectives of the QIHE Program, sensitive and confidential information is often discussed during CQC and Credentialing Sub-Committee meetings. All participants understand that information and parties under investigation or discussion by the Committee members are considered confidential. Prior to participating in CQC and Credentialing activities, committee members are required to sign a Confidentiality Statement which is kept on file in the Quality Department.

3.1 QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE OVERSIGHT (QIHEC) (QI 1, A, 5)

The Quality Improvement and Health Equity Committee (QIHEC) establishes strategic direction, recommends policy decisions, analyzes and evaluates the results of QIHE activities, including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other QIHE Program Committees, and ensures practitioner participation in the QIHE program through

planning, design, implementation, or review. The QIHEC ensures that appropriate actions and follow-up are implemented and evaluates improvement opportunities. The QIHEC meets and reports at least quarterly to the Commission. The QIHEC is a multi-disciplinary committee, the membership includes at least one Commission member, (Current chair & co-chair) and a broad range of practicing network physicians. Facilitating staff include the Chief Medical Officer, Chief Health Officer, Quality Improvement Director, Population Health Director, and Dental Director. Support staff and guests will be invited to attend the meetings as reporting requirements dictate.

3.2 CLINICAL QUALITY COMMITTEE (CQC)

The Clinical Quality Committee advises QI program activities and procedures performed to monitor and evaluate the quality, safety, and appropriateness of health care. The CQC meets at least quarterly and reports up to the QIC.

CQC RESPONSIBILITIES

- Clinical Oversight
    - Provide clinical oversite and guidance on quality, population health and community support programs and initiatives throughout development, monitoring, and ongoing evaluation phases. Including:
    - Analyzing demographic and epidemiological data.
    - Identifying at-risk member populations.
    - Selecting disease management clinical practice guidelines and quality activities.
    - Developing, communicating, and implementing clinical practice guidelines based on current medical standards of care.
    - Identifying sub-optimal care through the analysis of data referred from all departments.
    - Reviewing and approving identified trends, opportunities for improvement and recommendations for strategies to prevent adverse outcomes.
    - Identifying practitioners/providers not complying with HPSM medical care standards, service standards, guidelines and/or policies and procedures.
    - Reviewing and approving action plans for practitioners/providers in collaboration with company-wide departments.

- Evaluation Guidance & Review
    - Provide oversite and guidance on the evaluation of clinical, population health and community support programs planning and execution to foster a culture of continuous quality improvement.
- Compliance
    - Ensure HPSM's compliance with regulatory requirements that govern clinical programs, clinical quality initiatives, population health management, and community support programs and initiatives
    - Oversee the development of policies, activities and procedures that meet requirements provided by State and Federal regulators and the National Committee for Quality Assurance.
    - Delegation Oversite for Quality Improvement and Population Health Management Functions:
        - establishing performance standards,
        - monitoring performance through regular reporting, and
        - evaluating performance annually
        - provide findings and recommendations to the Delegation Oversight Committee for action for the delegate as needed

CQC MEMBERS

The Clinical Quality Committee consists of the representatives from the departments listed below. Additional participants and staff representatives provide useful information and/or serve as liaisons to their respective departments.

- Chief Medical Officer
- Chief Health Officer
- Medical Directors
- Dental Director
- Director of Quality Improvement
- Director of Provider Services
- Director of Pharmacy
- Director of Health Information Management
- Director of Behavioral Health
- Director of Integrated Care
- Director of Population Health
- Director of Medicare
- Manager, Clinical Oversight & Monitoring
- Manager, Integrated Care Management
- Manager, Population Health
- Clinical Quality Improvement Manager
- Manager, Integrated Programs

CQC MEMBER RESPONSIBILITIES

CHIEF MEDICAL OFFICER:

- Serves as the Committee co-chairperson
- Reports CQC activities to QIHEC and Commission

QUALITY IMPROVEMENT DIRECTOR:

- Serves as the Committee co-chairperson
- Reports CQC activities to the QIHEC, in the absence of the Chief Medical Officer
- Develop mechanisms to collect, store and profile data
- Reports summaries of site inspections, quality indicator screens, medical records audits, environmental health and safety/infection control issues, risk management issues and other issues as indicated to the Committee

3.3 CREDENTIALING AND PEER REVIEW COMMITEE

The committee is responsible for the review of credentialing files and makes decisions regarding credentialing and re-credentialing of practitioners. The Credentialing Committee makes decisions regarding provider organizational credentialing/re-credentialing. The committee is responsible for the review of performance data at the time of re-credentialing and making on-going contract recommendations as a result of re-credentialing.

The Credentialing sub-committee serves as the practitioner Peer Review Committee. Peer review issues are presented for review discussion and determination of appropriate improvement action plans. The committee makes a reasonable effort to obtain the facts and conduct – hearing procedures for health care practitioners.

The committee meets at least quarterly. The functions of the Credentialing Committee are:

- Review, recommend, and approve procedures for practitioner/provider credentialing/re-credentialing.
- Review and provide final decision of practitioner/provider credentials reviewed and presented by the CMO, or designee, that did not meet "clean file" category.
- Review and approve a practitioner/provider profile with input from all departments that analyze performance in conjunction with the re-credentialing process.
- Review and approve credentialing/re-credentialing standards/policy and procedures.
- Review and approve quality of care and service indicators for re-credentialing.
- Review of delegated credentialing performance.

3.4 PHARMACY AND THERAPEUTIC (P&T) COMMITTEE

The Pharmacy & Therapeutic (P&T) Committee meets and reports to the Commission at least quarterly. The Chief Medical Officer and Pharmacy Director serve as co-chairs.

P&T COMMITTEE MEMBERSHIP:

- Chief Medical Officer
- HPSM Pharmacists
- Network primary and specialty care practitioners
- Pharmacy Services Director

P&T COMMITTEE RESPONSIBILITIES AND FUNCTIONS:

- Formulating policies on the evaluation, selection, distribution, use and safety procedures relating to medication therapy.
- Developing and maintaining the Drug Formulary.
- Monitoring activities related to the Formulary Exception Policy.
- Monitoring prescribing practices and drug utilization for appropriateness.
- Submitting quarterly report to the Commission of the status of all activities.

3.5 UTILIZATION MANAGEMENT COMMITTEE (UMC)

The Utilization Management Committee provides direction to and oversight of the Utilization Management Program (UMC). The UMC meets at least quarterly and reports to the QIC quarterly. The Chief Medical Officer serves as the chair.

The UMC is a multi-disciplinary committee whose members include:

- Chief Medical Officer
- Medical Directors
- Dental Director
- UM Manager
- Director of Pharmacy
- Director of Health Services Analytics
- Director of Behavioral Health
- Director of Integrated Care
- Manager, Clinical Oversight & Monitoring
- Manager, Integrated Care Management
- Manager, Population Health

- Manager, Integrated Programs
- Quality Improvement staff representative
- Network practitioners as appropriate

UMC RESPONSIBILITIES AND FUNCTIONS

- Reviews and approves the UM Program Description that establishes direction for the organization
- Receives, reviews, and analyzes utilization reports on the progress of the UM Program
- Conducts new technology assessment
- Reviews recommendations for delegation of utilization management and makes recommendations to the QIHEC
- Formalizes UM policies and procedures
- Monitoring of delegated UM; monitoring of CAPs for delegated UM
- Conducts under/over utilization monitoring on practitioner specific and organizational-wide dimensions
- Evaluates satisfaction with the UM Program using member and practitioner input.

3.6 MEMBER EXPERIENCE AND ENGAGEMENT COMMITTEE (MEC)

The Member Experience and Engagement Committee(MEC) was established in 2019 as an interdisciplinary committee to assess and enhance efforts to improve member experience, as well as ensure the quality, safety, and appropriateness of services provided through HPSM to members. The Member Experience and Engagement Committee meets monthly. The Director of Population Health Management is the chairperson.

The MEC membership includes representation from the following departments:

- Behavioral Health & Integrated Services
- Care & Transitions Coordination
- Customer Support
- Population Health Management
- Health Information Management
- Marketing & Communications
- Grievance and Appeals

MEC RESPONSIBILITIES AND FUNCTIONS

Responsibilities of the MEC include reviewing and making recommendations for interventions to improve all service activities relative to:

- Reporting on Complaints and grievances
- Member and Provider Appeal trends
- Member satisfaction survey data
- Telephone and turnaround time standard performance
- Access and availability
- Enrollment service standards
- Plan operations
- Member satisfaction/dissatisfaction with providers

4. PATIENT SAFETY

Health Plan of San Mateo is committed to an ongoing collaboration with network practitioners, providers and vendors to build a safer health system. This will be accomplished by establishing quality initiatives that promote best practices, tracking outcomes and educating providers and members. The goals of the safety program include, but are not limited to:

- Informing and educating members and providers of issues affecting member safety
- Developing strategies to identify safety issues and promote reporting

HPSM also has a Potential Quality Issues (PQI) program that identifies deviations from expected provider performance or clinical care, as well as issues with the outcome of care. This is accomplished through the systematic evaluation of a variety of sources, such as grievances, utilization, medical/dental record and facility site reviews. Potential Quality Issues can also be referred by HPSM staff and providers. The reporting and processing of PQIs determines opportunities for improvement in the provision of care and services to HPSM members. Appropriate actions for improvement will be taken based on PQI outcomes.

ADMINISTRATIVE PATIENT SAFETY ACTIVITIES

In addition to the activities listed below, HPSM participates in many other patient safety activities. These activities include, but are not limited to:

- Conducting office site reviews as a part of the initial practitioners credentialing process, upon office relocation, and triennially thereafter
- Conducting a rigorous credentialing and re-credentialing process to ensure only qualified practitioners and organizations provide care in the network
- Establishing a process that monitors the continuity and coordination of care between the medical delivery system and behavioral healthcare, and between the medical delivery system and health delivery organizations.

RISK MANAGEMENT

The purpose of the Risk Management component of the QI Program is to prevent and reduce risk due to adverse member occurrences associated with care or service. The risk management function involves identifying potential areas of risk, analyzing the cause and designing interventions to prevent or reduce risk. The activities of Quality Improvement, Utilization Management, Customer Support, Pharmacy Services, Provider Services related to risk management will be coordinated.

MECHANISMS FOR COMMUNICATION

- HPSM website
- Newsletters
- Drug safety recalls, refill history and dosage alerts
- Safety specific letter to individual practitioners, providers or members

MONITORING AND EVALUATION

Patient safety activities will be monitored continuously and will be trended and reported quarterly. The Patient Safety Program will be evaluated annually.

4.1 SAFETY OF CLINICAL CARE ACTIVITIES

4.1.1 PRACTITIONER COMPLIANCE MONITORING

Health Plan of San Mateo will continue monitoring and evaluating practitioners' compliance with policies and procedures through on-site provider compliance surveys. The purpose of this monitoring is to ensure

compliance with established protocols and policies, as well as to assist in the implementation of corrective action plans, as indicated.

During each compliance survey, a site facility inspection will be conducted along with a review of medical records. The medical record score is based on a survey standard of at least ten randomly selected records per provider.

Upon completion of the review, the provider will be handed the completed survey tool, a summary of findings and a corrective action plan, if required. A corrective action plan is required for specific deficiencies noted. For compliance rating of "conditional pass" and "not pass" a follow-up survey is conducted.

4.1.1.1 FACILITY SITE REVIEWS (FSR)

HPSM conducts provider site reviews for all new Medi-Cal PCPs as a pre-contractual requirement prior to initial credentialing. HPSM conducts provider re-credentialing site reviews triennially for Medi-Cal Primary Care Providers, as a requirement of participation in the California State Medi-Cal Managed Care Program, regardless of the status of other accreditations and/or certifications. A full scope review is conducted utilizing the criteria and guidelines of California Department of Health Services Medi-Cal Managed Care (MMCD APL 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review).

Full Scope Facility Site Review
New providers are required to have a site review within thirty days of signing a contract with HPSM. If an overall score is less than 90%, there is a deficiency in a critical element, Pharmacy or Infection Control a Corrective Action Plan (CAP) is required to be completed by the provider. The provider will be placed in EPO (established patients only) until all CAP corrections have been addressed.

HPSM will review sites more frequently when determined necessary based on monitoring, evaluation or Corrective Action Plan (CAP) follow-up needs. Additional site reviews may be performed pursuant to a request from the Peer Review Committee, the Quality Improvement Committee, and the San Mateo Health Commission. Reviews may also be done at the discretion of the Medical Director or the Quality Improvement Nurse if patient safety or compliance with applicable standards is in question. A Facility Site Review is also required upon relocation of the provider's office.

The same audit criteria applicable for Initial Full Scope Site Review are applicable for subsequent site reviews.

The six areas of focus for the site review are:

- Access/Safety
- Personnel
- Office Management
- Clinical Services
- Preventive Services
- Infection Control

4.1.1.2 MEDICAL RECORD REVIEW (MRR)

Medical records are reviewed initially for each PCP as part of the site review process and every three years thereafter. During any medical record survey, reviewers have the option to request additional records for review.

Sites where documentation of patient care by multiple PCPs occurs in the same record are reviewed as a "shared" medical record system. Shared medical records are considered those that are not identifiable as "separate" records belonging to any specific PCP. A minimum of 10 records will be reviewed for an individual PCP or when two to three PCPs share records, 20 records are reviewed for four to six PCPs, and 30 records are reviewed for seven or more PCPs.

Medical records of new providers are reviewed within 90 calendar days of the date on which members are first assigned to the provider. An extension of 90 calendar days may be allowed *only if* the new provider does not have sufficient HPSM members assigned to complete a review. If there are still a small number of records for assigned members at the end of six months, a medical record review is completed on the total number of records available, and the scoring is adjusted according to the number of records reviewed.

The criteria assessed by a Medical Record Review are:

- Format
- Documentation
- Continuity/Coordination
- Pediatric Preventive, Adult Preventive and/or OB/CPSP Preventive

4.1.1.3 PHYSICAL ACCESSIBILITY REVIEWS (PAR)

Health Plan of San Mateo conducts a Physical Accessibility Review (PAR) for all existing and new primary care providers, High-Volume Senior and Person with Disabilities (SPD) Specialists, High- Volume SPDs Ancillary Services and CBAS Centers. Also, those defined with five or more SPD encounters per day. The Department of Health Care Services Policy Letter 12-006 and All Plan Letter 15-023 requires Medi-Cal managed care health plan to use FSR Attachments C, D and E appropriate to their provider type in line. Each survey tools comes with the Level of Accessibility and Accessibility Indicators.

Physical Accessibility Reviews are scheduled and performed triennially. Providers who move to a new location will receive a new PAR within 30 calendar days after the date the new site opened for business or HPSM's notification date. If there are no changes to the site and PAR remains the same, a signature and date from the office will be required to indicate there were no changes since the last PAR. Changes include physical changes to the parking lots, exterior building, interior building, restrooms, exams rooms, patient's diagnostic/treatment rooms and participant areas. Attachment 'C' is used for Providers offices or sites. There are 29 critical elements in this tool. If all 29 Critical elements are met, the provider or the sites will receive "Basic Access." If there are one or more deficiencies the provider or the site will receive "Limited Access." Medical Equipment determines if the provider office or the site meets ADA equipment requirements.

Attachment 'D' is used for Ancillary Services which are referred to Diagnostic and Therapeutic services. There are 34 Critical elements in this tool. If all 34 critical elements are met, the site will receive "Basic Access." If there are one or more deficiencies, the site will receive "Limited Access." Medical Equipment determines if the site meets ADA equipment requirements.

Attachment 'E' is used for Community Based Adult Services (CBAS). There are 24 critical elements. If all 24 Critical elements are met, the site will receive "Basic Access." If there are one or more deficiencies the site will receive "Limited Access."

Accessibility Indicators are the following:

Accessibility Indicator Symbols
P= Parking

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

Providers or the site will receive the Physical Accessibility Review results indicating their level of accessibility as well as a list of the accessibility indicators within compliance. Provider Services department will also receive a copy to be published in our HPSM Provider Directory and MMP website. The accessibility level determination is to provide our members with physical limitations with a list of providers that can accommodate their needs, it does not affect the provider's member enrollment.

HPSM will submit to DHCS updated SPD high volume provider documentation by January 31st of each year. Documentation will indicate any changes made to the high-volume benchmarks as a result of the availability of more complete utilization data. If no changes are made, HPSM will respond accordingly to DHCS.

4.1.2 QUALITY ISSUE IDENTIFICATION

To provide overall quality functions, each division and/or department will continually monitor specific important aspects of care. These aspects or activities of care and/or service will include, but is not limited to:

- Access/Availability
- Continuity/Coordination
- Health and Pharmacy Management Systems
- Under/Over Utilization
- Behavioral Healthcare
- Chronic/Acute Care
- High-Risk/High-Volume/Problem Prone Care
- Preventive Healthcare
- Member Satisfaction/Dissatisfaction (Customer Service)
- Member Appeals and Grievances
- Medical Record Documentation
- Clinical Practice Guidelines/Preventive Health Guideline Compliance
- HPSM Service Standards
- Individual Care Review
- Potential Quality Issue Tracking
- Credentialing
- Provider Relations
- Claims Analysis
- Marketing Feedback

The QIC, with input from its reporting committees, will develop and implement a process that addresses improving member safety. The goal of the process is to foster a supportive environment to aid practitioners and organizational providers improve safety in their practice. Activities that may be included in this process are:

4.2 CARE COORDINATION PROGRAMS

- Will continue to assist in the coordination of managed care efforts to reduce or prevent omission or duplicate orders when multiple providers are involved.
- Will continue to monitor emergency room utilization beyond a threshold of two or more times in any quarter to identify the lack of primary care, the absence of coordinated care, potential drug interactions, unnecessary testing and treatments, omission or duplication of care, and/or patient non-adherence with a care plan.

4.3 QUALITY MONITORING ACTIVITIES

- In accordance with regulatory requirements and guidance, the QI team maintains quality oversight for services provided to HPSM Medi-Cal members at the following Medi-Cal contracted facilities:
    - Skilled Nursing Facilities/Long Term Care Facilities including Intermediate Care Facilities/Home For Individuals With Developmental Disabilities
    - Regional Centers
    - Subacute Facilities

- At least annually, unless otherwise requested, quality assurance and improvement findings for our the above-listed are retrieved directly from the respective government websites including CA Department of Developmental Services, California Department of Public and Health CDPH, , which includes survey deficiency results, site visit findings, and compliant findings. The QI team also utilizes CMS resources that offer additional insight on the quality of care for our contracted SNFs.

- For the purposes of reporting, and internal quality improvement initiatives, the QI team utilizes claims data, which includes emergency room visits, healthcare associated infections requiring hospitalizations, and potentially preventable readmissions to identify trends and patterns that warrant further investigation on the quality of care being provided at the respective facility . The requested claims data is reported to DHCS via the template provided by DHCS on a quality basis.

- In addition to the claims data, Potential Quality Issues (PQIs) received for care provided at the above listed facilities are reviewed and included in the quality review. The PQIs are identified through a systematic review of a variety of data sources as applicable, including but not limited to the following sources :
    1. Information gathered through concurrent, prospective, and retrospective utilization review
    2. Referrals by health plan staff or providers
    3. Claims and encounter data
    4. Site reviews
    5. HEDIS medical record abstraction
    6. Medical/dental record audits
    7. Pharmacy utilization
    8. Phone log detail
    9. Grievances

- In efforts to prevent, detect, and remediate identified critical incidents, any identified trends/patterns in the quality of care being provided at our contracted provider sites/facilities Clinical Quality Committee (CQC) on a bi-annual basis.

- As needed, QI will readily collaborate with internal teams to assess the quality and appropriateness of care furnished to members and the efforts provided to support member's community integration.

4.4 DRUG SAFETY

HPSM will continue monitoring for appropriate medication use to ensure the safety of members. These techniques include, but are not limited to:

- Potential drug and drug disease interactions
- Analyzing pharmacy data to identify polypharmacy, potential adverse drug reactions, inappropriate medication usage, excessive controlled substance usage and voluntary drug recalls
- Assuring that affected members and practitioners are notified of FDA or voluntary drug alerts
- Notification and education of members and practitioners of other identified events
- Conducting pharmacy system edits to assist in avoiding medication errors

Working with contracted pharmacies to assure a system is in place for classifying drug-drug interactions and/or notifying dispensing providers of specific interactions when they meet HPSM's severity threshold

4.5 UTILIZATION MANAGEMENT

The concurrent review process has established a medical management process which follows identified participants throughout the healthcare delivery system to ensure optimal delivery of care including transition from acute to subacute, long term care and home settings.

Please refer to Health Plan of San Mateo UM Program Description for more details.

4.6 HEALTH MANAGEMENT PROGRAMS

HPSM will continue working to assist, communicate, and educate patients and practitioners in standard of care in all aspect of specific disease processes. These programs are especially important to help identify over and under-utilization, patient non-compliance, and care that does not meet the standards, thus assisting to reduce adverse medical events. Clinical practice guidelines go hand-in-hand with the disease management programs and addresses patient safety by communicating evidenced based standards of care to practitioners and members.

4.7 QUALITY IMPROVEMENT

- Establishes standards for medical record documentation
- Conducts an on-going medical review process that evaluates key components of documentation to address patient safety
- Establishes a rigorous process for investigation and resolution of complaints, especially quality of service and care complaints against practitioners and providers
- Monitors quality of care indicators to identify patterns and/or trends
  Strives to contract only with hospitals and ancillary providers that are JCAHO accredited or other nationally recognized accreditation organization

5. SERVING MEMBERS WITH COMPLEX HEALTH NEEDS

Health Plan of San Mateo (HPSM) continuously ensures that members with complex health needs receive medically necessary services in a timely manner. HPSM is committed to coordinating care for these members and ensuring access to appropriate specialty and primary care. This includes:

- Providing care coordination/case management services for
    - Members who have multiple comorbidities
    - Members with ESRD
    - Members with malignancies, HIV/AIDS, degenerative disorders
    - Members with significant co-existing medical and behavioral issues
- Identifying and addressing any barriers to care for members with complex needs coordinating care across the continuum

6. SERVING A DIVERSE MEMBER POPULATION

HPSM's DEI training program is a core part of our efforts to advance health equity for our members. It supports us in creating a better relationship and connectivity with HPSM's diverse member population. "Healthy is for everyone" means striving for equitable access to high quality health care services for every person in San Mateo County. The reality is that systemic injustices persist, and health care experiences are not equal for all. HPSM is committed to working towards improvements in this system through our health equity approach. Ongoing education fosters an inclusive environment within HPSM and externally with Network Providers, and other community-based contractors. We empower San Mateo County's residents to live their healthiest lives by building awareness and strong community partnerships. The DEI training program includes sensitivity, diversity, cultural competency and cultural humility, and health equity training programs.

The DEI training program implementation and evaluation progress will be reported to Quality Improvement and Health Equity Committee including at a minimum: training program materials; compliance reports; and any adjustments made to the training program. For more details on the DEI training program, reference HPSM's Culturally and Linguistically Appropriate Services (CLAS) program description.

7. QUALITY IMPROVEMENT AND HEALTH EQUITY PROGRAM ACTIVITIES

The QIHE Program's scope includes implementation of QIHE activities or initiatives. The QIHEC and the subcommittees select the activities that are designed to improve performance on selected high volume and/or high-risk aspects of clinical care and member service.

PRIORITIZATION

Certain aspects of clinical and service may identify opportunities to maximize the use of quality improvement resources. Priority will be given for the following:

- The annual analysis of member demographic and epidemiological data.
- Those aspects of care which occur most frequently or affect large numbers of members.
- Those diagnoses in which members are at risk for serious consequences or deprivation of substantial benefit if care does not meet community standards or is not medically indicated.
- Those processes involved in the delivery of care or service that through process improvement interventions could achieve a high level of performance.

USE OF COMMITTEE FINDINGS

To the degree possible, quality improvement systems are structured to recognize care for favorable outcomes as well as correcting instances of deficient or sub-optimal practice. Most practicing physicians provide care results in favorable outcomes. Quality improvement systems explore methods to identify and recognize those treatment methodologies or protocols that consistently contribute to improved health outcomes. Information of such results is communicated to the Commission and providers on a regular basis. Written

communication to primary practitioners is the responsibility of the Committee chairperson. Submission of written corrective action plans, as necessary, is required for the Committee's approval. Significant findings of quality improvement activities are incorporated into practitioner educational programs, the re-credentialing process, and the re-contracting process and personnel annual performance evaluations. All quality improvement activities are documented, and the result of actions taken recorded to demonstrate the program's overall impact on improving health care and the delivery system.

PREVENTIVE HEALTH/HEDIS MEASURES

The Clinical Quality Committee will determine aspects of care to be evaluated based on member population and regulatory requirements. At a minimum, HEDIS performance indicators will be monitored annually. These include:

- Adult's Access to Preventive/Ambulatory Health Services
- Ambulatory Care
- Antibiotic Utilization
- Antidepressant Medication Management
- Asthma Medication Ratio
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Breast Cancer Screening
- Care for Older Adults
- Cervical Cancer Screening
- Childhood Immunization Status – Combo 10
- Colorectal Cancer Screening
- Comprehensive Diabetes Care
- Controlling High Blood Pressure
- Depression Screening and Follow-Up for Adolescents and Adults
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
- Follow-Up After Emergency Department Visit for Mental Illness
- Follow-Up After Hospitalization for Mental Illness
- Hospitalization for Potentially Preventable Conditions
- Identification of Alcohol and Other Drug Services
- Immunizations for Adolescents
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Language Diversity of Membership
- Lead Screening in Children
- Mental Health Utilization
- Non-Recommended PSA-Based Screening in Older Men
- Oral Evaluation, Dental Services
- Osteoporosis Management in Women Who Had a Fracture
- Persistence of Beta Blocker Treatment After a Heart Attack
- Pharmacotherapy Management of COPD Exacerbation
- Plan All-Cause Readmissions
- Potentially Harmful Drug-Disease Interactions in the Elderly
- Prenatal and Postpartum Care
- Race/Ethnicity Diversity of Membership
- Statin Therapy for Patients with Cardiovascular Disease
- Statin Therapy for Patients with Diabetes
- Topical Fluoride for Children
- Transitions of Care

- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- Use of High-Risk Medications in the Elderly
- Use of Imaging Studies for Low Back Pain
- Use of Opioids at High Doses
- Use of Opioids from Multiple Providers
- Use of Services - Acute Hospital Utilization
- Use of Services – Ambulatory Care
- Use of Services – Emergency Department Utilization
- Use of Services – Inpatient Utilization – General Hospital/Acute Care
- Use of Services – Mental Health Utilization
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Well Child Visits (ages 0-15 months)
- Well Child Visits (16-30 months)
- Well Child and Adolescent Visits (3-21)

7.1 POPULATION HEALTH MANAGEMENT PROGRAMS

The Health Services Department staff, Clinical Quality Committee and network practitioners identify members with, or at risk for, chronic medical conditions. The Clinical Quality Committee is responsible for the development and implementation of Population Health Management strategies. Population health management is a framework that utilizes population identification monitoring data, health assessments and risk stratification to develop a continuum of care and health promotion services that includes health interventions to promote positive health outcomes across the entire membership population. HPSM's PHM Strategy was developed to meet the NCQA requirements. Detailed descriptions of PHM initiatives and programs can be found in *HPSM's Population Health Management Program Description*. HPSM will assess the needs of its members to determine the appropriate types of interventions to improve health outcomes. We will work with providers to assist with the population health management program using value-based payment arrangements and data sharing. HPSM will use evidence-based tools to assess member's health and provide interactive self-management tools for members to use to address their identified health issues. For those members with multiple of complex health conditions, HPSM will implement a coordinated care program to ensure access to quality care. All the population health management programs will be evaluated to assess if they have achieved their goals and determine areas of improvement.

Complex case management and chronic care improvement are major components of the population health management program. Specific criteria are used to identify members appropriate for each component. Member self-referral and practitioner referral will be considered for entry into these programs. Following confidentiality standards, eligible members are notified that they are enrolled in these programs, how they qualified, and how to opt-out if they desire. Case managers and care coordinators are assigned to specific members or groups of members and defined by stratification of the complexity of their condition and care required. The care coordinators/case managers help members navigate the care system and obtain necessary services in the most optimal setting.

Components of complex case management and chronic care improvement programs shall include:

1. Initial assessment of members' health status, including condition-specific issues.
2. Documentation of clinical history, including medications.
3. Initial assessment of the activities of daily living.
4. Initial assessment of behavioral health status, including cognitive functions.
5. Initial assessment of social determinants of health.
6. Initial assessment of life-planning activities.

7. Evaluation of cultural and linguistic needs, preferences or limitations.
8. Evaluation of visual and hearing needs, preferences or limitations.
9. Evaluation of caregiver resources and involvement.
10. Evaluation of available benefits.
11. Evaluation of community resources.
12. Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan.
13. Identification of barriers to member meeting goals or complying with the case management plan.
14. Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals.
15. Development of a schedule for follow-up and communication with members.
16. Development and communication of a member self-management plan.
17. A process to assess member progress against the case management plan.

7.2 CONTINUITY AND COORDINATION OF CARE

The continuity and coordination of care that members receive is monitored across all practice and provider sites. As meaningful clinical issues relevant to the membership are identified, they will be addressed in the quality improvement work plan. The following areas are reviewed for potential clinical continuity and coordination of care concerns.

- Primary care services
- OB/GYN services
- Behavioral health care services
- Inpatient hospitalization services
- Home health services
- Skilled nursing facility services
- Long Term Care
- Dental services

The continuity and coordination of care received by members include medical, dental, and behavioral health care. Health Plan of San Mateo collaborates with San Mateo County Behavioral Health and Recovery Services to ensure the following activities are accomplished:

- **Information Exchange:** information exchange between medical practitioners and behavioral health practitioners must be member-approved and be conducted in an effective, timely and confidential manner.
- **Referral of Behavioral Health Disorders:** Primary care practitioners are encouraged to make timely referral treatment of behavioral health disorders commonly seen in their practices, i.e., depression.
- **Evaluation of Psychopharmacological Medication:** Drug use evaluations are conducted to increase appropriate use or decrease inappropriate use and to reduce the incidence of adverse drug reactions.
- **Data Collection:** Data is collected and analyzed to identify opportunities for improvement and collaborate with behavioral health practitioners for possible improvement actions.
- **Implementations of Corrective Action:** Collaborative interventions are implemented when opportunities for improvement are identified.

7.3 CLINICAL PRACTICE GUIDELINES

HPSM provides its network providers access to evidence-based practice guidelines for assistance in making decisions about appropriate health care for specific clinical circumstances, including preventive care. Web links to specific guidelines developed by nationally recognized medical organizations, expert task forces, and health professional societies are posted on the provider section of the HPSM website. Some links connect to the expert organization websites and others are direct links to practice guideline documents. Provider Services will make certain that the provider newsletter promotes awareness of the clinical guidelines on the HPSM website, in at least one of its quarterly newsletters or news alerts in 2023.

HPSM's Quality department leads an annual review process of the of the posted guidelines to ensure they reflect the most up-to-date available clinical evidence and remain relevant to health conditions common in the member population. A summary of the currently posted guidelines noted with their publication dates and source organizations, is prepared and presented to the Quality Improvement Committee (QIC) for review, discussion, and approval at one of its quarterly meetings.

Prior to presenting the summary to the QIC, a Quality Improvement staff goes online to the source organization website for each posted guideline to check the published date of the last systematic evidence review. In general, guidelines that have been reviewed and updated within the past 3 – 5 years are considered up-to-date and are maintained on the HPSM website. Guidelines with publication dates older than 5 years that remain active on the source organization's website and have a proposed date for a future review are noted for discussion by the QIC. Members of the QIC comment on the posted guidelines and advise on any necessary additions or removals. QIC chairs lead a vote to approve the posted guidelines and any decisions for changes.

7.4 MEMBER EXPERIENCE

7.4.1 MEMBER SATISFACTION, COMPLAINT, AND GRIEVANCE/APPEAL MONITORING

An NCQA certified vendor conducts a member satisfaction survey (Consumer Assessment of Healthcare Providers and Systems – CAHPS) annually for the D-SNP members and for Medi-Cal members. The results of the surveys are reported to the MEC, Consumer Advisory Committee, QIHEC and Commission.

Quarterly summaries of complaints and grievances/appeals will be reported to the Member Experience and Engagement Committee (MEC), and Consumer Advisory Committee. Report will be trended by type of complaint, HPSM departments, sites, facilities and physicians as indicated. Cases that will be reviewed by the Chief Health Officer will be included in the quarterly summaries.

Any complaint that has a potential quality of care issue will receive a medical review as follows:

- The QI Nurse screens it immediately upon receipt for potential quality issues.
- Supporting documentation is requested from the provider, primary care sites, hospitals, etc.
- A Medical Director reviews the complaint and any supporting documentation, categorizes the quality of care concerns, communicates with the provider as indicated

7.4.2 CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS)

HPSM uses the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to assess member experience with the health plan. CAHPS is conducted annually for Medicare and Medi-Cal populations. The survey is conducted in the first half of the calendar year and measures members'

experiences over the previous 6 months. The survey sample is drawn from all members who have been enrolled for at least 6 months. The CAHPS survey asks members to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

7.4.3 HEALTH OUTCOMES SURVEY (HOS)

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

This self-report survey of plan members is conducted in English, Spanish, & Chinese. Baseline results of HOS are intended to help plans identify potential areas for improvement and evaluate the physical and mental health of members. The reporting is done within specific cohorts with a follow-up 2 years later.

8. MEMBER HEALTH EDUCATION/PROMOTION & WELLNESS PROGRAM

The Health Education program is reviewed annually to assess that there is an appropriate allocation of health education resources to address the health education needs and gaps of HPSM members. This assessment includes completing required readability and suitability checklists for health education materials; soliciting health educational request information from other HPSM department staff; conducting on-site evaluations of classes offered in the community; analyzing encounter data and other relevant data sources; and identifying other intervention activities to accomplish the objectives in the work plan.

Health education programs are offered to the member at no cost directly and/or through subcontractors or other formal agreement with providers that have expertise in delivering health education services.

HPSM conducts targeted outreach to members that is heavily based on mailings to educate them about resources available to them in the community. The Health Promotion Program Specialists monitor the availability and accessibility of programs/resources through self-referral or referral from provider for these programs/resources.

See Health Promotion Program Description for further details.

9. QUALITY IMPROVEMENT INTERVENTIONS

9.1 INITIAL HEALTH APPOINTMENT (IHA)

The Initial Health Appointment (IHA) has become a high priority in health plans, primary care and preventative services across California as the Medi-Cal population has a higher prevalence of chronic and/or preventable illnesses. Many of which could be modified through appropriate health behavior change and early detection to promote lifestyle changes. The IHA enables a provider to comprehensively assess the member's chronic, acute and preventative needs and to identify patients whose needs require additional coordination with other resources. The All Plan Letter (APL 22-030) requires all primary care providers to administer an IHA to all Medi-Cal managed care patients as part of their IHA and well care visits. It is required that health plan's reach a 100% compliance rate ensuring every member enrolled is seen by their primary care physician within the first 120 days of enrollment with the plan.

2024 IHA ACTION PLAN

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

The IHA CAP required by DHCS due to less than 100% of members receiving an IHA will be implemented and completed. CAP actions include:

1. Updating HPSM's website to contain updated information for Providers and revising the IHA training document for providers
2. Create IHA requirement attestations to be used to educate providers during Site Reviews.
3. Continue pay-for-performance(P4P) monetary incentive for PCPs for timely IHA completion in 2024 Under the Benchmark P4P IHA remains a payment metric for Family Practice and Adult track providers and reporting-only for Pediatric providers. This is based on prioritization in assigned quality metric sets. As part of P4P, monthly reports are sent to PCPs detailing level of performance.
4. HPSM is also incentivizing both the scheduling of the IHA and timely completion with inclusion of the IHA in its new Care Gap P4P. Care Gap P4P utilizes an interactive platform that allows PCPs to readily view and filter for their assigned members in need of an IHA.

HPSM QI RNs will continue to audit for IHA completion with regular Facility Site Review Medical Record Review audits. Any deficient IHA documentation is addressed at the time of the Facility Site Review by site review nurses. Consistently underperforming PCPs will be investigated and may be subject to a focused medical record review based on the identified deficiency(ies). The PCP may be given a corrective action plan based on the findings of the investigation and/or medical record review.

Members will continue to be informed through the evidence of coverage and a IHA reminder in new Medi-Cal member welcome packets.

9.2 DHCS WELL-CHILD VISITS IN THE FIRST 15 MONTHS HEALTH EQUITY PIP

Starting in 2024, the Quality Improvement Department will implement a disparity performance improvement project (PIP) on the Well-Child Visits in the First 15 Months of Life measure which requires six or more well-child visits in the first 0 to 15 months of life. (W30 6+)) The PIP will focus on the Hispanic population.

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

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

2024 HEALTH EQUITY **PIP** ACTION PLAN

For 2024, W30 6+ will be a key area of focus for HPSM and based on findings from barrier analysis and intervention planning, HPSM staff will conduct the following activities.

1. The County Home Visiting Program will conduct health education home visits to Hispanic members to provide culturally and linguistic appropriate health education regarding the importance of completing 6 well child visits by the 15th month of life.
2. Population Health will provide a quarterly report that includes all members reached out to by County Home Visiting and the result of the outreach to QI.
3. Qi will use the report to validate which members complete their well child visits,
4. QI will submit an annual evaluation of the PIP results to DHCS in the Fall of 2024.

9.2.1 DHCS NON CLINICAL PIP

Starting in 2024, the Quality Improvement Department will implement a 3 year non-clinical performance improvement project (PIP) on the Follow Up after Mental Health(FUM) and /Follow Up After Substance Abuse(FUA) HEDIS Measures.

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

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

2024 NON CLINICAL PIP ACTION PLAN

For 2024, FUM, FUA will be a key area of focus for HPSM and based on findings from barrier analysis and intervention planning, HPSM staff will conduct the following activities.

- Implement a process to provide notifications to providers when a patient is seen in the ED for SUD/SMH diagnosis.
- Provide the notification within 7 days of the ED visit.
- Track the percentage of notifications provided within 7 days of the ED visit.
- Submit an annual evaluation of the PIP results to DHCS in the Fall of 2024.

Requirement source	Area of Focus	QI Program	Line of Business	Project	Objectives	Planned Activities	Responsible Party	Frequency	Start Date	Finish Date
NCQA QI1	Accreditation/QI Program Documentation	Communication	All	QI Program Evaluation	Evaluate QI Program to identify opportunities for improvement and inform necessary programmatic changes.	Annual QI Program Description, Workplan and Evaluation	Mariana Ulloa	Annually	1/1/2024	3/1/2024
CMS	Members' Experience	HOS Reporting	CA	2024 Health Outcomes Survey (HOS) Summary Report	Review HOS Results to identify opportunities for target through quality improvement activities.	-Review HOS Report from CMS to and present HOS Summary Report to QIC - Collaborate with CQC and MEC on improvement activities of identified issues/recommendations by QIC	Mariana Ulloa	Annually	9/1/2024	12/31/2024
NCQA QI4	Quality of Clinical Care	Accreditation	Medi-Cal	Coordination of Care - BH and Medical	Implement improvement interventions for measures meeting factors and document results	Implement improvement plan for DEF and DEV measures. Complete Provider Survey. Complete remeasurement and analysis of all metrics and annual report.	Mariana Ulloa, BH, PHM, Provider Services	Annually	1/1/2024	12/31/2024
NCQA QI3	Quality of Clinical Care	Accreditation	Medi-Cal	Coordination of Care across settings and provider types	Implement improvement interventions for measures meeting factors and document results	Implement improvement plan for Diabetes Eye Exam, PCP Visits for Dialysis patients, Asthma ER and PCR measures. remeasurement and analysis of all metrics and annual report.	Mariana Ulloa, ICM, PHM	Annually	1/1/2024	12/31/2024
DHCS	Quality of Clinical Care	Communication	All	Clinical Guidelines on HPSM website	(1) Ensure clinical guidelines posted on HPSM website are current per source organizations and address common health conditions in HPSM membership. (2) Promote awareness and use of guidelines by provider network through provider newsletter article	Review source website for each posted guideline link to check for updates and confirm current status. At QIC meeting, present list of guidelines by health condition posted on website for QIC Committee review, confirmation of current status, suggested changes, and approval. Solicit input from QIC members and submit changes to Marketing for updates to website.	Mariana Ulloa	Annually	8/1/2024	12/31/2024
Ops	Quality of Clinical Care	HEDIS	Medi-Cal, CA	HEDIS MY2023 Project Plan	Ensure timely completion of all project deliverables by June 15, 2024.	- Create, implement and complete all project deliverables listed in the HEDIS MY2022 Project Plan. - Manage HEDIS vendors - Completion of test, production and admin runs. - Completion of MY2022 roadmap. - Completion of HEDIS production project. - Completion of chart review. - Completion & Submission of IDSS. - Completion & Submission of PLD files. - CAHPS	Michaela Trimm	Annually	1/1/2024	6/15/2024

Requirement source	Area of Focus	QI Program	Line of Business	Project	Objectives	Planned Activities	Responsible Party	Frequency	Start Date	Finish Date
DHCS	Quality of Clinical Care	DHCS PIPs	Medi-Cal	Health Equity PIP-W30(6+)	Reduce the disparity among the Hispanic/Latino population for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* (*W30–6*) measure	Complete Annual Submission of Progress by 9/30/2024.	Mariana Ulloa	Ongoing	1/1/2024	12/31/2024
DHCS	Quality of Clinical Care	DHCS PIPs	Medi-Cal	Mental Health FUM, FUA	Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or **within 7 days** of emergency department (ED) visit.	Complete Annual Submission of Progress by 9/30/2024.	Mariana Ulloa	Ongoing	1/1/2024	12/31/2024
DHCS	Quality of Service	Access & Availability	Medi-Cal	Initial Health Appointment(IHA) Compliance Improvement	Improve overall timely IHA completion for new Medi-Cal members	The IHA CAP required by DHCS due to less than 100% of members receiving an IHA will be implemented and completed. CAP actions include: 1. Revise IHA P&P to APL 22-030 requirements 2. Provider notification of changes to IHA requirement 3. Continue pay-for-performance(P4P) monetary incentive for PCPs for timely IHA completion in 2024 4. Conduct training webinars with providers on IHA requirements and reporting for the P4P incentive 5. Revise PCP monthly member engagement/assigned patient report to enable PCPs to more readily identify new Medi-Cal members in need of an IHA and deadline/date for completion to meet the timeliness requirement 6. Include an article in the provider newsletter on IHA requirements and resources 7. Continue monitoring IHA compliance on a quarterly basis, identifying trends in PCP compliance Continue PCP compliance monitoring and correction action activities. Continue IHA reminder insert in new Medi-Cal member welcome packets.	Harnoor Chahal	ongoing	1/1/2024	12/31/2024

Requirement source	Area of Focus	QI Program	Line of Business	Project	Objectives	Planned Activities	Responsible Party	Frequency	Start Date	Finish Date
DMHC, DHCS	Safety of Clinical Care	FSR	Medi-Cal	Facility Site Review, Medical Record Review	Comply with DHCS mandated credentialing and recredentialling reviews for Facility Site Review and Medical Record Reviews required for HPSM Provider network credentialing.	Facility Site Reviews are performed at PCP, Pediatric, and OB/GYNs that perform PCP services, upon initial credentialing before any new member assignments, & triennially thereafter for re-credentialing. Medical Record Reviews are performed approximately 6 months after the new provider has seen HPSM members to evaluate Coordination/Continuity of Care, Preventive Services and all other sections of the State mandated tool. Corrective Action Plans (CAPs) are instituted for deficiencies. Intermittent focused and monitoring reviews are performed between cycles to confirm CAP closures and to evaluate potential quality issues of concern. Continue to create educational and documentation materials to aid and education providers on latest DHCS mandated changes to the Facility Site Review Process.	Harnoor Chahal	Ongoing with Bi-annual reporting.	1/1/2024	12/31/2024
DHCS	Safety of Clinical Care	FSR	Medi-Cal, CA	Physical Accessibility Reviews	Comply with DHCS mandated Physical Accessibility Reviews required for HPSM Provider network credentialing.	Physical Accessibility Reviews (PAR) are performed utilizing State mandated tools Attachments "C", "D", & "E", on all PCPs, Pediatricians, and SPD benchmarked high producing Specialists and Ancillary Service Providers. This methodology is benchmarked with monthly reports to identify high producing SPD Specialists and Ancillary Service Providers which provide services to Seniors and Persons with Disabilities (SPDs) with 5 visits or more per day per annum. - Continue to work with Provider Services in updating changes to facilities and PCP offices.	Harnoor Chahal	Ongoing	1/1/2024	12/31/2024
DMHC, DHCS	Safety of Clinical Care	Quality of Care	All	Potential Quality Issues (PQI)	Improve awareness of PQIs and reporting process	Conduct training for all Health Service staff on PQIs and submission process. Continue providing PQI process education to HPSM providers through various provider education methods.	Harnoor Chahal	Annually	1/1/2024	12/31/2024

AGENDA ITEM: 4.5

DATE: August 14, 2024

MEMORANDUM

DATE: July 17, 2024

TO: San Mateo Health Commission

FROM: Pat Curran, Chief Executive Officer
Trent Ehrgood, Chief Financial Officer

RE: Approval of Amendment to Agreement with County of San Mateo for Third Party Administrative Services for the ACE Program

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Recommendation

Authorize the Chief Executive Officer to execute an agreement with the County of San Mateo to extend the Third-Party Administrator (TPA) services HPSM provides for the ACE Program for another 12 months through September 2025.

Background and Discussion

HPSM began administering ACE (Access and Care for Everyone) in February 2008. The ACE program is San Mateo County's local version of the State Coverage Initiative, which was intended to offer counties the opportunity to develop innovative programs for expanding access to the uninsured.

The ACE program has been successful by creating a program that is simple, transparent, and easy to use for participants. The addition of medical management has helped control cost, while improving outcomes, especially for participants that suffer from chronic conditions. The program has also created better awareness of cost and utilization for the County.

To qualify for ACE, individuals must reside in San Mateo County, be 19 or older without other health insurance coverage, ineligible for coverage through Medicare, Medi-Cal, or other insurance, and have incomes below 200% of the federal poverty level.

The number of participants covered under the ACE program was around 22,000 prior to the pandemic, then grew to around 27,000 during the pandemic. In April 2022, ACE participation dropped by around 6,000 (to around 21,000) after undocumented residents aged 50 and older became eligible for Medi-Cal. In January 2024, ACE participation dropped again to a new enrollment count of around 1,400 after undocumented residents ages 26 through 49 became eligible for Medi-Cal. Enrollment is expected to drop even further as the ACE redetermination continues through the end of the year, and more members are potentially determined eligible for Medi-Cal.

County Health is evaluating this program to determine long-term sustainability of the program due to the much lower enrollment. In the meantime, the TPA agreement with HPSM is being renewed with modifications to the fee structure.

Financial Impact

The TPA fee structure will continue at $8.50 per participant per month but will now include a minimum annual fee of $255,000 to account for the low enrollment and to ensure HPSM has sufficient funds to cover its cost to administer the program with low enrollment levels. The County has financial responsibility for all healthcare costs, so HPSM has no insurance risk for this program.

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF AMENDMENT TO AGREEMENT WITH COUNTY OF SAN MATEO FOR THIRD PARTY ADMINISTRATOR SERVICES FOR THE ACE PROGRAM

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has previously entered into an agreement with the County of San Mateo for the Health Plan of San Mateo to be the third-party administrator for the ACE Program;

B. The San Mateo Health Commission has renewed this TPA arrangement over the years, with the current agreement expiring September 30, 2024;

C. Both parties wish to extend the TPA arrangement for another 12 months through September 2025.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves the amendment to the agreement with San Mateo County for Third Party Administrator Services for the ACE Program to extend the term through September 2025; and

2. The San Mateo Health Commission authorizes the Chief Executive Officer to execute said amendment.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 14th day of August 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

MEMORANDUM

AGENDA ITEM: 4.6

DATE: August 14, 2024

DATE: July 17, 2024

TO: San Mateo Health Commission

FROM: Pat Curran, Chief Executive Officer
Trent Ehrgood, Chief Financial Officer

RE: Waive Request for Proposal and Approve Agreement with ASSC for Air Conditioning Retrofit Project

---

Recommendation

Waive Request for Proposal process and authorize the Chief Executive Officer to execute an agreement with Air Systems Service & Construction (ASSC) for air condition retrofit project in the amount not to exceed $462,980.

Background and Discussion

In 2015, HPSM purchased a five-floor building at 801 Gateway Blvd., South San Francisco. The building has two primary air conditioning (AC) systems on the roof (AC1 and AC2) that are original to the building and are around 25 years old. The two systems have six compressors combined, which are starting to fail due to age. Management has evaluated different options ranging from complete replacement (most expensive) to repair/retrofit. The retrofit option is more cost effective and includes replacing certain components, like the compressors, controllers, dampers, etc.

HPSM has recently been migrating HVAC maintenance services to ASSC, who is more responsive and more cost effective overall. ASSC provided a customized proposal in the amount of $462,980 to perform the retrofit work. ASSC's recommended approach and quote was determined to be the best option compared to other estimates, including our recent service provider, ATS. A waiver of the Request for Proposal process is requested due to the review of comparisons performed by staff and the responsiveness of services provided over recent months.

Fiscal Impact

This request is for ASSC to perform the air conditioner retrofit project for $462,980 in CY 2024.

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF WAIVING THE REQUEST FOR PROPOSAL PROCESS AND APPROVAL OF AGREEMENT WITH AIR SYSTEMS SERVICES & CONSTRUCTION (ASSC)

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. The air condition (AC) systems at 801 Gateway Blvd., South San Francisco are failing and in need of replacement;

B. Based on quotes received, management recommends using ASSC to repair and retrofit the AC system.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the request for proposal process and approves the agreement with ASSC for the AC retrofit project in the amount of $462,980 in CY 2024; and

2. Authorizes the Chief Executive Officer to execute said agreement.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 14th day of August 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

MEMORANDUM

AGENDA ITEM: 4.7

DATE: August 22, 2024

DATE: August 14, 2024

TO: San Mateo Health Commission

FROM: Pat Curran, Chief Executive Officer
Ian Johansson, Chief Compliance Officer

RE: Approval of Amendment to Agreement with Compliance Strategies

---

Recommendation

Authorize the Chief Executive Officer to execute an amendment to the agreement with Compliance Strategies to provide Medicare audit and consulting services through December 31, 2025. This amendment increases the expenditure for services by $411,100.

Background

HPSM has worked with Compliance Strategies since 2014 to improve readiness for and participate in CMS audit activities. Compliance Strategies specializes in preparing health plans for CMS audits, addressing compliance gaps, and improving performance in key operational areas such as grievances and appeals, pharmacy, utilization management, and care management/model of care.

HPSM has not been audited by CMS since 2016, and recently transitioned from the Cal MediConnect (CMC) program to the Exclusively Aligned Enrollment (EAE) Dual-Eligible Special Needs Plan (EAE D-SNP) program in 2022. These factors create a heightened risk for a CMS audit, when it occurs, due to changes in regulatory requirements and a higher chance HPSM will be selected for audit in 2024. CMS audits are incredibly intensive activities, lasting approximately 10 weeks beginning to end. Compliance Strategies consulting helps ensure HPSM can respond to a CMS audit, accurately and timely.

Compliance Strategies is also providing HPSM with consulting services in the areas of model of care, grievances and appeals, and an audit of an HPSM vendor. To perform these services well, and to minimize burden on HPSM staff, Compliance Strategies services help ensure compliance with CMS requirements and timely completion of required activities.

In February 2024, the Commission approved an increase of $100,000 to the original agreement. The not to exceed total was approved at $545,000 at that time. As (1) Medicare consulting work continues to be performed, additional support needs have been identified to support operational areas, and (2) additional support continues to be needed with grievances and appeals, an increase in the overall approved contract amount is needed. This increase reflects work planned through the remainder of 2024 and into 2025.

Fiscal Impact

The fiscal impact of this recommendation is an additional $411,100, for a total amount not to exceed $956,100. The increase of $411,100 will be used for (1) additional support for operational areas related to Medicare gap analysis and mock audit work, and (2) support with grievances and appeals being performed by Compliance Strategies. HPSM plans to conduct a request for proposal for Medicare comprehensive consulting services after HPSM's next CMS audit.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF AMENDMENT TO AGREEMENT WITH COMPLIANCE STRATEGIES

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. HPSM has not been audited by CMS since 2016, and the change in the Medicare duals model requires significant changes to HPSM's Medicare operations;
B. HPSM has a higher chance of being selected by CMS for a Medicare compliance audit in 2024;
C. HPSM has operational support needs for Medicare in the areas of compliance, vendor oversight, grievances and appeals, and model of care; and
D. HPSM will pursue a standing Medicare operational support agreement through the RFP process at the conclusion of the approved agreement with Compliance Strategies.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission authorizes the Chief Executive Officer to execute an amendment to extend the agreement with Compliance Strategies for services through December 31, 2025; and
2. Increase the contract amount by $411,100 for a total amount not to exceed $956,100.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 22nd day of August 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chair

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

DRAFT

AGENDA ITEM: 4.8

DATE: August 22, 2024

SAN MATEO HEALTH COMMISSION
Meeting Minutes
June 12, 2024 – 12:30 a.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor Boardroom
South San Francisco, CA 94080

Commissioners Present:	David J. Canepa	George Pon, R. Ph., Chair
	Bill Graham, Vice-Chair	Manuel Santamaria
	Barbara Miao	Kenneth Tai, M.D.
	Raymond Mueller	Ligia Andrade Zuniga
Commissioners Absent:	Jeanette Aviles, M.D., Michael Callagy Si France, M.D.,	
Counsel:	Kristina Paszek	
Staff Presenting:	Pat Curran, Amy Scribner, Chris Esguerra, M.D., Richard Moore, M.D.	

1. **Call to order/roll call**
   The meeting was called to order at 12:31 a.m. by Commissioner Pon, Chair. A quorum was present.

2. **Public Comment**
   Lisa Chamberlain, M.D., Professor of Pediatrics at Stanford University addressed the commission regarding the Baby Bonus Program. Her comments were related to Community Health Workers as part of this program and how they can help members, as well as the income disparities some experience that impact food insecurities and other basic needs. San Mateo County Board of Supervisor-elect, the Honorable Jackie Speier, also addressed the commission on the Baby Bonus Program. Her comments referred to the serious problem of 27,000 children in San Mateo County living in poverty and more than 10,000 going to bed hungry at night and the potential impact that this program could have in addressing these issues. There were no additional public comments at this time.

3. **Approval of Agenda**
   Commissioner Mueller moved approval of the agenda as presented (Second: Zuniga). **M/S/P.**

4. **Consent Agenda**
   Consent Agenda was approved as presented. Motion: Muller (Second: Zuniga) **M/S/P.**

5. **Specific Discussion/Action Items:**

   5.1 Approval of Funding for Baby Bonus Program

   Before discussion and presentation of this item, Commissioner Mueller began by confirming for the record that his activity related to the Baby Bonus Program as a County Supervisor would not be a conflict. County Attorney, Kristina Paszek confirmed this would not be a conflict for this voting item.

Ms. Amy Scribner reviewed her presentation on the Baby Bonus program. Her presentation is attached and was included in the meeting materials distributed prior to the meeting.

Ms. Scribner touched on the following highlights of her presentation:

- Baby Bonus Program includes the guaranteed income component and some enhanced services.
- This program would fall into the category of a portion of the Community Investment Fund which in whole represents $39 million of HPSM's Tangible Net Equity (TNE).
- Aspects of this Community Investment Fund will be based on community needs, systems gaps and capacity building that will have long-term impacts on our members.
- The methodology of measuring community needs is broken down into four categorical approaches: Population Needs Assessments; Member Experience; Workforce; and Voices of the Community to help staff understand what families need.
- Part of the program includes the launching of Community Health Workers, who will provide support for the program and services for members.
- Evaluation will be a very important role in the decision, making of investment leverages and strengths and financial sustainability.
- Intended impacts include health outcomes improvement with a main focus on reduced emergency room visits, increased well child visits and continued focus on access to prenatal care, as well as health equity/birth equity.
- Policy implications may go beyond SM County and our members by demonstrating the benefits of guaranteed income in lieu of the discontinued enhanced child tax credit that was implemented during COVID.
- HPSM has a unique opportunity to support newborns and families, as well as gathering data from providers and partners that can be passed on for evaluation.
- This program will pair with the state's goals of health equity, birth equity, and early childhood development as part of the new Community Investment Fund requirement that is part of our new contract with the state.
- She reviewed the framework of the program, which breaks the population served into three categories: current process/services; 2 experimental groups of 300 members each receiving supportive services and one also receiving $300/month for three years; all other hospitals will have 100 members receiving $300 a month for three years through the Baby and Me Program.
- It was pointed out that the reasoning for the different groups with guaranteed income and supportive services is to test and prove that it works. In order to accomplish this, a group needs to be pulled out and not receive enhanced supportive services so you can compare the data.
- The supportive services referenced are the Community Health Workers helping members navigate the health care system following birth.
- The program will add ten community health workers who will be HPSM employees that will provide support to families enrolled in the study.
- The experimental group will work directly with Stanford upon delivery and with the remaining care ecosystem to provide support where needed.

- Evaluation will look at the satisfaction of these services and will assist in the learning aspect of the program.
- There are other funders outside of HPSM that will be helping to fund the guaranteed income portion (to carry the additional 100 members) and funding to cover the evaluation.
- Ms. Scribner talked about the relationships and roles for HPSM, First 5, Stanford, and Community Health Workers play in policy change and data sharing.

Commissioner Maio asked if the $3.5 million is in addition to what Medi-Cal now covers through use of Community Health Workers. Ms. Scribner stated that since we are hiring them ourselves, we cannot bill for the services, which are a covered benefit. Mr. Curran added that we will need to create the pipeline of workers to deploy in the community and learn through this study.

Commissioner Graham added that a possible evolution of this could be that we demonstrate the success of the program and then there could be other agencies outside of HPSM that will take over responsibility and then could be funded by Medi-Cal.

Ms. Scribner outlined the financial impact of the request for the commission's approval: $3.5 million for the agreement with First 5 to administer the guaranteed income portion of the program; and, $3.5 million for the recruitment of the Community Health Workers who will be employed by HPSM. The program would begin in January 2025.

Commissioner Zuniga moved approval of the Baby Bonus Program as outlined for an amount of $7 million for a three year period. (Second: Graham) **M/S/P**

5.2 Update on PACE

Ms. Paszek, Deputy County Attorney, explained that this topic regarding the PACE program and anticipated request for proposal, she recommended that if any commissioners who are employed by employers who are likely to submit a proposal that the not participate in this portion of the meeting. Commissioner Tai who is employed by NEMS recused himself and exited the meeting at this time.

Dr. Chris Esguerra, Chief Medical Officer, and Dr. Richard Moore, Senior Medical Director, presented an update on the PACE program. Their presentation is attached to these minutes. Dr. Esguerra stated that PACE stands for Program for All Inclusive Care for the Elderly. This was discussed with the commission last year and was a topic of potential investment. The unique factor about PACE is that an organization is not able to set up operation independently but that it requires permission in counties which have a County Organized Health System (COHS) model, like San Mateo County. The distinction here is this is an RFP to identify an entity whereby the commission would provide a letter of support for them to set up a PACE program. We are looking for the added value for our members that would be eligible.

Dr. Moore stated that the purpose today is to present the information for the commission's feedback and will finalize the RFP process. This is a value add to our community for our robust community supports and adds value to the existing relationships we have in place. This would

become a one-stop shopping program for medical and social care. We are looking at being a strategic investor and what would that mean whether it is financial or administrative, such as part of the board of directors. This is still open for discussion.

Highlights of their presentation are as follows:

- PACE is a Program of All-inclusive Care for the Elderly
- A fully capitated program or basically a capitated insurance company
- Designed for patients 55 and over with chronic disabilities and illnesses who would otherwise be admitted to a skilled nursing facility.
- Includes everything offered by Medi-Cal and Medicare
- One of the benefits would be no prior authorizations are required
- Also include respite care, transportation, adult day services, skilled nursing facilities and custodial care.
- Model of Care is a full range of Interdisciplinary Team of 11 roles that are mandated and integrates all care for participants including drugs, transportation and meals.
- Individualized care plans are developed for participants and would ideally include a mental health worker.
- The RFP would help to identify an entity to be selected to support with a Letter of Support to the DHCS and CMS by the commission and HPSM as the local County Organized Health System.
- Dr. Moore reviewed the four focus areas of the RFP: capacity, demonstrated capability to meet the statement of work and regulatory requirements, ability to support existing community providers, and resources to implement a viable PACE program
- they would provide
- Dr. Moore reviewed the barriers, such as members needing to change their PCP, members losing their IHSS hours provided by family members, and members with mental health issues are excluded from participation.
- Dr. Moore reviewed the elements that RFP respondents would address within the RFP.
- There was discussion on how many PACE facilities there are, how many people can be served, are we looking for more than one, etc. Dr. Moore stated that there are approximately four in our general area, one facility had approximately 200 clients, and what we are hoping for at least one excellent facility.

Questions asked:

- Commissioner Pon asked if all the services are already provided to our members through HPSM. Dr. Esguerra explained that they are but this would be an independent insurance program that if members enrolled there they would drop from HPSM enrollment, and it may be that we will not find an PACE provider that that fits the criteria.
- Commissioner Pon asked about the chronic conditions that would be covered. Dr. Esguerra stated that stated there is a large list and members usually have more than one chronic condition that would qualify them to be in a nursing facility because they require so much support but would allow them to live in the community and get their services.
- Commissioner Pon asked if we feel we will find a provider who can provide all of the multidisciplinary roles. Dr. Moore gave examples of providers that are set up this way.

This is what would be identified through the RFP process but is the big question of who can provide this and how they would implement and maintain those disciplines at all times.

- Commissioner Santamaria asked about the advantages of the PACE program. Dr. Moore explained the most talked about advantage is the model of all services under one roof or one stop shop for medical services, support services like adult day health, and all the disciplines, physical therapy, occupational therapy and are sent out to see a specialist. This also provides a respite for the families. These doctors also make house calls or will see patients in skilled nursing facilities and over time develop a relationship with the patient's team.
- Commissioner Miao commented that a lot of people really appreciate the PACE program and asked how it affects our Medicare Advantage plan. Dr. Moore stated that our CareAdvantage members that switch over would disenroll from CareAdvantage. There may be others who have Medi-Cal but their Medicare somewhere else that would disenroll from us and enroll into the PACE provider that through the RFP process would make clear this would be a partnership with HPSM and strategic alignment between HPSM and the entity. The RFP process will identify the entity that would be best to be that partner. Another factor of involvement would be recognizing how this entity would identify and recruit members so we would be participating in that.
- Commissioner Graham asked if we moved forward with this and we give that approval and identify the space organization that we think fits the criteria we've established, would it also be open to residents of the county who are not members or participants in Health Plan of San Mateo. Dr. Moore stated it would. Mr. Curran added that in conversation with the National PACE Association, they concurred it is a good approach to emphasize what exists in the county now and how this program could add to and compliment services and not detract from what is already available for our members.

Dr. Moore concluded that the next steps would be to take the input from today's meeting and incorporate it into the RFP to get it ready to go. There is a PACE workgroup at the health plan, a multidisciplinary team from HPSM departments that will review the applications, report their findings to the leadership team, and then bring this back to the commission.

Commissioner Zuniga asked about individuals who are part of a regional center or under the developmental disability waivers or such, if they would be able to continue with these. Dr. Esguerra stated that regional care services are not covered under Medi-Cal and under a different funding stream, they do not get affected from a regional center perspective. This will be a question of how they work with regional centers. For those on waivers such as the 1915C waiver carve-out for home and community based waivers, that is a question we will need to understand to ensure it is being addressed. The regional center waivers would not be applicable.

6. Report from Chief Executive Officer

Mr. Curran reviewed his written report noting the financials year-to-date, state budget which has no new activity. There is no expected major benefit or population or funding changes over the next year. The budget is challenging, however, and the MCO tax will be a focus later in the year when we know more about its implications.

He reported that the July commission meeting is cancelled and the next meeting of the commission will be in August 2024.

7. Other Business

There was no other business discussed at this time.

8 . Adjournment

The meeting was adjourned at 1:36 pm

Submitted by:
C. Burgess

C. Burgess, Clerk of the Commission

Baby Bonus Program

San Mateo Health Commission

June 12, 2024

HealthPlan OF SAN MATEO
Healthy is for everyone

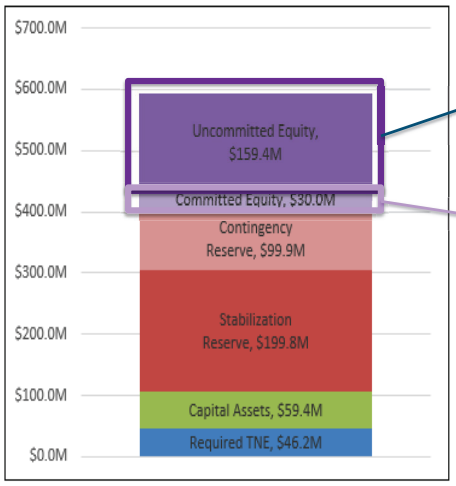
Recap from March 2024 Meeting

HealthPlan OF SAN MATEO
Healthy is for everyone

- At our 3/13/2024 meeting, we discussed the background and partnerships being created to develop the Baby Bonus Program in San Mateo County. This represents a **community investment** for HPSM that we think will have a long-term positive impact.
- Additionally in June 2023, we discussed potential **workforce development** opportunities that were identified through significant discovery.
- Today, we'll be walking through a proposal for **an enhanced Baby Bonus program** that marries guaranteed income and enhanced services for community investment and workforce development.

Proposed HPSM Investments

Tangible Net Equity (TNE)



A. Provider Investment Fund

B. Community Investment Fund

C. Innovation Center

D. Primary Care Investment

At 12/31/23 Pre-Audit, TNE = $594.7M
Uncommitted portion = $159.4M

B Community Investment Fund

Methodology: how we measure community needs

Need Category	Examples
Populational Needs Assessment	• Disparities Identified • HEDIS, MCAS, STARs impacts
Member Experience	• Grievances • Appointment Availability • Qualitative interviews
Workforce	• New benefit launch • Challenges in recruitment or retention
Voices of the Community	• Qualitative Feedback from members, providers, community partners and staff.

Community Investment Goals

Decision Making Considerations:

- ❑Alignment with the concepts of piloting and evaluating
- ❑Degree to which the investment leverages HPSM's unique strengths – *is HPSM the best fit for a funder/convener*
- ❑Financial sustainability of the investment – *e.g., plans for sustaining improvements after a one-time investment*

Baby Bonus Program

Rationale

Why are we doing this?

- **Health Outcomes improvement (**early well child visits), **access to care** (services and pre- and post-natal care), and **health equity** (birth equity a main priority for HPSM). P
- Potential **policy implications** beyond San Mateo County to demonstrate the benefits of guaranteed income, such as the **child tax credit** implemented during the pandemic but now discontinued.
- Leverages **HPSM's unique role** in having programs already in place to **support** newborns and their families and **data** to determine health outcome measures.
- Opportunity for multi-year **community investment** that aligns with the **state's bold goals** through its community investment requirement beginning 2026.

Project Framework

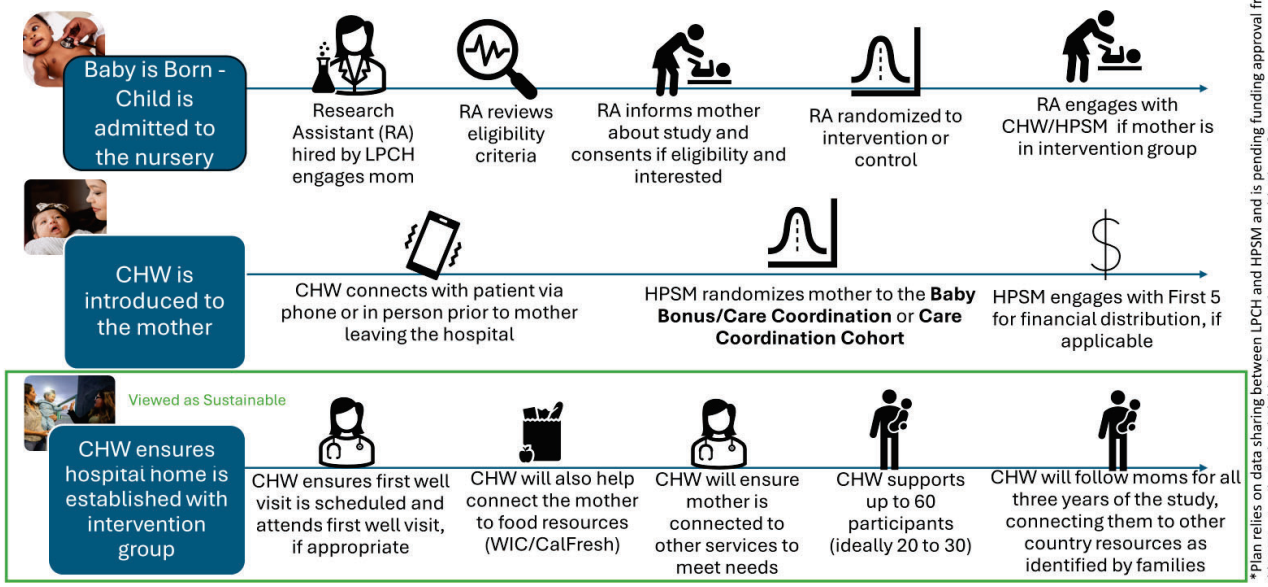
Lucille Packard Children's Hospital
Randomized Control Trial

Supportive Services

- HPSM will add 10 Community Health Workers (CHWs) to longitudinally support every family enrolled in the study
- Community Health Workers will work directly with Stanford upon delivery and with remaining care ecosystem to provide support where needed.
- Outcomes to be evaluated:
  - Well child visits
  - Utilization of SDOH (e.g. transportation, housing), medical and dental services
  - Satisfaction with CHW services

Connection to a Community Health Workers (CHW)

LPCH and HPSM will work together to enroll, randomize, and connect the intervention cohorts to a Community Health Worker, who is hired by HPSM



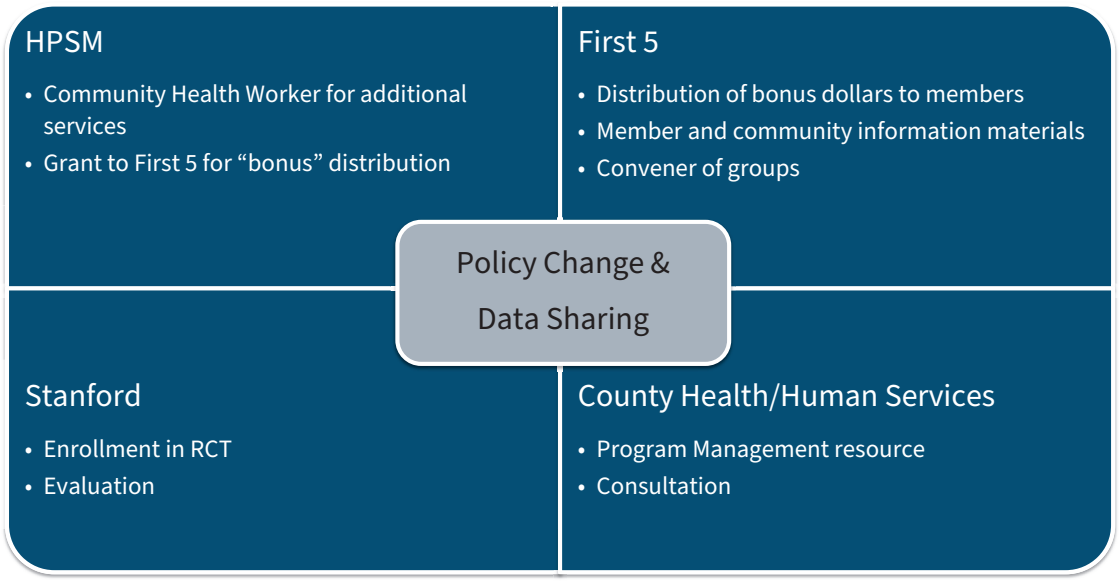
*Plan relies on data sharing between LPCH and HPSM and is pending funding approval from HPSM's board
**LPCH – Lucile Packard Children's Hospital; HPSM – Health Plan of San Mateo

Baby Bonus Funding Request

- **Total: $7,000,000**
- **CHW funding request for HPSM: $3,500,000**
  - CHWs salary plus benefits
  - Manager salary plus benefits
  - Consultative services for recruitment, training, onboarding, etc.
- **Bonus Funding request for First 5: $3,500,000**
  - Guaranteed income for 300 families
  - Services or administrative overhead support
  - Other funders will provide compensation for additional 100 families



Relationship Matrix



Sustainability

- HPSM adding Community Health Workers allows for benefitted services to be delivered
  - Currently no CHWs contracted in network*
- HPSM develops infrastructure for this new benefit along with caseload, providers enrolled in Medi-Cal and at the end of the program, CHWs can be hired by Network providers, CBOs or can be redeployed to other areas with need in the network.
- Bonus dollars mimic child credit so could impact policy change

*See Network Dashboard priority needs slide from May meeting at end of presentation

Next steps

- Vote on today's proposal
- HPSM to implement data use agreements and MOUs with stakeholders involved with Baby Bonus Program
- HPSM to begin building CHW workforce programming
  - Hiring, onboarding, consultative support
- Regular updates on Baby Bonus implementation progress
  - Winter Commission Meeting
  - Semi-annual thereafter

Questions?

HealthPlan OF SAN MATEO
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A Provider Investment Fund

Network dashboard: top priority needs

HealthPlan OF SAN MATEO
Healthy is for everyone

X Axis: **HPSM Member Access Priority**

Type	Contract Sufficiency	Real World Availability	Pop Needs Assessment	VOC*	Key Insights
Doulas		☑		☑	New benefit, new network
LTC/SNF		☑	☑	☑	Evergreen, finite number of beds in county, need for custodial beds
CHW		☑	☑	☑	New benefit, 0 in network contracted providers

*Voices of the Community

PACE Model Exploration
- State of the RFP

SAN MATEO HEALTH COMMISSION

June 12, 2024

HealthPlan OF SAN MATEO
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Starting Point - PACE Exploration

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- The current basic PACE model is not needed.
- Any PACE model must add value to the community and not replicate existing programs at HPSM or in the community.
- HPSM's partnership is as a strategic investor.
- Scope: HPSM is seeking a qualified Provider willing to develop a PACE Program in San Mateo County to serve frail elderly individuals who meet the nursing home level criteria established by the State of California.

What is PACE?

- **P**rogram of **A**ll-Inclusive **C**are for the **E**lderly
- A fully capitated, fully integrated, and comprehensive care program for adults age 55 or older living with chronic illnesses or disabilities
- This all-inclusive care model includes all services normally covered by Medicare and Medicaid.
- The PACE team is responsible for managing and paying for services delivered by contracted providers such as hospitals, nursing homes and specialists.

Model of Care

- Across ALL settings, PACE integrates and coordinates care for participants, including drugs, transportation and meals.
- 11 Interdisciplinary Team roles are mandated.
- An individualized care plan is developed to respond to all of the participant's needs – 24 hours a day, 7 days a week, 365 days a year.
- Ideally, a PACE center will include a mental health worker.

Purpose of the RFP

- Intent: For HPSM to issue a Letter of Support to a selected provider.
- California counties organized under County Organized Health Systems (COHS) must have a Letter of Support from the Heath Plan in that county in order for the Letter of Intent to be accepted by DHCS

Four Key Focus Areas

1. Capacity: Ability of the Provider to develop and operate a viable PACE program to meet the community-based long-term health care needs of the frail elderly population in San Mateo County.
2. Content: Demonstrated capability to meet the criteria set forth in the Statement of Work.
3. Support: Collaboration and coalition building with existing community providers including primary care providers.
4. Financial: Resources to develop and implement a financially viable PACE program until attainment of monthly cash-flow break-even and beyond. This would include demonstrating the capability to fund all capital and working capital needs of PACE program start-up and all CMS and DHCS fiscal soundness requirements through the state and federal application process and for the life of the program.

Our Perceived Barriers

- Members having to change their PCP, specialists, and other providers to those in the PACE program network.
- Members having to relinquish their IHSS hours, oftentimes provided by family members.
- Members with active mental health issues or unstable housing are excluded.
- Individuals who can obtain care through a variety of home-care arrangements and a community-based medical home, are possibly be less willing to change those arrangements.

Elements to Address

- History, governance structure, communities served, services currently provided, and rationale for wanting to establish a PACE Program in San Mateo County.
- Experience in operating PACE programs and having principles consistent with the PACE model of care.
- Depth of leadership and experience required to successfully address the challenges in developing a sustainable PACE program in San Mateo County.
- Current relationships with the community including potential key partners and stakeholders.
- Summary of executive level discussions and meetings leading to the decision to establish a PACE program in San Mateo County.
- Actions taken to date to determine the feasibility of establishing a PACE program in San Mateo County and the ability of the Responder to meet the challenges for operational readiness.

Elements to Address (cont'd)

- Proposal of the steps and actions to be taken during the start-up period to achieve compliance with PACE application requirements at both DHCS and CMS.
- Experience with primary, acute, and/or community-based long-term care services and experience in serving a Medicare and/or Medicaid population.
- Plan for successfully building census through an effective intake/outreach strategy and overcoming barriers such as members having to relinquish IHSS hours or change their primary care provider, specialists, and other providers to providers in the PACE contracted provider network.
- Plan, considering the geographical breadth of San Mateo County, for serving eligible members throughout the entire county.
- Plan for integrating service delivery model strategies to effectively address behavioral health issues to include substance abuse disorders.
- Plan for providing an inclusive and culturally competent workforce reflecting the diversity of the population.

Financial Viability & Commitment

- Provide realistic and justified financial projections, including cost estimates for capital related to the acquisition/construction/renovation of the PACE Center, architectural fees, PACE Center equipment and furniture, transportation vans, and working capital needs until the program reaches financial break-even.
- Provide any evidence that the organization or company has been financially successful with similar PACE start-ups.
- Provide a letter of commitment, signed by an officer or owner of the organization or company authorized to contractually bind the organization or company, to support the project to the point of financial break-even and beyond.
- Provide the organization or company's last 2 years of audited financial statements.
- If external financing is to be used, provide a letter of intent from the lender or financial guarantor.

Key Dates

- San Mateo Health Commission feedback
- Finalize RFP
- Solicit a Notice of Intent from potential Providers
- Clock starts with RFP distribution to potential Providers
  - Questions and responses (10 days)
  - Proposals due (3 weeks)
  - First round notifications (4 weeks)
  - Presentations by finalists
  - Final notification of selection (3 weeks)

Wherever the art of Medicine is loved, there is also a love of Humanity

-- Hippocrates (460 – 370 BCE)

Supplemental Slides

Why Consider PACE

- In the next 30 years, there will be a significant increase in people needing long term care with a 3-fold rise in the number of people over age 85 years.
- With this surge in total numbers of older adults comes an increasing prevalence of functional dependence and cognitive impairment as well as greater complexity of medical care needs.
- The traditional approach to long-term care has been nursing facility care or in-home care provided by family caregivers.
- The drivers include the high cost of residential care, the role of Medicaid on nursing home financing, and the plateau in nursing home bed capacity.

PACE Enrollee Requirements

- PACE programs can only enroll the following individuals:
  - At least 55 years old
  - Living in a PACE service area
  - Certified by their state as needing nursing facility care
  - Able to live safely in the community with PACE services at the time of enrollment

PACE Goals

- Throughout the development and growth of PACE, the overarching goal has remained very clear.
- This comprehensive care model aims to provide high-quality, person-centered care that enables older people who are at-risk for nursing home placement to remain living in the home or community setting.
- Complementary to that goal are efforts to minimize the need for hospitalization and to control health care costs by intensive management through an interdisciplinary team.

6 Critical Success Factors for PACE

1. Sufficient Demand for PACE Services
2. Positive Market Factors
3. Strong State Support
4. Adequate Payment for PACE Services
5. Sustained Organizational Capacity and Commitment to PACE
6. Adequate Capitalization

- PACE Critical Success Factors White Paper, National Pace Association, March 2013

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MEMORANDUM

AGENDA ITEM: 6.0

DATE: August 22, 2024

DATE: August 13, 2024

TO: San Mateo Health Commission

FROM: Patrick Curran

RE: CEO Report – August 2024

MCO (Managed Care Organization) Tax

As reported previously, the state re-implemented an MCO Tax last year. In this complex financial arrangement, health plans like HPSM pay a tax, which is leveraged to secure federal funding and directed toward specific programs and populations, such as Medi-Cal.

In the initial budget for 2024-25, the state proposed increasing the MCO Tax and directing a sizable portion of it to enhance Medi-Cal funding. This funding was intended for provider payments in order to increase access to care, especially because of the workforce challenges throughout the state. In 2024, we implemented an initial component of provider payment increases that took the form of a Targeted Rate Increase (so-called TRI payments). In the final state budget, much of the MCO Tax funding intended for Medi-Cal was redirected to fill in a large state budget hole.

Concurrently, there is a statewide coalition that has advocated for permanent MCO Tax funding for Medi-Cal, which would be accomplished through a ballot initiative. That state initiative is Measure 35, which will be on the November 2024 ballot. As a public agency, HPSM cannot advocate for or against any ballot initiative. We will present information about the MCO Tax and the ballot initiative at the September Health Commission meeting.

Baby Bonus Program

The Health Commission approved $7M in funding for this program at the June Commission meeting. Since that approval, planning work continues with stakeholders regarding implementation of the program. First 5 is the lead organization to implement the monthly payments to families. Stanford leads the research design process, and HPSM is beginning the planning for hiring the initial Community Health Worker (CHW) team. We are still targeting a January 1, 2025, implementation. We will present an update on this program to the Health Commission in early 2025.

Dental Program Evaluation

HPSM had an initial planning meeting with the Healthforce Center at UCSF, which the state has selected as the program evaluation agency. We are now 2.5 years into this 6-year pilot, and will be working with UCSF to ensure they have the necessary data and information to appropriately evaluate the success of this unique dental integration program.

HealthWorx

HPSM has been working with Health Management Associates (HMA) to perform an evaluation of our current HealthWorx program. The scope of that engagement is to not only evaluate whether to continue the program in its current form, but also to better understand the broader health coverage gaps of San Mateo County to explore what role HealthWorx or other product could play in expanding coverage. We will bring an update and potential recommendation to the Health Commission in late 2024 or early 2025.

Provider Investment and Primary Care Investment Funds

There are multiple work efforts taking place in these areas. The Health Commission approved overall criteria for these programs, as well as funding amounts, and teams are discussing specific criteria for potential provider rate changes as well as one-time investments. We will present an update on these programs to the Health Commission in early 2025.

State and Internal Audits

Our teams are very busy right now and over the next few months with several state audits, follow-up from prior audits, new state reporting requirements, NCQA accreditation preparation, and “mock” audits for CareAdvantage, in which we are receiving consultant expertise to identify gaps in our Medicare program for future audit readiness. These audits, including the preparation, actual audit meetings, and follow-up responses and documentation are very time-consuming. I am constantly impressed with the diligence and dedication of the HPSM staff, as these audits can be quite stressful.