HEALTH*matters* MD

HPSM's quarterly newsletter to update network providers on policy changes, regulatory requirements and best practices

Marketing & Communications | *Mat Thomas, Editor* | *Peggie Van, Designer*

HealthPlan OF SAN MATEO
Healthy is for everyone

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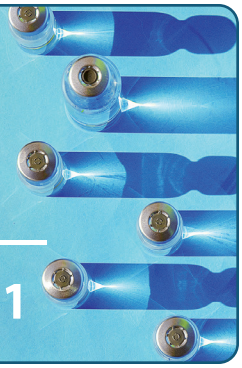

ALSO IN THIS ISSUE

CALAIM LAUNCHES IN 2022

The first reforms of California Advancing and Innovating Medi-Cal — or CalAIM — are coming this January. Here's what you need to know about the launch of this historic legislation.

CalAIM has been a long time in the making. Led by the Department of Health Care Services (DHCS), CalAIM strives to improve health outcomes and the quality of life for Medi-Cal members across California. CalAIM will allow Medi-Cal health plans like HPSM to cover new services that were previously not included as medical benefits or services.

While several components of CalAIM will not be implemented until 2023, two components of the program will begin to roll out in January of 2022, which are focused on supporting Medi-Cal beneficiaries with the most complex needs. These components are built off of previous federal waiver programs' successes, including Whole Person Care (WPC) and the Health Homes Program (HHP).

Enhanced Case Management (ECM)

ECM is the systematic coordination of services and comprehensive care management. This January, ECM will be rolled out as a statewide benefit for Medi-Cal beneficiaries who have the highest level of complexity. Some of these services were previously provided by the County-run WPC program, and these will be transitioning to HPSM. Such services will also be available to more HPSM members in the highest-risk category. This includes individuals who are experiencing homelessness, those who are frequently hospitalized or are at risk of institutionalization, children with complex needs and individuals transitioning from incarceration. To learn more, see the DHCS ECM Fact Sheet at **tinyurl.com/7xk2kff3**.

Community Supports

Community Supports include services that you may have heard referred to as "In Lieu Of Services" or ILOS. This component of CalAIM is focused on providing more flexibility for health plans to use medical revenue to cover services that could prevent other, less cost-effective medical utilization. In the near term, this means that HPSM will begin offering members the following services:

- Housing navigation
- Housing deposits
- Housing tenancy and sustaining services
- Home modifications
- Nursing home to RCFE/home transitions
- Nursing home diversions to RCFE/home
- Medically tailored meals

These services have been shown to help reduce hospitalization or institutionalization. Additional Community Supports may be added to HPSM's network over time as these programs are developed in San Mateo County. For more information, see the DHCS Community Supports Fact Sheet at **tinyurl.com/tttbdaku**.

How to learn more

Email **PSInquiries@HPSM.org** to learn more about the new services that will be available to your HPSM patients starting this January. Also check out this resource from the California Health Care Foundation: **tinyurl.com/3zxd6xsa**.

Next year is just the start of the CalAIM journey. HPSM will be exploring additional services to add over time, so please send us your suggestions about community organizations you think may be a good fit!

CalAIM | DHCS GOALS IN BRIEF

Prioritize those with complex needs by offering a "no wrong door" approach to people seeking help.

Enables Medi-Cal plans like HPSM to complement clinical care with new non-medical services, such as housing navigation support, peer support, meals and more.

Standardize availability of important non-medical services across California.

Previously, these services were launched as pilots in several California counties. CalAIM will begin making these services more consistent across health plans by defining ECM as a benefit for certain members. CalAIM also establishes a statewide definition of other optional Community Support services.

Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation.

CalAIM launches new value-based initiatives, incentivizing health plans and providers to modernize their systems and move to value-based payment.

OPTIMIZE YOUR PATIENTS' DENTAL CARE IN 2022

When HPSM Dental launches on January 1, 2022, HPSM will become the first health plan in California to integrate dental care with medical and behavioral health benefits for Medi-Cal members. The goal of this integration is to improve members' access to dental care and give providers a new way to support their patients' health. Here are some resources to help you and your patients make the most of this innovative pilot program.

Dental integration benefits

Learn how getting your patients dental care can improve their physical and mental health at **hpsm.org/dental-integration**

Dental provider information

Everything dental providers need to know about working with HPSM is at **hpsm.org/dental-provider-info**

Member dental education

Encourage your HPSM patients to learn about their new dental benefits by visiting **hpsm.org/member/hpsm-dental**

Dental providers needed

Tell the dental providers you know to apply to HPSM's growing dental network at **hpsm.org/hpsm-dental-providers**

HPSM Dental

MISSION:

- **Improve** our Medi-Cal members' oral health by increasing their knowledge of, access to and use of preventive dental services
- **Enhance** members' and providers' dental experience by supporting high-quality service
- **Achieve** better overall health outcomes by seamlessly integrating dental, medical and mental health care

HPSM Dental's mission is aligned with HPSM's core mission to ensure that San Mateo County's vulnerable and underserved residents have access to high-quality care, services and supports so they can live the healthiest lives possible. Managing our Medi-Cal members' dental care brings HPSM one step closer to realizing our vision that *healthy is for everyone*. Providers can help us fight to make that possible!

THANK YOU TO HPSM's BEHAVIORAL HEALTH PROVIDERS

In October of 2020, HPSM began contracting directly with the network of providers who offer mild-to-moderate behavioral health care services to HPSM members. On top of managing through the COVID-19 pandemic and the shift to virtual care that this required, over 100 behavioral health providers made the change to contract with HPSM last year.

Onboarding to a new payor organization is almost always challenging, but doing so in the midst of a historic increase in the need for behavioral health care services was no small feat. Fortunately, our behavioral health network came through when our members needed them most. HPSM staff, Behavioral Health and Recovery Services ACCESS Call Center staff, and our providers worked diligently to connect members with providers, often working off a long waitlist to help patients get the services they needed.

Thanks to our growing network of behavioral health providers, the wait time for members has been significantly improved. Over the last few months, our behavioral health providers have increased their availability and managed to ensure that members get connected to quality care.

Higher provider availability means our providers are receiving member referrals at a slower rate than before. But that could change – especially as we head into the winter months when seasonal changes impact people's mental health.

Behavioral health providers

Please keep HPSM updated, especially as it pertains to your:

- **Panel capacity** Let us know if you are available to take on new patients so we may continue referring patients to your practice or facility.
- **Reopening status** Many members are expressing increased interest in returning to in-person services either now or in the near future. Please update us if your in-person service availability changes. For resources on reopening your practice, please visit **hpsm.org/provider-covid-resources/reopen**.

@ HPSM_BH_Provider_Availability@hpsm.org

☎ 650-616-2580

Primary care providers

Please continue to screen, assess and diagnose mental health issues within your scope of practice. If a member needs behavioral health treatment beyond your capacity:

- Members can self-refer by calling the ACCESS Call Center at **1-800-686-0101**
- PCPs can download a Behavioral Health Referral Form at **hpsm.org/provider/behavioral-health**, fill it out and fax it to the ACCESS Call Center at **650-596-8065**

UPCOMING CHANGES TO HPSM's HOMEADVANTAGE PROGRAM

HPSM's HomeAdvantage program offers home-based medical care to over 1,000 CareAdvantage members with multiple chronic conditions at no cost as a complement to primary care services. There are some upcoming changes to the program that we want PCPs with patients in the program to know about.

New program vendor HomeAdvantage services have been provided by Landmark Health since 2016. However, going forward, a new HPSM vendor called Upward Health will provide HomeAdvantage services. Some members will be transitioned to the new vendor during the period of January to February 2022. All remaining members will be transitioned on March 1, 2022. Upward Health staff will provide the same services as Landmark Health, so the transition should be very smooth for members.

New service tier and branding The number of HomeAdvantage program tiers will expand from two to three. To help members and PCPs understand the differences between the three tiers, each will have its own name under the HomeAdvantage umbrella:

HomeAdvantage
(the program that most members are familiar with)

- Scheduled visits with a medical provider
- Live 24/7 phone support: members can call any time they have urgent needs or questions
- Urgent visits at home when people need them and their doctor is not available

HomeAdvantage OnDemand
(currently called AlertCare)

- Yearly health exam at home
- Live 24/7 phone support: members can call any time they have urgent needs or questions
- Urgent visits at home when people need them and their doctor is not available

NEW!
HomeAdvantage FocusCare

- 90-day post-discharge support after an event such as an inpatient, emergency room or hospital visit
- A home visit within three days of discharge to review care, treatment plan and medications
- Subsequent follow-up visits

PCPs who have assigned members in HomeAdvantage:

- You have been emailed more detailed information about this transition along with a list of your members impacted by the change.
- This email includes an introduction to Dr. Mihale, Upward Health's CMO. Please schedule a meeting with Dr. Mihale to learn more about how Upward can support your practice.
- Learn more by reading our provider announcement at **tinyurl.com/3zrumarx**.
- If you have questions or did not receive the email with your HomeAdvantage member list, please contact **PSInquiries@HPSM.org**.

DHCS | Medi-Cal Rx

MEDI-CAL RX REMINDER & PROCEDURAL UPDATES

In our two previous issues of *HealthMattersMD*, we informed you that outpatient pharmacy benefits for HPSM Medi-Cal members will transition from HPSM to fee-for-service (FFS) Medi-Cal on January 1, 2022. As of that date, these services will no longer be managed by HPSM. Instead, they will be administered by the California Department of Health Care Services (DHCS) in partnership with its contracted pharmacy benefits manager (PBM), Magellan. These pharmacy benefits will also be rebranded as "Medi-Cal Rx".

We have recapped the changes this entails for providers below. While some of this information has appeared in previous issues, this article includes the latest procedural updates for providers. We hope that giving you all the most up-to-date procedural instructions in one place will best help you prepare for this transition.

WHAT'S CHANGING *(FOR MEDI-CAL MEMBERS ONLY)*

FORMULARY Instead of a formulary, there is a preferred drug list called the Medi-Cal Rx "Contract Drug List" (CDL)

Starting January 1, 2022, you'll need to refer to the Medi-Cal Rx CDL instead of HPSM's formulary to find the list of covered drugs for beneficiaries. Like a drug formulary, the CDL may change over time. The Medi-Cal Rx CDL can be found at **medi-calrx.dhcs.ca.gov/home/cdl**. A drug lookup tool will also be available at **medi-calrx.dhcs.ca.gov/provider/drug-lookup**.

AUTHORIZATIONS You will need to submit pharmacy-benefit prior authorization (PA) requests to Magellan instead of HPSM

There are several instances when a PA is required before Medi-Cal will pay for a drug you are prescribing to a member:

- The drug is not on the Medi-Cal CDL
- The drug is on the Medi-Cal CDL, but is flagged as requiring a PA
- The drug is on the Medi-Cal CDL, but with restrictions exceeded by the prescription

Please keep in mind that under Medi-Cal Rx, PA requirements, review criteria and the process for handling authorization denials may differ from what HPSM has historically done.

Submit pharmacy PA requests to Magellan, the contracted PBM for DHCS. You can submit a PA request in the following ways:

The Medi-Cal Rx Provider Portal (sign-up required)
medi-calrx.dhcs.ca.gov/provider

Electronically (via CoverMyMeds)
covermymeds.com/main/prior-authorization-forms/magellan-rx

Fax
800-869-4325

Mail
Medi-Cal Rx Customer Service Center
Attn: PA Request
P.O. Box Number 730
Rancho Cordova, CA 95741-0730

TRANSITION Medi-Cal Rx will support the transition by honoring existing PA approvals from HPSM and allowing for a 180-day period when existing prescriptions will not require PA

During the transition, prescription coverage will depend on:

- **Existing prescription covered by PA** Medi-Cal Rx will cover the prescription for the duration of the PA, not to exceed one year from the date the prescription was written (exceptions apply)
- **Existing prescription covered without a PA** Medi-Cal Rx will continue covering for at least the first 180 days before requiring any PA
- **New prescription that requires PA under Medi-Cal Rx** You will need to submit a PA
- **New prescription that does not require PA under Medi-Cal Rx** No additional action needed

BILLING How pharmacies bill for prescriptions

Starting on January 1, 2022, pharmacies are to bill Magellan instead of HPSM (or HPSM's PBM, SS&C). To bill Magellan, pharmacies should use the following information: BIN 022659, PCN 6334225 and the 9-digit Cardholder Identification Number (CIN) or 14-character Benefits Identification Card (BIC) number located on the patient's ID card.

WHAT IS STAYING THE SAME

Medi-Cal Rx will not affect:

- Pharmacy benefits for HPSM CareAdvantage or HealthWorx patients (HPSM will continue to manage these)
- All other health care benefits currently managed by HPSM
- Pharmacy services typically billed on a medical and/or institutional claim instead of a pharmacy claim, which will continue to be billed through HPSM

TAKE THESE FOUR STEPS

to learn more about Medi-Cal Rx and stay informed about the transition

1) Check out more information about Medi-Cal Rx at **medi-calrx.dhcs.ca.gov/home**
2) Register for the new Medi-Cal Rx provider portal at **medi-calrx.dhcs.ca.gov/provider**
3) Subscribe to receive emails for the latest Medi-Cal Rx updates at **mcrxsspages.dhcs.ca.gov/Medi-CalRxDHCScagov-Subscription-Sign-Up**
4) Look out for information on upcoming Medi-Cal Rx training webinars

▶ **If you have questions, please email Magellan's Medi-Cal Rx Education and Outreach team at medicalrxeducationoutreach@magellan-health.com**

THREE TOOLS HPSM USES TO REDUCE HEALTH DISPARITIES

Since HPSM was founded in 1987, we have upheld the core belief that *healthy is for everyone*. Over time, we have found new ways to understand and actualize health equity for the more than 140,000 diverse members that we serve. This article explores some of the ways we use a health equity lens to reduce health disparities, including:

IMPROVING HEALTH EQUITY WITH THE POPULATION NEEDS ASSESSMENT

In June 2021, HPSM conducted an annual Population Needs Assessment (PNA) of our Medi-Cal membership. The goal of the PNA is to improve the health of our members. We do this by assessing member needs, identifying health disparities, and then using our findings to develop strategies that address these needs and disparities.

The PNA was informed by a variety of data sources, including (but not limited to):

- Healthcare Effectiveness Data and Information Set (HEDIS) results
- Claims data
- Language assistance services utilization data
- Member survey data, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey

To conduct the PNA, we segmented HPSM's Medi-Cal member population by several factors (including age, gender, language preference, race/ethnicity, geographic distribution and vulnerable group status).

Based on the PNA findings, we developed an action plan with targeted Health Education, Quality Improvement and Culturally & Linguistic Appropriate Services (CLAS) program strategies.

Some of the demographic information that the PNA highlights includes the following:

- HPSM's Medi-Cal line of business makes up a total of 77% of our total membership.
- HPSM's Medi-Cal membership is fairly young (the average age is 34.4 years).
- Almost 45% of our Medi-Cal membership identifies as Hispanic, while 19% identify as Asian or Pacific Islander.
- English or Spanish is the preferred language of close to 90% of our Medi-Cal members.

HPSM also found the following health disparities through the PNA:

- **Perinatal population** HPSM found higher rates of gestational diabetes and C-sections among certain subgroups as compared to the general population.
- **Cancer screening** HPSM's rates for cancer screening, specifically breast cancer and cervical cancer, decreased below the minimum performance level. Even accounting for this drop, the PNA results showed disparities in the African American population, as well as in populations that speak Korean and Arabic.
- **Language preference** Almost half of our Medi-Cal membership listed Spanish as their preferred language. The PNA, however, showed a lower percentage of Spanish-speaking providers compared to this member language preference.

Provider language capabilities are tracked through the Provider Directory Information Verification Change form. Make sure your information is up to date here: https://providers.hpsm.org/ChangeRequestProvider/.

These findings from the PNA help HPSM prioritize some of our work in health equity and disparities. For example, in 2022, a key focus area will continue to be the findings in the breast cancer screening measure. It is imperative that we continue to screen for these cancers and provide members with all accessible information so they can make the most informed decisions about their health.

Providers can also help members get the screenings they need by doing the following:

- Check which patients are due for a cancer screening:
  - Breast cancer screening is recommended for women 50-74.
  - Cervical cancer screening is recommended for women 21-64.
- Talk to patients about whether a screening is right for them during their primary care visits. If it is, make a referral on the spot.
- Give extra attention to members of color and members who have limited English proficiency. Remember, interpreter services are available for all HPSM members at no cost to member or provider. This way, you can focus on answering questions and addressing their concerns.

HPSM's PNA Action Plan provides other examples of high-priority areas that tackle some of our findings. HPSM's Population Health Team will provide more details on the PNA in upcoming provider forums.

- Analyzing health disparities among members through the **Population Needs Assessment**
- Supporting providers working with members who have limited English proficiency through **language assistance services**
- Providing members and providers with tools to improve **health literacy**

THE IMPORTANCE OF USING INTERPRETERS WHEN SERVING DIVERSE COMMUNITIES

When you use interpreters, patient experience is improved, and you significantly reduce the risk of communication errors, which can lead to negative health outcomes and clinical consequences.

To help you give the best care to your patients, HPSM provides telephonic, video-remote and in-person interpreter services. The use of interpreters not only helps you meet federal and state regulations for providing culturally and linguistically appropriate care, but also enables members to be fully informed about their health conditions and options for treatment.

Trained medical interpreters can provide unbiased and accurate information, whereas a relative might not have formal training as interpreters and may not be familiar with medical terminology and how to translate it. They might also add their own opinion in the delivery of the message.

To help support providers in accessing interpreter services, we have recently updated our language assistance services Page. For resources, how-to videos and tips, visit hpsm.org/provider-language-services.

HEALTH LITERACY SUPPORTS HEALTH EQUITY

Some socioeconomic factors and characteristics may make an individual more likely to struggle with health literacy, making health literacy an important part of health equity. To reduce the possibility of miscommunication, health care providers are responsible for ensuring that crucial health information is communicated clearly and in terms that the member can relate to.

What Is health literacy?

Health literacy refers to how easily people can find, comprehend, process and communicate health information in order to make informed decisions regarding their health. It is important to meet our members at their varying levels of health literacy.

The **teach-back method** is a good way to check how well you are explaining health information and that the patient understands correctly. When performing teach-back, clinicians may ask the member to repeat back care instructions or information on a new diagnosis. You can make the teach-back method work in a way that feels natural to you. Consider incorporating it into your day-to-day conversations gradually and in your own words. Here are some examples of potential teach-back questions:

Please note that teach-back is NOT a test of understanding. It is the clinician's responsibility to ensure they are communicating clearly.

- After this visit, I know your wife will ask what happened today. What will you tell her?
- Would you please show me how you are going to use your inhaler, so I know if I was able to explain it clearly?
- This is a new diagnosis for you, so I want to make sure I explained it clearly. Will you tell me in your own words what congestive heart failure is?

We look forward to working together with our provider community as we continue to develop these and other programs aimed at improving health equity. For more information about:

- **HPSM's PNA**, email the Health Education Department at **HealthEducationRequest@hpsm.org**
- **Interpreters**, email **interpreters@hpsm.org** or call the Population Health Team at **650-865-5413**
- **Health literacy** and other resources, go to **hpsm.org/health-tips**

PROVIDER RESOURCES

REFER YOUR PATIENTS FOR COMPLEX CASE MANAGEMENT

As part of our Population Health Management initiative, HPSM offers several special support programs to improve overall care delivery and health outcomes while helping our members reach their health goals. Complex Case Management is one of them. Through this program, an HPSM Case Manager:

- Acts as a care liaison between the member, their family/caretakers and their primary care provider
- Creates a goal-oriented care plan that includes a follow-up schedule with specific time frames
- Helps the member manage complex health issues or critical events
- Connects the member with HPSM programs, community resources and other healthcare providers that will help them achieve their health goals

HPSM identifies members who would benefit most from Complex Case Management through health assessments and data analysis of clinical records. A Case Manager then calls these members to ask if they want to join the program. But **you can refer any HPSM member for Complex Case Management**. The program is especially helpful to patients who have multiple chronic conditions, co-morbidities or co-existing functional impairments (such as sight impairment and mobility limitations).

Refer a member for Complex Case Management by completing the referral form at **hpsm.org/provider-forms** (there are separate forms for pediatric and pregnant patients)

For more information, visit **hpsm.org/care-coordination** or call **650-616-2060**

HPSM's HISPANIC HERITAGE MONTH WEBINAR & CULTURAL RESOURCES

In October, HPSM celebrated Hispanic Heritage Month by hosting a virtual webinar for our providers and staff. HPSM staff shared insights into the rich linguistic, racial and ethnic diversity of our membership, and highlighted resources available to our providers.

We presented this webinar to:

- Celebrate HPSM's diverse community of members, providers and staff
- Help providers support HPSM's members who identify as Hispanic/Latino/a/x, including by understanding the words that individuals may identify with
- Describe HPSM's initiatives to address health disparities among our membership, and share resources that are available to you as an HPSM provider
- Empower providers to have cultural conversations with patients and peers, and to continue their learning journey with resources such as:
  - Cultural Competency 101: **healthequity.wa.gov/clastrainingandresources**
  - Cultural Awareness at Work and in Leadership: **qualityinteractions.com/blog/cultural-awareness-in-healthcare-checklist**

Interested in learning more?

- Watch the webinar at **tinyurl.com/bp3j4b4e**
- See the webinar slides at **tinyurl.com/y6pnshpu**
- Learn more about HPSM's Health Equity and Health Promotion work by reaching out to **PSInquiries@HPSM.org**
- Read more about HPSM's health equity work on our website's provider landing page at **hpsm.org/provider**

REQUEST PRIOR AUTHORIZATION IN FOUR STEPS

Before delivering a non-emergency service, HPSM providers are expected to check the Medi-Cal Provider Manual[1] and HPSM's Prior Authorization Required list[2]. These provider resources indicate which codes are covered benefits and whether they require prior authorization or not.

To help us ensure prior authorization requests get answered as quickly as possible, providers must complete request forms correctly and accurately. Here are four simple steps to make that happen:

1. **Download the latest form at hpsm.org/provider/authorizations.** Make sure the form you are using is the most current. As of this publication, the form dated February 2020 is the most current form for general authorizations. Older request forms will not be accepted and may result in delay of payment.
   - Certain types of specialty authorizations, including Non-Emergency Medical Transport (NEMT) and nutritional supplements, require a unique form or have unique documentation requirements. Read more and download the latest forms at **hpsm.org/provider/authorizations/specialty-provider**.

2. **Complete the fillable PDF on your computer, typing information into the required boxes.** Here are some important tips to make sure your request is not rejected and is processed as quickly as possible:
   - **Hand-written forms will be rejected.** The only field that should be completed by hand is the signature field at the bottom of the form.
   - **Only enter information and check off items that are necessary.** You will select "Routine" for nearly all requests. Two common errors that result in reprocessing requests (and slow down response time) are:
     - Marking "Urgent" for non-urgent services.
     - Checking off items within the "Long Term Care (LTC) authorization requests" box when the request is not for a long-term care stay.
   - **Double-check your form to make sure you've entered correct information for your patient.** Common errors, such as incorrect member data, benefit not active, invalid National Provider Identifier (NPI) number or invalid diagnosis codes can result in your request being denied.

3. **Fax in the authorization form to 650-829-2045.** You may also include medical necessity documents with your fax. Don't use a cover-sheet with your fax. To prevent delays, please use only one form per patient, and one form per fax.

4. **Wait for prior authorization to be granted.** Urgent requests for all lines of business will be answered within 72 hours of receipt. Standard requests for Medi-Cal, HealthWorx and ACE patients will be answered within five business days from receipt. CareAdvantage requests will be reviewed within 14 calendar days from receipt.

Did you know? You can check the status of your authorization requests online! Please allow up to 48 hours for authorization status to update. Visit **hpsm.org/provider/portal** to sign up.

Still have questions? You can watch a new video on our website explaining how to properly submit a prior authorization form at **hpsm.org/provider/authorizations**.

[1] medi-cal.ca.gov

[2] hpsm.org/docs/default-source/provider-services/authorizations/20200901-q3---finalf26b4f475c5747f88fa5462ac13c16a1.pdf

HealthPlan OF SAN MATEO
Healthy is for everyone
801 GATEWAY BOULEVARD SUITE 100
SOUTH SAN FRANCISCO CA 94080

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PCPs: APPLY FOR FUNDING FROM HPSM's VACCINE INCENTIVE PROGRAM BY JANUARY 31

In recent issues of *HealthMattersMD*, we've provided updates on HPSM's ongoing efforts to increase our members' COVID-19 vaccination rates. You can help San Mateo County achieve our community vaccination goals while protecting your patients' health by applying to our COVID-19 Vaccine Incentive Program!

To apply for funding, submit a brief Plan of Action at tinyurl.com/4aa78795 by January 31, 2021

Once HPSM approves your plan, you will be eligible to earn two types of funds:

1) **Upfront funding** Receive $10 per unvaccinated assigned member to support your practice serving as a COVID-19 vaccinator (learn how to become a vaccinator at **hpsm.org/provider-covid-resources**)

2) **Outcomes funding** Receive $60 per unvaccinated assigned member who receives their first COVID-19 vaccine dose after your Plan of Action is approved, whether from your practice or someplace else

HPSM will let you know if your plan has been approved within 10 business days of receiving it. To ensure timely processing, please respond promptly to any follow-up inquiries from HPSM staff about your plan. Both types of funding are currently only available through **February 28, 2022**. We will notify participating providers if the program is extended beyond this date.