HealthPlan OF SAN MATEO
Healthy is for everyone

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THE SAN MATEO HEALTH COMMISSION
Regular Meeting
July 12, 2023 - 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor Boardroom
South San Francisco, CA 94080

AGENDA

1. **Call to Order/Roll Call**
2. **Public Comment/Communication**
3. **Approval of Agenda**
4. **Consent Agenda***
   - 4.1 Approve Amendment to Agreement with Milliman
   - 4.2 Approval of Quality Improvement (QI) Documents: 2022 QI Program Evaluation; 2023 QI Program Description; and 2023 QI Work Plan
   - 4.3 Approval of San Mateo Health Commission Meeting Minutes from June 14, 2023
5. **Specific Discussion/Action Items**
   - 5.1 Restructuring San Mateo Health Commission Standing Committees*
   - 5.2 Update on Regional D-SNP Presentation
6. **Report from Chairman/Executive Committee**
7. **Report from Chief Executive Officer**
8. **Other Business**
9. **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.

MEMORANDUM

AGENDA ITEM: 4.1

DATE: July 12, 2023

DATE: July 3, 2023

TO: San Mateo Health Commission

FROM: Trent Ehrgood, CFO

RE: Approval of Amendment to Letter of Engagement with Milliman Consultants for Actuarial Services Related to 2023 and 2024 Medicare D-SNP Bid

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Recommendation:

Increase limit to engagement with Milliman Consultants who is providing actuarial services related to HPSM's 2023 and 2024 Medicare Advantage (MA) and Part D (PD) bid submissions by $70,000 to a revised total of $620,000.

Background:

HPSM transitioned its Medicare CareAdvantage product from the Cal MediConnect demonstration program to a D-SNP effective January 2023. As a D-SNP, HPSM is required to submit an annual bid to CMS, which is a complex process.

At the February 2022 Commission meeting, an engagement with Milliman Consultants was approved for the 2023 and 2024 D-SNP bid submissions. The original estimated amount approved for the two years was $550,000.

The 2023 bid was completed in August 2022. The 2024 bid is currently in process and is expected to be completed in August 2023. Total cost for both years will be higher than originally estimated.

Scope of Work:

Milliman's work on the bid includes a suite of support services and deliverables, including:

- Preliminary projections of benefit year costs and revenue for Part C (MA) and Part D (PD)
- Advice and strategy support to develop D-SNP product and benefit package
- CMS delivery-ready bid pricing tool (BPT) (initial June submission and August re-submission), narrative bid substantiation, and actuarial certification, and
- Support through CMS's bid desk review and a final management report documenting the submitted bid information and major assumptions used in development.

Fiscal Impact:

For the 2023 bid process, the final Milliman fees were $284,409. Estimated fees for the 2024 bid are around $325,000. The recommendation is to increase the not-to-exceed amount for the two-year engagement by $70,000 (from $550,000 to $620,000), which allows some buffer.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF AMENDMENT TO
LETTER OF ENGAGEMENT WITH MILLIMAN CONSULTANTS
FOR ACTUARIAL SERVICES RELATED TO 2023 AND 2024 MEDICARE D-SNP BIDS

RESOLUTION 2023 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission approved a two-year engagement with Milliman Consultants in February 2022 for a total estimated cost of $550,000 to prepare HPSM's 2023 and 2024 D-SNP bid; and

B. The new estimated cost for both submissions is $620,000; and

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves an increase to the engagement with Milliman Consultants by $70,000 for the 2023 and 2024 MA-PD bid projects with an updated not to exceed amount of $620,000 for those activities.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of July 2023 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: 4.2

DATE: July 12, 2023

DATE: July 3, 2023

TO: San Mateo Health Commission

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

RE: Quality Improvement Program Documents: 2022 Quality Improvement Program Evaluation, 2023 Quality Improvement Program Description, and 2023 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): 2022 Quality Improvement Program Evaluation; 2023 Quality Improvement Program Description; and 2023 Quality Improvement Work Plan.

Background and Discussion:
The following summarizes the 2022 Quality Improvement Program Evaluation and the changes to the Quality Improvement 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 2022 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 2022 QI Program activities and provides guidance for the 2023 QI Program and Work Plan.

Trending and analysis of our clinical quality metrics reported in 2022 indicated that many preventative care services and screenings continue to decline through 2021. Most notably, cervical and breast cancer screening rates decreased from prior year rates which indicates continued impact of the Covid-19 pandemic. However, 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.

The Performance Improvement Project (PIP) aimed on increasing routine well care for older adolescents continued through 2022, as did the PIP on increasing breast cancer screenings for women who identify as Black or African American. We look forward to measuring the impact of these quality improvement efforts with our clinical metric reporting in 2023.

Quality Improvement Program Description

The QI Program description details the structure, membership, and responsibilities of the Quality Improvement committees as well as the operational committees that report to the Quality Improvement 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 2022 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. No significant changes were made to the overall QI structure, monitoring processes or committee oversight for 2023. While HPSM transitioned the Cal MediConnect Plan (a Medicare-Medicaid Plan) to a Dual Eligible Special Needs Plan (D-SNP) on January 1, 2023, the scope, systems and processes of the QI Program remain consistent for this member population for 2023.

Quality Improvement Work Plan

The QI Work Plan is the operational and functional component of the QI 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 2023 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. HPSM is conducting phone outreach to Black or African American identifying members and/or members with developmental disabilities and managed by the Golden Gate Region Center to improve cervical cancer screening rates for these populations. A PIP to improve the rate of early well-child visits for Hispanic/Latino identifying members is also in development. 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 APPROVAL OF
2022 QUALITY IMPROVEMENT PROGRAM EVALUATION
2023 QUALITY IMPROVEMENT PROGRAM DESCRIPTION
2023 QUALITY IMPROVEMENT WORK PLAN

RESOLUTION 2023 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission is required by the State to review and approve the Quality Improvement Program Description, the Quality Improvement Program Evaluation; 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 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. 2022 Quality Improvement Program Evaluation
    b. 2023 Quality Improvement Program Description
    c. 2023 Quality Improvement Work Plan

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of July 2023 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

2022 QUALITY IMPROVEMENT PROGRAM ANNUAL EVALUATION

Prepared in February 2023

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

CONTENTS

1. INTRODUCTION

This program evaluation provides a comprehensive overview of quality improvement activities conducted in 2022.

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 2022, HPSM was required to collect and report HEDIS measures for the Medi-Cal and CareAdvantage populations. The 2022 reporting year HEDIS results are an analysis of services provided in 2021 (measurement year). 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.

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.

Results from each specific HEDIS measure 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 2022 are of services provided to members enrolled in 2021.

2022 MEDI-CAL SUMMARY:

For Reporting Year (RY) 2022,

- 4 measures above HPL (above 90th percentile):
  - Childhood Immunization Status –combination 10
  - Immunizations for Adolescents –combination 2
  - Prenatal and Postpartum Care – Postpartum Care
  - Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)
- 3 measures below MPL (50th percentile):

- Cervical Cancer Screening
- Well-Child Visits in the First 30 Months of Life:
    - 6 or more well-child visits in first 15 months of life
    - 2 or more well-child visits in 15 to 30 months of life

CAREADVANTAGE/CAL-MEDICONNECT (CA-CMC) SUMMARY:

In 2022, HPSM successfully reported on all 55 measures required by CMS for Medicare-Medicaid Plans. In addition, all three CMS Core Quality Withhold HEDIS measure passed the performance requirement, significantly improving from 2021. These measures are Controlling High Blood Pressure (CBP), and Follow-up after Hospitalization for Mental Illness (FUH).

2022 PERFORMANCE IMPROVEMENT

The following areas represented opportunities for improvement and key areas of focus for 2022:
Adolescent Well-Care Visits (WCV)
Breast Cancer Screening (BCS)
Cervical Cancer Screening (CCS)
Comprehensive Diabetes Care (CDC)
- A1c Testing
- Poor A1c Control

Controlling High Blood Pressure (CBP)

3. QUALITY OF CLINICAL CARE ACTIVITIES

3.1 ADOLESCENT WELLCARE VISITS (WCV)

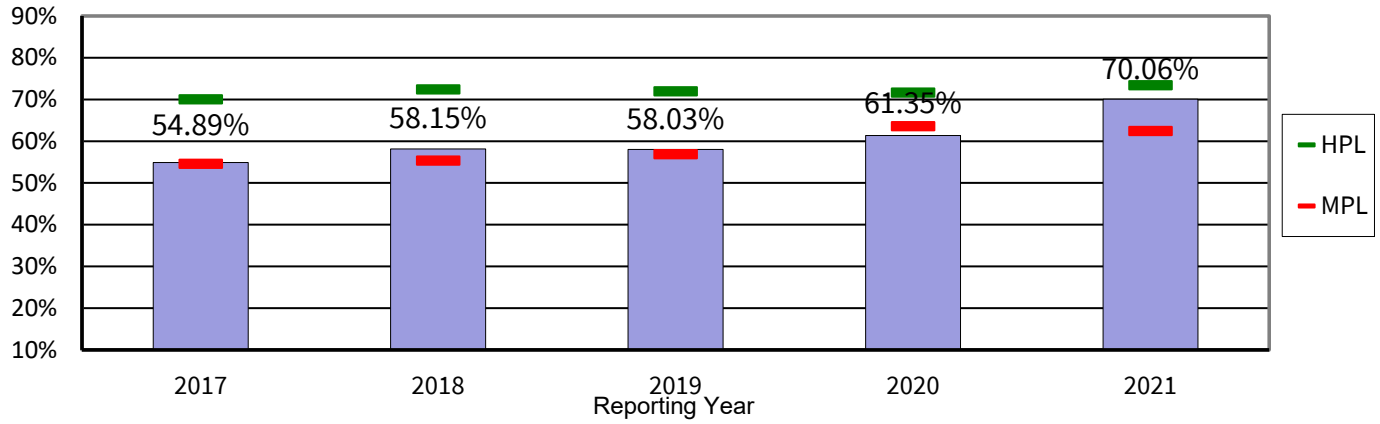
Abrev	Measure	MY2021	50th Percentile	MY 2021 Rate	MY 2019 Rate
WCV	Child and Adolescent Well-Care Visits (3-21 yrs)	56.92	45.31	48.8	N/A

Measure/Program	Adolescent WCV PIP Program
Objective:	By June 30, 2022, increase the percentage of adolescent well visits among 18 to 21 year olds assigned to Daly City Youth Clinic, from 11% to 15%.
Program Description	**Incentive Program –** HPSM had initiated a Performance Improvement Project (PIP) focused on improving AWC for young adults aged 18-21 years of age. However, due the COVID-19 pandemic, no real developments in the plan could take place and the PIP had to be put on hold. HPSM reinitiated this PIP in 2021. HPSM will offer a $25 Target incentive gift card for all teen members aged 18-21, who participate in a well visit at Daly City Youth Clinic
Trend:	Our rates have been lower for this age group than the average.

Goal Met/Not Met	The rate for MY2021 was 56.92 and did meet the MPL for this measure.
Barriers identified	Although we met the goals for this measure, we have identified some barriers in the past that continue to affect this 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 the full information on the importance of well visits.
Recommended interventions for barriers	Incentive program developed to ensure that members attend their well visit after appointment has been made
Whether yearly planned activities were met	Finalized internal process with BSI team on checking well visits for teens and ensuring they met well visit criteria. Finalized process with Daly City Clinic on how well visits would be checked and submitted by the clinic. As of January 2022, incentive program was launched and gift cards sent out to teens on a weekly basis
Any changes to the program	Provider site was also changed from Seqouia Youth Clinic to Daly City Youth Clinic due to resource constraints.

3.2 ASTHMA MEDICATION RATIO (AMR)

AMR HEDIS RESULTS

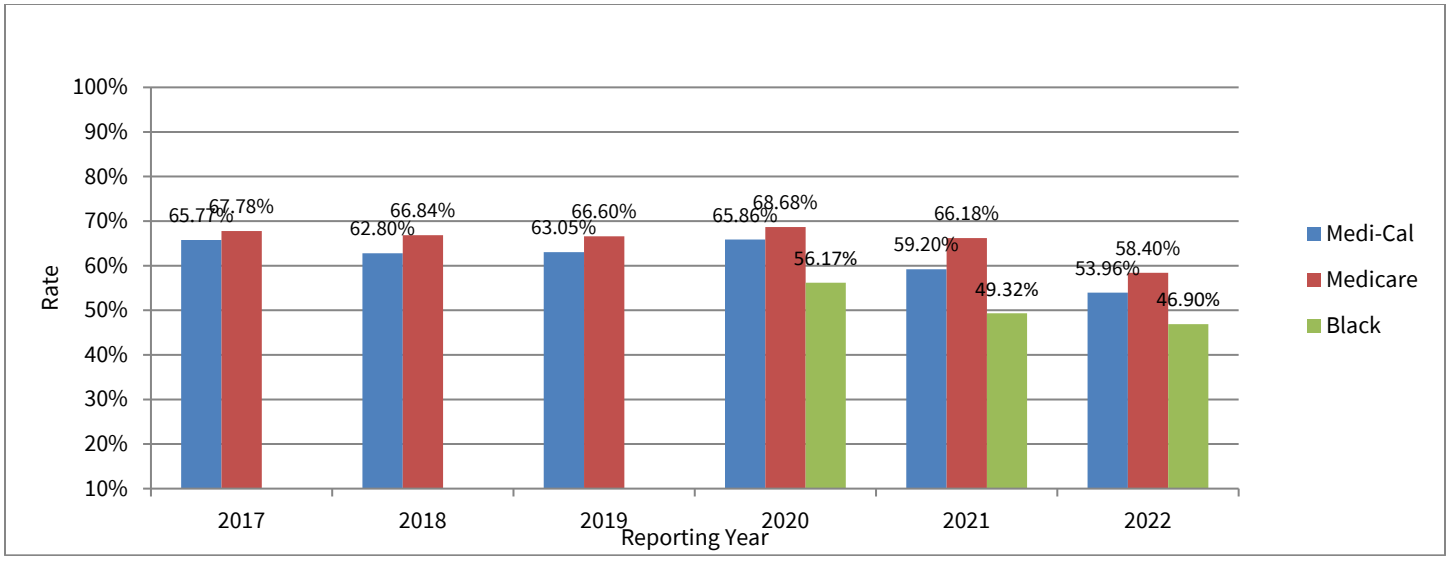


AMR has improved in recent years and no longer active improvement project in 2023. HPSM will continue to monitor AMR annually.

3.3 BREAST CANCER SCREENING (BCS)

BCS HEDIS RESULTS

The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.



For BCS Medi-Cal RY2022 MPL (50th percentile) was 53.93% and HPL (90th percentile) was 61.97%.

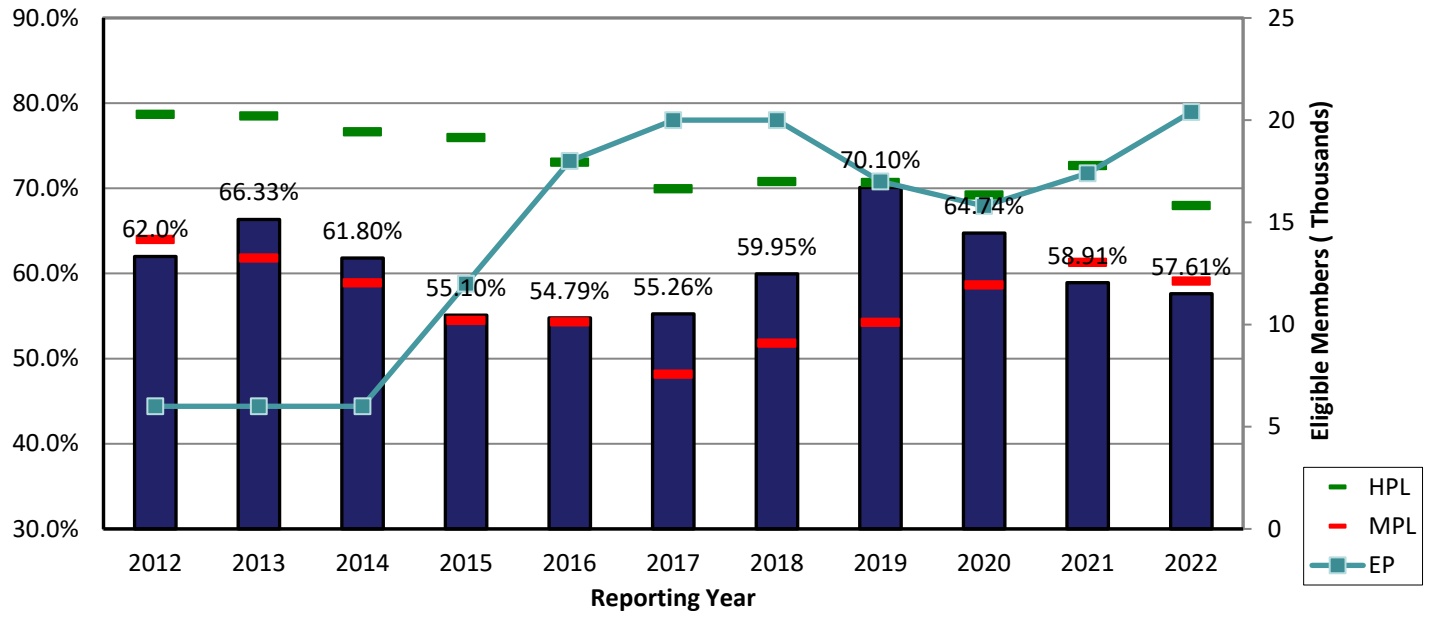
Measure/Program	BCS METRIC
Objective:	By December 31, 2022, increase the percentage of mammography screenings among continuously enrolled African American Medi-Cal members, ages 52 - 74 from 46.43% to 55.8%.
Program Description	1. **BCS/ ICM Outreach Program:** Direct outreach to non-compliant members through phone calls, discussing the importance of talking to their PCP about breast cancer screening. 2. **BCS Monthly Mailer:** HPSM will mail a postcard to eligible non-compliant members reminding them to talk to their PCP about whether a screening is right for them. This mailer also includes a link to our updated health tips page, which provides more information and resources on breast cancer. 3. **BCS Member Incentive Pilot:** In partnership with Ravenswood Family Health Clinic, HPSM will offer members assigned to the clinic incentive opportunities: 1) $10 Target gift card for discussing BCS with a Health Coach at the clinic; 2) $25 Target gift card for getting a breast cancer screening mammography.
Trend:	Our rate for BCS decreased from the prior year from 49.32% to 46.90%.
Goal Met/Not Met	The goal was not met for 2022.
Barriers identified	Because we did not meet the goal for this measure, and we see a disparity in the African American population, we want to increase rates in this population. Planned activities to understand barriers are as follows:

	1. Integrated care management team will reach out to African American members to understand barriers to mammography. 2. Ravenswood Family Health Center will share identified barriers discovered in health coaching sessions.
Recommended interventions for barriers	The BCS measure was added to the 2022 P4P Program. PCPs have access to P4P reports for their assigned members. Annual incentive payment was implemented. We conducted an outreach program to African American women aged 52-74 who are eligible and due for BCS. We asked them about barriers and facilitators to getting a screening. We field tested and edited the Staying Healthy mailer.
Whether yearly planned activities were met	Planned yearly activities were met.

3.4 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 :

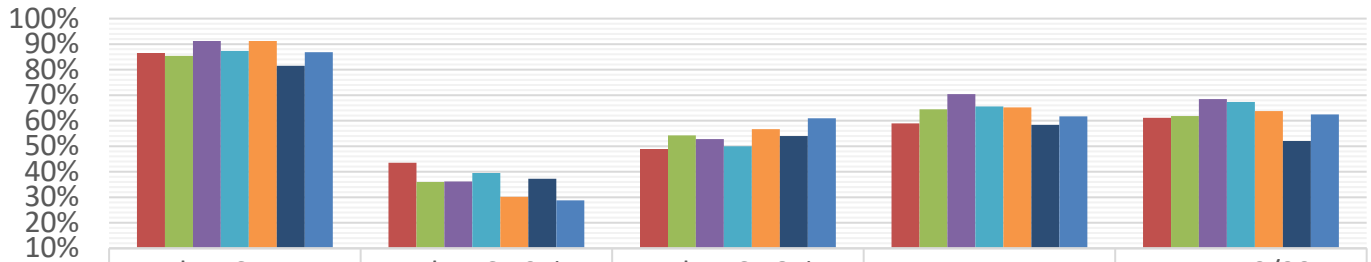


Measure/Program	CCS METRIC
Objective:	By December 31, 2022, increase CCS rate among women, ages 24 to 64, who are continuously enrolled in Medi-Cal from 58.94% (MY2020) to 59.12% (MY2021 MPL).
Program Description	**Staying Healthy Mailer:** Mailers will encourage members to ask PCP about recommended preventive care and screenings for women in their age group, promote benefits of recommended preventive screenings and tests for women, and encourage contacting PCP via telehealth to inquire about when next routine Pap test is due, and encourage members to adopt a healthy lifestyle which includes getting regular cancer screenings to detect early signs of changes, before developing symptoms. CCS Measure added to the P4P Program.
Trend:	Our rate for CCS decreased from the prior year from 58.91% to 57.61%.
Goal Met/Not Met	The goal was not met for 2022.
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 will conduct targeted proactive member outreach through mailers, member newsletters, and health information on our member website and social media. HPSM will also conduct scripted interviews with willing members to better understand barriers on the member level as well as explore other barriers to sexual and reproductive health.
Whether yearly planned activities were met	Planned yearly activities were met and will continue in 2023.
Any changes to the program	HPSM will partner with Clincs to validate data on reports.

3.5 COMPREHENSIVE DIABETES CARE (CDC)

CDC HEDIS RESULTS

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

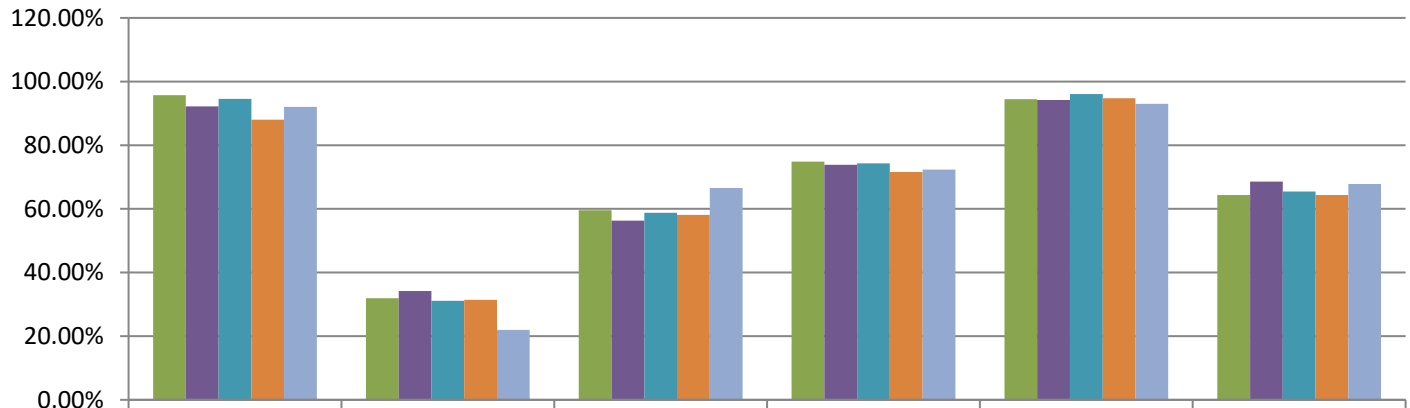


	HbA1C Test	HbA1C >9%	HbA1C <8%	Eye Exam	BP<140/90
2016	86.55%	43.52%	48.90%	58.92%	61.12%
2017	85.40%	36.01%	54.26%	64.48%	61.80%
2018	91.20%	36.19%	52.81%	70.42%	68.46%
2019	87.32%	39.51%	50.00%	65.61%	67.32%
2020	91.24%	30.17%	56.69%	65.21%	63.75%
2021	81.51%	37.23%	54.01%	58.39%	52.07%
2022	86.83%	28.78%	60.98%	61.71%	62.44%

Comprehensive Diabetes Care (CDC) 2021 MPLs & HPLs:

HEDIS Measure	Medicaid 50th Percentile*	Medicaid 90th Percentile*
Eye Exam (Retinal) Performed	51.36%	63.02%
HbA1c Testing	82.97%	88.08%
HbA1c Poor Control (>9.0%)	37.47%	27.98%
HbA1c Control (<8.0%)	46.83%	55.23%
Blood Pressure Control (<140/90 mm Hg)	58.52%	71.23%

Percentage of **CMC** members 18 - 75 years of age with diabetes who had each of the following tests or results within the measurement year:



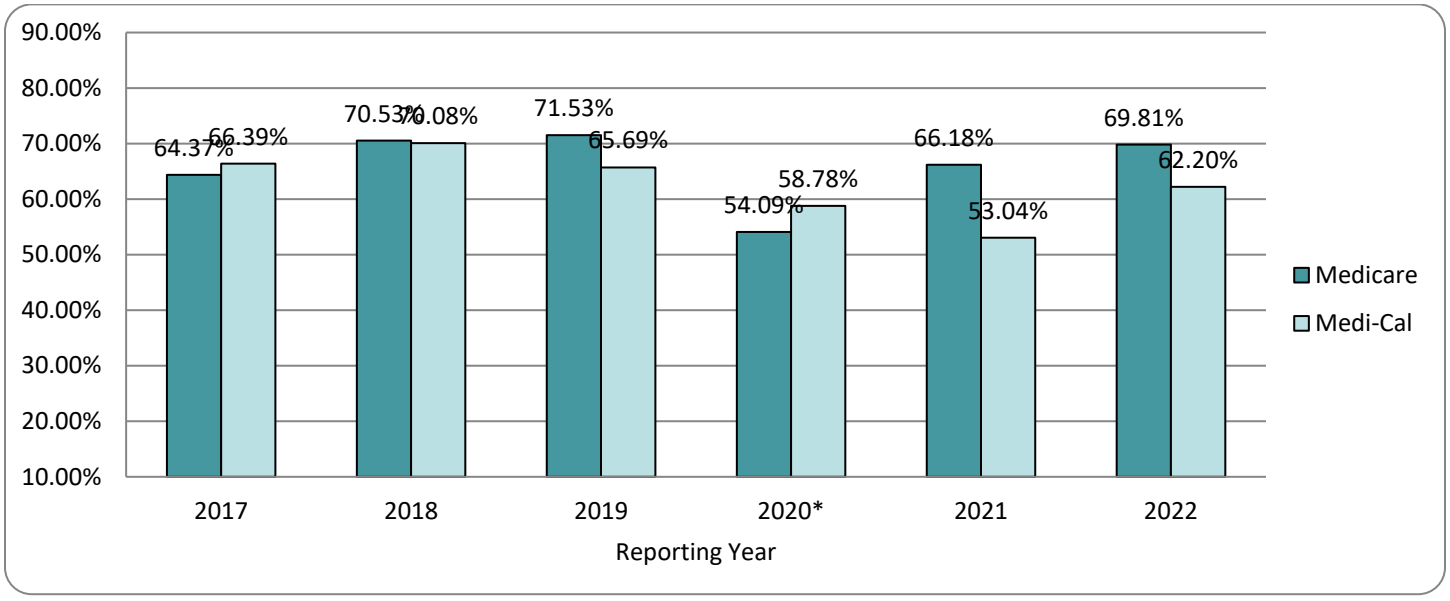
	HbA1C Test	HbA1C >9%	HbA1C <8%	Eye Exam	Nephropathy Scn	BP<140/90
2018	95.73%	31.91%	59.55%	74.87%	94.47%	64.32%
2019	92.21%	34.17%	56.28%	73.87%	94.22%	68.59%
2020	94.57%	31.11%	58.77%	74.32%	96.05%	65.43%
2021	88.03%	31.42%	58.10%	71.57%	94.76%	64.34%
2022	92.02%	21.95%	66.58%	72.32%	93.02%	67.83%

Measure/Program	Comprehensive Diabetes Care (CDC)
Objective:	For *Medicare* By Dec 31, 2022 reduce the number of CMC diabetics with a Hba1c in poor control from 31.24% (HEDIS MY2020) to less than 30%.
Program Description	Hba1c poor control (>9%) was maintained as payment measure for CMC benchmarking P4P for 2022. Care gap reports were included with monthly P4P reports so Provider offices could prioritize appointment outreach efforts.
Goal Met/Not Met	The HEDIS MY2021 final results for Hba1c poor control (>9) = 21.95%. Goal was met.

3.6 CONTROLLING HIGH BLOOD PRESSURE (CBP)

CBP HEDIS RESULTS

Percentage of members 18-85 years of age with hypertension whose blood pressure was controlled during the measurement year



For CBP Medi-Cal RY2022 MPL (50th percentile) was 55.35% and HPL (90th percentile) was 66.79%.

Measure/Program	Controlling Blood Pressure (CBP)
Objective:	By Dec 31, 2022, increase the rate of controlled blood pressure in Medi-Cal members diagnosed with hypertension from HEDIS MY2020 53.04% to 55.35% (MY2021 MPL rate) and in CMC members with hypertension from 66.18% to 71% (quality withhold benchmark).
Program Description	The Quality Team worked with the Provider Communications Team and developed targeted messaging for 10 identified Clinics. In the targeted messaging, which was sent via email, we encouraged the Clinics to reach out to all patients in the provided care-gap reports, including those known to have blood pressure monitoring devices , to schedule an encounter and/or to develop a tailored care plan for regularly reporting BP results to their PCP.
Trend:	The *Medicare* rate for CBP increased from 66.18% to 69.81%. The *Medi-Cal* rate for CBP increased from 53.04% to 62.20%.
Goal Met/Not Met	For 2022, HPSM did meet the MPL goal for Medi-Cal but did not meet the Quality Withhold benchmark rate for Medicare. However, the measure still passed for the Quality Withhold as over a 10% gap improvement was achieved. • The *Medicare* rate for CBP was 69.81% • The *Medi-Cal* rate for CBP was 62.20%

Whether yearly planned activities were met	Planned yearly activities were met.

3.7 INITIAL HEALTH ASSESSMENT (IHA)

IHA OUTREACH PROGRAM DESCRIPTION

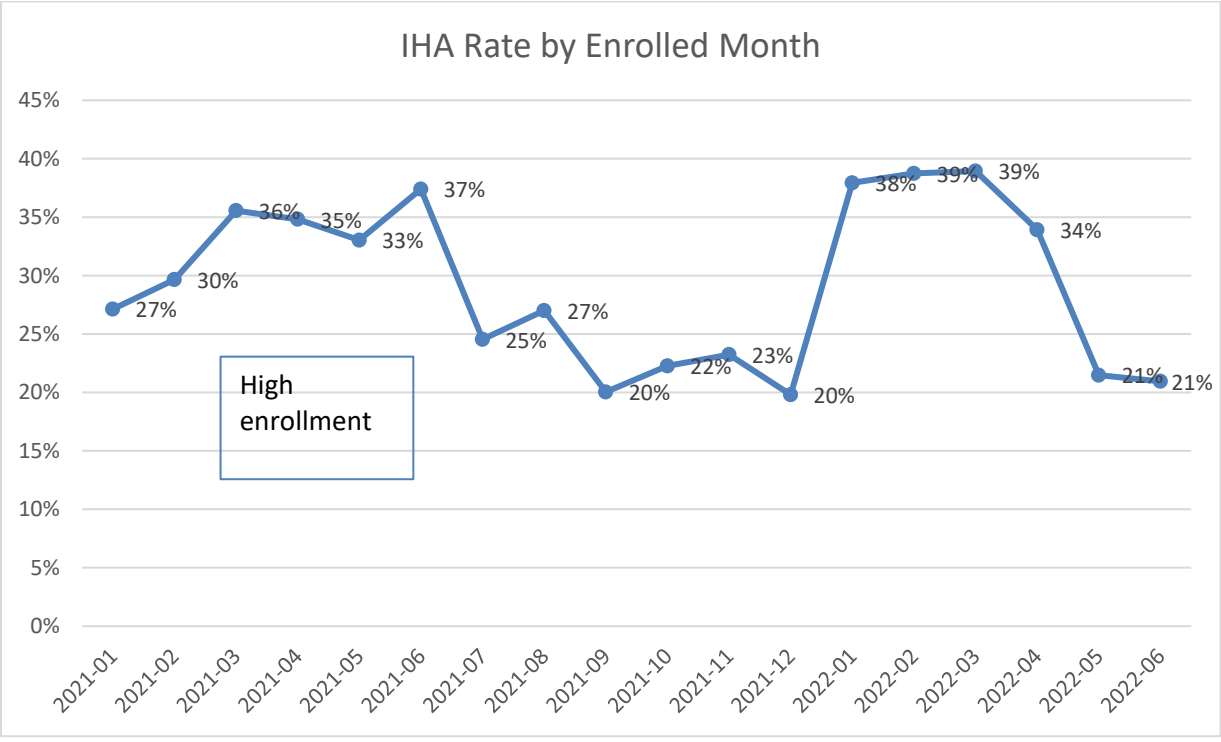
The Initial Health Assessment (IHA) has become an increasingly higher priority in health plans across California. Focus has also increased on primary care and preventative services as the Medi-Cal population has a higher incidence of chronic and/or preventable illnesses, many of which could be modified 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 08-003) requires all primary care providers to administer an IHA to all Medi-Cal managed care patients as part of their initial 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.

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 2021-2022



IHA PROVIDER EDUCATION

The Health Plan of San Mateo makes the providers aware of the requirement of the IHA and SHA/IHEBA 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 and SHA/IHEBA 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. Providers are given copies of the Staying Healthy Assessments for all age groups and appropriate languages for the practice population.

IHA BARRIERS

The SHA continues to be the greatest hurdle to higher compliance rates. With the increased emphasis on use of Electronic Health Records, the paper-based SHA has become more cumbersome for the provider and the office staff. Providers consistently ask about the availability of an electronic version of the SHA. Providers have asked for acceptable alternatives to the SHA.

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

IHA OUTREACH PROGRAM ACTION PLAN FOR 2023

Starting in 2023, the IHA was modified. The Initial Health Appointment still needs to occur within the first 120 days of enrollment, however, the SHA/IHEBA component is no longer required. HPSM has struggled to increase the timeliness of IHAs and will be implementing the following in 2023 to improve IHA rates.

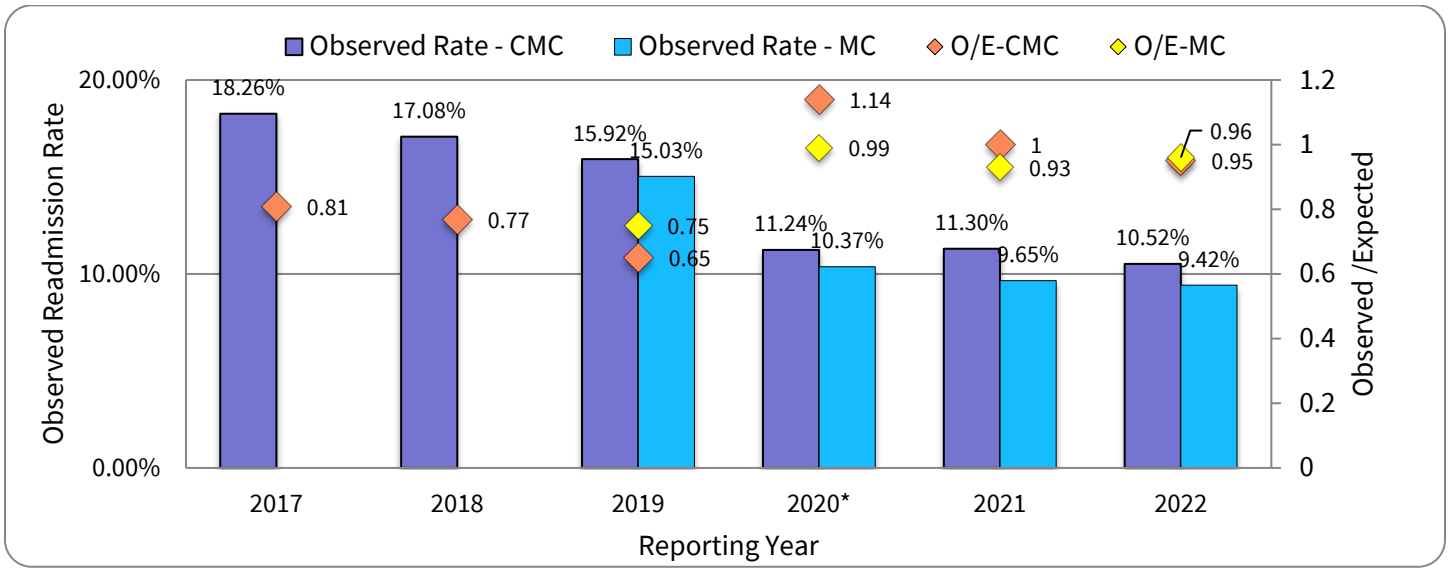
IHA completion will continue to be incentivized for Medi-Cal PCPs under HPSM Pay for Performance (P4P) program. As part of P4P, monthly reports sent to PCPs detailing level of performance.

- Provider notification of changes to IHA requirement
- Continue pay-for-performance(P4P) monetary incentive for PCPs for timely IHA completion in 2023
- Conduct training webinars with providers on IHA requirements and reporting for the P4P incentive
- 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
- Include an article in the provider newsletter on IHA requirements and resources
- 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.

3.8 PLAN ALL-CAUSE READMISSIONS (PCR)

PCR HEDIS RESULTS

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.



Measure/Program	PCR Metric
Objective:	Objective: Reduce 30-day readmissions so that the observed readmissions to the expected readmissions, based on member level of risk and acuity, is less than 1 for both Medicare and Medi-Cal populations.
Program Description	The Care Transition program is available to all HPSM members that are discharged from an in-patient hospital stay at any of our contracted facilities and are identified to have complex post discharge support needs. Working collaboratively with the facility staff, the Inpatient Review Nurse provides support for the members discharge back home. The Inpatient Review Nurse assesses the members in need of Care Transitions support using a complex needs assessment tool and refers members to the Integrated Care Management team (ICM).
Trend:	PCR measurement methodology changed in reporting year 2020 where members with 4 or more inpatient admissions were removed as outliers from the PCR observed readmission rate calculation. Because of this change in the measure calculation, observed readmission rates and ratios are not comparable to prior reporting years. However, from reporting years 2021 to 2022 for both Medi-Cal (from 9.65% to 9.42%) and CMC (from 11.30% to 10.52) populations indicate improvement. The observed to expected readmission ratio (O/E) for Medi-Cal increased from 0.93 to 0.96, but decreased for CMC from 1 to 0.95.

Goal Met/Not Met	While there was increase in O/E for Medi-Cal, PCR O/E were under 1 for both Medi-Cal and CMC populations. Goal was met.
Barriers identified	Lack of timely PCP follow up visits by members after discharge. This occurs because hospitals do not have a process in place or the necessary staff resources to communicate to the PCP that a discharge has happened. Also, members being discharged are unaware they need to follow up with their PCP because Hospital's lack resources to fully educate members at time of discharge on the importance of scheduling a timely PCP follow up visit. These factors prevent successful continuity of care for the member.
Recommended interventions for barriers	The care transitions program was restructured allowing availability of the program for members not only discharged from an in-patient stay at Seton, Mills, SMMC and Stanford but from all discharging facilities including but not limited to discharges from other hospitals, acute care facilities and SNFs. In collaboration with the Utilization Management's Inpatient Nurse team, all members identified for discharge are provided care transitions by the Inpatient Nurse assigned to a facility and referred to the Integrated Care Management (ICM) when identified to have a complex case need providing opportunity for members already engaged with their ICM Care Manager to continue being supported by that ICM Care Manager or assigned to an ICM Care Manager for care transitions. Members who are engaged with Enhanced Care Management (ECM) or HPSM's HomeAdvantage program are directed to the ECM or HomeAdvantage provider for care transitions and post discharge support.
Whether yearly planned activities were met	Yes
Any changes to the program	HPSM will continue to utilize the CT Team to bridge the gap in providing care transitions management to the members after discharge as described above. In 2023, CT program will also focus on engaging members to have lower rates of 14-day ED visits post discharge as well as higher rates of engagement with their PCPs post discharge.

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.

2022 Clinical Guidelines and Resources listed by Topic
New:
1. Primary Care Guidelines on Prescribing Controlled Substances

2. The CDC Guideline for Prescribing Opioids for Chronic Pain-(CDC 2016)
3. The CDC Guidelines for Treatment of Latent Tuberculosis-(CDC 2020)

Asthma

1. Asthma Management Guidelines - Clinician's Guide (NHLBI Dec 2020)
2. Global Initiative for Asthma (GINA) 2020 Guidelines
3. Asthma Care - Quick Reference Guide (NHLBI -revised 2012)
4. Asthma Medication Ratio Tip Sheet
5. Asthma Action Plan

Behavioral Health

1. ADHD Parents Medication Guide (APA 2013)
2. Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts (APA 2019)
3. Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescent (AAP 2019)
4. Developmental Services Referral Guide
5. Depression in adults: recognition and management (NICE Updated June 2022)
6. Depression in children and young people: identification and management (NICE 2019)
7. Guidelines for Assessment of and Intervention With Persons With Disabilities (APA Updated Feb 2022)
8. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management (AAP 2018)
9. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part II. Treatment and Ongoing Management (AAP 2018)
10. Guidelines for Psychological Practice for People with Low-Income and Economic Marginalization (AAP 2019)
11. Guidelines for Psychological Practice with Lesbian, Gay & Bisexual Clients (renamed APA GUIDELINES for Psychological Practice with Sexual Minority Persons) (APA 2021)
12. Guidelines for Psychological Practice with Older Adults (APA 2014)
13. Guidelines for Treatment of Patients with Substance Use Disorders (APA 2010)
14. PCP Referral Form for Behavioral Health and Recovery Services
15. Pharmacological Treatment of Patients with Alcohol Use Disorder (APA 2018)
16. Treating Depression in the Primary Care Setting

Cancer Screening

1. Breast Cancer Screening
2. Colorectal Cancer Screening (USPSTF 2021)
3. Cervical Cancer Screening Guidelines
4. Lung Cancer Screening (USPSTF 2021)
5. Grade Definitions for United States Preventive Services Task Force Recommendations
6. USPSTF Grade A and B Recommendations

Cardiovascular and Circulatory Guidelines

1. Guidelines for Management of Heart Failure (ACC - 2017)
2. CDC Guide to Effective High Blood Pressure, Cholesterol, and Cardiovascular Disease Prevention Programs, Including Pharmacists on the Care Team

Diabetes

1. Diabetes Prevention Program
2. Standards of Medical Care in Diabetes (ADA -2021)
3. Self Management Sessions (for patients at SMMC Clinic)
   Immunization Schedules

Schedules for Health Care Professionals

1. Birth to 18 years and Catch Up schedules (CDC 2022
2. Adult Immunization Schedule (CDC 2022)
3. Combination Vaccines

Easy-to-Read Schedules For Patients and Parents
1. Recommended for Babies and Children (birth to age 6)
2. Recommended for Children and Teens (age 7 to 18)
3. Recommended for Adults
4. Combination Vaccines – Information for Parents

Obesity
1. Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults (USPSTF- 2018)
2. Child or Teen Obesity Screening (USPSTF - 2017)
3. Adults Body Mass Index Calculator
4. Adult Body Mass Index Table

Pediatrics
1. ASD and ABA Referral Guidelines
2. Blood Lead Screening Guideline (CDPH 2019)
3. Blood Lead Poisoning Testing and Management (CDPH 2017)
4. Bright Futures Clinical Guidelines and Resources
5. Bright Futures Preventive Care Periodicity Schedule
6. Pediatric Therapy Eligibility Guidelines
7. Pediatric Care Coordination Supportive Services Referral Guide
8. Pocket Guide: Guidelines for Health Supervision of Infants, Children and Adolescents

STD Guidelines
1. CDC Sexually Transmitted Disease Treatment Guidelines (CDC 2021)
2. Chlamydia Screening (USPSTF 2014)
3. Disease Reporting Form – San Mateo County
4. HPV vaccine for child/teen (scroll to 18 months to 18 years on schedule or Birth-18 Years Immunization Schedule | Syndicated | CDC)
5. HPV vaccine information for parents

Source organization and websites for evidence-based guidelines posted on HPSM's website.
American Academy of Pediatrics (AAP)
American College of Cardiology (ACC)
American Diabetes Association (ADA)
American Psychiatric Association (APA)
Centers for Disease Control (CDC)
California Department of Public Health (CDPH)
National Heart Lung and Blood Institute (NHLBI)
National Institute for Health and Care Excellence (NICE)
U.S Preventive Services Task Force (USPSTF)

CLINICAL GUIDELINES ANNUAL REVIEW UPDATE

Annual review and approval by Quality Improvement Committee (QIC)

The Quality department presented the annual summary of the posted guidelines to the Quality Improvement Committee at its quarterly meeting in September 2022. All additional and updated guidelines were reviewed and approved by the QIC.

ACTION PLAN FOR 2023

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.

Due to staffing shortages and lack of certified site review (CSR) nurse (s), HPSM was only able to conduct one (1) site review in 2022.

- Of the 1 facility site review completed in 2022, the FSR score was 73 %.
- Of the 1 medical record review completed in 2022 , the MRR score was 93% %.

Following the Site Review, the provider abovementioned was issued a corrective action plan (CAP), which was closed May 11, 2022.

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
- 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.

Common Deficiencies identified in Adult Medical Record Review

- Primary language and linguistic needs were not documented.
- Evidence of tuberculosis screenings absent in medical record.
- Staying Healthy Assessments as part of the Initial Health Assessment (IHA) as well as subsequent Staying Health Assessments were not completed.
- 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
- No evidence of site personnel receiving safety/training information in various topics (i.e. Bloodborne pathogens exposure prevention, infection control/universal precautions, biohazardous waste handling, and etc.)
- Drugs are not handled safely and stored appropriately

FSR ACTION PLAN FOR 2023

- 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 by 10 by end of 2023
- 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 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
- Fill open QI Nurse position and begin the CSR process for respective candidate

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
PA= Participant Areas

A total of 8 Physical Accessibility Reviews (PAR) were done for 2022.

Below is the break down for 2022:

Level of Access:	# of PCP/Hospital
Basic Access	2
Basic Access/ Medical Equipment	0
Limited Access	6
Limited Access/Medical Equipment	0
No Access	0

Two facilities met all CE receiving "Basic Access." 6 sites received" Limited Access."
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.

We completed 42 PQI/Quality of Care Reviews from 1/1/2022 to 12/31/2022.

Final counts by PQI Level

Row Labels	Count
P0/S0	13
P0/S1	9
P0/S2	6
P1/S0	4
P1/S1	3
P2/S2	3
Grand Total	**38**

5.0 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)
  - Osteoporosis Testing in Older Adults (OTO)

- Physical Activity in Older Adults (PAO)
- Management of Urinary Incontinence in Older Adults (MUI)

REQUIREMENTS AND TIMEFRAMES:

In 2021, 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 2021 and summary reports are available the following July. The baseline for HPSM's Cohort 22 was collected in 2019 and the follow up survey for that population was collected in 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. The baseline conducted for HPSM's Cohort 20 was collected in 2017 and the follow-up survey for that population was collected in 2018 and the merged results are available in a report from CMS.

For Cohort 22 the original baseline sample size for was 1,200; however, 920 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 280. Of the 280 members in the analytic sample, 47 voluntarily disenrolled from HPSM and 23 died between baseline and follow up. Of the 210 members sent a follow up survey, 4 were determined to be ineligible. Of the remaining 206 members, there were 55 who did not complete the survey and 151 who returned a completed follow up survey. This represented an overall follow up response rate of 73.3% for HPSM, as compared with the National HOS follow up response rate of 63%.

HOS COHORT 22 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**
2019-2021 Cohort 22	18.05%	54.63%	27.32%	72.68%	⇔
2018-2020 Cohort 21	15.86%	60.92%	23.22%	76.78%	⇔
2017-2019 Cohort 20	21.12%	51.05%	27.83%	72.17%	⇔

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**
2019-2021 Cohort 22	14.68%	70.88%	14.44%	85.56%	⇔
2018-2020 Cohort 21	14.02%	67.05%	18.93%	81.07%	⇔
2017-2019 Cohort 20	15.29%	68.73%	15.98%	84.02%	⇔

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 as expected, the same as the national average

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

Table 3: *2019-2021 Cohort 22 Performance Measurement* Distributions of Members with Worse Self-Rated General and Comparative Health Status for MAO H7885, California, and HOS Total

	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	43.2%	49.3%	35.4%	35.4%	19.7%	30.8%
California	29.3%	32.2%	25.8%	30.6%	13.4%	18.2%
HOS Total	21.6%	24.9%	22.6%	27.8%	9.9%	13.6%

HPSM has seen an increase in the baseline versus follow up cohorts for this measure and especially in the mental health related response.

2021 HEDIS HOS MEASURES

The HEDIS HOS results measure Plan performance in the following four measures: Management of Urinary Incontinence in Older Adults (MUI), Physical Activity in Older Adults (PAO), Fall Risk Management (FRM), and Osteoporosis Testing in Older Women (OTO). Three components of the HEDIS HOS measures are used in the Medicare Star Ratings: Improving Bladder Control, Monitoring Physical Activity, and Reducing the Risk of Falling.

HEDIS HOS results are based on data from the HOS Round 24 surveys (combined *Cohort 24 Baseline* and *Cohort 23 Follow Up* data) collected in 2021. Prior rounds also combined baseline and follow-up surveys administered the calendar year.

Trending of over the last Three Survey Years:

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*
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%
2019 Round 22	68.67%	50.34%	32.67%	62.80%	65.82%	37.97%	80.68%

* Measures incorporated into the 2023 Medicare Star Ratings include the MAO 2021 *Improving Bladder Control* (MUI Treat Rate), and *Reducing the Risk of Falling* (FRM Manage Rate).

HPSM rates increased across all measures from prior survey year, except FRM Manage Rate.

HPSM 2021 HEDIS HOS Rates Compared to California, CMS Region 9 and National HOS Total:
Table 1: 2021 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	64.38%	51.25%	32.70%	68.36%	66.58%	36.13%	74.32%
California	57.98%	45.65%	19.23%	58.36%	55.18%	24.58%	60.14%
CMS Region 9	57.89%	45.20%	17.75%	56.56%	52.13%	24.49%	57.84%
HOS Total	59.30%	45.19%	15.76%	55.28%	49.92%	26.11%	55.63%

†See Table 3 results for all MAOs in the state.
* Measures incorporated into the 2023 Medicare Star Ratings include the MAO 2021 *Improving Bladder Control* (MUI Treat Rate), and *Reducing the Risk of Falling* (FRM Manage Rate).

HPSM performed well in all ratings.

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 2022 survey includes only child members. The HSPM conducts separate annual CAHPS surveys for its members with Medicare and child members with Medi-Cal. The surveys are mailed in English and Spanish with a follow up telephone call.

2022 Medicare CAHPS SURVEY SUMMARY

The response rate was 35.6%, which is an increase when compared to the 2021 response rate of 35.3%, 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:
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 national average for all MA contracts, the national average for all MMP contracts. This provides HPSM's case-mix adjusted mean score, over time, on a 0-10 scale. Statistical Significance indicates whether HPSM's rating was significantly above, below than or no difference to the national MA average. A score of N/A indicates that response rates to those items were not sufficiently high to render a reliable, comparable rate. As shown HSPM's rating on the composite items are below average across contract types.

Overall Health Plan Ratings	Primary MA State (CA) Score	National MA Score	Primary MMP State (CA) Score	National MMP Score	Your Contract's Score	Statistical Significance (Your Contract Versus National)	Reliability of Your Contract's Score
Rating of Health Plan	8.8	8.8	8.6	8.6	8.4	Below Average	Good
Rating of Health Care Quality	8.6	8.7	8.4	8.5	8.2	Below Average	Good
Personal Doctor	9.1	9.2	9.0	9.0	N/A	N/A	Very Low
Specialist	8.9	9.0	8.9	8.9	N/A	N/A	Very Low

MEDICARE-SPECIFIC AND HEDIS MEASURE RESULTS:

For this response, survey participants were asked whether they received a flu vaccination recently and whether they had ever received a pneumonia vaccination (yes or no). The table below shows HPSM's percentage of "yes" responses for these two items, the national average for all MA contracts, the national average for all MMP contracts, and whether the score was significantly greater than, less than, or equal to the national MA average. These items are not adjusted for case mix. HPSM scored well on the flu vaccine measure above the National MA and MMP average and is comparable to the National MA percentages for the pneumonia vaccine.

Medicare-Specific and HEDIS Measures	Primary MA State (CA) Score	National MA Score	Primary MMP State (CA) Score	National MMP Score	Your Contract's Score	Statistical Significance (Your Contract Versus National)	Reliability of Your Contract's Score
Annual Flu Vaccine	81%	75%	74%	69%	86%	Above Average	Good
Pneumonia Vaccine	76%	73%	61%	56%	67%	No Difference	Good

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 national average for all MA contracts, the national average for all MMP contracts, the plan's case-mix adjusted mean score on a 1-4 scale, and whether the plan's score was significantly above, below than or no difference to the national MA average. A score of N/A indicates that response rates to those items were not sufficiently high to render a reliable, comparable rate.

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?

Composite Measures	Survey Items Included in the Composite
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?
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

Health Plan Composite Measures	Primary MA State (CA) Score	National MA Score	Primary MMP State (CA) Score	National MMP Score	Your Contract's Score	Statistical Significance (Your Contract Versus National)	Reliability of Your Contract's Score
Getting Needed Care	3.39	3.45	3.31	3.38	3.26	Below Average	Good
Getting Appointments and Care Quickly	3.31	3.33	3.20	3.28	3.22	Below Average	Good
Doctors Who Communicate Well	3.71	3.75	3.69	3.72	N/A	N/A	Very Low
Customer Service	3.68	3.71	3.63	3.68	N/A	N/A	Very Low
Care Coordination	3.52	3.59	3.50	3.55	3.54	No Difference	Good

HPSM performed below average across contract types for the composite measures with a reliable result, and equivalent to other contract types for the Care Coordination measure.

2022 Medi-Cal CAHPS SURVEY SUMMARY

See APPENDIX B: 2022 MEDI-CAL CAHPS SURVEY RESULTS

5.3 GRIEVANCES AND APPEALS

The Grievances & Appeals Report representing data from 2022, 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

9. SUMMARY OF EFFECTIVENESS 2022

Adequacy of QI Program Resources	Securing adequate resources to support QI activities continued to be a challenge in 2022. In the beginning of 2021, the QI Department underwent a reorganization where staff that focused on the quality improvement initiatives were redeployed to focus on population health management and health equity efforts. These changes left vacancies in the department. As a result, QI staffing was spread thin and we had to assess priorities and transition responsibilities to remaining department staff to ensure coverage of high priority projects, especially for continued COVID-19 response and vaccination efforts. By mid-2022, three staff members were hired including, QI Specialist, QI Clinical Manager and a QI Nurse. The open positions remained unfilled at the end of 2022. The reorganization of the QI Department also initiated a transformation of how the quality improvement initiatives and programs are administered within HPSM. QI Department staff will retain 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 will be more 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 QIC committee structure remained the same in 2022. The committee continues to provide a forum for QI to report out of program activities. The committee continues to serve as an advisory role in our QI programming in 2022 and actively participate in discussions regarding opportunities for improvement, data analysis, intervention planning and evaluation. 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 and Pharmacy 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. This structure continued throughout 2022. Our CMO 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 Committee (QIC) 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 2023.

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

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

Abrev	Measure	MY2021	50th Percentile	MY 2020 Rate	MY 2019 Rate
CBP	Controlling High Blood Pressure*	62.20	55.35	53.04	(58.78)^
CDC >9	Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)* (lower is better)	28.78	43.19	37.23	30.17
CIS-10	Childhood Immunization Status –Combo 10*	54.85	38.20	61.56	51.58
IMA -2	Immunizations for Adolescents –Combo 2*	51.58	36.74	50.61	55.12
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents BMI Percentile Documentation* Counseling for Nutrition* Counseling for Physical Activity*	83.78 78.46 76.60	76.64 70.11 66.18	75.18 74.7 65.94	73.97
BCS	Breast Cancer Screening	53.96	53.93	59.20	65.86
CCS	Cervical Cancer Screening*	57.61	59.12	58.91	(64.72)^
CHL	Chlamydia Screening in Women	68.71	54.91	63.98	67.49
PPC -Post	Prenatal and Postpartum Care – Postpartum Care*	92.45	76.40	92.59	84.18
PPC-Pre	Prenatal and Postpartum Care – Timeliness of Prenatal Care*	89.31	85.89	90.0	87.59
WCV	Child and Adolescent Well-Care Visits (3-21 yrs)	56.92	45.31	48.80	N/A
W30	Well-Child Visits in the First 30 Months of Life • 6 or more well-child visits in first 15 months of life • 2 or more well-child visits in 15 to 30 months of life	25.73 69.14	54.92 70.67	20.03 76.94	N/A

New MPL = 50th Percentile
*Hybrid measure (chart review + admin & sup data)
^Rotated measure: MY 2018 rate reported (MY2019 measured rate)
Under MPL
Above HPL

ALL OTHER MCAS MEASURES

Measure Abbrev.	Measure	MY 2021 Rate	MY 2020 Rate	MY 2019 Rate
AMB-ED	Ambulatory Care: Emergency Department (ED) Visits per 1,000 member months	38.63	36.99	49.88
ADD-Init	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications – Initiation Phase	24.35	22.88	22.70
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	9.42 0.9597	9.64 0.9322	10.37 0.9926
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing	42.55	35.64	N/A
AMR	Asthma Medication Ratio	69.56	70.06	61.35
AMM -AP	Antidepressant Medication Management - Effective Acute Phase Treatment	67.59	66.47	67.02
AMM -CP	Antidepressant Medication Management - Effective Continuation Phase Treatment	51.48	51.09	49.37
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.19	78.15	N/A
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence •7-Day Follow-up •30-Day Follow-up	4.27 7.58	N/A	N/A
FUM	Follow-Up After Emergency Department Visit for Mental Illness •7-Day Follow-up •30-Day Follow-up	18.58 27.72	N/A	N/A

All administratively collected measures; Measure new to MCAS for MY2021

Measure Abbrev.	Measure	MY 2021 Rate	MY 2020 Rate	MY 2019 Rate
DEV^	Developmental Screening	43.02	24.24	45.28
COB^	Concurrent Use of Opioids and Benzodiazepines (lower is better)	15.91	18.56	18.46
OHD^	Use of Opioids at High Dosage in Persons Without Cancer (lower is better)	8.56	9.38	10.19
CDF^	Screening for Depression and Follow-Up Plan: Age 12 and Older	36.17	28.45	27.03
CCW^	Contraceptive Care: All Women Ages 15-44: •Most or moderately effective contraception •Long Acting Reversible Contraception (LARC)	25.26 5.25	24.34 4.99	24.38 5.17
CCP^	Contraceptive Care: Postpartum Women Ages 15-44: •Most or moderately effective contraception – 3 days •Most or moderately effective contraception – 60 days •LARC – 3 days •LARC – 60 days	26.91 52.41 14.88 25.93	25.75 50.17 13.89 23.97	15.79 42.34 7.54 22.73

All administratively collected measures
^Non-HEDIS measure

APPENDIX B: 2022 MEDI-CAL CAHPS SURVEY RESULTS

OVERVIEW

Medi-Cal CAHPS results were available every three years, using NCQA CAHPS and certified vendors prior to HPSM's NCQA Accreditation. 2020 CAHPS was not conducted for the Medi-Cal population due to the response and impact of the Covid-19 pandemic. NCQA CAHPS is now conducted annually. 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. In 2022, only the Child Survey was conducted for accreditation because the Adult and Child survey is conducted only every other year; therefore, no response rate is available for adults in 2022.

Table 1: CAHPS 2022 Response Rate Trends

	2016		2019		2021		2022
CAHPS Data	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Child**	**Child**
Sample size (includes oversampling)	1384	1731	1917	1659	1850	1799	1635
Patient Level Records Used: Complete & Valid	344	511	423	381	392	379	222
Total Response Rate: Complete/(sample-Ineligible)	**26.58%**	**31.56%**	**23.35%**	**23.06%**	**21.71%**	**21.34%**	**13.6%**

As Table 1 above shows, there were 222 completed surveys which is a decrease from 379 child responses in 2021. Although the response rate of 13.6 is low, it is sufficient for valid result reporting for 2022.

CHILD SURVEY RESULTS

Table 2 below shows trends in "Top box" ("Always" or "Usually") responses for composite items for the Child survey across collection years. Also included are the 2022 Top Box Scores for all plans in the SPH Book of Business(BOB) for comparison, and the Plan's NCQA Health Plan Rating (HPR). Comparing 2021 results shows improvement in the rating of the ***Getting Needed Care, Getting Care Quickly*** and ***Customer Service*** composite items and a decrease in ***Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor,*** and ***How Well Doctors Communicate***.

HPSM staff set 2022 Plan goals for ***How Well Doctors Communicate***, ***Getting Needed Care***, ***Getting Care Quickly*** and ***Customer Service*** based on Plan desired improvement percentile . The goal rates for ***Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor,*** and ***Rating of Specialist*** were set to match NCQA Quality Compass results.

The 2022 performance goal rates were not met for ***Rating of Personal Doctor, How Well Doctor's Communicate*** or ***Customer Service,*** but were met for ***Rating of Health Plan, Rating of All Health Care, Rating of Specialist, Getting Needed Care*** **and** ***Getting Care Quickly***.

There was a significant decrease in the ***Rating of Personal Doctor*** compared to the 2021 results, but a significant increase in the ***Getting Needed Care*** and ***Customer Service*** *measures*.

Table 2: Child Survey Results 2022 Trends and Comparisons

Measure	2016 Top-Box Scores	2019 Top-Box Scores	2021 Top-Box Scores	2022 Top-Box Scores	2021 to 2022 change	SPH BOB 2022 Top-Box Scores	NCQA HPR 2022	2022 Goal Rate	Goal Met
Rating of Health Plan	69.90%	78.30%	76.84%	74.80%	-2.04%	72.50%	66.67th	72.20%	Yes
Rating of All Health Care	68.00%	70.30%	77.93%	76.00%	-1.93%	71.20%	66.67th	74.30%	Yes
Rating of Personal Doctor	76.10%	79.30%	81.31%	74.70%	-6.61%	77.40%	10th	78%	No
Rating of Specialist Seen Most Often	71.6%+	81.4%+	N/A	88.40%	NA	73.90%	NA	73.80%	Yes
Getting Needed Care	77.80%	78.60%	82.66%	87.80%	5.14%	84.40%	NA	84.66%	Yes
Getting Care Quickly	77.40%	81.10%	81.14%	83.30%	2.16%	86.70%	NA	82.14%	Yes
How Well Doctors Communicate	92.30%	93.20%	93.98%	93.90%	-0.08%	94.40%	Not Measured	93.98%	No
Customer Service	89.40%	94.30%	86.35%	91.40%	5.05%	88.30%	Not Measured	95%	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 3 below shows trends in the responses to individual questions. Increases in ***Customer service provided information or help, Got check-up/routine appointment as soon as needed,*** and ***Ease of getting care, tests or treatment*** *were* significant. ***Personal doctor explained things, Personal doctor listened carefully,*** and ***Health plan forms were easy to fill,*** also increased in 2022.

Small decreases in ratings occurred for ***Personal doctor showed respect, Personal doctor spent enough time,*** and ***Customer service treated member with courtesy and respect.***

Table 3: 2022 Trend of Individual Items for Child Survey

	2016	2019	2021	2022	**Change 2021 to 2022**
Composites and Individual Items (2022)		**Always + Usually**	**Always + Usually**	**Always + Usually**	
Getting Care Quickly					
Q4. Got care as soon as needed when care was needed right away	75.83%	NA	NA	84.2%	**NA**
Q6. Got check-up/routine appointment as soon as needed	79.03%	82.66%	75.61%	82.40%	**6.79%**
Getting Needed Care					
Q9. Ease of getting care, tests or treatment	82.62%	84.17%	82.46%	87.40%	**4.94%**
Q23. Got appointment with specialist as soon as needed	NA	NA	NA	88.2	**NA**
How Well Doctors Communicate					
Q12. Personal doctor explained things	94.44%	92.89%	94.12%	95.10%	**0.98%**
Q13. Personal doctor listened carefully	94.06%	94.17%	95.59%	96.00%	**0.41%**
Q14. Personal doctor showed respect	95.44%	97.48%	98.03%	96.80%	**-1.23%**
Q17. Personal doctor spent enough time	85.21%	88.14%	88.18%	87.80%	**-0.38%**
Customer Service Composite					
Q27. Customer service provided information or help	85.53%	90.24%	77.88%	88.50%	**10.62%**
Q28. Customer service treated member with courtesy and respect	93.21%	98.35%	94.83%	94.30%	**-0.53%**
Forms Were Easy to Fill Out					
Q30. Health plan forms were easy to fill	93.11%	93.02%	94.63%	96.20%	**1.57%**

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

Table 4 below shows the Plan's NCQA HPR percentile results for 2022. The Plan scored in the 66.67th percentile for ***Rating of Health Plan*** and ***Rating of All Health Care*** and in the 10th percentile for ***Rating of Personal Doctor***. The measures ***Rating of Specialist, Getting Needed Care,*** and ***Getting Care Quickly*** did not generate enough responses to render a valid result. The measures ***How Well Doctors Communicate*** and ***Customer Service*** were not measured for NCQA.

Table 4-NCQA HPR percentiles with ranges

Measure	2016 Top-Box Scores	2019 Top-Box Scores	2021 Top-Box Scores	2022 Top-Box Scores	2021 to 2022 change	SPH BOB 2022 Top-Box Scores	NCQA HPR 2022
Rating of Health Plan	69.90%	78.30%	76.84%	**74.80%**	-2.04%	72.50%	**66.67th** (74.4-78.6%)
Rating of All Health Care	68.00%	70.30%	77.93%	**76.00%**	-1.93%	71.20%	**66.67th** (73.1-77.1%)
Rating of Personal Doctor	76.10%	79.30%	81.31%	**74.70%**	-6.61%	77.40%	**10th** (71.8-75.4%)
Rating of Specialist Seen Most Often	71.6%+	81.4%+	N/A	**88.40%**	NA	73.90%	**NA**
Getting Needed Care	77.80%	78.60%	82.66%	**87.80%**	5.14%	84.40%	**NA**
Getting Care Quickly	77.40%	81.10%	81.14%	**83.30%**	2.16%	86.70%	**NA**
How Well Doctors Communicate	92.30%	93.20%	93.98%	**93.90%**	-0.08%	94.40%	**Not Measured**
Customer Service	89.40%	94.30%	86.35%	**91.40%**	5.05%	88.30%	**Not Measured**

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

APPENDIX C: 2022 HPSM CONSUMER ADVISORY COMMITTEE GRIEVANCE & APPEALS REPORT

APPENDIX C 2022 HPSM CONSUMER ADVISORY COMMITTEE GRIEVANCE & APPEALS REPORT

HPSM Consumer Advisory Committee

Grievance & Appeals Report

Reporting Period:

Q4 2022 (Oct – Dec 2022)

Presented 01/17/2023

Table of Contents

1. Overview

1.1 Purpose

This report provides 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.

1.2 Methodology

The data for this report comes from three sources:

1. MedHOK: system of record for appeals and grievances
2. HEALTHsuite: system of record for authorizations, claims, and member eligibility
3. HPMS System (for CTM data)

All complaints closed during the reporting period were analyzed by line of business and type of complaint. For Medi-Cal and CCS, additional information is included in accordance with guidelines from the National Committee for Quality Assurance (NCQA).

Previously, complaints were reported based on the receive date. Starting in 2020, we are reporting cases by closure date, which allows the G&A unit to provide the data as soon as the quarter is over, without having to wait for all cases to close to determine timeliness and appropriate classification.

Please note that members assigned to Kaiser Permanente file their complaints directly with Kaiser, not with HPSM, since Kaiser is delegated for all grievance and appeals functions. Kaiser provides HPSM with quarterly data on the grievances and appeals filed with them by HPSM members; this data is included separately in this report.

Case data is pulled from MedHOK based on the date HPSM closed the case. If it is filed by a member's representative (e.g. family member, friend, attorney), the receive date is based on the date the member authorized that person to represent them, and the complaint timeliness is calculated using this receive date as the start date of the complaint.

By tracking and trending complaints filed with HPSM, the Grievance and Appeals (G&A) Unit hopes to identify and address the root causes leading to member dissatisfaction.

2. Rate of Complaints per 1,000 Members

The rate of complaints per 1,000 members allows the G&A Unit to compare complaint rates while accounting for the differences in enrollment numbers across different lines of business. Below are average enrollment numbers by line of business for Q4 2022.

Line of Business	Average Enrollment for Q4
CareAdvantage CMC	8,799
Medi-Cal Only (Excluding CCS)	135,914
HealthWorx	1,211
ACE	22,295
CCS/WCM	1,411
TOTAL	**169,630**

2.1 Goal Rate, by Line of Business

Complaint rates differ significantly by line of business in large part because each line of business serves a different population. For example, CareAdvantage CMC (CA CMC) members are older and/or have at least one disabling condition, which leads them to interact more frequently with the healthcare system. HPSM's assumption is that increased interaction leads to increased opportunity for member dissatisfaction. In contrast, Medi-Cal members, many of whom are healthy children or young adults, have a lower rate of complaints in part because these members do not need as many services and therefore have fewer interactions with HPSM and its providers.

Please note that HPSM is unable to quantify how much of the difference in complaint rates can be attributed to differences in members' level of interaction with the healthcare system versus other factors, such as differences in the way members are treated by providers or differences in access to care.

The G&A Unit reviewed the rate of complaints for each quarter since 2019. Given the low utilization rates during 2020 and early 2021, when vaccines were not available, the first two quarters of 2019 and the last two quarters of 2021 were used as a realistic reflection of what the grievance rate should look like. From this historical review, the G&A Unit identified the minimum and maximum rate of complaints per 1,000 members per month (previously reported per quarter) and set a goal for each line of business.

For Medi-Cal and CCS, Pharmacy benefits are no longer available through HPSM as of 1/1/2022. For that reason, pharmacy appeals were excluded from the complaint rate calculation for 2022. Grievances about pharmacy or prescription drug issues were included as these are still worked on by HPSM's G&A team. Most pharmacy grievances were resolved over the phone within one business day.

Line of Business	Min	Max	Goal
CareAdvantage CMC	5.60	6.76	6.18
Medi-Cal Only (Excluding CCS)	0.46	0.95	0.70
HealthWorx	1.44	2.75	2.10
ACE	0.09	0.20	0.14
CCS	0.24	2.62	1.43
TOTAL	**0.96**	**1.35**	**1.16**

2.2 Rate of Complaints per 1,000 members per month for 2022

Line of Business	Q1	Q2	Q3	Q4	Goal
CareAdvantage CMC	6.80	7.60	9.24	7.01	6.18
Medi-Cal Only (Excluding CCS)	0.62	0.68	0.64	0.52	0.70
HealthWorx	3.68	3.59	2.24	1.93	2.10
ACE	0.34	0.12	0.07	0.12	0.14
CCS	0.98	0.49	0.95	0.95	1.43
TOTAL	**0.91**	**0.99**	**1.03**	**0.82**	**1.16**

2.3 Analysis, Barriers, and Proposed Action

The rate of complaints per 1,000 members was above the goal for CareAdvantage CMC, which decreased slightly from Q3 and similar to the Q2 level. While we see a slight decrease, we are still investigating why these high numbers have been above the threshold all year. We will continue to track, especially as we move into the D-SNP in 2023.

The rate of complaints per 1,000 members was within the goal of Medi-Cal, HWx, CCS, and ACE. There are no proposed actions for these lines of business.

3. Timeliness of Complaint Resolution

3.1 Timeliness Rates for Complaint Resolution

The G&A Unit's goal, as mandated by the Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS), and the Department of Managed Health Care (DMHC), is to resolve at least 95% of grievances and appeals within the required regulatory timeframe. Below are the timeliness rates across all lines of business. This table excludes cases resolved within 24 hours of receipt.

Type of Complaint	# Received (all LOBs)	# Resolved Timely	Goal	% Resolved Timely (Q4 2022)
Grievances	318	316	95%	99.37%
Medical Appeals	67	64	95%	95.52%
Pharmacy Appeals	32	31	95%	96.88%

3.2 Analysis, Barriers, and Proposed Actions

The G&A Unit met the goal of 95% and processed 98.75% of all completed case investigations and case reviews for grievances timely. The Pharmacy Unit processed 96.88% of pharmacy appeals timely. For medical appeals processing, the G&A Unit met the goal, resolving 96.88% of

medical appeals timely. This quarter, despite staffing challenges, worked hard to meet and exceeded the goals.

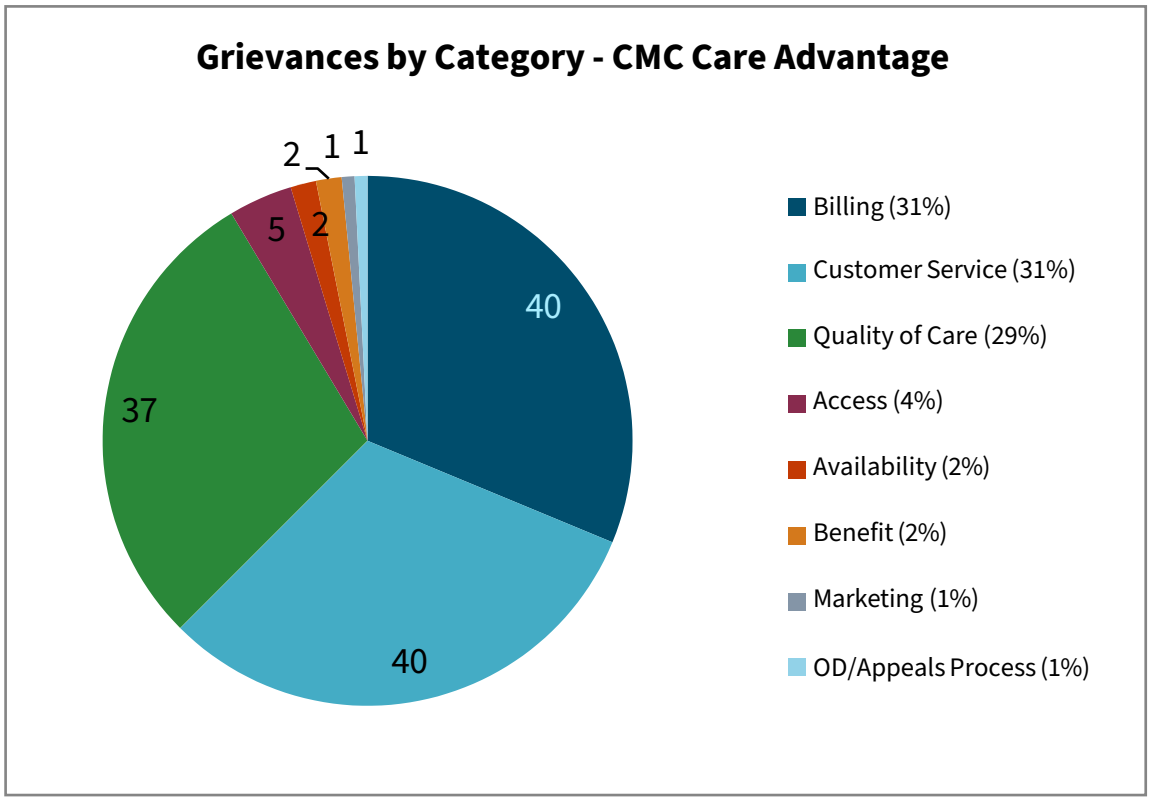
4. CareAdvantage Cal-MediConnect (CA CMC)

4.1 Number of Appeals and Grievances (Complaints) Received

LINE OF BUSINESS			Q1	Q2	Q3	Q4	TOTA
CareAdvantage CMC							
Appeals	**Part C**	**Expedited**	5	4	2	3	14
		Standard	14	21	20	23	78
	Part D	**Expedited**	12	7	17	9	45
		Standard	25	37	27	22	111
	Total Appeals		**56**	**69**	**66**	**57**	**248**
Grievances	**Part C**	**Expedited**	1	0	0	0	1
		Standard	99	115	156	114	484
	Part D	**Expedited**	0	0	0	0	0
		Standard	23	17	22	14	76
	Total Grievances		**123**	**132**	**178**	**128**	**561**
CareAdvantage CMC Total			**179**	**201**	**244**	**185**	**809**

4.2 Types of Grievances Received, by Category

The following graph shows the types of grievances received from CareAdvantage CMC members. A breakdown of subcategories is available as an addendum upon request.



4.3 Resolutions Within 24 Hours of Receipt

The following reflects complaints that were resolved by HPSM's staff within 24 hours of the member informing HPSM of the complaint. These complaints are not included in the count of grievances in the tables above and do not enter the formal grievance process.

- **24 - Hour Resolutions, by Type of Service**

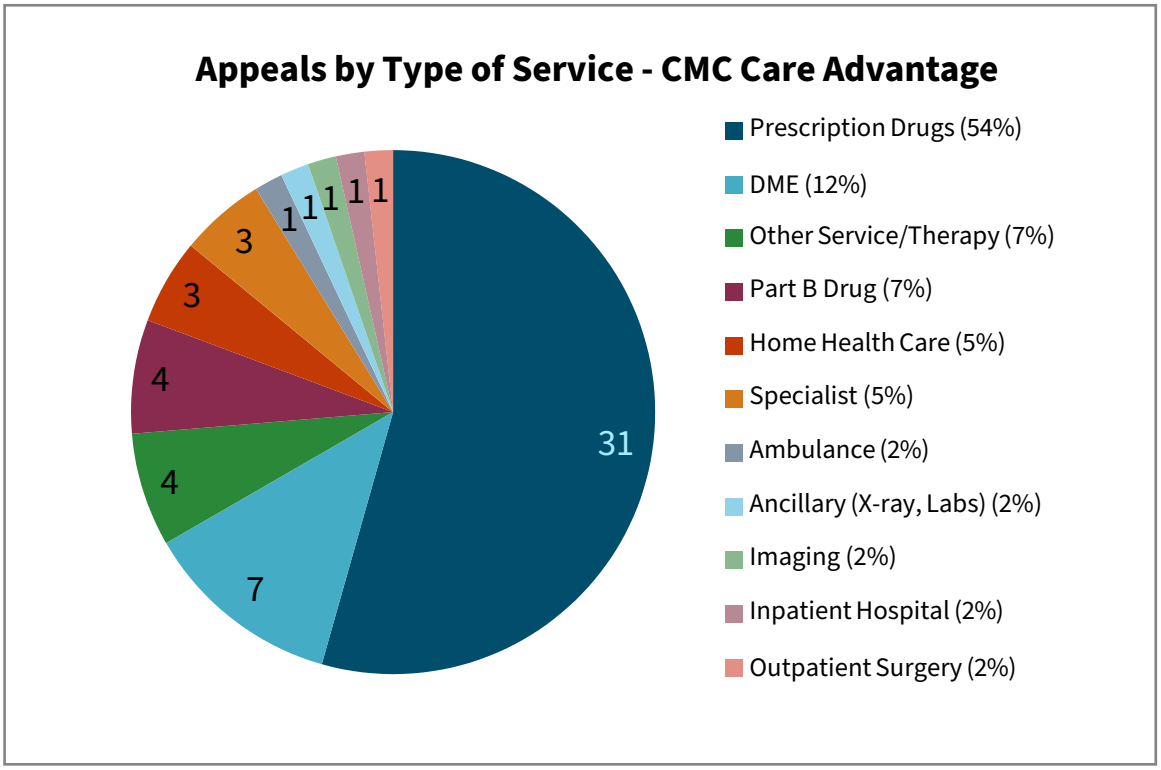
Types of Service	Q1	Q2	Q3	Q4	Total
Medical Services/Supplies	9	11	7	4	31
Prescription Drugs	40	28	28	10	106
Total	**49**	**39**	**35**	**14**	**137**

- **24 - Hour Resolutions, by Category**

Category	Part C Grievance	Part D Grievance
Access	1	9
Benefit	0	1

Category	Part C Grievance	Part D Grievance
Customer Service	3	0
Grand Total	**4**	**10**

4.4 Types of Appeals Received



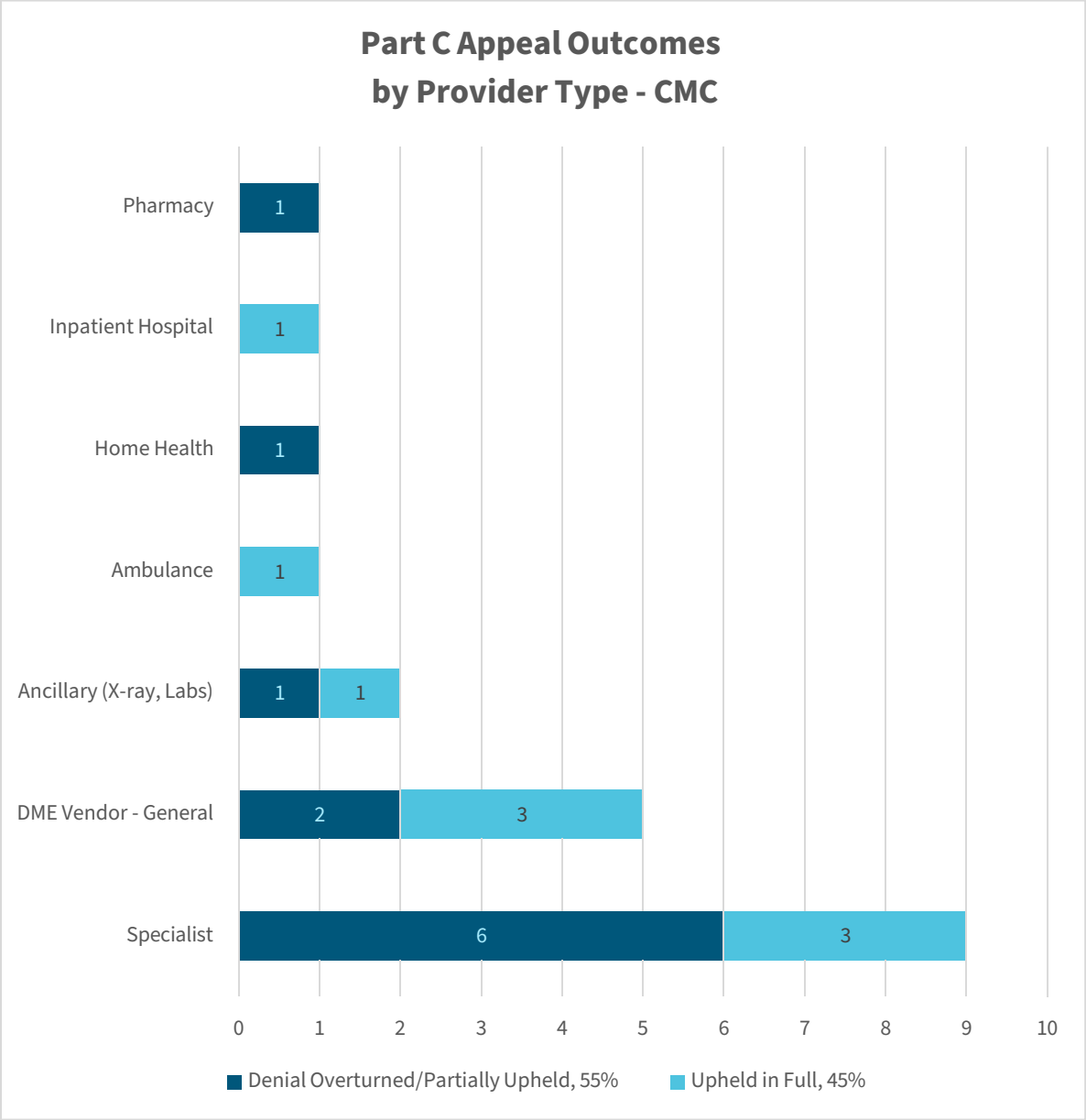
4.5 Rate of Overturned Appeals

The table below shows appeal outcomes depending on whether the benefit requested was a prescription drug (Medicare Part C) or a medical service or supply (Medicare Part D).

Type of Denial	Total Appeals	Overturned	Upheld in Part	Upheld in Full	Withdrawn or Dismissed
Part C- Medical	25	10	1	8	6
Part D - Prescription Drugs	31	16	0	12	3

Prescription drug appeals were overturned in full or in part **57.14%** of the time. For all other appeals, the overturn rate is **52.63%**. This is something HPSM is reviewing to determine root cause for overturned appeals.

Below is a breakdown of the number of Part C (medical) appeals by the type of provider:



4.6 Analysis, Barriers, and Proposed Actions/Solutions (CA CMC)

Grievances:

- The **volume of grievances has decreased from Q3 to Q4 2022.** The volume has increased from 123 grievances filed in Q1 to 132 filed in Q2 and finally, to 178 filed in Q3 2022, but dropped down to near Q1 levels for Q4 at 128.
- Grievances related to **Customer Service** remained stable and continued to be in the top spot, from 31% in Q1 to 39% in Q2 to 39% in Q3 and 31% in Q4.
- Grievances related to **Billing issues** increased to 31% in Q4 from 29% in Q1 to 20% in Q2 to 20% in Q3 2022.
- Grievances related to **Quality of Care** increased this quarter to 29%, rounding out the top 3.

Appeals:

- The **volume of appeals** decreased to near Q1 levels at 57 after 2 quarters of increases. Most appeals continue to be related to prescription drugs (54%), which decreased slightly, but has remained relatively stable. Durable Medical Equipment also decreased slightly at 12% of appeals. The third largest category shifted from Other Service/Therapy (13%) in Q2 to Specialist (11%) in Q3 back to Other Service/Therapy (7%) in Q4.
- The **overturn rate** for drug appeals has increased after decreasing last quarter from 50% in Q1, to 53% in Q2, to 41% in Q3 and up to 57% in Q4. Part C appeals had decreased in Q3 (34%), but jumped back up to 52.9% in Q4. This is slightly lower than the high in Q1. The most common overturn reason is additional clinical information being provided on appeal.

Proposed Action:

- HPSM will discuss trends on overturned appeals with UM and Medical Directors to determine if **additional provider education** is needed.
  HPSM will **monitor quality of care grievances** going forward to determine if this is an ongoing issue or not.

4.7 CTM Complaints

The CMS Complaint Tracking Module (CTM) tracks complaints filed by CareAdvantage CMC members directly with 1-800-MEDICARE. Since the inception of CareAdvantage CMC, HPSM has received very few CTM complaints. No CTM complaints have been received so far this year.

Parameter	2014	2015	2016	2017	2018	2019	2020	2021	2022
Total CTM Complaints	0	2	1	3	0	1	5	0	1
Rate Per 1000 Enrollees	0	0.02	0.01	0.03	0	0.02	0.57	0	0.02

Other MMP Plans Aggregate Rate	0.16	0.09	1.1	0.1	0.11	0.14	N/A	N/A	N/A

4.8 CTM Complaint Analysis & Proposed Action Plan

There are no proposed actions given that HPSM received one CTM complaint in 2022 from a provider who filed with HPSM and did not like the decision.

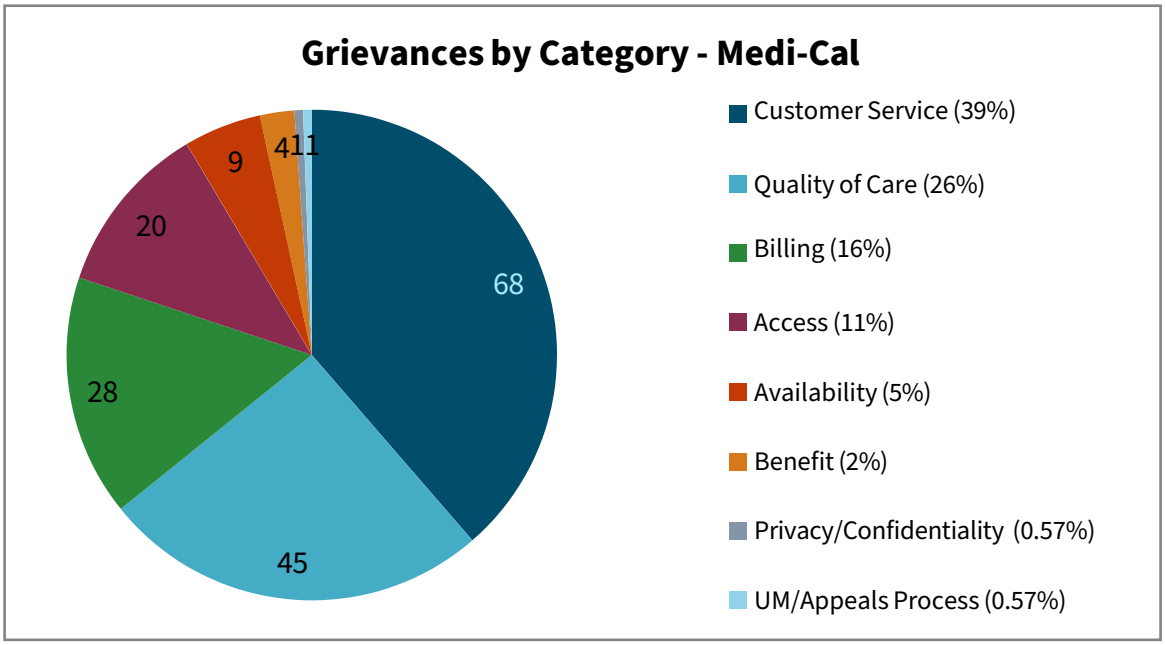
Medi-Cal (MC)

4.9 Number of Appeals and Grievances (Complaints) Received

LINE OF BUSINESS			Q1	Q2	Q3	Q4	TOTAL
Medi-Cal							
Appeals	**Medical Services**	**Expedited**	4	8	5	2	19
		Standard	25	38	24	35	122
	Drugs	**Expedited**	0	0	0	0	0
		Standard	2	0	0	0	2
	Total Appeals		**31**	**46**	**29**	**37**	
Grievances	**Medical Services**	**Expedited**	2	0	0	0	2
		Standard	182	188	210	170	750
	Drugs	**Expedited**	0	0	0	0	0
		Standard	10	19	15	6	50
	Total Grievances		**194**	**207**	**225**	**170**	**796**
Medi-Cal			**225**	**253**	**254**	**213**	**945**

4.10 Types of Grievances Received, by Category

The following graph shows the types of grievances received. A breakdown of subcategories is available as an addendum upon request.



4.11 Regulatory Grievances (DMHC Consumer Complaints)

Regulatory grievances are complaints that are escalated to the Department of Managed Health Care (DMHC) for secondary review. These complaints may be escalated by a member or a member's authorized representative, such as a family member or attorney. During Q4 of 2022, eleven regulatory grievances were filed:

- The majority were related to access/availability of BHT resources for youth.

4.12 Resolutions Within 24 Hours of Receipt

The following reflect complaints that were resolved by HPSM staff within 24 hours of the member informing HPSM of the complaint. These complaints are not included in the count of grievances in the tables above, and do not enter the formal grievance process.

- **24 - Hour Resolutions, by Type of Service**

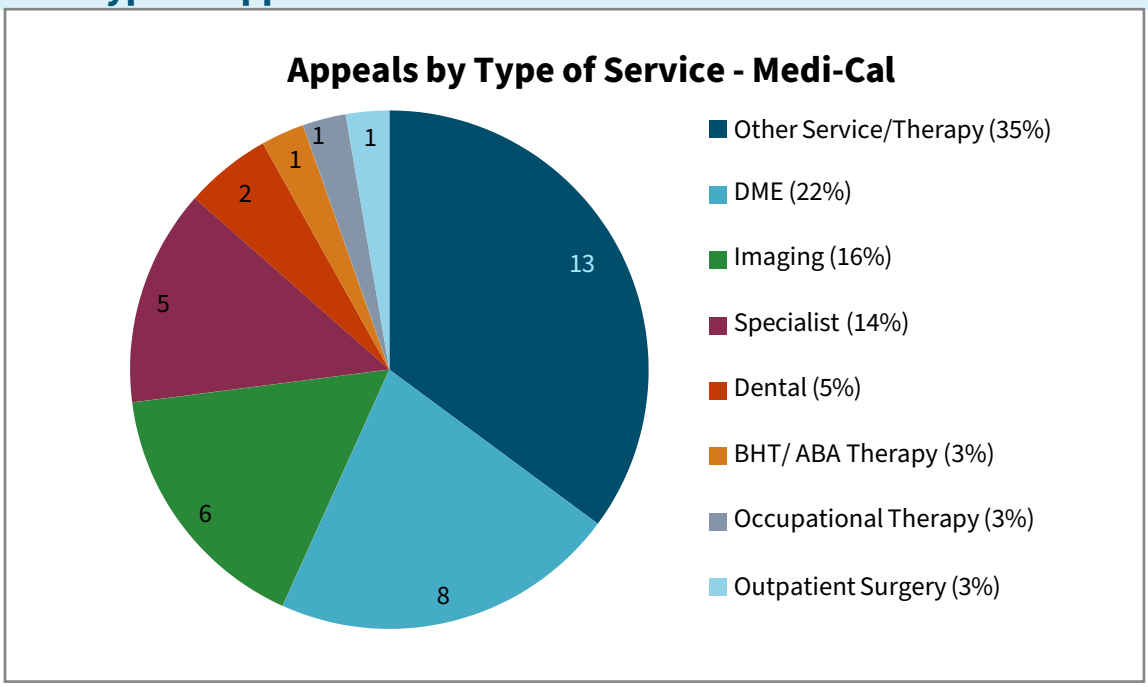
Types of Service	Q1	Q2	Q3	Q4	Total
Medical Services/Supplies	22	21	48	36	127
Prescription Drugs	6	0	9	6	21
Total	**28**	**21**	**57**	**42**	**148**

- **24 - Hour Resolutions, by Category**

Category	Medical Grievance	Pharmacy/Drug Grievance
Access	11	3
Availability	0	0
Benefit	7	1
Billing	3	1
Customer Service	12	1
Enrollment/Disenrollment	2	0
Marketing	1	0
Total	**36**	**6**

Note: We do not expect further pharmacy/drug grievances from MC members, but we will keep tracking them through this quarter.

4.13 Type of Appeals Received



4.14 Regulatory Appeals (Independent Medical Reviews & State Fair Hearings)

Regulatory appeals are appeals that are escalated to either the Department of Managed Health Care or the Department of Social Services for external review. Medi-Cal members have the right to escalate their appeals with either agency.

- The Department of Managed Health Care (DMHC) conducts an Independent Medical Review by an external physician and renders a decision to uphold or overturn the denial from HPSM.
- The Department of Social Services (DSS) conducts a State Hearing with an Administrative Law Judge, who renders a decision based on the member's legal rights.

During Q4, there were six cases filed for State Fair Hearing:

- One was dismissed, one was pending at the time of this report, and four were completed.

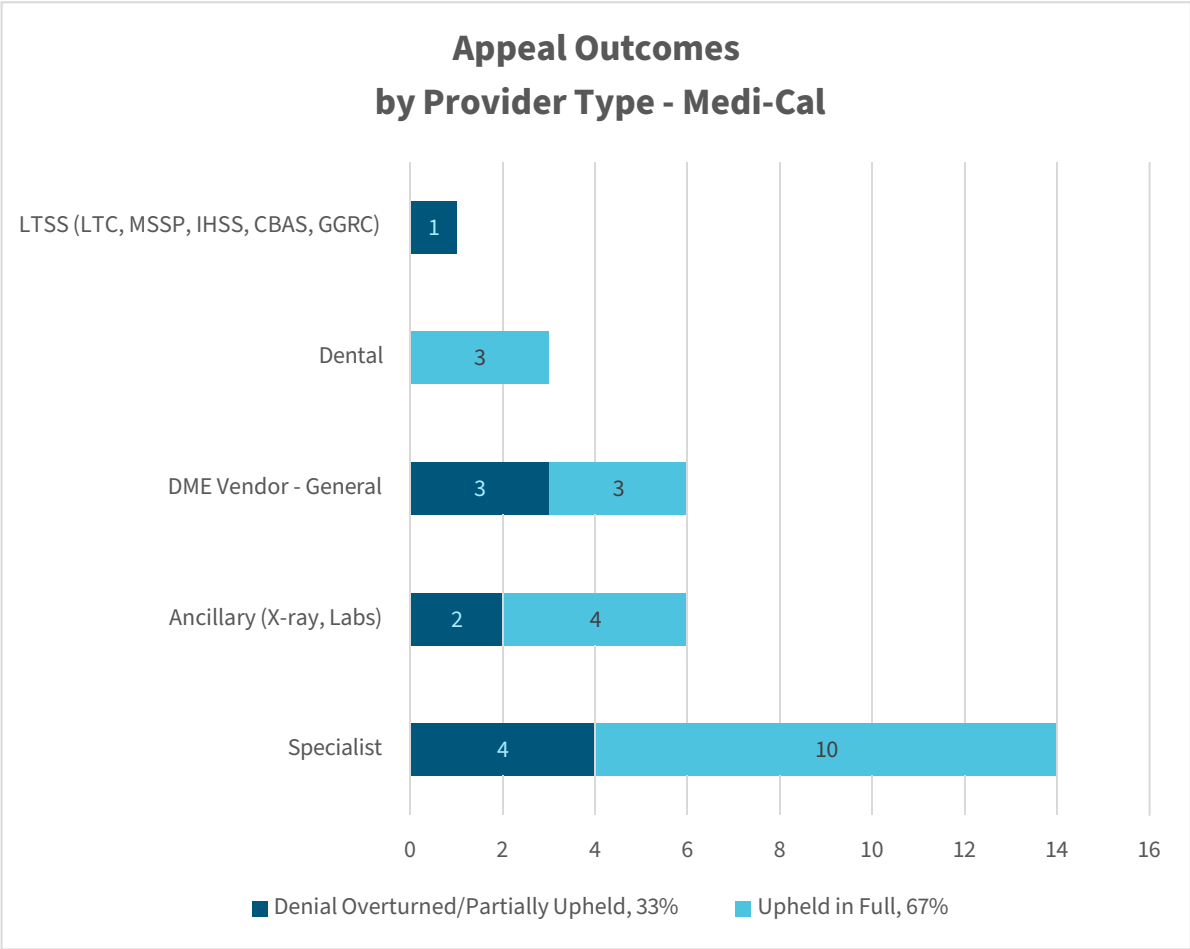
4.15 Rate of Overturned Appeals

The table below shows appeal outcomes depending on whether the benefit requested was a prescription drug or a medical service/supply.

Type of Denial	Total Appeals	Overturned	Upheld in Part	Upheld in Full	Withdrawn or Dismissed
Medical/Services	37	11	2	20	4

The Prescription drug benefit is no longer covered by HPSM Medi-Cal. For medical appeals, the overturn rate is **33.33%**.

Below is the breakdown of medical appeals by Provider Type:



4.16 Analysis, Barriers, and Proposed Actions/Solutions (MC)

Grievances:

- The **volume of grievances** remained consistent and saw the first decrease of the year in Q4 among Medi-Cal members with 194 grievances filed in Q1, 207 in Q2 and 225 in Q3, and 170 in Q4.
- The distribution of the **types of grievances** continued on a similar trend from Q3 to Q4, with Customer Service (39% this quarter) and Quality of Care (26% this quarter) as the highest type.
- HPSM received eleven **DMHC complaints,** which is an increase from prior quarters. The majority of these complaints were related to BHT treatment Access/Availability.

- **Grievances resolved in 24 hours** saw a slight decrease from Q3 but continued to be higher than in Q1 and Q2. Of note, all of these are now related to medical issues since pharmacy issues are now forwarded to the State Medi-Cal Rx program.

Appeals:

- The **volume of appeals** decreased from 31 appeals in Q1 to 46 in Q2 and down to 29 appeals in Q3, but went up slightly in Q4 to 37. By **type of service**, the largest areas again this quarter were Other Service/Therapy (35%), Specialist care (14%), and Durable Medical Equipment (22%). Additionally, there was a new category of imaging that received 16% of the appeals in Q4.
- The **rate of overturned medical appeals** has decreased from prior quarters to 33% in Q4 (from 40% in Q2 and 43% in Q3).
- There was a decrease in **Independent Medical Reviews** filed, though the small case numbers do not necessarily indicate a trend.

Proposed Action:

- **To address the increase in grievances against provider offices related to Quality of Care and Customer Service** HPSM's Provider Grievance Subcommittee will continue to meet regularly to review grievances by provider, identify problematic trends, and take action as appropriate. This is an inter-departmental effort between HPSM's Provider Services Department, Quality Department, Medical Directors, and Grievance and Appeals Unit.

4.17 NCQA Data Collection and Grouping

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 San Mateo County Behavioral Health and Recovery Services (BHRS) to treat mild-moderate mental health diagnoses, as well as services provided by Magellan Health to treat members with autism spectrum disorder and related diagnoses.

Note: For this report, we have calculated the rate of complaints per 1,000 members using the number of members who received services from BHRS.

Previously, we included children receiving ABA therapy in the total amount of behavioral health utilizing members. This data was received late in the quarter, so this caused a delay in reporting. Beginning in 2022, these children's complaints will continue to be part of the total complaint count, but the number of children serviced will not be added to the number of members receiving behavioral health services. The reported complaint rate will be slightly higher than if we were able to count all members serviced within the quarter, but the increase is not expected to be significant. The real rate can be calculated and provided upon request once the ABA utilization data is received.

Goal Rates

In general, the goal rate of complaints per 1,000 Medi-Cal members per month is set at **0.70** and the goal rate per 1,000 CCS members per month is set at **1.43**. These goal rates include all grievances and appeals for all services, not only those related to behavioral health; they are also calculated based on enrollment, not utilization of services.

In separating out behavioral versus non-behavioral health complaints, the G&A Unit has established separate goal rates in order to account for the more limited denominators in each of the data sets below.

Based on the data gathered for Q1 and Q2 of 2019, as well as Q3 and Q3 of 2021, the G&A Unit has set the following goal rates for all non-behavioral health grievances and appeals for 2022.

All goals were re-calculated after excluding Rx appeals. The new rates are also calculated as complaints per 1,000 members per month.

	Min	Max	Current goal
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 was also calculated using Q1 and Q2 of 2019, and Q3 and Q3 of 2021. The rate is based on utilization (Behavioral Health and ABA therapy users).

	Min	Max	Current goal
Behavioral Health: Grievances	0.10	0.33	**0.22**
Behavioral Health: Appeals	0.00	0.06	**0.03**

4.17.1 Medi-Cal and CCS Behavioral Health Grievances

For 2022, as explained above, the grievance rate is calculated without the quarterly count of children utilizing ABA therapy, due to report timing. Their grievances are still part of the total. The complaint rates are expected to be comparable even if calculated differently. Here is Q1 of 2022 compared to Q4 of 2022, and the new goal set for 2022.

	Q1 2022		Q4 2022		Goal
	Complaints Total	**Complaints per 1000 members per month**	**Complaints Total**	**Complaints per 1000 members per month**	
Access	10	0.32	14	0.44	N/A
Attitude and Service	1	0.03	2	0.63	N/A
Billing and Financial Issues	0	0.00	0	0.00	N/A
Quality of Care	9	0.28	1	0.03	N/A
Quality of Practitioner Office Site	0	0.00	0	0.00	N/A
Total Grievances	**20**	**0.63**	**17**	**0.55**	**0.22**

4.17.2 Medi-Cal and CCS Behavioral Health Appeals

Here is Q4 2022 compared to Q1 2022 and the new goal set for 2022.

	Q1 2022		Q4 2022		Goal
	Complaints Total	Complaints per 1000 members per month	Complaints Total	Complaints per 1000 members per month	
Access	0	0	0	0.00	N/A
Attitude and Service	0	0	0	0.00	N/A
Billing and Financial Issues	0	0	0	0.00	N/A
Quality of Care	0	0	1	0.03	N/A
Quality of Practitioner Office Site	0	0	0	0.00	N/A
Total Appeals	**0**	**0.00**	**1**	**0.03**	**0.03**

4.17.3 Medi-Cal and CCS Non-Behavioral Health Grievances

	Q1 2022		Q4 2022		Goal
	Complaints, Total	Complaints, Total	Complaints, Total	Complaints per 1000 members per month	
Access	45	0.12	41	0.09	N/A
Attitude and Service	78	0.21	79	0.47	N/A
Billing and Financial Issues	13	0.04	28	0.17	N/A
Quality of Care	45	0.12	41	0.24	N/A
Quality of Practitioner Office Site	0	0.00	0	0	N/A
Total Grievances	**181**	**0.50**	**189**	**0.46**	**0.99**

4.17.4 Medi-Cal and CCS Non-Behavioral Health Appeals

	Q1 2022		Q4 2022		Goal
	Complaints, Total	Complaints, Total	Complaints, Total	Complaints per 1000 members per month	
Access	29	0.08	33	0.01	N/A
Attitude and Service	3	0.01	3	0.01	N/A
Billing and Financial Issues	0	0.00	2	0.00	N/A
Quality of Care	5	0.01	1	0.00	N/A
Quality of Practitioner Office Site	1	0.00	0	0.00	N/A
Total Appeals	**38**	**0.10**	**39**	**0.09**	**0.14**

4.17.5 Analysis, Barriers, and Proposed Action:

(i) Behavioral Health complaint rates for Q4 2022, calculated as complaints per 1,000 members per month:

- The *rate of grievances* related to behavioral health services did not meet the goal of no more than 0.22 grievances per 1,000 utilizing members. The rate for Q1 (0.63) and for Q2 (0.50) and Q3 (.50) and Q4 (.55) were all above the goal. As a result, these grievances will be shared with HPSM's Behavioral Health team for further analysis to identify trends and potential actions. HPSM continues to notice an uptick in grievances regarding Behavioral Health Therapy (BHT) against HPSM and the delegate, Magellan.
- The *rate of appeals* related to behavioral health services met the goal in Q1, Q2 and Q3 2022, with both quarters being below the goal rate of no more than 0.03 appeals per utilizing member. Therefore, no action is proposed.

(ii) Non-Behavioral Health complaints for Q2 2022, calculated as complaints per 1,000 members *per month*:

- The *rate of non-behavioral health related grievances* met the goal in all quarters of 2022. The goal of no more than 0.99 grievances per 1,000 members per month was met with rates of 0.50 in Q1, 0.53 in Q2 2022, .63 in Q3 2022 and .46 in Q4. No action is proposed.

- The *rate of non-behavioral health appeals* was also within the goal of no more than 0.14 appeals per 1,000 members per month, with a rate of 0.10 in Q1, a rate of 0.12 in Q2 2022, a rate of .08 in Q3 2022 and a rate of .09 in Q4 2022. No action is proposed.

HealthWorx, ACE, and CCS

4.18 Number of Appeals and Grievances (Complaints) Received for Other Lines of Business

LINE OF BUSINESS	Q1	Q2	Q3	Q4	TOTAL
HEALTHWORX					
Appeals	1	3	6	2	12
Grievances	12	10	2	5	29
HealthWorx	**13**	**13**	**8**	**7**	**41**
ACE					
Appeals	2	1	2	3	8
Grievances	7	8	3	5	23
ACE Subtotal	**9**	**9**	**5**	**8**	**31**
CCS					
Appeals	1	1	1	0	3
Grievances	3	1	3	4	11
CCS Subtotal	**4**	**2**	**4**	**4**	**14**

4.19 Types of Grievances for HealthWorx, ACE, and California Children's Services (CCS)

CATEGORY	HW	ACE	CCS	TOTAL
Access	0	0	1	1
Billing	4	1	0	5
Customer Service	1	2	2	5
Enrollment/Disenrollment	0	1	0	1
Quality of Care	0	1	1	2
TOTAL	**5**	**5**	**4**	**14**

4.20 Resolutions Within 24 Hours of Receipt

The following reflect complaints that were resolved by HPSM staff within 24 hours of the member informing HPSM of the complaint. These complaints are not included in the count of grievances in the tables above, and do not enter the formal grievance process.

- **24 - Hour Resolutions, by Type of Service**

Types of Service	Q1	Q2	Q3	Q4	Total
Medical Services/Supplies	0	0	3	3	6
Prescription Drugs	36	14	5	7	62
Total	**36**	**14**	**8**	**10**	**68**

- **24 - Hour Resolutions, by Category**

Category	Medical Grievance	Pharmacy/Drug Grievance
Access	0	6
Billing	1	1
Customer Service	1	0
UM/Appeals Process	1	0
Grand Total	**3**	**7**

4.21 Analysis, Barriers, and Proposed Action

The number of grievances and appeals received from **HealthWorx** members decreased significantly over the year from a high of thirteen complaints received each quarter this year, to five in Q4. Similarly, complaints from **ACE** participants also decreased slightly to nine complaints received each quarter (Q1 and Q2) and five in Q3 and Q4. The number of complaints from **CCS** members remained stable from four complaints filed in Q1 to two complaints filed in Q2 2022 and back to four complaints in Q3 and Q4 2022.

Among these lines of business, the **types of grievances** received remained similar to past quarters. The largest area continues to be Quality of Care and billing, with a shift from Access & Availability to Customer Service in Q4.

Grievances resolved within 24 hours were related to prescription drug issues and medical services and supplies, which represented a significant decrease in prescription drugs in past quarters and the added grievances of medical services and supplies for the second quarter this year. The **overall number of grievances resolved within 24 hours decreased** from a high of 36 in Q1 to 10 in Q4 (with 8 in Q3 as the lowest).

No concerning trends are identified from this data, particularly given the small size of the data, and therefore no action is recommended.

5. Kaiser Permanente

This section includes data on grievances and appeals filed by HPSM members assigned to Kaiser Permanente as their primary care provider. Kaiser is delegated to intake, investigate, and resolve all complaints filed by or on behalf of HPSM members assigned to Kaiser.

5.1 Number of Appeals and Grievances (Complaints) Received by Kaiser

	Q1	Q2	Q3	Q4
Appeals	2	1	1	3
Grievances	42	56	34	56
Kaiser Total	**44**	**57**	**35**	**59**

5.1 Types of Kaiser Grievances and Appeals

Each grievance can have different grievance types, but only the primary reason is selected for each of the grievances reported in the next table.

Grievance Types	Q4
Authorization	1
Case Management / Care Coordination	28

Grievance Types	Q4
Discrimination	1
Member Informing Materials	5
Out-of-Network	1
PHI / Confidentiality / HIPAA	3
Plan Customer Service	1
Provider / Staff Attitude	3
Provider Availability	1
Referral	1
Technology / Telephone	3
Timely Access	8
Total Number of Grievances	**56**

For Kaiser Q4 appeals, this is the breakdown by benefit type:

Appeal Benefit Types	Q4
Case Management / Care Coordination	3
Total Number of Appeals	**3**

5.2 Analysis, Barriers, and Proposed Action

The number of ***appeals*** filed with Kaiser by HPSM members remained stable, with two appeals filed in Q1, only one appeal filed in both Q2 and Q3, and increased slightly to 3 appeals in Q4 2022.

The number of ***grievances*** filed with Kaiser by HPSM members increased from forty-four grievances in Q1 to fifty-seven in Q2, dropped back down in Q3 to thirty-four and increased in Q4 to fifty-six, which was similar to the Q2 2022 rate. Case Management/ Care Coordination continues to be the highest category of grievances. The other categories have remained stable. HPSM has requested a response regarding these increases from Kaiser and will work with Kaiser to identify if there is a need for further action on these trends.

6. Primary Care Provider (PCP) Changes by Provider

Reason for PCP Change	Number of Changes in Q4 2022
Difficulty Obtaining an Appointment.	31
Poor Service	23
Provider and Patient Incompatible	1
Total	**55**

A total of 55 members requested to change their assigned PCP effective Q4 of 2022 due to dissatisfaction. This is a decrease from the 93 members who requested to switch in Q1; 88 who requested to switch in Q2 and 73 who requested to switch in Q3.

In Q4, members switched away from a total of 21 different PCPs, which a slight decrease from Q1, Q2, and Q3. Of those, 17 were clinics and 4 were individual providers. One individual provider had four or more members switching away from their practice. With clinics, there were three that had four or more members choosing a different provider.

This data is shared with HPSM's Provider Services team quarterly for additional action as needed. These trends are similar to the past quarters.

2023 QUALITY IMPROVEMENT (QI) PROGRAM DESCRIPTION

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 2023, HPSM serves approximately 170,000 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).

During the COVID-19 pandemic in 2020 -2023, HPSM was notably affected by members needs during this time, which is reflected in some of our program descriptions as well as our Program Evaluation for 2022.

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. 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 PROGRAM

2.1 PURPOSE

The Quality Improvement (QI) Program provides a formal process to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety, 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 QI Program promotes the accountability of all employees and affiliated health personnel for the quality of care and services provided to our members.

2.2 GOALS

The goals of the QI Program are to:

- Provide timely access to high-quality healthcare for all members, through a cost-effective, safe, 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 and safety; and
- Resolve identified problems in a timely manner.

2.3 OBJECTIVES

- Design and maintain the quality improvement structure and processes that support continuous quality improvement, including measurement, trending, analysis, intervention and re-measurement.
- Meet the cultural and linguistic needs of the membership.
- Comply and coordinate with all governmental agency requirements.
- Support practitioners with participation in quality improvement 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 delegated activities by:
    - establishing performance standards,
    - monitoring performance through regular reporting, and
    - evaluating performance annually.

- 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
    - 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
    - identification and follow-up of non-utilizing members
    - profiles of physicians, and
    - measurement of compliance with practice guidelines
- Coordinate QI 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 QI 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 as appropriate.

2.4 EVALUATION OF THE QI PROGRAM

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

The annual QI Program Evaluation includes:

- A description of completed and going QI activities that address the quality and safety of clinical care and quality of services
- Trending of measures to assess performance in quality and safety of clinical and the quality of service indicator data
- Analysis of the results of the QI initiatives, including barrier analysis that evaluates the effectiveness of QI interventions for the previous year (demonstrated improvements in the quality and safety of clinical care and in the quality service)
- An evaluation of the overall effectiveness of the QI 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 PROGRAM

The QI Program provides for review and evaluation of all aspects of health care, encompassing both clinical care 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 integrates the review and evaluation of components to demonstrate the process is effective in improving health care.

Measuring clinical and service outcomes 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 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.

2.6 QI PROGRAM STRUCTURE

Oversight of the Quality Improvement 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 QI PROGRAM FUNCTIONAL AREAS AND RESPONSIBILITIES (QI 1.A.1)

The Quality Improvement Department is responsible for implementing a multidimensional and multi-disciplinary QI Program that effectively and systematically monitors and evaluates the quality and safety of clinical care and service rendered to members.

The Quality Improvement 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 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.
- Improve health care delivery by monitoring and implementing corrective action, as necessary, for access and availability of provider services to members.
- Conduct effective oversight of delegated providers.
- Ensure strong collaboration between QI 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:

- Provide staff support to the Quality Improvement Committee (QIC) and Clinical Quality Improvement Committee (CQC).
- Develop initial drafts of the QI Program documents for review and approval by the QIC.
- 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 & OVERSITE

The Population Health Management (PHM) team maintains the oversite of the PHM Program Strategy and is responsible for associated reporting. The QI team provides the systematic monitoring and measurement of health outcomes, patient safety and member satisfaction and identifies areas of improvement. 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, QIC, 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 QI PROGRAM AUTHORITY AND RESPONSIBILITY

The San Mateo Health Commission (Commission) assumes ultimate responsibility for the Quality Improvement (QI) Program and has established Quality Improvement Committee (QIC) 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 QI Program to the Chief Medical Officer (CMO).

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

Performance accountability of the Commission includes:

- Annual review and approval of the Quality Improvement Program description, Quality Improvement Work Plan and the Quality Improvement Program Evaluation.
- Review status of QIP and annual work plan at least quarterly.
- Evaluate effectiveness of QI activities and provide feedback to the QIC as appropriate.
- Establish direction and strategy for the QI 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 QIC, 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 QI 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 QI 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 Program (QIP).
- 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 QI 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 QIP 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 QI Program to HPSM leadership and staff via general staff, senior management team meeting, and other internal meetings.
- Delegating staff from other divisions to perform QI Program activities by agreement of appropriate division chief.

2.9.2 ROLE OF PARTICIPATING PRACTITIONERS

Participating practitioners serve on the QI 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 QI 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 QI Program. The designated behavioral health practitioner advises the Quality Improvement Committee (QIC) to ensure that the goals, objectives and scope of the QIP 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 Population 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 QI 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
- Utilization Management
- Customer Support
- Case Management
- Provider Services

- Health Services Analytics
    - Director of Health Services Analytics
    - Data Analysts
- Informatics
    - Information Systems Analysts
    - Biostatisticians
    - Statistical Analysis System (SAS) software suite – a comprehensive system for analyzing data

The Quality Improvement 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 QI ACTIVITIES (QI 1.A.1)

Health Plan of San Mateo may delegate Utilization Management, Quality Improvement, 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 QIP committees as appropriate and to the QIC.

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

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

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

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

2.9.7 ANNUAL REVIEW AND UPDATE OF QUALITY IMPROVEMENT PROGRAM

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

The annual evaluation assesses whether the QIP 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 QIC 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 QIP program recommendations is submitted to the Commission for annual approval. The following aspects of the Quality Department 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 QIP and outcome results from the previous year
- Evaluation and modification, if necessary, of the QIP 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 QIP is available upon request. This summary included information about the QIP's goals, processes, and outcomes as they relate to member care and service.

2.9.8 ANNUAL QUALITY IMPROVEMENT WORK PLAN

Annually the QI department develops a QI Work Plan for the calendar year. The Work Plan integrates QI reporting, studies from all areas of organization (clinical and service) and includes requirements for external reporting. The QI Work Plan is also based on the results of the annual program evaluation.

The Work Plan includes the following elements:

- Measurable objectives for each QI 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 QI Program.

Planned Additions to the QI Work Plan include:

- Scheduled reports to the QIC 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 PROGRAM

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

3. QUALITY IMPROVEMENT PROGRAM COMMITTEES

QI PROGRAM COMMITTEE MEETINGS

The Quality Improvement Committee (QIC) and subcommittees convene at regularly scheduled meetings, or more often is the chairperson deems it necessary; minimum frequency for QIC 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 QI 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.

QI PROGRAM COMMITTEE MINUTES

Comprehensive, accurate minutes are prepared and maintained for each QI 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 QI Program committees' meetings are provided for review to the:

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

QI PROGRAM COMMITTEE AGENDAS

The QI 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 QI Program committees' members and selected administrative personnel as deemed necessary (i.e., CEO, legal staff/counsel, Commission). All sensitive information, medical records and QIC findings are maintained in secure files.
QI Program reports, minutes, audit results and other Quality Improvement documentation are only distributed for review to the:

- Chief Medical Officer
- Chief Executive Officer
- San Mateo Health Commission
- QIC Committee members
- Regulatory bodies (as required and applicable)

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

QI PROGRAM COMMITTEE RESPONSIBILITIES AND FUNCTIONS

- Review the QI Program Description that establishes strategic direction for HPSM and forward to the Commission for approval.
- Evaluate the Quality 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 QI 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 efforts are prioritized, resources are appropriate, and resolutions occur.
- Prioritize quality improvement efforts and assure that resources are allotted.
- Approve Quality Improvement Program policies.
- Ensure appropriate oversight of delegated activities.
  Ensure integration, coordination, and communication among committees reporting to QIC.

QI 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 QIC).

Selected contracted practitioners and providers are invited to serve as members of a QI 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

A practitioner representative selected to participate on any QI 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 QIP expectations

REPORTING RELATIONSHIPS OF QI DEPARTMENT STAFF AND THE QI PROGRAM COMMITTEES (QI 1.A.1)

Methods of communication include, but are not limited to, quality improvement 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 is the focal point for convergence of quality improvement related activities and information.

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

CONFLICT OF INTEREST

Health care providers serving on any QI 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 QI 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 QI 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 COMMITTEE OVERSIGHT (QIC) (QI 1, A, 5)

The Quality Improvement Committee (QIC) establishes strategic direction, recommends policy decisions, analyzes and evaluates the results of QI activities, and ensures practitioner participation in the QI program through planning, design, implementation, or review. The QIC ensures that appropriate actions and follow-up are implemented and evaluates improvement opportunities. The QIC meets and reports at least quarterly to the Commission. The QIC is a multi-disciplinary committee, the membership includes at least one Commission member, (Current chair & co-chair) and practicing network physicians. Facilitating staff include the Chief Medical Officer, Quality Improvement 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
- Director of Quality Improvement
- Medical Directors
- Dental Director
- Director of Provider Services
- Director of Pharmacy
- Director of Health Services Analytics
- Population Health Officer
- Director of Behavioral Health
- Director of Integrated Care
- Director of Population Health
- 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 QIC and Commission

QUALITY IMPROVEMENT DIRECTOR:

- Serves as the Committee co-chairperson

- Reports CQC activities to the QIC, 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, PEER REVIEW AND PHYSICIAN ADVISORY 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 QIC
- 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 Services Analytics
- 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 LONG TERM CARE (LTC)/SKILLED NURSING CARE(SNF) QUALITY MONITORING

- Effective January 1, 2023, all Medi-Cal managed care plans (MCPs) are responsible for the full Long-Term Care (LTC) benefit at Skilled Nursing Facilities (SNF) and hospital-based SNFs. HPSM will continue offering this benefit to support our members with access to coordinated and integrated care.

- In accordance with APL 23-004, the QI team maintains quality oversight for LTC services provided. At least annually, unless otherwise requested, quality assurance and improvement findings for our contracted SNFs' are retrieved directly from the CDPH website, 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 representing SNF residents, 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 SNFs. 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 in relation to the SNF 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 SNFs are presented to the Clinical Quality Committee (CQC) on a bi-annual basis.

- As needed, QI will readily collaborate with the Care Coordination/Care Transitions teams to assess the quality and appropriateness of care furnished to members using LTSS 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. QUALITY IMPROVEMENT PROGRAM ACTIVITIES

The QI Program's scope includes implementation of QI activities or initiatives. The QIC 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
- Annual Dental Visit
- 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
- Medication Reconciliation Post-Discharge
- Mental Health Utilization
- Non-Recommended PSA-Based Screening in Older Men
- 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
- Transitions of Care
- 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)

6.1 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.

6.2 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.

6.3 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.

6.5 MEMBER EXPERIENCE

6.5.1 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, QIC 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 Medical 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

6.5.2 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. 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.

8. QUALITY IMPROVEMENT INTERVENTIONS

8.1 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.

2023 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. In 2023 these reports will be improved by adding sortable fields to help provider offices easily identify members that require an IHA.

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. Revised 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 2023
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

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.

8.2 CERVICAL CANCER SCREENING PLAN DO STUDY ACT(PDSA)

In 2023, HPSM Quality Improvement, Provider Services and Health Promotion staff will implement a new PDSA focused on Cervical Cancer Screening. Health Promotion staff will support the data validation efforts and Provider Services will serve as the liaison with Providers as described below.

Program Area Goal: : By February 28, 2023, increase the HPSM CCS rate for members living in San Mateo County and who are members of Coastside Clinic from the baseline rate of 38.07% to 43%.

2023 CCS PROGRAM AREA IMPROVEMENTS

Improvements to the CCS measure in 2023 will consist of partnering with Coastside Clinic in a data validation project. Efforts will include:

- Kick off meeting with Coastside Clinic and HPSM staff to plan project objectives.
- Coastside Clinic providing data reports of HPSM members with completed CCS.
- HPSM staff validating CCS completion reports provided by Coastside Clinic.
- Bi-weekly or monthly meetings to review reports and resolve data issues.

8.3 WELL-CHILD VISITS IN THE FIRST 30 MONTHS OF LIFE - (SWOT) ANALYSIS

The Well-Child Visits in the First 30 Months of Life (W30) measure requires six or more well-child visits in the first 0 to 15 months of life and two or more well-child visits between 15 to 30 months of life. In 2023, HPSM Quality Improvement(QI), Provider Services and Health Promotion staff will implement a SWOT Analysis focused on improving the W30 measure. QI, Provider Services and Health Promotion staff will support improvement as described below.

Program Area Goal: By September 23, 2023 increase the percentage of members aged 0 to 15 months who have completed 6 or more well child visits from 25.73% to the MY2021 MPL rate of 54.92%; and increase the percentage of members aged 15 to 30 months who have completed 2 or more well child visits from 69.14% to the MY2021 MPL rate of 70.67%.

2023 ACTION PLAN

For 2023, to support identified objections HPSM staff will implement the following strategies:

- Create Child and Youth Health Population Workgroup to improve W30 measure outcomes.
- Leverage established rapport with providers to provide education related to W30 compliance.
- Leverage relationship with the County's Family Home Visiting Program
- Explore the feasibility of a member incentive initiative for W30.

8.4 DHCS WELL-CHILD VISITS IN THE FIRST 15 MONTHS DISPARITY PIP

Starting in 2023, 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+))

PIP SMART AIM: The PIP Smart Aim will be determined when DHCS initiates the 2023 PIPS in mid-2023.

2023 HEALTH EQUITY ACTION PLAN

For 2023, W30 6+ will be a key area of focus for HPSM and based on findings from intervention planning, HPSM staff will conduct the appropriate activities.

8.5 DHCS PIP

Starting in 2023, the Quality Improvement Department will implement a performance improvement project (PIP) on a topic to be determined by DHCS by mid-2023.

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 Evaluation	Mariana Ulloa	Annually	1/1/2023	3/1/2023
NCQA ME7	Members' Experience	CAHPS Reporting	Medi-Cal, CA	2023 HEDIS and Medicare CAHPS Summary Reports	Perform at or above the national average across all CAHPS Composite, Ratings, Prescription Drug and HEDIS measures.	Conduct CAHPS surveys. Summarize and report out on CAHPS 2023 findings as well as present CAHPS to QI and Member Experience Committees	Mariana Ulloa	Annually	1/1/2023	12/1/2023
Ops	Members' Experience	Member Satisfaction Reporting	Medi-Cal, CA	2023 Medi-Cal and DSNP Summary Reports	Complete Survey of Members regarding level of satisfaction with HPSM.	Conduct Satisfaction surveys. Summarize and report out on findings as well as present to Member Experience Committee	Mariana Ulloa	Annually	6/1/2023	12/1/2023
CMS	Members' Experience	HOS Reporting	CA	2023 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	9/1/2023	12/31/2023
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 DSF and DEV measures. Complete Provider Survey. Complete remeasurement and analysis of all metrics and annual report.	Mariana Ulloa, BH, PHM, Provider Services	Annually	1/1/2023	12/31/2023
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.omplete remeasurement and analysis of all metrics and annual report.	Mariana Ulloa, ICM, PHM	Annually	1/1/2023	12/31/2023

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	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	8/1/2023	12/31/2023
Ops	Quality of Clinical Care	HEDIS	Medi-Cal, CA	HEDIS MY2022 Project Plan	Ensure timely completion of all project deliverables by June 15, 2023.	- 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.	Nicole Ford	Annually	1/1/2023	6/15/2023
DHCS	Quality of Clinical Care	MCAS	Medi-Cal	Cervical Cancer Screening (CCS)	Improve CCS rates from MY2021 rate of 57.61% to 57.64% (MPL RY2023)	Conduct PDSAs tests change interventions on targeted provider and member groups Continue P4P incentive for CCS for Adult and Family Practice Tracts Send CCS reminder letters to members due for CCS Conduct outreach for members due for CCS that are Black identifying or managed by GGRC to identify and resolve barriers to CCS	Mariana Ulloa, Scott Fogle, Health Promotion Team, Integrated Care Management Team	Ongoing	1/1/2023	12/31/2023

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	MCAS	Medi-Cal	Cervical Cancer Screening (CCS) PDSA	By November 3, 2023, increase the HPSM CCS rate for members assigned to Coastside Clinic from the baseline rate of 38.07% to 43% by conducting data validation with Coastside Clinic.	Data reconciliation with Coastside Clinic to identify data quality issues. To complete the data reconciliation, we will be providing Coastside Clinic with up-to-date care-gap reports detailing non-compliant CCS members. In turn, the Clinic will provide data detailing members they have identified as compliant in their system.	Mariana Ulloa	Quarterly	1/1/2023	11/30/2023
DHCS	Quality of Clinical Care	MCAS	Medi-Cal	Well Child Visits in first 30 Months (W30)	Improve Well Child Visit rates from 25.73% for the visits within first 15 months of life to 55.72% (MPL RY2023) and 69.14% for visits within first 30 months of life to 65.83% (MPL RY2023)	Conduct SWOT analysis for W30 Complete barrier analysis to identify areas for improvement interventions Continue P4P incentive for early well child visits.	Mariana Ulloa Scott Fogle PHM Child & Youth Work Group	Ongoing	1/1/2023	11/30/2023
DHCS	Quality of Clinical Care	MCAS	Medi-Cal	Well Child Visits in first 30 Months (W30) SWOT	Complete Analysis and Project Plan.	Implement 4 Strategies with 2 action items each to improve rates. Implement actions and report progress to DHCS.	Mariana Ulloa	Quarterly	1/1/2023	10/2/2023
DHCS	Quality of Clinical Care	DHCS PIPs	Medi-Cal	Health Equity PIP-W30(6+)	TBD	TBD	Mariana Ulloa	Ongoing	1/1/2023	12/31/2023
DHCS	Quality of Clinical Care	DHCS PIPs	Medi-Cal	TBD PIP	TBD	TBD	Mariana Ulloa	Ongoing	1/1/2023	12/31/2023

Requirement source	Area of Focus	QI Program	Line of Business	Project	Objectives	Planned Activities	Responsible Party	Frequency	Start Date	Finish Date
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 2023 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.	Mariana Ulloa, Provider Network Specialist, Harnoor Chahal	ongoing	1/1/2023	12/31/2023
DHCS	Quality of Service	Access & Availability	Medi-Cal	Member Timely Access Survey	Monitor access and availability of provider appointments	Complete member survey and present Results to Member Experience Committee	Mariana Ulloa, Member Experience Program	Annually	6/1/2023	12/31/2023

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.	1/1/2023	12/31/2023
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	1/1/2023	12/31/2023

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	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	1/1/2023	12/31/2023

DRAFT

SAN MATEO HEALTH COMMISSION
Meeting Minutes
June 14, 2023 – 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor Boardroom
South San Francisco, CA 94080

AGENDA ITEM: 4.3

DATE: July 12, 2023

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

1. **Call to order/roll call**
   The meeting was called to order at 12:33 p.m. by Commissioner Pon, Chair. A quorum was present.

2. **Public Comment**
   No public comments were made at this time.

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

4. **Approval of Consent Agenda**
   Commissioner Zuniga moved to approve the agenda as presented (Second: Aviles) **M/S/P.**

5. **Specific Discussion/Action Items**

5.1 Presentation on Provider Workforce

Ms. Colleen Murphey, Chief Operating Officer, gave an update regarding the broader framework of the strategic planning and the provider workforce which staff is in the process of at this time. Her presentation is attached to these minutes.

Ms. Murphey noted that over the next few months staff will be presenting on primary care, D-SNP exploration, PACE, and dental health for the framework of planning throughout the coming year. This information will lead to a couple of voting items and provide some context on the approach to these recommendations.

The timeline for strategic planning was reviewed showing the kickoff of the data collection began in February leading to the discussions in April and May and now are in the goal drafting process in June and July. The drafts will be presented to the commission in August and September as well as with other stakeholders and potential recommendations to the commission for approval in November.

Ms. Murphey gave a recap of the previous discussions with the commission regarding the environmental scan of what has been going on in the state noting policy transformations changing how healthcare dollars are used and align with health outcomes and health equity. Lasting impacts of COVID and provider burnout are a reality and strains to the safety net are a consideration going forward. The staff is also watching major trends in financial risk as well. Inside the organization, discussions in April included the health plan's strengths, weaknesses, opportunities, and threats (SWOTs).

Ms. Murphey reviewed the possible guiding principles that will help in making the decisions for the future and the criteria for the areas of focus. This includes conversation around the health plan's mission and alignment with enhancing access to care, focusing on clinical measures for improvement and impacts, health outcomes, leveraging strengths, and sustainability. She touched on financial and relationships in the Community and the role the health plan plays as an aggregator of data within the healthcare system in San Mateo County as well as a convener. Related to measurable progress, she talked about developing initiatives for the next five years with achievable goals listening to long term qualitative factors. Additionally, she touched on our financial resources and stewardship thereof as well as long term organizational health.

Commissioner Graham commented on the stewardship and suggested that this be expanded to the stewardship of the network as well. That is dependent on a continuum of care when there are unprecedented losses among healthcare providers.

Commissioner Canepa commented on the equity issue and certain areas in the county. Now that we are in a more competitive environment it will be important to focus on community needs and supporting our partners. Financial stewardship is an area that is important work moving forward to bridge gaps.

Commissioner Zuniga commented on the importance of strong relationships that can move the needle and develop trusted communications knowing that needs will be addressed.

Commissioner Aviles echoed comments made and noted that as a primary care provider, the impact on the member experience, relationships and the member voice piece within this work is an important focus.

Commissioner Callagy noted that one of the greatest threats and one of the greatest opportunities is through our workforce. The fact that San Mateo County is one of the most expensive areas in which to live in the country, attracting, retaining, and developing employees should be a topic of focus in the coming years in order to maintain a level of service to our customers.

Commissioner Mueller added that increasing access to members is another critical component.

5.2 Presentation on Workforce Development

Ms. Amy Scribner, Chief Health Officer, presented information related to the workforce development within the strategic planning. Her portion of the presentation is attached to these minutes.

Ms. Scribner reviewed the five areas related to workforce opportunities. Related to provider workforce, new provider types through CalAIM and social drivers within the Medi-Cal space. This includes community health workers, Doula, medically tailored meal providers, licensed boarding care homes, RCFEs and other care management type providers. Access to these new provider types will help members get care in a more holistic approach that will lead to health outcomes and health equity.

Ms. Scribner reviewed the process staff have taken which started months ago to explore the challenges in the workforce space. This process is to ultimately grow and retain providers to expand services in San Mateo County and possibly surrounding counties within the regional D-SNP model being explored. Interviews with stakeholders, funding and training organizations have been conducted to learn more about what is happening outside of our organization, and identify gaps and challenges within the state, regionally and locally. From this process several opportunities identified include tuition reimbursement, loan repayment, new cohorts of students or courses and a strong focus on medical and behavioral health providers. Another opportunity discussed was the idea of formal training and internships during schooling contributing to certification or licensure. And, next, the challenges for new graduates to secure interviews and employment due to lack of experience. This led to a deeper look at the role HPSM could play in the training arena. Ms. Scribner described the current intern and fellow programs at HPSM and the many collaboratives over the years. Recently the Enhance Care Management collaborative brought together providers from different organizations to share best practices. Also, HPSM is poised to link people by sending resumes and securing interviews for these individuals for potential job matching. This leads to a potential role as investor/funder in the area of technical assistance building to help support pipeline development. Next steps will be prioritization.

Commissioner Graham asked for clarification on which workforce we are talking about. Ms. Murphey confirmed it is Medi-Cal provider (both medical and non-medical providers) workforce and there is a way for the health plan to be part of that pipeline. Commissioner Graham added that another consideration is the providers being able to pay their workforce as key to this work on workforce. Commissioner Santamaria asked about the size of the workforce. Ms. Murphey explained that just the credentialed and clinical folks contracted with HPSM is about 12,000 and much more if you consider the front office staff which are to core to all of this. Ms. Scribner added that the HPSM annual population needs assessment considers how the membership matches to access and diving into this at future meetings would be helpful in deciding how to possibly bundle investor opportunities and how HPSM can play a role with value based payment, for example. Discussion ensued on the reasons why this investment in the workforce is important.

6. **Report from Chairman/Executive Committee**
   There were no comments or reports from the Executive Committee at this time.

7. **Report from Chief Executive Officer**
   Ms. Murphey reviewed some of the highlights of the CEO's written report.

8. **Other Business**
   No other business was discussed at this time.

9. **Adjournment**
   The meeting was adjourned at 1:19pm

Submitted by:
C. Burgess

C. Burgess, Clerk of the Commission

Attachment 1 to
SMHC Minutes 6-14-2023

Strategic Planning Update

San Mateo Health Commission

June 14, 2023

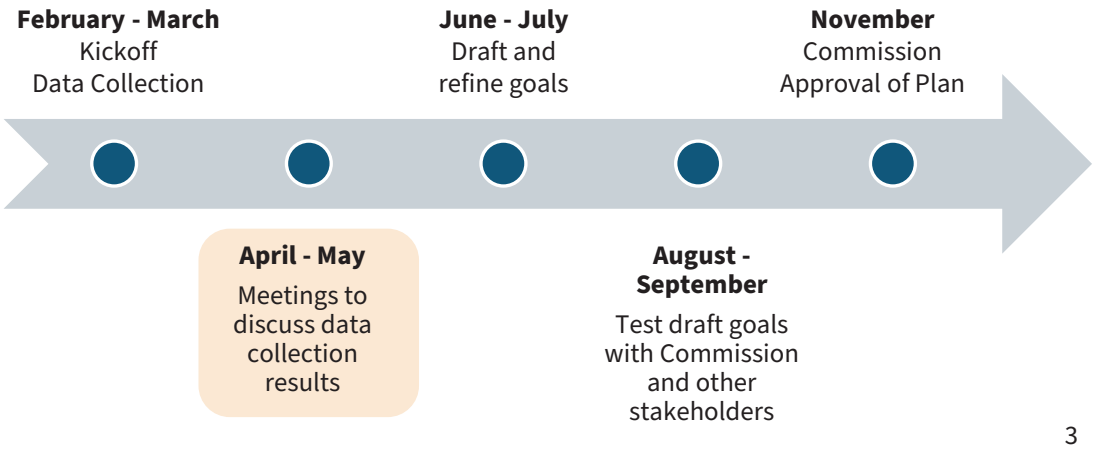
HealthPlan OF SAN MATEO
Healthy is for everyone

Health Commission Meeting Agenda Overview

HealthPlan OF SAN MATEO
Healthy is for everyone

Month	Topic
April 2023	Primary Care Investment Discovery Phase
May 2023	Regional DNSP Exploration PACE Exploration Potential Workforce/Provider Investments
June 2023	**Strategic Planning Update** **Provider Workforce Discovery Phase**
July 2023	Regional DSNP Discussion Healthworx Update and Proposal
August 2023	Regional DSNP 501c3 Formation (potential vote) Seton/AHMC Investment (potential vote)
Sept 2023	Primary Care Investments (potential vote) Provider Workforce Investments (potential vote)

Strategic Planning Timeline



Environmental Scan

- Statewide care transformation
- Accountability for Health Outcomes and Health Equity
- Growing competitive pressure
- Lasting impacts of the COVID-19 Public Health Emergency
- Shifting focus on financial risk

SWOT Snapshot

Internal Strengths

1. **Medi-Cal members' immunization rates, perinatal/postpartum care, Diabetes mgmt., dental care**
2. Care Advantage member satisfaction
3. Solid track record serving Duals
4. **Employee satisfaction + competitive in workforce**
5. Provider and partner satisfaction
6. Good fiscal management + healthy reserves
7. Staff committed to members
8. Strong external reputation

Internal Weaknesses

1. Limited access within provider network
2. Health disparities
3. Communication to providers
4. Communication across departments
5. Below national averages for health care quality
6. **Variability in employee engagement**

External Opportunities

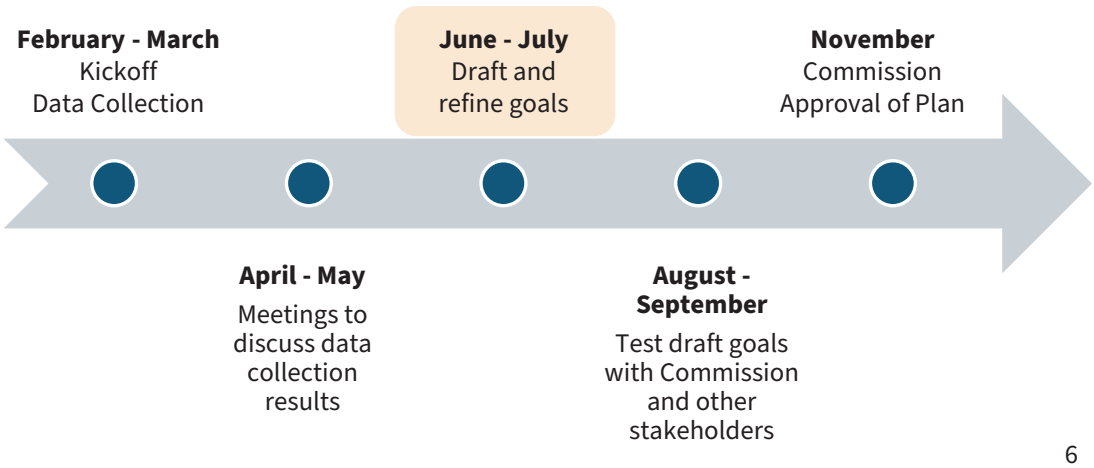
1. **Provider workforce pipeline**
2. **Innovate**
3. **Invest/fund beyond benefits + expand programs**
4. **Partner with community-based organizations to address social determinants**
5. Use data to improve member health and advocate for policy change

External Threats

1. Limited providers accepting Medi-Cal
2. HPSM talent recruitment and retention given competitive marketplace
3. **Competition with Kaiser for members**
4. **Constant regulatory changes strains bandwidth**
5. **Shifting community needs and community-based org. capacity**

Bold = new or different

Strategic Planning Timeline



Guiding Principles

1. **HPSM will focus on work that significantly advances our Mission:** ensuring that our members have access to high-quality care, services and supports.
2. **HPSM will measure and improve our impact upon health outcomes –** with a particular focus on meeting the needs of our members experiencing health disparities.
3. **HPSM will leverage our unique strengths,** with intentional planning about where we are best suited to play the role of convener, investor, partner, or lead implementor.
4. **HPSM will plan for long-term sustainability,** acting with the highest standards of financial stewardship and with consideration for the broader competitive and policy landscape we operate within.

From Principles to Practical Prioritization

Is this a goal that…

- ❑ **Meaningfully impacts member access** to high-quality care, services and supports in alignment with our mission.
- ❑ **Supports our members' journey to the best possible health outcomes**, including equitable outcomes and a positive member experience
- ❑ **Leverages HPSM's unique strengths** including our unique capabilities, resources, relationships and role within the health care ecosystem.
- ❑ Is a goal that we can make **measurable progress on** within a five-year time frame.
- ❑ Supports strong **stewardship of our financial resources**.
- ❑ Addresses threats and opportunities that **impact HPSM's long-term organizational health**

From Principles to Practical Prioritization

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Is this a goal that…

- ❑ **Meaningfully impacts member access** to high-quality care, services and supports in alignment with our mission.
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What's in a word?

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What do we mean when we say….

Meaningful Impact

We will consider both the **scale** of the impact, and the **acuity of the need** we are having an impact on

Why does this matter?

Our organization's scale and role in the healthcare ecosystem comes with an inherent responsibility to consider the population-level impact of our actions.

If not us, then who?

However, focusing on # of members impacted alone risks ignoring the

root causes of health disparities.

From Principles to Practical Prioritization

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Is this a goal that:

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What's in a word?

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What do we mean when we say….

Health Outcomes

in addition to **clinical measures** of health status, high quality health outcomes encompass **equitable** care outcomes without disparities, and a positive **member experience of care**.

Why does this matter?

Inequitable healthcare isn't high quality healthcare

We are centering equity and member experience as core to the definition of positive health outcomes, not as an "add on"

From Principles to Practical Prioritization

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Is this a goal that:

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What's in a word?

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What do we mean when we say….

Unique Strengths

our unique **capabilities**, **resources**, **relationships** and **role** within the health care ecosystem.

Why does this matter?

We need to consider the optimal use of the resources and time we have, and ask: "is this something that HPSM is best or uniquely positioned to do"? This allows us to

avoid duplication

and

focus on what only we can do

From Principles to Practical Prioritization

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Is this a goal that:

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What's in a word?

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What do we mean when we say….

Measurable Progress within five years

Metrics of success will include both **quantitative outcomes** measures, and **qualitative experience** information

Why does this matter?

If our metrics don't strike the right balance between aspirational and achievable, they aren't **motivating**.

And: members, providers and staff share feedback in a diversity of ways. An exclusive emphasis on *quantifiable* outcomes has **historically marginalized efforts** that have diffuse, long term, or harder to measure community benefits

From Principles to Practical Prioritization

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Is this a goal that:

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What's in a word?

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What do we mean when we say….

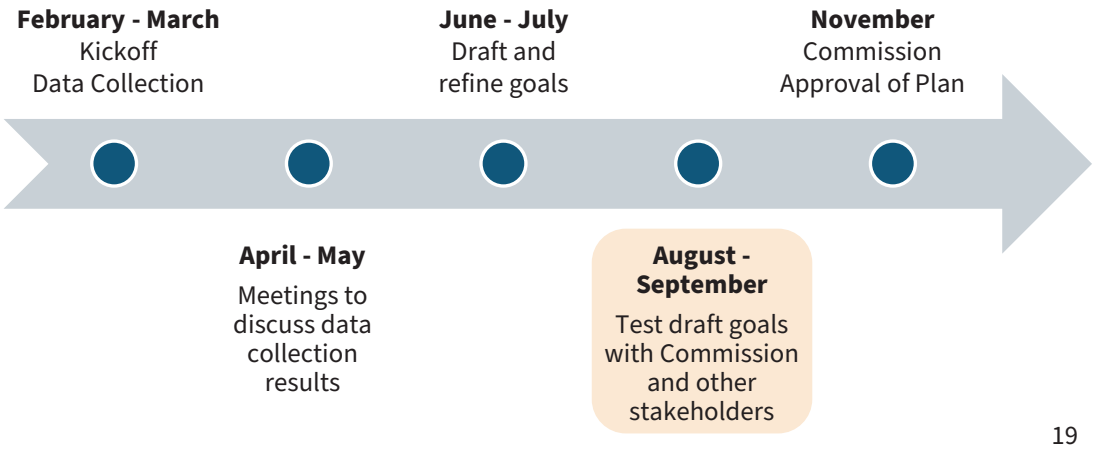
threats and opportunities

We are at a crossroads. The lasting effects of COVID-19, economic conditions, the competitive landscape, and new innovations are poised to create **significant changes** to the healthcare landscape in the coming years.

Why does this matter?

Choices we make now – about what role HPSM plays in our community, where we grow, and the innovations we invest our time and resources into – will have long-term implications for whether HPSM **fails, survives, or thrives**

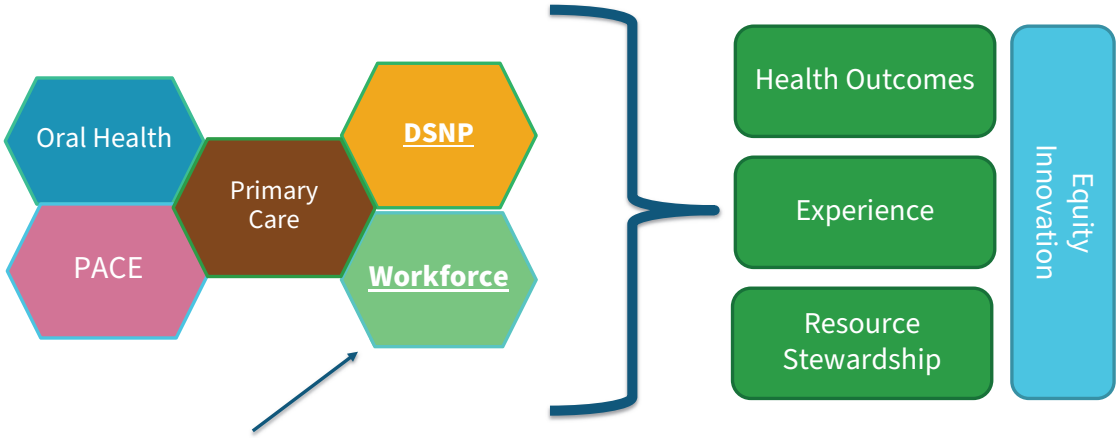
Next steps



Environmental Scan

- Statewide care transformation
- Accountability for Health Outcomes and Health Equity
- Growing competitive pressure
- Lasting impacts of the COVID-19 Public Health Emergency
- Shifting focus on financial risk

Areas of Opportunity - Updated



HPSM Strategic Investment: Workforce

San Mateo Health Commission

June 14, 2023

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Areas of Opportunity - Updated

HealthPlan OF SAN MATEO
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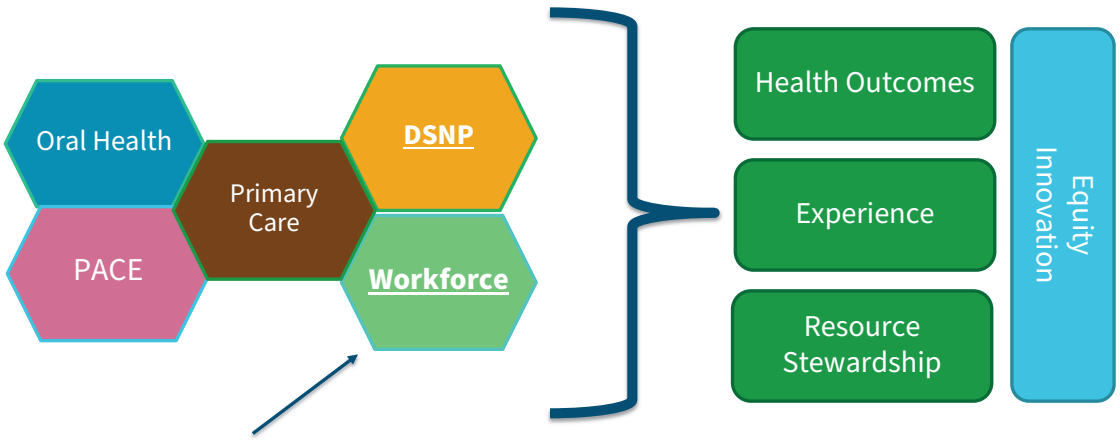
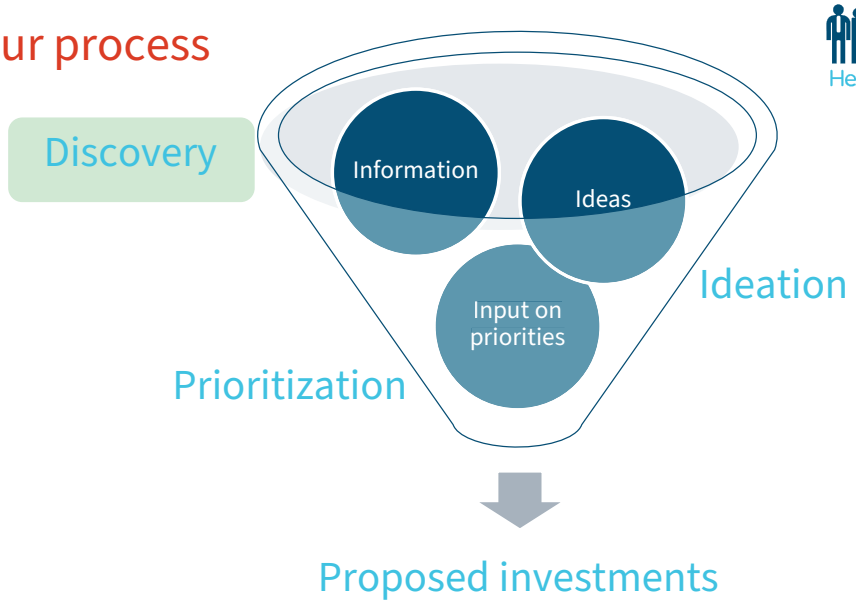


Defining the Problem

- Statewide care transformation
- Accountability for Health Outcomes and Health Equity
- Growing competitive pressure
- Lasting impacts of the COVID-19 Public Health Emergency
- Shifting focus on financial risk

Our process



Discovery Process

- Interviews with several stakeholders, funding and training organizations
- Discussed what is already happening in the space
- Discussed gaps/challenges
- Brainstorming of options and ideas

The Who

- California Department of Healthcare Access and Information (HCAI)
- Department of Healthcare Services (DHCS)
- Silicon Valley Foundation
- County Office of Equity
- UCSF Workforce
- Bay Area Community College Consortia
- Homebridge
- NEMS

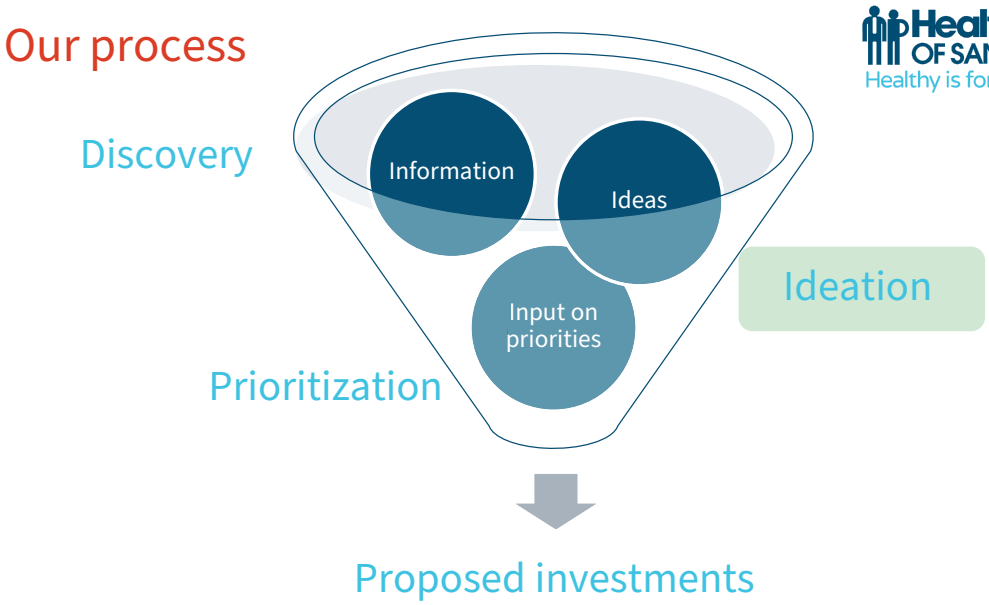
Learnings

- Several funding opportunities exist
  - Scholarships
  - Tuition reimbursement/loan repayment
  - Creation of classes
- Focus on medical providers and behavioral health providers
- Shortage areas get lots of focus and money
  - Rural areas

Gaps/Challenges

- Formal training opportunities
  - Practicum, internships
- Career Lattice
- Job interviews and job placements

Our process



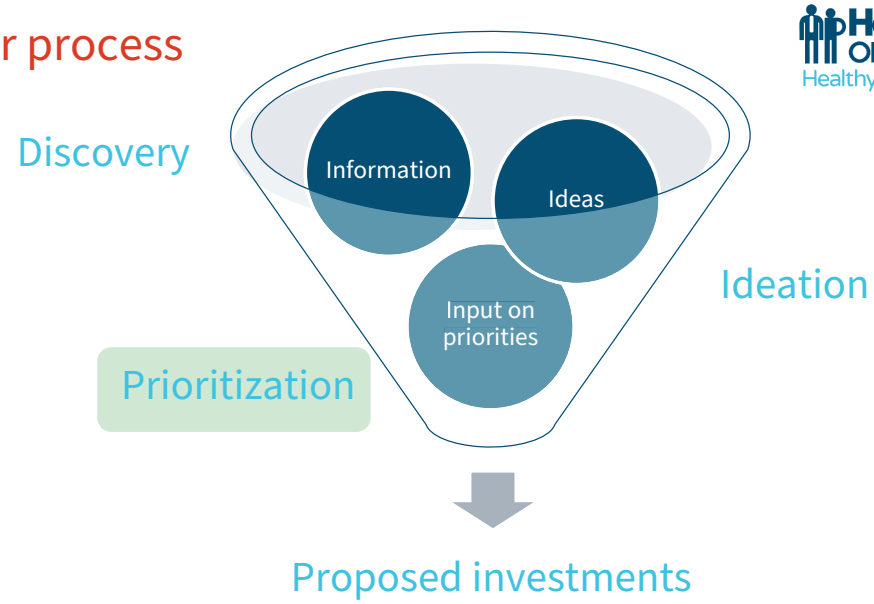
Potential HPSM role

- Trainer
  - Intern/fellowship cohorts
  - Collaboratives
  - Experience working in Medi-Cal and Medicare/Medi-Cal environment
- Job match/placement
  - Linkage with providers
  - Linkage with other local health plans

Identifying Options/Potential Solutions

- Investor/Funder – one time funding; infrastructure build
- Convener/Technical Assistance – building upon SNF and hospital collaboratives
- Innovator – pipeline development

Our process



Next Steps

- Potential pathways explored based on identified access needs
- Capturing your input on priorities during our fall Commission Onsite meeting
- Upcoming meetings and process – what do you need to know, what questions do you have?

Health Commission Meeting Agenda Overview

Month	Topic
April 2023	Primary Care Investment Discovery Phase
May 2023	Regional DNSP Exploration PACE Exploration Potential Workforce/Provider Investments
June 2023	Strategic Planning Update Provider Workforce Discovery Phase
July 2023	Regional DSNP Discussion Healthworx Update and Proposal
August 2023	Regional DSNP 501c3 Formation (potential vote) Seton/AHMC Investment (potential vote)
Sept 2023	Primary Care Investments (potential vote) **Provider Workforce Investments (potential vote)**

MEMORANDUM

AGENDA ITEM: 5.1

DATE: July 12, 2023

DATE: June 26, 2023

TO: San Mateo Health Commission

FROM: Patrick Curran, Chief Executive Officer
Chris Esguerra, MD, Chief Medical Officer

RE: Restructuring of the San Mateo Health Commission Standing Committees

---

With the end of the Public Health Emergency, we have been presented the opportunity to review, streamline, and update the standing committees and advisory groups that report to the Commission.

We propose the consolidation to three Standing Committees for the Commission: Finance/Compliance Committee, Quality Improvement and Health Equity Committee, and Consumer Advisory Committee.

With this consolidation, we also propose the dissolution of the following committees as they do not require direct oversight of the Commission: CCS Clinical Advisory Committee, CCS Family Advisory Committee, Physician Advisory Group and Peer Review/Credentialing Committee, Pharmacy and Therapeutics Committee, CareAdvantage Advisory Committee (formerly CMC Advisory Committee), and Children's Health Initiative.

Rationale/Discussion:
The three bodies reporting to the Commission streamlines committee oversight, ensures all policies have an oversight body, and establishes clear flows of accountability and communication into the Commission. These bodies, outlined below, are also required from a regulatory perspective. The other standing committees that we propose to dissolve do not have a regulatory requirement that they report directly to the Commission.

The Finance/Compliance Committee replaces the Finance/Executive Committee, covering matters around finance, compliance, and administrative policies.

The Quality Improvement and Health Equity Committee (formerly Quality Improvement Committee) oversees health equity, clinical, quality, and provider matters and policies; monitors and provides oversight over our quality and health equity efforts; and oversees our work with providers.

The Consumer Advisory Committee, which serves one of our bylaws functions of Public Policy Participation, oversees member and community inputs and feedback.

DRAFT

RESOLUTION OF
THE SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF RESTRUCTURING
STANDING COMMITTEES OF THE SAN MATEO HEALTH COMMISSION

RESOLUTION 2023 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has established committees and advisory groups to carry out its business which is approved annually by the Commission
B. The need for these committees to report directly to the Commission has changed and a restructuring will help streamline the conduct of business

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves the restructuring of its standing committees as follows:
    a. The following current standing committees will be dissolved:
        i. CCS Clinical and CCS Family Advisory Committees
        ii. Physician Advisory Group
        iii. Pharmacy and Therapeutics Committee
        iv. Peer Review/Credentialing Committee
        v. CareAdvantage Advisory Committee
        vi. Children's Health Initiative
    b. The new Standing Committees will consist of:
        i. Finance/Compliance Committee
        ii. Quality Improvement and Health Equity Committee
        iii. and Consumer Advisory Committee

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of July 2023 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

San Mateo Health Commission Subcommittees

San Mateo Health Commission

July 2023

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Agenda

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- Proposal
- Rationale
- Motion

Proposal 1

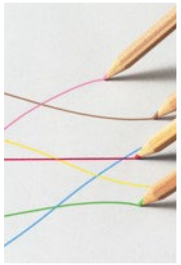
Solidify the Commission Advisory Committees to the Structure as follows:

Proposal 2

Dissolve the following committees as they do not require direct Commission oversight

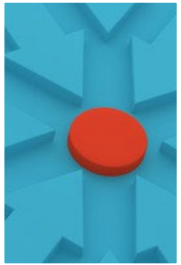
- CCS Clinical Advisory Committee
- Pharmacy and Therapeutics
- Peer Review/ Physician Advisory Group
- CCS Family Advisory Committee
- CareAdvantage Advisory Committee
- Children's Health Initiative

Rationale



Streamline committee oversight

Ensure all policies have a review home



Establish clear flows into the Commission

Analysis

Committee	HPSM equivalent	Named in	Where	Requirement to be designated or "of the board"?
QIHEC (formerly QIC)	**QIHEC**	DHCS contract Knox Keene Act CMS regulation	**DHCS** Exhibit A, Att III, 2.2.3 **Knox Keene Act** Title 28 CCR 1300.70(b)(2)(C) **CMS** 42 CFR 422.107(f)	Yes
Community Advisory Committee	**CAC**	DHCS contract Knox Keene Act	**DHCS** Exhibit A, Att III, 5.2.11(E) **Knox Keene Act** HSC 1300.69	Yes
Regulatory and Compliance Oversight	**Finance/ Compliance**	DHCS contract CMS regulation	**DHCS** Exhibit A, Att III, 1.3.1(F) **CMS** Chapter 21, Section 50.2.3 42 CFR 422.503(b)(4)(vi)(B) 42 CFR 423.504(b)(4)(vi)(B)	Yes
Credentialing/Peer Review	PRC	DHCS contract	Exhibit A, Att III, 2.2.12	No
C&L Committee(s)	MEC	DHCS contract	Exhibit A, Att III, 5.2.11	No
P&T Committee	P&T	Knox Keene Act CMS regulation	**Knox Keene Act** HSC 1367.41 **CMS** 42 CFR 422.136(b) 42 CFR 423.120(b)(1)	No
DSNP consumer participation*	CAAC	DHCS contract	**SMAC** Exhibit A, Attachment 1, Provision 4	No
Family Advisory Committee	CCS	DHCS APL	21-005	No
Clinical Advisory Committee	CCS	DHCS APL	21-005	No

The Dissolved Committees will continue to do work

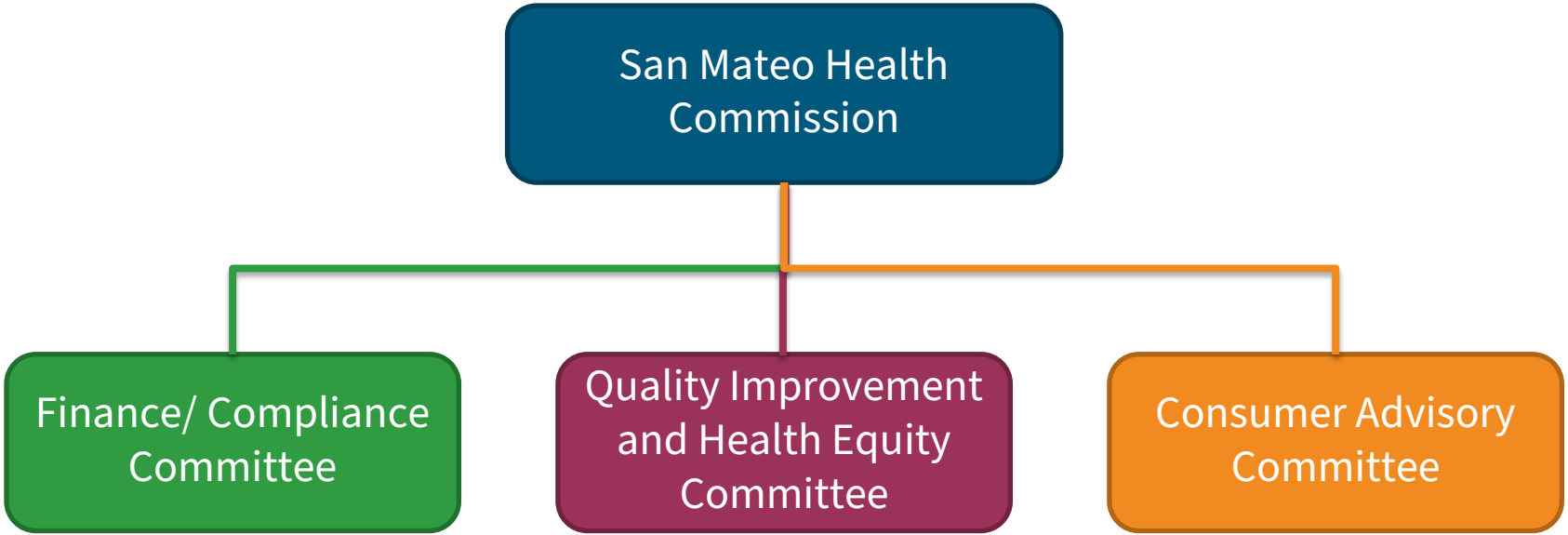
- The dissolved committees will re-form, perform relevant work and oversight, and report their activities to the relevant standing committee
- Should the motions be approved, dissolved committees will update their charters to ensure the minutes of their work flow into the standing committees

Action

Dissolve the following committees as they do not require direct Commission oversight

- CCS Clinical Advisory Committee
- Pharmacy and Therapeutics
- Peer Review/ Physician Advisory Group
- CCS Family Advisory Committee
- CareAdvantage Advisory Committee
- Children's Health Initiative

Restructure the Commission Subcommittees as follows:



Thank you

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Agenda Item: 5.2

Date: July 12, 2023

Regional DSNP Model Update
Health Commission Meeting

July 12, 2023

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Agenda

Background and Why

Formation Process

Timeline

Next Steps

Healthy is for everyone

Agenda

Background and Why

Formation Process

Timeline

Next Steps

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Medicare Primer

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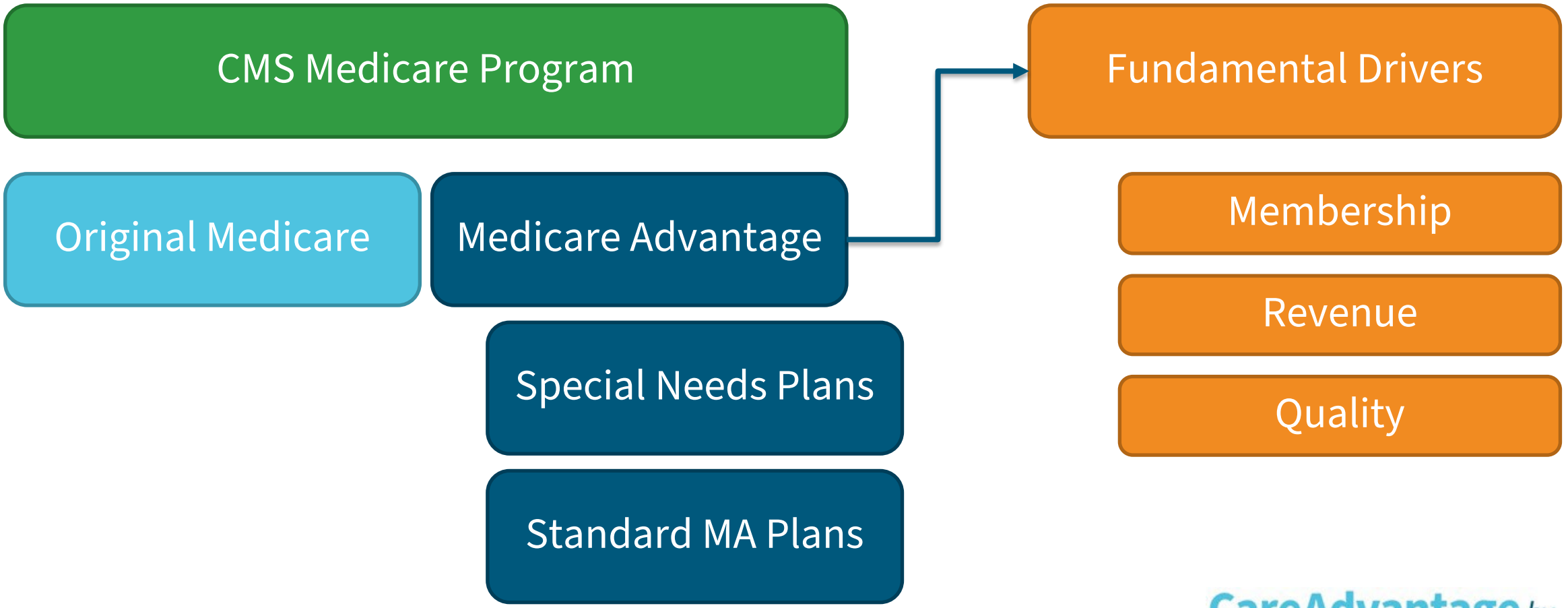
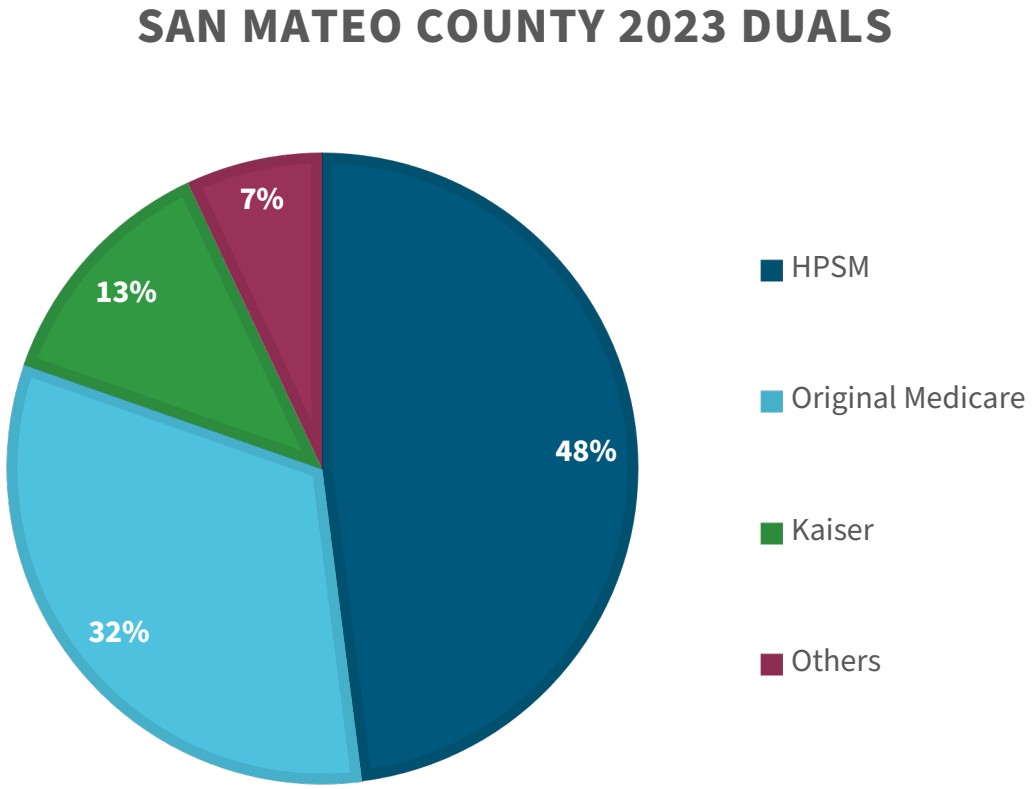


CareAdvantage by HealthPlan OF SAN MATEO

Focusing on Dually Eligible Members



San Mateo County "Duals" Medicare and Medi-Cal Eligible ~16,000

~5900 remain with Original Medicare

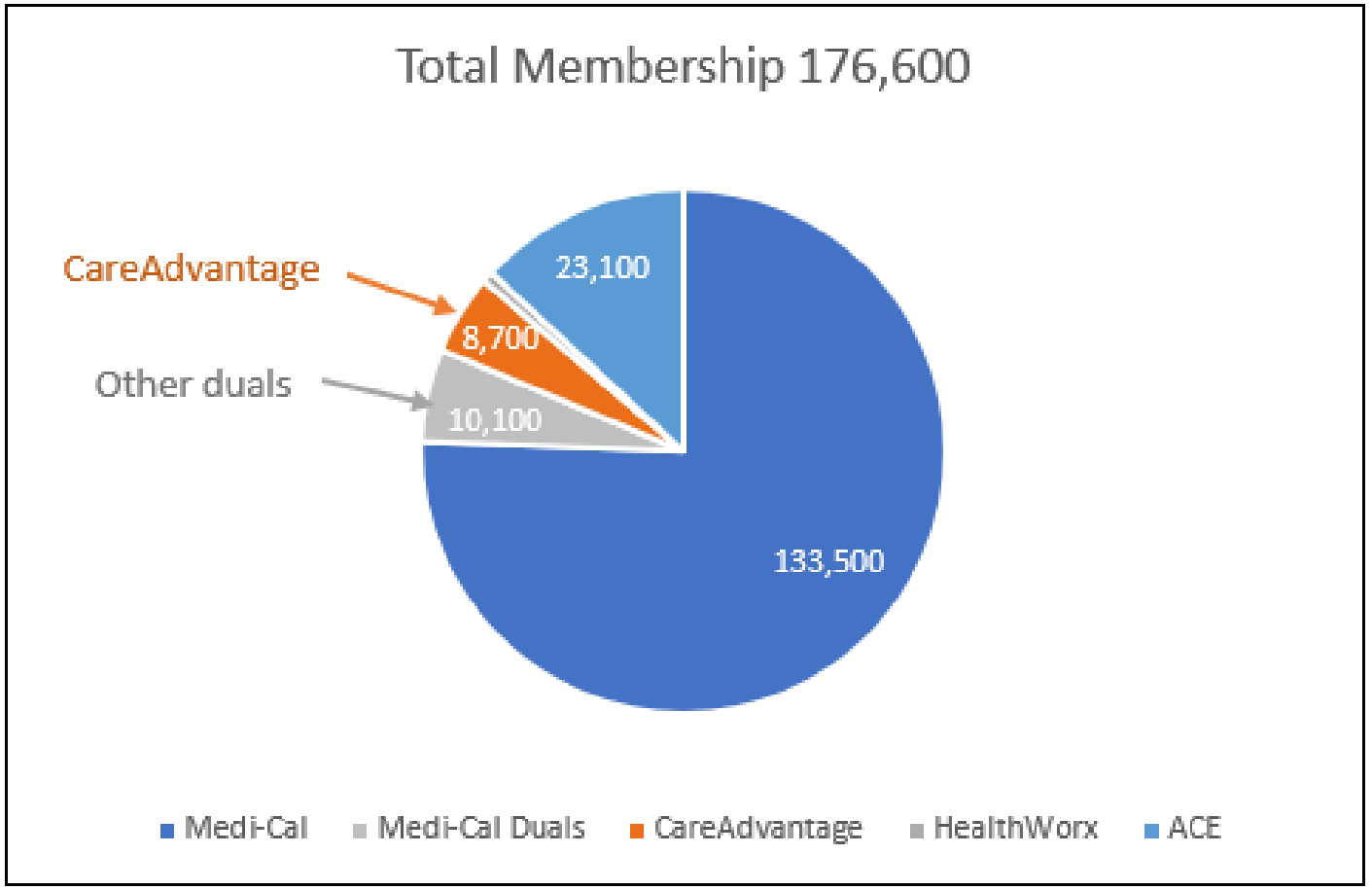
~2300 went with Kaiser

~8800 with CareAdvantage

HPSM's CareAdvantage Program is larger than 62% of D-SNPs nationally

HPSM Total Membership

Q1 2023



Medi-Cal	133,500	76%
Medi-Cal Duals	10,100	6%
CareAdvantage	8,700	5%
HealthWorx	1,200	1%
ACE	23,100	13%
Total	176,600	100%

Why a Regional D-SNP and Why Now?

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Challenge

- Other local plans must have a D-SNP by 2026, many with no experience, some with previously closed D-SNPs
- Establishing a D-SNP is costly and breakeven may be by year 3 or 4
- Regulators support localized efforts in California and are wary of large commercial plans
- Regulators seek innovative solutions to policy efforts

Opportunity

- HPSM has long standing experience with D-SNP
- Innovative and ground-breaking way for local plans to work together to scale local
- Opportunity to sustain and spread HPSM's innovation and community focus
- Further strengthen HPSM and local plans partnership with regulators

! This opportunity would not affect ongoing local San Mateo County efforts.

CareAdvantage by HealthPlan OF SAN MATEO

Agenda

Background and Why

Formation Process

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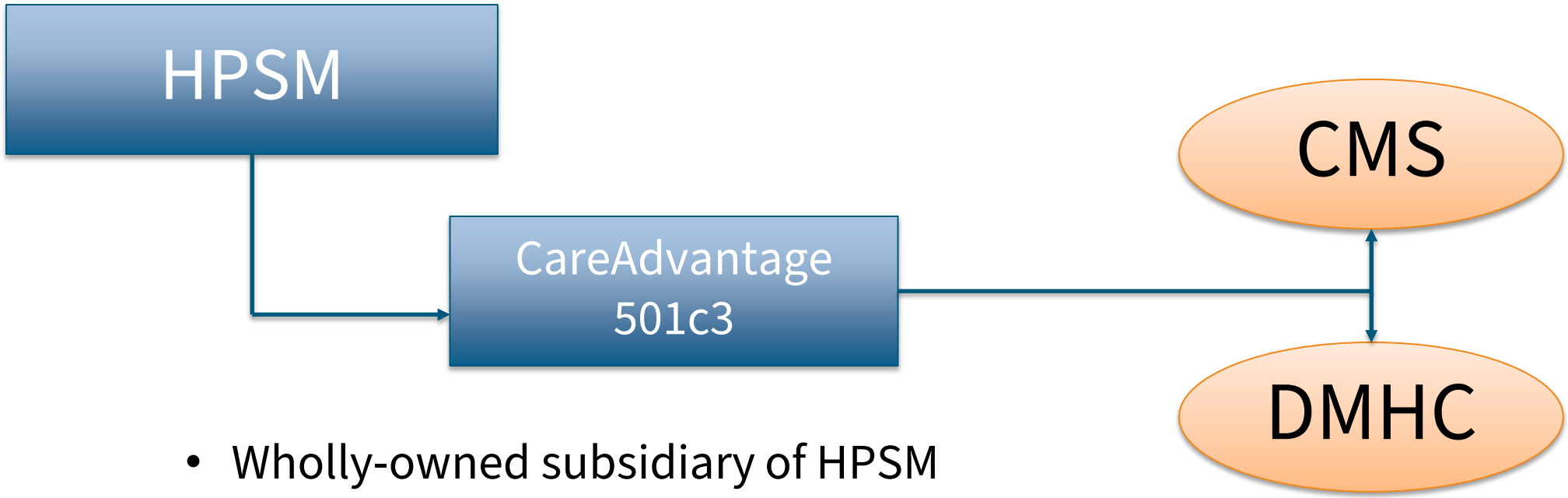
Healthy is for everyone

Formative Mission Statement

CareAdvantage is a fully integrated DSNP that is governed, financed, and operated by local Medi-Cal health plans for the benefit of its members and communities. CareAdvantage will excel in addressing the needs of seniors and persons living with disabilities. It will provide every member with a seamless experience of care and the opportunity for best possible health, working in collaboration with local providers and community partners.

Step 1: Create Subsidiary



- Wholly-owned subsidiary of HPSM
- Structured as 501c3
- Subsidiary holds contract with CMS for H6019
- Subsidiary is Knox-Keene licensed by DMHC
- Management Agreement with HPSM
- Establish financial reserves

Step 2: Other local plans join

- Plan 2 joins 501c3
- Initial reserve contribution made at agreed upon amount
- CareAdvantage applies for Service Area Expansion into Plan 2 county(ies) for H6019
- Additional plans could join using same process

Care Advantage Structure

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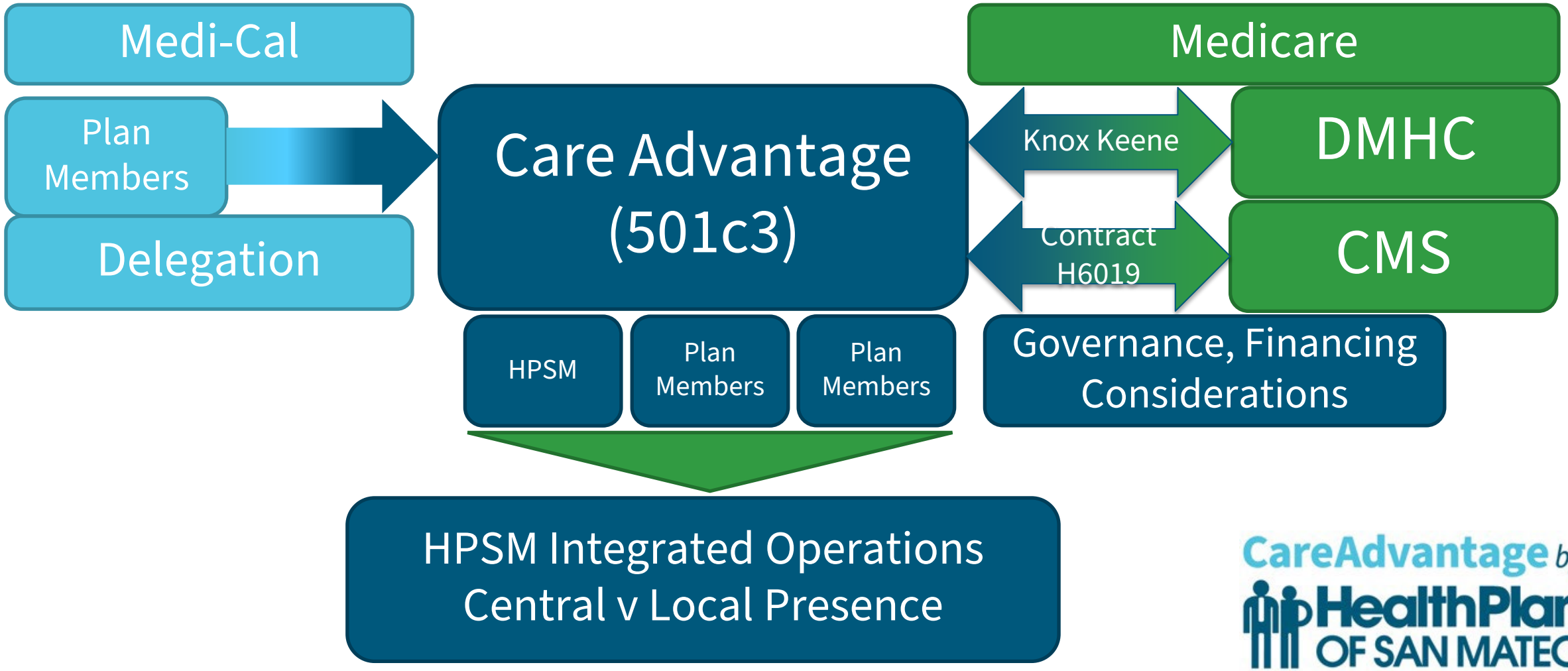
Regional Strategy, Locally Integrated



CareAdvantage by HealthPlan OF SAN MATEO

Cash Flow – Current State

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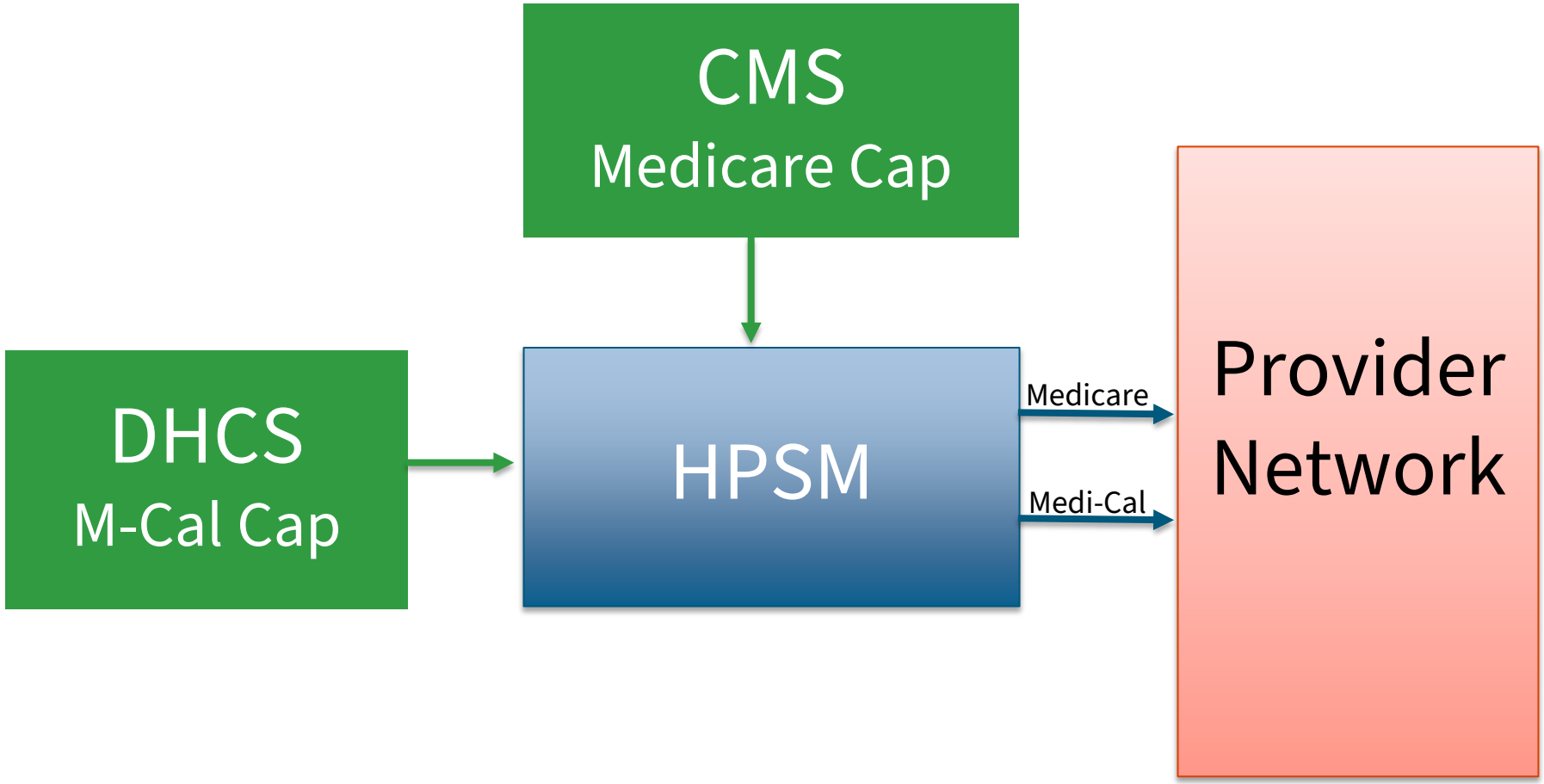

Cash Flow – Future State

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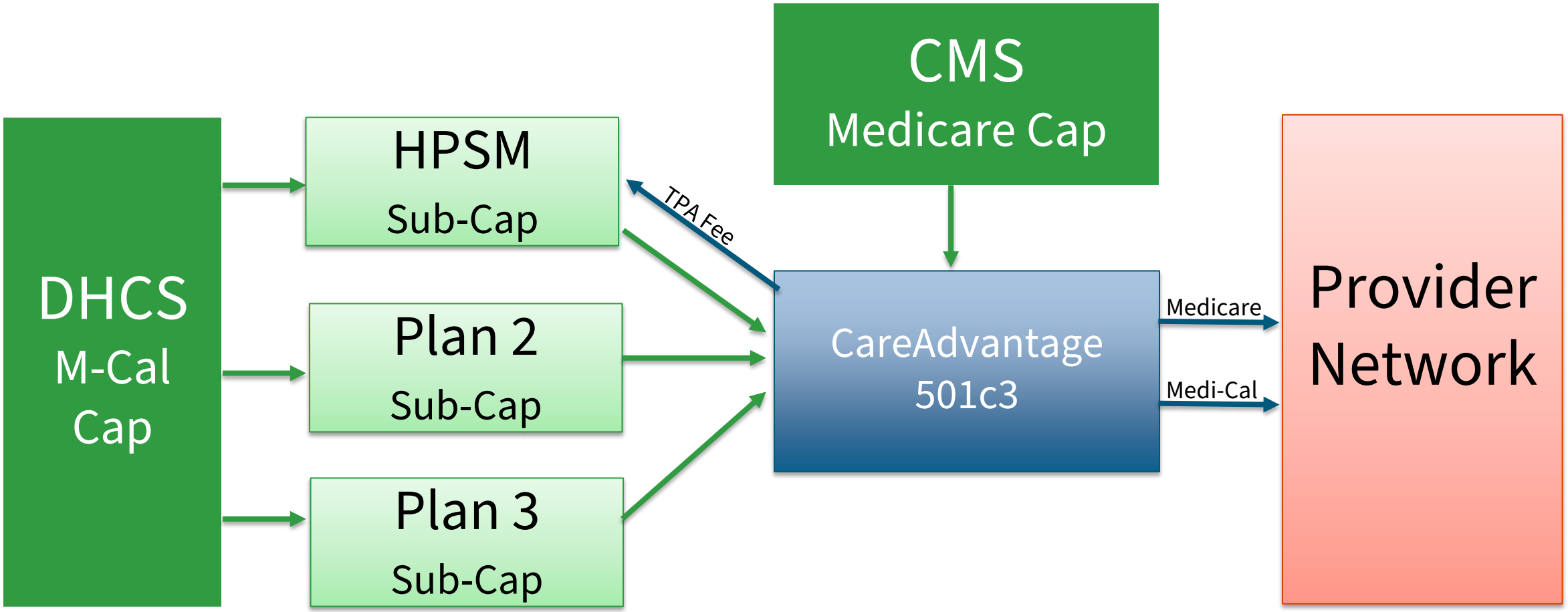

Agenda

Background and Why

Formation Process

Timeline

Next Steps

Healthy is for everyone

Timeline

- Exploration of local plan interest and identification of regulatory barriers, if any: March 2023
- HPSM Commission approval to create subsidiary (based on results of initial exploration): August 2023 (Step 1)
- Creation of Corporation/501c3: September-October 2023
- Initiate filing Knox Keene License for new entity: October 2023
- Deadline for local plans to join: April 2024 (Step 2)
- CMS and DMHC Service Area Expansion applications: November 2024
- CMS bid submission for newly expanded service area: June 2025
- Go-live date for expanded service area: January 2026

Short-term Timeline

- June-July 2023
  - Milliman financial analysis of proposed DNSP model
  - HPSM Health Commission discussion on regional model and incorporation
  - Subsidiary formation research, including potential costs involved and consulting assistance needed for 501c3 formation (legal) and Knox-Keene license application (regulatory/operational)
- August 2023
  - HPSM Health Commission vote to create 501c3
- October 2023 – April 2024
  - Initiate DMHC Knox-Keene application and CMS ownership change processes
  - Continue exploration and potential Health Commission votes to add local plans and initiate DMHC material modification process

Agenda

Background and Why

Formation Process

Timeline

Next Steps

Healthy is for everyone

August Health Commission Meeting

- Further discussion as needed
- Proposed Resolution for Vote
  - Authorization for HPSM to proceed forming a 501c3
  - Authorization for HPSM to expend up to $500,000 for costs for legal, financial, and regulatory consultation related to company formation
  - Authorization for Finance/Exec Committee to serve as the group to evaluate the financial model, as well as the criteria for other local plans to join the 501c3.

MEMORANDUM

AGENDA ITEM: 7.0

DATE: July 12, 2023

DATE: July 5, 2023

TO: San Mateo Health Commission

FROM: Patrick Curran

RE: CEO Report – July 2023

State Budget and Legislative Process

The 2023 California legislative session is now complete, though work on trailer bill language and budget clarification will continue. As anticipated, the final budget includes no notable reductions in Medi-Cal funding or member benefits, even though there is a significant budget deficit. The proposed coverage for all residents aged 26-49 regardless of documentation status is still included. That enhanced coverage means that as of January 1, 2024, all California residents who meet Medi-Cal eligibility requirements, regardless of documentation status, will be eligible for Medi-Cal coverage. This could affect many current ACE participants, and HPSM and San Mateo County have a workgroup in place to implement this transition. The other main budget item that affects Medi-Cal is the MCO Tax, which is highlighted below.

Managed Care Organization (MCO) Tax

The state budget includes a five-year $19 billion managed care tax. This mechanism of taxing all health plans helps fund the Medi-Cal program through a complex financing formula. The state discontinued this tax in 2022 but is now re-establishing the tax. It will begin in 2024, though there is the possibility that the state will ask CMS to retroactively implement the tax, which could affect 2023 funding.

The bill includes broad language about areas of funding, and the intent of the tax is that funds be used to enhance provider payment and provider participation in Medi-Cal. Payment rates for maternity, primary care, and behavioral health are specifically cited. There is much unknown about the mechanism for how the funds will flow, and we will update the Health Commission as we know more about the funding levels and timing.

Medi-Cal Redeterminations

Starting July 1, we see the first wave of HPSM members who lose coverage due to the reinstated redetermination process. This process includes verification by the member to the local Human Services Agency that the member continues to meet Medi-Cal eligibility criteria. If history is any indication, many members lose coverage simply by not completing all the needed paperwork on time. This process will occur over the next 12 months, as members each have a specific

redetermination date (i.e., it is not all done at once). As of the date of this memo, we do not yet have a final count for July, but hope to have one soon and will update the Health Commission as we know more. We are tentatively projecting to lose 10-15% of our Medi-Cal membership over the next year.

HealthWorx Program Evaluation

As mentioned in the February 2023 CEO Report, HPSM operates the HealthWorx program, which is licensed by the Department of Managed Health Care (DMHC) as a commercial health plan and serves approximately 1,200 members, most of whom are enrolled through San Mateo County's agreement with the union serving In-Home Supportive Services (IHSS) workers, as well as a small number of enrollees who are retirees from the City of San Mateo.

We will bring an update to the August meeting, which will include increasing our premium to San Mateo County by 20-30% due to higher medical costs and increasing administrative burden due to regulations from the Department of Managed Health Care (DMHC). Our proposal will be to use some of the increased premium to fund additional positions to address the regulatory burden, as well as consulting assistance to assist HPSM in evaluating longer term options for operating this local program.

Seton Medical Center Funding and AHMC Acquisition

At a March 10, 2020, special meeting of the San Mateo County Board of Supervisors, the main agenda item was discussion of proposed funding assistance to AHMC Healthcare, the potential buyer of Seton Medical Center and Seton Coastside. The motion made and approved by the Board of Supervisors was to appropriate $20 million in County funds with a request that Health Plan of San Mateo contribute $10 million of this amount subject to several conditions: (1) Closing of the transaction between Verity and AHMC and AHMC continuing to operate Seton Medical Center in Daly City as a full service hospital subject to the Attorney General's conditions: (2) Funds to be paid at a rate of $5 million per year over 4 years beginning at sale close; (3) Funds to be appropriate secured, as determined by staff/counsel; (4) AHMC continues to provide services that afford countywide public benefit; (5) Provision of satisfactory business plans and financials; (6) Negotiation of an appropriate form of agreement; and (7) Annual reporting in satisfaction of these conditions. As of May 2023, San Mateo County has made two $5 million payments to AHMC.

Since that meeting of the San Mateo County Board of Supervisors, the Health Commission has not acted on any request from San Mateo County or AHMC for HPSM funding to AHMC. HPSM recently received a proposal from AHMC, which we are now reviewing, requesting that HPSM contribute $10 million to AHMC. In light of the funding source, HPSM is engaging in discussions with AHMC regarding a potential HPSM investment, and in particular, how HPSM funding could be used to enhance access to care for HPSM members. We are planning on bringing a proposal for Health Commission consideration to the August or September meeting.