

-Virtual Meeting-

**THE SAN MATEO HEALTH COMMISSION
Regular Meeting
April 13, 2022 - 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., South San Francisco, CA 94080**

Important notice regarding COVID-19:

In the interest of public health and safety due to the state of emergency caused by the spread of COVID-19, this meeting of the San Mateo Health Commission will be conducted via teleconference pursuant to AB 361, which was signed by the Governor on September 16, 2021.

Public Participation

The San Mateo Health Commission meeting may be accessed through Microsoft Teams:

Join on your computer or mobile app

[Click here to join the meeting](#)

Or call in (audio only)

[\(833\) 827-5103,480262135#](tel:(833)827-5103,480262135#) United States (Toll-free)

Phone Conference ID: 480 262 135#

Members of the public wishing to provide public comment on items not listed on the agenda that are within jurisdiction of the Commission or to address an item that is listed on the agenda may do so by emailing comments before 10:00 am, April 13, 2022 to the Clerk of the Board at Corinne.Burgess@hpsm.org with "Public Comment" in the subject line. Comments received will be read during the meeting. Members of the public wishing to provide such public comment may also do so by joining the meeting on a computer, mobile app, or telephone using the link or number provided above and following the instructions for making public comment provided during the meeting.

AGENDA

- 1. Call to Order/Roll Call**
- 2. Public Comment/Communication**
- 3. Approval of Agenda**
- 4. Consent Agenda***
 - 4.1 Adopt a resolution finding that, as a result of the continuing COVID-19 pandemic state of emergency, meeting in person would present imminent risks to the health or safety of attendees
 - 4.2 Finance/Executive Committee, February 2022
 - 4.3 Consumer Advisory Committee, January 2022
 - 4.4 Physician Advisory Group, December 2021
 - 4.5 Pharmacy & Therapeutics Committee Minutes, December 2021
 - 4.6 Approval of Quality Improvement (QI) Documents: 2021 QI Program Evaluation; 2022 QI Program Description; and 2022 QI Work Plan

- 4.7 Approval of Amendments to Agreements for Print and Mailing Vendors: KPLLC, FolgerGraphics, and Clarity
- 4.8 Waive Request for Proposal and Approval of Amendment to Agreement with Progressive Discoveries
- 4.9 Approval of San Mateo Health Commission Meeting Minutes from February 9, 2022

5. Specific Discussion/Action Items

- 5.1 Audited Financial Statements for the Twelve-Month Period Ending December 31, 2021 by Moss-Adams, LLP.*
- 5.2 Approval of Funding from Children’s Health Initiative to Ravenswood Family Health Network for Dental Project.*
- 5.3 Overview on IT Security

6. Report from Chairman/Executive Committee

7. Report from Interim Chief Executive Officer

8. Other Business

9. Report Out on Closed Session

10. 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: April 13, 2022

DATE: April 6, 2022
TO: San Mateo Health Commission
FROM: Pat Curran, Interim Chief Executive Officer
RE: Approval of Teleconference Meeting Procedures Pursuant to AB 361

Recommendation

In the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, the San Mateo County Board of Supervisors has determined that meeting in person would present imminent risk to the health or safety of attendees. The Board of Supervisors has invoked the provision of AB 361 to continue meeting remotely through teleconferencing. The Board of Supervisors also strongly encourages all legislative bodies of the County of San Mateo, such as the San Mateo Health Commission, and its committees which are subject to the Brown Act to make a similar finding and continue to meet remotely through teleconferencing until the risk of community transmission has further declined.

Background and Discussion

On June 11, 2021, Governor Newsom issued Executive Order N-08-21 which rescinded his prior Executive Order N-29-20 and set a date of October 1, 2021 for public agencies to transition back to public meetings held in full compliance with the Brown Act. The original Executive Order provided that all provisions of the Brown Act that required the physical presence of members or other personnel as a condition of participation or as a quorum for a public meeting were waived for public health reasons. If these waivers were to fully sunset on October 1, 2021, legislative bodies subject to the Brown Act had to contend with a sudden return to full compliance with in-person meeting requirements as they existed prior to March 2020, including the requirement for full physical public access to all teleconference locations from which board (commission) members were participating.

On September 16, 2021, the Governor signed AB 361, a bill that formalizes and modifies the teleconference procedures implemented by California public agencies in response to the Governor's Executive Orders addressing Brown Act compliance during shelter-in-place periods. AB 361 allows a local agency to continue to use teleconferencing under the same basic rules as provided in the Executive Orders when certain circumstances occur or when certain findings have been made or adopted by the agency.

AB 361 also requires that, if the state of emergency remains active for more than 30 days, the agency must make findings by majority vote every 30 days to continue using the bill's exemption to the Brown Act teleconferencing rules. The findings are to the effect that the need for teleconferencing persists due to the nature of the ongoing public health emergency and the social distancing recommendations of local public health officials.

At its meeting on September 28, 2021, the San Mateo County Board of Supervisors found that in the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, meeting in person would present imminent risks to the health or safety of attendees. The Board of Supervisors accordingly resolved to continue conducting its meetings through teleconferencing, in accordance with AB 361, and encouraged other boards and commissions established by them to avail themselves of teleconferencing until the risk of community transmission has further declined. The San Mateo County Board of Supervisors has renewed its findings, adopting a substantially similar resolution at subsequent meetings since then.

At its meeting on October 13, 2021, and subsequently, the San Mateo Health Commission likewise found that in the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, meeting in person would present imminent risks to the health or safety of attendees. In light of that finding, the Commission has been conducting its meetings through teleconferencing. A renewed finding and resolution are needed in order for the Commission to continue to conduct its meetings through teleconferencing.

Fiscal Impact

There is no relative fiscal impact with the continuation of the San Mateo Health Commission meeting by means of teleconferencing in accordance with AB 361.

DRAFT

**RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION**

**IN THE MATTER OF APPROVAL OF TELECONFERENCE MEETING
PROCEDURES PURSUANT TO AB 361 (BROWN ACT PROVISIONS)**

RESOLUTION 2022 -

RECITAL: WHEREAS,

- A. In the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, the San Mateo County Board of Supervisors recently found that meeting in person would present imminent risk to the health or safety of attendees of public meetings and accordingly directed staff to continue to agendize its public meetings only as online teleconference meetings; and
- B. The Board of Supervisors strongly encouraged other legislative bodies of the County of San Mateo that are subject to the Brown Act to make a similar finding and avail themselves of teleconferencing until the risk of community transmission has further declined; and
- C. The San Mateo Health Commission must make such a finding under AB 361 in order to continue to conduct its meetings as online teleconference meetings.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission hereby finds that in the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, meeting in person would present imminent risk to the health or safety of attendees of public meetings for the reasons set forth in Resolution No. 078447 of the San Mateo County Board of Supervisors and subsequent resolutions made pursuant to AB 361; and
2. The San Mateo Health Commission directs staff to continue to agendize its meetings only as online teleconference meetings; and
3. The San Mateo Health Commission further directs staff to present, within 30 days, an item for its consideration regarding whether to make renewed findings required by AB 361 in order to continue to meet remotely.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of April 2022 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

Don Horsley, Chairperson

ATTEST:

APPROVED AS TO FORM:

BY: _____

C. Burgess, Clerk

Kristina Paszek

DEPUTY COUNTY COUNSEL

FINANCE/EXECUTIVE COMMITTEE MEETING
Meeting Summary – February 28, 2022
**** Teleconference Meeting****

Agenda Item: 4.2
Date: April 13, 2022

Important notice regarding COVID-19: Based on guidance from the California Department of Public Health and the California Governor's Office, in order to minimize the spread of the COVID-19 virus, the meeting was conducted via online meeting/teleconference. Members of the public were invited to submit public comment via email to the Assistant Clerk to the Commission in advance of the meeting and were also able to access the meeting using the web and teleconference information provided on the meeting notice.

Member's present: Don Horsley, Si France, M.D., Bill Graham, Mike Callagy

Member's absent: Ligia Andrade-Zuniga

Staff present: Pat Curran, Trent Ehrgood, Chris Baughman, Ian Johansson, Francine Lester, Anne Bentz, Amy Scribner, Colleen Murphey, Chris Esguerra, M.D., Katie Elyse-Turner,

Staff Absent:

- 1.0 Call to Order & Roll Call**– The meeting was called to order at 12:31 pm by Supervisor Horsley. A quorum was present.
- 2.0 Public Comment** – There was no public comment virtually or via email.
- 3.0 Approval of Meeting Summary for November 29, 2021** – The meeting summary for November 29, 2021, was approved as presented. **Horsley/Graham second. A roll call vote was unanimous.**
- 4.0 Adopt a resolution finding that, as a result of the continuing COVID-19 pandemic state of emergency, meeting in person would present imminent risks to the health or safety of attendees** – The Committee moved to adopt a resolution finding that, as a result of the continuing COVID-19 pandemic state of emergency, meeting in person would present imminent risks to the health or safety of attendees. **Horsley/Graham second. A roll call vote was unanimous.**
- 5.0 Preliminary Financial and Operational Report for the period ending December 31, 2021** – Mr. Ehrgood reviewed the financial report for Q4 of 2021. These are preliminary pre-audit results. HPSM ended the year with a \$30M surplus compared to the \$30M budget loss, which is creating a \$60M favorable budget variance. The fourth quarter of 2021 includes a combination of more revenue and less expense. Q4 is typically a lower utilizing month, and for 2021 it was especially low for hospital inpatient cost. He explained how Q4 is always the

more favorable of the four because it includes Cal-MediConnect (CMC) withhold revenue always recorded in December. He reminded the group that every year 4% of CMC revenue is withheld and HPSM has to earn that back through quality measures. This item alone is about \$9M and is included both in actual and in the budget (so not a budget variance).

He went over the major budget variances. The increase in membership is one factor, 2% higher than budget, comes out to \$9M more in revenue, with a similar increase in healthcare cost. Another big item is Pharmacy. The HPSM Pharmacy budget was only for the first three months of 2021, assuming the carveout would take place April 1st. Because the carveout did not occur until the end of the year HPSM ended up with more revenue compared to budget and more expense compared to budget, with a net margin of around \$9M from pharmacy. The other two big factors were more revenue and lower health care costs on a PMPM basis. He went over the revenue PMPM differences by line-of-business, noting an extra \$8M was accrued in the fourth quarter for additional estimated Medicare revenue for both Part C (from risk adjustments) and Part D (for pharmacy reconciliation). He went over healthcare cost variances, noting that hospital inpatient and long-term care are the primary drivers in savings compared to budget. Some adjustments were made in the fourth quarter to dial down inpatient cost estimates for the year based on more complete information on hospital admissions and the value of high-cost cases.

Mr. Ehrgood went over the summary surplus and loss by line of business. Particularly noteworthy is the Cal-MediConnect line which showed a \$13 million loss as of September, it was budgeted to have a \$5 million loss for the year but with the extra revenue recorded in the fourth quarter, which are estimates based on risk factors and Part D reconciliation revenue, 2021 is close to break even. The Medi-Cal LOB showed about a \$10M loss as of last quarter, it is now a \$5M loss, while improved and doing better than budget it is still showing losses. This line has shown losses consistently through recent years. HPSM had hoped the State would recognize this higher cost in their rate setting; it appears they have, as rates have started to catch up.

Mr. Ehrgood shared a slide showing the Tangible Net Equity (TNE) which is HPSM's reserve balance. The total reserve balance with the \$30M surplus is \$363M. Lastly, he went over an

overall summary of the major drivers to the year's surplus. There was a question about being required to give money back to the state for medical loss ratio (MLR) triggered by the better-than-expected financial performance. Mr. Ehrgood replied that the improved member mix for full-dual members, which is really a function of a lower number of people institutionalized, resulted in \$21M in excess revenue in 2021 of which \$8.7M must be returned. There are other MLR/risk-corridors that exist, but so far, none of them have created exposure for HPSM at this point. They will continue to monitor them and make reserves in the future if this changes. The financial report was approved as presented. **Graham/France second. A roll call vote was unanimous.**

6.0 Report from the Compliance Department – Mr. Johansson provided a presentation on Compliance issues for Q4 of 2021. The Centers for Medicare and Medicaid Services (CMS) sent HPSM a warning letter, specifically a notice of Non-Compliance regarding non-allowable changes to the formulary. In September of 2021, they did a formulary update, which was a generic substitution of a brand drug. In this instance, when the generic was introduced the update window did not allow for the generic substitution. No corrective action is required. He is working with Director of Pharmacy, Ming Shen to ensure this doesn't happen again.

Supervisor Horsley asked for a report to the full Commission about any attempts to penetrate the HPSM system. Mr. Johansson agreed to work with HPSMs Chief Information Officer and IT Operations Manager on a presentation for the April Commission meeting.

7.0 Other Business – Mr. Curran updated the group on the Kaiser deal with the State. HPSM through the statewide association is opposing this move. There is trailer bill language that has been released that confirms the State wants to pass this through the budget process and not a separate bill. There is an increasing voice of concern from various communities and counties. There is no Commission action required at this time.

8.0 Adjournment – The meeting was adjourned at 1:28 pm by Supervisor Horsley.

Respectfully submitted:

M. Heryford

M. Heryford

Assistant Clerk to the Commission

DRAFT

**RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION
FINANCE/EXECUTIVE COMMITTEE**

**IN THE MATTER OF APPROVAL OF TELECONFERENCE MEETING
PROCEDURES PURSUANT TO AB 361 (BROWN ACT PROVISIONS)**

RECITAL: WHEREAS,

- A. In the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, the San Mateo County Board of Supervisors recently found that meeting in person would present imminent risk to the health or safety of attendees of public meetings and accordingly directed staff to continue to agendize its public meetings only as online teleconference meetings; and
- B. The Board of Supervisors strongly encouraged other legislative bodies of the County of San Mateo that are subject to the Brown Act to make a similar finding and avail themselves of teleconferencing until the risk of community transmission has further declined; and
- C. The San Mateo Health Commission and its Committees must make such a finding under AB 361 in order to continue to conduct its meetings as online teleconference meetings.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The Finance/Executive Committee of the San Mateo Health Commission hereby finds that in the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, meeting in person would present imminent risk to the health or safety of attendees of public meetings for the reasons set forth in Resolution No. 078447 of the San Mateo County Board of Supervisors and subsequent resolutions made pursuant to AB 361; and
2. The San Mateo Health Commission directs staff to continue to agendize its meetings only as online teleconference meetings; and
3. The San Mateo Health Commission further directs staff to present, within 30 days, an item for its consideration regarding whether to make renewed findings required by AB 361 in order to continue to meet remotely.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 28th day of February 2022 by the following votes:

AYES: Horsley, Callagy, France, Graham

NOES: 0

ABSTAINED: 0

ATTEST:

BY: *Michelle Heryford*

Michelle Heryford

Assistant Clerk to the Commission

DRAFT

**HEALTH PLAN OF SAN MATEO
CONSUMER ADVISORY COMMITTEE MEETING
Meeting Minutes
Thursday, January 20, 2022
Virtual Teleconference**

**Agenda Item: 4.3
Date: April 13, 2022**

Important notice regarding COVID-19: Based on guidance from the California Department of Public Health and the California Governor's Office, in order to minimize the spread of the COVID-19 virus, the meeting was conducted via online meeting/teleconference. Members of the public were invited to submit public comment via email to the Assistant Clerk to the Commission in advance of the meeting and were also able to access the meeting using the web and teleconference information provided on the meeting notice.

Committee Members Present: Amira Elbeshbeshy, Ricky Kot, Marmi Bermudez, Gloria Flores-Garcia, Robert Fucilla, Judy Garcia

Committee Members Absent: Angela Valdez, Mary Pappas, Hazel Carrillo, Cynthia Pascual, Ortensia Lopez

Staff Present: Gabrielle Ault-Riche, Carolyn Thon, Charlene Barairo, Keisha Williams, Karla Rosado-Torres, Justin Cassida, Joshua Gaffud, Theresa Kopp, Sarah Munoz, Samareen Shami, Karen Fitzgerald,

1.0 Call to Order/Introductions: The meeting was called to order by Ms. Elbeshbeshy at 12:00 pm.

2.0 Public Comment: There was no public comment, either virtually or via email.

3.0 Approval of Meeting Minutes for October 28, 2021: The minutes from the October 28, 2021, CAC meeting was approved as presented. **Fucilla/Bermudez second. A roll call vote was unanimous.**

4.0 Approval of Teleconference Meeting Procedures Pursuant to AB 361: The committee moved to continue the practice of virtual meetings pursuant to AB361 which was signed by Governor Newsom in October 2021. **Fucilla/Kot second. A roll call vote was unanimous.**

5.0 HPSM Operational Reports and Updates:

5.1 CEO Update: Interim CEO, Pat Curran provided an update.

5.1.1 He spoke about the newly enacted dental benefit. HPSM now manages and coordinates a dental benefit for members effective January 1, 2022. There is some pent-up demand, and they are seeing some challenges in terms of adult access to care. He is happy to report that they are not hearing about challenges for access for children. They are

working on the referral process and trying to gain access within the network so members don't have to pay but admits that process will take a while so adult access will continue to be a challenge for a bit. There is a new dental director, Dr Michael Okuji, he comes from UCSF and will be starting in late January.

5.1.2 Mr. Curran also spoke briefly about the CalAIM program, which was implemented on January 1, 2022. On that date all members who were in the Whole Person Care (WPC) program through the County transitioned to the new program. At present, their focus is on establishing and continuing the relationships they have with existing providers, the County and other Providers who have helped with these very complex members.

5.1.3 Mr. Curran reminded the group that Maya Altman retired at the end of 2021. The San Mateo Health Commission (SMHC) has appointed Mr. Curran as the Interim CEO while the recruitment effort is underway. There should be word of the new CEO in about a month. He credited the staff for the smooth transition.

5.1.4 Lastly, he informed the committee that Governor Newsom proposed that all residents of California have insurance coverage regardless of documentation status. HPSM is a huge proponent of this measure and will advocate for this to end up in the final budget.

5.2 CMO Update: CMO, Chris Esguerra, M.D., updated the committee.

5.2.1 Dr. Esguerra spoke about the pharmacy carveout, which became effective January 1, 2022. It is now a function of the State of California. While some prescriptions are being filled for routine things, there are significant issues, such as eligibility. Members and pharmacies are reporting that they are no longer eligible in Magellan's system. Unfortunately, this is compounded by the fact that customer service is spotty. Members report long wait times, some waiting from 2-4 hours. There is no guarantee that their problems will be resolved once their call is answered as a high percentage of members say the information received is not actionable or consistent. The State has acknowledged there have been staffing and training issues and they are working on that. Unfortunately, this is causing issues for those in the California Children's Services (CCS) population. HPSM did receive information from SHIELD Health Care, who figured out a way to make nutrition products typically used by the kids in the CCS population. Dr. Esguerra will be sharing that information with the staff. He asked that committee members keep them informed of issues as they come up so that they can make the State aware of them. There was a question of how many individuals are affected by the carve-out. Dr. Esguerra said 14.5M individuals across California will be impacted by this. There was a question about what would happen to members when the transition from Coordinated Care Initiative (CCI) to Dual Eligible Special Needs Plans (D-SNP) occurs. Dr.

Esguerra said since this is under Medicare, HPSM will continue to manage the benefit, it will not be part of the carve out.

- 5.2.2** He commended HPSM staff for their work to ensure a smooth transition into the new year while in the midst of audits, accreditation work and a leadership change.
- 5.2.3** He spoke about the recent COVID surge, specifically the Omicron variant. He encouraged all to get vaccinated and boosted and to continue following all social distancing guidelines.
- 5.2.4** There was a pharmacy related question about data reported in the past for drug denials, appeals and overturn rates. Will Magellan be providing this data going forward? Dr. Esguerra said that he's not sure what they will be getting from Magellan, but he agreed to bring any information they share to the committee.

5.3 Provider Services: Network and Strategy Officer, Colleen Murphy provided a verbal report

- 5.3.1** She reported on surge planning, they have been seeing much higher COVID case rates and a lot of HPSM Providers staff are out with COVID. They are seeing the effects of the vaccines as cases appear to be milder. Transitions teams are effectively moving members thru emergency rooms, which are experiencing bottlenecks this week. They have been working with CFU's and skilled nursing facilities (SNFs) to ensure that members are vaccinated and boosted with great success. Though, they continue to be concerned with outbreaks and are working with Scott Morrow and the County to get the word out about some of the safety practices the SNFs are using for isolating members effectively. They are working with facilities to ensure they have the resources they need, though she warned that resources are tight, finding staffing is very challenging.
- 5.3.2** Director of Provider Services, Luarnie Bermudo provided network updates. They have recently contracted with 7 Bridges, a speech therapy Provider, and have credentialed 7 new therapists from their practice. They will work with PCPs and coordinate with schools to get the word out that 7 Bridges is accepting new patients.
- 5.3.3** Primary Care access continues to be a focus and engagement continues. They've extended their arrangement with Teledoc for 2022, this is for PCPs who don't have access to telehealth.
- 5.3.4** They are excited about the changes that CalAIM provides, like enhanced care management (ECM) and community supports (CS) which will allow them to reimburse HPSM members for important services. They have credentialed and have letters of support with seven different organizations primarily for ECM. The majority are county partners that HPSM has worked with in the past like Institute on Aging (IOA). Services range from housing, retention services to medically tailored meals.

5.3.5 She also announced that they have credentialed and contracted with over 70 new dental providers and have 134 going thru the credentialing process now. She was asked when that information might be available online. She replied that it is an ongoing process. There are 68 noted on the website right now. Information is dependent on when the providers get contracted, it usually takes about 3-4 days.

5.4 Population Needs Assessment (PNA) Results: Teresa Kopp, Program Manager, Health Equity kicked off the presentation.

5.4.1 The timing of this assessment is annual, the focus population is Medi-Cal (MC), which represents 77% of HPSM members. The goals of this assessment are several-fold, but they will start by identifying member health needs and disparities. They will then provide an evaluation of HealthEquity activities, culturally and linguistically appropriate services (CLAS), quality improvement (QI) activities and other available resources. Implementing targeted strategies for HealthEquity, CLAS and QI program services thru an action plan is an important part. She also went over membership and member demographics.

5.4.2 Mykaila Shannon, Population Health Specialist reviewed language, access, and practitioner availability for 2020. Threshold languages are English, Spanish, Cantonese, Mandarin, and Tagalog. They have seen appropriate utilization of the interpreter services thru HPSM staff and provider requests for both telephonic and video services across all threshold languages.

5.4.3 Sarah Munoz, Health Promotion Supervisor went over the disparity overview. They used the Healthcare Effectiveness Data and Information Set (HEDIS) measure data from 2020 to do their analysis. They did find disparities for 2020 in cervical cancer screenings, well-child visits and breast cancer screenings. They have initiatives in place to address the disparity in breast cancer screenings.

5.4.4 Katherine Rodrigues, Health Promotion Program Specialist went over the tobacco analysis. In December of 2019, 5,549 members identified as tobacco, nicotine, or vaping users, this was represented in all lines of business. She broke down some of the racial/ethnicity and language disparities.

5.4.5 Samareen Shami, Program Manager, Quality Improvement spoke about health disparities within the seniors and persons with disabilities (SPD), Perinatal, and Children & Adolescents populations. They are delving deep into the SPD population and have recently hired a fellow to focus specifically on this population. This person will also do an inventory of current programs and services and develop a tool kit for members and caregivers, as well as Providers. They hope to focus on assessing provider network language gaps to ensure that HPSM is meeting the needs of their main language groups.

They also hope to address tobacco and other health education related activities and ensure that HSPM has the resources available for their members and the conditions they face, not only for tobacco cessation but for any related disease or age group.

5.5 MS & CA Enrollment and Call Center Report: Gabrielle Ault-Riche, Director of Customer Support went over the enrollment and call center reports for Q4 of 2021, CareAdvantage Manager, Charlene Barairo reviewed the CareAdvantage section of this report.

5.5.1 HPSM continues to see an increase in Medi-Cal membership due to the governor's order suspending terminations except for those due to death, moves out of the county, or voluntary disenrollment.

5.5.2 The Member Services (MS) call monitoring goal states that at least 95% of all monitored calls meet the quality criteria and receive an overall score of at least 95%. Unfortunately, MS did not meet that goal in Q4 2021. MS Leadership is looking into additional coaching activities for those who did not meet the 95% goal.

5.5.3 Goals for the timeliness and quality of email response were met at 100%.

5.5.4 Ms. Barairo reviewed the CareAdvantage portion. In Q4, they enrolled a total 272 members. As of December 2021, there are 8,894 active CA members and throughout 2021 they've enrolled an average of 103 members each month. For this period, they disenrolled 215 members. The most common reason is death, followed by a move out of the area and dis-enrollment due to involvement in another plan.

5.5.5 The CA Call Center also has a customer service quality goal of at least 95% quality on monitored calls. The unit has met this goal in Q4 2021. In October 2021, HPSM transitioned to a cloud-based phone system. While the transition of staff to the system went smoothly, there have been difficulties with the reporting functionality. The CA Call Center analysis is therefore unavailable. Call Center leadership continues to work closely with HPSM IT and the phone vendor, and expect to have a solution in Q1, 2022.

5.6 Grievance and Appeals (G&A): Ms. Ault-Riche went over the G&A report for Q4 of 2021.

5.6.1 The rate of complaints per 1,000 members was slightly above goal for CA CMC and ACE. The rate for Healthworx was 3.07 points higher than the goal. Though this represents low overall volumes (around 10 cases per quarter), the G&A Unit will conduct additional review to determine if some of these cases are preventable.

5.6.2 Timeliness goals were met for grievances and appeals at 99% and 100% respectively.

5.6.3 Grievances resolved within 24 hours related to medical services were highest in Q2 and Q4 2021, 97% (73) were related to Customer Service. These spikes are a direct result of challenges HPSM's non-medical transportation (NMT) vendor faced. In Q2 the ride-share company Uber experienced a nationwide shortage of drivers, which impacted HPSM rides. This shortage was compounded by an increased volume of ride requests as

members resumed regular appointments given the decrease in COVID-19 transmission at that time. This trend has since stabilized. The Q4 spike was the result of problems HPSM's NMT vendor was experiencing with their phone system. The issue with the phone system has since been resolved, though the vendor continues to struggle with adequate staffing. Customer Support Leadership explored options for expanding availability through overseas call centers, but these options were abandoned due to concerns about the inability to protect member health information. Given the increase in grievances in 2021, the G&A Unit will conduct further analysis to understand the factors influencing this.

- 5.6.4** The overturn rate increased slightly, from 49% in Q3 to 59% in Q4 for prescription drugs. This may be the result of a decrease in the overall volume of prescription drug appeals. For medical appeals, the rate increased from 50% in Q3 to 53% in Q4.
- 5.6.5** There were no complaints filed with the Complaints Tracking Module (CTM), which are complaints that members file directly with CMS.
- 5.6.6** The volume of grievances increased in the last quarter, from 132 grievances in Q1 to 176 grievances in Q4. The rate of grievances per 1,000 members, however, remained well within goal. The volume of appeals decreased throughout the year, from 132 appeals in Q1 to 103 in Q4. This decrease was primarily within prescription drug appeals, though the decrease is not considered significant.
- 5.6.7** The number of appeals filed with Kaiser by HPSM members decreased significantly in the last two quarters of 2021, from 9-10 appeals in Q1 and Q2 to 3-4 appeals in Q3 and Q4. The reason for this decrease is unknown but does not indicate a trend given the small numbers. No action is proposed.
- 5.6.8** In Q4 a total of 94 members switched away from a total of 31 different PCPs due to dissatisfaction. Of those, 25 were clinics and 6 were individual providers. One of these individual providers had four or more members switching away from their practice; as did four of the clinics.

6.0 New Business: There was no new business.

7.0 Adjournment: The meeting was adjourned at 1:12 pm by Ms. Elbeshbeshy.

Respectfully submitted:

M. Heryford

M. Heryford

Assistant Clerk to the Commission

**RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION
CONSUMER ADVISORY COMMITTEE**

**IN THE MATTER OF APPROVAL OF TELECONFERENCE MEETING
PROCEDURES PURSUANT TO AB 361 (BROWN ACT PROVISIONS)**

RECITAL: WHEREAS,

- A. In the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, the San Mateo County Board of Supervisors recently found that meeting in person would present imminent risk to the health or safety of attendees of public meetings and accordingly directed staff to continue to agendize its public meetings only as online teleconference meetings; and
- B. The Board of Supervisors strongly encouraged other legislative bodies of the County of San Mateo that are subject to the Brown Act to make a similar finding and avail themselves of teleconferencing until the risk of community transmission has further declined; and
- C. The San Mateo Health Commission and its Committees must make such a finding under AB 361 in order to continue to conduct its meetings as online teleconference meetings.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The Consumer Advisory Committee of the San Mateo Health Commission hereby finds that in the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, meeting in person would present imminent risk to the health or safety of attendees of public meetings for the reasons set forth in Resolution No. 078447 of the San Mateo County Board of Supervisors and subsequent resolutions made pursuant to AB 361; and
2. The San Mateo Health Commission directs staff to continue to agendize its meetings only as online teleconference meetings; and
3. The San Mateo Health Commission further directs staff to present, within 30 days, an item for its consideration regarding whether to make renewed findings required by AB 361 in order to continue to meet remotely.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 20th day of January 2022 by the following votes:

AYES: Elbeshbeshy, Kot, Fucilla, Bermudez, Garcia, Flores-Garcia

NOES: 0

ABSTAINED: 0

ATTEST:

BY: *Michelle Heryford*

Michelle Heryford

Assistant Clerk to the Commission

OPEN SESSION-PHYSICIAN ADVISORY GROUP (PAG)

Meeting Minutes

December 14, 2021 7:30 a.m.

Virtual Meeting due to Public Emergency

Important notice regarding COVID-19: Based on guidance from the California Department of Public Health and the California Governor’s Office, in order to minimize the spread of the COVID-19 virus, the meeting was conducted via online meeting/teleconference. Members of the public were invited to submit public comment via email to Luarnie.Bermudo@hpsm.org in advance of the meeting and were also able to access the meeting using the web and teleconference information provided on the meeting notice.

Voting Committee Members	Specialty	Present (Yes or Excused)
Janet Chaikind, MD, Committee Chair	Pediatrics	Yes
Vincent Mason, MD	Pediatrics	Yes
Leland Luna, MD	Family Practice	Yes
Kenneth Tai, MD	Internal Medicine	Yes
Tom Stodgel, MD	Obstetrics and Gynecology	Yes
Randolph Wong, MD	General Surgery	Yes
Shakalpi Pendukar, DDS	Dental, DDS	Excused
Non-voting HPSM Staff Members	Title	Present (Yes or Excused)
Richard Moore	Medical Director	Yes
Colleen Murphey	Network and Strategy Officer	Yes
Paul de la Cruz	Credentialing Specialist	Yes
Treschere Lowery	Credentialing Specialist	Yes
Luarnie Bermudo	Provider Services Director	Yes
Molly Carter	Provider Services Program Specialist	Excused
Patrick Curran	Interim Chief Executive Officer	Yes
Karla Rosado-Torres	Grievance and Appeals Manager	Excused
Cynthia Cooper	Medical Director	Excused
Nicole Ford	Director of Quality	Yes
April Watson	Provider Network Manager	Yes
Scott Fogle	Provider Services Program Specialist	Excused
Stephanie Mahler	Clinical Network Liaison	Excused
Gabrielle Ault-Riche	Director of Customer Support	Yes
Marisa Cardarelli	Dental Manager	Yes
Clarissa Rivera-Loo	Network Liaison	Yes
Nicole Ford	Director Quality Improvement	Yes

	Item(s)	Discussion	Action	Responsible Parties	Due Date
1	Call to Order	Dr. Janet Chaikind called the meeting to order at 7:30 am. A quorum was present.	Quorum was present	J. Chaikind	12/14/2021
2	Public Comment	None	N/A	N/A	N/A
3	Meeting Agenda and Meeting Minutes	Agenda and Minutes disseminated to committee. Minutes for the October 2021 PAG Committee were approved.	Agenda approved; Minutes for October 2021 PAG Approved.	PAG	12/14/2021
4	HPSM Announcements	Pat Curran provided several organizational announcements. <ol style="list-style-type: none"> 1. Dental: HPSM is proceeding and taking on the administrative responsibility of the dental benefit starting January 1, 2022. We're opening spaces up at the dental school and increasing access for children. We're in the process of recruiting for a dental director. Lots of work done by the team, particularly around credentialing and contracting new providers. 2. CalAIM: This is a multi year/multi program initiative. HPSM has already been doing much of the work particularly around Enhance Case Management (ECM) and Community Supports (CS). The main programs we're implementing are ECM and CS. The state is prioritizing Whole Person Care, very high needs homeless population, to transition into ECM. There is 	N/A	Pat Curran	12/14/2021

		<p>also a new provider type, Community Health Workers, that we'll start to see more of particularly around ECM.</p> <ol style="list-style-type: none"> 3. Rx Carveout: This will be effective 1/1/2022. No changes to CA. 4. Many audits: the team has been impacted by back to back audits from DHCS, DMHC and NCQA. 			
5	Health Services Announcements	<ol style="list-style-type: none"> 1. Announced new Medical Director, Miriam Sheinbein. 		Dr. Richard Moore	N/A
6	Provider Services Announcements	<ol style="list-style-type: none"> 1. Announced HomeAdvantage transition. There was an RFP process and HPSM has selected Upward Health as the new HomeAdvantage vendors. 	N/A	Colleen Murphey/Lu arnie Bermudo	N/A
7	Adjournment	The meeting was adjourned to the Peer Review Committee (PRC) closed session.	N/A	N/A	N/A

Next Meeting for the Physician Advisory Group: 02/07/2022 at 7:30 am

PHARMACY & THERAPEUTICS (P&T) COMMITTEE
Meeting Summary
Wednesday, December 15, 2021 - 7:30 am to 9:30 am
Virtual Meeting via Microsoft Teams

AGENDA ITEM: 4.5

DATE: April 13, 2022

Important notice regarding COVID-19:

Based on the guidance from the California Department of Public Health and the California Governor's Office, in order to minimize the spread of the COVID-19 virus, the meeting was conducted via online meeting/teleconference. Members of the public were invited to submit public comments via email to Kelly.Chang@hpsm.org in advance of the meeting and were also able to access the meeting using the teleconference information provided on the meeting notice.

Members Present: Barbara Liang, George Pon and Jack Tayan

Members Absent: Dr. Chris Esguerra, Dr. Lena Osher, Jaime Chavarria, Jonathan Han, Varsha Gadgil, Niloofar Zabihi and Victor Armendariz.

Staff Present: Andrew Yau, Biyan Feng, Dr. Richard Moore, Jasmine Le-Thi, Kelly Chang, Laura Lo, and Matthew Lee and Ming Shen

Staff Absent: Dr. Cynthia Cooper and Karla Cruz-McKernan

1. Call to Order

Jack motioned for a call to order and Barbara seconded.

2. COVID-19 RESOLUTION (AB 361)

Jack motioned for approval of Covid-19 Resolution and Barbara seconded.

3. Public Comment

None

4. Approval of Meeting Minutes

Barbara motioned for approval of the prior meeting minutes and Ming seconded.

5. Approval of Agenda

The agenda was approved.

6. Old Business

No old business was discussed.

7. New Business

7.1 Pharmacy Department Policy Updates

Andrew presented an update to the Medical Drug Site of Care Policy and introduced a new policy entitled MCP DU and CL Access Policy. The update made to the Medical Drug Site of

Care Policy included changes required by DHCS which states that Medi-Cal Rx is responsible for drugs billed under the pharmacy benefit while HPSM is responsible for the cost of facility-administered drugs. The new policy, entitled MCP DU and CL Access Policy, outlines the Plan's approach for identifying, maintaining, and using the managed care portal that was created by Magellan/DHCS (portal allows the Plan to access pharmacy claims data processed under Medi-Cal Rx) and access to Clinical Liaisons.

Barbara asked about the scope of Clinical Liaison responsibilities and about the language outlined in the MCP DU and CL Access Policy. Ming responded by saying that much of the Policy contains language that mirrors DHCS' policies and that the purpose of the Policy is to outline who has access to the MCP Portal and Clinical Liaisons.

New Drugs to Market

7.2.1 New Protected Class Drugs

Matt provided a brief overview of 5 new protected class drugs that were recently approved, including 4 oral antineoplastics and 1 IV anticonvulsant. The recommendation was made to add the antineoplastics to the CMC, Medi-Cal and HealthWorx formularies with a prior authorization (PA) requirement. The IV anticonvulsant was recommended to be maintained non-formulary since it would likely be billed only under the medical benefit rather than pharmacy.

7.2.2 New Non-Protected Class Drugs

Matt presented on 8 new non-protected class drugs that were recently FDA-approved. Only Ticovac, a new vaccine for tick-borne encephalitis, was recommended for formulary addition to the CMC, Medi-Cal, and HealthWorx formularies.

7.3 New FDA-Approved Indications

Biyan reviewed new FDA-Approved indications for existing drugs on the market. The prior authorization criteria for Jakafi (new indication for chronic graft-versus-host disease) and Dupixent (new indication for those 6 years of age and older) were updated.

7.4 CMC Required Formulary Changes

Biyan discussed changes to the CMC formulary in response to CMS' concerns.

7.5 Formulary Considerations

Jasmine presented various formulary updates in response to new clinical guidelines, utilization data, and feedback from provider and staff. Some of the changes recommended included removing the 4 times a day testing requirement for Freestyle Libre, increasing the coverage duration for Wegovy to 6 months, removing Octagam from the Medi-Cal and HW formularies, and adding aspirin/dipyridamole ER, Difacid, and Drysol.

7.6 Medical Injectable Drug Class

Andrew presented a drug class review on filgrastim products including Neupogen, Nivestym, Zarxio and Granix. The recommendation was made to favor the biosimilar Zarxio over Neupogen and Nivestym since it was the most cost-effective filgrastim on the market.

7.7 BHRS Drug Monographs

7.7.1 Invega Hayfyera

Rukhsana presented on Invega Hayfyera, a new extended-release IM formulation of paliperidone. Barbara recommended adding it to the BHRS and CMC formularies with a prior authorization requirement while maintaining non-formulary status on the Medi-Cal and HealthWorx formularies.

7.7.2 Loreev XR

Barbara talked about Loreev XR, a new extended-release lorazepam product. She recommended maintaining the drug non-formulary due to its high price and lack of strong benefit compared to generic lorazepam.

7.7.3 Lybalvi

Rukhsana presented Lybalvi, a new combo medication containing olanzapine and samidorphan for treatment of schizophrenia and bipolar one disorder. She recommended adding the drug to the CMC formulary with a prior authorization requirement while maintaining it non-formulary on the Medi-Cal and HealthWorx formularies.

Barbara motioned for approval of all the formulary changes proposed and George seconded with the Committee approving with no objections.

8. Other Business/Announcements

Ming gave an update on Medi-Cal pharmacy carve-out which was scheduled for January 1st, 2022. Ming said that the Pharmacy department will work to facilitate a smooth transition and to mitigate member disruption.

Ming stressed that the Plan would continue to conduct Pharmacy and Therapeutic Committee meetings due to responsibilities surrounding formulary management for the CareAdvantage and HealthWorx lines of business. In addition, due to the Pharmacy department's increasing involvement surrounding the management of medical injectable drugs, P&T meetings will also be used as a forum to review updates made to how the Plan covers drugs billed under the medical benefit.

Jack asked whether the State would mandate the use of generics over brands. Ming responded by saying that because of rebates, the State sometimes prefers brand name products over generic.

Jack asked who would be handling Medi-Cal pharmacy prior authorization requests once the pharmacy carve-out has been implemented. Ming answered by stating that Magellan, the PBM contracted with DHCS, would be handling all outpatient pharmacy prior authorization requests. He added that all denials and appeals would be handled by DHCS.

George inquired about whether DHCS has a P&T committee. Ming answered by saying that the State does have something similar called the Medi-Cal Drug Advisory Committee. However, the Committee is only able to make recommendations as to whether a drug or product should be on the Contract Drug List and that the ultimate decision falls upon DHCS.

Barbara asked about whether members were notified about the pending change. Ming responded by saying that both the Plan and DHCS have mailed out letters and conducted various other outreaches.

Jack asked about whether existing prior authorization approvals will be grandfathered. Ming said yes and that all existing prior authorizations that have been approved are supposedly still valid through their stated duration but not to exceed 1 year with certain drug classes/categories allowed to continue through their stated duration not to exceed 5 years.

9. Adjournment

The meeting adjourned at 9:30am

MEMORANDUM

AGENDA ITEM: 4.6

DATE: April 13, 2022

DATE: March 28, 2022

TO: San Mateo Health Commission

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

RE: Approval of Quality Improvement Program Documents: 2021 Quality Improvement Program Evaluation, 2022 Quality Improvement Program Description, and 2022 Quality Improvement Work Plan

Recommendation:

Approve the attached HPSM quality documents for submission to the California Department of Health Care Services (DHCS): 2021 Quality Improvement Program Evaluation; 2022 Quality Improvement Program Description; and 2022 Quality Improvement Work Plan.

Background and Discussion:

The following summarizes the 2021 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 2021 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 2021 QI Program activities and provides guidance for the 2022 QI Program and Work Plan.

Trending and analysis of our clinical quality metrics reported in 2021 indicated that preventative care services and screenings decreased significantly during the public health emergency. Face-to-face outpatient visits declined as did preventative care services that involved in-person care such as, cervical cancer screenings, mammography, vital measurements, and laboratory services. Such services were often deferred to reduce the risk of spreading Covid-19.

In 2021, Covid-19 risk mitigation efforts continued, most prominently on ensuring full vaccination for all eligible members.

With the official end of the public health emergency mid-2021, some quality and patient safety monitoring programs such as Facility Site Review and Medical Record Review recommenced. In addition, several Performance Improvement Projects (PIPs) and Quality Improvement Projects (QIPs) began with planning and initial implementation in 2021.

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 2021 QI Program Evaluation indicates that the QI Program is effective in meeting many of its quality of clinical service goals as well as dynamic in meeting the emergent and continuing healthcare needs of our members caused by the Covid pandemic. No significant changes were made to the overall QI structure, monitoring processes or committee oversight for 2022.

However, changes to the Medi-Cal benefits administered by the Plan that became effective in 2022 changed the scope of the QI Program for the Medi-Cal population. The QI Program expanded with the dental services added to the Medi-Cal benefit in 2022. The dental services and provider network were integrated into established patient safety and quality of care programs and processes. Even though HPSM will no longer administer the outpatient pharmacy Medi-Cal benefit in 2022, the QI Program will continue to utilize available pharmacy data and monitor pharmacy related quality metrics for the Medi-Cal population.

Furthermore, the Health Promotion & Education, Population Health Management, Health Equity, and Culturally and Linguistically Appropriate Services (CLAS) programs were moved out the QI Program. While QI Program still draws from those areas for quality of care and service improvement work, they now operate as independent programs.

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 the detailed objectives, scope, timeline, deliverables, and person or operational unit responsible for each activity.

Quality improvement efforts in 2022 are focused on promoting the maintenance or reestablishment 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. The PIP aimed on increasing routine well care for older adolescents will continue, as will the PIP on increasing breast cancer screenings for women who identify as Black or African American. Efforts to improve blood pressure in members with hypertension focus on promoting and integrating remote blood pressure monitoring and telehealth. HPSM will sustain at-home blood pressure monitor accessibility for its members. Diabetes management and prevention intervention development work will also continue.

DRAFT

**RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION**

**IN THE MATTER OF APPROVAL OF
2021 QUALITY IMPROVEMENT PROGRAM EVALUATION
2022 QUALITY IMPROVEMENT PROGRAM DESCRIPTION
2022 QUALITY IMPROVEMENT WORK PLAN**

RESOLUTION 2022 -

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. 2021 Quality Improvement Program Evaluation
 - b. 2022 Quality Improvement Program Description
 - c. 2022 Quality Improvement Work Plan

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of April, 2022 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

Don Horsley, Chairperson

ATTEST:

APPROVED AS TO FORM:

BY: _____
C. Burgess, Clerk

Kristina Paszek
DEPUTY COUNTY COUNSEL



2021 QUALITY IMPROVEMENT PROGRAM ANNUAL EVALUATION

Prepared on 3/9/2022

2021 Quality Improvement (QI) Program Annual Evaluation

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

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1. INTRODUCTION

This program evaluation provides a comprehensive overview of quality improvement activities conducted in 2021.

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 2021, HPSM was required to collect and report HEDIS measures for the Medi-Cal and CareAdvantage populations. The 2021 reporting year HEDIS results are an analysis of services provided in 2020 (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.

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 2021 are of services provided to members enrolled in 2020.

2021 MEDI-CAL SUMMARY:

For Reporting Year (RY) 2021,

Four measures above HPL (above 90th percentile):

- Childhood Immunization Status –combination 10
- Prenatal and Postpartum Care – Postpartum Care (PPC-Pst)
- Antidepressant Medication Management – Both Effective Acute & Continuation & Phase Treatment (AMM-Acute & AMM-Cont)

Five measures below MPL (50th percentile):

- Weight Assessment & Counseling (WCC) - BMI
- Weight Assessment & Counseling (WCC) - Physical Activity
- Controlling High Blood Pressure (CBP)
- Cervical Cancer Screening (CCS)
- Diabetes Screening for Members with Schizophrenia or Bipolar Disorder (SSD)

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

In 2021, HPSM successfully reported on all 55 measures required by CMS for Medicare-Medicaid Plans. Only one CMS Core Quality Withhold HEDIS measure was above withhold benchmarks, Plan All-Cause Readmissions (PCR). The other two measures, Controlling High Blood Pressure (CBP) and Follow-up after Hospitalization for Mental Illness (FUH), were below set benchmarks as rates for both measures declined significantly in 2020. The Covid-19 pandemic has a significant impact on healthcare utilization, with preventative care services and care involving in-person visits – such as the collection of vitals or screenings – greatly reduced.

2021 PERFORMANCE IMPROVEMENT

The following areas represent opportunities for improvement and key areas of focus for 2021:

- Adolescent Well-Care Visits (WCV)
- Asthma Medication Ratio (AMR)
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Comprehensive Diabetes Care (CDC)

- A1c Testing
- Poor A1c Control

Controlling High Blood Pressure (CBP)

Timeliness of Prenatal and Postpartum Care (PPC)

Plan All-Cause Readmissions (PCR)

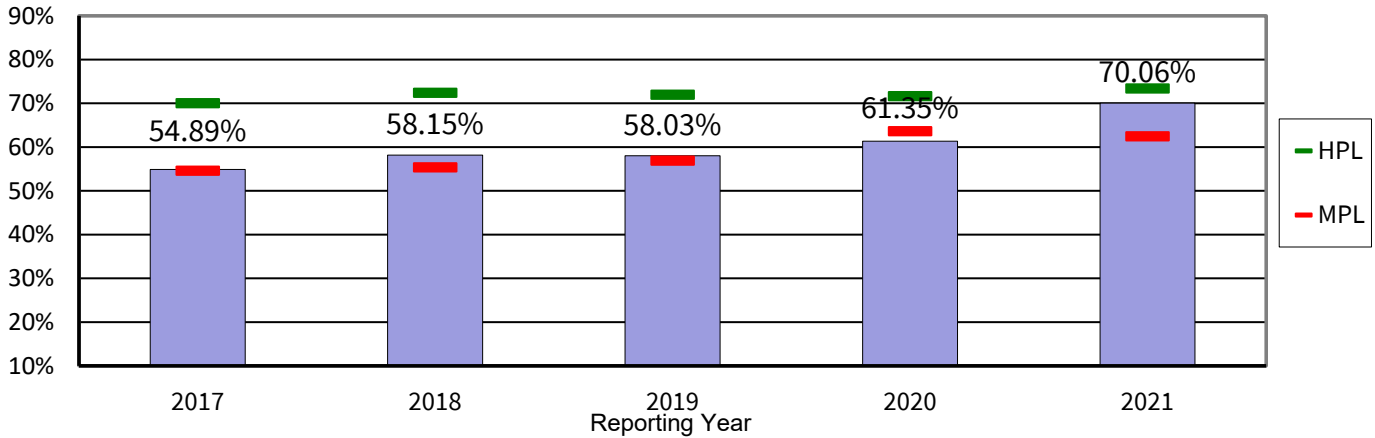
3. QUALITY OF CLINICAL CARE ACTIVITIES

3.1 ADOLESCENT WELLCARE VISITS (WCV)

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	First year of goal measurement, delayed due to pandemic delays.
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: <ol style="list-style-type: none"> 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	Incentive could not be initiated due to pandemic restrictions and resource constraints at the provider site.
Any changes to the program	Provider site was also changed from Sequoia Youth Clinic to Daly City Youth Clinic due to resource constraints.

3.2 ASTHMA MEDICATION RATIO (AMR)

AMR HEDIS RESULTS

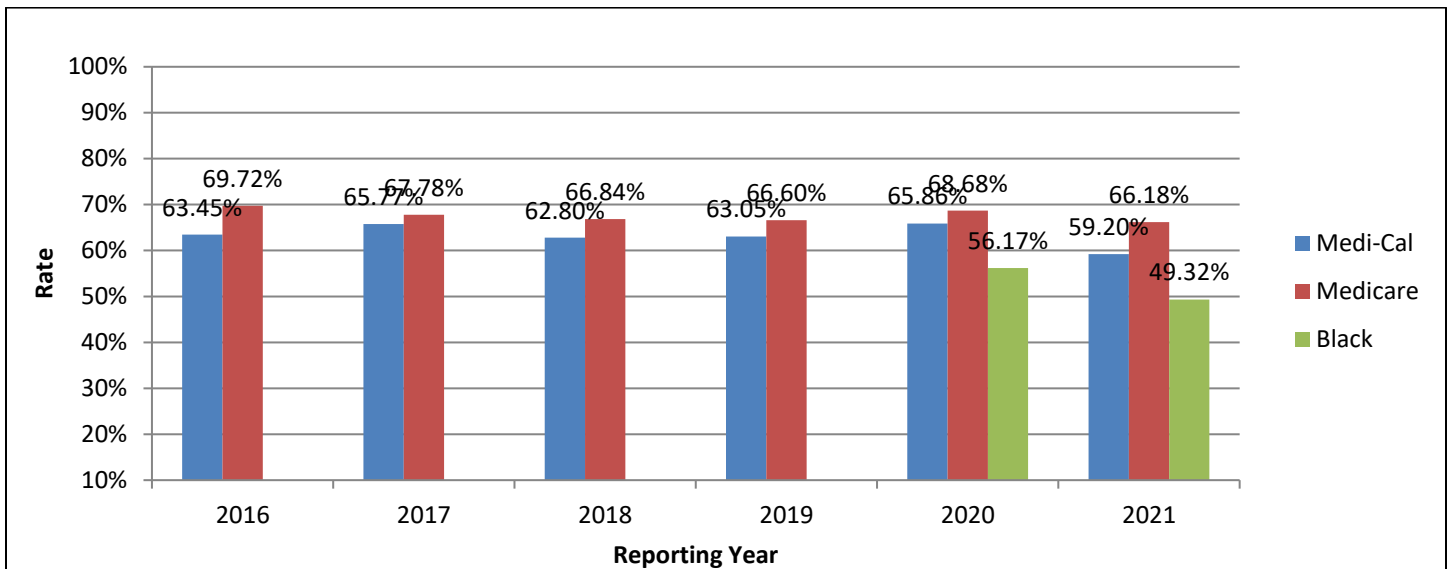


Measure/Program	AMR METRIC
Objective:	By 12/31/2021, increase the Medi-Cal Asthma Medication Ratio (AMR) rate of 58.03% (HEDIS 2019) to 62.3% (50th percentile).
Program Description	<ol style="list-style-type: none"> Asthma Outreach Program: Direct outreach to non-compliant members through phone calls, discussing the importance of taking their asthma medication. Pharmacy Letters to Providers: Beginning in 2019, HPSM’s pharmacy staff, using reports compiled of claims and pharmacy data, sends out a letter to the providers of high-risk individuals who have visited the emergency department and makes the provider aware of the recent visit. This letter prompts the provider to discuss asthma medication management with the member as well as possibly increasing their dosage of controller medications, if needed. Asthma Home Visiting Program Referrals: Direct referrals of all pediatric non-compliant members to SMC county’s asthma home visiting program, beginning in 2021.
Trend:	Our rate for AMR increased from the prior year from 61.35% to 70.06%, continuing the rising trend from prior years.
Goal Met/Not Met	For 2021, HPSM met the goal of 62.3% as our current rate is above this goal rate.

Barriers identified	<p>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:</p> <p>Members like to speak to a clinical team when discussing their asthma rather than HPSM Health Education staff</p> <p>Providers continued to report that members did not necessarily communicate to them about an asthma visit, making it difficult to follow up on their care when necessary,</p>
Recommended interventions for barriers	<p>As members prefer to speak to clinical staff, HPSM has decided to discontinue its direct calls to member program as members would just wish to speak to their PCP or Nurse Practitioner instead.</p> <p>Continuing with our interventions, especially around the letters from HPSM’s pharmacy team to our provider network as this has been well received. HPSM will also continue to refer pediatric members to the county’s home visiting program.</p>
Whether yearly planned activities were met	Planned yearly activities were met, although asthma calls were halted due to the first barrier identified above.
Any changes to the program	Discontinue direct outreach to members.

3.3 BREAST CANCER SCREENING (BCS)

BCS HEDIS RESULTS



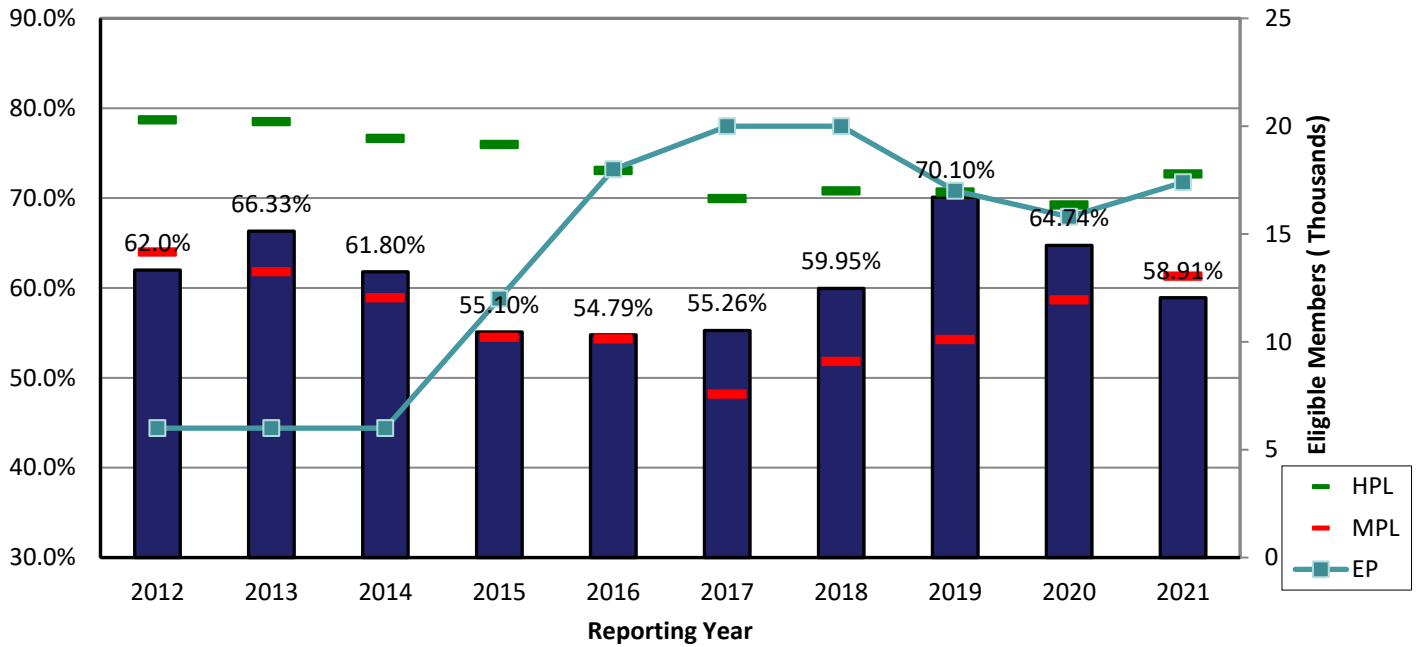
For BCS Medi-Cal RY2021 MPL (50th percentile) was 58.82% and HPL (90th percentile) was 69.22%.

Measure/Program	BCS METRIC
Objective:	By December 31, 2021, 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	<ol style="list-style-type: none"> 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 65.86% to 59.20%.
Goal Met/Not Met	The goal was not met for 2021.
Barriers identified	<p>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:</p> <ol style="list-style-type: none"> 1. Integrated care management team will reach out to African American members to understand barriers to mammography 2. Ravenswood will share identified barriers discovered in health coaching sessions.
Recommended interventions for barriers	<p>This initiative remained in the planning phase in 2021. We also experienced COVID related delays that prevented us from making as much progress as we would have hoped.</p> <p>Therefore, we will continue with our interventions. Outreach to African American members will continue to provide insight on specific barriers and facilitators, and our other interventions in the planning phase, including the BCS mailer and the incentive pilot program will encourage mammographs for the larger BCS eligible population.</p>

Whether yearly planned activities were met	Planned yearly activities were met and will continue in 2022.
Any changes to the program	Mailers may not be mailed monthly due to a delay in field testing but will mail by October 2022.

3.4 CERVICAL CANCER SCREENING (CCS)

CCS HEDIS RESULTS

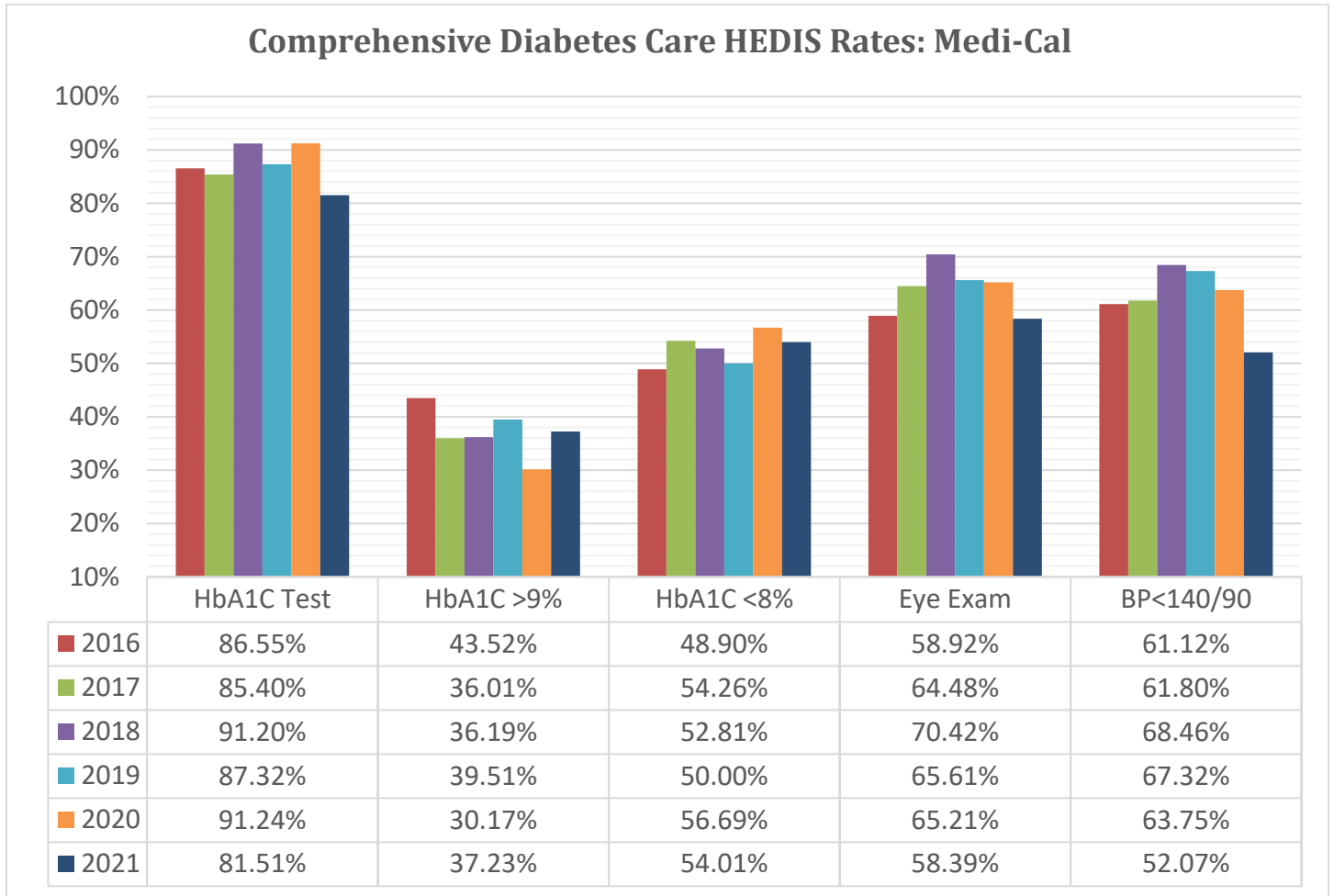


Measure/Program	CCS METRIC
Objective:	By December 31, 2021, increase the percentage of cervical cancer screenings among continuously enrolled members, ages 24-64 from 64.32% to 70.85%.
Program Description	Staying Healthy Mailer: Mailers will encourage members to ask PCP about recommended preventive care 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.
Trend:	Our rate for CCS decreased from the prior year from 64.74% to 58.91%.
Goal Met/Not Met	The goal was not met for 2021.
Barriers identified	<p>Prior conversation with PCPs and an analysis of HPSM resources have identified the following barriers:</p> <ol style="list-style-type: none"> 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	<p>This initiative remained in the planning phase in 2021. We also experienced COVID related delays that prevented us from making as much progress as we would have hoped.</p> <p>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.</p>
Whether yearly planned activities were met	Planned yearly activities were not met due to COVID related issues but will continue in 2022.
Any changes to the program	Due to COVID, planned activities were put on hold, but they will continue in 2022. Also, CCS has been included as a payable measure in HPSM’s P4P program for 2022

3.5 COMPREHENSIVE DIABETES CARE (CDC)

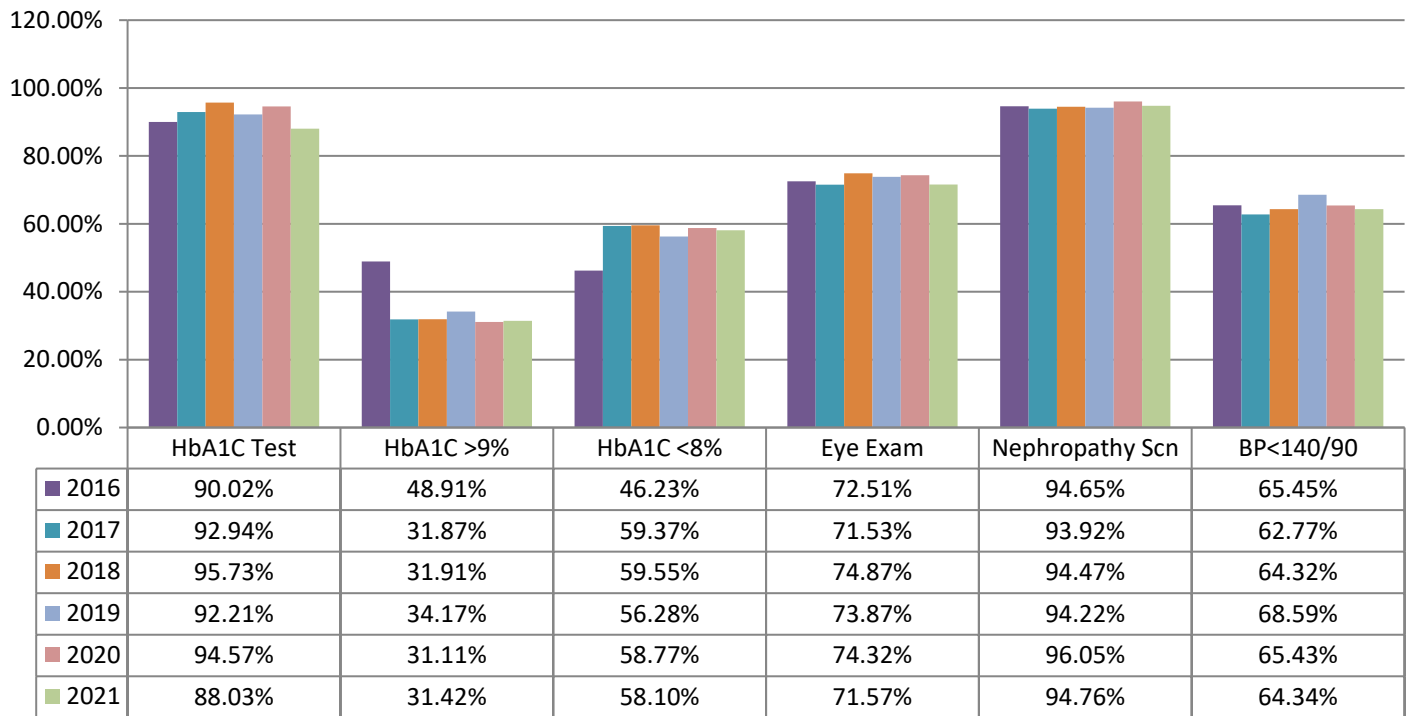
CDC HEDIS RESULTS



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%

Comprehensive Diabetes Care HEDIS Rates: Medicare



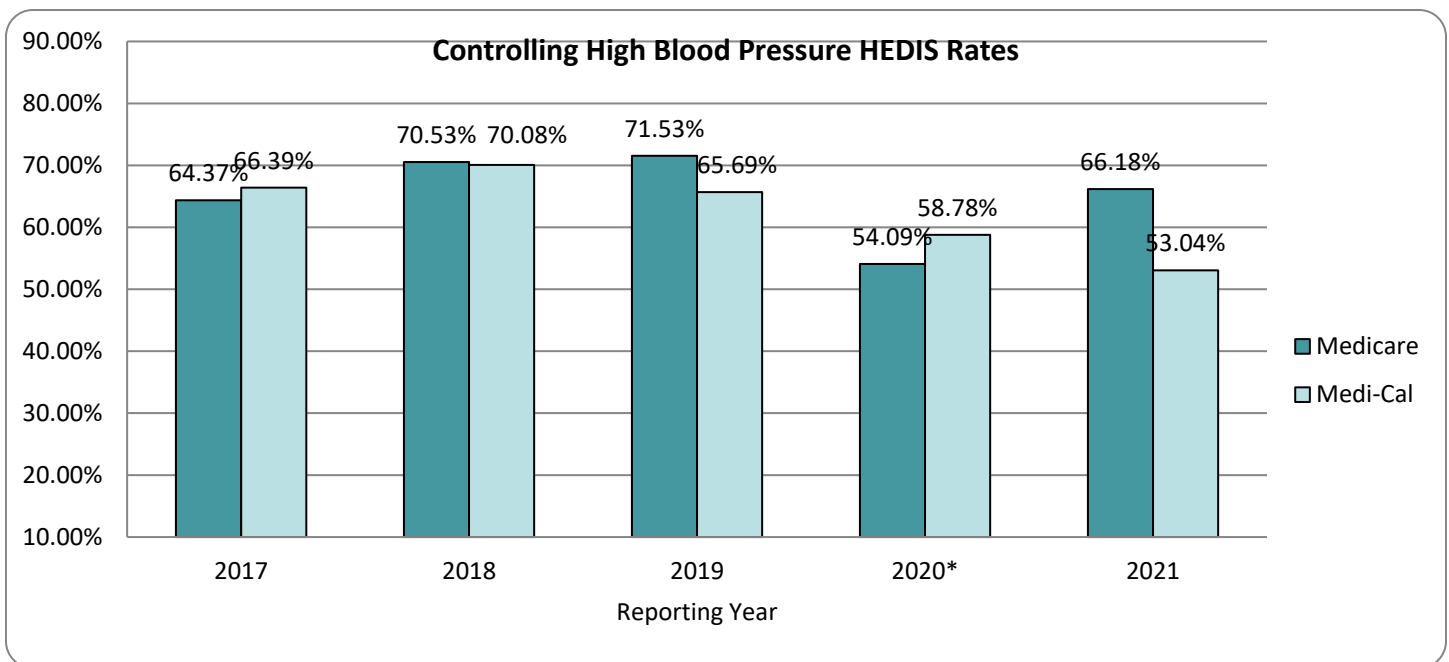
Measure/Program	Comprehensive Diabetes Care (CDC)
Objective:	<p><i>For Medi-Cal</i></p> <ul style="list-style-type: none"> By 12/31/2021, increase the Medi-Cal rate of the Comprehensive Diabetes Care (CDC) Eye Exam measure from 65.21% to 63.02% (90th percentile). By 12/31/2021, increase the Medi-Cal rate of the Comprehensive Diabetes Care (CDC) HbA1c Testing measure from 91.24% to 88.08% (90th percentile). By 12/31/2021, increase the Medi-Cal rate of the Comprehensive Diabetes Care (CDC) HbA1c Poor Control measure from 30.17% to 27.98% (90th percentile). By 12/31/2021, increase the Medi-Cal rate of the Comprehensive Diabetes Care (CDC) HbA1c Control measure from 56.69% to 55.23% (90th percentile). By 12/31/2021, increase the Medi-Cal rate of the Comprehensive Diabetes Care (CDC) Blood Pressure Control measure from 63.75% to 71.23% (90th percentile).
Program Description	<ul style="list-style-type: none"> Member Education: HPSM’s Health Promotion team provided members with diabetes management information, through communication channels such as the diabetes newsletter (sent out in November for Diabetes Awareness Month) and social media.

	<ul style="list-style-type: none"> • Provider Education: HPSM’s Health Promotion team continued to inform providers about Diabetes Self- Management Education and Training (DSME/T) programs available in the community. • Community Partnerships: HPSM’s Health Promotion team continues to partner with Diabetes Self- Management Education and Training (DSME/T) programs in the community in order to better connect our members to community resources and will partner with the Provider Services team to identify new community resources in 2022. • Internal Staff: HPSM’s Health Promotion team continues to maintain a Health Education Outreach Manual with talking points and a list of community resources for internal staff to reference when speaking with members.
Trend:	<p>Our <i>Medi-Cal</i> CDC measures, there was a decrease for Eye Exam, HbA1c Testing, HbA1c Control, Blood Pressure Control. For HbA1c Poor Control measure there was an increase, but a lower rate is better for this measure.</p> <ul style="list-style-type: none"> • Eye Exam measure from 65.21% to 58.39% • HbA1c Testing measure from 91.24% to 81.51% • HbA1c Poor Control measure from 30.17% to 37.23% • HbA1c Control measure from 56.69% to 54.01% • Blood Pressure Control measure from 63.75% to 52.07% <p>Our <i>Medicare</i> CDC measures, there was a decrease for Eye Exam, HbA1c Testing, HbA1c Control, Blood Pressure Control, and Nephropathy Scan. For HbA1c Poor Control measure there was an increase, but a lower rate is better for this measure.</p> <ul style="list-style-type: none"> • Eye Exam measure from 74.32% to 71.57% • HbA1c Testing measure from 94.57% to 88.03% • HbA1c Poor Control measure from 31.11% to 31.42% • HbA1c Control measure from 58.77% to 58.10% • Blood Pressure Control measure from 65.43% to 64.34% • Nephropathy Scan measure from 96.05% to 94.76%
Goal Met/Not Met	<p>For 2021 for <i>Medi-Cal</i> CDC measures, HPSM did not meet the goals set:</p> <ul style="list-style-type: none"> • The Eye Exam measure rate 58.39% is below the goal rate of 63.02% (90th percentile), but still above 51.36 (50th percentile) • The HbA1c Testing measure rate 81.51% is below the goal rate of 88.08% (90th percentile) and also below 82.97% (50th percentile) • HbA1c Poor Control measure rate 37.23% is above the goal rate of 27.98% (90th percentile), but still below 37.47% (50th percentile) • HbA1c Control measure rate 54.01% is below the goal rate 55.23% (90th percentile), but still above 46.83% (50th percentile) • Blood Pressure Control measure rate 52.07% is below goal rate of 71.23% (90th percentile), and also below 58.52% (50th percentile).
Barriers identified	<p>We did not meet the Medi-Cal goals set for this measure and have identified some barriers that affect this measure. These are as follows:</p> <ul style="list-style-type: none"> • During the pandemic, members have been hesitant to seek preventive care • The Mills Peninsula Diabetes Self- Management Education and Training (DSME/T) program, one of the main programs that members were referred to, ended in early 2021.

Recommended interventions for barriers	Continuing to partner with the Provider Services team to identify new diabetes self-management resources in the community to refer members to. HPSM's Health Promotion team will continue to refer SMMC assigned members to the SMMC diabetes self-management program and will continue to provide HPSM member, providers, and staff with information on diabetes self-management.
Whether yearly planned activities were met	Planned yearly activities were met, although the Mills Peninsula Diabetes Self- Management Education and Training (DSME/T) program, one of the programs that members were referred to, ended in early 2021.
Any changes to the program	Discontinue referrals to Mills Peninsula Diabetes Self- Management Education and Training (DSME/T) program because the program ended in early 2021. Continue to partner with the Provider Services team to identify new community resources in 2022.

3.6 CONTROLLING HIGH BLOOD PRESSURE (CBP)

CBP HEDIS RESULTS



For CBP Medi-Cal RY2021 MPL (50th percentile) was 61.80% and HPL (90th percentile) was 72.75%.

Measure/Program	Controlling Blood Pressure (CBP)
Objective:	By Dec 31, 2021 increase the <i>Medi-Cal</i> rate of controlled blood pressure from 65.69%* to 72.75% (90th percentile rate).

	<p>By Dec 31, 2021 increase the <i>Medicare</i> rate of controlled blood pressure from 71.53 %* to 73.48% (50th percentile rate).</p> <p>*Due to the pandemic, the 2019 HEDIS RY rate was reported for HEDIS RY 2020</p>
Program Description	<ul style="list-style-type: none"> Continued the Controlling Blood Pressure (CBP) pilot with NEMS through the end of 2021. The CBP pilot was a partnership between HPSM and clinic sites to provide health coaching and smart blood pressure monitors to HPSM members with uncontrolled hypertension. Member Education: HPSM’s Health Promotion team provided members with hypertension management information, including how to access a blood pressure monitor through communication channels such as newsletter and social media. Provider Education: HPSM’s Health Promotion team informed providers about the DME and pharmacy benefit guidelines for connecting members to a blood pressure monitor, including tips for treating patients with hypertension through the provider newsletter.
Trend:	<p>The <i>Medi-Cal</i> rate for CBP decreased from 65.69%* to 53.04%.</p> <p>The <i>Medicare</i> rate for CBP decreased from 71.53%* to 66.18%.</p> <p>*Due to the pandemic, the 2019 HEDIS RY rate was reported for HEDIS RY 2020</p>
Goal Met/Not Met	<p>For 2021, HPSM did not meet the goal</p> <ul style="list-style-type: none"> The <i>Medi-Cal</i> rate for CBP of 53.04% is below the goal rate of 72.57% (90th percentile) The <i>Medicare</i> rate for CBP of 66.18% is below the goal rate of 73.48% (50th percentile).
Barriers identified	<p>We did not meet the goal for this measure and have identified some barriers that affect this measure. These are as follows:</p> <ul style="list-style-type: none"> During the pandemic, members have been hesitant to seek preventive care The pandemic highlighted that there is a need to increase access to home BP monitors to all members. This was also flagged through conversations with NEMS as part of the CBP pilot and through conversations with other providers. <p>CBP Pilot specific barriers: NEMS had issues uploading data in 2021 since the gateway needed to upload data was not working properly.</p>
Recommended interventions for barriers	<ul style="list-style-type: none"> Continuing with member and provider education strategies around hypertension management and how to access a BP monitor. Plan to partner with different departments in HPSM that are also working on different hypertension self-management areas to align efforts (access to BP monitors through pharmacy and DME benefit, educating the provider network on how to access blood pressure monitors, health education on hypertension management etc).
Whether yearly planned activities were met	<p>Planned yearly activities were met.</p>

Any changes to the program	Discontinue the CBP pilot in 2022. Align efforts with different departments in HPSM that are already working on different hypertension self-management areas (access to BP monitors through pharmacy and DME benefit, educating the provider network on how to access blood pressure monitors, health education on hypertension management etc.) to ensure efforts are more impactful.
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INITIAL HEALTH ASSESSMENT (IHA)

IHA OUTREACH PROGRAM DESCRIPTION

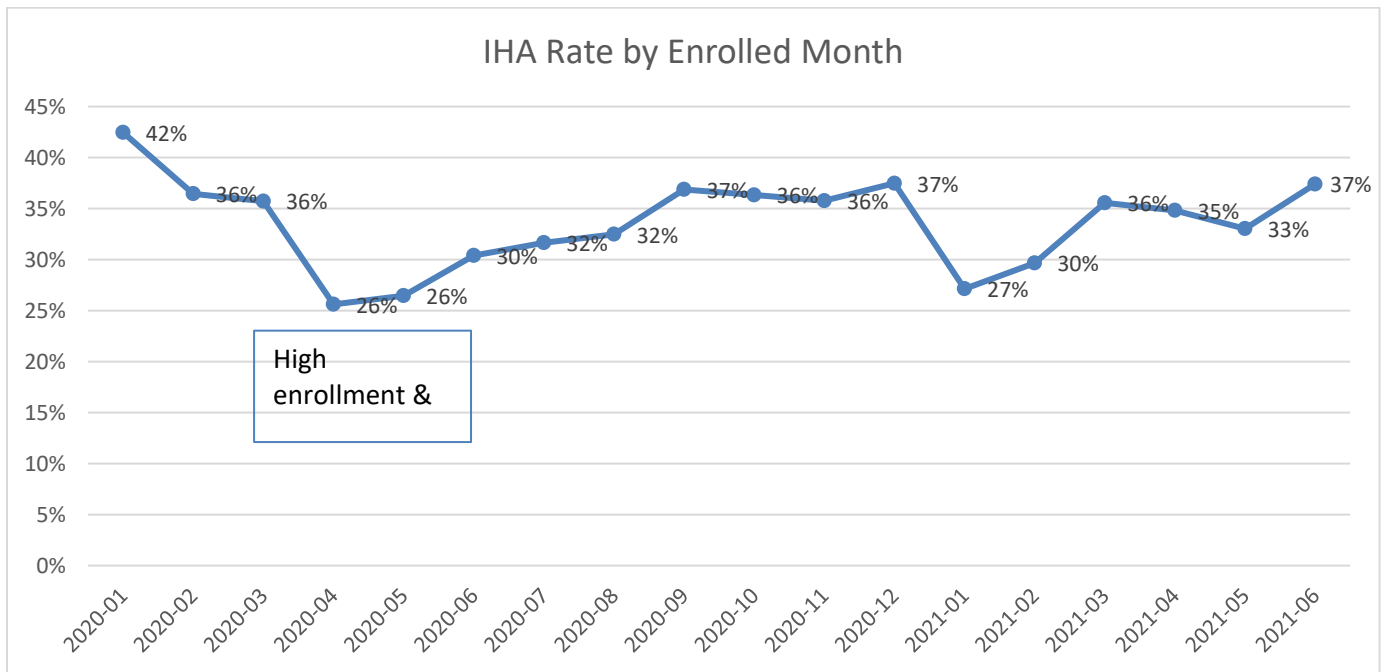
The Initial Health Assessment (IHA) has become an increasingly higher priority in health plans across California. Focus has also increased on primary care and preventative services as the Medi-Cal population has a higher incidence of chronic and/or preventable illnesses, many of which could be modified 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 2020-2021



IHA PROVIDER EDUCATION

The Health Plan of San Mateo makes the providers aware of the requirement of the SHA/IHEBA through three programs.

- Provider Services Outreach:** Periodic visits updating changes to existing programs, introducing new programs, and reinforcing on-going programs by provider service personnel.
- Pay for Performance Program:** Monthly reports sent to the provider detailing level of participation. Including Provider Services Pay for Performance promotion visits.
- 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 2022

The SHA proves to be a significant area for providers to comply with. Training has been developed to address this, but the additional component of a questionnaire in busy practices is a barrier to fully completing the IHA. Providers have

related the want to modify the questionnaire along with the difficulty in adding the questionnaire into their electronic health records. California Department of Health Care Services (DHCS) is aware of the issues. Until a modification from DHCS has been made aware to the health plan, training from all touch points to the providers and/or office staff will remain a focus. The Quality Improvement and Provider Services departments will continue to provide education to providers through 2022.

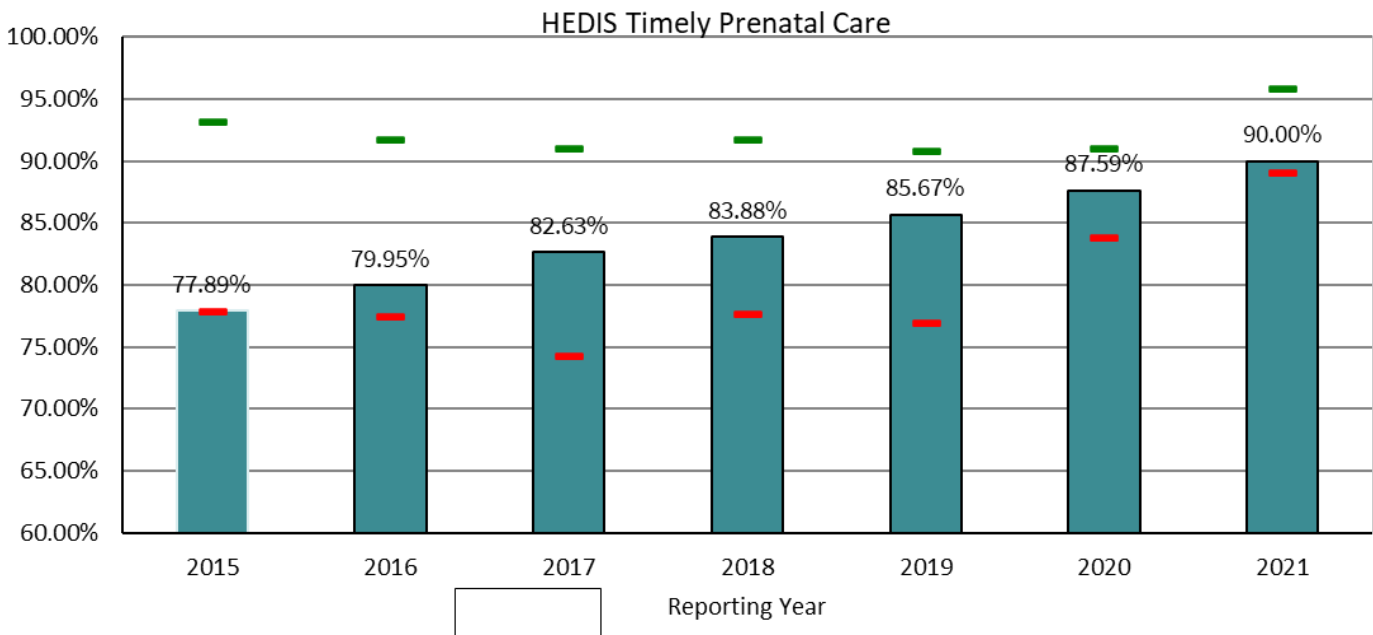
IHA completion will continue to be incentivized for Medi-Cal PCPs under HPSM Pay for Performance (P4P) program. As part of P4P, monthly reports sent to PCPs detailing level of performance.

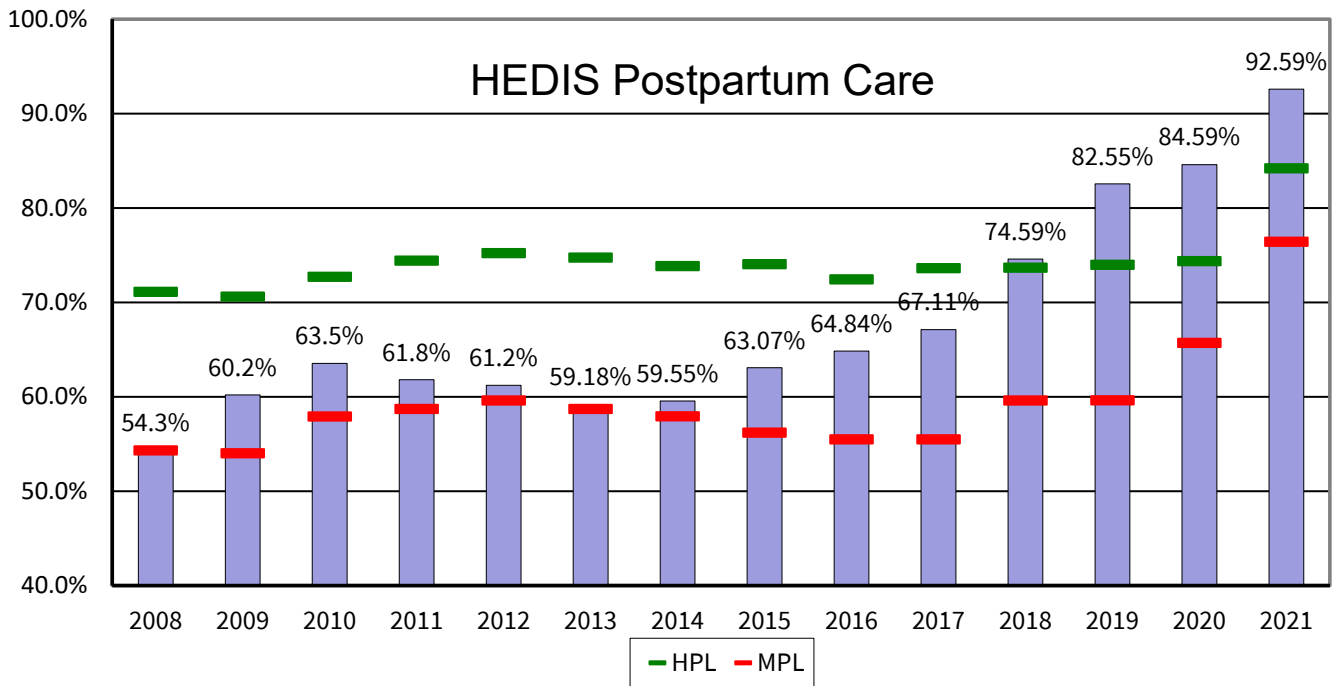
HPSM QI RNs will continue to audit for IHA completion with regular Facility Site Review Medical Record Review audits. Any deficient IHA and SHA/IHEBA documentation is addressed at the time of the Facility Site Review by site review nurses. Providers noncompliant or mostly noncompliant with consistent IHA completion will be asked to complete a Corrective Action Plan.

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

3.8 PRENATAL AND POSTPARTUM CARE (PPC)

PPC HEDIS RESULTS



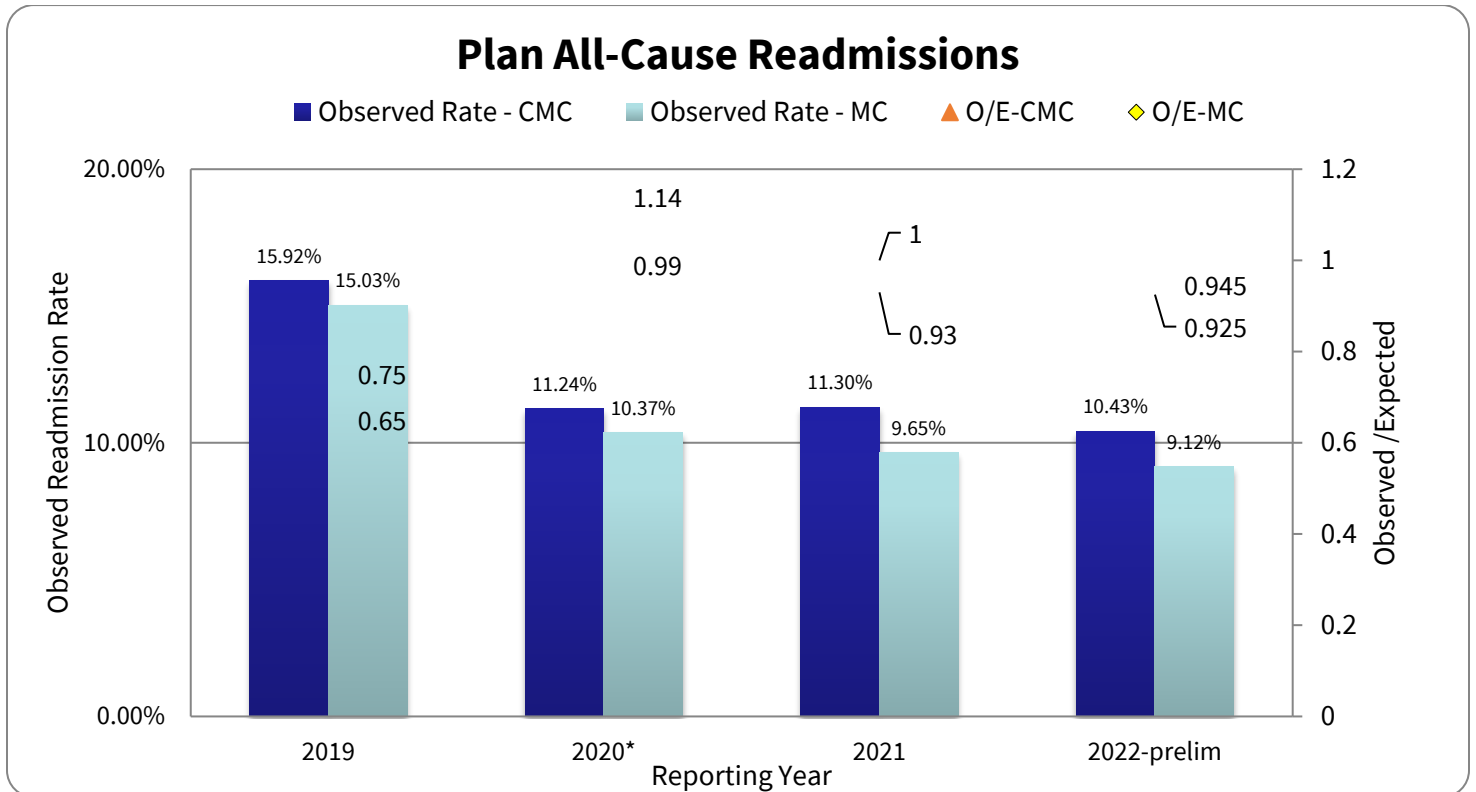


Measure/Program	PPC METRIC
Objective:	<p>Prenatal: By 12/31/2021, improve timely prenatal (within 42 days of enrollment or during the first trimester) care from 84.59% to 95.86%.</p> <p>Postpartum: By 12/31/2021, improve timely postpartum (7-84 days post-delivery) care from 87.59% and maintain at this level or higher, which is above the HPL of 84.18%.</p>
Program Description	<ol style="list-style-type: none"> 1. Baby + Me Program: The program encourages pregnant members to their OB/GYN for a prenatal visit within the first 12 weeks of pregnancy. It also encourages them to go their postpartum appointment after delivery their newborns. Members who complete their visits in a timely manner get an incentive \$50 target gift card. Also, we connect members with community resources to optimize wellness during and after pregnancy. In 2021, we continued to make outreach calls to enroll members into the program. 2. Other Communications: <ol style="list-style-type: none"> a. Website updates: updated website page for pregnancy which includes a section on b. Newsletters: we wrote information about Baby + me in a section of the newsletter. c. Social Media: we continually make pregnancy and Baby + me posts.
Trend:	Our rate for postpartum care increased from the prior year from 84.58% to 92.59%, continuing the rising trend from prior years.

	Our rate for prenatal care increased from the prior year from 87.59% to 90%, continuing the rising trend from prior year.
Goal Met/Not Met	For 2021, HPSM did not met the goal for Prenatal Care of 95.84% The current rate is 90.00% For 2021, HPSM met the goal for Postpartum Care of 84.18 (90 th %)The current rate is 92.59%
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: <ol style="list-style-type: none"> 1. Members not knowing they are pregnant until the second trimester. 2. Timely identification of pregnant women and those women who just delivered. First Prenatal appointment happens after the first twelve weeks or 42 days from enrollment. 3. Postpartum care happens before or after the 21-26 days recommendations. 4. Shortage of OB providers accepting new HPSM Medi-Cal members. 5. Mothers concerned about safety during well visits for their babies.
Recommended interventions for barriers	To address the issues we continue to face, we will continue to provide guidance on the importance of prenatal care and postpartum care via outreach. Also, connect members with community resources to ensure they are receiving the best during their pregnancy
Whether yearly planned activities were met	Planned yearly activities were met although we discontinued providing diapers and wipes due to budget constraints.
Any changes to the program	No changes to the program.

3.9 PLAN ALL-CAUSE READMISSIONS (PCR)

PCR HEDIS RESULTS



Measure/Program	PCR Metric
Objective:	Objective: The Quality Improvement Project (QIP) for reducing 30-day readmissions is aimed at reducing member readmission within 30 days across health care settings and practitioners, by decreasing the Plan All Cause (PCR) readmission rate by 2% from the baseline rate of 15.53% to 13.53%.
Program Description	The Care Transition program is available to all HPSM members that are discharged from an inpatient 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, decreased observed to expected readmission ratios (O/E) from reporting years 2020 to 2021 for both Medi-Cal and CMC populations indicate improvement.
Goal Met/Not Met	Undetermined due to measure changes
Barriers identified	Due to the pandemic, this program had to be shifted from in person to telephonic intervention. HPSM also was finding it difficult to track referrals to the CT team.
Recommended interventions for barriers	The inpatient review nurse now does the intake at any of our contracted facilities, in effect, expanding the scope of the program Referrals are made through the HPSM ticketing system.
Whether yearly planned activities were met	Yes, the yearly planned activities of expanding the program to all facilities and changing referral pathways was met.
Any changes to the program	Referral changes to the program.

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.

2021 Clinical Guidelines and Resources listed by Topic

Health Condition	Guidelines and Tools
Asthma and COPD	<ul style="list-style-type: none"> • National Asthma Education and Prevention Guidelines • Global Initiative for Asthma (GINA) 2020 Guidelines • Asthma Care Quick Reference Guide • Asthma Medication Ratio Tip Sheet • Asthma Action Plan • Diagnosis and Management of Chronic Obstructive Disease
Cardiovascular and Circulatory Guidelines	<ul style="list-style-type: none"> • Guidelines for Management of Heart Failure • Hypertension Treatment Algorithm • Lipid Management in Adults

Diabetes	<ul style="list-style-type: none"> • Standards of Care in Diabetes (American Diabetes Association)
Cancer Screening	<ul style="list-style-type: none"> • Screening for Lung Cancer • Primary Screening for Breast Cancer • Primary Screening for Cervical Cancer • Primary Screening for Colorectal Cancer
Obesity in Adults	<ul style="list-style-type: none"> • Weight Loss to Prevent Obesity-related Morbidity and Mortality in Adults • Adult BMI Calculator • Adult Body Mass Index Table
Obesity in Children & Teens	<ul style="list-style-type: none"> • Screening for Obesity in Children and Adolescents
Pediatric Preventive Health	<ul style="list-style-type: none"> • Blood Lead Screening Guideline (CDPH 2019) • Blood Lead Poisoning Testing and Management • ASD and ABA Referral Guidelines • Pediatric Therapy Eligibility Guidelines • Bright Futures Preventive Care Periodicity Schedule • Pocket Guide: Guidelines for Health Supervision of Infants, Children and Adolescents • Bright Futures Clinical Guidelines and Resources • Pediatric Care Coordination Supportive Services Referral Guide
Immunization Schedules	<ul style="list-style-type: none"> • Birth to age 18 schedule • Catch-up schedule: 4 months to 18 years • Adult schedule • Combination Vaccines
Sexually Transmitted Infections	<ul style="list-style-type: none"> • CDC Sexually Transmitted Disease Treatment Guidelines • Chlamydia Screening • Disease Reporting Form – San Mateo County • HPV vaccine for child/teen (scroll to 18 months to 18 years on schedule) • HPV vaccine information for parents
Behavioral Health	<ul style="list-style-type: none"> • Practice Guideline for Treatment of Patients with Substance Use Disorders • Guidelines for adolescent depression in primary care (GLAD-PC): Part I. Practice reparation, identification, assessment, and initial management • Guidelines for adolescent depression in primary care (GLAD-PC): Part II. Treatment and ongoing management • Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts • Treating Depression in the Primary Care Setting • Depression in children and young people: identification and management • Depression in adults: recognition and management • Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents • ADHD Parents Medication Guide • Developmental Services Referral Guide • Guidelines for Assessment of and Intervention With Persons With Disabilities • Guidelines for Psychological Practice for People with Low-Income and Economic Marginalization • Guidelines for Psychological Practice with Lesbian, Gay & Bisexual Clients • Guidelines for Psychological Practice with Older Adults • Guidelines for Treatment of Patients with Substance Use Disorders • PCP Referral Form for Behavioral Health and Recovery Services • Pharmacological Treatment of Patients with Alcohol Use Disorder

Source organization and websites for evidence-based guidelines posted on HPSM's website.

- American Academy of Pediatrics (AAP)
- American Academy of Child and Adolescent Psychiatry (AACAP)
- American College of Cardiology (ACC)
- American Diabetes Association (ADA)
- American Psychiatric Association (APA)
- Centers for Disease Control (CDC)
- California Department of Public Health (CDPH)
- Institute for Clinical Systems Improvement (ICSI)
- Joint National Committee Evidence Based Guidelines (JNC)
- 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 2021. As HPSM directly manages mild to moderate mental health services for Medi-Cal members and began directly contracting with behavioral health providers in October of 2020, a number of behavioral health clinical practices guidelines were added. Blood lead screening and resources were also added. In addition, a number of guidelines were updated in 2021, such as those for lung and colorectal cancers screenings and well as vaccination schedules for children and adults. All additional and updated guidelines were reviewed and approved by the QIC.

ACTION PLAN FOR 2022

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 March 4, 2020, the Department of Health Care Services released a new All-Plan Letter 20-004, that supersedes Policy Letters 14-004 and 03-02 and APL 03-007. 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) 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) 14-004, PL 03-002, and APL 03-007. MCPs are required to meet all requirements included in this APL by July 1, 2020."

On April 27, 2020, the Department of Health Care Services issued a revision to APL 20-004 in response to the COVID-19 outbreak and the subsequent Public Health Emergency (PHE). The letter suspends the all Facility Site Review requirements of APL20-004 with the resumption of FSR activities no sooner than 6 months after the lifting of the Public Health Emergency by the Governor of California.

On August 1, 2021, the DHCS lifted the suspension on the requirements for Facility Site Reviews. At that time, they gave health plans the option to resume in-person or virtual site reviews. Plans were not required to begin at that time. However, on January 1, 2022, all plans must once again meet the requirements of APL 20-004.

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 02-002 Dated May 16, 2002 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 02-002 Dated May 16, 2002, or superseding Policy Letter) Full Scope Site Review Survey 2014 and Medical Record Survey Tool 2014.

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 14-014). 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.

- Of the 18 facility site reviews completed in 2021, the average score was 93.6%.
- Of the 18 medical record reviews completed in 2021, the average score was 90.3%.

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:

- Emergency equipment for certain practices were not always appropriate
- Personal protective equipment was not readily available to staff

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 Healthy 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

Common Deficiencies identified in Pediatric Medical Record Review

- Documentation requirements for immunizations incomplete.

FSR ACTION PLAN FOR 2022

- Continue with our processes with completing FSR/MRRs delayed but PHE.
- Create additional new educational materials, for posting on the FSR page of HPSM's website. 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.

4.3 PHYSICAL ACCESSIBILITY REVIEW (PAR)

All Plan Letter 20-004 dated April 27, 2020, suspended all PAR activities until 6 months after the lifting of the Public Health Emergency. On August 1, 2021, the suspension was lifted. Plans were allowed to resume Physical Accessibility Reviews at their discretion through then end of 2021. January 1, 2022, PAR requirements have resumed.

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 for provider sites that serves a high volume of seniors and persons with disabilities (SPD). Attachment D is for ancillary services, it refers to diagnostic and therapeutic services but not limited to radiology, imaging, cardiac testing, kidney dialysis, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, and pulmonary testing. Lastly, attachment E is for community-based adult services (CBAS) and includes all facilities that provide bundle CBAS services but does not include licensed only adult daily health care center and programs.

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

Accessibility Indicator Symbols

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

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

Below is the break down for 2021:

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. Direct, appropriate, actions for improvement are taken based on outcome, risk, frequency, and severity.

We completed 37 PQI/Quality of Care Reviews from 1/1/2021 to 12/31/2021.

Final counts by PQI Level

Row Labels	Count
P0/S0	14
P0/S1	11
P0/S2	1
P1/S0	8
P1/S1	1
P2/S2	2
Grand Total	37

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-Medicconnect 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 2020, 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 2020 and summary reports are available the following July. The baseline was conducted for HPSM's Cohort 21 was collected in 2018 and the follow-up survey for that population was collected in 2020 and the merged results are available in a report from CMS. For the Cohort 21 the original baseline sample size for was 1,200; however, 858 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 342. Of the 342 members in the analytic sample, 54 voluntarily disenrolled from HPSM and 26 died between baseline and follow up. Of the 262 members sent a follow up survey, 5 were determined to be ineligible. Of the remaining 257 members, there were 110 who did not complete the survey and 147 who returned a completed follow up survey. This represented an overall follow up response rate of 57.2% for HPSM, as compared with the National HOS follow up response rate of 66.8%.

HOS COHORT 21 FOLLOW-UP RESULTS:

Improving or Maintaining Physical Health Score Results Trended over Three Cohorts

	Percent Better*	Percent Same*	Percent Worse*	Percent Better+Same*	Performance Results**
2018-2020 Cohort 21	15.86%	60.92%	23.22%	76.78%	↔
2017-2019 Cohort 20	21.12%	51.05%	27.83%	72.17%	↔
2016-2018 Cohort 19	15.35%	59.11%	25.55%	74.45%	↔

NA indicates that the MAO did not have results for the specified cohort.

* The percent better, same, worse, or better+same refers to beneficiary 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

	Percent Better*	Percent Same*	Percent Worse*	Percent Better+Same*	Performance Results**
2018-2020 Cohort 21	14.02%	67.05%	18.93%	81.07%	↔
2017-2019 Cohort 20	15.29%	68.73%	15.98%	84.02%	↔
2016-2018 Cohort 19	15.57%	66.87%	17.56%	82.44%	↔

NA indicates that the MAO did not have results for the specified cohort.

* The percent better, same, worse, or better+same refers to beneficiary 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

	General Health Fair or Poor		Comparative Physical Slightly Worse or Much Worse		Comparative Mental Slightly Worse or Much Worse	
	Baseline	Follow Up	Baseline	Follow Up	Baseline	Follow Up
	H7885	43.2%	46.3%	31.7%	30.3%	14.1%
California	30.2%	31.4%	26.5%	30.0%	13.3%	20.1%
HOS Total	22.5%	24.9%	22.6%	26.8%	10.0%	16.0%

HPSM has not seen a significant difference in the baseline versus follow up cohorts for this measure but a slight improvement in the physical health related response.

2020 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 23 surveys (combined *Cohort 23 Baseline* and *Cohort 21 Follow Up* data) collected in 2020. Prior rounds also combined baseline and follow-up surveys administered the calendar year.

Trending of over the last Three Survey Years:

	MUI Discuss Rate	MUI Treat Rate*	MUI Impact Rate	PAO Discuss Rate	PAO Advise Rate*	FRM Discuss Rate	FRM Manage Rate*	OTO Testing Rate
2020 Round 23	62.70%	44.53%	31.20%	57.35%	63.44%	31.65%	77.65%	58.80%
2019 Round 22	68.67%	50.34%	32.67%	62.80%	65.82%	37.97%	80.68%	59.73%
2018 Round 21	67.34%	50.76%	28.00%	64.17%	68.88%	36.33%	77.01%	57.82%

* Measures incorporated into the 2022 Medicare Star Ratings include the MAO 2020 *Improving Bladder Control* (MUI Treat Rate), *Monitoring Physical Activity* (PAO Advise Rate), and *Reducing the Risk of Falling* (FRM Manage Rate).

HPSM rates declined across all measures from prior survey year.

HPSM 2020 HEDIS HOS Rates Compared to California, CMS Region 9 and National HOS Total:

	MUI Discuss Rate	MUI Treat Rate*	MUI Impact Rate	PAO Discuss Rate	PAO Advise Rate*	FRM Discuss Rate	FRM Manage Rate*	OTO Testing Rate
H7885	62.70%	44.53%	31.20%	57.35%	63.44%	31.65%	77.65%	58.80%
California	59.23%	45.93%	18.89%	56.34%	53.85%	24.45%	60.98%	67.05%
CMS Region 9	58.80%	45.57%	17.68%	55.34%	51.69%	24.45%	59.13%	69.60%
HOS Total	59.70%	45.49%	15.91%	54.39%	49.73%	25.63%	56.09%	74.05%

[†]See Table 3 results for all MAOs in the state.

* Measures incorporated into the 2022 Medicare Star Ratings include the MAO 2020 *Improving Bladder Control* (MUI Treat Rate), *Monitoring Physical Activity* (PAO Advise Rate), and *Reducing the Risk of Falling* (FRM Manage Rate).

HPSM performed well comparatively for discussing and advising Physical Activity and Fall Risk Management measures as well as discussing Bladder Control. However, HPSM performed worse than comparative groups for Urinary Incontinence treatment as well as Osteoporosis Testing.

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 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. HPSM conducts separate annual CAHPS surveys for its members with Medicare and member with Medi-Cal. The surveys are mailed in English and Spanish with a follow up telephone call.

2021 Medicare CAHPS SURVEY SUMMARY

The response rate was 35.3%, which is an increase when compared to the 2020 response rate of 31.9%. 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 equivalent to the National MA average and similar to that of National MMP average.

Overall Health Plan Ratings	National MA	National MMP	HPSM	Statistical Significance	Reliability
Rating of Health Plan	8.8	8.8	8.6	No Difference	Good
Rating of Health Care Quality	8.7	8.7	8.5	No Difference	Good
Personal Doctor	9.2	9.1	N/A	N/A	Very Low
Specialist	9.0	9.0	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, but falls below the National MA percentages for the pneumonia vaccine.

Medicare-Specific and HEDIS Measures	National MA	National MMP	HPSM	Statistical Significance	Reliability
Annual Flu Vaccine	76%	67%	82%	Above Average	Good
Pneumonia Vaccine	72%	55%	65%	Below Average	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

Composite Measure	Survey Items Included
Getting Needed Care	<ul style="list-style-type: none"> In the last 6 months, how often was it easy to get appointments with specialists? In the last 6 months, how often was it easy to get the care, tests or treatment you thought you needed through your health plan?
Getting Appointments and Care Quickly	<ul style="list-style-type: none"> In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor’s office or clinic as soon as you thought you needed? Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
Doctors Who Communicate Well	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Personal doctor’s office follow up to give you test results Got test results as soon as you needed Doctor had medical records or other information about your care Doctor talked about prescription medicines Got help managing care Doctor was informed and up-to-date about specialty care

Medicare Health Plan Composite Measure Results

Health Plan Composite Measures	National MA	National MMP	HPSM	Statistical Significance	Reliability
Getting Needed Care	3.49	3.43	3.19	Below Average	Good
Getting Appointments and Care Quickly	3.37	3.30	3.15	Below Average	Good
Doctors Who Communicate Well	3.75	3.72	N/A	N/A	Very Low

Customer Service	3.72	3.68	3.52	Below Average	Good
Care Coordination	3.60	3.57	3.47	Below Average	Good

HPSM did not perform above the National MA average on any composite measure with a reliable result and similarly also scored below the National MMP average on all composite items.

2021 MEDI-CAL CAHPS SURVEY

See APPENDIX B: 2021 MEDI-CAL CAHPS SURVEY RESULTS & ANALYSIS REPORT

5.3 GRIEVANCES AND APPEALS

The Grievances & Appeals Report representing data from 2021, 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-Medicconnect (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 2021

Adequacy of QI Program Resources	Securing adequate resources to support QI activities continued to be a challenge in 2021. 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 that are in still being filled. This left QI staffing 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. This 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
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	<p>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.</p>
QI Committee Structure	<p>The QIC committee structure remained the same in 2021. 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 2021 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.</p>
Practitioner Participation and Leadership Involvement	<p>HPSM hired a Chief Medical Officer (CMO) in the Spring of 2021. 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 two medical directors with differing areas of expertise including Obstetrics & Gynecology and Primary Care. This structure continued throughout 2021. 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.</p> <p>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:</p> <ul style="list-style-type: none"> • Pharmacy • Utilization Management • Population Health • Integrated Care Management • Provider Services • Quality Improvement <p>This current structure supports practitioner participation and leadership involvement in QI Program Activities and will continue in 2022.</p>

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

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

Abrev	Measure	50th Percentile	MY 2020 Rate	MY 2019 Rate
AMR	Asthma Medication Ratio	62.43	70.06	61.35
CBP	Controlling High Blood Pressure*	61.80	53.04	(58.78)^
CDC >9	Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)* (lower is better)	37.47	37.23	30.17
AMM -AP	Antidepressant Medication Management - Effective Acute Phase Treatment	53.57	66.47	67.02
AMM -CP	Antidepressant Medication Management - Effective Continuation Phase Treatment	38.18	51.09	49.37
CIS-10	Childhood Immunization Status -Combo 10*	37.47	61.56	51.58
IMA -2	Immunizations for Adolescents -Combo 2*	36.86	50.61	55.12
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	80.50	75.18	
	BMI Percentile Documentation*	71.55	74.7	73.97
	Counseling for Nutrition*	66.79	65.94	
	Counseling for Physical Activity*			
BCS	Breast Cancer Screening	58.82	59.20	65.86
CCS	Cervical Cancer Screening*	61.31	58.91	(64.72)^
CHL	Chlamydia Screening in Women	58.44	63.98	67.49
PPC -Post	Prenatal and Postpartum Care - Postpartum Care*	76.40	92.59	84.18
PPC-Pre	Prenatal and Postpartum Care - Timeliness of Prenatal Care*	89.05	90.0	87.59
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.09	78.15	N/A
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing	35.43	35.64	N/A

Measure new to MCAS for MY2020, 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 mid	MY 2020 Rate	MY 2019 Rate	MY2019 CA MCP Med.
AMB-ED	Ambulatory Care: Emergency Department (ED) Visits per 1,000 member months		36.99	49.88	45.98
ADD-Init	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications – Initiation Phase		22.88	22.70	39.57
ADD-C/M	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications – Continuation and Maintenance Phase		N/A	N/A	44.52
CCW^	Contraceptive Care: All Women Ages 15-44:		24.34	24.38	23.27
	<ul style="list-style-type: none"> • Most or moderately effective contraception • Long Acting Reversible Contraception (LARC) 		4.99	5.17	5.07
CCP^	Contraceptive Care: Postpartum Women Ages 15-44:		25.75	15.79	5.61
	• Most or moderately effective contraception – 3 days		50.17	42.34	38.45
	• Most or moderately effective contraception – 60 days		13.89	7.54	2.23
	• LARC – 3 days		23.97	22.73	11.52
• LARC – 60 days					
WCV	Child and Adolescent Well-Care Visits (3-21 yrs)	26.83	48.80	N/A	N/A
W30	Well-Child Visits in the First 30 Months of Life	9.82	20.03		
	<ul style="list-style-type: none"> • 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 	63.49	76.94	N/A	N/A

Measure Abbrev.	Measure	MY 2020 Rate	MY 2019 Rate	MY2019 CA MCP Median
DEV^	Developmental Screening	24.24	45.28	32.22
COB^	Concurrent Use of Opioids and Benzodiazepines (lower is better)	18.56	18.46	13.20
OHD^	Use of Opioids at High Dosage in Persons Without Cancer (lower is better)	9.38	10.19	5.82
CDF^	Screening for Depression and Follow-Up Plan: Age 12 and Older	28.45	27.03	7.49
PCR	Plan All-Cause Readmissions <ul style="list-style-type: none"> • Observed rate (lower is better) • Observed to expected ratio 	9.64 0.9322	10.37 0.9926	9.44 .9898

APPENDIX B: 2021 MEDI-CAL CAHPS SURVEY RESULTS & ANALYSIS REPORT



2021 Medi-Cal CAHPS Survey Results & Analysis

August 2021

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1. Overview

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

Table 1: CAHPS Response Rate Trends

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

As Table 1 shows above there is a consistent decrease in response rate for both Adult and Child surveys for more recent collection years. However, response rates remained sufficient for valid result reporting for 2021.

2. Adult Survey Results

Table 2 below shows trends in “Top box” (“Always” or “Usually”) responses for composite items and supplemental items for the Adult survey across collection years. Comparison to 2019 results shows improvement in the *Rating of Health Plan* and *Rating of All Health Care*, with goal rates met for both measures

Getting Needed Care was an identified area in need of improvement from analysis of 2019 CAHPS results. While 2021 CAHPS comparative data for other plans is not available at the time of this report, there was marked improvement over the 2019 CAHPS rate. The goal rate was also met for this measure.

Review of the trend of responses to individual survey questions (Table 3) provides insight into the change in composite ratings. While there was general improvement in rating in items of the Getting Needed Care

composite, meeting the goal rate, the *appointment with Specialist* response increased significantly from 2019 to 2021.

Table 2: Adult Survey Results Trends and Comparisons

Measure	2013 Top-Box Scores	2016 Top-Box Scores	2019 Top-Box Scores	2021 Top-Box Scores	2019 to 2021 change	All Other Medical Health Plans 2019 Top-Box Scores	NCQA HPR 2020 (2019 data) Percentile	Goal Rate	Goal Met
Rating of Health Plan	56.50%	59.20%	58.23%	63.06%	0.048	56.80%	33.33rd to 66.67th	63.00%	Yes
Rating of All Health Care	52.70%	52.00%	50.18%	60.27%	0.101	52.80%	10th to 33.33rd	52.80%	Yes
Rating of Personal Doctor	64.60%	66.50%	68.65%	65.27%	-0.034	64.50%	33.33rd to 66.67th	69.80%	No
Rating of Specialist Seen Most Often	68.50%	71.6%+	71.20%	71.54%	0.003	65.00%	66.67th to 90th	71.70%	No
Getting Needed Care	81.20%	73.60%	77.60%	80.45%	0.029	78.20%	10th to 33.33rd	78.20%	Yes
Getting Care Quickly	75.80%	69.00%	79.30%	80.15%	0.008	76.00%	10th to 33.33rd	80.09%	Yes
How Well Doctors Communicate	87.40%	88.30%	93.10%	91.99%	-0.011	90.20%		90.20%	Yes
Customer Service	82.90%	88.8%+	88.70%	86.39%	-0.023	86.50%		86.50%	No
Shared Decision Making	45.70%	81.00%	78.90%	N/A		79.30%		79.30%	N/A

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.

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

Composite and Individual Items (2021)	Top-Box scores			Change 2019 to 2021
	2016	2019	2021	
Getting Care Quickly				
Q4. Got care as soon as needed when care was needed right away	NA	86.40%	NA	
Q6. Got check-up/routine appointment as soon as needed	65.63%	72.14%	73.64%	▲ 1.50%
Getting Needed Care				
Q9. Ease of getting care, tests or treatment	75.00%	82.85%	82.96%	▲ 0.11%
Q20. Got appointment with specialist as soon as needed	72.28%	72.41%	77.94%	▲ 5.53%
How Well Doctors Communicate				
Q12. Personal doctor explained things	85.56%	91.90%	89.38%	▼ -2.52%
Q13. Personal doctor listened carefully	87.64%	94.67%	93.75%	▬ -0.92%
Q14. Personal doctor showed respect	92.22%	95.16%	95.11%	▬ -0.05%
Q15. Personal doctor spent enough time	87.78%	90.65%	89.73%	▬ -0.92%
Coordination of Care				
Q17. Coordination of Care	NA	85.31%	86.67%	▲ 1.36%
Customer Service				
Q24. Customer service provided information or help	NA	81.02%	80.86%	▬ -0.16%
Q25. Customer service treated member with courtesy and respect	NA	96.35%	91.93%	▼ -4.42%

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

However, for 2021, there were decreases in the rating for *Rating of Personal Doctor*, *How Well Doctors Communicate* and *Customer Service* compared to 2019 results. Ratings of the *Personal Doctor* and *Specialist Seen Most Often* as well as *Customer Service* failed to meet the goal rate. As specified in Table 3, all other met the goal rate where applicable.

Trending of individual survey item results (Table 3) show that the decrease in *Doctors Communication* due to a lower *Doctor explained things* response. The decrease in *Customer Service* composite rate is primarily due to the significant decrease in *treatment with courtesy & respect* response. Significant decrease in this response is particularly concerning for the plan and is identified as an area of opportunity.

3. Child Survey Results

Table 2 below shows trends in “Top box” (“Always” or “Usually”) responses for composite items and supplement items for the Child survey across collection years. While 2021 CAHPS comparative data for other plans for is not available at the time of this report, comparison to 2019 results shows improvement in the rating of the *Getting Needed Care* and *Rating of All Health Care* composite items. Both measures met the goal rate.

Table 4: Child Survey Results Trends and Comparisons

Measure	2016 Top-Box Scores	2019 Top-Box Scores	2021 Top-Box Scores	2019 to 2021 change	All Other Medi-Cal Health Plans 2019 Top-Box Scores	NCQA HPR 2020 (2019 data) Percentile	Goal Rate	Goal Met
Rating of Health Plan	69.90%	78.30%	76.84%	-0.0146	69.70%	90th	78.20%	No
Rating of All Health Care	68.00%	70.30%	77.93%	0.0763	65.70%	33.33rd to 66.67th	72.90%	Yes
Rating of Personal Doctor	76.10%	79.30%	81.31%	0.0201	74.90%	66.67th	79.30%	Yes
Rating of Specialist Seen Most Often	71.6%+	81.4%+	N/A		75.60%	90th	81.40%	N/A
Getting Needed Care/Care Easily	77.80%	78.60%	82.66%	0.0406	80.50%	10th to 33.33rd	80.50%	Yes
Getting Care Quickly	77.40%	81.10%	81.14%	0.0004	84.90%	<10th	84.90%	No
How Well Doctors Communicate	92.30%	93.20%	93.98%	0.0078	91.80%		91.80%	Yes
Customer Service	89.40%	94.30%	86.35%	-0.0795	88.50%		88.50%	No
Shared Decision Making	79.8%+	72.6%+	N/A		75.20%		75.20%	N/A

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

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

Composite and Individual Items (2021)	Top-Box Scores			Change 2019 to 2021
	2016	2019	2021	
Getting Care Quickly				
Q4. Got care as soon as needed when care was needed right away	75.83%	NA	NA	
Q6. Got check-up/routine appointment as soon as needed	79.03%	82.66%	75.61%	▼ -7.05%
Getting Needed Care				
Q9. Ease of getting care, tests or treatment	82.62%	84.17%	82.46%	▬ -1.71%
Q23. Got appointment with specialist as soon as needed	NA	NA	NA	
How Well Doctors Communicate				
Q12. Personal doctor explained things	94.44%	92.89%	94.12%	▲ 1.23%
Q13. Personal doctor listened carefully	94.06%	94.17%	95.59%	▲ 1.42%
Q14. Personal doctor showed respect	95.44%	97.48%	98.03%	▬ 0.55%
Q17. Personal doctor spent enough time	85.21%	88.14%	88.18%	▬ 0.04%
Coordination of Care				
Q20. Coordination of Care	NA	NA	NA	
Customer Service Composite				
Q27. Customer service provided information or help	85.53%	90.24%	77.88%	▼ -12.36%
Q28. Customer service treated member with courtesy and respect	93.21%	98.35%	94.83%	▼ -3.52%

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

While there was improvement in the *Getting Care Quickly* measure from 2019 to 2021 survey results, it did not meet the goal rate.

There was a decrease in the *Rating of the Health Plan* and a significant decrease in *Customer Service* compared to the 2019 results. Both measures dropped below the goal rate. In trending the responses to individual questions for the *Customer Service* composite, both items declined with a significant decrease in the *providing information or help* rating.

As specified in Table 4, all other measures met the goal rate where applicable.

4. Analysis, Barriers, and Action Plan (Adult & Child)

4.1 Getting Needed Care & Getting Care Quickly

4.1.1 Qualitative Analysis

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

- a) **Trending of Access Grievances:** In 2020, HPSM's Grievance and Appeals Unit partnered with Provider Services to improve an existing quarterly report that trends member grievances by individual providers and clinics. This report now also includes the number of members who requested to switch away from a given primary care provider (PCP) due to dissatisfaction. In Quarter 3, 2020 HPSM's Physician Review Committee began reviewing these reports on a quarterly basis, identifying providers in need of escalation, and taking action as appropriate. This was a goal established in the 2019 CAHPS Results Report, so we are pleased to confirm that this intervention was implemented in 2020.
- Of note, although HPSM planned to trend results from the annual Member Timely Access Report, this report was not conducted in 2020. The survey was not conducted due to concerns about member priorities and not burdening members with a request at the height of the COVID-19 pandemic in the United States.
- b) **Outreach to Expand Pain Management Network:** HPSM's 2019 CAHPS Results Report identified pain management as an area in need of an expanded provider network given member need. In 2020 Provider Services repeatedly outreached to a previously contracted pain management provider, but the provider did not prove interested in re-contracting. In June 2021, Provider Services outreached to a list of local pain management providers and is currently in discussions with providers to gauge their interest. Given the limited number of pain management providers in the area, this is a difficult network to expand. The team has also been in conversation with one of HPSM's largest pain management providers in an effort to reduce barriers to care with this provider. This remains an area of focus for HPSM in 2021.

4.1.2 Barriers

- a) **Access to Primary Care:** In 2020, HPSM intended to grow its PCP network. Unfortunately, the COVID-19 pandemic negatively affected many PCP practices. Due to the pandemic many practices switched from in-person appointments to telehealth and may have seen a reduction in visits. As a result of these and other factors, HPSM experienced a higher-than-average rate of PCP retirements and contract terminations in 2020. In addition, HPSM staff time was diverted from PCP recruitment efforts to focus on COVID-related projects including building local COVID-testing capacity, long-term care facility outreach, and supporting the existing provider network in implementation of telehealth. At the same time, HPSM membership increased by 18% (almost 12,000 members) from January 2020 to July 2021 due to the hold on negative eligibility actions by the State of California. As a result, HPSM's existing PCP network was stretched to accommodate 18% more patients over only a year and a half.

Aside from the barriers unique to the COVID-19 pandemic, HPSM faces other barriers to PCP network adequacy. Many providers are affiliated with local provider groups, such as Sutter and

Dignity Health. HPSM contracts with these groups however they limit the number of Medi-Cal members they are willing to accept. This limits the number of independent practices available for outreach. Among remaining local practices, some providers are not enrolled in Medi-Cal and/or do not want to accept Medi-Cal rates or members. In addition, some PCP practices limit the number of Medi-Cal clients that they accept on their panel.

Additionally, some primary care providers are multi-specialty and primary care may not be the full focus of their practice. This can limit the number of office hours dedicated to primary care services for assigned members.

b) **Access to Specialty Care:** In 2020, HPSM's high volume provider types and high impact provider types met the goal of fewer than two complaints per 1,000 paid claims. Nonetheless, HPSM continues to closely monitor access to specialty care, given the following known barriers: limitations of certain specialist provider types in the market and/or geographic area, the perception among certain providers that Medi-Cal members are a more challenging and complex patient population, and some providers' unwillingness to accept Medi-Cal payment rates.

Additionally, some providers are contracted with the HPSM Medi-Cal network but limit the number of Medi-Cal patients they will see or limit their panel to only Medi-Cal patients with whom they have a prior relationship, further limiting timely access for new members who need to see these provider types.

4.1.3 Action Plan

Access to care remains a high priority for HPSM. As such, the Provider Services Department has outlined the following interventions for 2021:

1. Steps to increase timely access for primary care

- HPSM will cross-reference practitioner-level data on noncompliance with the point-in-time analysis of the provider timely access standards with access and availability member grievance data to identify any providers with multiple indications of access issues. We will also compare practitioner-level data to our primary care panel engagement rates and determine if providers need to be sent through our EPO (Established Patients Only) escalation pathway. We will also conduct a trending analysis with results of the 2019-2021 Timely Access Survey to identify any providers with year-over-year access issues.
- HPSM will conduct outreach to providers and dedicate process improvement resources to evaluating clinics that were both non-compliant with provider timely access standards for urgent appointments AND received access-related member grievances in 2020.
- HPSM will continue to engage in network expansion efforts by conducting outreach to new PCPs to join the network.

2. Steps to increase timely access for specialty care

- HPSM will cross-reference practitioner-level data on noncompliance with the point-in-time analysis of provider timely access standards with access and availability member grievance data to identify any providers with multiple indications of access issues. We will also conduct a trending analysis with results of the 2020 Provider Timely Access Survey to identify any providers with year-over-year access issues.
- will continue to engage in network expansion efforts by conducting outreach to new specialists to join the network.
- HPSM will continue working with our existing contracted specialists to determine if there are barriers to accepting new patients and how we could eliminate or mitigate those barriers.
- HPSM will continue to monitor provider timely access and member experience data compared to our standards on an annual basis.

4.2 How Well Doctors Communicate

4.2.1 Qualitative Analysis

The rates of this composite score increased for pediatric members and stayed relatively stable for adult members. Parents of children reported rates from 88% - 98% and adults reported rates from 89% - 95%, making this the highest rated area on HPSM's CAHPS. As such, HPSM has *not* identified communication by providers to be a priority area for 2021.

4.2.2 Barriers and Action Plan

The primary barriers for adequate communication between providers and members have yet to be fully investigated. HPSM plans to begin building an infrastructure in 2022 for increased member feedback to the plan. HPSM plans to hold member focus groups to discuss issues surrounding communication with providers. The intention is to deepen our understanding of the contributing factors to this area to better inform how we proceed with interventions.

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

4.3 Customer Service

4.3.1 Qualitative Analysis

For both adults and children, member experiences with HPSM's Member Services (MS) Call Center decreased. For children, rates dropped by over 12% for *Customer Support provided services or help*, indicating that members were not adequately receiving the assistance they needed. For both adults and children, *Customer service treated member with dignity and respect* also decreased significantly, which indicates a concerning shift away from HPSM's intended member experience.

4.3.2 Barriers

Members completed these surveys between February to May 2021, which directly corresponds with record-high call volumes from both the COVID-19 pandemic and increased membership. During this time, COVID-19 vaccines were released but only to certain populations. New information was being delivered to the Plan from San Mateo County Health as well as several other stakeholders on a daily and often hourly basis. As a result, the MS Call Center implemented a series of rapid notification systems and updated messaging, but MS Representatives struggled to learn and implement these rapidly changing instructions.

Call volumes increased by 15.5% in Q1 2021 and 11.6% in Q2 2021¹ as members called in to ask about vaccine eligibility, where to find a vaccine, and for help signing up for a vaccine online. At the same time, HPSM membership had increased by 16.5% (over 18,000 additional members) between January 2020 and May 2021. The dramatic increase in call volumes was therefore also the result of new Medi-Cal members and other members calling in with general requests.

The significant increase in call volume, coupled with the personal struggles MS Representatives were navigating as the result of the pandemic, may have conspired to leave members with longer hold times and decreased levels of attention, empathy, or patience from MS Representatives. Although MS teams frequently discussed the importance of serving members well during the pandemic, MS Representatives may have been too overwhelmed to provide customer service at the expected level.

¹ As compared to call volumes from Q1 and Q2 2020

4.3.3 Action Plan

HPSM is committed to increasing its *Customer Service* ratings in 2022. Although we expect ratings to naturally improve given that the stressors of the pandemic are subsiding, the Member Services Department will also implement the following interventions:

1) Steps to Increase Providing Accurate and Helpful Service

- a) The MS Department will conduct monthly refresher trainings on common member questions and processes to ensure that staff remain up to date on current processes and procedures. The MS Department will also continue to require all MS staff to pass its annual test measuring their ability to answer common member questions.
- b) The MS Department performs quality monitoring for three calls per MS Representative per month. This call monitoring measures both the accuracy of the information provided as well as the Representative's demeanor and level of respect. Each Representative has an objective of achieving a score of at least 95% per quarter on their monitored calls. MS Leadership will continue to track performance across quarters and take action as needed to address continued performance issues.

2) Steps to Increase Treating Members with Dignity and Respect

- a) MS Leadership will explore additional training resources on active listening and handling calls with empathy, dignity, and respect. MS staff currently take trainings through LinkedIn Learning, and MS Leadership will work with HPSM's Learning & Development Unit to establish a learner-driven training schedule. All MS staff attended a call de-escalation training in 2019, so MS Leadership will also explore options for refresher training in this area. Given the existing training schedule for 2021, this intervention will be scheduled to begin Q2 2022.
- b) As described above, MS Leadership will continue to monitor and evaluate calls against this objective and will take action as needed to address continued performance issues.
- c) To address the stressors the MS staff navigates in their personal lives, MS Leadership will promote existing resources such as the Employee Assistance Program, which offers free counseling and other wellness resources. We hope that use of these external resources will help reduce staff stress levels and improve staff patience and attentiveness to members while on the phone.

3) Steps to Increase Resources during High Call Volumes

- a) The MS Department will carefully consider its current policies and procedures to identify areas for increased efficiency, thereby maximizing staff available to answer the phones.
- b) The MS Department will be moving to a cloud-based call center system in September 2021. With this new system, the MS team will have easier access to real-time data on call volumes, hold times, and other key measures. Additionally, using a cloud-based system should decrease connectivity issues previously experienced throughout 2020 and 2021 because of staff working from home.

5. 2021/2022 Goals

HPSM is committed to maintaining its scores for *How Well Doctors Communicate*. It is also committed to increasing its scores for *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*. By implementing the strategies described above, HPSM aims to reach the following goals by August 2022:

CAHPS Top-Box Area	2021 Score	2022 Goal Score	Comments
<i>Getting Needed Care</i>	80.45% (adult) 82.66% (child)	82.45% (adult) 84.66% (child)	HPSM has made consistent improvement in this area since 2016, with a 2.85 percentage point increase from 2019 to 2021 among adults. HPSM will aim to increase this area by at least 2 percentage points in the next year.
<i>Getting Care Quickly</i>	80.15% (adult) 81.14% (child)	81.15% (adult) 82.14% (child)	HPSM has made consistent improvement in this area since 2016, with a 0.85 percentage point increase from 2019 to 2021 among adults and a 0.04 increase among children. HPSM will aim to increase this area by at least 1 percentage point in the next year.
<i>Customer Service</i>	86.39% (adult) 86.35% (child)	89.7% (adult) 95.3% (child)	HPSM intends to at least regain its 2019 score of 88.7% (adults) and 94.3% (children). We will also aim to increase these rates by at least 1%.

APPENDIX C: 2021 HPSM CONSUMER ADVISORY COMMITTEE GRIEVANCE & APPEALS REPORT



HPSM Consumer Advisory Committee

Grievance & Appeals Report

Reporting Period:

Q4 2021 (October – December 2021)

Presented 01/20/2022

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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 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.

Line of Business	Average Enrollment for Q4
CareAdvantage CMC	8,889
Medi-Cal Only (Excluding CCS)	120,567
HealthWorx	1,210
ACE	26,767
CCS	1,387
TOTAL	158,820

2.1 Goal Rate, by Line of Business

The 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 in 2019. From this historical review, the G&A Unit identified the minimum and maximum rate of complaints per 1,000 members and set a goal for each line of business. Below is a table of the minimum, maximum, and resulting goal rate for each program:

Line of Business	Min	Max	Goal
CareAdvantage CMC	16.80	23.40	20.10
Medi-Cal Only (Excluding CCS)	2.59	3.59	3.09
HealthWorx	4.33	6.05	5.19
ACE	0.21	0.69	0.45
CCS	7.24	9.98	8.61
TOTAL	3.40	4.17	3.79

2.2 Rate of Complaints per 1,000 members for 2021

Line of Business	Q1	Q2	Q3	Q4	Goal
CareAdvantage CMC	16.91	20.38	20.29	20.25	20.10
Medi-Cal Only (Excluding CCS)	2.32	2.05	2.07	2.31	3.09
HealthWorx	9.73	4.93	7.41	8.26	5.19
ACE	0.40	0.28	0.27	0.60	0.45
CCS	7.53	6.70	7.37	2.88	8.61
TOTAL	2.95	2.87	2.89	3.08	3.79

2.3 Analysis, Barriers, and Proposed Action

The rate of complaints per 1,000 members was slightly above goal for CareAdvantage CMC and ACE, but these differences are not significant. The rate for Healthworx was 3.07 points higher than the goal. Although this represents low overall volumes (around 10 cases per quarter), the G&A Unit will conduct additional review to determine if some of these cases are preventable or have a common root cause.

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 2021)
Grievances	333	329	95%	98.8%
Medical Appeals	46	46	95%	100%
Pharmacy	110	110	95%	100%

3.2 Analysis, Barriers, and Proposed Actions

The G&A and Pharmacy Units completed case investigations and case reviews in a timely manner during Q4 2021. While the goal is to resolve at least 95% of cases within the regulatory timeframe, 100% of appeals and 99% of grievances were resolved timely, indicating high levels of compliance with regulatory timeframes. Given these strong scores, no additional action is needed.

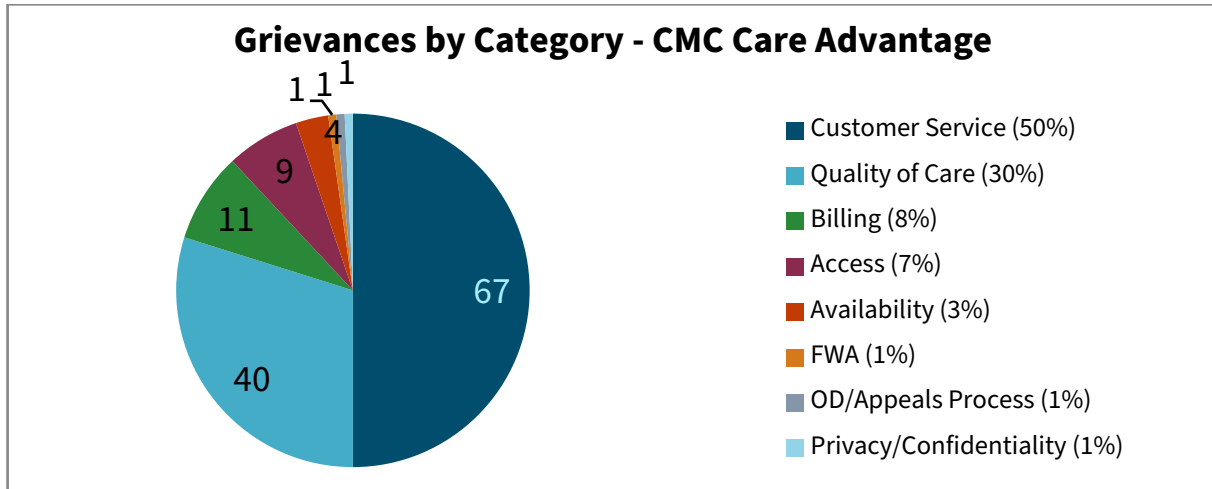
4. CareAdvantage Cal-MediConnect (CA CMC)

4.1 Number of Appeals and Grievances (Complaints) Received

LINE OF BUSINESS			Q1	Q2	Q3	Q4	TOTAL
CareAdvantage CMC							
Appeals	Part C	Expedited	25	1	5	1	32
		Standard	0	12	17	16	45
	Part D	Expedited	14	17	25	7	63
		Standard	17	26	26	22	91
	Total Appeals		56	43	51	46	196
Grievances	Part C	Expedited	0	1	0	1	2
		Standard	75	117	91	115	398
	Part D	Expedited	0	0	0	0	0
		Standard	16	5	15	18	54
	Total Grievances		91	123	106	134	454
CareAdvantage CMC Total			147	166	157	180	650

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.

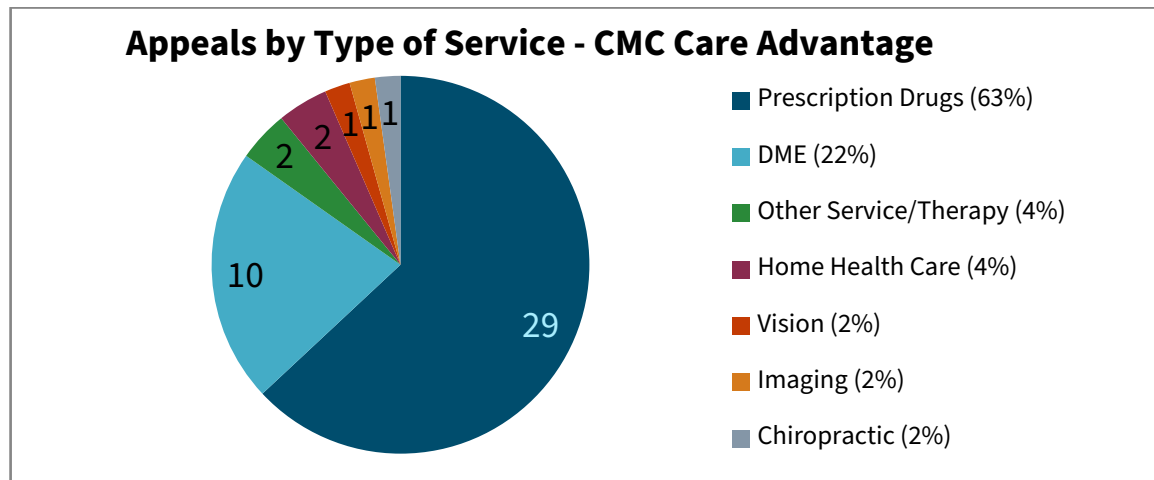
- 24 - Hour Resolutions, by Type of Service**

Types of Service	Q1	Q2	Q3	Q4	Total
Medical Services/Supplies	3	80	48	75	206
Prescription Drugs	17	27	48	34	126
Total	20	107	96	109	332

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

Category	Part C Grievance	Part D Grievance
Access	1	30
Availability	1	0
Billing	0	2
CD/Appeals Process	0	2
Customer Service	73	0
Grand Total	75	34

4.4 Types of Appeals Received



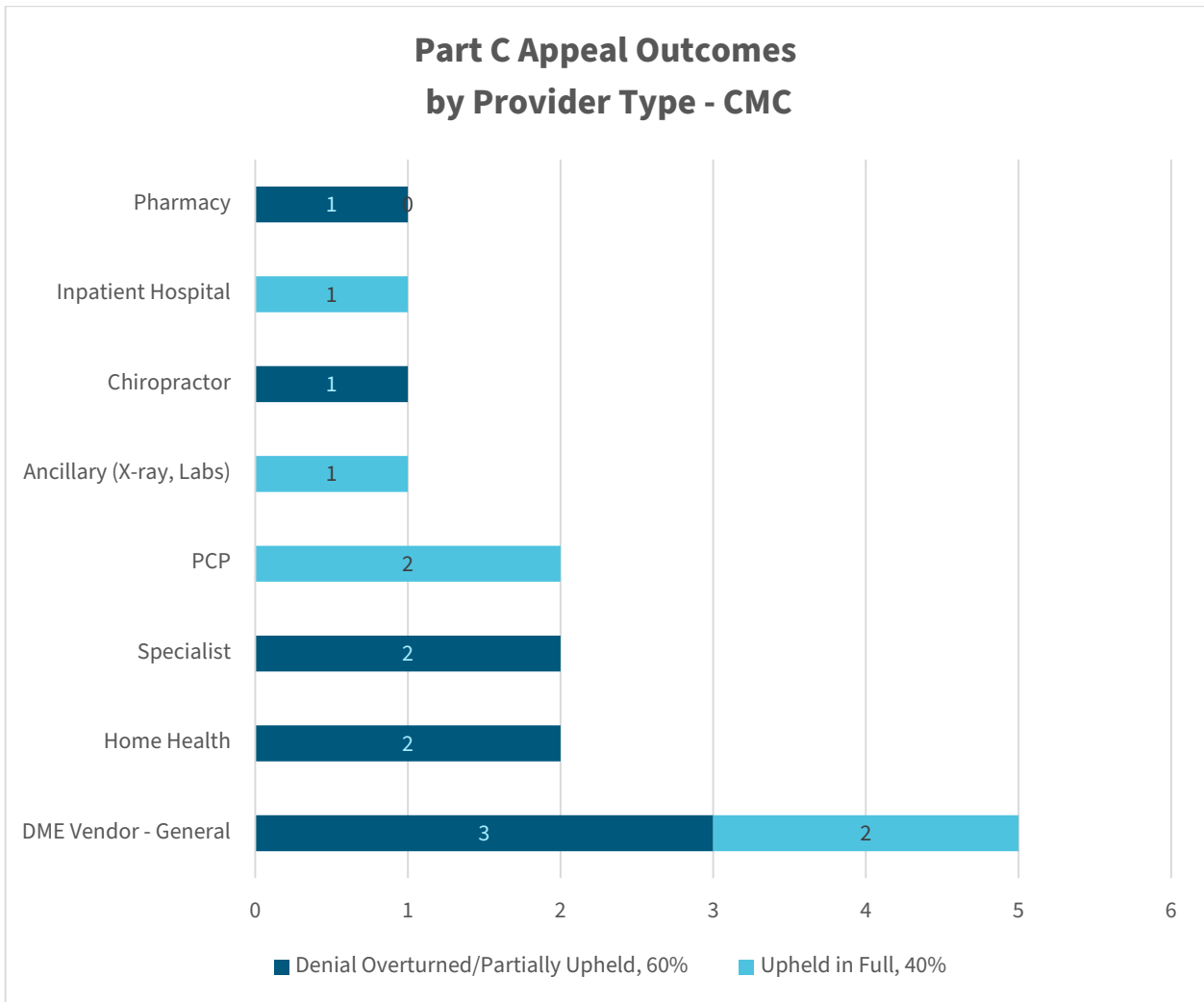
4.5 Rate of Overturned Appeals

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	Overtured	Upheld in Part	Upheld in Full	Withdrawn or Dismissed
Part C- Medical	17	9	0	6	2
Part D - Prescription Drugs	29	17	0	12	0

Prescription drug appeals were overturned in full or in part **59%** of the time. For all other appeals, the overturn rate is **53%**.

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* increased throughout the year, ending with 134 grievances in Q4 compared to 106 in Q3 and 123 in Q2. Given that the distribution of grievance types remained stable, the reason for the increase is unclear and warrants further analysis.

- Grievances related to Customer Service (50%) and Quality of Care (30%) remain the top two reasons for grievances, consistent with previous quarters.
- *Access and Availability related grievances* remained stable with 13 grievances in both Q3 and Q4 2021. Of those from Q4, six were the result of the member not receiving their requested service, either because the provider was not dispensing the service/item/drug or because there was no authorization on file. Four were due to the member not being able to schedule an appointment, and three were regarding access to an in-network specialist. This represents a standard distribution within access grievances.
- *Grievances resolved within 24 hours related to medical services* were highest in Q2 and Q4 2021 at 80 calls and 75 calls respectively. Of those received in Q4, 97% (73) were related to Customer. These spikes are a direct result of challenges HPSM's non-medical transportation vendor faced during these times. In Q2 the ride-share company Uber was experiencing a nationwide shortage of driver, which impacted HPSM rides. This shortage was compounded by an increased volume of ride requests as members resumed regular appointments given the decrease in COVID-19 transmission during that period. This trend has since stabilized. The Q4 spike was the result of problems HPSM's NMT vendor was experiencing with their phone system. The phone problems began in September 2021, resulting in 24-hour grievances being filed in October and November. The issue with the phone system has since been resolved, though the vendor continues to struggle with adequate staffing given the nationwide shortage of call center representatives. As a result, Customer Support Leadership explored options for expanding availability through overseas call centers, but these options were abandoned due to concerns about the inability to protect member health information.
- *Grievances resolved in 24 hours and related to prescription drugs* increased steadily throughout the year, from a low of 17 calls in Q1 to a high of 48 in Q3, but then dipped to 34 in Q4. After reviewing this data, HPSM's Pharmacy Services did not identify any trends in formulary changes or other policies to account for the change in grievance volume.

Appeals:

- The *volume of appeals* dropped for prescription drugs, from 51 appeals in Q3 to 29 in Q4. After a review of formulary and policy changes that may have accounted for this decrease, no trends were identified. Appeals related to Durable Medical Equipment (DME) remained stable with 10 appeals in Q4 compared to 8 cases in Q3. Home health care and other service/therapy also remained stable. While there were 3 Specialist appeals in Q3, there were none in Q4. As such, no trends are identified among medical appeals.

- The *overturn rate* increased slightly, from 49% in Q3 to 59% in Q4 for prescription drugs. This may be the result of a decrease in the overall volume of prescription drug appeals. For medical appeals, the rate increased from 50% in Q3 to 53% in Q4.
- **Proposed Action:**
 - No action is recommended for medical or pharmacy appeals since no trends were identified to indicate an area of concern.
 - Given the increase in grievances in 2021, the Grievance and Appeals Unit will conduct further analysis to understand the factors influencing this trend. Based on this analysis, further action will be taken as appropriate to address underlying causes of repeated issues.

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.

Parameter	2014	2015	2016	2017	2018	2019	2020	2021
Total CTM Complaints	0	2	1	3	0	1	5	0
Rate Per 1000 Enrollees	0	0.02	0.01	0.03	0	0.02	0.57	0
Other MMP Plans Aggregate Rate	0.16	0.09	1.1	0.1	0.11	0.14	N/A	N/A

4.8 CTM Complaint Analysis & Proposed Action Plan

There are no proposed actions given that HPSM did not receive any CTM complaints in 2021.

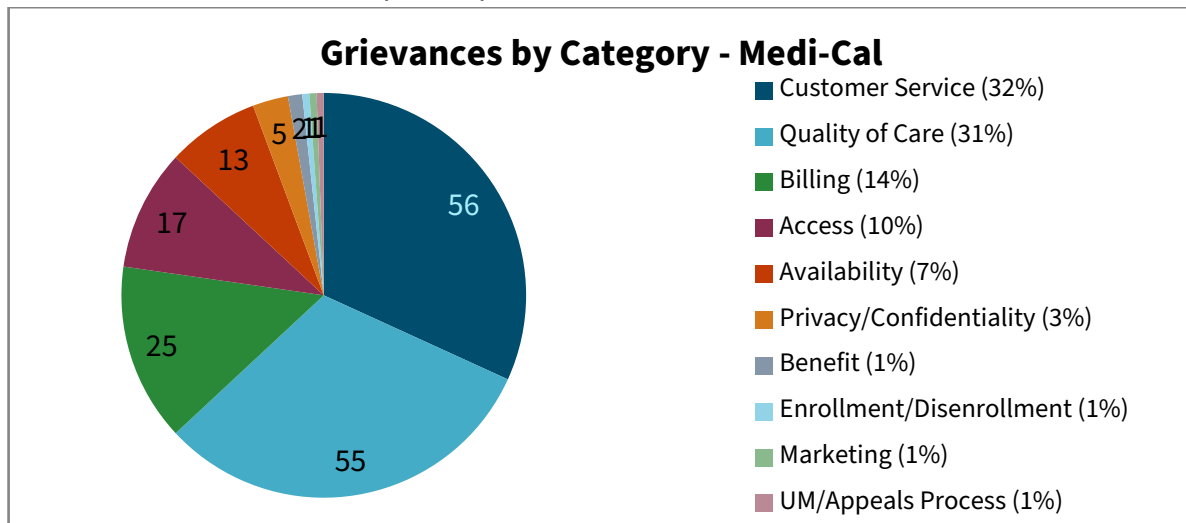
Medi-Cal (MC)

4.9 Number of Appeals and Grievances (Complaints) Received

LINE OF BUSINESS			Q1	Q2	Q3	Q4	TOTAL
Medi-Cal							
Appeals	Medical Services	Expedited	2	7	3	3	15
		Standard	35	25	21	24	105
	Drugs	Expedited	35	20	32	23	110
		Standard	60	64	52	53	229
	Total Appeals			132	84	108	103
Grievances	Medical Services	Expedited	0	0	0	0	0
		Standard	117	116	123	153	509
	Drugs	Expedited	0	0	0	0	0
		Standard	15	7	15	23	60
	Total Grievances			132	123	138	176
Medi-Cal Total			264	207	246	279	996

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 & State Fair Hearings for grievances)

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 2021, one regulatory grievance was filed, related to difficulty a mother experienced obtaining the birth certificate for her newborn from a contracted hospital.

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.

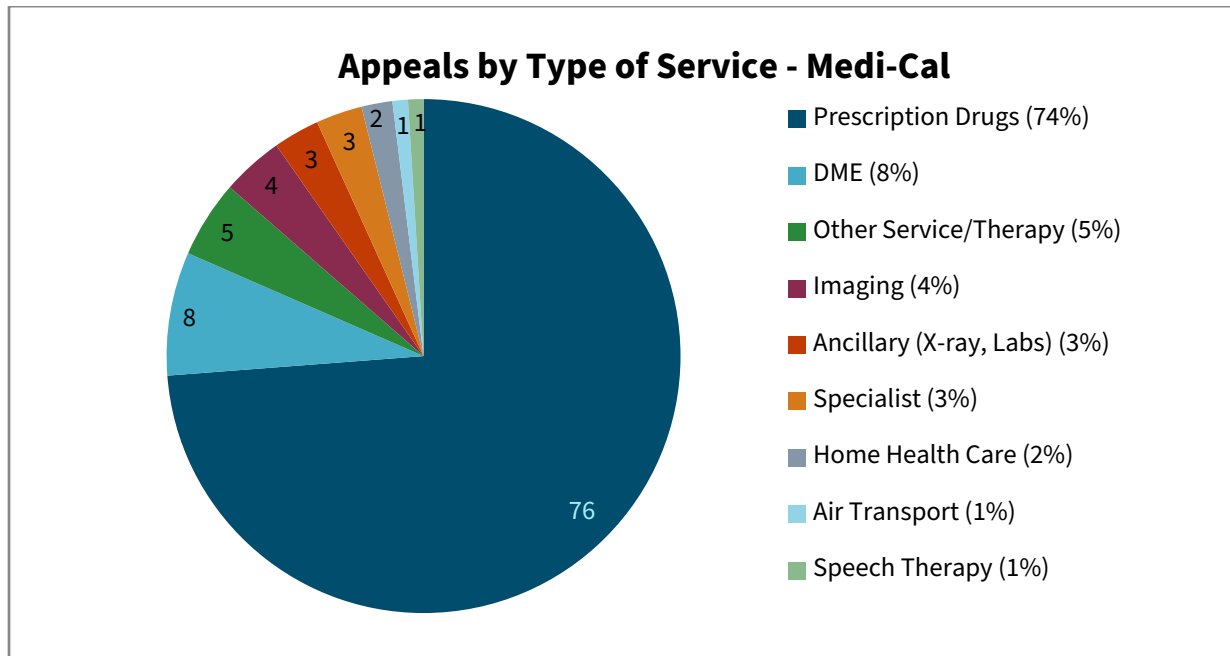
- **24 - Hour Resolutions, by Type of Service**

Types of Service	Q1	Q2	Q3	Q4	Total
Medical Services/Supplies	50	52	38	29	169
Prescription Drugs	87	54	72	43	256
Total	137	106	110	72	425

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

Category	Medical Grievance	Pharmacy/Drug Grievance
Access	4	42
Availability	1	0
Benefit	0	1
Customer Service	17	0
Marketing	2	0
UM/Appeals Process	5	0
Grand Total	29	43

4.13 Type of Appeals Received



4.14 Regulatory Appeals (Independent Medical Reviews)

Regulatory appeals are complaints that are escalated to the Department of Managed Health Care (DMHC) for secondary review/Independent Medical Review. These complaints may be escalated by a member or a member’s authorized representative, such as a family member or attorney. During Q4, the following five cases were filed:

- A denied pharmacy appeal for intra-peritoneal nutrition was overturned through IMR.
- A denied pharmacy appeal for Botox injections was overturned through IMR.
- A pending appeal for a glucose monitor. By the time the request was received, the first level appeal was already resolved in favor of the member.
- A denied appeal for Continuity of Care with an eye specialist. The decision was upheld by DMHC.
- A denied pharmacy appeal for biologics was overturned through IMR.

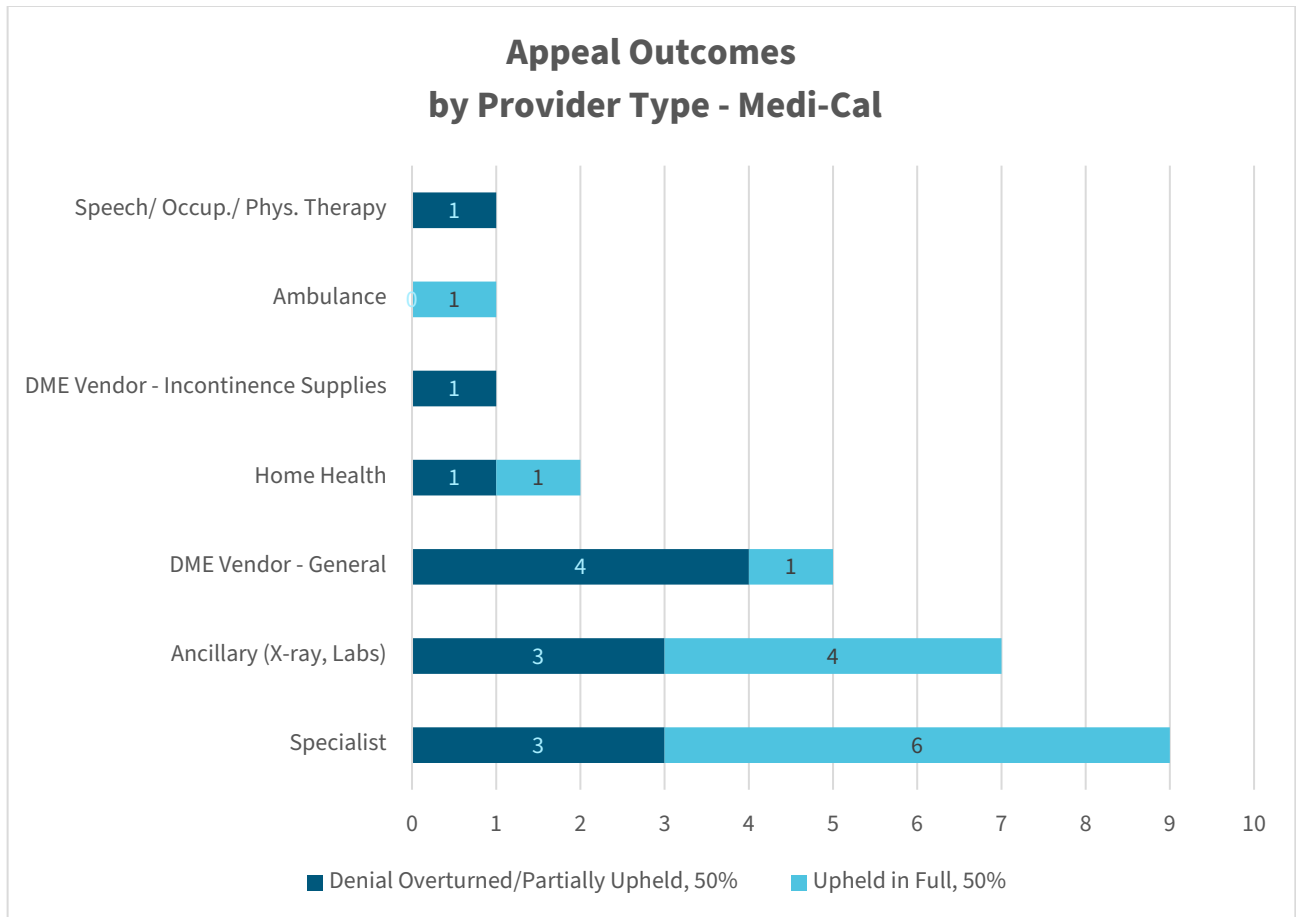
4.15 Rate of Overturned Appeals

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	Overtured	Upheld in Part	Upheld in Full	Withdrawn or Dismissed
Drugs	76	21	1	47	7
Medical/Services	27	13	1	12	1

Prescription drug appeals were overturned in full or in part **70%** of the time. For all other appeals, the overturn rate is **50%**.

This is the breakdown of Medical appeals by Provider Type:



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

Grievances:

- The *volume of grievances* increased in the last quarter, from 132 grievances in Q1 to 176 grievances in Q4. The rate of grievances per 1,000 members, however, remained well within goal, so this is not a concern.
- *Grievances by type of issue* present an interesting trend, and deeper analysis is needed to understand the specific increases in each of area and to determine significance. The number of grievances related to Quality of Care remained stable but accounted for a smaller percentage of grievances due to increases in Customer Support (Q3:48 vs. Q4:55), Billing (Q3:12 vs. Q4: 25), and Access/Availability (Q3:18 vs. Q4:30).
- HPSM received one regulatory grievances, compared to zero in the previous quarter.
- *Grievances resolved in 24 hours* decreased throughout the year for both medical and pharmacy-related issues. No trends have been identified to account for this gradual change.

Appeals:

- The volume of appeals decreased throughout the year, from 132 appeals in Q1 to 103 in Q4. This decrease was primarily within prescription drug appeals, though the decrease is not considered significant.
- Consistent with past quarters, most appeals (74%) were related to prescription drugs. The next highest appeal types, Durable Medical Equipment, Other Service/Therapy, and Imaging all remained stable from the previous quarter.
- The rate of overturned appeals increased significantly for prescription drugs, from 53% in Q3 to 70% in Q4. This was likely the result of efforts by HPSM's Pharmacy Services to ensure increased access to medications for members during the transition to Medi-Cal Rx effective January 1, 2022 given HPSM's concerns about access with this program.
- The rate of overturned appeals for medical services increased from 41% in Q3 to 50% in Q4, which is within the normal range seen quarter to quarter.
- Of the five cases filed with a regulatory agency in Q4, three were overturned by the agency. These cases were each for a different service and do not indicate a trend.
- **Proposed Action:**
 - The Grievance and Appeals Unit will conduct further analysis to better understand the factors leading to the increase in overall grievance volume among Medi-Cal members as well as to understand the increases in customer service, billing, and access/availability grievances.

- There are no proposed actions for appeals given the lack of concerning trend among these metrics.

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 or Magellan as the denominator. In this way, members who are not utilizing behavioral health services are not included in the rate and it is therefore a more accurate reflection of member experience.

Goal Rates

In general, the goal rate of complaints per 1,000 Medi-Cal members is set at 3.09 and the goal rate per 1,000 CCS members is set at 8.61. 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 2019, the G&A Unit has set the following goal rates for all non-behavioral health grievances and appeals. The goal for non-behavioral health services is set closer to the overall goal by line of business (3.09 complaints per 1,000 members for Medi-Cal and 8.61 per 1,000 for CCS).

	Min 2019	Max 2019	Current goal
Non-Behavioral Health: Grievances	2.56	4.14	3.26
Non-Behavioral Health: Appeals	0.67	1.35	1.00

For behavioral health services, the rate of complaints during 2019 was calculated taking utilization into account:

	Min 2019	Max 2019	Current goal
Behavioral Health: Grievances	0.3	1.7	1
Behavioral Health: Appeals	0.1	0.3	0.2

4.17.1 Medi-Cal and CCS Behavioral Health Grievances

The following table contains the number of behavioral health grievances closed during Quarter 4.

Q4 2021	
Category	Complaints Total
Access	1
Attitude and Service	0
Billing and Financial Issues	0
Quality of Care	7
Quality of Practitioner Office Site	0
Total Grievances	8

The complaint rate for behavioral health has not been calculated, because the Q4 utilization data was not available at the time this report was written. We do have the rate for Q3 2021, compared to Q2:

	Q2 2021		Q3 2021		Goal
	Complaints Total	Complaints per 1000 members	Complaints Total	Complaints per 1000 members	
Access	6	0.59	3	0.02	N/A
Attitude and Service	1	0.10	0	0.00	N/A
Billing and Financial Issues	0	0.00	0	0.00	N/A
Quality of Care	3	0.30	3	0.02	N/A
Quality of Practitioner Office Site	0	0.00	0	0.00	N/A
Total Grievances	10	0.99	6	0.05	1

4.17.2 Medi-Cal and CCS Behavioral Health Appeals

	Q4 2021
	Complaints Total
Access	5
Attitude and Service	0
Billing and Financial Issues	0
Quality of Care	0
Quality of Practitioner Office Site	0
Total Appeals	5

The following table was incomplete when Q3 was reported (utilization data was not available, as explained above). To provide the committee with all missing data, this table includes the complaint rate for Q3 and Q2:

	Q2 2021		Q3 2021		Goal
	Complaints Total	Complaints per 1000 members	Complaints Total	Complaints per 1000 members	
Access	2	0.20	4	0.03	N/A
Attitude and Service	0	0.00	0	0.00	N/A
Billing and Financial Issues	0	0.00	0	0.00	N/A
Quality of Care	0	0.00	0	0.00	N/A
Quality of Practitioner Office Site	0	0.00	0	0.00	N/A
Total Appeals	2	0.20	4	0.03	0.2

4.17.3 Medi-Cal and CCS Non-Behavioral Health Grievances

	Q3 2021		Q4 2021		Goal
	Complaints, Total	Complaints per 1000 members	Complaints, Total	Complaints per 1000 members	
Access	105	0.88	75	0.61	N/A
Attitude and Service	74	0.62	78	0.64	N/A
Billing and Financial Issues	9	0.08	21	0.17	N/A
Quality of Care	43	0.36	46	0.38	N/A

	Q3 2021		Q4 2021		Goal
	Complaints, Total	Complaints per 1000 members	Complaints, Total	Complaints per 1000 members	
Quality of Practitioner Office Site	1	0.01	1	0.01	N/A
Total Complaints	232	1.93	221	1.81	3.26

4.17.4 Medi-Cal and CCS Non-Behavioral Health Appeals

	Q3 2021		Q4 2021		Goal
	Complaints, Total	Complaints per 1000 members	Complaints, Total	Complaints per 1000 members	
Access	99	0.83	94	0.77	N/A
Attitude and Service	0	0.00	0	0	N/A
Billing and Financial Issues	0	0.00	2	0.02	N/A
Quality of Care	3	0.03	0	0	N/A
Quality of Practitioner Office Site	0	0.00	0	0	N/A
Total Appeals	102	0.85	96	0.79	1

4.17.5 Analysis, Barriers, and Proposed Action:

Behavioral Health complaint rates have not been calculated for Q4 2021, so the following analysis focuses on the Q3 2021 data presented above.

- The rate of grievances related to behavioral health services met the goal in both Q2 and Q3 2021. With a goal of 1 grievance per 1,000 members, there were 0.99 grievances filed about behavioral health services in Q2 and 0.05 grievances in Q3.
- Similarly, the rate of appeals met the goal in both quarters. With a goal of 0.2 appeals per 1,000 members, the rate in Q2 was 0.20 and the rate in Q3 was 0.03.

Non-Behavioral Health complaint data is available for Q4 2021.

- The rate of non-behavioral health related grievances was within the goal of 3.26 grievances per 1,000 members. The rate in Q3 was 1.93 and the rate in Q4 was 1.81 grievances per 1,000 members. This represents a slight but not significant increase in overall complaint volume, from 206 grievances in Q2, 232 grievances in Q3, and 221 grievances in Q4.
- The rate of non-behavioral health appeals were also within the goal of 1 appeal per 1,000 members for both quarters. The rate in Q3 was 0.85 and the rate in Q4 was 0.79 appeals per 1,000 members. The volume of appeals remained stable, with 100 appeals in Q2, 102 appeals in Q3, and 96 appeals in Q4.

Since the rate of grievances and appeals was within goal for both behavioral and non-behavioral health services, no action is recommended.

5. HealthWorx, ACE, and CCS

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

LINE OF BUSINESS	Q2	Q2	Q3	Q4	TOTAL
HEALTHWORX					
Appeals	8	5	2	1	16
Grievances	3	1	7	9	20
HealthWorx	11	6	9	10	36
ACE					
Appeals	2	2	2	2	8
Grievances	8	5	5	14	32
ACE Subtotal	10	7	7	16	40
CCS					
Appeals	7	7	5	4	23
Grievances	3	2	5	0	10
CCS Subtotal	10	9	10	4	33

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

CATEGORY	HW	ACE	CCS	TOTAL
Access	1	0	0	1
Availability	1	1	0	2
Billing	1	5	0	6
Customer Service	3	2	0	5
Quality of Care	3	5	0	8
UM/Appeals Process	0	1	0	1
TOTAL	9	14	0	23

5.3 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	4	5	3	4	16
Prescription Drugs	17	18	22	6	63
Total	21	23	25	10	79

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

Category	Medical Grievance	Pharmacy/Drug Grievance
Access	2	5
Billing	2	0
Customer Service	0	1
Grand Total	4	6

5.4 Analysis, Barriers, and Proposed Action

The number of grievances received from HealthWorx members increased from 3 grievances in Q1 to 9 cases in Q4. Interestingly, the number of appeals decreased in direct proportion, from 8 appeals in Q1 to only 1 appeal in Q4. HPSM has not identified a specific trend accounting for these changes.

Among ACE participants grievances increased from 8 cases in Q1 and 5 cases in quarters Q2 and Q3 to a high of 14 cases in Q4. The reason for this slight increase is unknown. Appeals from ACE participants remained stable.

The number of grievances and appeals among CCS members decreased throughout the year.

With regard to the type of grievances across these three programs, Quality of Care accounted for 35% of grievances, with Billing at 26% and Customer Service at 22%. This indicates an increase in Quality of Care and Billing grievances and a decrease in Customer Service cases.

As with previous quarters, most grievances resolved within 24 hours were related to prescription drug issues. These grievances decreased throughout the year, from 21 cases in Q1 to only 10 cases in Q4.

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

6. 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.

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

	Q1	Q2	Q3	Q4
Appeals	9	10	4	3
Grievances	16	31	62	62
Kaiser Total	25	41	66	65

6.1 Types of Kaiser Grievances and Appeals

Each grievance can have different grievance types, but only the first one is chosen for each of the grievances reported in the next table.

Grievance Types	Q4
Case Management / Care Coordination	38
Provider / Staff Attitude	6
Technology / Telephone	6
Out-of-Network	3
Billing	3
Timely Access	2
Member Informing Materials	2
Referral	1
Authorization	1
Total Number of Grievances	62

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

Appeal Benefit Types	Q4
Not Benefit Related	2
Emergency	1
Total Number of Appeals	3

6.2 Analysis, Barriers, and Proposed Action

The number of *appeals* filed with Kaiser by HPSM members decreased significantly in the last two quarters of the year, from 9-10 appeals in Q1 and Q2 to 3-4 appeals in Q3 and Q4. The reason for this decrease is unknown but does not necessarily indicate a trend given the small numbers. No action is proposed for this metric.

The number of *grievances* filed with Kaiser by HPSM members jumped substantially from 31 grievances in Q2 to 62 grievances in both Q3 and Q4. Kaiser responded that this dramatic increase is the result of a one-time recalibration of the methodology used to capture the volume of grievances according to new reporting requirements from the Department of Health Care Services. Kaiser confirmed that they do not expect significant or continued increases going forward. Given that 63% of these grievances are related to Care Coordination, HPSM has opened a dialogue with Kaiser to better understand the nature of these concerns. Additional details will be shared as HPSM learns more.

7. Primary Care Provider (PCP) Changes by Provider

Reason for PCP Change	Number of Changes in Q4 2021
Difficulty Obtaining an Appointment.	55
Poor Service	31
Provider and Patient Incompatible	8
Provider’s Attitude/Atmosphere	0
Total	94

A total of 94 members requested to change their assigned PCP effective Q4 of 2021 due to dissatisfaction.

In Q4 members switched away from a total of 31 different PCPs. Of those, 25 were clinics and 6 were individual providers. One of these individual providers had four or more members switching away from their practice; this was also the case for four of the clinics.

This data is shared with HPSM’s Provider Services team quarterly for additional action as needed.



AGENDA ITEM: 4.6B

DATE: April 13, 2022

2022 QUALITY IMPROVEMENT (QI) PROGRAM DESCRIPTION

2022 Quality Improvement (QI) Program Description Approval Form

X

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

X

Kenneth Tai, M.D.
Quality Improvement Committee Co -Chairperson
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X

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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.

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.

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 December 2021, HPSM serves approximately 130,000 members under the following lines of business: Medi-Cal, CareAdvantage Cal-MediConnect (CA CMC), HealthWorx, ACE and California Children's Services (CCS). All HPSM Dual eligible members of CA CMC and Medi-Cal Seniors and Persons with disabilities (SPDs) will be eligible for Coordinated Care Initiative Medi-Cal services.

During the COVID-19 pandemic in 2020 -2021, 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 2021.

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. While HPSM does not contract directly with its pharmacy network, HPSM's delegates this responsibility to its contracted pharmacy benefits manager. All pharmacy and 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 Cal MediConnect (MMP) 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 will transitioned from HPSM to fee-for-service (FFS) Medi-Cal. As of that date, these services are no longer be 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, 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 & OVERSIGHT

The Population Health Management (PHM) team maintains the oversight 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 the 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 oversight 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 are 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 if the chairperson deems it necessary; minimum frequency for QIC meetings will not extend beyond a quarterly basis. Meetings may be held in person or via teleconference.

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 mailed 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 confidentiality 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)
- Medical Director
- Dental Director

- Quality Improvement Director
- Practicing network physicians
- 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

- 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. These guidelines include, but not limited to, standards instituted and approved by the following:
 - American Academy of Family Physicians
 - American Board of Internal Medicine
 - American Academy of Pediatrics
 - American Academy of Ophthalmology
 - American College of Obstetricians and Gynecologists
 - California's Child Health and Disability Prevention Program
 - Health Care Effectiveness Data and Information Set (HEDIS)
 - United States Preventive Services Task Force
- 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.

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
- UM Manager
- Provider Network Manager
- Director of Provider Services
- Director of Pharmacy
- Director of Health Services Analytics
- Population Health Officer
- Director of Integrated Behavioral Health

- Manager, Long Term Services & Supports
- Manager, Prevention & Early Intervention
- Manager, Population Health
- Quality Improvement Nurse Supervisor

CQC MAJOR 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 COMMITTEE

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 Chief Medical Officer, or designee, is the chairperson. 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 QIC 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
- Care Coordination Manager
- 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
- Reviews, approves, and distributes medical criteria for review at least annually
- Monitors continuity and coordination of care
- 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 Customer Support is the chairperson.

The MEC membership includes representation from the following departments:

- Finance
- Behavioral Health & Integrated Services
- Care & Transitions Coordination
- Customer Support
- Population Health Management
- Health Services Analytics
- Marketing & Communications
- Quality Improvement
- Provider Services

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

4.1.1.6 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 Policy Letter 14-004 Full Scope Site Review Survey and Medical Record Survey Tool, and Policy Letter 12-006).

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 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

4.4 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.

4.5 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.

4.6 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 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 2022.

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 Medicare-Medicaid Plan (MMP) 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.
- The Chief Medical Officer/designee reviews the complaint and any supporting documentation, categorizes the quality of care concerns, communicates with the primary care 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 members experience with the health plan. CAHPS is conducted annually for Medicare and Medicaid . 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. The acronym "CAHPS" is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)(<https://www.ahrq.gov/cahps/about-cahps/index.html>).

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 his 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 CERVICAL CANCER SCREENING IMPROVEMENT

In 2022, HPSM Health Promotion staff will implement a new health promotion campaign focused on women's health that aligns with Marketing Communication's Staying Healthy Campaign, and supports the Quality department's goal to develop strategies with Prevention and Wellness Care Management Team that target low risk tier populations. Health Promotion staff will support the development of educational messages and scripts that will be applied in the components described below.

Program Area Goal: 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).

2022 CCS PROGRAM AREA IMPROVEMENTS

Improvements to the CCS outreach efforts in 2022 will consist of inclusion of routine cervical cancer screening in the following communication strategies:

- Website enhancements focused on women’s preventive health services
- Direct member mailings such as member newsletter and targeted mailers to subpopulations
- Social media
- Outreach script and talking points for HPSM member-facing staff, that promote routine cervical cancer screening

Cervical Cancer Screening (CCS) performance added as a payment measure in HPSM’s Pay for Performance (P4P) program for contracted Medi-Cal PCPs in the Adult and Family Practice Tracts.

8.2 BREAST CANCER SCREENING IMPROVEMENT

In 2022, HPSM Health Promotion will implement a new health promotion campaign focused on women’s health that aligns with Marketing Communication’s Staying Healthy Campaign and supports PHM’s goal to develop strategies with Prevention and Wellness Care Management Team that target low risk tier populations. Health Promotion staff will support the development of educational messages and scripts that will be applied to the components described below.

Program Area Goal: 'By Dec 31, 2022 improve the percentage of CMC women 50–74 years of age who had a mammogram to screen for breast cancer with the last two years (HEDIS BCS) from 61.93% to 64%

2022 BCS PROGRAM AREA IMPROVEMENTS

Improvements to the BCS outreach efforts in 2022 will consist of inclusion of routine breast cancer screening in the following communication strategies:

- Website enhancements focused on women’s preventive health services
- Direct member mailings such as member newsletter and targeted mailers to subpopulations
- Social media
- Outreach script and talking points for HPSM member-facing staff, that promote routine breast cancer screening

Breast Cancer Screening (BCS) performance added as a payment measure in HPSM’s Pay for Performance (P4P) program for CareAdvantage Cal-Medicconnect and Medi-Cal PCPs in the Adult and Family Practice Tracts.

8.3 BCS DISPARITY PERFORMANCE IMPROVEMENT PROJECT (PIP)

HPSM’s 2021 – 2022 Health Equity PIP focuses on reducing the breast cancer screening disparity (BCS) in African American women ages 50 – 74.. A shared objective is to convene and lead a cross-departmental team to identify HPSM system-level processes that are relevant to planning and implementing a targeted breast cancer screening intervention. Staff from HPSM’s Care Management’s Prevention and Early Intervention Team, Utilization Management, Quality, PHM, Provider Services, and Health Analytics will be active participants in the planning, implementation, and evaluation of a health equity intervention.

PIP SMART AIM: 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%.

2022 HEALTH EQUITY PROJECT ACTIVITIES AND ACTION PLAN

BCS/ ICM Outreach Program: Conduct direct outreach to members without evidence of BCS through phone calls, discussing the importance of talking to their PCP about breast cancer screening.

8.4 CONTROLLING HIGH BLOOD PRESSURE (CBP) IMPROVEMENT

The Controlling High Blood Pressure (CBP) HEDIS measure is the percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year. HPSM observed a significant decline in the in the CBP rate for both the Medi-Cal and CMC populations. HPSM attributes this decline to the effects of the Covid-19 pandemic, as healthcare utilization significantly decreased across most care types, in 2020. In particular, face-to-face outpatient visits significantly declined. While telephonic visits are possible, most of our providers did not have a way to measure blood pressure remotely even if they had telephonic visits with our members.

HPSM added automated blood pressure (BP) monitors to both our CMC and Medi-Cal formularies in July of 2021 to enable members with hypertension to be dispensed a BP monitor at the pharmacy if prescribed. BP monitors remain on the CMC forumulary in 2022. As pharmacy serviced are carved out for Medi-Cal members as of 2022, HPSM Medi-Cal members can still obtain a BP under their medical benefit as durable medical equipment (DME).

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% (CMC quality withhold benchmark).

2022 CBP IMPROVEMENT PROGRAM ACTION PLAN

HPSM will aim to conduct the following activities in 2022:

- Promote home BP monitors distribution to members with HTN to PCP.
- Create an inventory of blood pressure monitors distributed to members.
- Measure impact of home blood pressure monitoring and inform PCPs of members dispensed BP monitors.
- Educate providers of BP value reporting with CPTII codes or EMR data feeds to plan.
- Continue CBP P4P incentive and promote with PCPs to improve practice performance

8.5 INITIAL HEALTH ASSESSMENT (IHA)

The Initial Health Assessment (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 08-003) 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.

2022 ACTION PLAN

The Staying Healthy Assessment (SHA) also proves to be a difficult area for providers to comply with. Training has been developed to address this, but the additional questionnaire component in busy practices is hindering. Providers have relayed feedback that they want to modify the questionnaire along with the challenges they face when adding the questionnaire into their electronic health records. The state is aware of the issues and is in the early stages of modifying the questionnaire. Until a modification from DHCS has been made aware to the health plan, training from all touch points to the providers and/or office staff will remain a focus.

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.

HPSM QI RNs will continue to audit for IHA completion with regular Facility Site Review Medical Record Review audits. 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.

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

8.6 ADOLESCENT WELL CARE IMPROVEMENT PROJECT (PIP)

Starting in 2019, the Quality Improvement Department began implementing a performance improvement project (PIP) on Adolescent Well Care, through a collaborative effort with Sequoia Teen Health, school-based county clinic. The project aims to increase adolescent well care for our members aged 12-21 years old. Currently, through claims data, we have identified our most non-compliant members as those members aged 18-21 years old who are assigned to Sequoia Teen Health. We will aim to increase compliance by focusing on this age group. We will use key drivers and failure mode effects diagrams to assess weak points in the delivery of well care to members and develop interventions accordingly. In 2020, however, due to the pandemic, this program's starting date had to be delayed. It will continue in 2022.

PIP SMART AIM: 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%.

2022 ACTION PLAN

For 2022, adolescent well care will be a key area of focus for HPSM and based on our findings from intervention planning, we will aim to conduct the following activities:

- Develop a health education campaign for both parents and adolescents, increasing their knowledge of the importance of well care as well as services provided at no cost by the Health Plan of San Mateo.
- Develop an understanding of community-based areas where teens tend to congregate and use these areas to disseminate information about adolescent well care.
- Develop a pilot incentive program, in partnership with Daly City Youth Clinic to increase teen visits to the clinic
- Develop teen-centered approaches to well care and work with local clinics to implement these at pilot sites.

Area of Focus	QI Program	Line of Business	Project	Objectives	Planned Activities	Final Deliverable(s)	Previously Identified Issue	Responsible Party	Frequency	Start Date	Finish Date
Members' Experience	CAHPS Reporting	Medi-Cal, CMC	2022 CAHPS Summary Reports	Perform at or above the national average across all CAHPS Composite, Ratings, Prescription Drug and HEDIS measures.	Conduct CAHPS survey Summarize and report out on CAHPS 2020 findings as well as present CAHPS to HPSM staff	2022 CAHPS Summary Report Presentation; QIC Meeting Minutes Develop presentation for internal HPSM education; Develop recommendations for interventions with MEC	Timeliness of Care/Getting Care Quickly, Getting Needed Care Composite Measure, Customer Service measures were identified as opportunities for improvement.	Nicole Ford and MEC	Annually	7/1/2022	12/1/2022
Members' Experience	HOS Reporting	CMC/H7885	2022 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	Presentation for QIC		Nicole Ford	Annually	9/1/2022	12/31/2022
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	2022 Annual Quality Improvement Evaluation submit to QIC, Commission and DHCS		Nicole Ford	Annually	1/1/2022	3/1/2023
Quality of Clinical Care	PIPs	Medi-Cal	Child and Adolescent PIP - Adolescent Well Visits	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%.	Develop plan to educate teens on the importance of these visits as well as provide a potential incentive to increase well visit compliance	PHM responsible for all PIP documentation as necessary as well as member facing materials. Incentive submissions to state.	MY2020 WCV rate 48.8% Lowest compliance amongst ages 19-21 at 28.66%	PHM Team	ongoing	1/1/2021	6/30/2022
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.	•Meeting minutes for QIC will document presentation and review of clinical guidelines, Committee discussion including suggested changes and additions, and formal approval of guidelines posted on HPSM website. • Provider Newsletter will include article on Clinical Guidelines highlighting changes, if applicable, and reminder of availability on HPSM website.		Nicole Ford	Annually	9/1/2022	12/31/2022
Quality of Clinical Care	HEDIS	All	HEDIS MY2021 Project Plan	Ensure timely completion of all project deliverables by June 15, 2022.	- Create, implement and complete all project deliverables listed in the HEDIS MY2020 Project Plan. - Manage HEDIS vendor - Completion of test, production and admin runs. - Completion of MY2021 roadmap. - Completion of HEDIS production project. - Completion & Submission of IDSS. - Completion & Submission of PLD files. - Completion of chart extraction	Final submission of HPSM HEDIS data to HSAG auditors and NCQA.		Tim Shoemaker	Annually	1/1/2022	6/15/2022

Area of Focus	QI Program	Line of Business	Project	Objectives	Planned Activities	Final Deliverable(s)	Previously Identified Issue	Responsible Party	Frequency	Start Date	Finish Date
Quality of Clinical Care	PDSA	Medi-Cal, CMC	Controlling Blood Pressure (CBP) PDSA	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).	Promote home BP monitors prescriptions to members with HTN to PCP. Create an inventory of blood pressure monitors distributed to members. Measure impact of home blood pressure monitoring and inform PCPs of members dispensed BP monitors. Educate providers of BP value reporting with CPTII codes or EMR data feeds to plan. Promote P4P incentive for CBP performance	Monitor CBP rates for both LOBs monthly. Monitor PCP submission of BP values/CPTII codes. Report results out to various committees throughout 2022.	CBP measure for HPSM's members was previously identified as an issue due to rates for MY2020 under MPL (Medi-Cal) and quality withhold (CMC) benchmarks.	QI Program Specialist	Quarterly	1/1/2022	12/31/2022
Quality of Clinical Care	QIP	CMC	Improve Breast Cancer Screening (BCS) rates	By Dec 31, 2022 improve the percentage of CMC women 50–74 years of age who had a mammogram to screen for breast cancer with the last two years (HEDIS BCS) from 61.93% to 64%	Partner with Marketing Department's Staying Healthy Communication Campaign: Website enhancements focused on women's preventive health services, including recommended cancer screenings BCS measure added to 2022 P4P CMC benchmarking program as a incentive payment measure	Educational campaign content on breast cancer screening Monitor BCS rates for CMC members. Report of results to QI Committees. Monthly BCS care gap reports to assigned PCPs as part of P4P program, with annual incentive payout if performance benchmarked achieved by PCP.	Last HEDIS BCS rate (MY2020) for CMC member was below goal rate of 64%	Health Promotion Team, QI Program Specialist, Provider Network Program Specialist	Annually	1/1/2021	12/31/2022
Quality of Clinical Care	PIPs	Medi-Cal	Health Equity PIP/Improving Breast Cancer Screening (BCS) Rate for African American Women ages 50 - 74	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%	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.	PHM will successfully complete and meet timelines for submitting required PIP Modules 1 through 4 to HSAG.	Final results for RY 2020 HEDIS measures showed significant disparity is BCS rate for African American member population	Mykaila Shannon (PHM)	Quarterly	1/1/2021	12/31/2022
Quality of Clinical Care	QIP	Medi-Cal	Improve Cervical Cancer Screening (CCS) rates.	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).	Partner with Marketing Department's Staying Healthy Communication Campaign: Website enhancements focused on women's preventive health services, including recommended cancer screenings CCS added as payment measure for P4P program for Adult and Family Practice tracks	Educational campaign content on cervical cancer screening Monitor CCS rates for MC members. Report of results to QI Committees. Monthly P4P provider progress reports, annual payment based on performance	MY2020 CCS rate of 58.94% below MY2020 MPL of 61.31%	Health Promotion Team, QI Program Specialist, Provider Network Program Specialist	Ongoing	1/1/2021	12/31/2022
Quality of Service	Access & Availability	Medi-Cal	Initial Health Assessment (IHA) Compliance Improvement	Notify all contracted PCPs of the IHA and SHA completion timelines and requirements with the ending of public health emergency.	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. HPSM QI RNs will continue to audit for IHA completion with regular Facility Site Review Medical Record Review audits. 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. Continue IHA reminder insert in new Medi-Cal member welcome packets.	Quarterly IHA monitoring, monthly P4P reports on PCP performance with annual incentive payout if performance benchmarked achieved by PCP, Site Review/IHA audit CAPs if issued	MMCD 08-003	Quality Improvement Specialist, Provider Network Specialist, Tim Shoemaker	ongoing	1/1/2022	12/31/2022

2022 QI Work Plan Final

Area of Focus	QI Program	Line of Business	Project	Objectives	Planned Activities	Final Deliverable(s)	Previously Identified Issue	Responsible Party	Frequency	Start Date	Finish Date
Safety of Clinical Care	FSR	Medi-Cal	Facility Site Review, Medical Record Review	To comply with DHCS mandated credentialing 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. Prepare for lifting of Public Health Emergency and the resumption of site visits and rollout of new	Facility Site Review and Medical Record Review results are reported biannually; January 31st & July 31st to DHCS. On October 1st of each year, DHCS is notified if there are any changes to HPSM's methodology and/or benchmarks to identify high producing SPD Specialists and Ancillary Service Providers, for the purpose of performing Physical Accessibility Reviews.		Tim Shoemaker	Ongoing with Bi-annual reporting.	1/1/2022	12/31/2022
Safety of Clinical Care	FSR	Medi-Cal, CMC	Physical Accessibility Reviews	To 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, OB/GYN, 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.	Results of completed PAR reviews are provided to Provider Services which post the results in HPSM's Provider Directory, with the identified Access Level and Accessibility Indicators. A copy of the PAR results is given to the provider.	There are no correction action plan required for facility to make changes to meet the ADA requirement from the State. Outdated building and PCP offices often will meet "Limited Access" with some accessibility indicator.	Tim Shoemaker	Ongoing	1/1/2022	12/31/2022
Safety of Clinical Care	Quality of Care	All	Potential Quality Issues (PQI)	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.	All HPSM providers are trained and knowledgeable regarding the PQI process		Tim Shoemaker	Annually	7/1/2022	12/31/2022
Safety of Clinical Care	Quality of Care	All	Potential Quality Issues (PQI)	Trend potential quality of care issues of HPSM providers quarterly.	Continue to perform quarterly reports to trend potential quality issues of HPSM providers	Present trending results to CQC semiannually		Tim Shoemaker	Biannually	1/1/2022	12/31/2022
Quality of Clinical Care	QIP	CMC	Diabetes Management	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%.	Continue DM HbA1c poor control measure in P4P CMC benchmarking program as a incentive payment measure; Add data feed from Seton Hospital for regular HbA1c value capture	Monitor poor HbA1c rates for CMC members with diabetes monthly. Report of results to QI Committees. Monthly care gap reports to assigned PCPs as part of P4P program, with annual incentive payout if performance benchmarked achieved by PCP. Monthly data feed from Seton/AHM with Hb1ac values	Last HEDIS Ha1c poor control rate (MY2020) for CMC members above goal rate of 30%, where lower is better	QI Program Specialist, Provider Network Program Specialist, Director Health Services Analytics	Annually	1/1/2022	12/31/2022

2022 QI Work Plan Final

Area of Focus	QI Program	Line of Business	Project	Objectives	Planned Activities	Final Deliverable(s)	Previously Identified Issue	Responsible Party	Frequency	Start Date	Finish Date
Quality of Clinical Care	Accreditation	MC	Coordination of Care - BH and Medical	Select new measure meeting factors and document results	Identify metrics that meet factor requirements. Development and document measurement methodology as needed and initial/or current year results. Identify areas of improvement and set target improvement goals. Conduct barrier analysis for all measures. Develop improvement plan for 2 measures.	Annual report with measures selected, rationale for selection, results, set goals, barrier analyses and initial improvement plan for two measures		QI Team	Annually	1/1/2022	12/31/2022
Quality of Clinical Care	Accreditation	MC	Coordination of Care across settings and provider types	Select new measure meeting factors and document results	Identify metrics that meet factor requirements. Development and document measurement methodology as needed and initial/or current year results. Identify areas of improvement and set target improvement goals. Conduct barrier analysis for all measures. Develop improvement plan for 2 measures.	Annual report with measures selected, rationale for selection, results, set goals, barrier analyses and initial improvement plan for two measures		QI Team	Annually	1/1/2022	12/31/2022

MEMORANDUM

AGENDA ITEM: 4.7

DATE: April 13, 2022

DATE: March 28, 2022

TO: San Mateo Health Commission

FROM: Pat Curran, Chief Executive Officer

RE: Approval of Amendments to Agreements with Print and Mailing Services Vendors

Recommendation

Approve a resolution authorizing the Chief Executive Officer to execute amendments to the agreements for Print and Mailing Services. These amendments increase the expenditures for services by \$700,000. The term of the agreement remains for two years beginning January 1, 2021 through December 31, 2022.

Background and Discussion

HPSM performs a large volume of print and mailing services to meet State and the Centers for Medicare and Medicaid Services (CMS) requirements for printed hard copies of important informing materials to be mailed to the Plan's 145,000 members and more than 900 providers.

HPSM handles the printing, packaging and mailing of materials through a combination of internal staff resources and contracted vendors. Many years ago, HPSM invested in a small number of large, high-volume printers to handle print jobs that are more efficiently done internally, especially simple letter notices about key program changes. HPSM Administrative staff print and process these materials.

HPSM has been using multiple print and mailing vendors to provide services that would give HPSM more flexibility to choose the vendor that best fits timeline and delivery requirements as well as cost considerations and allowed HPSM to obtain competitive pricing for certain print jobs. In December 2016, the Commission approved a waiver of the Request for Proposal (RFP) process and agreements with print and mailing vendors DOME, KPLLC, AMP and Giant Horse for a period of 2 years beginning January 1, 2017. In December 2018, the Commission approved another waiver for two more years beginning January 1, 2019 for the two primary vendors at that time, KPLLC and Folgers. In 2020, the Commission approved \$1,737,400 for printing services provided by Folgers, KPLLC and a new provider which was to be identified through an RFP.

Due to new programs including Cal-AIM, Dental, Pharmacy and D-SNP, the cost of contracted printing increased significantly. While departments actively worked together to anticipate these costs to HPSM, the costs were much higher than anticipated. We are asking the Commission to approve amendments to increase the current agreements by a total of \$700,000.

Fiscal Impact

HPSM 2021-22 expenditures with vendors for print, processing and postage were requested to be budgeted for \$1,737,400. This request to add \$700,000 would increase the total cost of the agreements to \$2,437,400. The agreements will be with KPLLC, FolgerGraphics and Clarity, the new vendor identified from the RFP. In total, the sum of the agreements with all three collectively would be for a total amount not to exceed \$2,437,400 for the full two year term.

DRAFT

**RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION**

**IN THE MATTER OF APPROVAL OF AMENDMENTS TO
AGREEMENTS FOR PRINT AND MAILING VENDORS:
KPLLC, FOLGERGRAPHICS AND CLARITY**

RESOLUTION 2022 -

RECITAL: WHEREAS,

- A. HPSM does a large volume of print and mailing services to meet requirements from the State and the Centers for Medicare and Medicaid Services (CMS) to mail printed hard copies of important informing materials to members and providers; and
- B. Multiple print and mailing vendors give HPSM more flexibility to choose the vendor that best fits timeline and delivery requirements as well as cost considerations, and allows HPSM to obtain competitive pricing for certain print jobs; and
- C. In recent years, HPSM has been using KPLLC and FolgerGraphics as the primary outsourced print vendors, and in 2021, through an RFP, has added Clarity.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

- 1. The San Mateo Health Commission approves amendments to the current agreements to add \$700,000 to meet the current print demands for a total print and mailing budget to be allocated among the three vendors in an amount not to exceed \$2,437,400 for the full two year term ending December 31, 2022; and
- 2. Authorizes the Chief Executive Officer to execute said amendments.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of April 2022 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

Don Horsley, Chairperson

ATTEST:

APPROVED AS TO FORM:

BY: _____
C. Burgess, Clerk

Kristina Paszek
DEPUTY COUNTY COUNSEL

MEMORANDUM

DATE: March 31, 2022
TO: San Mateo Health Commission
FROM: Patrick Curran, Chief Executive Officer
RE: Waive Request for Proposal Process and Approval of Amendment to Agreement with Progressive Discoveries to continue supporting HPSM diversity, equity and inclusion efforts

Recommendation

Approve a waiver of the RFP process and approve an amendment to extend the agreement with Progressive Discoveries originally implemented in August 2021 to extend through June 30, 2023; and, adding \$185,000 for a total amount not to exceed \$285,000.

Background and Discussion

HPSM first contracted with Janet Williams in April 2021 to perform an organizational assessment of the current state of diversity, equity, and inclusion at HPSM. For that assessment, Janet reviewed documentation, conducted individual interviews, focus groups, and presented her recommendations to HPSM leadership in the summer of 2021.

HPSM entered into phase 2 of the agreement with Janet Williams in August 2021 to help HPSM implement the recommendations in her proposal, which included development of a steering committee and guiding that committee to further this work throughout the organization.

This extension through March 2023 allows Janet to continue supporting the steering committee, as well as the CEO and HPSM Leadership, to form structures that will endure and evolve to promote a work environment at HPSM that celebrates diversity, promotes equity, and creates a sense of belonging for every employee regardless of their background and lived experience.

Fiscal Impact

The original scope of work included an assessment of diversity, equity, and inclusion at HPSM and was extended to implement a steering committee. The contract amount so far is \$100,000. This amendment will increase the agreement by \$185,000 for a total amount not to exceed \$285,000 for an updated contract term ending June 30, 2023.

DRAFT

**RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION**

**IN THE MATTER OF APPROVAL OF WAIVER OF RFP
PROCESS AND AMENDMENT TO AGREEMENT WITH
PROGRESSIVE DISCOVERIES**

RESOLUTION 2022 -

RECITAL: WHEREAS,

- A. HPSM is committed to having a work environment that promotes diversity, equity, inclusion, and belonging;
- B. HPSM currently uses the service of Progressive Discoveries to provide consultation and guide these efforts;
- C. Progressive Discoveries is uniquely qualified for this consulting agreement based on the knowledge and experience of Janet Williams, as well as the trust and respect engendered by HPSM staff in her work.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

- 1. The San Mateo Commission approves an amendment to the agreement with Progressive Discoveries to extend the agreement through June 30, 2023;
- 2. Approves a waiver of the Request for Proposal (RFP) process; and
- 3. Authorizes the CEO to execute an amendment to add \$185,000 to the agreement with Progressive Discoveries for a contract maximum of \$285,000.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of April 2022 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

Don Horsley, Chairperson

ATTEST:

APPROVED AS TO FORM:

BY: _____
C. Burgess, Clerk

Kristina Paszek
DEPUTY COUNTY COUNSEL

DRAFT

SAN MATEO HEALTH COMMISSION
Meeting Minutes
February 9, 2022 – 12:30 p.m.

AGENDA ITEM: 4.9

DATE: April 13, 2022

****BY VIDEOCONFERENCE ONLY****

Important notice regarding COVID-19: Based on guidance from the California Department of Public Health and the California Governor’s Office, in order to minimize the spread of the COVID-19 virus, Health Plan of San Mateo offices were closed for this meeting, and the meeting was conducted via online meeting/teleconference. Members of the public were invited to submit public comment via email to the Clerk in advance of the meeting or express public comment throughout the meeting and were able to access the meeting using the web and teleconference information provided on the meeting notice.

Commissioners Present: Jeanette Aviles Bill Graham
Michael Callagy Barbara Miao
David J. Canepa George Pon, R. Ph.
Teresa Guingona Ferrer Kenneth Tai, M.D.
Si France, M.D. Ligia Andrade Zuniga, Chair
Don Horsley, Vice-Chair

Commissioners Absent: None

Counsel: Kristina Paszek

Staff Present: Luarnie Bermudo, Chris Baughman, Corinne Burgess, Pat Curran, Joy Deinla, Trent Ehrgood, Chris Esguerra, M.D., Karen Fitzgerald, Nicole Ford, Ian Johansson, Teresa Kopp, Francine Lester, Richard Moore, M.D., Colleen Murphey, Megan Noe, Amy Scribner, Vick Shaker, Vicki Simpson, Katie-Elyse Turner, April Watson, and Eben Yong.

1. Call to order/roll call

The meeting was called to order at 12:33p.m. by Chair, Commissioner Horsley. A quorum was present.

2. Public Comment

Commissioner Horsley announced that Commissioner Teresa Guingona Ferrer will be leaving the commission, and this will be her last meeting. Commissioner Horsley extended gratitude for her years of service and wished her well.

Commissioner Horsley opened the floor for any public comment. The clerk of the commission instructed those with public comment on using the raise hand feature in Teams to indicate their desire to make public comment. No other public comments were received via email or

verbally made at this time.

[Commissioner Canepa arrived at this time]

3. Approval of Agenda

Motion to approve the agenda as presented: **Pon / Second: Graham**

Verbal roll call vote was taken:

Yes: 10 – Callagy, Canepa, Ferrer, France, Graham, Horsley, Miao, Pon, Tai, Zuniga.

No: 0

4. Approval of Consent Agenda

Motion to approve the Consent Agenda as presented: **Pon / Second: Graham**

Verbal roll call vote was taken:

Yes: 10 – Callagy, Canepa, Ferrer, France, Graham, Horsley, Miao, Pon, Tai, Zuniga.

No: 0

5. Specific Discussion/Action Items

[Commissioner Aviles arrived at this time]

5.1 Appointment of Chief Executive Officer

Commissioner Horsley announced that the San Mateo Health Commission has been working over the past few months towards a selection of a new CEO following the retirement of Maya Altman in December. Less than a quorum of commissioners was gathered to form an Executive Search Committee and enlisted the services of an executive search firm to help identify qualified candidates for this position. Commissioner Horsley was pleased to announce that through this process, Mr. Patrick Curran has been selected and is recommended for final approval by the commission as the Chief Executive Officer with an annual salary of \$440,000 including the standard benefits for Health Plan of San Mateo employees.

Commissioner Horsley opened the floor for any public comment, and the clerk of the commission instructed on using the raise had feature to be recognized for public comment. Hearing none, Commissioner Horsley asked for the motion.

Commissioner Miao moved approval of the recommendation to appoint Patrick Curran to the position of Chief Executive Officer as stated: **Miao / Second: Callagy**

Verbal roll call vote was taken:

Yes: 11 – Aviles, Callagy, Canepa, Ferrer, France, Graham, Horsley, Miao, Pon, Tai, Zuniga.

No: 0

5.2 Member Health Equity Presentation

Mr. Curran introduced Teresa Kopp, Health Equity Program Manager, and Megan Noe, Quality Improvement Manager. Ms. Kopp gave an update on the Health Equity for HPSM members. The presentation reviewed is attached to these minutes.

Ms. Noe explained this history of the work leading to Health Equity which had its beginnings with the health plans Culturally and Linguistically Appropriate Services (CLAS) Program. CLAS included language assistance services and interpreter services which were provided telephonically, via video, and in person and made available to HPSM members during medical appointments and when interacting with health plan staff. Education opportunities for staff and our providers through CLAS has evolved into our broader Health Equity strategy. Staff is working to go beyond the standalone CLAS program elements to build a strategy or way of approaching our member-focused work across the organization. The aim is to address health inequities and increase access.

Ms. Kopp began by reviewing the demographics of the members served by the health plan by line of business, language preferences and gender to begin our discussion around our Health Equity strategy. About 80% of HPSM members are in the Medi-Cal line of business. Almost 90% of HPSM members across all lines of business speak either Spanish or English. This data is used as part of a process of designing health interventions in the areas where we'd like to improve or consider more closely in our process. She reviewed what the health plan is doing in this effort and spoke about the work being done to identify health disparities and interventions through community input either from HPSM members or community partners and evaluating the outcomes.

Ms. Kopp continued her review speaking about Culturally Inclusive Care approaches, noting policies and supports for people to create a culturally inclusive environment and an ongoing process of reflecting on our own culture are in place. She walked through the culturally inclusive care work streams, which is a combination of cultural humility and cultural competency. These work streams are around regular staff training, with special attention towards member-focused staff. Staff is creating resources and tools to support providers in creating culturally inclusive environments for members. There is also focus on what we can do as an organization by continuing to scope and potentially pursue multicultural health care distinction, and review discrimination related grievances to understand how we can integrate what we're hearing from members at the grievance level.

Ms. Kopp described the work related to Linguistically Appropriate Services consisting of interpreter and translation services, and how we approach providing these. This includes training tools and resources much like culturally inclusive care, but specific to linguistically

appropriate services. This entails reviewing and updating manuals, policies and procedures, and monitoring evaluation with attention to regulatory requirements to improve our systems organization-wide in supporting our members from the linguistic standpoint.

Moving on to community partnerships, Ms. Kopp reviewed some of the key partners involved with developing the health equity strategy. The plan is to share our strategy with them in order to receive their input and check in with them regularly.

Lastly, Ms. Kopp touched on health equity oversight, which is where the Commission plays a role. The health plan has several committees, including the Clinical Quality Committee, Quality Improvement Committee, and Member Experience and Engagement Committee. These committees partner closely and will include the new Diversity & Inclusion Committee (formerly JEDI).

Commissioner Graham thanked Ms. Kopp for this work and asked how hospitals can partner with the health plan in this area. Ms. Kopp stated staff is continuing to explore the area of providers, community based organizations and other groups working with our provider services on how to grow in this area. Commissioner Graham stated that this work being done is something that can be learned from and he is open to the opportunities it provides.

Commissioner Pon asked how these interpreter services are provided. Ms. Kopp confirmed they are provided through a vendor. Commissioner Ferrer commented that the linguistically translated services also need to be aware of the cultural component and nuances of culturally appropriate terms. Ms. Kopp stated that our vendor does consider the context of the conversation and is sensitive to cultural elements. She will look further into how this can be audited in the evaluation process. She added that on the strategy level, staff will be considering how to reach out for more community input including the Office of Diversity and Equity at BHRS, and others.

Commissioner Zuniga asked about strategies to engage indigenous communities in our area. Ms. Kopp stated this is one of the areas they are looking into as one of their goals. Staff is developing health interventions as health disparities are identified. Commissioner Zuniga asked about the youth population and engaging them to be responsible for their health, especially in our communities of color. Ms. Kopp stated we have health interventions that are youth focused and have been intentional around age and age representation.

5.3 Annual Compliance Report

Mr. Ian Johansson, Chief Compliance Officer, shared his presentation to give a report on the Compliance Program at HPSM and activities throughout 2021. His presentation is attached.

Mr. Johansson explained that the goal of the Compliance Program at HPSM is to help employees and commissioners to do the right thing. Guiding requirements help inform the development of the program and the compliance department supports stakeholders, staff, and the regulatory agencies outside of the organization. We are required to maintain a formal written compliance program which is reviewed and approved by the commission annually, as well as annual compliance trainings.

Mr. Johansson reported that last year the staff had many audits to perform within the last six months of the year. These included the Department of Managed Health Care (DMHC) financial audit and medical audit, and the Department of Health Care Services (DHCS) medical audit. In addition, staff was preparing the NCQA survey at the same time. We know that this will recur in three years so staff is looking ahead in preparation for this.

During all of these audits, staff was also tasked with implementation activities related to Cal AIM and the Dental integration. Of course, there were other impacts due to staff working from home for the second year due to COVID. He commented that HPSM staff are amazing and have adapted to all of this work from home connecting with one another behind the scenes, presenting material and answering questions in a way to satisfy regulators.

Results from the DMHC audits produced five findings which were resolved after receipt of the draft report and were then closed out to their satisfaction. This means we will not hear from them for another three years. However, the DMHC medical audit is still open as it can take them to 180 days to provide us with a draft report. Typically, whatever DMHC findings are rendered will be mirrored by DHCS. However, it will take a couple of months before we receive this information. Mr. Johansson will present any findings to the commission at a future meeting after they are received.

The last DHCS medical audit was performed two years ago so the review period was for 2020 and 2021. The issues identified were process issues and not of any significance. The corrective action plan (CAP) was submitted to DHCS which consisted of retraining opportunities and the work to remediate them has already begun by staff.

The NCQA survey results have not yet been received and we will have a follow up on what they call “Not Met, Must Pass” elements. More details on this are expected later this year. Out of the six categories of review, HPSM passed five and hope to have passed the one

outstanding element by the time of the final report. At this time, we have provisional status, meaning our NCQA accreditation status is maintained but some gaps will need to be closed.

Activities expected for 2022 include:

- The annual DHCS medical audit
- A CMS audit, which we have not had for six years
- Submittal of our D-SNP application
- Work on our Enhanced Case Management, Phase 2 changes which will result in more audits

Mr. Johansson concluded that he will talk more about mitigation activities, what is happening with corrective actions, and how staff is working to better position the health plan to respond to future audits and other impacts on the organization in a future report to the commission. He will also talk about the Compliance Effectiveness Survey results, compliance investigation performance, and the kinds of risks we are seeing.

Commissioner Horsley asked who is responsible for the response when there is a finding that requires a corrective action plan. Mr. Johansson explained that the Compliance Department works in collaboration with the respective unit or department. This way, Compliance can ensure the action is sustainable and meets the requirements. Sometimes, we will engage with DHCS in the form of technical assistance and they will share best practices.

6. Report from Chairman/Executive Committee

Commissioner Horsley had nothing to report from the Executive Committee, however, he gave Commissioner Ferrer the opportunity to comment on her resignation from the commission.

Commissioner Ferrer stated this was a difficult decision, but family matters have led her to move in this direction. She leaves knowing that the health plan and commission are in capable hands. She is confident in the work being done by the commission and staff related to Health Equity. She thanked commissioners for their individual impacts on her experiences on the commission over the years. She thanked staff for their work and support.

7. Report from Chief Executive Officer

Mr. Curran acknowledged staff on the NCQA survey work and audits that Mr. Johansson reported on today, and the implementation of the Dental Program.

He welcomed Dr. Michael Okuji, HPSM's new Dental Director. He commented on the challenges of dental access, but noted staff are making referrals every day, patients are getting care, and members are calling us for help with dental care for the first time ever. We are not experiencing

issues for access for children around preventive care but adult care is presenting a challenge. Adults who have been receiving care in the community were paying out of pocket; and there is a pent up demand for adults who have not received any care. Staff is working through securing more access for adults.

The Pharmacy Carve Out has begun and Ming Shen, HPSM's Pharmacy Director, has become a statewide leader and expert in this space. He has identified issues before they happened and is providing constructive suggestions to the state. Commissioner Aviles expressed gratitude for our clinicians for the work around pharmacy and noted that this is having a deep impact on our patients.

Mr. Curran shared slides to review the issue related to the state's proposed contract with Kaiser. He explained the current contractual arrangements with health plans in the various counties throughout California: some have competition among many plans, some have a two-plan model, and then those such as HPSM that are county organized health systems (COHS). This proposed contract between DHCS and Kaiser would be a direct agreement and would change the existing models. He explained how currently Kaiser members are assigned to HPSM, which we then assign to Kaiser through a pre-existing relationship the member has with Kaiser (Permission To Enroll). Most responsibilities for these members are delegated to Kaiser through this arrangement, however, not all. For example, dental, long term care and behavioral care are not delegated to them. As such, they are an integrated system, but participate in broader programs through HPSM.

Commissioner Miao asked about the member assignment process under this arrangement with Kaiser. Mr. Curran stated that members would be assigned directly to Kaiser and HPSM would not have any oversight of these members. The implications of the member assignment process are still unknown.

Commissioner Graham asked about the approval process of this proposal. Mr. Curran stated that there appears to be pre-existing authority to do this in non-COHS counties. In the COHS counties, it appears they will need additional approval through the legislature and CMS, but this has not yet been confirmed.

Commissioner Tai asked how many members are currently assigned to Kaiser through HPSM. Mr. Curran answered that it is approximately 8,000 but has been as much as 9,000 and this arrangement has worked for many years where members enroll with HPSM and then if they have a pre-existing relationship with Kaiser, HPSM presents these members to them for acceptance. Commissioner Miao asked how many members would be affected by this new contractual arrangement. Mr. Curran stated that he does not have numbers on this however the proposal indicates that Kaiser would be open to taking up to 25% more members, but this is statewide and may not reflect what would be expected locally. What Kaiser has stated is they

would grow in new Medi-Cal service areas in which they have existing business, foster children and dual eligible members.

Mr. Curran talked about some of the implications of this arrangement affecting local oversight of these members. It also sets a precedent of ending the COHS model, which has been in place for decades and could be the onset of dis-integration by duplicating contracting of services in the community rather than through HPSM. This includes services such as dental, long-term care, MSSP, CBAS and Community Supports, none of which Kaiser currently provide. The main issue is the change to the model and the impacts.

Mr. Curran's recommendation to the commission is that the organization oppose this direct contract because of the impact to the COHS model and the way this was done without any local involvement. This opposition would mean reaching out to state representatives, county officials, and community partners to present this position and seek support for the COHS model. We do not know what the impacts would be financially or operationally for HPSM, nor the implications for other stakeholders.

Commission Horsley explained this was not an action item on the agenda and County Counsel, Kristina Paszek stated that the commission could give staff direction only at this time. After discussion and opinions shared, the Commission directed staff to talk to our local health plan associations and consider how to oppose this arrangement. Mr. Curran stated he would keep the Commission abreast of any developments as this issue continues to evolve.

Colleen Murphey, Network and Strategy Officer, gave a brief update on the activities around the pandemic and the surge over the last couple of months. Her presentation is attached. Ms. Murphey talked about the focus on boosters and vaccinations in the month of December. County Health was able to reach nearly 100% of residents in congregate settings with vaccinations, including many staff in the nursing facilities. She touched on the Centers of Excellence, which were put into place earlier in the pandemic, and how that experience helped to quickly implement during the recent surge. HPSM put reimbursement arrangements in place to make sure cost would not be a barrier to getting people into needed isolation. These experiences have given way to being more prepared for future potential surges if they should strike as we continue the efforts towards boosters and vaccines.

8. Other Business

No other business was discussed.

9. Adjournment

The meeting was adjourned at 2:04 p.m.

Respectfully submitted:

C. Burgess

C. Burgess, Clerk of the Commission

HPSM's Draft Health Equity Strategy

*Attainment of the highest level of
health for all people.*



Health Equity Strategy Overview



- Health Equity Journey
- Program Structure
- HPSM Membership Demographics
- Strategy Process
- Focus Areas
- Oversight

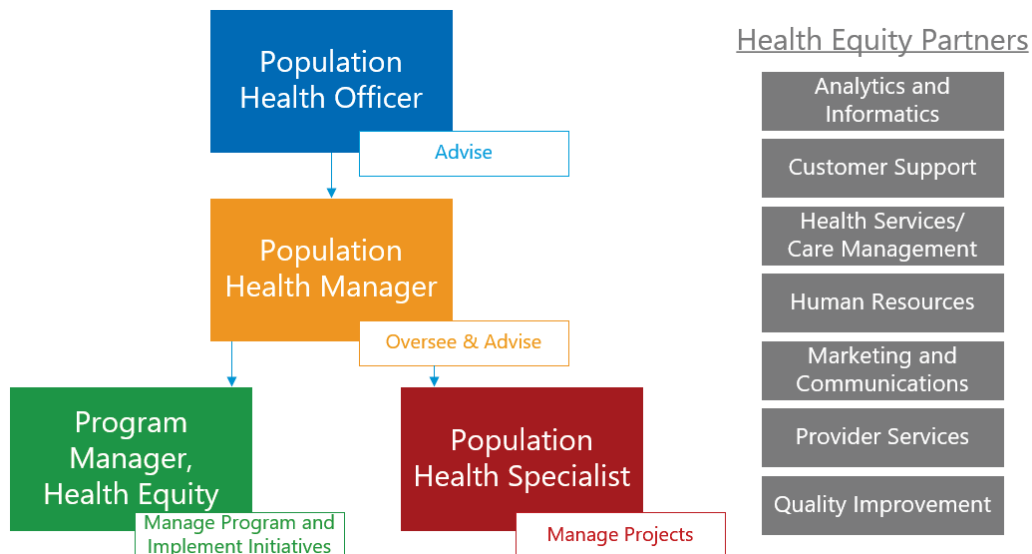
Health Equity Journey



- Culturally & Linguistically Appropriate Services (CLAS) Program
 - Language Assistance Services
 - Cultural Humility/Awareness Education for HPSM Staff and Provider Network
- CLAS Program is evolving into broader Health Equity Strategy
- Hired Health Equity Program Manager in July 2021
 - Role imbedded within the Population Health Management (PHM) team
- Health Equity Strategy is Member focused
- Broader organizational culture work focused on Diversity, Equity, Inclusion and Belonging underway as well, stay tuned for presentation on those efforts in April

3

Health Equity Organizational Structure

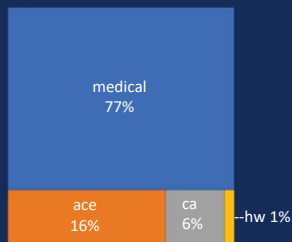


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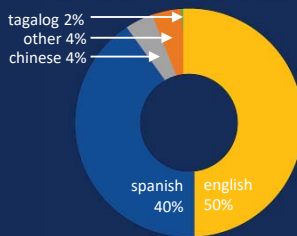
HPSM Member Demographics 2020

TOTAL MEMBERSHIP: 150,212

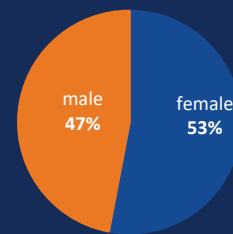
LINE OF BUSINESS



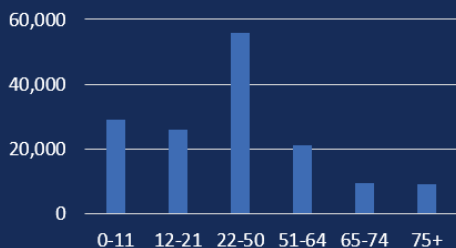
LANGUAGE PREFERENCE



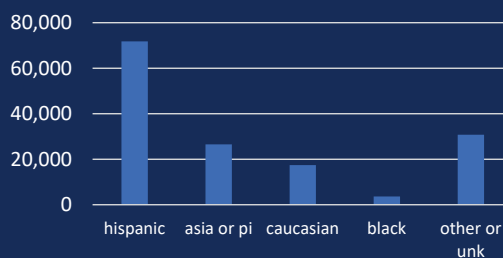
GENDER



AGE



RACE & ETHNICITY



Building the Health Equity Strategy



Programmatic and Regulatory Landscaping

- Gather input on current health equity programming and organizational priorities
- Identify regulatory requirements

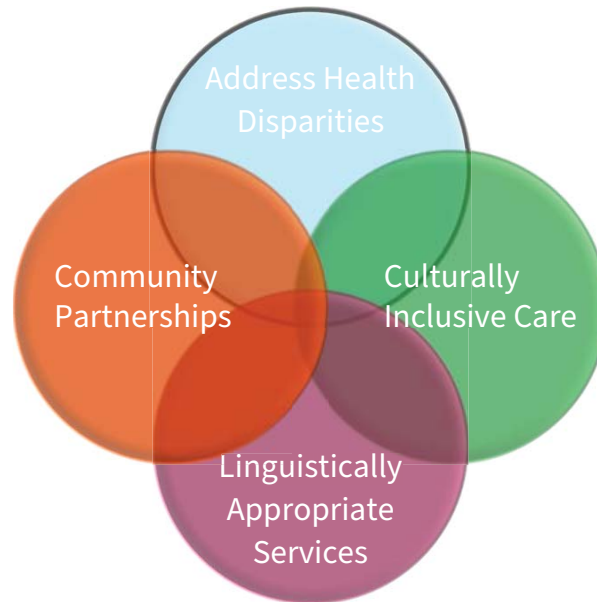
Input and Alignment

- Gather input from staff, leadership, and community partners
- Continue to ensure alignment between member and workforce equity efforts

Operationalizing, Implementing and Iterating

- Develop workplan to operationalize key workstreams
- Implement and evaluate health equity efforts
- Review strategy regularly to update and revisit key approaches

Health Equity Focus Areas



7

Addressing Health Disparities

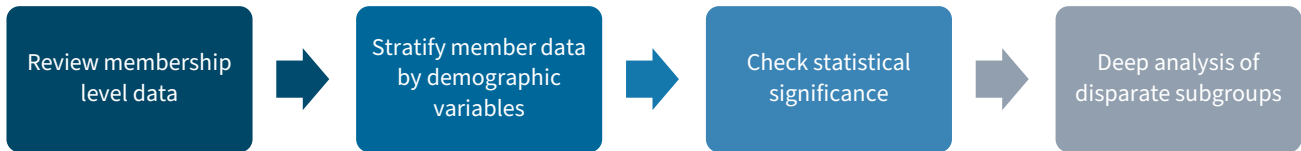
Health disparities are inequitable and are directly related to the current and historical unequal distribution of social, political, economic, and environmental resources.

Work Streams:

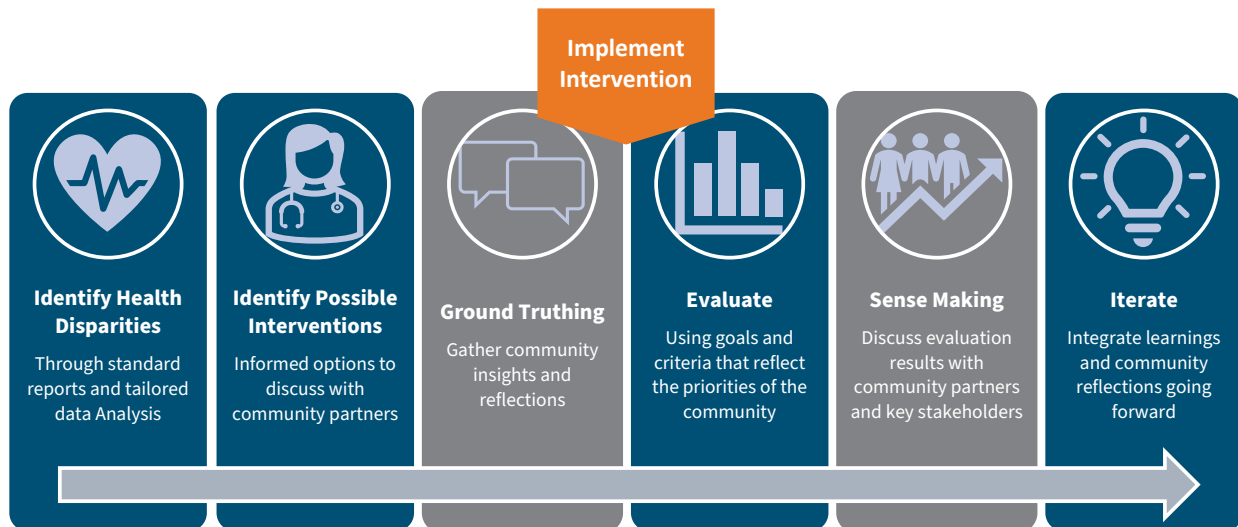
- Continue to identify health disparities through the **Population Assessment** and introduce new efforts to identify additional health disparities.
- Design and implement **initiatives** aimed at reducing health disparities.
- Continuous improvement of **data collection and technology infrastructure**.
- **Establish task forces** with both internal and external stakeholder to support developing interventions.

8

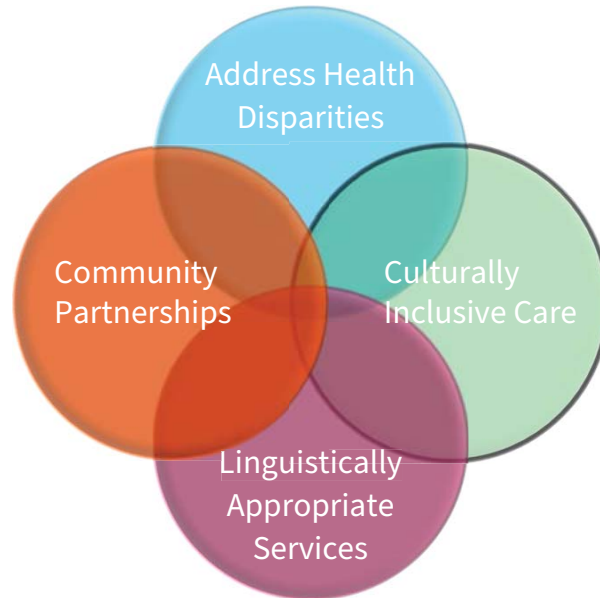
Identifying Health Disparities



Addressing Health Disparities



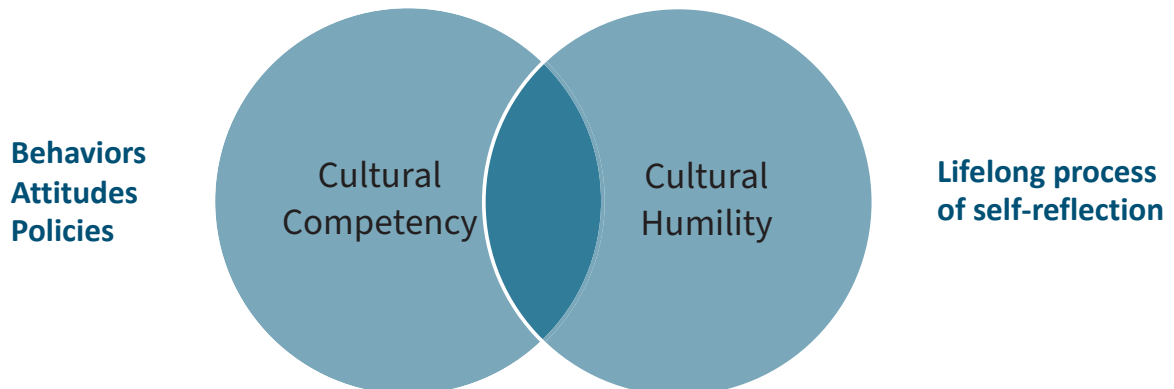
Health Equity Focus Areas



Culturally Inclusive Care Approach



Support HPSM staff and providers to engage in ongoing self-reflection on dimensions characterized by inequitable power, privilege, and injustice that affect the health and well-being of members and to develop the skills to navigate cultural differences.



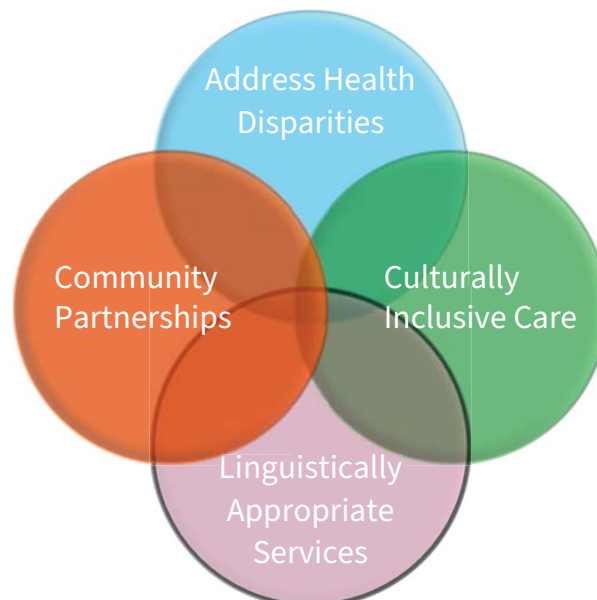
Culturally Inclusive Care

Work Streams:

- Regular **staff trainings** focused on creating a culturally supportive environment for members.
- Create **resources and tools** to support HPSM staff in providing culturally inclusive care.
- Partner with Provider Services to create **trainings, tools, and resources** helping Providers offer a culturally supportive environment for members.
- Continue to scope the **Health Equity/Multi-Cultural Healthcare Distinction**.
- Review **discrimination-related grievances**.

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Health Equity Focus Areas



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Linguistically Appropriate Services

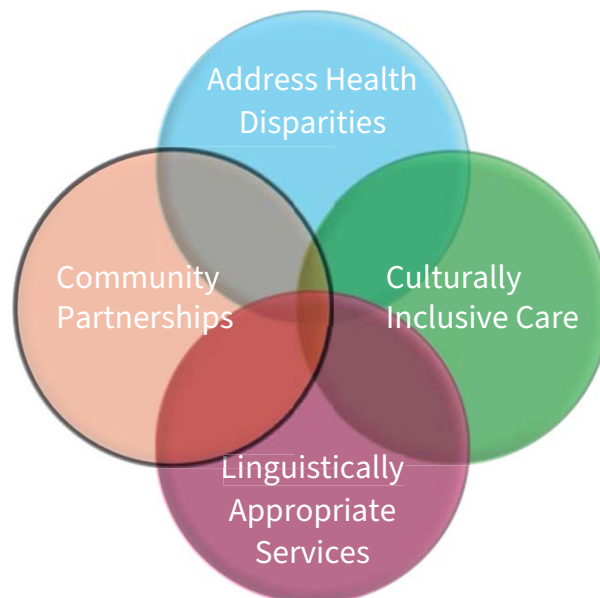


The shared ability to communicate is part of a patient-centered approach to healthcare.

Workstreams:

- Update **training, tools, and resources** for providers and HPSM's member-facing staff.
- Update process **manual, policies and procedures, and monitoring and evaluation** practices for interpreter services.
- Improve systems for **organization-wide oversight** of LAS.

Health Equity Focus Areas



Community Partnerships



Key Informants on Health Equity Strategy:

- San Mateo Pride Center
- Get Healthy San Mateo County
- BHRS Office of Diversity and Equity

Work Streams:

- Gather strategy input from Community Partners
- Develop **regular check ins and participate in community calls** with these and other partners as it relates to health equity.
- Engage community partners in **health disparities data analysis and intervention planning**.

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Health Equity Oversight



Regular Health Equity updates are provided to HPSM leadership. Oversight is provided through the committee structure.

Depending on the topic, health equity reports and updates are provided regularly to:

- Health Commission
- Clinical Quality Committee (CQC)
- Quality Improvement Committee (QIC)
- Member Experience and Engagement Committee (MEC)
- Diversity and Inclusion Committee (*workforce focus, formerly JEDI*)

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Questions

Teresa.Kopp@HPSM.org
Program Manager, Health Equity

2021 Annual Compliance Report

Ian Johansson, Chief Compliance Officer

February 9, 2022



Background



- **Status & Activities**

- Annual report provides an operational summary of HPSM's Compliance Program (prior year)
- Enables Commissioners:
 - To be knowledgeable about the operation of the program,
 - To exercise reasonable oversight with respect to the implementation and effectiveness of the program

Our Goal



- To establish a culture of compliance at HPSM that helps the organization and its employees “do the right thing”
- Achieved through:
 - Maintaining and implementing a Compliance Program
 - Educating our employees
 - Identifying and resolving compliance risks
 - Providing opportunities to engage our staff and stakeholders

3

Agenda



- 2021 - Year in review
 - Major activities
 - Risks & status
- 2022 – Outlook
 - Major Activities

4

2021 Risk Review



- External Audit activity
 - Four (4) external audits conducted
 - Department of Managed Health Care (DMHC) Financial Audit
 - DMHC Routine Medical Audit
 - Department of Health Care Services (DHCS) Medical Audit
 - National Committee for Quality Assurance (NCQA) Survey

5

2021 Risk Review



- Implementation Activity
 - CalAIM Phase One (1)
 - Enhanced Care Management (ECM)
 - In-Lieu of Services (ILOS) – now Community Supports
 - Medi-Cal Dental Benefit Integration

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2021 Risk Review



- COVID-19 Impacts
 - Second year of Work-from-Home (WFH)
 - Impacts of COVID-19 waves on health care system
 - Delta
 - Omicron
- Organization wide
 - Overlap of audit & implementation activities

7

2021 Outcomes



- Activities
 - DMHC Financial Audit
 - Five (5) findings
 - Incorrect date used for interest calculation; Timeliness of Provider Dispute Resolutions (PDR); Fidelity Bond language; Filings for Changes to Plan Personnel; Filings for Provider Contracts
 - Status: RESOLVED / CLOSED

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2021 Outcomes



- Activities
 - DMHC Medical Audit
 - Pending draft report
 - Status: OPEN

9

2021 Outcomes



- Activities
 - DHCS Medical Audit
 - 17 findings
 - Notification of key staff changes; Notice of Action content; Coordination with BHRS; Medical Record Documentation; Prior Authorization Requirements; Provider Enrollment; Provider Training; FWA Reporting
 - Status: OPEN
 - Corrective Action Plan (CAP) submitted

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2021 Outcomes



- Activities
 - NCQA Survey
 - Pending final report
 - File review of not-met, must-pass elements later in 2022
 - Passed five (5) of six (6) categories of review
 - Status: OPEN

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2022 Forecasting



- NCQA resurvey activity
- DHCS annual medical audit
- CMS Compliance Program Effectiveness (CPE) audit
 - Six (6) years since last audit
- DSNP development
- CalAIM ECM Phase Two (2)

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Next Update



- Mitigation Activities for 2022
- 2022 Compliance Effectiveness Survey Results
- 2021 Compliance Investigation Performance
- 2021 DMHC Medical Audit Results

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Questions?



- Contact me @
 - 650-616-2151
 - ian.johansson@hpsm.org
- Hotline available 24/7
 - 844-965-1241

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Thank You



Implications of Kaiser Direct Contract

Oversight: Eliminates local oversight over the approximately 8,000 Kaiser members currently assigned through HPSM.

Precedent: Ends the County Organized Health System (COHS) model, which has been in place for decades, setting the precedent for the state to make other changes to the health care delivery model without local input.

Dis-integration: Kaiser would need to contract separately for an array of services in the community rather than through HPSM, including dental, behavioral health, long-term care, MSSP, CBAS, and Community Supports.

Recommendation

HPSM opposes the direct contract with Kaiser because it is a fundamental change to the COHS model that is being done without local stakeholder involvement, including the San Mateo Health Commission.



Contact state representatives, county officials, and community partners to present the HPSM position and seek support.



Work through LHPC (our statewide association) and with other supportive organizations to advocate that any proposed change to the COHS model, whether through trailer bill language or other form, must have local stakeholder input and approval.



San Mateo Health Commission Update – COVID-19 Response Efforts

2/9/2022

COVID-19 Response Updates

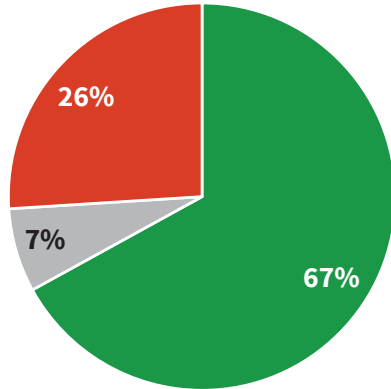


- HPSM Member Vaccination Focus
- Surge Response: Provider Collaboration

Total Eligible Members Vaccine Status

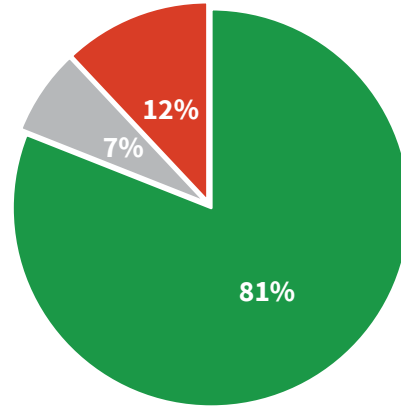


Vaccine Status for HPSM Members Age 5+



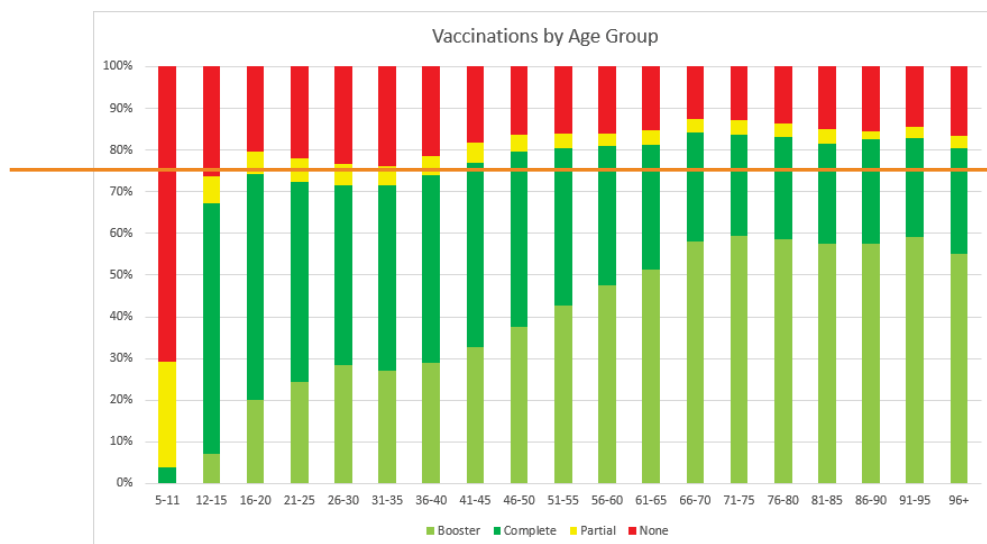
■ Complete ■ Partial ■ None
 HPSM data as of 2/4/2022 (some data lag may be impacting #s)

Vaccine status for San Mateo County



SMCH data as of 2/3/2022

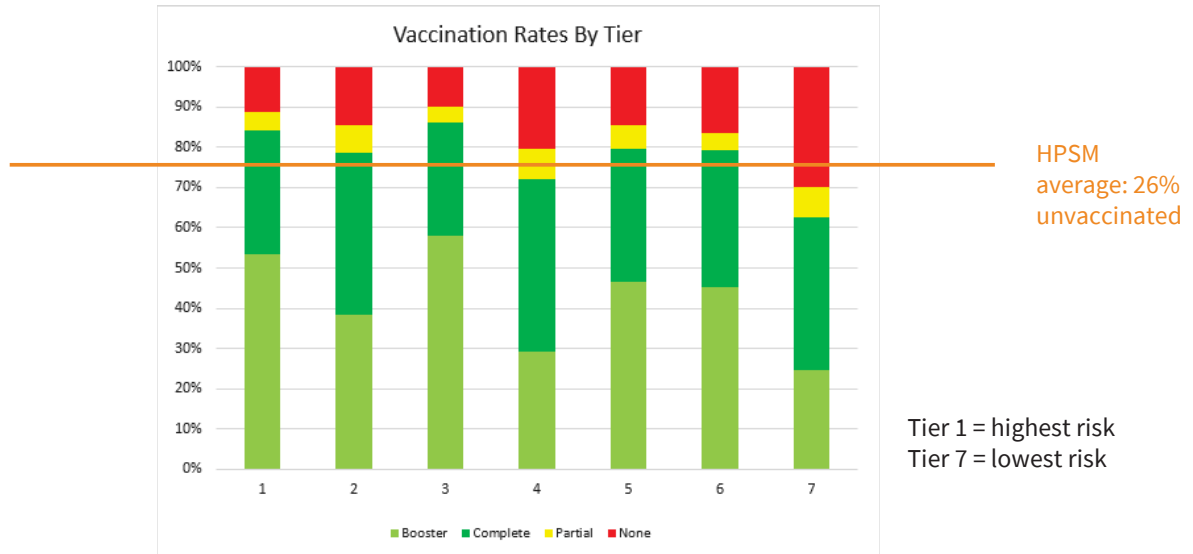
Focus area: pediatric members



HPSM average: 26% unvaccinated

HPSM data as of 2/4/2022 – note that data lag may be underreporting on vaccination numbers, particularly for recently-eligible younger members

Focus area: boosters for high risk members



HPSM data as of 2/4/2022 – note that data lag may be underreporting on vaccination numbers, particularly for recently-eligible younger members

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Supporting acute & post-acute providers during the surge



- **December:** outreach to all facilities to confirm vaccine and booster rates for residents and staff at congregate care; close to 100% of eligible members boosted prior to surge
- **January:** focused on reducing bottlenecks:
 - Held a Bay Area convening of hospitals and SNFs with 70 attendees from ~25 SNFs and Hospitals, attended by San Mateo County Health leaders:
 - Clarified complex admissions/cohorting guidance in coordination with public health authorities and clinicians, to reduce confusion as a barrier for facilities accepting admissions
 - Amplified information about MHOAC messaging and County Health resources available
 - Established two Centers of Excellence (San Bruno Skilled and Serenethos)
 - HPSM staff provided additional after-hours support for transitions
- **Ongoing reimbursement support:**
 - Additional reimbursement to support isolation costs when needed for long-term care members
 - Parity in reimbursement for Medi-Cal and CareAdvantage members needing skilled level of care to remove barrier to access based on line of business

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Surge response: learning collaborative attendees



Post Acute Facility Attendees:

- Grant Cuesta
- Jewish Home
- Millbrae Skilled Care
- Pacifica Nursing & Rehab
- Linda Mar Rehab
- SMMC 1A SNF
- Seton Coastside
- St. Anthony & St Christopher Care Center
- Atherton Post-Acute
- Brookside Skilled Nursing
- Burlingame Skilled Nursing
- Carlmont Gardens
- Peninsula Post-Acute
- San Bruno Skilled Nursing
- Golden Heights
- Golden Pavilion
- Pacific Heights Transitional Care
- City Post Acute
- Hearts & Hands
- East Bay Post Acute
- San Francisco Healthcare & Rehab
- Devonshire Oaks
- Sunnyvale Post-Acute

Hospital attendees:

- Kindred Hospital
- Mills Peninsula Hospital
- Seton Medical Center
- San Mateo Medical Center
- Sequoia Hospital
- Stanford Hospital

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Looking forward



- Leveraging the Learning Collaborative format and lessons learned to “future-proof” against surges (COVID-19 and otherwise):
 - Beginning to engage hospital partners to support capability building
 - Continuing rapid information sharing and overcommunication
 - Maintaining close partnerships with facilities able to scale up Centers of Excellence quickly when needed
 - Staying ready to implement our response playbook when cases increase, including financial support for surge costs, transitions support, operational flexibility
- Questions or ideas? Please reach out:
 - Colleen Murphey, Network and Strategy Officer, Colleen.Murphey@HPSM.org

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MEMORANDUM

AGENDA ITEM: 5.1

DATE: April 13, 2022

DATE: March 30, 2022

TO: San Mateo Health Commission

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

RE: Approval of Audited Financial Statements for Period Ending December 31, 2021

Recommendation

Approve HPSM's 2021 final audited financial statements.

Background information

HPSM's auditors, Moss Adams, completed their annual audit of HPSM's 2021 financial statements in March 2022. Moss Adams presented reports to the Finance/Executive Committee on March 28th, including details of their audit process and results of their findings. Two separate reports, described below, were presented.

Communications with Those Charged with Governance

The first report is a required communication to the Commission and includes a description of the audit scope and any findings resulting from the audit.

Report of Independent Auditors and Financial Statements with Supplementary Information

The second report is the full set of audited financial statements with footnotes. The auditors issued an unmodified opinion (which is good). There were no audit adjustments. The final audited financial result is a surplus of \$27.1M for the year, a considerable improvement over the budgeted loss of \$30.1M.

DRAFT

**RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION**

**IN THE MATTER OF ACCEPTANCE OF THE
AUDIT REPORT FOR FISCAL YEAR ENDING
DECEMBER 31, 2021**

RESOLUTION 2022 -

RECITAL: WHEREAS,

- A. Moss-Adams, LLP, an accounting firm, has conducted an audit of the San Mateo Health Commission financial statements for the fiscal year ending December 31, 2021; and
- B. The San Mateo Health Commission has reviewed the resulting report submitted by Moss-Adams, LLP.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

- 1. The San Mateo Health Commission formally accepts the audit report for the fiscal year ended December 31, 2021 as presented by Moss-Adams, LLP.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of April 2022 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

Don Horsley, Chairperson

ATTEST:

APPROVED AS TO FORM:

BY: _____
C. Burgess, Clerk

Kristina Paszek
CHIEF DEPUTY COUNTY COUNSEL

FINAL DRAFT

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**San Mateo Health Commission
(d.b.a. Health Plan of San Mateo)**

December 31, 2021

Communications to the Commissioners

To the Commissioners
San Mateo Health Commission
(d.b.a. Health Plan of San Mateo)

We have audited the financial statements of the business-type activities and the aggregate remaining fund information of San Mateo Health Commission d.b.a. Health Plan of San Mateo (a stand-alone government entity appointed by the San Mateo County Board of Supervisors) as of and for the year ended December 31, 2021 and have issued our report thereon dated [REDACTED], 2022. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility Under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated December 13, 2019, and amendment dated December 2, 2021, we are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS). As part of an audit conducted in accordance with U.S. GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit.

An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of San Mateo Health Commission d.b.a. Health Plan of San Mateo's internal control over financial reporting. Accordingly, we considered San Mateo Health Commission d.b.a. Health Plan of San Mateo's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

The supplementary information was subject to certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you on November 17, 2021.

Significant Audit Findings and issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by San Mateo Health Commission d.b.a. Health Plan of San Mateo are described in Note 1 to the financial statements. No new accounting policies were adopted and there were no changes in the application of existing policies during 2021. We noted no transactions entered into by San Mateo Health Commission d.b.a. Health Plan of San Mateo during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the financial statements were:

- Management's estimate of the liability for incurred but unreported claims expense is based on historical claims experience and known activity subsequent to year end. We evaluated the key factors and assumptions used to develop the incurred but unreported claims expense in determining that they are reasonable in relation to the financial statements taken as a whole.
- Management's estimate of the capitation receivable and revenue for eligible program beneficiaries is based upon a historical experience methodology using contracted rates and member counts. We evaluated the key factors and assumptions used to develop the capitation receivable in determining that they are reasonable in relation to the financial statements taken as a whole.
- Management recorded an estimated amount due to the State of California. The estimated payable for eligible Medi-Cal program beneficiaries is based upon estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. We evaluated the key factors and assumptions used to develop the estimated net realizable amounts. We found management's basis to be reasonable in relation to the financial statements taken as a whole.

- Management's estimate of the fair market values of investments in the absence of readily-determinable fair values is based on information provided by the fund managers. We have gained an understanding of management's estimate methodology and examined the documentation supporting this methodology. We found management's process to be reasonable.
- Management's estimate of the net pension asset is actuarially determined using assumptions on the long-term rate of return on pension plan assets, the discount rate used to determine the present value of benefit obligations, and the rate of compensation increases. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the financial statements taken as a whole.

Financial Statement Disclosures

The disclosures in the financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the financial statements were medical claims payable and capitation revenue.

Significant Unusual Transactions

We encountered no significant unusual transactions during our audit of San Mateo Health Commission d.b.a. Health Plan of San Mateo's financial statements.

Significant Difficulties Encountered in Performing the Audit

Professional standards require us to inform you of any significant difficulties encountered in performing the audit. No significant difficulties were encountered during our audit of the entity's financial statements.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. No such disagreements arose during the course of our audit.

Circumstances that Affect the Form and Content of the Auditor's Report

There may be circumstances in which we would consider it necessary to include additional information in the auditor's report in accordance with U.S. GAAS. There were no circumstances that affected the form and content of the auditor's report.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. There were no corrected and uncorrected misstatements, whose effects, as determined by management were material, both individually or in the aggregate, to the financial statements taken as a whole

Management Representations

We have requested certain representations from management that are included in the management representation letter dated [REDACTED], 2022.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a “second opinion” on certain situations. If a consultation involves application of an accounting principle to San Mateo Health Commission d.b.a. Health Plan of San Mateo’s financial statements or a determination of the type of auditor’s opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Significant Audit Findings or Issues

We are required to communicate to you other findings or issues arising from the audit that are, in our professional judgment, significant and relevant to your oversight of the financial reporting process. There were no such items identified.

This information is intended solely for the use of the Commissioners and management of San Mateo Health Commission d.b.a. Health Plan of San Mateo, and is not intended to be, and should not be, used by anyone other than these specified parties.

San Francisco, California
[REDACTED], 2022

FINAL DRAFT

FINAL DRAFT

*Report of Independent Auditors and
Financial Statements with Supplementary Information*

**San Mateo Health Commission
(d.b.a. Health Plan of San Mateo)**

December 31, 2021 and 2020

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Management's Discussion and Analysis

FINAL DRAFT

**San Mateo Health Commission
(d.b.a. Health Plan of San Mateo)
Management’s Discussion and Analysis
December 31, 2021, 2020, and 2019**

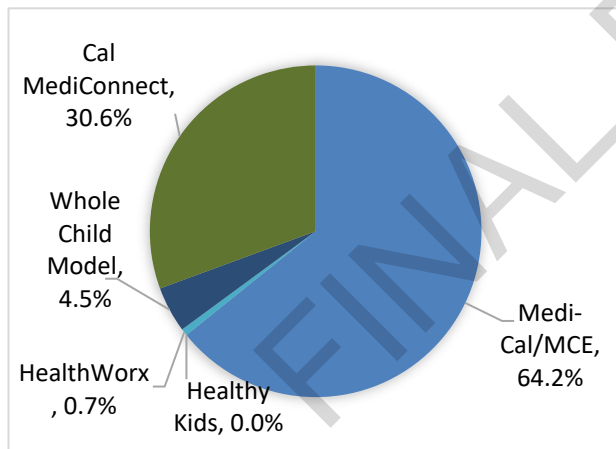
Our discussion and analysis of the San Mateo Health Commission, (d.b.a. Health Plan of San Mateo) (“HPSM” or the “Commission”), provides an overview of the Commission’s financial activities for the years ended December 31, 2021, 2020, and 2019. Please read it in conjunction with the Commission’s audited financial statements and accompanying notes, which begin on page 16.

FINANCIAL HIGHLIGHTS – PROPRIETARY FUND

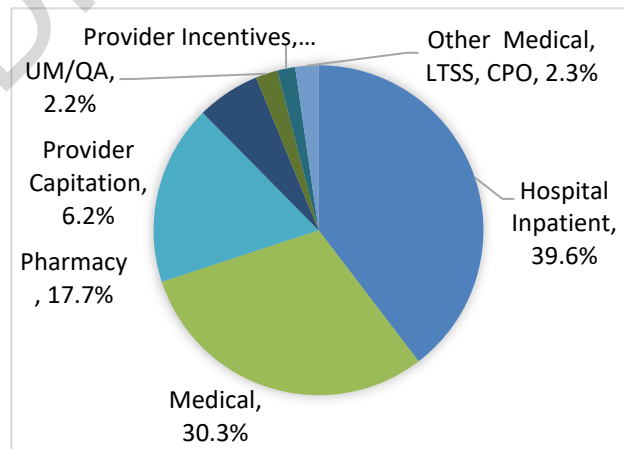
Overview of Financial Results

- Net surplus of \$27,108,819 in 2021, net deficit of \$14,749,370 in 2020, and net surplus of \$8,498,494 in 2019.
- Net operating revenues increased by \$123,505,694 (15.29%) in 2021, increased by \$26,791,049 (3.43%) in 2020, and increased by \$10,371,807 (1.35%) in 2019.
- Healthcare expenses increased by \$72,731,595 (9.70%) in 2021, increased by \$46,272,980 (6.58%) in 2020, and increased by \$30,706,928 (4.56%) in 2019.

2021 Percentage of Revenue by LOB



2021 Healthcare Dollar Spent



- Member months increased by 11.02% in 2021, increased by 2.37% in 2020, and decreased overall by 5.87% in 2019.
- In 2021, membership for Medi-Cal increased by 11.96%, HealthWorx by 5.01%, Whole Child Model by 4.43%, and Cal MediConnect by 1.49%. Increases are due to the Governor’s executive order to suspend disenrollments during the pandemic.
- In 2020, membership for Medi-Cal increased by 4.46% while the remaining lines showed declining membership: Whole Child Model by 23.05% due to realignment into the Medi-Cal program, Cal MediConnect by 2.22%, and HealthWorx by 1.52%.

San Mateo Health Commission
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- In 2019, membership for HealthWorx increased by 4.80% and the Whole Child Model remained flat. The remaining lines showed declining membership: Medi-Cal by 6.16%, Cal MediConnect by 2.31%, and Healthy Kids by 20.64%, as the population transitioned to Medi-Cal effective October 1st.

USING THIS ANNUAL REPORT

This annual report consists of a series of financial statements. The statements of net position, the statements of revenues, expenses, and changes in net position, and the statements of cash flows provide information about the activities of the Commission as a whole. Additionally, certain required supplemental information contains information regarding the Commission's budget and how actual operating results compare to the budget adopted by the Commission.

THE STATEMENTS OF NET POSITION AND THE STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

HPSM'S NET POSITION

HPSM's net position is the difference between its assets and liabilities as reported in the statements of net position on page 16. HPSM's net position increased by \$27,108,819 in 2021, decreased by \$14,749,370 in 2020, and increased by \$8,498,494 in 2019.

	<u>2021</u>	<u>2020</u>	<u>2019</u>
CURRENT ASSETS	\$ 690,762,963	\$ 579,567,247	\$ 538,792,065
CAPITAL ASSETS, NET	62,881,892	64,961,169	67,467,847
NET PENSION ASSET	2,373,317	1,463,514	989,040
ASSETS RESTRICTED AS TO USE	300,000	300,000	300,000
DEFERRED OUTFLOWS OF RESOURCES	2,351,463	3,279,910	2,921,645
Total assets and deferred outflows of resources	<u>\$ 758,669,635</u>	<u>\$ 649,571,840</u>	<u>\$ 610,470,597</u>
CURRENT LIABILITIES			
Medical claims payable	\$ 101,141,724	\$ 124,710,273	\$ 77,178,853
Providers incentives payable	9,095,674	4,870,000	6,479,966
Amounts due to the State of California	153,300,138	116,444,159	99,563,364
Accounts payable and accrued liabilities	131,731,595	66,857,397	76,322,150
Total liabilities	395,269,131	312,881,829	259,544,333
DEFERRED INFLOWS OF RESOURCES	3,022,421	3,420,747	2,907,630
Total liabilities and deferred inflows of resources	<u>\$ 398,291,552</u>	<u>\$ 316,302,576</u>	<u>\$ 262,451,963</u>
NET POSITION			
Invested in capital assets	\$ 62,881,892	\$ 64,961,169	\$ 67,467,847
Restricted by legislative authority	300,000	300,000	300,000
Unrestricted	297,196,191	268,008,095	280,250,787
Total net position	<u>\$ 360,378,083</u>	<u>\$ 333,269,264</u>	<u>\$ 348,018,634</u>

**San Mateo Health Commission
(d.b.a. Health Plan of San Mateo)
Management's Discussion and Analysis
December 31, 2021, 2020, and 2019**

CURRENT ASSETS

Current assets increased \$111,195,716 (19.19%) from 2020 to 2021, which includes an increase of \$55,984,646 (14.69%) in cash and investments, due the prior year timing difference of State capitation payments. HPSM intentionally holds a greater cash position due to the uncertainty of rate increases/cuts and cash flow from the State of California; an increase of \$57,874,894 (31.82%) in Medi-Cal and CareAdvantage capitation receivables due to timing differences of State capitation payments including the Private Hospital Directed Payments, and a decrease of \$1,663,824 (16.03%) in other accounts receivable and prepaids and other assets due primarily to a decrease in reinsurance recoveries and recoveries from Kaiser.

Current assets increased \$40,775,182 (7.57%) from 2019 to 2020, which includes a decrease of \$40,754,019 (9.66%) in cash and investments, due to lower interest rates and a timing difference on State capitation payments; an increase of \$81,000,503 (80.30%) in Medi-Cal and CareAdvantage capitation receivables due to timing differences of State capitation payments including the Hospital Quality Assurance Fee ("HQAF"), and an increase of \$528,698 (3.29%) in other accounts receivable and prepaids and other assets due to an increase in prepaid hardware/software expenses.

Current assets increased \$38,149,071 (7.62%) from 2018 to 2019, which includes an increase of \$18,108,839 (4.49%) in cash and investments, due to timing differences related to the distribution of funds related to various State programs; the State's continued overpayment of long-term care capitation; and higher interest rates on investments. HPSM intentionally holds a greater cash position due to the uncertainty of rate increases/cuts and cash flow from the State of California; an increase of \$19,519,981 (23.99%) in Medi-Cal and CareAdvantage capitation receivables due to timing differences of State capitation payment for the HQAF and a higher (than prior year) Part D expectation; and an increase of \$520,251 (3.34%) in other accounts receivable and prepaids and other assets due to an increase in prepaid hardware/software expenses.

CAPITAL ASSETS, NET

Capital assets decreased by \$2,079,277 (3.20%) in 2021, by \$2,056,678 (3.72%) in 2020 and by \$2,497,351 in 2019 (3.57%) due to depreciation expense combined with no substantial capital expenditures within the years.

NET PENSION ASSET

Net pension asset represents the excess value of pension assets above the projected liability, under Governmental Accounting Standards Board ("GASB") Statement No. 68, *Accounting and Financial Reporting for Pensions* ("GASB 68"). Net pension asset was \$2,373,317 at December 31, 2021, an increase of \$909,803 (62.17%) from \$1,463,514 at December 31, 2020. Net pension asset was \$1,463,514 at December 31, 2020, a change of \$474,474 (47.97%) from \$989,040 at December 31, 2019.

DEFERRED OUTFLOWS OF RESOURCES

Deferred outflows of resources represent the difference between projected and actual retirement investment earnings that are deferred under GASB 68. Deferred outflows of resources decreased to \$2,351,463 as of December 31, 2021, increased to \$3,279,910 as of December 31, 2020, and decreased to \$2,921,645 as of December 31, 2019.

**San Mateo Health Commission
(d.b.a. Health Plan of San Mateo)
Management's Discussion and Analysis
December 31, 2021, 2020, and 2019**

PROVIDERS INCENTIVES PAYABLE

Incentives payable to providers increased by \$4,225,674 (86.77%) in 2021, decreased by \$1,609,966 (24.85%) in 2020, and increased by \$2,988,611 (85.60%) in 2019. HPSM uses a pay for performance-based incentive model for primary care physicians ("PCP"). The change in year-end balances each year is a function of timing differences between the expense accrual during the performance year, and payments made in the subsequent year. See Note 6 for more information on the Provider Incentive Program.

ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

Accounts payable and accrued liabilities increased by \$64,874,198 (97.03%) from 2020 to 2021, decreased by \$9,464,753 (12.40%) from 2019 to 2020, increased by \$29,079,888 (61.55%) from 2018 to 2019. The 2021 increase is due primarily to the delay in Directed Payments to hospitals bringing that account liability to \$87,554,465. This increase was slightly offset by a payout of the Managed Care Organization ("MCO") liability from the prior year bringing the balance to \$0. The decrease in 2020 is due to a preliminary payment of the Intergovernmental Transfer ("IGT") at year-end deducing the Directed Payments liability. The 2019 increase is due primarily to the delay in payments to hospitals, bringing the hospital tax payable ("SB335") liability to \$22,546,279 and other Directed Payments (including IGT) to \$27,116,479. These increases were offset by payout of the Managed Care Organization ("MCO") liability from the prior year bringing the balance to \$0.

AMOUNTS DUE TO THE STATE OF CALIFORNIA

Amounts due to the State of California increased by \$36,855,979 (31.65%) in 2021, increased by \$16,880,795 (16.95%) in 2020, and decreased by \$7,136,064 (6.69%) in 2019. The 2021 increase is due to overpayments by the State related to long-term care. The increase in 2020 is primarily due to capitation overpayments by the State related to long-term care. The decrease in 2019 is primarily due to the repayment of the Medi-Cal Expansion MLR for July 2016-June 2017 offset by additional capitation overpayments by the State related to long-term care.

San Mateo Health Commission
(d.b.a. Health Plan of San Mateo)
Management's Discussion and Analysis
December 31, 2021, 2020, and 2019

DEFERRED INFLOWS OF RESOURCES

Deferred inflows of resources represent changes in assumptions and the difference between expected and actual experience in 2021, 2020 and 2019 that are deferred under GASB 68. Deferred inflows of resources decreased \$398,326 (11.64%) to \$3,022,421 as of December 31, 2021, increased \$513,117 (17.65%) to \$3,420,747 as of December 31, 2020, and increased \$1,405,177 (93.53%) to \$2,907,630 as of December 31, 2019.

	<u>2021</u>	<u>2020</u>	<u>2019</u>
OPERATING REVENUES			
Capitation and premiums			
Medi-Cal	\$ 598,298,004	\$ 489,076,148	\$ 473,054,522
CareAdvantage	-	-	43,087
Healthy Kids	-	54,432	2,786,238
HealthWorx	6,288,171	5,708,304	4,456,211
Whole Child Model	41,807,003	31,942,772	28,119,844
Cal MediConnect	285,128,975	281,234,803	272,765,508
Net operating revenues	<u>931,522,153</u>	<u>808,016,459</u>	<u>781,225,410</u>
OPERATING EXPENSES			
Health care expenses			
Hospital inpatient	325,930,565	337,280,939	280,297,522
Medical	249,498,616	214,014,110	224,403,033
Pharmacy	145,372,661	130,024,464	125,983,949
Primary care physician capitation	50,974,992	41,528,597	40,861,093
Utilization management and quality assessment allocation	17,833,608	17,856,597	17,732,900
Provider incentives	14,456,891	3,846,845	5,479,792
Long-term support services	8,014,071	3,025,895	2,881,058
Transportation	5,592,959	4,892,340	6,457,173
Care Plan Options/In-lieu of Services	2,533,725	2,662,603	-
Other medical - dental, reinsurance, etc. - net of reinsurance recoveries	2,517,300	(5,138,597)	(375,707)
Total health care expenses	822,725,388	749,993,793	703,720,813
General and administrative	51,474,667	48,544,008	50,566,190
MCO tax	34,808,380	31,144,340	31,099,624
Total operating expenses	<u>909,008,435</u>	<u>829,682,141</u>	<u>785,386,627</u>
Income (loss) from operations	<u>22,513,718</u>	<u>(21,665,682)</u>	<u>(4,161,217)</u>
NONOPERATING REVENUE			
Net interest and investment income	1,090,668	3,453,443	9,328,216
Other revenue	6,060	170	375
Rental income, net	1,194,644	1,152,620	1,086,584
Third-party administration fees	2,303,729	2,310,079	2,244,536
Total nonoperating revenue	<u>4,595,101</u>	<u>6,916,312</u>	<u>12,659,711</u>
Changes in net position	27,108,819	(14,749,370)	8,498,494
NET POSITION, beginning of year	<u>333,269,264</u>	<u>348,018,634</u>	<u>339,520,140</u>
NET POSITION, end of year	<u>\$ 360,378,083</u>	<u>\$ 333,269,264</u>	<u>\$ 348,018,634</u>

OPERATING REVENUES

HPSM's overall operating revenues increased by \$123,505,694 (15.29%) in 2021, increased by \$26,791,049 (3.43%) in 2020, and increased by \$10,371,807 (1.35%) in 2019.

The primary components for the increased revenues in 2021 are:

- Growth in membership (for all lines of business) resulted in \$59.2 million in increased revenue;
- New rates (effective January 2021) for Medi-Cal (including Full Duals, MCE and Whole Child Model) resulted in approximately \$49.3 million increased revenue. This includes an \$8.7m offset for the CCI member mix risk corridor;
- New rates (effective January 2021) for Cal MediConnect resulted in approximately \$7.9 million increased revenues;
- New rates for HealthWorx resulted in \$0.3 million increased revenue;
- Funding for directed payments and MCO tax increase by about \$6.8 million.

The primary components for the increased revenues in 2020 are:

- Growth in Medi-Cal membership resulted in \$12.8 million in increased revenue; while a decrease in Cal MediConnect membership resulted in \$5.1 million in decreased revenue;
- The lower Medi-Cal 18-month bridge period rates that went into effect July 1, 2019, carried into 2020, resulted in overall lower revenue in 2020 compared to 2019, which was offset by prior year rate adjustments for long-term care for an overall net increase of \$5.8 million;
- New rates (effective January 2020) for Cal MediConnect resulted in approximately \$8.2 million in increased revenues;
- New rates for HealthWorx resulted in \$1.4 million increased revenue;
- Funding for directed payments increase by about \$3.9 million.

The primary components for the increased revenues in 2019 are:

- New rates (effective January 2019) for Cal MediConnect resulting in approximately \$3.6 million in increased revenues;
- Prior year rate adjustments resulting in a new increase of approximately \$30 million, including restated 2017 rates for Cal MediConnect and Medi-Cal CCI Duals for a combined increase of \$5.5 million;
- A decrease of approximately \$31 million in revenues due to a deferral of the MCO Tax program until January 1, 2020, as approved by CMS; and

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- An increase of approximately \$7.7 million in revenues related to directed payments, such as, Proposition 56 and Ground Emergency Medical Transport.

INTEREST AND INVESTMENT INCOME

Net interest and investment income was \$1,090,668 in 2021, \$3,453,443 in 2020, and \$9,328,216 in 2019. The average rate of return for the investments was 0.31% in 2021, 0.59% in 2020, 2.07% in 2019.

OPERATING EXPENSES

Healthcare Expenses

Overall healthcare expenses increased \$72,731,595 (9.70%) from 2020 to 2021 due to:

- Membership growth for all lines of business in 2021 resulted in higher cost of \$61.7 million;
- Inpatient cost on a per member basis decreased by about \$18.7 million due to lower hospitalization;
- Net pharmacy cost on a per member basis increased by \$3.1 million;
- Outpatient and professional medical cost on a per member basis increased in 2021 by \$20.9 million, which is a return to previous levels after the large decrease in 2020 due to the pandemic;
- Overall long-term care cost decreased by \$14.4 million, partly from the timing of large prior year adjustments. There is a total of \$40 million in prior year rates adjustments that goes back to 2016, of which \$30 million was recognized in 2020, and another \$10M is recognized in 2021. This contributed a \$20 million decrease to the overall year over year change in long-term care cost;
- Other cost increased from the prior year by about \$20.6 million, including directed payments, provider incentives, UM/QA and prior year adjustments.

Overall healthcare expenses increased \$46,272,980 (6.58%) from 2019 to 2020 due to:

- Medi-Cal membership growth in 2020 resulted in higher cost of \$14.1 million, which is offset by a decline in Cal MediConnect membership resulting in lower cost of \$4.9 million;
- Both Inpatient and Pharmacy cost on a per member basis increased by about \$9 million combined mostly due to higher unit cost;
- Outpatient and professional medical cost on a per member basis decreased in 2020 by \$17.4 million, which was mostly due to lower utilization from canceled procedures due to the pandemic;
- Overall long-term care cost increased by \$42 million, which includes \$30 million in rate adjustments that goes back four years to 2017, for which there is offsetting revenue;
- Directed payments increased from the prior year by about \$3.5 million.

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Overall healthcare expenses increased \$30,706,928 (4.56%) from 2018 to 2019 due to:

- An increase in Inpatient costs of approximately \$20.4 million as a result of an increased rate of acute hospital admissions across all major lines of business, as well as an increase in State derived rates for both acute hospital and long-term care;
- An increase in Medical costs of approximately \$11 million, including \$4.5 million in increased directed payments (Proposition 56 and Ground Emergency Medical Transport), \$3.5 million in hospital outpatient costs, and \$3 million in other medical costs including medical pharmacy.
- Decreased Pharmacy costs of \$4.4 million is from lower number of scripts per member and lower cost per scripts
- Additional funding to provider incentives of \$3.4 million was made in 2019 based on the first full year of the new program, which began mid-2018.
- Other changes include \$2.6 million increase in LTSS ("Long Term Support Services") and \$2.6 million increase in transportation cost, offset by \$2.3 million decrease in provider capitation and \$2.8 million higher reinsurance recoveries compared to prior year.

General and Administrative ("G&A") Expenses

Total G&A expenses were \$51,474,667 in 2021, \$48,544,008 in 2020, and \$50,566,190 in 2019. The increase from 2020 to 2021 to an increase in salary and employee benefit costs along with an increase in printing and mailing costs to members as a result of the State taking over pharmacy benefits for MediCal members (originally effective April 1, 2021, but delayed until January 1, 2022). The decrease from 2019 to 2020 is lower than normal operating costs (for the building) due to the shelter-in-place order, in addition to intentionally keeping open positions vacant in an effort to control costs. The increase from 2018 to 2019 is primarily due to employee salary and benefit costs.

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MCO Tax

In 2009, Assembly Bill ("AB") No. 1422 ("AB1422") was passed by the legislature and signed by Governor Schwarzenegger. The bill provided that MCO would be subject to a gross premium tax on Medi-Cal capitation revenues. For revenues pertaining to June 30, 2013, and prior, the tax rate was 2.35%. In June 2013, Senate Bill ("SB") No. 78 ("SB 78") reauthorized the MCO premium tax through the State of California's fiscal year 2016. Beginning July 1, 2013 through June 30, 2016, the rate is equal to the state sales and use tax rate of 3.9375%. On March 1, 2016, SB X2-2 established a new MCO provider tax, to be administered by Department of Healthcare Service ("DHCS"), effective July 1, 2016 through June 30, 2019. On April 3, 2020, CMS approved a waiver for the broad-based and uniformity requirements related to the State of California's MCO tax, effectively renewing the program effective January 1, 2020. The tax was assessed by the DHCS on licensed healthcare service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate healthcare service plans ("AHCSP"), as defined, except as excluded by the bill. This bill established applicable taxing tiers and per enrollee amounts for the 2016-2017 and 2017-2018 and 2018-2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. HPSM paid \$34,808,380 in 2021, \$31,144,340 in 2020, and \$31,099,624 (through June 30, 2019) for MCO premium taxes. HPSM's tax liability of \$0 as of December 31, 2021, \$8,244,090 as of December 31, 2020, and \$0 as of December 31, 2019, is included in accounts payable and accrued liabilities in the statements of net position.

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	<u>2021 Actual</u>	<u>2021 Budgeted</u>	<u>Variance</u>
REVENUES			
Medi-Cal	\$ 598,298,004	\$ 498,005,761	\$ 100,292,243
HealthWorx	6,288,171	5,961,427	326,744
Whole Child Model	41,807,003	27,588,696	14,218,307
Cal MediConnect	285,128,975	267,245,244	17,883,731
Total revenues	<u>931,522,153</u>	<u>798,801,128</u>	<u>132,721,025</u>
HEALTH CARE EXPENSES			
Hospital inpatient	325,930,565	348,266,932	(22,336,367)
Medical	249,498,616	236,732,716	12,765,900
Pharmacy	145,372,661	76,448,712	68,923,949
Primary care physician capitation	50,974,992	46,626,001	4,348,991
Utilization management ("UM") and quality assessment ("QA") allocation	17,833,608	19,659,994	(1,826,386)
Provider incentives	14,456,891	6,447,033	8,009,858
Long-term support services	8,014,071	3,228,828	4,785,243
Transportation	5,592,959	6,392,784	(799,825)
Care Plan Options/In-lieu of Services	2,533,725	-	2,533,725
Other medical - dental, reinsurance, etc. - net of reinsurance recoveries	2,517,300	1,093,699	1,423,601
Total health care expenses	<u>822,725,388</u>	<u>744,896,699</u>	<u>77,828,689</u>
ADMINISTRATIVE EXPENSES			
Salaries and fringe benefits	39,758,976	41,041,910	(1,282,934)
Contract services	15,748,538	17,903,200	(2,154,662)
Office supplies and maintenance	6,091,313	6,589,050	(497,737)
Occupancy, equipment, and depreciation expense	3,974,113	4,581,500	(607,387)
Postage and printing	2,195,107	1,552,300	642,807
Other administrative expenses	1,328,346	1,302,575	25,771
UMQA healthcare allocation	(17,621,726)	(19,469,270)	1,847,544
Total administrative expenses	<u>51,474,667</u>	<u>53,501,265</u>	<u>(2,026,598)</u>
MCO tax	34,808,380	36,109,946	(1,301,566)
Total expenses	<u>909,008,435</u>	<u>834,507,910</u>	<u>74,500,525</u>
Income (loss) from operations	<u>22,513,718</u>	<u>(35,706,782)</u>	<u>58,220,500</u>
NONOPERATING INCOME (LOSS)			
Net interest and investment income	1,090,668	2,000,000	(909,332)
Other revenue and rental income	1,200,704	1,141,318	59,386
Third-party administrator fees	2,303,729	2,494,002	(190,273)
Total nonoperating income (loss)	<u>4,595,101</u>	<u>5,635,320</u>	<u>(1,040,219)</u>
Net income (loss)	<u>27,108,819</u>	<u>(30,071,462)</u>	<u>57,180,281</u>
Net position at beginning of year	333,269,264	333,269,264	-
Net position at end of year	<u>\$ 360,378,083</u>	<u>\$ 303,197,802</u>	<u>\$ 57,180,281</u>

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FINANCIAL HIGHLIGHTS – FIDUCIARY FUND

The table below is a summarized comparison of the assets, liabilities and fiduciary net position of the Health Plan of San Mateo Retirement Plan Fund as of December 31, and the changes in fiduciary net position for the years ended December 31:

	<u>2021</u>	<u>2020</u>	<u>2019</u>
TOTAL ASSETS	\$ 33,150,125	\$ 28,734,252	\$ 24,386,084
TOTAL LIABILITIES	<u>-</u>	<u>-</u>	<u>-</u>
TOTAL FIDUCIARY NET POSITION	<u>33,150,125</u>	<u>28,734,252</u>	<u>24,386,084</u>
TOTAL ADDITIONS	5,160,572	5,576,765	5,712,430
TOTAL DEDUCTIONS	<u>744,699</u>	<u>1,228,597</u>	<u>1,800,659</u>
INCREASE IN FIDUCIARY NET POSITION	4,415,873	4,348,168	3,911,771
FIDUCIARY NET POSITION - BEGINNING OF YEAR	<u>28,734,252</u>	<u>24,386,084</u>	<u>20,474,313</u>
FIDUCIARY NET POSITION - END OF YEAR	<u>\$ 33,150,125</u>	<u>\$ 28,734,252</u>	<u>\$ 24,386,084</u>

Total fiduciary fund net position as of December 31, 2021, increased by \$4,415,873 from December 31, 2020, due to an increase in fair value of investments.

Total fiduciary fund net position as of December 31, 2020, increased by \$4,348,168 from December 31, 2019, due to an increase in fair value of investments.

Total fiduciary fund net position as of December 31, 2019, increased by \$3,911,771 from December 31, 2018, due to an increase in fair value of investments

Report of Independent Auditors

To the Commissioners
San Mateo Health Commission
(d.b.a. Health Plan of San Mateo)

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of the business-type activities and the aggregate remaining fund information of San Mateo Health Commission d.b.a. Health Plan of San Mateo (a stand-alone government entity appointed by the San Mateo County Board of Supervisors), as of and for the years ended December 31, 2021 and 2020, and the related notes to the financial statements, which collectively comprise San Mateo Health Commission d.b.a. Health Plan of San Mateo's financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements present fairly, in all material respects, the respective financial position of the business-type activities and aggregate remaining fund information of San Mateo Health Commission d.b.a. Health Plan of San Mateo as of December 31, 2021 and 2020, and the respective changes in net position and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of San Mateo Health Commission d.b.a. Health Plan of San Mateo and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about San Mateo Health Commission d.b.a. Health Plan of San Mateo's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of San Mateo Health Commission d.b.a. Health Plan of San Mateo's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about San Mateo Health Commission d.b.a. Health Plan of San Mateo's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Other Matters

Required Supplementary Information

The accompanying Management's Discussion and Analysis on pages 1 through 11, and the accompanying supplementary schedule of changes in the net pension asset and related ratios, supplementary schedule of contributions, and supplementary schedule of investment returns – Health Plan of San Mateo Retirement Plan on pages 43 through 45 are not required parts of the financial statements but are supplementary information required by the Governmental Accounting Standards Board, who consider them to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic, or historical context. This supplementary information is the responsibility of San Mateo Health Commission d.b.a. Health Plan of San Mateo's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the financial statements, and other knowledge we obtained during our audit of the financial statements.

We do not express an opinion or provide any assurance on the supplementary information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

San Francisco, California

, 2022

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Financial Statements

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San Mateo Health Commission
(d.b.a. Health Plan of San Mateo) – Proprietary Fund
Statements of Net Position
December 31, 2021 and 2020

	<u>2021</u>	<u>2020</u>
ASSETS AND DEFERRED OUTFLOWS		
CURRENT ASSETS		
Cash and cash equivalents	\$ 257,910,849	\$ 203,340,970
Investments	179,148,167	177,733,400
Capitation receivable from the State of California	191,263,823	159,273,917
CareAdvantage receivable	48,482,765	22,597,777
Other accounts receivable	6,713,030	8,809,606
Prepays and other assets	7,244,329	7,811,577
Total current assets	<u>690,762,963</u>	<u>579,567,247</u>
CAPITAL ASSETS, NET		
Nondepreciable	15,667,814	15,667,814
Depreciable, net of accumulated depreciation and amortization	47,214,078	49,293,355
Total capital assets, net	<u>62,881,892</u>	<u>64,961,169</u>
NET PENSION ASSET	2,373,317	1,463,514
ASSETS RESTRICTED AS TO USE	<u>300,000</u>	<u>300,000</u>
Total assets	756,318,172	646,291,930
DEFERRED OUTFLOWS OF RESOURCES		
Total assets and deferred outflows of resources	<u>\$ 758,669,635</u>	<u>\$ 649,571,840</u>
LIABILITIES AND DEFERRED INFLOWS		
CURRENT LIABILITIES		
Medical claims payable	\$ 101,141,724	\$ 124,710,273
Incentives payable to providers	9,095,674	4,870,000
Amounts due to the State of California	153,300,138	116,444,159
Accounts payable and accrued liabilities	131,731,595	66,857,397
Total current liabilities	<u>395,269,131</u>	<u>312,881,829</u>
DEFERRED INFLOWS OF RESOURCES	<u>3,022,421</u>	<u>3,420,747</u>
Total liabilities and deferred inflow of resources	<u>\$ 398,291,552</u>	<u>\$ 316,302,576</u>
NET POSITION		
Invested in capital assets	\$ 62,881,892	\$ 64,961,169
Restricted by legislative authority	300,000	300,000
Unrestricted	297,196,191	268,008,095
Total net position	<u>\$ 360,378,083</u>	<u>\$ 333,269,264</u>

San Mateo Health Commission
(d.b.a. Health Plan of San Mateo) – Proprietary Fund
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended December 31, 2021 and 2020

	<u>2021</u>	<u>2020</u>
OPERATING REVENUES		
Capitation and premiums		
Medi-Cal	\$ 598,298,004	\$ 489,076,148
Healthy Kids	-	54,432
HealthWorx	6,288,171	5,708,304
Whole Child Model ("WCM")	41,807,003	31,942,772
Cal MediConnect	<u>285,128,975</u>	<u>281,234,803</u>
Net operating revenues	<u>931,522,153</u>	<u>808,016,459</u>
OPERATING EXPENSES		
Healthcare expenses		
Hospital inpatient	325,930,565	337,280,939
Medical	249,498,616	214,014,110
Pharmacy	145,372,661	130,024,464
Primary care physician capitation	50,974,992	41,528,597
Utilization management ("UM") and quality assessment ("QA") allocation	17,833,608	17,856,597
Provider incentives	14,456,891	3,846,845
Long-term support services	8,014,071	3,025,895
Transportation	5,592,959	4,892,340
Care Plan Options/In-lieu of Services	2,533,725	2,662,603
Other medical - dental, reinsurance, etc. - net of reinsurance recoveries	<u>2,517,300</u>	<u>(5,138,597)</u>
Total health care expenses	<u>822,725,388</u>	<u>749,993,793</u>
General and administrative		
Salaries and fringe benefits	39,758,976	38,014,312
Contract services	15,748,538	14,718,288
Office supplies and maintenance	6,091,313	6,186,284
Occupancy, equipment, and depreciation expense	3,974,113	4,885,030
Postage and printing	2,195,107	1,474,958
Other administrative expenses	1,328,346	935,518
UMQA healthcare allocation	<u>(17,621,726)</u>	<u>(17,670,382)</u>
Total general and administrative expenses	<u>51,474,667</u>	<u>48,544,008</u>
MCO tax	<u>34,808,380</u>	<u>31,144,340</u>
Total operating expenses	<u>909,008,435</u>	<u>829,682,141</u>
Income (loss) from operations	<u>22,513,718</u>	<u>(21,665,682)</u>
NONOPERATING REVENUE		
Net interest and investment income	1,090,668	3,453,443
Other revenue	6,060	170
Rental income	1,194,644	1,152,620
Third-party administrator fees	<u>2,303,729</u>	<u>2,310,079</u>
Total nonoperating revenue	<u>4,595,101</u>	<u>6,916,312</u>
Changes in net position	27,108,819	(14,749,370)
NET POSITION, beginning of year	<u>333,269,264</u>	<u>348,018,634</u>
NET POSITION, end of year	<u>\$ 360,378,083</u>	<u>\$ 333,269,264</u>

See accompanying notes.

San Mateo Health Commission
(d.b.a. Health Plan of San Mateo) – Proprietary Fund
Statements of Cash Flows
Years Ended December 31, 2021 and 2020

	<u>2021</u>	<u>2020</u>
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation and premium revenues	\$ 985,825,202	\$ 731,780,112
Healthcare expenses	(837,962,095)	(712,297,735)
General and administrative expenses	(96,942,517)	(67,319,141)
Other	297,291	(124,113)
	<u>51,217,881</u>	<u>(47,960,877)</u>
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from sale and maturities of investments	3,534,896	4,758,411
Payments for purchase of investments	-	(9,000,000)
Payments for purchase of capital assets	(182,898)	(385,482)
	<u>3,351,998</u>	<u>(4,627,071)</u>
Net increase (decrease) in cash and cash equivalents	54,569,879	(52,587,948)
CASH AND CASH EQUIVALENTS, beginning of year	<u>203,340,970</u>	<u>255,928,918</u>
CASH AND CASH EQUIVALENTS, end of year	<u>\$ 257,910,849</u>	<u>\$ 203,340,970</u>
RECONCILIATION OF INCOME (LOSS) FROM OPERATIONS TO NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES		
Income (loss) from operations	\$ 22,513,718	\$ (21,665,682)
Adjustment to reconcile income (loss) from operations to net cash provided by (used in) operating activities:		
Depreciation and amortization	2,262,175	2,892,160
Changes in operating assets and liabilities:		
Capitation receivable from the State of California	(31,989,906)	(80,234,959)
CareAdvantage receivable	(25,884,988)	(765,544)
Other accounts receivable	2,096,576	(1,551,324)
Prepays and other assets	212,686	346,599
Net pension asset	(379,682)	(319,622)
Medical claims payable	(23,568,549)	47,531,420
Incentives payable to providers	4,225,674	(1,609,966)
Amounts due to the State of California	36,855,979	16,880,795
Accounts payable and accrued liabilities	64,874,198	(9,464,754)
	<u>\$ 51,217,881</u>	<u>\$ (47,960,877)</u>

San Mateo Health Commission
(d.b.a. Health Plan of San Mateo) – Health Plan of San Mateo Retirement Plan
Statements of Fiduciary Net Position
December 31, 2021 and 2020

	2021	2020
ASSETS		
Cash and cash equivalents	\$ 874,320	\$ 714,447
Investments, at fair value		
Mutual funds	5,885,732	4,816,198
Pooled, common, and collective trusts	26,390,073	23,203,483
Total investments, at fair value	32,275,805	28,019,681
Interest and dividends receivable	-	124
Total assets	\$ 33,150,125	\$ 28,734,252
NET POSITION RESTRICTED FOR PENSIONS	\$ 33,150,125	\$ 28,734,252

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San Mateo Health Commission
(d.b.a. Health Plan of San Mateo) – Health Plan of San Mateo Retirement Plan
Statements of Changes in Fiduciary Net Position
Years Ended December 31, 2021 and 2020

	<u>2021</u>	<u>2020</u>
ADDITIONS		
Employer contributions	\$ 1,948,733	\$ 1,772,346
Investment income		
Net appreciation in fair value of investments	3,142,188	3,733,411
Dividends	65,519	63,678
Interest	4,132	7,330
Total investment income	<u>3,211,839</u>	<u>3,804,419</u>
Total additions	5,160,572	5,576,765
DEDUCTIONS		
Benefits paid to participants	<u>744,699</u>	<u>1,228,597</u>
INCREASE IN NET POSITION	4,415,873	4,348,168
NET POSITION RESTRICTED FOR PENSIONS		
Beginning of year	<u>28,734,252</u>	<u>24,386,084</u>
End of year	<u>\$ 33,150,125</u>	<u>\$ 28,734,252</u>

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**San Mateo Health Commission
(d.b.a. Health Plan of San Mateo)
Notes to Financial Statements**

NOTE 1 – DESCRIPTION OF OPERATIONS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of organization – The San Mateo Health Commission (the “Commission”) (d.b.a. Health Plan of San Mateo) (“HPSM”) was formed and organized by the Board of Supervisors of San Mateo County (the “County”) under an ordinance pursuant to Section 14087.51 of the Welfare and Institutional Code as a Health Insuring Organization (“HIO”). The majority of HPSM’s revenues are generated from a contract with the State of California Medi-Cal Program and a three-way contract between HPSM, the State of California, and the Centers for Medicare & Medicaid Services (“CMS”) for the Cal MediConnect Demonstration Program (“Cal MediConnect”). HPSM is included in the County of San Mateo’s basic financial statements as a discretely presented component unit.

HPSM is responsible for managing a capitated prepaid healthcare system for residents of the County who are eligible for services under the Medi-Cal Program. The California Legislature authorized the prepaid system in March 1986 and HPSM began operations on December 1, 1987, under a contract with the State of California (the “State”). HPSM has an executed contract with the State for the period of January 1, 2009 through December 31, 2022.

CMS originally approved the State’s request for HPSM to operate under a federal Medicaid freedom of choice waiver in November of 1987. The 1915(b) waiver allows for mandatory participation by Medi-Cal eligible San Mateo County residents in HPSM. Effective November 1, 2010, CMS transitioned all existing California 1915(b) waivers, including HPSM’s, into the State’s 1115(a) waiver. CMS renewed the State’s 1115(a) waiver and 1915(b) waiver for November 1, 2010 through December 31, 2026.

The eleven commissioners of HPSM (“Commissioners”) are appointed by the County Board of Supervisors. The current Commissioners include two members of the San Mateo County Board of Supervisors, the County Manager or his designee, a physician, four public members (a beneficiary or representative of a beneficiary served by the Commission, a representative of the senior and/or minority communities in San Mateo County, a representative of the business community in San Mateo County, and a public member at large), a representative of the San Mateo Medical Center physicians that serve members of HPSM, a representative of a hospital located in San Mateo County that serve members of HPSM, and a pharmacist.

HPSM acquired a license under the Knox-Keene Healthcare Services Plan Act of 1975, as amended (the “Act”) on July 31, 1998, and is regulated by the State’s Department of Healthcare Services (“DHCS”) and California Department of Managed Healthcare (“DMHC”). For the HealthWorx program, HPSM contracted with the San Mateo Public Authority for coverage of the In-Home Support Services (“IHSS”) employees as of August 1, 2001, and the City of San Mateo for Non-Merit Part-Time and Library Per Diem employees as of January 1, 2009. The current HealthWorx contracts are for the following periods: (1) IHSS – July 1, 2014 to December 31, 2021 and (2) the City of San Mateo – January 1, 2009 to December 31, 2021. The renewal is currently in process.

As of February 12, 2003, HPSM contracted with the County of San Mateo and the San Mateo County Children and Families First Commission for the Healthy Kids program. As of January 2004, the County of San Mateo is the sole contractor for Healthy Kids, as San Mateo County Children and Families First Commission is contracting directly with the County of San Mateo. This program covers children under the age of 19 with family income levels of 400% of poverty or lower, who do not qualify for Medi-Cal. The current Healthy Kids contract was for the period from January 1, 2010 to December 31, 2019. However, on October 1, 2019, the entire population transitioned to the Medi-Cal program, effectively ending the program.

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In July 2005, DHCS implemented the Quality Improvement Fee (“QIF”) program. This program imposed a 6% assessment from July 2005 through December 2007 and a 5.5% assessment effective January 1, 2008 through September 30, 2009, on the Commission’s non-Medicare revenue. In order to minimize the impact on HPSM, the San Mateo Community Health Authority (the “Health Authority”) was created. Effective February 23, 2006, all non-Medi-Cal programs were assigned to the Health Authority, thus reducing the resulting assessment levied on HPSM.

The Health Authority is a licensed health maintenance organization that operates in the County. The County’s Board of Supervisors established the Health Authority in accordance with State of California Welfare and Institutions Code (the “Code”) Section 14087.54. This legislation provides that the Health Authority is a public entity, separate and apart from the County, and is not considered to be an agency, division, or department of the County. Further, the Health Authority is not governed by, nor is it subject to, the Charter of the County and is not subject to the County’s policies or operational rules. The Health Authority received its Knox-Keene license on February 23, 2006, and accounting separately for the Health Authority from HPSM became effective March 1, 2006. The Health Authority was dissolved effective October 1, 2019.

Effective September 1, 2007, HPSM entered into an agreement with the County of San Mateo to provide third-party administrator (“TPA”) services to administer the benefits of their indigent care program (“ACE”). The current agreement ends March 31, 2023.

Effective April 1, 2014, HPSM entered into a three-way contract with CMS and the State of California for the Cal MediConnect. The Cal MediConnect program promotes coordination of care to seniors and people with disabilities who are dually eligible for both Medi-Cal and Medicare. The agreement results in a third Medi-Cal contract and a second Medicare contract. The contract is through December 31, 2022.

Health Plan of San Mateo Retirement Plan Fund accounts for the assets of the employee benefit plan held by HPSM in a trustee capacity. See Note 9.

Accounting standards – Pursuant to Governmental Accounting Standards Board (“GASB”) Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, HPSM’s proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989.

Proprietary fund accounting – HPSM utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis and financial statements are prepared using the economic resources measurement focus.

Cash and cash equivalents – Cash and cash equivalents are stated at cost which approximates current market value due to their short-term nature. All highly-liquid investments with original maturities of three months or less when purchased are considered cash equivalents.

Investments – Investments include mutual funds, pooled, common and collective trusts, debt obligations of the U.S. Government and its agencies, certificates of deposits, and money markets as permitted by the California Government Code for Investments. All short-term investments with a maturity of three months or less at the date of purchase are considered to be cash equivalents. These investments are carried at fair market value. The fair values of investments are based on quoted market prices. Changes in fair value of investments are included in net interest and investment income in the statements of revenues, expenses, and changes in net position.

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Capital assets – Capital assets include property and equipment which are stated at cost. Depreciation is provided on the straight-line basis over the asset’s estimated useful lives which are as follows:

Leasehold improvements	5 years
Building and improvements	39 years
Furniture and equipment	3 to 7 years

Leasehold improvements are amortized over the life of the improvement or the lease term, whichever is shorter. Upon retirement or disposal of capital assets, any gain or loss is included in results of operations in the period disposed.

Capital assets of \$9,000 or more are depreciated over their useful lives. Leasehold improvements of \$9,000 or more are amortized over the term of the related lease or their estimated useful lives.

HPSM evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

Assets restricted as to use – HPSM is required by the California DMHC to restrict cash of \$300,000 as of December 31, 2021 and 2020, for the payment of member claims in the event of its insolvency.

Medical claims payable – HPSM contracts with various providers, including physicians and hospitals, to provide certain healthcare products and services to enrolled Medi-Cal, CareAdvantage, HealthWorx, Whole Child Model, and Cal MediConnect beneficiaries. The cost of the healthcare products and services provided or contracted for is accrued in the period in which it is provided to a member and includes an estimate of the cost of services that have been incurred but not yet reported. The estimate for reserves for claims is based on projections of hospital and other costs using historical studies of claims paid. Estimates are monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions.

Amounts due to the State of California – When HPSM is made aware of changes to the State rate structure, such as rate decreases, risk corridors or program reconciliations, that significantly impact the financial outlook, an accrual for the estimated change is recorded. Such estimates are subject to the impact of changes in the regulatory environment and are subject to third party review. At the end of December 31, 2021 and 2020, HPSM had the following included in Amounts due to the State of California in the accompanying statements of net position:

	2021	2020
Risk corridor	\$ 28,519,224	\$ 19,789,224
Medi-Cal Expansion ("MCE") medical loss ratio ("MLR") reserve	3,666,077	3,666,077
Overpayments	121,114,837	92,988,858
Total	\$ 153,300,138	\$ 116,444,159

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Risk corridor – HPSM’s contract with DHCS is subject to various risk corridors. The Coordinated Care Initiative (CCI) demonstration program for full-dual members has multiple risk corridors that triggered liabilities. A medical loss ratio (MLR) risk corridor for the first two years (July 2014 through June 2016) resulted an estimated return of premiums of \$19,789,224. A separate member mix risk corridor triggered an additional return of premiums for calendar year 2021 of \$8,730,000. During the years ended December 31, 2021 and 2020, the reduction of premium revenue related to risk corridors was \$8,730,000 and \$0 respectively.

Medi-Cal Expansion (“MCE”) medical loss ratio (“MLR”) reserve – Effective with the enrollment of the Adult Expansion Population per the Affordable Care Act on January 1, 2014, HPSM is subject to DHCS requirements to meet a minimum of 85% medical loss ratio for this population. Specifically, HPSM will be required to expend at least 85% of the Medi-Cal capitation revenue received for this population on allowable medical expenses as defined by DHCS. In the event HPSM expends less than the 85% requirement, HPSM will be required to return to DHCS the difference between the minimum threshold and the actual allowed medical expenses. The original 85% MLR requirement was for January 2014 through June 2016, a 30-month period. In 2018, HPSM made a payment to the State of \$109 million related to the original reporting periods of January 2014 – June 2016. In 2019, HPSM made a payment to DHCS in the amount of \$15 million related to July 1, 2016 – June 30, 2017. As of December 31, 2021 and 2020, HPSM estimated a remainder liability of \$3,666,077, relating to reporting period July 1, 2016 – June 30, 2017. There are no estimated liabilities for DHCS between the minimum threshold and the actual allowed medical expenses for the reporting period July 2017 to June 2021.

Overpayments – DHCS pays HPSM based on the most recent CMS approved rates for the various Medi-Cal programs. HPSM records revenue using the anticipated final rates and records a liability for the excess payment received. DHCS has begun recouping overpayments in the current fiscal year.

Accounts payable and accrued liabilities – included in accounts payable and accrued liabilities on the statements of net position are the following:

	<u>2021</u>	<u>2020</u>
Intergovernmental ("IGT") and Directed Payments payable	\$ 87,554,463	\$ 6,223,574
MCO tax payable	-	8,244,090
Hospital Quality Assurance Fee ("HQAF") payable	24,921,566	30,406,984
Other program payable	7,556,901	8,548,519
Accounts payable and accrued expenses	6,971,318	10,167,714
Other healthcare liabilities	<u>4,727,347</u>	<u>3,266,516</u>
 Total	 <u>\$ 131,731,595</u>	 <u>\$ 66,857,397</u>

IGT payable – Welfare and Institutions Code provides for an IGT program relating to the Medi-Cal managed care capitation rates and the capitation rate ranges. Governmental funding agencies, defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, are eligible to transfer the non-federal share of the available IGT amounts. The IGT is used to fund the non-federal share of increases in Medi-Cal managed care actuarially sound capitation rates.

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Directed payments payable – Beginning with the July 1, 2017, rating period, the DHCS has implemented managed care Directed Payments: 1) Private Hospital Directed Payment (“PHDP”); 2) Designated Public Hospital Enhanced Payment Program (“EPP-FFS” and “EPP-CAP”); and 3) Designated Public Hospital Quality Incentive Pool (“QIP”). (1) For PHDP, the Department will direct Managed Care Plans (“MCP”) to reimburse private hospitals as defined in WIC 14169.51, based on actual utilization of contracted services. The enhanced payment is contingent upon hospitals providing adequate access to service, including primary, specialty, and inpatient (both tertiary and quaternary) care. The total funding available for the enhanced contracted payments are limited to a predetermined amount (pool). (2) For EPP-FFS and EPP-Capitated Pools, the Department has directed MCPs to reimburse California’s 21 Designated Public Hospitals (“DPH”) for network contracted services delivered by DPH systems, enhanced by either a uniform percentage or dollar increment based on actual utilization of network contracted services. (3) For QIP, the Department has directed the MCPs to make QIP payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to the delivery of services under the MCP contracts and increase the amount of funding tied to quality outcomes. To receive QIP payments the DPH and University of California hospitals must achieve specified improvement targets, which grow more difficult through year-over-year improvement or sustained high performance requirements. The total funding available for the QIP payments will be limited to a predetermined amount (pool).

HQAF payable – Established by AB 1653 (“AB1653”), the HQAF program allows additional draw down of federal funding to be used for increased payments to general acute care hospitals for inpatient services rendered to Medi-Cal beneficiaries. DHCS provides increased capitation payments to Medi-Cal managed healthcare plans who in turn expend 100 percent of any increased capitation payments on hospital services. In April 2011, SB90 was signed into law, which extended the HQAF through June 30, 2011. SB335, signed into law in September 2011, extended the HQAF portion of SB90 for an additional 30 months through December 31, 2013. The payments were received and distributed in a manner prescribed as a pass through to revenue. SB239, signed into law October 8, 2013, extended the program for an additional 36 months from January 1, 2014 through December 31, 2016. In November of 2016, California approved Proposition 52, which made SB239 permanent and also created HQAF V. The program period for HQAF V is from January 1, 2017 through June 30, 2019. An extension of the program known as HQAF VI, covering July 1, 2019 – December 31, 2021 was approved by the CMS in February 2020.

Other program payable – HPSM holds and administers funds to certain other entities who partner on programs to enhance the Community Care Settings Pilot (“CCSP”) and further HPSM’s mission to ensure access to high-quality, affordable healthcare for San Mateo County’s underserved residents.

Net position – Net position is classified as invested in capital assets, restricted by legislative authority or unrestricted. Invested in capital assets represents investments in building, furniture, and equipment, net of depreciation. Restricted net position consists of noncapital net position that must be used for a particular purpose, as specified by state regulatory agency, grantors, or contributors external to HPSM. Unrestricted net position consists of net position that does not meet the definition of restricted or invested in capital assets. The Commission, at its discretion, from time-to-time designates portions of unrestricted net position for the establishment of a stabilization reserve.

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Capitation and premium revenues – The State of California pays HPSM capitation revenue retrospectively on an estimated basis each month. Capitation revenue is recognized as revenue in the month the beneficiary is eligible for Medi-Cal services. These estimates are continually reviewed, and adjustments to the estimates are reflected currently in the Statements of revenues, expenses, and changes in net position. Eligibility of beneficiaries is determined by the County of San Mateo Department of Human Services and validated by the State of California. The State of California provides HPSM the validated monthly eligibility file of program beneficiaries who are continuing, newly added or terminated from the program in support of capitation revenue for the respective month.

The CMS pays HPSM capitation revenue each month. Capitation revenue is recognized in the month the beneficiary is eligible for Medicare services. Eligibility of members is determined by CMS.

The County of San Mateo and the City of San Mateo each pay HPSM HealthWorx premiums by the first of the month of coverage. The County of San Mateo pays HPSM Healthy Kids quarterly premiums prospectively based on the quarter's estimated member months. Subsequent to the end of the quarter, HPSM submits an adjustment invoice for the difference between the actual versus the estimated quarterly membership. Eligibility of members is determined by the San Mateo County Public Authority and the City of San Mateo.

Premium deficiencies – HPSM performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency is recorded. Management determined that no premium deficiency reserves were needed at December 31, 2021 or 2020.

Healthcare expenses – The cost of healthcare rendered to eligible beneficiaries is estimated and recognized as expense in the month in which the services are rendered. These estimates are continually reviewed, and adjustments to the estimates are reflected currently in the Statements of revenues, expenses, and changes in net position.

MCO tax – In November 2009, DHCS implemented AB1422 or MCO premium tax. This program imposes an assessment on HPSM's revenue. DHCS uses this assessment to obtain matching federal funds, which is used to sustain enrollment in the Healthy Families program. Effective with California SB78 and beginning July 1, 2012, HPSM was required to pay a gross premium tax on Medi-Cal revenue. For July 1, 2013 through June 30, 2016, the tax rate increased to 3.9375%. Beginning July 1, 2016, a new annual liability methodology for determining tax liability was instituted by the State. MCO tax expense was \$34,808,380 and \$31,144,340 for the years ended December 31, 2021 and 2020, respectively. As of December 31, 2021 and 2020, \$0 and \$8,244,090, respectively, was accrued. These amounts are included in accounts payable and accrued liabilities on the statements of net position.

Operating revenues and expenses – HPSM's primary operating revenue is derived from capitation. As defined by GASB Codification Section P80, *Proprietary Fund Accounting and Financial Reporting*, all operating revenues are considered program revenues since they are charges for services provided and program-specific operating grants. The primary operating revenue is derived from capitation and other sources in support of providing healthcare services to its members. Operating expenses are all expenses incurred to provide such healthcare services. Nonoperating revenues and expenses consist of those revenues and expenses that are related to financing and investing activities, result from net investment income, changes in the fair value of investments, and administrative fees relating to providing Third Party Administrator claims processing services for the County of San Mateo's Section 17,000 participants.

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Income taxes – HPSM operates under the purview of Internal Revenue Code (“IRC”) Section 115, and corresponding California Revenue and Taxation Code provisions. As such, it is not subject to federal income or state franchise taxes.

Use of estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. Management also discloses contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period based on these estimates and assumptions such as medical claims payable including incurred but not reported liability, capitation receivable from the State of California and CareAdvantage receivable, amounts due to the State of California including MLR and risk corridor, fair market value of investments, and net pension asset. Ultimate results may differ from those estimates.

Concentrations of risk – Financial instruments potentially subjecting HPSM to concentrations of risk consist primarily of bank demand deposits in excess of Federal Deposit Insurance Corporation (“FDIC”) insurance thresholds. HPSM believes no significant concentration of credit risk exists with these cash accounts.

HPSM’s business could be impacted by external price pressure on new and renewal business, additional competitors entering HPSM’s markets, federal and state legislation, and governmental licensing regulations of HMOs and insurance companies. External influences in these areas could have the potential to adversely impact HPSM’s operations in the future.

HPSM is highly dependent upon the State of California for its revenues. A significant portion of accounts receivable and revenue are from the State of California. Loss of the contracts with the State of California due to nonrenewal or legislative decisions that impact program funding or result in discontinuation could materially affect the financial position of HPSM.

New accounting pronouncements – In June 2017, the GASB issued Statement No. 87, *Leases* (“GASB 87”), which is effective for financial statements for periods beginning after December 15, 2019. GASB 87 increases the usefulness of financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. GASB 87 also establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance*, which deferred the effective date of GASB 87 to fiscal years beginning after June 15, 2021. HPSM is reviewing the impact of the adoption of GASB 87 for the fiscal year ending 2022.

In June 2020, the GASB issued Statement No. 97, *Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans – an amendment of GASB Statements No. 14 and No. 84, and a supersession of GASB Statement No. 32* (“GASB 97”). GASB 97 amends the criteria for reporting governmental fiduciary component units – separate legal entities included in a government’s financial statements. GASB 97 clarifies rules related to reporting of fiduciary activities under Statements No. 14 and No. 84 for defined contribution plans and to enhance the relevance, consistency, and comparability of the accounting and financial reporting of IRC Code section 457 plans that meet the definition of a pension plan. HPSM is reviewing the impact of the adoption of GASB No. 97 for the fiscal year ending 2022.

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NOTE 2 – CASH AND CASH EQUIVALENTS, INVESTMENTS, AND ASSETS RESTRICTED AS TO USE

Cash and cash equivalents investments – Cash and cash equivalents and investments as of December 31, 2021 and 2020 consist of the following:

	<u>2021</u>	<u>2020</u>
Cash on hand	\$ 500	\$ 500
Cash deposits	54,514,718	-
Cash equivalents	203,395,631	203,340,470
Investments	<u>179,148,167</u>	<u>177,733,400</u>
Total cash and cash equivalents and investments	<u>\$ 437,059,016</u>	<u>\$ 381,074,370</u>

Assets restricted as to use – Assets restricted as to use consist of \$300,000 of certificates of deposits as of December 31, 2021 and 2020.

The current investment policy of HPSM states the chief financial officer/treasurer has the authority to invest or reinvest HPSM’s surplus funds not required for immediate necessities in such a manner as to provide maximum return with adequate protection of the funds. Return on invested funds is secondary to safety of principal and liquidity. The Commission may invest in obligations of the U.S. Treasury and other U.S. agencies, bankers’ acceptances, commercial paper from issuing corporations of \$500 million and of the highest letter, and numerical rating as provided by Moody’s Investors Service, Inc., or Standard & Poor’s Corporation, certificates of deposits, repurchase agreements, and the State Treasurer’s Local Agency Investment Fund. No more than 10% of funds invested can be instruments of any single institution other than securities issued by the U.S. Government and its affiliated agencies. Additional restrictions are placed on the concentration of investments and the days until maturity. The table also identifies certain provisions that address interest rate risk, credit risk, and concentration risk.

<u>Authorized Investment Type</u>	<u>Maximum Maturity</u>	<u>Maximum Specified Percentage Portfolio</u>	<u>Maximum Investment in One Issuer</u>
U.S. Treasury Obligations	None	None	None
U.S. Agencies	None	None	None
Bankers’ Acceptances	270 days	40%	30%
Commercial Paper	180 days	10%	None
Negotiable Certificates of Deposits	2 years	30%	None
Repurchase Agreements	10 days	None	None
	75% of holdings - 4.5 years with no single purchase greater than 6 years		
	25% of holdings - month to month		
State Operating Funds and Reserves	month	None	None

State Treasurer’s Local Agency Investment Fund – HPSM has an investment in the State Treasurer’s Local Agency Investment Fund (“LAIF”). The investment in LAIF is carried at fair value, which approximates amortized cost. Generally, the investments in LAIF are available for withdrawal on demand. The investment in LAIF does not meet the criteria for risk categorization.

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LAIF has an equity interest in the State of California Pooled Money Investment Account ("PMIA"). PMIA funds are on deposit with the State's Centralized Treasury System and are managed in compliance with the California Government Code (the "Code") according to a statement of investment policy which sets forth permitted investment vehicles, liquidity parameters, and maximum maturity of investments. These investments consist of U.S. government securities, securities of federally-sponsored agencies, U.S. corporate bonds, interest-bearing time deposits in California banks, prime-rated commercial paper, bankers' acceptances, negotiable certificates of deposit, and repurchase and reverse repurchase agreements. The PMIA policy limits the use of reverse repurchase agreements subject to limits of no more than 10% of PMIA. The PMIA does not invest in leveraged products or inverse floating rate securities. The PMIA cash and investments are recorded at amortized cost, which approximates fair value.

County of San Mateo Pooled Fund – HPSM also has an investment in the County of San Mateo Pooled Fund ("CSMPF"). The investment in CSMPF is carried at fair value, which approximates amortized cost.

CSMPF funds are on deposit with the County's Treasurer and are managed in compliance with the Code, according to a statement of investment policy, developed by the Treasurer, reviewed and approved annually by the County Treasury Oversight Committee and the County Board of Supervisors.

The investment policies of the CSMPF are similar to those of the PMIA.

The amounts invested in LAIF and CSMPF are considered investments in an external investment pool and earn interest based on the blended rate of return earned by the entire portfolio in the pool. As HPSM does not own identifiable investment securities of the pool but participates as a shareholder of the pool, these investments are not individually identifiable and were not required to be categorized under GASB Statement No. 62 Section C20, *Cash Deposits with Financial Institutions*.

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A fair value hierarchy is also established which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in active markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

HPSM's equity in the investment pool is determined by the dollar amount of HPSM's deposits, adjusted for withdrawals and distributed investment income. Investment income is determined on an amortized cost basis. Interest payments, accrued interest, accreted discounts, amortized premiums, and realized gains and losses, net of administrative fees, are apportioned to pool participants every quarter. This method differs from the fair value method used to value investments in these financial statements as unrealized gains or losses are not apportioned to pool participants.

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Per CSMPF's investment policy, any request to withdraw funds shall be subject to the consent of the Treasurer and shall be released at no more than 12.5% per month, based on the month-end balance of the prior month. In accordance with California Government Code 27136 et seq, and 27133(h) et seq, these requests are subject to the Treasurer's consideration of the stability and predictability of the pooled investment fund, or the adverse effect on the interests of the other depositors in the pooled investment fund.

Investments and assets restricted as to use not subject to fair value hierarchy as of December 31:

	<u>2021</u>	<u>2020</u>
Certificate of deposits	\$ 300,000	\$ 300,000
San Mateo County Pooled Fund	106,831,321	105,708,812
Local Agency Investment Fund	<u>72,316,846</u>	<u>72,024,588</u>
Total investments and assets restricted as to use	<u>\$ 179,448,167</u>	<u>\$ 178,033,400</u>

There were no investments subject to fair value hierarchy as of December 31, 2021 and 2020.

The custodial credit risk, interest rate, credit risk, and concentration of credit risk under GASB Statement No. 62 Section C20, *Cash Deposits with Financial Institutions*, at December 31, 2021 and 2020 were as follows:

Custodial credit risk – Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, HPSM will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The Code requires financial institutions to secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under State Law. As of December 31, 2021 and 2020, deposits exposed to custodial credit risk as they were uninsured, and the collateral held by the pledging bank not in HPSM's name were \$257,910,849 and \$198,967,209, respectively.

Custodial credit risk for investments is the risk that, in the event of the failure of the counterparty to a transaction, HPSM will not be able to recover the value of its investments or collateral securities that are in the possession of another party. As of December 31, 2021 and 2020, HPSM did not hold investments exposed to custodial credit risk.

Interest rate risk – Changes in market interest rates will adversely affect the fair value of an investment. In accordance with its investment policy, HPSM manages the risk of market value fluctuations due to overall changes in the general level of interest rates by limiting the weighted average maturity of its portfolio to no more than five years.

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The weighted average maturity in years for the \$300,000 certificates of deposit included in assets restricted as to use was 0.31 and 0.47 as of December 31, 2021 and 2020, respectively. The weighted average maturity in years for the portfolio was 0.31 and 0.47 as of December 31, 2021 and 2020, respectively.

Credit risk – Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of rating by a nationally recognized statistical rating organization. Per GASB Statement No. 62 Section C20, *Cash Deposits with Financial Institutions*, unless there is information to the contrary, obligations of the U.S. Government or obligations explicitly guaranteed by the U.S. Government are not considered to have credit risk and do not require disclosure of credit quality. Presented below is the minimum rating required by (where applicable) the California Government Code or HPSM's investment policy and the actual rating as of year-end for each investment type.

Ratings as of December 31, 2021 and 2020 for the certificates of deposit were A-1.

Concentration of credit risk – The investment policy of HPSM contains certain limitations on the amount that can be invested in any one issuer and is listed in the table above. There are no investments in any one issuer (other than U.S. Treasury securities, mutual funds, and external investment pools) that represent 5% or more of the total HPSM's investments at December 31, 2021 and 2020.

NOTE 3 – CAPITATION RECEIVABLE FROM THE STATE OF CALIFORNIA

HPSM receives capitation from the State based upon the monthly capitation rate of each aid code (Medi-Cal category of eligibility). The State makes monthly payments based on actual members for the current month and changes for the prior 12 months.

HPSM estimates the current and prior years' capitation receivable based on the State's most current actual member counts by aid code. Currently, HPSM records the current year capitation receivable based on the most current actual member counts by aid code. The amounts are trued up on a monthly basis.

San Mateo Health Commission
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NOTE 4 – CAPITAL ASSETS

Capital asset activity for the fiscal year ended December 31, 2021 was as follows:

	<u>Beginning Balance</u>	<u>Increases</u>	<u>Decreases</u>	<u>Ending Balance</u>
Furniture and equipment	\$ 14,271,900	\$ 123,975	\$ -	\$ 14,395,875
Building improvements	23,028,338	58,923	-	23,087,261
Building	31,810,055	-	-	31,810,055
Land	15,667,814	-	-	15,667,814
Total capital assets	<u>84,778,107</u>	<u>182,898</u>	<u>-</u>	<u>84,961,005</u>
Less: accumulated depreciation and amortization	<u>19,816,938</u>	<u>2,262,175</u>	<u>-</u>	<u>22,079,113</u>
Capital assets, net	<u>\$ 64,961,169</u>	<u>\$ (2,079,277)</u>	<u>\$ -</u>	<u>\$ 62,881,892</u>

Capital asset activity for the fiscal year ended December 31, 2020 was as follows:

	<u>Beginning Balance</u>	<u>Increases</u>	<u>Decreases</u>	<u>Ending Balance</u>
Furniture and equipment	\$ 14,092,100	\$ 179,800	\$ -	\$ 14,271,900
Building improvements	22,822,656	205,682	-	23,028,338
Building	31,810,055	-	-	31,810,055
Land	15,667,814	-	-	15,667,814
Total capital assets	<u>84,392,625</u>	<u>385,482</u>	<u>-</u>	<u>84,778,107</u>
Less: accumulated depreciation and amortization	<u>16,924,778</u>	<u>2,892,160</u>	<u>-</u>	<u>19,816,938</u>
Capital assets, net	<u>\$ 67,467,847</u>	<u>\$ (2,506,678)</u>	<u>\$ -</u>	<u>\$ 64,961,169</u>

Depreciation and amortization expense for capital assets for the years ended December 31, 2021 and 2020 was \$2,262,175 and \$2,892,160, respectively.

**San Mateo Health Commission
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Notes to Financial Statements**

NOTE 5 – MEDICAL CLAIMS PAYABLE

The cost of healthcare services is recognized in the period in which it is provided and includes an estimate of the cost of services that have been incurred but not yet reported.

HPSM contracts with various providers, including physicians and hospitals, to provide certain healthcare products and services to enrolled Medi-Cal, Health Worx, Healthy Kids, WCM, IHSS, Cal MediConnect, and CareAdvantage beneficiaries. The cost of the healthcare products and services provided or contracted for is accrued in the period in which it is provided to a member and includes an estimate of the cost of services that have been incurred but not yet reported. The estimate for reserves for claims is based on projections of hospital and other costs using historical studies of claims paid. Estimates are monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions.

Activity for medical claims payable for the years ended December 31 is summarized as follows:

	<u>2021</u>	<u>2020</u>
Balance at beginning of period	\$ 124,710,273	\$ 77,178,853
Incurred		
Current year	726,170,101	668,239,974
Prior year	<u>3,668,064</u>	<u>21,015,999</u>
	<u>729,838,165</u>	<u>689,255,973</u>
Paid related to		
Current year	642,936,442	567,498,100
Prior year	<u>110,470,272</u>	<u>74,226,453</u>
Total paid	<u>753,406,714</u>	<u>641,724,553</u>
Balance at end of period	<u>\$ 101,141,724</u>	<u>\$ 124,710,273</u>

Medical claims payable decreased by \$23.6 million in comparison to the previous year. The decrease is primarily due to a retrospective rate adjustment resulting from a long-term care cost report appeal settlement. The medical claims payable balance as of December 31, 2020 included a \$30 million accrual, all of which was paid in 2021. The medical claims payable balance as of December 31, 2021 included an additional \$10 million accrual, which will be paid in 2022. This item contributes to the overall decrease in liability by \$20 million year over year.

NOTE 6 – INCENTIVES PAYABLE TO PROVIDER

As of July 1, 2018, HPSM implemented a Pay for Performance (“P4P”) program for our Primary Care Providers. Under the P4P program providers are financially rewarded for meeting quality outcome benchmarks measured and paid on an annual basis. The quality metrics target preventive and chronic condition management services identified as high impact for our patient population.

San Mateo Health Commission (d.b.a. Health Plan of San Mateo) Notes to Financial Statements

In October 2019, HPSM implemented a new quality incentive program with nursing facilities that provide skilled and/or long-term care services to HPSM members for meeting targeted quality measures. The program is designed to improve outcomes by incentivizing member access and high-quality care. The first measurement period is in 2020, with the first payments from results starting in 2021.

NOTE 7 – RESERVE FOR STABILIZATION AND MINIMUM TANGIBLE NET EQUITY

The Commission, at its discretion, from time to time designates portions of net position for the establishment of certain reserves. These reserves are Board designated and unrestricted. They are available to satisfy the unreserved net position.

As a limited license plan under the Act, HPSM is required to maintain a minimum level of tangible net equity. On November 9, 2016, the San Mateo Health Commission approved a change to the stabilization reserve from 250% of the minimum tangible net equity (“TNE”) as defined by the DMHC regulation to two (2) months of operating expenses. As of December 31, 2021 and 2020, the stabilization reserve was \$178,301,779 and \$154,945,080, respectively.

As of December 31, 2021, the minimum TNE was \$43,302,105. Total net position as of December 31, 2021, is \$360,378,083, which exceeds the minimum tangible net equity by \$317,075,978 and is 832% of TNE.

As of December 31, 2020, the minimum TNE was \$38,213,723. Total net position as of December 31, 2020, is \$333,269,264, which exceeds the minimum tangible net equity by \$295,055,541 and is 872% of TNE.

NOTE 8 – DEFERRED COMPENSATION FUND

HPSM contributes an amount equal to 7.5% of gross salary on behalf of the employee to an IRC Section 457 deferred compensation plan per Internal Revenue Service (“IRS”) regulations in lieu of social security. In July 2016, HPSM held a vote of its employees to determine for themselves whether or not to participate in social security effective October 1, 2016. Employees who voted to participate in social security would no longer receive the 7.5% of gross salary contribution. Those voting not to participate would continue to receive the contributions in lieu of social security.

All HPSM employees may participate in this deferred compensation plan under which employees are permitted to defer a portion of their annual salary until future years. For the years ended December 31, 2021 and 2020, HPSM contributed \$724,863 and \$714,238, respectively. The deferred compensation plan is administered by the International City Managers Association and the funds are invested under the terms of a trust agreement. The amounts are not available to employees until termination, retirement, death, or unforeseeable emergency.

The market value of the investments held equals the liability to plan participants under the deferred compensation plan. The deferred compensation investments consisted of various participant directed uninsured investments.

The assets in the plan are not available to pay the liabilities of HPSM. Therefore, the respective assets and liabilities are not reflected in the statements of net position of HPSM.

NOTE 9 – HEALTH PLAN OF SAN MATEO RETIREMENT PLAN – FIDUCIARY FUND

Effective January 1, 1994, HPSM established the Health Plan of San Mateo Employee Retirement Plan (the “Plan”). The Plan is a single-employer defined benefit pension (cash balance) plan administered by HPSM. Eligible HPSM employees become members of the Plan on the first day of employment. HPSM has the authority to amend or terminate the Plan at any time and for any reason by action of its Commission. The Plan does not issue a stand-alone financial report.

Under the Plan, participants’ account balances are credited with contributions equal to 10% of their annual compensation, plus interest of 5% on an annual basis effective January 1, 2005. Benefits are payable in the form of a single-sum payment upon termination or can be deferred through optional payment forms. Participants earn a vested right to accrued benefits upon completion of three years of service and upon death, permanent disability, or employer termination of the Plan. Contributions to the Plan are made by HPSM as no contributions are permitted by participants.

Summary of Significant Accounting Policies

Basis of accounting – The Plan fiduciary financial statements are prepared using the accrual basis of accounting. HPSM’s contributions are recognized in the period in which contributions are made. Benefits are recognized when due and payable in accordance with the terms of the Plan.

Investments – The Plan’s investments are reported at fair value, including certain investments held in pooled, common and collective trusts which are maintained for the collective investments are reinvestments of monies contributed to the funds.

Mutual funds – Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are open-end mutual funds that are registered with the U.S. Securities and Exchange Commission. These funds are required to publish their daily net asset value (“NAV”) and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded.

Pooled, common, and collective trusts – Units held in pooled investment accounts are valued using the NAV practical expedient of the pooled investment account as reported by the account managers. The NAV is based on the fair value of the underlying assets owned by the pooled investment account, minus its liabilities, and then divided by the number of units outstanding. The NAV of a pooled investment account is calculated based on a compilation of primarily observable market information. The funds invested in the Wells Fargo collective trusts are discretionary accounts managed by Wells Fargo; as a participant of those collective trusts, the Plan purchases and redemption of units from each fund are based on unit values as of the valuation date. Purchases and redemption of units may occur on a daily basis with no redemption fees or other restrictions. Further, the funds do not distribute their investment income to participants, but rather reinvest their investment income back into their respective funds.

**San Mateo Health Commission
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Investments by fair value level include the following as of December 31:

<u>Description</u>	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>2021</u>
Investments by fair value level				
Mutual funds	\$ 5,885,732	\$ -	\$ -	\$ 5,885,732
Total investments subject to fair value hierarchy	<u>\$ 5,885,732</u>	<u>\$ -</u>	<u>\$ -</u>	5,885,732
Investments not subject to fair value hierarchy				
Pooled, common, and collective trusts - at NAV				<u>26,390,073</u>
Total investments				<u>\$ 32,275,805</u>

<u>Description</u>	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>2020</u>
Investments by fair value level				
Mutual funds	\$ 4,816,198	\$ -	\$ -	\$ 4,816,198
Total investments subject to fair value hierarchy	<u>\$ 4,816,198</u>	<u>\$ -</u>	<u>\$ -</u>	4,816,198
Investments not subject to fair value hierarchy				
Pooled, common, and collective trusts - at NAV				<u>23,203,483</u>
Total investments				<u>\$ 28,019,681</u>

Plan description – Participant data for the Plan, as of the measurement date for the year indicated, is as follows:

	<u>2021</u>	<u>2020</u>
Retired and beneficiaries	12	12
Inactive	49	45
Active	<u>293</u>	<u>273</u>
Total participants	<u>354</u>	<u>330</u>

All employees are eligible to participate, except for the following: “leased” employees, nonresident aliens, temporary employees, and individuals designated by the employer as ineligible to participate in the Plan.

Retirement dates are either – Normal – first of the month following or coincident with attainment of age 65. Deferred – first of any month following actual retirement after age 65. Early – any age prior to age 65 following completion of at least 3 years of vesting service.

Benefits at normal retirement – Each participant will receive an accumulated credit account determined as the sum of the following:

- a) Effective January 1, 1994, 10% of compensation received as an employee prior to the effective date;
- b) Effective January 1, 1994, investment credits that would have been credited to the account prior to the effective date if it had been in place;
- c) For each year starting on or after January 1, 1994, 10% of compensation earned during the plan year; and

**San Mateo Health Commission
(d.b.a. Health Plan of San Mateo)
Notes to Financial Statements**

- d) For each year starting on or after January 1, 1994, an investment credit determined as the Investment Crediting Rate applied to the Accumulated Credit Account at the start of the year, plus the Investment Crediting Rate applied for half a year to the compensation credit for the year.

Investment credits under d) will be pro-rated for the length of participation in the year of payment.

Contribution – HPSM agrees to maintain and contribute funds to the Plan in an amount sufficient to pay the vested accrued benefits of participating members and the beneficiaries when the benefits become due. Members do not make contributions. The Finance Committee makes contributions based on the established funding policy.

Rate of return – For the years ended December 31, 2021 and 2020, the actual rate of return on the Plan's investments, net of investment expenses were 0.31% and 0.59%, respectively.

The following table summarizes changes in pension asset for the year ended December 31, 2021:

	Total Pension Liability	Plan Fiduciary Net Pension	Net Pension (Asset) Liability
Balance at December 31, 2020	\$ 27,270,738	\$ 28,734,252	\$ (1,463,514)
Changes during the year			
Service cost at beginning of year:	1,850,939	-	1,850,939
Interest	2,156,704	-	2,156,704
Differences between expected and actual experience	243,072	-	243,072
Changes in assumptions	54	-	54
Benefit payments	(744,699)	(744,699)	-
Contributions	-	1,948,733	(1,948,733)
Net investment income	-	3,211,839	(3,211,839)
Net change in total pension liability (asset)	<u>3,506,070</u>	<u>4,415,873</u>	<u>(909,803)</u>
Balance at December 31, 2021	<u>\$ 30,776,808</u>	<u>\$ 33,150,125</u>	<u>\$ (2,373,317)</u>
Total pension liability			\$ 30,776,808
Plan fiduciary net position			<u>33,150,125</u>
Net pension asset			<u>\$ (2,373,317)</u>
Plan fiduciary net position as a percentage of the total pension liability			107.71%
Covered payroll as of December 31, 2021, actuarial valuation			\$ 27,278,649
Net pension asset as a percentage of covered payroll			-8.70%

San Mateo Health Commission
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The following table summarizes changes in pension asset for the year ended December 31, 2020:

	<u>Total Pension Liability</u>	<u>Plan Fiduciary Net Pension</u>	<u>Net Pension (Asset) Liability</u>
Balance at December 31, 2019	\$ 23,397,044	\$ 24,386,084	\$ (989,040)
Changes during the year:			
Service cost at beginning of year	1,760,865	-	1,760,865
Interest	1,841,604	-	1,841,604
Differences between expected and actual experience	1,514,965	-	1,514,965
Changes in assumptions	(15,143)	-	(15,143)
Benefit payments	(1,228,597)	(1,228,597)	-
Contributions	-	1,772,346	(1,772,346)
Net investment income	-	3,804,419	(3,804,419)
	<u>3,873,694</u>	<u>4,348,168</u>	<u>(474,474)</u>
Net change in total pension liability (asset)			
Balance at December 31, 2020	<u>\$ 27,270,738</u>	<u>\$ 28,734,252</u>	<u>\$ (1,463,514)</u>
Total pension liability			\$ 27,270,738
Plan fiduciary net position			<u>28,734,252</u>
Net pension asset			<u>\$ (1,463,514)</u>
Plan fiduciary net position as a percentage of the total pension liability			105.37%
Covered payroll as of December 31, 2020, actuarial valuation			\$ 26,690,439
Net pension liability as a percentage of covered payroll			-5.48%

The following table summarizes the actuarial assumptions used to determine net pension liability and plan fiduciary net position as of December 31, 2021 and 2020:

Valuation date:	Contributions related to the actuarially determined contributions made for the plan year
Actuarial cost method:	January 1 to December 31
Amortization method:	Entry age normal actuarial cost method
Asset valuation method:	Level dollar, closed amortization
Actuarial assumptions:	Market value
Projected salary increases	5.00%
Mortality	Based on the Pri-2012 healthy mortality table for males and females, with future mortality improvements projected on a fully generational basis using projection scale MP-2020
Discount rate	7.50%

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The following table summarizes the sensitivity of net pension asset to changes in the discount rates as of December 31:

	1% Decrease (6.50%)	Current Discount Rate (7.50%)	1% Increase (8.50%)
Net pension liability (asset) as of December 31, 2021	\$ (388,718)	\$ (2,373,317)	\$ (4,143,955)
	1% Decrease (6.50%)	Current Discount Rate (7.50%)	1% Increase (8.50%)
Net pension liability (asset) as of December 31, 2020	\$ 359,150	\$ (1,463,514)	\$ (3,086,554)

Components of pension cost included in salaries and fringe benefits and deferred outflows and deferred inflows of resources, as calculated under the requirements of Accounting and Financial Reporting for Pensions ("GASB 68"), are as follows:

	2021	2020
Service cost	\$ 1,850,939	\$ 1,760,865
Interest cost	2,156,704	1,841,604
Projected earnings on plan investments	(2,199,404)	(1,848,978)
Current period difference between expected and actual experience	39,848	245,936
Current period effect of changes in assumptions	9	(2,458)
Current period difference between projected and actual investment earnings	(202,487)	(391,088)
Current period recognition of prior years' deferred outflows of resources	1,131,716	910,764
Current period recognition of prior years' deferred inflows of resources	(1,208,274)	(1,063,921)
Total pension cost	\$ 1,569,051	\$ 1,452,724
	2021	2020
Deferred outflows of resources as of December 31		
Difference between expected and actual experience	\$ 1,793,306	\$ 2,176,203
Changes in assumptions	19,269	25,932
Total	\$ 1,812,575	\$ 2,202,135
	2021	2020
Deferred inflows of resources as of December 31		
Changes in assumptions	\$ 10,906	\$ 13,737
Difference between projected and actual investment earnings	2,472,627	2,329,235
	\$ 2,483,533	\$ 2,342,972

**San Mateo Health Commission
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Notes to Financial Statements**

Deferred inflows of resources as of December 31, 2021, and 2020 consist of \$538,888 and \$1,077,775, respectively, of deferred outflows from difference between projected and actual investment earnings, presented in a consolidated format per GASB 68.

Amount reported as deferred outflows of resources and deferred inflows of resources to pension will be recognized in pension expense are as follows:

Year Ending December 31,

2022	\$	10,463
2023		(645,280)
2024		(212,492)
2025		93,556
2026		78,811
Thereafter		<u>3,984</u>
	\$	<u><u>(670,958)</u></u>

NOTE 10 – MEDICAL REINSURANCE (STOP-LOSS INSURANCE)

HPSM has entered into certain reinsurance (stop-loss) agreements with third parties to limit its losses on individual claims. Under the terms of these agreements, the third parties will reimburse HPSM certain proportions of the cost of each member's annual healthcare services in excess of specified deductibles (\$425,000 for all lines of business for all healthcare expenses excluding pharmacy), limited to \$2,000,000 in aggregate over all contract years per member.

Stop-loss insurance premiums of \$6,917,887 and \$4,359,518 are included in other medical expense in 2021 and 2020, respectively.

In 2021, there is a total of \$4,599,277 in recoveries: Medi-Cal \$3,196,053 and \$570,025 for 2021 and 2020 dates of service; Adult Expansion \$118,304 and \$0 for 2021 and 2020 dates of service; Cal MediConnect \$545,751 and \$62,822 for 2021 and 2020 dates of service; and WCM \$95,404 and \$10,918 for 2021 and 2020 dates of service.

In 2020, there is a total of \$5,095,900 in recoveries: Medi-Cal \$2,342,140 and \$508,551 for 2020 and 2019 dates of service; Adult Expansion \$0 and \$77,280 for 2020 and 2019 dates of service; Cal MediConnect \$342,292 and \$331,300 for 2020 and 2019 dates of service; and WCM \$972,070 and \$522,267 for 2020 and 2019 dates of service.

NOTE 11 – PROFESSIONAL LIABILITY INSURANCE

HPSM maintains insurance coverage for professional liability and errors and omissions insurance. The policy is an occurrence-based policy and designed specifically for health maintenance organizations to provide comprehensive professional liability insurance and errors and omissions insurance for HPSM employees and certain covered physicians. There have been no reductions in coverage or any claims that have exceeded coverage in any of the past three years.

NOTE 12 – COMMITMENTS AND CONTINGENCIES

In the ordinary course of business, HPSM is a party to claims and legal actions by enrollees, providers, and others. After consulting with legal counsel, HPSM’s management is of the opinion that any liability that may ultimately be incurred as a result of claims or legal actions will not have a material effect on the financial position or results of operations of HPSM.

NOTE 13 – HEALTHCARE REFORM

The Patient Protection and Affordable Care Act (“PPACA”) allowed for the expansion of Medi-Cal members in the State of California. Any further federal or state changes funding could have an impact on HPSM. With the changes in the executive branch, the future of PPACA and impact of future changes in Medi-Cal to HPSM is uncertain at this time.

NOTE 14 – SUBSEQUENT EVENTS

Subsequent events are events or transactions that occur after the statement of financial position date but before financial statements are available to be issued. The Commission recognizes in the financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the statement of financial position, including the estimates inherent in the process of preparing the financial statements. The Commission’s financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the statement of financial position but arose after the statement of financial position date and before financial statements are available to be issued.

The Commission has evaluated subsequent events through [REDACTED], 2022, which is the date the financial statements were available to be issued.

Supplementary Information

FINAL DRAFT

**San Mateo Health Commission
(d.b.a. Health Plan of San Mateo)
Supplementary Schedule of Changes in the Net Pension (Asset) Liability and Related Ratios**

	<u>2021</u>	<u>2020</u>	<u>2019</u>	<u>2018</u>
Total pension liability				
Service cost at beginning of year	\$ 1,850,939	\$ 1,760,865	\$ 1,555,503	\$ 1,409,343
Interest	2,156,704	1,841,604	1,654,496	1,493,432
Changes of benefit terms	-	-	-	-
Differences between expected and actual experience	243,072	1,514,965	561,651	579,658
Changes in assumptions	54	(15,143)	37,351	(2,171)
Benefit payments	<u>(744,699)</u>	<u>(1,228,597)</u>	<u>(1,800,659)</u>	<u>(1,168,557)</u>
Net change in total pension liability	3,506,070	3,873,694	2,008,342	2,311,705
Total pension liability beginning of fiscal year	<u>27,270,738</u>	<u>23,397,044</u>	<u>21,388,502</u>	<u>19,076,797</u>
Total pension liability end of fiscal year (a)	<u>\$ 30,776,808</u>	<u>\$ 27,270,738</u>	<u>\$ 23,396,844</u>	<u>\$ 21,388,502</u>
Plan fiduciary net pension				
Contributions	\$ 1,948,733	\$ 1,772,346	\$ 1,613,011	\$ 1,396,529
Net investment income	3,211,839	3,804,419	4,099,419	(1,086,108)
Benefit payments	<u>(744,699)</u>	<u>(1,228,597)</u>	<u>(1,800,659)</u>	<u>(1,168,557)</u>
Net change in Plan fiduciary net position	4,415,873	4,348,168	3,911,771	(858,136)
Plan fiduciary net position beginning of year	<u>28,734,252</u>	<u>24,386,084</u>	<u>20,474,313</u>	<u>21,332,449</u>
Plan fiduciary net position end of fiscal year (b)	<u>\$ 33,150,125</u>	<u>\$ 28,734,252</u>	<u>\$ 24,386,084</u>	<u>\$ 20,474,313</u>
Net pension (asset) liability end of fiscal year				
Plan's net pension (asset) liability (a) - (b)	\$ (2,373,317)	\$ (1,463,514)	\$ (989,240)	\$ 914,189
Plan fiduciary net position				
as a percentage of the total pension liability	107.71%	105.37%	104.23%	95.73%
Covered employee payroll	\$ 27,278,649	\$ 26,690,439	\$ 23,367,767	\$ 22,218,355
Net pension (asset) liability				
as a percentage of covered payroll	-8.70%	-5.48%	-4.23%	4.11%

**San Mateo Health Commission
(d.b.a. Health Plan of San Mateo)
Supplementary Schedule of Contributions**

	<u>2021</u>	<u>2020</u>	<u>2019</u>	<u>2018</u>	<u>2017</u>
Actuarial determined contribution	\$ 1,948,733	\$ 1,772,346	\$ 1,613,011	\$ 1,396,529	\$ 1,313,247
Contributions related to actuarially determined contribution	\$ 1,948,733	\$ 1,772,346	\$ 1,613,011	\$ 1,396,529	\$ 1,313,247
Contribution deficiency (excess)	\$ -	\$ -	\$ -	\$ -	\$ -
Covered payroll	\$ 27,278,649	\$ 26,690,439	\$ 23,367,767	\$ 23,367,767	\$ 20,084,266
Contribution as % of covered payroll	7.14%	6.64%	6.90%	5.98%	6.54%
Contributions made during the fiscal year	\$ 1,948,733	\$ 1,772,346	\$ 1,613,011	\$ 1,396,529	\$ 1,313,247
	<u>2016</u>	<u>2015</u>	<u>2014</u>	<u>2013</u>	<u>2012</u>
Actuarial determined contribution	\$ 1,164,095	\$ 1,437,466	\$ 1,367,854	\$ 1,321,835	\$ 1,382,058
Contributions related to actuarially determined contribution	\$ 1,164,095	\$ 1,459,445	\$ 1,333,194	\$ 1,361,858	\$ 1,440,249
Contribution deficiency (excess)	\$ -	\$ (21,979)	\$ 34,660	\$ (40,023)	\$ (58,191)
Covered payroll	\$ 18,167,831	\$ 16,535,874	\$ 15,989,836	\$ 14,768,660	\$ 13,203,459
Contribution as % of covered payroll	6.41%	8.83%	8.34%	9.22%	10.91%
Contributions made during the fiscal year	\$ 1,164,095	\$ 1,459,445	\$ 1,333,194	\$ 1,361,858	\$ 1,440,249

FINAL DRAFT

**San Mateo Health Commission and
San Mateo Community Health Authority
(d.b.a. Health Plan of San Mateo)
Supplementary Schedule of Investment Returns –
Health Plan of San Mateo Retirement Plan Fund**

<u>Years Ended December 31,</u>	<u>Rate of return</u>
2021	10.95%
2020	15.43%
2019	22.21%
2018	-5.05%
2017	16.57%

FINAL DRAFT

MEMORANDUM

AGENDA ITEM: 5.2

DATE: April 13, 2022

DATE: April 4, 2022

TO: San Mateo Health Commission

FROM: Patrick Curran, Chief Executive Officer

RE: Approval of Funding Recommendations for the Children's Health Initiative (CHI) Fund

Recommendation

Approve distributing \$85,000 in an up-front payment and an additional \$20,000 in incentive payments from the restricted Children's Health Initiative Fund to Ravenswood Family Health Network for a period of July 1, 2022, through June 30, 2024. This recommendation is to fund the capital improvement of a dental operatory to increase access to dental care for children and improve the overall quality of dental health.

Background and Discussion

In 2003, San Mateo County and key partners launched the Children's Health Initiative to achieve universal health insurance coverage for children in San Mateo County. HPSM played a critical role by administering a locally supported health insurance program called Healthy Kids that was designed to serve children ineligible for federal and state programs, generally due to immigration status.

In 2007, governance for this initiative was moved from San Mateo County to the San Mateo Health Commission with guidance by the Children's Health Initiative (CHI) Oversight Committee. HPSM operated the Healthy Kids program until 2018; the State expanded the Medi-Cal program in 2016, covering all children under the age of 19 regardless of immigration status. CHI had built up a reserve over many years of program operations; the reserve is managed by the County in a restricted Children's Health Initiative fund.

The CHI Oversight Committee operates through a Memorandum of Understanding (MOU) involving eight voting members. This MOU was last revised in January 2019. San Mateo County oversees the financial stewardship of the restricted fund established to support CHI. HPSM is one of the eight voting members and participates in the CHI Oversight Committee.

The dollars held in the CHI Fund were not contributed by HPSM. The funding was contributed by the following entities: San Mateo County, First Five San Mateo County, Peninsula Health Care District, and Sequoia Healthcare District.

Since Medi-Cal was expanded to cover all children, the CHI Oversight Committee has considered areas of investment for children in San Mateo County for the use of the remaining restricted reserve funds. Between December 2020 and September 2021, CHI recommended and the commission approved directing \$5,159,800 from the restricted fund for various programs to increase dental access, to administer an oral health planning grant, to provide support to immigrant families through Mission Assets Fund's San Mateo County Immigrant Relief Fund, and have returned funds to Sequoia Health Care District.

The proposed grant to Ravenswood Family Health Network will fund capital expenditures to include one dental chair and, associated equipment and instruments. This expansion project will increase the number of low-income children receiving dental services between July 1, 2022, through June 30, 2024. This increase of access to dental care will improve the overall quality of dental health.

The goals for this initiative include increasing access to children under age 18 with Medi-Cal coverage in San Mateo County; increasing the number of patients with a dental home; and, increasing overall quality of dental health. Ravenswood will construct one operatory, conduct targeted outreach, hold screening events in the community and provide a referral pathway to community partners. They will also submit semi-annual progress reports to HPSM towards the achievement of the goal of increasing 600 new Medi-Cal patients under age 18 during the two year period.

Fiscal Impact

The San Mateo Health Commission, as the governing body for CHI, must authorize release of funds from the restricted account. These funds do not have any financial impact on Health Plan of San Mateo and are not held in HPSM accounts. The estimated remaining dollars in the CHI restricted account after the distribution of these funds will be \$1.42M. After approval by the Commission, this recommendation will be brought to the San Mateo County Board of Supervisors for approval.

DRAFT

**RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION**

**IN THE MATTER OF APPROVAL OF FUNDING FROM THE
CHILDREN’S HEALTH INITIATIVE RESTRICTED FUND FOR
RAVENSWOOD FAMILY HEALTH NETWORK (DENTAL)**

RESOLUTION 2022 -

RECITAL: WHEREAS,

- A. The Children’s Health Initiative (CHI) was created in 2003 to achieve universal health insurance coverage in San Mateo County for children ineligible for federal and state programs;
- B. In 2007, governance for this initiative was moved to the San Mateo Health Commission with San Mateo County overseeing the financial stewardship of the restricted fund established to support CHI;
- C. The CHI Oversight Committee has conducted research and analysis of the needs facing children and their families; and
- D. Based on findings, the CHI Oversight Committee recommends funding the Ravenswood Family Health Network \$105,000 for project to increase dental access.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

- 1. The San Mateo Health Commission approves the agreement for a one-time distribution of \$85,000 from the restricted Children’s Health Initiative Fund to fund the capital improvement of a dental operatory and two \$10,000 incentive payments if specific goals are met during the period of July 1, 2022, through June 30, 2024; and
- 2. Authorizes the Chief Executive Officer to sign said agreement.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of April 2022 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

Don Horsley, Chairperson

ATTEST:

APPROVED AS TO FORM:

BY: _____
C. Burgess, Clerk

Kristina Paszek
DEPUTY COUNTY COUNSEL

AGENDA ITEM: 5.3

DATE: April 13, 2022

**Meeting materials are not included
for Item 5.3 – Overview on IT Security**

MEMORANDUM

AGENDA ITEM: 7.0

DATE: April 13, 2022

DATE: April 5, 2022
TO: San Mateo Health Commission
FROM: Patrick Curran
RE: CEO Report – April 2022

Vaccine Incentive Program

HPSM received the preliminary report from the state indicating that we made significant progress to reduce disparities in vaccine rates among HPSM members compared to the overall county. Many teams are involved in this effort, including staff performing outreach to providers and members, undertaking significant data analysis, and engaging primary care providers, as well as County Health, Legal Aid, and Wider Circle.

Dental Integration

The dental program is successfully matching members with providers every day. Now three months into implementation, we are receiving 30-40 calls per day with questions about benefits and accessing providers. As reported in February, adult access continues to be the main challenge, especially access to specialty care, which is a focused area of recruitment. We are also exploring a potential partnership with San Mateo County and San Mateo Dental Society to increase access and treatment for orthodontic services in our community. We are also planning to perform outreach to families to encourage preventive visits for children during the summer months.

Pharmacy Carve-Out

The state and its contractor Magellan have provided more resources and loosened restrictions for authorizations, which has reduced phone wait times and turnaround times for medication approval. We remain concerned about access to medication, especially for members with specialty drugs and members with special needs.

NCQA Accreditation

We received our accreditation status from the recent NCQA survey. We attained Provisional status, which means that we have successfully passed the majority of the accreditation categories. There are two areas in which we will have additional work during 2022 to improve scores, including Utilization Review and Population Health. Once those areas are remedied, our next regular NCQA survey will be in late 2024. I am extremely grateful for the work of many HPSM staff to help achieve our accreditation status, which is an important element of the state's CalAIM initiative.

Kaiser Direct Contract

HPSM continues to advocate in opposition to this proposed direct contract between the state and Kaiser, as it eliminates the innovative County Organized Health System (COHS) model that has worked for this community since 1987. The next step in the process is, through our statewide association Local Health Plans of California (LHPC), to voice opposition at a hearing on April 19th. The legislative assembly bill through which the direct contract is proposed is AB2724.

Program for Post-Discharge

HPSM partnered with the county and Bay Area Community Services (BACS) to establish a unique program for post-discharge hospitalized patients to render supportive services in a house in South San Francisco, which was staffed by clinical and social service staff. BACS ended their contract with HPSM for this program at the end of March. There were many important learnings from this program, which was also significantly affected by the pandemic. We will continue to explore opportunities with county and community partners to serve members that have needs in the community after hospital discharge or to prevent hospitalization.