HealthPlan OF SAN MATEO
Healthy is for everyone

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THE SAN MATEO HEALTH COMMISSION
Regular Meeting
November 13, 2019 - 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor, Boardroom
South San Francisco, CA 94080

AGENDA

1. **Call to Order/Roll Call**
2. **Public Comment/Communication**
3. **Approval of Agenda**
4. **Consent Agenda***
   - 4.1 Report from Finance/Executive Committee
   - 4.2 Physician Advisory Group Minutes, August & October 2019
   - 4.3 CCS Family and Clinical Advisory Committee, September 2019
   - 4.4 Pharmacy & Therapeutics Committee Minutes, September 2019
   - 4.5 Quality Improvement Committee Minutes, September 2019
   - 4.6 Approval of Amendment to Agreement with Cotiviti
   - 4.7 Approval of San Mateo Health Commission Meeting Minutes from October 9, 2019
5. **Specific Discussion/Action Items**
   - 5.1 Presentation on Long Term Care Collaboration and Payment Model.
   - 5.2 Approval of Agreements with Institute on Aging and Brilliant Corners.*
6. **Report from Chairman/Executive Committee**
7. **Report from Chief Executive Officer**
8. **Other Business**
9. **Adjournment**

**Items for which Commission action is requested.*

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

HealthPlan OF SAN MATEO

AGENDA ITEM: 4.1

DATE: November 13, 2019

M E M O R A N D U M

Date: November 4, 2019
To: San Mateo Health Commission
From: Trent Ehrgood, Chief Financial Officer
Subject: Financial Report for the 9-month Period Ending September 30, 2019

Preliminary 2019 Financial Results All Lines of Business

The preliminary financial result for all lines of business for the month of September is a surplus of $4,427,638. Year-to-date (YTD), the Plan has a surplus of $7,604,640. The table below shows a three-month trend, and YTD compared to budget. New lower premium rates went into effect in July, causing approximately $2M in reduced revenue per month for the remainder of the year. About $5M in favorable retro revenue adjustments were recorded in September, contributing to the surplus for the month.

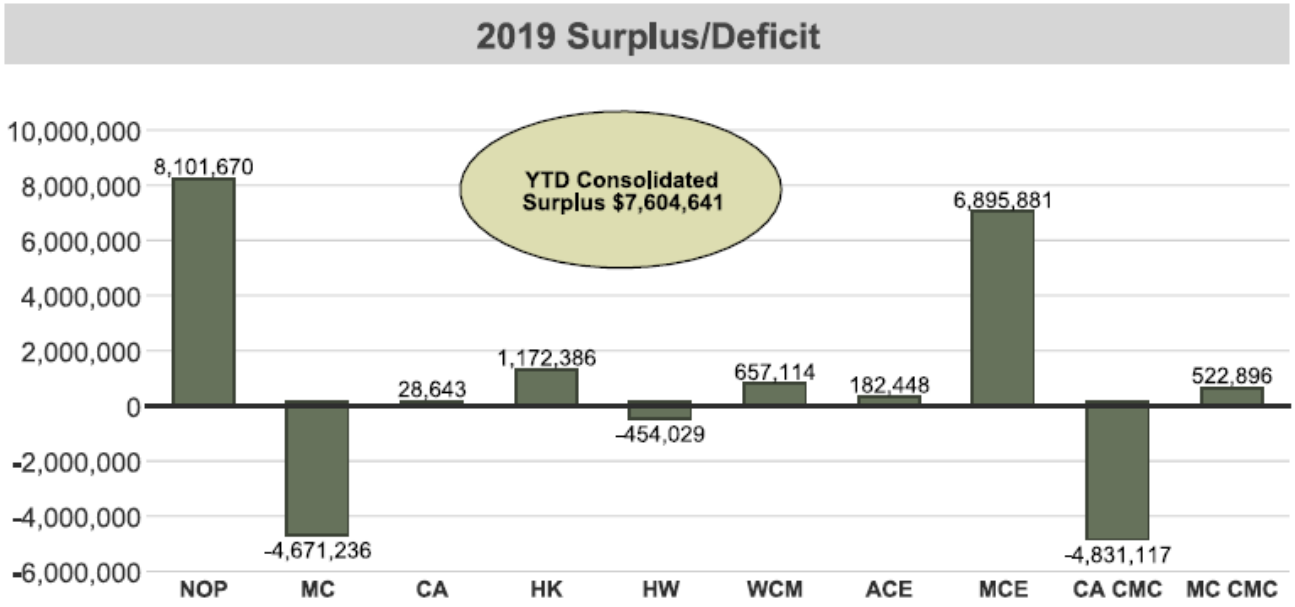
Directed payments that are included in both revenue and healthcare expenses include $45M in Sep and $95M YTD ($83M is PY, and $12M is CY). These amounts inflate revenue and expense but have zero effect to the bottom line.

	Monthly Trend			Year-To-Date		
	Jul	Aug	Sep	Actual	Budget	Variance
Operating Revenue	58,115,945	57,738,266	108,563,305	686,780,768	584,439,604	102,341,164
Healthcare Expenses	56,752,155	58,927,223	101,139,937	620,035,831	518,351,430	101,684,401
Administrative Expenses	4,249,384	4,410,492	4,121,220	37,835,024	39,648,792	(1,813,768)
Premium Taxes	(44,608)	-	-	31,099,624	40,925,408	(9,825,784)
Operating Income/(Loss)	(2,840,986)	(5,599,449)	3,302,148	(2,189,711)	(14,486,026)	12,296,315
Non-Operating Revenue	1,140,570	1,029,650	1,125,490	9,794,351	7,408,014	2,386,337
Net Income/(Loss)	(1,700,416)	(4,569,799)	4,427,638	7,604,640	(7,078,012)	14,682,652

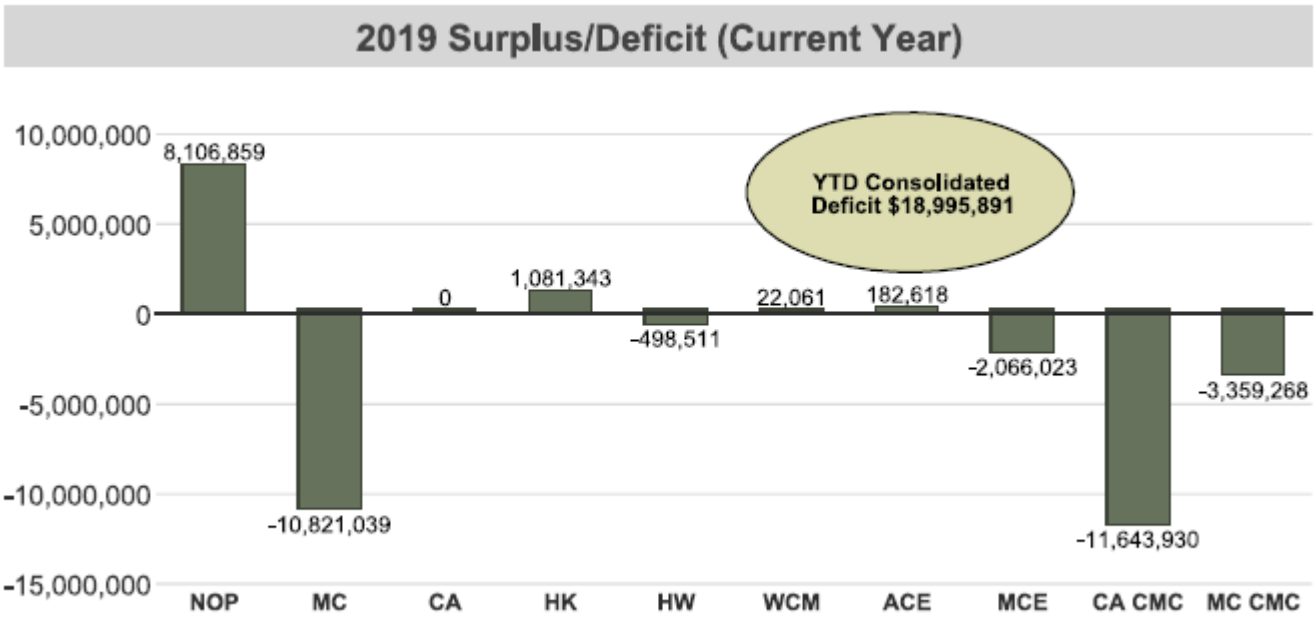
The table below separates prior year (PY) and current year (CY) transactions. The first nine months include $26.6M in favorable prior year transactions. The remaining current year transactions results in a YTD deficit of $19M, compared to the YTD budget deficit of $7.1M.

	YTD by PY/CY			Current Year YTD		
	Prior Year	Current Year	Total	Current Year	Budget	CY Variance
Operating Revenue	104,097,755	582,683,013	686,780,768	582,683,013	584,439,604	(1,756,591)
Healthcare Expenses	77,634,145	542,401,686	620,035,831	542,401,686	518,351,430	24,050,256
Administrative Expenses	-	37,835,024	37,835,024	37,835,024	39,648,792	(1,813,768)
Premium Taxes	(142,281)	31,241,905	31,099,624	31,241,905	40,925,408	(9,683,503)
Operating Income/(Loss)	26,605,891	(28,795,602)	(2,189,711)	(28,795,602)	(14,486,026)	(14,309,576)
Non-Operating Revenue	(5,360)	9,799,711	9,794,351	9,799,711	7,408,014	2,391,697
Net Income/(Loss)	26,600,531	(18,995,891)	7,604,640	(18,995,891)	(7,078,012)	(11,917,879)

The graph below shows the YTD Preliminary Financial Results by line of business combining current year and prior year transactions. YTD consolidated surplus is $7.6M.

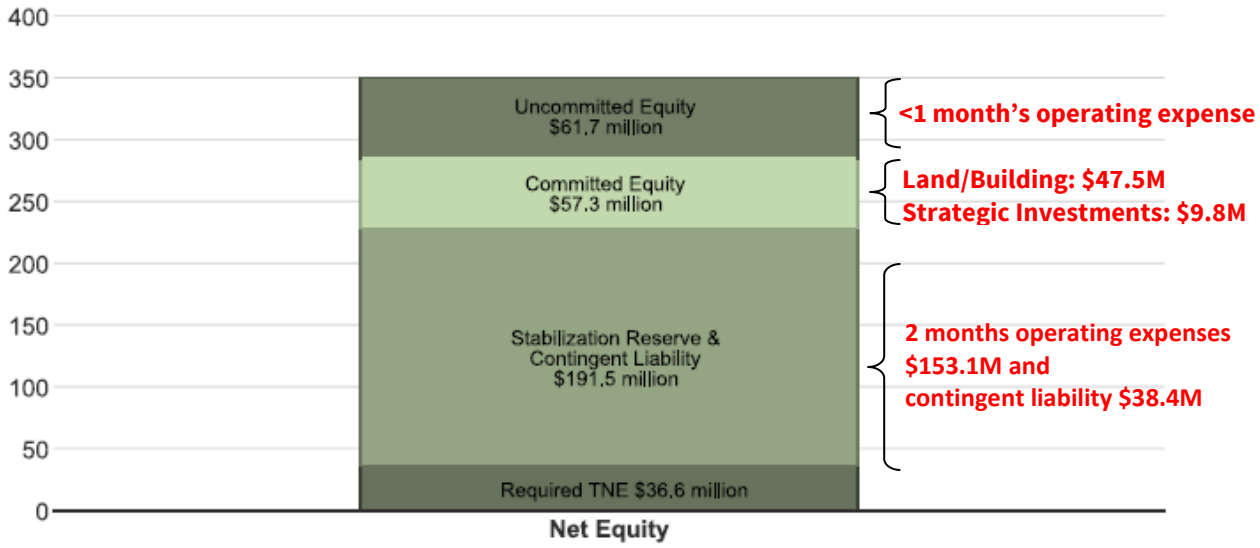


The graph below shows the YTD Preliminary Financial Results excluding prior period transactions. Prior period adjustments are typically due to updated rates or member counts from DHCS and adjustments to prior year medical costs, as necessary. Current Year consolidated deficit is $18.9M.



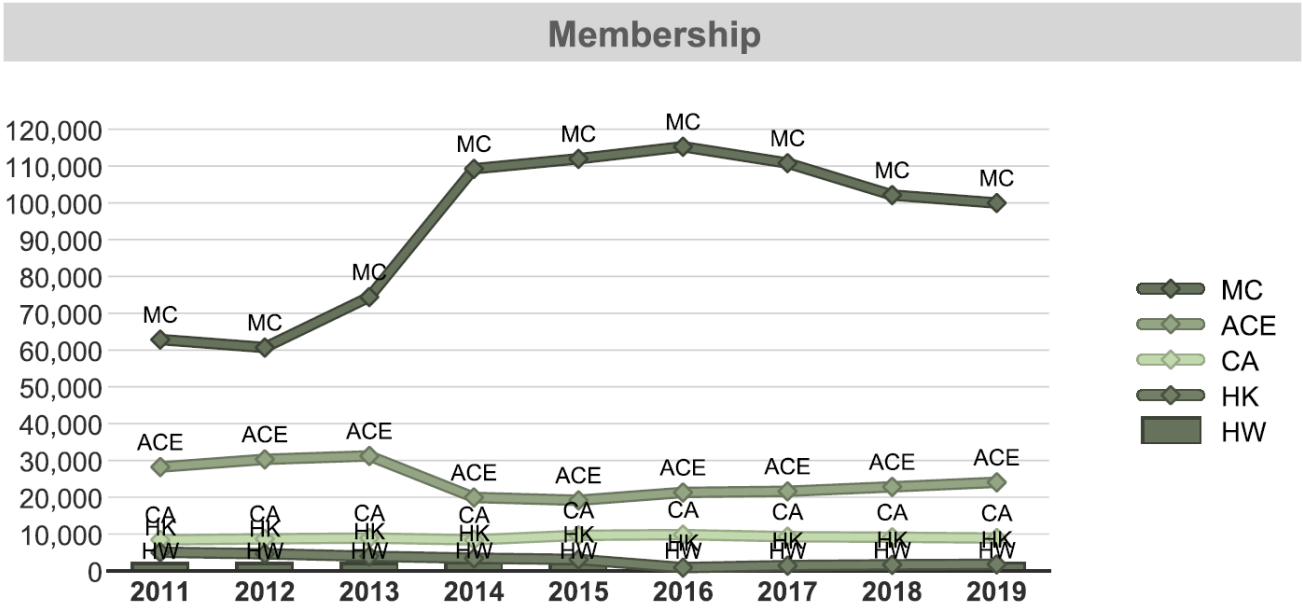
Stabilization Reserve and Tangible Net Equity (TNE)

The financial protocol requires us to have a minimum Stabilization Reserve of two month's operating expenses. The graph below reflects Net Equity as of September 30, 2019 at $347M.



Membership

Total membership at the end of September 2019 stands at 135,868. *There are two known data issues: Healthy Kids is overstated by approximately 200 members in September as a result of the State requesting the County load "Conditional eligibles"; and the ACE Participant count is overstated by approximately 2,000 due to a data issue with the State/County.



HIGHLIGHTS BY LINE OF BUSINESS (LOB)

Below are the highlights by major LOB of the current year performance compared to budget. The highlighted columns represent the current year only, excluding prior year adjustments. The variance column in this section compares Current Year to Budget. Detailed Statements of Revenue and Expense on a consolidated basis, as well as for every line of business, are provided beginning on page 15.

MEDI-CAL (MC)

	YTD Actual					
	Total	Prior Year	Current Year	YTD Budget	Variance	% Var.
Membership	623,172	-	623,172	619,137	4,035	*0.7%*
Operating Revenue	**$277,471 K**	**$43,926 K**	**$233,545 K**	**$228,248 K**	**$5,297 K**	***2.3%***
Healthcare Costs	**$248,767 K**	**$38,023 K**	**$210,743 K**	**$191,384 K**	**$19,359 K**	***10.1%***
Administrative Expenses	$12,668 K	$0 K	$12,668 K	$12,411 K	$257 K	*2.1%*
Premium Tax	$20,708 K	($247 K)	$20,955 K	$27,618 K	($6,663 K)	*-24.1%*
Total Expenses	$282,142 K	$37,776 K	$244,367 K	$231,413 K	$12,953 K	*5.6%*
Net Surplus/(Loss)	**($4,671 K)**	**$6,150 K**	**($10,821 K)**	**($3,165 K)**	**($7,656 K)**	*241.9%*
MLR (Net of Premium Tax)			*99.1%*	*95.4%*	*-3.7%*	

Current Year Performance

Directed payment gross-up adjustment:

- Revenue and healthcare cost gross-up adjustment (recorded May/Jun/Sep) is $46.2M, of which 39.3M is prior year, and $6.8M is current year.

MC Revenue Drivers:

- Revenue is above budget by $5.3M, of which 6.8M is the directed payment gross-up. The remaining difference is due to slightly lower than budget revenue yield PMPM.

MC Healthcare Expense:

- Healthcare cost is running $19.4M over budget, of which $6.8M is the directed payment gross-up. The remaining $12.6M is due to higher PMPM cost in the areas of hospital inpatient and LTC.

Medi-Cal Expansion (MCE)

	YTD Actual	Prior Year ADJ	Current Year	YTD Budget	Variance	% Var.
Membership	285,110	-	285,110	277,911	7,199	*2.6%*
Operating Revenue	**$183,671 K**	**$48,847 K**	**$134,823 K**	**$129,584 K**	**$5,240 K**	***4.0%***
Healthcare Costs	**$158,812 K**	**$39,761 K**	**$119,051 K**	**$109,500 K**	**$9,551 K**	***8.7%***
Administrative Expenses	$8,202 K	$0 K	$8,202 K	$9,090 K	($889 K)	*-9.8%*
Premium Tax	$9,761 K	$125 K	$9,637 K	$12,354 K	($2,718 K)	*-22.0%*
Total Expenses	$176,775 K	$39,886 K	$136,889 K	$130,945 K	$5,945 K	*4.5%*
Net Surplus/(Loss)	**$6,896 K**	**$8,962 K**	**($2,066 K)**	**($1,361 K)**	**($705 K)**	*51.8%*
MLR (Net of Premium Tax)			*95.1%*	*93.4%*	*-1.7%*	

Current Year Performance

Directed payment gross-up adjustment:

- Revenue and healthcare cost gross-up adjustment (recorded May/Jun/Sep) is $46M, of which 41.6M is prior year, and $4.4M is current year.

MCE Revenue Drivers:

- Revenue is above budget by $5.2M, of which$4.4M is the directed payment gross-up. Another $3.4M is due to the higher membership, and -$2.6M is due to lower than budget revenue yield.
- MCE was hit the hardest with lower premium rates that went into effect in July. This by itself is about a $2M per month decrease in revenue for this LOB. We will continue to see the YTD revenue variance erode through the remainder of the year.

MCE Healthcare Expense Trends:

- Healthcare cost is above budget by $9.6M, of which$4.4M is the directed payment gross-up. Another $2.8M is due to the higher membership, and the remaining $2.4M is due to higher PMPM cost in the areas of hospital IP, hospital OP, and physician FFS.

Whole Child Model, WCM (previously CCS)

	YTD Actual	Prior Year ADJ	Current Year	YTD Budget	Variance	% Var.
Membership	15,149	-	15,149	16,650	(1,501)	*-9.0%*
Operating Revenue	**$29,184 K**	**$2,147 K**	**$27,037 K**	**$28,310 K**	**($1,273 K)**	***-4.5%***
Healthcare Costs	**$26,323 K**	**$1,445 K**	**$24,878 K**	**$25,595 K**	**($717 K)**	***-2.8%***
Administrative Expenses	$1,627 K	$0 K	$1,627 K	$2,023 K	($396 K)	*-19.6%*
Premium Tax	$577 K	$66 K	$511 K	$749 K	($239 K)	*-31.8%*
Total Expenses	$28,527 K	$1,511 K	$27,015 K	$28,367 K	($1,352 K)	*-4.8%*
Net Surplus/(Loss)	**$657 K**	**$635 K**	**$22 K**	**($57 K)**	**$79 K**	*-138.7%*
MLR (Net of Premium Tax)			*93.8%*	*92.9%*	*-0.9%*	

Current Year Performance

Directed payment gross-up adjustment:

- Revenue and healthcare cost gross-up adjustment (recorded May/Jun/Sep) is $3.4M, of which 2.2M is prior year, and $1.2M is current year.

WCM Revenue Drivers:

- Revenue is below budget by $1,273K. This is a combination of 1) over budget by $1,213K due to the directed payment adjustment, 2) under budget by $2,552K due to lower membership, and 3) over budget by $66K due to slightly higher yield PMPM.

WCM Healthcare Expense Trends:

- In total, healthcare cost is running under budget by $717K. This is a combination of 1) over budget by $1,213K for the directed payment adjustment, 2) under budget by $2,307K due to lower membership, and 3) over budget by $377K in higher PMPM cost (IP over, offset by other categories being under).

CAREADVANTAGE (MC + CA Combined)

See detail reports attached for separate P&L by insurance product (MC and CA).

	YTD Actual	Prior Year ADJ	Current Year	YTD Budget	Variance	% Var.
Membership	79,145	-	79,145	81,702	(2,557)	*-3.1%*
Operating Revenue	**$190,259 K**	**$9,106 K**	**$181,153 K**	**$192,399 K**	**($11,247 K)**	***-5.8%***
Healthcare Costs	**$181,118 K**	**($1,589 K)**	**$182,707 K**	**$187,256 K**	**($4,549 K)**	***-2.4%***
Administrative Expenses	$13,448 K	$0 K	$13,448 K	$13,770 K	($321 K)	*-2.3%*
Premium Tax	$0 K	$0 K	$0 K	$0 K	$0 K	*0.0%*
Total Expenses	$194,567 K	($1,589 K)	$196,156 K	$201,026 K	($4,870 K)	*-2.4%*
Net Surplus/(Loss)	**($4,308 K)**	**$10,695 K**	**($15,003 K)**	**($8,627 K)**	**($6,376 K)**	*73.9%*
MLR (Net of Premium Tax)			*100.9%*	*97.3%*	*-3.5%*	

Current Year Performance

Directed payment gross-up adjustment:

- No directed payment adjustments for CMC line of business.

CMC Revenue Drivers:

- Revenue is below budget by $11.2M. The is the net of 1) below budget by $6.0M due to lower than budget membership, and 2) below budget by $5.2M due to lower premium yield (mostly on the CMS side).

CMC Healthcare Expense Trends:

- Healthcare cost is below budget by $4.5M. This is the net of 1) below budget by $5.9M due to lower than budget membership, and 2) over budget by $1.3M due to slightly higher cost PMPM. Lots of noise between cost categories that net to small variance PMPM.

HEALTHWORX, HEALTHY KIDS, ACE

HealthWorx:

- YTD performance through September shows a deficit of $454K, compared to budget deficit of $315K. Membership is running close to budget. The shortfall is due to healthcare cost running 6.7% higher than budget.

Healthy Kids:

- YTD performance through September shows a surplus of $1,172K, compared to budget surplus of $1,012K. The favorable budget variance is mostly a function of slightly higher than budget membership by about 4.5%.

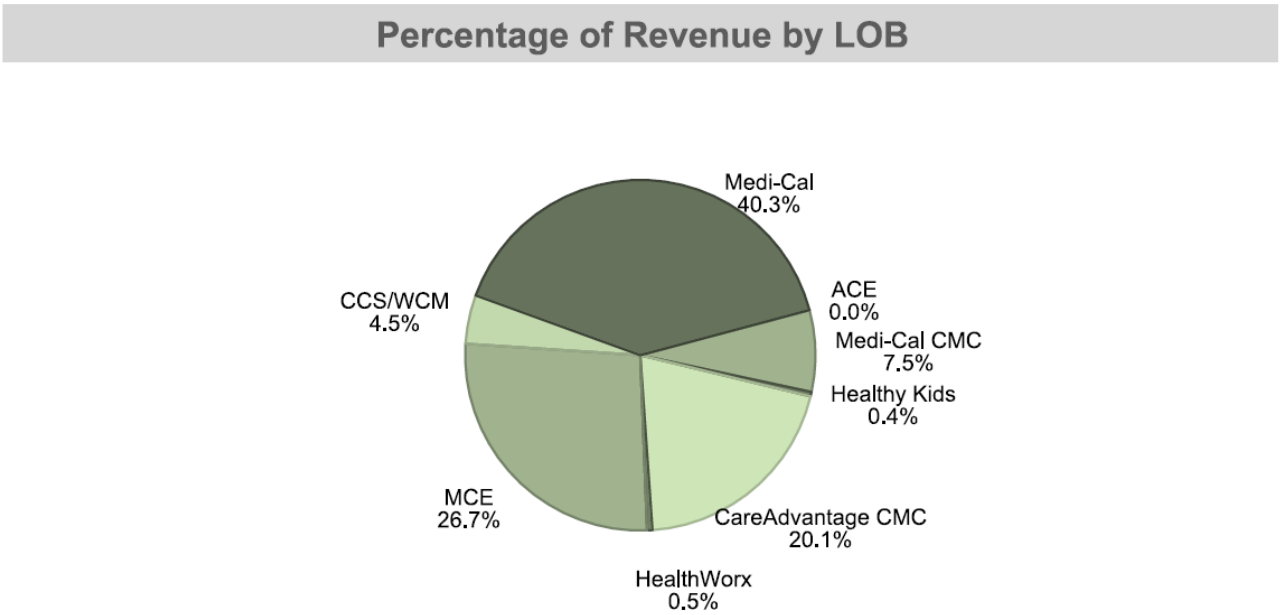
ACE:

- YTD performance through September shows a surplus of $182K, compared to a budget surplus of $129K. ACE membership is running 13% under budget.

HIGHLIGHTS OF ADDITIONAL METRICS

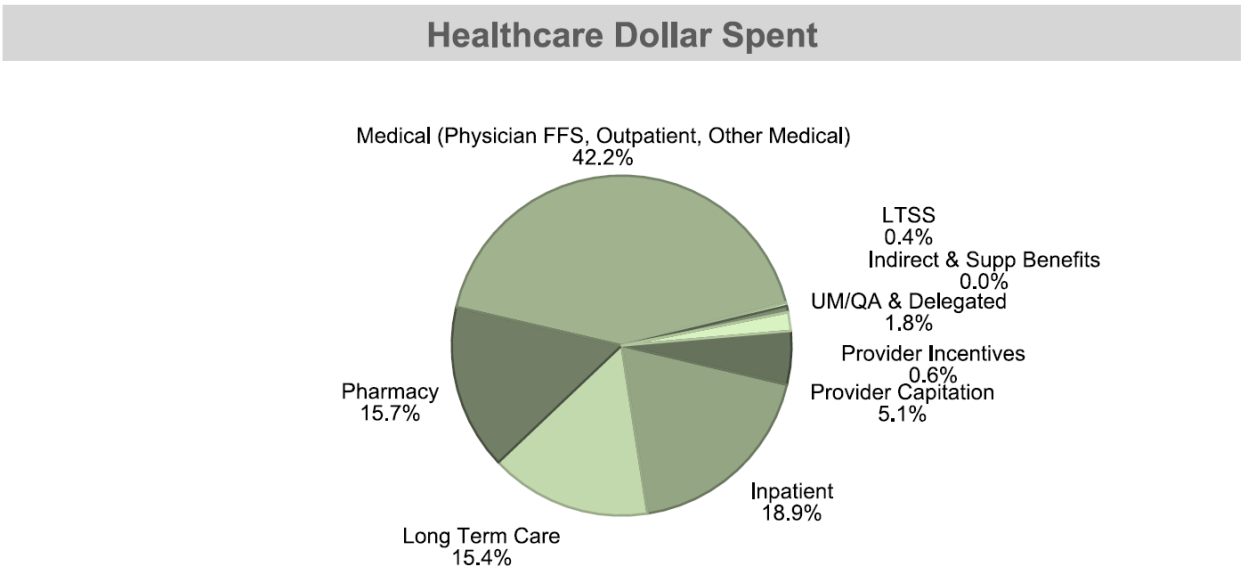
Revenue

Below is a depiction of revenue by each line of business in 2019. The largest share of HPSM revenue comes from the Medi-Cal Lines of Business: classic Medi-Cal, Medi-Cal Expansion, CCS/Whole Child Model and Medi-Cal CMC.



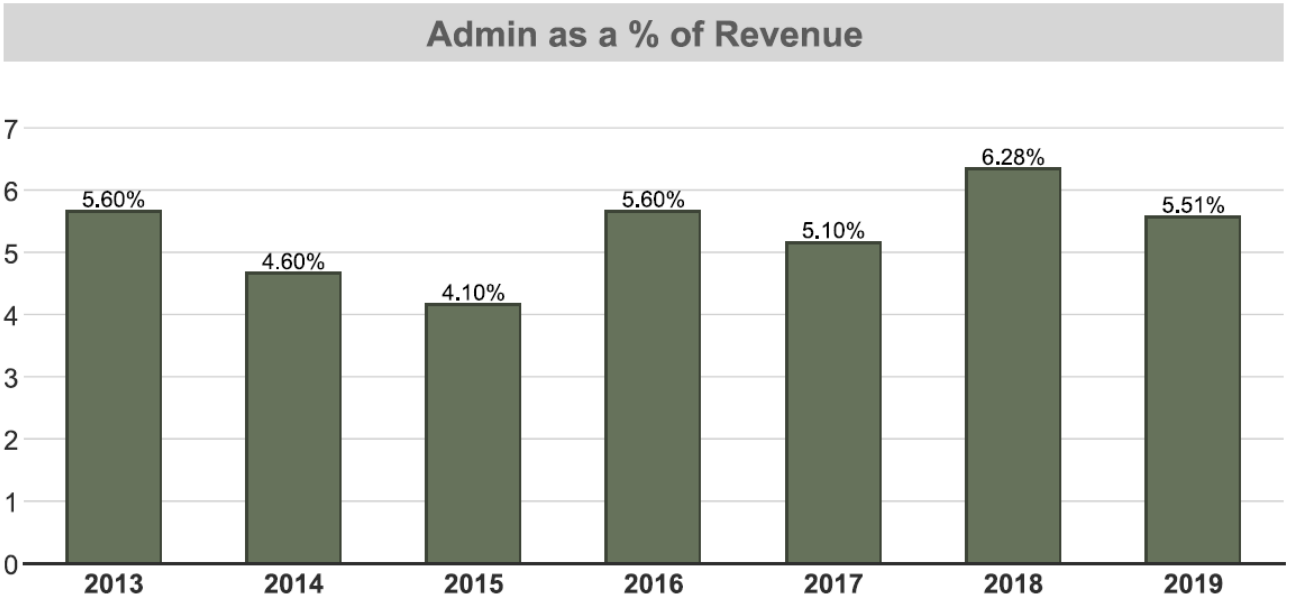
HealthCare Expenses

The graph below reflects how healthcare dollars are being spent in 2019.



Administrative Expenses

Administrative expenses are expressed as a percentage of net revenue received. The administrative expense percentage for 2019 is lower than usual due to the $95M in gross-up adjustments recorded in May/June/Sep. Without this adjustment, the admin percent would be closer to 6.4% for 2019. The percentage jump in 2018 was due to the transition of IHSS (financial) responsibility back to the State; therefore, resulting in lowered revenues.

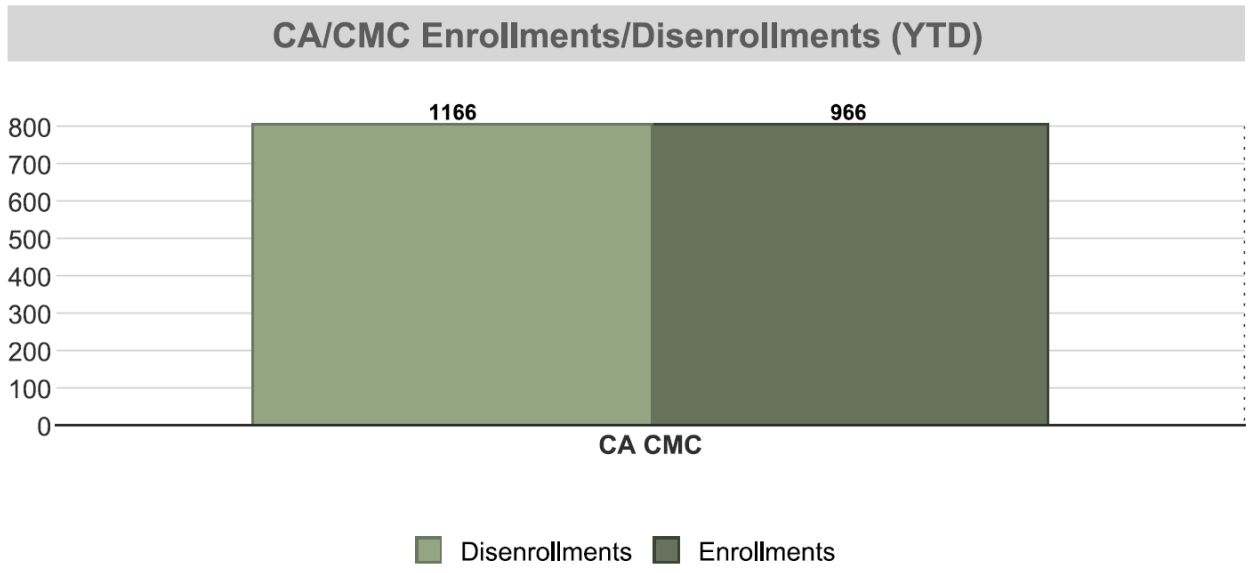


Investment and Interest

Total interest earned for September was $844,756 and $7,290,361 year to date.

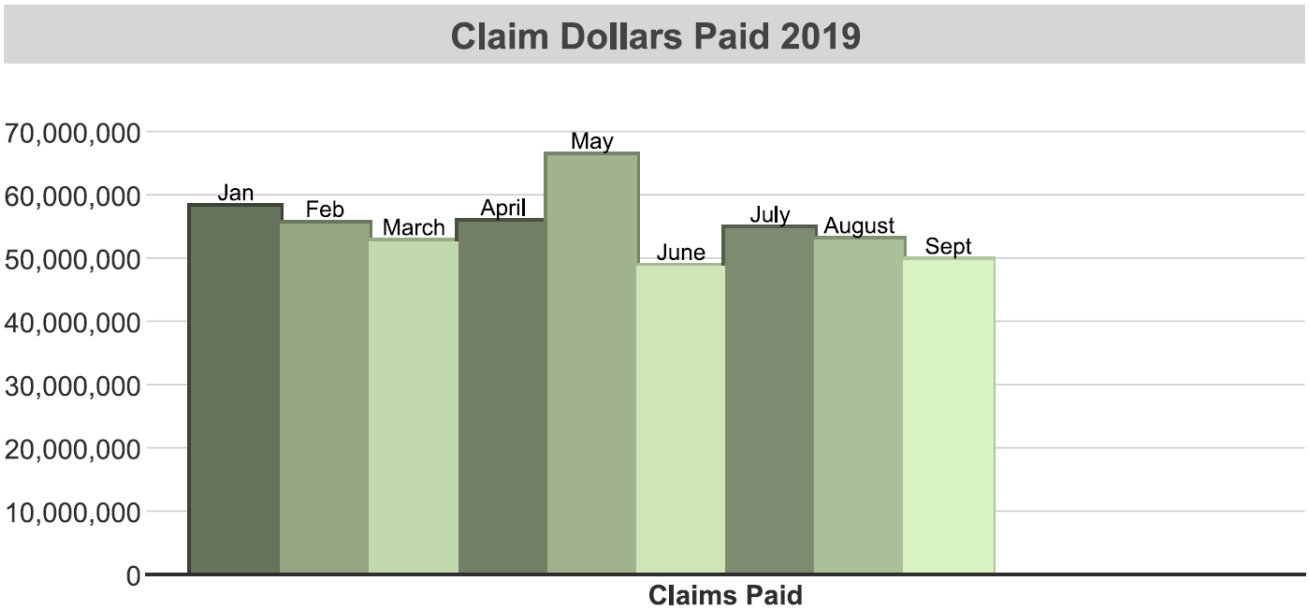
CMC Enrollment/Disenrollment

The YTD disenrollment's were higher than enrollments at the end of September 2019. The graph does not reflect the work of the CA Outreach Unit who saved 1,059 members (YTD) from being disenrolled. The CA Unit helps restore Medi-Cal eligibility or helps member restore SSI benefits.



CLAIMS

In the month of September, the Health Plan paid a total of 337,909 claims representing $49,360,009 worth of services to our members with 98.45% of those claims being paid within 30 days.



Health Plan of San Mateo

Fiscal Year 2019

Statistical and Financial Summary
September-19

Month					Year-to-Date			
Actual	Budget		Variance	Operating Margin	Actual	Budget		Variance
109,688,795	65,733,670	▲	$43,955,125	Total Revenue	696,575,119	591,847,618	▲	$104,727,501
101,139,937	56,764,438	▲	$44,375,499	Total Health Care Costs	620,035,831	518,351,430	▲	$101,684,401
4,121,220	4,276,384	▼	($155,164)	Total Operational Admin Expenses	37,835,024	39,648,792	▼	($1,813,768)
-	4,547,268	▼	($4,547,268)	Total MCO & AB78 Tax	31,099,624	40,925,408	▼	($9,825,784)
4,427,637	$145,580	▲	$4,282,057	Total Current Year Surplus (Deficit)	$7,604,641	($7,078,012)	▲	$14,682,653
3.8%				Admin Costs as a % of Revenue	5.4%			

Month			Membership	Year-to-Date		
Current	Prior	Variance		Current MM's	Budget MM's	Variance
98,286	99,277	(991)	Medi-Cal	908,282	897,048	11,234
8,865	8,859	6	CareAdvantage CMC	79,834	82,296	(2,462)
1,660	1,668	(8)	CCS	15,141	16,650	(1,509)
1,158	1,158	0	HealthWorx	10,395	10,305	90
1,743	1,623	120	Healthy Kids	14,415	13,680	735
24,022	24,268	(246)	ACE **	213,653	247,365	(33,712)
135,734 *	136,853 *	(1,119)	Total*	1,241,720 *	1,267,344 *	(25,624)

* Total does not include Medi-cal CMC members, who in theory are the same as the CA CMC membership

Health Plan of San Mateo
Consolidated Balance Sheet
September 30, 2019 and August 31, 2019

	Current Month	Prior Month
ASSETS		
Current Assets		
Cash and Equivalents	$ 270,491,097	$ 253,184,879
Investments	164,953,441	164,953,441
Capitation Receivable from the State	59,650,795	59,053,272
Other Receivables	52,089,600	46,891,983
Prepaids and Other Assets	7,544,170	7,983,453
Total Current Assets	554,729,103	532,067,028
Capital Assets, Net	67,979,767	68,199,733
Net Pension Asset	-	-
Assets Restricted As To Use	300,000	300,000
Total Assets	623,008,870	600,566,761
Deferred Outflows of Resources	3,508,821	3,508,821
Total Assets & Deferred Outflows	$ 626,517,691	$ 604,075,582
LIABILITIES		
Current Liabilities		
Medical Claims Payable	68,002,875	66,409,771
Provider Incentives	5,150,414	4,750,556
Amounts Due to the State	113,556,320	113,556,320
Accounts Payable and Accrued Liabilities	90,266,659	74,245,149
Total Current Liabilities	276,976,268	258,961,796
Net Pension Liability	914,189	914,189
Deferred Inflows of Resources	1,502,453	1,502,453
Total Liabilities & Deferred Inflows	$ 279,392,910	$ 261,378,438
NET POSITION		
Invested in Capital Assets	67,979,767	68,199,733
Restricted By Legislative Authority	300,000	300,000
Unrestricted		
Stabilization Reserve	153,138,000	153,138,000
Unrestricted Retained Earnings	125,707,014	121,059,412
Net Position	347,124,781	342,697,144
Total Liabilities & Net Position	$ 626,517,691	$ 604,075,582
Change in Net Position	$ 7,604,641	$ 3,177,003

Health Plan of San Mateo
Consolidated Statement of Revenue & Expense
for the Period Ending September 30, 2019

	Current Month	Year to Date	Annual Budget	Unexpended Budget	% of Budget
OPERATING REVENUES					
Capitation and Premiums					
Medi-cal (includes MCE & Offsets)	$ 82,050,833	$ 458,235,281	$ 473,499,993	$ 15,264,713	96.8%
CareAdvantage	-	43,087	-	(43,087)	-
Healthy Kids	329,994	2,809,863	3,447,360	637,497	81.5%
HealthWorx	374,483	3,343,628	4,417,348	1,073,720	75.7%
Whole Child Model	5,467,566	32,090,287	37,746,771	5,656,484	85.0%
CA Cal MediConnect	15,061,695	138,558,862	194,811,369	56,252,507	71.1%
MC Cal MediConnect	5,278,733	51,699,760	65,055,876	13,356,116	79.5%
Total Operating Revenue	108,563,305	686,780,768	778,978,717	92,197,949	88.2%
OPERATING EXPENSES					
Health Care Expense					
Provder Capitation	3,298,666	31,125,262	41,478,015	10,352,753	75.0%
Hospital Inpatient	12,074,919	115,652,399	143,997,383	28,344,984	80.3%
Long Term Care	10,356,926	94,382,808	119,263,529	24,880,721	79.1%
Pharmacy	10,286,897	96,291,947	134,730,733	38,438,786	71.5%
Medical	62,042,554	259,480,498	215,061,794	(44,418,704)	120.7%
Long Term Support Services	247,719	2,219,300	2,488,083	268,783	89.2%
Provider Incentives	406,738	3,538,274	4,321,597	783,323	81.9%
Health Care Supplemental Benefits	611,689	4,935,590	6,275,741	1,340,151	78.7%
Indirect Health Care Expenses	336,134	62,419	848,062	785,643	7.4%
UMQA, Delegated and Allocation	1,477,697	12,347,335	19,652,662	7,305,328	62.8%
Total Health Care Expenses	101,139,937	620,035,831	688,117,598	68,081,767	90.1%
Administrative Expense					
Salaries and Benefits	2,899,280	26,928,139	37,140,000	10,211,861	72.5%
Staff Training and Travel	10,223	147,353	363,550	216,197	40.5%
Contract Services	1,648,796	13,541,785	20,032,200	6,490,415	67.6%
Office Supplies and Equipment	466,019	3,811,532	6,643,000	2,831,468	57.4%
Occupancy and Depreciation	415,698	3,706,773	5,324,000	1,617,227	69.6%
Postage and Printing	113,572	1,124,398	1,737,400	613,002	64.7%
Other Administrative Expense	52,488	1,108,509	1,676,100	567,591	66.1%
UM/QA Allocation	(1,484,856)	(12,533,465)	(19,406,620)	(6,873,155)	64.6%
Total Admin Expense	4,121,220	37,835,024	53,509,630	15,674,606	70.7%
Premium Taxes	-	31,099,624	54,567,210	23,467,586	57.0%
Total Operating Expense	105,261,157	688,970,479	796,194,438	107,223,959	86.5%
Net Income/Loss from Operations	3,302,148	(2,189,711)	(17,215,721)	(15,026,010)	12.7%
NON-OPERATING REVENUES					
Interest Income, Net	844,756	7,290,361	6,000,000	(1,290,361)	121.5%
Rental Income, Net	89,176	811,069	1,073,883	262,814	75.5%
Third Party Administrator Revenue	191,437	1,692,682	2,803,470	1,110,789	60.4%
Miscellaneous Income	120	240	-	(240)	-
Net Non-operating Revenues	1,125,490	9,794,351	9,877,353	83,002	99.2%
CHANGES IN NET ASSETS	$ 4,427,637	$ 7,604,641	$ (7,338,368)	$ (14,943,008)	-103.6%
Admin exp as % of Net Revenues	3.80%	5.51%	6.87%		
Medical Loss Ratio	93.16%	94.56%	94.99%		

Health Plan of San Mateo
HPSM Statement of Revenue & Expense
for the Period Ending September 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
Total Operating Revenue	-	-	-	-	-	-	-
OPERATING EXPENSE							
Total Health Care Expense	-	-	-	-	-	-	-
Total Operating Expense	-	-	-	-	-	-	-
NON-OPERATING REVENUE							
Interest, Net	844,756	500,000	169.0%	7,290,361	4,500,000	2,790,361	162.0%
Rental Income, Net	89,176	89,490	99.7%	811,069	805,412	5,657	100.7%
Miscellaneous Income	120	-	-	240	-	240	-
Total Non-Operating	934,053	589,490	158.5%	8,101,670	5,305,412	2,796,258	152.7%
Net Income/(Loss)	$ 934,053	$ 589,490	158.5%	$ 8,101,670	$ 5,305,412	$ 2,796,258	152.7%
Medical Loss Ratio	-	-		-	-		
Member Counts	-	-	-	-	-	-	-

Health Plan of San Mateo
Medi-Cal Statement of Revenue & Expense
for the Period Ending September 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
State Capitation	$ 45,588,164	$ 25,129,713	181.4%	$ 306,290,735	$ 228,248,305	$ 78,042,430	134.2%
BHT Capitation	2,288,882	-	-	4,588,753	-	4,588,753	-
HepC Capitation	104,613	-	-	2,007,226	-	2,007,226	-
MC Cap Offset	(2,786)	-	-	(35,415,683)	-	(35,415,683)	-
Total Operating Revenue	47,978,874	25,129,713	190.9%	277,471,030	228,248,305	49,222,725	121.6%
OPERATING EXPENSE							
Provider Capitation	1,343,489	1,445,138	93.0%	12,647,860	13,080,565	(432,705)	96.7%
Hospital Inpatient	3,813,285	3,658,557	104.2%	37,877,848	33,658,924	4,218,924	112.5%
Long Term Care	6,150,331	5,475,540	112.3%	54,987,320	50,154,741	4,832,580	109.6%
Pharmacy	3,346,076	3,131,731	106.8%	28,003,460	28,397,853	(394,393)	98.6%
Physician Fee for Service	1,547,460	2,007,512	77.1%	19,947,958	19,344,180	603,777	103.1%
Hospital Outpatient	1,654,378	2,050,400	80.7%	19,861,675	18,781,211	1,080,463	105.8%
Other Medical Claims	1,947,802	1,753,024	111.1%	16,075,333	16,057,318	18,015	100.1%
Other HC Services	399,722	426,035	93.8%	4,067,904	3,902,391	165,513	104.2%
Directed Payments	21,305,074	-	-	46,163,374	-	46,163,374	-
Long Term Support Services	97,116	74,487	130.4%	984,485	682,289	302,196	144.3%
Provider Incentives	166,075	155,396	106.9%	1,653,442	1,423,396	230,046	116.2%
Health Care Supplmntl Benefits	(83,225)	158,825	-52.4%	1,826,959	1,454,805	372,154	125.6%
Indirect Health Care Expenses	201,772	32,926	612.8%	1,433,869	301,598	1,132,270	475.4%
UMQA (Allocation & Delegated)	365,625	460,555	79.4%	3,235,080	4,144,995	(909,915)	78.1%
Total Health Care Expense	42,254,980	20,830,129	202.9%	248,766,567	191,384,267	57,382,300	130.0%
G&A Allocation	1,368,536	1,338,599	102.2%	12,667,656	12,410,912	256,744	102.1%
Premium Tax	-	3,068,685	-	20,708,044	27,618,165	(6,910,121)	75.0%
Total Operating Expense	43,623,516	25,237,413	172.9%	282,142,266	231,413,344	50,728,922	121.9%
NON-OPERATING REVENUE							
Total Non-Operating	-	-	-	-	-	-	-
Net Income/(Loss)	$ 4,355,358	$ (107,700)	-4044.0%	$ (4,671,236)	$ (3,165,039)	$ (1,506,197)	147.6%
Medical Loss Ratio	88.07%	94.42%		97%	95.39%		
Member Counts	67,612	67,193	100.6%	623,172	619,137	4,035	100.7%

Health Plan of San Mateo
HealthWorx Statement of Revenue & Expense
for the Period Ending September 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
HealthWorx Premium	374,483	368,112	101.7%	3,343,628	3,313,011	30,617	100.9%
Total Operating Revenue	374,483	368,112	101.7%	3,343,628	3,313,011	30,617	100.9%
OPERATING EXPENSE							
Hospital Inpatient	(70,938)	59,135	-120.0%	334,204	532,218	(198,014)	62.8%
Pharmacy	145,225	109,414	132.7%	1,334,624	984,725	349,899	135.5%
Physician Fee for Service	77,371	80,924	95.6%	740,256	728,314	11,942	101.6%
Hospital Outpatient	96,986	79,986	121.3%	830,627	719,871	110,757	115.4%
Other Medical Claims	12,987	20,529	63.3%	157,583	184,758	(27,175)	85.3%
Other HC Services	0	-	-	0	-	0	-
Health Care Supplmntl Benefits	77	-	-	807	-	807	-
Indirect Health Care Expenses	3,434	583	589.0%	(223)	5,248	(5,471)	-4.3%
UMQA (Allocation & Delegated)	4,721	10,528	44.8%	63,272	94,751	(31,479)	66.8%
Total Health Care Expense	269,864	361,098	74.7%	3,461,150	3,249,885	211,265	106.5%
G&A Allocation	21,287	31,290	68.0%	276,783	290,110	(13,327)	95.4%
Premium Tax	-	9,733	-	59,724	87,593	(27,868)	68.2%
Total Operating Expense	291,151	402,121	72.4%	3,797,657	3,627,587	170,070	104.7%
NON-OPERATING REVENUE							
Total Non-Operating	-	-	-	-	-	-	-
Net Income/(Loss)	$ 83,333	$ (34,009)	-245.0%	$ (454,029)	$ (314,576)	$ (139,453)	144.3%
Medical Loss Ratio	72.06%	100.76%		105%	100.76%		
Member Counts	1,158	1,145	101.1%	10,417	10,305	112	101.1%

Health Plan of San Mateo
Healthy Kids Statement of Revenue & Expense
for the Period Ending September 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
Healthy Kids Premium	329,994	287,280	114.9%	2,809,863	2,585,520	224,343	108.7%
Total Operating Revenue	329,994	287,280	114.9%	2,809,863	2,585,520	224,343	108.7%
OPERATING EXPENSE							
Hospital Inpatient	14,790	19,868	74.4%	88,163	178,811	(90,648)	49.3%
Pharmacy	27,804	22,828	121.8%	264,458	205,450	59,008	128.7%
Physician Fee for Service	37,758	34,697	108.8%	361,480	312,273	49,206	115.8%
Hospital Outpatient	29,471	23,493	125.5%	292,593	211,438	81,155	138.4%
Other Medical Claims	11,109	9,584	115.9%	89,346	86,259	3,087	103.6%
Other HC Services	5,075	-	-	46,005	-	46,005	-
Health Care Supplmntl Benefits	35,786	37,233	96.1%	334,138	335,094	(955)	99.7%
Indirect Health Care Expenses	4,862	700	695.1%	42,813	6,296	36,518	680.0%
UMQA (Allocation & Delegated)	2,274	3,323	68.4%	21,029	29,907	(8,878)	70.3%
Total Health Care Expense	168,931	151,725	111.3%	1,540,026	1,365,528	174,498	112.8%
G&A Allocation	9,413	9,876	95.3%	103,797	91,570	12,227	113.4%
Premium Tax	-	12,920	-	(6,346)	116,280	(122,626)	-5.5%
Total Operating Expense	178,344	174,522	102.2%	1,637,477	1,573,378	64,099	104.1%
NON-OPERATING REVENUE							
Total Non-Operating	-	-	-	-	-	-	-
Net Income/(Loss)	$ 151,650	$ 112,758	134.5%	$ 1,172,386	$ 1,012,142	$ 160,244	115.8%
Medical Loss Ratio	51.19%	55.30%		55%	55.30%		
Member Counts	1,623	1,520	106.8%	14,295	13,680	615	104.5%

Health Plan of San Mateo
CareAdvantage Statement of Revenue & Expense
for the Period Ending September 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
CareAdvantage Premium	-	-	-	43,087	-	43,087	-
Total Operating Revenue	-	-	-	43,087	-	43,087	-
OPERATING EXPENSE							
Hospital Inpatient	-	-	-	17,495	-	17,495	-
Pharmacy	-	-	-	99	-	99	-
Physician Fee for Service	-	-	-	(1,719)	-	(1,719)	-
Hospital Outpatient	-	-	-	(1,760)	-	(1,760)	-
Other Medical Claims	-	-	-	314	-	314	-
Indirect Health Care Expenses	-	-	-	30	-	30	-
Total Health Care Expense	-	-	-	14,459	-	14,459	-
Total Operating Expense	-	-	-	14,459	-	14,459	-
NON-OPERATING REVENUE							
Total Non-Operating	-	-	-	-	-	-	-
Net Income/(Loss)	-	-	-	$ 28,628	-	$ 28,628	-
Medical Loss Ratio	-	-		34%	-		
Member Counts	-	-	-	-	-	-	-

Health Plan of San Mateo
ACE Statement of Revenue & Expense
for the Period Ending September 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
Total Operating Revenue	-	-	-	-	-	-	-
OPERATING EXPENSE							
Total Health Care Expense	-	-	-	-	-	-	-
G&A Allocation	141,316	212,845	66.4%	1,510,234	1,973,411	(463,177)	76.5%
Total Operating Expense	141,316	212,845	66.4%	1,510,234	1,973,411	(463,177)	76.5%
NON-OPERATING REVENUE							
Third Party Administror Revenue	191,437	233,623	81.9%	1,692,682	2,102,603	(409,921)	80.5%
Total Non-Operating	191,437	233,623	81.9%	1,692,682	2,102,603	(409,921)	80.5%
Net Income/(Loss)	$ 50,121	$ 20,777	241.2%	$ 182,448	$ 129,191	$ 53,256	141.2%
Medical Loss Ratio	-	-		-	-		
Member Counts	-	-	-	213,899	246,825	(32,926)	86.7%

Health Plan of San Mateo
CCS Statement of Revenue & Expense
for the Period Ending September 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
CCS Capitation	5,467,566	3,145,564	173.8%	32,090,287	28,310,078	3,780,209	113.4%
BHT Capitation	-	-	-	15,928	-	15,928	-
MC Cap Offset	(1,833,595)	-	-	(2,922,501)	-	(2,922,501)	-
Total Operating Revenue	3,633,971	3,145,564	115.5%	29,183,714	28,310,078	873,636	103.1%
OPERATING EXPENSE							
Provider Capitation	47,983	56,888	84.4%	439,490	487,013	(47,522)	90.2%
Hospital Inpatient	1,284,758	545,133	235.7%	7,235,348	4,914,062	2,321,286	147.2%
Long Term Care	135,099	77,700	173.9%	854,264	699,300	154,964	122.2%
Pharmacy	494,406	748,240	66.1%	4,935,144	6,734,158	(1,799,013)	73.3%
Physician Fee for Service	143,706	159,364	90.2%	1,687,335	1,505,868	181,468	112.1%
Hospital Outpatient	319,688	490,684	65.2%	2,400,370	4,416,156	(2,015,786)	54.4%
Other Medical Claims	400,156	380,504	105.2%	2,455,737	3,424,539	(968,802)	71.7%
Other HC Services	507,457	44,495	1140.5%	876,493	400,459	476,034	218.9%
Directed Payments	899,184	-	-	3,421,977	-	3,421,977	-
Provider Incentives	3,672	3,861	95.1%	52,151	34,753	17,398	150.1%
Health Care Supplmntl Benefits	15,014	6,115	245.5%	92,813	55,037	37,775	168.6%
Indirect Health Care Expenses	6,271	1,285	487.9%	(946,235)	11,567	(957,801)	-8180.8%
UMQA (Allocation & Delegated)	327,521	323,584	101.2%	2,818,305	2,912,258	(93,952)	96.8%
Total Health Care Expense	4,584,913	2,837,854	161.6%	26,323,194	25,595,168	728,026	102.8%
G&A Allocation	319,713	218,162	146.6%	1,626,519	2,022,706	(396,187)	80.4%
Premium Tax	-	83,250	-	576,886	749,250	(172,364)	77.0%
Total Operating Expense	4,904,626	3,139,266	156.2%	28,526,600	28,367,125	159,475	100.6%
NON-OPERATING REVENUE							
Total Non-Operating	-	-	-	-	-	-	-
Net Income/(Loss)	$ (1,270,656)	$ 6,298	-20175.4%	$ 657,114	$ (57,046)	$ 714,161	-1151.9%
Medical Loss Ratio	126.17%	92.67%		92%	92.87%		
Member Counts	1,668	1,850	90.2%	15,149	16,650	(1,501)	91.0%

Health Plan of San Mateo
MCE Statement of Revenue & Expense
for the Period Ending September 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
MCE Capitation	35,904,801	14,226,585	252.4%	204,626,469	129,583,627	75,042,842	157.9%
MC Cap Offset	754	-	-	(20,955,646)	-	(20,955,646)	-
Total Operating Revenue	35,905,555	14,226,585	252.4%	183,670,823	129,583,627	54,087,196	141.7%
OPERATING EXPENSE							
Provider Capitation	1,273,727	1,306,092	97.5%	12,491,473	12,019,201	472,272	103.9%
Hospital Inpatient	2,003,292	2,506,319	79.9%	24,444,500	23,211,298	1,233,202	105.3%
Long Term Care	633,216	645,363	98.1%	6,537,443	5,952,854	584,590	109.8%
Pharmacy	2,666,066	2,997,753	88.9%	27,665,605	27,651,379	14,225	100.1%
Physician Fee for Service	886,981	1,317,794	67.3%	13,681,411	12,821,093	860,318	106.7%
Hospital Outpatient	1,959,370	1,677,944	116.8%	17,394,365	15,477,419	1,916,945	112.4%
Other Medical Claims	780,972	747,199	104.5%	7,229,493	6,892,193	337,300	104.9%
Other HC Services	(11,816)	-	-	(99,095)	-	(99,095)	-
Directed Payments	23,174,739	-	-	45,974,235	-	45,974,235	-
Long Term Support Services	352	3,013	11.7%	8,980	22,165	(13,186)	40.5%
Provider Incentives	88,381	82,026	107.8%	760,372	756,613	3,759	100.5%
Health Care Supplmntl Benefits	367,086	159,641	229.9%	1,349,166	1,472,538	(123,372)	91.6%
Indirect Health Care Expenses	90,317	24,663	366.2%	(469,320)	227,496	(696,817)	-206.3%
UMQA (Allocation & Delegated)	171,492	332,897	51.5%	1,843,441	2,996,075	(1,152,633)	61.5%
Total Health Care Expense	34,084,174	11,800,706	288.8%	158,812,067	109,500,324	49,311,743	145.0%
G&A Allocation	782,385	980,435	79.8%	8,201,559	9,090,174	(888,615)	90.2%
Premium Tax	-	1,372,680	-	9,761,315	12,354,120	(2,592,805)	79.0%
Total Operating Expense	34,866,559	14,153,821	246.3%	176,774,942	130,944,618	45,830,324	135.0%
NON-OPERATING REVENUE							
Total Non-Operating	-	-	-	-	-	-	-
Net Income/(Loss)	$ 1,038,995	$ 72,764	1427.9%	$ 6,895,881	$ (1,360,991)	$ 8,256,872	-506.7%
Medical Loss Ratio	94.93%	91.81%		91%	93.41%		
Member Counts	30,674	29,879	102.7%	285,110	277,911	7,199	102.6%

Health Plan of San Mateo
CA CMC Statement of Revenue & Expense
for the Period Ending September 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
CA Cal MediConnect Premium	15,061,695	16,323,087	92.3%	138,558,862	143,687,195	(5,128,333)	96.4%
Total Operating Revenue	15,061,695	16,323,087	92.3%	138,558,862	143,687,195	(5,128,333)	96.4%
OPERATING EXPENSE							
Provider Capitation	633,468	640,310	98.9%	5,543,827	5,642,600	(98,773)	98.3%
Hospital Inpatient	4,865,370	4,879,229	99.7%	43,660,033	44,800,040	(1,140,008)	97.5%
Pharmacy	3,541,049	4,047,472	87.5%	33,308,603	36,307,934	(2,999,331)	91.7%
Physician Fee for Service	1,752,558	1,731,965	101.2%	14,450,736	15,482,035	(1,031,299)	93.3%
Hospital Outpatient	1,854,881	1,480,722	125.3%	16,369,887	13,282,846	3,087,041	123.2%
Other Medical Claims	1,376,077	1,852,431	74.3%	13,631,755	16,617,268	(2,985,513)	82.0%
Other HC Services	-	-	-	0	-	0	-
Provider Incentives	148,609	116,640	127.4%	1,351,423	1,046,320	305,102	129.2%
Health Care Supplmntl Benefits	595	81,823	0.7%	6,176	733,994	(727,817)	0.8%
Indirect Health Care Expenses	29,478	9,615	306.6%	1,461	86,250	(84,788)	1.7%
UMQA (Allocation & Delegated)	542,572	455,003	119.3%	3,692,777	4,095,024	(402,248)	90.2%
Total Health Care Expense	14,744,657	15,295,208	96.4%	132,016,678	138,094,310	(6,077,632)	95.6%
G&A Allocation	1,277,029	1,331,125	95.9%	11,373,301	12,341,619	(968,318)	92.2%
Total Operating Expense	16,021,686	16,626,333	96.4%	143,389,979	150,435,929	(7,045,950)	95.3%
NON-OPERATING REVENUE							
Total Non-Operating	-	-	-	-	-	-	-
Net Income/(Loss)	$ (959,991)	$ (303,247)	316.6%	$ (4,831,117)	$ (6,748,734)	$ 1,917,617	71.6%
Medical Loss Ratio	97.90%	93.70%		95%	96.11%		
Member Counts	8,865	9,169	96.7%	79,834	82,161	(2,327)	97.2%

Health Plan of San Mateo
Medi-Cal CMC Statement of Revenue & Expense
for the Period Ending September 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
MC Cal MediConnect Capitation	5,278,733	5,430,216	97.2%	51,699,760	48,711,868	2,987,892	106.1%
Total Operating Revenue	5,278,733	5,430,216	97.2%	51,699,760	48,711,868	2,987,892	106.1%
OPERATING EXPENSE							
Provider Capitation	-	-	-	2,613	-	2,613	-
Hospital Inpatient	164,362	199,286	82.5%	1,994,807	1,787,700	207,107	111.6%
Long Term Care	3,438,280	3,574,758	96.2%	32,003,780	32,067,438	(63,659)	99.8%
Pharmacy	66,270	128,226	51.7%	779,953	1,150,254	(370,301)	67.8%
Physician Fee for Service	62,256	311,406	20.0%	2,302,816	2,738,790	(435,974)	84.1%
Hospital Outpatient	230,071	296,971	77.5%	2,790,086	2,663,988	126,097	104.7%
Other Medical Claims	581,081	718,386	80.9%	6,282,214	6,444,298	(162,084)	97.5%
Other HC Services	-	-	-	(284)	-	(284)	-
Long Term Support Services	150,251	130,333	115.3%	1,225,835	1,156,574	69,261	106.0%
Provider Incentives	-	-	-	(279,114)	-	(279,114)	-
Health Care Supplmntl Benefits	276,355	76,203	362.7%	1,325,531	683,580	641,952	193.9%
Indirect Health Care Expenses	-	316	-	24	2,839	(2,815)	0.8%
UMQA (Allocation & Delegated)	63,492	51,832	122.5%	673,430	466,487	206,944	144.4%
Total Health Care Expense	5,032,418	5,487,717	91.7%	49,101,690	49,161,947	(60,258)	99.9%
G&A Allocation	201,542	154,050	130.8%	2,075,175	1,428,290	646,885	145.3%
Total Operating Expense	5,233,960	5,641,768	92.8%	51,176,865	50,590,237	586,628	101.2%
NON-OPERATING REVENUE							
Total Non-Operating	-	-	-	-	-	-	-
Net Income/(Loss)	$ 44,773	$ (211,551)	-21.2%	$ 522,896	$ (1,878,369)	$ 2,401,265	-27.8%
Medical Loss Ratio	95.33%	101.06%		95%	100.92%		
Member Counts	8,704	9,067	96.0%	78,456	81,243	(2,787)	96.6%

HEALTH PLAN OF SAN MATEO
STATEMENT OF CASH FLOWS - DIRECT & INDIRECT METHOD

FOR THE CURRENT PERIOD September 30, 2019

	CURRENT MONTH 9/30/2019	CURRENT YEAR YEAR-TO-DATE 2019
CASH FLOW PROVIDED BY OPERATING ACTIVITIES		
Group/Individual Premiums/Capitation	-	-
Title XVIII - Medicare Premiums	15,061,695	138,601,949
Title XIX - Medicaid Premiums	103,857,000	585,568,031
Investment and Other Revenues	(19,094)	(645,175)
Medical and Hospital Expenses	(97,803,649)	(619,324,266)
Administration Expenses	(4,499,659)	(81,920,365)
NET CASH PROVIDED BY OPERATING ACTIVITIES	**16,596,293**	**22,280,174**
CASH FLOW PROVIDED BY INVESTING ACTIVITIES		
Proceeds from Restricted Cash and Other Assets	-	-
Proceeds from Investments	-	-
Proceeds for Sales of Property, Plant and Equipment	-	-
Payments for Restricted Cash and Other Assets	-	-
Payments for Investments	-	100,000
Payments for Property, Plant and Equipment	(18,000)	(163,632)
Interest and Other Income Received	727,925	6,714,124
NET CASH PROVIDED BY INVESTING ACTIVITIES	**709,925**	**6,650,492**
CASH FLOW PROVIDED BY FINANCING ACTIVITIES:		
Principal payments under capital lease obligations	-	-
NET CASH PROVIDED BY FINANCING ACTIVITIES	**-**	**-**
NET INCREASE (DECREASE) IN CASH	**17,306,218**	**28,930,666**
CASH AND CASH EQUIVALENTS AT THE BEGINNING OF THE MONTH/PRIOR YEAR	**253,184,879**	**241,560,432**
CASH AND CASH EQUIVALENTS AT THE END OF THE MONTH	**270,491,097**	**270,491,097**
RECONCILIATION OF NET OPERATING INCOME TO NET CASH FROM OPERATING ACTIVITIES:		
Operating Income	3,302,148	(2,189,711)
	-	-
Depreciation and Amortization	237,965	2,149,063
Decrease (Increase) in Receivables	(5,397,575)	(21,284,999)
Decrease (Increase) in Prepaid Expenses	439,283	(890,217)
Decrease (Increase) in Net Pension/Inflows and Outflows	-	-
Decrease (Increase) in Affiliate Receivables	-	-
Increase (Decrease) in Amts due to State of CA	-	6,856,892
Increase (Decrease) in Accounts Payable	16,021,510	37,517,710
Increase (Decrease) in Medical Claims Payable	(4,637,847)	(9,605,838)
Increase (Decrease) in Incurred But Not Reported	6,230,951	8,068,216
Increase (Decrease) in Provider Risk Sharing	399,858	1,659,059
Increase (Decrease) in Unearned Premium	-	-
Aggregate Write-Ins for Adjustments to Net Income	-	-
TOTAL ADJUSTMENTS	**13,294,146**	**24,469,884**
NET CASH PROVIDED BY OPERATING ACTIVITIES	**16,596,293**	**22,280,174**
DETAILS OF WRITE-INS AGGREGATED FOR ADJUSTMENTS TO NET INCOME		
Unrealized (Gain)/Loss on Equity Securities	-	-
(Gain)/Loss on Sale of Assets	-	-
Prior Period Rent Expense	-	-
Realized (Gain)/Loss on Investment	-	-
TOTALS	**-**	**-**

FINANCE/EXECUTIVE COMMITTEE MEETING
Meeting Summary – September 19, 2019
Criminal Justice Training Room (CJTR), 400 County Center, First Floor,
Redwood City, CA 94063

Teleconference location: Health Plan of San Mateo Boardroom, 801 Gateway Blvd., South San Francisco, CA 94080

Member's present: Bill Graham, David Canepa, Mike Callagy, Bill Horsley, Si France, MD

Staff present: Maya Altman, Pat Curran, Trent Ehrgood, Francine Lester, Chris Baughman, Jennifer Nguyen, Dr. Susan Huang, Katie Elyse-Turner, Michelle Heryford

Guests: Laurel Finnegan

1.0 Call to Order – The meeting was called to order at 12:33 pm by Supervisor Canepa.

2.0 Public Comment – There was no public comment from either location.

3.0 Approval of Meeting Summary – The Meeting Summary from the July 29, 2019 meeting was approved as presented. **M/S/P**

4.0 Preliminary Financial and Operational Report for the 7-Month period ending July 31, 2019 – Mr. Ehrgood briefly went over the financial highlights for the 7-month period ending July 31, 2019. He noted that July was the start of lower Medi-Cal rates. The biggest decrease was seen in the expansion population. Supervisor Horsley asked why the rates were lowered. Mr. Erhgood reminded the group that the rates that went into effect on July 1st were derived from 2017 cost experience. That year, healthcare costs went down and HPSM is now seeing the results of lower revenue. The lower healthcare costs from 2017 are partly due to the way HPSM changed reimbursement to one of our primary hospitals. Also, Mr. Ehrgood noted that because of the State changing from a fiscal to calendar year, these lower rates will live with HPSM for 18 months instead of 12.

There is some good news, Mr. Ehrgood spoke about the theory and speculation surrounding the acuity of the Medi-Cal population during declining membership. The State asked Mercer, their actuarial firm, to do a study to see if there is a correlation between increased acuity during declining membership. They looked at membership

changes for the last 2 years by county and applied a risk score, the Medi-Care RX Risk Acuity Factor. The study found this correlation to be true and used this data to adjust rates to compensate for the higher cost. The good news is its being addressed. Unfortunately, the increase in rates probably won't compensate for what the real effect is.

Commissioner France asked about what can be done about the time lag and cost basis, acknowledging that profit and loss can be a roller coaster. Mr. Ehrgood remarked that not much can be done about the time lag but HPSM has been smart with retaining surpluses in the past, which has resulted in the healthy reserves we see today. Commissioner Graham said HPSM has managed their reserves well, more so than many other health plans, noting some of the challenges area health plans are currently experiencing. He commended Ms. Altman and HPSM for their long view. The real anomaly here is the additional 6-month period. Is there anything HPSM can do to make up for that asked Commissioner Callagy. Mr. Ehrgood said probably not much, they have brought their concerns to the State and made them aware of upcoming deficits. Unfortunately, one of the suggestions from the State includes lowering Provider rates and Ms. Altman reminded the committee that asking Providers to accept lower rates would be the absolute last option, doing so would be extremely disruptive. Mr. Ehrgood reminded the group that it may not be as detrimental as it seems. HPSM can weather this and still be okay.

He closed by noting the Medi-Cal line of business is not doing well as far as revenue covering costs. The Medi-Cal Expansion population group is close to budget and likely to break even. Whole child model is close to break even, there are slightly higher yields on the revenue but also slightly higher healthcare costs. He reported that CareAdvantage-CMC has a lot of prior year adjustments, mostly retro revenue. When looking at the 5-year trend, CMC wasn't losing as much as initially thought. There was a big loss at the end of 2018, but with prior year adjustments recorded in 2019, the 2018 loss is now closer to $8M. The financial report was approved as presented. **M/S/P**

5.0 Recommendation for Preliminary Approval of Dental Integration Program – Ms. Altman advised the Committee that HPSM is seeking preliminary approval of a Dental Integration Program. Mr. Ehrgood and Mr. Curran provided a presentation of the financial forecast as it relates to the Dental program. The first several slides had already been presented to the Commission. Mr. Ehrgood directed committee

members to Slide 13, on page 7. Data provided by the State for the years 2016-2018 was used for this report. Commissioner Callagy asked if the program is for preventable care or acute issues. Mr. Ehrgood replied probably both, he directed the Commissioner to slide 15, which shows the results of the cost data as well as the services that were provided in 2018. It breaks it down into different service categories. $5.14 is the 2018 PMPM cost for the County of San Mateo for Medi-Cal eligible members. It takes the total cost divided by the total population. Which means HPSM is looking at about $6.7M in services based on current use. Commissioner France said the biggest barrier is often utilization, Mr. Ehrgood concurred.

Mr. Ehrgood explained some of the assumptions used in the financial modeling. Commissioner France asked if it's the same as Medi-Cal coverage and if HPSM will become the exclusive dental provider in San Mateo county? Mr. Curran confirmed that members will need to get their dental benefits thru HPSM, who will control the fee schedule, including FQHC's. He stated that the FQHC's are naturally concerned with cash flow. He assured the group that when it comes to billing and other matters, they will bill the same as they do on the medical side, using the same process. Mr. Curran briefly went over that process, explaining that FQHC's may get less up front, but can bill the State for a wrap-around payment to make up the difference. In the end, the FQHC's will be made whole with their year-end reconciliation reporting. Ms. Altman replied this already occurs regularly on the medical side.

Supervisor Horsley asked if HPSM anticipates any difficulty with recruiting dentists. Mr. Curran replied that HPSM will increase the fee schedule about 30-40%, to cover more of the providers cost. He advised the group that while the goal for the program is to increase utilization and recruit dentists while being prudent in managing costs; the goal with providers is to build trust, pay quickly and make administrative functions easier.

Mr. Ehrgood went over the State rate setting process, and the projected financial estimates, indicating a $14.6M loss over the six-year pilot period. Commissioner France noted that in the forecast there is never a surplus, should it at least cover costs? Mr. Ehrgood directed him to the dental expense line, using 2018 as a baseline for costs. He stated costs will increase in the first few years due to increases to the fee schedule and increases in utilization. Mr. Curran said what is not factored in is the impact to medical costs. Commissioner Callagy asked if there is a way to measure this? Mr. Curran noted it is difficult, but they are looking at ER and outpatient claims to

help with this assessment; but are just starting now. They noted numerous studies that detail how dental coverage can benefit diabetes patients. Commission Callagy asked if HPSM should target or focus on certain populations? Mr. Curran said they may start with diabetics; expecting mothers and children will also be a priority.

Ms. Altman noted they will be looking for a dental director so that HPSM is ready in 2021. After the State publishes rates, they will seek provisional approval to look at additional staffing. She remarked that HPSM is motivated about this program and she wished more plans could do this.

Commissioner Callagy said there might be enough savings on the medical side to justify this, Mr. Ehrgood agreed that is part of the goal, as dental prevention has proven to be beneficial to overall medical health. Supervisor Canepa asked about the total reserves this program will use. Mr. Ehrgood reiterated if the 6 years play out as modeled, HPSM would incur $14.6 in losses over the six-year period. However, Ms. Altman made sure the group understood that's not $14M in year one. The first-year projection is a loss of $2.8M. Commissioner France noted the books look robust enough to handle this request. Supervisor Canepa inquired where does this come from in the reserves? It was noted that it is coming from the Strategic Investments bucket.

Mr. Ehrgood would like to use the slides presented today for their presentation at the San Mateo Health Commission on Wednesday, October 9, 2019. Supervisor Horsley made a motion for preliminary approval of the Dental Integration program, Supervisor Graham seconded the motion. **M/S/P**

6.0 **San Mateo Health Commission Agenda –** Ms. Altman went over the agenda for the October 9, 2019 San Mateo Health Commission meeting, she advised the group that the consent agenda is full, the main proposal however is the dental presentation. The agenda was approved as presented. **M/S/P**

7.0 **Other Business –** Mr. Ehrgood would like to change the meeting frequency for 2020. He is proposing meeting every other month for the upcoming year. The group agreed to the proposed changes. Ms. Lester will work on a calendar proposal for the next meeting. **M/S/P**

8.0 Adjournment – The meeting was adjourned at 1:34 By Supervisor Canepa. **M/S/P**

Respectfully submitted:

M. Heryford

M. Heryford
Assistant Clerk to the Commission

AGENDA ITEM: 4.2

DATE: November 13, 2019

PHYSICIAN ADVISORY GROUP
Meeting Minutes
August 7, 2019 - 7:30 a.m.
San Mateo Medical Center
222 W. 39th Avenue, Board Room, 2nd Floor
San Mateo, CA 94403

Committee Members Present:	Dr. Janet Chaikind, Kenneth Tai, Vincent Mason, Tom Stodgel, and Randolph Wong
Committee Members Excused:	Dr Hung-Ming Chu, James Hutchinson and Leland Luna
HPSM Members Present:	Rhonda Bibbins, Paul de la Cruz, Richard Moore, Colleen Murphey and Kati Phillips
HPSM Members Excused:	Maya Altman, Patrick Curran, Dr. Cynthia Cooper, Dr. Susan Huang

1. Call to Order
   Dr. Janet Chaikind (Chair) called the meeting to order at 7:30am. A quorum was present.

2. Public Comments
   No public comments were offered.

3. Approval of Agenda and Approval of June 5, 2019 Meeting Minutes
   The Agenda for August 7, 2019 was approved.
   Meeting Minutes June 5, 2019 were approved.

4. HPSM Announcements
   4.1 SNF/LTC Payment Model: Colleen reported that HPSM continues work on co-designing a new Long Term Care and Skilled Nursing payment model, to help address challenges with placement in the community. On October 1st, we are scheduled to launch this new payment model with our skilled nursing and long term care facilities. In order to design this payment model, we have been working with facilities to understand their pain points with payment and member admission. We are building in incentives for quality, focusing on quality indicators that we can objectively measure, similar to our approach with designing a new payment model for primary care. We are on track for an October 1st implementation.

5. Provider Services Announcements
   5.1 Palliative Care Network Development: Colleen reported that we are pursuing additional palliative care providers in the network. We have some today but we are working to build out a program with more robust program requirements. There are limited providers who offer community-based pediatric palliative care in California.

Dr. Chaikind asked what methods HPSM is using to look for these providers. Colleen shared that HPSM surveyed our current home health and hospice provider network, and have been soliciting input from hospitals across and outside of the county regarding who they refer to for home-based palliative care.

5.2 Diabetes Prevention Program Network Development: Colleen shared an update on efforts to contract with Diabetes Prevention Program (DPP) providers. Since this new benefit has rolled out, HPSM and other county plans have struggled to find providers who meet the requirements for Medicare to be a DPP provider. There are none in San Mateo County today, per the national database that tracks enrolled providers. Dr. Stodgel inquired about the requirements to be Medicare certified for DPP. Colleen shared that these include having your curriculum approved, and delivering a minimum volume of services. Dr. Stodgel asked what the site of care is. Colleen shared that the settings are diverse, including Albertsons, the YMCA, or in a clinic. Dr. Stodgel shared that a similar program that he is most familiar with is associated with Mills Peninsula hospital and is specific to managing pregnancy and diabetes. It works well. Primary (care providers) can do initial testing and then refer directly into this program. It provides counselling, testing, and valuable services during pregnancy. Kati shared that HPSM has been talking to the Mills Peninsula group. They are currently in pending status for program enrollment. HPSM is in discussions with the group about potentially expanding to meet the needs of a more general pre-diabetic population beyond pregnancy.

5.3 Pediatric Speech Therapy Network Development: Colleen reported that this is an area where we have had some grievances from members, or outside organizations, about lack of access. It has been an area of active provider recruitment for at least two years. Most recently, to expand access HPSM has decided to open up access to out of network speech therapists, which is something we have not done historically. Our Pediatric team is also now more heavily engaged in the referral management process: when providers are unable to make a referral, HPSM has requested that our providers send that referral to HPSM so we may directly assist trying to get the patient scheduled somewhere, even if the provider is out of network. We are continuing to closely monitor this and track the grievances as they come in.
Dr. Chaikind asked how HPSM is sharing this information with pediatric providers. Colleen said that HPSM sent out several fax blasts to the network and posted the information on HPSM's website. Kati noted that with SMMC providers in particular, some fax and notice distribution issues have arisen, and she is working with Ms. J. Papa to improve information distribution. Dr. Chaikind said she would be happy to help with this. Dr. Stodgel asked whether HPSM can send notifications via email. Colleen mentioned that HPSM has assessed current system capabilities, and our current systems do not allow us to manage email distribution list serves to the extent required to roll out provider email communications at this time. HPSM is exploring system modifications or new tools to be able to do this, and HPSM began collecting

email addresses in our quarterly provider data updates this year in preparation for moving to digital communication over time. Only a minority of providers have opted to provide a current email address at this time.

5.4 Non-Emergency Medical Transportation (NEMT) Network Development: Colleen reported that on July 1st, HPSM implemented new authorization requirements for non-emergency medical transport (NEMT). In advance of this change HPSM engaged several providers to provide feedback on the process, and help test the new authorization submission process. These new requirements are burdensome for providers but driven by a regulatory priority. HPSM is in regular conversation with our providers about how to make this new process easier. We worry that the additional requirements may restrict access in an area where access is already challenging, and are actively trying to recruit more providers. Dr. Stodgel and Dr. Chaikind inquired about what role ride-sharing applications like Uber play in our transportation network. Colleen and Kati clarified that while ride-sharing companies do comprise part of our network for non-medical transportation, they are not currently set up to take medical transport requests such as wheelchair vans or gurney vans.

5.5 Timely Access Survey: Kati reported that HPSM is initiating the Provider Timely Access survey process for this year. This is the annual DMHC requirement for monitoring access in the network for multiple services types. Based on the findings from this year's survey, and the discretion of the Credentialing Review Committee, anyone who is found to be out of compliance multiple years in a row will be brought to this committee to discuss the corrective action plan to help move these providers into compliance.

5.6 Credentialing Policy Review: In follow up to our last PAG/PRC session, Rhonda mentioned that in the committee materials we sent out prior to this meeting, we included red-lined versions of the P&Ps that were approved at our last session, to provide additional clarity on what had changed in the most recent versions.

6. Health Services Announcements
   6.1 None

7. Adjournment
   The meeting was adjourned the open session and moved to the PRC Closed Session.

Next Meeting: October 2, 2019

PHYSICIAN ADVISORY GROUP
Meeting Minutes
October 2, 2019 - 7:30 a.m.
San Mateo Medical Center
222 W. 39th Avenue, Board Room, 2nd Floor
San Mateo, CA 94403

Committee Members Present:	Drs. Janet Chaikind, Vincent Mason, Leland Luna, Kenneth Tai, Hung-Ming Chu,
Committee Members Excused:	Drs. Tom Stodgel, James Hutchinson, and Randolph Wong
HPSM Members Present:	Dr. Richard Moore, Colleen Murphey, Paul de la Cruz, Luarnie Bermudo, Kati Phillips, Molly Carter
HPSM Members Excused:	Maya Altman, Patrick Curran, Dr. Cynthia Cooper, Dr. Susan Huang

1. Call to Order
   Dr. Janet Chaikind (Chair) called the meeting to order at 7:30am. A quorum was present.

2. Public Comment
   No public comment was offered.

3. Approval of Agenda and Approval of August 2019 Meeting Minutes
   The Agenda for October 2, 2019 was approved. Meeting Minutes for August 2019 were not reviewed, and are pending approval (scheduled for December 2019 session).

4. HPSM Announcements

   4.1 Dr. Moore reported that HPSM has continued the feasibility evaluation of integrating Dental benefits. A financial impact analysis has been completed and will be presented to the HPSM Commission.

   4.2 Colleen shared that HPSM has launched the new Skilled Nursing and Long Term Care payment model effective 10/1/2019. As discussed in previous sessions of the PAG, this payment model was co-designed jointly by HPSM and the skilled nursing and long term care providers in our network who make up the majority of beds in our network. HPSM hosted a learning collaborative with these providers that met quarterly to provide training and process improvement resources. Separate sub-group sessions were held in addition to the learning collaborative meetings that were dedicated to co-designing the new payment model. The new payment model is intended to more fairly reimburse providers for complex high-needs patients, and reward providers for high quality care as determined by a set of quality measures such as readmissions. Feedback from our network providers so far has been positive and HPSM believes that this new payment model will help improve access.

5. Health Services Announcements

5.1 Dr. Moore noted that the KPC purchase of Seton Medical Center was approved. Provider contracts between provider organizations and the now-disbanded Verity Medical Group have been dissolving which the HPSM Health Services team is closely tracking to ensure that inpatient care capacity is not at risk.

6. Provider Services Announcements

6.1 Colleen announced that, effective September 1 2019, HPSM's Provider Service department underwent a re-organization. The purpose of the re-organization was to set up the team to better meet the changing needs of our providers and community, specifically:

- The need to increase value-based payment approaches
- The need to strengthen partnerships with large and consolidating provider groups and hospitals
- The need to strengthen both internal credentialing of providers and the oversight of delegated provider groups' credentialing
- Increased needs for high quality and accurate data about HPSM's provider network, both for members (e.g., via our provider directories), for our providers (e.g., via quality data reporting and directories), and to meet the increasing requirements of regulatory agencies.

In order to meet these needs, six positions within the Provider Services department were eliminated and seven new positions were created. Existing Provider Services staff were invited to apply for the new roles first, before recruiting was opened up to other HPSM staff and finally to external candidates. Provider Services staff were notified 3 months in advance of the changes going into effect to provide them time to either apply for the new positions or apply for other positions within or outside of HPSM.

The transition to the new structure was completed on September 1st. Four roles out of eleven remain open, so the Provider Services team has been working closely with other departments to make sure critical priorities are not dropped while we work to fill the open roles.

One of the changes of the reorganization affects this committee: a new role of Provider Credentialing Manager was created, which has been filled by Luarnie Bermudo who is present today. Luarnie will be taking over as the HPSM committee point of contact for the PAG and PRC, fulfilling the responsibility previously held by our Provider Services Manager Rhonda Bibbins who is no longer with HPSM. HPSM thanks Rhonda Bibbins for her contributions both to this committee and to HPSM members during her tenure with the health plan, and wishes her the best as she seeks

out opportunities closer to home. HPSM is delighted to welcome Luarnie to the Provider Services team, and to this committee. From her previous role as HPSM's Whole Person Care Program Manager, Luarnie brings both significant experience a deep provider and community relationships to this role.

6.2 Kati Phillips reported on developments to the Medi-Cal PCP Pay for Performance (P4P) program. On November 1st, HPSM is hosting a provider forum from 12 – 2pm for primary care providers to give HPSM feedback and input on the proposed changes to P4P measures for 2020.

6.3 Additionally Kati Phillips and Dr. Moore shared information about the new MCAS (Managed Care Accountability Set) measures that have been released. These measures are a replacement for the previous EAS quality measures and include a subset of HEDIS measures. Both the number of measures that HPSM is held accountable for, and the baseline performance level that HPSM must meet, have increased significantly. The new minimum performance level is to achieve 50th percentile performance whereas this minimum was previously 25th percentile. If HPSM falls below the minimum requirements, the penalties for low performance have increased and include potential financial sanctions and other corrective actions. To meet this higher bar, many departments across HPSM have been collaborating to develop a plan wide action plan and resource needs assessment. Improvements to data capture and more intensive engagement with our provider network will be required. Colleen shared copies of HPSM's most recent quarterly provider newsletter which include a pull-out poster outlining the new measures. This is also available online at https://www.hpsm.org/provider/resources/newsletters (Fall 2019 issue).

6.4 This concludes our open session network updates.

7. Adjournment

The meeting was adjourned to the PRC Closed Session.

The next meeting for the Physician Advisory Group is scheduled for December 4, 2019.

DRAFT

AGENDA ITEM: 4.3

DATE: December 12, 2019

CCS FAMILY ADVISORY COMMITTEE MEETING
Thursday, September 19, 2019 – 6:00 p.m.
2000 Alameda de las Pulgas
San Mateo, CA 94403

Meeting Summary

Members Present:	Lianna Chen, Marilyn Wendt, Gladis Gomez, Leticia Acevedo, and Rocio Jimenez, Carol Elliott.
Members Excused:	Stephanie Gradek, Faviola Morales, Miguel Sr. Bejar Arias, Doris Dablo, and Stephanie Bayless.
San Mateo County Members present:	Anand Chabra, M.D., Lizelle Lirio de Luna, Mitch Eckstein, Marsha Guevara, and Helen Phung.
San Mateo County Members Excused:	Glenn Ibarrientos.
HPSM Members Present:	Cynthia Cooper, M.D., and Sophie Scheidlinger.
HPSM Members Excused:	Jessica Arevalo, Susan Huang, M.D., Maya Altman.
Guests:	Jaqui Knudson, Family Voices; Ellen Frankel, Kidpower; Katie Humphrey, CCS Kaiser, Dr. Grace Chen, SMMC; and Rita Estrada, Interpreter

1. **Call to Order:** The meeting was called to order at 6:00 p.m. by Sophie Scheidlinger.

2. **Introductions:** Introductions were made around the room. Some of the guests present gave an introduction to their organizations and how they support the CCS population and community:
   - Carol Elliott from Gatepath shared that her organization has family resource centers which assist parents of special needs children in providing navigation of support services. The staff is mostly parents of children with special needs and bilingual Spanish. They also have access to the language line for simultaneous translation in any language that a family needs. She also works with a program which supports early identification of children with special needs through developmental screening and a Help Me Grow line which is general developmental information for parents of children ages 0-5. That line is available in English and Spanish and also offers simultaneous translation in any other language.
   - Jaqui Knudson, from Family Voices of California, explained they are a statewide collaborative working with parent run centers and families regarding health care for children with special health care needs. They also have a training program for parents called Project Leadership which helps provide education and information for families to become better advocates and understand legislation more closely. Her role is Outreach & Education Manager for the Whole Child Model Project across the State of California. Their office is in San Francisco but she is located in Orange County.
   - Katie Humphrey is the South Bay CCS Program Manager involved with the CCS Children whose Medi-Cal is assigned to Kaiser. She is primarily working on implementing the

Whole Child Care Model and looking at ways to improve services to the populations for which they have been assigned.

There will be presentations on Family Voices and Gatepath at future meetings to hear more about what they do.

Ms. Scheidlinger introduced Ms. Leticia Acevedo, Family Advisory Committee chair. She will facilitate the meeting through the agenda as presented.

3. **Public Comment:** There were no public comments.

4. **Approval of Minutes:** The minutes were approved as presented.

5. **Youth Advisory Committee & Transitions Work**
   Lianna Chen reported on the last Youth Advisory Committee on July 29th at the Redwood City main library. They had two guest speakers from Job Train. The discussion was focused on seeking employment, how to prepare a resume and cover letter, how to conduct themselves during an interview and how to handle questions. The speakers went through some situational questions to give the group a chance to practice how they would answer questions during an interview. The next meeting will be held in October and the topic is to be medical and health care. They are still getting good attendance at the meetings.

6. **Private Duty Nursing**

   a. **Report Out**
      Sophie shared the report on the activity from April through June for the two private duty nursing vendors. She explained that the members receiving these services are those who, if they did not receive this care in the home, we need to be in a nursing facility:

      —**Maxim:**
      - There were no new referrals
      - Currently caring for 15 existing patients
      - Three of these existing patients were under the 85% utilization threshold of hours utilized, however, all of these patients were fully staffed as of July so we expect this to improve.
      - The average utilization of hours authorized for all 15 members was 91% which we consider to be a successful quarter (90% is the goal).

      —**Premier:**
      - Maxim and Premier were recently purchased by the same company so they are now merging into one corporation. We will continue our relationship and don't expect this to impact the services to patients.
      - They received one referral in June and did admit this patient within 30 days
      - They have six patients. One of the six was under the 85% utilization
      - The average was at 100% - this is due to hospital stays they were able to meet the hour requirement.

Sophie explained there were only 21 members who qualified for these services because they are very complicated cases. There are four measures used to incentivize the PDN vendors. Two are about new referrals and new members; and two are about existing members. Regarding the new referrals, the vendors are accountable to admit any eligible member into services according to national guidelines; and for the existing patients, we are also incentivizing the vendors for providing the best care by using the hours authorized.

Sophie further explained the graph showing the performance over time, the percentage of quality **–** of the four measures starting in 2018 Maxim began to dip down in Q2 to 50% and affected their payment; then they came back up to 100% and have been at 100% throughout 2019**.**

b. Anticipation of new guidance from state

Sophie talked about some of the changes happening at the state level with this benefit. She stated that there was a lawsuit filed at the state level with CCS but mostly with Medi-Cal. The need to find workers to provide this benefit has been a problem for patients and was the reason the health plan entered into these special contracts and implemented these measures. Ultimately, the lawsuit found in favor of the patients and the members because the rate being paid to providers by Medi-Cal was too low to get workers to provide these services. Staff still does not know what the changes will look like and how they will impact the day to day operations. More reporting and accountability on behalf of the health plans and CCS state wide is expected.

7. Kid Power presentation on bullying/safety

Ms. Gomez introduced Ellen Frankel from Kidpower to speak about bullying and safety. Ms. Frankel described that Kidpower of California coordinates and presents private and group workshops in the Bay Area and Southern California. Their full name is Kidpower Teenpower Fullpower, International. The program is for all ages but started out as a program for children. Their topics cover fire safety, car safety, boat safety and people safety which means safety with people they know and strangers. So everything they teach is categorized around interpersonal safety with people. The skills they teach are focused on preventing some of the worst things people can do to other people such as abuse, bullying, abduction. The main focus is on boundaries which is a foundational skill. When we teach children to identify and learn their rights to protect their boundaries they can prevent a lot of traumatic experiences. They work with people from all walks of life and like to focus on those who might be considered more vulnerable such as those with complex medical conditions, the deaf or blind, people who have experienced trauma, those who are likely to experience prejudice because of their gender or ethnicity. They teach different options to keep themselves safe. Adults also need to learn about child safety and how to handle children with a safety problem.

Ms. Frankel described that the workshops are for parents and children to do together. They only work with the children if their adult is present to make sure the children get more out of this training. The skills they teach take a long time to become safety habits. The workshops are active and participatory, not lectures. The parents and children learn skills together and then continue to practice. They also offer workshops for parents only and professional development training for teachers, staff, administrators, etc. Medical providers who have the opportunity to interface with parents and children on a regular basis and learn a few of these skills can be crucial in helping protect child safety. They believe these skills will help prevent sexual abuse and other kinds of harm to children including bullying.

The question was asked about the number of people in an average group setting. Ms. Frankel stated it varies. These types of services are expensive however they receive grant funding so many of the groups they work with do not have to pay. They require 10 people minimum to have a group. When they serve parents, the number of people is unlimited and the same way with staff. When children are present, they do limit the number of children.

It was asked if the workshops are available in Spanish. They have 2 bilingual Kidpower instructors and have very limited availability. Most Kidpower instructors do other things in addition to teaching these workshops, however, they present all the time in English with an interpreter for many different languages.

Ms. Acevedo shared that she had attended a Kidpower workshop in the past which has helped her in her position as a supervisor in a school to deal with children who have been bullied or that have special needs. She expressed the importance of continuing to learn and grow these skills. She leads a Spanish speaking support group for parents with special needs children.

Ms. Frankel stated that this program will mesh with any other program teachers or others have encountered so it is not a system that would conflict with whatever current system a school is currently using. They have Kidpower centers in a number of cities in the United States and many international centers. Teachers have come to California for the training and return to teach this program in areas like Vietnam, India, Columbia, Mexico, France and they open their own Kidpower center. They have just celebrated their 30th anniversary and continue to work on developing and improving their curriculum.

The question was asked about online bullying and Ms. Frankel confirmed they do have a series that addresses these issues that are suited for the online world. They do get a lot of requests to focus on cyber bullying since it is a huge problem.

8. Adjournment/Closing Remarks

The next meeting will be held on December 12, 2019 at 6:00 pm. The meeting was adjourned at 6:50 pm

DRAFT

CCS CLINICAL ADVISORY COMMITTEE
Thursday, September 19, 2019 – 7:00 p.m.
2000 Alameda de las Pulgas
San Mateo, CA 94403

Meeting Summary

Members Present:	Michelle deBlank, Grace Chen M.D., Lianna Chen, Michelle Blakely, Carol Elliot, Marilyn Wendt, Leticia Acevedo, and Katie Humphrey.
Members Excused:	Benjamin R. Mandac, M.D., Sherri Sager, and Lee Sanders, M.D.
San Mateo County Members present:	Anand Chabra, M.D., Lizelle Lirio de Luna, Marsha Guevara, and Mitch Eckstein
San Mateo County Members Excused:	Glenn Ibarrientos.
HPSM Members Present:	Cynthia Cooper, M.D., and Sophie Scheidlinger.
HPSM Members Excused:	Maya Altman, Jessica Arevalo, and Susan Huang, M.D.
Guests:	Rita Estrada, Interpreter.

1. **Opening Remarks - Call to order** at 7:03 p.m. by Sophie Scheidlinger.
2. **Introductions:** Introductions were made.
3. **Public Comment:** None.
4. **Approval of Minutes:** June 20, 2019 minutes were approved as presented.
5. **Family Advisory Committee Report Out**
   Ms. Acevedo reported that there were four parents present at today's meeting. We had a presentation on Private Duty Nursing and a guest speaker, Ellen Frankel, from Kidspower.
6. **Youth/Young Adult Advisory Committee Report Out**
   Ms. Lianna Chen reported that their meeting was on Monday, July 29th at the Redwood City Main Library. They had two guest speakers from Job Train who spoke to the group about the services they offer which includes assistance in job search, resume writing, and other tips on securing employment. They did some interactive exercises to practice job interviews. The next meeting will be held in October and the topic will be medical and health care.

   The question was asked if the youth group is aware of the Medi-Cal expansion extension to the age of 26 and if this is a topic of discussion. It was stated that in January Medi-Cal will be extended to the undocumented up to the age of 26 and it will not count against public charge in case they are worried about this since it is a state funded program.

   There was discussion about public charge issues, healthy kids and ACE and how this works together. Public Charge is going to affect undocumented individuals and is making people worried that if they need any benefit they won't be able to change immigration status. Michelle deBlank

stated that the implementation of public charge won't impact many undocumented community members in reality. Most benefits these individuals get are through the state, so the federal public charge rule would not change that, nor will it impact services available to children. Sophie stated that she has not heard much from families about this issue. Dr. Chabra stated that they are hearing a bit through programs like WIC where people do not want to participate even though WIC is not part of the public charge and home visiting should not be affected but there is a general fear of public charge for any benefit. Public charge could be a good topic for the youth group for discussion.

Another topic discussed was the sunsetting of Healthy Kids program. Sophie explained the history and the threshold of the federal poverty line and how that affected the eligibility for Medi-Cal. The Healthy Kids package was not as comprehensive as Medi-Cal but served the population and was funded locally. The state agreed to roll Healthy Kids into Medi-Cal, which is a win for those locally funding and managing this program. It will be a better solution for those kids as they will have better protections under Medi-Cal. It will be managed at the state level and will still have monthly premiums handled by the state instead of the plans. This transition is effective as of October 1, 2019.

7. Private Duty Nursing

a. Report out:

Ms. Scheidlinger briefly reviewed the quarterly report on the two Private Duty Nursing providers that we have value based purchasing agreements with, Maxim and Premier. We track them on four measures in total: two are around new patients and referrals; and two are around exiting patients.

Maxim had no new referrals; 15 existing patients; of the 85% standard of utilization, there 3 that were below but were fully staffed by July 1st.

Maxim and Premier were both recently purchased by a larger company. They are still operating separately but slowly over time it is expected that they will become one organization. This should not impact our ability to work with them and have them staff these cases.

Premier had one referral in June. They admitted them into service within 30 days which is the requirement. They have six existing patients, one of which was under the 85% utilization. The average of all of the patients is still 100%.

Dr. Chabra revisited the question about the referrals and if we were able to confirm there were no referrals that had not been fulfilled. Sophie followed up with Packard and there was nothing found to be outstanding.

Looking at quarterly performance, Sophie pointed out that Maxim had a dip in Q3 of 2018 to 50% and then 75% in Q4 2018. Their quality payment drops by that percentage so they are motived by that and got themselves back up to 100%. Premier had been consistently at 100% from Q2 2018 through Q2 2019.

b. Anticipation of New Guidance From State:

Sophie reported that there was a lawsuit that was in a settlement for children throughout California. This was due to the state rates for Private Duty Nursing being so low that access was a problem state-wide. This was evident from the beginning of the CCS pilot so many years ago and was one of the first things that this committee brought to our attention. From this, the value based purchasing contracts with providers were established. Since then, we have been able to rectify this problem in San Mateo, however this did not address the problem statewide. As a result, the state is will be paying for those people impacted but they are also using this opportunity to make changes to the documentation and fill rates. We do not have much detail at this point but are anticipating new regulatory guidance. What they have indicated so far, in terms of our performance metric, our goal is 85% utilization (we don't want people to be below 85% utilization) and the state's utilization expectation is going to be 100%. This will be the case for everyone throughout the state. Because of this we will have to set higher expectations with our vendors. When we have more details we will share how we think this will impact us and if there are any changes that we make to the guidelines as a result. They did raise the rates for private duty nursing substantially about six months ago. This was the only rate change in this industry in the last 10 or more years.

8. Discussion of issues providers/community partners may be facing

Sophie opened the floor for anyone issues the group would like to voice:

a. Lyrica

Dr. Cooper reported that Lyrica is now on formulary as a generic. If you order the generic you don't need the diagnosis or prior auth anymore. If you want to order the brand name you will still have to go through the full process. For Diagnosis Codes for Drugs Dr. Cooper stated that they use the FDA approved codes.

b. Kaiser Transition Plans

Sophie reported that HPSM is working with Kaiser to take on Whole Child Model. The set up in the non-WCM counties where you have the CCS program and then the Managed Care Plan has been our set up with Kaiser. We have Kaiser assigned Medi-Cal members and Kaiser is then responsible for all of their primary care and all their CCS related condition related have been carved out of the Kaiser contract and assigned to CCS up until now. We have wanted to work with Kaiser to take the full child and we are now working towards doing that. Our target date is November 1, 2019. We are still working on approval from the state so it is not confirmed yet but we are working towards this deadline. If approved, those children will be fully delegated to Kaiser for their care and Katie Humphrey will come to the Clinical and Family Advisory meetings to hear about issues, etc. This will affect about 120 children in San Mateo County.

9. Adjournment/Closing Remarks

The meeting adjourned at 8:00 p.m.

DRAFT

AGENDA ITEM: 4.4

DATE: November 13, 2019

PHARMACY & THERAPEUTICS (P&T) COMMITTEE
Meeting Summary
Wednesday, Sept 11, 2019, 7:00-9:00 am
SMMC – Alcove Room
222 West 39th Avenue, 2nd floor
San Mateo, CA 94403

Members Present: Barbara Liang, Gary Horne, George Pon, Jack Tayan, Lena Osher, and Rukhsana Siddiqui.

Members Absent: Jaime Chavarria, Jonathan Han, Niloofar Zabihi, and Varsha Gadgil

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

Staff Absent: Karla Cruz-McKernan

1. **Call to Order**

2. **Approval of Meeting Minutes**
   The Committee unanimously approved the meeting minutes for Sept 11, 2019 with no objections.

3. **Approval of Agenda**
   The proposed agenda for the meeting was approved as presented.

4. **Old Business**
   Ming discussed the pharmacy carve out and its implications on HPSM. Ming stated that the Plan has been engaged in dialogue with DHCS and other external stakeholders in order to help facilitate a smooth transition to Fee-for-Service to the extent possible *(effective 1/1/2021)*. Jack asked whether there would be a need for future P&T Committee meetings after the pharmacy carve out since the State would be managing the formulary. Ming responded by saying that the P&T Committee meetings would still be required since the Plan would need to continue to manage the CMC and HealthWorx formularies. Ming ended by saying he would continue to keep the Committee informed with developments at the next P&T meeting.

5. **New Business**
   5.1 Consent Agenda
   Ming discussed with the Committee the consent agenda, which entails an annual review of the Medi-Cal formulary in order to ensure that it is comprehensive enough to meet member needs. The Committee was sent a link to the full formulary prior to the meeting in order to facilitate this review.

   Barbara motioned for approval of the consent agenda and Jack seconded with the Committee unanimously approving with no objections.

5.2 Pharmacy Department Policy Updates

Andrew presented an update to the Non-Formulary Exceptions Policy. For all non-formulary drug requests involving off-labeled indications, this update would outline what type of medical literature is acceptable to justify a drug's use for indications, which may or may not be appropriate. The guidance proposed is similar to CMS' guidance surrounding the use of medical literature as it pertains to oncology drugs. Under the revised policy, publications will only be considered if they are published as original manuscripts (not abstracts or commentary) in peer reviewed journal articles. In addition, the Plan will also consider the experimental design of the study and whether it is strong enough to determine the clinical efficacy of the drug being requested.

Andrew then discussed an update to the Coverage Duration Effectuations Policy, which standardizes the duration of approvals to 3 months for non-formulary drug requests involving multisource brand name drugs in instances where the generic formulation is unavailable due to a drug recall or shortage. The change proposed would only apply the Medi-Cal and HealthWorx lines of business. For CMC,the Plan is required to approve of such requests until the end of the benefit year as outlined in Chapter 6 of the Medicare Prescription Drug Benefit Manual.

George motioned for approval of the Pharmacy Department policy updates and Jack seconded with the Committee unanimously approving with no objections.

5.3 New Drugs to Market

5.3.1 New Protected Drug Class

Matt presented the new protected drug class drugs, which include Inrebic, Kanjinti, Nubeqa, Rozlytrek, Turalio, Xpovio and Zulresso. The recommendation was made to add all of these new drugs to the CMC formulary. For Medicaid, the recommendation was made to maintain these drugs non-formulary since none of them are on the Contract Drug List and there was not enough compelling reason to add any of them to the formulary.

5.3.2 New Non-Protected Drug Class

Matt presented the new non-protected class drugs, which included Annovera, Baqsimi, Katerzia, and Xenleta. Matt recommended adding Baqsimi to the formulary for CMC, Medi-Cal, and HealthWorx in order to provide a convenient formulary alternative to injectable glucagon. George asked how Baqsimi compared in price to injectable glucagon. Gary responded by saying that the price was similar and that he agreed with the recommendation to add the drug to the formulary. Matt then discussed Annovera, a new contraceptive, which he recommended to be added to the Medi-Cal formulary consistent with the Plan's broad coverage of contraceptives as mandated by regulatory requirements. For CMC, Matt recommended that the Annovera be maintained non-formulary due to its high cost and lack of benefit relative to the Nuvaring. Matt went on to recommend that all remaining new non-protected class drug class drugs be maintained non-formulary due to various factors such as the

lack of benefit compared to available formulary alternatives and/or expected low utilization. Request for these agents would be approved on a case-by-case basis using the Plan's Non-Formulary Exceptions Policy.

5.4 New FDA-Approved Indications

Matt presented the new FDA-approved indications. Matt recommended that no changes be made to the formulary nor any updates required to existing prior authorization criteria in light of these new indications.

5.5 CMS Required Formulary Changes

Matt presented the CMS required formulary changes, which are based on CMS' review of the Plan's CMC formulary. CMS conducts these type of reviews in order to ensure that the Plan's CMC formulary meets current industry standards. In response to CMS' review, HPSM has made changes to the prior authorization for Kalydeco and Rectiv. For Kalydeco, the prior authorization criteria was updated to allow for the approval of the granule formulation in those over the age of 6 months. For Rectiv, the prior authorization requirement was removed altogether.

5.6 Formulary Considerations

Jasmine discussed miscellaneous formulary changes. These changes were recommended in response to issues identified during the coverage determination and prior authorization process along with feedback derived from pharmacy staff and prescribers. The changes recommended vary in scope and involve the following drugs: Admelog vial/pen, colonscopy bowel preps, disclofenac 1% gel, epinephrine 0.15 auto-injector, Gardasil Injection, granisetron tablets, Pazeo eye drops, pregablain capsules, Riomet Solution, SSKI solution, Sublocade injection, Symjepi Injection, timolol GFS, tizandine Capsules, Vivitrol injection, acetic acid otic solution, and liothyronine tablets.

Next, Jasmine discussed recommended updates to the coverage criteria for Octagam and the non-preferred weight loss medications (e.g., Saxenda, Contrave, etc.). For Octagam, the recommendation was made to allow approval based on all medically accepted indications rather than just FDA-approved indications. This in response to the large number of requests received by the Plan for Octagam involving indications that have not been FDA-approved. For non-preferred weight loss medications, the recommendation was made to require the trial and failure of a stimulant (e.g., phentermine or diethylpropion) and Alli OTC as opposed to the current criteria, which requires trial and failure of any two of these agents. This change was recommended in order to ensure members utilize weight loss medications from two different drug classes prior to approval.

5.7 Drug Class Reviews

5.7.1 Multiple Sclerosis Agents

Andrew gave a brief background on Multiple Sclerosis (MS) where guideline recommendations do not prefer one agent over another. The recommendation was made to add Aubagio to the formulary due to high utilization and order to provide

another oral formulary treatment option. In addition, the recommendation was made to remove Rebif and Betaseron from formulary in favor of Avonex and glatiramer, two treatment options that are more cost-effective. Andrew also discussed two new drugs for MS: Mayzent and Mavenclad. He recommended maintaining these two drugs as non-formulary due to the lack of benefit compared to existing treatment options.

5.7.2 Sleep Disorders

Andrew discussed drugs used for the treatment of sleep disorders such as narcolepsy and obstructive sleep apnea (OSA). He made the recommendation that armodafinil be the preferred over modafinil due to its comparable efficacy, favorable kinetic profile, and cost. Andrew also recommended that approval of Xyrem be contingent upon trial and failure of more cost-effective formulary treatment options such as armodafinil or modafinil and stimulants such as methylphenidate. Sunosi, a new drug indicated for the treatment of obstructive sleep apnea, was recommended to be maintained non-formulary due to its high cost relative to other available agents and its limited track record for safety and efficacy.

Barbara asked if the Plan was going to grandfather existing patients who already on the modafinil, rather than trying to shift these patients to armodafinil. After a brief discussion, an agreement was made to grandfather existing members. Dr. Osher noted that some of her patients have difficulty sleeping due to the longer half-life of armodafinil versus the modafinil. Andrew stated that if a patient has tried and failed on armodafinil, the Plan would approve the modafinil.

5.7.3 Chronic Idiopathic Constipation

Andrew presented a drug class review on chronic idiopathic constipation (CIC). Andrew recommended that Linzess be added to the CMC formulary due to its similar cost and comparable efficacy relative to Amitiza, the Plan's preferred product. For the Medi-Cal and HealthWorx formularies, Andrew recommended to maintain Linzess non-formulary due to the lack of rebates, which still makes Amitiza the most cost-effective treatment option for those lines of business.

5.7.4 Pulmonary Arterial Hypertension

Biyan presented a drug class review on pulmonary arterial hypertension (PAD). The recommendation was made to add ambrisentan and tadalafil to the formulary as first-line treatment options along with sildenafil based on updated clinical guideline recommendations. The second-line preferred agent was recommended to be bosentan, third-line Adempas, followed by Uptravi as last-line. These recommendations were made based on a combination of factors including cost, clinical guideline recommendations, utilization data, and clinical studies. None of the infused and inhaled therapies for the treatment of PAD were recommended for addition to the formulary since these agents are typically administed under the medical benefit, not pharmacy. In addition, based on guideline recommendations,

none of these drugs are recommended as first- or second-line treatment options outside of those patients with poor prognosis.

5.8 Drug Monographs

5.8.1 Relizorb

Biyan reviewed Relizorb, a medical device approved to hydrolyze fats in enteral formula. Biyan presented data surrounding the efficacy of Relizorb, which was weak as only a few small-scale studies having been conducted on the device, one of them using pigs. In light of this, the Plan recommended that Relizorb be non-preferred and non-formulary for all lines of business until more robust data is available.

5.8.2 Vemlidy

Biyan presented a monograph on Vemlidy, a drug used for the treatment of chronic hepatitis B. Biyan noted that based on clinical studies, the efficacy of entecavir, tenofovir disoproxil fumarate (Viread), and tenofovir alafenamide (Vemlidy) were comparable. In addition, guideline recommendations place all three treatment options as first-line. Biyan recommended that both entecavir and tenofovir disoproxil fumarate be the preferred formulary treatment options due to favorable cost and superior efficacy. She also recommended that approval of tenofovir alafenamde (Vemlidy) require the trial and failure of both entecavir and tenofovir disoproxil fumarate. She also added that entecavir is an appropriate treatment option in patients who have documented bone or renal issues, a concern often cited by prescribers as a reason not to use tenovovir disoproxil fumarate.

5.8.3 Exondys

Biyan presented a drug monograph for Exondys, an intravenous (IV) drugs use for Duchenne Muscular Dystropyhy (DMD). Based on the clinical studies, Exondys has demonstrated the ability to reduce dystrophin levels, a surrogate endpoint which has failed to translate into any meaningful clinical benefits such as improvements in 6-minute walking distances. Ming noted that this is a perfect example of a drug that may not have enough good evidence to support its use, but still comes with a high price tag.

5.8.4 Makena Auto-Injector

Andrew presented a drug monograph on Makena (hydroxprogesterone caproate). He recommended that the generic hydroxyprogesterone caproate vial be added to formulary as the preferred formulary option for the prevention of preterm birth in women with a singleton pregnancy who have a history of singleton spontaneous preterm birth. Andrew mentioned that a new Makena auto-injector was recently approved which is injected intramusculary rather than subcutaneously. Outside a small reduction in injection site reactions, this new formulation of Makena offers no real clinical benefit over the generic vial. Therefore, the Plan recommended maintaining the Makena auto-injector non-formulary. Jasmine agreed with this change and noted that a number of prescribers have switched their patients from the

new autoinjector to the generic vial due to allergic reactions to the oil contained in the auto-injector.

5.8.5 Zulresso

Rukhsana presented a monograph on Zulresso, the first treatment option specifically FDA-approved for severe postpartum depression (PPD) in adults. Since the drug is administed via a continuous IV infusion over 60 hours, there was discussion amongst Committee members as to whether the drug would be approved under the pharmacy or medical benefit. Andrew noted the drug would most likely be approved under the medical benefit, but that it could theoretically be approved under the pharmacy benefit if billed by a pharmacy. Rukhsana recommended that the drug be added to the CMC formulary since it is a protected drug class drug and may require formulary placement per CMS regulations. Andrew added that if the drug is not included on CMS' Formulary Reference File, the Plan would eventually remove the drug from the CMC formulary since this would indicate that CMS would not expect the drug to be billed under the pharmacy benefit. For Medi-Cal and HealthWorx, the Rukhsana recommended maintaining the drug non-formulary due to expected lack of utilization under the pharmacy benefit, with request approved on a case-by-case basis using the same criteria established under the CMC line of business.

Gary motioned for approval of all of the recommended formulary changes and Barbara seconded with the Committee unanimously approving with no objections.

6. Other Business/Announcements

None

7. Adjournment

The meeting adjourned 9:00 am.
Next scheduled meeting: November 13, 2019 in the Alcove Room

AGENDA ITEM: 4.5

DATE: November 13, 2019

DRAFT

QUALITY IMPROVEMENT COMMITTEE MEETING
September 18, 2019, 6:00 p.m. – 7:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080
HPSM Boardroom, 1st Floor

QIC Members Present: Dr. Jaime Chavarria, Dr. Hung-Ming Chu, Dr. Maria Osmena Dr. Amelia Sattler and Dr. Kenneth Tai

QIC Member Excused: Dr. Jeanette Aviles

HPSM Members Present: Dr. Cynthia Cooper, Janet Davidson, Nicole Ford, Dr. Susan Huang, Ian Johansson, Megan Noe, Vicky Perez, Kati Phillips and Samareen Shami

HPSM Members Excused: Maya Altman

1. **Call to Order** by Dr. Kenneth Tai

2. **Approval of Quality Improvement Committee (QIC) agenda for September 18, 2019**
   Approved and seconded by the committee members.

3. **Approval of Quality Improvement Committee (QIC) minutes from June 19, 2019**
   The QIC minutes was approved and seconded by the committee members.

4. **Approval of Clinical Quality Committee (CQC) minutes from June 10, 2019**
   The CQC minutes was approved and seconded by the committee members.

5. **Approval of Service Quality Improvement Committee (SQIC) minutes from June 27, 2019**
   The SQIC minutes was approved and seconded by the committee members.

6. **Approval of Utilization Management Committee (UMC) minutes from July 22, 2019**
   The UMC minutes from July 22, 2019 was approved and seconded by the committee members.

7. **Clinical Guidelines Update and Review**
   Ms. Perez reported where Quality presents a summary of the clinical guidelines posted on HPSM website for providers use. This committee is notified annually with updates on different clinical guidelines. A list was created with different clinical guideline links currently available on the website as well as other resources and tools. Quality is required to report out on two new measures this year, which is also discussed in the MCAS interventions planning. In addition, a new section was added under Pediatrics: Bright Futures Periodicity initiative. Guidelines for health supervision for infants, children and teens – a tip sheet link is available in how to implement the guidelines along with a separate link to the schedule.

Comment from Dr. Susan Huang for Vicky and Nicole if helpful to report on U.S. Preventative Services Task Force guide has changed in recent years, which was 2014. Vicky stated the link shows, current as of 2014; however, the link is currently being reviewed with any updates as of 2019. Note: HPSM will continue to review on an annual basis if any changes are needed.

Comment from Dr. Kenneth Tai if any recent updates on the clinical guidelines? Ms. Perez stated the website is currently being updated and/or is in progress to be updated. There might be changes/reviewed end year.

Comment from Dr. Hung-Ming Chu stated the American Psychiatric Association is continuing to work on new guidelines as well as the Gonorrhea Treatment guideline.

7.1. Screening for Chlamydia and Gonorrhea (USPSTF-2014)
STD (Sexually Transmitted Diseases)
Screening for Chlamydia and Gonorrhea (USPSTF- 2014)
https://www.hpsm.org/docs/default-source/provider-services/chlamydia-screening.pdf?sfvrsn=49d68596_4
CDC Sexually Transmitted Guidelines (**2015**)
HPV Vaccine for Child/Teen (**CDC -2019)**
San Mateo County Disease Reporting Form (**2018**

Action: approved and seconded by the committee members.

7.2. Pharmacological Treatment of Patients with Alcohol Use Disorder (APA-2018)
Behavioral Health
Pharmacological Treatment of Patients with Alcohol Use Disorder (APA- 2018)
https://psychiatryonline.org/doi/book/10.1176/appi.books.9781615371969
Practice Guideline for the Treatment of Patients with Substance Use Disorders **(APA-2010)**
ADHD Parents Medication Guide **(AACAP-July 2013**)
PCP Referral Form for Behavioral Health and Recovery Services

Action: approved and seconded by the committee members.

8. MCAS Interventions Planning

Ms. Noe and Ms. Shami reported there have been some required changes from the state especially in the MCAS measure (Managed Care accountability set), which is essentially a subset of HEDIS measures. The topic of agenda includes 1) New MCAS Measure Changes, 2) MCAS Dashboard and 3) MCAS Related Planned Activities. The primary change in the MPL was from 25th percentile to 50th percentile across all measures. Quality has already identified several At-Risk measures -

- Well care visits
- Adolescent well care visit for asthma medication ratio/adult BMI
- Comprehensive Diabetes Care for A1c Testing/poor control

MCAS Dashboard chart shows how each of the measures are tracked -

- Measure indicator
- 50th percentile
- Final rate – 2018
- June/July/August reflects currently at each of the measures
- 2019 trends
- Difference to benchmark

MCAS Readiness Assessment

- Mapping current interventions across MCAS measures
- Identify gaps in programs
- Identify resource needs for the long term

Planned activities and interventions
Proposed 2020 MCAS priority areas with AMR/PPC/W15/CBP/ABA/CDC-Testing and Control/AWC/Chlamydia/PCR

Appreciate comments and feedback from the committee for guidance in some of the high priority focused areas.
Comment from Dr. Tai if June/July/August = 2019 data - yes, YTD 2019. Why is W15 below? Based on administrative rate data whereas unlike other measures, there have been no chart collections. And potentially providers are not necessarily coding and billing for the individual visits. Note: these are based on administrative claims data specifically for well care visits and adolescent well care visits.

Comment from Ms. Kati Phillips if the W15 is a required integral visits and/or six totals for 15 months = six total within 15 months. For example, HEDIS guidelines state if occurs the day after the child's 15th birthday, not counted.

Comment from Dr. Huang if the committee members could reach out to the community primary care practices under the capitation payment system, there is less incentive to submit every single encounter. This is to improve pediatric access for pediatric preventive health being reviewed very closely by Governor Newsom. Note: HEDIS is a performance measurement for specification. Dr. Tai commented with HEDIS, providers would require submission of these codes but not capturing because of capitation. Comment from Ms. Phillips where HPSM has a payment model for PCPs for encounter data submission metric for total encounters as well as patient engagement metric for all primary care claims submission. Note: HPSM monitors the payment structure on a monthly basis where there have been some PCPs removed from capitation with a large panel-size.
Comment from Dr. Tai if HPSM would notify providers with reminders; such as a post card reminder to patients. Ms. Shami stated we have multiple ways of notifying providers; such as implement fax blast; various interventions of informing families; such as, mail health education materials for adolescent well visits. Currently, the health educators are working to assess/revise the mailing situation to avoid multiple mailing to same member. Comment from Dr. Huang at the state level to restrict texting to members directly. Look at other ways to communicate to our members directly.

Lastly, Ms. Shami stated questions to keep in mind -

- Are these interventions member centered rather than measure focused
- What are the best ways to focus on members
- What are the best ways to communicate with providers
- How do we connect our programs/interventions better with providers objectives or current programs

Comment from Dr. Tai in the proposed MCAS where HPSM and providers could work proactively to manage our members in getting their visits, immunizations; such as, provide data to alert providers to avoid missing the timeframe beforehand. Ms. Shami stated Quality has the resource to work closely with providers; such as, available data tools. For other current activities, Quality is looking to develop community partnerships for health education guidelines; such as, A1C testing to go out soon and interventions with our Care Coordination and Pharmacy units. Quality is also looking to work with SMMC for a potential pilot – Sequoia Teen Wellness. Comment from Dr. Tai in terms of if HPSM uses text-based messaging vendors like Care Message to promote with patients? Yes, HPSM uses Care Message for the Prenatal Post-Partum Care program. In addition, HPSM is looking to expand with less restriction. Comment from Ms. Ford whether the state would allow health plans to use text messaging, which was an opt-in program. Presently, the state has lessened the restriction for plans to communicate for health messages. Lastly, who are some of the champions in your organization for HPSM to partner with for any of these measures to connect with our members?

9. **Next Meeting – December 18, 2019**

10. **Adjourn** – adjourned at 7:30 p.m. with no further business.

MEMORANDUM

AGENDA ITEM: 4.6

DATE: November 13, 2019

DATE: November 4, 2019

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: Approve an Amendment to the Agreement with Cotiviti

Recommendation

Approve an amendment to the agreement with Cotiviti, extending the term through December 31, 2022 with the total fiscal obligation not to exceed $4.1 million; and authorize the Chief Executive Officer to execute said amendment.

Background

HPSM processes over 1.5 million medical claims annually. Effectively applying the appropriate edits to these claims and reliably monitoring fraud, waste and abuse is critical to avoiding expensive and avoidable problems including higher claims error rates that result in overpayments, penalties for regulatory noncompliance and unnecessary overhead. For these reasons, HPSM utilizes an outside vendor to monitor and support internal efforts to ensure claims are reimbursed accurately.

In 2014, HPSM selected Cotiviti (formerly known as Verscend Technologies) to replace PCG Software (PCG) for claims editing software and to add post payment oversight and monitoring of potential fraud waste and abuse (FWA). Cotiviti was selected through an RFP process that included six proposals. Since going live on January 1, 2015, Cotiviti has continued to provide excellent customer service, accurate and supported findings with very little provider abrasion, and an effective FWA tool to monitor and trend provider billing practices. Furthermore, Cotiviti's edits have prevented approximately $10 million dollars in overpaid claims since implementation. In January 2018, the Commission approved a two-year extension extending the agreement to December 31, 2019 for a total of five years not to exceed $2.3 million.

In 2019, HPSM issued a Request for Proposal (RFP) that resulted in three proposals that were received and evaluated by a committee comprised of Claims, BSI and Compliance staff. The vendors were evaluated based on their written submissions, technical capabilities, cost and available support. After this evaluation process, the committee concluded that Cotiviti provided the best solution for HPSM's claims editing and FWA needs at the lowest cost.

HPSM has another agreement with Cotiviti for HEDIS measurement and software, in the amount of $1.23 million. The most recent amendment to that agreement was approved by the Commission in October 2019.

Discussion

Based on the excellent service, net savings to HPSM and high quality work provided by Cotiviti since 2014, and the results of the RFP conducted in 2019, we are requesting approval of a three-year extension through December 31, 2022 not to exceed a total of $4.1 million over eight years. This will increase the previously approved amount by $1.8 million.

Fiscal Impact

For services provided through September 2019, HPSM has expended $2,181,763 and is expecting to reach the $2.3 million previously approved by the end of 2019. Approximately 80 percent of the cost associated with this agreement is contingency-based causing fluctuations in cost based on provider behavior. HPSM is also experiencing an increase in fees as a result of introducing new edits.

The proposed amendment extends the agreement to December 31, 2022 in an amount not to exceed $4.1 million for both claims editing and FWA monitoring.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVALOF AMENDMENT OF AGREEMENT WITH COTIVITI

RESOLUTION 2019 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has an ongoing need for claims editing validation and ongoing oversight of potential FWA;
B. The San Mateo Health Commission has previously approved an agreement with Cotiviti that is set to expire December 31, 2019; and
C. A request for proposal was performed 2019 for these services that resulted in the selection of Cotiviti.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves an amendment to the agreement with Cotiviti extending the term through December 31, 2022 for an additional amount of $1.8 million for a new contract maximum of $4.1 million; and

2. Authorizes the Chief Executive Officer to sign this amendment.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of November, 2019 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
David Canepa, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

DRAFT

AGENDA ITEM: 4.7

DATE: November 13, 2019

SAN MATEO HEALTH COMMISSION
Meeting Minutes
October 9, 2019 – 12:30 p.m.
Health Plan of San Mateo - Boardroom
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

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

Commissioners Absent: Don Horsley.

Counsel: Kristina Paszek

Staff Present: Maya Altman, Gabrielle Ault Riche, Chris Baughman, Corinne Burgess, Pat Curran, Janet Davidson, Trent Ehrgood, Robert Fleming, Nicole Ford, Susan Huang, M.D., Ian Johansson, Francine Lester, Megan Noe, Keisha Payne, Kati Phillips, Karla Rosado-Torres, Rebecca Sullivan, Jim Winkel, and Eben Yong.

1. **Call to order/roll call**
   The meeting was called to order at 12:30pm by Commissioner Canepa. A quorum was present.

2. **Public Comment (deferred)**
   There were no public comments.

3. **Approval of Agenda**
   Commissioner Pon moved approval of the Agenda as presented. **M/S/P**

4. **Approval of Consent Agenda**
   Commissioner Zuniga moved approval of the Consent Agenda as presented. **M/S/P**

5. **Specific Discussion/Action Items**

   5.1 Discussion Action on Dental Integration

   Ms. Altman introduced the recommendation to approve the integration of dental benefits in the scope of services for HSPM members. This is a request for preliminary approval which includes hiring a Dental Director, modifying HPSM computer systems, recruiting providers and working with the Department of Health Care Services (DHCS) to initiate necessary contract changes, address readiness, perform provider and member outreach, and finalize revenue and cost estimates.

   Mr. Curran reviewed the presentation included in the Commission packet. He highlighted the legislation that allows HPSM to implement a six-year dental integration program in San Mateo County. The legislation requires stakeholder input, the creation of objectives for utilization and access, and a plan readiness assessment. The legislation also requires a

formal evaluation by an external entity. Mr. Curran then reviewed annual dental visit utilization in San Mateo County relative to the Statewide Denti-Cal average and average for all populations, including those commercially insured. The results indicate a large unmet need in the county, with utilization falling below even the statewide Denti-Cal average.

The program goals are to improve access to care, align quality incentives for improved oral health with overall health, and demonstrate that integrating medical and dental services for Medi-Cal is cost effective. Members will call HPSM to get help regarding benefits and access to the provider network as they do today for medical care, using their existing ID cards.

To prepare for this recommendation, staff performed operational and financial analyses, conducted several community stakeholder meetings, and worked with State officials to obtain historical utilization data. Work will continue with the State on the readiness assessment, contracting, and rates. There were four stakeholder meetings averaging 40-50 participants including private dentists, medical practices, school districts, Golden Gate Regional Center, First 5, and other organizations interested in this work.

Mr. Curran introduced Dr. John Blake from Long Beach Children's Dental Health Center and the Government Affairs Council Chair of the California Dental Association (CDA). Dr. Blake expressed CDA's support for the proposed dental program. CDA, which represents more than 27,000 dentists in California, has engaged in a several initiatives to improve access to care and the quality of oral health care for all Californians. He discussed advocating for requirements for children to have oral health assessments before entering school, developing clinical guidelines for both medical and dental practitioners for pregnant women and infants, and protocols for managing dental decay. CDA sponsors "CDA Cares" events where volunteer dentists provide dental services at no charge for those who cannot afford it. These events serve an average of 2,000 people; CDA held a CDA Care event in San Mateo County in 2017. In 2016, CDA advocated for the passage of Proposition 56, the Tobacco Tax Initiative, that provides funding for oral health and other preventive health service providers. Dr. Blade said CDA is excited about the proposed program in San Mateo County. Denti-Cal is a challenge for both patients and practitioners. While DHCS has sponsored a "pilot" dental managed care program for 25 years, the dental managed care contractors have underperformed compared to the State's fee-for-service dental program. The benefits of integrating dental and medical care extend beyond improved healthcare outcomes for the individual and could create cost savings for the system. HPSM is ideally poised to lead this work and test alternative approaches to care. Dr. Blake noted that HPSM has been incredibly successful in meeting the challenges of medical care by developing innovative approaches. HPSM's work in this arena is critical for showing everyone there is a better path forward to improve the health of the patients we serve.

Mr. Curran then introduced Dr. Rob Rideau, a dentist in private practice in San Mateo and Dental Director at Samaritan House. Dr. Rideau has practiced in this community for 35 years. Samaritan House, a volunteer-based organization, operates two medical / dental clinics, and sees patients who do not qualify for Medi-Cal or Denti-Cal. Dr. Rideau noted that, as a volunteer organization and a free clinic, the dentists who provide services are

unencumbered by billing and the need to submit service claims. The prevailing notion among private practice dentists is that Denti-Cal is too cumbersome. He reported there are only nine San Mateo County Dental Society members who provide care to Denti-Cal patients. By integrating medical and dental benefits, this program has the potential to create comprehensive health homes for members and revamp the system to make it more attractive for dentists' participation. This is a golden opportunity not only for San Mateo County but for the entire State of California.

Next to speak on behalf of the proposal was Emily Roberts, Health and Development Specialist at First 5 San Mateo and the current Chair of the San Mateo County Oral Health Coalition. She explained how the proposed program aligns with the ongoing work of the Oral Health Coalition. In 2016, the Oral Health Coalition undertook a strategic planning process soliciting input from more than 80 local stakeholders to address challenges related to oral health for residents, in particular low-income populations and children, pregnant women, seniors and people with disabilities. One of the key objectives identified was building provider capacity. The shortage of providers willing to see low-income patients is not unique to San Mateo County. Even with a strong commitment to increase local dentist capacity for Medi-Cal, the Coalition has not achieved the improvements needed., due more to systemic issues than the willingness of individual providers to serve low-income residents. The opportunity presented by the proposed dental program is exciting and unprecedented, built on a solid foundation of community engagement and direct alignment with the vision expressed by local stakeholders to improve access to care.

Ms. Chris Baughman, HPSM Chief Performance Officer, led the internal operational assessment. Speaking next, she emphasized the following:

- Local administration through HPSM will allow direct management of the dental benefit as opposed to delegating to a third party.
- HPSM will create a network, developing contract relationships with local dental providers.
- Current structures, such as the Member Services Call Center, Grievance and Appeals Unit, authorization and referral coordination processes, and claims payments will be used and expanded as needed.
- Integrating management of dental and medical benefits through care coordination is a critical component of this program.
- HPSM will provide more flexibility for authorization requirements to address some of the systemic issues.
- HPSM will develop a dental advisory committee of local dentists and other stakeholders to help Plan staff develop the program.
- Dentists will receive payment faster than they do under Denti-Cal and there will be fewer administrative burdens.

Trent Ehrgood, HPSM CFO, next described the financial modeling developed for the program. He explained that the financial forecast is based on State data about dental use in 2016 through 2018. An actuarial firm was hired to analyze the data and compare it to Medicaid data in other state. Based on this work, he concluded an estimated cost of $5.14

per member per month would be the basis for the financial analysis.

The program's goal is to increase utilization from a 30% to a 35% participation rate, which means that 35% of the members would receive some type of dental service during the year. Reimbursement to providers will be increased to 130% of the Denti-Cal fee schedule in the first year and 140% in the second year. While this amount may not cover all of a dentist's variable costs, Proposition 56, the Tobacco Tax, is expected to add additional payment for specific qualifying dental services. Including Prop 56 payments, reimbursement would approximate 160% of the current Denti-Cal rates, still not at the level of commercial insurance rates but at the payment level needed to ensure more access for Medi-Cal members.

Mr. Ehrgood next reviewed the State's rate setting process and presented a chart which shows anticipated revenue and PMPM cost based on the best information available. He noted that he, Pat Curran and Maya Altman met with the top State DHCS finance officials to advocate for adequate rates. While State officials informed us that they will use the same process used to set medical rates, a process that has a three-year lag, the State has at times (e.g., with the transportation benefit) increased rates earlier based on timely information about utilization.

In year one, the financial model projects a deficit of $2.8 million due to increasing costs without equivalent revenue from the state. The deficit grows in years two and three due to the revenues remaining flat while costs rise. The State rate setting process will recognize costs beginning in year four; at that time, the deficit will decrease, eventually reaching a breakeven point in year six. The assumption is HPSM will invest approximately $15 million over six years before the program is fully self-sustained.

Commissioner Pon asked about the Medi-Cal membership and the assumption that it will be stable throughout the six years. Mr. Ehrgood stated for the purposes of this forecast the membership numbers were kept the same.

Commission Miao asked if reserves are high enough to handle these forecasted deficits. Mr. Ehrgood answered yes and explained that, although HPSM's overall rates are currently decreasing, this is a limited circumstance covering the second half of 2019 through the end of 2020. In 2021, by the time the dental program begins, overall rates are expected to increase again. HSPM's current reserves are large enough to cover this temporary drop in reimbursement and the first several years of a dental program deficit.

Commissioner Tai asked if the $15 million loss over six years is the worst case scenario. Mr. Ehrgood then explained the possible low, medium and high loss scenarios and the assumptions behind them, which are driven by the level of participation in the program.

Commissioner Callagy asked about the correlation of dental care with better health outcomes. Mr. Ehrgood responded that, while there is evidence showing a correlation between increased oral health access and improved physical outcomes, the financial model does not include any assumptions about reduced health utilization as a result of dental

services since this is difficult to project or measure at this point.

Commissioner France asked Dr. Rideau to identify the top three issues facing dentists wishing to serve the Medi-Cal population and whether the proposed program addresses these issues. Dr. Rideau noted reimbursement rates, turnaround time on claims submission and authorizations. The proposed integration program does address these issues as has been described, he said.

Commissioner France also asked if other alternative solutions have been considered. For example, HPSM could use $15 million to build its own dental program to provide services directly to members via mobile vans. Mr. Curran responded that mobile vans could be an option. However, HPSM still will need to attract new private dentists, expand existing Denti-Cal dentist participation, and explore new treatment models. Commissioner France added that if these network strategies fall short, HPSM should consider providing services directly.

Commissioner Tai asked about DHCS' plans for dental care and the managed care plans. He also asked if DHCS has mandated metrics that HPSM needs to meet for the program to be deemed successful. Ms. Altman responded that the State is interested in integrating oral health in the other Medi-Cal managed care plans, pending the outcomes of the HPSM program. Ms. Carrie Gordon, Chief Strategy Officer from CDA, said the State is looking to this program as its best hope for setting those metrics because there nothing else has worked. There are dental quality metrics and the State will want to see if this proposed approach performs better than fee-for-service, with dental utilization as the primary metric.

Commissioner Miao asked if this program would cover all services or just preventive dental services. Ms. Altman replied we are required under the legislation to provide the same benefits as Denti-Cal. Denti-Cal is not a comprehensive benefit and provides only some dental services, not all.

Commissioner Aviles commented that this program is very exciting. From a member and service delivery perspective, integration is always better. There is an opportunity to determine if this program makes a difference for health outcomes overall, e.g., with diabetes and coronary artery disease. SMMC surveys of patients have shown that dental needs are a top priority for many patients.

Commissioner Callagy motioned for preliminary approval of the program integrating dental benefits beginning January 1, 2021 as presented. Commissioner Tai seconded the motion. **M/S/P.**

6. Report from Chairman/Executive Committee

Commissioner Canepa had nothing additional to report.

7. Report from CEO

Ms. Altman but thanked the Commission for the vote of support. She also thanked Pat Curran who led the effort to develop this program as well as all the speakers who came to the meeting

today to support the HPSM staff recommendation.

8. Other Business

There was no other business discussed at this time.

9. Adjournment

The meeting was adjourned at 1:40 p.m.

Respectfully submitted:

C. Burgess

C. Burgess
Clerk of the Commission

AGENDA ITEM: 5.1

DATE: November 13, 2019

MEMORANDUM

DATE: November 4, 2019

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer
Pat Curran, Deputy Chief Executive Officer

RE: Long-Term Care (LTC) Payment Model Implementation

Background and Discussion

In June 2018 the San Mateo Health Commission approved a one-year program called the LTC Partnership. HPSM implemented the LTC Partnership in October 2018, providing funding for eleven facilities to participate in a year-long learning collaborative and incorporate the tools of the LiveWell program, which focuses on staff engagement and improved care for patients. Those eleven facilities represent approximately 80% of the available long-term care beds in the county. We gave a progress report to the Health Commission in June and have now completed this phase of the learning collaborative.

During the LTC Partnership we discussed many of the systematic challenge of access to care for skilled nursing facilities. These include the aging of the population, members discharging from the hospital with complex medical and behavioral health conditions, fewer skilled nursing beds in the county over time, and a competitive labor market for skilled nursing facilities to hire and retain staff. Skilled nursing care is a significant expense category for HPSM, with approximately $120 million spent in 2018 on skilled nursing and long-term care services.

A sub-group the LTC Partnership met during the year to design a new payment model. In these sessions, facilities shared how various aspects of payment affects their ability to receive referrals. We designed a new payment model which encourages facilities to accept the most challenging and complex members, while also rewarding those facilities who have taken and continue to take many HPSM referrals. This new payment model went into effect in October 2019. While we cannot know with certainty the projected cost, we estimate that payment to skilled nursing facilities could increase by up to 6% per year, or $7 million. We included these projected increases in our financial estimates presented to the Commission in August.

We will now initiate phase two of the LTC Partnership, which requires no additional funding. Our goal for the next year is to focus on three areas: (1) hospital discharge and transition to skilled nursing facility; (2) clinical care during the stay at the skilled nursing facility; (3) appropriate and safe discharge from the skilled nursing facility to the community.

MEMORANDUM

AGENDA ITEM: 5.2

DATE: November 13, 2019

DATE: November 3, 2019

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer
Amy Scribner, Director of Behavioral Health

RE: Approval of Amendments to Agreements with Institute on Aging and Brilliant Corners

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Recommendation

Authorize the Chief Executive Officer to execute amendments to the agreements with the Institute on Aging (IOA) and Brilliant Corners (BC) for services related to the Community Care Settings Program (CCSP) and Measure K Housing Fund for Whole Person Care. These amendments accomplish the following:

- Allocate $7,804,319 to IOA;
- Allocate $2,339,007 to BC; and
- Extend the terms of both agreements by twelve months, through December 31, 2020.

Background

With the advent of Cal MediConnect and the Coordinated Care Initiative (CCI) in April 2014, HPSM became responsible for the integration of medical care and long-term services and supports. This includes long term custodial care in a nursing home as well as home and community-based services designed to support independence in the community. In addition, it created a new category of spending, Care Plan Options, which HPSM can use more flexibly to pay for services to help seniors and people with disabilities thrive in the community.

HPSM staff identified that lack of housing services and supports was a significant barrier to community living and aging in place for seniors and people with disabilities. Linking housing services to medical, behavioral health and social services is a critical need in this community.

As a result, in mid-2014, HPSM selected IOA and BC in a competitive RFP to implement a Community Care Settings Program. CCSP focuses on helping individuals move out of nursing homes into the community and helping members that need additional services to remain in their homes. The Commission approved the initial agreements with IOA and BC in August 2014 and has extended them four times since that point, most recently in July 2018.

CCSP is one of the "strategic investments" that align with the Plan's mission and priorities and were committed to in our current Strategic Plan. These investments are funded from HPSM's reserves,

which are currently over the minimum required reserve level set by Commission policy. The purpose of these investments is to ensure and improve the long-term viability of HPSM programs by investing in projects that help providers, members, and the Plan achieve overall quality, access, and service delivery goals.

Partners across the county have supported this work, coordinating care and services, and generating additional support for the program. In late 2016, the Whole Person Care (WPC) pilot application submitted by the County of San Mateo was approved with a total budget of $33 million annually, 50% of which is provided by the County. Our strategic investment in CCSP counts towards that match and this WPC funding enables us to continue to sustain CCSP. WPC is designed to test local initiatives to coordinate and integrate physical health, behavioral health and social services for vulnerable populations.

In addition, close partnership with the Housing Authority has enabled us to add 46 units of permanent supportive housing through preference agreements in affordable senior developments, with 17 of 20 new units added through an innovative approach known as Provider-Based Assistance Program. Also, the county continues to allocate funding annually from the County of San Mateo's Measure K tax fund to provide housing services and supports for individuals engaged in Whole Person Care-funding period started in 2016 for 4 years, with a total of $8 million in funding.

Discussion

Now nearly five years into CCSP operations, we can report the following results:

- **From proof-of-concept to sustained success**: We have now supported 290 transitions, of which 202 were from skilled nursing facilities and the remaining 88 were individuals we were able to maintain in the community, avoiding costly health crises. Retention in the community is high, with only 18 members returning to institutional care. Overall, 450 members have been touched, including 30 that are preparing for transition.
- **Dramatic cost savings:** The cost of care has been reduced by 35%, or an average of $6,595 per participant per month. The impact is highest for those who moved from skilled nursing facilities as their cost of care has decreased by more than 51%. Results from members who transitioned in 2014 to 2018 show that these savings are sustained over time.
- **Satisfied stakeholders:** Participant and provider satisfaction with the program is high. The program continues to receive recognition from organizations around the state and Country, including the John A. Hartford Foundation 2019 Business Innovation Award given to IOA. The Center for Health Care Strategies will release a new brief on CCSP later this month. This program has been replicated by the Inland Empire Health Plan in San Bernardino and Riverside counties and is under consideration by other health plans as well.

This year's budget reflects several updates from the past year's budget:

- **Enhancing CCSP and Whole Person care programming by:**
  - Expanding capacity for transitions and housing services and supports including support of Mainstream Vouchers via the Housing Authority
  - Continuing a step-down lower intensity case management level at 1:28-32 for individuals who need continued ongoing support

  - Continuing to provide training and support for caregivers of clients with difficult behaviors, whether stemming from mental illness or dementia
  - Developing additional infrastructure for recruitment and retention of new staff
  - Adding a Wellness Specialist to support a member's transition to and ongoing community living
  - NCQA accreditation for IOA's Long Term Services and Supports programming
- **Supporting County Partners and Residential Care Facilities for the Elderly (RCFEs)**
  - Continuing to support RCFEs through their licensing process to ensure they can continue to support current CCSP members (e.g. especially smaller RCFEs of 6 beds or less)
  - Expanding the contracted RCFE network
- **Leveraging external resources**
  - Using the Home and Community Based Alternatives and Assisted Living Waivers
  - Further expansion of Permanent Supportive Housing capacity in partnership with the Housing Authority through Provider-Based Assistance Program and additional preference agreements in two senior affordable housing developments
  - Providing housing services for medically vulnerable homeless individual (funded through Measure K)

Fiscal Impact

The total CCSP Year 4 budget is $10,143,326, with $7,804,319 allocated to IOA, $2,339,007 to BC, with $390,000 allocated within the budget for performance incentives (included within both IOA and BC budgets). In addition, Brilliant Corners receives funding from Measure K funding, used to access housing for Whole Person Care participants. The new terms for the IOA and BC agreements are January 1, 2020 through December 31, 2020.

CCSP is supported by a range of funding sources, including state waiver programs and local affordable housing voucher funds along with primary sources such as intergovernmental transfer funds; unspent budget dollars from the prior year; strategic investment funds from HPSM reserves to be allocated in HPSM's 2020 budget; Whole Person Care funding; and standard healthcare revenue. In addition, Brilliant Corners receives funding directly from Measure K funds that HPSM will pass through to BC. Approximately $6 million of the required funding is from prior year unspent dollars and Whole Person Care funding allocated to HPSM.

As part of its CalAIM proposal, the Department of Health Care Services will allow the use of In Lieu of Services (ILOS) mechanisms for funding programs like CCSP beginning in 2021. As a result, we anticipate that soon CCSP will finally be self-sustaining without heavy reliance on HPSM reserves. This is a major victory for the HPSM and other CMC plan advocacy efforts that have been underway for several years. CCSP program results were a significant factor in these advocacy efforts.

County Counsel will review the amendments and execution will be pended until their review is completed.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF AMENDMENTS TO AGREEMENTS WITH INSTITUTE ON AGING (IOA) AND BRILLIANT CORNERS (BC)

RESOLUTION 2019 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has previously entered into agreements with Institute on Aging and Brilliant Corners for services related to the Community Care Settings Program (CCSP) beginning August 2014;
B. Agreements with IOA and BC require amendments to implement the fifth year of the program during CY2020; and
C. Year 5 budget of the CCSP reflects maintenance of case management and housing supports to CCSP eligible members.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. Pending review by County Counsel, the San Mateo Health Commission authorizes the Chief Executive Officer to execute amendments to the agreements with the Institute on Aging (IOA) and Brilliant Corners (BC) for a term of January 1, 2020 to December 31, 2020.
2. Approves the Institute on Aging agreement for an amount not to exceed $7,804,319; and
3. Approves the Brilliant Corners agreement for an amount not to exceed $2,339,007.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of November, 2019 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
David J. Canepa, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

MEMORANDUM

AGENDA ITEM: 7.0

DATE: November 13, 2019

DATE: November 4, 2019

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: CEO Report

PG&E Power Outages

Last week I shared information with the Commission about HPSM activities during the rolling power outages. We worked closely with EMS and County Health to attempt to complement their efforts with HPSM members and providers. In summary, HPSM did the following:

- Through data analysis that began a while ago, identified high-risk and fragile members with electric medical equipment dependencies, such as oxygen-related or cardiopulmonary assist devices, dialysis, intravenous infusion, feeding/nutrition supplemental pumps, or mobility assist equipment.
- Outreached to identified members through HPSM's in-home complex care provider (Landmark), providing in-home checks on members, or called members via Landmark or our own care coordination staff.
- Developed an "HPSM Power Outage Quick Guide" with key HPSM recommendations for meeting member needs, including technical assistance for handling specific refrigerated medications and insulins. The guide also clarifies how to access replacement or emergency supplies of medications and alternative or supplemental equipment and supplies. The guide is posted on HPSM's website and is useful for providers, the after-hours nurse advice line staff, and internal staff.
- Performed outreach to targeted providers such those for DME, Home Health, Dialysis, and Nephrology to assess and reinforce their capacity to help their patients with service needs.
- Allowed authorization overrides for medical services and medications, considering special circumstances, spoilage, and member relocations.

Special thanks to Dr. Huang and HPSM's Health Services and Provider Services staff for all their extra effort these past two weeks.

CalAIM Proposal Released by DHCS

Last week, the Department of Health Care Services (DHCS) released a 181-page proposal for CalAIM, which stands for "California Advancing and Innovating Medi-Cal." CalAIM includes more than 20 initiatives. We will provide a summary to the Commission soon; however, in the meantime, here are some highlights of relevance to HPSM and San Mateo County:

- Enhanced care management (ECM) and In Lieu of Services (ILOS) – an ECM benefit would provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-need Medi-Cal beneficiaries enrolled in managed care plans. This benefit would be designed to replace Whole Person Care which is scheduled to end in 2020 (the hope and expectation is that health plans will contract with counties to continue county Whole Person Care programs. ILOS are flexible services provided as a substitute, or to avoid, other services such as a hospital or skilled nursing facility admission. An example of ILOS services provided by HPSM are the assisted living services HPSM provides to members moving out of more expensive skilled nursing facilities. Under an ILOS framework, HPSM would eventually be reimbursed for providing these services, which does not occur today. This is critical for sustaining programs like the Community Care Settings Program.

- Cal MediConnect (CMC) transition – under CalAIM CMC ends in December 2022, and the CMC enrollees will transition to Dual Eligible Special Needs Plans (D-SNPs). The State is also requiring all Medi-Cal managed care plans to assume responsibility for long-term and begin offering D-SNPs by 2023. The CalAIM proposal envisions a fully integrated long-term services and supports benefit in managed care by 2026, although how this transition will happen is unclear from the proposal.

- Full Integration Pilots – CalAIM also envisions at least some health plans that integrate physical health, behavioral health, and dental benefits. These plans would go live in 2024.

- Behavioral Health – this topic is focused more on counties, covering topics such as integrating behavioral health and substance use disorder programs under a single contract; changing the reimbursement structure for county mental health and substance use disorder services; and other topics of high importance to county programs.

- National Committee for Quality Assurance (NCQA) accreditation – plans are required to obtain NCQA accreditation within a few years. In return, the State will consider "deeming" audit requirements, i.e., if plans meet NCQA standards in certain areas, the State will not audit plans in those areas.

- Population Health Management and Shared Savings proposals (between the Sate and plans) are also included in CalAIM.

We will continue to update the Commission as we analyze the CalAIM proposal more closely. HPSM staff is involved in CalAIM workgroups on Enhanced Care Management and ILOS, NCQA, and Full Integration Pilots.

Seton Sale Update

As I reported last month, in late September the Attorney General issued his decision approving the sale of Verity's hospitals to Strategic Global Management (SGM) subject to certain conditions. The conditions largely align with those placed on the sale to Verity in 2015, adjusted for the time period remaining (e.g., most of the conditions that were originally valid for ten years now extend only through 2025). In October, SGM filed a motion with the bankruptcy court to allow the sale to proceed without the additional Attorney General conditions; the court granted this "enforcement" motion, overriding the additional Attorney General conditions. While this decision is subject to appeal, it now appears that the sale will proceed and likely close in mid or late November.

HPSM staff continues to negotiate with SGM representatives for new contractual terms for Medi-Cal reimbursement at Seton.

Master Plan on Aging

I have been appointed to two of the subcommittees for the Master Plan on Aging: The Long-Term Care (LTC) Subcommittee and the Subcommittee on Health and Well-Being. The LTC Subcommittee will focus on:

- A Long-Term Services and Supports Benefit for the middle class
- IHSS and other home and community-based services
- LTSS workforce, family caregivers, and technology
- LTSS financing and integration
- Institutional care

The Health and Well-Being subcommittee will sponsor forums on well-being and prevention; coordinated and integrated care systems (including alignment with CalAIM initiatives); and age-friendly health systems and the geriatric workforce.