HealthPlan OF SAN MATEO
Healthy is for everyone

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THE SAN MATEO HEALTH COMMISSION
Regular Meeting
August 9, 2023 - 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor Boardroom
South San Francisco, CA 94080

AGENDA

1. **Call to Order/Roll Call**
2. **Public Comment/Communication**
3. **Approval of Agenda**
4. **Consent Agenda***
   - 4.1 Finance Report
   - 4.2 CareAdvantage Advisory Committee Minutes, April 2023
   - 4.3 Consumer Advisory Minutes, April 2023
   - 4.4 Pharmacy & Therapeutics Minutes, May 2023
   - 4.5 Approval of San Mateo Health Commission Meeting Minutes from July 12, 2023
5. **Specific Discussion/Action Items**
   - 5.1 Proposal for Investment in AHMC Seton Medical Center*
   - 5.2 Formation of 501(c)(3)*
   - 5.3 Update on HealthWorx Agreement with San Mateo County
6. **Report from Chairman/Executive Committee**
7. **Report from Chief Executive Officer**
8. **Other Business**
9. **Adjournment**

**Items for which Commission action is requested.*

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Draft

FINANCE/EXECUTIVE COMMITTEE MEETING
Meeting Summary
June 26, 2023 – 12:30 pm

Agenda Item: 4.1

Date: August 9, 2023

Criminal Justice Training Center, 400 County Center, Redwood City, CA 94064

-or-

Health Plan of San Mateo -Boardroom 801 Gateway Blvd, South San Franciso, CA 94080

Member's present: Mike Callagy, Bill Graham, George Pon, Si France, M.D.

Members absent: Ligia Andrade-Zuniga

Staff present: Trent Ehrgood, Pat Curran, Francine Lester, Corinne Burgess, Glenn Smith, Michelle Heryford

1.0 Call to Order – The meeting was called to order by Commissioner Graham at 12:35 pm. A quorum was met.

2.0 Public Comment – There was no public comment.

3.0 Approval of Meeting Summary for May 8, 2023 – The meeting summary for May 8, 2023, was approved as presented. **Pon/France. M/S/P**

4.0 Regional D-SNP Discussion – Discussion was started by HPSM CEO, Pat Curran. He explained that the meeting goal was to provide the Committee with information and to receive guidance about their plan for a regional dual eligible special needs plan (D-SNP). There will be further discussion with the full Commission at a meeting in July and they hope to vote on it at the August meeting of the San Mateo Health Commission (SMHC). Mr. Curran provided some background and explained that HPSMs Medicare plan enrolls those who qualify for both Medicare and Medicaid/Medi-Cal and they are called "dual eligible" which means they qualify for Medi-Cal coverage through the State, and they qualify for Medicare. There are about 16,000 duals in San Mateo County. Those who have Medi-Cal in San Mateo County, have it through HPSM. Medicare is a choice program; therefore, one cannot automatically be placed into HPSM's Medicare plan. Because of this there is a lot of competition for this demographic, they are getting inundated with mailings from many urging them to join their plan, without knowing or caring if these individuals are dual eligible or not. What HPSMs plan allows is that even though you have Medicare and Medi-Cal, and separate drug coverage, you're still just dealing with one plan, with one coverage and one phone number for inquiries or assistance. HPSM will take care of all of it, which has been their specialty since 2006. Mr. Curran reminded the committee that regardless of what the Commission decides, HPSM will continue to operate this D-SNP in San Mateo County for many years. He explained that Chief Medical Officer, Dr. Chris Esguerra, would provide a presentation outlining the framework. This would take HPSMs existing Medicare

plan, which is a D-SNP, and create a 501C3. That entity would then be used to expand into other counties. Some of the things he asked the Committee to think about is: What are the ramifications and is there a legal structure from the State departments that govern HPSM to be able to do this. So far, all of the work that they've done in exploration has led to the conclusion that they can do it. They can set up a 501C3, transfer their Medicare license to that entity and then grow that entity into other areas in partnership with other plans. HPSM hopes to take advantage of a policy from the State which allows HPSM to use their authority to encourage people to enroll only in plans that are like them.

Dr. Esguerra started the presentation by reviewing challenges and opportunities with a regional D-SNP. HPSM is one of the few in the area to have a developed D-SNP program and as such is in a position to assist other health plans that must comply by 2026. Establishing a D-SNP is costly and may take 3-4 years to break even. Dr. Esguerra noted there is a push to make the dual special needs program more robust, the goal is to have a much more coordinated full experience for the Member who is duly eligible because, it is actually pretty fragmented with fundamentally very little care coordination which is the heart of the dual special needs plan federally. Area Health Plans are very concerned about setting up a D-SNP understanding that they will need to go through a significant amount of system changes, in addition to ramping up staff. Feasibility studies show them breaking even in year three, but likely more so in year four. This is largely because of the initial setup costs.

Dr. Esguerra went over the Formative Mission Statement which states: "CareAdvantage is a fully integrated DSNP that is governed, financed, and operated by local Medi-Cal health plans for the benefit of its members and communities. CareAdvantage will excel in addressing the needs of seniors and persons living with disabilities. It will provide every member with a seamless experience of care and the opportunity for best possible health, working in collaboration with local providers and community partners." The concept is about full integration and how that benefits members and the community.

Dr. Esguerra went over the process starting with Step 1: Create the subsidiary.

- It will start as a wholly owned subsidiary of HPSM.
- Structured as a 501C3.
- The subsidiary holds the contract with the Centers for Medicare & Medicaid Services (CMS) for H6019.

- The subsidiary will also have a Knox-Keene license from the Department of Managed Health Care (DMHC).
- The management agreement will be with HPSM.
- HPSM will establish the financial reserves.

Dr. Esguerra clarified HPSM would transfer its Medicare contract (ID #H6019) to the new 501C3 entity, and this new entity will be dealing with CMS, making the official entity CareAdvantage (CA) instead of HPSM. The primary reason for creating a separate entity is so that other health plans can become a part of it. Step 2: Other Local Plans Join:

- Plan 2 joins the 501C3.
- An initial reserve contribution will be made at an agreed upon among.
- CA applies for Service Area Expansion into Plan 2 county for H6019.
- Additional plans could join using the same process.

He noted that is easier for CA to apply for a service area expansion having already an established contract with CMS. This program is not for commercial plans who are also in the Medi-Cal space but for local plans like HPSM, it does not need to be a County Organized Health System (COHS) plan.

Mr. Curran was asked about the rationale and goal behind this. He stated three reasons: The first is to further State and Federal policy in ways that haven't been done before, which has become a HPSM tradition. Secondly, they hope to grow and achieve more scale and become more effective and efficient for HPSM members. The third reason is strategic. As the world continues to get more competitive, they believe there is a future in being more of a regional plan in partnership with other Plans, which may be a strategically better place to be than being solely in San Mateo County.

There was a question about the total number of dually eligible individuals, in San Mateo County, there are about 16K and there are about 5,900 in original Medicare. Presently there about 55K eligible in Alameda and about 45K in San Francisco, and about 100K in Partnership Health Plan counties. There was discussion around set up. It was noted that the step that takes the longest is obtaining the Knox Keene license from DMHC. They have been warned this can take anywhere from 12-18 months. After that there is an ovation process with CMS to transfer the contract from HPSM to the CA entity. That process is a lot shorter. They will then need to declare their intent to do the service area expansion and go through a bid process. There was also clarification on the goals, which is to continue to serve San Mateo County as they do now, while leveraging HPSM's experience

with dual eligible members in partnership with other Plans. Dr. Esguerra explained that most Plans in Northern California do not have experience running a D-SNP, but some did pursue a D-SNP in the past and closed it down because it was not viable.

CFO, Trent Ehrgood went over the cash flow piece noting that CA will have a direct contract with CMS for the Medicare portion. But if differs for the Medi-Cal side. Medi-Cal will still contract with each individual health plan like they do today, premiums will go to those health plans, and they will create a global capitation agreement with CA where money would pass through it for the Medi-Cal piece to CA. CA would then become the entity that serves and provides the services for Medicare and Medi-Cal. The contract with CMS is direct, the contract with Medi-Cal would be indirect. It would still pass through the other local health plans. Lastly, CA would then have an administrative services agreement with HPSM to fund all the administrative functions.

Dr. Esguerra went over the proposed governance structure and the administrative services. He also walked them through the timeline. Starting with the exploration of local plan interest and identification of regulatory barriers in March 2023 all the way to the go-live scheduled for January 2026. There was discussion about the ownership of the entity. Mr. Curran confirmed that HPSM will ultimately not own it once other Plans join. HPSM would form it and initially control the governance. He said the Commission vote in August will be to start the process to create the entity. HPSM will need to know if the Commission is open to other plans potentially joining, otherwise there is no point in doing this. There was a question about how much the initial investment would be. It's likely to be less than $500K, more in the ballpark of $200K for legal and consulting fees. Once the entity is created there will be some impact to HPSM's Finance and Compliance departments.

They dove a little deeper into the financing model, particularly the reserves and startup costs. Though it was stressed that they will be very cognizant that the startup, staff, and infrastructure costs are not disproportionately born by HPSM. Mr. Ehrgood explained that at times member Plans may have to contribute additional funding to cover operational losses. The idea is to use membership and profitability as the basis of that allocation between the different Member plans, where 75% of what's required to be put in would be based on the membership and 25% would be based on each region's profitability. Mr. Curran noted this is not a distribution system where if money is made everyone gets dividends back. The idea is the money goes in and if the reserves exceed 600%, it will be either used for member benefits, infrastructure, provider rates or an incentive that invests in the entity. There was more discussion about how the different plans might

collaborate and what the infrastructure would look like. Mr. Curran closed by asking Committee members what should be presented to the full Commission about this program. It was suggested that they show more detail than less as this is a significant project. The Committee agreed to proceed with a presentation to the full Commission at the August meeting.

5.0 **Provider Investment Overview –** There was no time to address this item. It will be added to the agenda for the August 7, 2023, meeting.

6.0 **Adjournment –** The meeting was adjourned at 2:00 pm by Commissioner Graham.

Respectfully submitted:

M. Heryford

M. Heryford
Assistant Clerk to the Commission

AGENDA ITEM: 4.2

DATE: August 9, 2023

Health Plan of San Mateo
CareAdvantage Advisory Committee
Friday, April 28, 2023 – 11:30 a.m.
Meeting Summary
801 Gateway Blvd., Boardroom
South San Francisco, CA 94080

Committee Members Present: Beverly Karnatz, Amira Elbeshbeshy, Claire Day, Gay Kaplan, Dr. Darlene Yee-Melichar, Jill Dawson, Oscar Rodriguez, Nina Rhee, Ricky Kot

Committee Members Absent: Pete Williams, Ligia Andrade Zuniga, Lisa Mancini

Staff Present: Chris Esguerra, M.D., Joy Deinla

Guest Present: Donovan Fernandez, Kellie Hanson, Chelsea Hargreaves

1. Call to Order / Introductions

The meeting was called to order at 11:30 a.m. by Gay Kaplan.

2. Public Comment

There were no public comments received via email prior to the meeting or made at this time. Ms. Hanson and Ms. Hargreaves shared a flier for their new Emerging Aging & Disability Resource Connection program, using the "No Wrong Door" approach to provide a coordinated point of entry for older adults and individuals with disabilities to help them access services and supports.

3. Approval of Minutes

The minutes for January 27, 2023, were approved as corrected with the spelling and consistency of Dr. Yee-Melichar's name. Motion to approve: Dawson / Second: Yee. Minutes were approved as corrected.

4. State/CMS Updates

Dr. Esguerra noted that previously the health plan had its CareAdvantage Medicare/Medi-Cal program known as Cal MediConnect which now has officially ended and will now be moving into a D-SNP (Duals Special Needs Plan). This is designed specifically for beneficiaries who are Medicare/Medi-Cal eligible. The health plan has ongoing work with the state towards alignment and coordination for our members. He talked about AB 1230 which is a bill that promotes look-alike Special Needs Plans that will force DHCS to enter contracts with plans even though they may not align with the Medi-Cal portion. It goes against the CMS and the State's intent to align Medicaid and Medi-Cal. He talked about how, in the past, people have joined these look-alikes to later find they do not align with services and then they will move away from them. This happens every year but there will be even more advertising sent to our

members during years' this open enrollment. Discussion ensued on what this might look like and he noted it is a bit confusing for members. Kaiser this year will be another competitor and we have already witnessed an influx this year into Kaiser enrollment away from HSPM. He will provide more details in the future on this bill.

Dr. Yee-Melichar also asked how this bill and the onset of redeterminations will affect our members. Dr. Esguerra answered that the health plan has been sending out a lot of communications in partnership with the county about the redetermination process which is beginning in April for July due dates. If someone loses their Medi-Cal, they have a four month deeming period in which to have it reinstated. Staff have processes in place to work with members and are typically able to reinstate their Medi-Cal. The message is to the community to pay close attention to the information they will be receiving and to reply to it quickly.

5. HPSM Updates

a. CareAdvantage D-SNP – post transition – Dr. Chris Esguerra

Dr. Esguerra reviewed his presentation on the transition from Cal MediConnect to the new D-SNP program. He explained that this transition was a lift and shift with staff supporting the process. Supplemental benefits were offered to members: Over the Counter at $90 per quarter; Healthy Food for those with qualifying conditions in the amount of $65 per quarter. Communications to members were updated with a brand refresh. The additional benefits are administered by debit card through a vendor. There were many calls and questions which overwhelmed the vendor. These benefits began back in January. Even though there were daily calls in the average of 600-1,000 between the health plan and the vendor, staff were able to get members what they needed.

Dr. Esguerra touched on the Pharmacy Carve Out noting that Part D transition was fine, however, the Medi-Cal portion of the carve out in California had issues. For a small subset of items, members had to deal with the State instead of HPSM. Our staff is helping members as much as possible through this transition. He encouraged the group that they have members experiencing problems to contact HPSM and staff will help.

Dr. Esguerra explained how staff triage requests depending on products requested. If it is something covered HSPM can handle internally and will work with the pharmacy on how we will cover it or with their OTC card. If not, HPSM will help them make the call to the State and work with the pharmacy with the information needed.

Ms. Karnatz encouraged us to use her (facility administrators) with the communications for the residents so when they are asked about issues, they will be able to help them. She also mentioned that the enrollment period was very aggressive last year with their approach to the residents. Dr. Esguerra explained that work around advertising is a focus and now when

you look at Medicare.gov HPSM does not have a STAR rating because we are new. This will change as we approach this year's open enrollment.

Mr. Fernandez asked about the OTC benefit and if the member does not use the funds in the quarter, do they lose this (use it or lose it). Dr. Esguerra confirmed they will lose it if it is not used within the quarter and members are told to use it and get all that they can. We are seeing more use on the grocery side. There was discussion on the use of these cards and the various items considered grocery rather than OTC (vitamins for example). Dr. Esguerra noted that members can get help from the CareAdvantage unit who can work with the vendor to fix any miscategorized items. Currently they do not have the demographic information and will hope to have more information on that at future meetings.

In closing, Dr. Esguerra explained there are about 16,000 dually eligible individuals in San Mateo County and 8,850 are in CareAdvantage. About 5,900 have Medicare original and the rest are split among Kaiser and other plans. The 5,900 are those we hope to reach. Our goal is to grow that enrollment through outreach to the community.

6. Presentation – CareAdvantage Brand Refresh – Joy Deinla

Ms. Deinla, HPSM's Marketing and Communications Manager, reviewed her presentation which is attached to these minutes. She touched on the following:

- Staff reviewed the current CareAdvantage brand and thought about ways to transition CareAdvantage from Cal MediConnect to the D-SNP program in a way that would have the new program stand out among other plans and still live under the Health Plan of San Mateo with consistent and effective messaging.
- The new branding includes a new logo "CareAdvantage by Health Plan of San Mateo"
- The process considered what our Dual Eligible members want from their health plan, how can we retain members and encourage others to join us over other plans.
- Focus on commitment to health equity, working with existing local partners, and cultivating new partnerships was identified as key factors in this approach
- Staff embarked on building a brand identity for members to connect with when thinking of CareAdvantage using good member experiences with our local and knowledgeable staff to help them.
- All-in-one coverage. Local care. Right here in San Mateo County – is the foundations of our new brand and characteristics of focus.
- Four pillars of our Brand: Specialized Plan; Local Coverage; Community Connections; Culturally Inclusive Care.

Next steps will be to incorporate this into the communications within the annual enrollment and communications that will be developed for community partners to share with their clients about CareAdvantage, providers, on our website, etc.

Ms. Rhee asked for materials to be shared with Aging and Adult Services as new materials come out to be shared with their staff to share with the public. She also asked about provider and member training opportunities as new benefits and information is being pushed out to the public, noting that older adults sometimes have trouble hearing or capturing the information. Ms. Karnatz asked for the member newsletters to be sent to the facility administrators so they can be informed of what the members are receiving and wondered about training at their level to be able to help their residents. Dr. Esguerra thanked them for this input on what we are doing for our communications with community partners such as talking points and education.

Ms. Kaplan asked about health plan presence at the community farmer's markets. Ms. Deinla stated that the staff is working on a calendar for community activations and will investigate the farmer's market idea. Ms. Kaplan asked how the pillars will be kept together and not become silos so that members will have access to each. Ms. Deinla stated that there was an internal launch of the brand, but a constant refresh will happen throughout the year.

Ms. Karnatz talked about their partnership with the health plan has been a model for her organization (Human Good). Dr. Yee-Melichar noted that membership recruitment is important but also mindful of membership retention and continuing to reinforce the messaging is needed. She thanked Joy for the presentation and expressed appreciation for the four pillars mentioned. She suggested that the Cultural Inclusion pillar may need to be more tailored to groups for the outreach.

Ms. Deinla added messaging in other languages go through translation and staff reviews to make sure the translations are not translated in ways that have other meanings. Retention messages will be out to the public, advertising outdoor in select zip codes such as bus stops and other news media. She shared her contact information and is open to all suggestions.

7. Discussion Topics:

a. Supplemental Benefits – looking to 2024 – Dr. Chris Esguerra
   - Dr. Esguerra reviewed his presentation which is attached to these minutes.
   - 2023 Benefits for CareAdvantage Program: Vision ($175 per year), Worldwide Emergency Coverage (up to $25K), Over the Counter Plus ($90 per quarter), Healthy Foods ($65 per quarter)

- He asked the group for their thoughts for 2024. Staff will be submitting a proposal in May and have a potential to change in August
- Regarding vision: data usage might be helpful in answering if it should be increased. The question of being able to carry over the benefit to the following year to have 2x the benefit for those who may not get new glasses each year was asked.
- Worldwide Emergency Coverage amount – what is the ideal amount (unsure)
- Over the Counter and Healthy Foods benefit – the idea of as bumping that up was discussed. The idea of it being available to all was discussed and Dr. Esguerra explained there are chronic condition regulations that cannot be changed. Another question asked was could this be increased and combined with Healthy Foods up to $200. Dr. Esguerra will check on this idea. Dr. Esguerra noted that members should talk to their PCP to see if there is something that may not have been documented that might make them eligible for these benefits.
- Next Dr. Esguerra asked if there were other benefits we should consider adding: i.e., Fitness, Transportation, and any other benefits. Ideas mentioned were supplemental support for utilities; support for IHSS background checks could help the healthcare provider; dental care support above Medi-Cal, hearing aids, and DME.
- Dr. Esguerra talked about the dental program demonstration pilot and possible benefit expansion soon to focus on prevention.
- Lastly, Dr. Esguerra reviewed the timeline that leads to more benefits being released in October

8. CCI Ombudsperson Report (Legal Aid)

Ms. Elbeshbeshy reported:

- The CCI Ombudsperson program has changed and will no longer be CCI. It will become Medi-Medi Ombudsperson for D-SNP program.
- Reported on specific cases where members were erroneously enrolled in Medicare, being disenrolled and having an impact on the Medi-Cal benefits. They are hearing that this is happening in other counties as well. Seems to be a Part D coverage problem and DHCS is working on this. Legal Aid is working on the enrollment issue.
- Asset requirements will be eliminated in January 2024. A request for a federal waiver has been submitted by DHCS to not check asset limits for renewals to eliminate potential gap coverage between now and January.
- No changes to CSRA (Community Spousal Resource Allowance). There was talk of a change but DHCS is leaving this intact.
- Reported that there were cases of people being terminated from their Medicare savings program during the public health emergency. This was determined to be not allowable and since then, have only seen one case of a person being disenrolled. It was announced that this decision was retroactive to March 2020.

- 2321 is a special rule during the renewal restart that if a person's income is $0 they will not be asked for any verification.
- Medi-Cal/Medicaid scams are on the rise in California and around the country. Members should never be asked to pay for the Medi-Cal applications or any information. Please share this with members.

9. LTC Ombudsperson Report

Mr. Rodriquez stated that the Ombudsman Services of San Mateo County, Inc. (OSSMC) has a new executive director who will either assign someone to this group or will attend these meetings in the future. They are now fully staffed with their new regional supervisor beginning next week. He reported they are having issues with long-term care residents in care facilities needing help with their Medi-Cal applications. He asked if someone or agency could come to the facilities to assist as these patients are unable to leave the facility due to their conditions. Dr. Esguerra stated that the HCU could help with this and if not the CareAdvantage Unit could help. CID also shared a contact to help as well.

10. Questions about reports distributed prior to meeting.

- **Health Risk Assessment/Care Plan Completion and LTSS Utilization Dashboard**
- **Grievance & Appeals Report**
- **Call Center & Enrollment Report**
- **IHSS Utilization Report**

Dr. Esguerra asked if there were any questions related to the reports.

Ms. Dawson noted the jump in referrals this month in IHSS, and they expect this to continue to rise. They are working on increasing the number of staff to meet that demand.

11. Other Discussion Topics

Dr. Esguerra asked if this group would be open to staff watching a live stream of this meeting. Dr. Yee-Melichar moved to allow streaming of this meeting for staff. There was a second to the motion and the group was in agreement.

12. Adjournment

The meeting was adjourned at 1:06 p.m.

Respectfully submitted:

C. Burgess

C. Burgess, Clerk of the Commission

DRAFT

HEALTH PLAN OF SAN MATEO
CONSUMER ADVISORY COMMITTEE MEETING
Meeting Minutes
Wednesday, April 19, 2023
801 Gateway Blvd. – 1st Floor Boardroom
South San Francisco, CA 94080

Agenda Item: 4.3

Date: August 9, 2023

Committee Members Present: Amira Elbeshbeshy, Ricky Kot, Ana Avendano, Ed.D, Hazel Carrillo
Committee Members Absent: Mary Pappas, Cynthia Pascual, Angela Valdez, Marmi Bermudez
Staff Present: Amy Scribner, Megan Noe, Keisha Williams, Clara Jennings, Daniel Le, Mackenzie Moniz, Talie Cloud, Sarah Munoz, Rustica Magat-Escandor, Sharon Bongolan, Chris Esguerra, M.D., Kiesha Williams, Michelle Heryford

1.0 Call to Order/Introductions: The meeting was called to order by Ms. Elbeshbeshy at 12:03 pm, a quorum was not met.

2.0 Public Comment: There was no public comment.

3.0 Approval of Meeting Minutes for January 18, 2023: The minutes from the January 18, 2023, will be distributed to the group for approval via email.

4.0 HPSM Operational Reports and Updates:

4.1 CEO Update: Chief Health Officer, Amy Scribner provided an update on behalf of Chief Executive Officer, Pat Curran. She reminded the group that redeterminations are in process. They are working with the coverage unit and getting data from the Human Services Agency (HSA). Redetermination will impact HPSM membership. Member Services Director, Kiesha Williams, will provide more information about this later in the agenda.

4.2 CMO Update: Ms. Scribner also provided an update on behalf of Chief Medical Officer, Dr. Chris Esguerra, focusing on HPSMs dental program. Prior to HPSM integrating and covering dental benefits in 2022, there were around 30 providers in San Mateo County contracted with the state Medi-Cal Dental program. Now that HPSM covers dental benefits, there are over 370 contracted dental providers. Members are being seen and getting services. HPSM has also partnered with the County using Measure K funds to promote orthodontic services for younger members to ensure they get access to this

oral care. Coming up, they will be announcing updates to the dental benefit that will promote prevention and overall oral health.

4.3 **Health Education Update:** Health Promotion Supervisor, Sarah Munoz provided a Health education update. She shared health education mailers recently sent to HPSM members. The first being the well-visit mailer; they have one for 12-17-year-olds and one for 18–21-year-old members. It emphasizes why well-visits are important, it also includes age-appropriate vaccination information and shows members how they can find their primary care provider information. It also includes additional items like the service line and rate benefit information. She also shared their cancer screening reminder letter that will be sent to members who are due for a cancer screening. This includes breast cancer, colorectal and cervical cancer screenings. At the last meeting Sarah spoke about the diabetes and tobacco cessation newsletters that were mailed to members and are currently on the HPSM website. They are planning a third newsletter, around mental health. It includes information on how to access mental health services, how to prepare for a visit with a mental health provider as well as resources. This newsletter will also be added to the website in about a month. They are conducting an assessment on the diabetes and nutrition support services with the Provider network and community partners. The goal is to get the current state and feel of the program as there have been many shifts since the pandemic. At the next meeting they would like to present their findings on the assessment and share how they plan to disseminate that information.

4.4 **Provider Services (PS**): Provider Services Contract Supervisor, Daniel Le provided an update on behalf of Director of Provider Services, Luarnie Bermudo. They continue to work with Providers for Oral Surgery and Endodontics, there are Non-Medi-Cal dental specialty Providers that have never worked with Managed Care Medi-Cal before and would like to build a relationship with HPSM, they hope to move them to a contract soon. They are also finalizing the addition of UCSF Endodontic and Prosthodontic departments to the network. Neither have worked with Medi-Cal Dental in the past. Blende Dental will be fully in-network soon. They are a high-cost provider that does not negotiate rates, but they are able to see urgent members with special needs that require sedation or hospital dentistry. There is an Oral Health Coalition created to address concerns around capacity and increasing the Provider network for general and specialty dentists. They have support from the dental societies, Federally Qualified

Health Center (FQHC) dentists, and oral health professionals in San Mateo County. There is a need for more pediatric dentists for pediatric dental emergencies in San Mateo county. They are in negotiations now with one general practice provider in San Mateo and a Periodontist. The focus this year is to increase general dentists in San Mateo and neighboring counties. New dental benefits are scheduled for May 1st as well as enhancements. A new referral management system (built internally) will begin testing soon, the planned go live date is July 2023. This will help to close the loop on referrals and will link directly to HEALTHsuite (HS) for updated comments and information for Member Services and CareAdvantage (CA) to access. There are new doula benefits in the network. They provided a webinar for interested doulas where they went over rates, the network, and support for Providers. The Grove Pilot was launched with the Palo Alto Medical Foundation (PAMF). This pilot will focus on supporting the CA population and developing strategies in PCP investments, there is more to come. Mr. Le also reported on Lyon Martin Health Services, which recently contracted with HPSM. They provide high quality, compassionate and trauma-informed medical, gynecological, and mental health care services to non-binary, gender nonconforming and intersex communities and cis-gender women with specific sensitivity to LGBQA sexual orientation, disability, size, race, ethnicity, and language regardless of immigration status or ability to pay. Legal Aid has also noted that they are ready to help members who encounter barrier or access problems to these services.

4.5 **Member Services (MS) Report:** Director of Member Services, Kiesha Williams reviewed the Member Services (MS) Call Center and Enrollment Report for Q1. As of March 2023, HPSM has a total of 175,911 members across all lines of business (LOBs). Enrollment numbers by LOB, shows that the Medi-Cal line has the highest enrollment with 141K members. Medi-Cal renewals started on April 1, 2023. For the June renewal HPSM has an established process with HSA that will commence on May 1st. HSA will send HPSM a report of members who have not returned their packets. HPSM will then reach out to their community partners to enlist their help in ensuring packets are returned in time. There will also be a robo call campaign by the CA and MS, they will reach out to all members that are in the report. There is also an option for members to call HSA directly, the agency is aware that they may receive an uptick of calls about this topic. The MS department will set up two call tents starting at 9:00 am and 4:00 pm each day for 14 months.

Call Center reporting is still on hold. There is a current Request for Proposal (RFP) effort going on right now for a new phone system. Call monitoring goals set at 95% for Q1 was not met. This was due to internal processes with their representatives that they are working on. They did meet their email goal which was also set at 95% for Q1. They received a little over 19K incoming emails from members and met the timeliness response for all of them. In April, the Call Center worked remotely and experienced high call volumes. In May, the Call Center staff will return to the HPSM offices as the building will be open to the public. There is a hybrid call schedule planned for MS. The Call Center staff will be on site Monday through Friday from 8:00am to 4:00 pm and they will also provide service to HPSM members on the 1st floor at the HPSM offices. She included an update on their recruitment efforts. They have successfully hired a Call Center Supervisor and a new Call Center Manager, Clara Jennings. There are a few Call Center Representative Positions open. They are looking for Chinese speaking reps in particular to fill a void that currently exists. There was a question about the types of emails they receive. The majority consist of individual emails from members either requesting information or sending in information, sometimes it's documentation of other health coverage (OHC).

4.6 CareAdvantage (CA) Enrollment and Call Center Report: Call Center Supervisor, Rustica Magat-Escandor gave a report on behalf of CareAdvantage Manager Charlene Barairo. She provided an overview of CA Call Center data, analysis, call monitoring, performance, and enrollment analysis. The Call Center data measures call response size, the data is pulled from HPSMs automatic call distribution (ACD) system. The system records all incoming and outbound calls as well as all data regarding call volume, speed to answer and the call abandonment metric. Call monitoring is done by Customer Support (CS) Quality Monitoring analysts who take three calls every month from the Navigators and from there criteria is measured based on the accuracy of the information provided, courtesy and demeanor of the representatives or navigators as well as the level of service provided. They meets monthly with Navigators and if they miss their goals, they look for opportunities for improvement.

Enrollment/Disenrollment Supervisor, Sharon Bongolan reported that CA enrollment decreased by .4% compared to last quarter. Overall CA enrollment has decreased by

.8%, which comes to 72 members over the last year. The baseline went from 8,870 members in January 2022 to 8,745 in March 2023. The Medicare open enrollment period, which is an annual window from January 1st to March 31st, allows beneficiaries of Medicare Advantage to make a one-time change in their current coverage. Between January and March of 2023, HPSM enrolled 224 members, of these 218 are new and 6 were re-enrolled, meaning that they returned to the Plan. This is an average of about 90 members per month. 139 members were disenrolled at this time. The most common reasons being death, enrollment in another plan or a move out of the County. She went over member enrollment and overall net enrollment, For Q1, there were 85 members that came to about 41 for January. She also shared the top Health Plans that HPSM members have left for, the top plans are Anthem Medical for Care More, Anthem MediBlue Prime, Kaiser, and New Day.

She reminded the group that all Cal-MediConnect (CMC) members have transitioned to the dual eligible, special needs plan (D-SNP) which became effective January 1st, 2023. Another 93 voluntarily enrolled during the Medi-Cal enrollment period but 22 cancelled their enrollment prior to January 1, 2023. Sharon went over more of the Call Center metrics including the abandonment rate. She confirmed that HPSM is currently under RFP for a new phone system. As this occurs, they continue to monitor the daily call status of staff, to address any issues they might identify. The Call Monitoring goal is set at 95%, they surpassed that at 98%. Analysis of call metrics are on hold. The CA unit are busy assisting members with new benefits, such as the over-the-counter benefit offered by Nations, there is also a worldwide emergency benefit and enhanced patient care. CMS surveillance call monitoring is also under way at this time. It started on February 1st and will go until May 31. Medi-Cal renewals are starting in April for June 2023 renewals. Letters were sent to Medi-Cal beneficiaries to inform them of the steps they need to take in order to minimize the risk of losing their Medi-Cal. They are also encouraged to contact HSA and submit the renewal packet. Members will have a 4-month deeming period. They recently hired two CA navigators and are conducting interviews now to hire three more CA navigators; they hope to find some that speak Spanish or Chinese. There were questions about qualifying for the OTC benefit with some Committee members noting it's hard to explain to HPSM members why some in the D-SNP may not be entitled to the additional benefits when often their friends, or even their own family

members are. HPSM employees have also heard these questions and concerns as well. They may consider looking at the data again and the 20 chronic conditions currently listed there.

4.7 Grievance and Appeals (G&A) Report: Chief Health Officer, Amy Scribner reviewed the Grievance and Appeals (G&A) report. Her numbers were a bit different from the MS report, as her report ended on December 31st and the MS report is current. As of December 31st, HPSM had 174K members. Medi-Cal numbers continue to increase because there have been no redeterminations during that period. Volume for all grievances and appeals decreased slightly from Q4 of 2022 to Q1 of 2023. Rate of complaints per 1,000 members were outside the goal for CA, CCS and Healthworx (HW). CA has been high for more than a year. Timeliness is above goal at 99.15%. Behavioral Health Therapy (BHT) access grievances increased in Q1 of 2023. Action steps taken include improved oversight and monitoring, transparency, and additional care coordination. It was noted that often a first appointment is available within regulatory timeframes, however, family schedules may not allow for acceptance. Kaiser grievances have increased significantly. They will address this directly with Kaiser and discuss opportunities for improvement during upcoming joint operations meeting. PCP change requests are stable and attributes to mostly larger clinics.

5.0 New Business: The committee discussed the CAC member survey conducted by Program Manager, Member Experience & Engagement, Mackenzie Moniz. She has not received feedback from all CAC members, she is asking those who have not responded to complete the survey, she offered a QR code to assist with this process. The committee also discussed streaming upcoming meetings. At current streaming is only available to HPSM employees but they hope to have it available to the public soon. The committee responded favorably to that update.

6.0 Adjournment: The meeting was adjourned at 1:17 pm by Ms. Elbeshbeshy in honor of former CAC member Judy Garcia.

Respectfully submitted:

M. Heryford

M. Heryford
Assistant Clerk to the Commission

PHARMACY & THERAPEUTICS (P&T) COMMITTEE
Meeting Summary
Wednesday 5/24/23 – 7:30am to 9:30am
SMMC BHRS, 2000 Alameda de las Pulgas, Suite 201, San Mateo
HPSM Boardroom, 801 Gateway Blvd, SSF

AGENDA ITEM: 4.4

DATE: August 9, 2023

Members Present: Barbara Liang, George Pon, Jonathan Han, Dr. Lena Osher, Niloofar Zabihi, Rukhsana Siddiqui, and Victor Armendariz

Members Absent: Dr. Bryan Gescuk, Jaime Chavarria, and Varsha Gadgil

Staff Present: Andrew Yau, Biyan Feng, Jasmine Le-Thi, Karla Cruz-McKernan, Kelly Chang, Laura Lo, and Dr. Richard Moore

Staff Absent: Dr. Chris Esguerra, Dr. Cynthia Cooper, Matthew Lee, Ming Shen, and Dr. Miriam Sheinbein

1. Call to Order
George Pon, Interim Chair called the meeting to order at 7:30 am.

2. Public Comment
None

3. Approval of Meeting Minutes
Victor motioned for approval of the prior meeting minutes and Dr. Osher seconded.

4. Approval of Agenda
Victor motioned for approval of the meeting agenda and Dr. Osher seconded.

5. Old Business
None

6. New Business

6.1 Pharmacy Department Policies
Andrew presented two updates to Pharmacy department policies and introduced a new policy.

- Continuous Glucose Monitor Policy (applies to CareAdvantage, Medi-Cal, HW): Update made to permit exceptions on a case-by-case basis in consultation with a medical director.
- Appeals Policy (applies to HealthWorx & ACE): Update clarifying that appeals may be accepted for non-formulary drugs, prior authorization requests, or step therapy exception requests.
- Real Time Benefit (applies to HealthWorx): New policy outlining the establishment of real time benefit for the HealthWorx line of business.

George asked whether the real time benefit tool would allow members to get their medication refills online. Andrew responded by saying it was meant to allow members to obtain their coverage and benefit information, not to order refills which can be done through their pharmacy.

6.2 New Drugs to Market

6.2.1 Protected Class Drugs Andrew introduced 7 new protected class drugs that were recently approved including the following: Jayprica, Krazati, Lunsumio, Orserdu, Rezlidhia, Vegzelam and Sunlenca. The recommendation was made to add Jaypirca, Krazati, Orserdu, Rezlidhia, and Sunlenca to the CareAdvantage and HealthWorx formularies.

6.2.2 Non-Protected Class Drugs

Andrew presented on 17 newly approved non-protected class drugs. The recommendation was made to add Stimufend and Rezvoglar to the CareAdvantage and HealthWorx formularies. The remaining drugs were recommended to be maintained non-formulary, either because they were healthcare-administrated drugs (which are usually obtained through the medical benefit) or due to the presence of more cost-effective formulary alternatives available. Drugs for rare diseases were also left off the formulary due to expected low utilization, with requests approved on a case-by-cases basis.

George asked how the Plan would approve healthcare-administrated drugs if requested. Andrew responded by saying it would be approved utilizing the Plan's Non-Formulary Exceptions Policy, with the requirement that a member try and fail on two formally alternatives first. If there are no formulary alternatives available, the Plan would then approve assuming that the member is using it for a medically-accepted indication.

Dr. Osher asked why Daybue wasn't added to the formulary since it was the only available treatment for Rett syndrome. Andrew responded by saying that the Plan typically does not add drugs used for the treatment of rare diseases due to expected low utilization. Doing otherwise would make the formulary too lengthy and not relevant for most HPSM members. Like any other drug used for the treatment of rare diseases, HPSM would review Daybue utilizing the Plan's Non-Formulary Exceptions Policy and would likely approve due to the lack of formulary options.

6.3 New FDA-Approved Indications

Andrew went over new FDA-approved indications for existing drugs on the market. For HealthWorx, the recommendation was made to remove the prior authorization requirement for sildenafil 20 mg (generic for Ravatio). Andrew conceded that this may result in some utilization for erectile dysfunction which is an excluded benefit. However, he added it wasn't worth committing Plan resources on reviewing prior authorization requests for a drug that has such low cost. For CareAdvantage, the recommendation was made to keep the prior

authorization requirement due to regulatory requirements surrounding the need to ensure it isn't being used for erectile dysfunction.

Dr. Moore asked whether there was a prior authorization requirement for the other strengths of sildenafil to ensure that the Plan did not pay for indications outside of pulmonary arterial hypertension. Andrew responded by saying that all other strengths of sildenafil were non-formulary and would be denied if requested since their only indication is for erectile dysfunction.

6.4 Formulary Considerations

6.4.1 Formulary Recommendations| Outpatient Pharmacy

Andrew presented formulary changes made to the outpatient pharmacy benefit including, but not limited to, the following: removal of the prior authorization requirement for Prolia and biosimilars for Neulasta, removing the step requirement for Veltassa and Trelegy (only for CareAdvantage), and adding various low-cost generics (fosinopril-hctz, eletriptan, and pioglitazone/metformin).

6.4.2 Formulary Recommendations | Medical Pharmacy Benefit

Andrew presented updates to drugs billed under the medical benefit. The recommendation was made to remove the prior authorization for testosterone injections (codes J1071 and J3145) due to their low cost.

Niloo was concerned about possible fraud, waste, and abuse if the prior authorization requirement were to be removed on testosterone. Andrew responded by saying current utilization was low and that the Plan would rely on providers to ensure these drugs weren't being abused. To better monitor these claims, Dr. Moore suggested doing a retrospective claims analysis with an emphasis on ICD-10 codes. Andrew agreed that this was something the Plan should do.

6.4.3 Formulary Recommendations | BHRS

Barbara presented the formulary recommendations for BHRS and recommended removing the prior authorization requirements for long-acting injectable antipsychotics. The reasoning behind this includes their high rate of approval, removing barriers to care, and to capture rebates.

6.5 Immunomodulator Formulary Updates | HealthWorx

Andrew presented updates to the immunomodulator drug class. The recommendation was made to add Amjevita, a new biosimilar to Humira, on to the Plan's HealthWorx formulary.

6.6 Pharmacy Drug Class Reviews

6.6.1 DPP-4 Inhibitors

Andrew presented a drug class review on DPP-4 Inhibitors. For CareAdvantage, the recommendation was made to favor Januvia and Tradjenta to maximize rebates on existing utilization. For HealthWorx, the recommendation was made to maintain preference for alogliptin due to it being the most cost-effective option available.

6.6.2 GLP-1 Agonists

Biyan presented a drug class review on GLP-1 agonists. For CareAdvantage, it was recommended to favor Mounjaro, Ozempic, and Rybelsus. For HealthWorx, it was recommended to add Ozempic to the formulary and to update the step requirement for Rybelsus (members must now step through metformin instead of an SGLT2 inhibitor). Andrew clarified that for HealthWorx, the Plan chose to maintain the step requirement through metformin for all GLP-1 agonist to ensure that these products were not being used for weight loss. The Plan was unable to do the same for CareAdvantage since CMS did not allow it. George commented that based on updated guidelines, metformin was no longer the preferred first-line option. Andrew agreed and expressed concerns that having such a requirement may prevent some HealthWorx members from getting it who would otherwise benefit from the drug. However, he added that the Plan would waive this requirement through the prior authorization process if proper documentation was provided.

6.6.3 Agents for Eosinophilic Asthma

Andrew presented a drug class review on agents for eosinophilic asthma. The recommendation was made to update the prior authorization criteria for Dupixent and Nucala to no longer step through Fasenra. This was to align with current utilization patterns and to maximize rebates.

6.7 Pharmacy Drug Monograph

6.7.1 Xolair

Andrew presented a drug monograph for Xolair. For CareAdvantage, the recommendation was made to remove Xolair from the formulary in favor of Dupixent, Nucala, and Fasenra to align with existing utilization and to capture rebates. For HealthWorx, it was recommended to maintain Xolair on the formulary but to update the prior authorization criteria to align with guideline recommendations surrounding chronic rhinosinusitis and nasal polyposis.
Victor motioned approval of all formulary changes proposed and Dr. Osher seconded with the Committee approving with no objections.

6.8 BHRS Drug Monographs

6.8.1 Xelstrym Tansdermal

Rukhsana presented a BHRS drug monograph for Xelstrym, a new transdermal product for the treatment of ADHD in adults and pediatric patients 6 years and older.

Barbara proposed maintaining Xelstrym non-formulary due to its high cost. Dr. Osher responded by saying some of her pediatric patients have insomnia with oral agents and it would be nice to have a transdermal option since they can be easily removed before sleep. Barbara agreed and said she would discuss it during the next BHRS P&T Committee meeting. She planned on providing an update at the next HPSM P&T Committee meeting.

6.8.2 Auvelity

Rukhsana presented Auvelity, a new formulation of dextromethorphan and bupropion approved for the treatment of major depressive disorder. The recommendation was made to add the drug to both the CareAdvantage and HealthWorx formularies with the requirement that members try and fail on two antidepressants from different classes (e.g., one SSRI and one SNRI).

6.8.3 Venlafaxine Besaylate ER

Rukhsana presented venlafaxine besaylate ER, a new formulation of venlafaxine indicated for the treatment of major depressive order and generalized anxiety. The recommendation was made to maintain it non-formulary due to more cost-effective options available on the formulary.

6.8.4 Dyanavel XR

Rukhsana presented on Dyanaval XR, a new drug for treatment of attention deficit hyperactivity disorder (ADHD) in patients 6 years and older. The recommendation was made to maintain it non-formulary due to the presence of more cost-effective formulary alternatives available.

6.9 Medical Pharmacy Review Guideline Updates

6.9.1 Intravitreal VGEF Inhibitors

Andrew presented an update to the approval criteria for Eylea in response to a provider's concern surrounding the step requirement which entails use of both Avastin and Lucentis first. The recommendation was made to allow step through Avastin only, but only for patients with DME and or diabetic retinopathy and have baseline visual acuity of 20/50 or worse.

Victor motioned approval of all formulary changes proposed and Dr. Osher seconded with the Committee approving with no objections.

7. Other Business/Announcements

Andrew said that the Plan was currently in the process of submitting the CareAdvantage formulary bid for calendar year 2024. In addition, the Plan was also exploring options surrounding future meeting locations.

8. Adjournment

The meeting adjourned at 9:45am

DRAFT

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

AGENDA ITEM: 4.5

DATE: August 9, 2023

Commissioners Present:	Michael Callagy	Barbara Miao
	David J. Canepa	Manuel Santamaria
	Bill Graham, Vice-Chair	Kenneth Tai, M.D.

Commissioners Absent: Jeanette Aviles, M.D., George Pon, R. Ph., Chair, Raymond Mueller, Si France, M.D., Ligia Andrade Zuniga

Counsel: Kristina Paszek

Staff Present: Chris Baughman, Charlene Barairo, Luarnie Bermudo, Gale Carino, Corinne Burgess, Karla Cruz-McKernan, Pat Curran, Janet Davidson, Trent Ehrgood, Chris Esguerra, M.D., Newsha Firoozye, Scott Fogle, Nicole Ford, Jacqueline Gonzales, Matt Javaheri, NaTausha Jefferson, Clara Jennings, Ian Johansson, Karla Mendoza-Pina, Mackenzie Moniz, Natasha Morris, Sarah Munoz, Colleen Murphey, Sheila Murray, Katie Nino, Megan Noe, Courtney Sage, Amy Scribner, Samareen Shami, Miriam Sheinbein, M.D., Ming Shen, Nick Tain, Keisha Williams, Eben Yong.

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

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

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

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

5. **Specific Discussion/Action Items**

   5.1 Restructuring San Mateo Health Commission Standing Committees

   Pat Curran introduced Dr. Esguerra who reviewed a presentation of the proposal to restructure the standing committees of the San Mateo Health Commission. The

presentation is attached to these minutes. Dr. Esguerra highlighted the proposal and rationale for this recommendation:

- This change would solidify the Commission's advisory committees by restructuring the consumer related committees to be overseen by the Consumer Advisory Committee and the clinical related committees to be overseen by the Quality Improvement and Health Equity Committee. The Finance Committee would remain the same with oversight of the Financial and Compliance activities of the Health Plan.
- The committees remaining and reporting to the Commission would be Finance/Compliance; Quality Improvement and Health Equity Committee; and Consumer Advisory Committee.
- Other committees that previously were overseen directly by the commission would be dissolved as standing committees, though they will re-form and continue to operate and report to their respective standing committees.

Dr. Esguerra explained that this restructuring streamlines committee oversight, ensures all policies have a review home and establishes clear flows into the Commission. If approved, the dissolved committees will update their charters to ensure the workflow of their minutes to the related standing committees.

Commissioner Miao stated that this action is good and streamlines the committees making oversight very clear. Commissioner Canepa felt it made sense to make these changes to streamline and update our committee names indicating their representation.

Commissioner Canepa motioned to restructure the standing committees as presented. (Second: Miao). **M/S/P**

5.2 Update on Regional D-SNP Presentation

Mr. Curran kicked off this presentation with an explanation of the purpose of this update, which is to give the Commission context regarding the establishment of a separate 501(c)(3) organization. He explained that more information and a formal proposal for the Commission's consideration will be presented at a future meeting.

Dr. Esguerra reviewed the presentation outlining the concept of establishing a separate 501(c)(3) for a Regional D-SNP organization. He touched on the following points:

- He explained that Medicare is a federal program focused on people who qualify due to age (65 and over) or certain individuals living with a disability.
- Members in our CareAdvantage program are eligible for both Medicare and Medi-Cal.
- CMS contracts with managed care plans like HPSM to coordinate these Medicare benefits.

- The fundamental drivers of success for the Medicare Advantage program are membership, revenue and quality scores, and appropriate utilization of services.
- 18,000 Dually Eligible people live in San Mateo County; 8,800 are members of CareAdvantage; 6,000 have original Medicare; 2,300 are Kaiser members; and less than 1,000 are enrolled with other Medicare Advantage plans.
- With 8,800 D-SNP members , HPSM is larger than approximately 62% of D-SNPs in the nation.
- Reasons for HPSM to consider the Regional D-SNP concept are:
    - All local plans must have a D-SNP by 2026 as part of CalAIM, but many have never operated a Medicare plan.
    - Establishing a D-SNP is costly and may take up to 4 years to break-even financially.
    - State and Federal Regulatory agencies are interested in innovative new models.
- Opportunities in expanding our D-SNP:
    - HPSM has long-standing experience operating a D-SNP.
    - This model is an innovative way for local plans to work together and scale operations while remaining local.
    - It is an opportunity to sustain and spread HPSM's expertise, working closely with community partners.
    - It further strengthens HPSM and local plan partnership with state and federal agencies.

Commissioner Callagy asked about the ideal number of plans to be included in this entity and about the financial incentives for HPSM. Dr. Esguerra replied that the ideal number is unknown at this time, but this will be part of the financial analysis.

Commissioner Canepa asked what the value for other health plans is in partnering with HPSM. He asked to hear more about the governance piece and budgeting. Dr. Esguerra stated that staff have been in conversations with other health plans, who are recognizing the tremendous amount of work required to implement their own D-SNP. Some have not had a D-SNP but will now be required to establish this by 2026. The value is HPSM's experience having had an established D-SNP, bringing expertise and experience. In addition, as D-SNP partners, the plans will work even more closely together and share their work and best practices. The value to HSPM is an investment in long-term sustainability by demonstrating our ability to manage this type of operation and expand it. It gives HPSM the opportunity to demonstrate HPSM's ability to innovate while also keeping our local presence.

Mr. Curran added that this endeavor could offer HPSM an opportunity to grow and achieve more scale, as well as help the state and federal government in their vision of more integrated care for beneficiaries. At the same time, the core business of serving the Medi-Cal members would not change.

Commissioner Tai asked if there will be a cost for plans to join. Dr, Esguerra stated there will be some cost in joining as well as governance commitment and Tangible Net Equity requirements. Dr. Tai asked if we would have commitments for other health plans of their intent to join. Mr. Curran added there have been some conversations but no commitments yet. Discussion ensued about workforce, marketing, membership populations of other health plans, related risk, and risk pools.

Other questions posed by Commissioners:

- Would all plans be equal partners?
- How will the quality scores affect HPSM which has an effect on rates?
- Under what conditions would HPSM accept other plans into this model?
- How would the entity be governed?

Dr. Esguerra touched on the creation of the subsidiary:

- Subsidiary would be formed by HPSM and structured as a 501(c)(3) at the onset.
- The 501(c)(3) would be Knox-Keene licensed by DMHC and hold the contract with CMS.
- There would be a management agreement between HPSM and the 501(c)(3).
- Financial reserves would be established and placed into the 501(c)(3).
- HPSM and the 501(c)(3) would satisfy all regulatory requirements.
- This concept and proposed model has been discussed with our regulatory partners.

Other health plans joining:

- Plans would make an initial contribution to reserves.
- A new D-SNP would not need to be established, rather a service area expansion application would be submitted to CMS.
- Additional plans could join using the same process (i.e., the structure doesn't fundamentally change if more than one plan joins).

Governance and Structure:

- Regional strategy but locally integrated
- Plans that join would become our partners and would delegate the Medi-Cal portion for dual eligibles to the 501(c)(3), which would fully integrate the benefits.
- Each of the plans would have representation on the board of this entity. The details of governance would need to be defined.
- Operationally the work would initially be performed by HPSM and structured as a management fee.

- Staffing options are being considered with HPSM handling or hiring staff in the plans' local area, continuing a local presence for member services, providers, sales, etc.

Commissioner Graham commented on the Knox -Keene licensing that can take 12 months to complete, and one of the challenges is getting commitments before starting the work. Mr. Curran added that this is a very important point in this process of applying for the Knox-Keene license and having commitments to join. He noted there would have to be very serious conversations before taking on a plan partner, and governance would be a key element of the discussion. The Knox-Keene process can be discontinued if no plans join.

Dr. Esguerra explained that the requirement of each plan having a D-SNP by 2026 is why the Knox-Keene licensing process begins now, which will give time for plans to join and meet the requirements.

Commissioner Canepa talked about the health plan continuing to be the lead agency and not release control of operations. He noted the need for this entity to be sustainable.

Commissioner Miao asked if there were limitations to the distance that HPSM could expand. Dr. Esguerra stated there is not and gave some examples of other plans that are operating counties with significant distances between them.

Dr. Esguerra reviewed the current cash flow of Medicare capitation from CMS and Medi-Cal capitation from DHCS. In the Regional D-SNP scenario, the Medi-Cal portion for enrolled D-SNP members would be delegated to the 501(c)(3). Dr. Tai commented that it looks like the 501(c)(3) will be taking the financial risk. Dr. Esguerra concurred.

Commissioner Miao asked about the differences in rates by county or region. Dr. Esguerra noted that the rates will be changing based upon which counties participate and HPSM would be working with the plans and actuaries to understand the impact on capitation rates depending on the service area.

Dr. Esguerra reviewed the timeline, which began in March 2023 with the exploration of local plan interest and identification of regulatory barriers. This timeline explains the proposal if the Commission were to approve the creation of the subsidiary, obtaining the Knox-Keene license, adding local plans that wish to join, applying for the service area expansion and moving forward to prepare for a go-live in January 2026. He focused on Step 1, which is the Commission's consideration of creating the subsidiary. He explained that staff is continuing discussions with other plans and our regulators.

Commissioner Graham clarified that the timeline allows time for the governance piece to be defined later and Step 1 is to begin by creating the entity. Dr. Esguerra concurred. Dr. Tai asked about care coordination and utilization management. Dr. Esguerra stated that this process would stay with HPSM, keeping the local aspects of our services and operations.

Dr. Esguerra explained that a financial analysis for this proposed D-SNP model is being performed for HSPM by Milliman. HPSM staff are researching potential costs to form this subsidiary and forming the application for the Knox-Keene license. In August, staff will bring for the Commission's further discussion and consideration a recommendation on the formation of this 501(c)(3). Mr. Curran explained that the cost of $500,000 is only for initial company formation and analysis. The real start-up costs of adding staff, preparing for enrollment growth will need to be co-funded by the plans potentially joining.

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

7. **Report from Chief Executive Officer**
   Mr. Curran noted next steps for the next commission meeting: more on the 501(c)(3) formation; proposal for potential investment in Seton Medical Center; and a presentation update on the HealthWorx program. In September we will have a follow-up on Primary Care discussion.

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

9. **Adjournment**
   The meeting was adjourned at 1:43pm

Submitted by:
C. Burgess

C. Burgess, Clerk of the Commission

Attachment 1 to
SMHC Minutes of July 12, 2023

San Mateo Health Commission Subcommittees

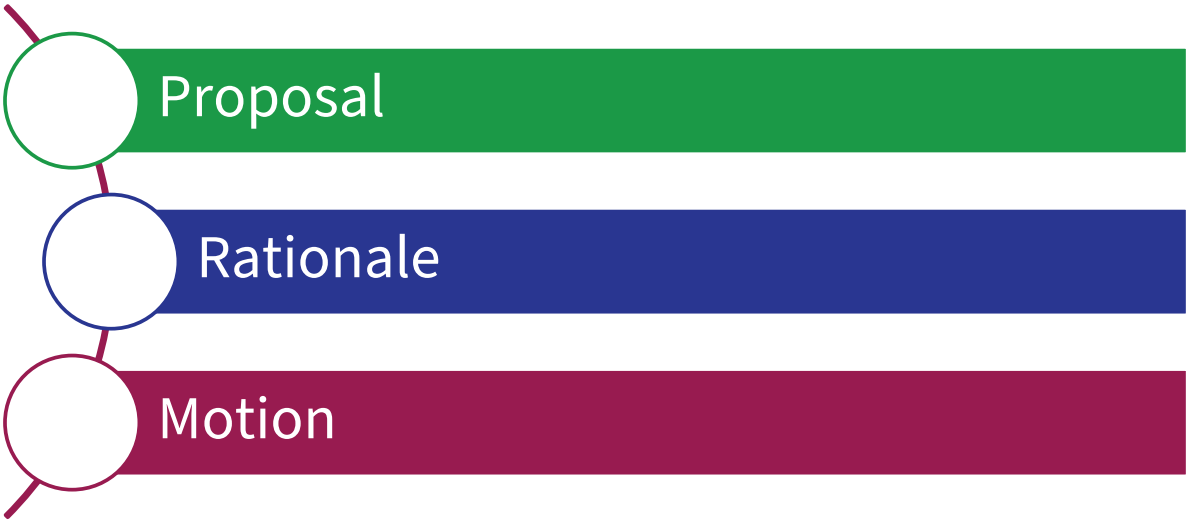
San Mateo Health Commission

July 2023

HealthPlan OF SAN MATEO
Healthy is for everyone

Agenda

HealthPlan OF SAN MATEO
Healthy is for everyone



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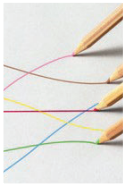

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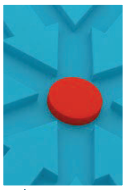

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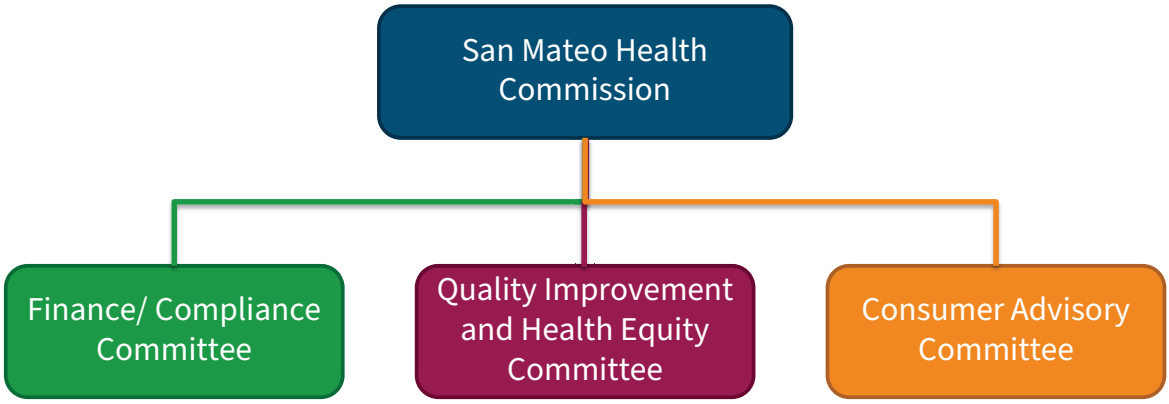

Thank you

Attachment 2 to SMHC Minutes

of July 12, 2023

Regional D-SNP Model Update Health Commission Meeting

July 12, 2023

HealthPlan OF SAN MATEO
Healthy is for everyone

CareAdvantage by HealthPlan OF SAN MATEO

Agenda

- Background and Why
- Formation Process
- Timeline
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HealthPlan OF SAN MATEO
Healthy is for everyone

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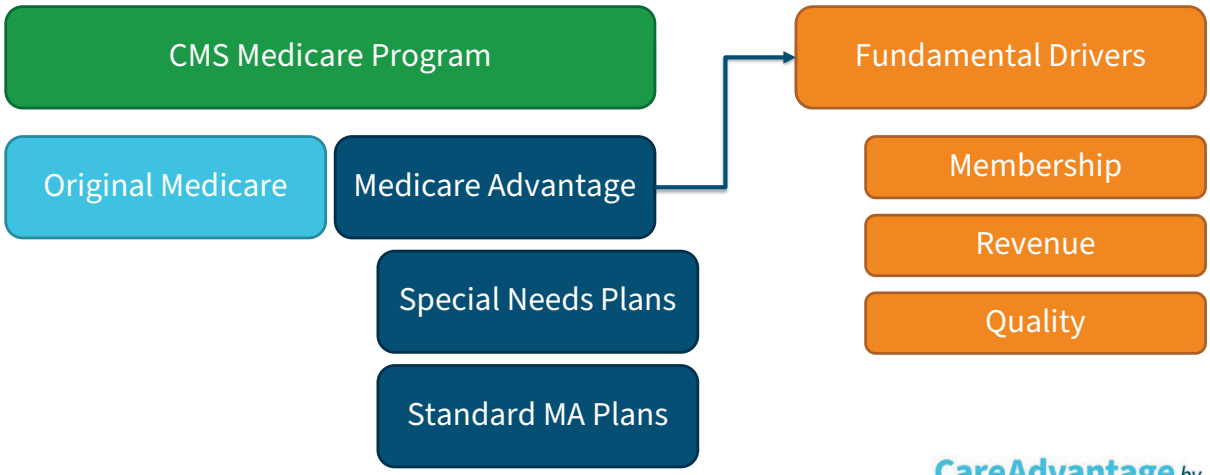
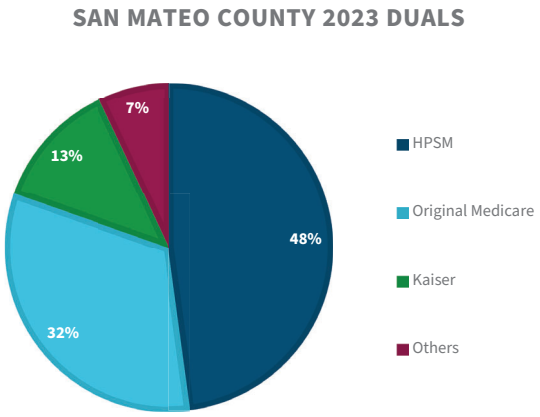


Focusing on Dually Eligible Members



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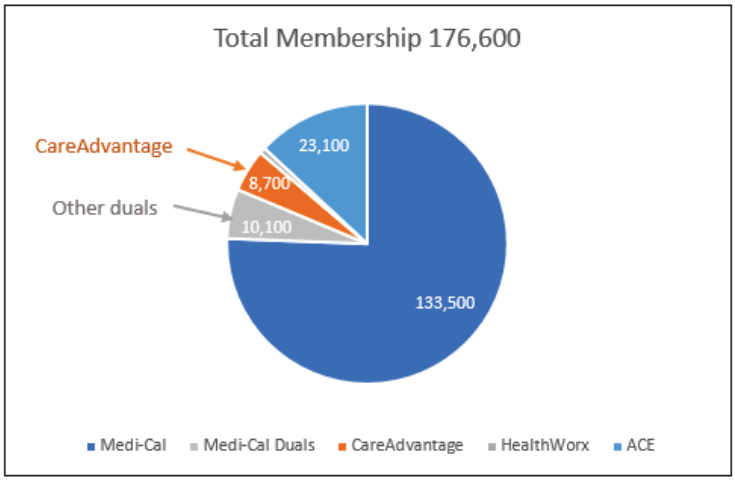
CareAdvantage by HealthPlan OF SAN MATEO

HPSM Total Membership

Q1 2023



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Why a Regional D-SNP and Why Now?

HealthPlan OF SAN MATEO
Healthy is for everyone

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CareAdvantage by HealthPlan OF SAN MATEO

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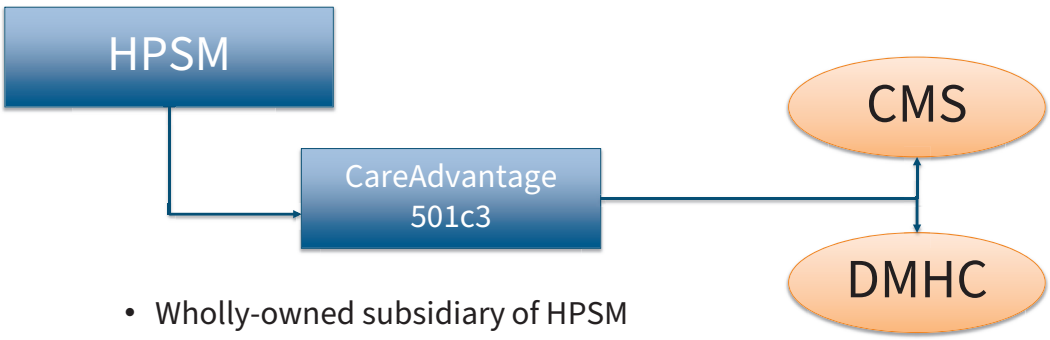

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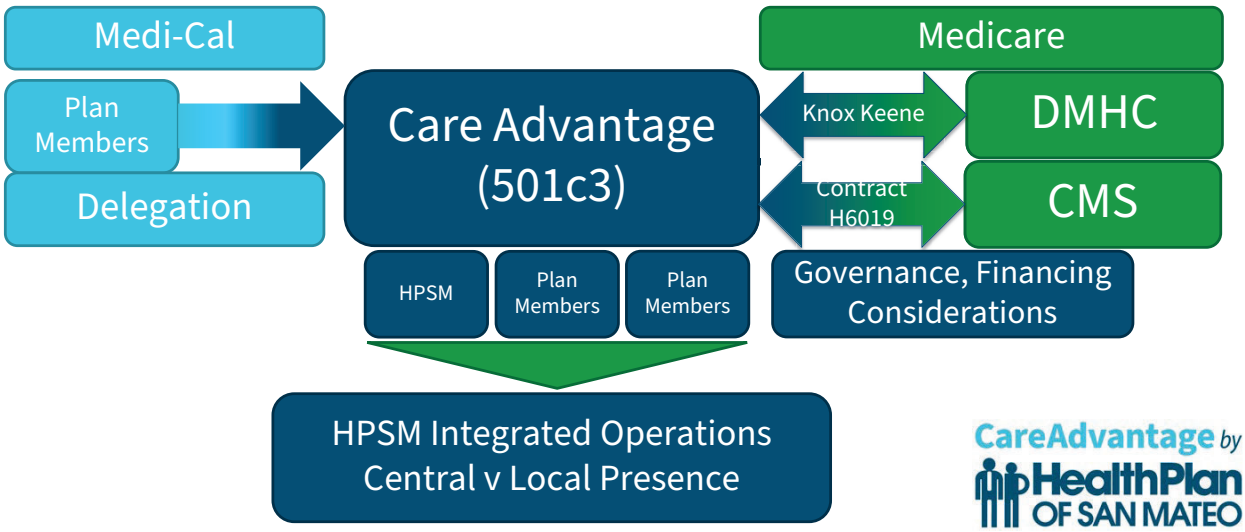
Care Advantage Structure

Regional Strategy, Locally Integrated



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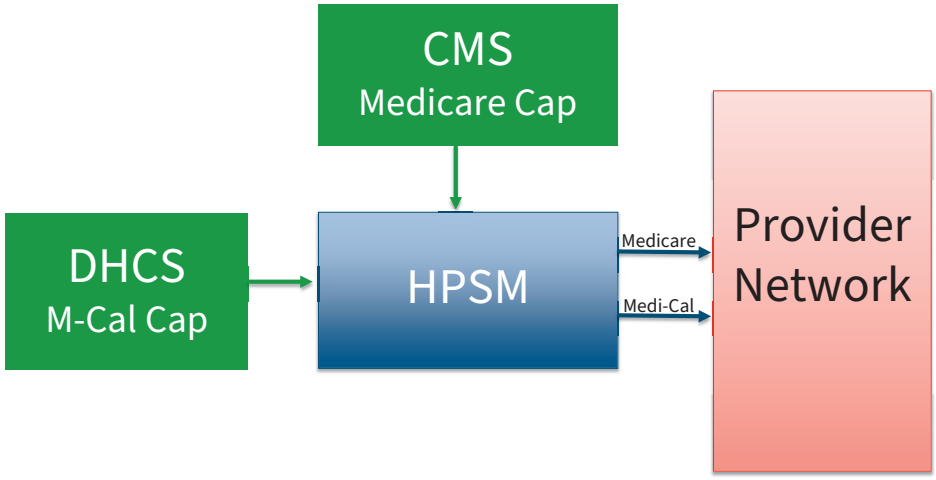

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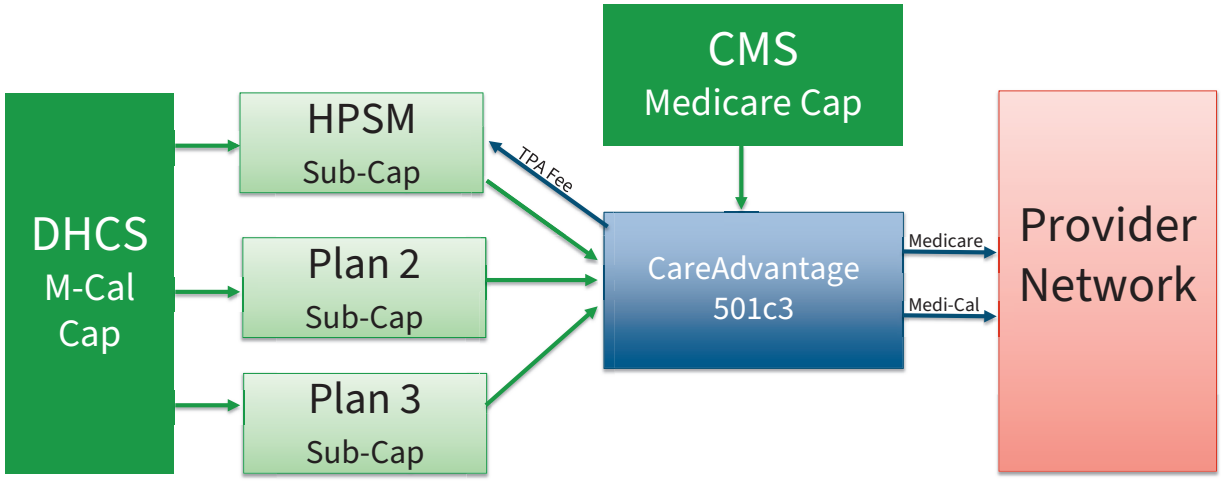

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San Mateo Health Commission Subcommittees

San Mateo Health Commission

July 2023

HealthPlan OF SAN MATEO
Healthy is for everyone

Agenda

HealthPlan OF SAN MATEO
Healthy is for everyone

- Proposal
- Rationale
- Motion

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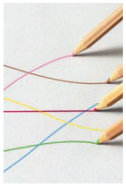

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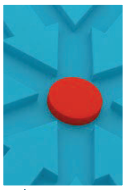

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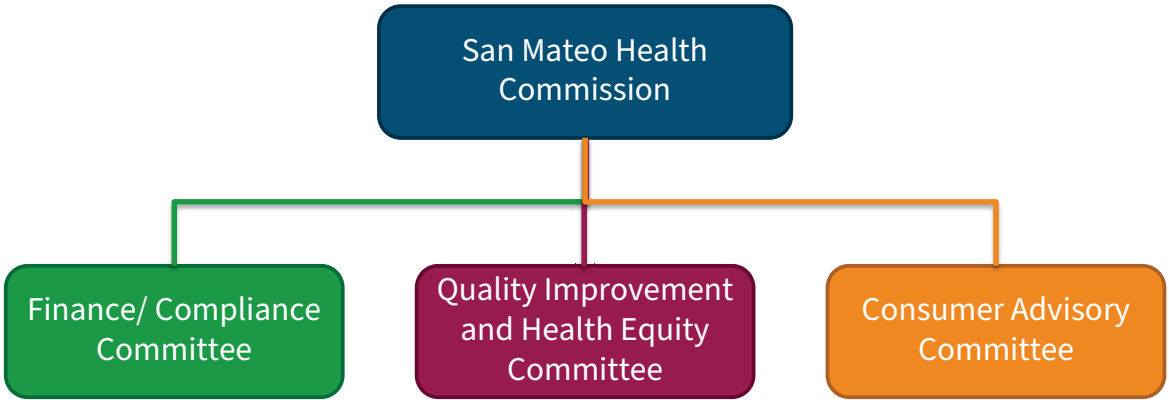

Thank you

Agenda Item: 5.2

Date: July 12, 2023

Regional DSNP Model Update
Health Commission Meeting

July 12, 2023

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Healthy is for everyone

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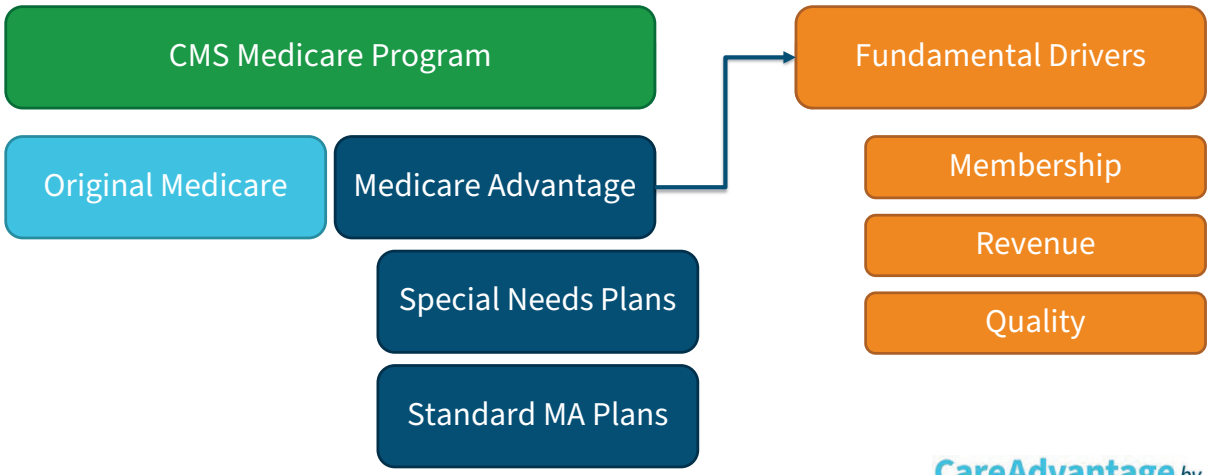

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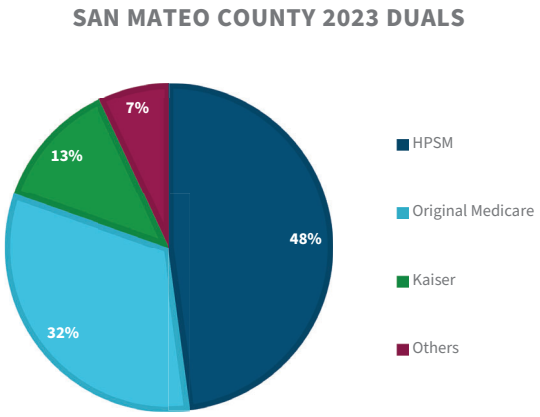

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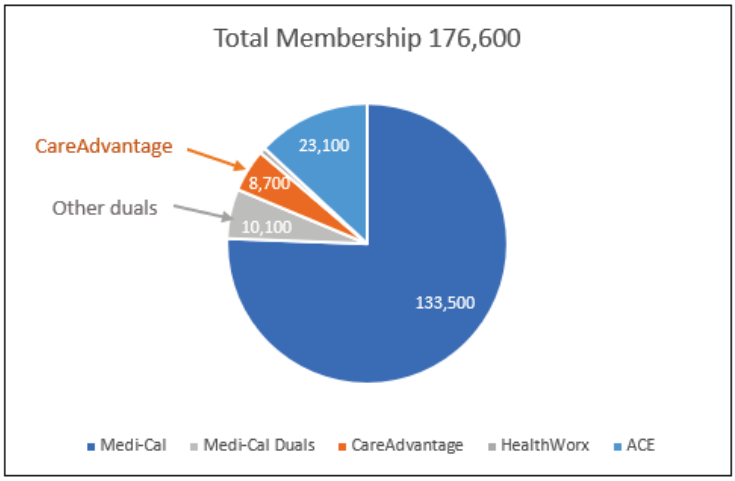

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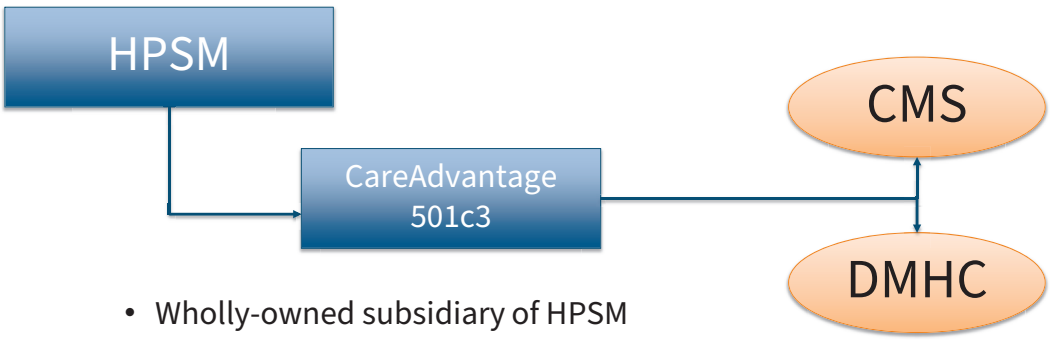

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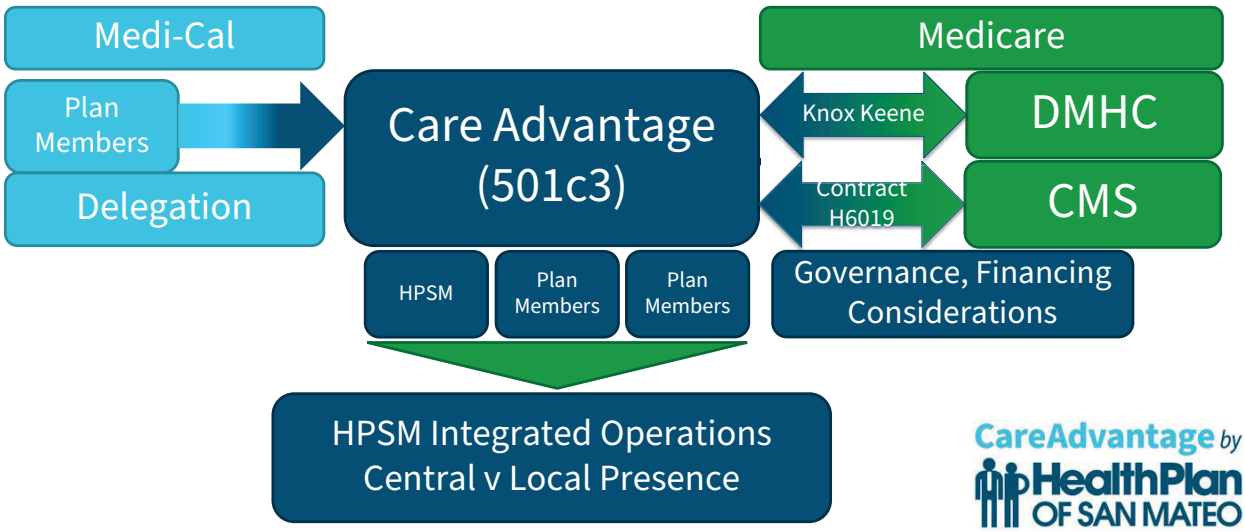

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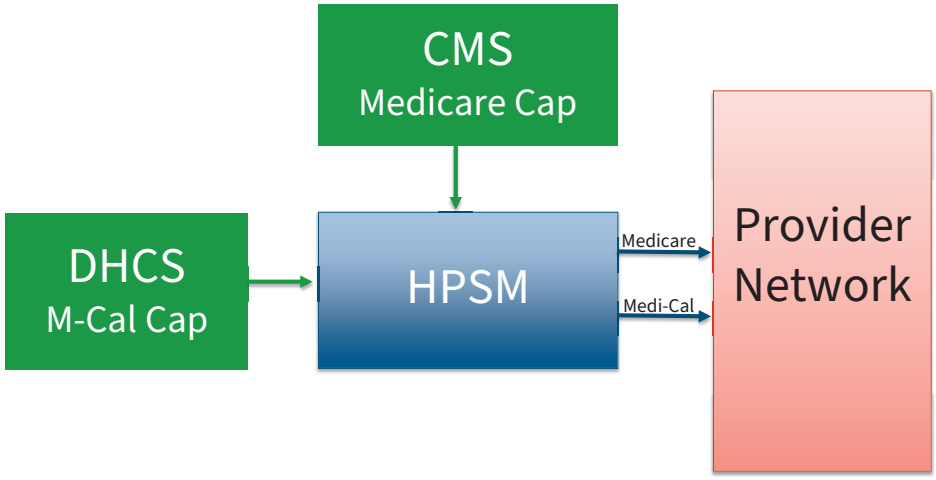

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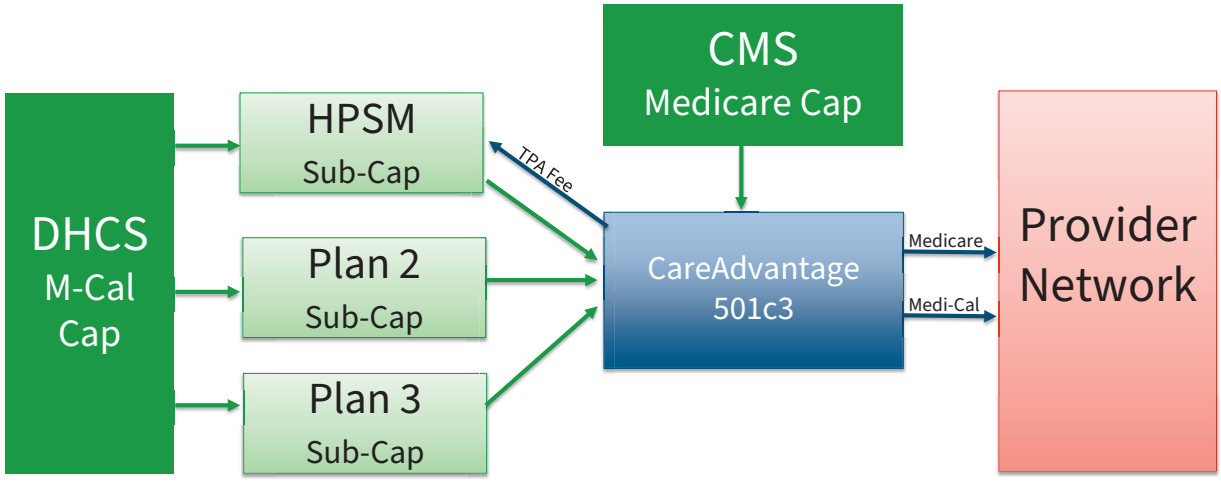

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MEMORANDUM

AGENDA ITEM: 5.1

DATE: August 9, 2023

DATE: August 1, 2023

TO: San Mateo Health Commission

FROM: Patrick Curran, Chief Executive Officer

RE: Investment in AHMC Seton Medical Center

Recommendation:

Provide one-time funding of $10,000,000 to AHMC Healthcare to support the cost of already completed infrastructure improvements as well as proposed enhanced access to care for HPSM members at AHMC Seton Medical Center – Daly City.

Background:

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

Discussion:

AHMC Healthcare has proposed to work with the physician community to increase access to care for HPSM members and for the entire community. We communicated several areas of challenging access: Hospital Dentistry, Dermatology, Rheumatology, Endocrinology, Psychiatry, and Pediatric Occupational and Speech Therapy Services.

AHMC Healthcare has communicated to HPSM that they are actively working on additional

physician resources in the areas of: General Surgery (specifically to improve access at the Breast Center), Psychiatry, Dermatology, and Hospital Dentistry. They are also considering the possibility of transitioning acute care beds at Seton Medical Center to Long-Term Care and Skilled Nursing beds, which would also improve access for HPSM members.

AHMC has also communicated to HPSM that they have already spent more than $65M in seismic upgrades to Seton Medical Center. Those seismic improvements were an important component of the sale to AHMC in 2020, since meeting seismic standards is a state requirement for all hospitals.

We believe that this $10M investment in Seton furthers our goal to increase access for our members, especially access to specific areas of specialty care in the northern part of the county. We are also encouraged by the potential for AHMC Seton Medical Center to add more permanent Long-Term Care (LTC) capacity to the community, since the number of LTC beds available to Medi-Cal members has steadily declined over the past decade. Most of the new access points for assisted living and LTC in the county are facilities that do not accept Medi-Cal, catering mostly to privately paying individuals.

We will work with AHMC Healthcare to develop metrics to evaluate how the proposed physician recruitment will increase access for HPSM members. We propose to make the payment in two installments, the first $5,000,000 by September 1, 2023, upon the development of agreed-upon metrics, and the second installment of $5,000,000 by March 31, 2024, which is consistent with the schedule outlined in the original resolution passed by the San Mateo County Board of Supervisors on March 10, 2020.

Fiscal Impact:

This recommendation is for a payment to AHMC Seton Medical Center of $10,000,000. HPSM has sufficient financial reserves to make this investment, and we believe that it is an important investment in access to care for HPSM members, especially those members in the northern part of the county.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF ONE-TIME FUNDING FOR AHMC SETON MEDICAL CENTER TO SUPPORT INFRASTRUCTURE COSTS AND INCREASE ACCESS TO CARE FOR HPSM MEMBERS

RESOLUTION 2023 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission is responsible for oversight of HPSM and its important role as a community health plan and steward of public dollars;

B. HPSM's mission is to ensure that San Mateo County's underserved residents have access to high-quality care services and supports so they can live the healthiest possible lives; and

C. HPSM seeks to further this mission by supporting AHMC Healthcare with a goal to increase access for our members, including specific areas of specialty care in the northern part of the county.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves the payment of $10,000,000 to AHMC Healthcare as outlined in the attached memo; and

2. Authorizes the Chief Executive Officer to enter into necessary agreements for this payment.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 9th day of August 2023 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

MEMORANDUM

AGENDA ITEM: 5.2

DATE: August 9, 2023

DATE: July 26, 2023

TO: San Mateo Health Commission

FROM: Patrick Curran, Chief Executive Officer

RE: Formation of 501(c)(3) Non-Profit Organization

Recommendation:

Authorize HPSM management to initiate the process of establishing a non-profit 501(c)(3) organization for the purpose of forming a jointly governed entity with other local Medi-Cal health plans that would provide Medicare and Medi-Cal benefits to dually eligible individuals.

Background:

HPSM has operated CareAdvantage, a Medicare Advantage Dual-Eligible Special Needs Plan (DSNP), since 2006. Medicare Advantage is a program in which health plans provide Medicare Parts A and B services, as well as Part D pharmacy services, to eligible beneficiaries. This program is administered by the Centers for Medicare and Medicaid Services (CMS). HPSM provides Medi-Cal benefits to 18,000 individuals in San Mateo County who are eligible for Medicare and Medi-Cal (so-called "dual-eligibles"), and serves approximately 8,800 of those same individuals who have also selected CareAdvantage to receive their Medicare benefits.

From 2014 to 2022, HPSM participated in Cal MediConnect, which was a demonstration program to integrate benefits and services for dual-eligible beneficiaries in California. The State of California and CMS are now embarking on an ambitious new program to align care and services for dually eligible Californians. As part of CalAIM, the state's transformation effort, all health plans serving Medi-Cal members must have an associated DSNP in place by January 2026 to serve dual-eligible beneficiaries.

HPSM is part of a statewide association of 17 local health plans, which were locally formed and are locally governed similar to HPSM. Of those 17 health plans, only 7 (including HPSM) currently have a DSNP in place. Therefore, 10 local health plans currently do not have a Medicare plan and will need to set up the infrastructure to provide Medicare benefits.

HPSM has proposed forming a new non-profit entity that would be jointly governed and financed by local health plans to serve dual-eligible members. We have discussed the proposed model with all three regulatory agencies (CMS, DHCS, and DMHC), and have not identified any regulatory barriers in forming this proposed regional DNSP model.

Discussion:

There are four main reasons for HPSM to pursue this unique and time-sensitive opportunity:

1. It leverages our more than 15 years of experience serving Medicare members in this community, building on our statewide reputation as a leader in serving elderly and disabled members.
2. It offers an innovative and groundbreaking way for local health plans to work together in a way that achieves more scale and retains each organization's commitment to being a local plan.
3. It presents an opportunity for HPSM to sustain and spread our innovative methods and community focus, building scale to better serve our existing CareAdvantage members.
4. It strengthens our partnership with state and federal regulatory agencies, who are supportive of this innovative model.

We have discussed this proposed regional D-SNP model with several local health plans, especially those serving members in northern and central California. All are in the midst of operational and financial analysis regarding how best to proceed.

We are seeking authorization for Step 1 of this process, which includes the following:

1. Authorization to initiate the process of forming a non-profit 501(c)(3).
2. Authorization to initiate the process of applying for a Knox-Keene license with the Department of Managed Health Care (DMHC) and the process of contract transfer (called "Novation") with CMS.
3. Authorization to form an ad hoc committee of the Health Commission to participate in discussions with other local health plans and establish criteria for partnership.
4. Authorization to spend up to $250,000 over the next six months for costs associated with this effort, which may include the following:
    a. Legal costs to establish the non-profit 501(c)(3) and to file applications with DMHC and CMS;
    b. Financial analysis to determine the financial implications of this expanded regional model;
    c. Operational readiness analysis to determine how best we could expand HPSM's administrative capability; and
    d. Consulting assistance from a firm with experience in joint ventures and plan partnerships to facilitate discussions with other health plans.

It is important to emphasize that this is only an initial step. The current plan involves submitting for approval by the Health Commission one of the following next steps, no later than April 2024:

I. Authorize HPSM to proceed with the regional D-SNP and invite one or more plan partners based upon the due diligence performed;
II. Authorize HPSM to close down the non-profit 501(c)(3) and dissolve the entity, as well as discontinue the application process with DMHC and CMS; or
III. Continue with formation of the non-profit 501(c)(3) even if no plan partners are successfully added. This path may be taken to keep the option open for plans to join at a later date, or that HPSM could use the non-profit 501(c)(3) to explore other opportunities that serve our mission.

Fiscal Impact:

This recommendation authorizes HPSM to incur up to $250,000 in costs related to organizational readiness, financial analysis, and company formation. Any additional costs related to actual implementation of a jointly governed regional D-SNP (true start-up costs) would only occur after the commission approval of the next steps as described above before April 2024 and would delineate the proposed costs to be incurred by HPSM and by other local plan partners.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF AUTHORIZATING HPSM TO FORM A 501(c)(3) NON-PROFIT ORGANIZATION

RESOLUTION 2023 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission is responsible for oversight of HPSM and its important role as a community health plan and steward of public dollars;

B. HPSM's mission is to ensure that San Mateo County's underserved residents have access to high-quality care services and supports so they can live the healthiest possible lives; and

C. HPSM has a unique and time-sensitive opportunity to develop a regional Medicare plan in collaboration with other local health plans to further enhance care and services for our members.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

The San Mateo Health Commission authorizes the following:

1. Initiate the process of forming a non-profit 501(c)(3).
2. Initiate the process of applying for a Knox-Keene license with the Department of Managed Health Care (DMHC) and the process of contract transfer with CMS.
3. Form an ad hoc committee of the Health Commission to establish criteria for inclusion and participate in discussion with other local health plans.
4. The Chief Executive Officer to enter into necessary agreements to spend up to $250,000 over the next six months to support this effort.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 9th day of August 2023 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

Agenda Item: 5.3
Date: August 9, 2023

HealthWorx Update

San Mateo Health Commission

August 9, 2023

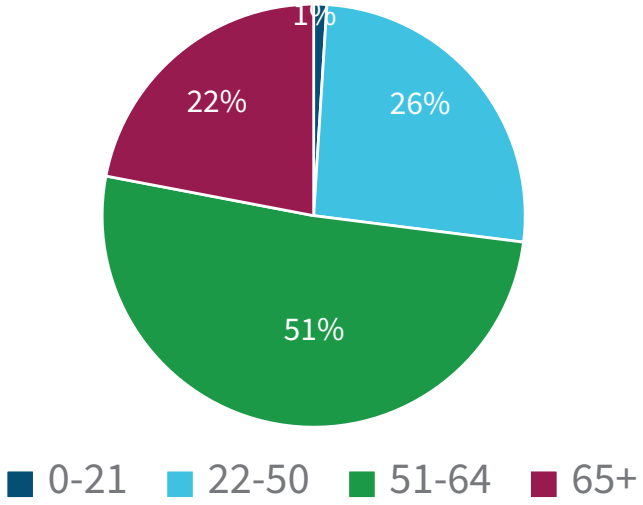
HealthPlan OF SAN MATEO
Healthy is for everyone

History

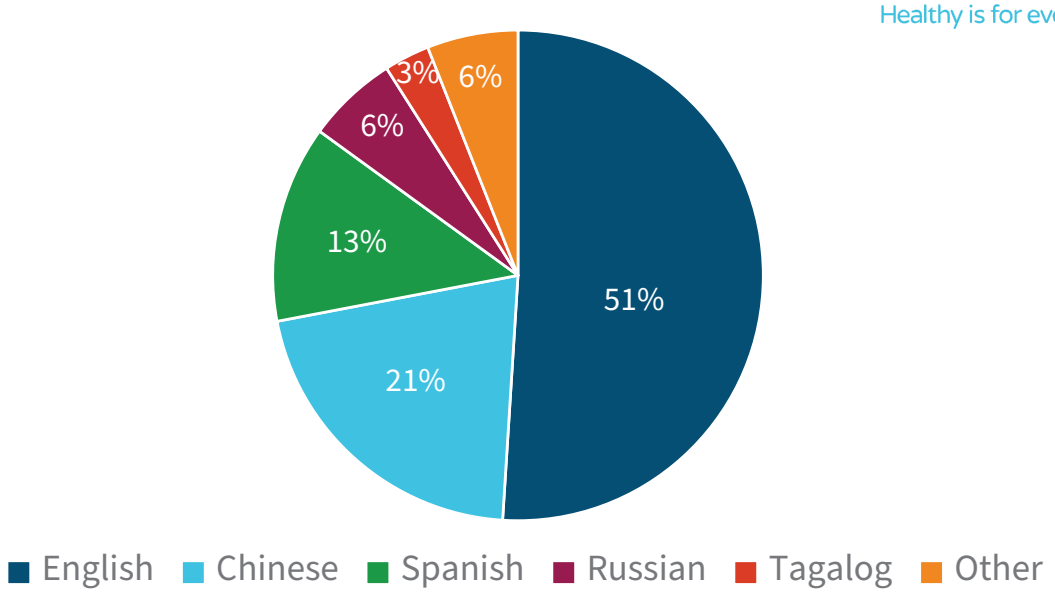
HealthPlan OF SAN MATEO
Healthy is for everyone

- HealthWorx is a commercial health plan licensed by the Department of Managed Health Care (DMHC).
- It was formed and started serving members in 2001.
- Membership is comprised of two arrangements:
  - Approximately 1,200 IHSS (In-Home Supportive Services) workers who receive health coverage from the San Mateo County Public Authority through its agreement with SEIU
  - Approximately 12 individuals, mostly retirees, of the City of San Mateo
- Membership has remained fairly constant throughout the life of the program.
- HPSM uses its Medi-Cal network as the provider network and pays Medi-Cal rates to providers for covered services.
- San Mateo is one of several counties in the state with this type of program (San Francisco, Santa Clara, Los Angeles, Monterey, and Alameda)

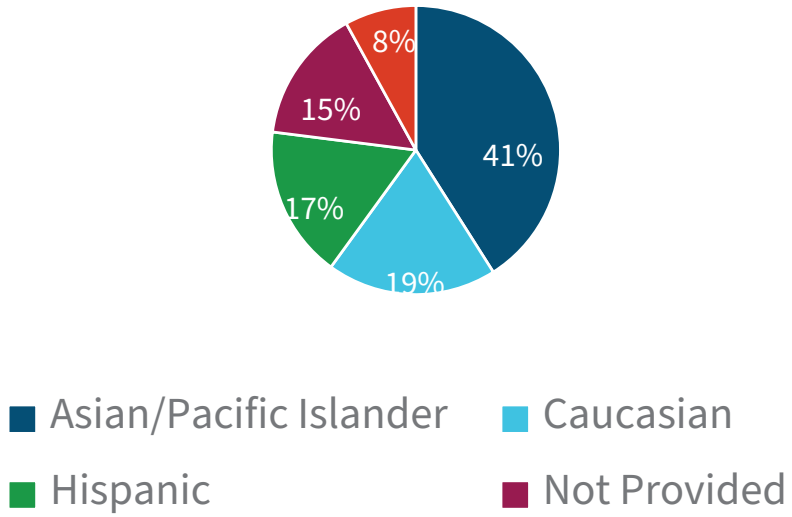
HealthWorx Members - Age



HealthWorx Members - Language



HealthWorx Members - Race/Ethnicity



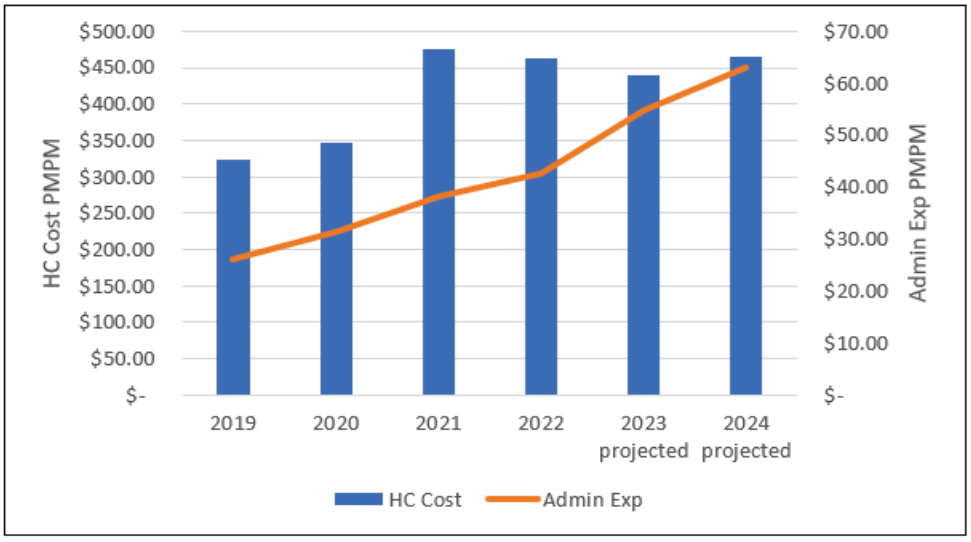
Current State

- **Historically, the DMHC has regulated these plans separately from commercial plans as a special category (so-called "IHSS Plans").**
- **Due to the passage of legislation, as well as DMHC interpretation of regulatory policies, HealthWorx is increasingly regulated by the same rules as any licensed commercial health plan in California.**
- **This has resulted in significant workload increase for staff, especially in areas such as behavioral health, compliance, financial reporting, and IT (i.e., mandates for transparent pricing tools on plan websites).**
- **Due to low membership, the financial performance can fluctuate dramatically. We incurred losses in 2019, 2021 and 2022 (2020 did not incur a loss mostly due to the dramatically lower access to many services during the pandemic). With low membership, one high-cost case can affect overall financial performance.**

Financing

- **San Mateo County funds the premium of its IHSS workers through a complicated arrangement with the State of California:**
  - **After the passage of the Affordable Care Act (ACA), the county had and still has an approximately $23M obligation due to Maintenance of Effort (MOE). The intent of MOE is that state and local agencies not discontinue coverage programs already in place before passage of the ACA.**
  - **The MOE amount includes the costs to cover the county portion of healthcare premium costs for the 1,200 members. The remaining costs are shared between state and federal funds if it does not exceed a specified maximum dollar amount per IHSS hour worked.**
  - **The county has not historically, nor do we anticipate that it will with any proposed premium increase, exceeded this maximum dollar amount.**

Health Care Cost and Admin PMPM



Increased admin load in 2023, 2024 projections.

Next Steps

- **Increase the HealthWorx member premium in 2024 and communicate to both San Mateo County and the City of San Mateo (approximately 9%, which equals the increase for 2023).**
- **Invest additional dollars in administrative support for the program to address increasing regulatory oversight.**
- **Engage a consultant in an overall market assessment to determine options for the HealthWorx program moving forward.**
  - **Of note, we can also use this opportunity to explore broader coverage gaps in the county, particularly in the coastal community**

MEMORANDUM

AGENDA ITEM: 7.0

DATE: August 9, 2023

DATE: August 1, 2023

TO: San Mateo Health Commission

FROM: Patrick Curran

RE: CEO Report – August 2023

Managed Care Organization (MCO) Tax

As reported last month, the state budget includes a five-year $19 billion managed care tax. This mechanism of taxing all health plans helps fund the Medi-Cal program through a complex financing formula. The state discontinued this tax in 2022 but is now re-establishing the tax. Many of the provisions will apply to our 2024 rates, though there may be some retroactive funding based upon CMS approval.

The next step is to learn more about the funding provisions and how they will be implemented. For example, there are specific targets for funding primary care, behavioral health, and maternity care, but there are many questions about how these will be implemented. There is also scant detail on how other aspects of the funding will be allocated. We will update the Health Commission and our provider community as we learn more.

Medi-Cal Redeterminations

In July, we saw the first wave of HPSM members who lost coverage due to the reinstated redetermination process. This process includes verification by the member to the local Human Services Agency that the member continues to meet Medi-Cal eligibility criteria.

In the first month, approximately 1,300 HPSM members lost Medi-Cal coverage. It is important to note that this doesn't mean they don't have health coverage, only that they didn't meet the Medi-Cal requirements or, more likely, that they didn't return completed paperwork. The state allows a 90-day period in which members may submit additional information to reinstate coverage.

This process will occur over the next 12 months, as members each have a specific redetermination date (i.e., it is not all done at once). We are still tentatively projecting to lose 10-15% of our Medi-Cal membership over the next year, but those projections may change as we learn more.