HealthPlan OF SAN MATEO
Healthy is for everyone

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South San Francisco, CA 94080

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-Virtual Meeting-

THE SAN MATEO HEALTH COMMISSION
Regular Meeting
December 8, 2021 - 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., South San Francisco, CA 94080

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

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

Join on your computer or mobile app

Click here to join the meeting

Or call in (audio only)
(833) 827-5103,,887144736# United States (Toll-free)
Phone Conference ID: 887 144 736#

Members of the public wishing to provide public comment on items not listed on the agenda that are within jurisdiction of the Commission or to address an item that is listed on the agenda may do so by emailing comments before 10:00 am, December 8, 2021 to the Clerk of the Board at Corinne.Burgess@hpsm.org with "Public Comment" in the subject line. Comments received will be read during the meeting. Members of the public wishing to provide such public comment may also do so by joining the meeting on a computer, mobile app, or telephone using the link or number provided above and following the instructions for making public comment provided during the meeting.

AGENDA

1. **Call to Order/Roll Call**
2. **Public Comment/Communication**
3. **Approval of Agenda**
4. **Consent Agenda***
   - 4.1 Adopt a resolution finding that, as a result of the continuing COVID-19 pandemic state of emergency, meeting in person would present imminent risks to the health or safety of attendees
   - 4.2 Report from Finance Committee
   - 4.3 Consumer Advisory Committee, October 2021
   - 4.4 CMC Advisory Committee, October 2021
   - 4.5 Approval of Compliance Policy CPO.000 – 2022 Compliance Program and Compliance Policy CP.026 – 2022 Code of Conduct

~Continued~

4.6 Waive Request for Proposal and Approve Amendment to Agreement with International Contact Inc.

4.7 Approval of Amendment to Agreement with Independent Living Systems (ILS)

4.8 Approval of Commission Meeting Dates for 2022

4.9 Approval of San Mateo Health Commission Meeting Minutes from November 10, 2021

5. Specific Discussion/Action Items

5.1 Discussion/Action on 2022 HPSM Budget*

5.2 Discussion/Action on Resolution of Appreciation for Maya Altman, Chief Executive Officer*

6. Report from Chairman/Executive Committee

7. Report from Chief Executive Officer

8. Other Business

9. CLOSED SESSION

Conference with Legal Counsel – Anticipated Litigation (Gov't Code section 54956.9(d)(2) (2 cases))
Action on Government Claim*

10. Report on Action Taken in Closed Session

11. Adjournment

**Items for which Commission action is requested.*

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

AGENDA ITEM: 4.1

DATE: December 8, 2021

MEMORANDUM

DATE: November 30, 2021

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: Approval of Teleconference Meeting Procedures Pursuant to AB 361

Recommendation

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

Background and Discussion

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

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

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

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

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

Fiscal Impact

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

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

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

RESOLUTION 2021 -

RECITAL: WHEREAS,

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

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

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

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 8th day of December 2021 by the following votes:

AYES:
NOES:
ABSTAINED:
ABSENT:

_____
Ligia Andrade Zuniga, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

FINANCE/EXECUTIVE COMMITTEE MEETING
Meeting Summary – November 1, 2021
Teleconference Meeting

Agenda Item: 4.2
Date: December 8, 2021

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

Member's present: Mike Callagy, Bill Graham, Ligia Andrade-Zuniga, Si France, M.D.

Member's absent: Don Horsley

Staff present: Maya Altman, Pat Curran, Trent Ehrgood, Chris Esguerra, M.D., Ian Johannson, Francine Lester, Katie-Elyse Turner. Amy Scribner, Michelle Heryford

Staff Absent:

1.0 Call to Order – The meeting was called to order at 12:32 pm by Ms. Andrade-Zuniga.

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

3.0 Approval of Meeting Summary for August 9, 2021 – The meeting summary was approved as presented**. Andrade-Zuniga/Graham: Second**
A roll call vote was unanimous.

4.0 Adopt a resolution finding that, as a result of the continuing COVID-19 pandemic state of emergency, meeting in person would present imminent risks to the health or safety of attendees – Ms. Andrade made a motion to continue meeting virtually throughout the public emergency per AB 361, a measure recently enacted by the State. **Graham/Callagy: second**
A roll call vote was unanimous.

5.0 Preliminary Financial and Operational Report for the period ending September 30, 2021 – Mr. Ehrgood reviewed the financial report for Q3 of 2021. He reminded the group that the budgeted loss was anticipated to be $8.4M, instead HPSM is reporting a $2.2M loss. HPSM also recorded a $6.7M reduction to revenue this quarter for the CCI member mix risk corridor. At the last meeting Mr. Ehrgood spoke about the

unexpected “windfall” for the CCI duals eligible members due to lower than expected long-term-care (LTC) cost. He was asked if HPSM had to pay that money back. At the time he noted they did not. However, he has since learned that HPSM does not get to keep it all of it. The CCI rates assume that a certain number of members would be placed in an institution; if the number of members in an institution decreases, which is what HPSM has experienced, they still get paid that same higher blended rate, but will end up with less cost. In the recent past, HPSM has not had a situation where the risk corridor was triggered, this year it was triggered because the difference (LTC revenue versus cost) was significant.

He briefly explained the CCI Member Mix Risk Corridor and how the rates are set for dual eligible members. The Medi-Cal portion is basically one blended rate that assumes a mix about the population. For example, they assumed that 7.8% of the population (for full dual non-CMC) would be institutional, which historically hasn’t changed much, but during COVID it did. The blended rate method creates an incentive for the health plan to move members out of the institutional category and out into the community. When that's done in smaller, incremental ways, HPSM benefits because the rate stays the same, but costs go down. But when it's done in an excessive way, which HPSM experienced this year, the benefit to the health plan ends up being larger than the state wants us to benefit financially. The way the risk corridor works, HPSM gets to keep 100% of the first 2.5% and will have to return 50% of anything over that, which should come to about $9.2M for the year. HPSM has recorded $6.7M of the $9.2M in September, representing 9 of the 12 months.

Mr. Ehrgood then moved to healthcare costs, first highlighting cost differences by line-of-business on a PMPM basis, noting the LTC savings for the CCI (dual) populations. He then highlighted full dollar variances noting healthcare cost variances that had revenue offsets.

Lastly, he summarized the surplus or deficit for each LOB compared to what was budgeted, and then summarized the take-aways for the meeting. There was a question about LTC. Specifically, if HPSM has studied the trends across the county and

the quality-of-care impacts of members being discharged to home instead of a nursing home? Mr. Ehrgood noted that traditionally it is hard to get members who are institutionalized out, even if they don't need to be there, as they often have nowhere to go. However, the pandemic changed this dynamic with fear of COVID in nursing homes. Ms. Altman reminded the group about the Nursing Home Collaborative that HPSM implemented about a year before COVID hit. Part of LTC payments now depend on quality, and the collaborative is trying to enforce that message. She also noted that the nursing home collaboratives helped during the pandemic with the creation of Centers of Excellence (COE's). These facilities were better prepared to deal with outbreaks and isolating patients. However, there is a need for more conversations to assist in providing a more supportive environment for patients and their families and to ensure that HPSM members are at the appropriate place. Commissioner France stated that the Program of All-inclusive Care for the Elderly (PACE) has helped tremendously noting the 80% lower COVID rate in nursing homes attributed to the program. He would like the full Commission to explore approving a PACE option in our county and would like to bring an overview of the program to an upcoming Commission meeting. The committee approved the report as presented.

Graham/Callagy: second.

A verbal roll call was unanimous.

6.0 Report from the Compliance Department – Mr. Johansson provided a report from the Compliance Department. There was a notice of non-compliance from the Centers of Medicare & Medicaid Services (CMS). The HPSM formulary uploaded a formulary change late last year which was actually for this year. It's since been corrected and a warning letter was sent there was no negative impact to the health plan. There were three grievance issues regarding timeliness. HPSM was fined $5K for each incident by DMHC. However, Magellan, the vendor for behavioral health therapy (BHT) paid $10,000 because it was discovered that they caused the timeliness issue in two of those cases. There was also a timely access issue, HPSM had difficulty placing a beneficiary with a speech therapist within the DMHC guidelines. HPSM received a $10K fine. There was also a privacy breach case at Kaiser. They had transposed demographic information for two members, information was sent for one beneficiary to another beneficiary. In this case, Kaiser takes the lead. They do all the investigation

and corrective actions, and then they simply give HPSM a notification of what happened so that they are aware. HPSM will then do follow up reporting to the Department of Health Care Services.

7.0 Other Business – There was no other business.

8.0 Adjournment – The meeting was adjourned at 1:33 pm by Ms. Andrade-Zuniga.

Respectfully submitted:

M. Heryford

M. Heryford
Assistant Clerk to the Commission

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Proposed Meeting Schedule

Finance-Executive Committee 2022

February 28, 2022	(Q4 2021 Financials – Preliminary)
March 28, 2022	(2021 Financial Audit Review)
May 9, 2022	(Q1 2022 Financials)
August 8, 2022	(Q2 2022 Financials)
November 7, 2022	(Q3 2022 Financials)
December 5, 2022	(2023 Proposed Budget)

DRAFT

HEALTH PLAN OF SAN MATEO
CONSUMER ADVISORY COMMITTEE MEETING
Meeting Minutes
Thursday, October 28, 2021
****Video Teleconference****

Agenda Item: 4.3
Date: December 8, 2021

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

Committee Members Present: Amira Elbeshbeshy, Rob Fucilla, Judy Garcia, Marmi Bermudez, Hazel Carrillo, Gloria Flores-Garcia, Ricky Kot
Committee Members Absent: Mary Pappas, Cynthia Pascual
Staff Present: Pat Curran, Gabrielle Ault-Riche, Colleen Murphey, Karla Rosado-Torres, Charlene Barairo, Nicole Ford, Michelle Heryford
Staff Absent: Maya Altman, Chris Esguerra, M.D., Richard Moore, M.D., Keisha Williams

1.0 Call to Order/Roll Call: The meeting was called to order at 12:02 pm by Ms. Elbeshbeshy.

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

3.0 Approval of Meeting Minutes for August 19, 2021: The August 19, 2021, minutes were approved as presented. **Kot/Second: Flores-Garcia. A roll call vote was unanimous.**

4.0 AB 361: Mr. Curran informed the committee about AB 361 which basically says the extension of the ability for public bodies to meet virtually will extend past October 1, 2021. It requires the committee to make a motion and approve the extension to continue to meet virtually. The motion passed. **Kot/Second: Flores-Garcia**. **A roll call vote was unanimous.**

5.0 HPSM Operational Reports and Updates

5.1 CEO Update: Mr. Curran provided an update on behalf of Ms. Altman.

5.1.1 He updated the group on the Pharmacy Carveout, in which HPSM members will be receiving their Medi-Cal (MC) pharmacy benefits through the State and their contractor Magellan. There continues to be transition work. Members will continue going to the pharmacies they see now. HPSM is concerned about the transition because of the volume of phone calls HPSM currently receives about prescription refills and the staffing Magellan will need to support these inquiries state-wide. Ms. Ault-Riche said that after the carveout complex issues will be forwarded to the pharmacy and CC teams, who will have access to a medical liaison at MediCalRX. Mr. Kot asked what would happen to the HPSM pharmacy team after January 1st. Mr. Curran replied that since the carveout will only impact the Medi-Cal line of business (LOB), the pharmacy team will continue their current work for all other lines of business. They will also get more involved with some of the coordination aspects of medical pharmacy such as injectables. Ms. Valdez asked if the Human Services Agency can still refer clients to HPSM for pharmacy related issues. Ms. Ault-Riche said they will be expected to reach out to Magellan directly for any pharmacy related issues, as HPSM will only step in for escalated or complex issues.

5.1.2 Mr. Curran reminded the group about HPSM Dental, the dental program being implemented on January 1st. This is a six-year pilot program. The short-term focus is on transition and continuity. If members are getting care now, they will continue to see their dentist whether that dentist is in the network or not. The goal is to try to remove barriers for the first three months or more. Over time they hope to increase access. Notification letters have been sent to members already and will be sent 90-, 60-, and 30-days before the January 1st transition.

5.1.3 The committee discussed ways to provide outreach and assistance to members about the new programs before implementation. Mr. Curran noted that for the dental program, ideally members should contact their current dentist to see if they will be participating. There isn't much that members can do beforehand about the pharmacy carveout besides continuing to get their medications from their current pharmacist. Members will not need to change their pharmacy or get new ID cards. Consumer advocates have noted that they are seeing many questions from members about the forms being sent to them. Ms. Ault-Riche asked the group to please let her know when there are questions about materials disseminated. The feedback is helpful and will guide efforts to simplify notification letter and forms. The Marketing and Communications Department (MARCOM) has created a user-friendly booklet about the dental benefit that will include key information. It is slated to be released in December. Dental providers will be listed on the electronic directory effective January 2021.

5.1.4 Mr. Curran also noted that there have not been any significant changes from the State in terms of disenrolling people. This is a looming concern but there doesn't seem to be any coverage changes scheduled for January 1, 2021. He also spoke briefly about CalAIM, a multi-year initiative by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program, and payment reform. Mr. Curran noted that this will mean more in-depth care coordination.

5.1.5 He advised the group that this is a very busy time for regulatory work with audits and accreditation work going on behind the scenes at HPSM. He ended by reminding the committee about Ms. Altman's retirement at the end of the year.

5.2 CMO Update: Chief Medical Officer, Chris Esguerra was not present, but he provided a written statement: "We at HPSM are busy with a lot of implementations for January 1, 2022. CalAIM integrates and acknowledges addressing social needs of members with high level of need. Our dental integration starts 1/1/2022, marking local, integrated coverage of dental benefits for Medi-Cal. Unfortunately, pharmacy will be carved out to the state starting 1/1/2022."

5.3 Provider Services: Ms. Murphey provided an update on several key changes related to the provider network and to vaccination rates.

5.3.1 She went over HPSM's vaccine efforts. Overall, vaccine rates in San Mateo County are very high, though the rate of members vaccinated lags by about 20 points. HPSM has recently launched a vaccine incentive program for Primary Care Providers (PCPs) with funding provided by the State. There are several reasons member vaccine rates are lower such as vaccine hesitancy, language, transportation, and information barriers. They are working with Legal Aid and Wider Circle as well as individual providers to act as trusted messengers to build vaccine confidence with members. They will provide dedicated funding to all participating PCPs. Many of the large clinics are vaccinators already, but a lot of the solo practitioners are not registered yet. It's an involved and expensive process, so HPSM is providing some funding to help with that. There are dollars that PCPs can receive for getting members vaccinated and the funding is flexible and can be used in whatever way they feel is most effective. Ms. Murphey offered to share some resources with the group.

5.3.2 She also spoke about HPSM's network of PCPs. A growing number of PCP's have retired or are nearing retirement, which is a big area of focus. Provider Services are working on trying to expand capacity with some of the larger providers and are in active conversations now about adding a new primary care location to an existing provider who will be able to handle about 100 more members.

5.3.3 Ms. Murphey informed the group about the transition of the Home Advantage benefit which is focused on members that have five or more chronic conditions. They hoped to expand the program. A Request for Proposal (RFP) was done, and Landmark, the current provider, was asked to participate in that along with other providers. The decision was made to contract with a new provider called Upward Health. They will begin transitioning in March of 2021.

5.4 Grievance and Appeals: Ms. Ault-Riche reviewed the Grievance & Appeals (G&A) report.

5.4.1 The Medi-Cal Rate of Complaints for Q3 is within the goal; CA was slightly over the goal as was HealthWorx (HW). HW numbers are small which makes any change look significant.

5.4.2 Timeliness goals were met for all G&A categories.

5.4.3 There were significant changes in the number of 24-hour resolutions. These are calls in which members express dissatisfaction, but the Call Center is able to find a solution during the call or within one business day. Resolutions related to medical services decreased in Q3 but those related to prescription drugs doubled. The decrease on the medical side appears to be related to increased access to transportation. When medical offices opened after the height of the pandemic, the demand for rides significantly increased. At the same time there was a nationwide shortage of Uber drivers, who are one of the main transportation suppliers for the benefit, which lead to delays in members receiving rides and a higher volume of 24-hour resolution calls. HPSM has been working closely with their transportation vendor to address this issue. The decrease in calls indicates improvement in transportation timeliness. 24-hour resolutions related to pharmacy issues, however, increased as did claims rejections by the pharmacy team. This could be related to the fact that before the public health emergency members needed to use 75% of their medication supply before getting more. This restriction was loosened to 50% at the beginning of the pandemic to ensure members had sufficient medication supplies. HPSM recently reverted to the 75% threshold, which may have led to the increase in pharmacy-related calls.

5.4.4 The overturn rate on prescription drug appeals decreased and is now at 49%, whereas previously 69% of pharmacy appeals were getting overturned. The Pharmacy Services team is investigating this change more closely to see if they can identify trends.

5.4.5 There were no complaints filed with the Complaints Tracking Module (CTM), which are complaints that members file directly with CMS.

5.4.6 Medi-Cal grievance and appeals rates are stable. The percentage of quality-of-care grievances increased, which has been referred to HPSM's Medical Directors and Quality team to review for trends.

5.4.7 Kaiser grievances doubled from Q1 to Q2 and again from Q2 to Q3. HPSM has asked Kaiser to do a root cause analysis to identify the sources of this increase. The majority of Kaiser grievances are about case management or care coordination. There was a question from the committee about how HPSM handles Kaiser G&A. Ms. Ault-Riche confirmed that HPSM only provides oversight of Kaiser and does not work grievances or appeals directly for Kaiser-assigned members.

5.4.8 Ms. Ault-Riche reviewed the number of PCP changes away from clinics and solo practitioners, which included 100 members asking to change their PCP in Q3 2021.

5.5 Member Services: Ms. Ault-Riche reviewed the Medi-Cal portion of the Enrollment and Call Center report, and Ms. Barairo reviewed the CareAdvantage section of this report.

5.5.1 Enrollment continues to trend up because of the hold on dis-enrollments. There are fewer new Medi-Cal enrollments this year than there were at the same time in 2020, which is likely an indication that they are reaching saturation of people who qualify for Medi-Cal in San Mateo County. The ACE line of business has a similar trajectory.

5.5.2 Calls to Member Services were up for much of the year but have since stabilized. Member Services anticipates seeing the call volume increase again as the transitions related to HPSM Dental, CalAIM, and the Pharmacy Carveout approach. Member Services is in the process of hiring additional call center staff and have recently hired a Call Center Supervisor.

5.5.3 Call center answering goals were met for August and September. Call abandonment rates are very low at 1-1/2%. Representatives in the call center have three of their calls selected per month and reviewed for call quality; for Q3, 95% of the calls that were reviewed met the quality standards. There were five calls that did not meet the standards, and those representatives received one on one coaching. Member Services has also started refresher trainings at staff meetings in which they review scenarios and different opportunities to help the call center reps stay current.

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

5.5.5 Ms. Barairo reviewed the CareAdvantage portion of the report. In Q3 CareAdvantage enrolled a total of 255 members; 185 were new members and 70 were re-enrolled. There were also 245 dis-enrollments. The top three reasons for dis-enrollment are moving out of the area, enrolling in a new plan, and passing away. HPSM leadership is evaluating how to remain competitive in the market, as other Medicare Advantage plans are

emerging in San Mateo County. The hope is that going forward, signing on with other health plans is not one of the top three reasons for leaving the plan.

5.5.6 The CareAdvantage team is working with San Mateo County HICAP to get HPSM members qualified and enrolled in the Qualified Medicare Beneficiary program (QMB). In January they mailed letters to 901 members. Some members qualified for free Medicare without using QMB. They now have 139 members getting free Medicare Part A through QMB and 50 of those are newly enrolled in CareAdvantage.

5.5.7 The CareAdvantage Call Center received 5,650 calls in Q3 and answered 93% of those. In Q3, they answered 86% of calls in 30 seconds, which is low compared to previous quarters but still meets the regulatory goal of 80%. The decrease in answer time is the result of CareAdvantage Navigators answering phones without the assistance of the Enrollment/Disenrollment team as they adjust workflows. The abandonment rate was at 2% and 97% of monitored calls in Q3 met the quality standards. These are both within goal.

5.5.8 The CareAdvantage Unit also hired a new CA Navigator in May. There are no proposed actions at this moment as all medical and DHCS requirements were met.

6.0 New Business: Proposed 2022 Meeting Dates: Ms. Ault-Riche reviewed the proposed meeting dates for 2022. Meetings will continue to be quarterly on the third Thursday of the month. The proposed dates for 2022 are January 20, April 21, July 21, and October 20. The meeting dates were approved as presented. **Flores-Garcia/Second: Bermudez. A roll call vote was unanimous.**

7.0 Adjournment: The meeting was adjourned at 1:17 by Ms. Elbeshbeshy.

Respectfully submitted:

M. Heryford

M. Heryford
Assistant Clerk to the Commission

AGENDA ITEM: 4.4

DATE: December 8, 2021

DRAFT

Health Plan of San Mateo
Cal MediConnect Advisory Committee
Friday, October 15, 2021 – 11:30 p.m.
Meeting Summary
-Virtual Meeting via Microsoft Teams-

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

Committee Members Present: Art Wolf, Beverly Karnatz, Gay Kaplan, Teresa Guingona Ferrer, Evelina Chang, Lisa Mancini, Kirsten Irgens-Moller, Ligia Andrade Zuniga, Dr. Darlene Yee-Melichar, Ricky Kot.

Committee Members Absent: Claire Day, Amira Elbeshbeshy, Nina Rhee, Diane Prosser, Sharolyn Kriger, Pete Williams.

Staff Present: Maya Altman, Pat Curran.

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.

3. Approval of Minutes

Motion to approve the minutes for July 16, 2021, were approved as presented: Ligia Andrade Zuniga / second: Teresa Guingona Ferrer. Approved unanimously.

4. Adopt a resolution finding that, as a result of continuing COVID-19 pandemic state of emergency, meeting in person would present imminent risks to the health or safety of attendees

Ms. Altman explained that the Health Plan of San Mateo as the San Mateo Health Commission operates under the jurisdiction of the San Mateo County Board of Supervisors and are subject to the Brown Act with our public meetings. During the pandemic, the Governor signed an Executive Order allowing flexibility to meet virtually. That Executive Order expired on September 30th but subsequently legislation passed signed by the Governor giving public bodies the opportunity to continue meeting virtually. The Board of Supervisors adopted a

resolution on September 28th which must be renewed every 30 days. This resolution endorses the findings that there is still a risk of transmission of the COVID virus and they will continue to meet virtually. In addition, they recommend other commissions and committees under their jurisdiction continue meeting virtually. The San Mateo Health Commission adopted a similar resolution and asking committees to adopt this as well.

Motion to approve the resolution to continue to meet virtually at this time. Gay Kaplan / seconded: Beverly Karnatz. Approved unanimously.

5. Approval of 2022 committee meeting dates

Ms. Kaplan announced the dates proposed for 2022:

January 21, 2022
April 15, 2022
July 15, 2022
October 21, 2022

All were in favor of these dates.

6. State/CMS Updates – Ms. Altman reported the following:

a. Governor Appointments

- Kim McCoy Wade – Ms. Wade was the Director of the Department of Aging to now be a Senior Advisor on Disability and Aging issues. This is a cabinet level position and will be a peer of the Secretary of Health and Human Services, Dr. Mark Ghaly. This was one of the main recommendations from the Master Plan for Aging Stakeholder Advisory Group because of the fragmentation of programs for people with disabilities and older crossing various agencies and departments that there was a need for strong leadership position to integrate these programs.
- Susan DeMarois has been appointed to head the California Department of Aging. She was a member of the Master Plan as Director of Policy for the Alzheimer Association in California.
- Claire Ramsey has been appointed as the Chief Deputy Director for Disability, Adults and Housing Integration at the California Department of Social Services. Claire comes from this area, was the representative on this committee for Legal Aid when the CMC Advisory Group began and is an excellent advocate and attorney.

b. MSSP (Multi-Purpose Senior Services Program) Update

Ms. Altman explained that before CMC, the goal was for health plans to integrate the MSSP program. This integration was a success. Ricky Kot is the Director of this program. MSSP unit works closely with HPSM Care Management Team and the IHSS

group for intensive Care Management for at risk people in the Nursing Home levels of care. This program allows for the purchase of non-traditional services such as respite care and home modifications. The MSSP site association asked to be pulled out of the CCI health plans requiring disintegration and the state went out to bid for the program. Fortunately, a compromise with state was reached to transition this program into the Enhanced Care Management in the new CalAIM program that pays for intensive care management. This will require plans to contract with counties, which HPSM already has in place, and work with community based organizations to provide some face to face visits. This creates a loss of funding loss to HPSM but it is the right thing to do.

Ricky Kot stated that this transition will result in no change in benefits for the members. The county is working with HPSM on the continuation of case management and the purchase of services.

7. HPSM Updates

a. Vaccine Incentive Program

Mr. Curran reported on the COVID vaccinations:
HPSM has been involved in substantial work with the providers, members, and county health. The state used various methods to deploy vaccine and vaccine strategies with a focus on equity and to provide more vaccinations, but disparities have been identified throughout the state within the Medi-Cal population. Because of this, the state has put substantial funding into the Vaccine Incentive Program through health plans. There is a gap between the general population in San Mateo County and the Medi-Cal population. The county has a 90% vaccination rate and the about 65% of the Medi-Cal population has been vaccinated. This 25% differential is fairly consistent around the state.

There is a small percentage of funding for an incentive program to get started and a larger portion related to outcomes based on closing the gap on the vaccination rate. He described the three areas of focus:

- Providers – a smaller amount of incentive dollars will go to providers who become vaccinators and submit a plan to accomplish this within their office.
- PCP Clinics – will receive a larger outcome-based incentive of $60 for every member assigned to the clinic that is vaccinated between September 1st through March 1st. He explained they can develop their own plan to accomplish this and patients may receive the vaccination anywhere. This incentive is to leverage PCPs to outreach to their patients who have not yet been vaccinated.
- Community based organizations
  – Legal Aid is focusing on educating people to dispel the fear in the community about their ability to get the vaccine regardless of immigration status.

- Wider Circle will focus peer to peer outreach, providing them with a list of names of individuals, many of whom are CMC members needing the vaccine.

Mr. Curran explained after exploring many opportunities, the health plan has chosen to use these resources realizing their ability to effectively outreach without needing additional infrastructure.

Mr. Wolf asked how the booster shots will play into this incentive program. Mr. Curran explained that this program focuses on the unvaccinated people. Ms. Altman added this program was developed before the booster shots became available. She stated there are about 30,000 HPSM members that have not been vaccinated at all.

Ms. Kaplan asked about the flu vaccine. Mr. Curran replied that there is outreach done by HPSM but is not done part of this program. Ms. Kaplan said she understands people can get both vaccines on the same day.

b. Changes to Medi-Cal Effective January 2022: Enhanced Case Management, Community Supports, and Medi-Cal Rx

Ms. Altman reported the changes effective January 1, 2022:

a. **Dental Program**
   Staff is being hired for this new program. The San Mateo Health Commission has formally approved the program. The rates have been received from the state that are acceptable.
b. **Cal MediConnect -**program changes within CalAIM
c. **Pharmacy Carve Out**
   This will not affect the CMC members because they are under Medicare but will affect all Medi-Cal members. They will now need to go to the state for approval of medications. HPSM will do its best to help members but will not be the administrator of these benefits as before. Members will be directed to a state-wide call center. She expressed concerns about the many calls the health plan currently receives from members who are trying to get their medications at the pharmacy and how these issues will be resolved when this transition takes place. Mr. Wolf asked what the state is doing to help members go through this transition. Ms. Altman replied that the state is sending notices to members but is concerned most people won't pay attention until they are directly impacted. Mr. Curran said that members can still go to the same pharmacy and the same medications will be covered but we know there are instances where people are in an urgent need, and currently we resolve the issue.

c. D-SNP Transition Update

Mr. Curran spoke about the transition of the CMC program to a Duals Special Needs Program (D-SNP) in January 1, 2023. He will ask Karla Rosado-Torres, who is leading this effort, to present information on this transition at a future meeting. He explained how the health plan administered a D-SNP from 2006 through 2014 through CMS and will return from the current three-way agreement between CMS, State, and health plan back to this D-SNP and will have the direct relationship as a D-SNP with CMS. This transition will involve a lot of behind the scenes work operationally. An application and approval including an annual financial bid process will have to take place. This should be seamless to the members but for staff it will be a significant undertaking for policies and procedures, documentation, and regulatory requirements. This will also revert the health plan back to the Medicare star rating system which is the quality rating system that is used by CMS. This is a significant function in running a Medicare plan and will involve a lot of planning.

Ms. Altman commented that the health plan is in a good position having run the Cal MediConnect program and having operated the D-SNP for several years in the past. Though the program keeps evolving, the health plan has been involved in this work and the state is now requiring all health plans in every county to become a D-SNP. For HPSM, we will be required to begin in 2023 but others will be required to go live in 2025 or 2026. This will be a significant undertaking, especially for those who have not been involved before. She expressed her hope that the local health plans will step up to get involved in these D-SNP plans because if they do not, the commercial health plans in the state that contract for Medi-Cal know how to do this will and she feels there are advantages to the community-based plans such as HPSM.

Mr. Wolf asked what members can expect in the way of communications and information during the upcoming open enrollment period. Mr. Curran responded that each fall members are inundated with information from every Medicare Advantage plan, including HPSM, to request members to join their plan. Ms. Altman commented that people sometimes get signed up by Medicare Advantage Plans that are duals but the member ends up paying more than they have to and some people will come back to CareAdvantage after learning this. Because they are on Medi-Cal, they can change quarterly with the D-SNP plan and don't have to wait for open enrollment. This is why HICAP is so critical as an objective third party explaining the advantages to those who are dual eligible of the various plans. She added that HICAP needs to be expanded but is mainly run by volunteers doing this work. Mr. Wolf asked if the health plan works with private brokers. Ms. Altman explained the health plan has its own marketing staff that are licensed brokers and do outreach to members.

Dr. Yee-Melichar asked about the effect on their medication prescription coverage in this transition. Mr. Curran asserted that it will not be affected.

d. Maya's Retirement

Ms. Altman stated that she is retiring at the end of this year and this will be her last meeting officially with this group. Gay Kaplan invited her to join us in January again. Ms. Altman stated she will miss everyone very much. CMC and programs for this population is very near and dear to her and is one of the reasons she took this job at the health plan. She saw the integration efforts in the 1990's with the Long-Term Services and Supports with Medical services offered by the health plan. It is exciting to see the progress in these areas.

Ms. Kaplan thanked Ms. Altman for all her efforts over these years, making these ideas a reality for the residents of San Mateo County and it is an amazing gift she has given them.

Mr. Wolf asked about future endeavors. Ms. Altman express her interest in the programs such as CMC that supports the older and disabled population. She is and will continue to serve on the board of HomeBridge.

Ms. Karnatz expressed her appreciation and on behalf of Human Good. The health plan has been a model to them for their efforts in other states and Ms. Altman has specifically been mentioned at their national convention.

Dr. Yee-Melichar wanted to thank Ms. Altman for all her efforts and wished she had more time to have worked with her through this group. She looks forward to seeing her at the HomeBridge meetings and elsewhere as well. She wanted to formally and officially recognize her through this group for all of her years of work.

8. CCI Ombudsperson Report (Legal Aid)

Ms. Chang reported:

- Eligibility for the undocumented population over 50 years old in Medi-Cal has a target implementation date of May 2022. They received clarification that IHSS is covered and HCBS covered under this eligibility.
- The change in the income level of the Asset Test is targeted for July 2022 going from $2,000 to $130,000. Elimination is targeted for January 2024.
- The moratorium on Medi-Cal negative actions, we do not have any updates if it will continue beyond the end of 2021.

- Spousal Impoverishment – the County has a tentative refresher training in the next quarter and will watch for updates about that.

9. LTC Ombudsperson Report

Ms. Irgens-Moller reported:

- Ombuds staff are now entering all facilities.
- Hillcrest in Redwood City, a 15-bed board and care facility with mostly behavioral health residents is closing at the end of November and they are concerned what will happen with these people. Behavioral Health is in the process of relocating the residents. It seems that the owner is retiring and can make a lot of money by selling the property. Ms. Altman commented that the state budget includes significant funding for the acquisition and rehabilitation of RCFEs and it is so critical to keep the facilities we have. There was discussion about investing in properties that could be a good RCFE site. Ms. Altman stated that Claire Ramsey who is the Chief Deputy Director for Disability, Adults and Housing Integration at the California Department of Social Services may be a good person to contact regarding possible real estate opportunities. Ms. Mancini added that the county is also interested in purchasing and she could be a good person to contact for possible RCFE site opportunities, as well as Amy Scribner, Population Health Director for the health plan.
- Residents are complaining that they think staffing is low but they have not been able to verify that at this point. Ms. Kaplan stated there was an article about how there is low staffing and licensing has not been out to the facilities. Ms. Irgens-Moller stated they are concentrating on the mitigation surveys rather than the regular annual surveys. They have been concentrating on infection control during COVID. As well, the issue is that families have not gone in so they haven't been able to make reports which means there has not been as many complaints from families and residents.

10. Questions about reports distributed prior to meeting.

a. HPSM Dashboards

Ms. Kaplan opened the floor for any questions on the reports distributed. She asked about the HRAs and ICPs. Ms. Altman explained that the health plan uses a vendor, Independent Living Systems (ILS) and it may be time to look closer to the process. Staff is looking into ways to incorporate more staff into performing these HRAs. It was noted that we are below the state average with the HRAs so Ms. Scribner and staff are looking at this closely and will bring more information to the January meeting.

Dr. Yee-Melichar asked about the Enrollment Specialist Dashboard that is listed to be presented. Ms. Altman stated that we heard that the report was not ready and will be brought to the next meeting. Mr. Curran shared that people are not dropping off Medi-Cal which is good, and the numbers are staying up. We are continuing to enroll

people so overall enrollment is increasing mostly due to the negative action. Also, we continue to track the churn in the plan, and how we can prevent it.

Ms. Altman talked about the nursing home utilization for the CMC members but not for all our members. Overall, the number is down which is unusual because we are usually scrambling to find beds for people. We are hearing from providers like Seton Coastside has 20 beds available. We will watch to see how long this continues. She thinks families may be more reluctant due to COVID to place their loved ones in nursing homes.

b. IHSS

Ricky Kot reported that have over 6,000 clients with IHSS comparted to 5,700 last year at this time so the numbers are continuing to grow. The Public Authority is trying to recruit more caregivers and providers. This is an ongoing challenge especially for the coast population. The state continues to change due to COVID, they have received a new instruction by November 30th all IHSS caregivers must show proof of vaccination. However, it is not clear who is responsible for monitoring this. There may be penalties but this is also unclear who will receive this penalty. Ms. Altman stated that the consumer is in charge as the employer. Mr. Wolf asked about the funds coming into the County for IHSS, what percentage increase will be anticipated for hours or new people. Mr. Kot stated this is usually based on the realignment and previous two years experience to determine the budget but he was unsure how the additional funds will affect the hours. Ms. Altman added that the HCBS spending plan there are workforce enhancements for IHSS workers including additional pay but she does not know how this will translate into the local county, and this is also temporary under the American Rescue Act and these funds will need to be spent by March of 2024.

Mr. Wolf asked about the closure of Senior Focus and finding a new vendor. Ms. Altman has not heard any recent update. She commented on a family run Adult Day Health Care program based in Orange County. They were in the process of negotiating and hopes this will open up. Temporarily, people have been directed to Avenidas in Palo Alto and Coastside but we are hoping this new one will open when they are able to come back on site.

Ms. Zuniga commented on the vaccination policy for the providers, she knows the consumer is the employer, but it has been tough for people. Some people do not have the capacity to hold people accountable to having this documentation with the vaccine. Also, there are a lot of providers who do not want to be vaccinated. She added that there are not that many registry workers. People are falling through the cracks and are not getting the care they need. This has been a struggle in the past and it is getting worse. We do not have a robust workforce. When you call the people on the registry, they don't

want to do certain things. And, what do people do when they have more complex needs. Then, making sure they are vaccinated. All of this becomes very difficult for people in this community and how can we support these people who do not have the capacity to enforce this. She talked about the problems people have of just keeping track of their hours, violations that they receive, running out of hours, and they don't know how to manage their care. She spoke about some training, surveys, and so much education people do not have. Mr. Kot reported that 83% of IHSS providers have received at least one dose of the vaccination. Of course, the ideal would be that all would be fully vaccinated. We continue to outreach to providers to help those who may be indecisive to provide them more accurate information about vaccinations. Regarding identifying caregivers, this is an ongoing task.

11. Group Discussion: Suggestions from the committee for future in Lieu of Services/Community Support offerings

There was no other discussion at this time.

12. Adjournment

The meeting adjourned at 1:00 p.m.

Respectfully submitted:

C. Burgess

C. Burgess, Clerk of the Commission

MEMORANDUM

AGENDA ITEM: 4.5

DATE: December 8, 2021

DATE: December 8, 2021

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer
Ian Johansson, Chief Compliance Officer

RE: Approval of Compliance Policy CP.000 – 2022 Compliance Program; and
Approval of Compliance Policy CP.026 – 2022 Code of Conduct

Recommendation

Approve HPSM Compliance Program document for 2022 - Compliance Policy CP.000; and approval of the Code of Conduct document for 2022 - Compliance Policy CP.026.

Background

The Health Plan of San Mateo (HPSM) values the contribution of all employees, commissioners, committee members, and contracted business partners toward the goal of providing the highest possible quality of services to its members and providers.

This Compliance Program defines the practices and policies that demonstrate HPSM's compliance with state and federal health care compliance requirements.

The Code of Conduct is created in accordance with state and federal requirements to provide guidance in following the ethical, legal, regulatory, and procedural principles that are necessary for maintaining high standards. This document serves as a guide for complying with HPSM's internal policies and procedures as well as with all applicable laws and regulations.

Discussion

These policies and corresponding documents are reviewed annually. Recommendations for revision or renewal are made by the Chief Compliance Officer and the Compliance Committee.

Compliance Program

The Compliance Program document was updated with HPSM's new Compliance Hotline number, 844-965-1241. The program document was reviewed and approved by the Compliance Committee on November 19, 2021. It is hereby submitted to the Commission for its annual review and approval.

Code of Conduct

The Code of Conduct was updated to 1) reflect HPSM's new Compliance Hotline number, 844-965-1241, and 2) allow for electronic provision of the Code of Conduct to Commissioners of the San Mateo Health Commission and its committees. This document was reviewed and approved by the Compliance Committee on November 19, 2021. It is hereby submitted to the Commission for its annual review and approval.

Fiscal Impact

The approval of these documents does not have a fiscal impact on HPSM.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF COMPLIANCE POLICY CP.000 – 2022 COMPLIANCE PROGRAM; and POLICY CP.026 – 2022 CODE OF CONDUCT

RESOLUTION 2021 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission and the Health Plan of San Mateo values the contribution of all employees, commissioners, committee members, and contracted business partners toward the goal of providing the highest possible quality of services to its members and providers; and
B. The Compliance Program describes how HPSM ensures compliance with all applicable laws and regulations; and the Code of Conduct serves as a guide for complying with HPSM's internal policies and procedures as well as with all applicable laws and regulations
C. These documents have been reviewed by the Compliance Committee and are submitted for Commission's review and approval for 2022.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves the attached 2022 Compliance Program and 2022 Code of Conduct for the Health Plan of San Mateo.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 8th day of December, 2021 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Ligia Andrade Zuniga, Chair

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

INTRODUCTION

The Health Plan of San Mateo (HPSM) is committed to conducting its business operations in compliance with ethical standards, contractual obligations, and all applicable state and federal statutes, regulations and rules, including those pertaining to Medicare, Medi-Cal, and operations of health plans. HPSM's compliance commitment extends to its own internal business operations as well as its oversight and monitoring responsibilities relating to its business partners and delegated entities that enable HPSM to fully implement all aspects of the Medicare benefits as well as HPSM's other lines of business.

The comprehensive Compliance Program described here incorporates the fundamental elements of an effective compliance program identified by the U. S. Department of Health and Human Services' Office of Inspector General (OIG), CMS regulations, and the Medicare Managed Care Manual and Prescription Drug Benefit Manual. Following these guidelines and good business practice, HPSM's Compliance Program:

- Assures compliance with and conformity to all applicable federal and state laws governing HPSM
- Assures compliance with contractual obligations
- Utilizes prevention, detection and correction tools for non-compliance
- Detects violations of ethical standards
- Combats fraud, waste and abuse
- Ensures effective education and training of staff; and
- Involves HPSM's Commission and CEO in the Compliance Program.

The Compliance Program is a continually evolving process that will be modified and enhanced based on compliance monitoring, identification of areas of business or legal risk, and as a result of evaluation of the program.

For purposes of this Compliance Program, unless otherwise stated, the term "All Employees" applies to all HPSM Employees, temporary employees, interns, volunteers, Commissioners, Contractors, and First Tier, Downstream, and Related Entities (FDRs). The Glossary, found in Appendix A, further defines these and other key terms used throughout this Compliance Program.

THE COMPLIANCE PROGRAM

This document addresses the fundamental elements of a compliance program. The Compliance Program establishes HPSM principles, standards, and Policies and Procedures regarding compliance with applicable laws and regulations, including those governing relationships among HPSM and federal and state regulatory agencies, participating providers, and Contractors. The Compliance Program is designed

to ensure operational accountability and that HPSM's operations and the practices of All Employees comply with applicable contractual requirements, ethical standards, and laws.

This Program was initially approved by HPSM's Chief Executive Officer (CEO) and HPSM's Governing Body, the San Mateo Health Commission/San Mateo Community Health Authority (Commission). It is reviewed annually by HPSM's Compliance Committee and the San Mateo Health Commission.

Key Elements of Compliance Program

The following are elements critical to HPSM's Compliance Program. Detailed descriptions of each area can be found below.

I. *Standards of Conduct, Policies and Procedures:* The Compliance Program outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to All Employees. HPSM compliance staff reviews new and modified standards on a regular basis, develops Policies and Procedures, and implements plans to meet contractual and legal obligations.

II. *Oversight:* The Compliance Program reflects a formal commitment of HPSM's Governing Body, the San Mateo Health Commission, which adopted this program. HPSM's Chief Compliance Officer, together with the Compliance Committee, oversees the Compliance Program's implementation, under the direction of the CEO. The Chief Compliance Officer and the Compliance Committee have the oversight and reporting roles and responsibilities set forth in this Compliance Program.

III. *Effective Training and Education:* The Compliance Program incorporates training and education relating to standards and risk areas, as well as continuing specialized education focused on the operations of HPSM's departments and its programs. HPSM communicates its standards and procedures by requiring Employees to participate in trainings upon hire as well as annual trainings.

IV. *Effective Lines of Communication:* HPSM has formal and routine mechanisms of communication available to All Employees, Providers, and Members. HPSM promotes communication through a variety of meetings and processes.

V. *Well Publicized Disciplinary Standards:* The Compliance Program encourages a consistent approach related to the reporting of compliance issues and adherence to compliance policies. It requires that standards and Policies and Procedures are consistently enforced through appropriate disciplinary mechanisms including, education, correction of improper behavior, discipline of individuals (suspension, financial penalties, sanctions, and termination), and disclosure/repayment if the conduct resulted in improper reimbursement.

VI. *Effective System for Routine Monitoring, Auditing, and Identification of Compliance Risks:* HPSM continues to implement monitoring and auditing reviews related to its operations and of those entities over which HPSM has oversight responsibilities. The Compliance Program and related Policies and Procedures address the monitoring and auditing processes in place to review the activities of HPSM, its providers, and Contractors. HPSM identifies risk areas through an operational risk assessment as well as by examining information collected from monitoring and auditing activities.

VII. *Procedures and Systems for Prompt Response to Compliance Issues:* Once an offense has been detected, HPSM is committed to taking all appropriate steps to respond appropriately to the offense and to prevent similar offenses from occurring. HPSM makes referrals to external agencies or law enforcement as appropriate for further investigation and follow-up.

APPLICABILITY

HPSM's Compliance Program applies to all HPSM products, including but not limited to: Medi-Cal, Medicare Parts C and D, HealthWorx and ACE.

CODE of CONDUCT

HPSM's Code of Conduct details the fundamental principles, values, and ethical framework for All Employees. The objective of the Code of Conduct is to articulate broad principles that guide All Employees in conducting their business activities in a professional, ethical, and legal manner. It is reviewed by the Compliance Committee annually. The Code provides guidelines for business decision-making and behavior whereas Compliance Policies and Procedures are specific and address identified areas of risk and operations.

The Code of Conduct and HPSM Policies and Procedures are available to all HPSM Employees from their time of hire via HPSM's intranet. As a condition of employment, HPSM Employees must certify within 14 calendar days of hire and annually thereafter that they have received, read, and will comply with HPSM's Code of Conduct. Commissioners will also certify that they have received, read, and will comply with these standards of conduct within 90 days of appointment and annually thereafter. All FDRs, including the Medicare Part D pharmacy benefits manager, are required to implement a Code of Conduct compliant with Chapter 21 of the Medicare Managed Care Manual, or utilize HPSM's Code of Conduct and disseminate it to their staff within 90 days of contracting with HPSM and annually thereafter. All managers are required

to discuss the content of the Code of Conduct with Contractors under their immediate supervision during contract negotiations for the purpose of confirming the Contractors' understanding of the HPSM's Code of Conduct. Contractors are encouraged to disseminate copies of HPSM's Code of Conduct to their employees, agents, and subcontractors that furnish items or services to HPSM and/or its members.

Review and Implementation of Standards

HPSM regularly reviews its business operations against new standards imposed by applicable contractual, legal, and regulatory requirements to ensure that All Employees operate under and comply with changing standards. HPSM develops Policies and Procedures to respond to changing standards and potential risk areas identified by HPSM, the OIG, CMS, DHCS, and DMHC. HPSM identifies risk areas through an operational risk assessment as well as by examining information collected from monitoring and auditing activities. These activities include internal reviews, contract monitoring, and external reviews of HPSM's operations by regulatory agencies. The Code of Conduct is reviewed annually by HPSM's Compliance Committee as are HPSM's compliance Policies and Procedures. Staff is informed of significant revisions annually, such as revisions that affect staff rights, responsibilities or job duties.

Compliance with Policies and Procedures

Policies and Procedures are written to help provide structure and guidance to the operations of the organization and ensure that HPSM stays current with contractual, legal, and regulatory requirements. HPSM Employees are responsible for ensuring that they comply with the Policies and Procedures relevant to their positions. At least annually, HPSM staff reviews and, as needed, updates Policies and Procedures. HPSM's Compliance Committee reviews and approves proposed changes and additions to HPSM's Compliance Policies and Procedures (a list of which can be found in Appendix B) and others as determined by the Leadership Team. Operational/Department Policies and Procedures are approved by HPSM Managers and Directors. These Policies and Procedures are set forth in HPSM's electronic Policies and Procedures Manual available to all employees through HPSM's intranet.

Compliance Policies and Procedures include the following:

- Commitment to comply with all federal and state standards
- Compliance expectations
- Guidance to employees and others on dealing with potential compliance issues
- Guidance on how to communicate compliance issues to appropriate staff
- Description of how potential compliance issues are investigated and resolved
- A commitment to non-intimidation and non-retaliation for good faith participation in the Compliance Program.

In addition, as part of HPSM's audit of FDRs, such as HPSM's pharmacy benefits manager, the FDRs must

certify that as a condition of employment its employees must comply with written policies and procedures and Code of Conduct.

Familiarity with Identified Standards

As indicated in the Code of Conduct, employees must be familiar with the standards related to potential risk areas for managed care organizations that relate to their job responsibilities.

OVERSIGHT

Governing Body

In its capacity as the Governing Body, the San Mateo Health Commission has the duty to assure that HPSM implements and monitors a Compliance Program governing HPSM's operations. The Chief Compliance Officer reports to the Commission on a periodic basis, but no less than annually. Reports include review of activities of the Compliance Program, results of internal and external audits, and reporting of other compliance-related issues.

Chief Compliance Officer

HPSM's Chief Compliance Officer is responsible for developing and implementing Policies and Procedures and practices designed to ensure compliance with Federal and State health care programs, including the Medicare Programs. The Chief Compliance Officer may only delegate tasks set forth in this Compliance Program to other HPSM Employees upon authorization from the CEO. The Chief Compliance Officer's job description is available upon request to the Human Resources Department.

The Chief Compliance Officer receives periodic training in compliance procedures and has the authority to oversee compliance and regularly reports on compliance activities to the Commission. Proper execution of compliance responsibilities and promotion of and adherence to the Compliance Program shall be factors in the annual performance evaluation of the Chief Compliance Officer.

The Chief Compliance Officer:

- Holds a full-time leadership level position at HPSM and reports directly to HPSM's CEO.
- Receives training in compliance issues and/or procedures at least annually.
- Has the necessary authority to oversee compliance.
- Serves as the Medicare Compliance Officer, in addition to Compliance Officer duties for all HPSM programs

- Oversees compliance standards and procedures.
- Submits reports to the CEO, the Compliance Committee, and the Commission regarding compliance issues.
- Reports compliance issues involving the CEO directly to the Commission.

The Chief Compliance Officer shall ensure that:

- The Code of Conduct and Policies and Procedures are developed, implemented, and distributed to All Employees.
- The Compliance Program is reviewed and updated if needed at least annually based on changes in HPSM's needs, regulatory requirements, and applicable law.
- HPSM Employee certifications confirming receipt, review, and understanding of the Code of Conduct are obtained at the time of hire (at new employee orientation) and annually thereafter.
- An appropriate education and training program that focuses on elements of the Compliance Program (including information on Medicare, Medi-Cal, and fraud, waste, and abuse) is implemented and provided to HPSM Employees and made available to Commissioners and Contractors, as appropriate. The Compliance Committee and the Commission are briefed on the status of compliance training.
- FDRs implement education and training for their staff involved in Medicare or Medi-Cal and that this training includes information about HPSM's Compliance Program.
- All data submitted to regulatory agencies are accurate and in compliance with reporting requirements.
- A work plan is developed to monitor the implementation and compliance with Medicare and Medi-Cal related Policies and Procedures.
- Marketing staff is aware of and follow the requirements for Medicare sales and marketing activities.
- Effective lines of communication are instituted, communication mechanisms such as telephone hotline calls are monitored, and complaints are investigated and treated confidentially (unless circumstances dictate the contrary) including any involving Medicare non-compliance or fraud.
- Inquiries and investigations with respect to any reported or suspected violation or questionable conduct including the coordination of internal investigations and investigations of FDRs are:
    - initiated timely and completed.
    - reported to the appropriate organization (DHCS, CMS or its designee, and/or law enforcement) as necessary
    - appropriate disciplinary actions and corrective action plans are implemented.
- Documentation is maintained for each report of potential non-compliance or fraud, waste, or abuse from any source including results and corrective action plans or disciplinary actions taken.
- Periodic reviews of the Participation Status Review process are completed with the Chief Human Resources Officer and other designated employees to ascertain that the process is conducted in accordance with HPSM Policies and Procedures.

- Compliance software and electronic files are maintained to support implementation of the Compliance Program.
- Each of the requirements of the Compliance Program has been substantially accomplished.

Compliance Committee

The Compliance Committee is responsible for overseeing the Compliance Program, subject to the direction of the CEO and the ultimate authority of the Commission. The Compliance Committee is chaired by the Chief Compliance Officer and meets on a quarterly basis. The Compliance Committee Charter identifies the responsibilities and membership of the Committee. HPSM maintains written minutes (as appropriate) of Compliance Committee meetings reflecting the reports made to the Committee and the Committee's decisions on issues raised (subject to applicable legal provisions concerning confidentiality.) The Compliance Committee Charter can be found in CP.001.

Managers / Supervisors

Managers/Supervisors must be available to discuss with each HPSM Employee under their direct supervision and every Contractor with whom they are the primary liaison:

- The content and procedures in this Compliance Program.
- The legal requirements applicable to Employees' and Contractors' job functions or contractual obligations, as applicable.
- That adherence to this Compliance Program is a condition of employment or contractual relationship.
- That HPSM shall take appropriate disciplinary action, including termination of employment or a Contractor's agreement with HPSM, for violation of the principles and requirements set forth in the Compliance Program and applicable law and regulations.

TRAINING

HPSM provides general and specialized compliance training and education, as applicable, to Commissioners and HPSM Employees to assist them in understanding the Compliance Program, including the Code of Conduct and Policies and Procedures relevant to their job functions. As a part of this process, all Commissioners and HPSM Employees are apprised of applicable state and federal laws, regulations, standards of ethical conduct and the consequences which shall follow from any violation of those rules or the Compliance Program.

Compliance and Fraud, Waste, and Abuse (FWA) Trainings

HPSM Employees are expected to complete compliance training within 14 calendar days of hire, and new Commissioners within 90 days of appointment to the HPSM Governing Body. HPSM Employees and Commissioners must complete compliance training annually thereafter.

New HPSM Employees receive a copy of the Code of Conduct during new hire compliance training and must attest that they have read and understood it. New Commissioners receive a copy of the Compliance Program and Code of Conduct upon appointment and annually thereafter.

Compliance trainings for HPSM Employees include information regarding:

- Health Insurance Portability and Accountability Act (HIPAA)
- Fraud, waste, abuse and neglect including the False Claims Act and the Fraud Enforcement and Recovery Act
- Compliance Program
- Code of Conduct
- Information on the confidentiality, anonymity, non-intimidation and non-retaliation for compliance-related questions or reports of potential non-compliance.
- Review of the disciplinary guidelines for non-compliant or fraudulent behavior.
- Review of potential conflicts of interest and HPSM's disclosure/attestation system.

HPSM Employees may receive additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Compliance training for Commissioners will focus on compliance and fraud, waste, and abuse.

Members of the Compliance Committee and other Leadership Team members are trained on how to respond appropriately to compliance inquiries and reports of potential non-compliance. This training also includes confidentiality, non-intimidation and non-retaliation against employees, and knowing when to refer the incident to the Chief Compliance Officer.

Federal guidance specifically requires that all FDRs receive general compliance training, and in light of this requirement, FDRs are informed of their obligation to provide compliance training to their employees. HPSM receives confirmation that its FDRs conduct their own compliance training for staff and downstream entities in accordance with CMS guidance as part of the annual FDR audit. FDRs that have met the FWA certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the training and educational requirements for FWA.

Documentation

Documentation requirements related to the training and education program are addressed in the following manner:

- Core annual training material topics are available through a web based tool. Core trainings include all-staff FWA, Compliance and HIPAA Privacy trainings. Confirmation of completion of assigned courses and post-test is documented through a web based tool and reviewed by the Chief Compliance Officer to ensure staff completes assigned trainings.
- Supplemental annual trainings, such as manager training, are conducted in-person, with sign-in sheets retained as evidence of training participation.
- Documentation of trainings for Commissioners is captured through roll-call at an ad hoc committee meeting.

All Compliance Program training documents are retained in accordance with HPSM's Document Retention Policy.

EFFECTIVE LINES OF COMMUNICATION

Effective lines of communication are established ensuring confidentiality between the Chief Compliance Officer, members of the Compliance Committee, HPSM managers and supervisors, HPSM Employees, Commissioners, and staff of FDRs. All Employees are encouraged to discuss compliance issues directly with their managers/supervisors or the Chief Compliance Officer. All Employees are advised that they are required to report compliance concerns and suspected or actual misconduct and violations of law.

The Chief Compliance Officer posts information such as the policies and procedures catalog (which includes the Code of Conduct as well as the Compliance Program) on HPSM's intranet, available to all HPSM Employees. Additional information can be posted as needed to update staff on changes in laws or regulations. The Chief Compliance Officer also informs Commissioners of any relevant federal and state fraud alerts and policy letters, pending/new legislation reports, updates, and advisory bulletins as necessary.

Establishment and Publication of Reporting Hotlines

All Employees have an affirmative duty under the Compliance Program to report all violations, suspected violations, questionable conduct or practices by a verbal or written report to HPSM to a supervisor or the Chief Compliance Officer. In the event any person wishes to remain anonymous, he/she may use HPSM's confidential hotline described below to report compliance concerns. The purpose of the hotline is to ensure that there is an effective line of communication for compliance issues between HPSM and its Commissioners, HPSM Employees, Contractors and/or members.

Compliance Hotline

HPSM has established a confidential Compliance Telephone Hotline (Compliance Hotline) for HPSM Commissioners, HPSM Employees, Contractors, Providers and Members and other interested persons to report any violations or suspected violations of law and/or the Compliance Program and/or questionable or unethical conduct or practices including, without limitation, the following:

- Incidents of fraud and abuse
- Criminal activity (fraud, kickback, embezzlement, theft, etc.)
- Conflict of interest issues
- Code of Conduct violations

HPSM currently uses a national hotline organization to administer its Compliance Hotline. The Compliance Hotline is accessible 24 hours a day, 365 days a year, excluding designated holidays (when callers will be routed to a voice mail message alerting them to call back during established hours of operation). A caller to the Compliance Hotline is initially greeted by a pre-recorded message that provides information regarding Compliance Hotline procedures and the caller's right to anonymity. Calls to the Compliance Hotline are not tape-recorded and will not be traced. The national hotline organization operator will ask the caller several questions relating to the reported issue, incident, etc. All reports are referred to HPSM's Chief Compliance Officer and investigated. Follow-up calls may be scheduled; however, information regarding the investigation and status of any action taken relating to the report may not be available to the caller.

The compliance hotline information is as follows: TOLL FREE COMPLIANCE HOTLINE (~~800~~844) ~~826~~965-~~6762~~1241.

HPSM publicizes the Compliance Hotline by appropriate means of communication to Commissioners, HPSM Employees, and Contractors including, but not limited to: e-mail notice and/or posting in prominent common areas, as well as on HPSM's intranet.

Confidentiality, Non-Intimidation and Non-Retaliation

HPSM takes all reports of violations, suspected violations, questionable conduct or practices seriously. Verbal communications via the Compliance Hotline and written or verbal reports to managers or supervisors or anyone designated to receive such reports shall be treated as privileged and confidential to the extent permitted by applicable law and circumstances. The caller/author need not provide his/her name.

HPSM's "Open Door" policy encourages HPSM Employees to discuss issues directly with their managers,

supervisors, the Chief Compliance Officer, other Leadership Team members, members of the Compliance Committee, or the CEO. These channels of discussion provide for confidentiality to the extent allowed by law.

HPSM maintains and supports a Non-Intimidation and Non -Retaliation policy which prohibits any retaliatory action against a Commission Member, HPSM Employee, or Contractor for making any verbal/written report in good faith. This includes qui tam relators who make a report under the federal or California False Claims Act.

Discipline shall not be increased because an Employee reported his or her own violation or misconduct. Prompt and complete disclosure may be considered a mitigating factor in determining an Employee's discipline. The non-tolerance for retaliation and intimidation is described in policy and reviewed in the annual compliance training. HPSM takes violations of the policy on non-intimidation and non-retaliation seriously; the Chief Compliance Officer reviews disciplinary and/or other corrective actions for such violations with the Compliance Committee, as appropriate.

Although Commissioners and HPSM Employees are encouraged to report their own potential wrongdoing, they may not use any verbal or written report in an effort to insulate themselves from the consequences of their own violations or misconduct. Commissioners, HPSM Employees, and Contractors shall not prevent or attempt to prevent, a Commissioner, HPSM Employee, or Contractor from communicating via the Compliance Hotline or any other mechanism. If a Commissioner, HPSM Employee, or Contractor attempts such action, he or she is subject to disciplinary action.

DISCIPLINARY STANDARDS

Conduct Subject to Discipline

HPSM Employees may be subject to discipline up to and including termination for failing to participate in HPSM's Compliance efforts. All new and renewing contracts include a provision that clarifies that a contract can be terminated because of a violation. The following are examples of conduct subject to enforcement and discipline:

- Failure to perform any required obligation relating to the Compliance Program or applicable law, including conduct that results in violation of any Federal or state law relating to participation in Federal and/or State health care programs.
- Failure to report violations or suspected violations of the Compliance Program or applicable law to an appropriate person or through the Compliance Hotline.
- Conduct that leads to the filing of a false or improper claim or that is otherwise responsible for the filing of a claim in violation of federal or state law.

Enforcement and Discipline

HPSM maintains a "zero tolerance" policy towards any illegal conduct that impacts the operation, mission or image of HPSM. Any employee or contractor engaging in a violation of laws or regulations (depending on the magnitude of the violation) may have their employment or contract terminated. HPSM shall accord no weight to a claim that any improper conduct was undertaken "for the benefit of HPSM". Illegal conduct is not for HPSM's benefit and is expressly prohibited.

The standards established in the Compliance Program must be fair and consistently enforced through disciplinary proceedings. These shall include the following:

- Prompt initiation of education to correct the identified problem.
- Disciplinary action, if any, as may be appropriate given the facts and circumstances of the investigation including oral or written reprimand, demotions, reductions in pay, and termination.

In determining the appropriate discipline or corrective action for any violation of the Compliance Program or applicable law, HPSM does not take into consideration a particular person's or entity's economic benefit to the organization.

All Employees should also be aware that violations of applicable laws and regulations could potentially subject them or HPSM to civil, criminal or administrative sanctions and penalties. Further, violations could lead to HPSM's suspension or exclusion from participation in Federal and/or State health care programs. Documentation of all actions taken will be done by the Chief Compliance Officer according to the guidelines set forth in the Compliance Program.

MONITORING and AUDITING

At the direction of the Chief Compliance Officer and/or Compliance Committee, HPSM's Compliance and Operational staff perform auditing and monitoring functions for the organization to ensure compliance with applicable law and the Compliance Program. They report, investigate and, if necessary and appropriate, correct, any inconsistencies, suspected violations or questionable conduct. The Chief Compliance Officer develops an auditing work plan that is approved by the Compliance Committee that addresses risks, including, but not be limited to, areas of risk identified in the OIG's Annual Work Plan for Medicare Managed Care, Medicare Administration, and Medi-Cal. Focused audits are conducted based on audit reports from HPSM regulators including DHCS, DMHC, and CMS. In addition, the Chief Compliance Officer develops auditing Policies and Procedures that are reviewed by the Compliance Committee.

Monitoring is an on-going process to ensure processes are working as intended. On-going checking and measuring can be performed daily, weekly, or monthly or on an ad hoc basis. Monitoring is be completed by department staff. Auditing is completed by independent compliance staff and is a more formal and objective approach to evaluate and improve the effectiveness of HPSM processes and to ensure oversight of delegated activities.

A risk assessment tool is used to conduct a baseline assessment of HPSM's major compliance and FWA risk areas. This includes Medicare business operations, such as marketing, enrollment, appeals and grievances, benefit/formulary administration, transition policy, utilization management, accuracy of claims payments, and oversight of FDRs. The risk assessment is completed annually.

Oversight of Delegated Activities

HPSM delegates certain functions and/or processes to FDRs. These include:

- Provider credentialing and re-credentialing at select facilities and for pharmacists
- PBM Pharmaceutical claims processing and aspects in the administration and delivery of the Medicare Part D benefit
- Mental health benefits, including claims processing and oversight of the grievance and appeals processes (for Medi-Cal, CareAdvantage, and HealthWorx lines of business)
- Transportation benefit for Medi-Cal and CareAdvantage CMC
- Grievances and appeals to Kaiser Permanente for those members assigned to Kaiser
- Imaging of claims

Contractors are required to meet all contractual, legal, and regulatory requirements and comply with HPSM Policies and Procedures and other guidelines applicable to the delegated functions. HPSM maintains oversight of these delegated functions and will conduct annual audits of delegated entities.

Oversight of Non-Delegated Activities

HPSM maintains oversight responsibility of the following activities that are not delegated to Contractors:

- Quality Improvement Program for Medicare and Medi-Cal lines of business
- Grievances and Appeals processes except as noted above
- Peer review process on specific, referred cases.
- Risk Management
- Pharmacy and drug utilization review as it relates to quality of care.
- Provider credentialing and re-credentialing, except as noted above

- Development of credentialing standards in specified circumstances
- Development of utilization standards
- Development of quality improvement standards
- Compliance

External Auditing for Pharmacy Benefits

As part of its work plan, HPSM developed a strategy to monitor and audit its pharmacy benefits manager and other entities that are involved in the administration or delivery of the pharmacy benefits, including Medicare Part D. HPSM seeks written assurances from its PBM that it has an adequate audit work plan in place that includes auditing of network pharmacies and reporting with respect to HPSM Members. HPSM receives audit reports on a regular basis. HPSM also seeks written assurances that the PBM has implemented corrective actions when appropriate. Contracts are amended as needed to ensure PBM compliance.

In addition, HPSM routinely generates a number of reports to aid in monitoring and oversight efforts. These reports include:

- Payment reports
- Drug utilization reports
- Physician prescribing reports
- Unusual utilization pattern reports

Finally, HPSM uses system edits to monitor the delivery of the prescription drug benefit. Examples of such edits are: controls on early refills, edits to prevent payment for excluded drugs, limits on the number of times a prescription can be refilled, and step therapy edits.

Internal Auditing

An annual auditing work plan is developed by the Compliance Department and includes:

- Internal audit schedule
- Audit report, including:
    - Audit objectives
    - Scope and methodology
    - Findings
    - Recommendations
- Audit staffing
- Approval, monitoring, and validation of corrective action plans

In developing the types of audits to include in the work plan, HPSM bases audits on the risk assessment to determine which risk areas will most likely affect HPSM. The Compliance Committee has input into the priority of the monitoring and audit strategy. In determining risk areas, HPSM reviews the annual OIG work plan, the CMS Prescription Drug Benefit Manual (Chapter 9), and resources developed by the industry that identify high risk areas in HPSM's programs and the health care industry.

The Chief Compliance Officer, Compliance Committee and business owners may ask the internal audit staff to conduct audits on specific topics not on the formal work plan should circumstances warranted such a review.

Finally, audits also may include follow up review of areas previously found non-compliant to determine if the corrective actions taken have fully addressed the underlying problem.

The work plan also includes a process for responding to all monitoring and audit results, including referral to appropriate agencies (e.g., CMS, the MEDIC, DHCS, law enforcement) when appropriate. All compliance actions taken will be tracked to evaluate the success of implementation efforts.

Compliance Program Effectiveness Audit

HPSM conducts annual effectiveness audits of its Compliance Program, the results of which are shared with the CEO, Compliance Committee and Commission. HPSM avoids self-policing through utilization of staff who do not report to the Chief Compliance Officer or other managers in the Compliance Department, or by outsourcing the audit to external auditors.

The HPSM Compliance Department maintains less formal measures of compliance program effectiveness, including internal and external audit results and a dashboard of reported compliance issues.

Audit Review

The Chief Compliance Officer submits regular reports of all auditing and corrective action activities to the Compliance Committee. When appropriate, HPSM informs the appropriate agency (e.g., DHCS, CMS or its designee including the appropriate MEDIC, or law enforcement) of aberrant findings.

PROMPT RESPONSE TO COMPLIANCE ISSUES

HPSM is committed to responding to compliance issues thoroughly and promptly and has developed policies to address the reporting of and responding to compliance issues. If an Employee becomes aware

of a violation, suspected violation or questionable or unethical conduct in violation of the Compliance Program or applicable law, the Employee must notify HPSM staff immediately. A Commissioner or Contractor should notify HPSM of a suspected violation or questionable unethical conduct by reporting the concern to the Chief Compliance Officer or CEO. Any such reports of suspected violations may also be made to the Compliance Hotline.

The Chief Compliance Officer refers compliance issues involving the CEO directly to the Commission. The CEO refers any issue that involves a Commissioner to the San Mateo Board of Supervisors.

HPSM maintains a Fraud, Waste and Abuse plan that defines the plan's approach to detecting, preventing and deterring fraud, waste and abuse. Significant fraud, waste and abuse issues are summarized to the Compliance Committee and a FWA Subcommittee of the Compliance Committee reviews potential cases of FWA to determine potential actions by HPSM, need for external assistance or determination that FWA has not occurred.

Reports of suspected or actual compliance violations, unethical conduct, fraud, abuse, or questionable conduct, whether made by Commissioners, Employees, Contractors, or third parties external to HPSM (including regulatory and/or investigating government agencies), in writing or verbally, formally or informally are investigated. These are subject to review and investigation by HPSM's Chief Compliance Officer and/or the Compliance Committee, in consultation with legal counsel.

Self-Reporting

HPSM makes appropriate referrals to the CMS or the MEDIC; DHCS Medi-Cal Managed Care Division's (MMCD) Program Integrity Section; DHCS Audits and Investigations; DMHC; other agencies, as appropriate; or law enforcement for further investigation and follow-up of cases involving FWA, following the self-reporting section of the policy on Fraud, Waste, and Abuse.

Participation Status Review and Background Checks

HPSM does not hire, contract with, or retain on its behalf, any person or entity that is currently suspended, excluded or otherwise ineligible to participate in Federal and/or State health care programs; and/or has ever been excluded from participation in Federal and/or State health care programs based on a Mandatory Exclusion. HPSM maintains policies on participation status for All Employees and providers.

Participation Status Review

HPSM reviews Commissioners, HPSM Employees and Contractors against appropriate exclusion lists to ensure that they are not excluded, suspended or otherwise ineligible to participate in Federal and/or

State health care programs. HPSM requires that potential Commissioners, Employees and Contractors disclose their Participation Status as part of the employment/contracting/appointment process and when Commissioners, Employees, and Contractors receive notice of any suspension, exclusion, debarment or felony conviction during the period of employment, contract or appointment. HPSM also requires those delegated to complete provider credentialing and re-credentialing that comply with Participation Status Review requirements with respect to their relationships with participating providers and suppliers. This review is conducted prior to employment or contractual engagement of a person or entity and monthly thereafter according to Participation Status Review Policies and Procedures.

Background Checks

HPSM has implemented additional Policies and Procedures relating to background checks for specified potential or existing Employees or Contractors as may be required by law and/or deemed by HPSM to be otherwise prudent and appropriate.

Notice and Documentation

HPSM and its Employees comply with applicable federal and state laws governing notice and disclosure obligations relating to Participation Status Reviews and background checks. Employees responsible for conducting the Participation Status Reviews and/or background checks shall record and maintain the results of the reviews and notices/disclosures and shall provide periodic reports to the Chief Compliance Officer.

DOCUMENTATION

The Chief Compliance Officer has established and maintains an electronic filing system for all compliance-related documents. These tools are used to:

- Manage all Policies and Procedures.
- Organize and manage contracts.
- Organize and manage agendas, minutes, and meeting materials for Compliance Committee meetings and the FWA Committee.
- Document compliance with the Department of Health Care Services Medi-Cal contract.
- Organize audit materials for regulators and provide web access to materials to regulators.
- Document incidents of potential fraud.
- Document internal audits and those of delegated entities.
- Complete staff attestations.
- Maintain Compliance training records.

Document Retention

All of the documents to be maintained in the filing system described above are retained for ten (10) years from end of the fiscal year in which the HPSM Medicare or Medi-Cal contracts expire or are terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary).

APPENDIX A

GLOSSARY

Abuse means practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to Federal and/or State health care programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

All Employees mean those HPSM Employees, interns, temporary employees, volunteers, Commissioners, contractors, or a First Tier, Downstream or Related Entity (FDR) who provide health or administrative services for an HPSM member.

Audit means a formal review of compliance with a particular set of internal (e.g., policies and procedures) or external (e.g., laws and regulations) standards used as base measures.

Centers for Medicare & Medicaid Services (CMS) means the Centers for Medicare & Medicaid Services, the operating component of the Department of Health and Human Services (DHHS) charged with administration of the Federal Medicare and Medicaid programs.

Code of Conduct means the statement setting forth the principles and standards governing HPSM's activities to which Commissioners, Employees, and Contractors are expected to adhere.

Commissioners mean the members of HPSM's Governing Body.

Compliance Committee means the committee designated by the CEO to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Program.

Compliance Program means the program (including, without limitation, Code of Conduct and Policies and Procedures) developed and adopted by HPSM to promote, monitor and ensure that HPSM's operations and practices and the practices of its Commissioners, Employees, Contractors, and FDRs comply with applicable law and ethical standards.

Contractor means any contractor, subcontractor, agent, or other person including FDRs which or who, on behalf of HPSM, furnishes or otherwise authorizes the furnishing of health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by HPSM.

Contractor Agreement means any agreement with a Contractor.

Department of Health Services (DHCS) means the California Department of Health Services, the State

agency that oversees the Medi-Cal program.

Department of Managed Health Care (DMHC) means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 et seq.

Downstream Entity is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with an HPSM Medicare line of business below the level of the arrangement between HPSM and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

HPSM Employee(s) means any and all Employees of HPSM, including all Leadership Team members, managers, supervisors, and other employed personnel include temporary staff. Interns and volunteers are also included in this reference.

First Tier Entity is any party that enters into a written arrangement, acceptable to the Centers for Medicare and Medicaid Services (CMS), with HPSM to provide administrative services or health care services to a Medicare beneficiary.

FDR is the term used to refer to a first tier, downstream or related entity.

Federal and/or State Health Care Programs means "any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program" as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

Fraud means an intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit to itself, him/herself or some other person and includes any act that constitutes fraud under applicable Federal or State laws including, without limitation, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit.

Governing Body means the San Mateo Health Commission/San Mateo Community Health Authority.

HPSM means the Health Plan of San Mateo, a County Organized Health System (COHS) created under California Welfare and Institutions Code Section 14087.5-14087.95 and San Mateo County Ordinance No.03067, as amended by Ordinance No. 04245.

HPSM Member means a beneficiary who is enrolled in one of HPSM's lines of business.

Manager / Supervisor means an Employee in a position representing HPSM who has one or more employees reporting directly to him or her. With respect to Contractors, the term "Supervisor" shall mean the HPSM Employee that is the designated liaison for that Contractor.

Mandatory Exclusion means an exclusion or debarment from Federal and/or State health care programs for any of the mandatory bases for exclusion identified in 42 U.S.C. § 1396a-7(a) and the implementing regulations including a conviction of a criminal offense related to the delivery of an item or service under Federal and/or State health care programs; and/or a felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service; related to health care fraud and/or related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

Medicare means both Part C (Parts A and B) and Part D of Medicare.

Medicare Drug Integrity Contractors (MEDICs) means a private organization contracted with CMS to assist in the management of CMS' audit, oversight, and anti-fraud and abuse efforts in the Medicare Part D benefit.

National Committee for Quality Assurance Standards for Accreditation of MCOs (NCQA Standards) means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Office of the Inspector General (OIG) means the Office of the Inspector General for the Department of Health and Human Services.

Participating providers and suppliers include all health care providers and suppliers (e.g. physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies etc.) that receive reimbursement from HPSM for items or services furnished to members.

Participation Status means whether a person or entity is currently suspended, excluded, or otherwise ineligible to participate in Federal and/or State health care programs and/or was ever excluded from participation in Federal and/or State health care programs based on a Mandatory Exclusion.

Participation Status Review means the process by which HPSM reviews its Commissioners, Employees, Contractors, and HPSM direct providers to determine whether they are currently suspended, excluded, or otherwise ineligible to participate in Federal and/or State health care programs; and/or were ever excluded from participation in Federal and/or State health care programs based on a Mandatory

Exclusion.

Policies and Procedures means the written policies and procedures regarding the operation of HPSM's Compliance Program and its compliance with applicable law, including those relating to Medicare and California's Medicaid program, Medi-Cal.

Related Entity means any entity related to HPSM by common ownership or control and (1) performs some of HPSM's management functions under contract or delegation, (2) furnishes services to Medicare beneficiaries under an oral or written agreement, or (3) leases property or sells materials to HPSM at a cost of more than $2500 during a contract period.

Waste means an overutilization or misuse of resources that result in unnecessary costs to the healthcare system, either directly or indirectly.

APPENDIX B

Compliance Policies and Procedures

Policy No.	Policy Title
CP.001	Compliance Committee Charter
CP.002	ACA Section 1557 Compliance
CP.003	Reporting Compliance Concerns
CP.004	Compliance Hotline
CP.005	Non Retaliation & Non-Intimidation
CP.006	False Claims Act Compliance
CP.007	Distribution of Compliance Program Materials
CP.008	Internal Auditing
CP.009	Notification Process for Compliance Issues
CP.010	Civil Rights Obligations for Subcontractors
CP.011	Risk Assessment Development Process
CP.012	Medi-Cal Document and Data Certification
CP.013	Internal Monitoring
CP.014	Administrative Service Agreements
CP.015	Significant Network Changes
CP.016	Investigating & Reporting Fraud, Waste, Abuse, and Neglect
CP.017	Conflict of Interest for Committee Members
CP.018	Policy Filing Process

CP.019	Document Retention
CP.020	California Public Records Act Requests
CP.023	Oversight of Delegated Entities
CP.024	Data Sharing with Delegates
CP.025	Compliance Trainings and Attestations
CP.026	Code of Conduct
CP.027	Corrective Action Plan (CAP) Monitoring Process
CP.030	Oversight Responsibilities for Medi-Cal Delegates
HP.001	Privacy Program
HP.002	Minimum Necessary Use and Permitted Uses
HP.003	Verification Requirements
HP.004	Member Authorization
HP.005	Restriction Requests
HP.006	Confidential Communications
HP.007	Access Requests to PHI
HP.008	Amending PHI
HP.009	Accountings of Disclosures
HP.010	Privacy Incidents
HP.011	Breach Notification
HP.012	Safeguarding Sensitive Information

HP.013	Business Associates and Other Arrangements
Hp.014	Notice of Privacy Practices
HP.100	HIPAA -HITECH Privacy and Security Glossary
HP.102	Security Management Process
HP.103	Workforce Security
HP.104	Security Awareness and Training
HP.105	Facility Security
HP.106	Workstation Server and Device Security
HP.107	Maintaining Confidentiality of ePHI
HP.108	Maintaining Integrity of ePHI
HP.109	Maintaining Availability of ePHI
HP.110	Data Backup & Disaster Recovery
HP.111	Physical Safeguards
HP.112	Disposal of Protected Health Information
HP.113	Security Incident & Data Compromise Procedure
HP.114	Acceptable Use Policy
HP.115	HPSM Wireless (WiFi) Access Policy
HP.116	HPSM Mobile Device Policy

Health Plan of San Mateo
Policy & Procedure Manual

Procedure: CP.026		Title: Code of Conduct	Original Effective Date: 01/15/2015
Revision: 45	Last Reviewed /Revised: ~~01/04~~11/09/2021	Dept: Compliance	Page 1 of 5

Approval By: Compliance Committee	**Date:** 11/19/2021
Approval By: San Mateo Health Commission	**Date:**
Annual Review Date: 01/01/2023	
Authored by: Chief Compliance Officer	
Pursuant To: ☒ DHCS Contract Provision Exhibit E, Attachment 2, Provision 26(B) [DRAFT Mega Rule Amendment] ☐ Health and Safety (H&S) Code ☒ CFR 42 CFR 438.608(a); 42 CFR 422.503(b)(4)(vi)(A); 42 CFR 422.504(b)(4)(vi)(A) ☐ APL / DPL	☐ W & I Code ☐ California Title # ☐ Organization Need ☒ Other Medicare Managed Care Guide Chapter 21, Sections 50.1.3; Medicare Prescription Drug Benefit Manual Chapter 9, Section 50.1.3
Departments Impacted: All	

Policy:

To document Health Plan of San Mateo's (HPSM) procedure for communicating the organization's Code of Conduct.

Scope

This procedure applies to (check all that apply):

☒ All LOBs/Entire Organization	☐ CCS	☐ Medi-Cal Expansion
		☐ Medi-Cal Adults
☐ ACE	☐ HealthWorx	☐ Medi-Cal Children
☐ CA-CMC / MMP	☐ Medi-Cal	☐ Other (specify)

Responsibility and Authority

- The Chief Compliance Officer is responsible for implementing a Compliance Program to ensure that HPSM services are provided in accordance with all applicable federal, state, and county laws and regulations.

Definitions

Code of Conduct means the statement setting forth the principles and standards governing HPSM's activities to which Commissioners, Employees, and Contractors are expected to adhere.

Commissioners mean the members of HPSM's Governing Body, the San Mateo Health Commission.

Committee Members means those individuals who are members of the Commission-appointed Committees of HPSM.

Procedure: CP.026		Title: Code of Conduct	Original Effective Date: 01/15/2015
Revision: 45	Last Reviewed /Revised: ~~01/04~~11/09/2021	Dept: Compliance	Page 2 of 5

Subcontractor means any subcontractor, agent, or other person which or who, on behalf of HPSM, furnishes or otherwise authorizes the furnishing of health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by HPSM.

Downstream Entity means any party that enters into a written arrangement, acceptable to the Centers for Medicare and Medicaid Services (CMS), with persons or entities involved with an HPSM Medicare line of business below the level of the arrangement between HPSM and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

First Tier Entity means any party that enters into a written arrangement, acceptable to the Centers for Medicare and Medicaid Services, with HPSM to provide administrative services or health care services to a Medicare beneficiary.

Related Entity means any entity related to HPSM by common ownership or control and (1) performs some of HPSM's management functions under contract or delegation, (2) furnishes services to Medicare beneficiaries under an oral or written agreement, or (3) leases property or sells materials to HPSM at a cost of more than $2500 during a contract period.

Procedure

1.0 Development of Code of Conduct

1.1 The Code of Conduct is a document which provides a statement of the principles and values by which HPSM operates.

1.2 The Code of Conduct is developed by the Chief Compliance Officer with review and input from HPSM Senior Management and the Compliance Committee.

1.3 Approval of the initial development of the Code of Conduct is obtained from the San Mateo Health Commission (SMHC), HPSM's governing body.

2.0 Review of the Code of Conduct

2.1 The Code of Conduct is reviewed on an annual basis by the Compliance Committee, which includes HPSM's Leadership Team.

2.2 The full Code of Conduct is taken to the San Mateo Health Commission for review and approval on an annual basis.

3.0 Distribution of the Code of Conduct

3.1 HPSM Employees

3.1.1 New Hire:

3.1.1.1 The Code of Conduct is distributed to new employees of HPSM according to Policy CP.025 (New Hire Trainings and Attestations).

3.1.1.2 New employees receive a copy of the Code of Conduct during New Hire Compliance Training.

3.1.1.3 Employees complete an Acknowledgement Form attesting that they have received the Code of Conduct, understand it, and commit to comply with it.

3.1.1.4 The Acknowledgement Form is maintained in HPSM's online training system for compliance reporting.

3.1.2 Annual review:

3.1.2.1 All HPSM Employees undergo an annual review of the Code of Conduct.

3.1.2.2 The annual review is an online review during HPSM's Annual Compliance Training.

3.1.2.3 The online training system tracks completion of the review for compliance reporting.

3.2 San Mateo Health Commissioners

3.2.1 Newly appointed

3.2.1.1 The Code of Conduct is distributed to new Commissioners of the SMHC within 90 days of appointment.

3.2.1.2 New Commissioners receive a ~~hard~~ copy of the Code of Conduct during New Commissioner Orientation.

3.2.1.3 They complete a Code of Conduct Acknowledgement Form attesting that they have received the Code of Conduct, understand it, and commit to comply with it.

3.2.1.4 The Code of Conduct Acknowledgement Form is entered into a tracking system for ease of compliance reporting.

3.2.1.5 The original of the Acknowledgement Form is kept by the Clerk of the Commission.

3.2.2 Annual Review

3.2.2.1 The Code of Conduct is distributed to all Commissioners of the SMHC on an annual basis.

3.2.2.2 The SMHC reviews and approves the Code of Conduct, which is reflected in the minutes of the Commission.

3.3 Members of Committees of the San Mateo Health Commission

3.3.1 Newly appointed

3.3.1.1 The Code of Conduct is distributed to new Committee Members within 90 days of appointment.

3.3.1.2 New Committee Members receive a ~~hard~~ copy of the Code of Conduct.

3.3.1.3 They complete a Code of Conduct Acknowledgement Form attesting that they have received the Code of Conduct, understand it, and commit to comply with it.

3.3.1.4 The Code of Conduct Acknowledgement Form is entered into a tracking system for ease of compliance reporting.

3.3.1.5 The original of the Acknowledgement Form is kept by the Clerk of the Commission.

3.3.2 Annual Review

3.3.2.1 The Code of Conduct is distributed to all Committee Members of the SMHC on an annual basis.

3.3.2.2 They complete a Code of Conduct Acknowledgement Form attesting that they have received the Code of Conduct, understand it, and commit to comply with it.

3.3.2.3 The Code of Conduct Acknowledgement Form is entered into a tracking system for ease of compliance reporting.

3.3.2.4 The original of the Acknowledgement Form is kept by the Clerk of the Commission.

3.4 FDRs, Vendors, and Subcontractors

3.4.1 FDRs, Vendors, and Subontractors receive a copy of HPSM's Code of Conduct attached to their contracts with HPSM.

3.4.2 FDRs receive a copy of the Code of Conduct on an annual basis, and must attest that they have:

3.4.2.1 received the Code of Conduct, understand it, and commit to comply with it, and

3.4.2.2 shared it with their employees and any downstream entities.

Related Documentation

- CP.023 Oversight of FDRs
- CP.025 Compliance Trainings and Attestations

Attachments

- HPSM Code of Conduct
- Code of Conduct Acknowledgement Form

Health Plan of San Mateo
Policy & Procedure Manual

Procedure: CP.026		Title: Code of Conduct	Original Effective Date: 01/15/2015
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Log of Revisions	
Revision Number	Revision Date
0	01/15/2015
1	02/11/2016
2	12/07/2016
3	12/01/2017
4	11/09/2018
5	11/09/2021

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HEALTH PLAN of SAN MATEO

CODE OF CONDUCT

~~2021~~2022

Table of Contents

A Message from the Chief Executive Officer

The Health Plan of San Mateo (HPSM) values the contribution of all employees, Commissioners, Committee Members, and Contracted Business Partners toward the goal of providing the highest possible quality of services to its members and providers. This *Code of Conduct* is created in accordance with state and federal requirements to provide guidance in following the ethical, legal, regulatory, and procedural principles that are necessary for maintaining high standards. This document serves as a guide for complying with HPSM's internal policies and procedures as well as all applicable laws and regulations.

This *Code of Conduct*, approved by the San Mateo Health Commission, applies to all HPSM staff, including employees, temporary staff and interns, as well as Commissioners, Committee Members, and Contracted Business Partners. In this document, the word *employee* encompasses all four groups unless otherwise stated.

The consequences for HPSM organizationally of failing to comply with this *Code of Conduct* can be serious, including member, financial, and reputational harm. Failure to comply may result in disciplinary actions up to and including termination.

Although this document was designed to provide overall guidance, it does not address every situation. Please refer to HPSM Policies and Procedures on HPSM's Intranet or in HPSM's Human Resources (HR) Policy Manual if additional direction is needed.

If there is no specific HPSM policy, this *Code of Conduct* becomes the policy. If a policy conflicts with this *Code of Conduct*, the *Code of Conduct* takes precedence. Questions or issues regarding this document or a policy should be discussed first with the immediate supervisor. If additional guidance is needed, one should go through the chain of authority up to and including HPSM's Chief Compliance Officer, other members of the Leadership Team, or the Chief Executive Officer. Any issues may also be reported confidentially and anonymously by using HPSM's compliance hotline at 1-~~800-826-6762~~844-965-1241.

Thank you for your commitment to HPSM and your dedication to serve our members, providers, and our community partners in an ethical, professional manner using the high standards which are embodied in this *Code of Conduct*.

Sincerely,

~~Maya Altman~~Pat Curran
Interim Chief Executive Officer

Introduction

The Health Plan of San Mateo (HPSM) is a local non-profit health care plan that offers health coverage and a provider network to San Mateo County's underserved population. We currently serve more than 130,000 County residents.

The County Board of Supervisors established the San Mateo Health Commission in 1986 to address and resolve the issues of poor access to physicians, an uncoordinated health care system endured by the county's growing population of Medi-Cal patients. In 1987, the Commission founded the Health Plan of San Mateo to provide access to a stable and comprehensive network of providers, and a benefits program that promotes preventive care with staff devoted to ensuring Medi-Cal patients receive high quality, coordinated health care.

Our Mission

To ensure access to high-quality care services and supports that help San Mateo County's vulnerable and underserved residents live the healthiest lives possible.

Our Vision

Healthy is for everyone *and we fight to make that happen.*

Our Values

- **Advocate** for the health and well-being of our members and other underserved residents of San Mateo County.
- **Partner** with providers and community organizations to overcome local challenges faced by members and providers.
- **Give** individual and personal attention to our members by being culturally and linguistically responsive to their unique needs.
- **Support** our providers by ensuring they receive timely payment for their services and by reducing administrative obstacles.
- **Strive** to be good stewards of public resources by focusing on the efficient use of services and funds.
- **Act** with the highest standards of ethics integrity and transparency.
- **Embrace** a work atmosphere that encourages employee growth and commitment to HPSM's mission.

Commitments

This *Code of Conduct* is intended to help both the Health Plan of San Mateo as a whole and individual employees stay true to the following commitments.

To HPSM Members
HPSM is committed to delivering quality, affordable health care by providing its members access to a network of credentialed health care providers, customer service staff, and a grievance and appeal process for timely problem resolution.

To HPSM Providers
HPSM is dedicated to providing efficient network management resources for its contracted providers, honoring contractual obligations, delivering quality health services, and bringing efficiency and cost-effectiveness to health care.

To HPSM Community Partners
HPSM is dedicated to advocating for healthcare needs of San Mateo County with a commitment to addressing challenges of access for the underserved.

To HPSM Contracted Business Partners
HPSM is committed to managing contractor and supplier relationships in a fair and reasonable manner. The selection of Contracted Business Partners, e.g. vendors, contractors, suppliers, and First-tier, Downstream, and Related entities (FDRs), is based on objective criteria including quality, technical excellence, price, delivery, adherence to schedules, service, and maintenance of adequate sources of staff and supply. HPSM will not communicate confidential information given to us by its suppliers unless directed to do so by the supplier or by law.

Code of Conduct

All HPSM employees, Commissioners, Committee Members, and Contracted Business Partners are responsible for following these standards.

1. Privacy and Confidentiality

1.1. Respect the privacy of members, providers, and co-workers by safeguarding their information from physical damage, maintaining member health information and business documents in a safe and protected manner, and following HPSM's record retention policies.

1.2. Protect the privacy of HPSM members' protected health information (PHI) according to federal and state requirements.

1.3. When using, disclosing, or requesting PHI, limit the information to the minimum amount needed to accomplish the work. Do not share or request more PHI than is necessary.

1.4. Only share medical, business, or other confidential information when such release is supported by a legitimate clinical or business purpose and is in compliance with HPSM policies and procedures, and applicable laws and regulations.

1.5. Whenever it becomes necessary to share confidential information outside HPSM for legitimate business purposes, release PHI only after obtaining a signed business associates agreement or a completed Authorization to Release Information Form.

1.6. Exercise care to ensure that confidential information, such as salary, benefits, payroll, personnel files, and information on disciplinary matters is carefully maintained and managed.

1.7. Do not discuss confidential member, provider, contractor, or employee information in any public area, such as elevators, hallways, stairwells, restrooms, lobbies, or eating areas.

1.8. Do not divulge, copy, release, sell, loan, alter, or destroy any confidential information except as authorized for HPSM business purposes or as required by law.

2. Security of Electronic Information

2.1. Practice good workstation security, which includes locking up offices and file cabinets; disposing of all paperwork in appropriate shredding receptacles; and covering all PHI or locking the computer if stepping away from the desk.

2.2. Take appropriate and reasonable measures to protect against the loss or theft of electronic media (e.g., laptops, flash drives, CDs/DVDs, photocopier hard drives, etc.) and against unauthorized access to electronic media that may contain member protected health information. Maintain and monitor security, data back-up, and storage systems.

2.3. Maintain computer passwords and access codes in a confidential and responsible manner. Only allow authorized persons to have access to computer systems and software on a "need-to-know" basis.

2.4. Do not share passwords or allow access to information to Contracted Business Partners, unless authorized to do so.

2.5. Transmit electronic confidential information securely in encrypted form.

3. Workplace Conduct

3.1. Respect the dignity of every employee, provider, member, and visitor while providing high-quality services and treating one another with respect and courtesy.

3.2. Communicate openly and honestly and respond to one another in a timely manner. Share information and ask questions freely.

3.3. Be civil and comply with existing policies about the treatment of colleagues, non-harassment, and respect in the workplace.

3.4. Conduct HPSM business with high standards of ethics, integrity, honesty, and responsibility, and act in a manner that enhances our standing in the community.

3.5. Support and observe a workplace free of alcohol, drugs, smoking, harassment, and violence.

3.6. Do not act in any way that will harm HPSM.

4. Use of Social Media

4.1. Do not engage in activity on social media sites that violates HPSM's mission, vision and values.

4.2. As an employee, when one's connection to HPSM is apparent, the employee must make it clear that the posting is on behalf of the individual and not HPSM.

4.3. Protect members' confidentiality and protected health information at all times. Do not write or say anything that violates HPSM's privacy, security, or confidentiality policies. Never post any information that can be used to identify an HPSM member's identity or health condition.

4.4. Maintain the confidentiality of HPSM business information and do not discuss this information on social media sites.

4.5. Always seek official approval from the Leadership Team before posting an official statement about HPSM. Only designated staff may speak on behalf of HPSM.

4.6. Employees may not use HPSM email addresses or phone numbers for personal use of social media.

5. Adhering to Laws and Regulations

5.1. Follow all state and federal laws and regulations, including reporting requirements.

5.2. Do not knowingly make any false or misleading statements, verbal or written, to government agencies, government officials or auditors.

5.3. Do not conceal, destroy, or alter any documents.

5.4. Do not give or receive any form of payment, kickback, or bribe or other inducements to members, providers, or others in an attempt to encourage the referral of members to use a particular facility, product, or service.

5.5. Avoid inappropriate discussions regarding business issues.

6. Safety

6.1. Comply with established safety policies, standards, and training programs to prevent job-related hazards and ensure a safe environment for members, providers, employees, and visitors.

6.2. Wear an HPSM badge at all times while in HPSM offices and when representing HPSM offsite.

6.3. Not share or lend an HPSM employee badge to any other individual, including visitors, other HPSM staff or co-located San Mateo County staff to access secured areas in HPSM offices. Badges are issued on a per-individual basis and may only be used by the individual who was issued that badge.

7. Conflict of Interest

7.1. Avoid actual, apparent, or potential conflicts between one's own interests and the interests of HPSM. Comply with all legal requirements concerning conflicts of interest and incompatible activities. Complete all disclosure documentation as required.

7.2. Act in the best interest of HPSM whenever functioning as an agent of HPSM in dealings with contractors, providers, members, or government agencies. This includes those acts formalized in written contracts as well as everyday business relationships with business partners, members, and government officials.

7.3. As an HPSM employee, do not directly or indirectly participate in, or have a significant interest in, any business that competes with or is a supplier to HPSM. Only engage with a competitor or supplier if participation is disclosed to HPSM in advance and agreed to in writing by the Chief Executive Officer (CEO). This standard also applies to members of one's immediate family.

7.4. As an HPSM employee, do not engage in outside employment or self-employment that may conflict with the work of HPSM. Adhere to HPSM's Outside Employment/Self-Employment Policy, which can be found in the Human Resources Policy Manual/Employee Handbook.

7.5. As an HPSM employee, do not accept gifts and other benefits with a total value of more than $50.00 from any individuals, businesses, or organizations doing business with HPSM.

7.6. As an HPSM employee, do not accept cash or cash equivalents (gift certificates, gift cards, checks or money orders) in any amount from any individuals, businesses, or organizations doing business with HPSM.

8. Protecting Assets

8.1. Protect HPSM's assets and the assets of others entrusted to HPSM, including information and physical and intellectual property, against loss, theft, and misuse. Assets include money, equipment, office supplies, business contacts, provider and

claims data, business strategies, financial reports, member utilization data, and data systems.

8.2. Take measures to prevent any unexpected loss or damage of equipment, supplies, materials, or services. Adhere to established policies regarding the disposal of HPSM properties.

8.3. Ensure the accuracy of all records and reports, including financial statements and reported hours worked.

8.4. Report expenses consistent with and justified by job responsibilities. Adhere to established policies and procedures governing record management and comply with HPSM's destruction policies and procedures.

8.5. Do not modify, destroy, or remove electronic communications resources (e.g., computers, phones, fax machines, etc.) that are owned by HPSM without proper authorization.

8.6. Do not install or attach any mobile or remote devices or equipment to an HPSM electronic communications resource without approval.

8.7. Use HPSM property and resources appropriately for the best interests of our members and HPSM and in accordance with HPSM's Acceptable Use Policy.

8.8. Follow all laws regarding intellectual property, which includes patents, trademarks, marketing, and copyrights. Do not copy software unless it is specifically allowed in the license agreement and authorized by the Chief Information Officer.

9. Participating in the Compliance Program

9.1. Report any potential instances of fraud, waste or abuse or any suspected violations of the *Code of Conduct* or law to the Chief Compliance Officer, any member of HPSM management or Human Resources staff. HPSM management and Human Resources staff are required to report suspected FWA and violations of the *Code of Conduct* to the Chief Compliance Officer. Concerns can also be reported anonymously through the Compliance Hotline (~~800-826-6762~~844-965-1241).

9.2. Cooperate fully with investigational efforts.

9.3. Act in accordance with HPSM's commitment to high standards of ethics and compliance.

10. Employment Practices

10.1. Conduct business with high standards of ethics, integrity, honesty, and responsibility. Act in a manner that enhances our standing in the community.

10.2. Employ and contract with employees and business partners who have not been sanctioned by any regulatory agency and who are able to perform their designated responsibilities.

10.3. Provide equal employment opportunities to prospective and current employees, based solely on merit, qualifications, and abilities.

10.4. Do not discriminate in employment opportunities or practices on the basis of race, color, religion, sex, national origin, ancestry, age, physical or mental disability, sexual orientation, veteran status, or any other status protected by law.

10.5. Conduct a thorough background check of employees and evaluate the results to assure that there is no indication that an employee may present a risk for HPSM.

10.6. Acts of intimidation, retaliation or reprisal against any employee who in good faith reports suspected violations of law, regulations, HPSM's *Code of Conduct*, or policies will not be tolerated.

10.7. Provide an open-door communications policy and foster a work environment in which ethical and compliance concerns are welcomed and addressed to ensure that the highest quality of care and service is provided.

10.8. Provide appropriate training and orientation so that employees can perform their duties and meet the needs of our members, providers, and the communities we serve.

11. Resolving Issues and Concerns

11.1 Protect the identity of people who call the Compliance Hotline, if they identify themselves, to the fullest extent possible or as permitted by law.

11.2 Evaluate and respond to allegations of wrongdoing, concerns and/or inquiries made to the Compliance Hotline in an impartial manner. All allegations will be thoroughly investigated and verified before any action is taken.

11.3 Take appropriate measures to identify operational vulnerabilities and to detect, prevent, and control fraud, waste, and abuse throughout the organization.

11.4 Report, as appropriate, actual or suspected violations of law and policy to the state or federal oversight agency or to law enforcement.

12. Committee Member Responsibilities

12.1 Committee members will not discriminate in decision-making/recommendations in their respective committees on the basis of race, color, religion, sex national origin, ancestry, age, physical or mental disability, sexual orientation, veteran status, or any other status protected by law.

MEMORANDUM

AGENDA ITEM: 4.6

DATE: December 8, 2021

DATE: November 23, 2021

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer
Karen Fitzgerald, Marketing and Communications Director

RE: Waive Request for Proposal Process and Approve an Amendment to Agreement with International Contact, Inc.

Recommendation

Approve a waiver of the RFP process and an amendment to the agreement with International Contact, Inc., extending the existing agreement implemented in January 2021 through December 2022, and increasing the total amount not to exceed to $205,000.

Background and Discussion

International Contact provides HPSM with translation services for four threshold (required) languages, in accordance with Medicare and Medicaid rules and regulations. They also provide translation services for several additional languages that a significant number of HPSM members prefer, beyond these minimum requirements. The vendor is in good standing with HPSM.

In 2021, translation expenses are projected to exceed the current contracted not to exceed amount of $95,000 for this vendor. This is due to:

- A high volume of COVID-19 related member communications;
- Regulatory updates to member materials; and
- A high volume of unanticipated, required member communications to support CalAIM, dental integration, and the pharmacy carve out.

To ensure that these member communication campaigns remain on track, staff proposes to extend the current agreement for another year through December 31, 2022, and increases the total amount not to exceed to $205,000. HPSM will initiate an RFP process in 2022 for new translation contracts beginning in 2023. In the meantime, a waiver of the RFP process is requested.

Fiscal Impact

The original scope of work included translation services for a total amount not to exceed of $95,000. This amendment increases the agreement by $110,000 for a total amount not to exceed of $205,000 and extends the contract term through December 31, 2022.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF WAIVE REQUEST FOR PROPOSAL AND APPROVAL OF AMENDMENT TO AGREEMENT WITH INTERNATIONAL CONTACT, INC.

RESOLUTION 2021 -

RECITAL: WHEREAS,

A. HPSM is required to provide timely and accurate translation services for HPSM members;

B. HPSM currently uses the services of International Contact, Inc., to translate member materials in accordance with Medicare and Medicaid rules and regulations; and

C. International Contact is highly qualified for this extended service agreement based on their knowledge and experience.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the request for proposal process and approves an amendment to the agreement with International Contact, Inc., to extend the agreement through December 31, 2022, and add $110,000 for a total not to exceed amount of $205,000; and

2. Authorizes the Chief Executive Officer to execute said amendment.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 8th day of December 2021 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT

_____
Ligia Andrade Zuniga, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

MEMORANDUM

AGENDA ITEM: 4.7

DATE: December 8, 2021

DATE: November 29, 2021

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer
Amy Scriber, Population Health Officer
Sophie Scheidlinger, Manager, Strategic Partnerships

RE: Amendment to Agreement with Independent Living Systems (ILS)

Recommendation

Authorize the Chief Executive Officer to execute an amendment to the agreement with Independent Living Systems (ILS), increasing the amount by $1.3 million for a total amount not to exceed of $9,470,000. The agreement term remains the same, October 1, 2017, through December 31, 2022.

Background and Discussion

HPSM has contracted with ILS since October 2017 to conduct Health Risk Assessments (HRAs) and Individualized Care Plans (ICPs) for members of CareAdvantage Cal MediConnect (CA CMC) and Seniors and Persons with Disabilities receiving Medi-Cal services. DHCS requires HRAs and ICPs as part of the Cal MediConnect and Medi-Cal programs.

The HRA is a survey used to identify and stratify member needs, facilitate program referrals, and inform the member's ICP. These activities are conducted when members enroll in HPSM and annually thereafter and are primarily telephonic. All assessment findings and referrals are sent to HPSM's Integrated Care Management team for any needed follow-up. HPSM has approximately 8,800 Cal MediConnect members and 4,500 Seniors and Persons with Disabilities who are contacted annually by ILS, as well as eligible new members enrolling in HPSM.

HPSM selected ILS through an RFP process, originally contracting with ILS from October 1, 2017, through September 30, 2020, for $6,328,800. HPSM expanded the scope of work with ILS in April 2020 for member outreach and health check-ins during the early stages of the COVID-19 pandemic, adding $471,200 to the agreement. In September 2020, the Commission extended the agreement through December 2022, adding $1,370,000. HPSM staff is currently reevaluating the scope of need for these services given the termination of the Cal MediConnect program in December 2022. However, HPSM's membership has grown substantially since March 2020, increasing the need for ILS services.

Fiscal Impact

This amendment increases the agreement by $1.3 million for a total amount not to exceed of $9,470,000. The agreement term remains the same.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF AN AMENDMENT TO AGREEMENT
WITH INDEPENDENT LIVING SYSTEMS

RESOLUTION 2021 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has contracted with Independent Living Systems (ILS) to provide Health Risk Assessment (HRAs) and Individualized Care Plan (ICPs) services for many HPSM members since October 2017;
B. ILS has demonstrated effective telephonic case management capabilities to identify potential and unmet member needs; and
C. HPSM membership has grown substantially since March 2020, increasing the need for ILS services.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves an amendment to the agreement with Independent Living Systems, increasing the agreement amount by $1.3 million for a total amount not to exceed $9,470,000; and
2. Authorizes the Chief Executive Officer to execute said amendment.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 8th day of December 2021 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Ligia Andrade Zuniga, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

AGENDA ITEM: 4.8

DATE: December 8, 2021

MEMORANDUM

DATE: November 23, 2021

TO: San Mateo Health Commission

FROM: Pat Curran, Interim Chief Executive Officer

RE: Commission Meeting Schedule for 2022

The San Mateo Health Commission meetings will be held on the 2nd Wednesday of the month at 12:30 p.m. During the public emergency, the meetings of the Commission will be held virtually until we are able to meet again in person. At that time, the meetings will again be held at the Health Plan of San Mateo, 801 Gateway Blvd., 1st Floor Boardroom, South San Francisco. The Commission meets nine times a year. Below are the meeting dates planned for 2022, unless notified otherwise.

Please note there will be no meeting scheduled for the months of March, July, and October in 2022:

January 12, 2022
February 9, 2022
April 13, 2022
May 11, 2022
June 8, 2022
August 10, 2022
September 14, 2022
November 9, 2022
December 14, 2022

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF SAN MATEO HEALTH COMMISSION
MEETING DATES FOR 2022

RESOLUTION 2021 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission meets on the 2nd Wednesday of the month nine times a year at 12:30 p.m.; and

B. The Commission wishes to adopt a schedule for 2022 for its scheduled meetings.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission adopts the schedule to meet on the 2nd Wednesday of each month at 12:30 pm with the exception of March, July and October 2022.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 8th day of December, 2021 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Ligia Andrade Zuniga, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

DRAFT

AGENDA ITEM: 4.9

DATE: December 8, 2021

SAN MATEO HEALTH COMMISSION
Meeting Minutes
November 10, 2021 – 12:30 p.m.

****BY VIDEOCONFERENCE ONLY****

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

Commissioners Present:	Jeanette Aviles	Bill Graham
	Michael Callagy	Barbara Miao
	David J. Canepa	George Pon, R.Ph.
	Teresa Guingona Ferrer	Kenneth Tai, M.D.
	Si France, M.D.	Ligia Andrade Zuniga, Chair
	Don Horsley, Vice-Chair	
Commissioners Absent:	None	
Counsel:	Kristina Paszek	
Staff Present:	Maya Altman, Luarnie Bermudo, Chris Baughman, Corinne Burgess, Marisa Cardarelli, Pat Curran, Trent Ehrgood, Chris Esguerra, M.D., Karen Fitzgerald, Robert Fleming, Ian Johansson, Richard Moore, M.D., Colleen Murphey, Amy Scribner, Sophie Scheidlinger, and Eben Yong	

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

2. **Public Comment**
   There were no public comments received via email or verbally made at this time.

3. **Approval of Agenda**
   Motion to approve the agenda as presented: **Horsley / Second: Graham**

Verbal roll call vote was taken:

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

No: 0

4. Approval of Consent Agenda

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

Verbal roll call vote was taken:

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

No: 0

5. Specific Discussion/Action Items

[Commissioner Canepa arrived at this time]

5.1 Discussion/Action on Approval of CalAIM Agreements

Ms. Altman introduced the request for approval of provider agreements to implement CalAIM. Enhanced Care Management (ECM) and In Lieu of Services (ILOS), now called Community Supports, are slated to begin on January 1, 2022, at least for certain populations and programs. HPSM staff has been working diligently to contract with providers for these services.

Ms. Altman introduced Amy Scribner, Population Health Officer, Luarnie Bermudo, the recently promoted Provider Services Director, and Edward Ortiz, Consultant, to present details on the programs and agreements to be approved. Their presentation is attached to these minutes.

Ms. Scribner described CalAIM and its goals to reform Medi-Cal and improve beneficiary outcomes. CalAIM will address social determinants of health in a broader more systematic way. It is a multi-year, multi-faceted initiative with various phases for implementation in the next several years. Also included are behavioral health reforms and standardization of Medi-Cal managed care benefits. HPSM has already been providing many of these benefits, such as long-term care, for many years.

Ms. Scribner reviewed Enhanced Care Management which will replace the County's pilot Whole Person Care (WPC) project, due to end on December 31, 2021. Most WPC clients will receive the ECM benefit or Community Supports starting in January. ECM is a new benefit targeted to the highest need individuals with a focus on in-person care management services. It must be delivered by community-based organizations or counties.

Community Supports include 14 potential service packages that health plans can implement as substitutes for more costly medical services. These services allow plans to address social determinants more consistently and effectively. Community Supports are optional for health plans to provide and for beneficiaries to accept. The menu of services available can change every six months, based on plan applications to the State. Also, because recently adopted State legislation will no longer allow health plans to offer the Multipurpose Senior Services Program (MSSP) as an integrated benefit, HPSM requested, and the Department of Health Care Services and the California Department of Aging agreed to allow HPSM to offer MSSP as an ECM benefit instead. MSSP services, provided by County Health's Aging and Adult Services Division under a contract with HPSM, include intensive care management services to help individuals who are at a nursing home level of care remain in the community.

Ms. Scribner reviewed the implementation timelines for ECM beginning in January 2021 through July 2023, including phases for various populations. These phases are controlled by DHCS. The first phase includes homeless individuals with complex health and/or behavioral health conditions; adult high utilizers of medical services; and individuals who have co-occurring chronic health conditions along with serious mental illness or substance use disorders. Subsequent phases include those at risk for long term care institutionalization or who want to transition from a nursing facility to the community; individuals coming out of incarceration; and children with complex physical-behavioral or developmental health needs. The youth population will have some overlap with the CCS and foster care populations and the criteria for eligibility for this group are still in development.

Ms. Scribner reviewed the phased approach for Community Supports, which is at the discretion of HPSM. Beginning in either January or July 2022, HPSM is implementing: housing navigation services; housing deposits; housing tenancy and sustaining services; recuperative care; respite services; nursing facility transitions or diversions to Assisted Living; nursing facility transitions to member homes; additional personal care or homemaker services; home modifications; and meals. Most of the elected Community Supports are offered through other HPSM programs already. Respite and Personal/Homemaker Care services will only be offered to MSSP clients in the beginning with expansion to other members later in the year.

Mr. Ortiz described the process used to select ECM and Community Supports providers. A request for information (RFI) was released in June 2021 to identify providers to participate in CalAIM programming. HPSM staff sent RFI's to 32 potential providers; 25 responded with completed RFI's. The RFI's purpose was to gauge organizational capacity, both current organizational readiness and possible future readiness and interest. HPSM staff then selected five to eight providers to support ECM beginning in January 2022. The process was like that used when HPSM established the Community Care Settings Pilot; however,

this time we found that the market had matured, with additional provider types and more responders in general. Staff also considered HPSM's workload and administrative capacity to oversee the program This is part of the reason for the phased implementation approach. Finally, Mr. Ortiz reviewed the criteria used to select the providers.

Next steps include ensuring provider readiness to meet contract requirements. Evaluation of all the responses continues as HPSM considers phasing in additional providers for future expansion of ECM and Community Supports. By the end of 2022, HPSM should have a robust network for a broad range of services.

Ms. Bermudo discussed the new credentialing and contracting pathways under development for CalAIM providers, who are not traditional medical providers. HPSM has created new policies and procedures that have been approved by DHCS and HPSM's Peer Review Committee. Staff is checking in with providers to help them through the enrollment application process and provide technical assistance. Provider contract templates are now completed and have also been approved by DHCS. Ms. Bermudo reflected on her start at HPSM several years ago as a Program Manager in support of Community Supports programs. Seeing these programs develop from concepts to be proved to statewide initiatives is gratifying. Next steps involve completing credentialing and contracting through the end of the year, ensuring appropriate network reporting to DHCS, and supporting these new providers through onboarding and training.

Commissioner Ferrer commended staff for the work that has been accomplished, going all the way back to the initial development of these networks by Mr. Ortiz in 2013. These relationships continue to benefit HPSM and its members.

Commissioner Horsley asked how the $11 million cost for provision of these services was estimated and wondered if it is sufficient. He noted the huge challenges in finding housing in this community. He also noted that he hoped HPSM could coordinate with County housing efforts. Ms. Altman said the $11 million cost figure is based on the additional funding received from the State in HPSM's rates for ECM services. In the initial rates DHCS sent, the total was only $4 million; based on feedback from all the health plans DHCS then increased the funding. Since this is a new program, we do not know if the funding is sufficient; much depends on how many people use ECM services. County Health is concerned the rates will not cover current Whole Person Care costs. Other entities find the rates satisfactory. Additional funding will also be available through CalAIM incentive programs and PATH funding. Both are short term funding sources available over the next two years, at least in part targeted to help counties with the Whole Person Care transition. Ms. Altman also commented that HPSM staff coordinate with County housing and human services staff on housing and homeless services.

Commissioner Horsley noted that County Health can provide services in ways that are difficult for HPSM to do. Ms. Altman agreed, explaining that DHCS requires ECM to be delivered in face-to-face encounters. Ms. Scribner noted that HPSM is not receiving upfront payment for Community Supports such as housing related services. However, costs for these services will be built into current cost reports that form the basis for the capitation HPSM will receive in future years.

Commissioner Zuniga commented about statewide discussions in the independent living community regarding partnerships with health plans. The Center for Independence of Individuals with Disabilities (CID), the local independent living center in San Mateo County was recently designated as the local Aging and Disability Resource Connection site, in collaboration with Aging and Adult Services. CID also is funded to help with transitions from nursing facilities and provide housing location services and there may be potential collaborations with HPSM. Ms. Altman responded that HPSM staff will reach out to CID to gauge interest; recruiting providers and partners for ECM and Community Supports is an ongoing process.

Motion to approve authorization for the Chief Executive Officer to execute provider agreements to implement CalAIM ECM and Community Supports: **Graham / Second: France**

Verbal roll call vote was taken:
Yes: 11 – Aviles, Callagy, Canepa, Ferrer, France, Graham, Horsley, Miao, Pon, Tai, Zuniga.
No: 0

6. Report from Chairman/Executive Committee

Commissioner Zuniga stated that the Search Committee's efforts to identify a new Chief Executive Officer continue. She had nothing additional to report from the Executive Committee.

7. Report from Chief Executive Officer

Ms. Altman referred the Commissioners to the attachment to her report, which lists all the new initiatives DHCS is leading. It is a striking illustration of the breathtaking scope of work the State is undertaking and, by extension, the workload for health plans. While not all the initiatives involve health plans directly, most will impact our community, members, and providers. One example is a project requiring health plans to work with local schools to improve access to behavioral health services for children and youth, especially preventive and early intervention services. This is new territory for most health plans, which do not have strong connections to schools in general. In San Mateo County, we do have two important school- based health centers, Daly City Youth Health Center and the Sequoia Teen Clinic. In addition to the DHCS project list, there are also many initiatives steered by the California Health and Human Services Agency (CHHSA) and other departments. For example, CHHSA is

leading a major health data exchange effort, which will impact all health care providers and plans, and DMHC has launched an initiative for health equity which we hope will be aligned with DHCS efforts in this area.

Ms. Altman noted that the Finance report included in the Commission packet shows results through the third quarter of 2021. The Plan is breaking even as of that date, a much better financial position than the budgeted $25 million deficit for that period.

The DMHC audit will occur next week followed by an NCQA re-accreditation materials deadline in December. The DHCS audit has now been completed and we are waiting for the DHCS report.

Commissioner Miao asked if more staffing is needed, given the volume of work required by the State. Ms. Altman responded that the 2022 proposed budget, to be presented at the December Commission meeting, includes some additional staffing. We are still carrying many vacant positions as well.

Commissioner Zuniga said she is excited about the behavioral health efforts in the schools and the opportunities for collaboration between schools and HPSM.

8. Other Business

No other business was discussed.

9. Closed Session

Conference with Legal Counsel – Anticipated Litigation (Gov't Code section 54956.9(d)(2) (2 cases))

Conference with Legal Counsel – Existing Litigation (Gov't Code section 54956.9)
City of South San Francisco v. Health Plan of San Mateo (Case No. 21-CIV-04614)

Public Employment Appointment (Gov't Code section 54957)
Interim Chief Executive Officer

Commissioner Zuniga moved the meeting to closed session at 1:17 p.m.

10. Report on Action taken in Closed Session

The meeting reconvened at 1:58 p.m. Kristina Paszek, Deputy County Counsel, reported that the Commission appointed Pat Curran as Interim CEO upon the retirement of Maya Altman. His compensation will be $420,000 annually plus the standard HPSM benefits package.

11. Adjournment

The meeting was adjourned at 1:59 p.m.

Respectfully submitted:

C. Burgess

C. Burgess, Clerk of the Commission

CalAIM Enhanced Case Management and Community Support Network Development

Commission Presentation

November 10, 2021

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Agenda

HealthPlan OF SAN MATEO
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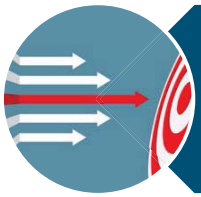
- CalAIM ECM and Community Supports Overview
  - Populations of Focus and Go-live
- Request for Information
  - Phased Approach
- Credentialing and Contracting

What is CalAIM?



California's opportunity to update and innovate its Medi-Cal program

Process with CMS with the goal of a better experience and improved outcomes for Medi-Cal beneficiaries (including dually eligible)

Acknowledges and incorporates addressing social determinants of health

January 1, 2022 implementation

Enhanced Case Management (ECM)

- Whole person care approach integrating both clinical and non-clinical factors and applying those to the care approach. Builds on current Whole Person Care and Health Homes programs.
- ***Benefit*** only for highest-need population, mostly in person visits and delivered predominantly by contracted CBOs.

Community Supports (formerly known as In Lieu of Services-ILOS)

- A set of 14 services that a plan can use to provide health-related services as an alternative or substitute for covered Medi-Cal benefits. Community Supports will be integrated with care management for high-risk members and will allow plans to address Social Determinants of Health in a more consistent way.
- Community supports can be added over time and are ***optional for plans to implement***

Timeline for ECM Populations of Focus

- Go-live for ECM is directed by DHCS

DHCS Stated Go-Live	ECM Population
1/1/22	Individuals experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions
1/1/22	Adult high utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits
1/1/22	Individuals at risk for institutionalization who have co-occurring chronic health conditions and: • Serious Mental Illness (SMI, adults); • Substance Use Disorder (SUD)
1/1/23	Individuals at risk for institutionalization who are eligible for Long Term Care services
1/1/23	Nursing facility residents who want to transition to the community
1/1/23	Individuals transitioning from incarceration
7/1/23	Children or youth with complex physical, behavioral, or developmental health needs (e.g., California Children's Services, foster care, youth with Clinical High-Risk Syndrome, or first episode of psychosis)

Phased Approach

- Go-live for CS is directed by HPSM

Service	Like-Services Current	Phase One Jan/22	Phase Two July/22
Transition/Navigation	✓	✓	
Deposits	✓	✓	
Tenancy & Sustaining	✓	✓	
Short-Term Post-Hosp	No		
Recuperative Care	✓		✓
Respite	✓		✓
Day Habilitation Prog	No		
NF Trans/Div to ALF	✓	✓	
Comm Trans NF-Home	✓	✓	
Personal /Homemaker Care	✓		✓
Home Modifications	✓	✓	
Meals/Rx Meals	✓	✓	
Sobering Centers	No		
Asthma Remediation	No		

Request for Information

Provider Phasing

Request for Information (RFI)

- HPSM dispatched an RFI to 32 providers, 25 responded
  - 13 Enhanced Care Management providers (ECM)
    - 4 San Mateo County Health - Depts/Programs
  - 19 Community Supports service responders (CS)
- Approach for 1/1/2022 is to transition Whole Person Care programs and most current CCSP/CBO services
  - Go-live will include contracts with ~ 5-8 providers
- Market for CS has matured significantly since HPSM launched CCSP offering additional provider options
- New benefit and services will evolve the way HPSM addresses larger population health solutions

Request for Information – Outcomes Focused

- Goal for RFI
  - Identify qualified providers for ECM/CS
  - Determine current capacity to serve (number of eligible members/capability of provider)
  - Identify/mitigate risk
  - Prioritize and stage implementation activities based on market capacity
  - Signal to market the need to evolve administrative capabilities and programming
- Criteria
  - Experience in delivering quality services
  - Administrative capability
  - Ability to integrate into larger HPSM ecosystem
  - Demonstrated ability to achieve positive outcomes
  - Need for service or commitment to Whole Person Care program

Request for Information – Next Steps

- Initiate conversations with key providers (WPC and Current CCSP/CBOs)
  - Readiness Process
  - DHCS/HPSM contract requirements
- Finalize population sizing and needs assessment
- Evaluate responses and develop a staging plan for other providers to join in later phases
- Initiate contracting (Now to EOY)

The RFI will be an ongoing tool to add new providers to the network in the near term…

Network Updates

Contracting and Credentialing

Network Updates: Credentialing

- Developed new credentialing pathways for CalAIM providers
- Polices and Procedures approved by the state and HPSM Peer Review Committee
- Initiated Credentialing Check-Ins with provider groups
- Other insights

Network Updates: Contracting

- ECM and CS boilerplate templates approved by the state
- Initiated contracting discussions and sent out boilerplate templates to provider groups
- All Phase 1 providers (e.g. WPC, IOA, etc.) are existing HPSM providers
- Other insights

Network Updates- Next Steps

- Continue Credentialing Provider Network to EOY
- Contracting Initiation from now until EOY
- Initiate Network Reporting (274 Report) state testing
- Provider Training and On-Boarding

End

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MEMORANDUM

AGENDA ITEM: 5.1

DATE: December 8, 2021

DATE: November 29, 2021

TO: San Mateo Health Commission

FROM: Maya Altman, CEO
Trent Ehrgood, CFO

RE: Approval of HPSM 2022 Budget

Attached is a slide deck with the 2022 budget overview. HPSM is forecasting a surplus of $6.2M with anticipated total revenues (operating and non-operating revenue) of $908.0M and total expenses of $901.8M.

Outlook for 2022

Below are some assumptions used in the development of the 2022 budget.

- Growth in Medi-Cal membership expected to continue, but at a slower rate, and Medi-Cal redetermination (disenrollment) starting around mid-year 2022.
- Draft Medi-Cal 2022 rates, which included adjustments for the pharmacy carveout, addition of Dental integration, addition of Enhanced Care Management (ECM), and added funding for In Lieu of Services (ILOS).
- Healthcare cost moving back toward pre-pandemic levels
- Increased staffing levels to support new programs, which also have added funding for the increased administrative cost.

Revenue and Health Care Budget Methodology

Medi-Cal revenue assumptions are based on draft rates received in early-October. Medicare revenue for the Cal Medi Connect population is based on estimates using current Medicare risk adjustment scores and anticipated risk adjustment model changes CMS has published for 2022.

Healthcare cost assumptions are based on anticipated utilization and unit cost changes. Utilization changes are based on movement back to pre-pandemic levels, and anticipated changes from various initiatives. Unit cost changes are based on estimated DHCS and CMS fee schedule changes, and other known provider contracting changes.

General and Administrative Expenses

General and administrative cost is calculated by department and expense type. Salaries and benefits are derived from a detailed list of positions and includes an overall reduction for anticipated vacancies due to normal turnover. Administrative expenditures for 2022 are projected to be $55.7M resulting in an administrative ratio of 6.2% of revenue. Additional staffing and incremental operating expenses related to dental integration and ECM are included in the budget. There is additional funding built into the Medi-Cal rates for these new administrative costs.

Finance Committee Review

The Commission's Finance/Executive Committee reviewed the proposed budget in more detail at their meeting on November 29, 2021 and recommend approval.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF ADOPTION OF OPERATING BUDGET
FOR 01/01/2022 - 12/31/2022

RESOLUTION 2021 -

RECITAL: WHEREAS,

A. The Finance Committee has reviewed details and assumptions for the budget for CFY2022; and

B. The Committee recommends approval of the budget, which is based on current available financial information;

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves the operating budget for CFY 2022 as presented and attached.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 8th day of December 2021 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Ligia Andrade Zuniga, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

Agenda Item: 5.1
Date: December 8, 2021

2022 Operating Budget

HPSM Commission

December 8, 2021

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Financial Summary and Outlook for 2022

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- The pandemic continues to cause financial variation, mostly savings in healthcare cost. Reduced physician visits and cancelled procedures in 2020 created the savings in that year. Reduced volume in long-term-care (LTC) facilities created savings in 2021.
- Budget revenue is based on draft Medi-Cal rates, which are expected to be updated with minor changes at a later date. Medi-Cal rate increases for 2022 were pretty good and pushes HPSM back to covering cost again.
- Medi-Cal rates include several adjustments in 2022. Rates will be reduced for the pharmacy carveout but are also being increased for the addition of the Dental benefit and Enhanced Care Management (ECM).
- In Lieu of Services (ILOS) is another area where there is new funding in 2022. This is an area where HPSM has incurred cost in the past with no reimbursement; but now the State is acknowledging this cost in rate setting.

Financial Summary and Outlook for 2022

Continued . . .

- Medicare revenue is risk adjusted based on the acuity of the member. Medicare revenue is expected to have smaller increases, partly due to the lower visit volume, which reduced opportunities for diagnosis capture.
- Lower earnings on our cash has also contributed to reduced income by about $6M annually due to the continued economic downturn.
- Management has kept administrative cost down by continuing to scrutinize hiring vacant positions, but new programs and benefits starting in 2022 will result in new positions. Medi-Cal rates include added dollars to fund these new programs.

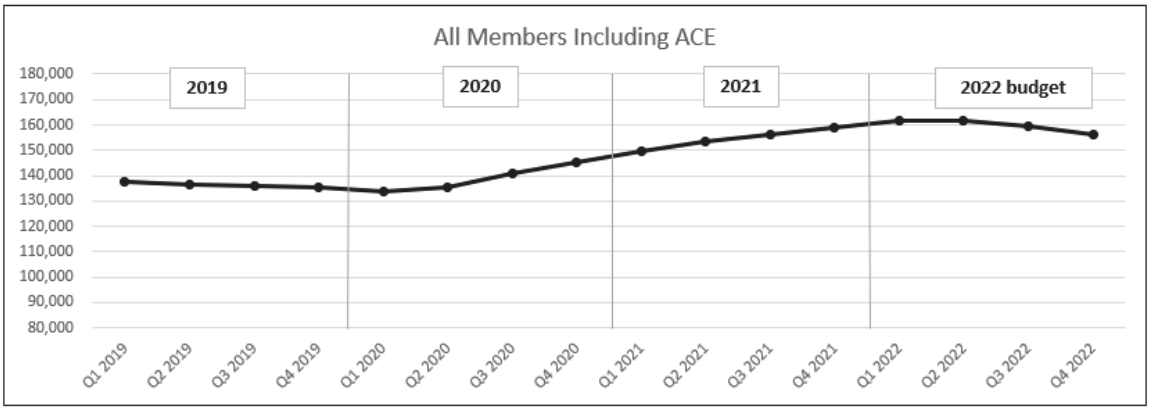
Proposed 2022 Budget

OPERATING REVENUES:		
Capitation & Premium Revenue	$	**903,665,508**
HEALTH CARE EXPENSE:		
Professional & OP Svs FFS	$	294,239,090
Inpatient Services		203,919,638
Long Term Care		165,253,991
Pharmacy		60,381,449
Provider Capitation (Incl. Kaiser)		50,933,383
UM / QA Costs		21,010,635
MLTSS (CBAS, MSSP, ECM)		20,594,064
Dental		17,803,262
Provicer Incentive Pool		9,215,592
Reinsurance/Other		2,670,893
Total Health Care Expenses	$	**846,021,997**
ADMINISTRATIVE EXPENSES	$	**55,751,215**
MCO Tax	$	-
Net Gain from Operations	$	**1,892,296**
NON-OPERATING REVENUES:		
Interest	$	1,000,000
Rental Income		1,175,881
ACE TPA Fees		2,187,301
Total Non-Operating Revenue	$	**4,363,181**
PROJECTED SURPLUS	$	**6,255,478**

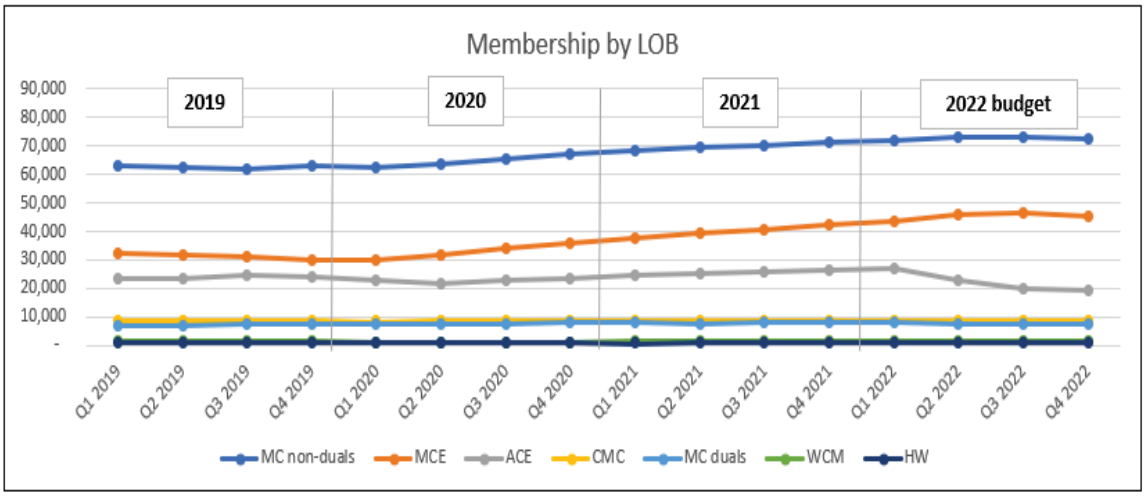
2022 Membership Assumptions

- HPSM has experienced a 19% increase in Medi-Cal membership since the beginning of 2020. This growth in Medi-Cal enrollment is expected to continue in early 2022, but at a slower pace, with small declines starting later in the year after the disenrollment process starts up again.
- CMC enrollment is expected to hold steady into 2022.
- New Medi-Cal eligibility criteria for immigrants over the age of 50 will result in a portion of members shifting from the ACE program to Medi-Cal starting in Q2 2022.

Membership Trends 2019-2022



Membership Trends 2019-2022



2022 Budget Summary by LOB

	Medi-Cal (non-duals)	Medi-Cal (duals)	MCE	WCM	CMC	HealthWorx	ACE	HPSM *	Total
Operating Revenue	$276,558 K	$89,121 K	$210,032 K	$34,485 K	$287,003 K	$6,466 K			$903,666 K
Health Care Expense	$255,051 K	$82,001 K	$193,040 K	$25,371 K	$284,452 K	$6,107 K			$846,022 K
Admin	$16,149 K	$3,606 K	$12,017 K	$1,672 K	$19,683 K	$482 K	$2,144 K		$55,751 K
MCO Tax	$0 K	$0 K	$0 K	$0 K	$0 K	$0 K			$0 K
Other Income							$2,187 K	$2,176 K	$4,363 K
Net Profit/(Loss)	$5,359 K	$3,515 K	$4,974 K	$7,443 K	($17,132 K)	($123 K)	$44 K	$2,176 K	$6,255 K
MLR	92%	92%	92%	74%	99%	94%			94%
Average Membership	72,661	7,791	45,416	1,381	8,857	1,228	22,277		159,611
Revenue PMPM	$ 317.18	$ 953.20	$ 385.38	$ 2,080.94	$ 2,700.44	$ 438.85	$ 8.18		

* *Interest Income & Rent Income*

Focus on Medical Cost

. . . a few areas of continued effort

- Improve utilization management, especially around inpatient, post-acute care and other facility cost.
- Focus on efficiency factors associated with lower revenue.
- Continue to focus on medical pharmacy utilization.
- Continue improvements on data analytics.
- Implement population health management approach for care management.

Administrative Budget

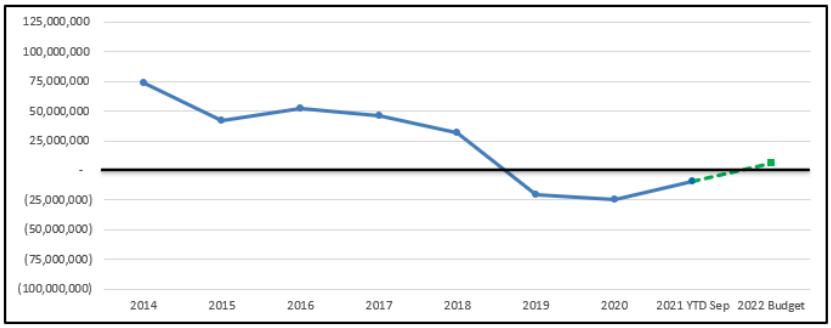
2021 to 2022 Change

Expense Category	2021 Budget	2022 Budget	Change	% Chng.
Salaries, Benefits, Training, Travel	41,382,680	45,451,750	4,069,070	9.8%
Consulting & Outside Services	17,562,400	16,794,300	(768,100)	-4.4%
Maintenance & Support	5,185,450	5,264,600	79,150	1.5%
Occupancy, Deprec & Amort	4,581,500	4,379,800	(201,700)	-4.4%
Postage, Delivery & Printing	1,552,300	1,799,000	246,700	15.9%
Office	1,403,600	1,519,000	115,400	8.2%
Other Admin Expenses	1,302,940	1,553,400	250,460	19.2%
Sub-Total	**72,970,870**	**76,761,850**	**3,790,980**	**5.2%**
UM/QA Allocation (to HC Cost)	(19,469,606)	(21,010,635)	(1,541,029)	7.9%
Total Admin Expense	**53,501,264**	**55,751,215**	**2,249,951**	**4.2%**
FTE's	320	334	14	4.4%

Note: FTE count include out of State employees paid thru agency

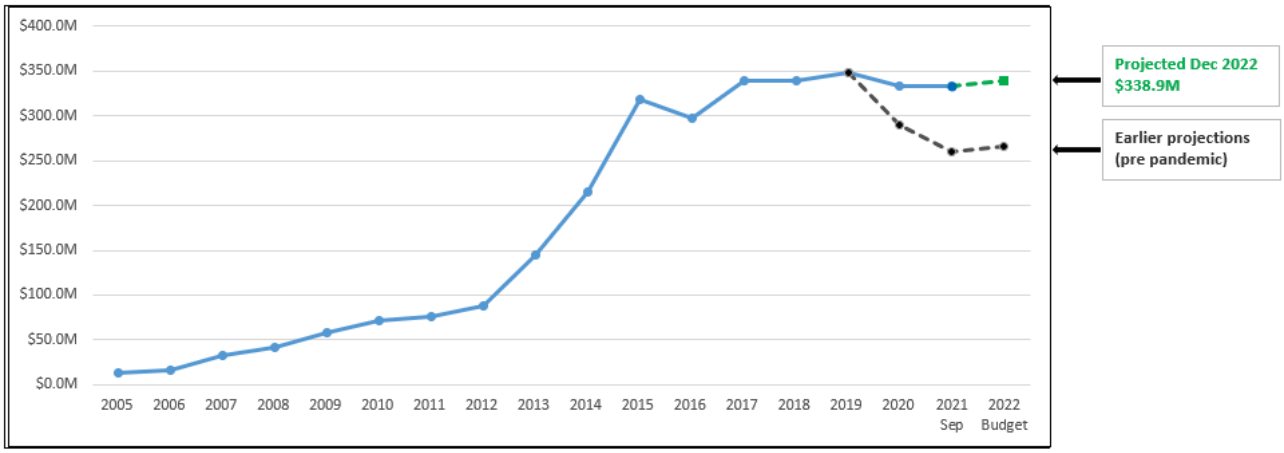
Historical Net Income/(Loss)

Eight-year trend – **Restated** w/ 2022 budget



	2014	2015	2016	2017	2018	2019	2020	2021 YTD Sep	2022 Budget
Revenue	$751,664 K	$851,603 K	$871,016 K	$860,542 K	$813,329 K	$767,506 K	$786,545 K	$666,572 K	$903,666 K
Healthcare Cost	$621,209 K	$741,544 K	$738,555 K	$717,251 K	$683,735 K	$719,271 K	$738,001 K	$615,815 K	$846,022 K
Admin Expense	$33,072 K	$36,365 K	$44,589 K	$46,764 K	$48,399 K	$50,566 K	$48,544 K	$37,365 K	$55,751 K
MCO Tax	$26,648 K	$35,332 K	$39,770 K	$57,351 K	$60,747 K	$31,242 K	$31,144 K	$25,648 K	$0 K
Operating Income/(Loss)	$70,736 K	$38,362 K	$48,102 K	$39,176 K	$20,448 K	($33,574 K)	($31,145 K)	($12,257 K)	$1,892 K
Non-Operating Revenue	$3,376 K	$3,263 K	$3,801 K	$7,390 K	$11,285 K	$12,685 K	$6,903 K	$3,454 K	$4,363 K
Net Income/(Loss)	$74,112 K	$41,625 K	$51,902 K	$46,565 K	$31,732 K	($20,889 K)	($24,242 K)	($8,803 K)	$6,255 K

Projected Tangible Net Equity (TNE)



Thank you

HealthPlan OF SAN MATEO
Healthy is for everyone

AGENDA ITEM: 5.2

DATE: December 8, 2021

Meeting materials are not included

for Item 5.2 – Resolution of Appreciation for Maya Altman, Chief Executive Officer

MEMORANDUM

AGENDA ITEM: 7.0

DATE: December 8, 2021

DATE: November 30, 2021

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: CEO Report

Reflections

I do not have any updates this month. Instead, I thought I'd reflect on my 16+ years at HPSM. I'm being interviewed at our monthly all staff meeting this week; one of the questions I'm pondering is what I'm most proud of as the leader of HPSM.

First, whenever I speak about the County Organized Health System (COHS) model, the model implemented by the San Mateo County Board of Supervisors in 1986-87 when current members of Congress Anna Eshoo and Jackie Speier were on the Board, I note that COHS plans are wonderful vehicles for community problem solving. That is how I've always seen the promise of HPSM, serving as a key part of the local health system, rooted in the community, and uniquely positioned to address local health issues together with other local health institutions and community-based organizations. In 2003, before I arrived at HSPM, County Health, HPSM, and leaders from many other organizations established the Children's Health Initiative, eventually creating the Healthy Kids insurance product sponsored by HPSM. The goal was to provide universal health coverage for all lower-income children in San Mateo County; together, we accomplished that well before Medi-Cal stepped up to cover all kids regardless of immigration status.

We have continued to respond to local concerns with creativity and passion. In 2006, we launched a Medicare product for dually eligible Medicare-Medi-Cal members, among the most vulnerable people we serve. In 2010, we added long-term care to our list of covered benefits. And, in 2014, we launched the Cal MediConnect federal-state demonstration program, again focusing on dually eligible members. Not all duals are older adults; many are younger people with severe mental illness or physical or intellectual disabilities. We started the Community Care Settings Program (CCSP) in 2014 as well, in part as a response to a shortage of nursing home beds for our most challenging members and what we feared was the County's pending closure of Burlingame Long Term Care, which would have eliminated nearly 300 nursing home beds. CCSP has helped hundreds of individuals move out of nursing homes or avoid them altogether. Along the way, we also were the first health plan in the state to integrate California Children's Services with managed care health plan operations back in 2013. This program serves severely ill children, many of them from Spanish speaking families.

The years of working closely together with San Mateo County Health and many other local organizations certainly helped us respond to the COVID-19 pandemic. Because we had initiated a nursing home collaborative, we had the trust and history to quickly establish a COVID center of excellence program to serve nursing home patients with COVID as safely as possible. Because of years working well together with County Health, we quickly leveraged each organizations' strengths to respond with effective campaigns shaped to ensure equitable access to vaccines. We are so grateful for County Health's leadership and perseverance during this terrible pandemic. There is of course more to do but we did as well in San Mateo County as any place in the country.

I'm proud HPSM is continuing to innovate and find new ways to serve our community. In 2022, the Dental Integration Program and Cal AIM will launch. Access to good dental care has long frustrated our members, leading to poorer health outcomes overall. HPSM worked to get special State legislation so we could offer the Medi-Cal dental benefit directly. And Cal AIM, especially the In Lieu of Services (ILOS) or Community Supports component, is built off programs that HPSM and our sister health plan, Inland Empire Health Plan (IEHP), have offered for several years using our own reserves.

Another point of pride is that HPSM, despite being the smallest Medi-Cal managed care plan in California, has had an outsized influence on State policy. The CCS integration program became broader State policy with the establishment of the Whole Child Model in nearly all the COHS plans throughout the state. IEHP and HPSM spent years advocating for implementing ILOS, which is the best way I know of to sustain financing for non-medical interventions such as housing, food, assisted living, and other social determinants of health that are not Medi-Cal benefits. Now the State of California is the leading state in the county in this area, having proposed the most ambitious ILOS program in the country.

Finally, and most important, I'm proud of the team we've built at HPSM. When I started in 2005, there were 70 employees and HPSM had nearly folded a couple of years prior to my arrival. Today, we have more than 300 employees. Thanks to many people, we have a strong culture and mission-driven employees who are intensely committed to the community and the organization. The leadership team is outstanding and ready to lead the organization for many years to come.

Thank you to the San Mateo Health Commission, whose membership has changed over the years but has always been incredibly supportive, creating the space for innovation and ensuring we always remain responsive to our members, providers, and community.