THE SAN MATEO HEALTH COMMISSION
Regular Meeting
March 11, 2020 - 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor, Boardroom
South San Francisco, CA 94080

AGENDA

1. Call to Order/Roll Call
2. Public Comment/Communication
3. Approval of Agenda
4. Consent Agenda*
   4.1 Report from Finance
   4.2 CMC Advisory Committee Minutes, January 2020
   4.3 CHI Oversight Committee Minutes, November 2019 and January 2020
   4.4 Consumer Advisory Committee, January 2020
   4.5 Physician Advisory Group Minutes, December 2019
   4.6 Quality Improvement Committee Minutes, December 2019
   4.7 Waive Request for Proposal, Ratify Agreement and Approve Amendment to Agreement with DME Consulting, Inc.
   4.8 Waive Request for Proposal and Approval of Agreement with DocuStream for Dental Program
   4.9 Approval of Amendment to Agreement with ALC
   4.10 Approval of 2020 Compliance Program and 2020 Code of Conduct
   4.11 Approval of Amendment to Agreement with SAS Institute, Inc.
   4.12 Approval of San Mateo Health Commission Meeting Minutes from January 8, 2020

5. Specific Discussion/Action Items
   5.1 Medi-Cal Healthier California for All (CalAIM) Presentation
   5.2 Annual Compliance Program Report
   5.3 Employee of the Year Presentation

6. Report from Chairman/Executive Committee
7. Report from Chief Executive Officer
8. Other Business
9. Adjournment

*Items for which Commission action is requested.

Government Code §54957.5 requires that public records related to items on the open session agenda for a regular commission meeting be made available for public inspection. Records distributed less than 72 hours prior to the meeting are available for public inspection at the same time they are distributed to all members, or a majority of the members of the Commission. The Commission has designated the Clerk of the San Mateo Health Commission located at 801 Gateway Boulevard, Suite 100, South San Francisco, CA 94080, for the purpose of making those public records available for inspection. Meetings are accessible to people with disabilities. Individuals who need special assistance or a disability-related modification or accommodation (including auxiliary aids or services) to participate in this meeting, or who have a disability and wish to request an alternative format for the agenda, meeting notice, agenda packet or other writings that may be distributed at the meeting, should contact the Clerk of the Commission at least two (2) working days before the meeting at (650) 616-0050. Notification in advance of the meeting will enable the Commission to make reasonable arrangements to ensure accessibility to this meeting and the materials related to it.
Preliminary 2019 Financial Results All Lines of Business

The preliminary financial result for all lines of business for the month of December is a deficit of $1,833,310. Year-to-date (YTD), the Plan has a surplus of $8,498,494. The table below shows a three-month trend, and YTD compared to budget. New lower MCE premium rates went into effect in July, causing approximately $2M in reduced revenue per month for the second half of the year.

In December, we changed our accounting method of grossing up hospital directed payments as revenue and expense, and instead will report these at “net” going forward. The YTD prior year portion of directed payments that were included in both revenue and healthcare expenses ($83M all hospital related) was reversed in December, leaving only the current year portion ($12M Prop 56 and GEMT), which will continue using the gross method.

<table>
<thead>
<tr>
<th>Monthly Trend</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Year-To-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Revenue</td>
<td>60,990,238</td>
<td>68,575,417</td>
<td>(35,121,013)</td>
<td>781,225,411</td>
</tr>
<tr>
<td>Healthcare Expenses</td>
<td>59,414,588</td>
<td>61,311,871</td>
<td>(57,041,475)</td>
<td>703,720,815</td>
</tr>
<tr>
<td>Administrative Expenses</td>
<td>4,029,063</td>
<td>4,000,351</td>
<td>4,701,752</td>
<td>50,566,188</td>
</tr>
<tr>
<td>Premium Taxes</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>31,099,624</td>
</tr>
<tr>
<td>Operating Income/(Loss)</td>
<td>(2,453,413)</td>
<td>3,263,195</td>
<td>(2,781,290)</td>
<td>(4,161,216)</td>
</tr>
<tr>
<td>Non-Operating Revenue</td>
<td>990,217</td>
<td>927,162</td>
<td>947,980</td>
<td>12,659,710</td>
</tr>
<tr>
<td>Net Income/(Loss)</td>
<td>(1,463,196)</td>
<td>4,190,357</td>
<td>(1,833,310)</td>
<td>8,498,494</td>
</tr>
</tbody>
</table>

The table below separates prior year (PY) and current year (CY) transactions. The full year now includes $39.8M in favorable prior year transactions. The remaining current year transactions results in a YTD deficit of $31.3M, compared to the YTD budget deficit of $7.3M.

<table>
<thead>
<tr>
<th>YTD by PY/CY</th>
<th>Prior Year</th>
<th>Current Year</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Revenue</td>
<td>29,784,883</td>
<td>751,440,528</td>
<td>781,225,411</td>
</tr>
<tr>
<td>Healthcare Expenses</td>
<td>(9,846,530)</td>
<td>713,567,345</td>
<td>703,720,815</td>
</tr>
<tr>
<td>Administrative Expenses</td>
<td>-</td>
<td>50,566,188</td>
<td>50,566,188</td>
</tr>
<tr>
<td>Premium Taxes</td>
<td>(142,281)</td>
<td>31,241,305</td>
<td>31,099,624</td>
</tr>
<tr>
<td>Operating Income/(Loss)</td>
<td>39,773,694</td>
<td>(43,934,910)</td>
<td>(4,161,216)</td>
</tr>
<tr>
<td>Non-Operating Revenue</td>
<td>(5,360)</td>
<td>12,655,070</td>
<td>12,659,710</td>
</tr>
<tr>
<td>Net Income/(Loss)</td>
<td>39,768,334</td>
<td>(31,269,840)</td>
<td>8,498,494</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Year YTD</th>
<th>Current Year</th>
<th>Budget</th>
<th>CY Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Revenue</td>
<td>751,440,528</td>
<td>778,978,717</td>
<td>(27,538,189)</td>
</tr>
<tr>
<td>Healthcare Expenses</td>
<td>713,567,345</td>
<td>688,117,598</td>
<td>25,449,747</td>
</tr>
<tr>
<td>Administrative Expenses</td>
<td>50,566,188</td>
<td>53,509,630</td>
<td>(2,943,442)</td>
</tr>
<tr>
<td>Premium Taxes</td>
<td>31,241,305</td>
<td>34,507,210</td>
<td>(23,325,305)</td>
</tr>
<tr>
<td>Operating Income/(Loss)</td>
<td>(43,934,910)</td>
<td>(17,215,721)</td>
<td>(26,719,189)</td>
</tr>
<tr>
<td>Non-Operating Revenue</td>
<td>12,665,070</td>
<td>9,877,353</td>
<td>2,787,717</td>
</tr>
<tr>
<td>Net Income/(Loss)</td>
<td>(31,269,840)</td>
<td>(7,338,368)</td>
<td>(23,931,472)</td>
</tr>
</tbody>
</table>
The graph below shows the YTD Preliminary Financial Results by line of business combining current year and prior year transactions.

The graph below shows the YTD Preliminary Financial Results excluding prior period transactions. Prior period adjustments are typically due to updated rates or member counts from DHCS and adjustments to prior year medical costs, as necessary.
Stabilization Reserve and Tangible Net Equity (TNE)
The financial protocol requires us to have a minimum Stabilization Reserve of two month’s operating expenses. The graph below reflects Net Equity as of December 31, 2019 at $348.0M.

Membership
Total membership at month-end stands at 132,615. *The ACE Participant count is overstated by approximately 2,000 due to a data issue with the State/County. This should be corrected for the February 2020 close.
HIGHLIGHTS BY LINE OF BUSINESS (LOB)
Below are the highlights by major LOB of the current year performance compared to budget. The highlighted columns represent the current year only, excluding prior year adjustments. The variance column in this section compares Current Year to Budget. Detailed Statements of Revenue and Expense on a consolidated basis, as well as for every line of business, are provided beginning on page 15.

MEDI-CAL (MC)

<table>
<thead>
<tr>
<th>YTD Actual</th>
<th>Current Year</th>
<th>YTD Budget</th>
<th>Variance</th>
<th>% Var.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership</td>
<td>832,022</td>
<td>832,022</td>
<td>818,316</td>
<td>13,706</td>
</tr>
<tr>
<td>Operating Revenue</td>
<td>$298,531 K</td>
<td>$298,908 K</td>
<td>$302,299 K</td>
<td>($3,391 K)</td>
</tr>
<tr>
<td>Healthcare Costs</td>
<td>$274,470 K</td>
<td>$277,064 K</td>
<td>$253,555 K</td>
<td>$23,509 K</td>
</tr>
<tr>
<td>Administrative Expenses</td>
<td>$16,830 K</td>
<td>$16,930 K</td>
<td>$16,750 K</td>
<td>$181 K</td>
</tr>
<tr>
<td>Premium Tax</td>
<td>$20,708 K</td>
<td>$20,955 K</td>
<td>$36,824 K</td>
<td>($15,869 K)</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>$312,109 K</td>
<td>$314,950 K</td>
<td>$307,129 K</td>
<td>$7,821 K</td>
</tr>
</tbody>
</table>

Net Surplus/(Loss) | ($13,578 K) | $2,464 K | ($16,042 K) | ($4,830 K) | ($11,212 K) | 232.1% |

MLR (Net of Premium Tax) | 99.7% | 95.5% | -4.2%

Current Year Performance

Directed payment gross-up adjustment:
- Change in accounting methodology - YTD prior year revenue and healthcare cost gross-up adjustment (recorded May/Jun/Sep) of $39.7M was reversed in Dec (now recorded at net), leaving $7.7M current year only for Prop 56 and GEMT (remains recorded at gross).

MC Revenue Drivers:
- DHCS rate setting changes decreased 2017 and 2019 rates for CCI duals by about $8M (split between PY and CY). There is an offset with the CCI duals on the MC-CMC LOB. The 2018 adjustments are still pending. The non-CMC dual population is still included in this MC LOB but will eventually be pulled out into a separate LOB in 2020 reporting.
- After these Dec adjustments, YTD revenue is below budget by $3.4M. This is made up of 1) higher revenue of $5.0M due to more members than budget, 2) higher revenue of $7.7M from directed payments, and 3) lower revenue of $16.1M due to lower than budget rates PMPM (partly due to CCI shift from MC to MC-CMC).

MC Healthcare Expense:
- Healthcare cost is running $23.5M over budget, of which $7.7M is the directed payment gross-up. The remaining $15.8M is due to higher membership (+4.2M), and higher PMPM cost (+$11.6M) in the areas of hospital inpatient and LTC.
Medi-Cal Expansion (MCE)

**Current Year Performance**

Directed payment gross-up adjustment:
- Change in accounting methodology - YTD prior year revenue and healthcare cost gross-up adjustment (recorded May/Jun/Sep) of $41.6M was reversed in Dec (now recorded at net), leaving $3.7M current year only for Prop 56 and GEMT (remains recorded at gross).

MCE Revenue Drivers:
- Revenue is below budget by $3.9M. This is made up of 1) higher revenue of $4.2M due to more members than budget, 2) higher revenue of $3.7M from directed payments, and 3) lower revenue of $11.8M due to lower than budget rates PMPM
- MCE was hit the hardest with lower premium rates that went into effect in July. This by itself is about a $2M per month decrease in revenue for this LOB, resulting in about $12M reduced revenue for last half of 2019.

MCE Healthcare Expense Trends:
- Healthcare cost is above budget by $9.1M, of which $3.7M is the directed payment gross-up. Another $3.5M is due to the higher membership, and the remaining $1.9M is due to higher PMPM cost in the areas of hospital IP and hospital OP.
Whole Child Model, WCM (previously CCS)

### Current Year Performance

**Directed Year Payment Gross-up Adjustment:**
- Change in accounting methodology - YTD prior year revenue and healthcare cost gross-up adjustment (recorded May/Jun/Sep) of $2.2M was reversed in Dec (now recorded at net), leaving $.4M current year only for Prop 56 and GEMT (remains recorded at gross).

**WCM Revenue Drivers:**
- In Dec, YTD revenue was reduced by about $6M retro back to July 2018 due to Medi-Cal membership flagged as CCS/WCM in error. The members remain in the CCS LOB for now (with reduced revenue) but will be moved to the MC LOB after more validating is done.
- After these Dec adjustments, revenue is below budget by $8.1M. This is a combination of 1) under budget by $.4M due to the directed payment adjustment, and 2) under budget by $3.4M due to lower membership, and 3) under budget by $5.1M due to lower premium PMPM (mostly from the large Dec adjustment).

**WCM Healthcare Expense Trends:**
- In total, healthcare cost is running under budget by $2.4M. This is a combination of 1) over budget by $.4K for the directed payment adjustment, 2) under budget by $3.0M due to lower membership, and 3) over budget by $.2M in higher PMPM cost (IP over, offset by other categories being under).
CAREADVANTAGE (MC + CA Combined)
See detail reports attached for separate P&L by insurance product (MC and CA).

<table>
<thead>
<tr>
<th></th>
<th>YTD Actual</th>
<th>Prior Year ADJ</th>
<th>Current Year</th>
<th>YTD Budget</th>
<th>Variance</th>
<th>% Var.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership</td>
<td>105,438</td>
<td>-</td>
<td>105,438</td>
<td>109,116</td>
<td>(3,678)</td>
<td>-3.4%</td>
</tr>
<tr>
<td>Operating Revenue</td>
<td>$272,766 K</td>
<td>$24,381 K</td>
<td>$246,385 K</td>
<td>$259,867 K</td>
<td>($11,483 K)</td>
<td>-4.4%</td>
</tr>
<tr>
<td>Healthcare Costs</td>
<td>$243,543 K</td>
<td>($2,326 K)</td>
<td>$245,869 K</td>
<td>$250,432 K</td>
<td>($4,563 K)</td>
<td>-1.8%</td>
</tr>
<tr>
<td>Administrative Expenses</td>
<td>$18,633 K</td>
<td>0 K</td>
<td>$18,633 K</td>
<td>$18,584 K</td>
<td>49 K</td>
<td>0.3%</td>
</tr>
<tr>
<td>Premium Tax</td>
<td>0 K</td>
<td>0 K</td>
<td>0 K</td>
<td>0 K</td>
<td>0 K</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>$262,176 K</td>
<td>($2,326 K)</td>
<td>$264,502 K</td>
<td>$269,015 K</td>
<td>($4,514 K)</td>
<td>-1.7%</td>
</tr>
<tr>
<td>Net Surplus/(Loss)</td>
<td>$10,590 K</td>
<td>$26,707 K</td>
<td>($16,117 K)</td>
<td>($9,148 K)</td>
<td>($6,969 K)</td>
<td>76.2%</td>
</tr>
</tbody>
</table>

MLR (Net of Premium Tax) | 99.0% | 96.4% | -2.6%

Current Year Performance

Directed payment gross-up adjustment:
- No directed payment adjustments for CMC line of business.

CMC Revenue Drivers:
- Revenue is below budget by $11.5M. This is the net of 1) below budget by $8.8M due to lower than budget membership, and 2) below budget by $2.7M due to lower premium yield (CA-CMC side under by $7.0M, and MC-CMC side over by $4.3M). The $4.3M over budget on MC-CMC is partly from the current portion shift from the MC LOB from revised CCI rates.

CMC Healthcare Expense Trends:
- Healthcare cost is below budget by $4.5M. This is the net of 1) below budget by $8.4M due to lower than budget membership, and 2) over budget by $3.9M due to slightly higher cost PMPM. Hospital IP and Hospital OP are running high, which is partially offset by lower than budget Pharmacy and Other Medical cost.
HEALTHWORX, HEALTHY KIDS, ACE

HealthWorx:
- YTD performance through December shows a deficit of $387K, compared to budget deficit of $424K. Membership is running close to budget. The improvement is slightly lower healthcare cost in the last two months. Also, the MCO tax has not been assessed for the last half of the year, creating a favorable budget variance, but this may still be assessed once the State budget is approved.

Healthy Kids:
- YTD performance through December shows a surplus of $1,393K, compared to budget surplus of $1,348K. Starting October 1, 2019, the Healthy Kids program ended, and most of these members were transitioned to the classic Medi-Cal program. Adjustments made since October 1st are mostly to claim cost estimates.

ACE:
- YTD performance through December shows a surplus of $243K, compared to a budget surplus of $140K. ACE membership is running 14% under budget.

HIGHLIGHTS OF ADDITIONAL METRICS

Revenue
Below is a depiction of revenue by each line of business in 2019. The largest share of HPSM revenue comes from the Medi-Cal Lines of Business: classic Medi-Cal, Medi-Cal Expansion, CCS/Whole Child Model and Medi-Cal CMC.
**HealthCare Expenses**
The graph below reflects how healthcare dollars are being spent in 2019.

Administrative Expenses
Administrative expenses are expressed as a percentage of net revenue received. The administrative expense percentage for 2019 has normalized to 6.47% after the reclass of the gross-up adjustments recorded in May/Jun/Shp. The percentage jump in 2018 was due to the transition of IHSS (financial) responsibility back to the State; therefore, resulting in lowered revenues.
Investment and Interest
Total interest earned for the month was $671,891 and $9,328,216 year to date.

CMC Enrollment/Disenrollment
The YTD disenrollment’s were slightly higher than enrollments at the end of December 2019. The graph does not reflect the work of the CA Outreach Unit who saved 1,347 members (YTD) from being disenrolled. The CA Unit helps restore Medi-Cal eligibility or helps member restore SSI benefits.

CLAIMS
In the month of December, the Health Plan paid a total of 339,246 claims representing $50,924,082 worth of services to our members with 98.8% of those claims being paid within 30 days.
**Investment and Interest**
Total interest earned for the month was $671,891 and $9,328,216 year to date.

**CMC Enrollment/Disenrollment**
The YTD disenrollment’s were slightly higher than enrollments at the end of December 2019. The graph does not reflect the work of the CA Outreach Unit who saved 1,347 members (YTD) from being disenrolled. The CA Unit helps restore Medi-Cal eligibility or helps member restore SSI benefits.

![CA/CMP Enrollments/Disenrollments (YTD)](image)

**CLAIMS**
In the month of December, the Health Plan paid a total of 339,246 claims representing $50,924,082 worth of services to our members with 98.8% of those claims being paid within 30 days.

![Claim Dollars Paid 2019](image)
### Health Plan of San Mateo
#### Fiscal Year 2019

**Statistical and Financial Summary**  
**December-19**

<table>
<thead>
<tr>
<th>Month</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>Operating Margin</th>
<th>Year-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td></td>
<td>(34,173,033)</td>
<td>65,669,484 ▼</td>
<td>($99,842,517) ▼</td>
<td>Total Revenue</td>
<td>793,885,121</td>
</tr>
<tr>
<td></td>
<td>(37,041,475)</td>
<td>56,588,722 ▼</td>
<td>($93,630,197) ▼</td>
<td>Total Health Care Costs</td>
<td>703,720,815</td>
</tr>
<tr>
<td></td>
<td>4,701,752</td>
<td>4,859,318 ▼</td>
<td>($157,566) ▼</td>
<td>Total Operational Admin Expenses</td>
<td>50,566,190</td>
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<tr>
<td></td>
<td>-</td>
<td>4,547,268 ▼</td>
<td>($4,547,268) ▼</td>
<td>Total MCO &amp; AB78 Tax</td>
<td>31,099,624</td>
</tr>
<tr>
<td></td>
<td>(1,833,310)</td>
<td>($325,824) ▼</td>
<td>($1,507,486) ▼</td>
<td>Total Current Year Surplus (Deficit)</td>
<td>$8,498,493</td>
</tr>
</tbody>
</table>

-13.8%

<table>
<thead>
<tr>
<th>Month</th>
<th>Current</th>
<th>Prior</th>
<th>Variance</th>
<th>Membership</th>
<th>Year-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current</td>
<td>Prior</td>
<td>Variance</td>
<td>Current MM's</td>
<td>Budget MM's</td>
</tr>
<tr>
<td></td>
<td>97,616</td>
<td>99,408</td>
<td>(1,792)</td>
<td>1,207,620</td>
<td>1,184,364</td>
</tr>
<tr>
<td></td>
<td>8,815</td>
<td>8,848</td>
<td>(33)</td>
<td>106,370</td>
<td>109,728</td>
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<tr>
<td></td>
<td>1,648</td>
<td>1,679</td>
<td>(31)</td>
<td>20,207</td>
<td>22,200</td>
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<tr>
<td></td>
<td>1,158</td>
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<td>0</td>
<td>13,869</td>
<td>13,740</td>
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<td></td>
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<td>0</td>
<td>14,406</td>
<td>18,240</td>
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<tr>
<td></td>
<td>23,378</td>
<td>23,204</td>
<td>174</td>
<td>284,255</td>
<td>329,820</td>
</tr>
<tr>
<td></td>
<td>132,615 *</td>
<td>134,297 *</td>
<td>(1,682)</td>
<td>1,646,367 *</td>
<td>1,678,092 *</td>
</tr>
</tbody>
</table>

* Total does not include Medi-cal CMC members, who in theory are the same as the CA CMC membership.
Health Plan of San Mateo  
Consolidated Balance Sheet  
December 31, 2019 and November 30, 2019

<table>
<thead>
<tr>
<th></th>
<th>Current Month</th>
<th>Prior Month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and Equivalents</td>
<td>$ 255,928,919</td>
<td>$ 271,219,257</td>
</tr>
<tr>
<td>Investments</td>
<td>165,899,471</td>
<td>165,899,471</td>
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<tr>
<td>Capitation Receivable from the State</td>
<td>52,906,226</td>
<td>59,999,218</td>
</tr>
<tr>
<td>Other Receivables</td>
<td>56,567,258</td>
<td>44,492,255</td>
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<tr>
<td>Prepaid and Other Assets</td>
<td>7,490,191</td>
<td>7,748,213</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>538,792,065</td>
<td>549,358,414</td>
</tr>
<tr>
<td><strong>Capital Assets, Net</strong></td>
<td>67,467,846</td>
<td>67,546,408</td>
</tr>
<tr>
<td><strong>Net Pension Asset</strong></td>
<td>989,040</td>
<td>-</td>
</tr>
<tr>
<td><strong>Assets Restricted As To Use</strong></td>
<td>300,000</td>
<td>300,000</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>607,548,952</td>
<td>617,204,823</td>
</tr>
<tr>
<td><strong>Deferred Outflows of Resources</strong></td>
<td>2,921,645</td>
<td>3,508,821</td>
</tr>
<tr>
<td><strong>Total Assets &amp; Deferred Outflows</strong></td>
<td>$ 610,470,597</td>
<td>$ 620,713,644</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Current Month</th>
<th>Prior Month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LIABILITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Claims Payable</td>
<td>67,219,697</td>
<td>65,599,127</td>
</tr>
<tr>
<td>Provider Incentives</td>
<td>6,479,966</td>
<td>5,931,510</td>
</tr>
<tr>
<td>Amounts Due to the State</td>
<td>99,563,364</td>
<td>113,556,320</td>
</tr>
<tr>
<td>Accounts Payable and Accrued Liabilities</td>
<td>86,281,307</td>
<td>83,358,102</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>259,544,334</td>
<td>268,445,059</td>
</tr>
<tr>
<td><strong>Net Pension Liability</strong></td>
<td>-</td>
<td>914,189</td>
</tr>
<tr>
<td><strong>Deferred Inflows of Resources</strong></td>
<td>2,907,630</td>
<td>1,502,453</td>
</tr>
<tr>
<td><strong>Total Liabilities &amp; Deferred Inflows</strong></td>
<td>$ 262,451,964</td>
<td>$ 270,861,701</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Current Month</th>
<th>Prior Month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NET POSITION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invested in Capital Assets</td>
<td>67,467,846</td>
<td>67,546,408</td>
</tr>
<tr>
<td>Restricted By Legislative Authority</td>
<td>300,000</td>
<td>300,000</td>
</tr>
<tr>
<td><strong>Unrestricted</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stabilization Reserve</td>
<td>130,897,771</td>
<td>153,138,000</td>
</tr>
<tr>
<td>Unrestricted Retained Earnings</td>
<td>149,353,016</td>
<td>128,867,534</td>
</tr>
<tr>
<td><strong>Net Position</strong></td>
<td>348,018,633</td>
<td>349,851,943</td>
</tr>
<tr>
<td><strong>Total Liabilities &amp; Net Position</strong></td>
<td>$ 610,470,597</td>
<td>$ 620,713,644</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Current Month</th>
<th>Prior Month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Change in Net Position</strong></td>
<td>$ 8,498,493</td>
<td>$ 10,331,802</td>
</tr>
<tr>
<td></td>
<td>Current Mo Actual</td>
<td>Current Mo Budget</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>OPERATING REVENUE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Operating Revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OPERATING EXPENSE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Health Care Expense</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Operating Expense</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NON-OPERATING REVENUE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest, Net</td>
<td>671,891</td>
<td>500,000</td>
</tr>
<tr>
<td>Rental Income, Net</td>
<td>94,361</td>
<td>89,490</td>
</tr>
<tr>
<td>Miscellaneous Income</td>
<td>60</td>
<td>-</td>
</tr>
<tr>
<td>Total Non-Operating</td>
<td>766,312</td>
<td>589,490</td>
</tr>
<tr>
<td><strong>Net Income/(Loss)</strong></td>
<td>$766,312</td>
<td>$589,490</td>
</tr>
<tr>
<td>Medical Loss Ratio</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Member Counts</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
## Medi-Cal Statement of Revenue & Expense
for the Period Ending December 31, 2019

### Operating Revenue

<table>
<thead>
<tr>
<th>Current Mo Actual</th>
<th>Current Mo Budget</th>
<th>% of Budget</th>
<th>Y-T-D Actual</th>
<th>Y-T-D Budget</th>
<th>Y-T-D Variance</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State Capitation</strong></td>
<td>$12,446,816</td>
<td>$24,683,577</td>
<td>50.4%</td>
<td>$369,385,327</td>
<td>$302,299,036</td>
<td>$67,086,291</td>
</tr>
<tr>
<td><strong>BHT Capitation</strong></td>
<td>$2,399,417</td>
<td>-</td>
<td>-</td>
<td>$8,204,920</td>
<td>-</td>
<td>$8,204,920</td>
</tr>
<tr>
<td><strong>HepC Capitation</strong></td>
<td>$135,997</td>
<td>-</td>
<td>-</td>
<td>$1,639,328</td>
<td>-</td>
<td>$1,639,328</td>
</tr>
<tr>
<td><strong>MC Cap Offset</strong></td>
<td>$(45,277,915)</td>
<td>-</td>
<td>-</td>
<td>$(80,698,604)</td>
<td>-</td>
<td>$(80,698,604)</td>
</tr>
<tr>
<td><strong>Total Operating Revenue</strong></td>
<td>$(30,295,685)</td>
<td>$24,683,577</td>
<td>-122.7%</td>
<td>298,530,970</td>
<td>302,299,036</td>
<td>$(3,768,066)</td>
</tr>
</tbody>
</table>

### Operating Expense

| Provider Capitation | $1,370,414 | $1,436,081 | 95.4% | $16,714,020 | $17,388,807 | $(674,786) | 96.1% |
| Hospital Inpatient | $2,770,933 | $3,545,520 | 78.2% | $48,236,840 | $44,295,484 | $3,941,355 | 108.9% |
| Long Term Care | $7,740,382 | $5,634,442 | 137.4% | $75,917,522 | $67,058,066 | $8,859,455 | 113.2% |
| Pharmacy | $3,694,350 | $3,106,673 | 118.9% | $37,388,502 | $37,717,873 | $(329,371) | 99.1% |
| Physician Fee for Service | $(4,637,328) | $1,971,872 | -235.2% | $23,114,322 | $25,259,797 | $(2,145,475) | 91.5% |
| Hospital Outpatient | $2,171,815 | $2,013,998 | 107.8% | $26,192,539 | $24,823,207 | $1,369,332 | 105.5% |
| Other Medical Claims | $1,925,912 | $1,721,902 | 111.9% | $21,634,810 | $21,223,025 | $411,784 | 101.9% |
| Other HC Services | $1,532,454 | $418,472 | 366.2% | $6,510,982 | $5,157,806 | $1,353,175 | 126.2% |
| Directed Payments | $(38,843,971) | - | - | $7,284,260 | - | $7,284,260 | - |
| Long Term Support Services | $(413,890) | $73,165 | -565.7% | $878,512 | $901,784 | $(114,272) | 87.3% |
| Provider Incentives | $592,534 | $152,637 | 388.2% | $2,560,492 | $1,881,308 | $679,184 | 136.1% |
| Health Care Supplmntl Benefits | $(158,754) | $156,006 | -101.8% | $2,325,716 | $1,922,822 | $402,894 | 121.0% |
| Indirect Health Care Expenses | $146,767 | $32,342 | 453.8% | $1,144,126 | $398,624 | $745,502 | 287.0% |
| Delegated UM/QA | $7,969 | - | - | $(208,634) | - | $(208,634) | - |
| Healthcare Allocation | $373,801 | $460,555 | 81.2% | $4,867,411 | $5,526,660 | $(659,249) | 88.1% |
| UMQA (Allocation & Delegated) | $381,770 | $460,555 | 82.9% | $4,658,777 | $5,526,660 | $(867,883) | 84.3% |
| **Total Health Care Expense** | $(21,726,612) | $20,723,666 | -104.8% | $274,470,419 | $253,555,265 | $20,915,154 | 108.3% |
| G&A Allocation | $1,454,770 | $1,521,070 | 95.6% | $16,930,349 | $16,749,648 | $180,701 | 101.1% |
| Premium Tax | - | $3,068,685 | - | $20,708,044 | $36,824,220 | $(16,116,176) | 56.2% |
| **Total Operating Expense** | $(20,271,842) | $25,313,420 | -80.1% | $312,108,811 | $307,129,133 | $4,979,679 | 101.6% |

### Non-Operating Revenue

| Miscellaneous Income | $(45) | - | - | - | - | - | - |
| **Total Non-Operating** | $(45) | - | - | - | - | - | - |
| **Net Income/(Loss)** | $(10,023,889) | $(629,843) | 1591.5% | $(13,577,841) | $(4,830,097) | $(8,747,744) | 281.1% |

| Medical Loss Ratio | 71.72% | 95.88% | 98.79% | 95.1% |
| Member Counts | 68,041 | 65,993 | 103.1% | 832,022 | 818,316 | 13,706 | 101.7% |
## HealthWorx Statement of Revenue & Expense
for the Period Ending December 31, 2019

<table>
<thead>
<tr>
<th>OPERATING REVENUE</th>
<th>Current Mo Actual</th>
<th>Current Mo Budget</th>
<th>% of Budget</th>
<th>Y-T-D Actual</th>
<th>Y-T-D Budget</th>
<th>Y-T-D Variance</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthWorx Premium</td>
<td>370,272</td>
<td>368,112</td>
<td>100.6%</td>
<td>4,456,211</td>
<td>4,417,348</td>
<td>38,863</td>
<td>100.9%</td>
</tr>
<tr>
<td>Total Operating Revenue</td>
<td>370,272</td>
<td>368,112</td>
<td>100.6%</td>
<td>4,456,211</td>
<td>4,417,348</td>
<td>38,863</td>
<td>100.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPERATING EXPENSE</th>
<th>Current Mo Actual</th>
<th>Current Mo Budget</th>
<th>% of Budget</th>
<th>Y-T-D Actual</th>
<th>Y-T-D Budget</th>
<th>Y-T-D Variance</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient</td>
<td>42,251</td>
<td>59,135</td>
<td>71.5%</td>
<td>298,452</td>
<td>709,624</td>
<td>(411,172)</td>
<td>42.1%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>139,895</td>
<td>109,414</td>
<td>127.9%</td>
<td>1,802,773</td>
<td>1,312,967</td>
<td>489,806</td>
<td>137.3%</td>
</tr>
<tr>
<td>Physician Fee for Service</td>
<td>83,419</td>
<td>80,924</td>
<td>103.1%</td>
<td>972,495</td>
<td>971,085</td>
<td>1,410</td>
<td>100.2%</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>71,406</td>
<td>79,986</td>
<td>89.3%</td>
<td>1,046,993</td>
<td>959,828</td>
<td>87,165</td>
<td>109.1%</td>
</tr>
<tr>
<td>Other Medical Claims</td>
<td>13,013</td>
<td>20,529</td>
<td>63.4%</td>
<td>205,014</td>
<td>246,344</td>
<td>(41,331)</td>
<td>83.2%</td>
</tr>
<tr>
<td>Other HC Services</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>0</td>
<td>-</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Health Care Supplmntl Benefits</td>
<td>100</td>
<td>-</td>
<td>-</td>
<td>1,085</td>
<td>-</td>
<td>1,085</td>
<td>-</td>
</tr>
<tr>
<td>Indirect Health Care Expenses</td>
<td>3,346</td>
<td>583</td>
<td>573.9%</td>
<td>6,792</td>
<td>6,997</td>
<td>(205)</td>
<td>97.1%</td>
</tr>
<tr>
<td>Healthcare Allocation</td>
<td>11,724</td>
<td>10,528</td>
<td>111.4%</td>
<td>89,555</td>
<td>126,335</td>
<td>(36,780)</td>
<td>70.9%</td>
</tr>
<tr>
<td>UMQA (Allocation &amp; Delegated)</td>
<td>11,724</td>
<td>10,528</td>
<td>111.4%</td>
<td>89,555</td>
<td>126,335</td>
<td>(36,780)</td>
<td>70.9%</td>
</tr>
<tr>
<td>Total Health Care Expense</td>
<td>365,154</td>
<td>361,098</td>
<td>101.1%</td>
<td>4,423,158</td>
<td>4,333,180</td>
<td>89,978</td>
<td>102.1%</td>
</tr>
<tr>
<td>G&amp;A Allocation</td>
<td>40,437</td>
<td>35,556</td>
<td>113.7%</td>
<td>359,988</td>
<td>391,529</td>
<td>(31,541)</td>
<td>91.9%</td>
</tr>
<tr>
<td>Premium Tax</td>
<td>-</td>
<td>9,733</td>
<td>-</td>
<td>59,724</td>
<td>116,790</td>
<td>(57,066)</td>
<td>51.1%</td>
</tr>
<tr>
<td>Total Operating Expense</td>
<td>405,591</td>
<td>406,836</td>
<td>99.8%</td>
<td>4,842,870</td>
<td>4,841,499</td>
<td>1,371</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

## NON-OPERATING REVENUE

<table>
<thead>
<tr>
<th>Total Non-Operating</th>
<th>-</th>
<th>-</th>
<th>-</th>
<th>-</th>
<th>-</th>
<th>-</th>
<th>-</th>
</tr>
</thead>
</table>

| Net Income/(Loss)   | $ (35,319)       | $ (38,274)       | 92.3%       | $ (386,659)  | $ (424,151)  | $ 37,492       | 91.2%       |

| Medical Loss Ratio  | 98.62%           | 100.76%          | 100.61%     | 100.76%      | 100.76%      |                 |             |
| Member Counts       | 1,158            | 1,145            | 101.1%      | 13,933       | 13,740       | 193            | 101.4%      |
### Health Plan of San Mateo
**Healthy Kids Statement of Revenue & Expense**
for the Period Ending December 31, 2019

<table>
<thead>
<tr>
<th></th>
<th>Current Mo Actual</th>
<th>Current Mo Budget</th>
<th>% of Budget</th>
<th>Y-T-D Actual</th>
<th>Y-T-D Budget</th>
<th>Y-T-D Variance</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OPERATING REVENUE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Kids Premium</td>
<td>(23,058)</td>
<td>287,280</td>
<td>-8.0%</td>
<td>2,786,238</td>
<td>3,447,360</td>
<td>(661,122)</td>
<td>80.8%</td>
</tr>
<tr>
<td>Total Operating Revenue</td>
<td>(23,058)</td>
<td>287,280</td>
<td>-8.0%</td>
<td>2,786,238</td>
<td>3,447,360</td>
<td>(661,122)</td>
<td>80.8%</td>
</tr>
<tr>
<td><strong>OPERATING EXPENSE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>(39,666)</td>
<td>19,868</td>
<td>-199.7%</td>
<td>16,488</td>
<td>238,415</td>
<td>(221,927)</td>
<td>6.9%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>43</td>
<td>22,828</td>
<td>0.2%</td>
<td>264,146</td>
<td>273,933</td>
<td>(9,787)</td>
<td>96.4%</td>
</tr>
<tr>
<td>Physician Fee for Service</td>
<td>(7,441)</td>
<td>34,697</td>
<td>-21.5%</td>
<td>348,756</td>
<td>416,364</td>
<td>(67,609)</td>
<td>83.8%</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>(7,478)</td>
<td>23,493</td>
<td>-31.8%</td>
<td>281,628</td>
<td>281,917</td>
<td>(290)</td>
<td>99.9%</td>
</tr>
<tr>
<td>Other Medical Claims</td>
<td>753</td>
<td>9,584</td>
<td>7.9%</td>
<td>88,173</td>
<td>115,012</td>
<td>(26,840)</td>
<td>76.7%</td>
</tr>
<tr>
<td>Other HC Services</td>
<td>(121,369)</td>
<td>-</td>
<td>-</td>
<td>(75,364)</td>
<td>-</td>
<td>(75,364)</td>
<td>-</td>
</tr>
<tr>
<td>Health Care Supplmntl Benefits</td>
<td>-</td>
<td>37,233</td>
<td>-</td>
<td>334,138</td>
<td>446,792</td>
<td>(112,653)</td>
<td>74.8%</td>
</tr>
<tr>
<td>Indirect Health Care Expenses</td>
<td>(3,538)</td>
<td>700</td>
<td>-505.7%</td>
<td>42,793</td>
<td>8,395</td>
<td>34,399</td>
<td>509.8%</td>
</tr>
<tr>
<td>Healthcare Allocation</td>
<td>(5,867)</td>
<td>3,323</td>
<td>-176.6%</td>
<td>14,274</td>
<td>39,876</td>
<td>(25,602)</td>
<td>35.8%</td>
</tr>
<tr>
<td>UMQA (Allocation &amp; Delegated)</td>
<td>(5,867)</td>
<td>3,323</td>
<td>-176.6%</td>
<td>14,274</td>
<td>39,876</td>
<td>(25,602)</td>
<td>35.8%</td>
</tr>
<tr>
<td>Total Health Care Expense</td>
<td>(184,563)</td>
<td>151,725</td>
<td>-121.6%</td>
<td>1,315,032</td>
<td>1,820,704</td>
<td>(505,673)</td>
<td>72.2%</td>
</tr>
<tr>
<td>G&amp;A Allocation</td>
<td>(18,865)</td>
<td>11,223</td>
<td>-168.1%</td>
<td>83,600</td>
<td>123,582</td>
<td>(39,982)</td>
<td>67.7%</td>
</tr>
<tr>
<td>Premium Tax</td>
<td>-</td>
<td>12,920</td>
<td>-</td>
<td>(6,346)</td>
<td>155,040</td>
<td>(161,386)</td>
<td>-4.1%</td>
</tr>
<tr>
<td>Total Operating Expense</td>
<td>(203,428)</td>
<td>175,686</td>
<td>-115.7%</td>
<td>1,392,286</td>
<td>2,099,326</td>
<td>(707,040)</td>
<td>66.3%</td>
</tr>
<tr>
<td><strong>NON-OPERATING REVENUE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-Operating</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net Income/(Loss)</strong></td>
<td>$180,370</td>
<td>$111,412</td>
<td>161.9%</td>
<td>$1,393,952</td>
<td>$1,348,034</td>
<td>$45,918</td>
<td>103.4%</td>
</tr>
<tr>
<td>Medical Loss Ratio</td>
<td>800.43%</td>
<td>55.30%</td>
<td>55.30%</td>
<td>47.09%</td>
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<td>Current Mo Budget</td>
<td>% of Budget</td>
<td>Y-T-D Actual</td>
<td>Y-T-D Budget</td>
<td>Y-T-D Variance</td>
<td>% of Budget</td>
</tr>
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<tr>
<td><strong>OPERATING REVENUE</strong></td>
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<tr>
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<td><strong>Net Income/(Loss)</strong></td>
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<td>$ 42,602</td>
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<td>$ 42,602</td>
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<td>1.13%</td>
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<tr>
<td>Member Counts</td>
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# Health Plan of San Mateo
## ACE Statement of Revenue & Expense
### for the Period Ending December 31, 2019

<table>
<thead>
<tr>
<th></th>
<th>Current Mo Actual</th>
<th>Current Mo Budget</th>
<th>% of Budget</th>
<th>Y-T-D Actual</th>
<th>Y-T-D Budget</th>
<th>Y-T-D Variance</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OPERATING REVENUE</strong></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Total Operating Revenue</td>
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<tr>
<td><strong>OPERATING EXPENSE</strong></td>
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</tr>
<tr>
<td>Total Health Care Expense</td>
<td>-</td>
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<td>-</td>
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<td>-</td>
</tr>
<tr>
<td>G&amp;A Allocation</td>
<td>166,888</td>
<td>241,859</td>
<td>69.0%</td>
<td>2,000,724</td>
<td>2,663,297</td>
<td>(662,573)</td>
<td>75.1%</td>
</tr>
<tr>
<td>Total Operating Expense</td>
<td>166,888</td>
<td>241,859</td>
<td>69.0%</td>
<td>2,000,724</td>
<td>2,663,297</td>
<td>(662,573)</td>
<td>75.1%</td>
</tr>
<tr>
<td><strong>NON-OPERATING REVENUE</strong></td>
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<td></td>
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</tr>
<tr>
<td>Third Party Administror Revenue</td>
<td>181,713</td>
<td>233,623</td>
<td>77.8%</td>
<td>2,244,536</td>
<td>2,803,470</td>
<td>(558,935)</td>
<td>80.1%</td>
</tr>
<tr>
<td>Total Non-Operating</td>
<td>181,713</td>
<td>233,623</td>
<td>77.8%</td>
<td>2,244,536</td>
<td>2,803,470</td>
<td>(558,935)</td>
<td>80.1%</td>
</tr>
<tr>
<td><strong>Net Income/(Loss)</strong></td>
<td>$ 14,825</td>
<td>$(8,237)</td>
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<td>$ 243,812</td>
<td>$ 140,173</td>
<td>$ 103,639</td>
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<tr>
<td>Medical Loss Ratio</td>
<td>-</td>
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<tr>
<td>Member Counts</td>
<td>-</td>
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<td>-</td>
<td>284,501</td>
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<td>(45,319)</td>
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<td>Current Mo</td>
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<td>Current Mo Budget</td>
<td>% of Budget</td>
<td>Y-T-D</td>
<td>Actual</td>
<td>Y-T-D Budget</td>
<td>Y-T-D Variance</td>
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<td><strong>OPERATING REVENUE</strong></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>CCS Capitation</td>
<td>(3,253,326)</td>
<td>3,145,564</td>
<td>-103.4%</td>
<td>34,440,272</td>
<td>37,746,771</td>
<td>(3,306,499)</td>
<td>91.2%</td>
</tr>
<tr>
<td>BHT Capitation</td>
<td>-</td>
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<td>-</td>
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<td>15,928</td>
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</tr>
<tr>
<td>MC Cap Offset</td>
<td>(3,397,501)</td>
<td>-</td>
<td>-</td>
<td>(6,320,428)</td>
<td>-</td>
<td>(6,320,428)</td>
<td>-</td>
</tr>
<tr>
<td>Total Operating Revenue</td>
<td>(6,650,827)</td>
<td>3,145,564</td>
<td>-211.4%</td>
<td>28,135,771</td>
<td>37,746,771</td>
<td>(9,611,000)</td>
<td>74.5%</td>
</tr>
<tr>
<td><strong>OPERATING EXPENSE</strong></td>
<td></td>
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<tr>
<td>Provider Capitation</td>
<td>47,589</td>
<td>59,663</td>
<td>79.8%</td>
<td>582,722</td>
<td>666,000</td>
<td>(83,278)</td>
<td>87.5%</td>
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<tr>
<td>Hospital Inpatient</td>
<td>722,553</td>
<td>543,823</td>
<td>132.9%</td>
<td>9,872,200</td>
<td>6,545,531</td>
<td>3,326,669</td>
<td>150.8%</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>146,075</td>
<td>81,400</td>
<td>179.5%</td>
<td>1,259,188</td>
<td>943,500</td>
<td>315,688</td>
<td>133.5%</td>
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<tr>
<td>Pharmacy</td>
<td>552,897</td>
<td>748,240</td>
<td>73.9%</td>
<td>6,617,384</td>
<td>8,978,877</td>
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<td>73.7%</td>
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<td>Physician Fee for Service</td>
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<td>1,983,959</td>
<td>(17,815)</td>
<td>99.1%</td>
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<td>3,189,881</td>
<td>5,888,208</td>
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<td>78.3%</td>
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<td>(514,757)</td>
<td>44,495</td>
<td>-1156.9%</td>
<td>462,218</td>
<td>533,946</td>
<td>(71,727)</td>
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<td>Directed Payments</td>
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<td>-</td>
<td>374,571</td>
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<td>Provider Incentives</td>
<td>13,047</td>
<td>3,861</td>
<td>337.9%</td>
<td>72,165</td>
<td>46,337</td>
<td>25,828</td>
<td>155.7%</td>
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<td>Health Care Supplmntl Benefits</td>
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<td>6,115</td>
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<td>99,370</td>
<td>73,383</td>
<td>25,987</td>
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<tr>
<td>Indirect Health Care Expenses</td>
<td>(208,710)</td>
<td>1,285</td>
<td>-16240.2%</td>
<td>(1,105,326)</td>
<td>15,422</td>
<td>(1,120,748)</td>
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<tr>
<td>Delegated UM/QA</td>
<td>(93)</td>
<td>-</td>
<td>-</td>
<td>(5,771)</td>
<td>-</td>
<td>(5,771)</td>
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<tr>
<td>Healthcare Allocation</td>
<td>281,224</td>
<td>323,584</td>
<td>86.9%</td>
<td>3,841,854</td>
<td>3,883,010</td>
<td>(41,156)</td>
<td>98.9%</td>
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<tr>
<td>UMQA (Allocation &amp; Delegated)</td>
<td>281,131</td>
<td>323,584</td>
<td>86.9%</td>
<td>3,836,083</td>
<td>3,883,010</td>
<td>(46,927)</td>
<td>98.8%</td>
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<td>34,124,224</td>
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<td>247,901</td>
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<td>999,000</td>
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<td>Total Operating Expense</td>
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<td>37,853,049</td>
<td>(4,378,580)</td>
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<tr>
<td><strong>NON-OPERATING REVENUE</strong></td>
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<td></td>
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</tr>
<tr>
<td>Total Non-Operating</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net Income/(Loss)</strong></td>
<td>$ (5,031,664)</td>
<td>$ (28,605)</td>
<td>17590.0%</td>
<td>$ (5,338,698)</td>
<td>$ (106,278)</td>
<td>$ (5,232,420)</td>
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<td>111.77%</td>
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<td>20,215</td>
<td>22,200</td>
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<td>91.1%</td>
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</table>
## MCE Statement of Revenue & Expense
for the Period Ending December 31, 2019

<table>
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<tr>
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<th>Current Mo Budget</th>
<th>% of Budget</th>
<th>Y-T-D Actual</th>
<th>Y-T-D Budget</th>
<th>Y-T-D Variance</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OPERATING REVENUE</strong></td>
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<td>MCE Capitation</td>
<td>11,656,994</td>
<td>13,872,443</td>
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<td>171,200,957</td>
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<td>(45,209,539)</td>
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<td>(66,164,452)</td>
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<td>(66,164,452)</td>
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<td>Total Operating Revenue</td>
<td>(33,552,544)</td>
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<td>-241.9%</td>
<td>174,507,625</td>
<td>171,200,957</td>
<td>3,306,668</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Provider Capitation</td>
<td>1,232,456</td>
<td>1,276,518</td>
<td>96.6%</td>
<td>16,198,239</td>
<td>15,848,753</td>
<td>349,486</td>
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<td>Hospital Inpatient</td>
<td>763,755</td>
<td>2,346,532</td>
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<td>16,198,239</td>
<td>15,250,894</td>
<td>947,344</td>
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<td>Long Term Care</td>
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<td>659,265</td>
<td>117.6%</td>
<td>8,730,454</td>
<td>7,930,648</td>
<td>799,806</td>
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<td>2,372,004</td>
<td>2,923,130</td>
<td>81.2%</td>
<td>35,753,438</td>
<td>36,420,768</td>
<td>(667,330)</td>
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<td>Physician Fee for Service</td>
<td>(1,797,392)</td>
<td>1,284,990</td>
<td>-139.9%</td>
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<td>16,676,064</td>
<td>(463,663)</td>
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<td>1,636,175</td>
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<td>728,599</td>
<td>105.7%</td>
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<td>9,077,990</td>
<td>271,558</td>
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<tr>
<td>Other HC Services</td>
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<td>-</td>
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<td>(112,533)</td>
<td>-</td>
<td>(112,533)</td>
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<td>3,983,307</td>
<td>-</td>
<td>3,983,307</td>
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<tr>
<td>Long Term Support Services</td>
<td>1,946</td>
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<td>12,668</td>
<td>30,979</td>
<td>(18,312)</td>
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<td>Provider Incentives</td>
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<td>79,984</td>
<td>390.1%</td>
<td>1,233,216</td>
<td>996,566</td>
<td>236,650</td>
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<td>Health Care Supplmntl Benefits</td>
<td>415,528</td>
<td>155,667</td>
<td>266.9%</td>
<td>2,169,042</td>
<td>1,939,541</td>
<td>229,502</td>
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<tr>
<td>Indirect Health Care Expenses</td>
<td>(1,731)</td>
<td>24,049</td>
<td>-7.2%</td>
<td>(603,776)</td>
<td>299,645</td>
<td>(903,421)</td>
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<td>(58,321)</td>
<td>-</td>
<td>(58,321)</td>
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<tr>
<td>Healthcare Allocation</td>
<td>176,768</td>
<td>332,897</td>
<td>53.1%</td>
<td>2,644,962</td>
<td>3,994,766</td>
<td>(1,349,804)</td>
</tr>
<tr>
<td>UMQA (Allocation &amp; Delegated)</td>
<td>178,982</td>
<td>332,897</td>
<td>53.8%</td>
<td>2,586,642</td>
<td>3,994,766</td>
<td>(1,408,125)</td>
</tr>
<tr>
<td>Total Health Care Expense</td>
<td>(35,170,779)</td>
<td>11,450,745</td>
<td>-307.2%</td>
<td>149,165,648</td>
<td>143,852,560</td>
<td>5,313,089</td>
</tr>
<tr>
<td>G&amp;A Allocation</td>
<td>648,785</td>
<td>1,114,083</td>
<td>58.2%</td>
<td>10,464,476</td>
<td>12,268,012</td>
<td>(1,803,536)</td>
</tr>
<tr>
<td>Premium Tax</td>
<td>-</td>
<td>1,372,680</td>
<td>-</td>
<td>9,761,315</td>
<td>16,472,160</td>
<td>(6,710,845)</td>
</tr>
<tr>
<td>Total Operating Expense</td>
<td>(34,521,994)</td>
<td>13,937,508</td>
<td>-247.7%</td>
<td>169,391,440</td>
<td>172,592,732</td>
<td>(3,201,292)</td>
</tr>
<tr>
<td><strong>NON-OPERATING REVENUE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-Operating</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net Income/(Loss)</td>
<td>$ 969,450</td>
<td>$ (65,065)</td>
<td>-1490.0%</td>
<td>$ 5,116,185</td>
<td>$ (1,391,775)</td>
<td>$ 6,507,960</td>
</tr>
<tr>
<td>Medical Loss Ratio</td>
<td>104.82%</td>
<td>91.61%</td>
<td>-</td>
<td>90.54%</td>
<td>92.97%</td>
<td>-</td>
</tr>
<tr>
<td>Member Counts</td>
<td>29,575</td>
<td>29,129</td>
<td>101.5%</td>
<td>375,238</td>
<td>366,298</td>
<td>8,940</td>
</tr>
</tbody>
</table>
## Health Plan of San Mateo
### CA CMC Statement of Revenue & Expense
for the Period Ending December 31, 2019

<table>
<thead>
<tr>
<th>Current Mo Actual</th>
<th>Current Mo Budget</th>
<th>% of Budget</th>
<th>Y-T-D Actual</th>
<th>Y-T-D Budget</th>
<th>Y-T-D Variance</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OPERATING REVENUE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CA Cal MediConnect Premium</td>
<td>19,660,230</td>
<td>17,041,391</td>
<td>115.4%</td>
<td>195,180,549</td>
<td>194,811,369</td>
<td>369,179</td>
</tr>
<tr>
<td>Total Operating Revenue</td>
<td>19,660,230</td>
<td>17,041,391</td>
<td>115.4%</td>
<td>195,180,549</td>
<td>194,811,369</td>
<td>369,179</td>
</tr>
</tbody>
</table>

| **OPERATING EXPENSE** | | | | | | |
| Provider Capitation | 543,476 | 643,952 | 84.4% | 7,363,461 | 7,574,455 | (210,994) | 97.2% |
| Hospital Inpatient | 5,808,689 | 4,923,292 | 118.0% | 59,364,328 | 59,569,918 | (205,590) | 99.7% |
| Pharmacy | 2,590,267 | 4,060,730 | 63.8% | 43,196,091 | 48,490,123 | (5,294,032) | 89.1% |
| Physician Fee for Service | 1,726,795 | 1,746,827 | 98.9% | 19,968,438 | 20,722,516 | (754,078) | 96.4% |
| Hospital Outpatient | 1,976,333 | 1,485,572 | 133.0% | 22,206,217 | 17,739,561 | 4,466,656 | 125.2% |
| Other Medical Claims | 1,729,300 | 1,858,498 | 93.1% | 18,331,102 | 22,192,762 | (3,861,660) | 82.6% |
| Other HC Services | 0 | - | - | 0 | - | 0 | - |
| Provider Incentives | 310,868 | 117,022 | 265.7% | 1,893,327 | 1,397,386 | 495,941 | 135.5% |
| Health Care Supplmntl Benefits | 749 | 82,091 | 0.9% | 8,288 | 980,266 | (971,978) | 0.9% |
| Indirect Health Care Expenses | (145,781) | 9,646 | -1511.3% | (130,447) | 115,188 | (245,635) | -113.3% |
| Delegated UM/QA | 10,643 | - | - | 129,580 | - | 129,580 | - |
| Healthcare Allocation | 675,911 | 455,003 | 148.6% | 5,260,686 | 5,460,032 | (199,346) | 96.4% |
| UMQA (Allocation & Delegated) | 686,554 | 455,003 | 150.9% | 5,390,266 | 5,460,032 | (69,766) | 98.7% |
| Total Health Care Expense | 15,227,251 | 15,382,633 | 99.0% | 177,591,072 | 184,242,208 | (6,651,136) | 96.4% |
| G&A Allocation | 1,885,879 | 1,512,577 | 124.7% | 15,634,020 | 16,656,131 | (1,022,111) | 93.9% |
| Total Operating Expense | 17,113,130 | 16,895,210 | 101.3% | 193,225,092 | 200,898,339 | (7,673,247) | 96.2% |

| **NON-OPERATING REVENUE** | | | | | | |
| Total Non-Operating | - | - | - | - | - | - | - |
| **Net Income/(Loss)** | $2,547,100 | $146,182 | 1742.4% | $1,955,456 | $(6,086,970) | $8,042,427 | -32.1% |

- Medical Loss Ratio: 77.45% | 90.27% | 90.99% | 94.57% |
- Member Counts: 8,815 | 9,199 | 95.8% | 106,370 | 109,728 | (3,358) | 96.9% |
# Medi-Cal CMC Statement of Revenue & Expense
for the Period Ending December 31, 2019

## Operating Revenue

<table>
<thead>
<tr>
<th></th>
<th>Current Mo Actual</th>
<th>Current Mo Budget</th>
<th>% of Budget</th>
<th>Y-T-D Actual</th>
<th>Y-T-D Budget</th>
<th>Y-T-D Variance</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>MC Cal MediConnect Capitation</td>
<td>15,370,600</td>
<td>5,448,003</td>
<td>282.1%</td>
<td>77,584,959</td>
<td>65,055,876</td>
<td>12,529,083</td>
<td>119.3%</td>
</tr>
<tr>
<td>Total Operating Revenue</td>
<td>15,370,600</td>
<td>5,448,003</td>
<td>282.1%</td>
<td>77,584,959</td>
<td>65,055,876</td>
<td>12,529,083</td>
<td>119.3%</td>
</tr>
</tbody>
</table>

## Operating Expense

<table>
<thead>
<tr>
<th></th>
<th>Current Mo Actual</th>
<th>Current Mo Budget</th>
<th>% of Budget</th>
<th>Y-T-D Actual</th>
<th>Y-T-D Budget</th>
<th>Y-T-D Variance</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Capitation</td>
<td>38</td>
<td>-</td>
<td>-</td>
<td>2,650</td>
<td>-</td>
<td>2,650</td>
<td>-</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>297,408</td>
<td>199,939</td>
<td>148.8%</td>
<td>2,684,912</td>
<td>2,387,517</td>
<td>297,396</td>
<td>112.5%</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>3,807,073</td>
<td>3,754,625</td>
<td>101.4%</td>
<td>42,646,992</td>
<td>43,331,315</td>
<td>(6,684,322)</td>
<td>98.4%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>63,637</td>
<td>128,646</td>
<td>49.5%</td>
<td>961,509</td>
<td>1,536,192</td>
<td>(574,683)</td>
<td>62.6%</td>
</tr>
<tr>
<td>Physician Fee for Service</td>
<td>125,136</td>
<td>312,426</td>
<td>40.1%</td>
<td>2,825,782</td>
<td>3,676,068</td>
<td>(850,286)</td>
<td>76.9%</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>230,044</td>
<td>297,944</td>
<td>77.2%</td>
<td>3,602,561</td>
<td>3,557,821</td>
<td>44,740</td>
<td>101.3%</td>
</tr>
<tr>
<td>Other Medical Claims</td>
<td>713,672</td>
<td>720,739</td>
<td>99.0%</td>
<td>8,479,179</td>
<td>8,606,516</td>
<td>(127,336)</td>
<td>98.5%</td>
</tr>
<tr>
<td>Other HC Services</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>(284)</td>
<td>-</td>
<td>(284)</td>
<td>-</td>
</tr>
<tr>
<td>Long Term Support Services</td>
<td>542,892</td>
<td>132,915</td>
<td>408.5%</td>
<td>2,080,880</td>
<td>1,555,319</td>
<td>525,561</td>
<td>133.8%</td>
</tr>
<tr>
<td>Provider Incentives</td>
<td>(294)</td>
<td>-</td>
<td>-</td>
<td>(279,408)</td>
<td>-</td>
<td>(279,408)</td>
<td>-</td>
</tr>
<tr>
<td>Health Care Supplmntl Benefits</td>
<td>345,951</td>
<td>76,452</td>
<td>452.5%</td>
<td>1,956,750</td>
<td>912,937</td>
<td>1,043,813</td>
<td>214.3%</td>
</tr>
<tr>
<td>Indirect Health Care Expenses</td>
<td>-</td>
<td>317</td>
<td>-</td>
<td>24</td>
<td>3,791</td>
<td>(3,767)</td>
<td>0.6%</td>
</tr>
<tr>
<td>Delegated UM/QA</td>
<td>(358)</td>
<td>-</td>
<td>-</td>
<td>(453)</td>
<td>-</td>
<td>(453)</td>
<td>-</td>
</tr>
<tr>
<td>Healthcare Allocation</td>
<td>79,989</td>
<td>51,832</td>
<td>154.3%</td>
<td>990,598</td>
<td>621,982</td>
<td>368,616</td>
<td>159.3%</td>
</tr>
<tr>
<td>UMQA (Allocation &amp; Delegated)</td>
<td>79,631</td>
<td>51,832</td>
<td>153.6%</td>
<td>990,145</td>
<td>621,982</td>
<td>368,163</td>
<td>159.2%</td>
</tr>
<tr>
<td>Total Health Care Expense</td>
<td>6,205,187</td>
<td>5,675,836</td>
<td>109.3%</td>
<td>65,951,693</td>
<td>66,189,457</td>
<td>(237,764)</td>
<td>99.6%</td>
</tr>
<tr>
<td>G&amp;A Allocation</td>
<td>399,837</td>
<td>175,050</td>
<td>228.4%</td>
<td>2,998,756</td>
<td>1,927,606</td>
<td>1,071,150</td>
<td>155.6%</td>
</tr>
<tr>
<td>Total Operating Expense</td>
<td>6,605,024</td>
<td>5,850,886</td>
<td>112.9%</td>
<td>68,950,449</td>
<td>68,117,063</td>
<td>833,386</td>
<td>101.2%</td>
</tr>
</tbody>
</table>

## Non-Operating Revenue

<table>
<thead>
<tr>
<th></th>
<th>Current Mo Actual</th>
<th>Current Mo Budget</th>
<th>% of Budget</th>
<th>Y-T-D Actual</th>
<th>Y-T-D Budget</th>
<th>Y-T-D Variance</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Non-Operating</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net Income/(Loss)</strong></td>
<td><strong>$ 8,765,576</strong></td>
<td><strong>($ 402,884)</strong></td>
<td><strong>-2175.7%</strong></td>
<td><strong>$ 8,634,510</strong></td>
<td><strong>($ 3,061,187)</strong></td>
<td><strong>$ 11,695,697</strong></td>
<td><strong>-282.1%</strong></td>
</tr>
<tr>
<td>Medical Loss Ratio</td>
<td>40.37%</td>
<td>104.18%</td>
<td>85.01%</td>
<td>101.74%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member Counts</td>
<td>8,620</td>
<td>9,097</td>
<td>94.8%</td>
<td>104,506</td>
<td>108,504</td>
<td>(3,998)</td>
<td>96.3%</td>
</tr>
</tbody>
</table>
## Health Plan of San Mateo
ALL LOB UNITS Statement of Revenue & Expense for the Period Ending December 31, 2019

### OPERATING REVENUE

<table>
<thead>
<tr>
<th>Current Mo Actual</th>
<th>Current Mo Budget</th>
<th>% of Budget</th>
<th>Y-T-D Actual</th>
<th>Y-T-D Budget</th>
<th>Y-T-D Variance</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Capitation</td>
<td>$12,446,816</td>
<td>$24,683,577</td>
<td>50.4%</td>
<td>$369,385,327</td>
<td>$302,299,036</td>
<td>$67,086,291</td>
</tr>
<tr>
<td>CCS Capitation</td>
<td>(3,253,326)</td>
<td>3,145,564</td>
<td>-103.4%</td>
<td>34,440,272</td>
<td>37,746,771</td>
<td>(3,306,499)</td>
</tr>
<tr>
<td>MCE Capitation</td>
<td>11,656,994</td>
<td>13,872,443</td>
<td>84.0%</td>
<td>240,672,076</td>
<td>171,200,957</td>
<td>69,471,119</td>
</tr>
<tr>
<td>BHT Capitation</td>
<td>2,399,417</td>
<td>-</td>
<td>-</td>
<td>8,220,848</td>
<td>-</td>
<td>8,220,848</td>
</tr>
<tr>
<td>HepC Capitation</td>
<td>135,997</td>
<td>-</td>
<td>-</td>
<td>1,639,328</td>
<td>-</td>
<td>1,639,328</td>
</tr>
<tr>
<td>CareAdvantage Premium</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>43,087</td>
<td>-</td>
<td>43,087</td>
</tr>
<tr>
<td>Healthy Kids Premium</td>
<td>(23,058)</td>
<td>287,280</td>
<td>-8.0%</td>
<td>2,786,238</td>
<td>3,447,360</td>
<td>(661,122)</td>
</tr>
<tr>
<td>HealthWorx Premium</td>
<td>370,272</td>
<td>368,112</td>
<td>100.6%</td>
<td>77,584,959</td>
<td>44,173,348</td>
<td>33,411,611</td>
</tr>
<tr>
<td>CA Cal MediConnect Premium</td>
<td>19,660,230</td>
<td>17,041,391</td>
<td>115.4%</td>
<td>195,180,549</td>
<td>194,811,369</td>
<td>369,179</td>
</tr>
<tr>
<td>MC Cal MediConnect Capitation</td>
<td>15,370,600</td>
<td>5,448,003</td>
<td>282.1%</td>
<td>128,554,156</td>
<td>119,263,529</td>
<td>9,290,627</td>
</tr>
<tr>
<td>MC Cap Offset</td>
<td>(93,884,954)</td>
<td>-</td>
<td>-</td>
<td>(153,183,484)</td>
<td>-</td>
<td>(153,183,484)</td>
</tr>
<tr>
<td>Total Operating Revenue</td>
<td>(35,121,013)</td>
<td>64,846,371</td>
<td>-54.2%</td>
<td>781,225,411</td>
<td>778,978,717</td>
<td>2,246,693</td>
</tr>
</tbody>
</table>

### OPERATING EXPENSE

| Provider Capitation | 3,193,973         | 3,416,213   | 93.5%        | 40,861,093   | 41,478,015     | (616,922)  | 98.5%       |
| Hospital Inpatient  | 10,351,974        | 11,638,109  | 89.0%        | 151,743,366  | 143,997,383    | 7,745,983  | 105.4%      |
| Long Term Care      | 12,468,542        | 10,129,732  | 123.1%       | 128,554,156  | 119,263,529    | 9,290,627  | 107.8%      |
| Pharmacy            | 9,413,093         | 11,099,660  | 84.8%        | 125,983,949  | 134,730,733    | (8,746,784)| 93.5%       |
| Physician Fee for Service | (4,770,644) | 5,591,100   | -85.3%       | 65,406,619   | 69,705,853     | (4,299,235)| 93.8%       |
| Hospital Outpatient | 6,541,759         | 6,027,852   | 108.5%       | 78,904,462   | 73,636,487     | 5,267,975  | 107.2%      |
| Other Medical Claims | 5,341,725        | 5,440,356   | 98.2%        | 61,664,796   | 66,027,702     | (4,362,906)| 93.4%       |
| Other HC Services   | 896,328           | 462,967     | 193.6%       | 6,785,019    | 5,691,752      | 1,093,267  | 119.2%      |
| Directed Payments   | (83,858,553)      | -           | -            | (11,642,138) | -              | (11,642,138)| -          |
| Long Term Support Services | 130,948        | 209,018     | 62.7%        | 2,881,059    | 2,488,083      | 392,977    | 115.8%      |
| Provider Incentives | 1,228,171        | 353,505     | 347.4%       | 5,479,793    | 4,321,597      | 1,158,196  | 126.8%      |
| Health Care Supplmntl Benefits | 616,911 | 513,564     | 120.1%       | 6,894,390    | 6,275,741      | 618,649    | 109.9%      |
| Indirect Health Care Expenses | (209,627) | 68,923     | -304.2%      | (645,766)    | 848,062        | (1,493,827)| -76.2%      |
| Delegated UM/QA     | 20,375            | -           | -            | (143,599)    | -              | (143,599)  | -           |
| Healthcare Allocation | 1,593,550       | 1,637,722   | 97.3%        | 17,709,340   | 19,652,662     | (1,943,322)| 90.1%       |
| UMQA (Allocation & Delegated) | 1,613,925 | 1,637,722   | 98.6%        | 17,565,741   | 19,652,662     | (2,086,921)| 89.4%       |
| Total Health Care Expense | (37,041,475) | 56,588,722  | -65.5%       | 703,720,815  | 688,117,598    | 15,603,216 | 102.3%      |
| G&A Allocation     | 4,701,751         | 4,859,318   | 96.8%        | 50,566,188   | 53,509,630     | (2,943,442)| 94.5%       |
| Premium Tax         | 2,339,724         | 4,547,268   | -            | 31,099,624   | 54,567,210     | (23,467,586)| 57.0%       |
| Total Operating Expense | (32,339,724) | 65,995,308  | -49.0%       | 785,386,627  | 796,194,438    | (10,807,812)| 98.6%       |

### NON-OPERATING REVENUE

<p>| Interest, Net       | 671,891           | 500,000     | 134.4%       | 9,328,216    | 6,000,000      | 3,328,216  | 155.5%      |
| Rental Income, Net  | 94,361            | 89,490      | 105.4%       | 1,086,584    | 1,073,883      | 12,701     | 101.2%      |
| Third Party Administror Revenue | 181,713       | 233,623     | 77.8%        | 2,244,536    | 2,803,470      | (558,935)  | 80.1%       |</p>
<table>
<thead>
<tr>
<th></th>
<th>15</th>
<th></th>
<th>375</th>
<th></th>
<th>375</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous Income</td>
<td>947,980</td>
<td>823,113</td>
<td>12,659,710</td>
<td>9,877,353</td>
<td>2,782,357</td>
<td>128.2%</td>
</tr>
<tr>
<td>Total Non-Operating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Income/(Loss)</td>
<td>$(1,833,309)</td>
<td>$(325,824)</td>
<td>$8,498,494</td>
<td>$(7,338,368)</td>
<td>$15,836,862</td>
<td>-115.8%</td>
</tr>
<tr>
<td>Medical Loss Ratio</td>
<td>105.47%</td>
<td>93.85%</td>
<td>93.81%</td>
<td>94.99%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member Counts</td>
<td>117,857</td>
<td>117,933</td>
<td>1,751,071</td>
<td>1,786,846</td>
<td>(35,775)</td>
<td>98.0%</td>
</tr>
</tbody>
</table>
### HEALTH PLAN OF SAN MATEO

**STATEMENT OF CASH FLOWS - DIRECT & INDIRECT METHOD**

**FOR THE CURRENT PERIOD December 31, 2019**

<table>
<thead>
<tr>
<th>CASH FLOW PROVIDED BY OPERATING ACTIVITIES</th>
<th>CURRENT MONTH</th>
<th>CURRENT YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group/Individual Premiums/Capitation</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Title XVIII - Medicare Premiums</td>
<td>19,660,230</td>
<td>195,223,636</td>
</tr>
<tr>
<td>Title XIX - Medicaid Premiums</td>
<td>(71,770,541)</td>
<td>(598,136,170)</td>
</tr>
<tr>
<td>Investment and Other Revenues</td>
<td>(122,183)</td>
<td>(53,985)</td>
</tr>
<tr>
<td>Medical and Hospital Expenses</td>
<td>40,010,827</td>
<td>(694,920,810)</td>
</tr>
<tr>
<td>Administration Expenses</td>
<td>(3,525,041)</td>
<td>(92,513,613)</td>
</tr>
<tr>
<td><strong>NET CASH PROVIDED BY OPERATING ACTIVITIES</strong></td>
<td>(15,746,708)</td>
<td>5,871,397</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CASH FLOW PROVIDED BY INVESTING ACTIVITIES</th>
<th>CURRENT MONTH</th>
<th>CURRENT YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proceeds from Restricted Cash and Other Assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Proceeds from Investments</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Proceeds for Sales of Property, Plant and Equipment</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Payments for Restricted Cash and Other Assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Payments for Investments</td>
<td>-</td>
<td>100,000</td>
</tr>
<tr>
<td>Payments for Property, Plant and Equipment</td>
<td>(171,756)</td>
<td>(378,662)</td>
</tr>
<tr>
<td>Interest and Other Income Received</td>
<td>628,126</td>
<td>8,775,753</td>
</tr>
<tr>
<td><strong>NET CASH PROVIDED BY INVESTING ACTIVITIES</strong></td>
<td>456,370</td>
<td>8,497,091</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CASH FLOW PROVIDED BY FINANCING ACTIVITIES:</th>
<th>CURRENT MONTH</th>
<th>CURRENT YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal payments under capital lease obligations</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>NET CASH PROVIDED BY FINANCING ACTIVITIES</strong></td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NET INCREASE (DECREASE) IN CASH</th>
<th>CURRENT MONTH</th>
<th>CURRENT YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(15,290,338)</strong></td>
<td>14,368,488</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CASH AND CASH EQUIVALENTS AT THE BEGINNING OF THE MONTH/PRIOR YEAR</th>
<th>CURRENT MONTH</th>
<th>CURRENT YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>271,219,257</strong></td>
<td>241,560,432</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOTAL ADJUSTMENTS</th>
<th>CURRENT MONTH</th>
<th>CURRENT YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(12,965,418)</strong></td>
<td>10,032,615</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>NET CASH PROVIDED BY OPERATING ACTIVITIES</th>
<th>CURRENT MONTH</th>
<th>CURRENT YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(15,746,708)</strong></td>
<td>5,871,397</td>
<td></td>
</tr>
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</table>

### RECONCILIATION OF NET OPERATING INCOME TO NET CASH FROM OPERATING ACTIVITIES:

| Operating Income | Operating Income | Depreciation and Amortization | Decrease (Increase) in Receivables | Decrease (Increase) in Prepaid Expenses | Decrease (Increase) in Net Pension/Inflows and Outflows | Decrease (Increase) in Affiliate Receivables | Increase (Decrease) in Amts due to State of CA | Increase (Decrease) in Accounts Payable | Increase (Decrease) in Medical Claims Payable | Increase (Decrease) in Incurred But Not Reported | Increase (Decrease) in Provider Risk Sharing | Increase (Decrease) in Unearned Premium | Aggregate Write-Ins for Adjustments to Net Income | **TOTAL ADJUSTMENTS** | **NET CASH PROVIDED BY OPERATING ACTIVITIES** |
|------------------|------------------|-------------------------------|-----------------------------------|----------------------------------------|-------------------------------------------------|---------------------------------------------|-----------------------------|---------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------|-------------------------------------------------|--------------------------|-----------------------------|
| (2,781,290)      | (4,161,218)      | 250,318                        | (4,662,157)                        | 258,023                                | 89,124                                          | 89,124                                      | 13,992,956                                | (25,062,706)                                | 3,114,151                                      | (1,493,581)                                    | 548,455                                      | -                                                  | **(12,965,418)**              | **10,032,615**             |
|                  | (15,746,708)     | 5,871,397                      |                                   |                                        |                                                 |                                             |                                           |                                             |                                              |                                              |                                             |                                          |                                        | (15,746,708) | 5,871,397     |

### DETAILS OF WRITE-INS AGGREGATED FOR ADJUSTMENTS TO NET INCOME:

<table>
<thead>
<tr>
<th>Unrealized (Gain)/Loss on Equity Securities</th>
<th>(Gain)/Loss on Sale of Assets</th>
<th>Prior Period Rent Expense</th>
<th>Realized (Gain)/Loss on Investment</th>
<th><strong>TOTALS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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</tr>
</tbody>
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I:\DMHC\DMHC Cashflow-MONTHLY\2019\DMHC CASHFLOW 2019 12 Final.xlsx

2/14/2020
FINANCE/EXECUTIVE COMMITTEE MEETING
Meeting Summary – December 2, 2019
Criminal Justice Training Room (CJTR), 400 County Center, First Floor,
Redwood City, CA 94063

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

Member’s present: Don Horsley, Bill Graham, David Canepa

Member’s absent: Mike Callagy, Si France, MD

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

Guests: Peggy Jensen, Tony Bayudan

1.0 Call to Order – The meeting was called to order at 12:30 pm by Supervisor Canepa.

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

3.0 Approval of Meeting Summary for November 4, 2019 – Supervisor Horsley moved
to accept the November 4, 2019 meeting summary; Commissioner Graham seconded
the motion. The November 4, 2019 Meeting Summary was approved as presented.

M/S/P

4.0 Preliminary Financial and Operational Report for the Period ending October 31,
2019 – Mr. Ehrgood reviewed the financial summary. He noted that the recorded loss
for October is $1.4M. He reminded the group that rates went down in July, and as a
result, HPSM will continue to see losses until the end of the year. Mr. Ehrgood updated
the Committee on some open items that will result in adjustments to be recorded in
future months. He reported that they are still looking into the Whole Child Model
(WCM) eligibility issue, trying to determine where the breakdown exists. There will
likely be adjustments made down the road once this is resolved. Additional revenue
from Cal-MediConnect quality withholds are pending for the 2018-19 years and will be
recorded as HPSM becomes confident the dollars are earned. The annual
reconciliation for the 2018 Part D pharmacy benefit is completed as well, resulting in a
pick-up of around $3.5M, which will be recorded in December. Lastly, the Coordinated
Care Initiative (CCI) for dual eligible members, which does not have the same rate
setting process as classic Medi-Cal, is still using 2018 rates and will continue to do so
until updated rates come in.
5.0 HPSM 2020 Budget – Mr. Ehrgood presented the proposed HPSM Budget for 2020. His presentation was two-fold, he also used the budget information to educate the committee about nuances between the different lines of business. Mr. Ehrgood started with some high-level criteria used in developing the budget. HPSM is anticipating a continued decline in Medi-Cal membership, although at a slower pace. Healthcare costs continue to rise at a faster pace than the premium revenue. The Medi-Cal Expansion (MCE) population’s lower rates are causing significant losses for that line, to the tune of approximately $2M per month, which will continue until December of 2020. Mr. Ehrgood noted the ramp up of Long-Term Care (LTC) and the new payment model that occurred in October, however they are not seeing the true effect of that yet. There are new initiatives to improve monitoring and management of healthcare costs. The 2020 year will include activities related to the Dental ramp up as well as the proposed Pharmacy carve out by the State, both scheduled to occur in January 2021 as well as changes to the 1115 Waiver through CalAIM. However, ramp-up of costs related to the dental program is omitted from the budget, with the exception of the dental director position.

Mr. Ehrgood noted there are now 6 lines of business instead of 7, as the Healthy Kids line is now incorporated with the regular Med-Cal line. Supervisor Horsley inquired about the Medi-Cal Expansion (MCE), specifically how it differs from Medi-Cal. He also wanted to know why the MCE is not part of Medi-Cal (MC). Mr. Ehrgood explained that the Medi-Cal Expansion is part of the Affordable Care Act therefore reimbursement is different, he also explained that there are minimum medical loss ratios involved. Ms. Altman explained how ACA dollars are counted and closely scrutinized by the Centers for Medicare & Medicaid Services (CMS). Commissioner Graham asked why members are moving from ACE to Medi-Cal. Ms. Altman noted that recent legislature passed by the state means some undocumented members are now eligible for coverage until the age of 26 thru the Medi-Cal line. Mr. Ehrgood said the projected loss is $58.2M, which is $2.3 worse than the original projections made earlier in August. He also showed how this compares to 2019 projections and the 2019 budget.

He briefly went over the decline of membership by county, and how the State’s actuary team used this to make an acuity adjustment to rates. Although the statewide average membership decreased by 4.2%, San Mateo County has the second to the highest decline at 9.1%. Members are either moving out of the county or they are losing their Medi-Cal benefits due to finding jobs, etc. However, the loss of healthy members leaves the line with higher acuity members. Ms. Jensen inquired about the
decline in school-aged children. Mr. Ehrgood said they have not looked at school-aged kids specifically but said he could come back with those numbers.

He went over some of the drivers behind healthcare costs, which is mostly based on the rate at which members utilize services and the actual unit cost for those services. Supervisor Horsley asked Mr. Ehrgood to explain why utilization is up. Mr. Ehrgood responded that it is mostly due to members having higher acuity, the numbers show the acuity of the population is going up. While the State has incorporated the higher utilization into their rates going forward, it is not quite enough to offset the current utilization by HPSM’s members. Commissioner Graham inquired if there is a way to monitor how well HPSM handles chronic disease, specifically a chronic disease management program. Mr. Ehrgood said HPSM has decided to incorporate some new measures to look at medical costs oversight. Ms. Altman noted that Dr. Huang would speak about HPSM’s efforts in this area.

Dr. Huang informed the group about HPSM’s goal to improve Health Services data analytics by translating the aggregate financial and claims information data into more actionable and operational data for teams in Medical Management. They hope to furnish Providers with actionable reports about their individual panels and members, focusing on care gaps and utilization patterns. Secondly, HPSM is also looking at opportunities at managing key healthcare cost drivers as related to acute and post-acute services by focusing on opportunities on inpatient, skilled nursing facilities and sites of service. Within this, the focus will be on hospital short stays, as well as promoting pro-active discharge planning and community placement linked thru community resources like IHSS, CCSP, MSSP, etc. The third point is about optimizing care delivery and clinical quality of complex care models, specifically to specify the value of in-house type programs like Landmark, as well as focusing on the integration and expansion of appropriate behavioral health levels of service and care access in tandem with the County BHRS. The fourth point is about establishing a foundation for medical pharmacy operations, this is actual strategic and intentional pro-active medical management of the right drugs, dosing, and timing as well as rates and prescriber and pharmacy communications and education. In the past while HPSM actively managed the pharmacy benefit they have not been able to monitor the benefits or costs of drugs that are coming from the medical benefit side and filled at a retail pharmacy or administered in the providers practice or at a SNF facility. They will leverage the pharmacy team’s expertise for this purpose. Lastly, regarding the increase in the focus of quality performance improvement, HPSM plans to actively
manage the member facing and provider facing programs like the pay-for-performance program (P4P) as well as some member incentive programs to help increase the performance on care quality measures in the hopes of exceeding the State minimum performance levels and earning back all CMS quality withhold dollars. Mr. Ehrgood wrapped up his presentation by going over the administrative portion of the budget. There is a net increase of six positions, that includes a dental position as well as a credentialing position for BHRS. Ms. Altman said they will come to the Commission regarding BHRS as HPSM wishes to take on some of the credentialing duties, she noted HPSM has already taken on utilization management functions. Supervisor Horsley commended Mr. Ehrgood for a good job on the budget presentation. Mr. Ehrgood will bring a condensed version to the San Mateo Health Commission meeting on December 11, 2019. Supervisor Horsley made a motion to approve the 2020 budget, Supervisor Canepa seconded the motion. The budget was approved as presented.

6.0 Approval of Proposed Finance/Executive Committee Meeting Dates for 2020 - Mr. Ehrgood went over the proposed meeting dates for the 2020 calendar year, noting the reduced number of meetings for 2020. They will now occur approximately every other month. Supervisor Horsley made a motion to approve the proposed dates, Commissioner Graham seconded the motion. The 2020 meeting dates were approved as presented.

7.0 San Mateo Health Commission Agenda – Ms. Altman briefly reviewed the agenda for the San Mateo Health Commission meeting on Wednesday, December 11, 2019. Supervisor Horsley made a motion to approve the SMHC agenda and Commissioner Graham seconded the motion. The SMHC agenda was approved as presented.

8.0 Other Business – There was no other business.

9.0 Adjournment – The meeting was adjourned at 1:31 pm By Supervisor Canepa.

Respectfully submitted:

M. Heryford

M. Heryford
Assistant Clerk to the Commission
Health Plan of San Mateo  
Cal MediConnect Advisory Committee  
Meeting Minutes  
Friday, January 17, 2020 – 10:00 a.m.  
Health Plan of San Mateo  
801 Gateway Blvd., Boardroom  
South San Francisco, CA  94080


Committee Members Absent: Diane Prosser.

Staff Present: Maya Altman, Gabrielle Ault-Riche, Adrienne Lebsack, Ricky Kot, Nina Rhee, Pat Curran, Katie-Elyse Turner

1. Call to Order  
The meeting was called to order at 11:35 a.m. by Gay Kaplan.

2. Public Comment  
Teresa Guingona Ferrer presented information on the Census 2020 to the group. She explained some of the process and the importance of completing the census.

Ligia Andrade Zuniga reported on activities through CID and partnerships they are working on. They will be looking at how these partners can collaborate on how to better serve people with disabilities. A flier with this information will be finalized soon and sent to this committee when completed.

There were no further public comments at this time.

3. Approval of Minutes  
The minutes for the October 25, 2019 meeting were approved as presented with Christina Kahn and Lisa Mancini abstaining from the vote. M/S/P.

4. CCI Ombudsman Services Report (Legal Aid)  
Ms. Berke Vinson reported what they are seeing in the office related to CMC members:

- Reported on the bill regarding the increase to the aged and disabled federal poverty level to 138% which passed but will likely not be implemented until August 1st.
- The “Yo-Yo” bill was passed but is still awaiting federal approval on implementation.
- AB 683 related to the asset levels for aged and disabled population did not pass but is up again. It is important to support this bill as much as possible. Currently there is no asset limit until people turn 65 or become disabled then there is an asset limit of $2000 for individuals and $3000 for couples. This bill would increase the asset level for
individuals to $10,000 and to $15,000 for couples and up with additional household members and exempts certain assets such as pensions.

- HSA has received funding for two positions to help people with their Medi-Cal renewal process which will reduce the problem of people dropping off Medi-Cal for paperwork reasons (late or incorrect information).
- MOU between the Health Plan and HSA has been completed which will allow more information sharing and give the plan the ability to reach out to members to help with timely Medi-Cal renewals.
- Reported on the county’s ability to take telephonic authorizations for people who want to designate someone as their representative. To resolve this, they are working with the county to improve their explanation to people about verbal authorizations for those that may be unable to physically sign paperwork.

Ms. Vinson noted that she will be retiring, and Amira Elbeshbeshy will be taking her place on this committee.

Ms. Altman reported that there is a new Human Services Director for the County, Ken Cole. He was the director of the housing authority. We have worked with him on housing issues for many years and has worked a lot on homelessness issues.

5. **LTC Ombudsperson Services Report**

Ms. Kirsten Irgens-Moller reported:

- Seton sale - the buyer has backed out and the staff there are getting nervous. They seem optimistic that there are new buyers in wings.
- Lost an administrator at Millbrae Skilled, a nursing facility, earlier today.
- Working on the Census and reminding the small six-bed board and care facilities, where people would not have their own individual address, to find a person responsible for doing the count in those places. They are giving a training with all their volunteers.
- Skilled Nursing Facilities are having trouble finding psychiatrists for their health plan members.

6. **Customer Support Reports**

Ms. Gabrielle Ault-Riche reported that we are including an enrollment and call center report for the first time this quarter and that those metrics will be included in this report going forward. She added that if there are any questions or information that committee members would like to see to let her know.

Highlights of the 3rd Quarter of 2019 G&A Report:

- One of our PCP’s recently left the network. There had been an increase in CareAdvantage enrollment in the 3rd Quarter however, we have lost over 90 CMC
members in past couple of months due to this. Staff has been doing a lot of outreach to members to explain that transition and to connect them with a new PCP.

- There is a new MOU with Human Services which will allow collaboration in their new Navigators program to outreach. Staff currently calls all CareAdvantage members who lose their Medi-Cal to reinstate them within the two-month deeming period and avoid a disruption to their coverage.

- Call Center metrics indicate 90% of CareAdvantage calls are answered within 30 seconds. The regulatory standard is 80%.

- HPSM is recruiting for Call Center Navigators; Spanish and Chinese speakers, in particular, are needed.

- Grievances and Appeals have seen an increase in both areas in the 3rd Quarter of 2019:
  - Increase in Quality of Care grievances.
  - Increase in Appeals related to DME.
  - Overturned Appeals rate remains low.
  - Timeliness in resolving cases has been between 96-98%.

7. **HRA-ICP Improvement Efforts**

Adrienne Lebsack, Program Manager for Adult Programs, reviewed the presentation (attached) covering some of the improvement projects going on with Health Risk Assessments (HRAs) and Care Plans (ICPs). She explained what HRAs and ICPs are, the process for each and how they kick off the Interdisciplinary Care Team (ICT) and the cycle of the Care Coordination process that occurs. This process takes place upon enrollment and annually for all CMC and Medi-Cal SPD members or more frequently for those who are at higher risk.

There were questions about the PCPs involvement and what happens if the PCPs are not participating. Ms. Lebsack explained PCPs receive the information and the member is able to bring this to their appointment with the doctor. Ms. Turner added that the ICPs feed the care coordination work and the team helps connect members with needed programs.

A concern was raised about the accuracy of the self-reporting element of the HRAs. Ms. Lebsack reported that she pulls files to compare member self-reported HRA data for accuracy and found that members are reporting accurately. However, duplication in questions has led to the HRA revision project. The team will scrutinize every question to make sure HPSM derives a meaningful response from members and not ask for information we already have.

It was asked if HRAs are completed for people residing in a facility. Ms. Lebsack stated that ILS, the vendor who performs these assessments, needs contact information in order to reach out. Staff is in the process of looking into ways to reach more of these people.

Improvements that are underway are:

- Revising the HRA
- ICT/ICP Improvements (getting the members engaged and getting the providers to engage as well to make this work better to get more meaningful care plan)
• Reducing “Unable to Reach” rate within HRA completion for new members
• Improvement on ICP completion within 90 days of enrollment.

The last two bullets are PIPs (Performance Improvement Plans) goals set by CMS and DHCS. They would like to see the “unable to reach” rate reduced to under 16% and improve ICP completion for the same member group to over 80%.

The HRA revision is targeted to roll out on January 1, 2021. Ms. Turner stated that HPSM will be engaging this committee in developing this. Ms. Altman added that one purpose is to get the members’ personal goals as opposed to medical goals. Ms. Irgens-Moller added that the Long-Term Care Ombudsman could be a resource since they are in the facilities every week. There have been problems with people falling off the plan and not understanding the impact. It would help to get a list of health plan members in the facilities in order to check in with them. Ms. Lebsack said health plan staff are working on this within a couple of facilities.

A question about home visits was asked. Ms. Turner reported on Wider Circle which is a program meant to address social isolation by creating peer groups, creative friendships, and social connections. They do have a community-based presence working in communities and people’s homes. Staff has collaborated with Wider Circle to develop a pilot idea this year to do home based HRAs. There is a small target population to start of people who have asked for home based or non-telephonic assessment and some new members. Ms. Andrade Zuniga suggested partnering with CID. Ms. Day asked about tracking the reasons why people are hard to reach to know the difference between those who have dementia or difficulty understanding, and just not available to talk.

Beverly Karnatz and Christina Kahn spoke about concerns related to provider changes or patients dropping off of CareAdvantage and not realizing the ramifications of this move. Ms. Ault-Riche stated that staff works very hard to explain the benefits of CareAdvantage to members and if they are seeking to disenroll, they are referred to HICAP. Ms. Kahn stated she has seen a shift for the smaller provider offices and was concerned about the providers getting what they need from the health plan. Mr. Curran addressed the difficulty faced by smaller offices. Standards and regulations that must be followed may pose a challenge for smaller offices. The health plan performs a provider survey each year in order to identify ways to support and help providers. Staff has developed a new payment model to incentivize improved outcomes as opposed to volume-based incentives. Next year, a new Practice Coach position will be implemented to work with smaller clinics.

8. Updates and Discussion
Ms. Katie-Elyse Turner deferred the updates and discussion section of the agenda to the next meeting in April. She noted that there were no significant updates to the numbers reported on the dashboard. The educational topics discussed with CMS and DHCS over the last quarter of 2019 were related to the flu vaccine efforts and quality measures. At the next meeting, she will review these topics as well as the IHSS report.
9. Other State/CMS Updates

- Ms. Altman thanked Tricia Berke Vinson for her years of service now that she will be officially retiring from Legal Aid.
- Ms. Altman reported that Ligia Andrade Zuniga has been elected as the chair for the San Mateo Commission.
- Ms. Altman reported on an event that will be taking place in Mountain View next week where she will be speaking for the Alzheimer’s Association focusing on the Master Plan. She invited the group to attend to hear Kim McCoy-Wade who is the Director of the Department of Aging who will be presenting, as well as Joe Simitian.
- Ms. Altman reported on Medi-Cal reform previously called CalAIM but being changed to Medi-Cal Healthier California for All. She will report more at the next meeting.
- Ms. Altman reported on the Master Plan for Aging which came out of an executive order from the Governor last year. Ms. Altman has been appointed the stakeholder advisory committee established late last year and is the only health plan representative. She explained some of the work required related to LTSS and includes IHSS. The sub-committees will review all the recommendations and organize the report which will be presented to the full stakeholder advisory committee in February and will either be approved or changed, and then go to the Governor and cabinet for consideration.

The state has rebranded this effort as “Together We EngAGE: Master Plan for Aging”. They have been holding listening sessions around the state for people to attend or call into and all these meetings are open to the public. The LTSS sub-committee is reviewing the hundreds of recommendations submitted to identify the major themes and consolidate them. Of course, not everyone is in agreement making it a challenge to present recommendations that are potentially controversial.

She shared her thoughts on what is important to include regarding IHSS:
- Health and LTSS integration – how do develop more of an infrastructure as many parts of the state have very few services available;
- How to organize state leadership to set intentional targets for rebalancing programs (reduce the use of SNFs to what is absolutely necessary)
- Coordination between IHSS and health, particularly in Managed Care Plans. The state needs to take a stronger role in encouraging coordination among health plans and all counties because IHSS tends to be isolated from health.
- She also brought up the possibility of a pilot which was not really well received – a partial carve-in for people who feel that they cannot direct their own care and for those that want it.

Ms. Kaplan said she would like to see us break down the silos and work through regulations. The issue of not being able to talk to anyone on the team without a written permission impacts continuity of care, continuum of care and quality of care for each agency/worker involved.
Ms. Andrade Zuniga expressed concerns about people who cannot communicate their wants and needs. She stated that whenever we push for policy-change we need to remember that it will affect people’s lives and how it will impact the community. She expressed that regulations on IHSS need to change because people are not all the same adding that the amount people are paid also needs to change. Ms. Altman stated that the topic of workforce has risen to the top and housing to some extent.

10. **Adjournment**
   The meeting adjourned at 1:00 p.m.

Respectfully submitted:

* C. Burgess

C. Burgess  
Clerk of the Commission
Overview for 2020

- HRA-ICT-ICP & Care Coordination Processes
- Projects/goals going into 2020
- Plans for projects
HRA-ICT-ICP Process

- **Health Risk Assessment** (HRA): a survey conducted upon enrollment and annually for all CMC and MC-SPD members.
  - 33 questions with some assigned weight by HPSM to generate a risk score (5+ = high risk)
  - Includes 10 LTSS-related questions required by DHCS
  - A “complete” HRA requires response to 15 specified questions

- **Interdisciplinary Care Team** (ICT): upon completion of an HRA, a nurse case manager develops the care plan and invites the member and their PCP to an ICT meeting for further consultation with an advanced practice clinician.

- **Individualized Care Plan** (ICP): finalized post ICT to address health concerns and care coordination efforts; sent to member and PCP.

- **Independent Living Systems** (ILS): vendor contracted to initiate/complete the HRA by phone/mail; also completes the ICT meeting from which the ICP is created by ILS nurse case managers.

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Care Coordination Process

[Diagram showing the flow between HRA, ICT, ICP, and Member Care Team]
Projects/Goals going into 2020

- HRA Revisions
  - By using analyses of current adult HRA, we hope to identify opportunities for improvement in question structure/scoring to better inform program(s) usage/enrollment.

- ICT/ICP Improvements
  - There has been challenges with engaging members in the ICT/ICP process, therefore we need to have better follow-up with members and provide better member info in order to have the best chance of contacting the member and PCP.

- PIP – Core 2.1
  - Reducing “unable to reach” rate within HRA completion for new members within 90 days of enrollment. Targeting \(\leq 16\%\). Required by CMS/DHCS.

- PIP – Core 3.2
  - Improvement on ICP completion within 90 days of enrollment. Targeting \(\geq 80\%\) overall ICP completion. Required by CMS/DHCS.

What are we going to do?

- HRA Revisions
  - Gather stakeholders to make revision decisions
    - Clinical, quality, and population health considerations
    - Technical builds of HRA
    - Materials redevelopment
  - Confirm on revisions and enact plan to roll-out on Jan. 1, 2021

- ICT/ICP Improvements
  - Leverage member touchpoints for engagement opportunities
  - Care team data availability, training and awareness of their role on Care Team and in meeting, participation in ICT
What are we going to do?

- **PIP – Core 2.1 (Goal: improving unable to reach rate for HRA)**
  - Ensure all contact information is being routed to ILS and utilized appropriately
  - Opportunities for in-person HRAs (Wider Circle)
  - Leverage touchpoints and communications with new members
  - Oversight of outreach call timing and spread throughout the initial enrollment period

- **PIP – Core 3.2 (Goal: improving overall Care Plan completion rate)**
  - Current process mandates that an HRA is completed prior to ICP development
  - Oversight of ILS staffing changes with impact to ICP completion queues
  - Regularly reconciling "opened" or "developed" care plans against "completed" (mailed) Care Plans

Thank You
Meeting Summary
November 8, 2019 @ 9:00 a.m.
Health Plan of San Mateo
801 Gateway Blvd, Boardroom
South San Francisco, CA  94080

Voting Members Present:
Deanna Abriahamian, Emily Roberts, Kitty Lopez, Cheryl Fama, Francine Serafin-Dickson, Srija Srinivasan, Rayna Lehman, Maya Altman, Manny Santamaria, and Pamela Kurtzman.

Voting Members Absent: None.

Non-Voting Members Present:
Michelle Blakely, Tricia Berke-Vinson, Janet Chaikind, M.D., Teresa Guingona Ferrer, Sophie Scheidlinger, Pat Curran, Marmi Bermudez, Emily Gudaitis, and Wendy Todd.

1. Call to Order / Introductions
Meeting was called to order at 9:00 am by Srija Srinivasan.

2. Public Comment
No public comment.

3. Minutes from August 26, 2019
Minutes from August 26, 2019 were approved as presented.

4. Recap of Discussion:

a. Design & Discovery
   Ms. Todd recapped the call that happened in October:
   • Established focus areas
   • Gathered data regarding problems to be addressed to ground data into related community issues
   • Drafted a theory of change incorporating assumptions, wording, and direction.
   • Due diligence around core ideas and strategies, and funding opportunities
   • Developed next steps for making grants and recommendations to vote on in January.
   • Restated purpose statement includes “children’s health” addressing community needs.
     o Stated that it should include “because it is the right thing to do”

5. Early Mental Health
Ms. Todd briefly reviewed the environmental context, EMH assumptions, and the guiding principles and talked about where there was alignment among the committee members on the guiding principles. The high level theory of change includes the short-term outcome; strategy; and 2020 potential funding opportunities. She asked the group to think about what might be missing, what opportunities might be out there, and what questions they may have about the opportunities being presented for exploration.
Ms. Blakely and Ms. Roberts talked about opportunities and key questions/ considerations related to Early Childhood Mental Health listed in the presentation including leveraging new state and local existing ECMH funding streams to serve children in San Mateo county and to research how to access those funds to support kids in infant/toddler centers, and pre-schools. She stated:

- There are approximately 26 centers in San Mateo County that are receiving state contracted dollars and half are administered through the County Office of Education.
- Other funding is provided directly to the state but they are also part of the traditional learning communities.
- Less than half the children are receiving ECMH consultations.
- There has been deeper work to provide additional social emotional support training to teachers. There is a layer of capacity building that wasn’t there five years ago. The question is what the full range of opportunities is for parents and providers to be able to increase their capacity and provide better services.
- How much money does the state contract dollars actually equate to in implementation?

She described the under earning that is happening in some areas that could be utilized to pay for services. Infant /Toddler programs are maxing out their contracts leaving a potential gap to support this care. Pre-School programs are underspending presenting the possibility of shifting funds among centers. There is a full range of early identification and support to the family and treatment to the child. The wrap around process is important to ensure there is full range opportunity for families. There are gaps for infant/toddlers who are not in family child care, so is there a way to have greater identification and linkages for those families.

- In the 26 centers, there are about 1,400 children; leaving a gap of the about 4,000 children we think are not being covered.
- The hope is to set up a way where we can reach them through general family outreach so that parents or providers who have concerns or questions about a child will have a number to call and get help.

Ms. Srinivasan noted that through home visiting, public health nurses who coach women through their pregnancy have an opportunity to hear of challenges in the childcare setting and could be working with the family on strategies to engage with the childcare provider but this is not the same as the ECMH consultation. There is a specific intervention called Early Childhood Mental Health Consultation that is focused on coaching providers and pre-school teachers on ways to assess and address behaviors. This could provide a better opportunity to keep the child in the learning environment. Another opportunity is to have discussion with stakeholders around consultation. The vision and strategy in the theory of change sets a nice frame to be able to bring to the table the collective county vision for our kids.

There was discussion around the state contract department’s decisions on funding. The way contract dollars may be used will be made by May of 2020. The state then does a retroactive look when they determine the use of contract dollars. In January or February the county will roll out their strategy around ECMH consultations. They are in conversations regarding early identification, connection to services and care coordination. The state is also focusing on this.
There are also conversations at the state for the Master Plan for Early Learning and Care around family and linkages in early education.

First Five is interested in looking at shared collaboration with different sectors around early learning, health and family social service organizations. These are the same kids and they are looking at these to better talk about our data, our vision, our mission and strategies in supporting.

Ms. Srinivasan talked about Measure K resources and the work of the StarVista contract which focuses in specific geographic communities to provide support for childcare providers and pre-school teachers to help children who are having issues and avoid being expelled from school. She asked about the level of potential underspend. Ms. Blakely explained the StarVista model funded by Measure K will provide treatment, however outside of this, the treatment is a gap. Underspending is a few percentage points in pre-school contracts. The struggle is how to use it – for salary and benefits, consultation, facilities, or services. The county has asked the state to allow under earnings from one contract to shift to another site and this has been happening for about six years successfully. But with the struggle around salaries and benefits she feels this may change. Ms. Srinivasan added, the measure K investments through 2021 are somewhat baked, but the board has a sub-committee looking at all its Measure K investments to consider any changes for 2021-23 so there could be a change in amount or prioritization.

Ms. Altman raised the issue about not having a place to go for services once screenings happen. Ms. Blakely stated children above the age three to four are the kids that need to get picked up in those early settings. The vision is to provide the intervention wherever the kid is in their development but for sure in the health homes from birth to three and kids in childcare will go to the infant-toddler program.

Ms. Roberts said First 5 just completed a survey on family engagement and found that families who have Medi-Cal have a pathway and for others there is no clear pathway. And, screening is not happening in every early childcare setting or primary care setting. Developmental screening isn’t called out as a part of the consultation model so because it is capacity driven, it is more provider capacity focused.

Ms. Vinson concurred that treatment availability is a concern especially for those who speak Spanish or other languages specific to 0-5. Ms. Srinivasan talked about gaps for children ages 5-13 where the mental health network gap seems the most significant. Ms. Vinson expressed concern that there could be an event bigger gap than we are able to identify in the 0-5 since these children are not picked up until they are in schools. Ms. Srinivasan said there is bigger penetration of the 0-5 than for the 5-13 because we have a robust history of the 0-5 through OB, home visiting, and WIC that we actually tend to catch them and have a better grab of the earliest than that of the older.

Ms. Roberts commented that the question about network capacity after screening is a valid one. She stated, however, until we screen effectively we will not have the numbers to show the need. This is important information in order to advocate for more service delivery. These conversations are happening through Help Me Grow to track closely whether or not a family that was referred, what are the barriers, is there waitlists, etc.
Dr. Chaikind spoke about having multiple ways to enter into services and that we should be using all the different entry opportunities to get into these services. It doesn’t always come up in the health arena. We need to ensure we have multiple entry points and make entry as easy as possible.

Ms. Fama expressed concerns for the 6-12 year olds stated that she hears from the schools that the biggest problems they have are behavioral issues. Ms. Srinivasan explained that the focus on 0-5 is based on the full alignment of the committee. Ms. Roberts described, however, that F5s in many counties are looking at a birth to third grade initiatives and alignment with Medi-Cal managed care plans.

**Sensory Processing Disorder**

Ms. Scheidlinger described sensory processing disorder which is a condition where the brain has trouble receiving and responding to information that comes with the senses. It can be the over or under reacting to food, touch, sounds, textures. Treatments vary depending on the sense that is being over or under stimulated. Many treatments are deliverable in a home or community based setting. Education and distribution of that information will be an important way of addressing this issue. This condition is not a recognized disorder in the diagnostic assessment manual so it is controversial and a separate diagnosis. It is considered a symptom of autism. A majority of children on the spectrum do exhibit significant sensory issues however, most children with sensory issues are not on the spectrum. It can be found in those with ADHD, OCD and there are some who do not present with any other issue.

The seven senses of sensory issues:

- **External senses** – tactile, gustatory, visual, auditory, olfactory (touch, taste, sight, sound, smell); and
- **Body centered senses** – vestibular (balance, movement, inner ears; proprioceptive (body positioning, motor planning, muscles, joints)

She explained some people are able to read these senses and self-regulate but for others it may be more automatic and may be related to an individual’s development. The senses of touch, taste, sight, sound, smell can be tied to patterned repetitive sensory stimulation and helps organize the child’s developing brain. She reviewed a chart modelled by Dr. Winnie Dunn showing the relationship between neurological thresholds and behavioral responses. This tool is a processing framework, critical to the sensory processing to the standardized tool that is used to assess challenges in this area. She described the difference between the different symptoms and reactions that children may have: those who may be under responsive to the over-responsive, etc. She explained that this is a continuum overall, people are impacted by their environment in which they express these tendencies so not everyone is a type nor consistent in that type throughout the course of their lives. There are people who represent different types and in different places along that continuum in different settings.

She talked about the various interventions that include clinical, non-clinical, material and equipment that can help by pairing behavioral health services with the appropriate intervention. There has been great success by helping families and children understand what
works for them. She described some of the therapy approaches and the differences: occupational therapy, community and home based opportunities for intervention; sensory diets, mental health services, and adjustments and accommodations in education. When understanding the framework and what can be a trigger there is more sensitivity with awareness in the school and home setting. This can help when dealing with reaction from the child who is being triggered. It was stated that everyone fits into this spectrum but the extreme of the spectrum is where the challenge can present and certain scenarios or environments can push a person further into that space. There might be a certain place where a child who is not otherwise challenged finds that scenario very challenging.

She talked about some of the opportunities to improve the sensory processing differences:

- targeted or universal screening for sensory difference in PCP offices with validated tools being used by parent, provider, childcare provider
- Agreeing upon what level of sensory differences would benefit from additional support
- Increasing services available
- These are not medically delivered services so education becomes critical

Regarding key questions/considerations:

- Initial funding focuses on planning and hiring an expert to conduct screenings and deliver education in the community
- What interventions and strategies for co-payment might be helpful
- What interventions that are community or home-based or not Medi-Cal covered once we find the services. Right now the funding is through Measure K which is limited and could possibly decrease.

Ms. Srija explained that BHRS Pre-to-Three team conducts this sensory assessment and uses Measure K funds to pay for the children they deem warrant treatment and what that treatment will be. There are treatments that Medi-Cal will not pay for so they explore what bucket will be appropriate for specific interventions.

Ms. Kurtzman stated that some of these children don’t get picked up until they become school age and she feels there would be missed opportunities if we only reach the pre-to-three children and once the children get into school we will be able to identify them. Ms. Scheidlinger concurred that some of these issues don’t even present that early and before entering school. The idea would be the initial funding would have to be a planning grant because there is more to explore. She has been working with the SSF clinic and we have a localized expert for those who have developed these programs in other places as well.

Ms. Srinivasan shared that 16% of 7-11 year olds had symptoms of sensory processing disorder; 5% of children younger than 7 years old had such symptoms; for the 0-3 group, 20-30% have sensory intervention based on the screening.

The discussion moved into the effects children may experience due to trauma and how this plays into sensory processing. Ms. Scheidlinger touched back to the statement on the environmental cycle and the relational development, this can be very disruptive by trauma. These treatments have been helpful for children who have been impacted by trauma and are
similarly helpful treatments for children who have sensory issues. Ms. Blakely added that it would be great have the person who would be our expert build awareness and common language and understanding of this in the community. Ms. Lopez added that a goal should be to identify the risk factors for children that could present further challenges and we as well as the providers and parents should be on alert for that.

**Expanded insurance for uninsured parents**

Ms. Roberts talked about and idea of funding some mental health services for uninsured parents. She noted there are those who may otherwise be uninsured that have restrictive Medi-Cal during pregnancy and have some coverage for mental health shortly beyond. And, there are other buckets that can cover mental health service provision for these individuals on a short term basis. There are some supports for otherwise uninsured adults but there may be other gaps where ongoing adult issues that would require one-on-one therapy for parents or issues such as domestic violence that a PCP would give ongoing therapy beyond the six month mark or the one-year postpartum mark, there could be a need to consider how we can provide those services to the parent and pilot a child health intervention.

While we don’t have answers we have been asking providers in the community to see if there is a need for families. In the data from the health assessments done in the county and the First 5 parent survey, mental health for parents in terms of depression and other significant mental health challenges comes up as the biggest issue that people identify. We wanted to elevate it for discussion to consider how we can identify the unmet need and is this a tangible real issue that we can focus on. If CHI covered the cost of parental mental health support, could we look at long term impact of that, look at the child’s mental health and child’s development and look at some proxies for child development to see if this is helpful to provide these types of services.

And could this pilot possibly be palatable for DHCS to support in the future. Srijan added that undocumented adults in our county have full scope Medi-Cal during pregnancy and post-partum. A state bill extends post-partum to 1 year if someone is identified with mental health needs during the early post-partum period. Ms. Srinivasan explained there is no funded therapy within our network beyond post-partum.

Tricia Vinson thought it would be good to explore and would like to see it expanded noting public charge causing fear about using Medi-Cal and the stigma against using mental health services. Some of the funding could be used to educate people as to the benefit to the children in using these services. Ms. Srinivasan further defined that this is an exploration because at this point we don’t have an expected outcome and we don’t know who we would pilot this with. Could we start Ravenswood and County health to get some baseline data and use that as a model of implementation? There would still be the people who would be opting out due to fear of the public charge and other barriers around utilizing mental health services. Ms. Altman suggested we think about peer support groups which has been successful and might be a way to start breaking down some of the cultural barriers.

Another suggestion was to use the screening tools related to post-partum depression as a pathway where this is a time when parents or parents to be are most receptive to accepting intervention.
6. **Children’s Oral Health**

**NEMS**
Ms. Srinivasan outlined the proposal around NEMS with a goal to expand provider capacity to help improve access to oral healthcare for children with low-income households, especially in North County. NEMS is in a position to add dental capacity at their Daly City location. The opportunity would be to fund the capital expenses of up to three operatories. The cost is about $60,000 per operatory. With this investment we could incorporate some deliverables that relate to the number of new patients seen and targets for wait times for kids to be seen as a way to tie that investment to materializing to improve the access for low-income kids where we know there is a specific gap. Questions developed around this idea:

- How could we assure that NEMS prioritizes new children in the plans clinic and what they will otherwise achieve with our without our funding.
- Are there other dental providers who would also be interested in developing new capacity
- How would NEMS and other partners coordinate the outreach and assure that additional capacity was available to public need or refer to it.

Ms. Roberts added that though this is a North County specific investment, the idea is that the children now that are seen have to travel (if at all) far South which adds an additional burden around capacity to anything south of North County. Sonrisas San Mateo center statistics show that probably about 25% of their patients are from outside of their district (this includes all ages); 50% of Medicaid visits in San Mateo are pediatrics. On average per month they see about 600 visits in San Mateo.

Ms. Kurtzman stated that it will be stretch for the Sequoia Health Care District to provide funds for this North and Daly City area. She is not sure how many Sequoia Health Care District residents would utilize that. She noted they have helped Sonrisas because some of their residents do go there.

The next question was about dentists to serve. Ms. Roberts stated that NEMS does not have a Pediatric dentist but they have dentists who are training to also see children. Mr. Curran said there would have to be more discussion about real capacity. He talked about Dell Capacity Grants and a template for the deliverables and how to do it to ensure both sides understand what they are getting into. The sense they got from NEMS is that since it isn’t built yet and since they have not hired yet, they will prioritize based upon the model. Ms. Fama talked about mobile operatories as a way to bring capacity to that area.

**CDA Training**

Pat Curran explained originally the recommendation was around a training program that the CDA offers which prepares dentists to work with children with special needs. The cost for the two day training would be approximately $55,000 and could accommodate up to 25 dentists. The original recommendation was to fund the training and stipulate that attendees commit to receiving a certain number of referrals for these special needs children and would also receive education credit.
Since then, he has had some conversations that now lead to a different approach, and that training alone is insufficient. They have seen systemically that training alone does not speak to the readiness of a patient or the readiness of the dentist to take the patient.

The recommendation which is not completely developed would be to build on a mobile program where you go to the patient, do an assessment with the patient, and once you have established a relationship, to have the hygienist make the connection to a dentist and hand hold the process. Ms. Roberts added that there are current relationships with CCSMT and some other places where children with disabilities are currently seen and that could be built upon. Ms. Srinivasan explained that within CCS there are two primary medical therapy units where kids with the biggest challenges receive physical therapy and occupational therapy. At those locations CCS has partnered with Ravenswood to provide dental services on site at those medical therapy locations. So if Ravenswood, that is well positioned to do Virtual Dental Home (VDA) work and assessment, have the capacity of a hygienist to be at the medical therapy unit helping to get the family and child ready to connect with one of the dentists who is trained by CDA that would highly increase the chances that there wouldn’t be any leakage of the child getting to the dentist.

Ms. Scheidlinger added that there are children who are going to have that sensitivity to dental work regardless of what we do will need sedation to be seen by a dentist. That has been the gap they have heard about from CCS families consistently. It is no doubt that the other gap also exists but what keeps coming back is the fact that there is no one to do that sedation dentistry and its complicated as both a medical and dental benefit. Ms. Roberts added that with this population there could be a need for the child to also receive other services for which they would need sedation and could possibly be combined to provide more care within one session of sedation instead of two and to do this at an early stage to include some preventative procedures. Ms. Fama added that we should think about connecting this with the hospitals because some need the security of the hospital. It was noted that there are other children who also need this sedation to receive services seen outside of the CCS MTU’s that could include children with sensory issues.

**Cavity Free at Three**

Mr. Curran explained the Cavity Free-at-Three funding would be to implement a program of training and education with a focus on prevention in children 0-3 years of age. These programs focus on training trainers to go to pediatric offices and early childhood education centers to provide fluoride varnish in schools and sealants. They train locations to be able to do those themselves. This builds on the work already being done by CDHP. They measure the number of people trained and the number of fluoride varnish applications performed. They don’t currently have data yet on outcomes. The programs in Colorado and New York have been going for about 7 years running through the public health departments.

While we do not yet have the costs, Mr. Curran stated these are not expensive programs however, there is a sustainability question. Ms. Roberts stated a communications component or campaign could be another opportunity targeting children.
Ms. Altman stated that in the CalAIM proposal, the state wants to get to 60% utilization for kids for dental so there is a lot of momentum with dental overall and really aligns with the state. Mr. Curran added that a potential benefit is communication and training is not income specific so you can go after as many pediatric clinics or early childhood centers as possible. Prop 56 dollars is restricted to education and training and cannot be used for direct services and there is 4 years more guaranteed.

Ms. Vinson commented that our aim should be to present these efforts as pilot programs so there could be a possibility of state funding in the future for the cavity free at three. Ms. Kurtzman concurred that education, cultural shifts, and building systems that are sustainable models leads to a perspective of developing strategies and a systems that we can bring to Sacramento showing something that has made a difference in San Mateo County. She likes all these ideas around training and around education that benefit everyone and is long term.

Ms. Bermudez suggested we look at tying this to Medi-Cal retention if families utilize the service and then find benefits of it and then stay in the program. There are Medi-Cal administrative activities where we could do marketing trying to keep your Medi-Cal and that could be invested in MA.

7. Governance & Grant Making
Ms. Srinivasan talked about the current structure of the CHI Oversight Committee, and the history of events which have brought us to the theory of change being developed to guide the process of how this group will move forward with the pooled funds collected over the years. There was discussion around the voting and non-voting members, how entities become or remain voting members and how to manage the funding entities’ individual investments.

There was recognition that some of the future funding opportunities may not be a fit for each of the funding members and there may be a desire to have funds returned to them. There was also recognition that some of the members with votes, while not being funding members, bring expertise and perspectives that create value to the decisions made as well as those non-voting members who participate.

After discussion, it was proposed for the group’s consideration that:
- If a voting member wishes to have funds returned but feel their contributions still warrants a vote in the decision making that this should be proposed to the group.
- If an entity wishes to become a voting member they should submit a proposal to the group for consideration demonstrating how they add material to sustaining the success of the committee.
- If an entity finds that the direction of the committee no longer fits the direction they can withdraw their participation as a voting member to a non-voting member.

One of the continuing themes expressed by the committee has been the value of the collaboration among these entities and even those as non-voting members, the expertise and perspectives add value to the decision making process. Ms. Altman added that the group has always been able to operate on consensus among all of the voting and non-voting members.
Ms. Srinivasan suggested that the group, which typically meets twice a year, meet in January, April and July for the first part of 2020.

Ms. Srinivasan noted that since the county no longer operates healthy kids as of October 1st, the CHI group gave permission to continue to support the staff costs through December 31st. She explained that the staff hours for 2020 would equate to $25,000 for the year to continue this staff support. The group was in favor of continuing to fund the staff support in the amount of $25,000 June of 2020.

Ms. Srinivasan suggested that the group, which typically meets twice a year, meet in January, April and July for the first part of 2020.

**Grant Making**

Ms. Srinivasan explained the planning group will move forward to work with the information presented and discussed today for recommendations to be presented to the committee in January and subsequent meetings in April and July.

Ms. Srinivasan outlined the balance of the CHI Trust fund noting that after allowing for the hold on $1.2M with state reconciliations, staff support, Kaiser coverage for remaining 21 children that has been agreed to and reserving about $1M for a reserve balance, the working funds for possible grants and project funding is about $3-4M.

Srija summarized the areas that are closest to being brought to the group for a vote:

- NEMS dental project to expand provider capacity
- CDA with Ravenswood VDH add on
- The idea of a planning grant to support the sensory differences pathway development
- Early Childhood Mental Health will need more time to develop proposal
- Mental Health for uninsured parents will also need more research that may end up in RFP.

8. Adjournment - Meeting adjourned at 12:00 p.m.
CHI OVERSIGHT COMMITTEE MEETING
Meeting Summary
January 31, 2020 @ 9:00 a.m.
Health Plan of San Mateo
801 Gateway Blvd, Boardroom
South San Francisco, CA 94080

Voting Members Present:
Deanna Abrahamian, Kitty Lopez, Cheryl Fama, Francine Serafin-Dickson, Srika Srinivasan, Rayna Lehman, Manny Santamaria, and Pamela Kurtzman.

Voting Members Absent: Maya Altman.

Non-Voting Members Present:
Tricia Berke-Vinson, Janet Chaikind, M.D., Sophie Scheidlinger, Joey Vaughn, and Pat Curran

Guests: Wendy Todd, Cindy Donis, and Toni DeMarco

1. Call to Order / Introductions
Meeting was called to order at 9:00 am by Sophie Scheidlinger.

2. Public Comment
No public comment.

3. Minutes from November 8, 2019
Kitty Lopez stated that the wording regarding the voting process should be rephrased to say that the items listed as the voting structure were the proposal for the group’s consideration rather than stating it was a “consensus” of the group. Others agreed and the minutes from November 8, 2019 were approved with this change to the third paragraph on page 9 pf 10 regarding the voting.

4. Introductions/Review Anticipated Meeting Outcomes
Introductions were made around the room. Wendy commented that this meeting is an experiment and learning process in the idea of grant making and walk through a couple of grant proposals and recommendations.

5. Children’s Oral Health

a. Approval of Dental Capacity Grant Recommendation
Wendy Todd introduced theory of change that has been discussed at previous meetings that “if young children and pregnant women had better access to preventive oral health services, oral health information, and treatment, then there would be a decrease in disease and reduction of health disparities among high risk populations”.

DRAFT
She pointed out the short term outcomes we are hoping to achieve, the various strategies previously discussed, and the potential funding opportunities leading to today’s recommendation.

Pat Curran reviewed the recommendation to support NEMS in Daly City as a funding opportunity to increase dental access for children. There were a number of questions and concerns discussed including outreach, how the funding would be spent, the types of visits that would be included as part of the incentives, and that the population served would be San Mateo County Medi-Cal / Denti-Cal children. It was established that this grant proposal would offer the opportunity to better identify the needs and gaps for improvement. After much discussion, the group was comfortable moving approval of the grant recommendation of the $210,000 funding over the two-year period of January 1, 2021 through December 31, 2022 as follows:

- Initial funding of $150,000
- 2nd payment of $30,000 upon verified 2,500 visits for children who qualify for Medi-Cal in San Mateo County seen during the term of the grant funding;
- 3rd payment of $30,000 upon verified reporting of 3,000 visits for children who qualify for Medi-Cal in San Mateo County and seen during the grant term; and
- A six-month reporting to occur within 30 days of the six-month mark (July 31, 2021; January 31, 2022; and July 31, 2022).

The nine voting members of the committee approved the motion with seven affirmative votes; and, two abstentions (Sequoia Healthcare District and Peninsula Health Care District). Mr. Curran explained that the specifics discussed would be communicated with NEMS and included in the MOU. He will bring the MOU back to this committee in May for review before it is signed.

6. **Early Mental Health**

   a. **Early Mental Health**

Ms. Todd talked about the theory of change that had been discussed at previous meetings regarding Early Childhood Mental Health: “*If mental health issues were either prevented and/or identified early among low-income families with young children and identified needs were addressed through effective treatment, then there would be less need for services and supports later in the life and younger children would be set up for better academic success, health, and well-being.*”

She stated that the group then decided that “*if more children would be screened, there would be increased enrollment and engagement in mild to moderate mental health and occupational therapy services, and that undocumented and uninsured parents would have better access to mental health*”. The strategy to be reviewed today is around Sensory differences and this opportunity covers two of the short-term outcomes desired.
Ms. Scheidlinger reviewed the Sensory Processing Planning grant proposal. She explained what sensory processing is using Dunn’s Model of Sensory Processing that outlines four categories of behavioral responses. She stated that on the extreme of the spectrum and in certain environments there are opportunities for intervention where we may be able to deal with challenges in terms of their school environment and at home. Toni DeMarco explained that as the children develop, their capacity to self-regulate becomes more non-adaptive and they can become more rigid, especially when they reach school age.

Ms. Scheidlinger explained that the proposal is about a system change to address the identified gap of the need for early identification and intervention noting the potential for misdiagnosis and unnecessary pharmaceutical interventions. There was discussion about the percentages of children who need this treatment and it was stated that data indicates about 5-10% of children go undiagnosed but that the reality is likely much higher. Screening and understanding in the community are limited to that the extent that children are not appropriately screened at PCP offices or in early education environments. A quote from Dr. Grady who has been developing this work - “the biggest advantage in doing sensory screening is the parents and teachers increased understanding of what the child is experiencing”.

Questions from the committee members included: where the referrals come from, how much of the funding would be used to fund treatment, timeline and milestones for the project, what infrastructure would be necessary relative to the number of kids served and how an investment in this work would be sustained. It was explained that there are a variety of resources such as general medical community, children and family services for court ordered families, and others. Ms. Srinivasan added out of the 45,000 kids on Medi-Cal of whom 5,000 are 0-5 years old, about 5-10% have this underlying challenge that goes undiagnosed.

Ms. Scheidlinger explained the proposal:

- Development of a pilot
- Establish a primary, clinical based site; and early warning site (pre-school)
- Pay for staffing of Clinical and Community Expert, and Part-Time Project Manager
- Goal is to have the children served at the pilot sites with access to appropriate screening and the pathway into treatment
- Development of a stakeholder group to dictate the ongoing process by identifying what is required to make a systems change, aligning the community on the service needs, selection of the pilot sites, and hiring / engagement with this staff.

The funding structure is for a three-year grant, 2020-2023, with milestones and goals to be hit to draw down the annual funding. Ms. Scheidlinger explained the recommendation is to
hold aside the grant amount of $984,000 for the three years and not commit it to another resource of this structure. At this point, the actual funding would be for year one of $328,000 to BHRS and HPSM which will be used to increase screening and enrollment engagement in mental health services. At the end of the three-year timeframe the goal would be to have all children have access through this pilot to appropriate identification and treatment, increase screenings for sensory differences in San Mateo County and get to a universal screening model. As well, to increase access to occupational therapy and mental health services, and clinical improvement using standardized tools and progress reports.

Ms. Scheidlinger explained that the pilot would explore the system change needed to develop this by moving away from the direct payment of service model to developing a delivery model. This proposal does not outline the payment of services for a number of kids to get occupational therapy, for example but could possibly pay for services that are not covered by Medi-Cal. However, the primary role is the development of the pilot, staffing of these roles, the development of a plan to increase engagement, education, awareness and understanding out in the community. Ms. DeMarco added that the clinician will be able to help in this area and would have the ability to do that kind of training with all parts of the educational, medical, and mental health so everyone is cross trained and that person could also provide sensory profile screenings. Committee members expressed support for training key partners in the community and suggested models that could sustain such a training component, such as development of training modules and a train-the-trainer approach.

Ms. Scheidlinger explained that year one would be focused on developing the stakeholder community, the hiring of the roles, selection of the pilot sites and the integration of those roles into the pilot sites to begin the work. Year two would be when the pilot commences and learnings take place, and year three is the pivot year when planning of the longer-term potential of moving beyond the pilot sites and out into the community.

Ms. Scheidlinger addressed the question about sustainability by saying that part of the intent is to benefit from the learnings gained through the development of the pilot and identifying what changes could be made for the entirety of the system in San Mateo County. With that, hopefully there will be elements that can be brought to leadership as needed to figure out the investment required in moving forward. The sustainability is uncertain at this point, however, there may be some proof of concept learnings that can be used to show the benefits to the emotional and social well-being of the children.

Ms. Demarco commented that BHRS has a strong foundation on the train-the-trainer model already that sustains their NMT (Neurosequential Model of Treatment) program. She added that another question is what could be the cost savings down the road, what other activities are the children engaged in as opposed to juvenile hall among other places, where these kids would normally end up being treated. This is an important question to not lose in the long term.
Ms. Kurtzman motioned to approve the proposal but wants to ensure there will be locations identified in South County and offered assistance to facilitate that.

Ms. Srinivasan seconded the motion clarifying that the approval is for the first-year funding and a setting aside of the three-year funds for this pilot. Ms. Serafin-Dickson added the clarification that after the first year, the group could consider moving forward with the funds set aside for the subsequent years. The nine voting members were all in favor of this first-year grant as stated and setting aside the full three-year funding for this pilot.

7. Governance & Reflections
   a. Approval of Revised MOU
      The MOU was tabled for review at the next meeting. Ms. Srinivasan will reach out before the next meeting to get input from the group to prepare for the May meeting.

8. Next Steps:
   Ms. Todd asked the group to share with her and Ms. Srinivasan any ideas or interests in other organizations or initiatives that they would like the planning team to start exploring. Ms. Todd pointed out the pipeline list that are other opportunities still in development:
      o **Oral Health:** Cavity Free at Three; and, Ravenswood/CDA Training
      o **Early Mental Health:** Early Childhood Mental Health

9. Adjournment
   The meeting adjourned at 11:00 a.m.
HEALTH PLAN OF SAN MATEO
CONSUMER ADVISORY COMMITTEE MEETING
Meeting Minutes
Thursday, January 9, 2020
801 Gateway Blvd. 1st Floor-Boardroom
South San Francisco, CA 94080

Committee Members Present: Tricia Vinson, Robert Fucilla, Judy Garcia, Angela Valdez, Amira Elbeshbeshy
Committee Members Absent: Ricky Kot, Mary Pappas, Hazel Carrillo, Cynthia Pascual
Staff Present: Maya Altman, Gabrielle Ault-Riche, Carolyn Thon, Charlene Barairo, Rustica Magat-Escandor, Pat Curran, Karla Rosado-Torres, Richard Moore, Vicky Perez, Megan Noe, Colleen Murphey, Kiesha Payne, Samareen Shami, Kati Phillips, Michelle Heryford

1.0 Call to Order/Introductions: The meeting was called to order at 12:00 noon by Ms. Vinson and introductions were made.

2.0 Public Comment: Ms. Vinson noted that this is her last meeting. Amira Elbeshbeshy, Staff Attorney from the Legal Aid Society of San Mateo will facilitate going forward.

3.0 Approval of Agenda: The agenda was approved as presented. M/S/P

4.0 Approval of Meeting Summary for September 12, 2019: The September 12, 2019 Meeting Summary was approved as presented. M/S/P

5.0 HPSM Operational Reports and Updates

5.1 CEO Update: Ms. Altman provided an update on the Seton/KPC purchase. Verity has thrown out the purchasing agreement and filed a lawsuit against KPC for breach of contract. The purchase agreement was for Seton Coastside and 2 hospitals in Los Angeles. Verity has also shared their plans to close St. Vincent’s Hospital one of the two hospitals included in the deal. Ms. Altman believes the City and County of Los Angeles is likely to keep St. Vincent’s open, but not as an acute care facility, it will likely serve some other healthcare purpose. Verity is looking for another buyer, they have enough cash flow to last them a few months. HPSM is monitoring the situation closely. She also reported the Infusion Center at Seton closed last month due to a mass resignation. HPSM will work with staff to ensure members are cared for. Governor Newsom’s budget is scheduled to be released soon. Medicaid reform proposals are included in the budget. Ms. Altman is a Member of the Master Plan on Aging Stakeholder Advisory Committee, there is a forum on January 23, 2020 sponsored by the Alzheimer’s organization in Mountain View. She invited all those interested to attend. She announced that HPSM’s Chief Medical Officer, Dr. Susan Huang has resigned. Dr. Moore is the interim CMO. Ms. Vinson inquired about the new plans for Medicaid to end CCI and move to D-SNP’s. Are there concerns about the
5.2 **CMO Update:** Dr. Richard Moore provided a report on behalf of Dr. Susan Huang. He spoke further about the Seton Infusion Center closure. They are identifying members who need assistance. The majority of patients receiving chemotherapy were transitioned to St. Mary’s Medical Center. There are 30 non-chemotherapy infusions, who will utilize the home infusion option. Dr. Moore noted the Pharmacy was key in identifying which drugs are appropriate for home infusion. HPSM is encouraging those who qualify for home infusion to take advantage of this service. There was one patient that requested to change oncologists. The Care Coordination team is working to transfer this member to either SMMC or Stanford. He remarked that the systems worked together impressively to transition 40 patients in total. Ms. Vinson inquired on the number of health plans that use the facility daily. Ms. Murphey replied they have an average inpatient census of 80 per day. A large portion of those are HPSM members. Dr. Moore noted recent news articles that claim Seton was the 2nd busiest Cancer Center after UC. Ms. Altman also remarked that Seton is the 5th highest volume hospital in terms of Medicaid. HPSM Medicare patients make up close to 50% of the census.

Dr. Moore also shared HEDIS news. The Minimum Performance level (MPL) is moving up from 25% to 50%. Medi-Cal has 29 HEDIS measures, much of which rely on medical records. In a 10-week period; 5,900 medical records were obtained and reviewed. No Medi-Cal measures were below the MPL; 5 measures were above the High-Performance level (HPL). The CareAdvantage side successfully reported on all 55 items required by the Centers for Medicare & Medicaid Services (CMS). Overall, it was an excellent report. They are also working on Phase 2 of the Long-Term Care Collaborative, which up until now, involved mostly Skilled Nursing Facilities (SNF’s). They’d like to expand to integrate hospitals. Specifically, they’d like to enhance the discharge processes from the hospitals to the SNF’s. He informed the group that the Dental integration program has been delayed for 6 months by the state. Finally, he noted that the American Cancer Society has reported that Cancer rates has dropped 29%. This has been mainly attributed to reduced smoking rates and advances in lung cancer treatment. Immunotherapy breakthroughs have greatly helped.
5.3 **Quality Improvement** – Ms. Noe discussed HPSM’s recent flu campaign. She passed out flu cards with alerts and reminders, which were given to members and added to the HPSM website. They also distributed talking points to internal HPSM member facing departments. She highlighted some of the chronic disease programs they are working on. They have partnered with Mills Peninsula on the Diabetes Prevention Program (DPP) to get members connected. To help combat high blood pressure; there is a new pilot project with NEMS and SMMC. They are also partnering with county public health work groups for asthma. They are developing new women’s health programs and campaigns for breast cancer screenings. Ms. Perez spoke about a recent HPSM program focusing on cervical cancer screening disparity. As noted by Dr. Moore, HPSM did well with the general population. However, they did notice the rate was below the MPL for the disabled community. They are actively working with Commissioner Ligia Andrade Zuniga to address this disparity at both the Provider and Member level. Ms. Shami reported on Adolescent Well Care, a HEDIS measure that HPSM has not tracked in a while. AWC is not performing as well as they hoped. They found that getting 19-21-year old’s in for regular doctor visits is a challenge. They are working with Sequoia Hospital’s Teen Health Advisory Board to address this. As Dr. Moore reported, the prenatal and post-partum numbers for timely visits are good. Ms. Shami credited the direct touch they have with these members for this improvement. She noted their desire to expand their Maternal health program, so that is not just an incentive program. They are hoping to provide more comprehensive care, address maternal mental health, make inquiries on the health of the baby as well as connect members to resources like WIC, Black Infant Health and other programs that promote the health of both mother and baby. They have been working with Marketing and Communications to change the logo and branding. “Baby and Me”, is the new name of the program. She passed around information cards they have recently printed as well as posters that will be posted at OB-GYN and PCP offices. Ms. Altman congratulated the group for their efforts, she noted the numbers have not always been this good, there has been a lot of improvement in the last few years.

Ms. Garcia asked about pneumonia shots. Specifically, when one should get one and how often. Dr. Moore noted that Prevnar is the recommended vaccine for pneumonia. It was suggested that you get one at age 65, he said the jury is still out about whether it needs to be repeated. He suggested checking with your PCP especially if you are pre-disposed. Ms. Vinson, said that might be something to share with HPSM members, they may have questions about that as well. Dr. Moore agreed and said it’s not just pneumonia, individuals should inquire about vaccines or boosters for all immunizations at their annual doctor visit. Ms. Noe said they did a pneumonia awareness campaign in the spring of 2019. They are rethinking how to approach that for 2020. She also announced the addition of an Adult Preventive Health section on the HPSM website, they will include immunization and booster information there. Ms. Vinson asked if there are quality improvements planned for behavioral health care
issues? Ms. Noe confirmed that they are focusing on depression screening, they are also planning to follow up on members who are hospitalized with a mental health illness. Ms. Shami reminded the group of the creation of the Maternal Mental Health program that is part of Baby and Me. Ms. Vinson inquired if there is anything planned for BHT therapy. Ms. Murphey noted that will be addressed in the Grievance & Appeals and Provider Services report. She did say that they are proceeding with de-delegating the management of the network for mild to moderate from BHRS.

5.4 Grievance and Appeals: Ms. Rosado-Torres reviewed the Grievance & Appeals (G&A) report. In Q3 2019, CMC, Medi-Cal, and CCS were not within the goal rate of complaints per 1,000 members. The CCS program has a small number of members, making it susceptible to large changes in calculated rates that may indicate a significant change in member experience. The total number of complaints received for CCS was 9 cases. CA-CMC’s rate of 22.66 complaints per 1,000 members is higher than the goal, the need for improvement is limited. The G&A Unit continued to improve its case timeliness during Q3 2019 and was able to complete all case investigation and case review in a timely manner. The volume of grievances slightly increased during Q3 2019 as compared to Q2 2019. However, the percentage of grievances related to Customer Service decreased in that same time. The percentage of grievances related to Quality of Care increased from 25% to 32%. The percentage of appeals related to prescription drugs increased in Q3 from Q2. Appeals related to Durable Medical Equipment (DME) increased in Q3. There was a decrease in the percentage of Other Service/Therapy appeals. The rate of overturned appeals for medical services is slightly higher. It was noted that prescription drug appeals are overturned in full or in part 61% of the time. For all other appeals the overturn rate is 46%. Ms. Vinson inquired on the term “overturned.” Ms. Rosado-Torres replied that overturned refers to appeals that after a second review are approved. Ms. Vinson inquired further about what happens when the decision is upheld by HPSM but overturned by Maximus or DMHC, would that reflect as overturned or upheld on the G&A report? Ms. Ault-Riche said it would be reflected as upheld. She also said they could provide information at the next meeting on the second level appeal decisions if the committee would like that. Ms. Vinson stated that she believes that is an important piece of information to help members get the whole picture. Mr. Fucilla inquired on the Prescription appeals numbers, stating that 61% appears high, he wondered how many actual cases that represented. Ms. Rosado-Torres replied that it involves 23 cases. Ms. Elbeshbeshy asked if there are proposed changes for the initial review process to bring down the number of overturned appeals. That is not likely, she advised the group that there is a quick 24-hour turnaround time for these decisions. The majority are denied due to lack of information. Once the information is provided it is often overturned. Ms. Vinson asked if they could provide more information about the cases that are dismissed. Ms. Rosado-Torres answered they are often dismissed because the member did not go through the proper process, often skipping the G&A step with HPSM. Ms. Ault-Riche asked Ms. Vinson and the committee for feedback on information they’d like to see at
subsequent meetings. Ms. Vinson said she could get back to her later with specifics but in general she noted that the committee wants to know how the Plan is doing. Especially from the perspective of the Department of Managed Health Care (DHMC). She reported on appeals for prescription drugs, DME, Other Service/Therapy, Specialists and medical services. Finally, she provided the numbers of those who asked to change their assigned Primary Care Provider (PCP) in Q3 2019. 78 members switched away from a total of 27 different PCPs. Of those, 19 were clinics and 8 were individual providers.

5.5 **Provider Services:** Ms. Murphey provided a verbal report on Provider Services. She announced the removal of Dr. Sverdlov from the network. The PS unit is working with Customer Service to help with communication for the many Russian speaking patients Dr. Sverdlov served. The department is also actively recruiting NEMT. They have secured two new providers, Uride and Prolcon Transport. Over thirty providers have been contacted to contract with HPSM. Unfortunately, the majority are not Medi-Cal enrolled which prohibits HPSM from contracting with them. HPSM is attempting to assist providers with enrollment in Medi-Cal, a process that can take six months or longer. They are in active negotiation with several providers, discussing terms now. Recruiting for speech therapy continues. HPSM is closely monitoring a recent increase in access grievances related to BHT services. They have been meeting weekly with Magellan to discuss member cases, process improvements to network management and access functions at Magellan. The recuperative care pilot was launched, funded by measure K dollars. There are 6 beds for SMMC in South San Francisco. She also reported on a new OB-GYN provider and two Optometrists. Finally, Ms. Murphey reported on a new contract with Enara Health for the Diabetes Prevention Program (DPP).

5.6 **Member Services:** Ms. Ault-Riche reviewed the Member Services and CareAdvantage report. Enrollment is continuing to see decreases with the Medi-Cal line. She announced a data sharing agreement with Human Services, they will collaborate on case by case problem solving. The Member Services call center has plans to help HS with outreach calls to those who are within three weeks of their redetermination date and haven’t submitted their redetermination packet. They are working on talking points for that now. She advised the committee that as a result of Dr. Sverdlov leaving the network, the CA line has 90 dis-enrollments, these members will remain under the Medi-Cal for the time being. Call center performance continues to do well. She announced two new sections in the MS report, one for Kaiser, which showed their call center doing very well in Q3 2019. They are also monitoring their email correspondence with members to ensure they meet quality and timeliness standards. Currently she is focusing on the makeup of the committee. She noted the need for more consumer advocate voices from the community. Toward that end she is actively seeking new members and looking for suggestions. There was a question by Mr. Fucilla about the total Medi-Cal census, she replied it currently stands at 98,286. She noted that at this time two years ago the number was over 110,000. Ms. Vinson
inquired if there were any questions or concerns from members regarding public charge. Ms. Ault-Riche replied there have not been many. The department did some education around that issue. She said it is hard to attribute the decrease, which is happening state-wide, it is particularly bad in some of the more affluent counties like Santa Clara, San Mateo and San Francisco. She hopes their efforts can prevent the Medi-Cal churn piece at least. Ms. Altman reminded the group that HPSM will have some new members, with undocumented teens coming to the plan as Medi-Cal members as a result of new state legislation. Since there was no quorum, the committee decided to meet again on March 5, 2020 to vote on Item 6.0 – CAC 2020 Meeting Dates.

6.0  New Business: There was no new business.

7.0  Adjournment: The meeting was adjourned at 1:06 pm by Ms. Vinson. M/S/P

Respectfully submitted:

M. Heryford

M. Heryford
Assistant Clerk to the Commission
Physician Advisory Group Minutes  
December 4, 2019 – 7:30 a.m.  
San Mateo Medical Center  
222 W. 39th Avenue, Boardroom, 2nd Floor  
San Mateo, CA 94403

Members Present: Drs. Janet Chaikind, Vincent Mason, Kenneth Tai, Hung-Ming Chu, Tom Stodgel, James Hutchinson, Ralph Wong

Members Absent: Drs. Leland Luna

Staff Present: Colleen Murphey, Paul de la Cruz, Luarnie Bermudo, Kati Phillips, Molly Carter, and Drs. Richard Moore, Susan Huang, Cynthia Cooper.

<table>
<thead>
<tr>
<th>Item(s)</th>
<th>Discussion</th>
<th>Action</th>
<th>Responsible Parties</th>
<th>Due Date</th>
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</thead>
<tbody>
<tr>
<td>1  Call to Order</td>
<td>Dr. Janet Chaikind (Chair) called the meeting to order at 7:30am. A quorum was present.</td>
<td>Approved</td>
<td>J. Chaikind</td>
<td>N/A</td>
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<td>2  Public Comment</td>
<td>None</td>
<td>N/A</td>
<td>N/A</td>
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<td>3  Meeting Agenda and Meeting Minutes</td>
<td>The agenda for December 4, 2019 was distributed to the committee.</td>
<td>The agenda for December 4, 2019 was approved.</td>
<td>PAG</td>
<td>12/4/2019</td>
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<td></td>
<td>The meeting minutes from October 2, 2019 were distributed to the Committee at the meeting. The Committee reviewed the minutes without corrections.</td>
<td>The meeting minutes for 10/02/2019, were reviewed and have been approved.</td>
<td>PAG</td>
<td>12/4/2019</td>
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<td>4  HPSM Announcements</td>
<td>4.1 Dhcs Audit C. Murphey provided an update to the committee regarding the HPSM 2019 Dhcs Audit results/findings. She reported that the audit went well and preliminary information suggests that Provider Services was able to close a prior finding. HPSM will be informed of final results in January at the DHCS exit conference.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<td></td>
<td><strong>Health Services Announcements</strong></td>
<td>None</td>
<td>N/A</td>
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<td>6</td>
<td><strong>Provider Services Announcements</strong></td>
<td>N/A</td>
<td>N/A</td>
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<td>This concludes our open session network</td>
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<td>7</td>
<td><strong>Adjournment</strong></td>
<td>The meeting was adjourned to the Peer Review Committee (PRC) closed session.</td>
<td>N/A</td>
<td>N/A</td>
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Next Meeting for the Physician Advisory Group: February 4, 2020 at 7:30 am
QUALITY IMPROVEMENT COMMITTEE MEETING
December 18, 2019, 6:00 p.m. – 7:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080
HPSM Boardroom, 1st Floor

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

HPSM Members Present: Dr. Cynthia Cooper, Nicole Ford, Ian Johansson, Sarah Munoz,
Megan Noe, Kati Phillips, Katie-Elyse Turner and Samareen Shami

1. Call to Order by Dr. Jeanette Aviles.

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

3. Approval of Quality Improvement Committee (QIC) minutes from September 18, 2019
   Approved and seconded by the committee members.

4. Approval of Clinical Quality Committee (CQC) minutes from September 9, 2019
   Approved and seconded by the committee members.

5. Approval of Service Quality Improvement Committee (SQIC) minutes from September 26, 2019
   Approved and seconded by the committee members.

6. Approval of Utilization Management Committee (UMC) minutes from October 28, 2019
   The draft UMC minutes was approved and seconded by the committee members.

7. Culturally & Linguistically Appropriate Services (CLAS) and Health Education Activities
   Update
   Ms. Sarah Munoz, Health Promotion Specialist oversees the Health Education Program and
   Cultural Linguistic Appropriate Services Program. These are the primary focus areas for 2020,
   which consist of HPSM internal committee for class-related activities. In addition, Quality oversees
   the following programs:
   - Serving a diverse membership/culturally & linguistically appropriate services
     - HPSM Staff Education
     - Cultural Awareness Provider Education
     - Language Assistance Program
     - Disparities
     - Diabetes
   - Health education/wellness prevention
     - Member Incentive Programs
     - Health Education Member Campaigns
     - Diabetes Self-Management Program
     - Tobacco Cessation
     - Community Partnerships/Resources
2020 Focus Areas

- **Diabetes**
  - Looking to build a more robust program in 2020 with the focus to increase membership who have received A1C test and reduce percentage of members with poor control for A1C defined as >9

- **Tobacco cessation**
  - Ensure compliance with all aspect of the Tobacco All Plan Letter, including:
    - Identifying tobacco users
    - Services for pregnant women
    - Prevention of tobacco use in children and adolescents
    - Provider training

- **Other Quick Health Education Updates**
  - Baby + Me Program
  - Flu Campaign

- **CLAS**
  - Enhance interactions and communications with the LGBTQ + community
  - Understand commonly used terminology and gender-neutral language
  - Determines best practices for working with the LGBTQ + community

- **Mental Health Awareness**
  - Mental health awareness trainings – May 2020 for internal staff
  - Health education guide online for members
  - Provider newsletter
  - Community partnerships/resources

**Comments:**
Dr. Aviles commented the information is available to patients; however, the bigger challenges for patients for those not engaged and/or have not engaged successfully overall. The Medical Center has significant number of unassigned/not engaged patients who might have diabetes. SMMC has worked with HPSM to get some of the claims data. We need face-to-face with patients versus face-to-face with providers. It would be helpful for SMMC to receive notification from HPSM as well as understand the claims data for those patients with diabetes. In addition, how would members get reimbursed for their flu shots? How does HPSM track claims data as majority of pharmacies don’t use the registry. Ms. Munoz stated members need to show their member ID at the local pharmacies.

For the LGBTQ + community, SMMC has spent significant amount of time with training staff to work with the community. The best opportunity for training would be online for providers. If there is an opportunity to offer and publicize, there might be an interest to sign up to work with the community.

SMMC has conducted number of calls to members assigned for mental health awareness; such as, what kind of health needs do you have? The top choice was dental and second was a number of classified muscular-skeletal pain issues.

Dr. Chavarria commented in the LGBTQ + community training, many questions were asked by the peers to staff. Need more workshop trainings available in this area. In addition, would HPSM promote vaccinations such as measles vaccine? Ms. Munoz stated HPSM provided a small campaign announcement on our HPSM website in the Provider/Member Newsletter.
Ms. Turner commented HPSM is working around the telephonic health risk assessment and has mandated a care plan process. An area we identified was an opportunity for improvement in trying to engage PCPs in the Inter-Disciplinary Care Team meetings as part of HPSM's care plan development.

Dr. Sattler commented we have some HPSM patients who are probably able to access our pharmacy management and diabetes education classes. It would be beneficial to look at other program management options availability. Presently, Stanford is looking at auto-referral for patients; such as, the A1C/pharmacy/diabetes education programs. Note: still in the pilot-phase for auto-referral.

Dr. Osmenta commented there are only few patients at our facility with diabetes but they are connected with Stanford, primarily the pediatric cases.

Dr. Tai commented on the A1C testing in terms of our clinics wanted to test A1C for patients; however, many of the Plans don’t cover the service. A question if Health Plan will reimburse for A1C testing at the point of care or not. Ms. Ford will loop back with Dr. Tai’s question for further research if A1C is covered or not. There is another area needing further research around the tobacco program whether to use text messaging for patients would be feasible or not, in order not to overwhelm the patients with text messaging.

Dr. Chu commented there are other groups related to BHRS if needing to contact for specific populations. There is a group called Total Wellness whose focus is primarily around diabetes care. Meanwhile, BHRS has a number of community initiatives focused to do community outreach work. It was recommended for HPSM to join some of these community activities in order to promote the diabetes program.

For LGBTQ + community, BHRS works closely with the Pride Center – Office of Diversity Entity. There are number of training and training materials available, which are tailored for providers and especially to BHRS staff who are trained in the LGBTQ + community. Lastly, there has been lacking in health data points in terms of the LGBTQ + communities.

8. 2019 Medicare CAHPS and HOS Results

Ms. Samareen Shami, QI Specialist reported on CAHPS and HOS cohorts. Note: first time HPSM has received follow up data for an MMP cohort.

**Health Outcomes Survey (HOS) Overview**

Gather health status data in Medicare Managed Care for use in quality improvement activities, public reporting, MAO accountability and improving health outcomes. Self-reported survey of CMC members conducted in English, Spanish & Chinese.

Our Cohort 19 is our first year of responses to follow up surveys. The data describes changes in the health status over time for beneficiaries. Note: The approximately 484 members responded to the baseline survey conducted in 2016. Of those, 211 were available to participate in the follow-up survey in 2019. We are looking to receive the report for Cohort 20 next year.
**HOS Measures**  
Health status measures – physical (PCS) & mental (MCS) component summary scores  
Chronic medical conditions  
Functional status (ADLs)  
Clinical measures  
Effectiveness of care (HEDIS) measures – fall risk management (FRM); osteoporosis testing in older adults (OTO); physical activity in older adults (PAO); management of urinary incontinence in older adults (MUI)

**2019 Consumer Assessment of Healthcare Providers and Systems (CAHPS)**  
Overview – member experience survey; conducted annually for Medicare and every 3 years for Medicaid (only MCR in 2019); conducted in the first ½ of the year and measures members’ experiences over the previous 6 months; survey sample drawn from all members who have been enrolled for at least 6 months  
Review specific - rating of health plan; rating of health care quality; rating of personal doctor; rating of specialist. Response rate above state MMP and above average MMP nationally. There was a significant drop in our Care Coordination composite measure and we continue to need improvement in areas such as the Getting Needed Care measure. These measures deal directly with care at the provider office. Our strengths lie in our pharmacy related measures and our continued strong performance in the flu and pneumonia vaccine measures. An area of focus is member engagement and experience, which was identified this year.  
Note: separate PPT attachments were distributed and presented at the December QIC meeting. We consolidated all activities for CAHPS and HOS under the new committee, Member Experience and Engagement Committee.

9. **Other Business**  
Ms. Ford announced on behalf of HPSM, Dr. Susan Huang is no longer the Chief Medical Officer effective 12/16/2019. Meanwhile, Dr. Huang is finalizing some projects before her departure from HPSM. The following medical directors 1) Dr. Cynthia Cooper, 2) Dr. Richard Moore and 3) Dr. Stephen Whitgob will continue to oversee and review the clinical guidelines for Quality. In the interim, Maya Altman is also the point of contact for Quality.

Dr. Chu announced his retirement will be end of February 2020 and this will be the last QIC meeting for December 2019. Dr. Chu extended his appreciation from his colleagues and the support from the physicians. The new Medical Director or Deputy Medical Director of BHRS will be part of QIC once appointed. Ms. Ford thanked Dr. Chu’s representation and contribution.

In addition, HPSM is looking for additional committee members such as clinicians/other specialties, which does not necessarily have to be contracted with HPSM. Please contact Nicole Ford directly by email.

10. **Adjournment**  
Next Meeting – March 18, 2020
MEMORANDUM

DATE: January 28, 2020

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer
       Marwan Kanafani, Director of Health Services Operations

RE: Waive Request for Proposal (RFP) Process and Ratify Amendment to the Agreement with DME Consulting Group, Inc.

Recommendation

Waive RFP process and ratify an amendment to the agreement with DME Consulting Group, Inc. This amendment extends the contract three years, through December 31, 2022, and increases the agreement maximum by $1 million.

Background and Discussion

HPSM has contracted with DME Consulting Group to conduct in home assessments and submit written recommendations for members’ durable medical equipment (DME) for many years. However, the Consulting Group’s services have been limited to a few equipment areas. In 2017, HPSM asked DME Consulting to engage members earlier in the process to improve service timeliness; Plan staff also expanded the use of DME Consulting to cover additional categories of equipment. These changes have led to improved DME services for members.

Based on a comprehensive home assessment, DME Consulting can make impartial recommendations based on member needs rather than relying only on recommendations from the equipment supplier or the prescribing physician, who is unlikely to be familiar with the patient’s home environment. In 2018, the Commission approved an amendment to the DME Consulting Group agreement, approving an agreement maximum of $500,000 and a two-year term extension through December 31, 2019. In 2019, DME Consulting performed approximately 800 reviews and the expectation is that subsequent years will result in at least the same number of assessments.

Due to the unique nature of the services provided, the existing relationships developed between DME Consulting and HPSM, DME vendors and network providers, it is in the members’ best interest to extend the agreement with DME Consulting. Therefore, a waiver of the RFP process is requested.

Fiscal Impact

The estimated expense for the three-year extension of the agreement is $1 million based upon the average number of monthly assessments performed by DME Consulting. The new term is through December 31, 2022 and the new agreement maximum is $1.5 million.
RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER TO WAIVE REQUEST FOR PROPOSAL PROCESS
AND RATIFY AN AMENDMENT TO THE AGREEMENT WITH DME
CONSULTING GROUP, INC.

RECITAL: WHEREAS,

A. DME Consulting Group, Inc. performs evaluation services for HPSM members to ensure the most appropriate equipment is being provided to members through comprehensive home assessments;

B. The number of assessments per year has increased and is expected to increase in upcoming years; and

C. Due to the unique nature of these services and the existing relationships with HPSM, DME vendors, and participating providers, it is in the members’ best interest to extend the current agreement with DME Consulting Group, Inc.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the request for proposal process and ratifies an amendment to extend the agreement with DME Consulting Group, Inc. through December 31, 2022; and

2. Approves an increase in the contract maximum of $1 million for a new not to exceed amount of $1.5 million.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of March 2020 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

______________________________
Ligia Andrade Zuniga, Chairperson

ATTEST:

APPROVED AS TO FORM:

BY: _________________________
C. Burgess, Clerk

DEPUTY COUNTY COUNSEL
MEMORANDUM

DATE: February 24, 2020
TO: San Mateo Health Commission
FROM: Maya Altman, Chief Executive Officer
      Pat Curran, Deputy Chief Executive Officer
      Chris Baughman, Chief Performance Officer

RE: Waive Request for Proposal and Approve Agreement with DocuStream, Inc.

Recommendation

Approve a waiver of the Request for Proposal (RFP) process and authorize the Chief Executive Officer to execute a three-year agreement with DocuStream, Inc. for the provision of dental authorizations and claims paper/fax forms processing and gateway electronic billing clearinghouse services for the dental integration program. The agreement is effective from March 1, 2020 through February 28, 2023 with a total not to exceed amount of $671,400.

Background and Discussion

HPSM began working with DocuStream in 2017 for the electronic processing of medical authorizations that are submitted via fax by providers. This has been a successful relationship, not only decreasing the administrative burden on HPSM staff by reducing the number of manual entries, but also by improving turnaround time for providers and decreasing the number of provider telephone calls. In October 2019, the Commission approved a dental integration program to begin operations in 2021. HPSM selected DocuStream to process incoming dental authorization and claim forms for that program, based on this vendor’s experience in the field of medical and dental authorizations and claims processing, as well as HPSM’s direct experience.

DocuStream has been a good business partner during the implementation and subsequent operations for medical authorizations. The team is responsive and works closely with the business and technical teams at HPSM when issues arise. Implementation of the dental program is an extension of DocuStream’s medical processes; therefore, staff requests a waiver of the RFP process.

Fiscal Impact

The term of the proposed agreement is three years, from March 1, 2020 through February 28, 2023. HPSM estimates that annual costs for authorizations, claims processing, and clearinghouse services will be approximately $215,800, for a three-year total of $647,400. With an implementation fee of $24,000, the contract maximum is $671,400. Since 2017, HPSM’s DocuStream expenses related to medical activities have been $212,050.
RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF WAIVE REQUEST FOR PROPOSAL
AND APPROVAL OF AGREEMENT WITH DOCUSTREAM, INC.
FOR DENTAL INTEGRATION PROGRAM

RESOLUTION 2020 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has approved the implementation of dental integration services.
B. HPSM needs to receive dental authorizations and claims electronically from dental providers.
C. DocuStream, Inc. has successfully provided this service for HPSM’s medical authorizations.
D. Staff recommends the expansion of DocuStream medical services to cover dental providers.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the Request for Proposal (RFP) process and approves the agreement with DocuStream from March 1, 2020 through February 28, 2023 for a not-to-exceed amount of $671,400; and
2. Authorizes the Chief Executive Officer to execute said agreement.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of March 2020 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

__________________________
Ligia Andrade Zuniga, Chairperson

ATTEST:

APPROVED AS TO FORM:

__________________________
Kristina Paszek
DEPUTY COUNTY COUNSEL

BY: _________________________
C. Burgess, Clerk
MEMORANDUM

DATE: February 28, 2020

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer
       Carolyn Thon, Project Manager

RE: Approval of Amendment to Agreement with American Logistics Company, (ALC)

Recommendation

Authorize the Chief Executive Officer to execute an amendment to the agreement with American Logistics Company (ALC) for services related to Non-Medical Transportation (NMT). This amendment removes the not to exceed amount in the current agreement; the term of the agreement remains the same, January 1, 2019 through December 31, 2021.

Background and Discussion

In July 2017, the Department of Health Care Services (DHCS) established a Non-Medical Transportation (NMT) benefit and required all Managed Care Plans to provide NMT for members to obtain medically necessary Medi-Cal covered services. Non-medical transportation provides rides to and from Medi-Cal covered services, including but not limited to doctor offices, hospitals, diagnostic testing labs, rehabilitation therapy facilities, behavioral health services, and dental services.

HPSM has had an agreement with ALC since 2009 to provide transportation services to CareAdvantage members. In May 2017, the Commission approved an amendment to the ALC agreement to include the expanded scope of the transportation benefit to Medi-Cal and CareAdvantage members.

In May 2018, HPSM issued an RFP for transportation management services and received proposals from three vendors. ALC was selected based on pricing, proposal content, willingness to accept HPSM’s performance standards, and experience administering the transportation benefit for HPSM and other California Medi-Cal managed care plans. On October 10, 2018, the Commission approved an agreement with ALC to provide the NMT benefit to HPSM’s Medi-Cal and CareAdvantage Cal MediConnect members. That agreement was for a three-year term, through December 2021, and included a contract maximum of $9 million, based on an estimate for ride usage.

During the ride scheduling process, ALC verifies that the requested rides are for health-related services, that the member has no other means of transportation and the level of transportation assistance needed. ALC schedules rides through either their own contracted fleet of drivers or ALC’s rideshare partner (in August 2019, ALC transitioned from contracting with Lyft to Uber as their rideshare partner), depending on the member’s need for door-to-door or curb-to-curb service. ALC has provided access to the ALC Relay System which provides real time and historical member ride tracking. HPSM staff can view and activate rides through the Relay System.
The graph below displays NMT usage in 2019. In 2019, 93% of rides were provided through Uber. There were approximately 4,700 unduplicated users which is about 4% of eligible Medi-Cal and CareAdvantage CMC members. The majority of rides were to physician offices and pharmacies.

The current agreement includes performance standards for ALC’s on-time performance and complaints per 100 rides. In 2019:

- 96% of ALC rides arrived on-time which is within the 92% performance standard
- The complaint rate was 0.14 per 100 rides which is within the performance standard of 1 or less complaints per 100 rides.

HPSM staff monitors ride usage to ensure that members are using the rides appropriately. Members that misuse the ride benefit are placed on a restricted ride list. These members’ scheduled rides must be pre-authorized by the Customer Support call center.

**Fiscal Impact**

NMT is a Medi-Cal benefit for which all HPSM members are eligible. As such it is a health-care related expense and NMT costs are incorporated in HPSM’s Rate Development Template (RDT) used by the Department of Health Care Services to set HSPM’s capitation rates. Since is impossible to project ride usage and these costs will eventually be reflected in HPSM's rates, the contract maximum should be removed for this agreement.
RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF AMENDMENT
TO AGREEMENT WITH AMERICAN LOGISTICS COMPANY

RESOLUTION 2020 -

RECITAL: WHEREAS,
  A. The San Mateo Health Commission entered into an agreement with American Logistics Company for services related to Non-Medical Transportation in 2018; and
  B. Non-Medical Transportation is a health-care related benefit and its costs will be reflected in HPSM’s capitation rates received from the Department of Health Care Services; and
  C. Use of this service has doubled in the past one-and-a-half years and it is impossible to project usage accurately.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:
  1. The San Mateo Health Commission approves the amendment to the agreement with American Logistics Company to remove the not to exceed amounts in the current agreement.
  2. Authorizes the Chief Executive Officer to execute said amendment.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of March, 2020 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_________________________________
Ligia Andrade Zuniga, Chairperson

ATTEST:

APPROVED AS TO FORM:

BY: _________________________
    C. Burgess, Clerk

_______________________________
Kristina Paszek
DEPUTY COUNTY COUNSEL
DATE: February 7, 2020
TO: San Mateo Health Commission
FROM: Maya Altman, Chief Executive Officer
       Ian Johansson, Chief Compliance Officer
RE: Approval of Compliance Policy CP.000 – 2020 Compliance Program; and
    Approval of Compliance Policy CP.026 – 2020 Code of Conduct

Recommendation
Approve HPSM Compliance Program document for 2020 - Compliance Policy CP.000; and

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, with recommendations for
revision or renewal made by the Chief Compliance Officer and the Compliance Committee.

Compliance Program
The Compliance Program document did not have any substantive changes with the exception the
addition of new applicable polices which include:
   • CP.015 Significant Network changes
   • CP.018 Policy Filing Process
   • CP.020 California Public Records Act Requests
   • CP.027 CAP Management Process
These newly added policies were developed to support HPSM operations and were approved by the Compliance Committee. The Compliance Committee subsequently approved the updated Compliance Program document as attached on December 20, 2019 and is hereby submitting it to the Commission for its annual review and approval.

**Code of Conduct**
The Code of Conduct (attached) had no substantive changes and was also reviewed and approved by the Compliance Committee on December 20, 2019. 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.
RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF COMPLIANCE
POLICY CP.000 – 2020 COMPLIANCE PROGRAM AND
POLICY CP.026 – 2020 CODE OF CONDUCT

RE bât 4R: WHEREAS,

A. The San Mateo Health Commission and the Health Plan of San Mateo value the contributions 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 2020.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:


PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of March 2020 by the following votes:

AYES:
NOES:
ABSTAINED:
ABSENT:

________________________________________
Ligia Andrade Zuniga, Chair

ATTEST:

APPROVED AS TO FORM:

BY: ____________________________
C. Burgess, Clerk
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:
  o initiated timely and completed.
  o reported to the appropriate organization (DHCS, CMS or its designee, and/or law enforcement) as necessary
  o 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) 826-6762.

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 for 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:
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 the Compliance Manager, 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.


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.
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HEALTH PLAN of SAN MATEO

CODE OF CONDUCT

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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.

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
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).

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.
DATE: February 24, 2020

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer
Pat Curran, Deputy Chief Executive Officer
Chris Baughman, Chief Performance Officer

RE: Approve Amendment to Agreement with SAS, Inc.

Recommendation

Authorize the Chief Executive Officer to execute an amendment to the agreement with SAS, Inc. The agreement is effective from March 11, 2020 through the completion of the Scope of Work with a total not to exceed amount of $425,000.

Background

SAS has offered software and reporting services to support the internal reporting and data services of HPSM since 1998. HPSM has utilized SAS products and services as the organization’s core data management platform, allowing us to integrate varying data sources as well as format and extract data to meet extensive reporting and analytical needs. The SAS platform is supported by HPSM’s Informatics Department, consisting of eight full-time staff including seven trained in the SAS programming language.

The software supports the responsibilities of the HPSM data and reporting units, including: the generation and maintenance of more than 800 HPSM internal reports; gathering, aggregating and reporting of HEDIS data; utilization reporting; evaluations of specific clinical programs and interventions; support for CMS, DHCS, DMHC and other agency audits; support of compliance related activities; ad hoc reports; and decision support data for critical financial decision making.

Discussion

The need for internal analysis and reporting has increased as the organization has grown. In addition, there is a growing need for HPSM’s business units to access and generate their own reports based on predetermined and vetted data points. In 2017, the Commission approved an additional SMS module as a first step in facilitating this access. However, at this point, the SAS data structure must be reconfigured in order to provide self-service opportunities to HPSM’s business
units consistently and efficiently. Through this amendment, SAS staff will provide professional services to complete this reconfiguration ($252,000). Also, a second version of SAS must be purchased to allow for development of the new structure while meeting ongoing data needs in the current production instance ($164,960). Finally, there is a contingency of $8,100 for a total not to exceed amount of $425,000.

**Fiscal Impact**

The term of the proposed amendment is from March 11, 2020 through the completion of the Scope of Work, with a contract maximum of $425,000. Funding has been budgeted in HPSM’s 2020 budget.
RESOLUTION 2020 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has entered into an agreement with SAS Inc. (SAS) as the organization’s core data management platform to integrate varying data sources and to format and extract data to meet reporting and analytical needs;
B. The business units of HPSM desire to access and generate their own reports based on predetermined and vetted data elements;
C. There is a need to add a second instance of SAS to allow for the development of the data structure for this self-service.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves the amendment with SAS, Inc. from March 11, 2020 through the completion of the Scope of Work for a not-to-exceed amount of $425,000; and
2. Authorizes the Chief Executive Officer to execute said agreement.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of March, 2020 by the following votes:

AYES:
NOES:
ABSTAINED:
ABSENT:

_________________
Ligia Andrade Zuniga, Chairperson

ATTEST:

APPROVED AS TO FORM:

BY: _________________________
C. Burgess, Clerk

DEPUTY COUNTY COUNSEL
SAN MATEO HEALTH COMMISSION
Meeting Minutes
January 8, 2020 – 12:30 p.m.
Health Plan of San Mateo - Boardroom
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

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

Commissioners Absent: Si France, M.D.

Counsel: Kristina Paszek


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

2. Public Comment
   Mr. Sonny Le from the US Census Bureau spoke about the 2020 Census and the importance of participation. He explained that the process has begun with advertising on billboards, TV, and radio and encouraged everyone to participate and encourage others to do so as well. The Census is safe, confidential and important to everyone; it forms the basis for local funding of health care and affordable housing as well as political representation. He offered to speak with interested organizations or with individuals.

   There were no other public comments.

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

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

5. Specific Discussion/Action Items

   5.1 Discussion/Action on Election of Officers

   Commissioner Horsley made a motion to elect Ligia Andrade Zuniga as the Chair of the Commission for 2020. M/S/P.
Commissioner Canepa made a motion to elect Commissioner Horsley as the Vice-Chair of the Commission for 2020. **M/S/P.**

Commissioner Pon made a motion to elect Corinne Burgess as the Clerk of the Commission and Michelle Heryford as the Assistant Clerk of the Commission. **M/S/P.**

### 5.2 Presentation - 2019 HEDIS Results

Ms. Altman introduced Nicole Ford, Director of Quality Improvement, to review 2019 HEDIS results. These are the major measures of quality for HPSM and are increasingly important in this new year as plans could be subject to sanctions if certain quality standards are not met.

Ms. Ford reviewed her presentation, included in the Commission packet. HEDIS stands for the Health Effectiveness Data Information Set, the performance metrics that assess the effectiveness and accessibility of a Plan’s care for its members. Most of the metrics measure preventative care and cover the prior year’s membership and services. The results presented today therefore cover services provided in 2018. Submissions are audited by NCQA to ensure all plans are collecting and reporting measures in standardized ways, so results are comparable across health plans nationally. The data used is gathered through medical, lab and pharmacy claims, as well as in some cases through a sampling of medical records.

Ms. Ford explained the HEDIS performance levels (MPL – Minimum Performance Level and HPL – High Performance Level) which are the benchmarks for each measure. In 2020 the benchmark for minimum performance will increase from the 25th percentile to the 50th percentile. While there are currently 29 Medi-Cal measures for which DHCS requires plan performance above the MPL, the number of measures will increase in 2020.

The work performed by staff and vendors for HEDIS reporting included collecting and reviewing approximately 6,430 medical records within 10 weeks. HPSM passed the medical record validation in the first review indicating staff was accounting for everything appropriately according to NCQA standards.

**Medi-Cal**

- No measure results fell below MPL.
- Performance on five measures scored above HPL: immunizations for adolescents; avoidance of antibiotic treatment in adults; use of imaging studies for low back pain; weight assessment and counseling for physical activity; and prenatal and postpartum care.
- HPSM was ranked 8th among 53 plans based on overall results.
Care Advantage Cal MediConnect

- Successfully reported all 55 required measures on time
- Passed all HEDIS related quality withhold benchmarks for controlling high blood pressure; hospital readmissions; and follow-up after hospitalization for mental illness.

Ms. Ford reviewed the results for selected individual measures:

- **Prenatal Care** – care within 1st trimester or within 42 days of enrollment. Approaching the HPL on this measure for 2019; slightly above the new 50th percentile requirement.
- **Postpartum Care** – visit between 21 and 56 days after delivery. Surpassed the HPL in 2019. Expanding the outreach program to include infant well visits. HPSM was almost the top-rated plan.
- **Cervical Cancer Screening** – at least every three or five years depending on age. Significant improvements were seen in 2019, almost to the HPL. Noted that 2020 focus will be on women with disabilities. HPSM ranked 5th on this measure across plans.
- **Diabetes Care** – is made up of six measures including HbA1C testing, testing results, eye exams, nephropathy screening and blood pressure. HbA1C is currently slightly below the new 50th percentile; testing results where lower is better, HPSM results need to improve to reach the new 2020 benchmark; high blood pressure has been stable – is reliant on medical records review – new wireless blood pressure monitoring program is promising for improving performance.
- **Plan All-Cause Readmissions** – readmissions within 30 days of discharge. Lower is better for this measure. For the last three years HPSM has had fewer readmissions than expected for the population.
- **Follow-Up after Hospitalization for Mental Illness** – follow up by mental health care provider within seven and 30 days after discharge. Slight decrease in 2019 but have done well with this measure. This year a new process is being implemented with the care coordination team reviewing admissions while the patient is in the hospital and coordinating a visit within 7 days of discharge.

### 5.3 Presentation on the Children's Health Initiative

Ms. Srija Srinivasan, Deputy Chief of San Mateo County Health, updated the Commission on recent activities of the Children's Health Initiative (CHI) Oversight Committee, which the Commission oversees. The current health care landscape is driving changes in the scope and role of this Committee.

The Committee’s initial goal when it was established in 2003 was to ensure that all children in San Mateo County had insurance coverage through some combination of Healthy Kids and other federal or state coverage. San Mateo County was one of the first three counties in California to work towards universal health insurance for children with a goal of encouraging the state and federal government to assume responsibility for providing insurance to all children. This goal has been reached with the State of
California being the first state in the country to insure undocumented low-income children beginning in 2019. Nearly all children covered locally through Healthy Kids are now eligible for Medi-Cal or Covered California, leading to the closure of the Healthy Kids program at the end of September 2019. Data indicate that 98% of children in San Mateo County are now insured. The Committee also oversees a financial reserve that has accumulated over the life of the Children’s Health Initiative, thanks to the financial contributions of the Committee’s member organizations.

As a result, the role of the CHI Committee needs to be reassessed. The Committee includes nine voting entities that have played financial, operational and advocacy roles. Lucile Packard Children’s Hospital, the San Mateo Medical Center, Ravenswood Family Health Center and others have also offered wonderful support. Recently, the Committee has initiated a planning process to determine how to focus remaining reserve funding on key children’s health priorities, with consideration for each participating entity’s strategic priorities. Two funding areas have emerged across these entities as shared priorities: oral health and early childhood mental health. Three meetings in 2020 have been planned to continue the process of developing recommendations in these areas to bring to the Commission for consideration. Along with these recommendations, the Committee hopes to have recommendations to present to the Commission after the first half of 2020.

Commissioner Tai extended congratulations for the success of the work done through CHI, especially now that the State is assuming responsibility for all children’s coverage.

6. **Report from Chairman/Executive Committee**
   Commissioner Zuniga had nothing additional to report.

7. **Report from CEO**
   Ms. Altman reported:
   - **Seton Sale**
     Ms. Altman reported that the deal to sell Seton to KPC now seems to be at risk. Verity terminated the purchase agreement with KPC and filed a lawsuit against KPC. Verity has also announced the closure of St. Vincent’s Hospital in Los Angeles (the Attorney General conditions only required a new buyer to keep the hospital open for one year). Seton leadership has stated there are currently no plans to close Seton or Seton Coastside and there is enough funding to continue operations for some time while searching for another buyer or renegotiating with KPC. HPSM staff is monitoring the situation closely to ensure HPSM members continue to receive appropriate and timely care.

   - **Dental Integration Pilot**
     Ms. Altman reported that the State has delayed the start of the dental integration program by six months for a new go live date of July 1, 2021. HPSM staff continues with implementation activities.
• **2020 Census**
  Ms. Altman met with Commissioner Guingona Ferrer and Sonny Le about the Census and the health plan will be doing its part to help.

• **Chief Medical Officer**
  Ms. Altman thanked Dr. Susan Huang for her service at HPSM. Ms. Altman is reviewing the CMO job description and will consider some restructuring changes. Dr. Chris Esguerra, formerly HPSM’s Deputy CMO, is helping in the interim through a consulting contract.

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

9. **Adjournment**
   The meeting was adjourned at 1:30 p.m.

Respectfully submitted:

   **C. Burgess**

C. Burgess, Clerk of the Commission
Meeting materials are not included

for Item 5.1 – Medi-Cal Healthier California for All (CalAIM) Presentation
2019 Annual Compliance Report

Ian Johansson, Chief Compliance Officer

March 11, 2020
Background

- **Status & Activities**
  - Annual report provides an operational summary of HPSM’s Compliance Program (prior year)
  - Enables Commissioners:
    - To be knowledgeable about the operation of the program
    - To exercise reasonable oversight with respect to the implementation and effectiveness of the program
Our Goal

• To establish a culture of compliance at HPSM that helps the organization and its employees “do the right thing”

• Achieved through:
  – Maintaining and implementing a Compliance Program
  – Educating our employees
  – Identifying and resolving compliance risks
  – Providing opportunities to engage our staff and stakeholders
Agenda

• 2019 - Year in review
  – Risk Ranking
  – Experience

• 2020 - Outlook
  – Risk Ranking
  – Rationale
2019 Risk Ranking

• 2018 → 2019
  – Shift to fewer risk areas with broader impact

1. Plan-Wide Compliance Needs Assessment
2. Integration & Expansion of Compliance Monitoring
3. Comprehensive Delegation Oversight Model
4. Continue IT Security Work
2019 Experience

• Plan Wide Compliance Needs Assessment
  – Evaluation of opportunities for improvement in Compliance support
  – January ’19 – June ’19 - Focus Groups
    • 50+ staff & 2 local plan interviews
  – Key learnings
    • Business owner and Compliance staff needs for success
2019 Experience

• Results
  – Split Compliance team – 2 managers
    • Focus on team support, education and growth
  – Added Compliance Program Manager
    • Individual charged with identifying areas for improvement on ongoing basis
  – Continued external audit preparation efforts
2019 Experience

• Results - 2019 DHCS Audit
  – 13 total findings
    • 28% improvement v. 2018
  – 3 repeat
    • 25% improvement v. 2018
2019 Experience

• **Enhanced Compliance Monitoring**
  - Continued work to improve compliance dashboards
  - Created new process to manage corrective action plans
    • Goal: Achieve resolution of compliance issues quicker

• **Creating a delegation oversight model**
  • Linking business owners and committees to monitoring data and audit outcomes
2019 Experience

- **IT Security work**
  - Created IT security committee
  - Accountable to Compliance Committee & Leadership
  - Pursuing recommendations by security vendors
    - 2 Factor Authentication (2FA) for VPN and O365
    - Email security messaging
  - Roadmap for other security projects
Compliance Monitoring

• Issue Investigation & Resolution
  – From 2019
    • Privacy ↓
    • FWA & other non-compliance ↓
    • Regulatory agency actions ↓
  – Performance
    • 72 total issues reported (↓ 33%)
    • 10 reported to the Commission (↓ 23%)
2020 Outlook

1. Plan-Wide Compliance Needs Assessment
2. Integration & Expansion of Compliance Monitoring
3. Comprehensive Delegation Oversight Model
4. Continue IT Security Work
2020 Outlook

• **Recommendation: Continuity**
  - Efforts begun in 2019 will take more time to address
  - Proposal is to continue risk areas into 2020
    • Document and report progress to stakeholders & Commission
  - Continue monitoring for success or areas of improvement
    • Follow-up survey with focus group participants
Next Commission Update

• Compliance Program Effectiveness Audit Results
• Compliance Survey Results
Questions?

• Contact me @
  – 650-616-2151
  – ian.johansson@hpsm.org
  – 3rd floor

• Hotline available 24/7
  – 800-826-6762
Thank You
Meeting materials are not included

for Item 5.3 – Employee of the Year Presentation
DATE: March 2, 2020

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: CEO Report

**Coronavirus Preparations**

We are working closely with County Health to track issues related to the virus. So far, we have not received many calls from members on this issue. However, we are refining our business continuity procedures in case “social distancing” becomes imperative and employees need to work from home. We have also posted links to the CDC on our website and continue to provide updates to the staff.

**Leadership Changes at the Department of Health Care Services (DHCS)**

I am very pleased that Dr. Brad Gilbert, recently retired Chief Executive Officer of Inland Empire Health Plan, has been appointed to the position of Director of DHCS. I cannot think of anyone more qualified to serve in that role. Many years ago, Dr. Gilbert also served as the Public Health Director and Public Health Officer for San Mateo County. In other news, Jacey Cooper has been named the State Medi-Cal Director, replacing Mari Cantwell, who filled that role for several years. Mari is now a consultant for the Local Health Plans of California and is helping the health plans as we prepare for the implementation of CalAIM in 2021.

**Other State Issues**

CalAIM, the State’s proposal to reform Medi-Cal over the next five years, continues to take shape. DHCS held a convening with staff from all the health plans in early February, where the program was described in more detail. The Governor has proposed significant funding – about $1.4 billion annually for the initial implementation years. The Governor’s budget also includes about $600 million in incentive funding to help health plans build infrastructure to provide the non-medical benefits contemplated in CalAIM. For example, these might include services such as recuperative care and housing resources for nursing facility transitions like those HPSM has offered for the past several years. However, the top priority for the State and counties is ensuring Whole Person Care program resources are maintained to the greatest extent possible in 2021, after the Whole Person Care Program is scheduled to end. HPSM and County Health are working together to ensure this occurs. A presentation on CalAIM is scheduled for the Commission meeting on March 11.
The federal government rejected the State of California’s proposed continuation of the Medi-Cal Managed Care Organization (MCO) tax, which would have brought $1 billion in additional funding to the State. The State has adjusted its proposal and resubmitted the tax to CMS for approval. The Governor did not assume any of this funding in his proposed budget for FY 2020-21.

**Seton Medical Center**

There is still no word on the future of Seton Medical Center from Verity or the Bankruptcy Court. The Board of Supervisors will hold a Special Meeting on Wednesday, March 4, from 7:00 – 9:00 pm at the Daly City Council Chambers to consider the potential health impacts of a Seton closure.

**Timely Access Report**

In late January, the Department of Managed Health Care (DMHC) released its annual report analyzing timely access to health care providers across all health plans in the State, both Medi-Cal and commercial plans. HPSM again ranked highly, among the top four health plans in the state, on access to all provider types (primary care, specialty care, non-physician mental health and ancillary services) for both urgent and non-urgent appointments. Kudos to HPSM’s providers and HPSM’s Provider Services Department for ensuring our members have great access to care.

**Master Plan for Aging**

The Master Plan for Aging’s Long-Term Services and Supports (LTSS) subcommittee will release its report this month. A report draft is available on the MPA website, [https://www.chhs.ca.gov/home/master-plan-for-aging/subcommittees/ltss/](https://www.chhs.ca.gov/home/master-plan-for-aging/subcommittees/ltss/)

I am on this subcommittee as well as the Health and Wellbeing Subcommittee. The LTSS reports addresses five “big ideas:”

1. An LTSS system that all Californians can easily navigate
2. Access to LTSS in every community
3. Affordable LTSS choices
4. Highly valued, high quality workforce
5. Streamlined state and local administrative structures

The report also addresses health and LTSS integration issues, such as how to improve CalAIM to ensure it serves older adults and people with disabilities in the best ways possible and how to ensure dual eligibles receive highly integrated care.