HealthPlan OF SAN MATEO
Healthy is for everyone

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South San Francisco, CA 94080

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www.hpsm.org

THE SAN MATEO HEALTH COMMISSION
Regular Meeting
May 13, 2020 - 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., South San Francisco, CA 94080

Important notice regarding COVID-19:
Pursuant to the Shelter in Place Orders issued by the San Mateo County Health Officer, the Governor's Executive Order N-29-20, and the CDC's social distancing guidelines which discourage large public gatherings the **Health Plan of San Mateo offices will be closed for this meeting**. The following alternatives are available to members of the public to access this meeting and to provide comment to the Commission:

Click Here to: Join SMHC Meeting

or join by telephone by dialing
+1 209-214-7696 United States, Stockton (Toll)
(833) 827-5103 United States (Toll-free)
Conference ID: 172 752 725#

Members of the public wishing to provide public comment on items not listed on the agenda that are within jurisdiction of the Commission or to address an item that is listed on the agenda may do so by emailing comments by 10:00 a.m. on May 13, 2020 to the Clerk of the Board at Corinne.Burgess@hpsm.org with "Public Comment" in the subject line. Comments received will be read during the meeting.

AGENDA

1. **Call to Order/Roll Call**
2. **Public Comment/Communication**
3. **Approval of Agenda**
4. **Consent Agenda***
   - 4.1 Approval of Audited Financial Statements for the Twelve-Month Period Ending December 31, 2019
   - 4.2 Finance Committee Minutes, February 2020
   - 4.3 Consumer Advisory Committee Minutes, March 2020
   - 4.4 Pharmacy & Therapeutics Committee Minutes, November 2019 and March 2020
   - 4.5 Ratification of Amendment to Agreement with Independent Living Systems
   - 4.6 Approval of Amendment to Agreement with the San Mateo County Health System for Rate Range Intergovernmental Transfer (IGT) Funding for State FY 2018-19
   - 4.7 Approval of Amendment to Agreement with University of California Regents
   - 4.8 Approval of San Mateo Health Commission Meeting Minutes from March 11, 2020 and April 20, 2020

5. Specific Discussion/Action Items

5.1 Discussion – COVID-19 Impacts and Related Activities

6 Report from Chairman/Executive Committee

6. Report from Chief Executive Officer

7. Other Business

8. Adjournment

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

AGENDA ITEM: 4.1

DATE: May 13, 2020

M E M O R A N D U M

DATE: May 4, 2020

TO: San Mateo Health Commission

FROM: Trent Ehrgood, Chief Financial Officer

RE: Approval of Audited Financial Statements for Period Ending December 31, 2019

Recommendation

HPSM's auditors, Moss Adams, completed the annual audit of HPSM's 2019 financial statements in March 2019. Under normal circumstances, Moss Adams would present their findings to the Finance and Executive Committee and the Commission. Due to cancelled or postponed meetings related to the shelter-in-place Public Health Order, staff is submitting the final reports directly to the Commission for approval. Two reports are included.

Communications with Those Charged with Governance

The first report is required communication to the Commission and includes a description of the audit scope and any findings resulting from the audit. Also included at the end of this report is a copy of the required representation letter from HPSM.

Report of Independent Auditors and Financial Statements with Supplementary Information

The second report is the full set of audited financial statements with footnotes. The auditors issued an unmodified opinion (which is good). There were no audit adjustments, so the final surplus of $8.5M is unchanged from the draft year-end financial statements presented at the Finance and Executive Committee meeting on February 24, 2020.

The Accounting Team

A big thank you to HPSM's Controller, Francine Lester, and her accounting team for their hard work maintaining a complex set of books and strong internal controls.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF ACCEPTANCE OF THE AUDIT REPORT FOR FISCAL YEAR ENDING DECEMBER 31, 2019

RESOLUTION 2020 -

RECITAL: WHEREAS,

A. Moss-Adams, LLP, a firm of accountants has conducted an audit of the San Mateo Health Commission financial statements for the fiscal year ending December 31, 2019; and

B. The San Mateo Health Commission has reviewed the resulting report submitted by Moss-Adams, LLP.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission formally accepts the audit report for the fiscal year ended December 31, 20198 as presented by Moss-Adams, LLP.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of April, 2020 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

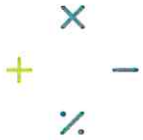
_____
Ligia Andrade Zuniga, Chair

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
CHIEF DEPUTY COUNTY COUNSEL



Communications with
Those Charged with Governance

San Mateo Health Commission and San Mateo Community Health Authority (d.b.a. Health Plan of San Mateo)

December 31, 2019

MOSSADAMS

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Communications with Those Charged with Governance

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

We have audited the combined financial statements of the business-type activities and the aggregate remaining fund information of San Mateo Health Commission (a stand-alone government entity appointed by the San Mateo County Board of Supervisors) (the "Commission"), and San Mateo Community Health Authority (the "Health Authority"), collectively known as Health Plan of San Mateo ("HPSM"), as of and for the year ended December 31, 2019, and have issued our report thereon dated April 8, 2020. Professional standards require that we advise you of the following matters relating to our audit.

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

As stated in our engagement letter dated June 24, 2019, our responsibility, as described by professional standards, is to form and express an opinion about whether the combined financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. Our audit of combined financial statements does not relieve you or management of your respective responsibilities.

Our responsibility is to plan and perform the audit in accordance with auditing standards generally accepted in the United States of America and to design the audit to obtain reasonable, rather than absolute, assurance about whether the combined financial statements are free from material misstatement. An audit of combined financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of HPSM's internal control over financial reporting. Accordingly, we considered HPSM's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

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

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by HPSM are described in Note 1 to the combined financial statements. During the year, HPSM adopted Governmental Accounting Standards Board ("GASB") Statement No. 84, *Fiduciary Activities*. There were no changes in the application of existing policies during 2019. We noted no transactions entered into by HPSM during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the combined financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

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

- Management's estimate of the liability for incurred but unreported claims expense is based on historical claims experience and known activity subsequent to year end. We evaluated the key factors and assumptions used to develop the incurred but unreported claims expense in determining that they are reasonable in relation to the combined financial statements taken as a whole.

- Management's estimate of the capitation receivable and revenue for eligible program beneficiaries is based upon a historical experience methodology using contracted rates and member counts. We evaluated the key factors and assumptions used to develop the capitation receivable in determining that they are reasonable in relation to the combined financial statements taken as a whole.

- Management recorded an estimated amount due to the State of California. The estimated payable for eligible Medi-Cal program beneficiaries is based upon estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. We evaluated the key factors and assumptions used to develop the estimated net realizable amounts. We found management's basis to be reasonable in relation to the combined financial statements taken as a whole.

- Management's estimate of the fair market values of investments in the absence of readily-determinable fair values is based on information provided by the fund managers. We have gained an understanding of management's estimate methodology and examined the documentation supporting this methodology. We found management's process to be reasonable.

- Management's estimate of the net pension asset (liability) is actuarially determined using assumptions on the long-term rate of return on pension plan assets, the discount rate used to determine the present value of benefit obligations, and the rate of compensation increases. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the financial statements taken as a whole.

Financial Statement Disclosures

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

Significant Difficulties Encountered During the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements

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

Disagreements with Management

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

Management Representations

We have requested certain representations from management that are included in the attached management representation letter dated April 8, 2020.

Management's Consultations with Other Independent Accountants

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

Independence

We are required to disclose to those charged with governance, in writing, all relationships between the auditors and HPSM that in the auditor's professional judgment, may reasonably be thought to bear on our independence. We know of no such relationships and confirm that, in our professional judgment, we are independent of HPSM within the meaning of professional standards.

Other Significant Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as HPSM's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition of our retention.

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

Moss Adams LLP

San Francisco, California
April 8, 2020

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April 8, 2020

Moss Adams LLP
101 Second Street, Suite 900
San Francisco, CA 94105

We are providing this letter in connection with your audits of the combined financial statements of the business-type activities and the aggregate remaining fund information of San Mateo Health Commission (a stand-alone government entity appointed by the San Mateo County Board of Supervisors) (the "Commission") and San Mateo Community Health Authority (the "Health Authority"), collectively known as Health Plan of San Mateo ("HPSM"), as of and for the years ended December 31, 2019 and 2018 and the related notes to the combined financial statements, for the purpose of expressing an opinion as to whether the combined financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States (U.S. GAAP). Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

Except where otherwise stated below, immaterial matters less than $1,170,000 collectively are not considered to be exceptions that require disclosure for the purpose of the following representations. This amount is not necessarily indicative of amounts that would require adjustment to or disclosure in the financial statements.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves as of April 8, 2020,

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated June 24, 2019, for the preparation and fair presentation of the financial statements in accordance with U.S. GAAP.
2. We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.
3. We acknowledge our responsibility for the design, implementation and maintenance of internal controls to prevent and detect fraud.
4. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.
5. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of U.S. GAAP.
6. All events subsequent to the date of the financial statements and for which U.S. GAAP requires adjustment or disclosure have been adjusted or disclosed.
7. The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP.

Information Provided

8. We have provided you with:
    a. Access to all information, of which we are aware that is relevant to the preparation and fair presentation of the financial statements such as records, documentation and other matters;

b. Minutes of the meetings of commissioners, directors, and committees of directors, or summaries of actions of recent meetings for which minutes have not yet been prepared;

c. Additional information that you have requested from us for the purpose of the audit;

d. Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.

9. All transactions have been properly recorded in the accounting records and are reflected in the combined financial statements.

10. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

11. We have disclosed to you all information that we are aware of regarding fraud or suspected fraud that affects the entity and involves—

    a. Management,

    b. Employees who have significant roles in internal control, or

    c. Others when the fraud could have a material effect on the combined financial statements.

12. We have no knowledge of any allegations of fraud or suspected fraud, affecting the entity's financial statements communicated by employees, former employees, analysts, regulators or others.

13. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

14. We are not aware of any pending or threatened litigation, claims, and assessments whose effects should be considered when preparing the financial statements and we have not consulted legal counsel concerning litigation, claims, or assessments.

15. We have disclosed to you the identity of the entity's related parties and all the related party relationships and transactions of which we are aware.

16. We are not aware of—

    a. Violations or possible violations of laws or regulations, such as those related to the Medicare antifraud and abuse statutes, including but not limited to the Anti-Kickback Act, Limitations on Certain Physician Referrals (commonly referred to as the "Stark law"), and the False Claims Act, in any jurisdiction whose effects should be considered for disclosure in the combined financial statements or as basis for recording a loss contingency other than those disclosed or accrued in the combined financial statements.

    b. Possible illegal acts brought to the attention of management.

    c. Unasserted claims or assessments that our lawyer has advised us are probable of assertion and must be disclosed in accordance with GASB 62 section 1500, *Reporting Liabilities*, paragraph .114 and section C50, *Claims and Judgments*, paragraph .115.

    d. Other liabilities or gain or loss contingencies that are required to be accrued or disclosed by GASB 62 section 1500 paragraph .114 and section C50 paragraph .115.

17. HPSM has satisfactory title to all owned assets, and there are no liens or encumbrances on such assets nor has any asset been pledged as collateral, except as disclosed to you and reported in the combined financial statements.

18. HPSM has complied with all aspects of contractual agreements that would have a material effect on the combined financial statements in the event of noncompliance.

19. HPSM has been in compliance with the requirements of licensure under the Knox-Keene Health Care Service Plan act of 1975.

20. We have determined the estimated liability, associated with our contract with the Department of Health Care Services (DHCS) for the Adult Expansion, Medical Loss Ratio (MLR) corridor calculations for the time period of January 1, 2014 to June 30, 2016 and July 1, 2017 to June 30, 2017, which is recorded as a payable to the State of California in the combined financial statements. The estimated payable has been determined using appropriate claims, encounters data and calculated in accordance with our executed contract with DHCS provisions and instructions. To the

best of our knowledge and belief, the estimated payable is properly accrued and estimated as of December 31, 2019 and 2018.

21. Capitation and premium revenue as disclosed in Note 1 of the combined financial statements is fairly stated in accordance with GAAP.

22. We have complied with all restrictions on resources and all aspects of contractual agreements that would have a material effect on the combined financial statements in the event of noncompliance.

23. We have disclosed to you any change in HPSM's internal control over financial reporting that occurred during HPSM's most recent fiscal year that has materially affected, or is reasonably likely to materially affect, HPSM's internal control over financial reporting.

24. We have no intention of terminating any of our pensions or taking any other action that could result in an effective termination or reportable event for any of the plans. We are not aware of any occurrences that could result in the termination of any of our pension to which we contribute.

25. We have responded fully and truthfully to all inquiries made to us by you during your audits.

26. There have been no internal or external investigations relating to compliance with applicable laws and regulations, including investigations in progress that would have an effect on the amounts reported in the combined financial statements or on the disclosure in the notes to the combined financial statements.

27. We have made available to Moss Adams all known reviews, surveys and inquiries from Federal, State and local regulatory authorities completed or ongoing. We confirm that we are not aware of any non-compliance with laws and regulations.

28. No violations or possible violations of laws or regulations, such as those related to the Medicare and Medicaid antifraud and abuse statutes, in any jurisdiction, whose effects are considered for disclosure in the combined financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the combined financial statements. This is including, but not limited to, the anti-kickback statute of the Medicare and Medicaid Patient and Program Protection Act of 1987, limitations on certain physician referrals (the Stark law), and the False Claims Act.

29. There have been no oral or written communications from regulatory agencies, governmental representatives, employees, or others concerning the investigations or allegations of noncompliance with laws and regulations in any jurisdiction (including those related to the Medicare and Medicaid antifraud and abuse statutes), deficiencies in financial reporting practices, or other matters that could have a material adverse effect on the combined financial statements.

30. We have appropriately reconciled our books and records (e.g., general ledger accounts) underlying the combined financial statements to their related supporting information (e.g. sub ledger or third-party data). All related reconciling items considered to be material were identified and included on the reconciliations and were appropriately adjusted in the combined financial statements. There were no material un-reconciled differences or material general ledger suspense account items that should have been adjusted or reclassified to another account balance. There were no material general ledger suspense account items written off to a statement of net position account, which should have been written off to an income statement account and vice versa.

31. The liability for health unpaid claims and claims adjustment expenses, including amounts for incurred but not reported claims and estimated recoveries for salvage and subrogation have been determined using appropriate estimated ultimate costs of settling the claims (including the effects of inflation and other societal and economic factors), considering past experience adjusted for current trends and any other factors that would modify past experience. The estimated liability is to the best of our knowledge and belief, an accurate estimate of our incurred but unreported health claims liability as of December 31, 2019 and 2018. The data used in projecting the ultimate unpaid claims and claims adjustment expense is complete and accurate, and is reconciled to the underlying accounting records.

32. Management has no knowledge of a large pool of impending claims outstanding at December 31, 2019 and 2018 that would materially affect the estimate for liability for health unpaid claims and claims adjustment expenses, including amounts for incurred but not reported claims.

33. The Medicare Part D estimated reconciliation settlements recorded at December 31, 2019 and 2018 are to the best of our knowledge and belief, an accurate estimate of our reconciliation settlements for Medicare at that date. The settlements are for the Part D reinsurance amounts, Low Income Cost Sharing Subsidy, and aggregate risk-sharing provisions. The estimate is based upon Prescription Drug Event data submitted to the Centers for Medicare & Medicaid Services ("CMS"), which we have received from our pharmacy benefits manager. We believe the effect of any rejected claims, on our estimate is inconsequential. We believe any rejected claims would be successfully resubmitted. We believe the data used in determining our estimated settlements is complete and accurate, and is reconciled to the underlying source records.

34. We calculated our estimate for a receivable from CMS related to: risk rating adjustments using assumptions and methods by PopHealth, a third party vendor; and Part D estimates using assumptions and methods from Cadre, a third party vendor. These assumptions and methods resulted in an estimate for a receivable from CMS related to risk rating adjustments and Part D based on CareAdvantage's previous adjustments of our risk rating and pharmacy data derived from claims data that we have submitted to CMS for the prior years. Receivables from CMS were $21,832,233 and $18,492,304 for the respective years ended 2019 and 2018. We believe the assumptions and methods used by our third-party vendors to estimate the balance represents an accurate estimate of our accounts receivable from CMS related to risk rating adjustments and Part D. The data used in projecting the estimate is complete and accurate, and is reconciled to the underlying records.

35. Amendments to the State Medi-Cal contract established a two year risk corridor for the Coordinated Care Initiative which impacts the Medi-Cal and Cal MediConnect lines of businesses. HPSM would be responsible or retain up to 1% of losses and gains. The State and HPSM would equally share any gains or losses between 1% and 2.5% and DHCS would be responsible or keep any gains or losses greater than 2.5%. Management has estimated the impact to HPSM for this two year period to be $19,789,224, which includes an estimated profit of 2%. We believe the estimated balance is to the best of our knowledge and belief, an accurate estimate of amounts due back to the State related to the two year Risk Corridor program. The data used in projecting the estimate is complete and accurate, and is reconciled to the underlying records.

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

37. The Centers for Medicare & Medicaid Services (CMS) pays HPSM capitation revenue each month. Capitation revenue is recognized in the month the beneficiary is eligible for Medicare services. Eligibility of members is determined by CMS.

38. For the year ended December 31, 2019 and 2018, approximately $110k and $2.05 million of IHSS related revenue and expenses have been recorded in the combined financial statements, inclusive of estimated true-up amounts resulting in immaterial net impact to net position in both years. The estimate was developed based on the most recent approved contracted rates and eligible member months. HPSM assumes full risk for IHSS provider payments through 2019, subject to reconciliation to be performed by the State.

39. All reinsurance transactions entered into by HPSM are final and there are no side agreements with reinsurers, or other terms in effect, which allow for the modification of term under existing reinsurance arrangements. Furthermore, HPSM's reinsurance arrangements meet the risk transfer provisions or are accounted for as deposits.

40. We believe that the actuarial assumptions and methods used to measure pension liabilities and costs for financial accounting purposes are appropriate in the circumstances.

41. We agree with the findings of specialists in evaluating the liabilities for pension costs, and receivables related to Medicare Part C and have adequately considered the qualifications of the specialist in determining the amounts and disclosures used in the combined financial statements and underlying

accounting records. We did not give or cause any instructions to be given to specialists with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the specialists.

42. Pay for Performance, provider incentive, withhold, capitation and other arrangements with providers wherein HPSM is obligated to provide for a settlement of accounts with providers have been calculated in accordance with the existing arrangements and are included in the combined statement of net positions at net realizable value, giving consideration to all amounts due under arrangements. We believe provider incentives payable is fairly stated as of December 31, 2019 and 2018.

43. Board designated reserves have been approved by the Commission and is complete and accurate.

44. HPSM has accepted the following responsibilities related to the non-attest services provided related to the drafting the combined financial statements and related footnotes as of December 31, 2019 and 2018:

    a. Make all management decisions and perform all management functions.

    b. Designate an individual with suitable skill, knowledge, and / or experience to oversee the non-attest services.

    c. Evaluate the adequacy and results of the non-attest services performed.

    d. Accept responsibility for the results of the non-attest services performed.

    e. Establish and maintain internal controls including monitoring ongoing activities.

45. Adequate consideration has been given to, and appropriate provision made for, audit adjustments by third-party organizations or other regulatory agencies.

46. We believe that the actuarial assumptions and methods used to measure net pension liability for financial accounting purposes are appropriate in the circumstances.

47. We have the intent and ability to commit the necessary resources to become compliant with the laws and regulations contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") by the required compliance deadlines. We have no information that indicated that a significant vendor may be unable to sell to HPSM; a significant customer may be unable to purchase from HPSM; or a significant service provider may be unable to provide services to HPSM, in each case because of their respective inability to comply with HIPAA.

48. We have reviewed all recently released accounting pronouncements and have evaluated those that may have an effect on HPSM in the current and subsequent periods and disclosed as appropriate in the combined financial statements.

49. We are not aware of any reason that Moss Adams LLP would not be considered to be independent for purposes of HPSM's audit.

50. To our knowledge, there are no instances where any officer or employee of HPSM has an interest in a company with which HPSM does business that would be considered a "conflict of interest." Such an interest would be contrary to HPSM's policy.

51. Pending changes in the organizational structure, financing arrangements, or other matters that could have a material effect on the combined financial statements of HPSM are properly disclosed.

52. We have performed an analysis of expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under our contracts. Based on our analysis, we believe no premium deficiency reserves are necessary at December 31, 2019 and 2018, respectively.

53. We have determined that HPSM's deferred compensation fund is not considered a fiduciary activity in accordance with GASB 84, *Fiduciary Activity*, because HPSM does not have control of the assets of the deferred compensation fund.

54. We acknowledge our responsibility for presenting the Management's Discussion and Analysis, Supplementary Schedule of Changes in Net Pension (Liability) Asset and Related Ratios, Supplementary Schedule of Contributions, and Supplementary Schedule of Investment Returns – Health Plan of San Mateo Retirement Plan Fund in accordance with accounting principles generally accepted in the United States of America and we believe the Management's Discussion and Analysis and Supplemental Pension and Post Benefit Retirement Information are measured and presented in accordance with the prescribed guidelines. The methods of measurement and presentation of the Management's Discussion and Analysis and Supplemental Pension and Post Benefit Retirement Information have not changed from those used in the prior periods, and we have disclosed to you any significant assumptions or interpretations underlying the measurement and presentation of the required supplementary information.

55. HPSM held investments at December 31, 2019 that have experienced a significant decline in market value in 2020 as a result of market reaction to the coronavirus outbreak. The Company will continue to monitor the situation closely, but the market volatility and the continuing situation surrounding the coronavirus is uncertain. At this time, management believes the decline in fair value for these securities is temporary.

To the best of our knowledge and belief, no events have occurred subsequent to the balance sheet date and through the date of this letter that would require adjustment to or disclosure in the aforementioned combined financial statements.

DocuSigned by:
Maya Altman
1E120A1BD67C41A...
Maya Altman, CEO

DocuSigned by:
Trent Ehrgood
D8052145A7BD4C5...
Trent Ehrgood, CFO

DocuSigned by:
Francine Lester
805CD2656409406...
Francine Lester, Controller


MOSSADAMS

Report of Independent Auditors and
Combined Financial Statements with Supplementary Information

San Mateo Health Commission and San Mateo Community Health Authority (d.b.a. Health Plan of San Mateo)

December 31, 2019 and 2018

MOSSADAMS

Table of Contents

Management's Discussion and Analysis

San Mateo Health Commission and
San Mateo Community Health Authority
(d.b.a. Health Plan of San Mateo)
Management's Discussion and Analysis
December 31, 2019, 2018, and 2017

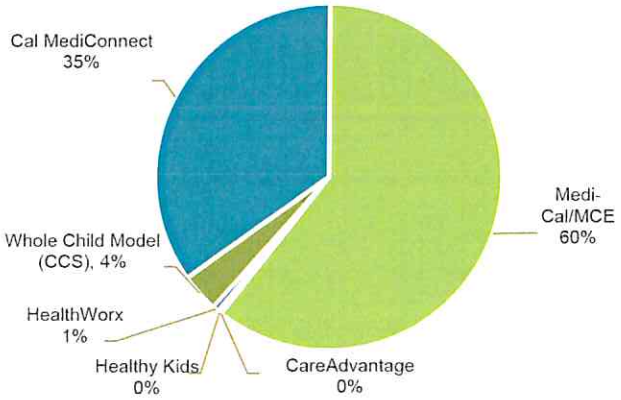
Our discussion and analysis of the San Mateo Health Commission and San Mateo Community Health Authority, (d.b.a. Health Plan of San Mateo) ("HPSM" or the "Commission"), provides an overview of the Commission's financial activities for the years ended December 31, 2019, 2018, and 2017. Please read it in conjunction with the Commission's audited combined financial statements and accompanying notes, which begin on page 16.

FINANCIAL HIGHLIGHTS – PROPRIETARY FUND

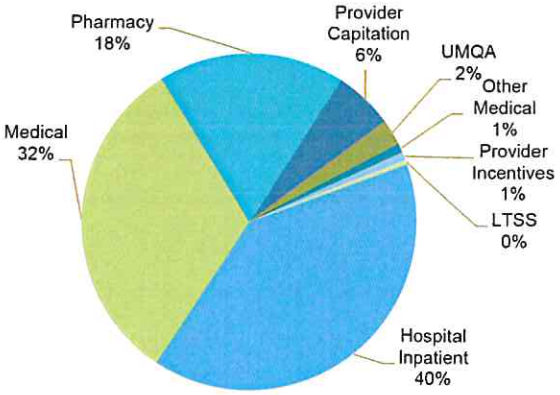
Overview of Financial Results

- Net surplus of $8,498,494 in 2019, net surplus of $273,216 in 2018, and a net surplus of $41,824,456 in 2017.
- Net operating revenues increased by $10,371,807 (1.35%) in 2019, decreased by $135,567,423 (14.96%) in 2018, and increased by $114,129,354 (14.40%) in 2017.
- Healthcare expenses increased by $30,706,928 (4.56%) in 2019, decreased by $91,418,257 (11.96%) in 2018, and increased by $30,500,383 (4.16%) in 2017.

Percentage of Revenue by LOB



Healthcare Dollar Spent



- Member months decreased overall by 5.87% in 2019, by 3.63% in 2018, and by 2.00% in 2017.
  - In 2019, membership for HealthWorx increased by 4.80% and the Whole Child Model remained flat. The remaining lines showed declining membership: Medi-Cal by 6.16%, Cal MediConnect by 2.31% and Healthy Kids by 20.64%, as the population transitioned to Medi-Cal effective October 1st.
  - In 2018, membership increased for the Whole Child Model (formerly reported as California Children's Services ("CCS") Pilot) by 4.64%, HealthWorx by 4.61%, and Healthy Kids by 28.81% due to the transition in of California's Children's Health Insurance Program ("CHIP") members. Medi-Cal and Cal MediConnect continued to experience decreases, by 4.23% and 2.89%, respectively.

- In 2017, all lines of business showed a decrease: Medi-Cal by 1.01%, California Children's Services ("CCS") Pilot by 0.28%, HealthWorx by 0.56%, and Cal MediConnect by 0.89%. The Healthy Kids program experienced the largest decline at 35.21%, as the transition to Medi-Cal continued.

USING THIS ANNUAL REPORT

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

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

HPSM'S NET POSITION

HPSM's net position is the difference between its assets and liabilities as reported in the combined statements of net position on page 16. HPSM's net position increased by $8,498,494 in 2019, increased by $273,216 in 2018, and increased by $41,824,456 in 2017.

	2019	2018	2017
CURRENT ASSETS	$ 538,792,065	$ 500,642,994	$ 668,560,900
CAPITAL ASSETS, NET	67,467,847	69,965,198	72,833,122
NET PENSION ASSET	989,040	-	2,255,652
ASSETS RESTRICTED AS TO USE	300,000	300,000	300,000
DEFERRED OUTFLOWS OF RESOURCES	2,921,645	3,508,821	1,323,356
Total assets and deferred outflows of resources	$ 610,470,597	$ 574,417,013	$ 745,273,030
CURRENT LIABILITIES			
Medical claims payable	$ 77,178,853	$ 75,047,186	$ 74,069,985
Providers incentives payable	6,479,966	3,491,355	1,209,287
Amounts due to the State of California	99,563,364	106,699,428	290,984,514
Accounts payable and accrued liabilities	76,322,150	47,242,262	37,610,611
Total liabilities	259,544,333	232,480,231	403,874,397
NET PENSION LIABILITY	-	914,189	-
DEFERRED INFLOWS OF RESOURCES	2,907,630	1,502,453	2,151,709
Total liabilities and deferred inflows of resources	$ 262,451,963	$ 234,896,873	$ 406,026,106
NET POSITION			
Invested in capital assets	$ 67,467,847	$ 69,965,198	$ 72,833,122
Restricted by legislative authority	300,000	300,000	300,000
Unrestricted	280,250,787	269,254,942	266,113,802
Total net position	$ 348,018,634	$ 339,520,140	$ 339,246,924

CURRENT ASSETS

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

Current assets decreased $167,917,906 (25.12%) from 2017 to 2018. Included is a decrease of $146,944,909 (26.69%) in cash and investments, due primarily to repayment of the Adult Expansion Medical Loss Ratio ("MLR"), and cash takebacks by the State to recover overpayments of capitation (from January 2015 through June 2017) for Medi-Cal and Cal MediConnect. These takebacks are expected to continue in 2019. HPSM intentionally holds a greater cash position due to the uncertainty of rate increases/cuts and cash flow from the State of California; a decrease of $18,547,892 (18.57%) in Medi-Cal and CareAdvantage capitation receivables due to a decrease in memberships; and a decrease of $2,425,105 (13.47%) in other accounts receivable and prepaids and other assets due to payments received against 2017 balances related to the In-Home Support Services ("IHSS") program, which ended in 2017 and general timing variances.

Current assets decreased $53,183,841 (7.37%) from 2016 to 2017. Included is a decrease of $51,832,719 (8.60%) in cash and investments, due primarily to cash takebacks by the State to recover overpayments of capitation (from July 2015 through February 2016) for the Adult Expansion program. These takebacks are expected to continue in 2018. HPSM intentionally holds a greater cash position due to the uncertainty of rate increases/cuts and cash flow from the State of California; a decrease of $9,467,686 (8.66%) in Medi-Cal and CareAdvantage capitation receivables due to rate and risk score adjustments; and an increase of $8,116,565 (82.15%) in other accounts receivable and prepaids and other assets due partially to an accrual of expected pharmacy drug rebates.

CAPITAL ASSETS, NET

Capital assets decreased by $2,497,351 (3.57%) in 2019 due to depreciation expense combined with no substantial capital expenditures. In 2018, capital assets decreased by $2,867,924 (3.94%) as there were no new capital expenditures related to the headquarters. In 2017, capital assets increased by $3,217,435 (4.23%) as renovations and upgrades to HPSM headquarters were completed.

NET PENSION ASSET (LIABILITY)

Net pension asset represents the excess value of pension assets above the projected liability, under Governmental Accounting Standards Board ("GASB") Statement No. 68, *Accounting and Financial Reporting for Pensions* ("GASB 68"). Net pension asset was $989,040 at December 31, 2019, a change of $1,903,229 (208.19%) from the liability balance of $914,189 at December 31, 2018, which was the result of less than favorable fourth quarter returns. At December 31, 2017 the net pension asset was $2,255,652.

DEFERRED OUTFLOWS OF RESOURCES

Deferred outflows of resources represent the difference between projected and actual retirement investment earnings that are deferred under GASB 68. Deferred outflows of resources decreased to $2,921,645 as of December 31, 2019, increased to $3,508,821 as of December 31, 2018, and increased to $1,323,356 as of December 31, 2017.

PROVIDERS INCENTIVES PAYABLE

Incentives payable to providers increased by $2,988,611 (85.60%) in 2019, by $2,282,068 (188.71%) in 2018, and by $425,805 (54.35%) in 2017. HPSM uses a pay for performance-based incentive model for primary care physicians ("PCP"). Under the Benchmark P4P program, providers are financially rewarded for meeting quality outcome benchmarks measured and paid on an annual basis. The quality metrics target preventive and chronic condition management services identified as high impact for our patient population.

The increase in 2019 is related to the timing of payments to providers, as the benchmark period transitioned from quarterly payments to an annual basis. The increase in 2018 is related to the timing of payments to providers. The increase in 2017 was due to increased participation by physicians added to the network.

ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

Accounts payable and accrued liabilities increased by $29,079,888 (61.55%) from 2018 to 2019, increased by $9,631,651 (25.61%) from 2017 to 2018, and increased by $43,692,563 (53.74%) from 2016 to 2017. The 2019 increase is due primarily to the delay in payments to hospitals, bringing the hospital tax payable ("SB335") liability to $22,546,279 and other Directed Payments (including the Intergovernmental Transfer ("IGT")) to $27,116,479. These increases were offset by payout of the MCO liability from the prior year bringing the balance to $0. The 2018 increase is due to a timing difference of the MCO tax payable at year-end bringing the liability to $15,620,952; payout of IGT for prior years, which decreased the liability to $6,551,900; and timing differences related to health care service partner program payments increasing the liability to $13,419,796. The 2017 changes consist of timing of the MCO tax payment at year-end bringing the payable to $0 in 2017; payout of the 2016 SB335, which went from $13,769,847 to $0 in 2017; and payout of IGT, which decreased the payable to $20,699,306 in 2017.

AMOUNTS DUE TO THE STATE OF CALIFORNIA

Amounts due to the State of California decreased $7,136,064 (6.69%) to $99,563,364 in 2019; decreased $184,285,086 (63.33%) to $106,699,428 in 2018; and decreased $39,850,898 (12.05%) to $290,984,514 in 2017. The decrease in 2019 is primarily due to the repayment of the Medi-Cal Expansion MLR for July 2016-June 2017 offset by additional capitation overpayments by the State related to long term care. The decrease in 2018 is primarily due to the repayment of the Medi-Cal Expansion MLR for the initial reporting period of January 2014-June 2016, in addition to the State's recoupment of overpayments related to Cal MediConnect for 2016 and 2017. The 2017 decrease is primarily due to the end of the MLR requirement associated with the Medi-Cal Expansion program. The MLR requirement was extended in 2018 by Department of Health Care Services ("DHCS"). The 2016 increase is primarily due to rate recasting back to April 2014 for the CCI Medi-Cal Dual and Cal MediConnect populations, as well as, the recording of a risk corridor related to the same period.

DEFERRED INFLOWS OF RESOURCES

Deferred inflows of resources represent changes in assumptions and the difference between expected and actual experience in 2018 that are deferred under GASB 68. Deferred inflows of resources increased $1,405,177 (93.53%) to $2,907,630 as of December 31, 2019, decreased $649,256 (30.17%) to $1,502,453 as of December 31, 2018, and increased $897,907 (71.61%) to $2,151,709 as of December 31, 2017.

	2019	2018	2017
OPERATING REVENUES			
Capitation and premiums			
Medi-Cal	$ 473,054,522	$ 482,922,478	$ 557,487,882
CareAdvantage	43,087	-	160,853
Healthy Kids	2,786,238	3,450,951	2,645,495
HealthWorx	4,456,211	3,976,417	3,064,323
CCS Pilot	28,119,844	36,962,191	30,047,768
Cal MediConnect	272,765,508	243,541,566	313,014,705
Net operating revenues	781,225,410	770,853,603	906,421,026
OPERATING EXPENSES			
Health care expenses			
Hospital inpatient	280,297,522	259,929,845	247,978,279
Medical	224,403,033	213,354,610	195,952,493
Pharmacy	125,983,949	130,356,564	128,662,838
Primary care physician capitation	40,861,093	43,165,045	38,780,017
Utilization management and quality assessment allocation	17,565,742	17,348,225	15,493,610
Other medical - dental, reinsurance, etc.	6,248,624	6,451,631	3,926,656
Provider incentives	5,479,792	2,081,737	1,356,110
Long-term support services	2,881,058	326,228	132,282,139
Total health care expenses	703,720,813	673,013,885	764,432,142
General and administrative	50,566,190	48,398,869	46,763,832
MCO tax	31,099,624	60,457,515	60,790,230
Total operating expenses	785,386,627	781,870,269	871,986,204
(Loss) income from operations	(4,161,217)	(11,016,666)	34,434,822
NONOPERATING REVENUE			
Net interest and investment income	9,328,216	7,964,343	3,840,741
Other	375	70,314	307,177
Rental income, net	1,086,584	1,045,871	1,034,742
Third-party administration fees	2,244,536	2,209,354	2,206,974
Total nonoperating revenue	12,659,711	11,289,882	7,389,634
Increase in net position	8,498,494	273,216	41,824,456
NET POSITION, beginning of the year	339,520,140	339,246,924	297,422,468
NET POSITION, end of the year	$ 348,018,634	$ 339,520,140	$ 339,246,924

OPERATING REVENUES

HPSM's overall operating revenues increased by $10,371,807 (1.35%) in 2019, decreased by $135,567,423 (14.96%) in 2018, and increased by $114,129,354 (14.40%) in 2017.

The primary components for the increased revenues in 2019 are:

- New rates (effective January 2019) for Cal MediConnect resulting in approximately $3.6 million in increased revenues;
- Prior year rate adjustments resulting in a new increase of approximately $30 million, including restated 2017 rates for Cal MediConnect and Medi-Cal CCI Duals for a combined increase of $5.5 million;
- A decrease of approximately $31 million in revenues due to a deferral of the MCO Tax program until January 1, 2020, as approved by CMS; and
- An increase of approximately $7.7 million in revenues related to directed payments, such as, Proposition 56 and Ground Emergency Medical Transport.

The primary components for the decreased revenues in 2018 are:

- Financial responsibility of the In-Home Support Services ("IHSS") program transferred from HPSM back to the State effective January 2018 resulting in approximately $125 million decreased revenues from prior year (and corresponding expense);
- Reinstatement of the Adult Expansion MLR requirement back to July 2016 resulting decreased revenues of approximately $15 million;
- Proposition 56 add-on rates (effective July 2017) for Medi-Cal; Adult Expansion and Whole Child Model resulting in approximately $7.6 million in increased revenues; and
- New MCO tax rates (effective July 2018) for Medi-Cal, including Adult Expansion and Whole Child Model resulting in an increase in revenues of approximately $3.5 million.

The primary components for the increased revenues in 2017 are:

- New rates (effective January 2017) for Cal MediConnect resulting in approximately $12.5 million in increased revenues;
- True-up of retro-rate adjustments for the CCS Pilot Program resulting in approximately $1.34 million of increased revenues;
- Increase in estimates for In-Home Support Services ("IHSS") revenues back to 2014 of approximately $54.5 million to account for contracted rates rather than paid rates by the State; and

- Full year impact of the removal of the Adult Expansion MLR requirement, which would have offset revenues by approximately $12.6 million.

INTEREST AND INVESTMENT INCOME

Net interest and investment income was $9,328,216 in 2019, $7,964,343 in 2018, and $3,840,741 in 2017. The average rate of return for the investments was 2.07% in 2019, 2.34% in 2018, and 0.972% in 2017.

OPERATING EXPENSES

Healthcare Expenses

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

- An increase in Inpatient costs of approximately $20.4 million as a result of an increased rate of acute hospital admissions across all major lines of business, as well as an increase in State derived rates for both acute hospital and long term care;

- An increase in Medical costs of approximately $11 million, including $4.5 million in increased directed payments (Proposition 56 and Ground Emergency Medical Transport), $3.5 million in hospital outpatient costs, and $3 million in other medical costs including medical pharmacy.

- Decreased Pharmacy costs of $4.4 million is from lower number of scripts per member and lower cost per scripts

- Additional funding to provider incentives of $3.4 million was made in 2019 based on the first full year of the new program, which began mid-2018.

- Other changes include $2.6 million increase in LTSS ("Long Term Support Services") and $2.6 million increase in transportation cost, offset by $2.3 million decrease in provider capitation and $2.8 million higher reinsurance recoveries compared to prior year.

Overall health care expenses decreased $91,418,257 (11.96%) from 2017 to 2018 due to:

- A decrease for IHSS costs of approximately $132 million resulting from the transfer of financial responsibility (from HPSM) to the State effective January 2018;

- Full year impact of the Medi-Cal Transportation benefit, which increased expenses approximately $2.5 million;

- An increase in Inpatient costs of approximately $10 million as a result of increased number of admissions across all major lines of business, as well as an increase in Medi-Cal inpatient reimbursement in order to align Health Plan contracted hospital rates with State fee for service rates;

- An increase in Medical costs of approximately $17.4 million, including landmark and behavioral health services, as well as substantial increases in the cost and utilization of radiation and injectable drug treatments; and

- An increase in Cal MediConnect ("CMC") capitation costs of $4 million due to an increase in specialty vendor capitation.

Overall health care expenses increased $30,500,383 (4.16%) from 2016 to 2017 due to:

- An increase in Medi-Cal Medical costs of $4.5 million due to an increase in the specialist cost per service;

- Increase in estimates for In-Home Support Services ("IHSS") expenses back to 2014 of approximately $54.5 million to account for contracted rates rather than reported rates by the State;

- End of contract for global capitation paid to the County Health Services for the Adult Expansion population assigned to them resulting in a decrease of approximately $44 million;

- A decrease in Pharmacy costs across all lines of business of approximately $10 million;

- An increase in Transportation costs as a new Medi-Cal benefit was rolled out in 2017; and

- An expansion of behavioral health services to all lines of business (previously only CareAdvantage and child covered).

General and Administrative ("G&A") Expenses

Total G&A expenses were $50,566,190 in 2019, $48,398,869 in 2018, and $46,763,832 in 2017. The increase from 2018 to 2019 is primarily due to employee salary and benefit costs. The increase from 2017 to 2018 is due to the new software and related equipment, as well as, an increase in employee salary and benefit costs. We also experienced an increase in depreciation expense due to the new building. The administrative expenses as a percentage of operating revenues were 6.47% in 2019, 6.28% in 2018, and 5.16% in 2017.

MCO Tax

In 2009, Assembly Bill ("AB") No. 1422 ("AB1422") was passed by the legislature and signed by Governor Schwarzenegger. The bill provided that Medi-Cal Managed Care Organizations ("MCO") would be subject to a gross premium tax on Medi-Cal capitation revenues. For revenues pertaining to June 30, 2013, and prior, the tax rate was 2.35%. In June 2013, Senate Bill ("SB") No. 78 ("SB 78") reauthorized the MCO premium tax through the State of California's fiscal year 2016. Beginning July 1, 2013 through June 30, 2016, the rate is equal to the state sales and use tax rate of 3.9375%. On March 1, 2016, SB X2-2 established a new MCO provider tax, to be administered by DHCS, effective July 1, 2016 through June 30, 2019. On April 3, 2020, CMS approved a waiver for the broad-based and uniformity requirements related to the State of California's MCO tax, effectively renewing the program effective January 1, 2020. The tax was assessed by the Department of Health Care Service ("DHCS") on licensed health care service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate health care service plans ("AHCSP"), as defined, except as excluded by the bill. This bill established applicable taxing tiers and per enrollee amounts for the 2016-2017 and 2017-2018 and 2018-2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. HPSM paid $31,099,624 (through June 30th), $60,457,515, and $60,790,230, for 2019, 2018, and 2017, respectively, in MCO premium taxes. As of December 31, 2019 and 2018, HPSM's tax liability was $0 and $15,620,952, respectively, included in accounts payable and accrued liabilities in the combined statements of financial position.

	2019 Actual	2019 Budgeted	Variance
REVENUES			
Medi-Cal	$ 473,054,522	$ 473,499,993	$ (445,471)
CareAdvantage	43,087	-	43,087
Healthy Kids	2,786,238	3,447,360	(661,122)
HealthWorx	4,456,211	4,417,348	38,863
CCS Pilot Program	28,119,844	37,746,771	(9,626,927)
Cal MediConnect	272,765,508	259,867,245	12,898,263
Total revenues	781,225,410	778,978,717	2,246,693
HEALTH CARE EXPENSES			
Hospital inpatient	280,297,522	143,997,383	136,300,139
Medical	224,403,033	220,890,743	3,512,290
Pharmacy	125,983,949	134,730,733	(8,746,784)
Primary care physician capitation	40,861,093	41,478,015	(616,922)
Long-term support services	2,881,058	119,263,529	(116,382,471)
Utilization management ("UM") and quality assessment ("QA") allocation	17,565,742	19,652,662	(2,086,920)
Other medical - dental, reinsurance, etc.	6,248,624	3,782,937	2,465,687
Provider incentives	5,479,792	4,321,597	1,158,195
Total health care expenses	703,720,813	688,117,599	15,603,214
ADMINISTRATIVE EXPENSES			
Salaries and fringe benefits	36,225,476	37,140,000	(914,524)
Contract services	19,331,001	20,395,750	(1,064,749)
Office supplies and maintenance	4,883,875	5,324,000	(440,125)
Occupancy, equipment, and depreciation expense	5,000,636	6,643,000	(1,642,364)
Postage and printing	1,564,317	1,737,400	(173,083)
Other administrative expenses	1,270,226	1,676,100	(405,874)
Utilization management and quality assessment allocation	(17,709,341)	(19,406,620)	1,697,279
Total administrative expenses	50,566,190	53,509,630	(2,943,440)
MCO tax	31,099,624	54,567,210	(23,467,586)
Total expenses	785,386,627	796,194,439	(10,807,812)
Loss from operations	(4,161,217)	(17,215,722)	13,054,505
NONOPERATING INCOME			
Net interest and investment income	9,328,216	6,000,000	3,328,216
Other	1,086,959	1,073,883	13,076
Third-party administrator fees	2,244,536	2,803,470	(558,934)
Total nonoperating income	12,659,711	9,877,353	2,782,358
Net income (loss)	8,498,494	(7,338,369)	15,836,863
Net position at the beginning of year	339,520,140	339,520,140	-
Net position at the end of year	$ 348,018,634	$ 332,181,771	$ 15,836,863

FINANCIAL HIGHLIGHTS – FIDUCIARY FUND

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

	2019	2018	2017
TOTAL ASSETS	$ 24,386,084	$ 20,474,313	$ 21,332,449
TOTAL LIABILITIES	-	-	-
TOTAL FIDUCIARY NET POSITION	24,386,084	20,474,313	21,332,449
TOTAL ADDITIONS	5,712,430	310,421	4,539,817
TOTAL DEDUCTIONS	1,800,659	1,168,557	2,640,460
INCREASE (DECREASE) IN FIDUCIARY NET POSITION	3,911,771	(858,136)	1,899,357
FIDUCIARY NET POSITION - BEGINNING OF YEAR	20,474,313	21,332,449	19,433,092
FIDUCIARY NET POSITION - END OF YEAR	$ 24,386,084	$ 20,474,313	$ 21,332,449

Total fiduciary fund net position as of December 31, 2019, increased by $3.9 million from December 31, 2018, due to an increase in fair value of investments.

Total fiduciary fund net position as of December 31, 2018, decreased by $0.86 million from December 31, 2017, due to a decrease in fair value of investments.

MOSSADAMS

Report of Independent Auditors

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

Report on the Financial Statements

We have audited the accompanying combined financial statements of the business-type activities and the aggregate remaining fund information of San Mateo Health Commission (a stand-alone government entity appointed by the San Mateo County Board of Supervisors) (the "Commission") and San Mateo Community Health Authority (the "Health Authority"), collectively known as Health Plan of San Mateo ("HPSM") as of and for the years ended December 31, 2019 and 2018, and the related notes to the financial statements, which collectively comprise HPSM's combined financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and aggregate remaining fund information of San Mateo Health Commission and the San Mateo Community Health Authority (d.b.a. Health Plan of San Mateo) as of December 31, 2019 and 2018, and the respective changes in net position and cash flows for the years ended December 31, 2019 and 2018, in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matters

As discussed in Note 1 to the combined financial statements, HPSM adopted Governmental Accounting Standards Board's Statement No. 84, *Fiduciary Activities*, for the Health Plan of San Mateo Retirement Plan Fund, which required retrospective application. Our opinion is not modified with respect to this matter.

Other Matters

Required Supplementary Information

The accompanying Management's Discussion and Analysis on pages 1 through 12, and the accompanying supplementary schedule of changes in the net pension (liability) asset and related ratios, supplementary schedule of contributions, and supplementary schedule of investment returns – Heath Plan of San Mateo Retirement Plan on pages 45-47 are not required parts of the combined financial statements but are supplementary information required by the Governmental Accounting Standards Board who considers them to be an essential part of financial reporting for placing the combined financial statements in an appropriate operational, economic, or historical context. This supplementary information is the responsibility of HPSM's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the combined financial statements, and other knowledge we obtained during our audit of the combined financial statements. We do not express an opinion or provide any assurance on the supplementary information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Moss Adams LLP

San Francisco, California
April 8, 2020

Combined Financial Statements

San Mateo Health Commission and
San Mateo Community Health Authority
(d.b.a. Health Plan of San Mateo) – Proprietary Fund
Combined Statements of Net Position
December 31, 2019 and 2018

	2019	2018
ASSETS AND DEFERRED OUTFLOWS		
CURRENT ASSETS		
Cash and cash equivalents	$ 255,928,918	$ 241,560,431
Investments	165,899,471	162,159,119
Capitation receivable from the State of California	79,038,958	62,858,906
CareAdvantage receivable	21,832,233	18,492,304
Other accounts receivable	7,258,282	7,617,874
Prepaids and other assets	8,834,203	7,954,360
Total current assets	538,792,065	500,642,994
CAPITAL ASSETS, NET		
Nondepreciable	15,667,814	15,667,814
Depreciable, net of accumulated depreciation and amortization	51,800,033	54,297,384
Total capital assets, net	67,467,847	69,965,198
NET PENSION ASSET	989,040	-
ASSETS RESTRICTED AS TO USE	300,000	300,000
Total assets	607,548,952	570,908,192
DEFERRED OUTFLOWS OF RESOURCES	2,921,645	3,508,821
Total assets and deferred outflows of resources	$ 610,470,597	$ 574,417,013
LIABILITIES AND DEFERRED INFLOWS		
CURRENT LIABILITIES		
Medical claims payable	$ 77,178,853	$ 75,047,186
Incentives payable to providers	6,479,966	3,491,355
Amounts due to the State of California	99,563,364	106,699,428
Accounts payable and accrued liabilities	76,322,150	47,242,262
Total current liabilities	259,544,333	232,480,231
NET PENSION LIABILITY	-	914,189
DEFERRED INFLOWS OF RESOURCES	2,907,630	1,502,453
Total liabilities and deferred inflow of resources	$ 262,451,963	$ 234,896,873
NET POSITION		
Invested in capital assets	$ 67,467,847	$ 69,965,198
Restricted by legislative authority	300,000	300,000
Unrestricted	280,250,787	269,254,942
Total net position	$ 348,018,634	$ 339,520,140

See accompanying notes.

San Mateo Health Commission and
San Mateo Community Health Authority
(d.b.a. Health Plan of San Mateo) – Proprietary Fund
Combined Statements of Revenues, Expenses, and Changes in Net Position
Years Ended December 31, 2019 and 2018

	2019	2018
OPERATING REVENUES		
Capitation and premiums		
Medi-Cal	$ 473,054,522	$ 482,922,478
CareAdvantage	43,087	-
Healthy Kids	2,786,238	3,450,951
HealthWorx	4,456,211	3,976,417
Child Care Services ("CCS") Pilot	28,119,844	36,962,191
Cal MediConnect	272,765,508	243,541,566
Net operating revenues	781,225,410	770,853,603
OPERATING EXPENSES		
Healthcare expenses		
Hospital inpatient	280,297,522	259,929,845
Medical	224,403,033	213,354,610
Pharmacy	125,983,949	130,356,564
Primary care physician capitation	40,861,093	43,165,045
Utilization management ("UM") and quality assessment ("QA") allocation	17,565,742	17,348,225
Other medical - dental, reinsurance, etc.	6,248,624	6,451,631
Provider incentives	5,479,792	2,081,737
Long-term support services	2,881,058	326,228
Total health care expenses	703,720,813	673,013,885
General and administrative		
Salaries and fringe benefits	36,225,476	33,852,978
Contract services	19,331,001	17,613,426
Office supplies and maintenance	4,883,875	5,481,776
Occupancy, equipment, and depreciation expense	5,000,636	5,095,724
Postage and printing	1,564,317	1,623,903
Other administrative expenses	1,270,226	1,294,841
UMQA healthcare allocation	(17,709,341)	(16,563,779)
Total general and administrative expenses	50,566,190	48,398,869
MCO tax	31,099,624	60,457,515
Total operating expenses	785,386,627	781,870,269
Loss from operations	(4,161,217)	(11,016,666)
NONOPERATING REVENUE		
Net interest and investment income	9,328,216	7,964,343
Other revenue	375	70,314
Rental income, net	1,086,584	1,045,871
Third-party administration fees	2,244,536	2,209,354
Total nonoperating revenue	12,659,711	11,289,882
Increase in net position	8,498,494	273,216
NET POSITION, beginning of the year	339,520,140	339,246,924
NET POSITION, end of the year	$ 348,018,634	$ 339,520,140

See accompanying notes.

San Mateo Health Commission and
San Mateo Community Health Authority
(d.b.a. Health Plan of San Mateo) – Proprietary Fund
Combined Statements of Cash Flows
Years Ended December 31, 2019 and 2018

	2019	2018
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation and premium revenues	$ 793,359,804	$ 592,199,923
Healthcare expenses	(697,093,251)	(664,104,581)
General and administrative expenses	(90,341,173)	(86,572,500)
Other	(53,985)	898,067
Net cash provided by (used in) operating activities	5,871,395	(157,579,091)
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from sale and maturities of investments	8,875,754	8,064,531
Payments for purchase of capital assets	(378,662)	(125,993)
Net cash provided by investing activities	8,497,092	7,938,538
Net increase (decrease) in cash	14,368,487	(149,640,553)
CASH AND CASH EQUIVALENTS, beginning of year	241,560,431	391,200,984
CASH AND CASH EQUIVALENTS, end of year	$ 255,928,918	$ 241,560,431
RECONCILIATION OF INCOME FROM OPERATIONS TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Loss from operations	$ (4,161,217)	$ (11,016,666)
Adjustment to reconcile loss from operations to net cash used in operating activities		
Depreciation	2,876,013	2,993,917
Changes in operating assets and liabilities		
Capitation receivable from the State of California	(16,180,052)	15,332,542
CareAdvantage receivable	(3,339,929)	3,215,350
Other accounts receivable	359,592	1,280,813
Prepaids and other assets	(836,238)	1,673,998
Net pension (liability) asset	89,124	335,120
Medical claims payable	2,131,667	977,201
Incentives payable to providers	2,988,611	2,282,068
Amounts due to the State of California	(7,136,064)	(184,285,086)
Accounts payable and accrued liabilities	29,079,888	9,631,652
Net cash provided by (used in) operating activities	$ 5,871,395	$ (157,579,091)

See accompanying notes.

San Mateo Health Commission and San Mateo Community Health Authority (d.b.a. Health Plan of San Mateo) – Health Plan of San Mateo Retirement Plan

Statements of Fiduciary Net Position

December 31, 2019 and 2018

	2019	2018
ASSETS		
Cash and cash equivalents	$ 679,773	$ 747,460
Investments, at fair value		
Mutual funds	4,465,831	3,777,289
Pooled, common, and collective trusts	19,239,549	15,948,042
Total investments, at fair value	23,705,380	19,725,331
Interest and dividends receivable	931	1,522
Total assets	$ 24,386,084	$ 20,474,313
NET POSITION RESTRICTED FOR PENSIONS	$ 24,386,084	$ 20,474,313

See accompanying notes.

San Mateo Health Commission and
San Mateo Community Health Authority (d.b.a. Health Plan of San Mateo) – Health Plan of San Mateo Retirement Plan
Statements of Changes in Fiduciary Net Position
Years Ended December 31, 2019 and 2018

	2019	2018
ADDITIONS		
Employer contributions	$ 1,613,011	$ 1,396,529
Investment income (loss)		
Net appreciation (depreciation) in fair value of investments	3,989,441	(1,182,626)
Dividends	90,496	80,209
Interest	19,482	16,309
Total investment income (loss)	4,099,419	(1,086,108)
Total additions	5,712,430	310,421
DEDUCTIONS		
Benefits paid to participants	1,800,659	1,168,557
INCREASE (DECREASE) IN NET POSITION	3,911,771	(858,136)
NET POSITION RESTRICTED FOR PENSIONS		
Beginning of year	20,474,313	21,332,449
End of year	$ 24,386,084	$ 20,474,313

See accompanying notes.

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

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

HPSM is responsible for managing a capitated prepaid health care system for residents of the County who are eligible for services under the Medi-Cal Program. The California Legislature authorized the prepaid system in March 1986 and HPSM began operations on December 1, 1987, under a contract with the State of California (the "State"). HPSM has an executed contract with the State for the period of January 1, 2009 through December 31, 2020.

CMS originally approved the State's request for HPSM to operate under a federal Medicaid freedom of choice waiver in November of 1987. The 1915(b) waiver allows for mandatory participation by Medi-Cal eligible San Mateo County residents in HPSM. Effective November 1, 2010, CMS transitioned all existing California 1915(b) waivers, including HPSM's, into the State's 1115(a) waiver. CMS renewed the State's 1115(a) waiver for November 1, 2010 through December 31, 2020.

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

HPSM acquired a license under the Knox-Keene Health Care Services Plan Act of 1975, as amended (the "Act") on July 31, 1998, and is regulated by the State's Department of Health Care Services ("DHCS") and California Department of Managed Health Care ("DMHC"). For the HealthWorx program, HPSM contracted with the San Mateo Public Authority for coverage of the In-Home Support Services ("IHSS") employees as of August 1, 2001, San Mateo County for coverage of San Mateo County Extra Help employees as of September 1, 2006, and the City of San Mateo for Non-Merit Part-Time and Library Per Diem employees as of January 1, 2009. The current HealthWorx contracts are for the following periods: (1) IHSS – July 1, 2014 to December 31, 2020 and (2) the City of San Mateo – January 1, 2009 to December 31, 2020. As a result of HealthWorx program's commercial status, members who have extinguished all available COBRA benefits are eligible for an Individual Coverage Plan ("ICP").

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

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

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

Effective September 1, 2007, HPSM entered into an agreement with the County of San Mateo to provide third party administrator ("TPA") services to administer the benefits of their indigent care program ("ACE"). The current agreement is for the period April 1, 2015 to March 31, 2020.

Effective April 1, 2013, HPSM entered into a second Medi-Cal contract (Plan #703) with the State of California. This contract covers the Child Care Services ("CCS") Pilot Initiative. CCS Services were previously covered under the primary Medi-Cal contract. The current contract is for the period April 1, 2013 to June 30, 2017. Effective July 1, 2018 the program transitioned to the Whole Child Model ("WCM"), and is once again part of the primary Medi-Cal contract (Plan #503).

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

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

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

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

Basis of combination – The accompanying combined financial statements as of December 31, 2019 and 2018, and for the years then ended, include the Commission and the Health Authority, collectively known as HPSM. The operations of the Health Authority are included from the date of its inception on February 1, 2006.

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

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

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

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

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

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

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

Assets restricted as to use – HPSM is required by the California Department of Managed Health Care to restrict cash of $300,000 as of December 31, 2019 and 2018, for the payment of member claims in the event of its insolvency.

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

Amounts due to the State of California – When HPSM is made aware of changes to the State rate structure, such as rate decreases, risk corridors or program reconciliations, that significantly impact the financial outlook, an accrual for the estimated change is recorded. Such estimates are subject to the impact of changes in the regulatory environment and are subject to third party review. At the end of December 31, 2019 and 2018, HPSM had the following included in Amounts due to the State of California in the accompanying combined statements of net position:

	2019	2018
Risk corridor	$ 19,789,224	$ 19,789,224
Medi-Cal Expansion ("MCE") medical loss ratio reserve	3,666,077	13,635,176
Overpayments	76,108,063	72,110,202
Other liabilities	-	1,164,826
Total	$ 99,563,364	$ 106,699,428

Risk corridor – Amendments to the State Medi-Cal contract established a two-year (July 2014 through June 2016) risk corridor for the Coordinated Care Initiative. This impacts the Medi-Cal and Cal MediConnect lines of business. HPSM is responsible or retains up to 1% of losses or gains. The State and HPSM equally shares any gains or losses between 1% and 2.5%. DHCS are responsible or keep any gains or losses greater than 2.5%.

MCE medical loss ratio ("MLR") reserve – Effective with the enrollment of the Medi-Cal Adult Expansion Population per Affordable Care Act ("ACA") on January 1, 2014, HPSM was subject to DHCS requirements to meet a minimum 85% MLR for this population through June 30, 2016. Specifically, HPSM was required to expend at least 85% of the Medi-Cal capitation revenue received for this population on allowable medical expenses as defined by DHCS. In the event HPSM expends less than the 85% requirement, HPSM was required to return to DHCS the difference between the minimum threshold and the actual allowed medical expenses.

For the year ended December 31, 2017, HPSM received retro-capitation for the FY15/16 rate period, which did not meet the minimum threshold and recorded a $22.6 million reduction to Medi-Cal capitation revenue. DHCS extended the MLR requirement in 2018 to cover FY16/17. For the year ended December 31, 2018, HPSM did not meet the minimum threshold for the FY16/17 period and recorded a $18.75 million reduction to Medi-Cal capitation revenue. For the year ended December 31, 2019, HPSM estimates to have met the minimum threshold and did not record a reduction of Medi-Cal capitation. In 2018, HPSM made a payment to the State of $109 million related to the original MLR reporting periods of January 2014 - June 2016. In 2019, HPSM made a payment to DHCS in the amount of $15 million related to the July 1, 2016 – June 30, 2017 MLR.

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

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

	2019	2018
Intergovernmental ("IGT") and Directed Payments payable	$ 27,116,479	$ 6,551,900
MCO tax payable	-	15,620,952
Hospital Quality Assurance Fee ("HQAF") payable	22,546,279	1,182,882
Other program payable	9,493,791	13,419,796
Accounts payable and accrued expenses	7,632,569	6,077,484
Other healthcare liabilities	9,533,032	4,389,248
Total	$ 76,322,150	$ 47,242,262

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

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

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

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

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

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

The Centers for Medicare & Medicaid Services ("CMS") pays HPSM capitation revenue each month. Capitation revenue is recognized in the month the beneficiary is eligible for Medicare services. Eligibility of members is determined by CMS.

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

In-Home Supportive Services ("IHSS") – The DHCS pays IHSS payments directly to the San Mateo County's Department of Social Services. As part of the CCI, HPSM assumes full risk for IHSS provider payments. These amounts are included in both capitation revenue and health care expenses respectively, in HPSM's combined financial statements. Additionally, HPSM pays MCO tax on the revenue. For the years ended December 31, 2019 and 2018, approximately $490,983 of takebacks and $18.2 million of IHSS-related revenue and expenses have been recorded in the combined financial statements, inclusive of estimated true-up amounts resulting in $0 net impact to net position in both years. IHSS expenses is included in long-term support services in HPSM's combined statements of revenues, expenses, and changes in net position.

Premium deficiencies – HPSM performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency is recorded. Management determined that no premium deficiency reserves were needed at December 31, 2019 or 2018.

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

MCO tax – In November 2009, DHCS implemented AB1422 or MCO premium tax. This program imposes an assessment on HPSM's revenue. DHCS uses this assessment to obtain matching federal funds, which is used to sustain enrollment in the Healthy Families program. Effective with California SB78 and beginning July 1, 2012, HPSM was required to pay a gross premium tax on Medi-Cal revenue. For July 1, 2013 through June 30, 2016, the tax rate increased to 3.9375%. Beginning July 1, 2016, a new annual liability methodology for determining tax liability was instituted by the State. MCO tax expense was $31,099,624 and $60,457,515 for the years ended December 31, 2019 and 2018, respectively. As of December 31, 2019 and 2018, $0 and $15,620,952, respectively, was accrued for the premium tax due on cash receipts. These amounts are included in accounts payable and accrued liabilities on the combined statements of net position.

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

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

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

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

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

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

New accounting pronouncements – In January 2017, the GASB issued Statement No. 84, *Fiduciary Activities* ("GASB 84"), which is effective for financial statements for periods beginning after December 15, 2018. GASB 84 establishes criteria for identifying fiduciary activities of all state and local governments and clarifies whether and how business-type activities should report their fiduciary activities. Further, the GASB 84 provides that governments should report activities meeting certain criteria in a fiduciary fund in the basic financial statements and present a statement of fiduciary net position and a statement of changes in fiduciary net position. HPSM adopted GASB 84 in the current fiscal year and have reflected the activities of the Retirement Plan fund in the accompanying statement of fiduciary net position and statement of changes in fiduciary net position. See Note 9 for accounting policies.

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

Reclassifications – Certain financial statement reclassifications have been made to prior year balances for comparability purposes and had no impact on changes in net position or net position as previously reported.

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

Cash and cash equivalents investments – Cash and cash equivalents and investments as of December 31, 2019 and 2018, consist of the following:

	2019	2018
Cash on hand	$ 500	$ 500
Cash deposits	53,636,786	200,309,580
Cash equivalents	202,291,632	41,250,351
Investments	165,899,471	162,159,119
Total cash and cash equivalents and investments	$ 421,828,389	$ 403,719,550

Assets restricted as to use – Assets restricted as to use consist of $300,000 of certificates of deposits as of December 31, 2019 and 2018.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HPSM's investments and assets restricted as to use by fair value level include the following as of December 31:

Description	Level 1	Level 2	Level 3	2019
Investments by fair value level				
Mutual funds	$ -	$ -	$ -	$ -
Total investments subject to fair value hierarchy	$ -	$ -	$ -	-
Investments and assets restricted as to use not subject to fair value hierarchy				
Certificate of deposits				300,000
San Mateo County Pooled Fund				103,906,993
Local Agency Investment Fund				61,992,478
Total investments and assets restricted as to use				$ 166,199,471

Description	Level 1	Level 2	Level 3	2018
Investments by fair value level				
Mutual funds	$ -	$ -	$ -	$ -
Total investments subject to fair value hierarchy	$ -	$ -	$ -	-
Investments and assets restricted as to use not subject to fair value hierarchy				
Certificate of deposits				400,000
San Mateo County Pooled Fund				101,584,446
Local Agency Investment Fund				60,474,673
Total investments and assets restricted as to use				$ 162,459,119

The custodial credit risk, interest rate, credit risk, and concentration of credit risk under GASB Statement No. 62 Section C20, *Cash Deposits with Financial Institutions*, at December 31, 2019 and 2018, were as follows:

Custodial credit risk – Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, HPSM will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The Code requires financial institutions to secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under State Law. As of December 31, 2019 and 2018, deposits exposed to custodial credit risk as they were uninsured, and the collateral held by the pledging bank not in HPSM's name were $255,928,919 and $241,560,432, respectively.

Custodial credit risk for investments is the risk that, in the event of the failure of the counterparty to a transaction, HPSM will not be able to recover the value of its investments or collateral securities that are in the possession of another party. As of December 31, 2019 and 2018, HPSM did not hold investments exposed to custodial credit risk.

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

The weighted average maturity in years for the $300,000 certificates of deposit included in assets restricted as to use, was 0.33 and 0.56 as of December 31, 2019 and 2018, respectively. The weighted average maturity in years for the portfolio was 0.33 and 0.56 as of December 31, 2019 and 2018, respectively.

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

Ratings as of December 31, 2019 and 2018 for the certificates of deposit were A-1.

Concentration of credit risk – The investment policy of HPSM contains certain limitations on the amount that can be invested in any one issuer and is listed in the table above. There are no investments in any one issuer (other than U.S. Treasury securities, mutual funds, and external investment pools) that represent 5% or more of the total HPSM's investments at December 31, 2019 and 2018.

NOTE 3 – CAPITATION RECEIVABLE FROM THE STATE OF CALIFORNIA

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

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

NOTE 4 – CAPITAL ASSETS

Capital asset activity for the fiscal year ended December 31, 2019, was as follows:

	Beginning Balance	Increases	Decreases	Ending Balance
Furniture and equipment	$ 14,014,509	$ 250,162	$ (172,571)	$ 14,092,100
Building improvements	22,694,156	128,500	-	22,822,656
Building	31,810,055	-	-	31,810,055
Land	15,667,814	-	-	15,667,814
Total capital assets	84,186,534	378,662	(172,571)	84,392,625
Less accumulated depreciation and amortization for	14,221,336	2,876,013	(172,571)	16,924,778
Total accumulated depreciation	14,221,336	2,876,013	(172,571)	16,924,778
Capital assets, net	$ 69,965,198	$ (2,497,351)	$ -	$ 67,467,847

Capital asset activity for the fiscal year ended December 31, 2018, was as follows:

	Beginning Balance	Increases	Decreases	Ending Balance
Furniture and equipment	$ 14,176,556	$ 125,993	$ (288,040)	$ 14,014,509
Building improvements	22,694,156	-	-	22,694,156
Building	31,810,055	-	-	31,810,055
Land	15,667,814	-	-	15,667,814
Total capital assets	84,348,581	125,993	(288,040)	84,186,534
Less accumulated depreciation and amortization for	11,515,459	2,993,917	(288,040)	14,221,336
Total accumulated depreciation	11,515,459	2,993,917	(288,040)	14,221,336
Capital assets, net	$ 72,833,122	$ (2,867,924)	$ -	$ 69,965,198

Depreciation expense for capital assets for the years ended December 31, 2019 and 2018, was $2,876,013 and $2,993,917, respectively.

NOTE 5 – MEDICAL CLAIMS PAYABLE

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

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

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

	2019	2018
Balance at the beginning of the period	$ 75,047,186	$ 74,069,985
Incurred		
Current year	641,151,739	620,729,557
Prior year	(5,396,292)	(11,490,596)
	635,755,447	609,238,961
Paid related to		
Current year	565,847,390	547,991,237
Prior year	67,776,390	60,270,523
Total paid	633,623,780	608,261,760
Balance at end of the period	$ 77,178,853	$ 75,047,186

Medical claims payable increased by $2 million in comparison to the previous year. The increase is primarily due to timing differences in payments to providers for State directed supplemental payments including Proposition 56 and Ground Emergency Medical Transport.

NOTE 6 – INCENTIVES PAYABLE TO PROVIDER

As of July 1, 2018, HPSM implemented a new Benchmark Pay for Performance ("P4P") program structure for our Medi-Cal Primary Care Providers. Providers can participate in the Benchmark P4P program or the Fee for Service ("FFS") P4P program for Medi-Cal members. The FFS P4P program is also available to PCPs for CareAdvantage members. Under the Benchmark P4P program providers are financially rewarded for meeting quality outcome benchmarks measured and paid on an annual basis. The quality metrics in both P4P programs target preventive and chronic condition management services identified as high impact for our patient population.

NOTE 7 – RESERVE FOR STABILIZATION AND MINIMUM TANGIBLE NET EQUITY

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

As a limited license plan under Knox-Keene Health Care Services Plan Act of 1975 (the "Act"), HPSM is required to maintain a minimum level of tangible net equity. On November 9, 2016, the San Mateo Health Commission approved a change to the stabilization reserve from 250% of the minimum tangible net equity ("TNE") as defined by the Department of Managed Health Care regulation to two (2) months of operating expenses. As of December 31, 2019 and December 31, 2018, the stabilization reserve was $130,897,771 and $145,368,000 respectively.

As of December 31, 2019, the minimum TNE was $31,191,877. Total net position as of December 31, 2019, is $348,018,634 which exceeds the minimum tangible net equity by $316,826,757 and is 1,116% of TNE.

As of December 31, 2018, the minimum TNE was $30,378,835. Total net position as of December 31, 2018, is $339,520,140, which exceeds the minimum tangible net equity by $309,141,306 and is 1,118% of TNE.

NOTE 8 – DEFERRED COMPENSATION FUND

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

All HPSM employees may participate in this deferred compensation plan under which employees are permitted to defer a portion of their annual salary until future years. For the years ended December 31, 2019 and 2018, HPSM contributed $749,128 and $808,520, respectively. The deferred compensation plan is administered by the International City Managers Association and the funds are invested under the terms of a trust agreement. The amounts are not available to employees until termination, retirement, death, or unforeseeable emergency.

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

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

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

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

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

Summary of Significant Accounting Policies

Basis of Accounting

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

Investments

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

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

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

Investments by fair value level include the following as of December 31:

Description	Level 1	Level 2	Level 3	2019
Investments by fair value level				
Mutual funds	$ 4,465,831	$ -	$ -	$ 4,465,831
Total investments subject to fair value hierarchy	$ 4,465,831	$ -	$ -	4,465,831
Investments not subject to fair value hierarchy				
Pooled, common, and collective trusts - at NAV				19,239,549
Total investments				$ 23,705,380

Description	Level 1	Level 2	Level 3	2018
Investments by fair value level				
Mutual funds	$ 3,777,289	$ -	$ -	$ 3,777,289
Total investments subject to fair value hierarchy	$ 3,777,289	$ -	$ -	3,777,289
Investments not subject to fair value hierarchy				
Pooled, common, and collective trusts - at NAV				15,948,042
Total investments				$ 19,725,331

Plan Description

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

	2019	2018
Retired and beneficiaries	11	11
Inactive	41	41
Active	276	277
Total participants	328	329

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

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

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

a) Effective January 1, 1994, 10% of compensation received as an employee prior to the effective date;

b) Effective January 1, 1994, investment credits that would have been credited to the account prior to the effective date if it had been in place;

c) For each year starting on or after January 1, 1994, 10% of compensation earned during the plan year; and

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

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

Contribution

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

Rate of Return

For the year ended December 31, 2019 and 2018, the actual rate of return on the Plan's investments, net of investment expenses, were 20.06% and -5.05%, respectively.

The following table summarizes changes in pension liability for the year ended December 31, 2019:

	Total Pension Liability	Plan Fiduciary Net Pension	Net Pension (Asset) Liability
Balance at December 31, 2018	$ 21,388,502	$ 20,474,313	$ 914,189
Changes during the year			
Service cost at beginning of year	1,555,503	-	1,555,503
Interest	1,654,496	-	1,654,496
Differences between expected and actual experience	561,851	-	561,851
Changes in assumptions	37,351	-	37,351
Benefit payments	(1,800,659)	(1,800,659)	-
Contributions	-	1,613,011	(1,613,011)
Net investment income	-	4,099,419	(4,099,419)
Net change in total pension liability (asset)	2,008,542	3,911,771	(1,903,229)
Balance at December 31, 2019	$ 23,397,044	$ 24,386,084	$ (989,040)
Total pension liability			$ 23,397,044
Plan fiduciary net position			24,386,084
Net pension asset			$ (989,040)
Plan fiduciary net position as a percentage of the total pension liability			104.23%
Covered payroll as of December 31, 2019, actuarial valuation			$ 23,367,767
Net pension asset as a percentage of covered payroll			-4.23%

The following table summarizes changes in pension asset for the year ended December 31, 2018:

	Pension Liability	Fiduciary Net Pension	Pension (Asset) Liability
Balance at December 31, 2017	$ 19,076,797	$ 21,332,449	$ (2,255,652)
Changes during the year			
Service cost at beginning of year	1,409,343	-	1,409,343
Interest	1,493,432	-	1,493,432
Changes of benefit terms	-	-	-
Differences between expected and actual experience	579,658	-	579,658
Changes in assumptions	(2,171)	-	(2,171)
Benefit payments	(1,168,557)	(1,168,557)	-
Contributions	-	1,396,529	(1,396,529)
Net investment income	-	(1,086,108)	1,086,108
Administrative expenses	-	-	-
Net change in total pension liability (asset)	2,311,705	(858,136)	3,169,841
Balance at December 31, 2018	$ 21,388,502	$ 20,474,313	$ 914,189
Total pension liability			$ 21,388,502
Plan fiduciary net position			20,474,313
Net pension liability			$ 914,189
Plan fiduciary net position as a percentage of the total pension asset			95.73%
Covered payroll as of December 31, 2018, actuarial valuation			$ 22,218,355
Net pension liability as a percentage of covered payroll			4.11%

The following table summarizes the actuarial assumptions used to determine net pension liability and plan fiduciary net position as of December 31, 2019 and 2018:

	Contributions related to the actuarially determined contributions made for the plan year
Valuation date:	January 1 to December 31
Actuarial cost method:	Entry age normal method
Amortization method:	Level dollar, closed amortization
Asset valuation method:	Market value
Actuarial assumptions:	
Projected salary increases	5.00%
Mortality	Based on the Pri-2012 healthy mortality table for males and females, with future mortality improvements projected on a fully generational basis using projection scale MP-2019
Discount rate	7.50%

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

	1% Decrease (6.50%)	Current Discount Rate (7.50%)	1% Increase (8.50%)
Net pension liability (asset) as of December 31, 2019	$ 583,208	$ (989,040)	$ (2,396,168)

	1% Decrease (6.50%)	Current Discount Rate (7.50%)	1% Increase (8.50%)
Net pension liability (asset) as of December 31, 2018	$ 2,464,158	$ 914,189	$ (464,249)

Components of pension cost included in salaries and fringe benefits and deferred outflows and deferred inflows of resources, as calculated under the requirements of GASB 68, are as follows:

	2019	2018
Pension cost		
Service cost	$ 1,555,503	$ 1,409,343
Interest cost	1,654,496	1,493,432
Projected earnings on plan investments	(1,528,664)	(1,608,328)
Current period effect of benefit changes	-	-
Current period difference between expected and actual experience	91,656	99,598
Current period effect of changes in assumptions	6,093	(373)
Current period difference between projected and actual investment earnings	(514,151)	538,887
Administrative expenses	-	-
Current period recognition of prior years' deferred outflows of resources	1,088,629	450,144
Current period recognition of prior years' deferred inflows of resources	(651,427)	(651,054)
Total pension cost	$ 1,702,135	$ 1,731,649

	2019	2018
Deferred outflows of resources as of December 31		
Difference between expected and actual experience	$ 1,272,067	$ 1,075,109
Changes in assumptions	32,916	2,549
Difference between projected and actual investment earnings	-	1,506,580
Total	$ 1,304,983	$ 2,584,238

	2019	2018
Deferred inflows of resources as of December 31		
Difference between expected and actual experience	$ 56,497	$ (137,203)
Changes in assumptions	182,135	(440,667)
Difference between projected and actual investment earnings	1,053,336	-
	$ 1,291,968	$ (577,870)

Deferred outflows of resources as of December 31, 2019 consist of $1,304,983 of deferred outflows and $1,291,968 of deferred inflows from difference between projected and actual investment earnings, presented in a consolidated format per GASB 68.

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

Year Ending December 31,	
2020	$ (153,157)
2021	71,052
2022	320,703
2023	(335,040)
2024	97,749
Thereafter	11,708
	$ 13,015

NOTE 10 – MEDICAL REINSURANCE (STOP-LOSS INSURANCE)

HPSM has entered into certain reinsurance (stop-loss) agreements with third parties to limit its losses on individual claims. Under the terms of these agreements, the third parties will reimburse HPSM certain proportions of the cost of each member's annual health care services in excess of specified deductibles (for 2016 and 2015, $425,000 for all lines of business for all health care expenses excluding pharmacy), limited to $2,000,000 in aggregate over all contract years per member.

Stop-loss insurance premiums of $2,775,579 and $2,403,992 are included in other medical expense in 2019 and 2018, respectively. In 2019, there is a total of $3,286,208 in recoveries: Medi-Cal $916,910 and $24,363 for 2019 and 2018 dates of service; Adult Expansion $648,040 and $201,141 for 2019 and 2018 dates of service; Cal MediConnect $296,741 and $23,064 for 2019 and 2018 dates of service; and CCS $856,378 and $319,571 for 2019 and 2018 dates of service. In 2018, there is a total of $1,918,255 in recoveries: Medi-Cal $973,360 and $110,301 for 2018 and 2017 dates of service; Adult Expansion $53,964 for 2017 dates of service; Cal MediConnect $58,152 and $90,166 for 2018 and 2017 dates of service; and CCS $552,528, $28,991, and $50,793 for 2018, 2017 and 2016 dates of service.

NOTE 11 – PROFESSIONAL LIABILITY INSURANCE

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

NOTE 12 – COMMITMENTS AND CONTINGENCIES

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

NOTE 13 – HEALTH CARE REFORM

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

NOTE 14 – SUBSEQUENT EVENTS

HPSM held investments at December 31, 2019, that may experience a significant decline in market value in 2020 as a result of market reaction to the coronavirus outbreak. HPSM will continue to monitor the situation closely, but the market volatility and the continuing situation surrounding the coronavirus is uncertain. At this time, management believes any potential decline in fair value for these securities is temporary.

Subsequent to December 31, 2019, the World Health Organization declared the novel coronavirus outbreak a public health emergency. In addition to the impact to our operations, it is unclear whether any additional funding will be made available to HPSM to pay for medical claims for members who may contract coronavirus. At this time, it is not possible to estimate the purchased healthcare costs to HPSM that may be incurred

Supplementary Information

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

	2019	2018	2017	2016
Total pension liability				
Service cost at beginning of year	$ 1,555,503	$ 1,409,343	$ 1,343,189	$ 1,187,234
Interest	1,654,496	1,493,432	1,369,003	1,265,064
Changes of benefit terms	-	-	-	-
Differences between expected and actual experience	561,851	579,658	641,930	365,418
Changes in assumptions	37,351	(2,171)	977	4,080
Benefit payments	(1,800,659)	(1,168,557)	(2,334,774)	(875,405)
Net change in total pension liability	2,008,542	2,311,705	1,020,325	1,946,391
Total pension liability beginning of fiscal year	21,388,502	19,076,797	18,056,472	16,110,081
Total pension liability end of fiscal year (a)	$ 23,397,044	$ 21,388,502	$ 19,076,797	$ 18,056,472
Plan fiduciary net pension				
Contributions	$ 1,613,011	$ 1,396,529	$ 1,313,247	$ 1,164,095
Net investment income	4,099,419	(1,086,108)	2,920,884	1,401,293
Benefit payments	(1,800,659)	(1,168,557)	(2,334,774)	(875,405)
Net change in Plan fiduciary net position	3,911,771	(858,136)	1,899,357	1,689,983
Plan fiduciary net position beginning of year	20,474,313	21,332,449	19,433,092	17,743,109
Plan fiduciary net position end of fiscal year (b)	$ 24,386,084	$ 20,474,313	$ 21,332,449	$ 19,433,092
Net pension liability (asset) end of fiscal year				
Plan's net pension liability (asset) (a) - (b)	$ (989,040)	$ 914,189	$ (2,255,652)	$ (1,376,620)
Plan fiduciary net position as a percentage of the total pension asset	104.23%	95.73%	111.82%	107.62%
Covered employee payroll	$ 23,367,767	$ 22,218,355	$ 20,084,266	$ 18,167,831
Net pension liability (asset) as a percentage of covered payroll	-4.23%	4.11%	-11.23%	-7.58%

San Mateo Health Commission and San Mateo Community Health Authority (d.b.a. Health Plan of San Mateo)
Supplementary Schedule of Contributions

	2019	2018	2017	2016	2015
Actuarial determined contribution	$ 1,613,011	$ 1,396,529	$ 1,313,247	$ 1,164,095	$ 1,437,466
Contributions related to actuarially determined contribution	$ 1,613,011	$ 1,396,529	$ 1,313,247	$ 1,164,095	$ 1,459,445
Contribution deficiency (excess)	$ -	$ -	$ -	$ -	$ (21,979)
Covered payroll	$ 23,367,767	$ 22,218,355	$ 20,084,266	$ 18,167,831	$ 16,535,874
Contribution as % of covered payroll	6.90%	6.29%	6.54%	6.41%	8.83%
Contributions made during the fiscal year	$ 1,613,011	$ 1,396,529	$ 1,313,247	$ 1,164,095	$ 1,459,445

	2014	2013	2012	2011	2010
Actuarial determined contribution	$ 1,367,854	$ 1,321,835	$ 1,382,058	$ 1,192,417	$ 1,148,871
Contributions related to actuarially determined contribution	$ 1,333,194	$ 1,361,858	$ 1,440,249	$ 1,156,479	$ 1,124,362
Contribution deficiency (excess)	$ 34,660	$ (40,023)	$ (58,191)	$ 35,938	$ 24,509
Covered payroll	$ 15,989,836	$ 14,768,660	$ 13,203,459	$ 12,680,263	$ 11,485,618
Contribution as % of covered payroll	8.34%	9.22%	10.91%	9.12%	9.79%
Contributions made during the fiscal year	$ 1,333,194	$ 1,361,858	$ 1,440,249	$ 1,156,479	$ 1,124,362

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

Years ended December 31	Rate of return
2019	20.06%
2018	-5.05%
2017	15.17%
2016	7.68%
2015	-0.28%


MOSSADAMS

DRAFT

AGENDA ITEM: 4.2

DATE: May 13, 2020

FINANCE/EXECUTIVE COMMITTEE MEETING
Meeting Summary – February 24, 2020
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

Members present: Don Horsley, Bill Graham, Mike Callagy, Si France, M.D.

Staff present: Pat Curran, Chris Baughman, Trent Ehrgood, Ian Johansson, Katie-Elyse Turner, Francine Lester, Michelle Heryford

1.0 Call to Order – The meeting was called to order at 12:43 pm by Trent Ehrgood, HPSM CFO.

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

3.0 Approval of Meeting Summary – The meeting summary from the December 9, 2019 meeting was approved as presented. **M/S/P**

4.0 Preliminary Financial and Operational Report for the 12-month period ending December 31, 2019 – Mr. Ehrgood reviewed the financial report. The 2019 year closed with a surplus of close to $8.5M. This version includes adjustments made during the audit, so this should tie to the final audited financials, which is almost complete, and will be presented to the Committee next month.

Mr. Ehrgood noted a change in accounting method, HPSM will no longer gross-up revenue and healthcare costs for hospital directed payments. The guiding principles that led to this decision were around the element of risk, and HPSM's role as principal versus agent. These principals guide whether HPSM uses a gross versus net method for recording transactions like directed payments. The conclusion was that The Plan should use the net method for the hospital directed payments and keep the gross method for Prop56 and GEMT. In order to eliminate the hospital related gross-up transactions made in previous months, HPSM reversed the accumulated total of about $83M in December. This is what is causing the negative amounts in December revenue and healthcare cost. The effect to the bottom line is zero. Going forward, only the directed payments where the health plan has risk (like Prop56 and GEMT) will be

recorded in this gross-up method. About $12M in directed payment (for Prop56 and GEMT) remains in year-to-date revenue and healthcare cost for the year. This change in accounting methodology has been validated by HPSM's auditors.

The Plan also made several other true-up adjustments in December. The minutes from the December Committee meeting (for Oct close), indicated that there were several adjustments pending, that would be recorded by year-end. It turns out most of them were somewhat offsetting. Below are a few of the larger adjustments.

1) Return of $2M in Medi-Cal revenue due to date-of-death audit performed by DHCS (unfavorable adj.).
2) Reversal of an old $2M liability that never materialized (favorable adj.)
3) Recorded around $6M in remaining 2018 CMC withhold revenue (favorable adj.)
4) Reversed around $6M in overstated Whole Child Model revenue due to eligibility flag error (unfavorable adj.)
5) Shift in about $8M revenue from Medi-Cal line-of-business to the CMC line-of-business, which is due to a change in the DHCS rate setting method for dual members (between CMC and non-CMC duals).

Mr. Ehrgood noted a change to the Tangible Net Equity (TNE) graph. HPSM removed the $38M contingent liability from the Stabilization Reserve, as this liability is no longer high risk. This made the Uncommitted Equity larger. This change to the TNE graph is only for illustrative purposes and is not an adjustment to the books or to total reserve levels. Mr. Ehrgood briefly went over the numbers by line-of-business (LOB). With Medi-Cal, he reminded the group that the non-CMC duals are still comingled here but will be separated into a unique LOB soon. The big adjustment with Medi-Cal was the shift of about $8M from this LOB to CMC for duals, causing a big drop in Medi-Cal YTD revenue. On the Medi-Cal Expansion LOB, HPSM continues to see the effect of lower rates that went into effect July 1st of this year and is the main cause for lower than budget revenue.

The Whole Child Model (WCM) LOB, is where the $6M in reduced revenue was recorded in December due to the eligibility issue that erroneously flagged members as WCM. HPSM, so far, has only adjusted the overstated revenue, but still left the members in this LOB for now. The Plan will need more time to properly ID the members before getting them in the right bucket. They will likely shift to either the MC or MCE line-of-

business. For CMC, there were two large favorable adjustments. The first was the $8M shift in revenue from Medi-Cal, due to the revised rate setting method performed by DHCS for duals. The second adjustment was picking up the remaining $6M in withhold revenue for 2018.

Commissioner France asked if declined enrollment is an aftershock of the ACA mandate roll back? Mr. Ehrgood replied that it is likely attributed to the economy; healthy employable people are leaving the area or getting jobs. The financial report was approved as presented. **M/S/P**

5.0 Report from the Compliance Department – Mr. Johansson went over the Compliance Report. There was agency action from the Department of Health Care Services (DHCS). In January of 2019 HPSM failed to comply with DHCS provider network data reporting. Specifically, they did not include required information in 274 files submissions. There was a penalty of $80,000 suggested, however, the penalty was stayed upon appeal. They are awaiting final disposition of the corrective action plan (CAP). The second case involved agency action from Centers of Medicare and Medicaid Services (CMS). In March of 2018 there was non-compliance with Section 50.6 of Ch. 4 of the Managed Care Guide. HPSM members were eligible for $0 co-pays for Part D drugs by receiving Home and Community Based Services (HCBS). HPSM began working with CMS who later released a nationwide memo with corrections by DHCS of dual eligible beneficiaries state-wide going back to 2012. HPSM employees Carolyn Thon and Charlene Barairo identified this problem that affected not only HPSM members but 30,000 Medi-Cal members statewide. HPSM reimbursed the copay, which should have been paid by the low-income subsidy. The last case was self-disclosure by the Compliance Department to CMS. HPSM failed to meet the 95% compliance threshold for verbal notification of decisions for expedited organization determinations made in 2019. HPSM met that 87% of the time. They took the following corrective actions:

- Self-disclosed to CMS on January 13, 2020
- Retraining of staff involved in processing decisions
- Change to mailing process to expedite delivery of letters
- Planning for use of technology to automate verbal notification to members.

The compliance report was approved as presented. **M/S/P**

6.0 San Mateo Health Commission Agenda – The SMHC agenda was approved as presented. **M/S/P**

7.0 Other Business – There was no other business.

8.0 Adjournment – The meeting was adjourned at 1:33 pm by Supervisor Horsley. **M/S/P**

Respectfully submitted:

M. Heryford

M. Heryford
Assistant Clerk to the Commission

DRAFT

HEALTH PLAN OF SAN MATEO
CONSUMER ADVISORY COMMITTEE MEETING
Meeting Minutes
Thursday, March 5, 2020
801 Gateway Blvd. 1st Floor-Boardroom
South San Francisco, CA 94080

AGENDA ITEM: 4.3

DATE: May 13, 2020

Committee Members Present: Amira Elbeshbeshy, Ricky Fucilla, Angela Valdez, Mary Pappas, Judy Garcia.

Committee Members Absent: Ricky Kot, Cynthia Pascual, Hazel Carrillo

Staff Present: Maya Altman, Pat Curran, Gabrielle Ault-Riche, Karla Rosado-Torres, Dr. Richard Moore, Kiesha Williams, Charlene Barairo, Carolyn Thon, Megan Noe, Vicky Perez, Samareen Shami, Colleen Murphey, Kati Philips.

1.0 Call to Order/Introductions: The meeting was called to order at 12:01 pm by Ms. Elbeshbeshy and introductions were made.

2.0 Public Comment: There was no public comment.

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

4.0 Approval of Meeting Minutes for January 9, 2020: The meeting summary from the January 9, 2020 meeting was approved as presented. **M/S/P**

5.0 HPSM Operational Reports and Updates

5.0 2020 Meeting Dates: Ms. Ault-Riche presented the new meeting dates and times; she is proposing a 90-minute meeting on the last Thursday of the month at the current quarterly frequency. She noted the current meeting dates do not align with the completion dates of the reports, which means the information there is often several months old. She also informed the group of her efforts to increase membership in the committee with members from the community. More members will mean more voices and the current one-hour meeting time is already a challenge to meet. She would like to start the new schedule on April 23rd. Ms. Pappas replied that she would not be able to participate if the Committee goes ahead with the proposed schedule. Ms. Ault-Riche inquired if the third Thursday would work, Ms. Pappas responded affirmatively. Ms.

Ault-Riche will meet with data providers to see if that is feasible for the reports necessary. The committee was fine with the proposed 90-minute time frame. Meetings will now go from Noon-1:30 pm. The committee will decide via email on the newly proposed dates, once they are determined.

5.1 **CEO Update:** Ms. Altman announced that Dr. Moore would be updating the group in depth on COVID19 and the Coronavirus during his report. She remarked that HPSM is taking the lead set by the County public Health Department. There has not been extensive messaging with Providers, and she noted there has not been many calls from Members at this point as well. HPSM will continue to take measures that make sense and follow county health protocols. Pharmacies are ensuring 90-day supplies of medications. HPSM is reviewing their Business Continuity Plan (BCP) to see if more telecommuting is necessary and to determine critical staffing levels. Ms. Altman also provided an update on Seton Hospital. There was a board meeting on March 4th, hundreds of Seton workers were in attendance. There is a rumor that there will be a closure next week. There is an immediate action plan in place with the County. She noted that legally, Verity cannot just abandon patients. HPSM will continue to monitor the situation.

Ms. Altman also announced that Governor Newson has named a new Director to the Department of Health Care Services (DHCS), Dr. Bradley Gilbert; is the former Public Health officer in San Mateo, and the Former CEO of Inland Empire Health Plan (IEHP), HPSM's counterpart in Riverside County. She also spoke of State proposals to reform Medi-Cal, they are still being finalized but Ms. Altman said they are very excited about some of the proposals, especially those that will allow HPSM to continue the Community Care Setting and Recuperative Placement programs they have been so successful with.

Ms. Pappas asked if there is a plan for Seton patients, she wondered if HPSM can arrange to have them seen at hospitals in San Francisco County, should Seton close. Ms. Altman responded that it is not likely, as there are not enough beds. Ms. Altman noted there may be more interest in keeping Seton Coastside open, even more than the main campus in Daly City. She noted that if Coastside closes, it would be difficult to find another provider in that area.

5.2 **CMO Update:** Dr. Moore presented to the committee on the Coronavirus and COVID-19. He stated the virus is very common and educated the group that the Coronavirus

is a type of SARS. He displayed the differences between COVID 19 and the flu, pointing out the respiratory issues involved with this virus. Those with compromised immune systems are highly susceptible. He provided resource pages from the San Mateo County health site and The Centers for Disease Control Centers and Prevention (CDC) which are also on the HPSM website. Many HPSM Providers are utilizing the website as well. He went over tips and preventative measures that individuals can use to protect themselves. Ms. Garcia inquired on masks and who should use them. Dr. Moore noted the CDC does not recommend the public at large using them. He noted the spread is inevitable, but HPSM is being pro-active. He provided notes and tips on hand washing. Ms. Pappas suggests that folks stay away from nursing homes. Dr. Moore agreed noting the recent spate of nursing home deaths in Washington State. Ms. Barairo said there is a call center run by the County for those with questions about COVID-19. Ms. Elbeshbeshy said testing is covered Medi-Cal and Medicare. She asked if there is a plan for outreach to members to make them aware of this, noting that many may be worried about the price. Ms. Altman noted the cost isn't really the factor, because there is not a sufficient number of tests available. She would like to do outreach, but test kits are just not available to the majority of the population right now. Dr. Moore ended by noting that the CAHPS survey will be out in March. There will be a tip sheet with FAQ's.

5.3 **Quality Improvement:** Ms. Munoz did a presentation about the Population Needs Assessment (PNA) Annual report. This is a new requirement by DHCS for all managed care plans. She went over the report requirements as well as the timeline and phases. They are in the first phase, data gathering, the report is due on June 30, 2020. The final report will come to the CAC in September. She also provided an update on the Culturally and Linguistically Appropriate Services' (CLAS) program. This year's subject is Mental Health awareness. Ms. Shami updated the group on the County Needs Assessment. She reported that they highlighted 5 areas of focus they would like to work on for the next 3-5 years:

1. Addressing asthma needs for the Pediatric population.
2. Increased lead screening
3. Prevention and management of gestational diabetes.
4. Adolescent mental health and alcohol and other drug use.
5. Maternal mental health and mood disorders.

The County will do an improvement charter to map out problems in each area. She noted that all five points are in line with many of HPSM's goals. She spoke of the need to understand the population, and to find where disparities lie. They will collect data and share that with the County. HPSM will use the results to develop a plan with strategies for each one of the focus areas. She also noted the CAHPS survey should be coming around in May, they will develop a sheet of FAQ's to help with that effort.

5.4 Grievance and Appeals: Ms. Rosado-Torres reviewed the G&A Report, she started by informing the group that the newly proposed meeting dates mean they will gather data differently; noting that as the meetings change the reports may too. She went over the report for Q4 of 2019. They met their goal on the overall rate of complaints, she reviewed the rate of overturned appeals and noted that grievances for prescription drugs and DME went down. The department has added a new section to the report related to the Complaint Tracking Module (CTM), it tracks complaints filed by CareAdvantage-CMC members that are filed directly with Medicare. Since the inception of CareAdvantage CMC, HPSM has received very few CTM complaints. There is also a new section devoted to Medi-Cal regulatory cases or cases that go thru the DMHC Consumer Complaint process or the State Fair Hearing process. There were a total of 17 cases for Q4 of 2019, she provided a breakdown of the results. HPSM is still awaiting a final determination on two cases. She went over the Appeals, how they are categorized and the outcomes. Overturned appeals; grievances have the same trend as the CareAdvantage line they have decreased. Quality of Care and NON-BHRS cases have decreased as well. She advised group of the addition of the Kaiser Whole Child Model section. A total of 59 members requested to change their PCP in Q4 of 2019. Ms. Ault-Riche took this time to introduce Georgina Wilson-Gonzalez as an author of these extensive reports.

5.5 Provider Services: Ms. Murphey provided an update from the Provider Services department starting with ABA services: HPSM continues weekly and daily monitoring with Magellan, their delegate who provides these services. Some recent improvement steps they have been working with Magellan on include the addition of new providers to their network, and additional monitoring. Magellan is going to track the utilization of authorized service hours per provider. She also reported on pediatric speech therapy, HPSM sent out notifications to referring providers and therapists in February asking them to begin sending referrals for summer services to HPSM, so that they can help coordinate care and plan for the expected increase in needed services during months that school services may not be available. This communication campaign also included posting the notice online on the HPSM website. She reported a majority of

Skilled Nursing Facilities are visiting HPSM on Friday as part of a larger learning collaborative. They will discuss concerns around risks in nursing homes.

Ms. Murphey also provided a brief update on Seton. HPSM continues to monitor Seton and has a meeting planned with in-network SNF and Hospital staff scheduled for 3/6/2020 in which they will discuss:

- COVID-19 strategies for facilities. Concern is particularly high about COVID-19 in Skilled Nursing Facilities.
- Best practices for discharge planning and care transitions between hospitals and SNF/LTC facilities
- Discuss the plan for Seton patient transitions, should these be needed.

There is no closure currently planned for Seton. HPSM will be discussing the member transition scenario as a hypothetical only for the sake of preparedness.

Ms. Murphey also provided an update on Behavioral health regarding de-delegation. To better support the County, HPSM and BHRS jointly decided to work together to transition some of the administrative functions of managing the behavioral health benefit to HPSM, to free up BHRS capacity to focus on their strength as a provider. HPSM will be hosting provider forums in the coming months to answer questions about what this means for them, and to begin the process of gradually transitioning administrative functions such as contracting, credentialing and claims payment to HPSM. The joint goal is for this process to be as non-disruptive to providers as possible.

5.6 **Member Services:** Ms. Williams reviewed the Member Services and Care Advantage report. The Medi-Cal line of business continues to see a decrease, there was an average decrease of 2.6% overall for this line in 2019. They did a recent Memorandum of Understanding (MOU) with the Health Coverage Unit (HCU) in an effort to retain enrollments in Medi-Cal. Call center metrics were met a majority of the time for Q4 of 2019. HPSM provides customer support via email communications. Regulations require plans to respond to member email inquiries within one business day of submission. Goals were met for email inquiries from HPSM members. Ms. Williams noted that the last Member Services report of 2019 included information on the Kaiser Call Center, however Kaiser has since retired their Call Center reports. Ms. Ault-Riche remarked that they are in the process of getting that data back. Ms. Barairo reviewed the CareAdvantage Enrollment and Call Center report. Enrollment continues to

decrease, the count for the last quarter of 2019 stood at 8,813. She went over current enrollments and dis-enrollment numbers, noting that the majority of dis-enrollments are due to death. She credited their work with HPSM's Marketing and Communications department for achieving the monthly enrollment target. She noted that the recent MOU with the HCU unit, noting they will continue to work with them and Legal Aid to HPSM members retain their Medi-Cal. The Call Center average speed to answer for Q4 was 14 seconds. She went over the average call times for 2019. All goals for Q4 were met in this area, including the abandonment rate. Analysis for 2019 shows the department exceeded all goals and requirements even while they were short-staffed. They are currently looking for Chinese and Spanish speaking Navigators. They have also hired a Customer Support Coordinator, this position floats between the Customer Support, G&A and CareAdvantage departments to help and support where needed.

6.0 New Business: There was no new business.

7.0 Adjournment: The meeting was adjourned at 12:51 pm by Ms. Elbeshbeshy. **M/S/P**

Respectfully submitted:

M. Heryford

M. Heryford
Assistant Clerk to the Commission

AGENDA ITEM: 4.4

DATE: May 13, 2020

PHARMACY & THERAPEUTICS (P&T) COMMITTEE
Meeting Summary
Wednesday, Nov 13, 2019, 7:00-9:00 am
SMMC – Alcove Room
222 West 39th Avenue, 2nd floor
San Mateo, CA 94403

Members Present: Barbara Liang, George Pon, Jack Tayan, Jonathan Han, Lena Osher, and Niloofar Zabihi.

Pharmacy Intern: Clark Ma

Members Absent: Jaime Chavarria, Rukhsana Siddiqui, and Varsha Gadgil

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

Staff Absent: Karla Cruz-McKernan

1. Call to Order

2. Approval of Meeting Minutes

Committee unanimously approved the meeting minutes for Sept 11, 2019 with no objections.

3. Approval of Agenda

The proposed agenda for the meeting was approved as presented.

4. Old Business

None

5. New Business

5.1 Pharmacy Department Policy Updates

Matt presented an update on the following policies:

- Utilization Management Exception Policy: Updated to address age limit exceptions, with approval based on whether use for the patient's age is supported by the FDA or other acceptable sources as outlined by the Plan.

- Non-Formulary Exceptions Policy: Updated to require that a member trial and fail on maximally tolerated doses of a generic prior to the approval of a multisource brand name product.
- Nutritional Supplements for Medical Conditions: Updated to require the use of the World Health Organization's growth chart as a benchmark to assess the need for nutritional supplementation in premature infants, replacing the Fenton growth chart, which was too narrow in scope.

George asked what the difference was between the WHO organization growth chart and the Fenton growth chart. Andrew explained that the Fenton chart is geared toward premature infants whereas the WHO organization growth chart is used for full term infants. However, one of the major limitations of the Fenton growth chart is that it is only accurate up to a certain point within the first few months of the infant's life. Andrew followed by saying that the recommendation was made based on input from CCS nutritionists.

5.2 New Drugs to Market

5.2.1 New Protected Drug Class

Matt presented the new protected drug class drugs which included Asparlas, Drizalma, and Nayzilam. The recommendation was made to add all the new drugs to the CMC formulary. For the MC and HW formularies, the recommendation was made to maintain non-formulary status due to their absence on the Contract Drug List.

Dr. Osher asked if Nayzilam is categorized as a control substance like Diazepam. Matt responded by saying that it was.

5.2.2 New Non-Protected Drug Class

Matt presented on the new non-protected class drugs, which included Aklief, Beovu, Duaklir Pressair, Govke Hyopen, Katerzia, Nourianz, Rinvoq ER, Rybelsus, Sylynd Tab, Tosymra Nasal Spray, Vyndadaz, Vyndamax, Wakix, and Zelnorm. The recommendation was made to add Gvoke to the CMC, MC, and HW formularies to provide a more convenient way to administer glucagon. Due to anticipated high demand, Rybelsus recommended to be added to the MC and HW formularies with a step requirement (Step 1: SGLT2 inhibitor). However, it was recommended to be maintained non-formulary for CMC due to rebate implications. Slynd, a new oral progestin-only contraceptive, added to the MC and HW formularies but not to the CMC formulary.

George asked whether it was appropriate to remove injectable glucagon now that the Gvoke is on the formulary. Andrew recommended to keep the generic injectable glucagon

on the formulary due to existing utilization and lack of familiarity for Gvoke among the prescriber and member community.

5.3 New FDA-Approved Indications

Matt presented the New FDA approved indications for existing drugs on the market. The coverage criteria for Nucala updated to allow for use in those 6 years of age and older, instead of 12 years of age and older.

5.4 CMS Required Formulary Changes

Prior authorization and step criteria for various drugs on the CMC formulary updated in response to CMS formulary concerns.

5.5 Formulary Considerations

Jasmine presented miscellaneous formulary changes. These changes were recommended in response to issues identified during the coverage determination and prior authorization process along with feedback derived from pharmacy staff and prescribers. The Plan recommended formulary and/or utilization management changes to the following drugs: Amitiza, Banzel, ezetimibe, fluphenazine, simvastatin, cephalexin, itraconazole, hydroxyprogesterone multidose vial, Januvia, ketoconazole/Ketodan, Onglyza, and Vimpat.

5.6 Drug Class Reviews

5.6.1 Phosphate Binders for CKD

Andrew gave a brief overview on chronic kidney disease (CKD) and the current treatment options for hyperphosphatemia. The recommendation was made to maintain aluminum hydroxide and Phosylra Solution non-formulary on all lines of business due to safety and high cost respectively. Lanthanum carbonate recommended to be added to the MC and HW formularies to provide a cost-effective formulary noncalcium-containing phosphate binder in addition to sevelamer. Due to high utilization, Auryxia and Velphoro was recommended to be added to the CMC formulary with a prior authorization, requiring that patients try and fail on two more cost-effective noncalcium-containing phosphate binders first. For MC and HW, Auryxia and Velphoro maintained non-formulary due to high cost, with approval contingent upon the same criteria established under the CMC line of business.

Matt raised the question as to whether there should be language in the coverage criteria for Auryxia and Velphoro to specify that a member must try and fail on maximally tolerated doses. Ming and Jasmine responded by saying that the proposed criteria was preferable since it would allow the pharmacists more discretion in determining what is considered adequate.

5.6.2 Inflammatory Bowel Disease

Biyan gave a brief background on inflammatory bowel disease (IBD), which includes Crohn's disease and ulcerative colitis. Treatment options and therapeutic approaches were reviewed. The Plan recommended a prior authorization requirement for budesonide EC capsules for the CMC formulary due to high cost and the availability of cost-effective formulary alternatives. In addition, preference was given to the generic Lialda, generic Apriso ER, and generic Delzicol due to favorable cost and comparable efficacy to other high cost formulations of mesalamine. Lastly, the prior authorization criteria for Stelara updated to account for ulcerative colitis, a new indication.

5.6.3 P2Y12 Inhibitors

Clark presented on P2Y12 Inhibitors. Based on guideline recommendations and cost, the recommendation was made to add prasugrel to the CMC, MC, and HW formularies. In addition, Brilinta was recommended to be added to the MC and HW formularies with a step requirement (Step 1: prasugrel or clopidogrel), mirroring the CMC line of business.

A discussion ensued regarding Brilinta and the proposed step requirement, which now includes prasugrel. Ming felt that a step therapy requirement was a good balance between allowing access to the drug while encouraging use of more cost-effective options such as prasugrel and clopidogrel in accordance to guideline recommendations.

George asked why there was such high utilization for clopidogrel when studies have shown it to be less effective compared to prasugrel and Brilinta for patients with ACS and a stent. Jasmine responded by saying prescriber familiarity with the drug was a contributing factor since it was the first P2Y12 inhibitor on the market.

5.6.4 SGLT2 Inhibitors

Andrew presented on SGLT2 inhibitors. The recommendation was made to add the Steglatro to the MC and HW formularies due to favorable cost and to promote the use of SGLT2 inhibitors, due to their cardiovascular benefits. For the CMC line of business,

Steglatro was recommended to be maintained non-formulary due to low utilization and rebate implications.

5.7 Drug Monographs

5.7.1 Atovaquone Suspension

Clark reviewed atovaquone suspension, a quinone antiprotozoal agent used for the prevention and treatment of mild-to-moderate pneumocystis jirovecii pneumonia (PCP). The Plan recommended to add a prior authorization requirement for the CMC line of business to ensure patients have tried and failed on sulfamethoxazole-trimethoprim or dapsone whenever possible based on guideline recommendations and cost. For the MC and HW formularies, atovaquone suspension recommended to be removed from the formulary for similar reasons, to encourage use of sulfamethoxazole-trimethoprim or dapsone.

5.7.2 Envarsus XR

Biyan presented a drug review on Envarsus XR, an oral calcineurin inhibitor immunosuppressant. Clinical studies comparing Tacrolimus and Envarsus XR found no significant differences between the two agents. Due to the high number of requests, the Plan recommended adding to the CMC formulary in order to establish coverage criteria. For the MC and HW formularies, it was recommended to maintain the drug off the formulary with approval based on the criteria established under the CMC line of business.

Matt asked whether Envarsus XR should be approved under Medicare Part B or Part D for the CMC line of business. Andrew responded by saying that the drug could be approved under either and would be determined upon effectuation. Jasmine asked whether the Plan was obligated to approve of requests if the patient was initiated on therapy in the hospital. Ming responded by saying that based on the data available (which was outlined in the drug class review), there is no indication that switching patients from Envarsus XR to tacrolimus or vice versa would result in subtherapeutic levels.

5.7.3 Xofluza

Andrew presented on Xofluza, an oral drug taken for the treatment of influenza. Xofluza requires a one-time dose in contrast to oseltamivir which requires twice daily dosing over 5 days. The Plan recommended adding the Xofluza to formulary in order to provide

another treatment option for influenza and to remove barriers to access since the drug must be taken within 48 hours upon onset of symptoms in order to be effective.

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

6. Adjournment

Ming had discussed the status of the FFS pharmacy carve out and mentioned that plans are working with the State on how to approach and plan for a 2021 transition that minimizes disruption to patients and providers.

Ming also talked about other efforts happening at the state level that are upcoming such as California Advancing and Innovating Medi-Cal (CalAIM), which is a multi-year initiative by proposal by DHCS to improve the quality of life and health outcomes of the Medi-Cal population through various reforms.

The meeting adjourned at 9:00 am.

Next scheduled meeting: March 11, 2020 at San Mateo Medical Center.

PHARMACY & THERAPEUTICS (P&T) COMMITTEE
Meeting Summary
Wednesday, March 11, 2020 – 7:00am to 9:00am
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor, Boardroom
South San Francisco, CA 94080

Members Present: Gary Horne, George Pon, Jack Tayan, and Rukhsana Siddiqui

Via Telecom: Barbara Liang, Matthew Lee, and Jonathan Han

Members Absent: Jaime Chavarria, Lena Osher, Niloofar Zabihi, and Varsha Gadgil

Staff Present: Alexander Chen (pharmacy intern), Andrew Yau, Biyan Feng, Dr. Cynthia Cooper, Jasmine Le-Thi, Kelly Chang, Karla Cruz McKernan, Ming Shen, and Dr. Richard Moore

Staff Absent: None

1. **Call to Order**
   Andrew motioned call to order

2. **Approval of Meeting Minutes**
   Committee unanimously approved the meeting minutes from Nov 13, 2019 with no objections.

3. **Approval of Agenda**
   George motioned for approval and Gary seconded the motion.

4. **Old Business**
   None

5. **New Business**

5.1 New Drugs to Market

5.1.1 New Protected Drug Class

Matt presented 7 new drugs, including 6 new antineoplastics and 1 anticonvulsant. With the exception of the IV products, formulary addition was recommended to the CMC line of business. For the Medi-Cal and HealthWorx lines of business, formulary addition of Truxima and Zirabev was recommended *(biosimilars for Rituxan and Avastin respectively)* in lieu of their reference products.

5.1.2 New Non-Protected Drug Class Drugs

Matt presented an overview 15 new drugs recently approved. The recommendation was to add Jatenzo, Ubrelvy, and Ziextenzo to the CMC formulary. Jatenzo is an oral testosterone, Ubrelvy is a CGRP inhibitor for acute migraines, and Ziextenzo is a new biosimilar for Neupogen. For the Medi-Cal and HealthWorx formulary, only Ziextenzo was recommended to be added.

5.2 New FDA-Approved Indications

Matt gave an update on new FDA-approved indications for existing drugs on the market. The recommendation was made to update the Entresto coverage criteria due to new data demonstrating its superior efficacy over ACEi/ARB therapy in heart failure patients who have recently been hospitalized. Erleada coverage criteria was recommended to be updated due to a new indication for metastatic castration-sensitive prostate cancer, favoring abiraterone. Coverage criteria for Vascepa was established due to a new indication for the reduction of cardiovascular risk when added to maximally tolerated statin therapy. Lastly, the coverage criteria for Xeljanz XR recommended to be updated due to a new indication for the treatment of ulcerative colitis in those who have previously failed on TNF-alpha inhibitors.

5.3 CMS Required Formulary Changes

Matt presented updates to the prior authorization criteria for Auryxia and Repatha due to CMS concerns.

5.4 Authorized Generics

Andrew explained the differences between authorized generic drugs and traditional generic drugs. The recommendation was made to prefer the authorized generics, including albuterol HFA, insulin aspartate, and insulin lispro, whenever possible due to equal efficacy and lower cost. The only exception to the rule is Symbicort on the CMC formulary due to lower net cost for the branded product as a result of Part D rebates available.

Dr. Cooper asked whether physicians keep track of the proportion of generic drugs they prescribe versus brand. Andrew responded by saying that regardless of whether they do so or not, the pharmacies typically auto-substitute all brands for the generic when available due to favorable margins, something which is permitted under California law.

5.5 Reusable Insulin Pens

Andrew presented on reusable insulin pens. He noted that although there is not much utilization, the Plan does not have any on its formulary. Andrew added that the Plan currently covers some insulin cartridges and that it would make sense to also cover the reusable insulin pens that go with them. The recommendation was made to add the Autopen and Novopen to the formulary due to favorable cost relative to the other reusable insulin pens on the market.

Barbara asked why InPen was so expensive relative to the other pens and asked whether it has features that other pens lack. Andrew responded by saying that the InPen has Bluetooth capability allowing providers to track blood glucose. However, Andrew noted that most glucose testing meters also have this feature, including the Plan's preferred brand ForaCare.

5.6 Formulary Considerations

Jasmine presented various recommended formulary and coverage criteria changes in response to prior authorization volume, new clinical guideline recommendations, availability of newly launched generics, and feedback from providers.

George motioned for approval of all the formulary changes outlined in sections 5.1 to 5.6. Jack seconded the motion, with the Committee approving with no objections.

5.7 Drug Class Reviews

5.7.1 CFTR Modulators for Cystic Fibrosis

Andrew presented a drug class review on CFTR Modulators used for the treatment of Cystic Fibrosis. Based on clinical guideline recommendations, efficacy, and safety, it was recommended to prefer Trikafta over all other agents whenever possible due to superior efficacy compared to other agents despite having the highest net cost.

5.7.2 Osteoporosis

Andrew presented a drug class review on osteoporosis. The recommendation was made to prefer Prolia as the injectable agent of choice based on guideline recommendations and favorable cost. This is followed by Tymlos due to favorable cost and comparable efficacy and safety relative to Forteo.

5.7.3 PCSK9 Inhibitors

Biyan presented a drug class review on PCSK9 inhibitors. The recommendation was made to prefer Repatha on the CMC formulary while maintaining both Repatha and Praluent non-formulary on the Medi-Cal and HealthWorx formularies. This recommendation was based on a number of factors, such as overall net cost (after accounting for rebates), clinical efficacy, safety, and the availability of other formulary alternatives such as statins and ezetimibe which guidelines recommendations prefer.

5.7.4 Parkinson's |Key Focus: Nourianz

Biyan presented a drug class review on Parkinson's disease. The recommendation was made to prefer selegiline and rasagiline among the MAO-B inhibitors. In addition, Osmolex was recommended to be added to the formulary to shift utilization away from Gocovri ER.

5.7.5 Alzheimer's

Biyan presented a drug class review on Alzheimer's disease. The recommendation was made to require a step for rivastigmine patches, with members required to have tried and failed on the rivastigmine capsules first. Galantamine ER and memantine XR recommended to be added to the formulary due to favorable cost and favorable once daily dosing.

Dr. Moore had concerns about the recommendation to add a step requirement for the rivastigmine patches. Based on his experience, many patients have problems tolerating oral formulations of cholinesterase inhibitors due to the high rate of nausea and diarrhea associated with these drugs. It would be difficult to convince a member and/or his family members to switch to rivastigmine capsules after having tried and failed on donepezil for example. Andrew suggested changing the step requirement to allow payment of rivastigmine patches once a member has tried and failed on any one formulary oral cholinesterase instead of the rivastigmine capsules in particular. Dr. Moore agreed that this was appropriate.

5.7.6 OTC Lubricant Ophthalmic Products

Andrew presented on over-the-counter lubricant eye products, noting that there were none on the formulary for CMC or Medi-Cal. The recommendation was made to add various lubricant ophthalmic products to formulary to provide cost-effective options for

the treatment of dry eyes. This is consistent with guideline recommendations which cite lubricant eye drops as first-line treatment options when pharmacologic therapy is required. Andrew ended by saying that these changes would not apply to the HealthWorx formulary since over-the-counter drugs are generally excluded under that line of business.

5.8 Drug Monographs

5.8.1 Caplyta | BHRS

Rukhsana presented on Caplyta, a new atypical antipsychotic for the treatment of schizophrenia in adults. It is available in a capsule formulation and dosed once daily. Rukhsana noted that Caplyta has a lower incidence of adverse effects compared to other oral antipsychotics based on the package labeling.

Barbara recommendation to add the drug to the CMC formulary since it is a protected class drug and therefore requires mandatory formulary placement. For the Medi-Cal and HealthWorx formulary, she recommended maintaining the Caplyta non-formulary due to high cost relative to other agents available.

George asked about the side effects for Caplyta, such as hypotension or EPS. Rukhsana responded by saying that the drug may cause EPS similar to other atypical antipsychotics on the market, but at a much lower rate. This is probably due to its low affinity for dopamine relative to the other agents.

5.8.2 Secuado|BHRS

Secuado is a transdermal formulation of asenapine for the treatment of adults with schizophrenia. This is the first antipsychotic available in a patch formulation in the United States. Secuada will be marketed as an easier to administer product compared to the oral agents on the market. Rukhsana said having a patch may not necessarily address compliance issues if that was the intent of this product since patients would still need to remember to reapply a new patch once daily. She added that long-acting injectable products would probably be more effective in that regard. Rukhsana ended by recommending that the drug be added to the CMC formulary due to regulatory requirements surrounding the formulary placement of protected class drugs while maintaining it non-formulary on the Medi-Cal and HealthWorx formularies.

Jack asked about the pricing for the new product and Barbara responded by saying that it should be similar to the sublingual formulation.

Gary motioned for the approval of all of the formulary changes recommended during the drug class reviews and monographs. George seconded the motion with the Committee unanimously approving without objections.

6. Other Business/Announcements

Ming informed the Committee that Dr. Bradley Gilbert was recently appointing as the head of the Department of Health Care Services (DHCS). Ming added that Dr. Gilbert experience makes him uniquely qualified to head DHCS as a former CEO and CMO of IEHP. Dr. Gilbert is well suited to understand the challenges, needs, and capabilities of managed care plans.

Ming also discussed how the Plan is preparing for challenges surrounding the impacts of Covid-19. One of the changes that is being instituted is permitting members to get their medications

filled earlier so that they can have enough supply to avoid leaving their home. This is accomplished by lowering the threshold for refills from 75% to 50%, with the percent indicative of how much a member's previous supply has been exhausted *(based on the days supply submitted by the pharmacy on the previous fill).* In addition, those who need early refills can also have their pharmacy call the Plan's pbm to request for an override. The pharmacy department is also preparing by having the necessary infrastructure ready and available to enable employees to work from home. Ming ended by saying that HPSM is continually monitoring for developments surrounding Covid-19 and will make all necessary adjustments to ensure member access.

7. Adjournment

The meeting adjourned at 9:00 am.

Next scheduled meeting: May 13, 2020 at San Mateo Medical Center unless otherwise specified due to the Covid-19.

MEMORANDUM

AGENDA ITEM: 4.5

DATE: May 13, 2020

DATE: May 4, 2020

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

Katie-Elyse Turner, Medicare Risk Adjustment & Interim Duals Demo Director

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

Recommendation

Ratify the Chief Executive Officer's execution of an amendment to the agreement with Independent Living Systems (ILS) for a revised total amount not to exceed $6,800,000. The amendment adds $471,200 to the existing agreement and a new statement of work for member outreach and needs assessments related to the COVID-19 pandemic. The term of the agreement remains October 1, 2017 through September 30, 2020.

Background

HPSM contracts with ILS to conduct Health Risk Assessments (HRAs) and Individualized Care Plans (ICPs) for approximately 8,500 CareAdvantage Cal MediConnect (CA CMC) and 8,000 Medi-Cal Seniors and Persons with Disabilities (MC SPD) members. The HRA is a survey used to identify and stratify member needs, facilitate program referrals, and inform the member's ICP. These activities are conducted when members enroll in HPSM and annually thereafter and are primarily telephonic.

In responding to the COVID-19 pandemic, staff recognized that proactive outreach to our most vulnerable members, primarily those enrolled in CA CMC or identified as MC SPD, should be a top organizational priority. As ILS runs a number of other case management programs in addition to their work for HPSM, they had developed a COVID-19 "mini assessment" to identify potential member needs (e.g., food access, medication availability) in this unique situation.

ILS made this assessment process available to HPSM and agreed to both integrate the mini assessment into existing HRA-ICP work for members currently in those queues, as well as conduct ad hoc outreach to all members not currently in the HRA-ICP queue for potential needs identification and resource connection. All assessment findings and referrals are communicated back to HPSM for additional follow-up by the Care and Transitions Coordination team, as needed.

Discussion

In February 2017, HPSM issued a Request for Proposals (RFP) for a vendor to provide all HRA and ICP services. ILS was selected based on their proposal content, health plan experience, flexibility in systems, and overall cost. The agreement with ILS for HRA-ICP services became effective October 1, 2017 and those activities are ongoing.

Given ILS' continued commitment to supporting outreach and HRA-ICP case management activities for HPSM's most complex members, their demonstrated strength in telephonically assessing members and making program referrals, and their swift action to develop and implement a COVID-19 member needs assessment, staff recommended that HPSM request the ILS team's assistance with member outreach and assessment activities at this time.

Looking ahead, staff anticipates a continued partnership with ILS for HRA-ICP services beyond the term of the current agreement, which is set to expire on September 30, 2020. Staff will provide an update to the Commission later this year for review.

Fiscal Impact

The existing agreement with ILS for the term of October 1, 2017 through September 30, 2020 was approved in July 2017 with a total amount not to exceed $6,328,800. This amendment adds $471,200 for ILS to complete COVID-19 specific outreach and assessment work, bringing the revised total contract amount not to exceed to $6,800,000. No changes are made to the term.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF RATIFICATION OF AMENDMENT TO AGREEMENT WITH INDEPENDENT LIVING SYSTEMS (ILS)

RESOLUTION 2020 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission is contracted with Independent Living Systems (ILS) to provide Health Risk Assessment (HRAs) and Individualized Care Plan (ICPs) services for its Cal MediConnect and Medi-Cal Seniors and Persons with Disabilities members;
B. ILS has demonstrated effective telephonic case management capabilities and developed a COVID-19 specific assessment to identify potential and unmet member needs;
C. Proactive member outreach and connection with community and health plan resources is a critical activity during this national pandemic.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission ratifies the Chief Executive Officer's execution of the amendment to the agreement with Independent Living Systems as described in the attached memo;
2. The term of the Independent Living Systems agreement remains as October 1, 2017 through September 30, 2020 with a revised total not to exceed amount of $6,800,000.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of May, 2020 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Ligia Andrade Zuniga, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

MEMORANDUM

AGENDA ITEM: 4.6

DATE: May 13, 2020

DATE: May 13, 2020

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: Amendment to Agreement with County of San Mateo dba San Mateo County Health for Rate Range Intergovernmental Transfer (IGT) Funding for State FY 2018-2019.

Recommendation

Approve an amendment to agreement with San Mateo County Health System to provide additional funding related to IGTs for State Fiscal Years 2018-2019.

Background and Discussion

Federal Medicaid law allows local public entities such as counties to transfer permissible public funds to the State Medicaid agency (the Department of Health Care Services) to be used as the nonfederal share of Medicaid expenditures, which are then eligible for federal matching funds. San Mateo County has used this mechanism to increase funding for San Mateo Medical Center (SMMC) and the San Mateo County Health System for many years. County funds transferred to the State have funded the nonfederal share of Medi-Cal managed care capitation payment increases paid by the State to HPSM. The federal Medicaid program matches these funds and the entire amount is paid to HPSM through increased Medi-Cal capitation. HPSM has then paid the entire amount to SMMC or the Health System.

Since 2005, when San Mateo County and HPSM began implementing IGTs, the Commission has approved agreements with San Mateo Medical Center (SMMC) or the Health System to allow increased reimbursement to the hospital and the Health System.

Starting in 2017, the supplemental IGT provides for additional funding related to the Medi-Cal Managed Care Rate Ranges. The available IGT amount is the difference between the Medi-Cal managed care plan's contracted capitation rates and the top of the plan's actuarially sound rate range, as determined by the Department of Health Care Services.

This agreement provides for the payment to the County Health System of the total amount of the increased capitation due to the rate range IGT. In return, the County Health System agrees to remain a participating provider in the Plan, maintain current emergency room licensure status, maintain current surgery suites, and maintain the provision of mental health and substance use services and community-based services.

Fiscal Impact

Since this is a pass through arrangement, there is no fiscal impact to HPSM. The term of the agreement is July 1, 2015 through December 31, 2022.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF AMENDMENT TO AGREEMENT WITH SAN MATEO COUNTY HEALTH SYSTEM RELATED TO MEDI-CAL MANAGED CARE RATE RANGES FOR THE SFY 2018-2019 INTERGOVERNMENTAL TRANSFER FUNDING

RESOLUTION 2020 -

RECITAL: WHEREAS,

A. Since 2005, the San Mateo Health Commission has approved participation in Intergovernmental Transfer (IGT) Funding with the federal government of matching funds paid to HPSM in order to increase payment to the San Mateo Medical Center (SMMC) or the San Mateo County Health System;

B. This amendment related to the Base Rate IGT for SFY 2018-2019 will make provision for the payment to the County Health System of the total amount of the increased capitation due to the Medi-Cal Managed Care Rate Ranges IGT.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. Authorize the Chief Executive Officer to execute an amendment to the agreement with San Mateo County Health System for additional funding related to the Medi-Cal Managed Care Rate Ranges IGT for State Fiscal Years 2018-2019.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of May, 2020 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Ligia Andrade Zuniga, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

MEMORANDUM

AGENDA ITEM: 4.7

DATE: May 13, 2020

DATE: May 5, 2020

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer
Colleen Murphey, Chief Network and Strategy Officer

RE: Approval of Amendment to Agreement with Regents of University of California

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Recommendation

Approve an amendment to the agreement with Regents of University of California for the services of Clarissa Kripke, M.D., and her colleagues at UCSF, who provide services to HPSM members with developmental disabilities (DD). This amendment extends the agreement one year through June 30, 2021, increases the annual agreement by $22,656, to $353,844 for this additional one-year term, and adds an additional adult residential facility to the scope of Dr. Kripke's practice.

Background

Beginning in 2005, as part of the sequential closure of several State operated Developmental Centers for consumers with developmental disabilities, an increasing number of DD clients were placed in community facilities in San Mateo County. This deinstitutionalization effort culminated in 2008 with the closure of Agnews Developmental Center in San Jose but has continued. HPSM is responsible for ensuring coordination of medical services for HPSM DD clients who often need enhanced or specialized services. The Plan works closely with Golden Gate Regional Center (GGRC) to ensure medical services are coordinated with the social services and support provided by the Regional Center, including but not limited to those adult residential facilities and DD group homes that are part of GGRC's system of medical and supportive services.

Discussion

Dr. Kripke is a licensed Family Practitioner who also serves as the Director of the Office of Developmental Primary Care in the Department of Family and Community Medicine at UCSF. As such she is an expert in the provision of care for DD consumers. HPSM has contracted with UCSF for Dr. Kripke's services since 2007, and she has provided consultative patient care services for DD clients in various group homes throughout San Mateo County. Dr. Kripke also provides ongoing primary care services at the group homes, and coordination of the unique needs of the DD clients in conjunction with Golden Gate Regional Center, DD group home administrators, HPSM's Care Coordination Unit, and the consumers' families. By addressing the specialized needs of these clients with comprehensive case management and primary care services, HPSM has been able to

improve quality of care and reduce inappropriate hospital and emergency room utilization for HPSM DD clients. Dr. Kripke's services include frequent direct clinical services, with on call services 24/7. Additionally, Dr. Kripke has expanded her scope of care to include an additional adult residential facility resulting in an increase in the number of clients Dr. Kripke and her colleagues serve. This agreement has been amended to account for the increase in the cost of Dr. Kripke's practice given the increase in the number of clients her practice services.

Fiscal Impact

This amendment extends the current agreement one year, through June 30, 2021, increases the agreement amount by $22,656, to $353,844 – a 6.84% increase compared to the amount spent in the prior year, and adds an additional adult residential facility to the scope of Dr. Kripke's practice.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF AMENDMENT TO AGREEMENT WITH THE REGENTS OF UNIVERSITY OF CALIFORNIA

RESOLUTION 2020 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has previously entered into an agreement with the Regents of University of California for the ongoing services provided by Dr. Clarissa Kripke for developmentally disabled clients since the closing of Agnews Developmental Center in 2007;

B. The agreement is due to expire and both parties wish to continue the agreement to provide these services.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves this amendment to:
    a. extend the agreement with the Regents of University of California for the services provided by Clarissa Kripke, M.D. and her colleagues as outlined in the attached memorandum for one year through June 30, 2021;
    b. increase the dollar amount by $353,844, for this one-year term; and
    c. adds an additional adult residential facility to the scope of Dr. Kripke's practice; and
2. Authorizes the Chief Executive Office to sign said amendment.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of May 2020 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Ligia Andrade Zuniga, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

DRAFT

AGENDA ITEM: 4.8

DATE: May 13, 2020

SAN MATEO HEALTH COMMISSION
Meeting Minutes
March 11, 2020 – 12:30 p.m.
Health Plan of San Mateo - Boardroom
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

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

Commissioners Absent: Jeanette Aviles, M.D., Si France, M.D., Bill Graham

Counsel: Kristina Paszek

Staff Present: Maya Altman, Gabrielle Ault-Riche, Chris Baughman, Luarnie Bermudo, Corinne Burgess, Pat Curran, Trent Ehrgood, Karen Fitzgerald, Robert Fleming, Nicole Ford, Michelle Heryford, Ian Johansson, Francine Lester, Rob Lindley, Colleen Murphey, Keisha Payne, Kati Phillips, Monica Raj, Karla Rosado-Torres, Sophie Scheidlinger, Amy Scribner, Vicky Shih, Rebecca Sullivan, Katie-Elyse Turner, and Eben Yong.

1. **Call to order/roll call**
   The meeting was called to order at 12:31 pm by Commissioner Zuniga. A quorum was present.

2. **Public Comment**
   There was no public comment made at this time.

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

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

5. **Specific Discussion/Action Items**

5.1 Medi-Cal Healthier California for All (CalAIM) Presentation

Ms. Altman introduced Rebecca Sullivan, Government and Regulatory Affairs Manager, and Amy Scribner, Director of Behavioral Health, to present on CalAIM, the State's proposal for Medi-Cal reform over the next five years.

Ms. Sullivan explained that CalAIM stands for California Advancing and Innovating Medi-Cal, a multi-year initiative by DHCS to improve the quality of life and health outcomes for the Medi-Cal population by implementing broad delivery system, program, and payment reform. CalAIM initiatives include Medi-Cal managed care, behavioral health,

dental and several other programs and services. She noted that many CalAIM reforms have already been implemented or are about to be implemented by HPSM, for example dental Integration, the Community Care Settings Program, the integrated Medicare product (Cal MediConnect), and HPSM's strong county partnerships.

CalAIM builds on successful pilots (e.g., Whole Person Care,, Health Homes, and the Coordinated Care Initiative), and addresses homelessness, behavioral health care access, treating children with complex medical conditions, justice-involved populations, and the aging population. Ms. Sullivan shared a long list of initiatives scheduled for implementation over the next five years. Two initiatives, Enhanced Care Management (ECM) and In Lieu of Services (ILOS), are targeted to go live in 2021 and will be explained in more detail by Ms. Scribner. There will also be managed care capitated rate reforms (such as rate setting by region rather than by county) and DHCS will require all plans to have a Dual Eligible Special Needs Plan (D-SNP). The current Cal MediConnect (CMC) program will end in December 2022 and CMC plans will be expected to have D-SNPs in place by January 2023. HPSM is well positioned for this shift having administered a D-SNP in the past.

CalAIM requires all Medi-Cal managed care plans to be accredited by the National Committee on Quality Assurance (NCQA). HPSM recently completed NCQA accreditation. The State also proposes pilots for full integration of physical, oral, and behavioral health. HPSM is well on the way with its work in both dental and behavioral health integration.

CalAIM timelines are as follows: Enhanced Care Management and In Lieu of Services effective 2021; new population health management requirements effective 2022; D-SNP product in place in CMC counties by 2023; full integration health plan pilots in place by 2024. The NCQA accreditation requirement is targeted for 2025 and Long-Term Services and Supports (LTSS) requirements will be implemented by 2026. HPSM already has an LTSS program and is accredited.

Ms. Scribner described Enhanced Care Management (ECM), a proposed new benefit that will target health plans' top one percent of high users of health care, namely those members that are homeless, are transitioning from nursing facilities, and have behavioral health and substance use disorders. Plans will be expected to arrange for much more intensive face-to-face care coordination for these members by working with partners such as counties and community-based organizations. In Lieu of Services (ILOS) are services that are not Medi-Cal benefits but are provided in place of high cost services. HPSM's Community Care Settings Program (CCSP) is an example; through CCSP, HPSM pays for assisted living and other services in place of costlier Nursing Facility stays.

Federal funding for Whole Person Care (WPC) programs sponsored by counties will end on December 31, 2020, to be replaced by ECM and ILOS, paid for by health plans. The plans are in turn expected but not required to contract with the counties for many of these services. CalAIM requires health plans to submit their roadmaps for transitioning to ECM and ILOS services by July 1, 2020.

Ms. Scribner reviewed the 13 ILOS options in CalAIM, noting that 11 of the 13 are currently operational through WPC, CCSP, and the Measure K funded housing program.

Because of this the health plan is well positioned for the go live in January 2021. ILOS will help HPSM make these programs financially sustainable far into the future.

Supervisor Canepa asked how much Measure K funding is allocated toward these services. Ms. Scribner responded that $2 million in annual funding, scheduled for four years, is passed through HPSM to pay for housing for the homeless and others ineligible for the Community Care Settings Program. She explained this funding also is used for housing navigation services, rental deposits, housing tenancy and sustaining services, and the recuperative care program.

Commissioner Zuniga asked if the stakeholder workgroups for CalAIM include representatives of people with disabilities. Ms. Sullivan stated that the workgroups include a wide array of stakeholders including consumer advocates. Ms. Scribner added that a representative from Disability Now is in the ECM workgroup.

Commissioner Tai asked if the full integration pilot is like HPSM's dental integration pilot. Ms. Altman said it is and in fact the State is hoping that positive results from HPSM's pilot will spur adoption by other plans in 2024 and beyond. HPSM is also working with County Behavioral Health and Recovery Services to integrate administrative functions and services in preparation for full integration by 2024.

Commissioner Tai asked if members would see any differences in benefits between CMC and the D-SNP. Ms. Sullivan responded that the program will be very similar; however, the D-SNP program now offers additional flexibilities not included in CMC. For example, the D-SNP program now allows plans to offer supplemental benefits such as food programs and other services that are not standard Medicare benefits.

Ms. Altman reiterated that HPSM is well positioned for CalAIM based on partnerships with the County. Some counties have asked the State to mandate health plans contract with them. HPSM and San Mateo County have long had a strong relationship which unfortunately is not the case in some other parts of the state.

5.2 Annual Compliance Program Report

Mr. Johansson reported on HPSM's compliance program. The goal of the compliance program is to help staff and commissioners do the right thing through education, identifying and resolving potential risk factors, providing opportunities to engage staff and stakeholders, and maintaining the compliance program overall.

In 2019, staff focused on the following: 1) a needs assessment; 2) integration and expansion of compliance monitoring; 3) a comprehensive delegation oversight model; and 4) IT security work. The annual State audit resulted in 11 total findings, a 40% improvement over 2018. There were only two repeat findings, a 50% improvement compared to the prior year. HPSM established an IT security steering committee to enhance security efforts, implementing new safety measures such as dual factor authentication and email security through clear identification of emails from outside HPSM.

The number of compliance incidents is down overall by approximately one third for the year. The Compliance staff continues to diligently perform investigative monitoring.

The compliance effectiveness survey was recently sent to staff to gather feedback on HPSM's compliance program.

Commissioner Canepa asked how many IT breaches HPSM experienced last year. Mr. Johansson responded that there were no major breaches. The IT security steering committee continues to review and respond to potential threats. Ms. Altman added that because HPSM backs up data every day the threat from ransomware attacks is minimal.

Commissioner Horsley asked how Mr. Johansson and the staff maintain enthusiasm and readiness for compliance. Mr. Johansson responded that he and his staff continually look for ways to improve compliance processes and results. The Compliance Department itself is audited annually by an outside entity that evaluates processes and helps identify any requirements that still need to be addressed. Surveys are conducted to learn what works and what does not. Staff is working to improve training to include more appealing visuals to engage staff more effectively. HPMS staff are very engaged as is evident in their survey responses and the issues they report. Ms. Altman added that Mr. Johansson is very creative in his approaches and goes the extra mile to improve. An example is the recent focus group effort to solicit from other HPSM managers and staff ways to improve compliance effectiveness, including how to reduce compliance burdens on all staff while maintaining a high-quality compliance program.

5.3 Employee of the Year Presentation

Ms. Altman was pleased to announce that the Health Plan has implemented a new award this year, based on a recommendation from the Employee Task Force. The Task Force recommended honoring an exceptional employee as Employee of the Year. The qualifications for nomination are "an exceptional employee who embodies HPSM's mission, vision and values by embracing a work atmosphere that encourages employee growth and commitment to HPSM's mission; demonstrating commitment to our members' and our community; being a good steward of public resources; and acting with the highest standards of ethics, integrity and transparency."

Ms. Altman announced that Ms. Vicky Shih has been selected as HPSM's first recipient of the "Employee of the Year" award. Ms. Shih is HPSM's Informatics Manager and is responsible for the department that analyzes HPSM's extensive data resources to create reports required by regulators and payers as well as those reports needed to guide development of new programs and interventions. Ms. Shih was nominated by her staff, she has been at the health plan for 20 years and is one of the hardest workers Ms. Altman has ever met. She is both a statistician and a nurse. The volume of reporting performed by her department is enormous. Chris Baughman commented on Mr. Shih's diligence and dedication, noting specifically Ms. Shih's actions to ensure monthly report synching goes smoothly by staying up all night watching for any glitches.

Ms. Shih thanked the organization for this honor. She expressed her gratitude stating she enjoys working at HPSM will continue to do her best.

6. Report from Chairman/Executive Committee

Commissioner Zuniga had nothing additional to report.

Commissioner Zuniga gave the floor to Commissioner Canepa who noted the San Mateo County Board of Supervisors approved an appropriation of $20 million to support the the new owners of Seton Hospital. He stated that the Board of Supervisors would like to request that HPSM join in this support, contributing $10 million of the total $20 million committed by the Board. Commissioner Canepa requested that the next meeting agenda include consideration for this support. Finally, he stressed the importance of Seton Medical Center.

Commissioner Horsley explained that the proposal discussed at the Board of Supervisors meeting was outlined as $20 million over a four-year period with the first two years of funding coming from the County of San Mateo and the remaining two years potentially coming from HPSM. He noted that the funding would be secured with land either at Seton Coastside or at the Daly City Seton Medical Center campus. He further explained that it is hoped this action will provide an incentive for a potential buyer to close a deal to keep the hospital open.

7. Report from CEO

Ms. Altman reported on HPSM's activities related to COVID-19:

- Staff has ramped up cleaning efforts throughout the building including special attention to the boardroom and other public and staff gathering areas.
- Pharmacy has always generally allowed 90-day refills for most medications but is extending that allowance to all medications except for opioids. Pharmacy has also loosened the early refill requirement to allow refills to be done earlier so members can more easily obtain all the medications they need.
- All links to the CDC and Health Department have been placed on the HPSM website.
- Staff has updated the Plan's business continuity plan and has identified critical staffing needs should there be a need to decrease staffing yet maintain operations.
- Staff has been encouraged to telecommute as much as possible.
- Staff that normally would go to hospitals to perform tasks have been limited to telephonic contact only.
- Staff has been instructed on hygiene recommendations and given the supplies to ensure their safety and the safety of others.

8. Other Business

There was no other business discussed at this time.

9. Adjournment

The meeting was adjourned at 1:22 p.m.

Respectfully submitted:

C. Burgess

C. Burgess, Clerk of the Commission

DRAFT

SAN MATEO HEALTH COMMISSION
Special Meeting Minutes
April 20, 2020 – 3:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

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

Commissioners Present:	David J. Canepa	Barbara Miao
	Si France, M.D.	George Pon, R.Ph.
	Bill Graham	Kenneth Tai, M.D.
	Teresa Guingona Ferrer	Ligia Andrade Zuniga, Chair
	Don Horsley, Vice-Chair	
Commissioners Absent:	Jeanette Aviles, M.D., Michael Callagy	
Counsel:	Kristina Paszek	
Staff Present:	Maya Altman, Corinne Burgess, Pat Curran.	

1. **Call to order/roll call**
   The meeting was called to order at 3:31 pm by Commissioner Zuniga.

2. **Roll Call**
   A roll call was taken, and a quorum was present.

3. **Public Comment**
   No public comments were received to be read. There was no public comment made on the call.

4. **Closed Session: Conference with Legal Counsel – Anticipated Litigation (Significant exposure to litigation pursuant to Government Code Section (54956.9(d)(2) (1 Item) Action on Government Claim**
   Commissioner Zuniga moved the commission into Closed Session at 3:33 p.m.

5. **Report on Action taken in Closed Session**

   Commissioner Zuniga reconvened the meeting to open session at 3:43 p.m.

Kristina Paszek reported from closed session that the commissioners who were present online for the call unanimously voted to deny the government claim.

3. Adjournment

The meeting was adjourned at 3:45 p.m.

Respectfully submitted:

C. Burgess

C. Burgess, Clerk of the Commission

AGENDA ITEM: 5.1

DATE: May 13, 2020

Meeting materials are not included

for Item 5.1 – Discussion – COVID-19 Impacts and Related Activities

MEMORANDUM

AGENDA ITEM: 7.0

DATE: May 13, 2020

DATE: May 6, 2020

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: CEO Report

Coronavirus Impacts and Related Activities

HPSM staff continues to focus intensively on COVID-19 issues affecting members, providers, and staff.

Members

I have communicated with the Commission about HPSM's outreach to members before but here is a recap and update:

- HPSM has identified about 25,000 members who are considered especially at risk for social isolation or other needs, including those members aged 65 or over and those with disabilities or underlying health conditions.
- Staff has developed programs with several of HPSM's partners to reach out to members or provide additional services, e.g.,
    - Wider Circle has called many members both to check on their wellbeing as well as provide much needed social contact. Of note, Wider Circle has set up "buddy calls:" members calling other members for social contact and support, as often as weekly. Wider Circle has also identified members with needs for meal or grocery delivery and engaged volunteers to fill these needs.
    - Independent Living Systems (ILS), HPSM's partner that works with members to develop Health Risk Assessment based on members' self-reported responses to questions about their health status, has also called many members. ILS is focused more on well-being rather than social calls and has been administering a mini COVID assessment to ensure members are educated about and safeguarding against the virus.
    - Landmark Health is still engaged with the high-risk members assigned to their physicians. Most interaction is done via the phone, and call volume has increased substantially. In some cases, if absolutely needed, LMH clinical staff visit members in their homes with the appropriate personal protective equipment.
    - HPSM is working with the County on some initiatives, e.g.,
        - HPSM has engaged volunteers identified by San Mateo County to write "Dear Neighbor" letters to members, providing support to these members without violating their privacy.

        - HPSM staff is working with the County, including Aging and Adult Services staff, to ensure HPSM's eligible members can participate in the "Great Plates Program," launched by the Governor to provide restaurant meals to older adults isolated in their homes. This program will also support local restaurants.

    - HPSM's Nurse Advice Line, operated through a third-party vendor, has seen a dramatic increase in call volume.
    - HPSM has just initiated a contract with Teledoc, a telemedicine service, through LA Care, our sister public health plan in Los Angeles. This service is targeted to those members who cannot access their own primary care provider through telehealth, to ensure members can receive needed primary care services.

- HPSM has developed a program for employees to make social calls to members, including employees who may not otherwise have contact with members. Interested employees are trained and all calls are tracked with members referred to services both provided by HPSM or community organizations as needed.
- The Plan's Quality staff is calling pregnant members to ensure they have everything they need for their new babies. Staff is hearing that some moms are having trouble finding diapers, wipes, and formula; HPSM is finding supplies of these items and sending them to members. Quality staff is also calling members with asthma to ensure they know how to stay safe and healthy.

Providers

HPSM has focused efforts on supporting Skilled Nursing Facilities (SNFs). It is being reported that anywhere from one-third to 40% of COVID deaths in California have been among nursing facility residents. Many of the residents in nursing facilities are on Medi-Cal and most are also HPSM members. Early on, HPSM partnered with San Mateo County Public Health to select several SNF Centers of Excellence, based on criteria such as excellent infection control and ability to isolate COVID patients. HPSM offered these nursing facilities increases in Medicare reimbursement for all HPSM patients as an additional incentive. So far, three have contracted with HPSM for this service, including St. Francis, Seton, and Pacifica Rehab. These facilities are prepared to admit COVID positive patients from hospitals, from other nursing facilities, or from the community.

Provider Services staff also hold weekly calls, together with Public Health, with all the nursing facilities in the county. The goal is to share best practices and issues in order to enhance these facilities' capacity for COVID preparations. Currently, we are encouraging testing of all staff and residents of nursing facilities, especially those who had any COVID positive patients or staff.

Finally, County Public Health has also targeted other congregate living facilities where outbreaks have occurred, sending in strike teams for assessment, testing, training, and medical support. HPSM is working on ways to support these efforts as best we can.

All providers are suffering deep financial distress and seeing sharp declines in patient volume. Other provider focused assistance from HPSM includes:

- Helping providers, especially the smaller practices, quickly convert to telehealth services
- Paying primary care providers for telemedicine/telehealth visits in addition to monthly capitation
- Early advances of pay for performance bonuses
- Acceleration of a payment increase to Community Based Adult Services (CBAS) centers, all of which have had to shift to in-home telehealth care rather than care and services in congregate settings
- Staff will continue to evaluate needs and respond as necessary to help support providers

Staff

The shift to remote work has gone remarkably smoothly. HPSM has supported the transition by offering on-line training and events related to working remotely, ergonomics, and dealing with issues like working effectively with children in the home. Staff have formed many on-line teams to tackle COVID related priorities, remote work challenges, and their regular work. Leadership huddles every morning and all managers and supervisors also meet often, at least once a week.

Leadership has begun planning a safe return to office-based work, highly dependent of course on local health officer orders. We have surveyed staff about their high priority issues related to returning to the office. It is likely, as for many organizations, that we will have more staff telecommuting more often than before the pandemic.

Federal and State Issues

As you know, there is an incredible amount of activity at state and federal levels related to COVID-19. Both CMS and state agencies have loosened many restrictions around provision of health care in various settings (e.g. ability to pay providers the same for telemedicine as is paid for in-person visits). Agencies have also made several decisions that are very favorable for Medi-Cal members. The Governor issued an executive order pausing redeterminations for Medi-Cal eligibility for at least three months, meaning that no one on Medi-Cal should lose health coverage during this pandemic. Similarly, CMS extended the deeming period for Cal MediConnect members, meaning these members will have six months to regain Medi-Cal eligibility if for some reason they do lose their Medi-Cal coverage (the current deeming period for Cal MediConnect is two months). CMS also extended the special enrollment period for Part A beneficiaries who lack Part B to buy Part B with State financial support. HPSM staff engaged

with Justice in Aging, a national older adult advocacy organization, to lobby CMS for these changes.

The federal government has also approved funding packages, which include funding for many of our providers, as well as states and counties. We are still trying to understand how these additional funds will affect our providers, many of whom are in very difficult funding situations.

On May 14, the Governor will release the "May Revise," his updated budget proposal for State Fiscal Year 2020-21. All indications are that the budget will present very bad news and that he will propose severe cuts to many state programs. At the same time, we expect Medi-Cal enrollment to increase because of the high numbers of unemployed. Based on prior experience in difficult economic times, we can expect to see payment cuts to providers, Medi-Cal benefit eliminations, and reduced eligibility for Medi-Cal among certain populations. A staff team has begun planning for Medi-Cal enrollment increases.

Finally, on behalf of HPSM, I want to express deep appreciation and gratitude for the tremendous work of County Health and all of the workers on the front line of this terrible epidemic.

Other News

- The judge overseeing the Verity bankruptcy has approved the sale of Seton Medical Center and Seton Coastside to AHMC, a hospital group in Southern California that is closely associated with Apollo Medical, a physician organization. This is the buyer supported by physicians and many of the staff at Seton Medical Center. The Attorney General will need to review the transaction so the sale is not expected to close before July. The judge also recently approved the sale of St. Francis, another Verity-owned hospital in Los Angeles, to Prime Healthcare Services, and the sale of St. Vincent, the other Verity hospital in LA, to Dr. Patrick Soon-Shiong, who formerly owned Seton through Verity.

HPSM was selected to be a participant in the Center to Advance Consumer Partnership's Early Adopter Program, which fosters strong consumer/member engagement for health plans and other organizations. This program will help HPSM build its programs for member involvement and will involve focus groups and other techniques for evolving HPSM beyond a member focused organization to a truly member driven health plan. Thank you to Gabrielle Ault-Riche, Director of Customer Support, and Katie-Elyse Turner, Director of Risk Adjustment and Interim Duals Demonstration Director, for leading this effort.