801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

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www.hpsm.org

-Virtual Meeting-

THE SAN MATEO HEALTH COMMISSION
Regular Meeting
October 13, 2021 - 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., South San Francisco, CA 94080

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

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

Join on your computer or mobile app

Click here to join the meeting

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

Members of the public wishing to provide public comment on items not listed on the agenda that are within jurisdiction of the Commission or to address an item that is listed on the agenda may do so by emailing comments before 10:00 am, Oct6ober 13, 2021 to the Clerk of the Board at Corinne.Burgess@hpsm.org with "Public Comment" in the subject line. Comments received will be read during the meeting. Members of the public wishing to provide such public comment may also do so by joining the meeting on a computer, mobile app, or telephone using the link or number provided above and following the instructions for making public comment provided during the meeting.

AGENDA

1. **Call to Order/Roll Call**
2. **Public Comment/Communication**
3. **Approval of Agenda**
4. **Consent Agenda***
   - 4.1 Adopt a resolution finding that, as a result of the continuing COVID-19 pandemic state of emergency, meeting in person would present imminent risks to the health or safety of attendees
   - 4.2 CHI Oversight Committee, August 2021
   - 4.3 Waive Request for Proposal and Approve Amendment to Agreement with American Logistics Company

~Continued~

4.4 Waive Request for Proposal and Approve Amendment o Agreement with Cotiviti, Inc.
4.5 Approval of Amendment to Agreement with Human Affairs International of California Inc.
4.6 Approval of San Mateo Health Commission Meeting Minutes from September 8, 2021

5. Specific Discussion/Action Items
5.1 Presentation on HPSM Justice, Equity, Diversity, and Inclusion Efforts
5.2 Discussion/Action on Approval of Agreement with Upward Health*
5.3 Discussion/Action on Approval of Children's Health Initiative Funding Recommendations*
5.4 Discussion/Action on Agreement with Morgan Consulting*

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

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

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

10. Report on Action taken in Closed Session
11. Adjournment

**Items for which Commission action is requested.*

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

MEMORANDUM

AGENDA ITEM: 4.1

DATE: October 13, 2021

DATE: September 29, 2021

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: Approval of Teleconference Meeting Procedures Pursuant to AB 361

Recommendation

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

Background and Discussion

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

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

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

At its September 28, 2021, meeting, the San Mateo County Board of Supervisors found that in the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-10, meeting in person would preset imminent risks to the health or safety of attendees, The Board of Supervisors accordingly resolved to continue conducting its meetings through teleconferencing, in accordance with AB 361, and encouraged other boards and commissions established by them to avail themselves of teleconference until the risk of community transmission has further declined. A copy of the resolution adopted by the Board of Supervisors, which details the reasons for its findings, is attached.

Fiscal Impact

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

RESOLUTION NO. 078447

BOARD OF SUPERVISORS, COUNTY OF SAN MATEO, STATE OF CALIFORNIA

* * * * * *

RESOLUTION FINDING THAT, AS A RESULT OF THE CONTINUING COVID-19 PANDEMIC STATE OF EMERGENCY, MEETING IN PERSON WOULD PRESENT IMMINENT RISKS TO THE HEALTH OR SAFETY OF ATTENDEES

RESOLVED, by the Board of Supervisors of the County of San Mateo, State of California, that

WHEREAS, on March 4, 2020, pursuant to section 8550, *et seq*., of the California Government Code, Governor Newsom proclaimed a state of emergency related to the COVID-19 novel coronavirus and, subsequently, this Board of Supervisors declared a local emergency related to COVID-19, and the proclamation by the Governor and declaration by this Board remain in effect; and

WHEREAS, on March 17, 2020, Governor Newsom issued Executive Order N-29-20, which suspended certain provisions in the California Open Meeting Law, codified at Government Code section 54950, *et seq*. (the "Brown Act"), related to teleconferencing by local agency legislative bodies, provided that certain requirements were met and followed; and

WHEREAS, on June 11, 2021, the Governor issued Executive Order N-08-21, which extended certain provisions of Executive Order N-29-20 that waive otherwise-applicable Brown Act requirements related to remote/teleconference meetings by local agency legislative bodies through September 30, 2021; and

WHEREAS, on September 16, 2021, Governor Newsom signed AB 361, which provides that a local agency legislative body may continue to meet remotely without complying with otherwise-applicable requirements in the Brown Act related to remote/teleconference meetings by local agency legislative bodies, provided that a state of emergency has been declared and the legislative body determines that meeting in person would present imminent risks to the health or safety of attendees, and provided that the legislative body makes such finding at least every thirty days during the term of the declared state of emergency; and

WHEREAS, this Board concludes that there is a continuing threat of COVID-19 to the community, and that Board meetings have characteristics that give rise to risks to health and safety of meeting participants (such as the increased mixing associated with bringing together people from across the community, the need to enable those who are immunocompromised or unvaccinated to be able to safely continue to participate fully in public governmental meetings, and the challenges with fully ascertaining and ensuring compliance with vaccination and other safety recommendations at such meetings); and

WHEREAS, California Department of Public Health and the federal Centers for Disease Control and Prevention caution that the Delta variant of COVID-19, currently the dominant strain of COVID-19 in the country, is more transmissible than prior variants of the virus, that it may cause more severe illness, and that even fully vaccinated individuals can spread the virus to others, resulting in rapid and alarming rates of COVID-19 cases and hospitalizations (https://www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html); and

WHEREAS, the County has an important interest in protecting the health and safety of those who participate in meetings of this Board and of the County's various other legislative bodies; and

WHEREAS, this Board of Supervisors and several other County legislative bodies typically meet in-person in public building where other essential governmental functions take place, such that increasing the number of people present in those buildings may impair the safety of the occupants; and

WHEREAS, the COVID-19 pandemic has informed County agencies about the unique advantages of online public meetings, which are substantial, as well as the unique challenges, which are frequently surmountable; and

WHEREAS, in the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, the San Mateo County Board of Supervisors finds that meeting in person would present imminent risks to the health or safety of attendees, and the Board will therefore invoke the provisions of AB 361 related to teleconferencing for meetings of the Board of Supervisors, and this Board strongly encourages other County legislative bodies to make similar finding and continue meeting remotely through teleconferencing.

NOW, THEREFORE, IT IS HEREBY DETERMINED AND ORDERED that

1. The recitals set forth above are true and correct.
2. The Board of Supervisors finds that meeting in person would present imminent risks to the health or safety of meeting attendees and directs the

Clerk and County Manager to continue to agendize public meetings of the Board of Supervisors only as online teleconference meetings.

3. The Board of Supervisors strongly encourages all legislative bodies of the County of San Mateo that are subject to the Brown Act, including but not limited to, the Planning Commission, the Assessment Appeals Board, the Civil Service Commission, and all other oversight and advisory boards, committees and commissions established by the Board of Supervisors and subject to the Brown Act, to make a similar finding and avail themselves of teleconferencing until the risk of community transmission has further declined, and directs the County Manager to provide necessary support for these legislative bodies to continue teleconferencing procedures when they have adopted such findings.

4. Staff is directed to return to this Board in a public meeting no later than thirty (30) days after the date of adoption of this resolution with an item for the Board to consider regarding whether to make the findings required by AB 361 in order to continue meeting remotely under its provisions.

* * * * * *

RESOLUTION NUMBER: 078447

Regularly passed and adopted this 28th day of September, 2021

AYES and in favor of said resolution:

Supervisors: *DAVE PINE*

CAROLE GROOM

DON HORSLEY

WARREN SLOCUM

DAVID J. CANEPA

NOES and against said resolution:

Supervisors: *NONE*

President, Board of Supervisors
County of San Mateo
State of California

Certificate of Delivery

I certify that a copy of the original resolution filed in the Office of the Clerk of the Board of Supervisors of San Mateo County has been delivered to the President of the Board of Supervisors.

Assistant Clerk of the Board of Supervisors

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

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

RESOLUTION 2021 -

RECITAL: WHEREAS,

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

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

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

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of October 2021 by the following votes:

AYES:
NOES:
ABSTAINED:
ABSENT:

_____
Ligia Andrade Zuniga, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

DRAFT

AGENDA ITEM: 4.2

DATE: October 13, 2021

-Virtual Meeting – Microsoft Teams-
CHI OVERSIGHT COMMITTEE MEETING
Meeting Summary
September 20, 2021, 11:00 am
Health Plan of San Mateo

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

Voting Members Present:

Deanna Abrahamian, Pamela Kurtzman, Cheryl Fama, Srija Srinivasan, Julie Lind, Manny Santamaria, Pat Curran, Kitty Lopez.

Voting Members Absent:

None.

Non-Voting Members Present:

Emily Roberts, Teresa Guingona Ferrer, Joey Vaughn.

Guests: Wendy Todd, Consultant

1. **Call to Order / Introductions**

   Meeting was called to order at 11:03 pm by Pat Curran.

2. **Public Comment**

   No public comments were received in advance of the meeting via email or made on the teleconference meeting.

3. **Approval of Minutes from August 31, 2021**

   Motion to approve the minutes from August 31, 2021: **Kurtzman / Second: Lind**

   Verbal roll call vote:
   Yes: 8 – Abrahamian, Lopez, Srinivasan, Curran, Fama, Santamaria, Lind, Kurtzman.
   No: 0

4. **Discussion/Action on Return of Funds – Sequoia Health Care District**

   Ms. Srinivasan explained the intention of the spreadsheet was to show the details on the actions of the recommendations and the amounts from each funding entity, to show a running tally of the CHI Trust Fund balances and the math for the recommendation for return of funds to Sequoia Health Care District for our discussion today. Ms. Kurtzman explained the events leading to the

request for the return of the funds to SHCD and the decision making outside of their board specifically for Children's Health Initiative. Ms. Kurtzman did express their approval of the recommendations for funding of Mission Asset Fund, NEMS, Sonrisas, the Oral Health Mapping. The request is for the return of all of the remaining funds contributed by SHCD in the amount of $1,004,400.

Ms. Srinivasan pointed out the amount that would be left over in the trust fund is $1.4 million with a target to distribute or commit by July 2022. Ms. Roberts asked Ms. Kurtzman about what the procedure could be used going forward if there were opportunities that would come from this group for SHCD involvement. Ms. Kurtzman responded that the procedure would include her bringing any proposal from CHI to the SHCD board for approval to determine if it would have an impact on the district's population. Ms. Fama asked for clarification of the numbers related to Peninsula HealthCare District. Ms. Srinivasan reviewed the numbers and calculation of the 15% from PHCD. Ms. Lopez asked if the voting members would change with the return of funds to SHCD. Mr. Curran stated that the planning committee discussed and that their recommendation was to not change the voting members going forward since some have contributed funds and some have not, with an eye for potential addition funds, and with a target of July 2022 for the distribution of the remaining funds. Ms. Kurtzman appreciated the opportunity to continue in the participation and the ability to advocate for any opportunities that will be presented in the future.

Motion to approve the return of all remaining funds as was contributed to the Sequoia Health Care District in the amount of $1,004,400: **Srinivasan/ Second: Lopez**

Verbal roll call vote for August 31, 2021, minutes:
Yes: 8 – Abrahamian, Srinivasan, Lopez, Curran, Fama, Santamaria, Lind, Kurtzman.
No: 0

5. Next Steps

Mr. Curran explained that the next step will be to package together these recommendations and bring them to the October 13, 2021, San Mateo Health Commission for approval. Ms. Srinivasan reported that she has a meeting to brief Supervisor Groom and Supervisor Canepa about the Mission Asset Family Recovery Fund so by the time this reaches the commission and the Board of Supervisors, they will have heard about it from staff.

Ms. Curran asked Ms. Todd to review with the group the questions reflecting on all of the work done over the past several months.

CHI Reflection

1. What have you learned along this journey so far regarding the collaborative effort to grant out funds from CHI Trust?

- Go slow to go fast. Took some time to understand situation when COVID hit. Then when there was alignment on MAF we could go fast.
- Relief to recovery orientation is a useful frame. CHI able to take steps to contribute to relief and now, recovery. Appreciate we all want to have an impact and have an equity lens.
- It is not easy to figure out best investments partially paralysis through analysis. There are funding limitations, and we are super conscious about picking right opportunity to make biggest impact.
- Collaboration not always easy but worth it.
- Things change and change is name of game. Lean into it and it can be messy. Good things can come out of collective thinking and pooling resources.
- Special to have HPSM, to have reserves, integration of dental – it's helpful to plan ahead in partnership with others.

2. What is most important to you/what stands out to you about what we've accomplished to date?

- Very deep commitment to health equity – when we've gone back to equity based approaches that is when we are successful. When we look at underpinnings of health that is when we see success. It is the origin of this group. Access for all and everyone is deserving of health.
- Planning team is the glue – the conductors of the train – there work in between meetings has resulted in moving money out of reserves to community.

3. What would you like, if anything, to see improve with our collaborative effort?

- Our focus on equity….Could you learn from community – community voice to be more a part of what we are doing?
- Could we reflect/hear more about the impact of CHI – a retrospective.
- We can learn from how MAF does their work, how they implement their values.
- Lean on learning from MAF, county staff working with families, Sonrisas.
- Let's keep listening and asking is there anything we are missing?
- Difficult to figure out needs and how individual orgs (SHCD) can do something really big. What is the large scale collective efforts that could make a difference?
- Interested in continuing to hear any challenges with children's medical/health needs in SMC.
- Is there a venue to learn and co-develop strategy around new infusion of behavioral health money coming from state? Safe schools' coalition – Talk with Nancy about where gaps are with schools in prep for future state funding. SHCD is contributing 5 million to schools. Karen Li is SHCD staff who is highly engaged. They are doing needs assessment work.

6. Adjournment

The meeting adjourned at 11:55 a.m.

MEMORANDUM

AGENDA ITEM: 4.3

DATE: October 13, 2021

DATE: October 4, 2021

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer
Gabrielle Ault-Riche, Director of Customer Support
Carolyn Thon, Project Manager

RE: Waive RFP and Approve Amendment to Agreement with American Logistics Company

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Recommendation

Approve a waiver of the Request for Proposal (RFP) process and authorize the CEO to execute an amendment to the agreement with HPSM's current Non-Medical Transportation (NMT) provider, American Logistics Company (ALC). This amendment extends services for three years through December 31, 2024.

Background

NEMT involves member transportation necessary to access any Medi-Cal covered service. ALC has been HPSM's NMT vendor since the firm was selected through an RFP process in 2009:

- 2009: Selected through RFP process to administer the CareAdvantage (CA) ride benefit.
- 2015: Selected through a subsequent RFP to continue offering the CA ride benefit.
- 2017: Commission approved a contract amendment to expand ALC's scope to cover all Medi-Cal members to comply with DHCS' mandated benefit expansion. An RFP was not conducted in 2017 given the two-month turn-around time DHCS provided to Plans to implement the expanded benefit. In July 2017, ALC initiated alternative transportation services through a partnership with the rideshare company Lyft, which increased the capacity of the ALC network beyond ALC-contracted drivers.
- 2018: HPSM issued an RFP for transportation management services, receiving proposals from three vendors. The RFP review committee selected ALC based on pricing, proposal content, willingness to comply with HPSM's performance standards, and experience

administering the transportation benefit for HPSM and other California Medi-Cal managed care plans.

- 2021: The current ALC agreement expires on December 31, 2021.

Discussion

Staff recommends waiving the RFP process and extending the ALC agreement for the following reasons:

1. ALC's performance has consistently met contract standards.
2. DHCS has informed Plans it is changing the way NMT data are collected in early 2022. ALC has started developing encounter-based files and anticipates completion by the end of the first quarter in 2022. Unless HPSM contracted with a vendor who already had an established encounter data process, HPSM would not meet the DHCS deadline for implementation, which could result in penalties from DHCS.
3. There are several programs starting in 2022 which impact the ability of Customer Support staff to work on an RFP or establishing processes, training staff, and implementing data exchanges with a new vendor. These include HPSM Dental, Medi-Cal Pharmacy Carve-out, and the implementation of a new call center system.

Fiscal Impact

The proposed amendment extends the agreement with ALC through December 31, 2024. The amendment also provides improvements to the NMT process to reduce cost and improve member experience. ALC's proposed rates will increase, the first time in three years that ALC has increased rates. This rate increase includes the following:

1. Additional services such as encounter file development; monitoring for fraud, waste, and abuse (FWA); and administration of the restricted ride list (RRL).
2. Additional qualified drivers to ensure timeliness of rides.

This amendment will increase the contract amount by approximately $430,000 annually for a projected annual amount of $5.2 million. The amendment also includes a 5% rate increase in the second and third years.

As approved by the Commission in March 2020, this agreement will continue without a contract maximum amount. NMT is a mandatory benefit for Medi-Cal and CareAdvantage CMC, so HPSM is required to provide rides regardless of member demand. As such, these costs are eventually reflected in HPSM's rates from the CA Department of Health Care Services.

DRAFT

RESOLUTION OF THE

SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVING A WAIVER OF THE REQUEST FOR PROPOSAL PROCESS AND AN AMENDMENT TO THE AGREEMENT WITH AMERICAN LOGISTICS COMPANY

RESOLUTION 2021 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission executed its most recent agreement with American Logistics Company for non-medical transportation services in 2018;
B. Non-Medical Transportation is a health-care expense, and its costs are reflected in HPSM's capitation rates received from the Department of Health Care Services; and
C. American Logistics Company has offered a favorable proposal to continue providing Non-Medical Transportation, including assumption of additional services.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the Request for Proposal (RFP) process and authorizes the Chief Executive Officer to execute an amendment to the agreement with American Logistics Company to extend Non-Medical Transportation services through December 31, 2024.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of October 2021 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Ligia Andrade Zuniga, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

MEMORANDUM

AGENDA ITEM: 4.4

DATE: October 13, 2021

DATE: October 5, 2021

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer
Chris Esguerra, M.D., Chief Medical Officer

RE: Waive Request for Proposal and Approve Amendment to Agreement with Cotiviti

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Recommendation

Approve a waiver for the RFP process and an amendment to extend the term of the agreement with Cotiviti, Inc. by three years, and increase the contract maximum by $795,000 for a total contract maximum amount not to exceed $2.025 million for Health Effectiveness Data Information Set (HEDIS) and Managed Care Accountability Set (MCAS) measure calculation, software and services. The new term will be from October 15, 2021, to October 14, 2024.

Background and Discussion

HPSM is required to collect and report specific HEDIS measures for Medi-Cal and CareAdvantage Cal MediConnect contracts for the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS).

Cotiviti, Inc. formerly known as Verscend Technologies, Inc. and Verisk Health, Inc., has provided HPSM with HEDIS data analytics software since 2013. In November 2016, and again in October 2019, the Commission waived the RFP process and approved amendments extending the current agreement. In February 2019 HPSM added monthly HEDIS measure calculation and data extracts from Cotiviti for regular quality metric monitoring and to inform our provider value-based payment incentive programs. HPSM also has a separate agreement for both claims editing and fraud, waste, and abuse monitoring in the amount of $4.1 million. Both products were selected through RFP or other competitive processes.

Cotiviti is a widely used HEDIS software vendor. Several other Medi-Cal Managed Care plans, such as San Francisco Health Plan, Kaiser Foundation Health Plan North, and Alameda Alliance for Health, also use Cotiviti's software for HEDIS data analytics.

In addition to HEDIS measures, the firm's software can calculate non-HEDIS CMS Core measures. Starting with 2020 reporting, seven non-HEDIS CMS Core Set measures were added to the MCAS, a group of quality metrics required by DHCS. Cotiviti will provide calculation and analysis of these seven CMS Core Set measures along with the entire library of HEDIS measures, enabling HPSM to report and regularly monitor the full set of MCAS measures.

Cotiviti has provided excellent services over the past eight years and has readily accommodated specialized HEDIS reporting and non-HEDIS CMS Core Set measurement to enable full MCAS reporting and monthly monitoring. Extending the agreement an additional three years will ensure that HPSM has the necessary time to conduct the RFP, select the most qualified vendor, and implement a new vendor if Cotiviti is replaced.

Fiscal Impact

The annual average cost of this agreement is approximately $265,000. The amendment will extend the term of the agreement three years through October 14, 2024, and increase the contract maximum by $795,000, bringing the contract maximum to $2.025 million for HEDIS and MCAS measure analytics services.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF A WAIVER OF THE RFP PROCESS
AND APPROVAL OF AN AMENDMENT TO
THE AGREEMENT WITH COTIVITI, INC.

RESOLUTION 2021 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission is required to report HEDIS metrics to CMS and the Managed Care Accountability Set to DHCS annually;
B. The San Mateo Health Commission has used Cotiviti, Inc. for HEDIS measure calculation and analysis since 2013;
C. Cotiviti, Inc. can provide full HEDIS and Managed Care Accountability Set measure calculation and analysis software and services; and
D. Staff recommends the continued use of these services.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the request for proposal process and approves an extension of the agreement with Cotiviti, Inc. through October 14, 2024, and the addition of $795,000 for a total contract maximum of $2.025 million for data analytics services; and
2. Authorizes the Chief Executive Officer to execute said amendment.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of October 2021 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Ligia Andrade Zuniga, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

MEMORANDUM

AGENDA ITEM: 4.5

DATE: October 13, 2021

DATE: October 4, 2021

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: Amendment to Agreement with Human Affairs International of California, Inc.

Recommendation

Authorize the Chief Executive Officer to execute a two-year extension of the agreement with Human Affairs International of California, Inc., a subsidiary of Magellan Health, to administer Medi-Cal benefits and services for children requiring Behavioral Health Treatment (BHT).

Background

In September 2014, as a result of State legislation, HPSM and other Medi-Cal managed care plans assumed responsibility for administering benefits and services related to autism spectrum disorders (ASD) among children. These services, known as Behavioral Health Treatment (BHT), are defined as professional services and treatment programs – including, Applied Behavior Analysis (ABA) - that develop or restore the functioning of an individual with autism. In July 2018, further State legislation led to HPSM and other Medi-Cal managed care plans expanding the BHT benefit to include children who need the treatment but do not necessarily have ASD.

The BHT benefit is available to HPSM members who: (i) are between 0 and 21 years of age; (ii) have a recommendation from a licensed physician and surgeon or a licensed psychologist that evidence-based BHT services are medically necessary; (iii) are medically stable; and (iv) are without need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.

From 2014 to 2016, HPSM contracted with County Behavioral Health and Recovery Services to manage the BHT benefit. However, BHRS declined to continue managing the benefit in 2016. HPSM then released an RFP to select a new entity to handle the BHT benefit, selecting Human Affairs International. Magellan has offered an excellent and comprehensive program for the past four years, ensuring continuity of services and maintaining competitive pricing. Magellan has a national presence in Autism related programs, and serves health plans across the nation, including commercial and Medicaid plans.

Discussion

The number of unique children receiving BHT throughout 2020 totaled 357. On average, 269 unique children were open to services in a quarter. About 63% of these children were in the 0-7 age group, and 37% were in the 8-20 age group.

Since the implementation of the agreement in early 2017, Magellan has assumed responsibility for utilization management, network oversight, claims administration, and case management functions specific to the Medi-Cal BHT benefit, including the expansion of services to newly eligible children in July 2018. Magellan's autism related operations are certified by the National Committee for Quality Assurance (NCQA), which has benefited HPSM's NCQA accreditation efforts.

Prior to considering an extension of this agreement, HPSM conducted another Request for Proposal (RFP) in late 2020 with four respondents, two of which were engaged in finalist discussions. Magellan was again selected as the BHT vendor.

This renewal, since it delegates some health plan functions to another health plan, will also require approval from the California Department of Managed Health Care (DMHC). However, contracted obligations will continue uninterrupted.

Fiscal Impact

DHCS currently provides HPSM supplemental payments for each member utilizing Behavioral Health Therapy services in each month, separate from the capitation amounts HPSM receives for all Medi-Cal beneficiaries. However, DHCS has indicated plans to merge the supplemental payments into the overall Medi-Cal rate. HPSM's goal is to maintain BHT costs below the rates received from DHCS. The estimated annual fees for Magellan are approximately $6 million in year one and $6.3 million in year two.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF AN AMENDMENT TO THE AGREEMENT
WITH HUMAN AFFAIRS INTERNATIONAL

RESOLUTION 2021 -

RECITAL: WHEREAS,

A. HPSM is required to provide Behavioral Health Treatment services to eligible children who are members of the Health Plan; and
B. HPSM selected Human Affairs International through two RFP processes, the most recent conducted in 2020.

NOW THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission authorizes the Chief Executive Officer to execute an amendment to the agreement with Human Affairs International, a subsidiary of Magellan Health, for the administration of Behavioral Health Treatment Medi-Cal benefits, extending the term of the agreement two years.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of October 2021 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Ligia Andrade Zuniga, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

DRAFT

AGENDA ITEM: 4.6

DATE: October 13, 2021

SAN MATEO HEALTH COMMISSION
Meeting Minutes
September 8, 2021 – 12:30 p.m.

****BY VIDEOCONFERENCE ONLY****

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

Commissioners Present:	Jeanette Aviles, M.D.	George Pon, R.Ph.
	David J. Canepa	Barbara Miao
	Teresa Guingona Ferrer	Kenneth Tai, M.D.
	Si France, M.D.	Ligia Andrade Zuniga, Chair
	Don Horsley, Vice-Chair	
Commissioners Absent:	Michael Callagy, Bill Graham	
Counsel:	Kristina Paszek	
Staff Present:	Maya Altman, Gabrielle Ault-Riche, Luarnie Bermudo, Chris Baughman, Corinne Burgess, Marisa Cardarelli, Pat Curran, Chris Esguerra, M.D., Nicole Ford, Francine Lester, Richard Moore, M.D., Colleen Murphey, Amy Scribner, and Eben Yong.	

1. **Call to Order/Roll Call**
   The meeting was called to order at 12:31 pm by Chair, Commissioner Zuniga. A quorum was present.

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

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

Verbal roll call vote was taken:

Yes: 8 – Aviles, Canepa, Ferrer, Horsley, Miao, Pon, Tai, Zuniga.

No: 0

4. Approval of Consent Agenda

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

Verbal roll call vote was taken:

Yes: 8 – Aviles, Canepa, Ferrer, Horsley, Miao, Pon, Tai, Zuniga.

No: 0

5. Specific Discussion/Action Items

5.1 Discussion/Action on Approval of Dental Integration Program Implementation

Ms. Altman said she was excited to recommend approval of the Dental Integration Program. She noted that this is much-needed in San Mateo County. Dental utilization for both adults and children on Medi-Cal is below the state average; and it is well documented that oral health is critical for overall health and wellbeing. While the Commission granted preliminary approval for this program in October 2019 for a January 2021 start, the program has been delayed due to the pandemic and State budget issues in 2020. The preliminary approval included approval for the hiring of a Dental Director as well as other system preparations. The request today is for final approval to hire staff to begin operations on January 1, 2022. HPSM had expected to receive final payment rates from the State for this program by late August, and the State did send those rates on August 20. However, HPSM staff found significant errors that have been communicated to State actuaries, who are now re-evaluating them. Although we do not have final rates to share with the Commission, it is critical we begin hiring staff to be prepared for the January 2022 start date. Therefore, we are presenting a worst-case financial scenario based on rates received to date. We believe the final adjusted rates will improve this financial projection. Also, it is important to note that HPSM's overall financial performance so far this year is better than anticipated. The 2021 HPSM budget projected a $30 million deficit; however, as of the end of July we recorded a small year-to-date surplus. HPSM financial staff's most recent projection is for a deficit of $8 million in 2021.

Ms. Altman introduced Pat Curran, Deputy CEO; Chris Baughman, Chief Performance Officer; Marisa Cardarelli, Dental Benefits Manager; Jennifer Nguyen, Business System Analyst; and, Trent Ehrgood, Chief Financial Officer. She thanked these and other staff who have worked diligently to implement this program and have dealt with massive readiness requirements from DMHC and DHCS. She commended Mr. Curran for his leadership and commitment to the dental program.

Mr. Curran shared a presentation attached to these minutes. He thanked staff and Caroline Davis, a consultant, who have all spent many months preparing for this program. Work began in 2017 with discussions with the California Dental Association and the State Department of Health Care Services (DHCS) about a potential pilot in San Mateo County. In California, Medi-Cal dental services are offered through a separate program operated by the State through a contract with Delta Dental. These discussions led to legislation passed in 2018 allowing San Mateo County to test a pilot for integrated medical and dental benefits administered through the same organization. HPSM staff held extensive local stakeholder meetings with private dentists, other dental providers, HPSM members and committees, school districts, advocacy organizations, and community members to develop the program and garner community support.

The State legislation requires a formal evaluation to be conducted by an external entity and to be paid for by HPSM. The amount is included in this recommendation and is approximately $250,000. The evaluation will examine how the program achieves the triple aim: member experience; improvement in medical and dental outcomes; and cost effectiveness.

Medical and dental integration has only been done on a small scale even in the commercial world. The short-term goals of this program focus on increasing access to dental care and preventive services. The other major goal is to align medical and dental services to improve overall health outcomes.

HPSM recently sponsored a series of focus groups with members, learning that dental care was important to members who received dental care in the past couple of years, adults not seen recently, and parents of young children. Access was reported as a challenge not only due to wait times but due to the lack of information about who to call and where to go. Members do not understand dental benefits covered for the different age groups. These challenges resulted in members failing to receive dental care, often paying out of pocket for certain services, and feeling distrust in the information available. Finally, Mr. Curran reported that the Children's Health Initiative (CHI) Oversight Committee, originally established to oversee the Healthy Kids Program, has recommended funding for Northeast Medical Services and Sonrisas, two dental providers in the county, to increase dental service capacity. These recommendations will be on the October Commission agenda.

Ms. Baughman, Chief Performance Officer, provided an overview of preparations for dental integration. Staff training is underway to ensure appropriate handling of member and provider questions. HPSM will leverage its expertise with medical benefit functions to address provider credentialing, prior authorization processes, and prompt claims payments under the dental benefit. Staff has met with many local dental providers to

understand the issues they grapple with, which are largely administrative burdens. Easing provider burden is another goal of the program, which could lead to more dentists joining the HPSM network. Ms. Baughman thanked Greg Protacio, Senior System Configuration Analyst, and the Claims Processing Team for their work in configuring and testing systems to prepare for the implementation.

Ms. Jennifer Nguyen, Business System Analyst, gave an update on program readiness activities as required by the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC). HPSM staff have submitted updated policies, contracts, and member materials, including 116 documents for DHCS and 82 documents for DMHC. In addition, staff have developed dental materials and resources to prepare internal staff for this transition. Marketing and Customer Support Teams have developed member notices and a dental booklet to help members understand their benefits, as well as a logo for dental services. Members will receive notices about the transition of dental services 90, 60 and 30 days prior to program launch. Ms. Nguyen thanked the HPSM project team.

Ms. Marisa Cardarelli, Dental Benefits Manager, provided an update for dental provider engagement. Staff began provider recruitment efforts by contacting dental providers identified through State data as serving HPSM members from 2018 through 2020 to ensure continuity of care for members. Staff contacted the top 30 providers by volume as well as an additional 25 providers in neighboring counties, including high volume providers like San Mateo Medical Center, Ravenswood, Gardner, dental schools, Sonrisas, Children's Choice, and solo providers. Two mobile dental clinics were also contacted -- one visits skilled nursing facilities. Staff has learned about the administrative challenges providers now face, including slow turnaround times for authorization approvals and difficulties finding specialists for patient referrals. HPSM will approve authorizations within one week for routine matters and within three days for urgent authorizations, a substantial reduction from the current State practice of approvals within six to eight weeks. Under HPSM's program, providers can send specialty referrals directly to HPSM's dental team, which will locate specialty dentists who can provide services and ensure services are delivered to the patient. Another key benefit for providers is the ability to call a local health plan and speak directly to staff, which will build positive relationships with providers and ensure quality care that improves overall member and provider satisfaction.

Providers will control the number of new patients they accept on an ongoing basis. HPSM will continue its outreach to current Medi-Cal dental providers in all neighboring counties and work with local dental societies to reach providers via webinars, emails, and other channels. Staff recently presented to the 450 members of the Santa Clara Dental Society.

Trent Ehrgood, Chief Financial Officer, reiterated that the rates received from the State to date are disappointing. However, positive discussions have occurred with the State's actuary about assumptions used for the 2022 dental rates. We believe the State's actuary made a large error, neglecting to include some critical utilization data, and have submitted documentation; our expectation remains that the State will recognize this error and provide substantially improved rates. The recommendation is to approve the program, despite the limited rates information received to date, so HPSM can hire staff for a program start in January 2022. Mr. Ehrgood described the worst-case scenario based on the best information available, which projects a $15 million deficit over six years with close to breakeven experience starting in year five. In year one, a $3.5 million deficit is projected. We expect to have updated rate information from the State in a few weeks.

Commissioner Miao asked if the State will allow a cost reconciliation after the third year to recoup expenses. Mr. Ehrgood replied that, because HPSM is a risk bearing entity, this would not be allowed. CMS requires the State to set prospective risk-based rates. If the State pays too much, HPSM keeps the difference; conversely, the HPSM bears the cost if the State's rates are too low relative to expenses.

Commissioner Miao asked about past dental utilization and projected future utilization. Mr. Ehrgood responded that currently about 30% of Medi-Cal members have seen a dentist in the last year or two. For modeling purposes, a 35% utilization rate was built into the projections; however, the goal is increase utilization more, especially for children in the initial years.

Commissioner Maio asked if dental benefits differ by age group. Mr. Curran responded that more preventive services are covered for children than adults while restorative services are more often provided to adults although there are more restrictions for adult restorative benefits.

Commissioner Horsley asked if co-pays are required and if private practice dentists have been recruited. Mr. Curran answered that there are no co-pays for Medi-Cal services. Ms. Cardarelli said staff initially is recruiting dentists currently accepting Medi-Cal dental and then calling dentists not accepting Medi-Cal patients. Staff is finding that many do not know much about Medi-Cal dental coverage and have many questions about payment and how the program will work. Mr. Curran added that few active dentists take Denti-Cal and there is likely a whole generation of dentists who know nothing about Denti-Cal.

Commissioner Ferrer asked what happens when a patient needs services not covered by the benefit. Ms. Cardarelli responded Medi-Cal dental coverage specifics are included in a check list and HPSM staff will educate members and providers about current coverage. HPSM will also work with members on a case-by-case basis to access additional coverage

when benefit limits are reached but medical necessity points to the need for additional services.

Commissioner Aviles acknowledged that dental integration and support will be costly and difficult. She acknowledged that there are not many dentists available to Medi-Cal enrollees and appreciates HPSM's efforts.

Mr. Curran explained next steps, including hiring staff, sending member notifications, and updating the Commission with additional financial information as it is received from the State.

Motion for approval to implement the Dental Integration Program as presented: **Miao / Second: France**

Verbal roll call vote was taken:
Yes: 8 – Aviles, Canepa, Ferrer, Horsley, Miao, Pon, Tai, Zuniga.
No: 0

6. Report from Chairman/Executive Committee

Commissioner Zuniga reported that the CEO Search Committee met recently, discussing criteria and questions for the candidates. They reviewed and commented on outreach materials developed by County Human Resources.

7. Report from Chief Executive Officer

- The CalAIM program promotes the provision of In Lieu of Services (ILOS), which include non-medical services such as housing and food that are necessary for overall health. For the past several years, the Commission has invested reserve funding in programs like the Community Care Settings Program (CCSP), which helps members transition from or avoid nursing facilities. These types of programs are considered ILOS. For the first time, the State has included this spending in development of HPSM's capitation rates. HPSM's 2022 rates will include 2019 ILOS spending as an add on, totaling several million in funding. This is a big victory for it ensures that programs like CCSP will be sustainable far into the future.
- KALW, a local NPR affiliate, recently aired a story about an HPSM member who was helped by the CCSP program. Kojo had been homeless for many years, in and out of nursing homes. He has been housed and medically stable for the past five years, thanks to CCSP. The KALW reporter did a good job of connecting CCSP to the ILOS concept in CalAIM, illustrating the potential for CalAIM reforms to help the homeless, especially aging homeless individuals, a rapidly growing problem throughout the State.

- HPSM's Vaccine Incentive Plan was just approved by the State, earning the Plan more than $500,000 to fund additional efforts to ensure HPSM members receive COVID vaccines. Up to $2.7 million may be available, depending on HPSM success in achieving benchmark vaccine rates. Funding includes payment incentives for providers as well as enhanced partnerships with County Health and neighborhood focused efforts.
- Ms. Altman reported that the State will soon release a plan under CalAIM for Foster Care. She will report to the Commission once the plan is made public.
- The next Commission meeting will be in person unless Brown Act flexibilities are extended.

8. Other Business

There was no other business discussed.

9. Adjournment

The meeting was adjourned at 1:35 p.m.

Respectfully submitted:

C. Burgess

C. Burgess, Clerk of the Commission

Dental Integration Program

San Mateo Health Commission Meeting
September 8, 2021

HealthPlan OF SAN MATEO
Healthy is for everyone

Agenda

HealthPlan OF SAN MATEO
HPSM Dental

- Background on dental integration program
- Overview of benefit administration
- Plan readiness activities
- Provider engagement
- Financial impact
- Next steps

Background: Legislative Action Taken

- Permissive language that DHCS may authorize a six-year dental integration pilot in San Mateo County no sooner than July 1, 2019
- Requires a process for stakeholder input, objectives for utilization and access, and an HPSM readiness assessment
- Includes a formal evaluation by an external entity:
  - HPSM is responsible for funding, estimated contribution $250,000
  - DHCS has developed and evaluation design and will select evaluator

Goals of Dental Integration

- Improve access to care for dental services, especially preventive services
- Align quality incentives for improved oral health with overall health
- Demonstrate through formal evaluation that integrating medical and dental services for Medi-Cal is cost-effective
  - Investing in preventive dental care reduces overall medical care costs, especially for non-traumatic dental ER visits, hospital admissions, and costs for diabetic care

Recent Developments

- Conducted focus groups with members regarding their experience with dental care and access.
- The Children's Health Initiative (CHI) Committee approved two grants to local clinics specifically targeted at improving access for low-income children
  - Two operatories at the NEMS Daly City location
  - One operatory at the Sonrisas San Mateo location

Overview of Dental Benefit Administration

- Approach to Dental Benefit Integration
- Leveraging HPSM's Expertise and Current Processes
- System Changes
  - HEALTHsuite
  - DocuStream

Readiness Activities

- DHCS and DMHC Readiness
- Internal Readiness
- DHCS Monthly Working Meetings

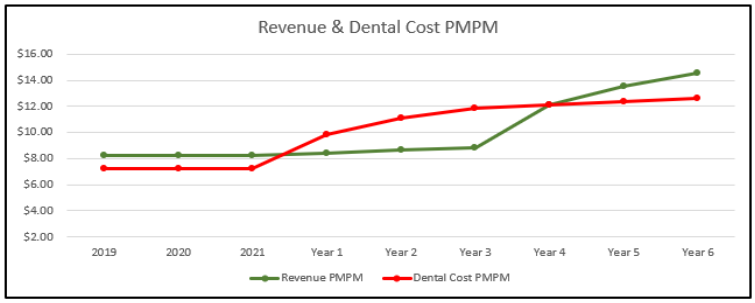
Provider Engagement

- Recruitment efforts
  - FQHC's, UOP, UCSF, current Medi-Cal Dental providers
- Reduce administrative burden for providers
- Participation options
- Strategy for continuous recruitment of additional general and specialty dentists

RDT Rate Setting Assumptions

Worst Case Scenario

Year	Base Yr 2019	2020	2021	Year 1 2022	Year 2 2023	Year 3 2024	Year 4 2025	Year 5 2026	Year 6 2027
Year 1	2019 cost + 3yr trend factor								
Year 2		2020 cost + 3yr trend factor							
Year 3			2021 cost + 3yr trend factor						
Year 4				Year 1 cost + 3yr trend factor					
Year 5					Year 2 cost + 3yr trend factor				
Year 6						Year 3 cost + 3yr trend factor			



Updated Six Year Forecast by Year

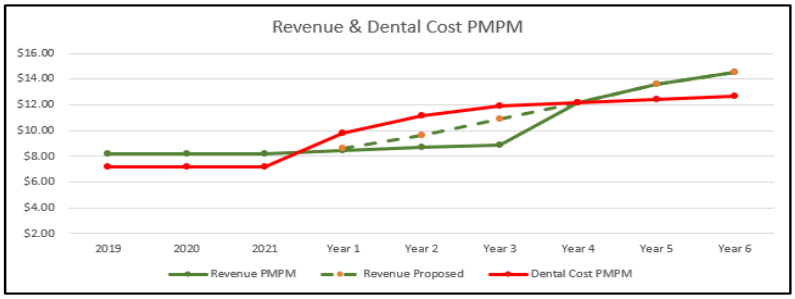
Worst Cases Scenario

	Baseline 2019	Year 1 CY 2022	Year 2 CY 2023	Year 3 CY 2024	Year 4 CY 2025	Year 5 CY 2026	Year 6 CY 2027	6-Year Total
Medi-Cal Membership	111,228	117,655	112,098	112,098	112,098	112,098	112,098	
Revenue		$11,861,184	$11,651,042	$11,880,089	$16,333,815	$18,283,346	$19,575,987	$89,585,462
Dental Expense	$9,622,302	$13,856,014	$14,939,269	$15,999,957	$16,319,957	$16,646,356	$16,979,283	$94,740,836
Admin Expense		$1,506,030	$1,581,332	$1,660,398	$1,743,418	$1,830,589	$1,922,118	$10,243,885
Net Income/(Loss)		($3,500,861)	($4,869,559)	($5,780,267)	($1,729,560)	($193,599)	$674,586	($15,399,259)
MLR %		116.8%	128.2%	134.7%	99.9%	91.0%	86.7%	
Admin %		12.7%	13.6%	14.0%	10.7%	10.0%	9.8%	
Profit %		-29.5%	-41.8%	-48.7%	-10.6%	-1.1%	3.4%	

RDT Rate Setting Assumptions

Discussion with DHCS

Year	Base Yr 2019	2020	2021	Year 1 2022	Year 2 2023	Year 3 2024	Year 4 2025	Year 5 2026	Year 6 2027
Year 1	2019 cost + 3yr trend factor								
Year 2		2020 cost + 3yr trend factor							
Year 3			2021 cost + 3yr trend factor						
Year 4				Year 1 cost + 3yr trend factor					
Year 5					Year 2 cost + 3yr trend factor				
Year 6						Year 3 cost + 3yr trend factor			



Next Steps

- Recruit additional HPSM staff
- Continue provider outreach and contracting
- Member notifications (Oct. 1 , Nov. 1, Dec. 1)
- Bring updated financial projections to October Commission meeting
- System testing and staff training
- Go-live on January 1, 2022

Questions and Discussion

HealthPlan OF SAN MATEO
Healthy is for everyone

AGENDA ITEM: 5.1

DATE: October 13, 2021

Meeting materials are not included

for Item 5.1 – Presentation on HPSM Justice, Equity Diversity, and Inclusion Efforts

MEMORANDUM

AGENDA ITEM: 5.2

DATE: October 13, 2021

DATE: October 4, 2021

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer
Amy Scribner, Population Health Officer

RE: Approval of Agreement with Upward Health

Recommendation

Approve an agreement with Upward Health to provide services for HPSM's HomeAdvantage program for a term extending through December 31, 2023. Upward Health will replace Landmark Health, the organization that has provided similar services since 2016. The annual program cost is approximately $4.5 million, substantially lower compared to Landmark Health costs.

Background and Discussion

The Commission approved funding for team-based in-home care in June 2016, to be delivered by Landmark Health providers through the HomeAdvantage program. HomeAdvantage was launched in November 2016; currently, approximately 1,200 HPSM CareAdvantage Cal MediConnect (CMC) members are receiving medical care in their homes – slightly more than half of the 2,000 members targeted for engagement.

The Commission approved covering the costs of this program from Health Plan reserves as a strategic investment in alignment with HPSM's 2016-18 Strategic Plan. Specifically, this is a high-quality, home-based medical and social care program for HPSM's most vulnerable and complex members. It helps achieve the strategic goal of ensuring high quality care and services for HPSM members. The Commission approved a contract extension with Landmark Health in 2020 to cover services in 2020 and 2021.

Over time, the program was expected to cover its cost in two ways while maintaining and improving quality of care for program recipients. First the annual health assessments performed by Landmark were expected to ensure appropriate coding for risk adjustment. Second, healthcare costs were expected to decrease from improved management and care coordination, and by provision of timely care in members' homes. Several program evaluations have been conducted by HPSM and third parties, specifically Mathematica Policy Research (funded by the California Health Care Foundation – a summary is attached) and Milliman Consulting. These evaluations concluded that the program had some success in reducing health care costs and improving overall health quality. In addition, HPSM paid

Landmark bonuses based on quality achievements. While this was a risk sharing agreement for the initial years, in 2019 the risk sharing elements were removed from the agreement. In 2019, Landmark refunded HPSM $5 million, based on 2018 risk share findings.

In 2021, HPSM conducted a Request for Proposal (RFP) process for HomeAdvantage services. Six provider organizations responded to the RFP and four finalists were selected for interviews. The selection process included a cross-functional team representing multiple HPSM departments. The team chose Upward Health, based on the organization's experience with social determinants of health and behavioral health as well as medical care, and the overall costs proposed. In addition, Upward Health is willing to participate as an Enhanced Care Management provider under the CalAIM program.

The HomeAdvantage program will retain core longitudinal home-based care services, including annual visits plus on demand services as well as "event driven" care to help stabilize members following a hospital discharge or other major health event. Finally, some members will graduate from the longitudinal program when they no longer require high touch services. Member transitions from Landmark Health to Upward Health will begin in the fourth quarter of 2021 and will be completed by March 1, 2022.

Fiscal Impact

The cost of the HomeAdvantage program currently is approximately $5.5 million per year. This contract with Upward Health will reduce annual program costs by about $1 million, to approximately $4.5 million per year. This is due to lower costs associated with the program plus graduation of members who no longer require high intensity services.

Revenue and reduced medical cost are expected to offset the $4.5 million annual program cost. Additionally, revenue generated by the new Enhanced Care Management benefit will help cover the care management costs associated with the program.

The term of the agreement with Upward Health is for two years, through December 31, 2023.

Mathematica
Progress Together

Issue Brief

Matthew J. Niedzwiecki, Jia Pu, and Maggie Samra

Innovations in Medicaid: Impacts of a Home-Based Intensive Care Model for Complex Medicaid Beneficiaries

Key Findings

1. **Reduced ED visits and inpatient stays with an associated behavioral health diagnosis.** A primary goal of the intensive care model was to reduce ED visits and inpatient stays. Evidence suggests that the intervention successfully reduced ED visits and inpatient stays, driven by reductions in visits with an associated behavioral health diagnosis.
2. **Increased probability of a follow-up visit with a primary care provider within 30 days of hospital discharge.** The intensive care model was associated with higher use of primary care overall, and a much higher probability of a follow-up visit with a primary care provider within 30 days of hospital discharge, an expected result because the intervention prioritized patients recently discharged from the hospital.
3. **Particularly strong effects for members with behavioral health diagnoses at baseline.** Members with behavioral health diagnoses at baseline experienced a decrease in ED visits and increase in outpatient visits that was at least as large if not larger than members without a documented behavioral health diagnosis.

I. Introduction

Effectively managing care for individuals with complex health care needs has the potential to both improve health care quality and reduce costs, but relatively few models have been implemented in a Medicaid population. The California Health Care Foundation invested in an innovative care delivery model by supporting a partnership between Landmark Health and two California Medicaid managed care health plans, the Inland Empire Health Plan (IEHP) and the Health Plan of San Mateo (HPSM). Building on the model it developed for Medicare Advantage populations outside California, Landmark delivered coordinated home-based services, including on-demand clinical care and connections to social services, to two cohorts of high-risk Medicaid managed care members with multiple medical or behavioral health needs, many of whom were also dually eligible for Medicare.[1] To understand the impacts of the home-based intensive care model on utilization and quality of care and to identify lessons learned in adapting the model to serve Medicaid enrollees, the California Health Care Foundation, IEHP, HPSM, and Landmark contracted Mathematica to evaluate the initial implementation of the model from 2016 to 2018.

Our evaluations build on a growing body of evidence around intensive care models for high-risk patients. While evidence has been mixed, systematic reviews of programs in the late 1990s and early 2000s found positive results for approaches that focus on the hospital-to-home transition and provide home-based visits along with other core program components such as interdisciplinary care teams, regular interprofessional care meetings to review patients and patient care plans, and after-hours urgent telephone services.[2,3] More recently, a randomized quality improvement trial administered by CareMore Health found a complex care management program reduced total medical expenditures by 37 percent and inpatient utilization by 59 percent for a group of high-need, high-cost Medicaid patients.[4] Similarly, results from the Center for Medicare & Medicaid Innovation's Independence at Home Demonstration showed that delivering home-based primary care to targeted Medicare beneficiaries with multiple chronic conditions and functional limitations improved the quality of care and lowered Medicare expenditures. In its second performance year, the Independence at Home program saved Medicare an average $1,010 per beneficiary and yielded positive impacts on quality-of-care indicators, including follow-up contact from providers after inpatient stays, hospital readmissions, and ED visits and stays for ambulatory care sensitive conditions (ACSC), which are defined as admissions that might have been preventable with appropriate access to primary care.[5] However, findings about the impact of intensive care models for high-risk patients have not been consistent. A randomized evaluation of the Camden Coalition's hotspotting program, a post-discharge transition intervention that helps connect a population with medical and social complexity and substantially higher health care utilization to existing clinical and social resources, found no significant impact on participants' 180-day readmission rate.[6]

Model overview

Landmark's model for high-risk patients aims to reduce high-cost medical service use, such as emergency department visits and inpatient stays, and to improve patients' quality of life through more intensive, home-based medical management. The approach involves interdisciplinary care teams, in-home medical services, crisis management available at any time and every day, and coordination of health care and social services. Landmark tailors the intervention to patients based on their health status, care utilization needs, and available social supports.

Our findings from evaluating the Landmark–IEHP partnership over two years and Landmark–HPSM partnership over twenty-one months are consistent with this literature and reveal important lessons for applying intensive care models to high-need, high-cost Medicaid enrollees. IEHP and HPSM each contracted with Landmark according to their unique needs, so the target populations and study designs for the two plans were distinct, but both targeted dually eligible beneficiaries. We synthesize major findings for dually eligible beneficiaries – those receiving both Medicare and Medicaid services – from the two evaluations in Table I.1. The remainder of the brief presents more detailed findings from the two evaluations individually, including findings for the Medicaid-only IEHP population, which were consistent with those found for dual eligible members.

Table I.1. Summary of impacts of the intensive care model for members dually eligible for Medicare and Medicaid

Outcome category	IEHP Y1/Y2	HPSM
Hospital-based care		
Inpatient stays	↓↑	↓
Inpatient stays with a behavioral health diagnosis	↓↓	↓
ED visits	↓↓	↓
ED visits with a behavioral health diagnosis	↓↓	↓
Ambulatory care		
Primary care visits	↑↑	↑
Primary care visits (non-Landmark)	↑↑	↓
Specialty care visits	↑↑	↑
30-day prescription drug fills	↑↑	↓
Quality of care		
30-day post discharge follow-up	↑↑	↑
ACSC stays	↓↑	↓
30-day hospital readmissions	↓↓	↓

Notes: Arrows indicate the direction of the change, and statistically significant results ($p < 0.05$) are indicated by dark green arrows.

II. Impacts of the Home-Based Intensive Care Model among Inland Empire Health Plan Members

In 2016 Landmark began providing the home-based intensive care model to dual-eligible and Medicaid-only beneficiaries enrolled with IEHP. Our evaluation compared outcomes over two years for 359 dually eligible IEHP members engaged by Landmark (36 percent of the total engaged cohort) to a matched cohort of 2,865 IEHP members who were eligible for the home-based intensive care model but not engaged by December 2016. Members in both groups were continuously observable through the two-year follow up period that ended December 2018. We conducted separate analyses for Medicaid-only members, presented at the end of this section, but focus on our findings for dual eligible members in this synthesis brief, since the Landmark-HPSM partnership included only dual-eligible members.

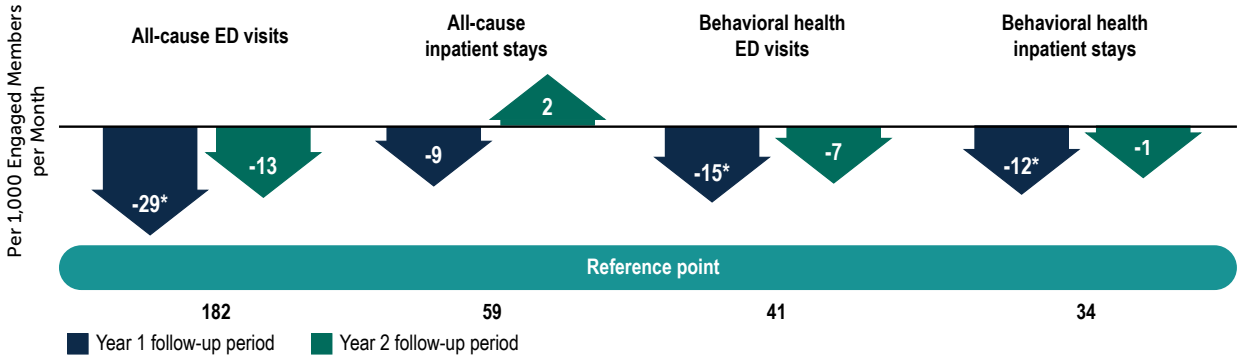
Dual-eligible members were, on average, 65 years old, and 50 percent had at least one recorded behavioral health diagnosis in the baseline period. Their average Chronic Illness and Disability Payment system score was 3, indicating these members were substantially less healthy and had a greater need for care than the average Medicaid beneficiary. Comparison group members had similar demographic and health characteristics as engaged members. Further details about the evaluation methods are available in the "Methods" box at the end of this brief.

A. What were the impacts of the model on ED visits and inpatient stays, including those with a behavioral health diagnosis, for dual-eligible members?

A primary goal of the intervention was to reduce ED visits and inpatient stays. We found evidence that the intervention led to a decrease in ED visits and hospital stays in the first year, particularly for the subset of events that had an accompanying behavioral health diagnosis. The home-based intensive care model was associated with 29 fewer all-cause ED visits per 1,000 engaged members per month relative to the comparison group (about 16 percent

lower than our reference point, defined as the baseline rate among the engaged members). Similarly, considering visits with a behavioral health diagnosis, the intervention led to 15 fewer ED visits and 12 fewer inpatient stays per 1,000 engaged members per month relative to those of the comparison group (about 37 percent and 35 percent lower than our reference point, respectively). These findings are consistent with the program's expected reduction in ED visits and inpatient stays among frequent users through better use of usual care. We did not, however, detect any statistically significant changes in ED visits or inpatient stays in the second year.

Figure II.1. Impact on ED visits and inpatient stays among engaged IEHP members



* Significantly different from zero at the .05 level, two-tailed test.

B. What were the impacts of the model on the use of ambulatory care services such as primary care, specialty care, and prescription drugs, for dual-eligible members?

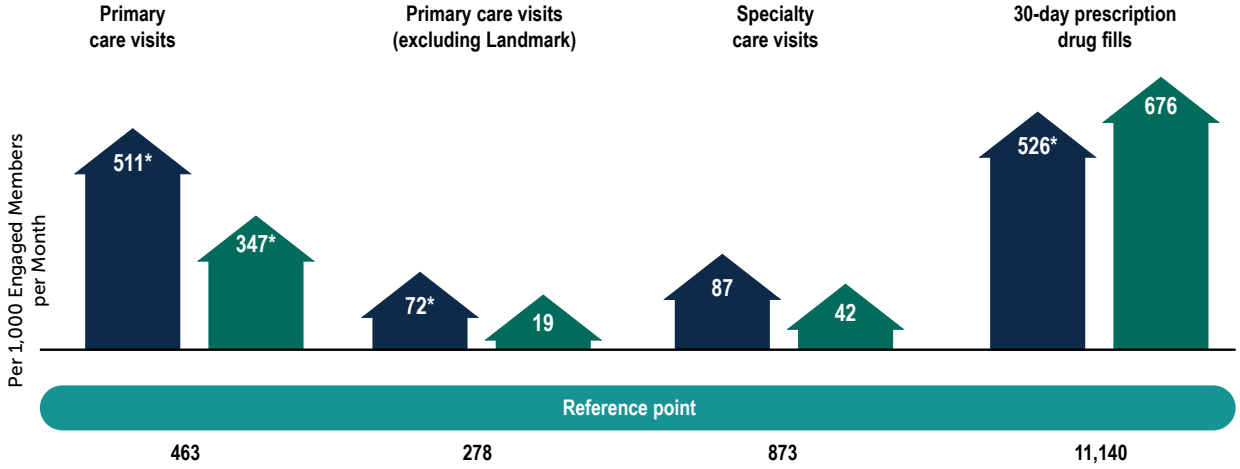
We hypothesized that overall, primary care visits would increase. Primary care visits with Landmark providers should increase because of the convenience of in-home visits. Visits with non-Landmark outpatient providers could increase because of increased referrals from Landmark providers, or they could decrease if the in-home services act as a substitute for non-Landmark primary care providers.

We found strong evidence that the intervention led to an increase in outpatient visits for engaged members in both program years, mainly driven by primary care visits. In the first year, the home-based intensive care model was associated with 72 more primary care visits per 1,000 engaged members per month relative to those of the comparison group (about 16 percent higher than our reference point). The program's impact was even larger when accounting for visits with Landmark providers, leading to 511 more primary care visits per 1,000 engaged members per month (almost twice our reference point). This association was still statistically significant in the second year when accounting for visits with Landmark providers.

We found no statistically significant associations between the model and changes in specialty care visits. The null result could indicate that the intervention had no impact, or that it caused an increase in specialty care use among some patients and a decrease among others that resulted in no net change at the population level.

For prescription drugs, the intervention could cause an increase in medication fills, due to increased medication adherence or better disease management, or it could also cause a decrease in prescription drug use because of a reduction in simultaneous use of multiple drugs in treatment. We found a significant increase in medication use in both years. In the first year, the 30-day prescription drug fill rate increased by 526 fills per 1,000 members per month more in the engaged group than in the comparison group.

Figure II.2. Impact on outpatient services and prescription drugs among engaged IEHP members



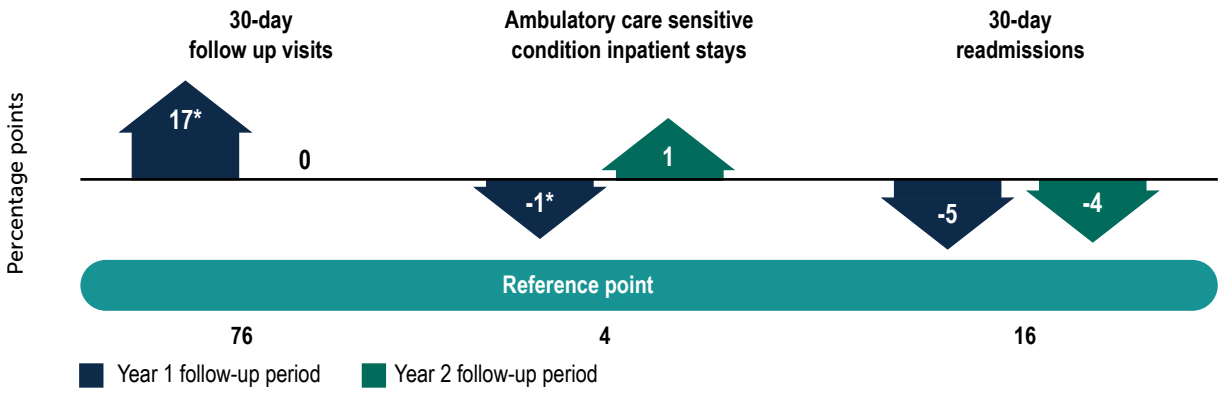
* Significantly different from zero at the .05 level, two-tailed test.

C. What were the impacts of the model on quality of care measures, including 30-day follow-up after hospital discharge, ACSC stays, and 30-day hospital readmissions, for dual-eligible members?

The program also aims to improve the transition to home after hospital discharge. Consistent with this goal, we found strong evidence of an increase in the probability of a 30-day post-discharge follow-up visit with a primary care provider, including visits with Landmark providers, in the first year. The probability of having a post-discharge follow-up increased by 17 percentage points more in the engaged group (to 93 percent) than in the comparison group, but we did not find a similar impact in the second year.

In addition, we expected that the model would have a positive impact on other quality-of-care outcomes, including reducing the probability of having ACSC inpatient stays and 30-day all-cause hospital readmissions. Although the program was associated with a 1 percentage point decrease in the probability of having ACSC stays among engaged members in the first year (about 25 percent lower than our reference point), we did not observe a similar impact in the second year. We did not find any evidence that there was a change in 30-day readmissions in either program year.

Figure II.3. Impact on quality of care measures among engaged IEHP members



* Significantly different from zero at the .05 level, two-tailed test.

D. What were the impacts of the model for Medicaid only members?

To assess program impacts for Medicaid-only members, we compared outcomes over the first year among 812 Medicaid-only IEHP members who engaged with Landmark by December 2016 with those of a matched cohort of 391 IEHP Medicaid-only members ineligible for the home-based intensive care model because of their enrollment with independent practice associations. We could not evaluate the program's impacts for Medicaid-only members in the second year because of sample attrition in the comparison group caused by the exit of one comparison independent practice association from IEHP's network. The comparison group members had similar demographic and health characteristics as the engaged members.

Overall, we found some evidence that the program reduced ED visits and inpatient stays in the first program year. In particular, the program led to a decrease in the probability of having two or more all-cause ED visits or an inpatient stay with an accompanying behavioral health diagnosis. The program was also associated with an increase in outpatient care utilization, mainly driven by primary care visits, and use of prescription drugs. We found an increase in the probability of having a post-discharge visit with an IEHP primary care provider or a Landmark provider within 30 days of a hospital discharge, but no impact on ACSC inpatient stays or 30-day readmission rates. We summarize major findings for Medi-Cal only enrollees for the IEHP evaluation in Table II.1.

Table II.1. Summary of impacts of the intensive care model for Medi-Cal only members

Outcome category	IEHP Y1
Hospital-based care	
Inpatient stays	↓
Inpatient stays with a behavioral health diagnosis	↓
ED visits	↓
ED visits with a behavioral health diagnosis	↓
Ambulatory care	
Primary care visits	↑
Primary care visits (non-Landmark)	↑
Specialty care visits	↑
30-day prescription drug fills	↑
Quality of care	
30-day post discharge follow-up	↑
ACSC stays	↓
30-day hospital readmissions	↓

Notes: Arrows indicate the direction of the change, and statistically significant results ($p < 0.05$) are indicated by dark green arrows.

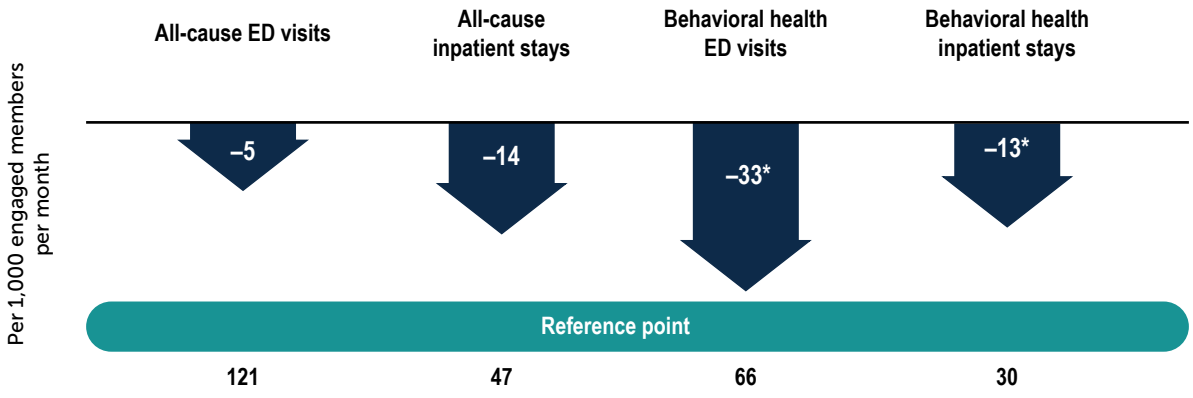
III. Impacts of the Home-Based Intensive Care Model among Health Plan of San Mateo Members

In November 2016, Landmark began providing coordinated home-based services, including clinical care, for HPSM's Medicare and Medicaid dual-eligible population with multiple medical conditions and some co-occurring behavioral health conditions. We studied a cohort of 2,101 dual eligible HPSM beneficiaries between February 2015 and October 2018 where over 60 percent of individuals enrolled with Landmark. The study population had an average age of 78 years old; 50 percent had at least one recorded behavioral health diagnosis in the baseline period; and the average Hierarchical Condition Category risk score was 2.15, indicating that these members should cost more than twice the average Medicare beneficiary based on demographics and diagnoses. Unlike in the IEHP context, the HPSM evaluation included only those who were dual eligible for Medicaid and Medicare; we did not study Medicaid-only members in this evaluation. We used a single interrupted time series model to assess how trends in health care utilization and quality of care changed after the home-based intensive care model started engaging beneficiaries in November 2016. Further details about the methods are available in the Methods box at the end of the brief.

A. What were the impacts of the model on ED visits and inpatient stays, including those with a behavioral health diagnosis?

We hypothesized that the home-based intensive care model would reduce inpatient and ED use, overall and for the subset of events that had an accompanying behavioral health diagnosis. We found that the intervention was associated with reductions in the subset of ED visits and inpatient stays with a behavioral health diagnosis but not for ED visits and inpatient stays overall. The intervention was associated with 33 fewer ED visits with an associated behavioral health diagnosis per 1,000 engaged members per month (about 50 percent lower than our reference point, what would be predicted without the intervention) and 13 fewer inpatient stays with a behavioral health diagnosis per 1,000 engaged members per month relative to what would have been predicted absent the intervention (about 43 percent lower). We also found a negative association between the home-based intensive care model and all-cause ED visits and inpatient stays, but these findings were not statistically significant. The association of the intervention with a larger decrease in ED visits and inpatient stays with accompanying behavioral health diagnoses suggests that the Landmark model may be more successful with patients who have both medical and behavioral health comorbidities rather than either medical or behavioral health conditions on their own.

Figure III.1. Impact on ED visits and inpatient stays among engaged HPSM members



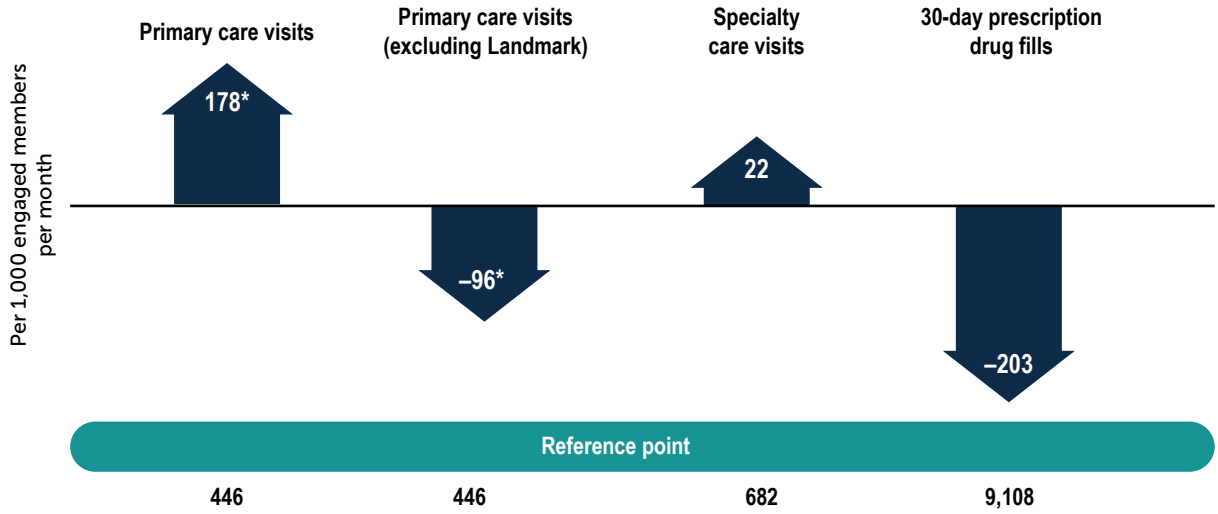
* Significantly different from zero at the .05 level, two-tailed test. Data from 2016-2018.

B. What were the impacts of the model on the use of ambulatory care services such as primary care, specialty care, and prescription drugs?

Consistent with our hypothesis, we found evidence that the intervention led to an increase in primary care visits for engaged members. The intervention was associated with 178 more primary care visits (including visits with Landmark providers and non-Landmark primary care providers) per 1,000 engaged members per month relative to the counterfactual trend line. In contrast to the IEHP context, we found evidence of substitution from non-Landmark to Landmark providers among HPSM beneficiaries. Although we found increased primary care visits with all providers (considering both Landmark and non-Landmark), we saw decreased visits to non-Landmark primary care providers that were associated with the intervention: 96 fewer primary care visits with non-Landmark providers per 1,000 engaged members per month.

We found no statistically significant associations between the home-based intensive care model and changes in specialty care visits or 30-day standardized prescription fills.

Figure III.2. Impact on outpatient services and prescription drugs among engaged HPSM members

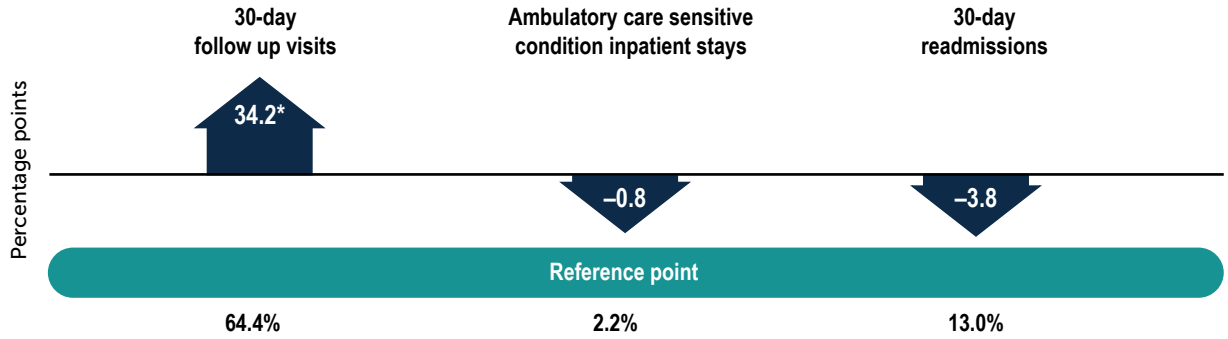


* Significantly different from zero at the .05 level, two-tailed test. Data from 2016-2018.

C. What were the impacts of the model on quality of care measures, including 30-day follow-up after hospital or skilled nursing facility discharge, ACSC inpatient stays, and 30-day hospital readmissions?

We expected that the home-based intensive care model would have a positive impact on the three quality of care outcomes we considered. Our analyses showed that the intervention was associated with a 34-percentage point increase in the probability of a 30-day follow-up visit after an inpatient or skilled nursing facility stay. We assessed follow up visits after discharge from inpatient and skilled nursing facilities.[7] However, we found no strong evidence of a change in ACSCs or 30-day readmissions.

Figure III.3. Impact on quality of care measures among engaged HPSM members



* Significantly different from zero at the .05 level, two-tailed test. Data from 2016-2018.

IV. Discussion

Overall, our estimates of the effect of Landmark's home-based intensive care model were consistent with the program's theory of action in terms of direction and magnitude. We found consistent evidence that the interventions were associated with decreases in ED visits and inpatient stays with an associated behavioral health diagnosis, increases in primary care visits, and a greater probability of primary care follow-up after discharge from inpatient stays (and skilled nursing facility stays for HPSM members). For members with documented behavioral health diagnosis at baseline, there were larger associated decreases in ED visits and inpatient stays, suggesting the population with behavioral health diagnoses – roughly half the study population – might experience particularly favorable impacts from home-based interventions. Despite having comprehensive insurance coverage that mitigates financial barriers, previous studies have documented organizational and geographic barriers to access for the dually eligible population.[8] Our work affirms that home-based intensive care models show promise for improving access among high-risk dually eligible enrollees.

To consider the net effect of these reductions in ED and inpatient care, balanced against increases in primary care, we monetized observed changes in utilization in the IEHP evaluation using the California Medicaid reimbursement rate schedule, and found no statistically significant change in these standardized costs over the two years, suggesting these changes largely offset one another. Although Medi-Cal often contracts through managed care rather than fee-for-service, we used the reimbursement rate schedule to understand how decreases in some types of services, like ED visits, might offset increases in other types of services, like primary care visits. This exercise helps illustrate changes in overall resource use, but does not estimate the impact of Landmark services on total costs to Medi-Cal in the short run.

We found mixed results for other outcomes. For specialist visits and prescription drug use, we found an increase in the IEHP context, but no evidence of change associated with the intervention in the HPSM context. In both evaluations, we found no strong evidence for reductions in 30-day all-cause hospital readmissions or inpatient stays for ACSC. The differences may be attributable to differences in the study populations (the HPSM population of dually eligible beneficiaries was considerably older on average) or differences in local-level implementation.

Our findings also align with the broader literature on home-based primary care. In a recent review article that examined outcomes in home-based primary care programs that treated homebound older adults, the authors found evidence for decreased ED visits in four of nine studies and decreases in hospital stays in six of nine studies (but increases in one study).[9] The articles in that review were mostly observational studies, and the one study that was a randomized controlled trial found null results for ED visits and hospital stays.[10]

While the first-year evaluation of the IEHP and Landmark partnership used mixed methods and interviewed key stakeholders, the studies otherwise did not include survey measures of patients' well-being, their quality of life, or any other benefits of the intervention. One can infer from reductions in ED visits and inpatient stays that the intervention had a positive impact on members' well-being, but other improvements in quality of life might not have been captured.

Another limitation was that our evaluations were not based on a randomized controlled trial. Both evaluations were rigorously designed and used comparison groups when possible, however. The IEHP evaluation used a difference-in-differences design with an untreated comparison group, and the HPSM study used a single interrupted time series approach that used trends from the pre-intervention time period as a counterfactual to the intervention. Due to the lack of a comparison group, the HPSM study may also be confounded by other unmeasured changes in the health care and social service support systems that occurred around the same time as the Landmark intervention. We know of no specific changes in this time period. Both evaluation methods generate more reliable results than analyses that do not use a comparison group or account for pre-intervention trends in the outcomes. Despite these limitations, the evaluation results can be interpreted with confidence, especially where the findings align across the two studies and with the broader literature.

V. Lessons Learned

In summary, we found that Landmark's home-based intensive care model in the IEHP and HPSM settings accomplished many of its goals by changing patterns of health care use for engaged members. The model was associated with statistically significant decreases in ED visits and inpatient stays with an associated behavioral health diagnosis, increases in primary care visits, and increased rates of follow-up after discharge from inpatient and skilled nursing facility stays. As interest grows in innovative approaches for providing home-based care to complex patients, particularly in response to the COVID-19 pandemic, we reflect on some lessons from the two evaluations that can inform future efforts.[11]

First, adjusting to the Medicaid managed care landscape was a challenge. Medicaid enrollees, including dually eligible enrollees, differ markedly from the Medicare Advantage population in which Landmark's model was first developed, in that they suffer from higher rates of substance use disorders, have significant mental health needs, and have more functional limitations related to activities of daily living and instrumental activities of daily living. Many also have unmet social needs, including lack of access to transportation, unstable housing or homelessness, unsafe living conditions, unemployment or underemployment, and deep poverty, that complicate their effective treatment.[12] During an interview in 2017, Landmark operational staff described challenges in providing care to patients with behavioral health diagnoses, including connecting them to needed community resources. In response, Landmark hired additional social workers and behavioral health providers and reworked the approach to engaging beneficiaries. For example, in the IEHP setting, Landmark assigned social workers to lead the initial patient visit to better address patients' social and community support needs as a foundation for later medical management interventions, changes that appear to have made progress as the impact analysis findings show. The Landmark experience illustrates how programs newly adapted to provide comprehensive care and home-based visits to Medicaid enrollees will require tailoring to the unique needs of the Medicaid population if they were developed for Medicare Advantage or other populations.

Second, the intervention had a larger impact on ED visits and inpatient stays for members with behavioral health diagnoses at baseline, which was unexpected to the evaluators given the challenges of working with populations that have both physical and behavioral health needs. Our findings suggest the population with behavioral health needs might be a particularly high-need population that found considerable benefit from the home-based intensive care model. Future interventions might consider

focusing on beneficiaries with co-occurring behavioral health needs, particularly when resources are limited and health plans must selectively target subgroups.

Third, based on findings from the IEHP study, which separately identified changes in the first and second year of the intervention, there are concerns that the positive impacts might not be sustained over time. The IEHP study found positive impacts in the first year that were generally not sustained into year two. Although churn was generally an issue in the Medicaid-only population, it was less common in the dually eligible population, meaning these results are not attributable simply to sample selection. As health care innovators consider home-based intensive care models, they should expect that results may be uneven over time, and look to confirm whether early experiences persist. When managing chronic conditions such as diabetes and high blood pressure, it is also possible that the long-term benefits of care management may take more than two years to accrue.

Finally, the two evaluations presented in this brief represent an important investment in rigorous evaluation work. But the evaluations also highlight the challenges of conducting non-experimental studies when examining impacts for high-cost, high-need populations. Even the most carefully designed non-experimental studies cannot completely eliminate potential selection bias, where members who self-select to engage with the home-based intensive care model might be different than comparison beneficiaries who do not. Non-experimental studies also risk regression-to-the-mean bias, in which members likely engage with services after a crisis and then appear to improve over time simply because their reference point is their moment of crisis. Future studies could generate stronger evidence if they employ a randomized controlled trial, which mitigates biases and allows researchers to estimate a true causal impact of the intervention. Although not always feasible from technical, ethical, or cost perspectives, randomized controlled trials are the gold standard for generating evaluation evidence that health care plans and policymakers can rely on to inform their decision making.

The partnership between Landmark, IEHP, and HPSM represented a novel care model that aimed to provide better care to Medicaid members with multiple chronic conditions. While providing services to a cohort of high-risk and high-cost Medicaid members is challenging, the partnership succeeded in achieving favorable results on several of the core outcomes of the intervention. Moreover, all partners were committed to learning from their experience and to broadly disseminating those findings, a commendable effort not consistently seen with health care innovations. Together with findings from other programs, our findings support the idea that providing coordinated home-based services that include a behavioral health component and address patients' unmet social needs can meaningfully reduce acute care spending. Supported by a growing body of evidence, home-based care models have established themselves as an important approach to improving the quality and efficiency of care for patients with complex health care needs across the spectrum of healthcare payers.

Endnotes

[1] Landmark selected adult beneficiaries with five or more chronic conditions from the following diagnoses documented in claims: hypertension, heart disease and heart failure, chronic kidney disease, diabetes, pulmonary disease, cancer, vascular disease, depression, dementia, and liver disease. Eligibility for Landmark's services was not conditional on utilization.

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[7] IEHP and HPSM defined their quality metrics for follow up care differently. The HPSM study examined follow-up care following inpatient and SNF stays, while the IEHP study only looked at follow up following inpatient stays.

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[12] Spencer A., B. Freda, T. McGinnis, and L. Gottlieb. "Measuring Social Determinants of Health among Medicaid Beneficiaries: Early State Lessons." Center for Health Care Strategies website. https://www.chcs.org/media/CHCS-SDOH-Measures-Brief_120716_FINAL. pdf. Published December, 2016. Accessed November 2, 2020

Acknowledgements

This brief and the two Landmark evaluations were produced with support from the California Health Care Foundation. The Inland Empire Health Plan and the Health Plan of San Mateo provided data for the evaluations.

Methods for IEHP Study

Regression analysis. The impact estimates are based on a difference-in-differences study design. With this design, we measure program effects as the change in outcomes among study participants before versus after enrollment relative to the change in outcomes among a comparison group with similar characteristics over the same period. In this analysis, we define the pre-enrollment period as the year before each participant's enrollment date and the post-enrollment period as the two years after. Under the assumption that external trends affect both groups similarly, a comparison group that is well matched on observable and unobservable characteristics will produce unbiased estimates of program effects. The relative difference between the treatment and comparison group is calculated by comparing the pre-post difference among engaged group members to the pre-post difference among comparison group members.

Sample selection. Our main analysis sample is restricted to beneficiaries who were continuously enrolled with IEHP and observable for the entire analysis period, 2015-2018. We imposed this restriction to ensure that (1) there were no gaps in enrollment and (2) our sample did not change over time in ways that would bias our results. N = 3,224 dually eligible enrollees (years 1 and 2); N = 1,203 Medi-Cal only enrollees (year 1 only)

Sensitivity analyses. We also analyzed the sensitivity of our results by implementing two difference-in-differences analysis models, one without adding any covariates to the regression model and the other excluding extreme values (higher than the 99th percentile) from the continuous outcome measures. Both models provided results consistent with the findings from the primary analysis.

Qualitative analyses. We conducted interviews in 2016 and 2017 with IEHP and Landmark operational staff and IEHP primary care providers who treated Landmark-engaged patients.

Methods for HPSM Study

Regression analysis. We used a single interrupted time series model with a study sample that included all members eligible for home-based intensive care services, regardless of whether they engaged with the intervention (intention-to-treat). To account for the gradual ramp-up in engagement, we assessed the association between each outcome variable and the fraction of the beneficiary cohort engaged with Landmark rather than the association with time since Landmark began enrollment. We could not identify a viable comparison group within HPSM's patient population because all beneficiaries in HPSM who met chronic conditions criteria were eligible for home-based intensive care services, and more than half those eligible beneficiaries enrolled. The single interrupted time series approach, which does not require a comparison group, uses many time periods in the pre-intervention period to estimate trends in the outcome variable of interest, such as ED visits per 1,000 members per month, and then uses this forecast as a counterfactual against which to compare the observed outcomes during the intervention period. The estimated effect of the intervention is the difference between the outcome observed in the data and the forecast benchmark drawn from pre-intervention trends.

Sample selection. Our main analysis sample is restricted to beneficiaries who were continuously dually eligible and enrolled with HPSM for the entire analysis period from February 2015 to October 2018. We imposed this restriction to ensure that (1) there were no gaps in enrollment and (2) our sample did not change over time in ways that would bias our results. N = 2,101 dually eligible enrollees.

Sensitivity analyses. We conducted several sensitivity analyses to test the robustness of our main analysis to alternative choices for sample selection and regression model specification. In one sensitivity analysis, we conducted a placebo test that restricted the sample to beneficiaries who were never engaged with home-based intensive care services during the study period. For this never-engaged group, we would expect to see no break in outcome trends around the time Landmark began engaging with HPSM beneficiaries. These alternative sample and model choices enabled us to test the robustness of our results to different decisions we made about how to conduct our analysis. Results reported in this brief are consistent across multiple sensitivity analyses and the placebo test, which gives us confidence that we are observing a real effect of the intervention.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF AN AGREEMENT
WITH UPWARD HEALTH

RESOLUTION 2021 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has contracted with Landmark Health since 2016 to provide in-home medical services through the HomeAdvantage Program;
B. HPSM staff released an RFP in 2021 to evaluate Landmark Health and other potential providers for HomeAdvantage services; and
C. Upward Health was selected as the new contractor based on its service offerings and total costs proposed.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves an agreement with Upward Health with a term through December 31, 2023, for an annual payment amount of approximately $4.5 million; and
2. Authorizes the Chief Executive Officer to execute the agreement.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of October 2021 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Ligia Andrade Zuniga, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

MEMORANDUM

AGENDA ITEM: 5.3

DATE: October 13, 2021

DATE: October 5, 2021

TO: San Mateo Health Commission

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

RE: Approval of Funding Recommendations for the Children's Health Initiative (CHI) Fund

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Recommendation

Approve distributing **$5,159,800** from the restricted Children's Health Initiative Fund to the following entities:

a. **$3,225,150** to the Mission Assets Fund for the San Mateo County Immigrant Families Recovery Fund;
b. **$210,000** to North East Medical Services (NEMS) to help fund two dental operatories in Daly City;
c. **$105,000** to Sonrisas Dental Health to help fund one dental operatory in San Mateo;
d. **$100,000** to First Five San Mateo County to administer an oral health planning grant;
e. **$1,004,400** to Sequoia Healthcare District as a return of funds;
f. **$343,500** to Peninsula Health Care District as a return of funds;
g. **$171,750** to First Five San Mateo County as a return of funds.

Background and Discussion

In 2003, San Mateo County and key partners launched the Children's Health Initiative to achieve universal health insurance coverage for children in San Mateo County. HPSM played a critical role by administering a locally supported health insurance program called Healthy Kids that was designed to serve children ineligible for federal and state programs, generally due to immigration status.

In 2007, governance for this initiative was moved from San Mateo County to the San Mateo Health Commission with guidance by the Children's Health Initiative (CHI) Oversight Committee. HPSM operated the Healthy Kids program until 2018; the State expanded the Medi-Cal program in 2016, covering all children under the age of 19 regardless of immigration status. CHI had built up a reserve over many years of program operations; the reserve is managed by the County in a restricted Children's Health Initiative fund.

The CHI Oversight Committee operates through a Memorandum of Understanding (MOU) involving eight voting members. This MOU was last revised in January 2019. San Mateo County oversees the financial stewardship of the restricted fund established to support CHI. HPSM is one of the eight voting members and participates in the CHI Oversight Committee.

It is important to emphasize the dollars held in the CHI Fund are not dollars contributed by HPSM. The funding was contributed by the following entities: San Mateo County, First Five San Mateo County, Peninsula Health Care District, and Sequoia Healthcare District.

Since Medi-Cal was expanded to cover all children, the CHI Oversight Committee has considered areas of investment for children in San Mateo County using the remaining restricted reserve funds. In December 2020, CHI recommended directing $2,000,000 from the restricted fund to Mission Assets Fund's San Mateo County Immigrant Relief Fund. This recommendation followed research and analysis by the CHI Oversight Committee on the needs facing children and their families during the COVID-19 pandemic, including San Mateo County's action to direct $4 million to this fund and estimated unmet need from applicants living in San Mateo County.

Since that initial investment, the Mission Assets Fund has developed a program called the Immigrant Families Recovery Fund to support families that are ineligible for the Federal expanded child tax credit through monthly financial support, combined with supportive services over a two-year period and robust evaluation to determine the impact of the program. CHI recommended an initial investment of $2,000,000 in July 2021 and increased that recommendation by $1,225,150 at its August 2021 meeting for a total recommended contribution of $3,225,150.

The CHI Oversight Committee is also making recommendations for three investments to support increased access to dental care and preventive services for low-income children. The proposed grants to NEMS and Sonrisas fund additional capacity and these organizations will prioritize access for low-income children. The Oral Health Planning Grant will be administered through First Five, which will contract with one or more entities to organize oral health screenings through schools and other organizations that serve children.

The final set of recommendations is returning funding to the organizations which contributed money to CHI, based on each organization's choice. In the case of Sequoia Healthcare District, CHI will return all remaining funds. In the case of First Five and Peninsula Health Care District, CHI will return a portion of the remaining funds.

Fiscal Impact

The San Mateo Health Commission, as the governing body for CHI, must authorize release of funds from the restricted account, which is a reserve built up over many years of funding CHI. However, the funds do not have any financial impact on Health Plan of San Mateo and are not held in HPSM accounts. The estimated remaining dollars in the CHI restricted account after these distributions is $1.4M. After approval by the Commission, these recommendations will be brought to the San Mateo County Board of Supervisors for approval.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF FUNDING FROM THE CHILDREN'S HEALTH INITIATIVE RESTRICTED FUND

RESOLUTION 2021 -

RECITAL: WHEREAS,

A. The Children's Health Initiative (CHI) was created in 2003 to achieve universal health insurance coverage in San Mateo County for children ineligible for federal and state programs;
B. In 2007, governance for this initiative was moved to the San Mateo Health Commission with San Mateo County overseeing the financial stewardship of the restricted fund established to support CHI;
C. The CHI Oversight Committee has conducted research and analysis of the needs facing children and their families; and
D. Based on findings, the CHI Oversight Committee recommends distributing $5,159,800 from the restricted Children's Health Initiative fund.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves the one-time distribution of **$5,159,800** from the restricted Children's Health Initiative Fund to the following entities:
    a. **$3,225,150** to the Mission Assets Fund for the San Mateo County Immigrant Families Recovery Fund;
    b. **$210,000** to North East Medical Services (NEMS) to help fund two dental operatories in Daly City;
    c. **$105,000** to Sonrisas Dental Health to help fund one dental operatory in San Mateo;
    d. **$100,000** to First Five San Mateo County to administer an oral health planning grant;
    e. **$1,004,400** to Sequoia Health Care District as a return of funds;
    f. **$343,500** to Peninsula Health Care District as a return of funds;
    g. **$171,750** to First Five San Mateo County as a return of funds.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of October 2021 by the following votes:

AYES:
NOES:
ABSTAINED:
ABSENT:

_____
Ligia Andrade Zuniga, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

MEMORANDUM

AGENDA ITEM: 5.4

DATE: October 13, 2021

DATE: October 4, 2021

TO: San Mateo Health Commission

FROM: Maya Altman, CEO

RE: Ratification of an Agreement with Morgan Consulting Resources

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Recommendation

Ratify execution of an agreement with Morgan Consulting Resources for recruitment services to fill HPSM's Chief Executive Officer position. The agreement is for an amount not to exceed $115,000 and for a term of October 1, 2021, through January 31, 2022.

Background and Discussion

In July 2021, HPSM's Chief Executive Officer announced her retirement effective January 1, 2022. Also in July, the Commission created a Search Committee to work with the San Mateo County Human Resources Department to identify candidates to interview for this position. The Search Committee subsequently decided to engage a consultant specializing in health executive recruitment.

County Human Resources developed a Request for Proposal that was dispatched to several recruiting firms. Two responded and the Search Committee conducted interviews with representatives from both firms, ultimately selecting Morgan Consulting Resources. The recruitment is expected to be completed within approximately 16 weeks. HPSM has used Morgan Consulting in the past to help recruit for difficult-to-fill senior financial and medical positions.

Fiscal Impact

Morgan Consulting Resources has agreed to handle the recruitment for a fee not to exceed $115,000, including expenses. The agreement term is October 1, 2021, through January 31, 2022. San Mateo County Human Resources executed the agreement with Morgan Consulting; HPSM will reimburse the County.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF RATIFYING AN AGREEMENT
WITH MORGAN CONSULTING RESOURCES

RESOLUTION 2021 -

RECITAL: WHEREAS,

A. HPSM's Chief Executive Officer announced her retirement effective January 1, 2022;

B. The San Mateo Health Commission formed a Search Committee to identify and interview candidates for this position;

C. The Commission Search Committee decided to engage a consulting firm specializing in health executive recruitment to assist the Committee and County Human Resources released an RFP on behalf of the Search Committee; and

D. The Commission Search Committee selected Morgan Consulting Resources after interviewing the two RFP respondents.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission ratifies an agreement with Morgan Consulting for recruitment services, in an amount not to exceed $115,000.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of October 2021 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Ligia Andrade Zuniga, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

MEMORANDUM

AGENDA ITEM: 7.0

DATE: October 13, 2021

DATE: October 4, 2021

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: CEO Report

Dental Program

Last week, HPSM received updated rates for the new Dental Program starting in January, which was very good news. So far, our analysis shows the updated rates will put the program close to break-even in 2022, instead of a $3.5 million deficit as recently presented to the Commission under a worst-case scenario. The State and Mercer, the State's actuary, acknowledged a large amount of data was missed in developing their initial rates. The six-year forecast for the program should be close to break-even as well. More information will be presented to the Commission once the rates have been fully analyzed.

Health Plan Ratings

In September, the National Committee on Quality Assurance released its 2021 health plan ratings. HPSM achieved a four of five-star rating. This is the first year HPSM has been rated by NCQA, since the Health Plan only recently became accredited. Ratings are based on three categories of measures: patient experience; preventative services; and treatment services. You can find more information on the ratings for Medi-Cal plans in California at: https://reportcards.ncqa.org/health-plans?filter-plan=Medicaid&pg=1&dropdown-state=California&filter-state=California

Vaccine Updates

The most recent local data we have related to HPSM vaccine rates is from September 29, 2021. As of that date:

- More than 70% of HPSM members, or approximately 90,000 individuals, have now received at least one vaccine dose, leaving about 38,000 members who remain unvaccinated. HPSM members account for a large proportion of unvaccinated individuals in the county.

- While more than 60% of teens aged 12-15 have received one dose, about 11,500 are still unvaccinated.

- More than 50% of members in all ethnic groups have now received at least one dose of the vaccine. The rate for Black members is lower compared to other ethnic/racial groups.
- The data show steady increases in the number of Spanish language speakers receiving the vaccine.

CalAIM

The third model of care submission for CalAIM was due to the State on October 1st. This document describes our proposed provider network for Enhanced Care Management and Community Support Services (formerly called In Lieu of Services). Agreements with these providers will be brought to the Commission for approval at the November Commission meeting.