Health Plan of San Mateo
Healthy is for everyone

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THE SAN MATEO HEALTH COMMISSION and
THE SAN MATEO COMMUNITY HEALTH AUTHORITY
Regular Meeting
April 11, 2018 - 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor, Boardroom
South San Francisco, CA 94080

AGENDA

1. **Call to Order/Roll Call**
2. **Public Comment/Communication**
3. **Approval of Agenda**
4. **Consent Agenda***
   - 4.1 CHI Oversight Committee Minutes, January 2018
   - 4.2 Physician Advisory Group Minutes, February 2018
   - 4.3 Consumer Advisory Minutes, March 2018
   - 4.4 Approval of Amendment to Agreement with HealthTrio
   - 4.5 Approval of Amendments to Agreements with Landmark Health of California, LLC and Landmark Medical of California, PC (Landmark)
   - 4.6 Approval of San Mateo Health Commission Meeting Minutes from March 14, 2018
5. **Specific Discussion/Action Items**
   - 5.1 Discussion/Action on Audited Financial Statements for the Twelve-Month Period Ending December 31, 2017 by Moss-Adams, LLP*
   - 5.2 Compliance Oversight Training and Compliance Program Effectiveness Survey Results
6. **Report from Chairman/Executive Committee**
7. **Report from Chief Executive Officer**
8. **Closed Session**
   - 8.1 PUBLIC EMPLOYEE PERFORMANCE EVALUATION
     Title: Chief Executive Officer
9. **Reconvene Open Session (and report on closed session)**
10. **Action on 2018 Compensation and Performance Goals for Chief Executive Officer.***
11. **Other Business**
12. **Adjournment**

**Items for which Commission action is requested.*

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AGENDA ITEM: 4.1

MEETING DATE: April 11, 2018

DRAFT

CHI OVERSIGHT COMMITTEE MEETING
Meeting Summary
January 26, 2018 - 9:00 a.m.
Health Plan of San Mateo
801 Gateway Blvd, 2nd Floor, Sunrise Room
South San Francisco, CA 94080

Present: Pat Curran, Cheryl Fama, Pamela Kurtzman, Francine Serafin-Dickson, Ashley McDevitt, Sherri Sager, Joey Vaughn, Janet Chaikind, M.D., Srija Srinivasan, Maria DeAnda, Rayna Lehman, Kitty Lopez, Sasha Martinez, and Manny Santamaria.

1. **Call to Order: Welcome, Introductions and Agenda Review**
   Meeting was called to order at 9:00 am by Srija Srinivasan. Ms. Srinivasan introduced Pat Curran, HPSM Deputy CEO who will be the chair for this meeting. Introductions were made. Mr. Michael Odeh from Children Now was a guest speaker at the meeting.

2. **Public Comment**
   No public comment.

3. **Minutes from July 21, 2017**
   Minutes from July 21, 2017 were approved as presented.

4. **Children's coverage enrollment statistics**
   Ms. Srinivasan reviewed the information on the Medi-Cal and Healthy Kids Enrollment figures. She noted that this information is reviewed by staff monthly as enrollment changes and she gives an update at this meeting twice a year.

   - **Medi-Cal:** enrollment is at about 48,000 kids, which is a 4% decrease from one year ago. This seems to be the trend across other safety net programs. Discussion ensued as to the reason for the decline which could be aging out, people moving, more rigid eligibility criteria, and possibly immigration issues.
   - **Healthy Kids:** smaller population: almost 1,400 kids in the program and had a 40% increase from a year ago because of the programming of the CalHEERS eligibility system for the CHIP group between 2014 and 2016 and the last open enrollment was the first full year of renewals for Covered California getting flagged and put into this CHIP bucket. We will know more after the next open enrollment if it all has been captured in this data.
   - **Census Data:** analysis of the data shows that we have gone from 96% to 97% insured. From the 2016 census, we have 2,644 kids remaining uninsured in San Mateo County. This is the lowest we have been able to go. The 97% rate is our 3 year running average and at this point in time we may be a little higher than 97% as trends have been running up with the ACA and Medi-Cal Expansion.

5. **Information and Discussion of National and State policy landscape for Children's Coverage**
   Mr. Odeh, Director of Health Policy from Children Now reviewed his presentation about the status of children's health insurance in California.

- Children Now is a statewide policy research and advocacy organization focused on kids issues with programs that cover about 5.6 million kids, Mr. Odeh works on the health care issues. They have a team that works on child welfare, early childhood, K-12 education, and try to find policies that address the intersections of these areas. He handed out some marketing materials showing their slogan "Pro-Kid".
- He described Children Now -The Children's Movement of California, and the importance of getting kids connected with health coverage and health services.
- Medicaid started in 1965 building to 1997 with the Children's Health Insurance Program (CHIP) and in 2010 with the ACA, moving to defense mode in the last year given the attacks on the ACA and the expiration of CHIP funding. CHIP has now been extended to 2023.
- Covered California covers about 77,000 kids.
- Statewide, the number of insured kids is about 97% based on the latest year of available data; about 218,000 undocumented kids have received full-scope coverage through SB75 expansion.
- The estimated number of uninsured kids is around 100,000 statewide.
- Mr. Odeh reviewed the activity in 2017 related to the attempts to repeal and replace ACA and the significance of the December tax bill repeal of the ACA individual mandate.
- He explained history and status of CHIP Funding; about 2 million in California benefit from that coverage through Medi-Cal; occasionally has to be reauthorized; September 2017 CHIP funds expired. Left over funds were patched through. December 2017 congress passed a short term extension of $2.85 billion available retroactively until March 2018; then the tax deal was passed which repealed the individual mandate the federal government would actually pay more to enroll a kid in the marketplace then they would for CHIP making CHIP cheaper to extend. After the government shut down a continuing resolution was passed that funds for only a couple more weeks bringing us back to the same issue. The silver lining is the six-year reauthorization of the CHIP program.
- The reauthorization dials down the CHIP federal matching share that goes from 88% to 65%, and the state budget will have to absorb the extra cost. It includes a maintenance of effort provision over the six years. However, beginning in 2020 states will be able to scale the coverage over 300% of poverty. Ms. Srinivasan added that in SF, SM and Santa Clara counties the maintenance of effort is on the state not the counties but the state in the last go-around passed language in their budget trailer bill kept the maintenance of effort with the state but requires the three counties to stay in these local programs. She stated this is something to keep in discussion noting the disruption for families as they go from the Covered California to the CHIP bucket, they don't necessarily have the same provider networks, continuity of care protections.
- Unresolved issues in federal policy include: DACA/DREAM Act/Immigration; Community health center funding; and, Maternal, Infant Early Childhood Home Visiting (MIECHV) that expired on September 2017.
- The Governor's budget proposal has uncertainty around health care spending but has no trigger cuts in place; it assumes a 65% match for CHIP FMAP; anticipates about $900 million more General Fund revenue in the May revise.
- Prop 56 supplemental payments: are in Managed Care, rules and payment levels are being released. Mr. Curran said we have not received payments but it will happen. He does not expect it to increase access.

- Other Priorities:
  - Pediatric preventive health and dental services in Prop 56
  - Developmental screenings via AB 11
  - Increased access to asthma preventative services in Medi-Cal AB391)
  - Enroll eligible children in Medi-Cal enrollment through Express Lane Eligibility with WIC
  - Strengthen consumer voice and the Medi-Cal Children's Health Advisory Panel (MCHAP)
  - Monitor implementation of Whole Child Model pilot in CCS in July 2018

- Issues noted (statewide):
  - Decline in Well-Care visits
  - California has a lower rate in health screenings than other states
  - Developmental screenings are down, with only 1/3 of children state-wide getting those screenings. There was discussion about why that is the case – some providers are not coding for this because there is no incentive; work is being done to capture this with a template; local data seem to indicate the 80-85% of Medi-Cal kids received a developmental screen. Sherri Sager and Kitty Lopez to talk off line on how to incorporate this into the electronic medical record that could also possibly trigger automatic referrals.
  - Well-Child visit is indicating the same trend.
  - Immunizations locally are better than the statewide figures.

- **Other items discussed:**
  - Prop 56 issues
  - Same day visit road block
  - Access issues for Well Child care visits.
  - Opportunities to use nursing and other parts of the health care team to provide some of these screening components leaving the providers to review the abnormal screenings (as opposed to the normal ones that can be done by others).
  - September 2019 expiration; lower FMAP; maintenance of effort ending; what is going to happen locally and statewide.
  - Sherri Sager commented that in Congress there are many who do not understand the difference between Medicaid and Medicare and use the terms interchangeably. She encouraged taking every opportunity for advocacy and educating. She gave an sample quick education: Medicare is for Seniors over 65 with some exceptions for people with disabilities and when you are employed you pay into the program; Medicaid is funded through general funds and is a match between federal dollars and state dollars 50% of beneficiaries are children and pregnant women, about 70% of the beneficiaries come from a family with one or more working people – it is not a welfare program.

- Continue this conversation: expert at the January meeting and in July go back to the spreadsheet; where is the money; what assumptions did we make; are we still feeling okay with the key themes discussed previously.
- Pending the February budget agreements if there is something that comes from that then we might need some clarification.
- Another suggestion is to have more information about what is happening locally at the July meeting.

- Sherri Sager suggested that with this being an election year at the next meeting everyone should come prepared with a couple of questions regarding children's health and the Medi-Cal program and think about the policy impacts on children.
- She also suggested that the group come up with talking points. Recognition of how important this - such as if we put some of the funding into prevention in children's and adolescent mental health they might not need to be worrying about issues on the adult side and whether or not emergency room physicians can release holds under 72 hours if we can do something to prevent those situations from happening.
- Silicon Valley Community Foundation's Choose Children campaign – Manny S will send information to the group. It is an initiative they launched to ensure that the next California Governor has ECE and Early Childhood issues at the top of his mind as well. They have had individual candidate forums with the top 5 and will be sponsoring a California-wide panel with Gavin Newsome as the front-runner and hope to have four of them at the same time in June possibly in San Jose.
- Can we put Manny on the agenda for July in terms of the results of that and what the next step is? And he can bring the director.
- If you haven't joined the Children's Movement, do so. This does not threaten any of your status and you can be listed on the letters you want to be on but it shows the breath of the community that supports issue that impact children makes a difference. Sherri is trying to push it nationally.
- Making the talking points in layman's language six to nine times and the more we can embrace and adopt common language we have a greater chance of getting through the barriers.

6. <u>Other Updates</u>

Pat Curran had nothing additional to report at this time.

7. <u>Adjournment</u>

Meeting adjourned at 10:07 a.m.

Respectfully submitted:

C. Burgess

C. Burgess
Clerk of the Commission

Next CHI Oversight Committee Meeting: Friday, July 13, 2018 at 9:00 a.m.

DRAFT

AGENDA ITEM: 4.2

MEETING DATE: April 11, 2018

PHYSICIAN ADVISORY GROUP
Meeting Minutes
February 7, 2018 - 7:30 a.m.
San Mateo Medical Center
222 W. 39th Avenue, Alcove Room, 2nd Floor
San Mateo, CA 94403

Committee Members Present: Drs. Janet Chaikind, Randolph Wong, Hung-Ming Chu, Leland Luna, James Hutchinson, Tom Stodgel, Kenneth Tai.

Committee Members Excused: Dr. Vincent Mason

HPSM Members Present: Richard Moore, M.D., Patrick Curran, Rhonda Bibbins, Cynthia Cooper, MD., Kati Phillips, Paul de la Cruz.

HPSM Members Excused: Maya Altman

1. Call to Order

Dr. Janet Chaikind (Chair) called the meeting to order at 7:30 a.m.

2. Public Comment

No public comment was offered.

3. Approval of October 2017 Meeting Minutes

Meeting Minutes for October 4, 2017 were approved by all committee members.

4. Approval of Agenda

Dr. Chu made a motion to approve the February 7, 2018 meeting agenda and Dr. Wong seconded the motion. The agenda was approved unanimously.

5. New Business

5.1 Announcements

Dr. Moore reported that the biggest impact on The Health Plan of San Mateo is the retirement of Dr. Margaret Beed which was effective Friday 2, 2018. Dr. Moore and Dr. Cooper are filling in for her position while the company is searching for a new replacement.

5.2 Provider Services Announcements

Rhonda reported that we have recently launched an On Line Provider Searchable Directory effective January 1, 2018. This gives the members, providers and as well as us the opportunity to search by name and location. There is a link in the program to Google Maps so that the member can log in their zip codes and by the area that they live in they can search for a provider. This is a State requirement.

Kati reported that as of July 1, 2018 we will be implementing a New Primary Care Payment Models. In preparation for that we have had several meetings with a payment set group which is a subset of providers participating in our primary care clinical partnership learning collaborative. This group has monthly meetings. Prior to the payment implementation we are rolling out several initiatives prior to July 1st. One is a targeted member reassignment process. We are looking into the claims data that are based on where the members are assigned as opposed to where they have been seen and targeting high volume utilizers of non-assigned primary care clinics. We are also looking into capacity limits by clinic. In addition we are issuing reports that the providers can view before July 1st. We will have more information to come.

6. HPSM Update

Pat reported that we are streamlining how we do our work and interaction with physicians. This includes streamlining the authorizations and claims payment process. This has decreased the timeliness in which the authorizations are done. This has reduced the phone calls coming in by 1,000 calls a month. 95% of our claims are being paid within 15 days. Doing the transactions quickly reduces questions and confusion. We have also increased payments in some specialty care groups from 123% of Medi-Cal to 175% of MediCal to increase access. We are reviewing what the issues are with harder to access specialties such as OB, Orthopedics and Behavioral Health which has reflected a reduction in access to BHRS.

7. Adjournment

The meeting adjourned to PRC Closed Session.

The next meeting of the Physician Advisory Group is scheduled for April 4, 2018.

DRAFT

AGENDA ITEM: 4.3

DATE: April 11, 2018

HEALTH PLAN OF SAN MATEO
CONSUMER ADVISORY COMMITTEE MEETING
Meeting Minutes
Thursday, March 01, 2018
801 Gateway Blvd. 1st Floor-Boardroom
South San Francisco, CA 94080

Committee Members Present: Danilyn Nguyen, Ricky Kot, Mary Pappas, Angela Valdez
Staff Present: Gabrielle Ault-Riche, Pat Curran, Carolyn Thon, Ed Garcia, Mat Thomas, Jose Santiago, Charlene Barairo
Guests: Wendy Todd, HPSM Consultant

1.0 **Call to Order/Introductions:** Ms. Nguyen called the meeting to order at 12:06 pm.

2.0 **Public Comment:** There was no public comment.

3.0 **Approval of Agenda:** The group agreed to change the order of the agenda, addressing Item 6.0 before 5.0.

4.0 **Approval of Meeting Minutes for January 11, 2018:** The January 11, 2018 Meeting Summary was approved as presented. **M/S/P**

6.0 **New Business: Strategic Planning (presented out of order):** Mr. Curran introduced Wendy Todd, consultant to HPSM. She's helping the Plan form a 3 year Strategic Plan. They are hoping to get as much input from stakeholders outside of the organization as possible. She asked those on the committee who are not employees of HPSM to participate in the discussion and proceeded with a series of questions.
First Question: "**What are HPSM's strengths?"** Danilyn replied that she thought access was a strong point, with members not having a problem finding a suitable provider. Single Payer in SM County was noted by Ricky Kot, he mentioned that it is helpful to his agency. Mary noted that access for members has improved over the years, in prior years members had to find their own provider. Member Services are always available and always responsive, noted Danilyn. Ricky also mentioned how the HPSM services go beyond what is offered by Medi-Cal, like CCSP and some of the dental care.
Second Question: **"What are HPSM's weaknesses?"** Mary noted that share of costs is outdated and has not changed in 30 years. Affordability is a big issue, especially in this county. Danilyn noted that care coordination for those transitioning from a hospital to a LTC or SNF is challenging and should be more of a collaborative effort. She proposes working with community based organizations, local hospitals and social

workers. In many of these cases they are unaware who the "social workers" are representing, and remarked that many may be Care Coordination managers but are often referred to as social workers. She noted the confusion around those in the Plan and using Kaiser. There is often confusion over who covers what and where to go. Often members are confused and the Legal Aid office is often confused as well. Some clarity around that partnership would be beneficial to members. Ricky Kot noted a need for more education for Providers. He feels many could benefit from clarification of services available, especially in the area of DME. Danilyn requested further education around the transportation services offered as many are unaware of that benefit.

Third Question: **"What did you think is the most important benefit to the community?"** Mary noted that HPSM is a safety net for healthcare. Wendy asked for something more specific. Care Coordination was noted. Danilyn noted how successfully the Plan is connected to the community and other organizations in the county. She remarked on how the partnership between the Plan and Legal Aid has enabled them to help those in the community in ways beyond healthcare, for example conservatorships and housing. Mary noted the success of the Navigator program (thru CareAdvantage), she said it is an amazing program that works and HICAP refers people there often.

Final Question: **"If you could wave a magic wand, what would you change?"** Mary noted she'd change the Basic Needs $600 fee. Danilyn noted the procedural complications surrounding the ABA Therapy services program. Mary agreed that access to children's services under ABA is very difficult. Ricky noted that there is a perception that there is a high turnover at HPSM making stabilization of these services difficult. Angela mentioned the challenges surrounding the dental coverage, as members are directed to reach out to the dental provider (Denti-Cal) for assistance, instead of the Plan which they are comfortable dealing with. Mary noted that our members are lucky that we provide dental coverage at all, as many don't. Mental Health services are often hard to access, one must reach out to the County or BHRS, and that is sometimes daunting. Ricky noted the importance of working with Medi-Cal to keep members enrolled and prevent churning. He thinks being more pro-active about member's enrollment dates and reminding them about it will help. Mary mentioned that they have a dedicated person to deal with Medi-Cal at HICAP and that has helped. Ricky mentioned that we need to recruit more committee members to address the concerns of HPSM's members. Wendy ended by inviting the members participating to reach out to her via email if they have anything to add.

5.0 HPSM Operational Reports and Updates

5.1 CEO Update:

Pat Curran gave the CEO report on behalf of Maya Altman. He noted that there haven't been any significant changes at the State or Federal level lately that would impact HPSM or their members.

5.2 Grievance and Appeals:

Ms. Ault-Riche verbally reviewed the submitted Grievance and Appeals Report.

- CareAdvantage/CMC – 2017 was stable, but higher than 2016, especially in Appeals. Though appeals increased in Q3 they are going down.
- Quality of Care grievances are a bit higher this quarter than last. They are unsure why, but are keeping an eye on it.
- DME continues to be the biggest issue in Types of Appeals received.
- The Rate of Overturned Appeals is moving in the right direction. The numbers are low, which reinforces that decisions made initially are correct.
- Medi-Cal grievances and appeals are stable but higher than 2016. Quality of Care grievances are up here as well. Ms. Pappas asked if the Customer Service numbers reflect communications with providers or the Plan. Ms. Ault-Riche said it could be either, but the majority is about providers.
- The biggest Type of Appeal under Medi-Cal continues to be DME and Prescription Drugs.
- Resolutions within 24 hours of receipt, has been stable across quarters but has gone up slightly.
- Unfortunately they are not meeting their goals for Timeliness of Complaint Resolution. The Pharmacy is still doing well at 96% but grievances and medical appeals are presently at 93%; while close it does not meet their goal of 95%. Part of this is due to three new coordinators in Q3, which meant cases due in Q4 was delayed a bit. Ms. Pappas asked why are there so many complaints surrounding the Pharmacy and Prescription Drugs. Ms. Ault-Riche said while these are usually solved within 24 hours, they are often stressful as members are usually at the pharmacy, dealing with eligibility questions in real time. Sometimes it's something as minor as a number being off by one digit, or a member may not have their ID. There are a number of reasons, but they are usually resolved quickly.
- A total of 63 members requested to change their assigned PCP during Quarter 4 due to dissatisfaction. Members switched away from a total of 29 different PCP's. 14 were clinics and 15 were individual providers. For 2 providers, 5 or more Members requested to switch away from their practice. One was a clinic and the other one was

an individual physician. Ms. Murphy noted that they spoke with the individual physician and determined his panel may be too large for the number of slots.

- Danilyn noted that if Medi-Cal members have an erroneous OHC, associated with Access, they can always reach out to the Legal Aid society for assistance. They are often able to help very quickly.

5.3 Provider Services:

Ms. Murphy introduced herself to the group as the new Director of Provider Services. She asked for input on what the group hopes to see from the Provider Services department at upcoming meetings. They are eager to share how they are serving their providers, changes in the network and general information about what they are working on. Danilyn noted that they are interested in Provider Education. She inquired on the information provided to medical professionals. Asking specifically about what they should know and what they do know. Colleen agreed that sharing resources and getting feedback would be helpful for all.

5.4 Member Services:

Mr. Santiago went over the Member Services report. Enrollment is at 147,300+ for all Lines of Business. Member Services received approximately 19,046 calls in Q4. The average speed to answer was 56 seconds, which means they did not meet their goal of answering 80% of calls within 30 seconds. Call times continue to fluctuate due to staffing levels and call volume. Abandonment rates have been steady at 5%. The CareAdvantage unit is within standard with 95% of all calls answered within 30 seconds. There were only 3 complaints in 2017 for Medicare Advantage/Prescription Drug Plans. These complaints are usually related to enrollment/disenrollment and are often resolved within one to two days of receipt. HPSM has received 5 out of 5 starts in the past several years for this measure.

7.0 Adjournment

The meeting was adjourned at 12:57 pm.

Respectfully submitted:

M. Heryford

M. Heryford
Assistant Clerk to the Commission

MEMORANDUM

AGENDA ITEM: 4.4

DATE: April 11, 2018

DATE: March 26, 2018

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: Amendment to the Agreement with HealthTrio , LLC

Recommendation

Approve an amendment to the agreement with HealthTrio, LLC to provide NCQA required health appraisals for all Medi-Cal members, increasing the maximum amount by $224,000, from $2.5 million to $2.724 million; and authorize the Chief Executive Officer to execute said amendment. The term of the agreement remains the same, January 1, 2017 through December 31, 2021.

Background and Discussion

In 2017, HPSM was awarded interim accreditation status, the first step toward full accreditation, by the National Committee for Quality Assurance (NCQA), the premier accreditation body for health plans. NCQA accreditation is a strategic organization goal in HPSM's 2016-18 Strategic Plan. It also is a requirement for HPSM's participation in Cal MediConnect. The next step is full NCQA accreditation, which HPSM staff is now working to achieve.

In December 2016, the Commission approved an agreement with HealthTrio to provide software applications and host web-based provider and member portals. These portals provide information and tools for members and providers to interact with HPSM in an efficient and secure manner and also are requirements of full health plan accreditation from NCQA.

An additional NCQA Accreditation requirement is for HPSM to make a heath appraisal available to all Medi-Cal members to identify and manage health risks through evidence-based tools. The health appraisal must cover components such as demographics, health history, self-perceived health status, provision of effective behavior change strategies and identification of special hearing or vision needs, and language preferences. The health appraisal must be made available to all members online and in print. This health appraisal and its components are specific to the NCQA's Population Health Management accreditation standard and, unfortunately, have distinct and separate requirements from the health risk assessments that HPSM administers to Cal MediConnect members and Medi-Cal seniors and persons with disabilities.

Four vendors that have NCQA certification for their health appraisal products responded to HPSM's solicitation. The health appraisal product offered through HealthTrio was selected based on its simplicity of language and question branching logic as well as the clarity of the assessment report provided back to the member. The assessment report includes behavior change approaches to

improve health outcomes that are tailored to each member's specific responses. HealthTrio provides the most suitable health appraisal to meet the needs of our members as well as provides the most reasonable and competitive price point. In addition, health appraisals will be readily and securely accessible to members through the member portal.

Fiscal Impact

The initial set-up fee is $5,000 and the annual fee is $32,000 which includes the first 2,500 usages of the health appraisal product. The fee structure is on a per health appraisal basis, with amount per usage decreasing with higher total usage volumes. Staff estimates that annual health appraisal usage will not exceed 20,000 for a maximum per usage cost of $77,500 annually. The contract addendum with Health Trio, LLC will not exceed $224,000. The total contract maximum with Health Trio increases to $2.724 million and the agreement term remains the same, January 1, 2017 through December 31, 2021.

DRAFT

RESOLUTION OF THE

SAN MATEO HEALTH COMMISSION and
THE SAN MATEO COMMUNITY HEALTH AUTHORITY

IN THE MATTER OF APPROVAL OF AMENDMENT
TO AGREEMENT WITH HEALTH TRIO, LLC

RESOLUTION 2018 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has previously entered into an agreement with HealthTrio, LLC to provide software and services related to the operation of a provider and member web portal, beginning December 14, 2016;
B. HPSM is required to provide a web-based health appraisal to its members for National Committee for Quality Assurance (NCQA) accreditation;
C. After receiving proposals from four NCQA certified health appraisal products, HPSM staff identified that of HealthTrio, LLC to be most suitable for members and the most cost competitive.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves the amendment to the agreement with HealthTrio, LLC for the additional amount of $224,000 for health appraisal services; and
2. Authorizes the Chief Executive Officer to sign this amendment.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of April, 2018 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
David J. Canepa, Chair

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
John Nibbelin
CHIEF DEPUTY COUNTY COUNSEL

MEMORANDUM

AGENDA ITEM: 4.5

DATE: April 11, 2018

DATE: April 2, 2018

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: Amendments to the Agreements with Landmark Health of California, LLC and Landmark Medical of California, PC (Landmark)

Recommendation

Authorize the Chief Executive Officer to amend the agreements with Landmark Health of California, LLC and Landmark Medical of California, PC (collectively, "Landmark") to increase the contract maximum by $1,350,000, for a total amount not to exceed $23,672,968. The terms of the agreements remain the same, operating through December 31, 2019.

Background

The Commission approved funding for team-based in-home care in June 2016, to be delivered by Landmark providers through the HomeAdvantage program. HomeAdvantage was launched in November 2016; as of March 2018, around 1,200 HPSM CareAdvantage Cal MediConnect (CMC) members are receiving needed medical attention in their homes – nearly half of the 2,500 members targeted for engagement.

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

The 2,500 targeted members represent approximately 25% of HPSM's total CareAdvantage CMC membership, and are members with five or more chronic conditions who require significant care management resources. Many of HPSM's chronically ill members cannot easily leave their homes and, as a result, cannot easily access care in office-based settings. Also, primary care physicians alone may not be fully capable of handling the multitude of medical, behavioral health, and social needs of this population. A care model that can deliver personalized, 24/7 care in a variety of settings by a diverse team of professionals is needed to meet the complex needs of CareAdvantage's chronically ill population.

After careful deliberations and extensive discussions with multiple organizations, Landmark was selected as the preferred partner for two primary reasons: (1) Landmark is led by executives and clinicians with deep experience implementing similar programs with proven success at other health plans who lead the industry in effective care management; and (2) Landmark offers a risk-based approach whereby Landmark benefits only through measurable and significant improvement in clinical quality and overall costs.

HomeAdvantage is comprised of mobile providers and a supporting interdisciplinary team including social workers, mental health providers, pharmacists and dietitians to deliver services where members reside. Landmark also coordinates acute care episodes in the hospital, skilled nursing facilities (SNFs), and/or other facilities, and collaborates with other providers in HPSM's provider network. The program is designed to improve quality, clinical outcomes, and patient satisfaction, in addition to bringing significant reductions in medical costs.

Discussion

As the HomeAdvantage program has taken shape, additional opportunities to improve care and health outcomes have come to light. Two such examples are among members transitioning from hospitals to a skilled nursing facility for a short-term stay prior to being discharged back home, and among members who reside in a long-term care facility and may not see a provider frequently enough to meet complex medical needs.

HPSM solicited proposals from several organizations to deliver clinical services in the Health Plan's high volume skilled nursing facilities to address these concerns; Landmark Health provided a proposal that outlined the most effective approach, one that staff believes will improve health outcomes while reducing length of stay and readmissions for short-term stay patients and preventing acute admissions for those in long-term care. In order to test this approach, HPSM plans to use Landmark staff to provide care for HPSM members within seven target skilled nursing and long-term care facilities through a new body of work called the SNFist Program. Six of the facilities see the highest number of HPSM members, and Seton's upcoming SNF inpatient unit will also be included in this program. Unlike the CareAdvantage-focused HomeAdvantage program, the SNFist Program will be available both to CareAdvantage CMC and Medi-Cal members without other health coverage, and aims to reduce the average length of stay and prevent avoidable hospital admissions for members staying in any of the selected facilities. The program will launch in stages from April through July 2018.

Fiscal Impact

The amendment increases the contract maximum by up to $1,350,000 through the end of 2019, when the current contracts end (to include an additional $450,000 in 2018 and $900,000 in 2019). The current contracted amount is up to $22,322,968. With these amendments, the revised contracts will cover an amount not to exceed $23,672,968.

The net savings are estimated between $1.5 million and $2 million for the full 1.5 years of the SNFist program. Savings are primarily driven by a reduction in average length of stay for members with short-term needs within the targeted facilities.

The original maximum amount of $22,322,968 includes a one-time implementation cost of $300,000; program costs of $14,275,376; shared savings payments of $7,241,219; and, quality incentive payments of $506,374. The financial impact to HPSM was estimated to be a net reduction of $7,167,374 in expected medical costs for this population over the length of the agreement. An evaluation to determine financial impacts to date will be initiated later this year.

DRAFT

RESOLUTION OF THE

SAN MATEO HEALTH COMMISSION and
THE SAN MATEO COMMUNITY HEALTH AUTHORITY

IN THE MATTER OF APPROVAL OF AMENDMENTS TO AGREEMENTS WITH LANDMARK HEALTH, LLC AND LANDMARK MEDICAL OF CALIFORNIA, PC

RESOLUTION 2018 -

RECITAL: WHEREAS,

A. HPSM has agreements with Landmark Health of California, LLC and Landmark Medical of California, PC (collectively "Landmark") for in-home care;
B. Landmark has engaged 1,200 HPSM members in services under this program;
C. HPSM solicited proposals to implement a SNFist program to provide clinical services in the Plan's contracted skilled nursing facilities with high volumes of HPSM members; and
D. Landmark submitted a proposal that outlined an effective approach for improving health outcomes, reducing lengths of stay, and reducing the number of admissions to hospitals from long term care facilities.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves amendments to the agreements with Landmark to increase the not to exceed amount by $1,350,00 for a new contract maximum of $23,672,968 for a term that remains 40 months (or three years and four months) beginning September 1, 2016 and ending December 31, 2019; and
2. Authorizes the Chief Executive Officer to execute the necessary amendments.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of April, 2018 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
David J. Canepa, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
John Nibbelin
CHIEF DEPUTY COUNTY COUNSEL

DRAFT

SAN MATEO HEALTH COMMISSION and
SAN MATEO COMMUNITY HEALTH AUTHORITY
Meeting Minutes
March 14, 2018 – 12:30 p.m.
Health Plan of San Mateo - Boardroom
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

AGENDA ITEM: 4.6

DATE: April 11, 2018

Commissioners Present:	Jeanette Aviles, M.D.	George Pon, R.Ph.
	Teresa Guingona Ferrer	Kenneth Tai, M.D.
	Peggy Jensen	Ligia Andrade Zuniga, Vice Chair
Commissioners Absent:	David J. Canepa, Don Horsley, and Si France, M.D.	
Counsel:	Kristina Paszek	
Staff Present:	Maya Altman, Gabrielle Ault-Riche, Charlene Barairo, Chris Baughman, Colleen Murphey, Corinne Burgess, Pat Curran, Karen Fitzgerald, Robert Fleming, Nicole Ford, Michelle Heryford, Jimmy Holman, Marwan Kanafani, Francine Lester, Ian Johansson, Khoa Nguyen, Katie-Elyse Turner, Melora Simon, Vicki Simpson, Michael Smigielski, and Eben Yong.	

1. **Call to order/roll call**
   The meeting was called to order at 12:32 p.m.by Commissioner Zuniga who welcomed our newest commissioner, Dr. Kenneth Tai. A quorum was present.

2. **Public Comment**
   There was no public comment.

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

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

5. **Specific Discussion/Action Items**

   5.1 Discussion/Action to Waive Request for Proposal and Approve Agreement with Collective Medical Technologies, Inc.

   Maya Altman explained this agenda item is to waive the request for proposal process and approve an agreement with Collective Medical Technologies, Inc. Pat Curran, Deputy CEO, introduced the product related to this agreement, called PreManage:

   - PreManage includes hospital, health plan and medical group components that would allow all entities to use this same product;
   - It is a notification tool that holds emergency room visit history, including prescriptions, diagnoses, imaging and lab test results collected from all ERs visited, thereby helping reduce duplication, improve efficiency, and lower costs;
   - All San Francisco hospitals have recently signed with PreManage;

- Health plan care coordination staff can set criteria to receive real time information about which members are in emergency rooms, instead of waiting for information to arrive via a claim and allowing staff to act immediately if warranted;
- Information can also be made available to the primary care clinics who then will know immediately if one of their patients present in an emergency room;
- Currently Mills-Peninsula is the only hospital in San Mateo County using this tool; Stanford is planning to use it; San Mateo Medical Center is working on systems issues in order to implement; Sequoia (non-contracted) is implementing; and staff is working with Seton to encourage Seton's use as well; and
- HPSM does not begin payment of the monthly subscription fee until a majority of local hospitals are using the product.

Commissioner's questions:

- How will this tool fit with health information exchanges (HIEs)?
    - It is not integrated with electronic health records or an HIE. However, it is an easy to use add-on dedicated to emergency room activity.
- Will information in the ER be for HPSM members only or will it interface with other systems?
    - Hospitals will see any patient who has ever had an encounter at another hospital ER – however, HPSM staff will only see Health Plan membership.
- Is this a portal providers will sign into or will it provide notifications?
    - While it is a portal, criteria may be set to target members who may have been to the ER more than three times in the last six months, for example. Push notifications are sent including information on diagnoses and treatment (opiate prescriptions, for example).
- Are the funds requested solely for the software package or is more staff needed as well?
    - Funds requested are for the software. The system will be integrated within current workflows for the plan and hospitals with no additional staff.
- Is this a web-based system?
    - Yes.

Ms. Altman added that this is also a good opportunity for collaboration among the Hospital Consortium hospitals. Mills-Peninsula has also advocated implementing this program in San Mateo County.

Commissioner Tai stated that this system will be most beneficial if all the hospitals are on this platform. Mr. Curran added that San Francisco has taken the lead and most San Francisco hospitals have implemented at this point and are just starting to use it.

Mr. Curran then discussed overall provider strategies and investments. He reviewed the attached handout detailing strategies and Commission investments to improve operations and support provider engagement in addressing cost and quality. These activities include:

- Infrastructure: Provider portal and DocuStream help reduce the amount of transaction time for providers in submitting claims and authorizations, and accessing payment information;

- Incentives: Clinical Partnership group has been meeting for two years and nearing the end of phase one, with a new payment model developed by the group to be implemented in July; increase to reimbursement for specialist providers; HomeAdvantage program administered by Landmark Health through a shared savings incentive;
- Information: More investment requests in the future related to information sharing such as PreManage to ensure real time and good information is available to providers; and electronic reports for providers to access information on members are being expanded.

Commissioner Tai moved to waive the request for proposal process and approve the agreement with Collective Medical Technologies, Inc. for the PreManage tool. **M/S/P.**

7. Report from Chief Executive Officer [Taken out of Sequence]

Ms. Altman reported on the following:

- The final federal budget act extended the Children's Health Insurance Program (CHIP) for 10 years and made Dual Eligible Special Needs Plans permanent.
- In April, HPSM's auditors will report on 2017 financial results; preliminary information is that the results are more favorable than projected; one major factor is the receipt in December 2017 of favorable 2017 rates from the state for Cal MediConnect and the Coordinated Care Initiative.
- DMHC has released its Timely Access Report covering 2016 results. HPSM was the highest scoring health plan in the State; however, this is the first year DMHC has presented this information and results should be viewed with caution.
- The California Dental Association (CDA) has approached HPSM about doing an integrated dental health care pilot. Utilization of dental services by the Medi-Cal population is low throughout the state; utilization in San Mateo County is even lower than the state average. State legislation governing HPSM would need to be amended to allow the Plan to offer dental services. This would be permissive language only; a community planning process would then commence to determine if such a pilot is feasible and supported by our community partners. Staff has started discussions with these partners, in particular the Dental Coalition.
- Recruitment efforts for a new Chief Medical Officer are underway; the Health Services staff has been doing an excellent job in the meantime

Commissioner's questions:

- Would the dental pilot result in an increase in capitation from the state?
    - Yes. HPSM would pay for Denti-Cal services instead of the State Denti-Cal program; the costs would be folded into the Plan's rates. While staff has not yet determined the financial feasibility, we expect initial losses. However, dental services are not that costly and the cost experience would eventually be considered in the rate setting process by the actuaries.

- What is the main reason why dental services are under-utilized in San Mateo County?
    - Very few private dentists participate. The largest providers are FQHC clinics (Ravenswood and SMMC). Only 30 out of 900 dentists in San Mateo County participate.

5.2 Discussion – Strategic Plan Update

Khoa Nguyen reviewed his presentation on HPSM's strategic plan, a copy of which is attached. Highlights include:

- Background on the 2016-18 strategic plan, especially for those Commissioners who were not here when the plan was developed, including:
    - Reconfirmation of organizational mission, vision and values;
    - Identification of key drivers and trends in the healthcare environment;
    - Establishment of broad goals and linking of those goals to organizational, departmental, and staff performance objectives;
    - Identification of performance metrics for the organization, departments, and staff.
- Review of the various quality and satisfaction metrics; operational metrics; and, financial metrics comparing 2016 to 2017:
    - Members - how do you rate your health plan (from CMS surveys)?
    - Providers - satisfaction with the health plan (surveyed 500 providers in 2017);
    - Quality metrics - based on HEDIS measures and comparable with other plans throughout the country;
    - Operational Metrics - staff engagement surveys; NCQA accreditation; disaster recovery and business continuity plan; and completion of root cause analyses.
    - Financial Metrics -Medicare stabilization efforts and overall administrative efficiency.
- Key takeaways:
    - Successes – Medicare Cal MediConnect financials; employee engagement; and HEDIS scores;
    - Moving forward with internal operational goals; and
    - Stabilized positive member and provider satisfaction.
- Review of 2018 department goals and metrics:
    - Department goal boards for Health Services, Member Services, CareAdvantage Unit and Provider Services were displayed so commissioners could review with leaders of each department immediately following the meeting.
- Planning process and what to expect next:
    - Continue progress on strategic plan goals through 2018;
    - Engaging Commission committee members, Commissioners, and staff to determine key priorities for 2019-2021, with development of a plan to support the goals and metrics identified;
    - Stakeholder input process to be completed by the end of March;
    - Commission retreat on June 15 will include a review of the results of stakeholder process and discussion of a draft strategic plan; and
    - Final strategic plan will be presented to the Commission for approval in late summer.

Commissioner's questions:

- Was the staff engagement survey developed in house or was an established tool used?
  - Survey developed by a firm using questions that are comparable with similar organizations.
- Is input from people with disabilities being collected through the process?
  - Committee members from the Consumer Advisory, CMC Advisory, and CCS advisory committees being collected. Ms. Zuniga recommended Craig McCulloh with the Commission on Disabilities to be included for his advice on this input.

8. Report from Chairman/Executive Committee

Commissioner Zuniga had nothing additional to report.

9. Report from Chief Executive Officer

[Report was given out of sequence, following item 5.1]

8. Other Business

There was no other business.

9. Adjournment

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

Respectfully submitted:

C. Burgess

C. Burgess
Clerk of the Commission

ATTACHMENT 1
March 14, 2018 Minutes

Provider Strategy and Investments

HealthPlan OF SAN MATEO
Healthy is for everyone

Strategy	Premise	Commission Investments	Measures
Infrastructure	Reducing administrative time on transactions will increase time spent on patient care and quality improvement	• Provider portal • DocuStream	• Provider Satisfaction • Phone call volume • Turnaround time
Incentives	Thoughtful payment changes will improve access and quality of care	• Clinical Partnership • Specialty Fees • Landmark	• Quality scores • Timely Access • Medical cost trends
Information	Timely and actionable information will support provider engagement in addressing cost and quality	• eReports • **PreManage**	• P4P measures • ER costs

Strategic Plan Updates

Commission Meeting
March 14, 2018

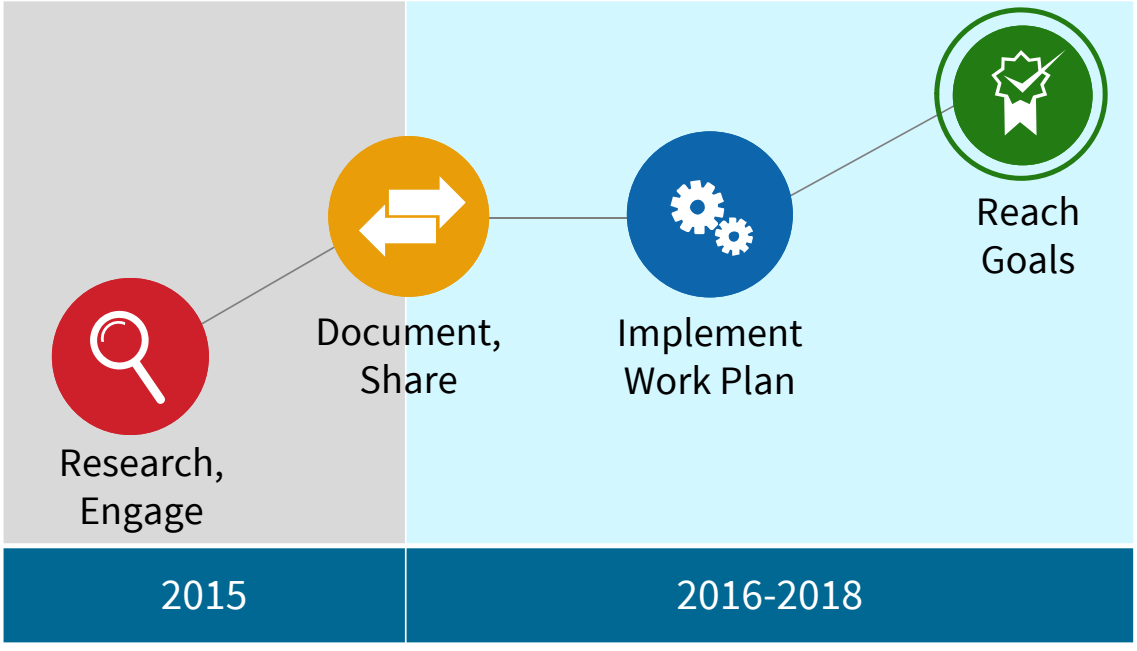
HealthPlan OF SAN MATEO
Healthy is for everyone

Agenda

HealthPlan OF SAN MATEO
Healthy is for everyone

- Background 2016-2018 Strategic Plan
- 2017 Updates
- Planning process for 2019-2021


HealthPlan
OF SAN MATEO
Healthy is for everyone
Strategic Plan
2016-2018


Research,
Engage
Document,
Share
Implement
Work Plan
Reach
Goals
2015
2016-2018

Focus

- Mission, Vision and Values
- Healthcare Environment
- Goals
  1. Ensure High Quality Care and Services
  2. Operate Strong Internal Processes
  3. Sustain Financial Stability

Ensure High Quality Care and Services

Member Satisfaction Metrics	2016	2017
Achieve score greater than 90 in CAHPS survey to CareAdvantage members	**88**	**87**
Achieve score greater than 79 in survey to Medi-Cal adults	**69**	**70**
Achieve score greater than 87 in survey to Medi-Cal kids	**84**	**85**

Ensure High Quality Care and Services

Provider Satisfaction Metrics	2016	2017
Achieve score greater than 95% of HPSM providers that are very satisfied/ satisfied	**90%**	**89%**
Quality Metric		
Achieve at least two High Performing Levels (HPLs) and zero Minimum Performance Levels (MPLs) in HEDIS Medi-Cal ratings	**1 HPL 0 MPL**	**2 HPL 0 MPL**

Operate Strong Internal Processes

Operational Metrics	2016	2017
Attain greater than 58% High Engagement and less than 5% Low Engagement in annual employee survey	**48%** **10%**	**50%** **7%**
Obtain NCQA accreditation for Medi-Cal by Dec 2017	**NA**	**Yes**
Complete and implement a disaster recovery plan by Dec 2018	**NA**	**NA**
Complete and implement a business continuity plan by Dec 2018	**NA**	**NA**
Complete six formal root cause analyses annually	**1**	**6**

Sustain Financial Stability

Financial Metrics	2016	2017
Achieve a medical loss ratio (MLR) less than 90% for the Medicare portion of CareAdvantage CMC	**97.7%**	**April**
Operate with an overall administrative expense less than 5.5% of total revenue	**5.6%**	**April**

Key Takeaways

- Success
  - Medicare CMC financials
  - Employee engagement
  - Quality HEDIS scores
- Plugging along with internal operations
- No change with member/ provider satisfaction

Departments

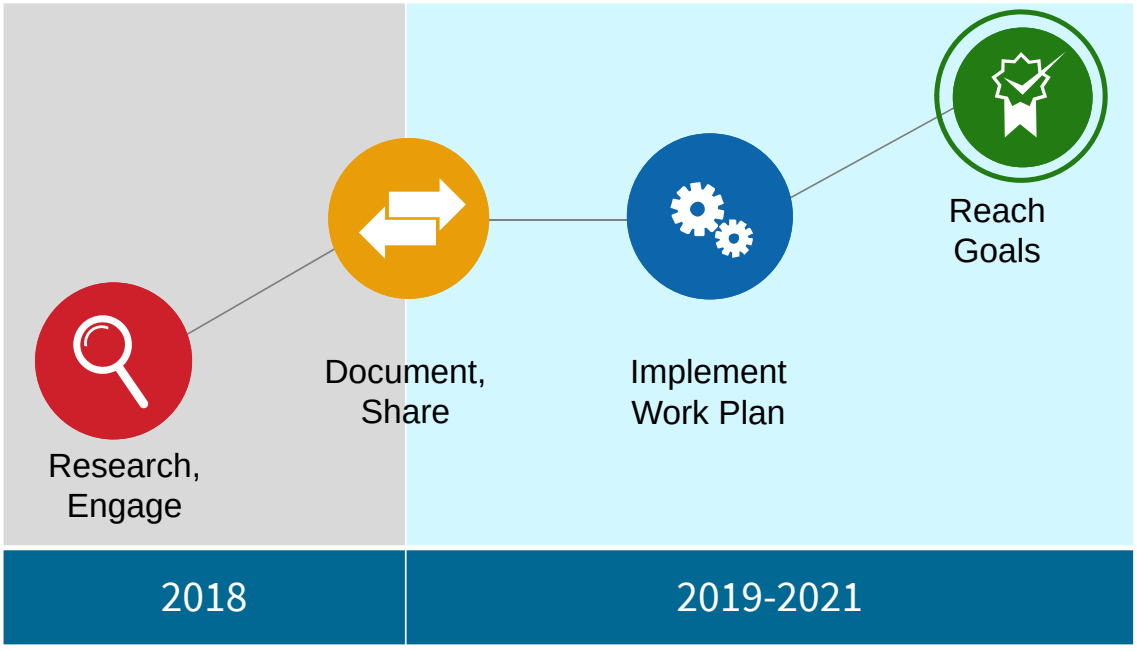
- Health Services
- Member Services
- CareAdvantage Unit
- Provider Services
- IT
- Finance
- Claims
- Grievance and Appeals
- Marketing
- Informatics
- Adult Demonstrations
- Business Systems Integration
- Human Resources
- Compliance
- Facilities

2018 Department Goals and Metrics

- Improvement from X to Y
- Staff engagement
- Less is better

Planning Process for 2019-2021

HealthPlan OF SAN MATEO
Healthy is for everyone



What to Expect Next

- Now- end of March: Stakeholder input
- June 15: Commission annual retreat
- July/ August: Approve strategic framework

Stakeholder Input

- Commissioners
- Advisory Committees
- County Partners: Health System Leadership, BHRS, Aging and Adult Services, Family Health Services
- Key Providers : Medical Center, NEMS, Ravenswood
- Community Partners: Legal Aid, HICAP

Thank You

AGENDA ITEM: 5.1

DATE: April 11, 2018

MEMORANDUM

DATE: March 23, 2018

TO: San Mateo Health Commission

FROM: Michael Smigielski, Chief Financial Officer
THROUGH: Maya Altman, Chief Executive Officer

RE: Audited Financial Statements for the Twelve-Month Period Ending December 31, 2017

Attached is a copy of the presentation which will be reviewed by Moss-Adams, LLP along with the Draft Communication with Those Charged with Governance, and the Independent Auditor's Report and Financial Statements for December 31, 2017.

These are for your review and approval.

RESOLUTION OF THE

SAN MATEO HEALTH COMMISSION and
THE SAN MATEO COMMUNITY HEALTH AUTHORITY

IN THE MATTER OF ACCEPTANCE OF THE
AUDIT REPORT FOR FISCAL YEAR ENDING DECEMBER 31, 2017

RESOLUTION 2018 -

RECITAL: WHEREAS,

A. Moss-Adams, LLP, a firm of accountants has conducted an audit of the San Mateo Health Commission financial statements for the fiscal year ending December 31, 2017; and

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

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission formally accepts the audit report for the fiscal year ended December 31, 2017 as presented by Moss-Adams, LLP.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of April, 2018 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
David J. Canepa, Chair

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
John Nibbelin
CHIEF DEPUTY COUNTY COUNSEL

MOSSADAMS

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

Report of Independent Auditors

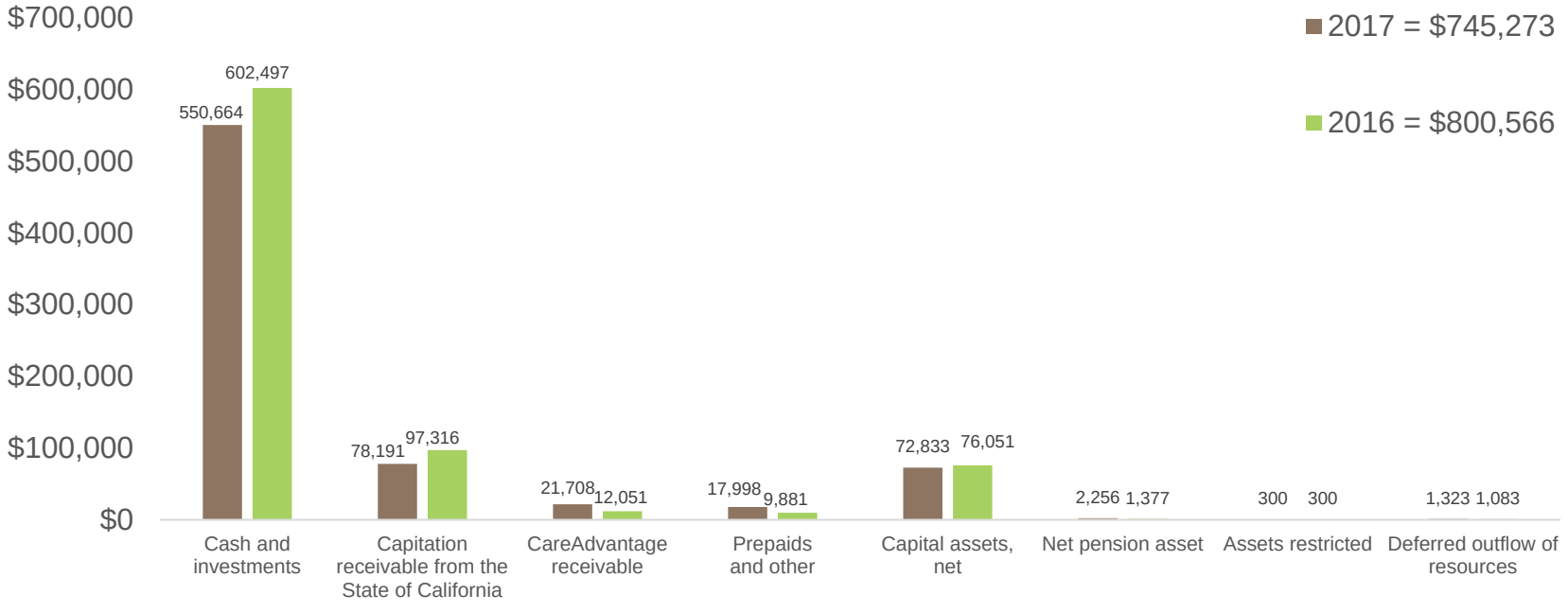
Report of Independent Auditors

Unmodified Opinion

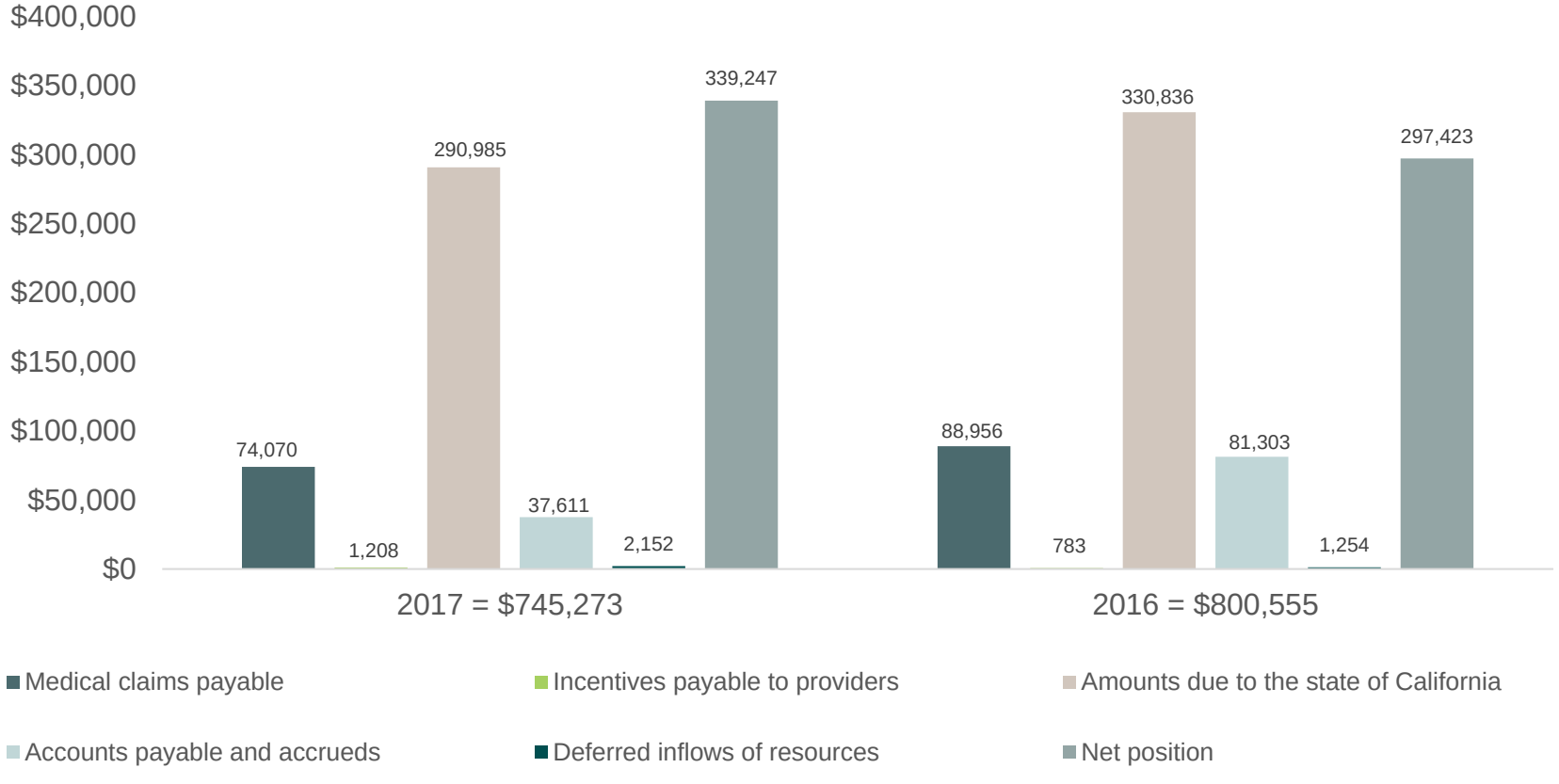
Combined financial statements are fairly presented in accordance with generally accepted accounting principles.

COMBINED STATEMENTS OF NET POSITIONS

Asset Composition (in thousands)



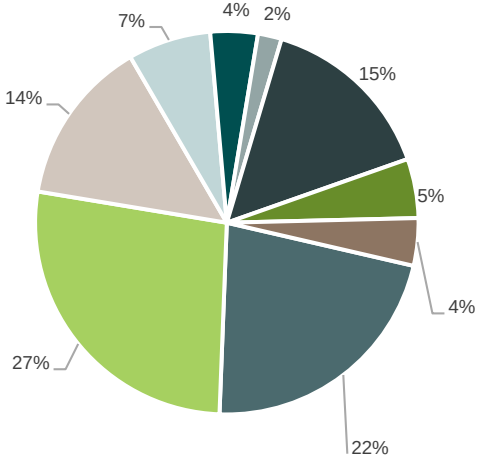
Liabilities and Net Position (in thousands)



Operations

Income Statements (in millions)

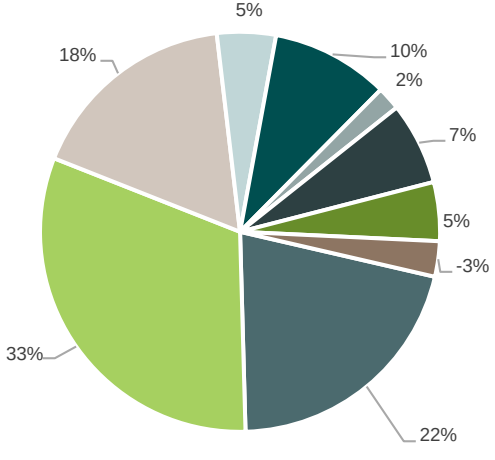
December 31, 2017
$906.4



Total Operating Expenses
as a % of Total Operating Revenues

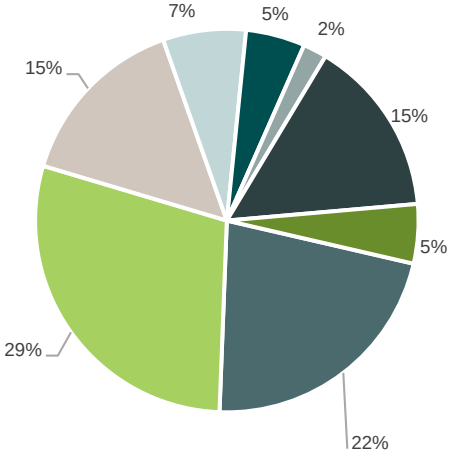
- Medical
- Hospital inpatient
- Pharmacy
- MCO tax
- PCP cap
- Utilization management
- Long-term support services
- General and administrative
- Excess (deficit)

December 31, 2016
$792.3



Income Statements (in millions)

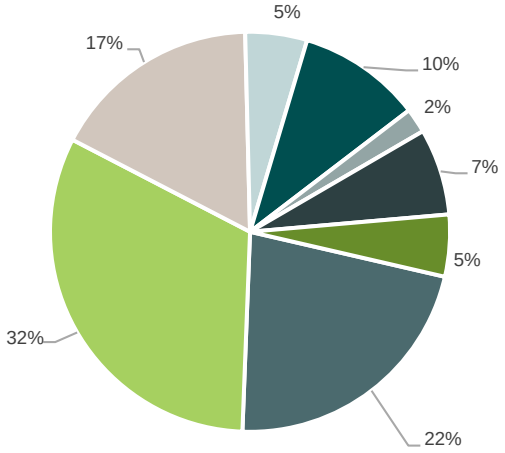
December 31, 2017
$872



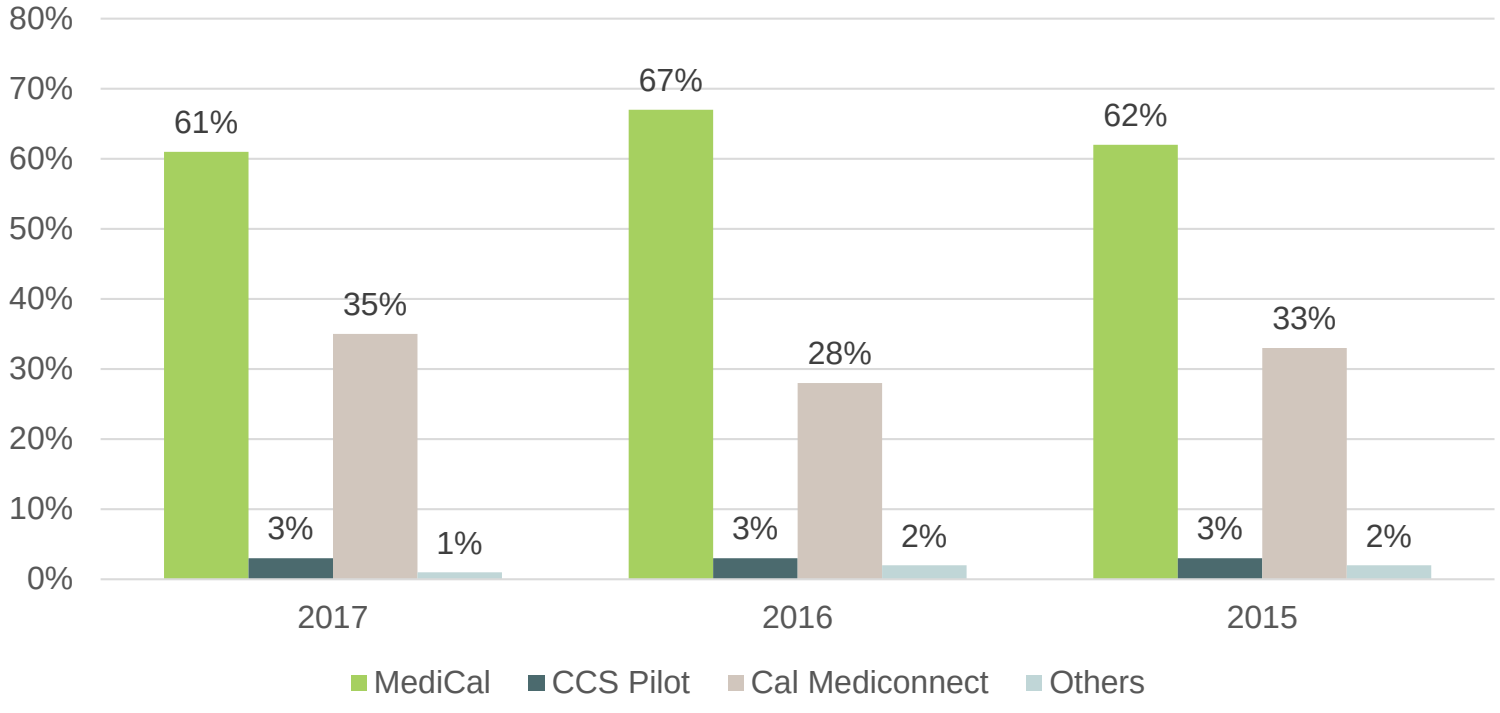
Total Operating Expenses

- Medical
- Hospital inpatient
- Pharmacy
- MCO tax
- PCP cap
- Utilization management
- Long-term support services
- General and administrative

December 31, 2016
$816.4



Revenue Trend



Important Board Communications

- AU-C Section 260 – *Communications with Those Charged with Governance*
- Accounting estimates are reasonable
- No audit adjustments
- No issues discussed prior to our retention as auditors
- No disagreements with management

Questions?

THANK YOU

Communications with
Those Charged with Governance

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

December 31, 2017

Communications with Those Charged with Governance

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

We have audited the combined financial statements of San Mateo Health Commission and San Mateo Community Health Authority (d.b.a. Health Plan of San Mateo) ("HPSM") as of and for the year ended December 31, 2017, and have issued our report thereon dated April, 12, 2018. Professional standards require that we advise you of the following matters relating to our audit.

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

As stated in our engagement letter dated September 21, 2016, our responsibility, as described by professional standards, is to form and express an opinion about whether the combined financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. Our audit of combined financial statements does not relieve you or management of your respective responsibilities.

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

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

Planned Scope and Timing of the Audit

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

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by HPSM are described in Note 1 to the combined financial statements. During the year, HPSM adopted Governmental Accounting Standards Board ("GASB") Statement No. 82, *Pension Issues – an amendment of GASB Statement 67, 68, 73*. There have been no other accounting policies adopted and there were no changes in the application of existing policies during 2017. We noted no transactions entered into by HPSM during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the combined financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

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

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

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

- Management's estimate of the amounts payable to the State of California related to the contract with the Department of Health Care Services ("DHCS") for the Adult Expansion, Medical Loss Ratio ("MLR") corridor calculations for the time period of January 1, 2014 to June 30, 2016, is based upon appropriate claims and encounters data, and was calculated in accordance with the provisions and instructions of the executed contract with DHCS. We evaluated the key factors and assumptions used to develop the amounts payable to the State of California in determining that they are reasonable in relation to the combined financial statements taken as a whole.

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

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

Financial Statement Disclosures

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

Significant Difficulties Encountered During the Audit

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

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. None of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to the combined financial statements taken as a whole.

Disagreements with Management

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

Management Representations

We have requested certain representations from management that are included in the attached management representation letter dated April 12, 2018.

Management's Consultations with Other Independent Accountants

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

Independence

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

Other Significant Audit Findings or Issues

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

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

San Francisco, California
April 12, 2018

Report of Independent Auditors and
Combined Financial Statements

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

December 31, 2017 and 2016

Table of Contents

Management's Discussion and Analysis

San Mateo Health Commission and
San Mateo Community Health Authority
(d.b.a. Health Plan of San Mateo)
Management's Discussion and Analysis
December 31, 2017, 2016, and 2015

Our discussion and analysis of the San Mateo Health Commission and San Mateo Community Health Authority, (d.b.a. Health Plan of San Mateo) ("HPSM" or the "Commission"), provides an overview of the Commission's financial activities for the years ended December 31, 2017, 2016, and 2015. Please read it in conjunction with the Commission's audited combined financial statements and accompanying notes, which begin on page 11.

FINANCIAL HIGHLIGHTS

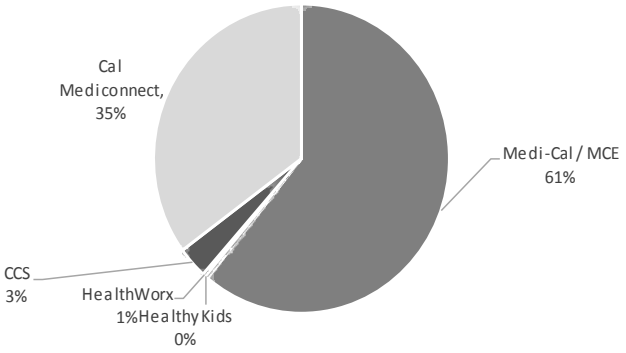
Overview of Financial Results

- Net surplus of $41,824,456 in 2017, net deficit of $20,336,592 in 2016, and a net surplus of $103,430,837 in 2015.

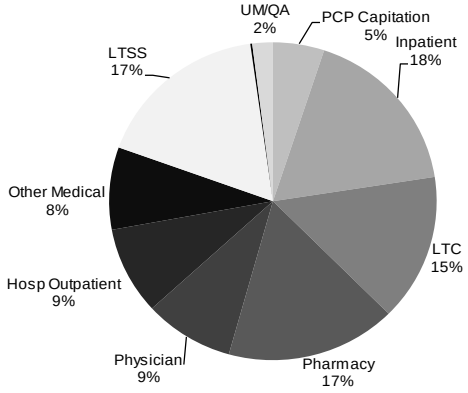
- Net operating revenues increased by $114,129,354 (14.41%) in 2017, decreased by $118,667,030 (13.03%) in 2016, and increased by $182,075,913 (24.98%) in 2015.

- Healthcare expenses increased by $30,500,383 (4.16%) in 2017, decreased by $3,468,124 (0.47%) in 2016, and increased by $141,087,581 (23.66%) in 2015.

Percentage of Revenue by LOB



Healthcare Dollar Spent



- Member months decreased overall by 2.00% in 2017, by 4.07% in 2016, and by 7.56% in 2015.

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

    - In 2016 Medi-Cal increased by 6.67% and the CCS Pilot program also increased by 3.63%. The remaining programs all showed a decrease. HealthWorx decreased by 3.69%. Healthy Kids decreased by 42.83%, as the majority of the program transitioned to Medi-Cal. CareAdvantage decreased by 16.43%, as more members were reassigned to the Cal MediConnect program, which decreased by 6.00%.

- In 2015 Medi-Cal increased by 9.15%. The CCS Pilot program increased by 5.51%, while Healthy Kids decreased 12.86%, as families continue to move to Medi-Cal and/or Covered California. HealthWorx had a slight increase of 1.93%. CareAdvantage decreased by 90.60%; however, most of the members were reassigned to the Cal MediConnect program, which increased by 381.64% as the program completed a full year of operation.

USING THIS ANNUAL REPORT

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

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

HPSM's NET POSITION

HPSM's net position is the difference between its assets and liabilities as reported in the combined statements of net position on page 14. HPSM's net position increased by $41,824,456 in 2017, decreased by $20,336,592 in 2016, and increased by $103,430,837 in 2015.

	2017	2016	2015
CURRENT ASSETS	$ 668,560,900	$ 721,744,741	$ 569,559,764
CAPITAL ASSETS, NET	72,833,122	76,050,557	68,860,680
NET PENSION ASSET	2,255,652	1,376,620	1,633,028
ASSETS RESTRICTED AS TO USE	300,000	300,000	300,000
DEFERRED OUTFLOWS OF RESOURCES	1,323,356	1,082,648	1,102,454
Total assets and deferred outflows of resources	$ 745,273,030	$ 800,554,566	$ 641,455,926
CURRENT LIABILITIES			
Medical claims payable	$ 74,069,985	$ 88,956,228	$ 63,583,454
Provider incentives payable	1,209,287	783,482	742,344
Amounts due to the State of California	290,984,514	330,835,412	205,053,853
Accounts payable and other accrued liabilities	37,610,611	81,303,174	52,724,548
Total liabilities	403,874,397	501,878,296	322,104,199
DEFERRED INFLOWS OF RESOURCES	2,151,709	1,253,802	1,592,667
Total liabilities and deferred inflows of resources	$ 406,026,106	$ 503,132,098	$ 323,696,866
NET POSITION			
Invested in capital assets	$ 72,833,122	$ 76,050,557	$ 68,860,680
Restricted by legislative authority	300,000	300,000	300,000
Unrestricted	266,113,802	221,071,911	248,598,380
Total net position	$ 339,246,924	$ 297,422,468	$ 317,759,060

CURRENT ASSETS

Current assets decreased $53,183,841 (7.37%) from 2016 to 2017. Included is a decrease of $51,832,723 (8.60%) in cash and investments, due primarily to cash takebacks by the State to recover overpayments of capitation (from July 2015 through February 2016) for the Adult Expansion program. These takebacks are expected to continue in 2018. HPSM intentionally holds a greater cash position due to the uncertainty of rate increases/cuts and cash flow from the State of California; a decrease of $9,467,686 (8.66%) in Medi-Cal and CareAdvantage capitation receivables due to rate and risk score adjustments; and an increase of $8,116,565 (82.15%) in other accounts receivable and prepaids and other assets due partially to an accrual of expected pharmacy drug rebates.

Current assets increased $152,184,977 (26.72%) from 2015 to 2016. Included is an increase of $149,112,645 (32.89%) in cash and investments, HPSM intentionally holds a greater cash position due to the uncertainty of rate increases/cuts and cash flow from the State of California; an increase of $5,293,349 (5.09%) in Medi-Cal and CareAdvantage capitation receivables due to rate and risk score adjustments, and; a decrease of $2,221,017 (18.35%) in other accounts receivable and prepaids and other assets.

Current assets increased $164,835,381 (40.73%) from 2014 to 2015. Included is an increase of $132,297,970 (41.20%) in cash and investments, HPSM intentionally holds a greater cash position due to the uncertainty of rate increases/cuts and cash flow from the State of California; an increase of $33,020,242 (46.47%) in Medi-Cal and CareAdvantage capitation receivables due to rate and risk score adjustments and; a decrease of $482,831 (3.84%) in other accounts receivable and prepaids and other assets due to the close-out of our office lease and other prepaid expenses.

CAPITAL ASSETS

Capital assets decreased by $3,217,435 (4.23%) in 2017 as there were no new capital expenditures related to the headquarters. In 2016, capital assets increased by $7,189,877 (10.44%), as renovations and upgrades to HPSM headquarters were completed. In 2015, capital assets increased by $65,493,256 (1,944.91%) due to the purchase (and renovation) of land, building, and parking structure located at 801 Gateway Blvd. in South San Francisco, which as of December 21, 2015, served as HPSM headquarters.

NET PENSION ASSET

Net pension asset represents the excess value of pension assets above the projected liability, under Governmental Accounting Standards Board ("GASB") Statement No. 68, *Accounting and Financial Reporting for Pensions* ("GASB 68"). Net pension asset increased to $2,255,652 (63.85%) at December 31, 2017, from $1,376,620 at December 31, 2016. Net pension asset was $1,633,028 at December 31, 2015. HPSM adopted GASB 68 reporting in 2015.

DEFERRED OUTFLOW

Deferred outflows of resources represent the difference between projected and actual retirement investment earnings that are deferred under GASB 68. Deferred outflows of resources increased to $1,323,356 (22.23%) as of December 31, 2017, from $1,082,648 as of December 31, 2016. Deferred outflows of resources were $1,102,454 at December 31, 2015, when GASB 68 was adopted.

INCENTIVES PAYABLE TO PROVIDERS

Incentives payable to providers increased by $425,805 (54.35%) in 2017, by $41,138 (5.54%) in 2016, and by $380,262 (105.02%) in 2015. HPSM uses a pay for performance-based incentive model for primary care physicians ("PCP"). The model identifies key health quality performance indicators and pays physicians for performing or achieving them. The increase in 2017 is related to the timing of payments to providers. The increase in 2016 was due to increased participation by physicians added to the network. The increase in 2015 is related to the timing of payments to providers.

ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

Accounts payable and accrued liabilities decreased $43,692,563 (53.74%) from 2016 to 2017, increased $28,578,626 (54.20%) from 2015 to 2016, and decreased $2,739,902 (4.94%) from 2014 to 2015. The 2017 changes consist of timing of the MCO tax payment at year-end bringing the payable to $0 in 2017; payout of the 2016 hospital tax payable ("SB335"), which went from $13,769,847 to $0 in 2017; and payout of Intergovernmental Transfer ("IGT"), which decreased the payable to $20,699,306 in 2017. The 2016 changes consist of an increase in the hospital tax payable ("SB239") from $5,192 to $13,769,847 due to a rate change for FY14/15; an increase in MCO tax payable from $0 to $13,750,306 due to reinstatement of the tax beginning in July 2016; an increase in Intergovernmental Transfer from $31,067,313 million to $46,600,985 million, due to a FY14/15 rate change; and a $10,088,147 million decrease of the SB78 Sales Tax, also related to State rate changes. The 2015 change is due to a payout of the 2014 hospital tax payable, which was partially offset by an increase in IGT from $22,117,500 million in 2014 to $31,067,313 million in 2015.

AMOUNTS DUE TO THE STATE OF CALIFORNIA

Amounts due to the State of California decreased $39,850,898 (12.05%) to $290,984,514 in 2017; increased $125,781,559 (61.34%) to $330,835,412 in 2016; and increased $140,508,785 (217.69%) to $205,053,853 in 2015. The 2017 decrease is primarily due to the end of the medical loss ratio ("MLR") requirement associated with the Medi-Cal Expansion program. The requirement ended June 30, 2016. Also, the State began the takeback process for overpayments due to prior year rate adjustments. The 2016 increase is primarily due to rate recasting back to April 2014 for the CCI Medi-Cal Dual and Cal MediConnect populations, as well as, the recording of a risk corridor related to the same period. The 2015 increase is due to State capitation rate changes for the SFY15/16 period, in addition to the MLR ratio requirement associated with the Medi-Cal Expansion program. Managed Care Plans are required to spend 85% of premiums received on health care costs. The difference between the actual costs and 85% must be returned to the State.

DEFERRED INFLOW

Deferred inflows of resources represent changes in assumptions and the difference between expected and actual experience in 2017 that are deferred under GASB 68. Deferred inflows of resources increased $897,907 (71.61%) to $2,151,709 as of December 31, 2017, $338,865 (21.28%) to $1,253,802 as of December 31, 2016. Deferred inflows of resources were $1,102,454 as of December 31, 2015, when GASB 68 was adopted.

	2017	2016	2015
OPERATING REVENUES			
Capitation and premiums			
Medi-Cal	$ 557,487,882	$ 528,489,927	$ 562,519,075
CareAdvantage	160,853	10,472,394	9,349,509
Healthy Kids	2,645,495	2,587,982	3,845,225
HealthWorx	3,064,323	3,027,381	3,101,981
CCS Pilot	30,047,768	26,747,540	31,698,482
Cal MediConnect	313,014,705	220,966,448	300,444,430
Net operating revenues	906,421,026	792,291,672	910,958,702
OPERATING EXPENSES			
Health care expenses			
Hospital inpatient	247,978,279	262,060,776	233,926,947
Medical	195,952,493	180,129,892	169,429,112
Pharmacy	128,662,838	139,078,731	137,389,812
Primary care physician capitation	38,780,017	78,470,754	103,014,815
Long-term support services	132,282,139	55,411,693	74,614,204
Utilization management and quality assessment allocation	15,493,610	15,851,353	11,824,758
Provider incentives	1,356,110	776,273	4,005,234
Other medical - dental, reinsurance, etc.	3,926,656	2,152,287	3,195,001
Total health care expenses	764,432,142	733,931,759	737,399,883
General and administrative	46,763,832	44,589,790	36,365,142
MCO tax	60,790,230	37,907,311	37,026,019
Total operating expenses	871,986,204	816,428,860	810,791,044
Income (loss) from operations	34,434,822	(24,137,188)	100,167,658
NONOPERATING REVENUE			
Net interest and investment income	3,840,741	1,010,944	605,126
Other	307,177	6,890	568,144
Rental income, net	1,034,742	728,856	86,310
Third-party administration fees	2,206,974	2,053,906	2,003,599
Total nonoperating revenue	7,389,634	3,800,596	3,263,179
Changes in net position	41,824,456	(20,336,592)	103,430,837
NET POSITION, beginning of the year	297,422,468	317,759,060	214,328,223
NET POSITION, end of the year	$ 339,246,924	$ 297,422,468	$ 317,759,060

OPERATING REVENUES

HPSM's overall operating revenues increased by $114,129,354 (14.41%) in 2017, decreased by $118,667,030 (13.03%) in 2016, and increased by $182,075,913 (24.98%) in 2015.

The primary components for the increased revenues in 2017 are:

- New rates (effective January 2017) for Cal MediConnect resulting in approximately $12.5 million in increased revenues;
- True-up of retro-rate adjustments for the CCS Pilot Program resulting in approximately $1.34 million of increased revenues; and
- Increase in estimates for In Home Support Services ("IHSS") revenues back to 2014 of approximately $54.5 million to account for contracted rates rather than paid rates by the State; and
- Full year impact of the removal of the Adult Expansion MLR requirement, which would have offset revenues by approximately $12.6 million

The primary components for the decreased revenues in 2016 are:

- Recasted rates back to April 2014 for the Coordinated Care Initiative ("CCI") dual population and Cal MediConnect resulting in approximately $89 million of decreased revenues;
- New rates (effective July 2016) for the MCE from $518.27 pmpm to $435.22 pmpm;
- Retro-rate adjustments for the CCS Pilot Program resulting in approximately $2 million of decreased revenues;
- Healthy Kids member conversion to Medi-Cal; and
- Projected Risk Corridor repayment to the State of approximately $20 million in revenue off-set (covers back to 2014)

The primary components for the increased revenues in 2015 are:

- Rate increases back to 2014 for the addition of Home and Community Based Services ("HCBS"), primarily In Home Services and Supports ("IHSS"), to our Medi-Cal contracts for Cal MediConnect and Coordinated Care Initiative (April 2014), and Special Needs Persons with Disabilities (July 2014), resulting in approximately $75 million of additional revenues;
- Rate increases back to July 2014 for Medi-Cal and Medi-Cal Expansion program ("MCE") due to a change in institutional member reimbursement methodology resulting in approximately $30 million of additional revenues;

- Full year operation of Cal MediConnect into the program; and
- Increased risk scores for CareAdvantage and Cal MediConnect programs.

INTEREST AND INVESTMENT INCOME

Net interest and investment income was $3,840,741 in 2017, $1,010,944 in 2016, and $605,126 in 2015. The average rate of return for the investments was 0.972% in 2017, 0.736% in 2016, and 0.557% in 2015.

OPERATING EXPENSES

Health Care Expenses

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

- An increase in Medi-cal Medical costs of $4.5 million due to an increase in the specialist cost per service.
- ♦ Increase in estimates for In Home Support Services ("IHSS") expenses back to 2014 of approximately $54.5 million to account for contracted rates rather than reported rates by the State;
- ♦ End of contract for global capitation paid to the County Health Services for the Adult Expansion population assigned to them resulting in a decrease of approximately $44 million.
- ♦ A decrease in Pharmacy costs across all lines of business of approximately $10 million;
- ♦ An increase in Transportation costs as a new Medi-Cal benefit was rolled out in 2017 and
- An expansion of behavioral health services to all lines of business (previously only CareAdvantage and child covered).

Overall health care expenses decreased $3,468,124 (0.47%) from 2015 to 2016 due to:

- Reduction of the global capitation paid to County Health Services for the MCE population assigned to them; and
- Recording of IHSS expenses for 2016 (only) whereas 2015 had multiple years recorded.

Overall health care expenses increased by $141,087,581 (23.66%) from 2014 to 2015 due to:

- A 67% growth in MCE membership resulting in $72 million additional healthcare expenditures;
- Retro-inclusion of IHSS resulting in additional healthcare expenditures of approximately $72 million; and
- An increase in Pharmacy costs across all lines of business.

General and Administrative ("G&A") Expenses

Total G&A expenses were $46,763,832 in 2017, $44,589,790 in 2016, and $36,365,142 in 2015. The increase from 2016 to 2017 is due to the new software and related equipment, as well as, an increase in employee salary and benefit costs. The increase from 2015 to 2016 is due increased outside services contracts for the CMS program audit and new and expanded community programs. We also experienced an increase in depreciation expense due to the new building. The administrative expenses as a percentage of operating revenues were 5.09% in 2017, 5.63% in 2016, and 3.99% in 2015.

MCO Tax

In 2009, Assembly Bill No. 1422 ("AB1422") was passed by the legislature and signed by Governor Schwarzenegger. The bill provided that Medi-Cal Managed Care Organizations ("MCO") would be subject to a gross premium tax on Medi-Cal capitation revenues. For revenues pertaining to June 30, 2013, and prior, the tax rate was 2.35%. In June 2013, Senate Bill No. 78 ("SB 78") reauthorized the MCO premium tax through the State of California's fiscal year 2016. Beginning July 1, 2013 through June 30, 2016, the rate is equal to the state sales and use tax rate of 3.9375%. On March 1, 2016, SB X2-2 established a new MCO provider tax, to be administered by DHCS, effective July 1, 2016 through July 1, 2019. The tax would be assessed by the Department of Health Care Service ("DHCS") on licensed health care service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate health care service plans ("AHCSP"), as defined, except as excluded by the bill. This bill would establish applicable taxing tiers and per enrollee amounts for the 2016-2017, 2017-2018 and 2018-2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. HPSM paid $60,790,230, $37,907,311, and $37,026,019, for 2017, 2016, and 2015, respectively, in MCO premium taxes. As of December 31, 2017, HPSM's tax liability was $0, included in accounts payable and accrued liabilities in the combined statements of financial position.

	Actual	Budgeted	Variance
REVENUES			
Medi-Cal	$ 557,487,882	$ 528,558,697	$ 28,929,185
CareAdvantage	160,853	-	160,853
Healthy Kids	2,645,495	1,374,414	1,271,081
HealthWorx	3,064,323	3,058,347	5,976
CCS Pilot Program	30,047,768	29,331,522	716,246
Cal MediConnect	313,014,705	290,786,570	22,228,135
Total revenues	906,421,026	853,109,550	53,311,476
HEALTH CARE EXPENSES			
Hospital inpatient	247,978,279	263,262,968	(15,284,689)
Medical	195,952,493	204,789,406	(8,836,913)
Pharmacy	128,662,838	159,704,084	(31,041,246)
Primary care physician capitation	38,780,017	41,907,312	(3,127,295)
Long-term support services	132,282,139	74,533,299	57,748,840
Utilization management ("UM") and quality assessment ("QA") allocation	15,493,610	17,974,630	(2,481,020)
Other medical - dental, reinsurance, etc.	3,926,656	3,320,440	606,216
Provider incentives	1,356,110	5,146,401	(3,790,291)
Total health care expenses	764,432,142	770,638,540	(6,206,398)
ADMINISTRATIVE EXPENSES			
Salaries and fringe benefits	30,874,856	36,619,350	(5,744,494)
Contract services	16,567,209	20,433,650	(3,866,441)
Office supplies and maintenance	5,118,864	5,675,870	(557,006)
Occupancy, equipment, and depreciation expense	5,478,101	5,830,100	(351,999)
Postage and printing	1,294,713	1,583,300	(288,587)
Other administrative expenses	1,800,972	1,800,780	192
Utilization management and quality assessment allocation	(14,370,883)	(17,974,630)	3,603,747
Total administrative expenses	46,763,832	53,968,420	(7,204,588)
MCO tax	60,790,230	37,907,311	22,882,919
Total expenses	871,986,204	862,514,271	9,471,933
Income (loss) from operations	34,434,822	(9,404,721)	43,839,543
NONOPERATING INCOME			
Net interest and investment income	3,840,741	1,000,000	2,840,741
Other	1,341,919	988,696	353,223
Third-party administrator fees	2,206,974	2,188,614	18,360
Total nonoperating income	7,389,634	4,177,310	3,212,324
Net income (loss)	41,824,456	(5,227,411)	47,051,867
Net position at the beginning of year	297,422,468	297,422,468	-
Net position at the end of year	$ 339,246,924	$ 292,195,057	$ 47,051,867

Report of Independent Auditors

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

Report on the Financial Statements

We have audited the accompanying combined statements of net position of the San Mateo Health Commission (a stand-alone government entity appointed by the San Mateo County Board of Supervisors) (the "Commission") and San Mateo Community Health Authority (the "Health Authority"), collectively known as Health Plan of San Mateo ("HPSM") as of December 31, 2017 and 2016, and the related combined statements of revenues, expenses, and changes in net position, cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the combined financial position of the San Mateo Health Commission and the San Mateo Community Health Authority (d.b.a. Health Plan of San Mateo) as of December 31, 2017 and 2016, and the combined results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Required Supplementary Information

The accompanying Management's Discussion and Analysis on pages 1 through 10, and the accompanying supplementary schedule of changes in the net pension asset and related ratios and supplementary schedule of contribution on page 38 and 39, are not required parts of the combined financial statements but are supplementary information required by the Governmental Accounting Standards Board who considers them to be an essential part of financial reporting for placing the combined financial statements in an appropriate operational, economic, or historical context. This supplementary information is the responsibility of HPSM's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the combined financial statements, and other knowledge we obtained during our audit of the combined financial statements. We do not express an opinion or provide any assurance on the supplementary information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

San Francisco, California
_____, 2018

Combined Financial Statements

San Mateo Health Commission and
San Mateo Community Health Authority
(d.b.a. Health Plan of San Mateo)
Combined Statements of Net Position
December 31, 2017 and 2016

	2017	2016
ASSETS AND DEFERRED OUTFLOWS		
CURRENT ASSETS		
Cash and cash equivalents	$ 391,200,984	$ 444,583,888
Investments	159,463,475	157,913,290
Capitation receivable from the State of California	78,191,448	97,316,226
CareAdvantage receivable	21,707,654	12,050,562
Other accounts receivable	8,898,687	2,295,000
Prepaids and other assets	9,098,652	7,585,775
Total current assets	668,560,900	721,744,741
CAPITAL ASSETS, NET		
Nondepreciable	15,667,814	15,667,814
Depreciable, net of accumulated depreciation and amortization	57,165,308	60,382,743
Total capital assets, net	72,833,122	76,050,557
NET PENSION ASSET	2,255,652	1,376,620
ASSETS RESTRICTED AS TO USE	300,000	300,000
Total assets	743,949,674	799,471,918
DEFERRED OUTFLOWS OF RESOURCES	1,323,356	1,082,648
Total assets and deferred outflows of resources	$ 745,273,030	$ 800,554,566
LIABILITIES AND DEFERRED INFLOWS		
CURRENT LIABILITIES		
Medical claims payable	$ 74,069,985	$ 88,956,228
Incentives payable to providers	1,209,287	783,482
Amounts due to the State of California	290,984,514	330,835,412
Accounts payable and accrued liabilities	37,610,611	81,303,174
Total current liabilities	403,874,397	501,878,296
DEFERRED INFLOWS OF RESOURCES	2,151,709	1,253,802
Total liabilities and deferred inflow of resources	$ 406,026,106	$ 503,132,098
NET POSITION		
Invested in capital assets	$ 72,833,122	$ 76,050,557
Restricted by legislative authority	300,000	300,000
Unrestricted	266,113,802	221,071,911
Total net position	$ 339,246,924	$ 297,422,468

See accompanying notes.

San Mateo Health Commission and
San Mateo Community Health Authority
(d.b.a. Health Plan of San Mateo)
Combined Statements of Revenues, Expenses, and Changes in Net Position
Years Ended December 31, 2017 and 2016

	2017	2016
OPERATING REVENUES		
Capitation and premiums		
Medi-Cal	$ 557,487,882	$ 528,489,927
CareAdvantage	160,853	10,472,394
Healthy Kids	2,645,495	2,587,982
HealthWorx	3,064,323	3,027,381
Child Care Services Pilot	30,047,768	26,747,540
Cal MediConnect	313,014,705	220,966,448
Net operating revenues	906,421,026	792,291,672
OPERATING EXPENSES		
Health care expenses		
Hospital inpatient	247,978,279	262,060,776
Medical	195,952,493	180,129,892
Pharmacy	128,662,838	139,078,731
Primary care physician capitation	38,780,017	78,470,754
Long-term support services	132,282,139	55,411,693
Utilization management ("UM") and quality assessment ("QA") allocation	15,493,610	15,851,353
Provider incentives	1,356,110	776,273
Other medical - dental, reinsurance, etc.	3,926,656	2,152,287
Total health care expenses	764,432,142	733,931,759
General and administrative		
Salaries and fringe benefits	30,874,856	29,136,485
Contract services	16,567,209	16,350,206
Office supplies and maintenance	5,118,864	4,364,813
Occupancy, equipment, and depreciation expense	5,478,101	5,653,786
Postage and printing	1,294,713	1,182,053
Other administrative expenses	1,800,972	1,698,167
UM/QA Healthcare Allocation	(14,370,883)	(13,795,720)
Total general and administrative expenses	46,763,832	44,589,790
MCO tax	60,790,230	37,907,311
Total operating expenses	871,986,204	816,428,860
Income (loss) from operations	34,434,822	(24,137,188)
NONOPERATING REVENUE		
Net interest and investment income	3,840,741	1,010,944
Other revenue	307,177	6,890
Rental income, net	1,034,742	728,856
Third-party administration fees	2,206,974	2,053,906
Total nonoperating revenue	7,389,634	3,800,596
Increase (decrease) in net position	41,824,456	(20,336,592)
NET POSITION, beginning of the year	297,422,468	317,759,060
NET POSITION, end of the year	$ 339,246,924	$ 297,422,468

San Mateo Health Commission and
San Mateo Community Health Authority
(d.b.a. Health Plan of San Mateo)
Combined Statements of Cash Flows
Years Ended December 31, 2017 and 2016

	2017	2016
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation and premium revenues	$ 837,759,819	$ 941,381,227
Healthcare expenses	(787,561,886)	(698,719,079)
General and administrative expenses	(107,232,741)	(87,139,909)
Other	(1,381,603)	581,726
Net cash (used in) provided by operating activities	(58,416,411)	156,103,965
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from sale and maturities of investments	5,368,595	-
Payments for purchase of investments	-	(47,135,791)
Payments for purchase of capital assets	(335,088)	(10,645,016)
Net cash provided by (used in) investing activities	5,033,507	(57,780,807)
Net (decrease) increase in cash	(53,382,904)	98,323,158
CASH AND CASH EQUIVALENTS, beginning of year	444,583,888	346,260,730
CASH AND CASH EQUIVALENTS, end of year	$ 391,200,984	$ 444,583,888
RECONCILIATION OF INCOME FROM OPERATIONS TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Income (loss) from operations	$ 34,434,822	$ (24,137,188)
Adjustment to reconcile income (loss) from operations to net cash (used in) provided by operating activities		
Depreciation	3,552,523	3,409,207
Loss on disposal of assets	-	45,930
Changes in operating assets and liabilities		
Capitation receivable from the State of California	19,124,778	(10,534,567)
CareAdvantage receivable	(9,657,092)	5,241,218
Other accounts receivable	(6,603,687)	221,369
Prepaids and other assets	(1,042,023)	2,146,550
Net pension asset	(221,833)	(62,651)
Medical claims payable	(14,886,243)	25,372,774
Incentives payable to providers	425,805	41,138
Amounts due to the State of California	(39,850,898)	125,781,559
Accounts payable and accrued liabilities	(43,692,563)	28,578,626
Net cash (used in) provided by operating activities	$ (58,416,411)	$ 156,103,965

See accompanying notes.

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

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

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

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

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

HPSM acquired a license under the Knox-Keene Health Care Services Plan Act of 1975, as amended (the "Act") on July 31, 1998, and is regulated by the State's Department of Health Care Services ("DHCS") and California Department of Managed Health Care ("DMHC"). For the HealthWorx program, HPSM contracted with the San Mateo Public Authority for coverage of the In Home Support Services ("IHSS") employees as of August 1, 2001, San Mateo County for coverage of San Mateo County Extra Help employees as of September 1, 2006, and the City of San Mateo for Non-Merit Part-Time and Library Per Diem employees as of January 1, 2009. The current HealthWorx contracts are for the following periods: (1) IHSS – July 1, 2014 to December 31, 2017, (2) Extra Help – September 1, 2011 to August 31, 2015 (now terminated), and (3) the City of San Mateo – January 1, 2009 to December 31, 2018. As a result of HealthWorx program's commercial status, members who have extinguished all available COBRA benefits are eligible for an Individual Coverage Plan ("ICP"). HPSM fully expects the above noted contracts, with the exception of Healthy Families and the San Mateo County Extra Help HealthWorx, to renew after the current contract end dates.

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

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

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

In September 2005, HPSM entered into an agreement with the CMS and became a MediCareAdvantage Organization ("MAO") under the commercial name CareAdvantage. As an MAO, HPSM provides medical services to its dual eligible members. The service contract for fiscal year 2006 became effective on January 1, 2006 through December 31, 2006, and was not renewed. The final Medicare contract was for the period of January 1, 2016 to December 31, 2016. The contract terminated December 31, 2016, when the CareAdvantage program closed.

Effective September 1, 2007, HPSM entered into an agreement with the County of San Mateo to provide third party administrator ("TPA") services to administer the benefits of their indigent care program ("ACE"). The current agreement is for the period April 1, 2015 to March 31, 2018.

Effective April 1, 2013, HPSM entered into a second Medi-Cal contract (Plan #703) with the State of California. This contract covers the CCS Pilot Initiative. CCS Services were previously covered under the primary Medi-Cal contract. The current contract is for the period April 1, 2013 to June 30, 2017. An extension is pending.

Effective April 1, 2014, HPSM entered into a three-way contract with CMS and the State of California for the Cal MediConnect Pilot program. The Cal MediConnect program promotes coordination of care to seniors and people with disabilities who are dually eligible for both Medi-Cal and Medicare. The agreement results in a third Medi-Cal contract and a second Medicare contract. The contract is through December 31, 2019.

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

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

Basis of combination – The accompanying combined financial statements as of December 31, 2017 and 2016, and for the years then ended, include the Commission and the Health Authority, collectively known as HPSM. The operations of the Health Authority are included from the date of its inception on February 1, 2006.

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

Investments – Investments include debt obligations of the U.S. Government and its agencies, certificates of deposits, and money markets as permitted by the California Government Code for Investments. These investments are carried at fair market value. The fair values of investments are based on quoted market prices. Changes in fair value of investments are included in net interest and investment income in the combined statements of revenues, expenses, and changes in net position.

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

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

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

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

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

Assets restricted as to use – HPSM is required by the California Department of Managed Health Care to restrict cash of $300,000 as of December 31, 2017 and 2016, for the payment of member claims in the event of its insolvency.

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

Amounts due to the State of California – When HPSM is made aware of changes to the State rate structure, such as rate decreases, risk corridors or program reconciliations, that significantly impact the financial outlook, an accrual for the estimated change is recorded. Such estimates are subject to the impact of changes in the regulatory environment and are subject to third party review:

- *Risk corridor* – Amendments to the State Medi-Cal contract established a two-year risk corridor for the Coordinated Care Initiative. This impacts the Medi-Cal and Cal MediConnect lines of business. HPSM would be responsible or retain up to 1% of losses or gains. The State and HPSM would equally share any gains or losses between 1% and 2.5%. DHCS would be responsible or keep any gains or losses greater than 2.5%. As of December 31, 2017 and 2016, a total of $19,789,224 is reflected on the combined statements of net position in the estimated amounts due to the State of California.

- *Medical loss ratio ("MLR")* – Effective with the enrollment of the Medi-Cal Adult Expansion Population per ACA on January 1, 2014, HPSM was subject to DHCS requirements to meet a minimum 85% MLR for this population through June 30, 2016. Specifically, HPSM was required to expend at least 85% of the Medi-Cal capitation revenue received for this population on allowable medical expenses as defined by DHCS. In the event HPSM expends less than the 85% requirement, HPSM was required to return to DHCS the difference between the minimum threshold and the actual allowed medical expenses. For the year ended December 31, 2017, HPSM received retro-capitation for the FY15/16 rate period, which did not meet the minimum threshold and recorded a $22.6 million reduction to Medi-Cal capitation revenue. Likewise, as of December 31, 2016 HPSM included an estimated return of funds of $10.3 million. A total of $113.6 million as of December 31, 2017 was reflected on the combined statements of net position in the estimated amounts due to the State of California.

- Miscellaneous adjustments relating to IHSS reconciliation and Agnews totaling $7 million are reflected on the combined statements of net position in amounts due to the State of California.

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

- IGT payable – Welfare and Institutions Code provides for an IGT program relating to the Medi-Cal managed care capitation rates and the capitation rate ranges. Governmental funding agencies, defined as counties, cities, special purpose districts, state university teaching hospitals and other political subdivisions of the state, are eligible to transfer the non-federal share of the available IGT amounts. The IGT is used to fund the non-federal share of increases in Medi-Cal managed care actuarially sound capitation rates. As of December 31, 2017 and 2016, $20,669,306 and $46,600,985, respectively, were accrued for the expected payout.

- Assembly Bill ("AB") 1653 ("AB1653")/SB 335 ("SB335") Payable – On September 8, 2010, AB1653 established a Hospital Quality Assurance Fee ("HQAF") program allowing additional draw down of federal funding to be used for increased payments to general acute care hospitals for inpatient services rendered to Medi-Cal beneficiaries. DHCS provides increased capitation payments to Medi-Cal managed health care plans who in turn expend 100 percent of any increased capitation payments on hospital services. In April 2011, SB90 was signed into law, which extended the HQAF through June 30, 2011. SB335, signed into law in September 2011, extended the HQAF portion of SB90 for an additional 30 months through December 31, 2013. The payments were received and distributed in a manner prescribed as a pass through to revenue. SB239, signed into law October 8, 2013, extended the program for an additional 36 months from January 1, 2014 through December 31, 2016. As of December 31, 2017 and 2016, $0 and $13,769,847, respectively, were accrued for payments to the hospitals.

- Assembly Bill ("AB") 85 Payable – On June 27, 2013, Governor Brown signed into law AB85, that provides a mechanism for the state to redirect state health realignment funding to fund social service programs at the County level, as a result of the Medicaid Expansion afforded by the ACA. The redirected amount is determined according to respective formula options for California public hospitals, County Medical Services Programs ("CMSP") counties and Article 13 counties. For CMSP Counties, which San Mateo is one, AB85 outlines that 60% of health realignment that would otherwise been received will be redirected. As an offset to this redirection, 75% of the difference between the lower bound and upper bound rates for the Medi-Cal Expansion population will be paid to the County Hospital. As of December 31, 2017 and 2016, approximately $4,098,243 and $1,310,709 were accrued for related to AB85 for payment to the County of San Mateo Health System.

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

Capitation and premium revenues – The State of California pays HPSM capitation revenue retrospectively on an estimated basis each month. Capitation revenue is recognized as revenue in the month the beneficiary is eligible for Medi-Cal services. These estimates are continually reviewed, and adjustments to the estimates are reflected currently in the combined statements of revenues, expenses, and changes in net position. The Centers for Medicare & Medicaid Services pays HPSM capitation revenue each month. Capitation revenue is recognized in the month the beneficiary is eligible for Medicare services.

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

In Home Supportive Services ("IHSS") – The Department of Health Care Services pays IHSS payments directly to the Santa Mateo County's Department of Social Services. As part of the Coordinated Care Initiative ("CCI"), HPSM assumes full risk for IHSS provider payments. These amounts are included in both capitation revenue and health care expenses respectively, in HPSM's combined financial statements. Additionally, HPSM pays MCO tax on the revenue. For the year ended December 31, 2017 and 2016, approximately $125 million and $45 million of IHSS related revenue and expenses have been recorded in the combined financial statements, inclusive of estimated true-up amounts resulting in $0 net impact to net position in both years.

Premium deficiencies – HPSM performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency is recorded. Management determined that no premium deficiency reserves were needed at December 31, 2017 or 2016.

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

MCO tax – In November 2009, DHCS implemented AB1422 or Managed Care Organization ("MCO") premium tax. This program imposes an assessment on HPSM's revenue. DHCS uses this assessment to obtain matching federal funds, which is used to sustain enrollment in the Healthy Families program. Effective with California SB78 and beginning July 1, 2012, HPSM was required to pay a gross premium tax on Medi-Cal revenue. For July 1, 2013 through June 30, 2016, the tax rate increased to 3.9375%. Beginning July 1, 2016, a new annual liability methodology for determining tax liability was instituted by the State. MCO tax expense was $60,790,230 and $37,907,312 for the years ended December 31, 2017 and 2016, respectively. As of December 31, 2017 and 2016, $4,304,471 and $3,998,922, respectively, was accrued for the premium tax due on cash receipts. The 2017 and 2016 credits are the result of premium overpayments (by the State to HPSM) due to retro-active rate adjustments, which are lower than the rates originally paid. These amounts are included on the combined statements of net position in accounts payable and accrued liabilities.

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

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

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

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

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

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

New accounting pronouncements – In March 2016, the GASB issued Statement No. 82, *Pension Issues* ("GASB 82"), which is effective for financial statements for periods beginning after June 15, 2017. GASB 82 improves financial reporting by enhancing consistency in the application of financial reporting requirements to certain pension issues. HPSM is reviewing the impact of the adoption of GASB 82 for the fiscal year ending 2018.

In March 2017, the GASB issued Statement No. 85, *Omnibus* 2017 ("GASB 85"), which is effective for financial statements for periods beginning after June 15, 2017. GASB 85 addresses practice issues that have been identified during the implementation and application of certain GASB Statements, including issues related to blending component units, goodwill, fair value measurement and application, and postemployment benefits (pensions and other postemployment benefits). HPSM is reviewing the impact of the adoption of GASB 85 for the fiscal year ending 2018.

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

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

NOTE 2 – CASH AND CASH EQUIVALENTS AND INVESTMENTS

Cash and cash equivalents and investments – Cash and cash equivalents and investments as of December 31, 2017 and 2016, consist of the following:

	2017	2016
Cash on hand	$ 500	$ 500
Cash deposits	350,636,426	404,311,879
Cash equivalents	40,564,058	40,271,509
Investments	159,463,475	157,913,290
Total cash and cash equivalents and investments	$ 550,664,459	$ 602,497,178

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

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

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

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

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

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

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

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

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

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

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

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

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

Per CSMPF's investment policy, the Treasurer will honor all requests to withdraw funds for normal cash flow purposes and apportionments. Any request to withdraw funds for purposes other than cash flow and apportionment, such as external investing, shall be subject to the consent of the Treasurer and will normally be released at 20% per month. In accordance with California Government Code 27136 et seq, and 27133 (h) et seq, these requests are subject to the Treasurer's consideration of the stability and predictability of the pooled investment fund, or the adverse effect on the interests of the other depositors in the pooled investment fund.

HPSM's investments by fair value level include the following as of December 31:

Description	Level 1	Level 2	Level 3	2017
Investments by fair value level				
Total investments subject to fair value hierarchy	$ -	$ -	$ -	$ -
Investments not subject to fair value hierarchy				
San Mateo County Pooled Fund				$ 100,002,091
Local Agency Investment Fund				59,461,384
Total investments				$ 159,463,475

Description	Level 1	Level 2	Level 3	2016
Investments by fair value level				
Total investments subject to fair value hierarchy	$ -	$ -	$ -	$ -
Investments not subject to fair value hierarchy				
San Mateo County Pooled Fund				$ 98,961,495
Local Agency Investment Fund				58,951,795
Total investments				$ 157,913,290

The custodial credit risk, interest rate, credit risk, and concentration of credit risk under GASB Statement No. 62 Section C20, *Cash Deposits with Financial Institutions*, at December 31, 2017 and 2016, were as follows:

Custodial credit risk – Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, HPSM will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The Code requires financial institutions to secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under State Law. As of December 31, 2017 and 2016, deposits exposed to custodial credit risk as they were uninsured, and the collateral held by the pledging bank not in HPSM's name were $391,200,982 and $444,583,889, respectively.

Custodial credit risk for investments is the risk that, in the event of the failure of the counterparty to a transaction, HPSM will not be able to recover the value of its investments or collateral securities that are in the possession of another party. As of December 31, 2017 and 2016, HPSM did not hold investments exposed to custodial credit risk.

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

The weighted average maturity in years for the $300,000 certificates of deposit was 0.56 and 1.22 as of December 31, 2017 and 2016, respectively. The weighted average maturity in years for the portfolio was 0.56 and 1.22 as of December 31, 2017 and 2016, respectively.

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

Ratings as of December 31, 2017 and 2016 for the certificates of deposit was A-1.

Concentration of credit risk – The investment policy of HPSM contains certain limitations on the amount that can be invested in any one issuer and is listed in the table above. There are no investments in any one issuer (other than U.S. Treasury securities, mutual funds, and external investment pools) that represent 5% or more of the total HPSM's investments at December 31, 2017 and 2016.

NOTE 3 – CAPITATION RECEIVABLE FROM THE STATE OF CALIFORNIA

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

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

NOTE 4 – CAPITAL ASSETS

Capital asset activity for the fiscal year ended December 31, 2017, was as follows:

	Beginning Balance	Increases	Decreases	Ending Balance
Furniture and equipment	$ 13,897,430	$ 279,126	$ -	$ 14,176,556
Building improvements	22,638,194	55,962	-	22,694,156
Building	31,810,055	-	-	31,810,055
Land	15,667,814	-	-	15,667,814
Total capital assets	84,013,493	335,088	-	84,348,581
Less accumulated depreciation and amortization for Furniture and equipment	7,962,936	3,552,523	-	11,515,459
Total accumulated depreciation	7,962,936	3,552,523	-	11,515,459
Capital assets, net	$ 76,050,557	$ (3,217,435)	$ -	$ 72,833,122

Capital asset activity for the fiscal year ended December 31, 2016, was as follows:

	Beginning Balance	Increases	Decreases	Ending Balance
Furniture and equipment	$ 13,055,514	$ 1,059,366	$ 217,450	$ 13,897,430
Building improvements	13,098,476	9,585,648	45,930	22,638,194
Building	31,810,055	-	-	31,810,055
Land	15,667,814	-	-	15,667,814
Total capital assets	73,631,859	10,645,014	263,380	84,013,493
Less accumulated depreciation and amortization for Furniture and equipment	4,771,179	3,409,207	217,450	7,962,936
Total accumulated depreciation	4,771,179	3,409,207	217,450	7,962,936
Capital assets, net	$ 68,860,680	$ 7,235,807	$ 45,930	$ 76,050,557

Depreciation expense for capital assets for the years ended December 31, 2017 and 2016, was $3,552,523 and $3,409,207, respectively.

NOTE 5 – MEDICAL CLAIMS PAYABLE

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

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

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

	2017	2016
Balance at the beginning of the period	$ 88,956,228	$ 63,583,454
Incurred		
Current year	597,763,831	588,860,765
Prior year	(14,809,766)	2,498,738
	582,954,065	591,359,503
Paid related to		
Current year	525,099,352	502,151,325
Prior year	72,740,956	63,835,404
Total paid	597,840,308	565,986,729
Balance at end of the period	$ 74,069,985	$ 88,956,228

NOTE 6 – PROVIDER INCENTIVES PAYABLE

As of January 1, 2008, HPSM's risk sharing agreement with care providers was replaced with a pay for performance based system. The program rewards primary care providers for their performance related to quality indicators including but not limited to submission of encounter data, asthma action plans, referral to an Obstetrician in the first trimester, effective treatment of diabetes patients, and maintenance of an open panel. Many of these are included in the capitation payment and others are reimbursed with claims submissions.

NOTE 7 – OPERATING LEASE OBLIGATIONS

Rental expense for operating lease for office space for the years ended December 31, 2017 and 2016, was $25,084 and $52,701, respectively, and is included in occupancy, equipment, and depreciation expense in the combined statements of revenues, expenses, and changes in net position.

NOTE 8 – RESERVE FOR STABILIZATION AND MINIMUM TANGIBLE NET EQUITY

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

As a limited license plan under Knox-Keene Health Care Services Plan Act of 1975 (the "Act"), HPSM is required to maintain a minimum level of tangible net equity. On November 9, 2016, the San Mateo Health Commission approved a change to the stabilization reserve from 250% of the minimum tangible net equity ("TNE") as defined by the Department of Managed Health Care regulation to two (2) months of operating expenses. As of December 31, 2017, the stabilization reserve of 250% was $145,368,000. As of December 31, 2016, stabilization reserve of 250% was $136,100,000.

As of December 31, 2017, the minimum TNE was $34,323,697. Total net position as of December 31, 2017, is $ $339,246,924, which exceeds the minimum tangible net equity by $304,923,227 and is 988% of TNE.

As of December 31, 2016, the minimum TNE was $31,527,302. Total net position as of December 31, 2016, is $297,422,468, which exceeds the minimum tangible net equity by $265,895,166 and is 943% of TNE.

NOTE 9 – DEFERRED COMPENSATION FUND

HPSM contributes an amount equal to 7.5% of gross salary on behalf of the employee to an Internal Revenue Code Section 457 deferred compensation plan per Internal Revenue Service ("IRS") regulations in lieu of social security. In July 2016 HPSM held a vote of its employees to determine for themselves whether or not to participate in social security effective October 1, 2106. Employees who voted to participate in social security would no longer received the 7.5% of gross salary contribution. Those voting not to participate would continue to receive the contributions in lieu of social security.

All HPSM employees may participate in this deferred compensation plan under which employees are permitted to defer a portion of their annual salary until future years. For the years ended December 31, 2017 and 2016, HPSM contributed $865,089 and $1,361,928, respectively. The deferred compensation plan is administered by the International City Managers Association and the funds are invested under the terms of a trust agreement. The amounts are not available to employees until termination, retirement, death, or unforeseeable emergency.

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

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

NOTE 10 – RETIREMENT PLAN

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

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

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

	2017	2016
Retired and beneficiaries	8	7
Inactive	38	37
Active	265	254
Total participants	311	298

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

	2017	2016
Pension cost		
Service cost	$ 1,343,189	$ 1,187,234
Interest cost	1,369,003	1,265,064
Projected earnings on plan investments	(1,419,867)	(1,341,363)
Current period effect of benefit changes	-	-
Current period difference between expected and actual experience	108,618	65,021
Current period effect of changes in assumptions	165	726
Current period difference between projected and actual investment earnings	(300,203)	(11,986)
Administrative expenses	-	-
Current period recognition of prior years' deferred outflows of resources	341,360	275,613
Current period recognition of prior years' deferred inflows of resources	(350,851)	(338,865)
Total pension cost	$ 1,091,414	$ 1,101,444

	2017	2016
Deferred outflows of resources as of December 31		
Difference between expected and actual experience	$ 768,688	$ 300,397
Changes in assumptions	3,440	3,354
Difference between projected and actual investment earnings	-	778,897
Total	$ 772,128	$ 1,082,648

	2017	2016
Deferred inflows of resources as of December 31		
Difference between expected and actual experience	$ (217,909)	$ (298,615)
Changes in assumptions	(697,028)	(955,187)
Difference between projected and actual investment earnings	(685,544)	-
	$ (1,600,481)	$ (1,253,802)

Deferred inflows of resources as of December 31, 2017 consist of $551,228 of deferred outflows and ($1,236,772) of deferred inflows from difference between projected an actual investment earnings, presented in a consolidated format per GASB 68.

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

Year Ending December 31,	
2018	$ (200,910)
2019	(200,910)
2020	(374,867)
2021	(150,658)
2022	98,992
Thereafter	-
	$ (828,353)

The following table summarizes changes in pension asset for the year ended December 31, 2017:

	Total Pension Liability	Plan Fiduciary Net Pension	Net Pension Asset
Balance at December 31, 2016	$ 18,056,472	$ 19,433,092	$ (1,376,620)
Changes during the year			
Service cost at beginning of year	1,343,189	-	1,343,189
Interest	1,369,003	-	1,369,003
Changes of benefit terms	-	-	-
Differences between expected and actual experience	641,930	-	641,930
Changes in assumptions	977	-	977
Benefit payments	(2,334,774)	(2,334,774)	-
Contributions	-	1,313,247	(1,313,247)
Net investment income	-	2,920,884	(2,920,884)
Administrative expenses	-	-	-
Net change in total pension liability (asset)	1,020,325	1,899,357	(879,032)
Balance at December 31, 2017	$ 19,076,797	$ 21,332,449	$ (2,255,652)

Total pension liability	$ 19,076,797
Plan fiduciary net position	21,332,449
Net pension asset	$ (2,255,652)
Plan fiduciary net position as a percentage of the total pension asset	111.82%
Covered payroll as of December 31, 2017, actuarial valuation	$ 20,084,266
Net pension asset as a percentage of covered payroll	11.23%

The following table summarizes changes in pension liability for the year ended December 31, 2016:

	Total Pension Liability	Plan Fiduciary Net Pension	Net Pension Asset
Balance at December 31, 2015	$ 16,110,081	$ 17,743,109	$ (1,633,028)
Changes during the year			
Service cost at beginning of year	1,187,234	-	1,187,234
Interest	1,265,064	-	1,265,064
Changes of benefit terms	-	-	-
Differences between expected and actual experience	365,418	-	365,418
Changes in assumptions	4,080	-	4,080
Benefit payments	(875,405)	(875,405)	-
Contributions	-	1,164,095	(1,164,095)
Net investment income	-	1,401,293	(1,401,293)
Administrative expenses	-	-	-
Net change in total pension liability (asset)	1,946,391	1,689,983	256,408
Balance at December 31, 2016	$ 18,056,472	$ 19,433,092	$ (1,376,620)

Total pension liability	$ 18,056,472
Plan fiduciary net position	19,433,092
Net pension asset	$ (1,376,620)
Plan fiduciary net position as a percentage of the total pension asset	107.62%
Covered payroll as of December 31, 2016, actuarial valuation	$ 18,167,831
Net pension asset as a percentage of covered payroll	7.58%

The following table summarizes the actuarial assumptions used to determine net pension liability and plan fiduciary net position as of December 31, 2017 and 2016:

	Contributions related to the actuarially determined contributions made for the plan year
Valuation date:	January 1 to December 31
Actuarial cost method:	Entry age normal method
Amortization method:	Level dollar, closed amortization
Asset valuation method:	Market value
Actuarial assumptions:	
Projected salary increases	5.00%
Mortality	Based on the RP-2014 healthy mortality table for males and females adjusted to 2006, with future mortality improvements projected on a fully generational basis using projection scale MP-2017
Discount rate	7.50%

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

	1% Decrease (6.50%)	Current Discount rate (7.50%)	1% Increase (8.50%)
Net pension asset as of December 31, 2017	$ (868,129)	$ (2,255,652)	$ (3,487,285)

	1% Decrease (6.50%)	Current Discount rate (7.50%)	1% Increase (8.50%)
Net pension asset as of December 31, 2016	$ (71,377)	$ (1,376,620)	$ (2,536,025)

NOTE 11 – MEDICAL REINSURANCE (STOP-LOSS INSURANCE)

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

Stop-loss insurance premiums of $2,677,753 and $1,985,404 are included in other medical expense in 2017 and 2016, respectively. In 2017, there is a total of $2,316,115 in recoveries: Medi-cal $352,889 and $201,657 for 2017 and 2016 dates of service; Cal MediConnect $890,825 and $534,339 for 2017 and 2016 dates of service; and CCS $336,406 for 2017 dates of service. In 2016, there is a total of $1,874,019 in recoveries: Medi-Cal $275,115 and $445,750 for 2016 and 2015 dates of service; Cal MediConnect $139,271 and $536,853 for 2016 and 2015 dates of service; and CCS $241,678 and $235,352 for 2016 and 2015 dates of service.

NOTE 12 – PROFESSIONAL LIABILITY INSURANCE

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

NOTE 13 – COMMITMENTS AND CONTINGENCIES

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

NOTE 14 – HEALTH CARE REFORM

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

Supplementary Information

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

	2017	2016	2015
Total pension liability			
Service cost at beginning of year	$ 1,343,189	$ 1,187,234	$ 1,253,303
Interest	1,369,003	1,265,064	1,283,904
Changes of benefit terms	-	-	-
Differences between expected and actual experience	641,930	365,418	(460,027)
Changes in assumptions	977	4,080	(1,471,505)
Benefit payments	(2,334,774)	(875,405)	(709,190)
Net change in total pension liability	1,020,325	1,946,391	(103,515)
Total pension liability beginning of fiscal year	18,056,472	16,110,081	16,213,596
Total pension liability end of fiscal year (a)	$ 19,076,797	$ 18,056,472	$ 16,110,081
Plan fiduciary net pension			
Contributions	$ 1,313,247	$ 1,164,095	$ 1,459,445
Net investment income	2,920,884	1,401,293	(70,676)
Benefit payments	(2,334,774)	(875,405)	(709,190)
Administrative expenses	-	-	-
Other	-	-	-
Net change in Plan fiduciary net position	1,899,357	1,689,983	679,579
Plan fiduciary net position beginning of year	19,433,092	17,743,109	17,063,530
Plan fiduciary net position end of fiscal year (b)	$ 21,332,449	$ 19,433,092	$ 17,743,109
Net pension asset end of fiscal year			
Plan's net pension asset (a) - (b)	$ (2,255,652)	$ (1,376,620)	$ (1,633,028)
Plan fiduciary net position as a percentage of the total pension asset	111.82%	107.62%	110.14%
Covered employee payroll	$ 20,084,266	$ 18,167,831	$ 16,553,874
Net pension asset as a percentage of covered payroll	-11.23%	-7.58%	-9.86%

San Mateo Health Commission and
San Mateo Community Health Authority
(d.b.a. Health Plan of San Mateo)
Supplementary Schedule of Contributions
December 31, 2017

	2017	2016	2015	2014	2013
Actuarial determined contribution	$ 1,313,247	$ 1,164,095	$ 1,437,466	$ 1,367,854	$ 1,321,835
Contributions related to actuarially determined contribution	$ 1,313,247	$ 1,164,095	$ 1,459,445	$ 1,333,194	$ 1,361,858
Contribution deficiency (excess)	$ -	$ -	$ (21,979)	$ 34,660	$ (40,023)
Covered payroll	$ 20,084,266	$ 18,167,831	$ 16,535,874	$ 15,989,836	$ 14,768,660
Contribution as % of covered payroll	6.54%	6.41%	8.83%	8.34%	9.22%
Contributions made during the fiscal year	$ 1,313,247	$ 1,164,095	$ 1,459,445	$ 1,333,194	$ 1,361,858

	2012	2011	2010	2009	2008
Actuarial determined contribution	$ 1,382,058	$ 1,192,417	$ 1,148,871	$ 1,175,390	$ 728,849
Contributions related to actuarially determined contribution	$ 1,440,249	$ 1,156,479	$ 1,124,362	$ 1,890,727	$ -
Contribution deficiency (excess)	$ (58,191)	$ 35,938	$ 24,509	$ (715,337)	$ 728,849
Covered payroll	$ 13,203,459	$ 12,680,263	$ 11,485,618	$ 10,190,445	$ 8,514,283
Contribution as % of covered payroll	10.91%	9.12%	9.79%	18.55%	0.00%
Contributions made during the fiscal year	$ 1,440,249	$ 1,156,479	$ 1,124,362	$ 1,890,727	$ -

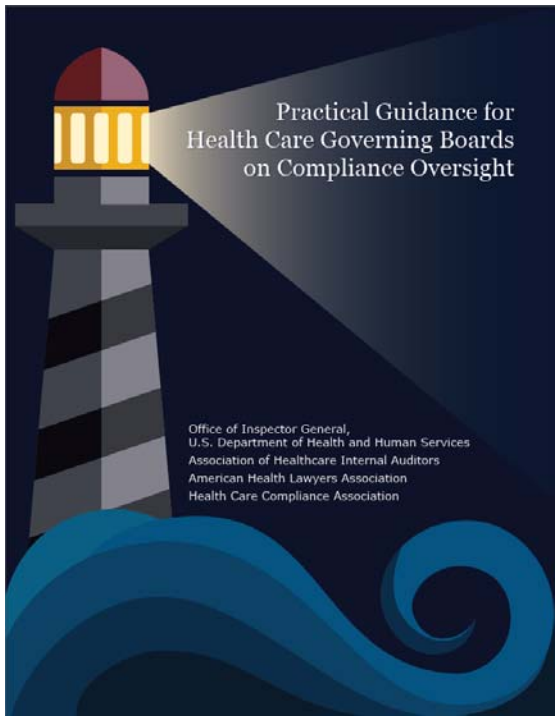
HealthPlan OF SAN MATEO
Healthy is for everyone

Agenda Item: 5.2
Date: April 11, 2018

OIG Training & 2017 Compliance Survey Results

April 11, 2018

Background



- Educational resource
  - Joint effort with the Inspector General of the Department of Health and Human Services (HHS OIG)
  - Provides guidance and practical ideas for compliance oversight and reporting
- Part of Commission annual training

Programmatic expectations

- Centers for Medicare & Medicaid Services (CMS)
  - Medicare
    - "The sponsor's governing body must exercise reasonable oversight…of the sponsor's compliance program"
  - Medicaid
    - The establishment of a Regulatory Compliance Committee on the Board of directors…charged with overseeing the organization's compliance program…"

HHS OIG expectations

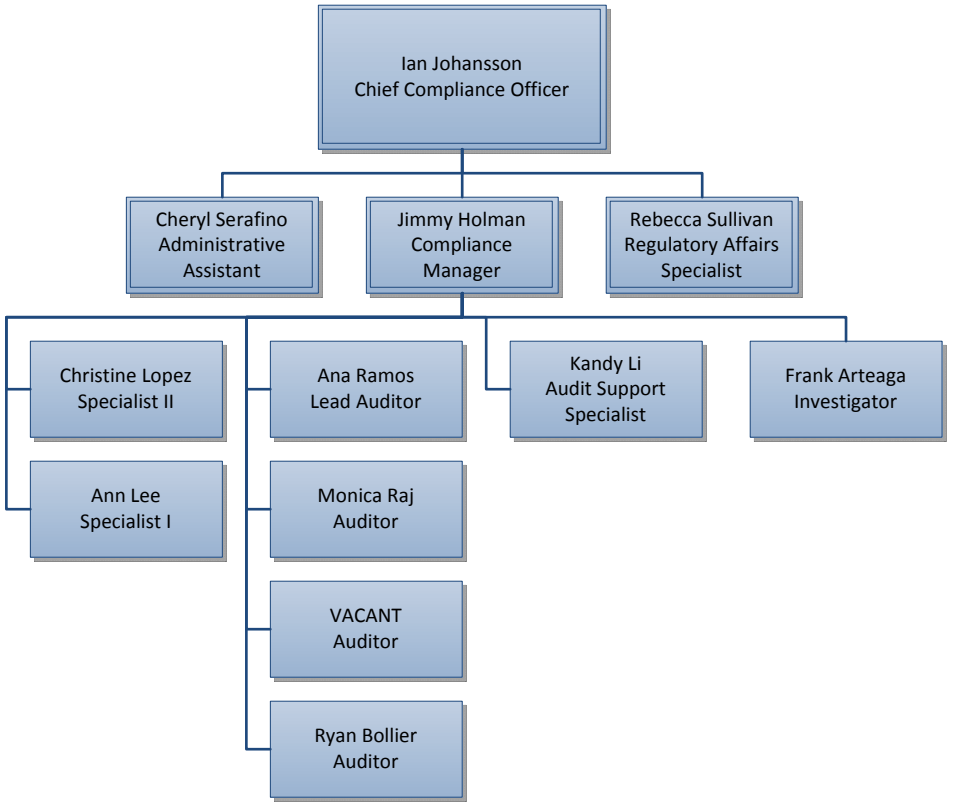
- Act in good faith
- Receive adequate information
- Use recognized benchmarks
- Put forth meaningful effort
- Understanding scope and adequacy
- Flexibility based on size
- Make informed decisions

Scope and adequacy

- Small managed care organization
- Well staffed compared to peers
- Year-over-year improvement in external audits
  - Successful close of CMS audit
  - Reduction in DHCS audit findings 2014-2016
  - Positive effectiveness audit results

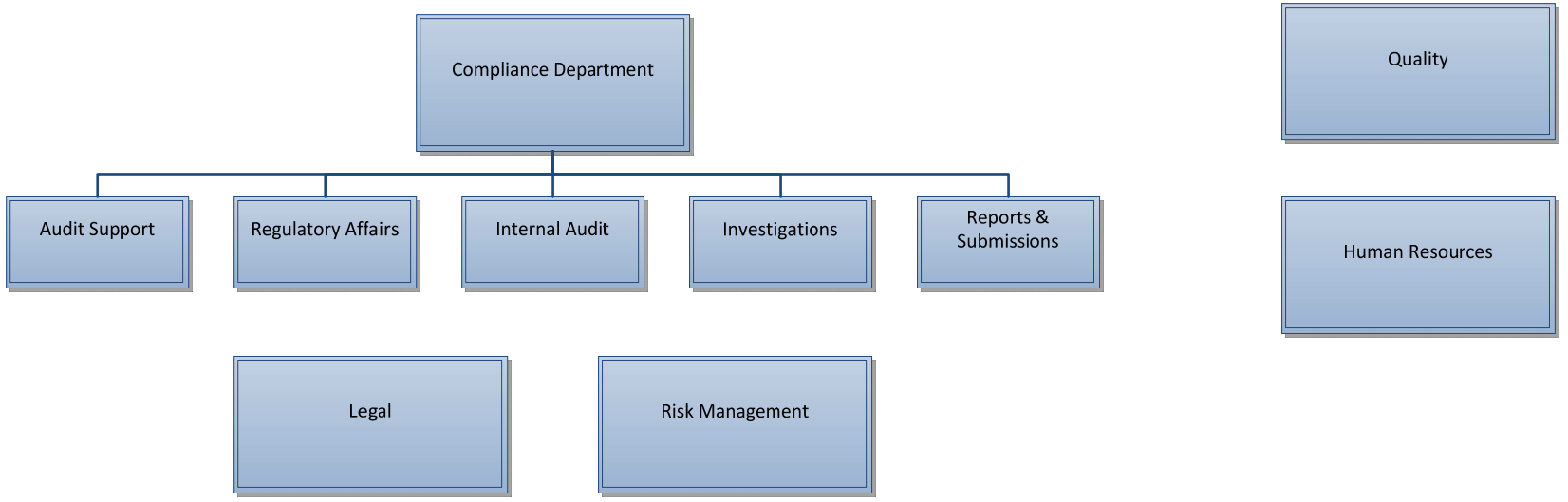
Department staffing

- Staffing is continuously assessed
- Effectiveness audit, survey and performance data reviewed
- Staff input key



Roles and relationships

- Compliance, HR and Quality are separate functions
- Legal and Risk Management are shared responsibilities



Reporting to the Commission

HealthPlan OF SAN MATEO
Healthy is for everyone

- At least once per year
  - Actual:
    - 4 times to Commission
    - 5 times to Finance/Executive Committee
- Compliance Program metrics
  - Audit results, effectiveness survey results, risk assessment/ranking, significant compliance issues
- Annual compliance training
- Other operational presentations

Identifying and auditing risk areas

- Based on annual risk assessment & ranking
  - Internal/external audit results are priority
  - Input from stakeholders
  - New laws/regulations
  - Employee survey
  - Management survey
- Ranking reviewed quarterly
- Ranking previewed for Commission

Identifying and auditing risk areas

HealthPlan OF SAN MATEO
Healthy is for everyone

- Internal audits use state/federal tools & methods
- Negative results require corrective action
- Performance trended audit-to-audit
  - And year-over-year
- Results reviewed with stakeholders
- Stakeholders have input into audit scope

Identifying and auditing risk areas

- Participation in program is key
- Increase in issues reported year-over-year
  - 98% reported directly
- Communication efforts
  - Regular meetings with
    - managers
    - stakeholders
    - departments

Identifying and auditing risk areas

- Data driven initiatives
  - Early indicators
  - Retrospective reviews
- Regular communication
- Transparency in results
- Focus on continuous quality improvement

Accountability & compliance

- Responsibility of entire organization
  - Messaged regularly throughout the organization/year
- "A way of life"
  - Launched "Compliance Week"
  - Effectiveness Survey
  - Effectiveness Audit
  - Positive reinforcement
  - Transparency

Your part in the program

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- Be curious
  - Ask questions
  - Ask for data
  - Ask for regular reports on risks and outcomes
  - Ask about infrastructure
- Make informed decisions for HPSM and our members
- Please read the HHS OIG document

Compliance Effectiveness Survey

- Conducted annually
- Staff feedback on prior calendar year activity
- Factors into risk assessment/ranking

- Conducted February 22 – March 9, 2018

Goals from 2016

- Improve participation to 95%
  - Held “Compliance Week”
  - Increased communication
- Survey redesigned
  - One question removed
- Follow-up activities
  - Department training on non-intimidation/retaliation

Results & trend

	2017	AVG
Participation Rate	**74%**	↑ 9
Familiar with Compliance Program	**98%**	no change
I know where to view a copy of HPSM's Code of Conduct	**98%**	↑ **2**
I know where to locate HPSM's P&Ps	**96%**	↓ **1**
I am aware of the P&P that relate to my job	**96%**	↓ **1**
The name of HPSM's Compliance Officer is	**98%**	no change
I know where the Compliance Officer's office is located	**97%**	↑ **3**
I would feel comfortable reporting to Compliance Officer	**99%**	↑ **1**
Observed workplace behavior that felt violated Code or policy, law	**6%**	↓ **6**
If YES to previous, did not report it	**1.55%**	↓ **2.45**
Do you know about HPSM's policy on non-retaliation and non-intimidation?	**95%**	↑ **2**
Fear of retaliation would prevent me from reporting	**24%**	↓ **3**
Confident compliance will ensure concern is addressed timely	**98%**	↑ **3**
Confident compliance will ensure concern is addressed confidentially	**98%**	↑ **2**

Next steps

- Present results to all departments and staff
- Create action plan on key indicators
  - Compliance Committee input
- Increase participation in 2019
- Conduct non-intimidation/non-retaliation training

Questions?

- Email: ian.johansson@hpsm.org
- Call: 650-616-2151
- Office: 3rd floor, west side (near garage)

Thank You

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MEMORANDUM

AGENDA ITEM: 7.0

DATE: April 11, 2018

DATE: April 2, 2018

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: CEO Update

State Updates

Cal MediConnect (CMC) and the Coordinated Care Initiative (CCI)

As I've noted in previous months, now that the program's continuation is assured for two additional years, through 2019, participating health plans are working to improve the CMC capitation rate structure. While we received favorable CCI and CMC rates for 2017 in December of last year, concern remains about how to pay on an ongoing basis for those nursing home residents moving out of long term care into assisted living. Late last year, the coalition of ten health plans participating in CMC submitted a rate restructuring proposal to DHCS. The major goal of the proposal is to strengthen the financial incentives for health plans to place members currently living in long term care facilities in less restrictive, more independent settings, particularly assisted living. A meeting to review the proposal with State staff was held in January; State officials wanted more information. The plans are researching possible approaches and continuing negotiations with the State.

California Children's Services Whole Child Model

After nearly two years of preparation, the State Department of Health Care Services (DHCS) is poised to begin implementation of the Whole Child Model (WCM), an approach based on San Mateo County's and HPSM's experience with the CCS pilot, which was started in 2013. The WCM will start in July in several of the County Organized Health Systems, namely Central California Alliance for Health (Santa Cruz, Merced, and Monterey counties), CenCal (Santa Barbara and San Luis Obispo counties), and San Mateo (there are some tweaks to our original CCS pilot). In January 2019, Cal Optima and Partnership Health Plan of California will also start the program. The San Mateo County CCS community is proud of the work we've done to lead the State in this program for enhancing family experiences and outcomes in the CCS program.

Universal Health Coverage

There continues to be a great deal of activity at the State level directed toward a single payer system and universal coverage. The State Assembly Select Committee on Healthcare Delivery Systems and Universal Coverage, which convened several meetings beginning late last year, issued its final report on March 13, 2018. The report recommends both short and longer term policy solutions. Short term solutions include expanding Medi-Cal coverage and Covered

California advance premium tax credits to income eligible undocumented adults, enhancing Covered California premium subsidies, limiting out of network hospital prices, increasing Medi-Cal provider payments, exploring a Medicaid Public Option, requiring price transparency for hospitals and medical groups, and establishing an all-payer claims database. The longer-term solution would include development of a "path toward unified public financing" and would begin with the establishment of a planning commission "responsible for advancing progress toward universal coverage and unified health care financing". At this point, there is no clear course of action that will be taken in response to these findings. However, legislation has been introduced to begin addressing some of some of these issues.

Chief Medical Officer Recruitment

We have retained a recruiting firm to help with this critical search. I expect a presentation of a slate of potential candidates within the next month. In the meantime, the Health Services Department has been functioning well, a testament to the quality and commitment of the staff.

Hospital Contract Negotiations

Negotiations with Verity and Seton Medical Center to continue hospital and outpatient services are underway. We have also resumed negotiations with Dignity Health System, based on the contract framework negotiated with Sutter Health last year.

AGENDA ITEM: 8.1

DATE: April 11, 2018

Meeting materials are not included

for Closed Session Item 8.1

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION and
SAN MATEO COMMUNITY HEALTH AUTHORITY

AGENDA ITEM: 10.0

DATE: April 11, 2018

IN THE MATTER OF CHIEF EXECUTIVE OFFICER'S
2018 COMPENSATION AND PERFORMANCE GOALS

RESOLUTION 2018 -

RECITAL: WHEREAS,

A. In March 2017, The San Mateo Health Commission adopted 2017 Performance Goals and a compensation package for the Chief Executive Officer position;

B. The San Mateo Health Commission has reviewed the performance and accomplishments of Maya Altman, Chief Executive Officer for this time period;

C. The San Mateo Health Commission has considered new performance goals and a compensation package for 2018 for Maya Altman, Chief Executive Officer.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves a _____% increase in base salary for the Chief Executive Officer retroactively to January 1, 2018 and retains the current car allowance; and

2. The San Mateo Health Commission approves the 2018 Performance Goals as outlined in the attached memorandum.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of April, 2018 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
David J. Canepa, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
John Nibbelin
CHIEF DEPUTY COUNTY COUNSEL

2018 Draft Performance Goals:
Chief Executive Officer

1. Meet 2018 organizational metrics as outlined in the 2016-18 Strategic Plan.
2. Lead successful advocacy campaign for the restructuring of the CCI and CMC Medi-Cal rates to include improved financial incentives for transition of long term care residents to community settings.
3. Lead successful campaign to advocate for state and federal extension of the CMC and CCI programs beyond December 2019.
4. Improve HPSM's overall Medi-Cal quality score ranking from 6th to 5th through improved primary care engagement and updated payment and P4P models.
5. Launch SNFist program with goal of active participation of six high volume skilled nursing facilities by end of 2018.
6. Launch a SNFist Collaborative similar to the Clinical Partnership by the end of 2018.
7. Complete evaluation of HomeAdvantage/Landmark program.
8. Develop a program for workforce development by the end of 2018.
9. Working with Aging and Adult Services, focus efforts to meet unmet Long Term Services and Supports among CMC and CCI members.
10. Working with Behavioral Health and Recovery Services, improve the care model for complex shared HPSM-BHRS clients.