Health Plan of San Mateo
Healthy is for everyone

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THE SAN MATEO HEALTH COMMISSION
Regular Meeting
March 11, 2026 - 12:30 p.m. Pacific Time
Health Plan of San Mateo
801 Gateway Blvd., Boardroom
South San Francisco, CA 94080

This meeting of the San Mateo Health Commission will be held in the Boardroom at 801 Gateway Blvd., South San Francisco. Members of the public wishing to view this meeting remotely may access the meeting via YouTube Live Stream using this link: https://youtube.com/live/O9TZr2-Idw0?feature=share Please note that while there is an opportunity to provide public comment in person, there is no means of doing so via the Live Stream link.

AGENDA

1. **Call to Order/Roll Call**
2. **Public Comment/Communication**
3. **Approval of Agenda***
4. **Consent Agenda***
   - 4.1 Waive RFP and Approve Amendment to Agreement with Optum Insight, Inc.
   - 4.2 Waive RFP and Approve Agreement with Pellera (Mainline) for HEALTHsuite Platform Refresh
   - 4.3 Approval of Agreement with Compliance Strategies
   - 4.4 Waive RFP Process and Approve Amendment to Agreement with SS&C Health (PBM)
   - 4.5 Waive RFP Process and Approve Amendment to Agreement with Previon Solutions, LLC
   - 4.6 Draft Community Advisory Committee Minutes – January 21, 2026
   - 4.7 Draft Finance/Compliance Committee Minutes – February 23, 2026
   - 4.8 San Mateo Health Commission Meeting Minutes from January 14, 2025
5. **Specific Discussion/Action Items**
   - 5.1 Healthworx Program*
   - 5.2 501 (c)(3) Update
6. **Report from Chief Executive Officer**
7. **Other Business**
8. **Adjournment**

**Items for which Commission action is requested.*

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

MEMORANDUM

AGENDA ITEM: 4.1

DATE: March 11, 2026

DATE: March 4, 2026

TO: San Mateo Health Commission

FROM: Eben Yong, Chief Information Officer

RE: Waive RFP process and Approve Amendment to Agreement with Optum Insight, Inc.

Recommendation:

Waive the request for proposal (RFP) process and ratify approval of an agreement with OptumInsight, Inc. (Optum). The agreement is for a contract maximum of $1,934,025 and a five-year term that ends March 31, 2031.

Background:

In June 2005, HPSM contracted with ("Ingenix"), now known as OptumInsight, Inc., for data, software, and a license agreement. Since then, Optum has provided HPSM software related to claims payment and processing. The agreement covers ongoing use of Medi-Cal and Medicare Prospective Payment Systems Interface products for claims processing software and services. Over the course of the agreement, HPSM has been satisfied with the data management and other products and services. Optum continues to provide software applications and implementation services that have afforded HPSM features to ensure efficient claims management. Optum is the only company that provides the prospective payment systems claims processing software components that work with AMISYS (HPSM's claims payment system in use from 1992-2011) and HEALTHsuite (in use from 2011 to the present). Therefore, a waiver of the RFP process is necessary.

Fiscal Impact:

This is a five-year agreement with a contract maximum of $1,934,025. The term is April 1, 2026 through March 31, 2031. Costs are in the range of $377,000 to $408,000 per year. The first year of this new agreement represents a 3.9% increase over current software license fees due to one-time implementation services, with years two through five showing 3.3% annual increases.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF WAIVE RFP PROCESS AND APPROVE AMENDMENT TO AGREEMENT WITH OPTUM INSIGHT, INC.

RESOLUTION 2025 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has previously entered into agreements with OptumInsight, Inc. (Optum), beginning in June 2005;
B. Since 2005, HPSM has utilized the Optum licensed software and tools to simplify claims management for timely and efficient claims processing and to meet compliance goals; and
C. Optum is the only company to provide claims processing software components that work with HPSM's current claims system, HEALTHsuite.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the request for proposal process and ratifies a five-year agreement with OptumInsight, Inc. which includes a contract maximum of $1,934,025 and a term that ends March 31, 2031.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of March, 2026 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Bill Graham, Chairperson

ATTEST:

BY: _____
M. Heryford, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

MEMORANDUM

AGENDA ITEM: 4.2

DATE: March 11, 2026

DATE: March 4, 2026

TO: San Mateo Health Commission

FROM: Eben Yong, Chief Information Officer

RE: Waive RFP process and Approve Agreement with Pellera (Mainline) for HEALTHsuite Platform Refresh

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Recommendation:
Waive the RFP process and ratify approval of an agreement with Pellera (Mainline). The agreement is for a contract maximum of $520,000.00 that covers equipment procurement, installation and services.

Background:
HPSM's HEALTHsuite environment is a mission-critical system responsible for claims adjudication, encounter processing, member eligibility, and many related core business functions. The hardware and associated backup/data-protection components currently in use are approaching end-of-support and end-of-patching windows. To ensure operational resiliency, security posture, and performance, HPSM initiated a refresh project consistent with the organization's long-term infrastructure modernization strategy. The proposed solution replaces aging compute nodes, augments network pathways, introduces updated storage-adjacent connectivity, and deploys a more modern, resilient, and supportable backup and data-protection model.

HPSM has used HEALTHsuite as its core claims and member system since 2011. HEALTHsuite is developed and supported by RAM Technologies, and Pellera (Mainline) is the approved vendor for IBM equipment used to run HEALTHsuite. Related to HEALTHsuite equipment procurement, HPSM has experienced three successful implementation cycles, in 2011, 2015 and 2020. Pellera (Mainline) has worked with RAM and HPSM since 2008, when RAM and HEALTHsuite were selected in a competitive RFP, and continues to support HPSM. Therefore, a waiver of the RFP process is recommended.

Fiscal Impact:
The proposed solution from Pellera (Mainline) provides an integrated and supportable path forward by replacing aging computer hardware, updating network connectivity, and modernizing the backup and data-protection layer supporting HEALTHsuite. The proposed solution includes IBM Power10 computer, Cisco Nexus switching components, the Cobalt Iron Compass platform, and associated software and implementation services. The amount requested is not to exceed $520,000.00.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF AGREEMENT WITH PELLERA (MAINLINE) FOR HEALTHSUITE PLATFORM RESEARCH

RESOLUTION 2026 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has previously entered into agreements with Pellera (Mainline), beginning in 2008; and
B. Since 2008, HPSM has implemented IBM hardware and software to support HEALTHsuite (developed and supported by RAM Technologies), HPSM's core claims and member system; and
C. Pellera (Mainline) is the RAM-approved vendor to procure and implement IBM equipment in support of HEALTHsuite.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the request for proposal process and ratifies an agreement with Pellera (Mainline), which includes a contract maximum of $520,000 to procure and implement IBM equipment in support of HEALTHsuite.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of March, 2026 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Bill Graham, Chairperson

ATTEST:

BY: _____
M. Heryford, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

MEMORANDUM

AGENDA ITEM: 4.3

DATE: March 11, 2026

DATE: March 4, 2026

TO: San Mateo Health Commission

FROM: Pat Curran, Chief Executive Officer
Ian Johansson, Chief Government Affairs and Compliance Officer

RE: Approval of Agreement with Compliance Strategies

Recommendation

Authorize the Chief Executive Officer to execute an agreement with Compliance Strategies to provide Medicare audit and consulting services through December 31, 2026 with a total amount not to exceed $500,000.

Background

HPSM has worked with Compliance Strategies since 2014 to improve readiness for and participate in CMS audit activities. Compliance Strategies specializes in preparing health plans for CMS audits, addressing compliance gaps, and improving performance in key operational areas such as grievances and appeals, pharmacy, utilization management, and care management/model of care.

HPSM has not been audited by CMS since 2016. While CMS aims to audit all health plans every five years, CMS focuses its annual audits on plans that pose higher risk than their peers. The length of time since HPSM's last CMS audit creates heightened risk for audit selection in 2026. CMS audits are incredibly intensive activities, lasting approximately 10 weeks beginning to end. Compliance Strategies consulting helps ensure HPSM can respond to and perform well in a CMS audit. Compliance Strategies is also providing HPSM with consulting services for its Medicare model of care. As previously discussed with the Commission, HPSM has worked to improve performance with its model of care. These efforts will continue into 2026, to help HPSM maintain compliance with CMS requirements.

Fiscal Impact

This agreement is for a one-year term through December 31, 2026, with a total contract amount not to exceed $500,000. The agreement is for consulting services for audit preparation and model of care support.

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF AGREEMENT WITH COMPLIANCE STRATEGIES

RESOLUTION 2026 -

RECITAL: WHEREAS,

A. HPSM has not been audited by CMS since 2016; and
B. HPSM has a higher chance of being selected by CMS for a Medicare compliance audit in 2026; and
C. HPSM has operational support needs for Medicare model of care.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission authorizes the Chief Executive Officer to execute an agreement with Compliance Strategies in an amount not to exceed $500,000 through December 31, 2026; and
2. Authorizes the Chief Executive Officer to execute said agreement.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of March, 2026 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Bill Graham, Chairperson

ATTEST:

BY: _____
M. Heryford Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

MEMORANDUM

AGENDA ITEM: 4.4

DATE: March 11, 2026

DATE: March 4, 2026

TO: San Mateo Health Commission

FROM: Pat Curran, Chief Executive Officer

RE: Waive Request for Proposal and Approve Amendment to Agreement with SS&C Health for Pharmacy Benefit Management (PBM) Services

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Recommendation:

Approve a waiver of the request for proposal (RFP) process and authorize the Chief Executive Officer to execute an amendment to extend the agreement with SS&C Health for Pharmacy Benefit Management (PBM) services. The amendment will extend services for one year through December 31, 2026.

Background and Discussion:

Pharmacy benefit management services are a necessary component to the provision of the pharmacy benefit to health plan beneficiaries. PBM services include but are not limited to the following: pharmacy claims processing and payment transactions, formulary development and maintenance, pharmacy network contracting and management, a 24/7 pharmacy help desk call center, drug rebate negotiations and collections, and regulatory compliance support to state and federal requirements pertaining to the pharmacy benefit.

SS&C Health (f/k/a DST Pharmacy Solutions, and prior to that, Argus Health Systems) has served as HPSM's contracted PBM for pharmacy benefit services since they were originally selected through the completion of an RFP process back in 2012. SS&C Health has been a longstanding vendor partner of HPSM's, providing pharmacy benefit management services that enable HPSM to offer pharmacy benefit coverage to our members.

With respect to the waiver of the RFP process, as mentioned in prior memo regarding PBM services, initiating a PBM transition for 2026 was not considered practical given the significant competition for PBM implementation resources, as many other local health plans are going live with a new D-SNP lines of business in 2026 due to California requirements.

As such, HPSM staff recommend maintaining continuity through waiving the request for proposal process and approving the amendment to extend PBM services with SS&C Health through December 31, 2026.

Fiscal Impact:

The amendment will extend our agreement with SS&C Health through December 31, 2026. SS&C Health has generally maintained the same administrative rates as the prior arrangement, particularly for the core administrative expenses associated with prescription claims processing. As with prior years, the total fiscal impact is heavily dependent on actual prescription drug utilization, as the primary administrative expense is tied to paid prescription claim volume. Our current estimate for direct administrative expenses in 2026 is an upper threshold of $660,000 (in contrast to an upper threshold of $800,000 annually for 2025).

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL TO WAIVE REQUEST FOR PROPOSAL PROCESS AND APPROVE AMENDMENT TO AGREEMENT WITH SS&C HEALTH TO EXTEND PBM SERVICES

RESOLUTION 2026 -

RECITAL: WHEREAS,

A. HPSM has a need to maintain pharmacy benefit management (PBM) services for the provision of the pharmacy benefit to health plan beneficiaries.
B. SS&C Health has been a longstanding vendor partner that enables HPSM to provide pharmacy benefit coverage services.
C. SS&C Health has agreed to a reasonable amendment proposal to HPSM where both parties desire to extend offered services for one year through December 31, 2026.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the request for proposal process and approves an amendment to the agreement with SS&C Health to extend pharmacy benefit management services through December 31, 2026 in an amount not to exceed $660,000.
2. Authorizes the Chief Executive Officer to execute said amendment.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of March 2026 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Bill Graham, Chairperson

ATTEST:

BY: _____
M. Heryford, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

MEMORANDUM

AGENDA ITEM: 4.5

DATE: March 11, 2026

DATE: March 4, 2026

TO: San Mateo Health Commission

FROM: Pat Curran, Chief Executive Officer
Chris Esguerra, M.D., Chief Medical Officer
Ming Shen, Director of Pharmacy

RE: Waive Request for Proposal and Approve Amendment to Agreement with Previon Solutions, LLC for Part D Mailing Services

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Recommendation:

Waive the Request for Proposal process and authorize the allocation of $400,000 in funding for calendar year 2026 under the existing agreement with Previon Solutions, LLC for Part D printing and mailing services for the period of January 1, 2026 through December 31, 2026.

Background and Discussion:

As a Part D sponsor, HPSM must meet state and Centers for Medicare and Medicaid Services (CMS) communication and mailing requirements regarding Medicare Part D benefits and services provided to HPSM Medicare beneficiaries. In addition to other standard required mailings, Part D mailing requirements are complex in nature and involve communications with member-specific details such as Explanation of Benefit (EOB) mailings that provide each member with individualized details on benefit utilization.

Due to the nature and complexity of Part D mailing requirements, staff is requesting a waiver of the request for proposal process and continued funding of the existing agreement with Previon Solutions, LLC as its vendor for Part D mailing services. The existing agreement auto-renews annually in one-year increments and accordingly renews for the period January 1, 2026 through December 31, 2026.

HPSM estimates printing and mailing obligations for Part D EOBs to remain relatively stable in 2026, inclusive of alternative format needs such as large print. As such, HPSM anticipates future annual cost changes to be mostly based on annual inflationary increases.

Fiscal Impact:

We are estimating 2026 expenditures for Part D mailing services to come in at around $400,000, which would be a $15,000 increase from 2025 to cover service costs. This assumes demand for alternative format needs will remain relatively stable. Actual costs are utilization based, dependent on membership and the number of individuals that utilize the Part D benefit large print format materials.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF WAIVE REQUEST FOR PROPOSAL AND APPROVE FUNDING FOR CONTINUATION OF PART D MAILING SERVICES

RESOLUTION 2026 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission is required to meet Part D mailing requirements as a Part D sponsor operating a Medicare line of business

B. The Health Plan of San Mateo has an existing agreement with Previon Solutions, LLC to provide printing and mailing services;

C. Previon Solutions, LLC, has demonstrated the capability to support Part D mailing requirements over the years, including the sustained demand in large print activity.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the request for proposal process and authorizes the allocation of $400,000 in the budget to cover Part D printing and mailing services provided under the existing agreement with Previon Solutions, LLC for the period January 1, 2026 through December 31, 2026.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of March, 2026 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Bill Graham, Chairperson

ATTEST:

BY: _____
M. Heryford, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

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DRAFT

HEALTH PLAN OF SAN MATEO
COMMUNITY ADVISORY COMMITTEE MEETING
Meeting Minutes
Wednesday, January 21, 2026
801 Gateway Blvd. – 1st Floor Boardroom
South San Francisco, CA 94080

Agenda Item: 4.6

Date: March 11, 2026

Committee Members Present: Angela Valdez, Amira Elbeshbeshy, Jill Dawson, Kay Lee, Lizelle Lirio de Luna, Rob Fucilla

Committee Members Absent: Kathryn Greis, Hazel Carillo, Ana Avendano Ed.D., Ligia Andrade-Zuniga

Staff Present: Julian Aldana, Luarnie Bermudo, Tejasi Khatri, Greg Mays, Megan Noe, Amy Scribner, Gale Carino, Colleen Murphy, Rustica Magat-Escandor, Karla Mendoza-Pina, Michelle Heryford.

1.0 Call to Order/Introductions: The meeting was called to order by Amira Elbeshbeshy at 12:06 pm, a quorum was met.

2.0 Public Comment: There was no public comment.

3.0 Approval of Meeting Minutes for October 15, 2025: The minutes for October 15, 2025, were approved as presented. **Fucilla / Valdez MSP**

4.0 Consent Agenda: The consent agenda was approved as presented. **Fucilla / Valdez MSP**

5.0 HPSM Operational Reports and Updates:

5.1 Leadership Report: Amy Scribner reports:

- HPSM is experiencing a significant decline in membership driven by Medi-Cal redetermination issues, reduced auto-enrollment since July 2025, and the usual January drop—which was larger than normal this year. Many members are losing coverage because renewal packets are not being returned. HPSM is monitoring trends closely and will present more complete analysis next quarter. On the positive side, the governor's preliminary state budget introduced no new cuts or spending, and the deficit is smaller than projected. No immediate policy changes or operational impacts are expected until the May budget revision.

5.2 Grievance and Appeals Report: Greg Mays reports:

- In Quarter 4 of 2025, the Grievance & Appeals department reported an overall decrease in complaint rates—from 1.38 to 1.14 per 1,000 members—with notable improvements across CareAdvantage, Medi-Cal, and CCS, while small-membership programs like HealthWorks and

ACE showed higher ratios due to minimal volume changes. CareAdvantage met 100% timeliness on grievances and pharmacy appeals, though Medi-Cal appeals fell short because 10 cases were marked late (nine of which appear to be misclassified rather than actually late). Grievance volumes totaled 141 for CareAdvantage and 240 for Medi-Cal, with 43 PCP changes processed, primarily to 39th Avenue Clinic, Fair Oaks Health Center, and Pacific Medical Clinic. Committee members expressed strong appreciation for the exceptionally low complaint rates and overall performance.

5.3 Provider Services, Provider Manual, and Network Development: Julian and Luarnie reports:

- An overview of the annual Provider Manual updates and recent network expansion efforts. Julian shared that the Provider Manual was refreshed across 12 sections, with notable changes including a new Behavioral Health Treatment (BHT) section, updated Enhanced Care Management (ECM) and Community Supports (CS) referral forms, an extended pharmacy appeal reconsideration window (60 to 65 days), and the launch of the Teen Wellness Rewards Program offering a $25 incentive for youth preventive visits. Luarnie highlighted significant network growth over the past quarter, including new contracts with Apria for oxygen DME, Brilliant Corners for transitional rent, Journey Health as the plan's first Community Health Worker provider, Inspira for BHT/ABA, expanded dental coverage (general and pediatric), a new ambulatory surgery center, Coastside Optometry to improve vision access, and Advanced Radiology & Imaging. She also noted substantial provider rate increases rolled out throughout 2025—with additional increases for podiatry and chiropractic effective January 1, 2026—strengthening provider engagement and access across the network.

5.4 CAC Updates: Phone Number Discussion & 2026 Schedule / Planned Presentations: Megan Noe reports:

- An update from the Community Advisory Committee (CAC), delivered by Megan on behalf of program manager Mackenzie Moniz. The team reported that a previously raised issue about unreturned phone calls was resolved after discovering that a fax number—not a phone line—had been used, and warm-transfer protocols between Legal Aid and Member Services were put in place to prevent future problems. Megan also reviewed the purpose and scope of the CAC, emphasizing its role in shaping HPSM programs, improving equity and cultural responsiveness, and elevating member and community voices. She noted active efforts to increase direct member participation, with several new members currently being oriented. Additional updates included distribution of CAC swag bags and a shift from individualized lunches to a buffet format, with dietary needs to be collected in advance. Committee discussion centered on the longstanding challenge of recruiting

Medi-Cal members and the value of strengthening lived-experience representation moving forward.

5.5 ICM Department & Community Resources: Gale and Tejasi reports:

- An in-depth overview of CalAIM services, led by Tejasi and Gale, with additional insights from Kay and Jill. The presentation explained how Enhanced Care Management (ECM) delivers intensive, person-centered care coordination for Medi-Cal members with complex needs, while Community Supports (CS) offers non-clinical services addressing housing stability, nutrition, home safety, and other social drivers of health; HPSM currently implements 11 of the 15 available supports, including the newly required Transitional Rent benefit administered by Brilliant Corners. The team described multiple referral pathways (provider referral, self-referral, and HPSM data-driven identification), the use of updated ECM/CS referral forms, and the timelines for processing routine and urgent requests. They also reviewed Community-Based Adult Services (CBAS)—a long-standing Medi-Cal benefit separate from CalAIM—highlighting its medical and social supports delivered in adult day health centers, its countywide transportation options, and its role in helping members remain safely in the community. Committee members requested more data on ECM and CS (including enrollment and identification processes), clarification on child welfare ECM providers, and future presentations featuring member stories to illustrate how these programs interact with IHSS, FSP, and Care Court. Kay, representing a CBAS center, described strong demand, transportation-enabled access across the county, and continued success rebuilding awareness post-COVID.

5.6 Provider Service Report:

- The Provider Services report was combined with Item 5.3, which included the Provider Manual updates and Network Development overview

5.7 Member Services Report: Karla reports:

- Member Services activity for Q4, with Karla reporting declines across all major lines of business—including a 3.69% decrease in Medi-Cal membership (a net loss of 5,437 members), continuing downward trends in ACE and CCS, and stable but slightly reduced HealthWorks enrollment. The call center remained highly effective, answering 11,293 calls with a low 2.74% abandonment rate and maintaining a six-minute average handle time while also completing 780 voicemails and 1,210 email responses. Staffing stood at 13 customer service navigators, with active recruitment for additional bilingual Tagalog and Spanish staff. Member Services also facilitated 773 pediatric PCP assignments through HRA outreach, completed 34 HRAs across 49 families, and continued work on system upgrades—including an IVR demographic pre-screening enhancement and implementation of workforce management tools. Quarter 4 also saw the soft launch of a

new after-call survey to gather real-time member satisfaction feedback.

5.8 CareAdvantage Report: Rustica Magat- Escandor reports:

- The CareAdvantage report showed continued strong performance, with membership reaching 8,475—an increase of 3% since January 2025—driven by 247 new enrollments and 32 reenrollments, though partially offset by 214 disenrollments due to death, relocation, or plan changes. Call center operations exceeded regulatory standards, answering 86% of calls within 30 seconds, maintaining an average 21-second hold time, and achieving a 0% disconnect rate, while monitored calls earned an exceptional 99.8% quality score. Additional updates included the mailing and required activation of new Nations Benefits OTC/grocery cards, staffing improvements with a newly hired Spanish-speaking navigator and a filled Enrollment/Disenrollment Specialist role, and a successful "All Aboard" member event with nearly 400 attendees. Members were also informed of 2026 benefit adjustments, including reductions in OTC funds (from $95 to $75 per quarter) and grocery allowances (from $70 to $25 per quarter), with no carryover provisions.

6.0 New Business: There was no new business.

7.0 Adjournment: The meeting was adjourned at 1:28 pm by Amira Elbeshbeshy.

Respectfully submitted:

V. Alvarez

V. Alvarez

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DRAFT

FINANCE/COMPLIANCE COMMITTEE MEETING

Meeting Summary

February 23, 2026, 12:30 pm

Agenda Item: 4.7

Date: March 11, 2026

County Executive Conference Room, 500 County Center, Redwood City, CA 94064
-or-
Health Plan of San Mateo-Boardroom 801 Gateway Blvd, South San Francisco, CA 94080

Member's present: Manuel Santamaria, Mike Callagy, Si France M.D., Shabnam Gaskari

Members absent: Bill Graham

Staff present: Trent Ehrgood, Ian Johansson, Francine Lester, Chris Esguerra, M.D. Cheryl Serafino, Michelle Heryford

1.0 **Call to Order –** The meeting was called to order by Commissioner Santamaria at 12:31 pm. A quorum was met.

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

3.0 **Approval of Meeting Summary for August 18, 2025 –** The meeting summary for August 18, 2025, was approved as presented. **Callagy/France M/S/P**

4.0 **Preliminary Financial Report for the 12-month period ending December 31, 2025** – HPSM CFO, Trent Ehrgood, reviewed the financial report for 2025. The year-end financial audit is underway with Baker Tilly, formerly Moss-Adams. The results and findings will be reviewed at the March 23rd Finance meeting. Mr. Ehrgood noted that a few adjustments are expected, which may result in a slightly more favorable net outcome, but the current preliminary figures show an $18 million loss for the year. He detailed the shift from a

projected $80 million surplus to an $18 million loss and provided an in-depth analysis of the drivers behind the budget variance. He broke down the $18 million loss into a $14 million benefit from prior year adjustments and a $33 million current year loss. These prior year adjustments included $6.3 million in additional revenue, of which $3.3 million is from the return of 2024 Medi-Cal withholds, $1.4 million in Medicare revenue, and $7 million in favorable healthcare cost adjustments, including reinsurance recoveries and true ups to claim estimates. They discussed three major unbudgeted items: $21 million in provider rate increases, $30 million returned due to the Unsatisfactory Immigrant Status (UIS) risk corridor, and $8 million in long-term care rate increases. These, combined with higher-than-expected healthcare costs, accounted for a significant portion of the budget variance.

Higher inpatient utilization, increased outpatient costs (including expensive cell and gene therapies), and behavioral health treatment for children (brought in-house for improved access) contributed to the increased healthcare costs. Dental costs also rose, particularly due to pent-up demand from the UIS population. Claims estimates for Q1 and Q2 were adjusted in Q3 and Q4, resulting in a downward revision of earlier surpluses and higher losses in later quarters. Mr. Ehrgood provided a detailed explanation of the estimation process and the impact of retroactive adjustments on quarterly results.

Mr. Ehrgood analyzed membership trends in Medi-Cal, focusing on the dynamics between the Satisfactory Immigrant Status (SIS) and UIS populations, the effects of policy changes, and the implications for revenue, costs, and future planning. The average Medi-Cal membership was 2.4% higher than budgeted for the year but there was a decline in the last quarter of 2025. The overall increase in the first half of the year was driven by the UIS adult population growth as they became eligible for Medi-Cal in January 2024, while SIS continued to decline due to ongoing redetermination processes. The committee discussed policy changes affecting eligibility as well as the impact of California's removal of immigration status as a barrier to Medi-Cal eligibility. An enrollment freeze for UIS adults starting in 2026 is expected to cause further declines. Declining enrollment typically results in higher average acuity, as healthier members are more likely to drop coverage. This shift increases per-member costs and may lead to larger losses in the short term but will eventually be reflected in higher rates set by DHCS based on the new cost experience. Early 2026 data indicates both SIS and UIS populations are declining faster than anticipated. There is also the potential for further reductions in covered populations due

to state and federal budget pressures. They discussed the importance of scenario planning and stress testing various scenarios including the complete loss of UIS membership to assess the health plan's ability to withstand financial shocks.

Ian Johansson, Chief Government Affairs and Compliance Officer summarized the governor's January budget proposal, noting a small short-term deficit but projected long-term structural deficits of $15–$30 billion. The committee acknowledged that significant changes to Medi-Cal coverage, especially for UIS, could occur under future administrations. Mr. Johannson and Mr. Ehrgood outlined scenarios where the UIS population could lose Medi-Cal coverage entirely or be shifted out of managed care, depending on state decisions in response to budget pressures and federal funding reductions. Mr. Ehrgood described ongoing efforts to model the impact of such changes on reserves, administrative costs, and program commitments. There was a consensus to emphasize the importance of presenting these analyses and potential scenarios to the full Commission, ensuring transparency and proactive planning.

There was discussion about the impact of provider rate increases and capacity-building grants, and how they impact the financials, as well as the rationale for maintaining these commitments despite budget pressures. Mr. Ehrgood explained that maintaining provider rate increases is essential for network stability, as providers have operated on discounted fees for years. The leadership team supports continuing these investments to prevent further strain on the provider network.

Mr. Ehrgood went over Tangible Net Equity, also known as the reserves. He highlighted the steps taken to ensure that there are more reserves than required and shared how investments in provider investments and grants do not threaten those funds.

The financial report was approved as presented. **France/Gaskari MSP**

5.0 **2026 Meeting Dates –** The proposed meeting dates for 2026 were approved as presented. **France/Gaskari MSP**

6.0 **Other Business –** Commissioner Si France took this opportunity to announce his impending departure from the San Mateo Health Commission. He will attend the March

Commission meeting but noted that this was likely his last Finance/Compliance committee meeting. He offered his assistance during the transition. He expressed his appreciation and gratitude for serving on the Commission and Finance sub-committee. He outlined his plans to remain active in the community and to continue serving the mission in diverse ways. He reminded the group that he would still be around to collaborate with them outside his role as Commissioner as needed. Commissioner Santamaria thanked him for his service and good work as well as his experience and insight. Mr. Ehrgood expressed his appreciation and thanked him for his contributions and engagement to both the Commission and the Finance/Compliance committee.

7.0 Adjournment – The meeting was adjourned at 1:43 pm by Commissioner Santamaria.

Respectfully submitted:

M. Heryford

M. Heryford
Clerk to the Commission

Financial Update

Presentation to Finance/Compliance Committee

February 23, 2026

HealthPlan OF SAN MATEO
Healthy is for everyone

2025 Budget by Quarter

HealthPlan OF SAN MATEO
Healthy is for everyone

	Q1 *	Q2	Q3	Q4	Total
Capitation revenue	297,848,358	297,240,699	296,639,372	296,043,829	**1,187,772,259**
Healthcare cost	247,756,414	245,911,232	245,499,269	245,250,859	**984,417,775**
Administrative expenses	19,613,748	19,963,903	20,705,950	21,089,017	**81,372,618**
MCO Tax	20,008,040	20,008,040	20,008,040	20,008,040	**80,032,159**
Income/(loss) from operations	10,470,156	11,357,524	10,426,114	9,695,913	**41,949,706**
Non-operating revenue	9,972,279	9,681,972	9,381,972	9,081,972	**38,118,194**
Net income/(loss)	20,442,435	21,039,495	19,808,085	18,777,885	**80,067,900**

* Updated Q1 budget column by moving $1,750K provider grant item from admin expense to healthcare cost.

Q4 2025 Preliminary Financial Results

	Q1 (Jan-Mar)	Q2 (Apr-Jun)	Q3 (Jul-Sep)	Q4 (Oct-Dec)	YTD Total	YTD Budget	Budget Variance
Operating Revenue:							
Capitation	467,129,448	304,195,903	331,992,727	468,022,747	1,571,340,825	1,187,772,258	383,568,567
UIS Risk Corridor		(13,050,000)	(6,525,000)	(11,225,000)	(30,800,000)	-	(30,800,000)
DHCS Incentives				298,989	298,989	-	298,989
Total Operating Revenue	467,129,448	291,145,903	325,467,727	457,096,736	1,540,839,814	1,187,772,258	353,067,556
Healthcare cost	421,376,041	247,736,332	311,031,911	458,071,379	1,438,215,663	984,417,775	(453,797,888)
Administrative expenses	17,731,830	17,871,955	20,465,839	20,243,682	76,313,306	81,372,618	5,059,312
MCO Tax	20,555,697	18,921,401	22,345,249	20,013,499	81,835,846	80,032,159	(1,803,687)
Income/(loss) from operations	7,465,880	6,616,215	(28,375,272)	(41,231,824)	(55,525,001)	41,949,706	(97,474,707)
Non-operating revenue	9,545,895	9,359,070	9,503,975	8,785,070	37,194,010	38,118,194	(924,184)
Net income/(loss)	17,011,775	15,975,285	(18,871,297)	(32,446,754)	(18,330,991)	80,067,900	(98,398,891)

YTD December 2025 – PY/CY

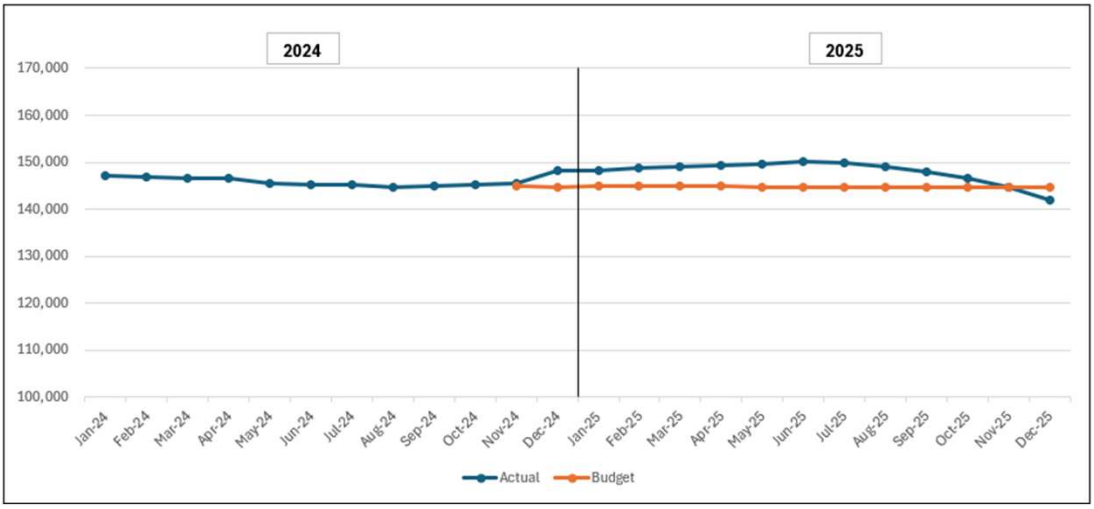
	YTD by PY/CY			Current Year YTD		
	Prior Year	Current Year	Total	Current Year	Budget	CY Variance
Operating Revenue:						
Capitation	373,497,772	1,197,972,214	1,571,469,986	1,197,972,214	1,187,772,258	10,199,956
UIS Risk Corridor		(30,929,161)	(30,929,161)	(30,929,161)	-	(30,929,161)
DHCS Incentive		298,989	298,989	298,989	-	298,989
Total Operating Revenue	373,497,772	1,167,342,042	1,540,839,814	1,167,342,042	1,187,772,258	(20,430,216)
Healthcare cost	358,630,230	1,079,585,433	1,438,215,663	1,079,585,433	984,417,775	(95,167,658)
Administrative expenses	-	76,313,306	76,313,306	76,313,306	81,372,618	5,059,312
MCO Tax	-	81,835,846	81,835,846	81,835,846	80,032,159	(1,803,687)
Income/(loss) from operations	14,867,542	(70,392,543)	(55,525,001)	(70,392,543)	41,949,706	(112,342,249)
Non-operating revenue	9,281	37,184,729	37,194,010	37,184,729	38,118,194	(933,465)
Net income/(loss)	14,876,823	(33,207,814)	(18,330,991)	(33,207,814)	80,067,900	(113,275,714)

Medi-Cal Revenue	6,301,000
Medicare Revenue	1,492,000
HC Cost	7,084,000
Total PY Adjustments	14,877,000

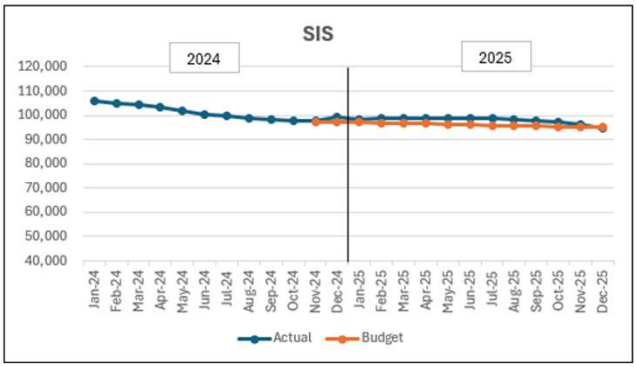
Average Membership
Variance to Budget

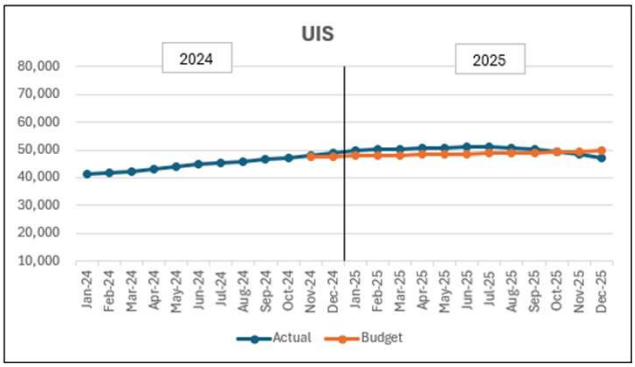
LOB	Avg. Actual	Avg. Budget	Variance	% Var
Medi-Cal	74,337	74,686	(349)	-0.5%
Medi-Cal Expansion	55,444	53,219	2,226	4.2%
Whole Child Model	1,096	1,057	39	3.7%
Medi-Cal Full Duals	8,927	7,632	1,295	17.0%
Sub-total Medi-Cal	139,805	136,594	3,211	2.4%
Medicare D-SNP	8,295	8,266	30	0.4%
HealthWorx	1,317	1,286	31	2.4%
Total at Risk	149,417	146,145	3,272	2.2%
+ ACE	895	1,237	(342)	-27.6%
Grand Total	150,313	147,382	2,931	2.0%

Medi-Cal Membership by Month



Medi-Cal Membership – SIS/UIS





Budget Variance by Major Drivers

favorable/(unfavorable)

		YTD Dec		Revenue	Expense
1	Prior year adjustments not in the budget	14,876,819			
	Current year variances:				
2	Membership higher than budget	5,526,602	<<	28,692,465	(23,165,863)
3a	Revenue: Yield PMPM variance to budget	(18,845,997)			
3b	Revenue: UIS Risk Corridor	(30,800,000)			
4	Revenue: Maternity supplemental payment	1,466,035			
5	Healthcare cost: CY PMPM variance to budget	(65,881,625)			
6	Healthcare cost: CY directed payments	(4,157,099)			
7	Healthcare cost: strategic investments	(1,697,375)			
8	ECM (rev-exp variance)	(1,907,096)	<<	(3,017,108)	1,110,012
9	DHCS Incentive Program (rev-exp)	(1,076,720)	<<	298,989	(1,375,709)
10	Administrative cost variance to budget	7,327,224			
11	Administrative cost: strategic investments	(2,267,912)			
12	MCO Tax variance (rev-exp variance)	(28,287)	<<	1,775,400	(1,803,687)
13	Non-op revenue (*CY portion) variance to budget*	(933,461)			
	Total current year	(113,275,710)			
	Total consolidated budget variance	**(98,398,891)**			

Healthcare Cost

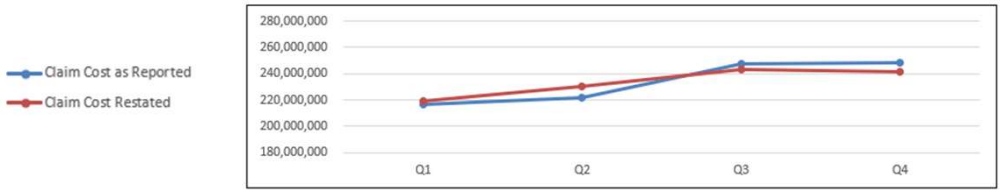
Detail by Category of Service

		YTD Actual					
		Total	Prior Year	Current Year	YTD Budget	Variance	% Var.
1	Provider Capitation	29,561,887	1,264,972	28,296,915	26,401,019	(1,895,895)	-7.2%
2	Hospital Inpatient	217,743,727	3,110,931	214,632,796	195,259,257	(19,373,539)	-9.9%
3	LTC/SNF	182,587,716	(127,645)	182,715,361	168,779,553	(13,935,809)	-8.3%
4	Pharmacy	67,230,976	(1,389,712)	68,620,688	71,304,611	2,683,923	3.8%
5	Physician FFS	114,245,979	(1,586,736)	115,832,715	101,634,583	(14,198,133)	-14.0%
6	Hospital Outpatient	126,667,529	(1,227,423)	127,894,952	115,308,163	(12,586,789)	-10.9%
7	Other Medical Claims (incl. Other HC Serv)	134,831,520	(1,497,101)	136,328,621	117,798,886	(18,529,734)	-15.7%
8	Directed Payments	418,889,745	365,713,750	53,175,995	49,018,896	(4,157,099)	-8.5%
9	Long Term Support Services	2,507,130	24,594	2,482,537	1,725,697	(756,840)	-43.9%
10	CPO/In-lieu of Services	16,060,606	499,828	15,560,777	12,122,623	(3,438,154)	-28.4%
11	Dental	58,716,646	(1,516,134)	60,232,780	51,735,200	(8,497,581)	-16.4%
12	ECM	3,769,454	(57,239)	3,826,693	4,936,705	1,110,012	22.5%
13	Provider Incentives	15,889,850	(1,250,972)	17,140,823	15,897,500	(1,243,322)	-7.8%
14	Provider Incentives (DHCS/CalAIM)	1,375,709	-	1,375,709	-	(1,375,709)	n/a
15	Supplemental Benefits (D-SNP)	3,432,598	-	3,432,598	3,105,415	(327,183)	-10.5%
16	Transportation	13,336,809	-	13,336,809	18,868,790	5,531,981	29.3%
17	Strategic Investments (one-time grants)	3,447,375	-	3,447,375	1,750,000	(1,697,375)	-97.0%
18	Indirect Health Care Benefits	844,391	(3,337,767)	4,182,157	1,592,422	(2,589,735)	-162.6%
19	UMQA	27,076,017	6,884	27,069,133	27,178,456	109,323	0.4%
	Total Healthcare Cost	1,438,215,663	358,630,230	1,079,585,433	984,417,775	(95,167,658)	-9.7%

provider rate increase

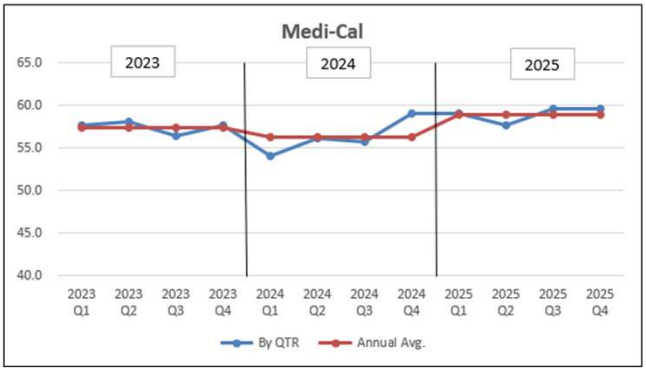
Claim Estimate Adjustments to Prior Quarters of the Current Year

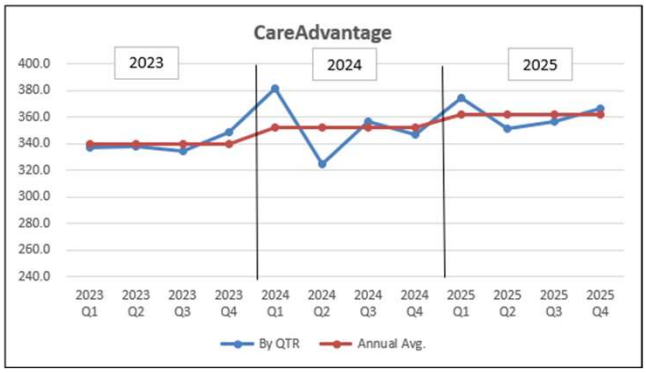
		A	B	C	D	
		Q1	Q2	Q3	Q4	YTD Total
1	Expense per financials by Qtr	216,713,270	221,539,517	247,725,388	248,131,323	934,109,498
2	Adjustments made in Q2	(1,284,367)	1,284,367			-
3	Adjustments made in Q3	2,712,663	6,184,694	(8,897,357)		-
4	Adjustments made in Q4	897,326	1,611,972	4,524,375	(7,033,673)	-
5	Cumulative change from original	2,325,622	9,081,032	(4,372,982)	(7,033,673)	-
6	Adjusted estimate as of 12/31/25	219,038,892	230,620,549	243,352,406	241,097,651	934,109,498



Hospital Utilization

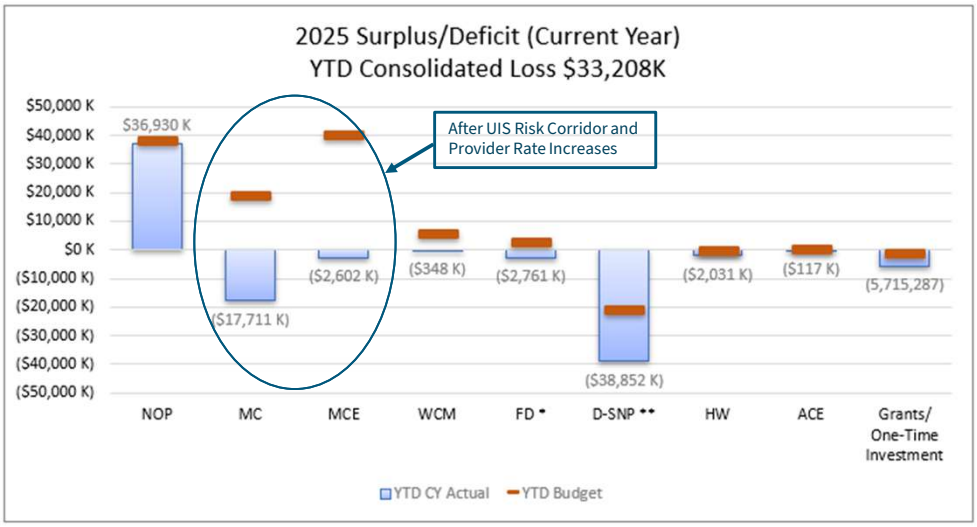
Admits/1000/Yr





Note: Hospital admission count is from inpatient authorization records, which doesn't account for all hospital admissions.

CY YTD Surplus/Deficit by LOB

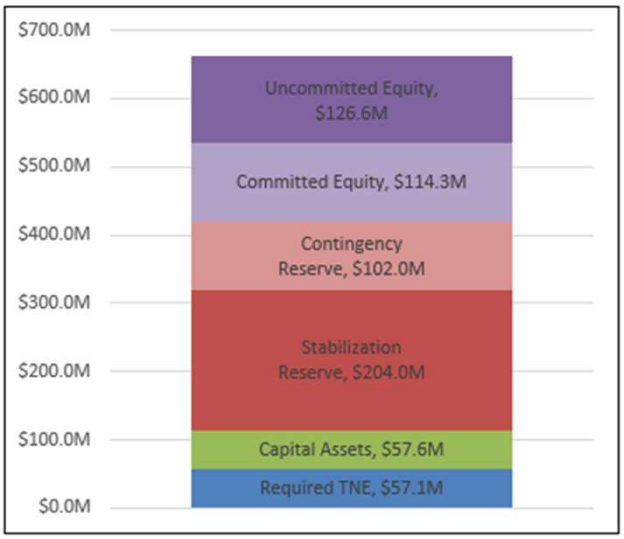


* FD includes M-Cal portion of D-SNP

** D-SNP includes Medicare portion only

Tangible Net Equity (TNE)

Balance at 12/31/2025 = $661.7M
Uncommitted portion = $129.6M



Committed Equity:

	Funding	Spend	Balance
Provider	$100.0M	$18.5M	$81.5M
Primary Care	$30.0M	$3.7M	$26.3M
Baby Bonus	$7.0M	$0.5M	$6.5M
	$137.0M	$22.7M	$114.3M

Q4 2025 Summary

- Q4 includes $7M increase to claim cost estimates for prior quarters of the current year (mostly to Q3). This includes additional cost to account for a higher hospital admission rate and other high-cost cases.
- YTD claim cost also includes increased LTC cost of about $8M tied to newly published DHCS LTC rates retro to 1/1/2025. Approximately $5.2M of this was recorded in Q3 when the rates were published. DHCS is evaluating potential adjustments to HPSM's capitation rates for 2025 and may include additional funding for the increased LTC rates. If so, this won't happen until around Q3 of 2026 (so potential increased revenue to HPSM).
- The cumulative UIS risk corridor recorded thru Q4 is $30.8M, which represents a return of Medi-Cal premiums not included in the budget.

Q4 2025 Summary

continued . . .

- Cost related to provider rate increases and provider grants equals $21.6M through December also not included in the budget. This is expected spend of the $130M approved strategic use of reserves.
- CareAdvantage losses are running higher than budget. This is a combination of lower revenue and higher healthcare cost. Medicare revenue often improves over time with favorable retro adjustments from risk adjustment in subsequent years. For healthcare cost, both hospital inpatient and hospital outpatient cost was almost 10% higher in the second half of the year compared to the first half of the year on a PMPM basis (after adjusting for increased membership).
- [new note] 2025 hospital admission rate is running higher in 2025 compared to 2024 for both Medi-Cal and CareAdvantage.

Questions?

DRAFT

SAN MATEO HEALTH COMMISSION
Meeting Minutes
January 14, 2026 – 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor Boardroom
South San Francisco, CA 94080

AGENDA ITEM: 4.8

DATE: March 11, 2026

Commissioners' Present:	Jeanette Aviles, M.D.	Kenneth Tai, M.D.
	Raymond Mueller	Manny Santamaria, Vice-Chair
	Michael Callagy	Jackie Speier
	Shabnam Gaskari	Bill Graham, Chair
	Amira Elbeshbeshy	
Commissioners' Absent:	Si France, M.D.	
	Ligia Andrade Zuniga	
Counsel:	Kristina Paszek	
Staff Presenting:	Pat Curran, Luarnie Bermudo, Courtney Sage, Ian Johansson, Chris Esguerra, M.D.	

1. **Call to order/roll call**
   The meeting was called to order at 12:37 p.m. by Commissioner Graham, Chair. A quorum was present.

2. **Public Comment**
   There were no public comments.

3. **Approval of Agenda:** The agenda was approved as presented. Motion: Speier (Second: Santamaria) **M/S/P.**

4. **Consent Agenda:** The consent agenda was approved as presented. Motion: Santamaria (Second: Speier) **M/S/P.**

5. **Specific Discussion/Action Items:**

   5.1 Election of Officers: The Commission elects the positions of Chair and Vice-Chair annually. These officers usually serve two one-year terms. The Commission also appoints the position of Clerk to the Commission annually.

   Commissioner Gaskari moved to elect Commissioner Bill Graham to serve his second 1-

year term as Chair of the Commission. (Second: Tai) **MSP**

Commissioner Gaskari moved to elect Commissioner Manuel Santamaria to serve his second 1-year term as Vice Chair of the Commission. (Second: Graham) **MSP**

Commissioner Graham moved to appoint Michelle Heryford as the Clerk to the Commission. (Second: Speier) **MSP**

5.2 Behavioral Health Treatment (BHT) Benefit Update: Luarnie Bermudo, Director of Provider Services, and Courtney Sage, Director of Behavioral Health, provided an update on the Behavioral Health Treatment (BHT) benefit. In 2024 HPSM chose to bring this benefit in house. It had previously been delegated to BHRS and then Magellan Health. They detailed the rationale, implementation process, outcomes, and ongoing challenges. Ms. Bermudo shared HPSMs strategic plan illustrating the six key areas of focus. Bringing BHT in-house aligns with all six areas, but she emphasized goal two about enhancing access and experience. This goal underscores HPSM's commitment to improving the overall experience for their members. Ms. Sage explained that HPSM is responsible for providing specific behavioral health benefits for their members and is accountable to the Department of Health Care Services (DHCS) the Department of Managed Health Care (DMHC) and the Centers for Medicare and Medicaid Services (CMS). As noted, HPSM has at times delegated the management of behavioral health (BH) benefits to other parties. The scope typically includes management of the network, utilization review, and claims. In 2007 HPSM began delegating the management of the CareAdvantage (CA) BH benefits to BHRS, which is still in place. BHRS is managing specific Medicare benefits that extend beyond what is already covered by Medi-Cal. BHRS is also responsible for two of their own Medi-Cal BH benefits, the specialty mental health benefit and the substance abuse treatment benefit. HPSM is not responsible for benefits members receive from BHRS. Prior to 2020, BHRS was contracted with HPSM for the management of the mild to moderate mental health benefit. The work done to transition that benefit in-house increased HPSM's knowledge and capacity to support the BH needs of their members.

Ms. Bermudo shared some of their observations and experiences leading up to the decision to bring BHT back in-house. Post pandemic while contracted with Magellan, they implemented a request for proposal for BHT. They ramped up their oversight and monitoring and collected more data about the BHT experience. During that process, they discovered significant gaps. They became aware of workforce shortages and high

turnover. From an access standpoint, there were members who had difficulty receiving timely care, especially afternoon appointments. Many members experienced extremely long wait lists, often waiting months to receive callbacks or status of referrals. In addition, HPSM was an outlier compared to other plans in terms of the costs, but utilization was low. Because of this there was an increased rate of grievances. Many of these grievances escalated to the state. When that occurs, plans can be sanctioned and penalized. Over 23% of penalties from 2016-2020 were BHT related. On October 1st, 2024, HPSM began managing the benefit. During the transition period, they leveraged existing processes and bult on some of the lessons learned from bringing in mild to moderate in 2020. They built the network, gained trust from BHT providers, provided significant rate increases, and changed the fee schedule. The two grant investments approved by the Commission also increased access for HPSM members.

Ms. Sage shared the noteworthy decrease in grievances since bringing the benefit in-house. In 2022, when they first noticed the spike, they initiated the discovery process, which included data review and stakeholder engagement. They pivoted quickly to get more involved in the BHT benefit to address member concerns, initiating a corrective action plan and scheduling bi-weekly meetings with Magellan. They also hired a clinical care manager in early 2023 to directly support members. The interventions can be seen in the reduction of the number of grievances that went to enforcement. At present, they are reporting an 180% increase in the number of new referrals per month and 50% increase in the number of utilizers per month. In Q3 of 2025 there was an average of 407 users. She noted that they are closely monitoring member satisfaction, and she admitted that there is a slight increase in the average cost per member, per month, which aligns with increased access. There was discussion about the difficulty in measuring how effective this benefit is. It was acknowledged that it is very complex. Part of the BHT benefit and ABA is to provide skills training for parents to learn how to work through certain behaviors and situations. Every case is different and care plans have variability in them reflecting on the individual and what support resources they need.

5.3 2026 Health Police Outlook: Ian Johansson, Chief Government Affairs and Compliance Officer, provided an overview of recent and upcoming federal and state policy changes, including the impact of HR1, the California budget proposal, and anticipated coverage and funding shifts. An enrollment freeze for the unsatisfactory immigration status (UIS) population went into effect on January 1st of 2026. Cuts to

the prospective payment system (PPS) rates for federally qualified health centers (FQHC), the adult dental benefit and the Prop 56 dental rate elimination will go into effect in July. A group of individuals will also lose coverage under the satisfactory immigration status (SIS) because the federal government changed the definition of qualified non-citizens. The state has said that they are not intending to provide state only coverage to that group. He also spoke about the expiration of the MCO tax, which will reduce revenue. Mr. Johansson explained that work requirements and shortened redetermination periods are expected to result in the loss of coverage for approximately half a million Californians, with further details to be clarified in the May budget revise.

He also spoke about the contrast between the governor's optimistic budget deficit projections and the Legislative Analyst's Office's (LAO) more conservative estimates, noting that the governor's proposal does not account for a potential recession and defers major decisions to the May revise. Commission members discussed advocacy efforts to extend the MCO tax. Mr. Johansson explained that state associations and medical groups are lobbying for an extension, but the outcome depends on federal negotiations. HPSM's approach to navigating these changes is grounded in established guiding principles, focusing on the use of reserves, community partnerships, and maintaining alignment with organizational values.

5.4 501(c)(3) Update: Chris Esguerra, M.D., Chief Medical Officer, went over recent steps taken in the formation of the 501(c)(3) entity that HPSM is pursuing. Members of the HPSM Leadership Team met with the firm of Delfino, Madden, O'Malley, Coyle, and Koewler along with county attorneys Kristina Paszek and John Nebbelin. Dr. Esguerra discussed the ongoing process of forming a 501(c)(3) foundation to expand HPSM's community impact, including lessons learned from other health plan foundations, governance considerations, funding restrictions, and the scope of activities.

The foundation is intended to support both HPSM members and the broader community, enabling activities and funding not possible under HPSM's current structure, such as demonstration projects, rapid response to community needs, and partnerships with other funders. The Commission reviewed models from other health plan foundations, considering board composition, community representation, and legal requirements such as the Brown Act. They also discussed conflict-of-interest rules, with the goal of balancing control and community input. Commission Attorney, Kristina Paszek explained that HPSM funds provided to the foundation must be used

for public purposes within HPSM's scope, with further restrictions possible depending on the funding source. She also noted that the foundation can accept less restricted funds from other sources.

The discussion addressed the need for dedicated foundation staff, potential shared services with HPSM, and the expected administrative costs, as well as best practices and compliance. The Commission agreed that the foundation's bylaws and articles of incorporation will define its scope and activities. A detailed community needs assessment and focus determination will be conducted after formation.

6. **Report from Chief Executive Officer:** Pat Curran, HPSM CEO provided an update. He informed the Commission of a possible February agenda item regarding HPSM applying to participate in a Veterans Administration (VA) program to redesign VA services in the community, with further details to be provided at a future meeting. He explained that the VA is opening a procurement for a 10-year program to redesign services for eligible members. HPSM may consider applying to be on the list of organizations for potential procurement. The initial step involves no commitment and aligns with HPSM's mission.

7. **Other Business:** There was no other business.

8. **Adjournment:** The meeting was adjourned at 2:10 pm by Commissioner Graham.

Submitted by:

M. Heryford

M. Heryford, Clerk of the Commission

Behavioral Health Treatment (BHT) Update

January 2026

Commission Update

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Our objectives today

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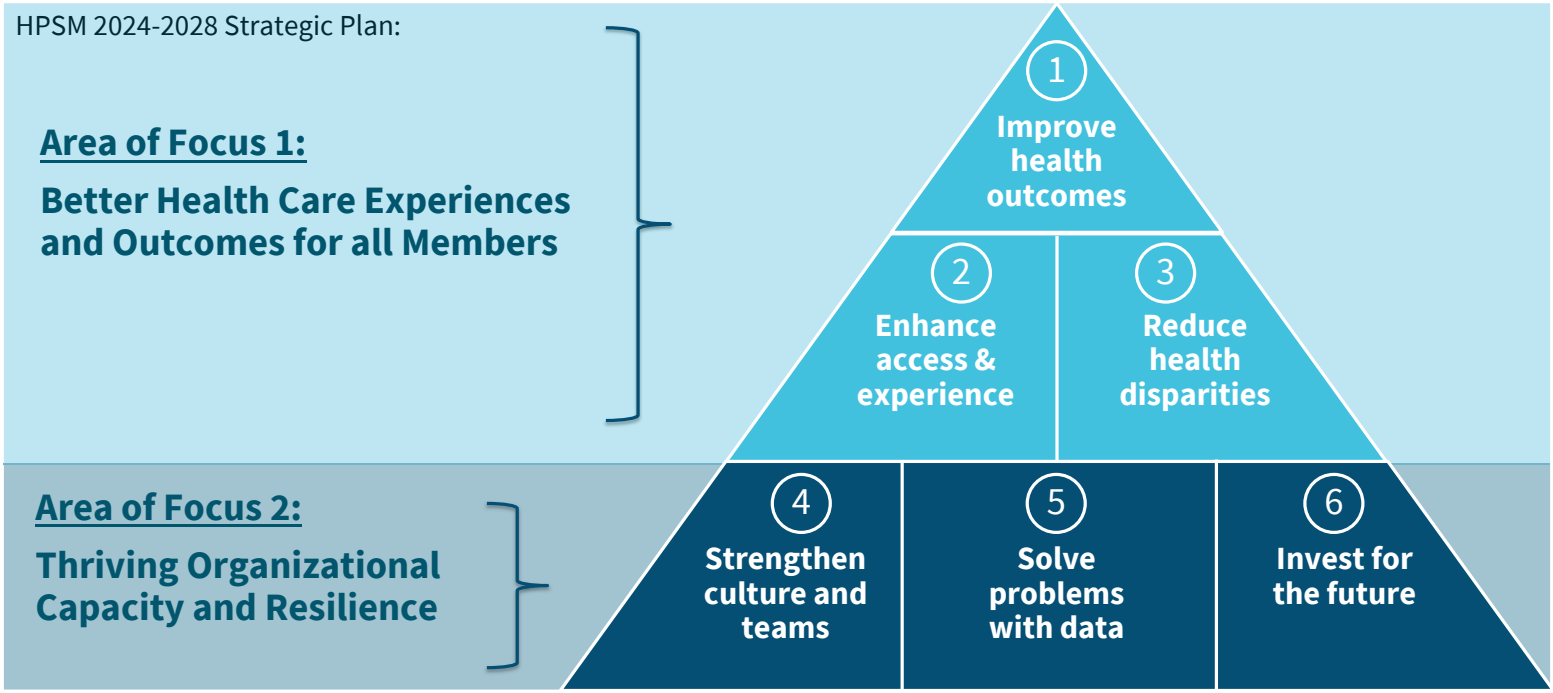
- Provide context and background on BHT in San Mateo County
- Share the HPSM BHT Experience: Pre and Post Magellan Contracting
- Share insights on lessons learned and identify areas of opportunities

Agenda

- Strategic Plan and Organizational Priority
- Background and Context
- Before: Contract Out Experience
- After: In-House Experience
- Lessons Learned

HPSM's 2024-2028 Strategic Plan



Goal 2: Enhance Access & Experience

We will increase access to high-quality member-centered care.

A Provider Investment Fund

Network dashboard: top priority needs

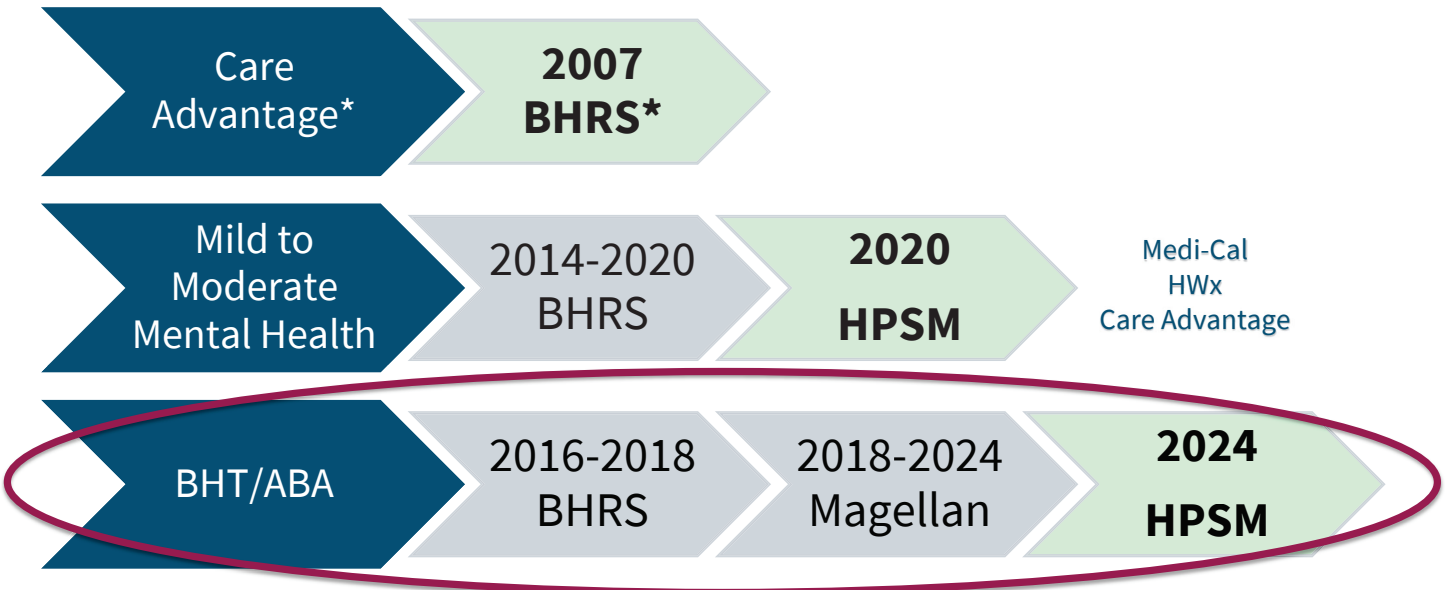
X Axis: **HPSM Member Access Priority**

Primary Care	**Primary Dental**	**Dental Specialty**
Behavioral Health	**NEMT**	**Speech/Occupational Therapy**
Gender Affirming	**CalAIM**	**OB/GYN**
Ophthalmology	**Optometry**	**Community Health Workers**
Neurology	**Doula**	**LTC/SNF**

Agenda

- Strategic Plan and Organizational Priority
- Background and Context
- Before: Contract Out Experience
- After: In-House Experience
- Lessons Learned

HPSM Contracting Out BH Benefit



* BHRS is contracted with HPSM for specific MH and SUD services that are covered by Care Advantage.

* BHRS is also contracted with HPSM for some Hwx responsibilities, but this is not listed here due the very small population

The BHT/ABA benefit

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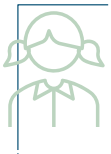
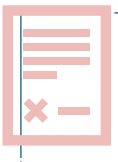
Medi-Cal benefit

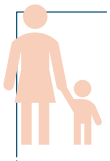


Under age 21

With or without an autism diagnosis



Requires provider Referral



Requires caregiver involvement

Time intensive (multiple hours and days per week)

Agenda

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- Strategic Plan and Organizational Priority
- Background and Context
- Before: Contract Out Experience
- After: In-House Experience
- Lessons Learned

Landscape Analysis

Network Gaps and Community Feedback
Provider shortages, rate concerns/transparency and provider satisfaction concerns

Facilitating Access to Services
Referring providers unclear on referral outcomes and families needing more support for 1st appts

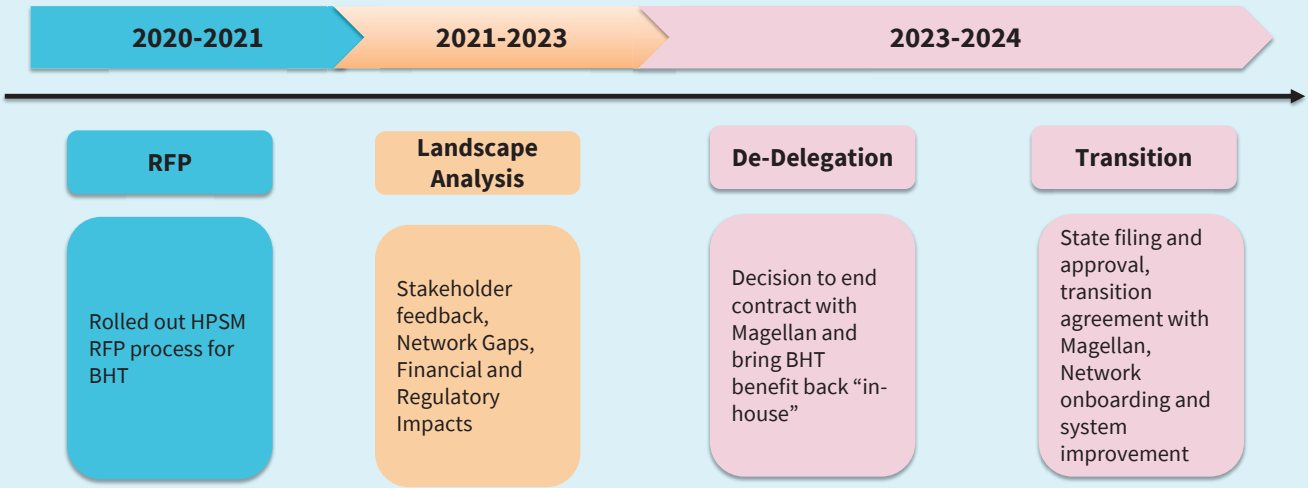
Financial Impact
High cost (~8.9 Million 2024) , low utilization (HPSM utilization lower than state average)

Appointment Availability Impacts
Waitlists and alternative appointment time gaps for families

Systems and Data
Lack of systems and transparency to track appointment matching and follow up

Regulatory Impact
High grievance rates and 23% (~$47K) of HPSM penalties between 2016-2020 were BHT related

Decision Timeline



Areas of focus for transition

Provider Network	Quality and Adequacy Network Rates and Investments
Member Experience	Notifications Seamless transition
Systems/Processes	Development of processes and trainings RMS system updates
Staffing	BH team- 5 of 6 team members are bilingual Spanish speaking Provider Services
Regulatory compliance	NCQA Accreditation DHCS and DMHC

Agenda

- Strategic Plan and Organizational Priority
- Background and Context
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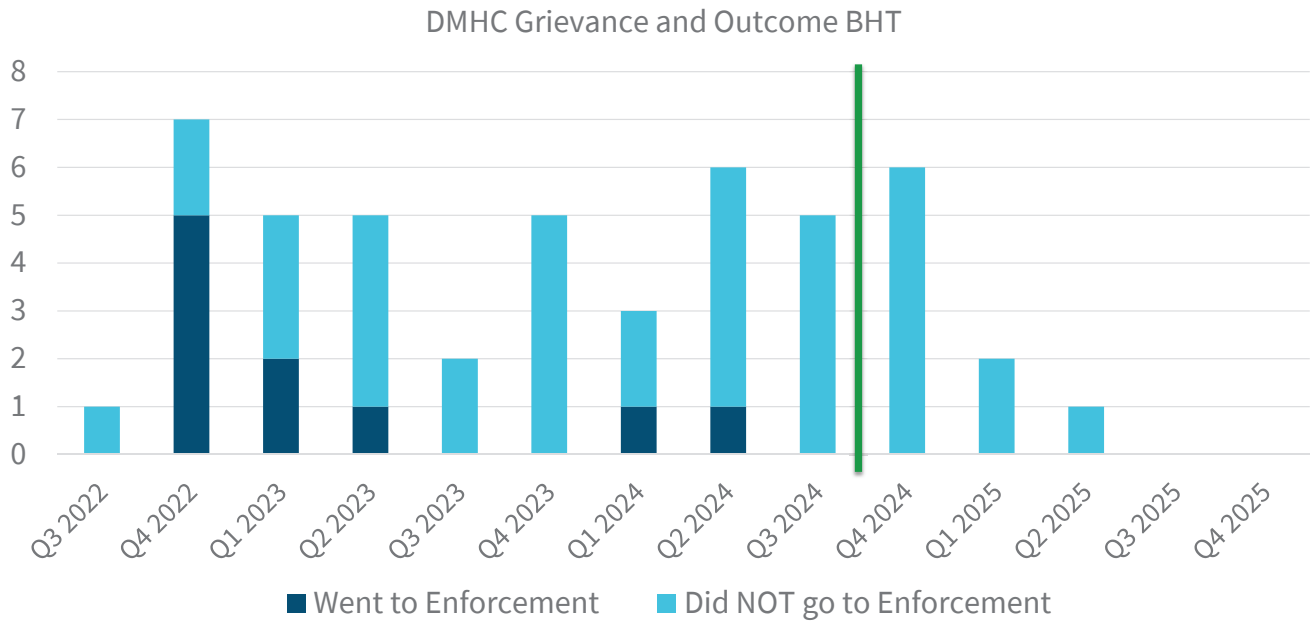
- After: In-House Experience
- Lessons Learned

DMHC Grievances



BHT Access Metrics

	Q1 2024 (Magellan)	Q1 2025 (HPSM)	Q3 2025 (HPSM*)	Observations Q1 2024 to Q3 2025
Network Provider Groups	35	40	42	**+ 20%**
Avg # of New Referrals/Mo	20	47	56	**+ 180%**
Avg # of Utilizers/Mo	271	358	407	**+ 50%**
Avg # of Hours/Mo	30	30	35*	**+16%**
Member satisfaction- Survey	66%	N/A	75%	**+13%**
Avg Cost Per Member Per Month	$2,710	$2,452	$2,915*	**+ 7.6%***

*significant IBNR

Agenda

- Strategic Plan and Organizational Priority
- Background and Context
- Before: Contract Out Experience
- After: In-House Experience
- Lessons Learned

Lessons Learned

- Oversight and Monitoring over **provider** and **member access and experience**
- Prioritize resource and time **investment**
- Leveraging **existing systems** and functions
- **System enhancements** to support referral network
- Incorporate **feedback** from stakeholders (e.g. community, providers, members, etc.)

Feedback from Referring provider:

"ABA referrals through HPSM BHT are my FAVORITE referrals to make.

The process is clear, simple, unencumbered. Kids get connected – and if families are having trouble, it's SUPER easy to get help to figure out what's going on. The team that manages the referral support email responds quickly, reliably… with useful, practical information.

The ABA referral/matching process through HPSM BHT should be the model for all forms of developmental care coordination. Providers' lives would be easier, and patients would more consistently get the care they need."

-Provider at Gardner Packard Children's Health Center

2025

- Appreciate they are getting call back
- Being matched to a specific provider
- So grateful to get an explanation of the and get their questions answered
- Appreciate that our network is flexibly and individualized

Thank you

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Behavioral Health Coverage Structure

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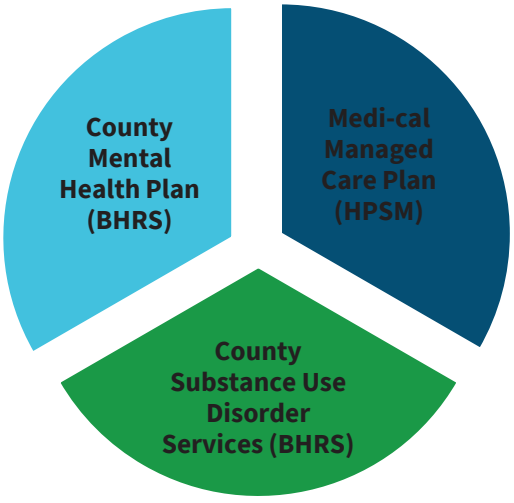
Several parties may be involved in the management of the Medi-cal Behavioral Health Benefit for a member

- Managed Care Plan (HPSM)
  - Non-specialty Mental health (NSMH)
  - **BHT/Applied Behavioral Analysis(ABA)**
- Mental Health Plan-(BHRS)
  - Specialty Mental Health (SMH)
- Drug Medi-Cal Organized Delivery System(BHRS)
  - Substance use treatment



Member Experience

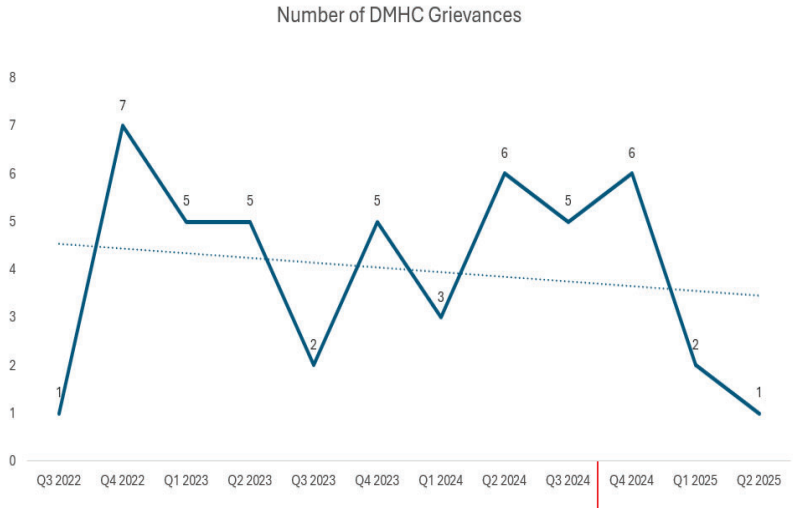
	Number of Respondents	Overall Satisfaction
HPSM Q1: Liking the services Received	24 (5.5%)	78.1% (agree & Strongly Agree)
HPSM Q2:Would choose this provider in the future	24 (5.5%)	75.9% (agree & Strongly Agree)
Magellan-2024	13 (3.4%	66.7%

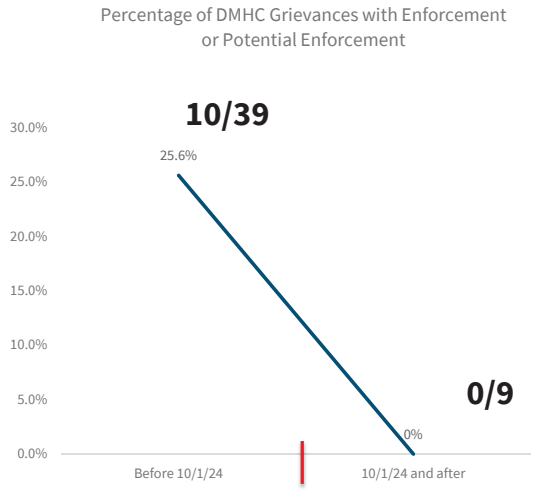
Magellan: Overall, how satisfied or dissatisfied are you with Magellan's Autism Support Services?

*Calculated from the full BH member experience survey which includes BHT and NSMH services

- 78.1% liked the services they received (agree or strongly agreed)
- 75.9% Would chose this provider again in the future (agree or strongly agree
- 66.7% Overall, how satisfied or dissatisfied are you with Magellan's Autism Support Services?

DMHC Grievances- BHT

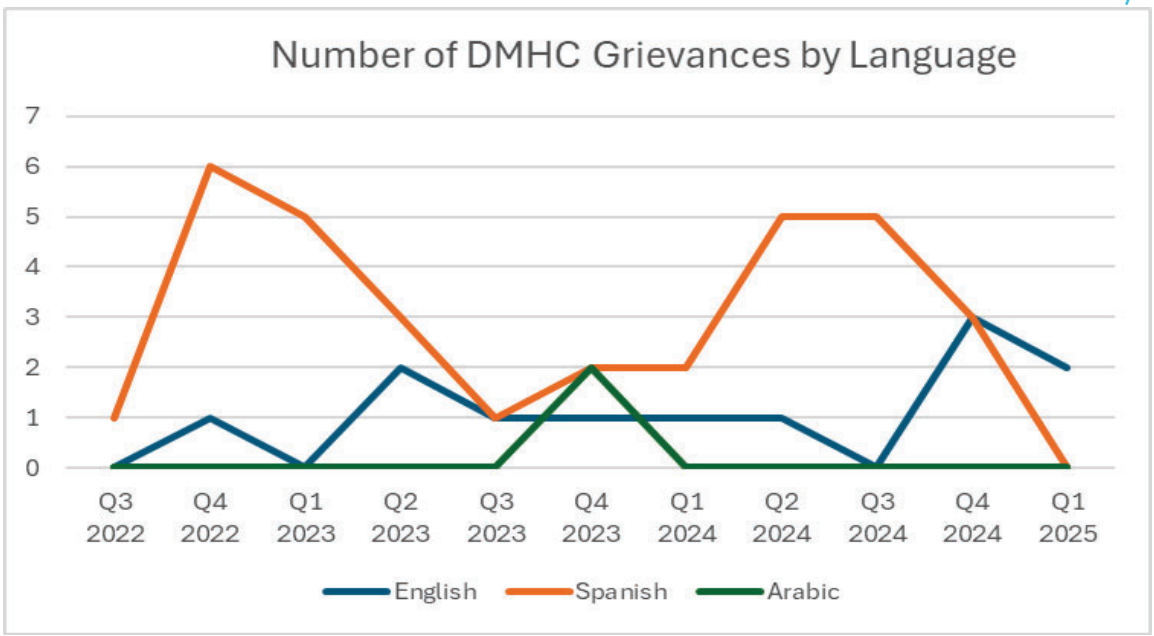




Redline indicates date of De-delegation

47 of the 48 DMHC grievances for BHT were filed by Legal Aid

DMHC Grievances by member language



BHT Benefit

Eligibility Criteria

- Under 21 for whom a licensed physician, surgeon, or psychologist determines that BHT services are Medically Necessary, regardless of diagnosis. They must be medically stable and not have need for 24 hour medical/nursing monitoring

Provider Types

- Qualified Autism Service Provider: Board Certified Behavior Analyst (BCBA), Licensed Practitioner
- Qualified Autism Service Professional: Associate Behavior Analyst (ABA), Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant
- Qualified Autism Services Paraprofessional: Paraprofessional

Services

- Behavioral-Analytic Assessment and development of behavioral treatment plan
- BHT services such as Applied Behavior Analysis, and other evidence based behavioral intervention services
- Observation and Direction

Sources: CMS SPA https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA14-026.pdf, https://www.dhcs.ca.gov/formsandpubs/laws/Documents/CA_SPA_18-011package.pdf
APL 23-010 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-010.pdf

Background

Starting in 2022 increased challenges for members accessing BHT/ABA services.

In 2023, HPSM determined that bringing the BHT/ABA benefit in house was the best course of action.

Through out 2023, HPSM organized across departments to ensure readiness to manage the benefit in-house.

Starting on 10/1/ 2024 HPSM began managing the BHT/ABA benefit.

Current State-contract and rates (2023)

- Magellan BHT contract end date is 12/31/23
- Data Shared in a 9/21 commission meeting
  - Estimated annual fees:
    - Year 1: $5,786,490
    - Year 2: 6,201,910
  - 2020 unique members served in a quarter
    - 269 (0-7: 63%, 8-20: 37%
- Current Capitated PCPM
  - 0-6: $2,690
  - 7+: $1,946

2026 Health Policy Update
January 14, 2026

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2026 Health Policy Agenda

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- 2025 Health Policy Recap
- 2026 California Budget Proposal
- Implementation of HR.1 in 2026
- Next Steps

2025 Health Policy Recap

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2025 Recap

2025 Health Policy Recap

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- Federal
  - HR.1 (One Big Beautiful Bill Act, OBBBA) signed into law July 4, 2025
- California
  - 2025-26 CA Budget signed into law in June 2025

2025 Federal Recap

Effective Dates for Key Provisions

	2025				2026				2027				2028				2029			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Eligibility and Access									Work requirements							Copayments for expansion adults				
									Option to Delay											
									6-month eligibility redetermination											
									Shorten Medicaid retroactive coverage											
Payment and Financing – Provider Taxes									Limits on provider taxes and rates							Ramp-down of provider tax cap				
									Potential Transition Period											
Payment and Financing – SDPs									Cap new State Directed Payments (SDPs) above Medicare rate							Gradual reduction of SDPs above Medicare rate				
Payment and Financing – Other									Abortion provider restrictions							CMS authority related to waiving improper payments eliminated				
Immigrant Coverage												Change to federal funding for emergency Medi-Cal services								
												Ends federal funding for some noncitizens								

Q1: Jan–Mar **Q2:** Apr–Jun **Q3:** Jul–Sept **Q4:** Oct–Dec

7

2025 State Recap

HR.1 & 2025-26 Budget Impacts

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2025	2026	2027	2028
• Ban on payment to prohibited entities	• Qualified non-citizen eligibility change	• 6-month redeterminations	• $35 copays
• Elimination of WQIP	• MCO Tax expiration	• Work Requirements	• Work Requirements (if delayed)
	• Emergency Medi-Cal match rate change	• Retroactive coverage limitation	• Provider tax reduction start
	• **UIS enrollment freeze (01/26)**	• UIS premiums	• State directed payment reduction start
	• UIS PPS cut		
	• UIS dental cut		
	• Prop 56 dental cut		

6

2025 Recap

Effect on HPSM

- Less federal funding = pressure on CA budget
- California *will* need to consider changes to Medi-Cal
  - Payment to Planned Parenthood from State-only funds?
  - Implementation of copays
  - Implementation of work requirements
  - Modification of State Directed Payments, provider & managed care organization taxes
- We (HPSM) will need to consider effects of state and federal cuts on our network and members

2025 Recap

What do we do, now?

- Evaluate decision making
- Consider decisions for the 2026 HPSM budget
- Monitor for direction from the State
- Continue the discussion with the Commission

2026 California Budget Proposal

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State Budget Timeline

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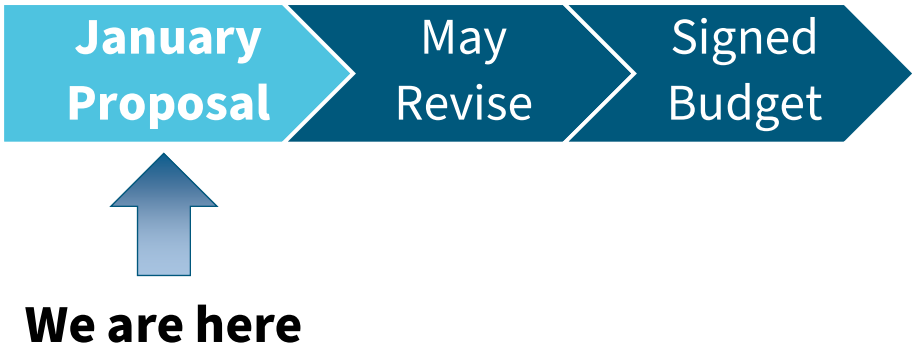
- Where are we in the process?



January Budget Proposal

- Estimated $2.9 billion deficit
- No new spending proposed
- Focus on implementing programs and funding reductions already effect
  - Up to, and from the 2025-26 California Budget agreement

January Budget Proposal

- Governor's Office estimations
  - $43 billion in new revenues
- No inclusion or estimation of economic downturn
- Acknowledgement that estimations, and proposed actions may change
  - Starting with the May Revise

Key considerations

- Legislative Analyst's Office (LAO) budget deficit estimate @ $18 billion
- LAO estimates significant structural deficits beginning 2027-28 fiscal year
  - $38 billion in the first year
- January Budget estimates are significantly smaller
  - ~$15 billion 2026-27, and ~$16 billion 2027-28 ($22 billion shortfall)

Impacts to Medi-Cal

- 2026 Budget Proposal Summary estimates ~$3 billion in funding shortfalls in Medi-Cal due to HR.1
  - $1.1 billion due to MCO tax expiration
  - $373 million to implement community engagement (work) requirements
  - $463 million to implement 6-month redeterminations
  - $653 million to Hospital Quality Assurance Fee (HQAF) modification
  - $658 million to reduction in federal matching rate for emergency Medicaid

Impacts to Medi-Cal

- October 1, 2026, several groups under the "qualified non-citizen" eligibility group will be moved to restricted Medi-Cal
  - The cost for State-only coverage is estimated to be $768 million, and is not included in the budget proposal
- 2025-26 budget cuts will go into effect as previously disclosed

Cuts in the 2025-26 Budget

- Cuts to coverage for members with Unsatisfactory Immigration Status (UIS) **[mm/yy]**
  - Enrollment freeze for ages 19 and up **[In Effect]**
  - Elimination of the Prospective Payment System (PPS) ["wrap payment"] for FQHCs and RHCs **[07/26]**
  - Elimination of dental care ages 19 and up **[07/26]**

Cuts in the 2025-26 Budget

- Other cuts
  - Eliminates Prop 56 payments for dental **[07/26]**

Implementation of HR.1 in 2026

Forecast

Implementation forecast

- Qualified non-citizen definition change **(10/26)**
- Work requirements **(01/27)**
- Redetermination 12 → 6 months for expansion group **(01/27)**
- Limited retroactive coverage **(01/27)**

Forecast

Implementation forecast

- January budget indicates newly ineligible non-citizens will be moved to limited-scope (emergency) Medi-Cal
  - Not shifted to state-only full-scope coverage
- DHCS has begun releasing draft guidance to counties and plans

What's next

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Big Picture

Planning for the road ahead

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Big Picture

Effects on HPSM (graphic)

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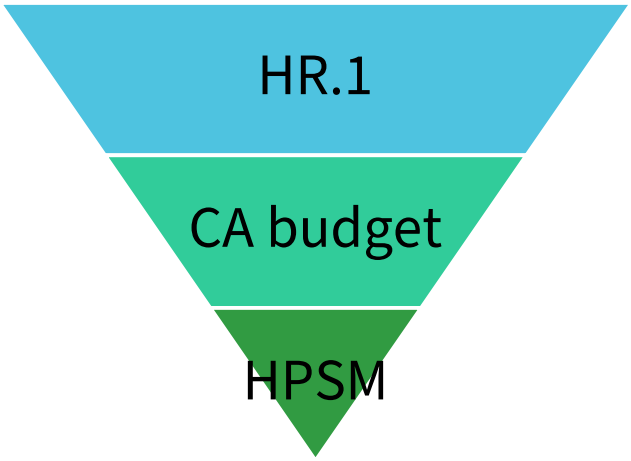

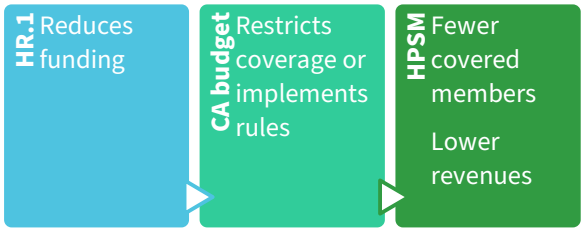

Big Picture

Approaching uncertainty with clear high-level priorities

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1

- **Core operations** to uphold our mandate as a local, community-organized Medi-Cal and Duals plan

2

- **Long-standing precedents** aligned with our Mission, Vision, and local priorities

3

- **New opportunities** to consider to advance our strategic goals, including long-term sustainability

Big Picture

Grounded in our HEALTHY values

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- H **Health care** that puts members at the center of everything we do.
- E **Equitable** access to quality services and supports for all members.
- A **Advocacy** for members disproportionately impacted by health inequities.
- L **Local** health care based in San Mateo county provided in partnership with community resources.
- T **Transparency** and accountability achieved through local governance.
- H **Honesty** is the core of our service to members, providers, business partners and the community.
- Y **You** - because HEALTHY is for everyone!

Big Picture

Next 4 months (through May 2026)

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- Monitor for signs of budget health
  - LAO estimates, economic trends, DHCS communication
- Monitor for finalized DHCS guidance on 2025-26 & HR.1 implementation
- Continue conversation with the Commission on real-world impacts & potential decision making

Questions?

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Invest for the Future
HPSM Strategic Goal 6
Update on our 501(c)(3) Formation Effort

January 2026

Chris Esguerra, MD

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Agenda

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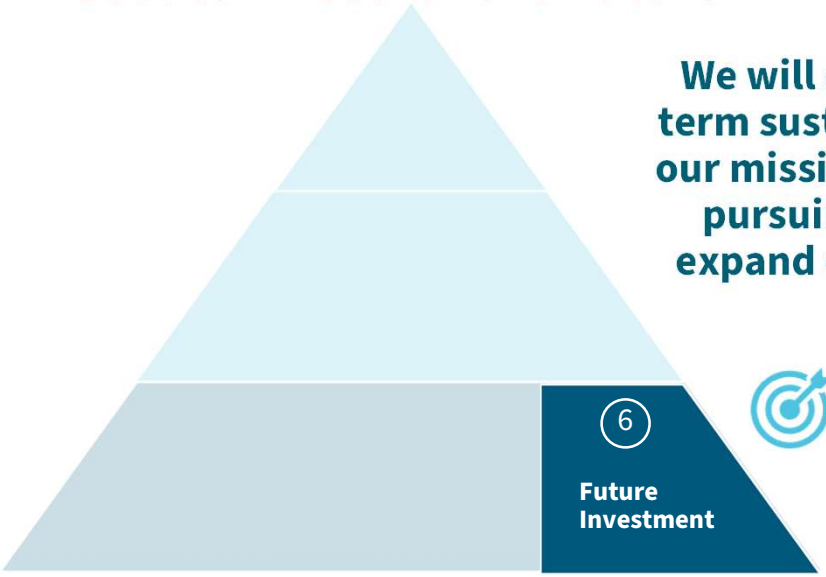
- Provide a recap of our journey and discussions for the new entity
- Update on the work towards the 501(c)(3)
- Future Decisions

Goal 6: Invest for the Future

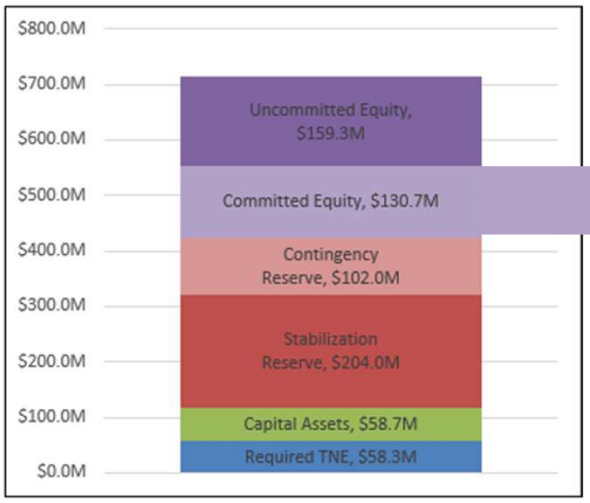


We will ensure HPSM's long-term sustainability to advance our mission, by evaluating and pursuing opportunities to expand or invest differently.

All investments of HPSM reserves were made applying our impact criteria.

Tangible Net Equity (TNE)

Balance at 6/30/2025 = $713.0M
Uncommitted portion = $159.3M



Primary Care Investments
Provider Rates
Baby Bonus

Grounding: approaching uncertainty with clear high-level priorities

HealthPlan OF SAN MATEO
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1
- **Core operations** to uphold our mandate as a local, community-organized Medi-Cal and Duals plan

2
- **Long-standing precedents** aligned with our Mission, Vision, and local priorities

3
- **New opportunities** to consider to advance our strategic goals, including long-term sustainability

Retreat x HPSM Leadership Prioritization

Prioritization of themes

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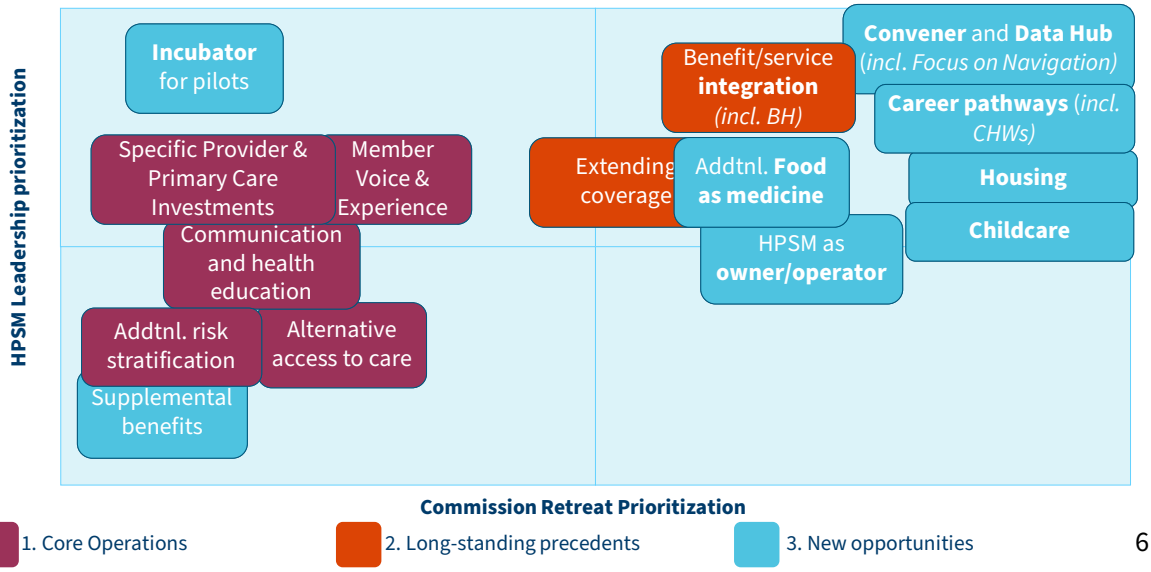

Top priorities in brief

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What

- **Employment** (incl. CHWs)*
- Supporting **Housing** Access*
- Service & System **Navigation***
- **Childcare**
- ***Behavioral Health*** *ecosystem**
- ***Food*** *as Health**
- *Preserving* ***Healthcare Coverage***

How

- Strong support for HPSM leveraging our strengths as a **convener** and **data hub**
- Endorsement to continue our precedent of **piloting integration efforts**

Emerging priority

** Early exploration and/or piloting underway in these areas*

Timeline

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Why a New Entity?

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New Capabilities, Community Impact	Address HPSM's Limitations

• Focuses on the community broadly
• Anchor funder
  • Receiving and distributing
• Organizer and convener
• Entity as operator
• Testing and learning
  • Supporting and/or deploying pilots
	• Focus on core operations as defined by regulations and longstanding precedents
	• Efforts limited to HPSM members

The What: New Entity Considerations

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Legal	Governance	Mission	Capabilities
• 501(c)(3) Foundation	• Strong HPSM influence on the board with community voice	• Align with HPSM • Serve the community, with a focus on those with higher needs	• Align private/public funding • Leverage HPSM's expertise

Summary

What we did

Defined the why and broadly the what 501(c)(3) focused on San Mateo County

Authorized HPSM to begin the process of legally establishing the 501(c)(3) organization

What we will do

Decide on articles of incorporation, bylaws, funding

Current Progress

- Engaged with firm Delfino Madden to assist with 501(c)(3) formation
- Gathered information from IEHP Foundation
- Learning process, key decisions, and key boundaries

Learnings to Share: IEHP Foundation

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IEHP Foundation

- Board
  - 11 members, 2 designated by IEHP CEO (bylaws indicate at least 7 members)
- Focus
  - Inland Empire and surrounding communities
  - Invest in the strength and capacity of local community-based organizations
  - Focusing on those serving families with children in low income communities with the poorest health outcomes
- How
  - Build organizational strength
  - Systems change

Learnings to Share: HPSM funding

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HPSM Funding of a Foundation

- Must be a public purpose
- Purpose is within HPSM's scope
- HPSM's funding can be restricted to fulfill requirements

Foundation Scope, Activities, and Governance

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Nonprofit Scope	Nonprofit Activities	Governance

• **Employment** (incl. CHWs)
• Supporting **Housing** Access
• Service & System **Navigation**
• **Childcare**
• **Behavioral Health** ecosystem
• **Food** as Health
• Preserving **Healthcare Coverage**
	• Funding and supporting organizations that support the scope
	• Help develop community capabilities to fulfill the scope when there are no existing resources
	
	Are there other activities we wish to consider?
		• Considerations
		  • Conflicts of interest rules (for HPSM and from IRS for nonprofit)
		  • Brown Act
		• Election of directors
		  • Election by Nonprofit board
		  • Selected by CEO
		  • Length of terms

What we will recommend and decide

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- Funding
- Articles of Incorporation
- Bylaws

Thank you

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MEMORANDUM

AGENDA ITEM: 5.1

DATE: March 11, 2026

DATE: March 4, 2026

TO: San Mateo Health Commission

FROM: Patrick Curran, CEO

RE: Recommendation to terminate contract with San Mateo County and City of San Mateo for the Healthworx Program

---

Recommendation:

We recommend that HPSM not renew its three-year agreement with San Mateo County to continue the Healthworx program, as well as notify the City of San Mateo about the end of the program. The current Healthworx agreement expires on December 31, 2026.

Background:

This program is one that HPSM administers for approximately 1,300 IHSS workers through San Mateo County, as well as a very small number (less than 15) part-time employees with the City of San Mateo. HPSM has administered this program for many years, and the enrollment has not changed significantly during that time.

Over the past few years, the Department of Managed Health Care (DMHC) has removed many of the previous flexibilities we had in administering this program. Now we must follow all the rules and report requirements of any commercial health plan. This causes a disproportionate amount of work for our teams, diverting staff resources which we need for our core programs. In 2024, we engaged Health Management Associates (HMA), in collaboration with San Mateo County Health, to explore ways to expand or revise this program, including participation in Covered California, but no path forward was feasible.

Since our three-year agreement to administer the program ends in December 2026, we engaged in discussions during 2025 with San Mateo County Health about alternatives. We believe that they are developing coverage options for this subset of IHSS workers. We have therefore decided to make this recommendation to the Health Commission to not renew our three-year agreement and end the Healthworx program in December 2026. We will incur additional expenses in 2027 to close out the program and ensure all claims are paid, but that work should not extend beyond 2027.

We do not take this recommendation lightly. However, we saw no path forward to growing membership and making the program sustainable, and unlike our core programs, including Medicare, Medi-Cal and ACE, there are other coverage options for these individuals.

Financial Implications:

Due to the small membership in this product (1,300), the actual experience of the plan fluctuates widely, making it difficult to predict the financial impact. However, we know that we will be able to better allocate and prioritize staff time and resources to our remaining lines of business that have been allocated disproportionately to Healthworx because of increasing regulatory requirements.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF DISCONTINUING ADMINISTRATION OF THE HEALTHWORX PROGRAM.

RESOLUTION 2026 -

RECITAL: WHEREAS,

A. HPSM has administered the Healthworx program on behalf of approximately 1,300 individuals for many years in a full-risk contract; and
B. The administrative burden of the program has increased significantly in the past few years due to elimination of flexibilities by the Department of Managed Health Care; and
C. HPSM has not identified viable pathways to grow the program in a manner that would make it sustainable in the long-term; and
D. Therefore, HPSM recommends terminating the Healthworx program at the end of 2026 and ensure a smooth transition for the 1,300 individuals in the program to other forms of health coverage.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves notification to San Mateo County, the City of San Mateo, and the State of California Department of Managed Health Care to terminate the Healthworx program at the end of December 2026.
2. Authorizes the CEO to take actions internally and externally to carry out this termination.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of March, 2026, by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Bill Graham, Chairperson

ATTEST:

BY: _____
M. Heryford, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

Agenda Item: 5.1
Date: March 11, 2026

Healthworx Program

HPSM Health Commission

March 11, 2026

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History of Healthworx

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- Healthworx is a commercial health plan licensed by the Department of Managed Health Care (DMHC).
- It was formed and started serving members in 2001.
- Membership is comprised of two arrangements:
  - Approximately **1,300** IHSS (In-Home Supportive Services) workers who receive health coverage from the San Mateo County Public Authority through its agreement with SEIU
  - **10-15** individuals, mostly part-time employees, of the City of San Mateo
- Membership has remained fairly constant throughout the life of the program.
- HPSM uses its Medi-Cal network as the provider network and pays Medi-Cal rates to providers for covered services.
- San Mateo is one of several counties in the state with this type of program (San Francisco, Santa Clara, Los Angeles, Monterey, and Alameda)

2

Current State of Healthworx

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- Historically, the DMHC has regulated these plans separately from commercial plans as a special category (so-called "**IHSS Plans**").
- Due to the passage of legislation, as well as DMHC interpretation of regulatory policies, Healthworx is **increasingly regulated** by the same rules as any licensed commercial health plan in California.
- This has resulted in significant **workload increase for staff**, especially in areas such as behavioral health, compliance, claims, financial reporting, and IT (i.e., mandates for transparent pricing tools on plan websites).
- Due to **low membership**, the financial performance can fluctuate dramatically.

3

Health Care Cost and Admin PMPM

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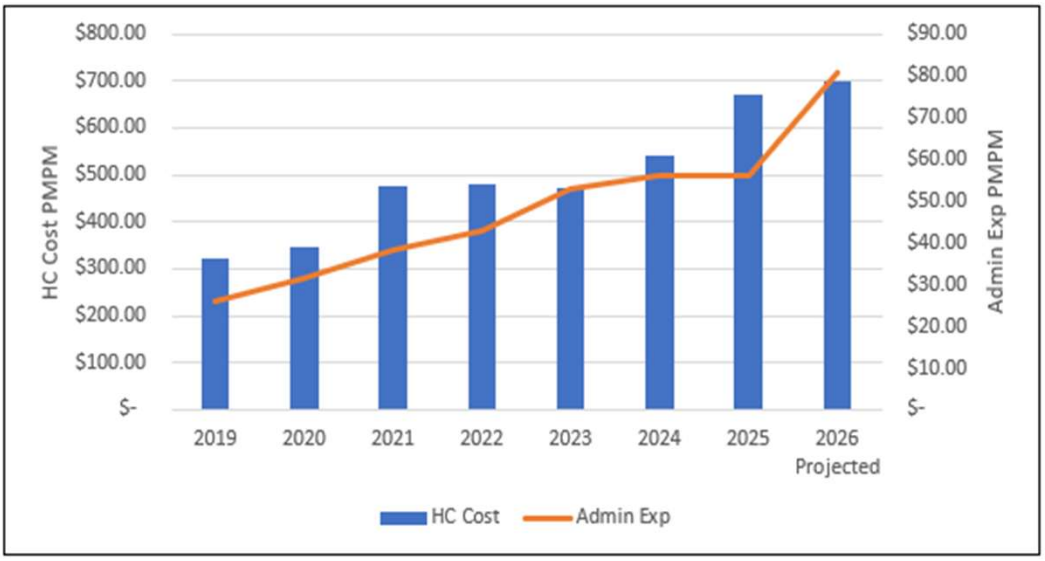

4

Financing

- San Mateo County funds the premium of its IHSS workers through a complicated arrangement with the State of California:
  - After the passage of the Affordable Care Act (ACA), the county had and still has an approximately $28.82M obligation due to Maintenance of Effort (MOE). The intent of MOE is that state and local agencies not discontinue coverage programs already in place before passage of the ACA.
  - The MOE amount includes the costs to cover the county portion of healthcare premium costs for the 1,300 members. The remaining costs are shared between state and federal funds if it does not exceed a specified maximum dollar amount per IHSS hour worked.
  - The county has not historically exceeded this maximum dollar amount, though with increased costs it could in the future.

5

Action Items from August 2023

- ✓ Increased the Healthworx member premium in 2024 and 2025 and communicate to both San Mateo County and the City of San Mateo.
- ✓ Invested additional dollars in administrative support for the program to address increasing regulatory oversight.
- ✓ Engaged a consultant in an overall market assessment to determine options for the Healthworx program moving forward.

6

Market Assessment in 2024

- HPSM engaged Health Management Associates (HMA) to understand the coverage needs of the community, especially for low-income residents.
- HMA evaluated two options to grow Healthworx that may align with HPSM's mission:
  - Expand Healthworx to the Covered California marketplace
  - Offer Healthworx as a commercial insurance product to uninsured San Mateo County residents

7

Report Findings – Program Viability

- To ensure longer term viability, Healthworx needs to have membership of 5,000-10,000.
- Entering Covered California is not a viable option due to the administrative complexity, high risk of potential losses, and low opportunity to attract membership based on current health plan competition.
- Increasing enrollment in Healthworx with San Mateo County to include more than the 1,300 members is not feasible.
- If HPSM were to address the uninsured members in San Mateo County, the best vehicle would be a non-insured coverage program similar to ACE.

8

Conclusion

- The current Healthworx program is not able to increase membership beyond 1,300 (current) and will become increasingly expensive to both operate and to offer to the county as an option.
- It would take significant administrative work and financial investment in systems and reserves to develop a new product for Covered California with little opportunity to grow membership.
- Any potential coverage expansion for county residents would involve developing a new non-licensed coverage program or adapting the current ACE program.
- We worked with San Mateo County Health throughout 2025 to allow sufficient time to explore other coverage options for members starting January 2027.

9

Recommendation

- Formally notify San Mateo County and City of San Mateo that HPSM will no longer offer Healthworx as an option beyond December 31, 2026.
- Continue to explore affordable coverage options for low-income San Mateo County residents. This could mean using the existing framework of the ACE program as a template.

10


Questions and Discussion
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Agenda Item: 5.2

Date: March 11, 2026

Invest for the Future
HPSM Strategic Goal 6
Update on our 501(c)(3) Formation Effort

March 2026

Chris Esguerra, MD

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Agenda

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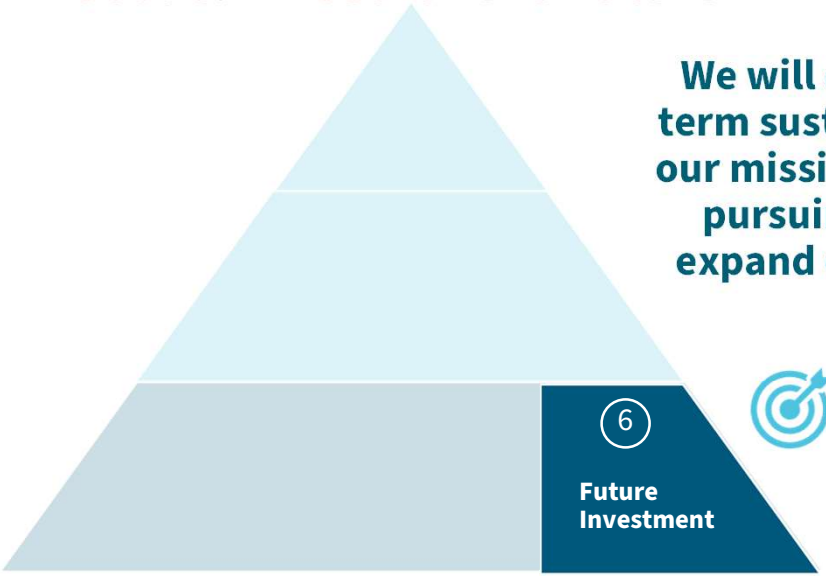
- Provide a recap of our journey and discussions for the new entity
- Update on the work towards the 501(c)(3) and discussions
- Further Decisions

Goal 6: Invest for the Future

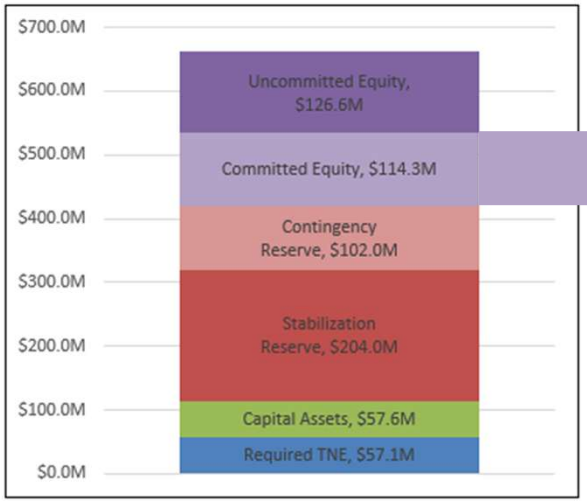


We will ensure HPSM's long-term sustainability to advance our mission, by evaluating and pursuing opportunities to expand or invest differently.

All investments of HPSM reserves were made applying our impact criteria.

Tangible Net Equity (TNE)

Balance at 12/31/2025 = $661.7M
Uncommitted portion = $129.6M



Committed Equity:

	Funding	Spend	Balance
Provider	$100.0M	$18.5M	$81.5M
Primary Care	$30.0M	$3.7M	$26.3M
Baby Bonus	$7.0M	$0.5M	$6.5M
	$137.0M	$22.7M	$114.3M

Grounding: approaching uncertainty with clear high-level priorities

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1
- **Core operations** to uphold our mandate as a local, community-organized Medi-Cal and Duals plan

2
- **Long-standing precedents** aligned with our Mission, Vision, and local priorities

3
- **New opportunities** to consider to advance our strategic goals, including long-term sustainability

Retreat x HPSM Leadership Prioritization

Prioritization of themes

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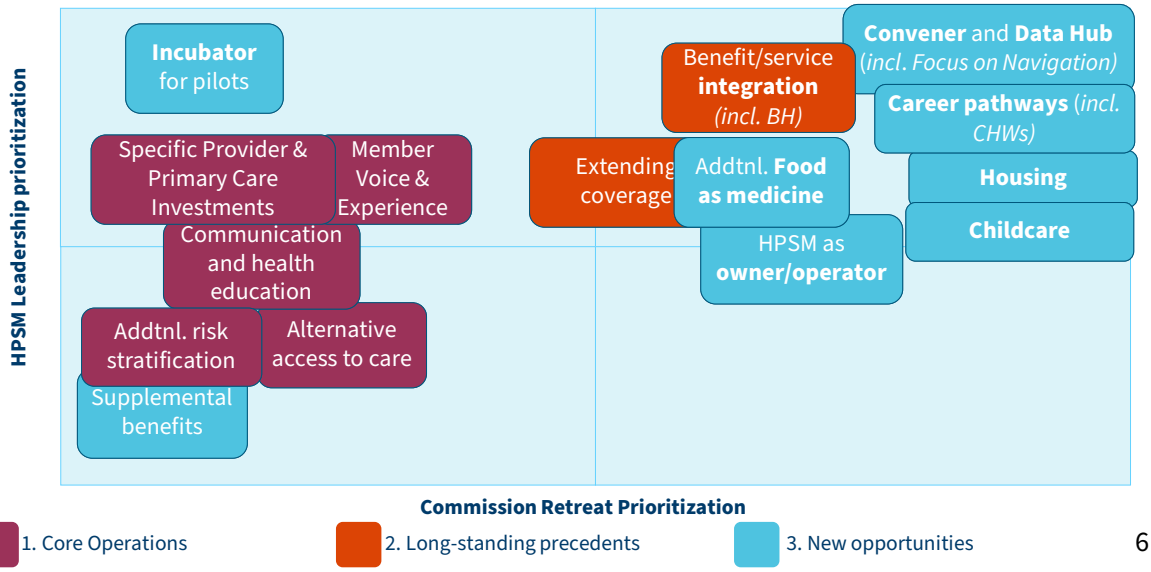

Top priorities in brief

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What

- **Employment** (incl. CHWs)*
- Supporting **Housing** Access*
- Service & System **Navigation***
- **Childcare**
- ***Behavioral Health*** *ecosystem**
- ***Food*** *as Health**
- *Preserving* ***Healthcare Coverage***

How

- Strong support for HPSM leveraging our strengths as a **convener** and **data hub**
- Endorsement to continue our precedent of **piloting integration efforts**

Emerging priority

** Early exploration and/or piloting underway in these areas*

Timeline

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Why a New Entity?

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New Capabilities, Community Impact	Address HPSM's Limitations

• Focuses on the community broadly
• Anchor funder
  • Receiving and distributing
• Organizer and convener
• Entity as operator
• Testing and learning
  • Supporting and/or deploying pilots
	• Focus on core operations as defined by regulations and longstanding precedents
	• Efforts limited to HPSM members

The What: New Entity Considerations

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Legal	Governance	Mission	Capabilities
• 501(c)(3) Foundation	• Strong HPSM influence on the board with community voice	• Align with HPSM • Serve the community, with a focus on those with higher needs	• Align private/public funding • Leverage HPSM's expertise

Summary

What we did

Defined the why and broadly the what 501(c)(3) focused on San Mateo County

Authorized HPSM to begin the process of legally establishing the 501(c)(3) organization

What we will do

Decide on articles of incorporation, bylaws, funding

Current Progress

- Engaged with firm Delfino Madden to assist with 501(c)(3) formation
- Gathered information from IEHP Foundation
- Learning process, key decisions, and key boundaries

Learnings: IEHP Foundation

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IEHP Foundation

- Board
  - 11 members, 2 designated by IEHP CEO (bylaws indicate at least 7 members)
- Focus
  - Inland Empire and surrounding communities
  - Invest in the strength and capacity of local community-based organizations
  - Focusing on those serving families with children in low income communities with the poorest health outcomes
- How
  - Build organizational strength
  - Systems change

Foundation Scope, Activities, and Governance

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Nonprofit Scope

- **Employment** (incl. CHWs)
- Supporting **Housing** Access
- Service & System **Navigation that promotes Access**
- **Childcare**
- **Behavioral Health** ecosystem
- **Food** as Health
- Preserving **Healthcare Coverage**

Nonprofit Activities

- Funding and supporting organizations that support the scope
- Help develop community capabilities to fulfill the scope when there are insufficient existing resources
- Leverage and align dollars from other funders to fulfill scope
- Facilitate testing and evaluation of new models to promote innovation

Governance

- Considerations
  - Conflicts of interest rules (for HPSM and from IRS for nonprofit)
  - Brown Act
- Election of directors
  - Election by Nonprofit board
  - Selected by CEO
  - Length of terms

Scope Language

The specific purposes of this corporation are to ensure San Mateo County's underserved residents have access to high-quality care services and supports so they can live the healthiest lives possible by:

(i) providing financial and other forms of support for charitable and educational programs and organizations in San Mateo County and surrounding communities, including but not limited to programs that promote employment opportunities in healthcare, housing access and stability, service and system navigation to promote access to healthcare for individuals and families, access to affordable childcare, food security and nutrition initiatives, behavioral health services and supports, and efforts aimed at preserving healthcare coverage for underserved residents;

(ii) providing support to and promoting activities and programs that meet unique or underserved healthcare needs and healthy living in innovative ways, and ensure the availability of and access to high-quality care services;

(iii) engaging in any other activities in furtherance of the purposes for which the corporation is formed; and

(iv) receiving, investing and utilizing funds, property and in-kind materials or services acquired through the solicitation of contributions, donations, grants, gifts, and bequests and the like for the purposes for which the corporation is formed.

Governance Discussion

What we have learned

- Keep the number of 501(c)(3) board members reasonable
- HPSM CEO can designate 501(c)(3) board members (control)
- HPSM CEO can remove a designated 501(c)(3) board member (control)
- The 501(c)(3) board can elect to remove an elected director by majority
- Bylaws can set a high bar for changes (durability, binding to HPSM mission)

Our proposal

- 5 board members, 3 selected by HPSM CEO (nuance discussion)
- HPSM CEO can remove designated 501(c)(3) board member (not elected)
- 501(c)(3) board can elect to remove an elected director by majority
- 4/5 vote needed to update Bylaws (nuance discussion)

Governance Options to Discuss

501(c)(3) Board appointment	Option 1: HPSM CEO appoints 3 of 5. Appointee can be a HPSM Commissioner or former Commissioner
	Option 2: HPSM Commission appoints 3 of 5. Appointee can<u>NOT</u> be a current or incoming HPSM Commissioner
501(c)(3) bylaws and articles changes	Option 1: HPSM Commission has the right to approve substantial changes to 501(c)(3) bylaws and articles after 4/5 approval vote from foundation board
	Option 2: 501(c)(3) bylaws and articles change can occur upon 4/5 approval vote from foundation board

Learnings: HPSM funding

HPSM Funding of a Foundation

- Must be a public purpose
- Purpose is within HPSM's scope
- HPSM's funding can be restricted to fulfill requirements

Funding

Safeguards	• Articles of Incorporation and Bylaws of the 501(c)(3) define its activities • IRS regulations over 501(c)(3) • Restricted gift agreement for HPSM funds (only HPSM can modify the terms of the gift)
Proposal	• One time, $25,000,000 restricted gift[1] • ~20% of uncommitted reserves • Restricted gift language to align with HPSM's mission, boundaries of use of funds, and define reporting and accountability

[1] These funds would not be counted towards HPSM's medical expense or incurred claims

Forthcoming:
What we will recommend and decide

- Articles of Incorporation
- Bylaws
- Funding and Restricted Gift Agreement

Thank you

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MEMORANDUM

AGENDA ITEM: 6.0

DATE: March 11, 2026

DATE: March 4, 2026

TO: San Mateo Health Commission

FROM: Patrick Curran

RE: CEO Report – March 2026

Application for Veterans Affairs IDIQ

HPSM is planning to apply to participate in the ten-year VA procurement process to improve Community Care Connect (CCN), the component of the health care program that incorporates health care services to VA members in non-VA facilities. Approximately 50% of the care to the 9.2 million VA beneficiaries is provided outside the VA. This application does not commit HPSM to participate in any program; it allows HPSM to participate in work group meetings and be able to bid on future projects. We believe that improving access and care for veterans is central to our mission.

On February 26th I was invited to participate in a session in Washington, DC hosted by the White House to provide input regarding how to improve services to VA members. HPSM was one of only a few local community plans invited to this session, in which we emphasized the need for local engagement of providers, community organizations, and especially veterans themselves, to design improvements to the system.

HR1

Much of the work happening in HR1 implementation relates to the rules surrounding work requirements, the so-called Community Engagement criteria. Since states will need to start implementing this component as part of the qualification process for Medicaid beginning in January 2027 (for adults in the Medicaid expansion aid category), the state of California and counties are working on ways to make that process as streamlined as possible. Since adult expansion members will also need to re-enroll every six months, this work is critical to ensuring people retain coverage.

HPSM Budget Update in May

By May we will begin to see early 2026 trends in both enrollment and overall financial performance due to the changes made in Medi-Cal enrollment (such as the ending of pandemic enrollment flexibilities and limits to UIS adult member enrollment). We will also have insight into our Q1 financial situation to see if we can identify any trends related to state and federal policy changes. Our May Commission meeting will also include the approval of our 2025 audited financial statements. Finally, though the official state May Revise may not be announced until May 14th (the day after the Health Commission meeting), we hope to communicate insights regarding the upcoming 2026-27 state budget.