

THE SAN MATEO HEALTH COMMISSION
Regular Meeting
November 12, 2025 - 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/MhdmZT1gSf0?feature=share>. Please note that while there is an opportunity to provide public comment in person, there is no means for 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 QIHEC Meeting Minutes – June 26, 2025
 - 4.2 San Mateo Health Commission Meeting Minutes from September 10, 2025
- 5. Specific Discussion/Action Items**
 - 5.1 State & Federal Health Policy Update
 - 5.2 HPSM Exploration to Form a 501(c)(3) Entity*
 - 5.3 Request for Community Investment to Support Local Food Needs*
 - 5.4 Formation of CEO Search Committee*
- 6. Report from Chief Executive Officer**
- 7. Other Business**
- 8. Adjournment**

**Items for which Commission action is requested.*

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QUALITY IMPROVEMENT HEALTH AND EQUITY IMPROVEMENT
COMMITTEE

March 20, 2025, 6:00 p.m. – 7:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd.
South San Francisco CA 94080

Agenda Item: 4.1
Date: Nov. 12, 2025

Voting Members	Committee	Specialty	Present (Yes or Excused)
Jeanette Aviles, M.D.		SMMC Physician (Internal Medicine)	Yes
Kenneth Tai, M.D.		PCP (Internal Medicine)	Excused
Jaime Chavarria, M.D.		PCP (Family Medicine)	Yes
Maria Osmena, M.D.		PCP (Pediatric)	Yes
Nazleen Bharmal, M.D.		Chief Health Equity Officer, Stanford Medicine	Yes
Alpa Sanghavi, M.D.		SMMC Physician (Chief of Quality and Patient Experience)	Yes
Curtis Chan, M.D.		Deputy Health Officer, San Mateo County	Yes
Non-voting HPSM Staff		Title	Present (Yes or Excused)
Chris Esguerra, M.D.		CMO	Yes
Amy Scribner		CHO	Yes
Nicole Ford		QI Director	Yes
Mackenzie Moniz		Program Manager	Yes
Miriam Sheinbein, M.D.		Medical Director	Yes
Kaylee Knowles		Program Manager	Yes

1. Call to Order

The meeting was called to order by Dr. Aviles.

2. Public Comment/Communication

No public comments received.

3. Approval of Agenda

Approved by the Committee members.

4. Approval of Agenda

Approved by the Committee members.

5. Approval of Consent Agenda:

5.1. QIHEC minutes from December 19, 2025

5.2. UMC minutes from January 27, 2025

5.3. PRC minutes from December 10, 2024

Approved by the Committee members.

6. Utilization Management Review

Dr. Esguerra explained the ongoing efforts to reduce and clean up prior authorization requirements over the past two years. The goal is to make the process more flexible and clinically relevant, ensuring it supports providers rather than hindering them. For example, home health services, prior authorization is not required for the first three visits. Providers can conduct evaluations and determine the necessary care before seeking authorization for additional visits. Another example, in the case of physical therapy for adults, up to 20 visits are allowed without prior authorization. Providers can request additional visits if needed, explaining the necessity for extended care. Dr. Esguerra mentioned that the process has been designed thoughtfully, with a focus on removing unnecessary prior authorizations, especially for preventive measures like DEXA scans for osteoporosis, which no longer require prior authorization.

The team is currently reviewing other areas where prior authorizations can be reduced or eliminated. They plan to present their findings and recommendations in the June meeting, seeking input from members on additional areas to consider. Dr. Esguerra asked for the committee's feedback the next meeting. The current prior authorization list will be sent to committee members prior to the next meeting to facilitate

7. Clinical Guidelines

- 7.1.** Diagnostic Evaluation, Testing, Counseling and Disclosure of Suspected Alzheimer's Disease and Related Disorders (Alzheimer's Association)
- 7.2.** Medicare Annual Wellness Visit Algorithm for the Assessment of Cognition (Alzheimer's Association)
- 7.3.** Operationalizing the Detection of Cognitive Impairment during The Medicare AWW in a Primary Care Setting (Alzheimer's Association)
- 7.4.** Revised Criteria for Diagnosis and Staging of Alzheimer's Disease (Alzheimer's Association)
- 7.5.** Dementia Care Evidence Based Nonpharmacological Practices to Address Behavioral and Psychological Symptoms of Dementia (Gerontological Society of America)

Approved by the Committee members.

8. 2024 QIHE Evaluation, 2025 QIHE Program Description, 2025 QI Work Plan Review & Approval

The annual Quality Improvement and Health Equity (QIHE) Program documents were distributed and reviewed by the committee members. Ms. Ford presented the comprehensive quality improvement and health equity program description, evaluation, and work plan required for managed care plans. They summarized the clinical quality metrics, patient safety, and quality monitoring efforts, and areas of focus for 2025, including well-child visits and osteoporosis screening.

Approved by the Committee members.

9. 2024 CAHPS Results

Ms. Moniz shared the 2024 Consumer Assessment of Healthcare Provider and Systems (CAHPS) survey results, covering Medicare, Medi-Cal child, and Medi-Cal adult populations. The survey measures member experiences in various categories, including health plan, healthcare, customer service, and doctor communication.

Strengths identified in the survey include high ratings for annual flu vaccines, healthcare quality, and personal doctor ratings. These areas reflect positive member experiences and effective healthcare delivery.

Opportunities for improvement were identified in care coordination, getting care quickly, and how well doctors communicate. These areas require targeted efforts to enhance member experience and satisfaction.

The committee discussed the importance of making CAHPS data actionable for providers. They emphasized the need to share relevant data with providers and offer guidance on how to improve member experiences based on survey results.

10.2023 HOS Results

Ms. Ford presented the Health Outcomes Survey (HOS) results for Medicare members, focusing on measures related to urinary incontinence, physical activity, and fall risk management. The plan performed well compared to regional and national benchmarks.

The plan received high ratings for managing urinary incontinence, promoting physical activity, and reducing fall risks. These areas are crucial for improving the quality of life for Medicare members.

The committee discussed the importance of addressing disparities in health outcomes. They recognized the need to focus on vulnerable populations and ensure equitable access to care and support services.

The plan aims to continue monitoring and improving health outcomes for Medicare members. Future actions include targeted interventions to address identified disparities and enhance overall member well-being.

11. Adjournment:

Dr. Aviles adjourned the meeting.

Next meeting Thursday June 26, 2025

DRAFT

SAN MATEO HEALTH COMMISSION
Meeting Minutes
October 8, 2025 – 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor Boardroom
South San Francisco, CA 94080

AGENDA ITEM: 4.2
DATE: November 12, 2025

Commissioners' Present: Jeanette Aviles, M.D. Kenneth Tai, M.D.
Raymond Mueller Manny Santamaria, Vice-Chair
Amira Elbeshbeshy Ligia Andrade Zuniga
Shabnam Gaskari

Commissioners' Absent: Michael Callagy
Si France, M.D.
Bill Graham, Chair
Jackie Speier

Counsel: Kristina Paszek

Staff Presenting: Chris Esguerra, M.D., Amy Scribner, Nicole Ford, John Okonne, Megan Noe

1. Call to order/roll call

The meeting was called to order at 12:36 p.m. by Commissioner Santamaria, Vice-Chair. A quorum was present.

Commissioner Ray Mueller arrived at 12:40 pm.

2. Public Comment

There were no public comments.

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

4. Consent Agenda: The consent agenda was approved as presented. Motion: Aviles (Second: Andrade-Zuniga) **M/S/P.**

5. Specific Discussion/Action Items:

5.1 Health Outcomes and Population Health Updates: Amy Scribner, HPSM Chief Health Officer, opened by reviewing HPSMs population health initiatives and health outcomes. She went through the different lines of business (LOB) at HPSM and how they measure outcomes for each. Nicole Ford, HPSM Director of Quality Improvement, reviewed the National Committee for Quality Assurance (NCQA) health plan rating, which focuses on the Medi-Cal LOB.

Health plans are rated in 3 categories:

- Private/Commercial
- Medicare Advantage (not supplemental or Special Needs)
- Medicaid.

Ratings are based on measures of clinical quality from NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) and patient experience from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) that are collected and submitted by health plans annually. Overall ratings are calculated on a 0–5 scale in half-points (5 is highest) and rounded to the nearest half-point. Plans are not rated against other Medicaid plans or commercial plans, but rather on how all plans are doing for that particular measure. Health Plans can also receive an additional half point for their accreditation status. The domains used by NCQA in their measures include patient experience, prevention and population, and treatment. The source for patient experience is the CAHPS survey. There are five measures that are each weighted at 1.5. Example measures: Getting Care Quickly, Rating of Primary Care Doctor. The source for the prevention and population domain is HEDIS. There are eighteen measures in this domain, two are triple weighted. Example measures: Child Immunizations, Breast Cancer Screening, Postpartum Care. The third and largest category is treatment. HEDIS is also the source for this domain. There are twenty-eight measures, three of which are triple weighted. Example measures: Glycemic Control for Patients with Diabetes, Controlling High Blood Pressure, Asthma Medication Ratio, and Follow-up after ED visit for Mental Illness. NCQA awarded HPSM a score of 4.0 for 2025. For context, the highest rated health plan for Medicaid received a 4.5.

John Okonne, Director of Medicare, provided an overview of the Medicare Stars written framework and announced HPSMs preliminary results for measurement year 2024. The Medicare star ratings are used by the Center for Medicare and Medicaid Services (CMS) to measure the quality of health and drug services HPSM provides to their CareAdvantage (CA) members. Star ratings are based on a scale of one to five, with five stars being the highest rating. These rates are calculated as a weighted average that compares the performance of all Medicare plans. There is a two-year lag. Star ratings for 2025 are based on data from 2023. The star ratings for 2026 will be based on data from 2024. The lag is known as the star rating cycle. There are four levels for the star ratings: measure, domain, summary and overall. There are five domains for Part C and four domains for Part D. Not all are weighted equally. Plans are graded on a curve. CMS pulls Star measures from already existing data sources that reflect clinical, operational, and member experience outcomes. Star ratings are important because they are a regulatory requirement, they support membership growth and are a financial incentive. High performing plans receive a 5% quality bonus payment. In Measurement year 2024/Star year 2026 HPSM maintained 3 stars overall, Part C also received 3 stars and Part D received 3.5 stars. Nineteen measures improved year over year, seven were statistically significant, HPSM received four stars in the "Health Plan Quality Improvement"

measure and five stars in eight different measures. Mr. Okonne was asked if he knows what the impact to member experience, financial health, and membership growth will be based on anticipated cuts to Medicare. He responded that there will definitely be impacts, however they hope to mitigate them with the default enrollment pilots which enable HPSM to enroll members 90 days before they become eligible for CA. This should help to maintain membership for the next couple of years. Dr. Esguerra also noted that HR1 and much of the federal activity focuses on Medicaid. Medicare will not see many cuts but rather increased scrutiny of financial activities and fraud, waste, and abuse. There was a question about CA enrollment numbers, Mr. Okonne replied that this is the first year where HPSM has maintained net positive enrollment every month. Mainly due to default enrollment, Part A buy-in and monthly sales and marketing outreach.

Megan Noe, Director of Population Health, closed by reviewing general awareness and priority topics for clinical health outcomes improvement. She shared their general approach and how they arrive at the priority focus areas. Much of the data and information comes from HEDIS measures, MCAS measures and STARS. This data is fed into the Population Needs Assessment (PNA). They also look at member demographics, condition prevalence, and disparities and inequities that occur within those measures. Pharmacy claims data, social determinants of health data, and member engagement and utilization are also considered. This information is then tied into the programmatic gap assessment. They use that information to look at areas where there is low performance, decreasing trends on rates and gaps for HPSM members. They reconcile this with what they already have in place and look for areas where gaps still exist and where they want to focus on improvement. This is how they arrive at their priorities. Ms. Noe also explained their approach to assessing disparities and reviewed health disparities from the 2025 PNA. The disparities include primary care engagement, diabetes and hypertension management, cancer screenings, and oral health evaluations. She closed by sharing the priority areas for improvement which include perinatal health, youth health, adult preventative health, and chronic condition management. There was some discussion with the Commission about disparities and why they exist. It was noted that fundamental access plays a big part; members feeling like they are welcomed and that they are part of the community is important. In many cases this underlying piece has not been addressed. They also discussed how chronic condition management is an issue that might benefit from community support. Group activities with members sharing the same condition may provide the support and motivation many need.

5.2 HPSM Investing for the Future - Continued Discussion: Chris Esguerra, M.D., HPSM Chief Medical Officer, resumed discussions regarding a new entity. This is grounded in HPSM's work of investing for the future, goal six in the strategic initiative. This goal will ensure HPSMs long term sustainability to advance their mission by evaluating and pursuing opportunities to expand or invest differently. He is seeking input and feedback from the

Commission on the structure and governance. With an uncertain future looming, he reviewed HPSM's prioritization that starts with core operations, then long-standing precedents, and finally new opportunities. He reviewed the map created at the retreat in April which highlights the top priorities. He added "preserving healthcare coverage" as an emerging priority. Dr. Esguerra listed the capabilities and community impact a new entity would provide and listed HPSMs limitations.

He provided more detail about the Inland Empire Health Plan (IEHP) Foundation created by IEHP and the SCAN Foundation created by Scan Health Plan. One of the questions for the creation of the HPSM foundation is the legal structure, which would be a 501(C)(3), a non-profit entity that can receive and distribute money from a non-profit perspective. He also spoke briefly about a 501(C)(4). The latter is about policy and advocacy, something for later consideration. Dr. Esguerra noted that governance for this entity is about the level of influence and community representation. When setting up the board and by-laws, the composition of the board is a critical decision, especially regarding influence and aligning with HPSMs "Healthy is for Everyone" mission. He asked the Commission what governance should look like, how much influence and control should HPSM have, what role HPSM should play, and what vision and alignment should be present? These decisions will come after more information gathering and discussions about governance, and purpose. There were some questions about who might sit on the board, funding for the new entity, and if it might help with the MLR calculation in some way. Dr. Esguerra noted that discussions about funding and the impact to MLR will be discussed at a later time. There was discussion about HPSMs influence being a positive factor for the foundation in terms of serving the public. When the entity reaches out for private dollars, they can say they are uniquely situated to deliver results to those who are underserved in the community based on the goals and alignment that has been achieved through the health plan. Next steps include coming back to the Commission with a proposal to allow HPSM to explore the creation of this entity and to get started with the set up.

6. Report from Chief Executive Officer: There was no CEO report for October.

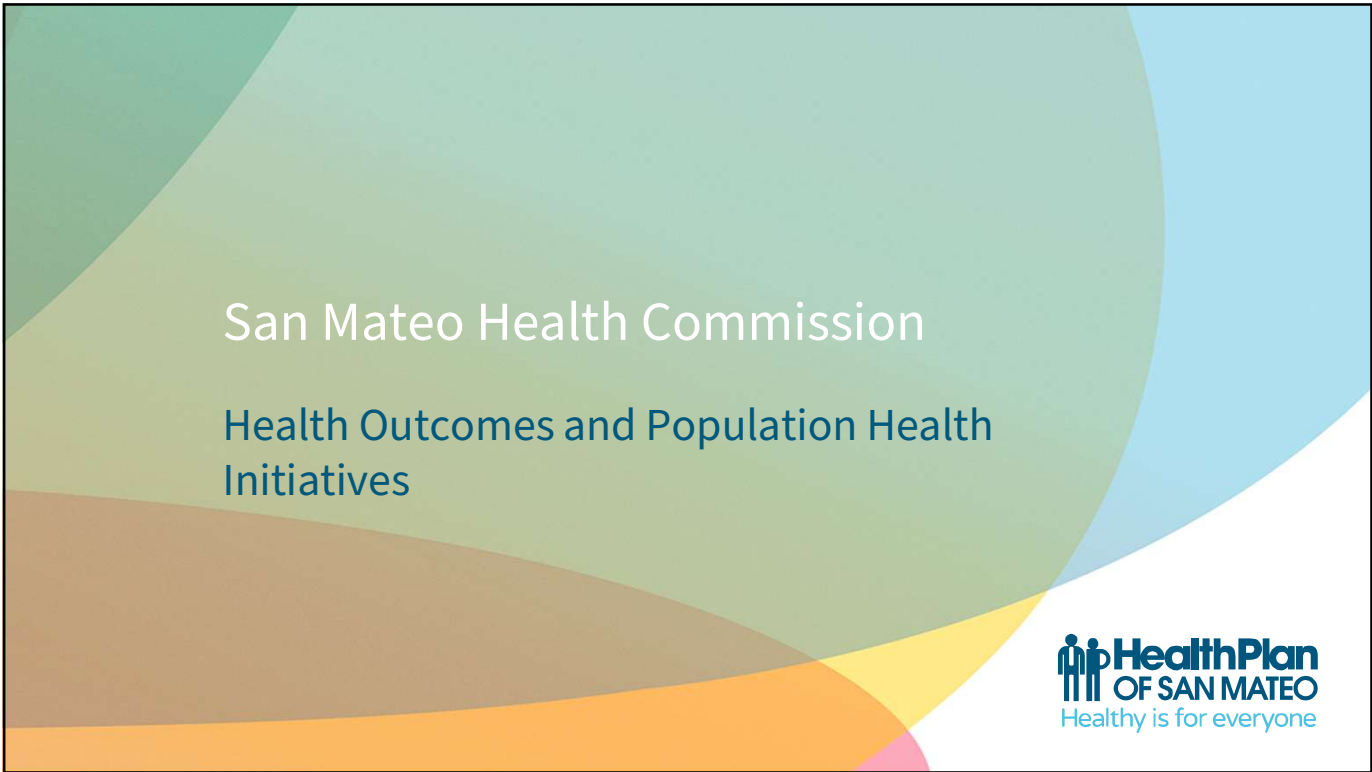
7. Other Business: Chris Esguerra, HPSM Chief Medical Officer, informed the group that Commissioner Gaskari will be filling an open position on the Finance/Compliance Committee effective immediately.

8. Adjournment: The meeting was adjourned at 1:52 pm by Commissioner Santamaria.

Submitted by:

M. Heryford

M. Heryford, Clerk of the Commission



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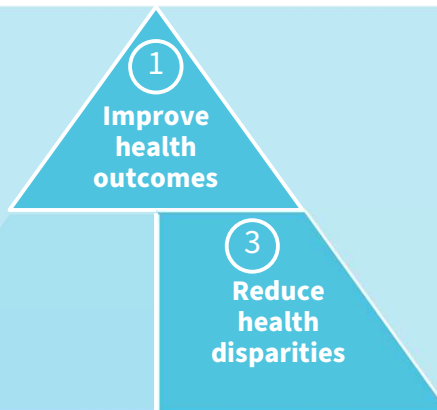
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Our themes today



Area of Focus 1:

Better Health Care Experiences and Outcomes for all Members



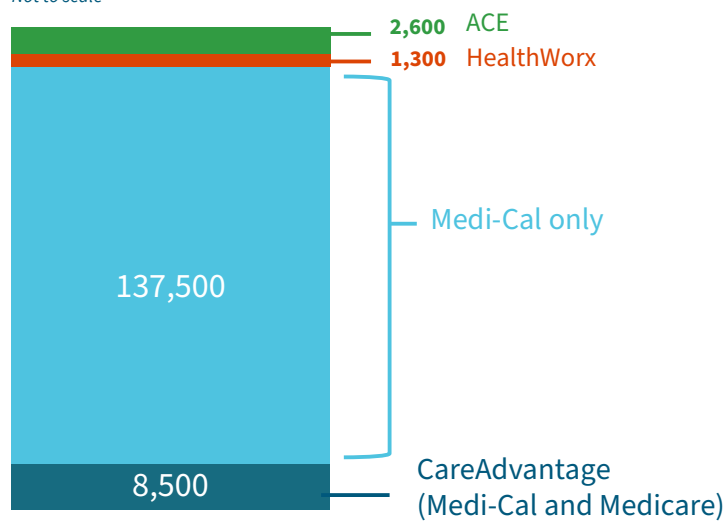
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How we measure outcomes



HPSM Members

Not to scale



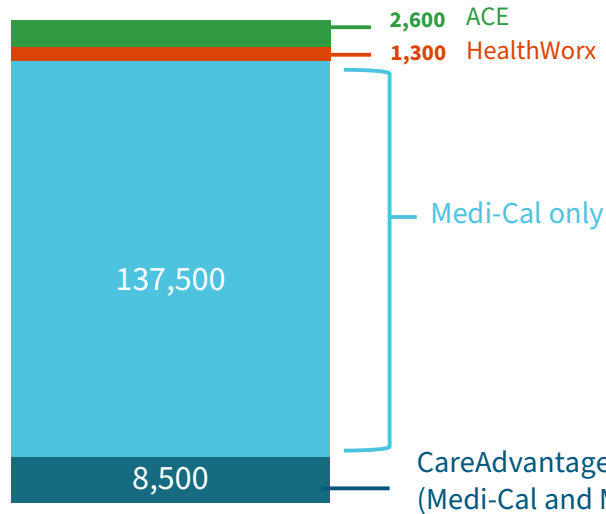
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How we measure outcomes

HPSM Members

Not to scale



Outcomes Methodology

Not to scale

NCQA Health Plan
Rating &
accreditations

Medicare Stars
rating

Population
Health
Initiatives

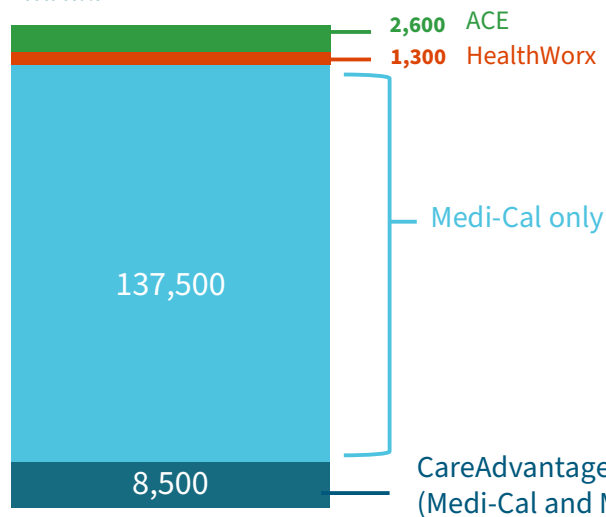
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How we measure outcomes

HPSM Members

Not to scale



Outcomes Methodology

Not to scale

**NCQA Health Plan
Rating &
accreditations**

Medicare Stars
rating

Population
Health
Initiatives

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2025 NCQA Health Plan Rating

Presented by

Nicole Ford, Director of Quality Improvement



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NCQA Health Plan Rating



- A rigorous assessment of health plans' clinical quality and member satisfaction
- Health plans are rated in 3 categories: Private/Commercial, Medicare Advantage (not supplemental or Special Needs), and Medicaid
- Ratings are based on measures of clinical quality from NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) and patient experience from Consumer Assessment of Healthcare Providers and Systems (CAHPS) that are collected and submitted by health plans annually
- Overall rating calculated on a 0–5 scale in half-points (5 is highest), displayed as Stars and rounded to the nearest half-point

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Rating Methodology



Overall score is a weighted average of all measure



Each measure is assigned a score on a 1 to 5 scale. Measure performance is determined by plan submitted rate for each measure compared to the 10th, 33.33rd, 66.67th and 90th measure percentiles for **all** submitting health plans.



Additional 0.5 Star for NCQA Health Plan Accreditation status

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Measure Rates and Percentiles

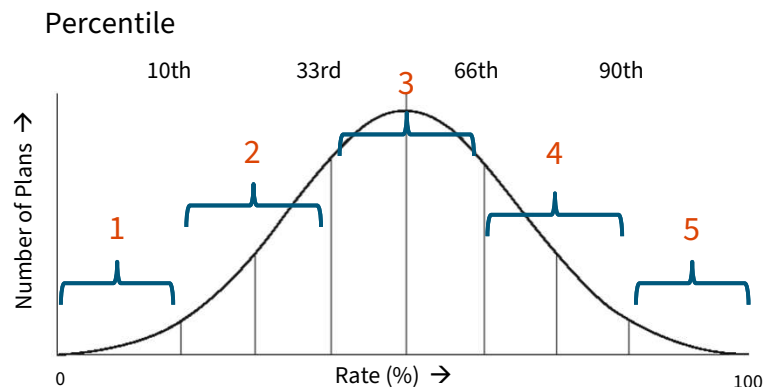


Result:

$$\text{Measure Rate: } \frac{\text{Service or Result}}{\text{Eligible Population}} = \frac{1,008}{1,628} = 61.92\%$$

Performance:

How does this rate compare to that of all the other plans?



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NCQA HPR Domains



Patient Experience

- Source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- 5 measures, weighted at 1.5x each
- Example Measures: Getting Care Quickly, Rating of Primary Care Doctor

Prevention & Population

- Source: Health Effectiveness Data Information Set (HEDIS)
- 18 measures, 2 weighted 3x
- Example Measures: Child Immunizations, Breast Cancer Screening, Postpartum Care
- Population measures are plan's ability to collect race and ethnicity of members from direct sources (i.e. member, state/CMS) as well as member's spoken and written language preferences.

Treatment

- Source: HEDIS
- 28 measures, 3 weighted 3x
- Example Measures: Glycemic Control for Patients With Diabetes, Controlling High Blood Pressure, Asthma Medication Ratio, Follow-up after ED visit for Mental Illness

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HPSM's 2025 NCQA Health Plan Rating



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reportcards.ncqa.org/health-plans

San Mateo Health Commission dba Health Plan of San Mateo

California



Health Plan Rating[®]

★★★★★ 4.0 of 5

Other Accreditations, Certifications, and Distinctions

✓ Health Equity Accreditation

INSURANCE TYPE ⓘ

Medicaid

PRODUCT TYPE

HMO

NEXT REVIEW DATE

12/14/2027

MEMBERS ENROLLED

147,972

EVALUATION PRODUCT

Renewal Survey

WEBSITE

<http://www.hpsm.org>



Last update: 09/15/2025
Ratings are updated annually (September)

Medi-Cal

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What does our rating mean?

- Comparative performance for health plans
- Medicaid:
 - 4.5 highest rating ; 14 plans of 212 with a numeric rating, 3 Medi-Cal plans
 - 4.0 rating: 48 plans total, 5 Medi-Cal plans
- 11 plans (8 Commercial and 3 Medicare) received a 5.0 Star Rating out of 998



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Questions?

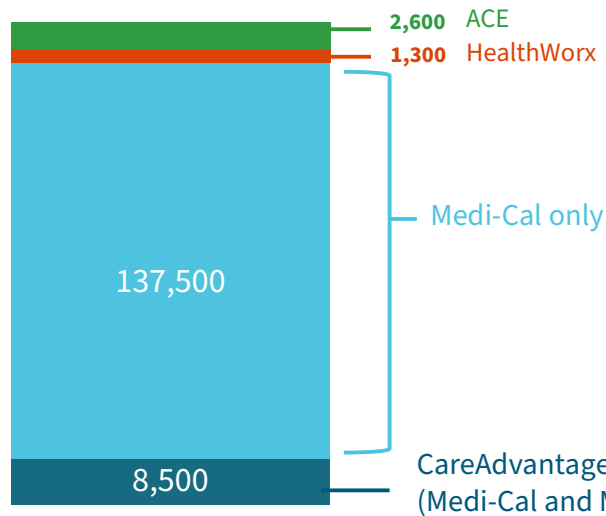


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How we measure outcomes

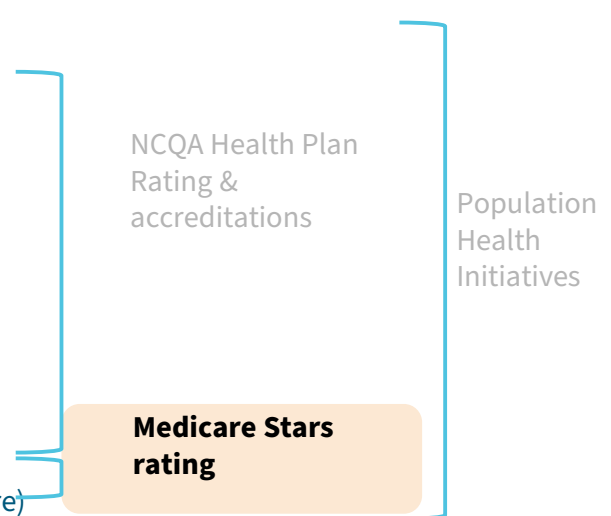
HPSM Members

Not to scale



Outcomes Methodology

Not to scale



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Medicare Star Ratings Oversight

Measurement Year (MY) 2024/Star Year (SY) 2026

Presented by:
John Okonne, Director of Medicare



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Objectives



Inform Health Commission

Provide overview of Medicare Star Rating framework



Report Results

Announce HPSM's Medicare Star Ratings results

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Agenda



- *What are Medicare Star Ratings?*
- *Why are Medicare Star Ratings Important?*
- *How did we Perform?*

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What are Medicare Star Ratings?

Medicare Star Ratings 101 Refresher / Overview



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What are Medicare Star Ratings?



☆☆☆☆☆	5 Stars: Excellent
☆☆☆☆	4 Stars: Above Average
☆☆☆	3 Stars: Average
☆☆	2 Stars: Below Average
☆	1 Star: Poor

- Measures the quality of the health and drug services we provide to our CareAdvantage members
- Based on a scale of 1 to 5 stars (*with 5 Stars being the highest rating*). Compared to all MA[^]
- There is a two-year lag (*data from measurement year, is used to calculate results, two years later*)

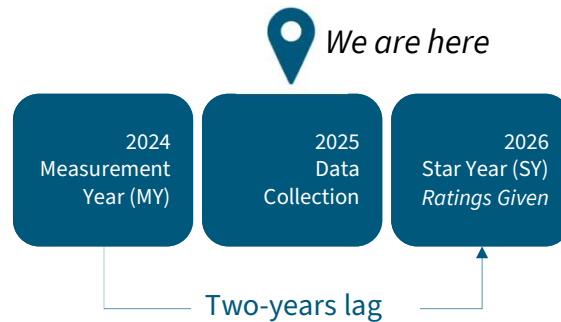
[^]Compares our performance against all Medicare Advantage plans which allows for side-by-side evaluation

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What are Medicare Star Ratings?

Star Rating Cycle Two-years Lag



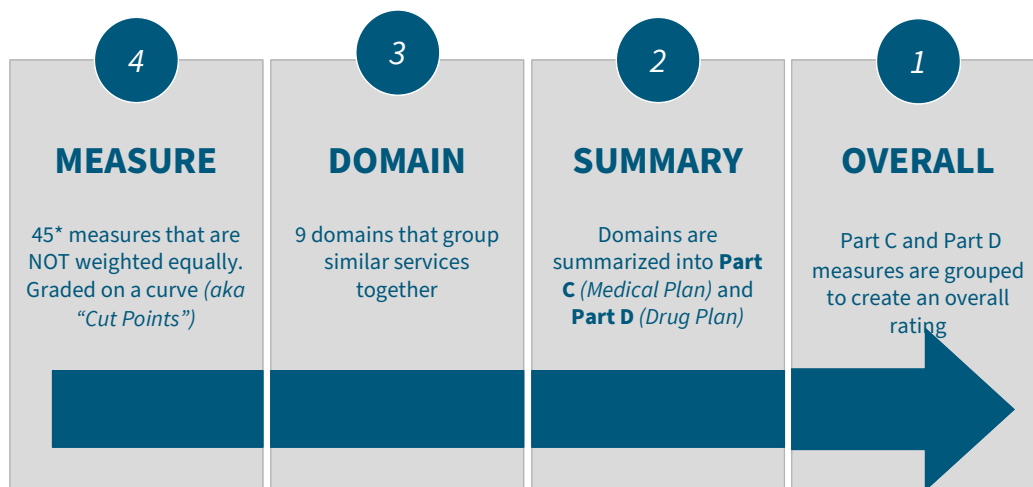
- The *Star Rating Cycle* consists of MY, Data Collection, and SY
- Two-years lag between performance period and rating period
- Measure Year (MY) 2024 performance, dictates Star Year (SY) 2026 Star Ratings

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What are Medicare Star Ratings?

Four Levels of the CMS Star Ratings Framework



*Five Type of Measures: "Outcome" reflect improvements; "Intermediate Outcomes" reflect actions taken (EX: Blood Sugar Controlled); "Access"; "Patient Experience"; "Process"; "Quality Improvement". Aligns with the CSM "Meaningful Measures" framework.

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What are Medicare Star Ratings?



Staying Healthy: Screenings, Tests, & Vaccines

Help members to maintain healthy lifestyle through regular screening.



Managing Chronic (Long Term) Conditions

Help members to manage chronic conditions through Care Mgt.



Member Experience with Health Plan

Help members to have high-quality experience through care coordination.



Member Complaints and Changes in the Health Plan's Performance

Help members to address their concerns by resolving issues.



Health Plan Customer Service

Help members to get connected to TTY, Interpreter; review / decide appeals timely.

There are 5 Part C Domains

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What are Medicare Star Ratings?



Drug Plan Customer Service

Help members to get connected to TTY, Interpreter; review / decide appeals timely.



Member Complaints and Changes in the Drug Plan's Performance

Help members to address their concerns by resolving issues.



Member Experience with Drug Plan

Help members to have high-quality experience through care coordination.



Drug Safety & Accuracy of Drug Pricing

Help members to adhere to medication at accurate prices.

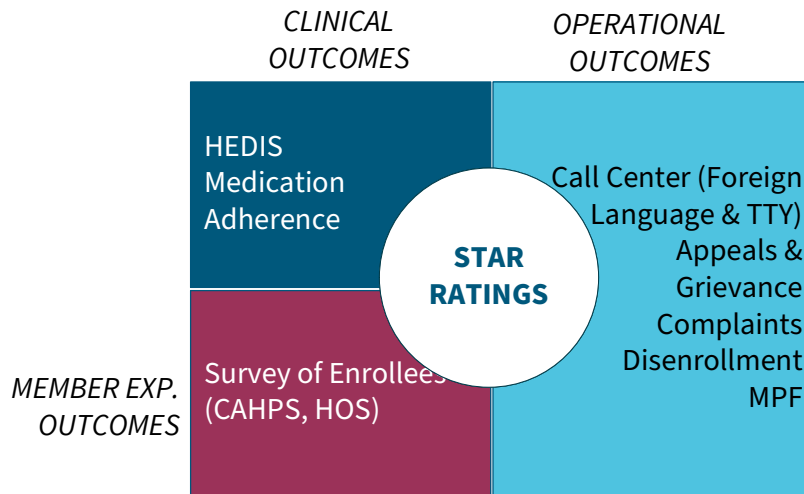
There are 4 Part D Domains

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What are Medicare Star Ratings?

CMS pulls Star measures from already existing data sources



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Why are Medicare Star Ratings Important?



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Why are Medicare Star Ratings Important?

The Business Case & Value Proposition



A Regulatory Requirement

Low Performance/Expansion Denial:
Two consecutive years of < 3 Stars
(any combination of a Part C, D or Overall)



Supports Membership Growth

A Useful Yardstick for Members to
use to Decide Plan Selection: As
such, may impact retention / growth



A Financial Incentive

More Benefits for Members: High
performing (4+) health plans receive
a 5% Quality Bonus Payment

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How did we Perform in MY2024 / SY2026?



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Star Ratings Dashboard MY24/SY26



3.0 Stars: Overall Rating

3.0 Stars: Part C

3.5 Stars: Part D

- ✓ 19 measures improved YOY
- ✓ 7 of which were “statistically significant”
- ✓ 4 Stars in “Health Plan Quality Improvement” measure
- ✓ 5 Stars in eight measures
- ✓ Continue to double down on Med. ADH & CAHPS



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THANK YOU!
Questions?

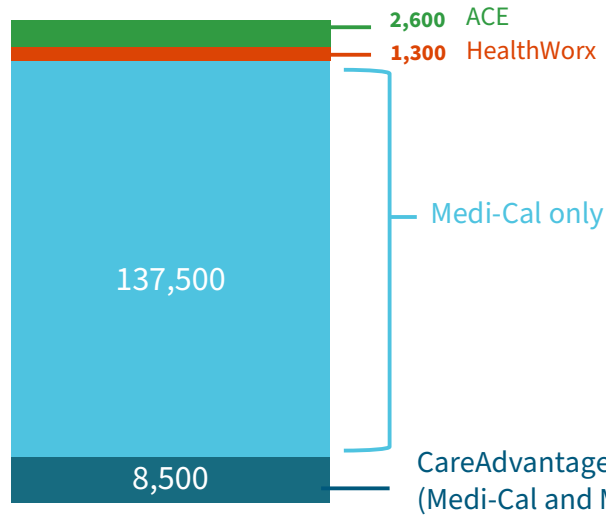


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How we measure outcomes

HPSM Members

Not to scale



Outcomes Methodology

Not to scale

NCQA Health Plan
Rating &
accreditations

Medicare Stars
rating

**Population
Health
Initiatives**

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2025/2026 Population Health Improvement Areas

Megan Noe, Director of Population Health

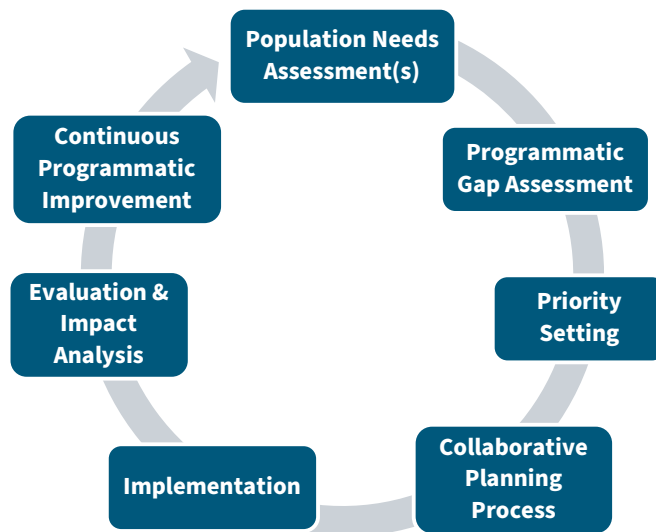
Prepared by:

Talie Cloud, Population Health Program Manager



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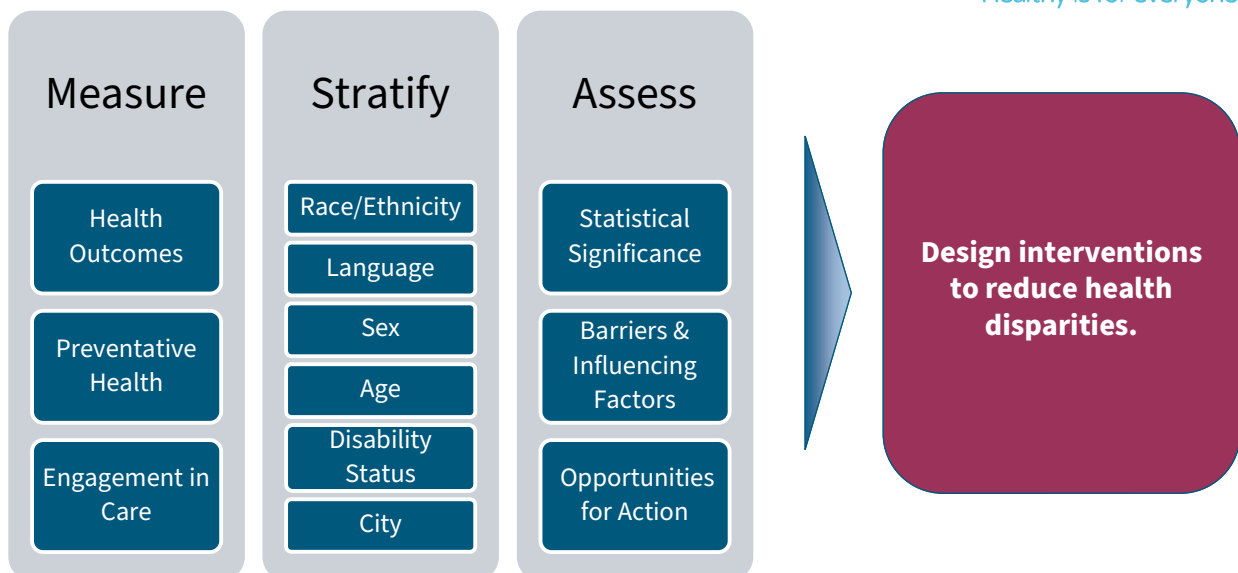
Population Health Strategy



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Process to assess for disparities



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Health Disparities Analysis At A Glance

HPSM Members, 2025 PNA



Demographic Variable	Subgroup	Persistent Disparities
Age	17-21	- Primary care engagement - Diabetes & Hypertension management
Race/Ethnicity	Black	- Diabetes & Hypertension management - Cancer screenings (breast, colon)
Language Preference	Portuguese	- Primary care engagement - Oral health evaluations
	English	- Primary care engagement - Diabetes & Hypertension management - Cancer screenings (breast, colon, cervical)
Disability Status	People with Disabilities	- Diabetes & Hypertension management - Cancer screenings (breast, cervical)

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Health Outcomes Priority Areas



Perinatal Health



- Prenatal Access
- Care Coordination

Youth Health



- Well Child Visits

Adult Preventive Health



- Engagement with Care
- Osteoporosis Screening

Chronic Condition Management



- Hypertension Management

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Thank you!



Invest for the Future HPSM Strategic Goal 6

Chris Esguerra, MD



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Agenda



- Provide a recap of our HPSM Strategic Initiative, Invest for the Future (Goal 6) efforts to date
- Further discuss the structure, governance, and purpose of the new entity
- Gather input and feedback from the Commission

2



3

Goal 6: Invest for the Future

HealthPlan
OF SAN MATEO
Healthy is for everyone

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

⑥
Future Investment

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

4

Grounding: approaching uncertainty with clear high-level priorities



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

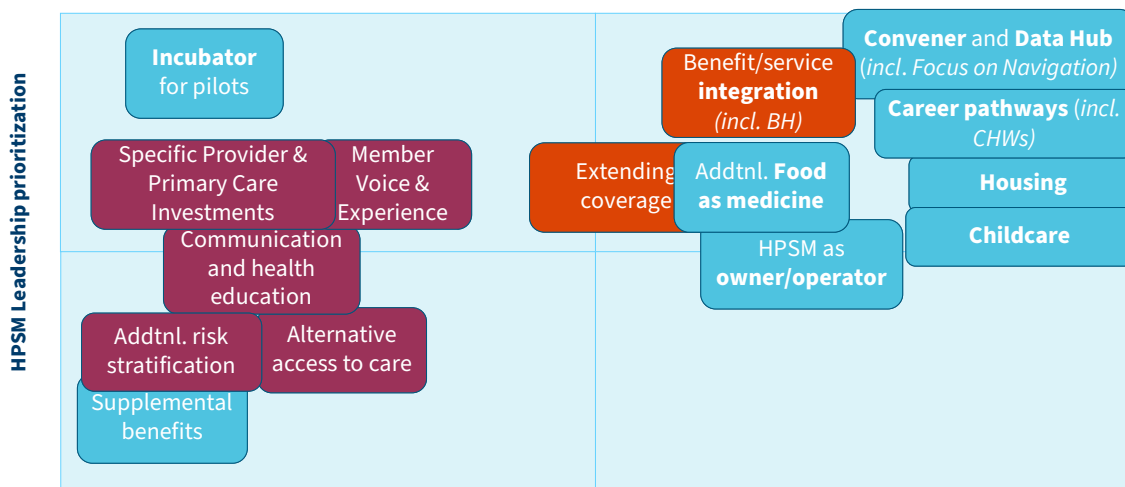
3

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

5

Retreat x HPSM Leadership Prioritization

Prioritization of themes



Commission Retreat Prioritization



1. Core Operations



2. Long-standing precedents



3. New opportunities

6

6

Top priorities in brief



What

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

* Early exploration and/or piloting underway in these areas

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

7

7

Timeline



8

8

We previously discuss the Why
Let's consider the What



9

Why a New Entity?



New Capabilities, Community Impact

- Focuses on the community broadly
- Anchor funder
 - Receiving and distributing
- Organizer and convener
- Entity as operator
- Testing and learning
 - Supporting and/or deploying pilots

Address HPSM's Limitations

- Focus on core operations as defined by regulations and longstanding precedents
- Efforts limited to HPSM members

10

10

Existing Examples – More Detail



Foundation Overview

- Established 2021
- Vision: We will not rest until the promise of Vibrant Health exists for all of us
- Focus areas:
 - Access and Equity
 - Reduce and manage chronic conditions
 - Improve outcomes

Foundation Governance

- Two plan seats on the board (out of 10 seats)
- Other board seats come from the community

Foundation Overview

- Established 2008
- Vision: where all of us can age well with purpose
- Focus areas:
 - Data equity
 - Models of care and financing
 - Financial security
 - Healthy equity in aging

Foundation Governance

- Three seats occupied by individual on both SCAN (health plan) and the SCAN foundation (out of 13)

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11

The What: New Entity Considerations



Legal

- 501(c)(3) Foundation
- For later consideration:
 - 501(c)(4) Policy and Advocacy

Governance

- HPSM Influence and Community Representation
- Board composition

Mission

- Align with HPSM? County?
- Broader community mission?

12

12

Discussion



- What should governance look like?
- How much influence/control should HPSM have?
- What role should the new entity play in the community?
- What vision/mission alignment should be present for the new entity?

13

13

Next Steps



- We will consolidate and bring back a proposal to a future Commission meeting
- Thank you for your feedback

14

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Thank you



AGENDA ITEM: 5.1

DATE: November 12, 2025

Item 5.1 – State & Federal Health Policy Update

A presentation will be provided at the meeting.

MEMORANDUM

AGENDA ITEM: 5.2

DATE: November 12, 2025

DATE: November 05, 2025

TO: San Mateo Health Commission

FROM: Chris Esguerra, MD, Chief Medical Officer

RE: Authorizing HPSM to Explore the Formation of a 501(c)(3) organization

Recommendation:

Authorize HPSM management to initiate the process of establishing a non-profit 501(c)(3) organization for the purpose of serving the broader San Mateo County community as an anchor institution.

Background:

Following the Commission retreat in April 2025, overlapping Commission and HPSM leadership priorities included promoting employment opportunities in San Mateo County starting with community health workers; supporting housing access; developing service and system navigation; addressing childcare needs; enhancing the behavioral health ecosystem; promoting food as health; and addressing the emerging issue of preserving healthcare coverage.

In addition, HPSM's prioritization approach is as follows: 1) core operations that fulfill our mandate as a community-organized Medi-Cal and Duals plan; 2) long-standing precedents aligned with our Mission, Vision, and local priorities; and 3) new opportunities to consider advancing our strategic goals, including long-term sustainability.

Further work from HPSM leadership identified where HPSM can fulfill the identified priorities. The work also identified gaps that pointed to the consideration of a new organization.

Discussion:

Based on Commission discussions, the new organization would fulfill two purposes:

1. Address HPSM's limitations
 - a. HPSM's efforts are limited to HPSM members. When a San Mateo County resident is no longer an HPSM member, we do not have their data or capability to interact with them
 - b. HPSM's top two prioritization items focus on core operations as defined by regulatory mandates and long-standing precedents, especially in uncertain times
2. Need for new capabilities with a broader community impact
 - a. Serve as an anchor and convening funder, receiving and distributing public and private funds with a focus
 - b. Serve as organizer and convener
 - c. Lead testing and learning such as supporting pilots
 - d. Potentially serve as an operator

Initial discussions on the governance, mission, and capabilities of the organization included the following principles:

- Strong HPSM influence on the board with community voice
- A mission that aligns with HPSM and the County
- The ability to align private and public funding
- Leverage HPSM's expertise

The recommendation to explore the formation of a 501(c)(3) begins the process to gather the necessary materials and map out the process for formation.

What is not addressed in this recommendation are decisions on bylaws, board composition, and mission/vision; determination of the activities of the organization; and funding for the organization. These discussions will be brought to subsequent Commission meetings.

Fiscal Impact:

This recommendation authorizes HPSM to incur up to \$250,000 in costs related to legal, financial, and regulatory consultation for the formation of the 501(c)(3) organization.

**RESOLUTION OF
THE SAN MATEO HEALTH COMMISSION**

**IN THE MATTER OF APPROVAL OF
COMMITTEE AND ADVISORY GROUP MEMBERSHIP
AND MEMBERSHIP REPRESENTATION FOR 2025**

RESOLUTION 2025 -

RECITAL: WHEREAS,

- A. The San Mateo Health Commission is responsible for oversight of HPSM and its important role as a community health plan and steward of public dollars;
- B. HPSM's mission is to ensure that San Mateo County's residents with greater needs have access to high-quality care services and support so they can live the healthiest lives possible; and
- C. HPSM has identified its limitations and an opportunity to broadly serve the San Mateo County community through the formation of a 501(c)(3) organization.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

- 1. The San Mateo Health Commission authorizes HPSM to explore the formation of a 501(c)(3) organization
- 2. The San Mateo Health Commission authorizes the Chief Executive Officer to spend up to \$250,000 for legal, financial, and regulatory consultation related to the 501(c)(3) formation

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of November 2025 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

Chairperson

ATTEST:

APPROVED AS TO FORM:

BY: _____
M. Heryford, Clerk

Kristina Paszek
DEPUTY COUNTY COUNSEL

MEMORANDUM

AGENDA ITEM: 5.3

DATE: November 12, 2025

DATE: November 05, 2025

TO: San Mateo Health Commission

FROM: Amy Scribner, Chief Health Officer
Pat Curran, Chief Executive Officer

RE: Community Investment to Support Local Food Needs

Recommendation:

Approve HPSM's CEO to grant up to \$500,000 to San Mateo County food banks, distribution centers, or other food related community-based organizations to support food related needs for San Mateo County residents and HPSM members.

Background:

Food insecurity plagues the United States. The USDA Economic Research Services estimated 13.5% of U.S. households were food insecure in 2023. In San Mateo County, nearly 35,000 individuals and 22,000 households receive food assistance via CalFresh. California has noted food insecurity as a major issue statewide. As a result, in addition to federal benefits like SNAP/CalFresh and Women, Infants and Children's (WIC) benefits, California has invested locally in managed care plans through the Medically Tailored Meals/Medically Supported Food Community Supports and the California Universal Meals Program. Despite efforts at the national and statewide level, gaps continue to exist. Those gaps have become more pronounced with federal cuts on SNAP (CalFresh locally) benefits.

Discussion:

Living in San Mateo County is expensive and for HPSM Medi-Cal recipients' access to core services like CalFresh/SNAP through the Human Services Agency help make food more accessible. Due to proposed cuts from H.R. 1, this access will become more challenging and may result in loss of food assistance or reduced benefits, increasing pressure on local food banks, pantries, and safety net programs. Providing grants to local food agencies aligns with HPSM's mission to ensure that San Mateo County's residents have access to high quality care services and supports so they can live the healthiest lives possible. This grant will also support San Mateo County's recent allocation for food resources and will ensure that HPSM members continue to have consistent access to food resources, despite federal changes and cut.

Fiscal Impact:

HPSM will provide up to \$500,000 of one-time grants to local organizations focused on supporting access to food resources for San Mateo County residents, in turn supporting HPSM members who rely on food resources each month.

DRAFT

**RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION**

**IN THE MATTER OF APPROVAL OF A ONE TIME GRANT OF
\$500,000 TO LOCAL FOOD RESOURCES IN SAN MATEO COUNTY TO
ADDRESS GAPS AND SUPPORT ACCESS TO FOOD RESOURCES.**

RESOLUTION 2025 -

RECITAL: WHEREAS,

- A. HPSM members and other low-income San Mateo County residents experience gaps in consistent access to food resources.
- B. Proposed changes federally, via H.R. 1, will impact CalFresh access, which may result in loss of food assistance or reduced benefits, increasing pressure on local food banks, pantries, and safety net programs.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

The San Mateo Health Commission authorizes HPSM's CEO to grant up to \$500,000 to San Mateo County food banks, distribution centers, or other food related community-based organizations to support food related needs for San Mateo County residents and HPSM members.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of November, 2025 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

Bill Graham, Chairperson

ATTEST:

APPROVED AS TO FORM:

BY: _____

M. Heryford, Clerk

Kristina Paszek

DEPUTY COUNTY ATTORNEY

MEMORANDUM

AGENDA ITEM: 5.4

DATE: November 12, 2025

DATE: November 5, 2025
TO: San Mateo Health Commission
FROM: Patrick Curran, CEO
RE: Formation of CEO Search Committee

Recommendation:

I recommend that the HPSM Health Commission form a Search Committee consisting of no more than five (5) current members to lead the recruitment for a new HPSM Chief Executive Officer. I also recommend that the Search Committee have at least one meeting before the end of 2025.

Background:

As I have already informed the commissioners, I intend to retire in October 2026. I am so grateful for the opportunity to serve in this role for what will be almost five years by the time I retire. I enter this next phase of life knowing that HPSM is in good hands with your leadership and the dedication of more than 400 mission-driven staff.

I am announcing my retirement now so that the Commission will have several months to conduct a thorough search and identify my successor. At this point, I recommend the formation of a committee with no more than five (5) Health Commission members (less than a quorum) to facilitate the search for a new CEO. A committee process can perform a substantial part of the recruitment and recommend finalists to be interviewed by the Commission as a whole.

Regarding the Search Committee, I recommend that Bill Graham and Manny Santamaria, as the Chair and Vice-Chair, as well as Mike Callagy, who will help coordinate the search through San Mateo County's Human Resources (HR) team, be part of the search committee, as well as two additional members. Having the County's HR team lead the search process will ensure confidentiality as candidates move through the process.

There are no requirements for the make-up of this committee, so the Health Commission can select in any way it sees fit. I am confident that any members you select will perform this work with passion and skill, as you do with everything else.

I look forward to meeting with the Search Committee and outlining a process for recruitment, including timelines, in the next few weeks. One of the first decisions for the Search Committee will be whether to engage a national executive search firm.

DRAFT

**RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION**

**IN THE MATTER OF A FORMATION OF A SEARCH COMMITTEE FOR A NEW CHIEF EXECUTIVE OFFICER OF
HEALTH PLAN OF SAN MATEO.**

RESOLUTION 2025 -

RECITAL: WHEREAS,

- A. The Chief Executive Officer of the Health Plan of San Mateo has announced his retirement effective October 2, 2026; and
- B. The San Mateo Health Commission must search for and identify a successor for the CEO position.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

- 1. The San Mateo Health Commission approves the formation of a Search Committee to include no more than five commissioners; and
- 2. Authorizes the Search Committee to oversee the search for a new CEO.

Members of the Search Committee:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of November, 2025,
by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

Bill Graham, Chairperson

ATTEST:

APPROVED AS TO FORM:

BY: _____
M. Heryford, Clerk

Kristina Paszek
DEPUTY COUNTY ATTORNEY

AGENDA ITEM: 6.0

DATE: November 12, 2025

Item 6.0 – No CEO Report for November Meeting