HealthPlan OF SAN MATEO
Healthy is for everyone

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THE SAN MATEO HEALTH COMMISSION
Regular Meeting
September 10, 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/KUj2EpN9Yjc?feature=share Please note that while there will be 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 Agreement with San Mateo County for CHA/CHIP support
   - 4.2 Annual Review of Compliance Program Materials
   - 4.3 CAC Minutes (draft) – July 16, 2025
   - 4.4 Finance/Compliance Committee Minutes (draft) – August 18, 2025
   - 4.5 San Mateo Health Commission Meeting Minutes (draft) - July 09, 2025
5. **Specific Discussion/Action Items**
   - 5.1 Approval of $7.5M for Primary Care Investment Grants*
   - 5.2 Update on Baby Bonus Program
   - 5.3 Update on HPSMs Investing for the Future/Goal 6 efforts
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.

AGENDA ITEM: 4.1

DATE: September 10, 2025

MEMORANDUM

DATE: September 3, 2025

TO: San Mateo Health Commission

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

RE: Approval of Community Health Assessment (CHA)/Community Health Improvement Program (CHIP) funding grant

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Recommendation

Approve HPSM's CEO to grant $340,000 of funding to San Mateo County Health for CHA/CHIP support.

Background information

While there is currently no requirement for a Local Health Jurisdiction (LHJ) to complete a Community Health Assessment (CHA)/Community Health Improvement Program (CHIP), those like the County of San Mateo that do, operate on varying cycles based on public health accreditation, hospital community needs assessments, and/or or other locally determined timelines. As part of the California Advancing Innovation in Medi-Cal (CalAIM) Population Health Management Initiative, all Medi-Cal Managed Care Plans (MCPs) are required to engage in local health department CHA/CHIP processes to fulfill their Population Needs Assessment (PNA) requirement.

As part of meaningful participation in the LHJs' CHAs/CHIPs, Managed Care Plans (MCPs) are required to contribute resources to support the LHJs' CHAs/CHIPs in the service areas where they operate, in the form of funding and/or in-kind staffing, starting on January 1, 2025. MCPs are strongly encouraged to contribute these resources in a manner that is at least commensurate with the number of Medi-Cal members served by the MCP within a given LHJ. Starting on January 1, 2024, MCPs were required to work with LHJs to determine what combination of funding and/or in-kind staffing the MCP would contribute to the LHJs' CHA/CHIP process and report this to the Department of Healthcare Services (DHCS).

In 2024, HPSM committed to in kind donations (staff time) to lead and participate in improvement activities via all 3 CHIP workgroups and the Steering Committee to San Mateo County's LHJ.

In 2025, Kaiser and HPSM received a joint proposal to provide $600,000 in funding to support CHA and CHIP work in San Mateo County. More specifically, the requests were centered around 3 areas: data collection for the next CHA process ($400,000 total), training and capacity building for CHIP members ($125,000 total), and a community navigation landscape analysis survey and convening of community health workers and community members to increase understanding of the current landscape of community navigator services, as well as identify best practices and opportunities for improvement and expansion of services ($75,000 total). HPSM reviewed all requests utilizing decision-making criteria

to determine appropriate funding levels granted. These criteria centered on non-duplication, proposed outcomes of funding advancing health in HPSM population, and alignment with HPSM's strategic plan. HPSM rejected two of the funding requests: Community Landscape (CHW) given the overlaps with other work in this space and Training and Capacity Building due to lack of outcomes. However, HPSM recommends approval of the requested funding for the data collection for the CHA work. In coordination with Kaiser who will be providing a $60,000 grant, HPSM recommends providing a $340,000 one-time funding grant to County Health to support the LHJ CHA data collection process (to amount requested) as it will benefit HPSM members as well as the larger San Mateo County community and aligns with HPSM's Strategic Plan. Additionally, HPSM will continue to provide in-kind staffing (via staff time) to participate in or facilitate (all 3) CHIP workgroups.

Fiscal Impact

HPSM will provide $340,000 to San Mateo County Health to support the next LHJ Community Health Assessment (CHA) process and can be allocated toward identified improvement activities that will support HPSM members and the community in San Mateo County.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF A
GRANT OF $340,000 TO SAN MATEO COUNTY HEALTH
TO SUPPORT A REQUIRED LHJ COMMUNITY HEALTH ASSESSSMENT

RESOLUTION 2025 -

RECITAL: WHEREAS,

A. HPSM is required to meaningfully participate and provide resources to the Local Health Jurisdiction in support of the Community Health Assessment (CHA) and Community Health Improvement Program (CHIP)
B. HPSM will continue to partner and support San Mateo County Health via in-kind supports (staff time) to support the CHA/CHIP process.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission authorizes the Chief Executive Officer execute a Memorandum of to grant $340,000 to San Mateo County for the Community Health Assessment.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 10th day of September 2025 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Bill Graham, Chair

ATTEST:

BY: _____
M. Heryford, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
CHIEF DEPUTY COUNTY COUNSEL

MEMORANDUM

AGENDA ITEM: 4.2

DATE: September 10, 2025

DATE: September 3, 2025

TO: San Mateo Health Commission

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

RE: Approval of 2025 Compliance Program; and 2025 Code of Conduct

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Recommendation

Approve HPSM Compliance Policy CP.000 2025 Compliance Program, Compliance Policy CP.009 2025 Notification Process for Compliance Issues, and CP.026 the 2025 Code of Conduct document.

Background

The Health Plan of San Mateo (HPSM) values the contribution of all employees, commissioners, committee members, and contracted business partners toward the goal of providing the highest possible quality of services to its members and providers.

This Compliance Program (CP.000) defines the practices and policies that demonstrate HPSM's compliance with state and federal health care compliance requirements.

The Notification Process for Compliance Issues (CP.009) specifies which issues are reported to the attention of the Finance/Compliance Committee and the Commission.

The Code of Conduct (CP.026) serves as a guide for complying with HPSM's internal policies and procedures as well as with all applicable laws and regulations. The Code of Conduct is (1) created in accordance with state and federal requirements to (2) provide guidance in following the ethical, legal, regulatory, and procedural principles that are (3) necessary for maintaining high standards.

Discussion

These policies and corresponding documents are reviewed annually. Recommendations for revision or renewal are made by the Chief Government Affairs and Compliance Officer and the Compliance Committee.

Compliance Program

The Compliance Program document had several minor changes for 2025, updating applicable laws, definitions, and the policy catalog. The program document was reviewed and approved by the Compliance Committee on August 18, 2025. It is hereby submitted to the Commission for its annual review and approval.

Notification Process for Compliance Issues

The Notification Process for Compliance Issues was originally drafted in 2017 in response to HPSM's Centers for Medicare and Medicaid Services (CMS) Program Audit the previous year. The policy specifies how compliance issues are reported within HPSM, to the internal Compliance Committee, the Finance/Compliance Committee, and the Commission. Given the applicability to the Commission, Commission approval was added as the final approval step for the policy. The Notification Process for Compliance Issues was reviewed and approved by the Compliance Committee on August 18, 2025. It is hereby submitted to the Commission for review and approval.

Code of Conduct

The Code of Conduct had two minor changes to reduce confusion on instructions for reporting fraud, waste, and abuse, and clarifying to which HPSM committees the Code of Conduct applies. The Code of Conduct was reviewed and approved by the Compliance Committee on August 18, 2025. It is hereby submitted to the Commission for its annual review and approval.

Fiscal Impact

The approval of these documents does not have a fiscal impact on HPSM.

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF
2025 COMPLIANCE PROGRAM and
2025 NOTIFICATION PROCESS FOR COMPLIANCE ISSUES and
2025 CODE OF CONDUCT

RESOLUTION 2025 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission and the Health Plan of San Mateo values the contribution of all employees, commissioners, committee members, and contracted business partners toward the goal of providing the highest possible quality of services to its members and providers; and
B. The Compliance Program describes how HPSM ensures compliance with all applicable laws and regulations; the Notification Process for Compliance Issues describes how compliance issues are communicated to the Commission, and the Code of Conduct serves as a guide for complying with HPSM's internal policies and procedures as well as with all applicable laws and regulations
C. These documents have been reviewed by the Compliance Committee and are submitted for Commission's review and approval for 2025.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves the attached 2025 Compliance Program, 2025 Notification Process for Compliance Issues, and 2025 Code of Conduct documents for the Health Plan of San Mateo.

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

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Bill Graham, Chair

ATTEST:

BY: _____
M. Heryford, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

INTRODUCTION

The Health Plan of San Mateo (HPSM) is committed to conducting its business operations in compliance with ethical standards, contractual obligations, and all applicable state and federal statutes, regulations and rules, including those pertaining to Medicare, Medi-Cal, and operations of health plans. HPSM's compliance commitment extends to its own internal business operations as well as its oversight and monitoring responsibilities relating to its business partners and delegated entities that enable HPSM to fully implement all aspects of the Medicare benefits as well as HPSM's other lines of business.

The comprehensive Compliance Program described here incorporates the fundamental elements of an effective compliance program identified by the U. S. Department of Health and Human Services' Office of Inspector General (OIG), CMS regulations, and the Medicare Managed Care Manual and Prescription Drug Benefit Manual. Following these guidelines and good business practice, HPSM's Compliance Program:

- Assures compliance with and conformity to all applicable federal and state laws governing HPSM
- Assures compliance with contractual obligations
- Utilizes prevention, detection, and correction tools for non-compliance
- Detects violations of ethical standards
- Combats fraud, waste, and abuse
- Ensures effective education and training of staff; and
- Involves HPSM's Commission and CEO in the Compliance Program.

The Compliance Program is a continually evolving process that will be modified and enhanced based on compliance monitoring, identification of areas of business or legal risk, and as a result of evaluation of the program.

For purposes of this Compliance Program, unless otherwise stated, the term "All Employees" applies to all HPSM Employees, temporary employees, interns, volunteers, Commissioners, Contractors, and First Tier, Downstream, and Related Entities (FDRs). The Glossary, found in Appendix A, further defines these and other key terms used throughout this Compliance Program.

THE COMPLIANCE PROGRAM

This document addresses the fundamental elements of a compliance program. The Compliance Program establishes HPSM principles, standards, and Policies and Procedures regarding compliance with applicable laws and regulations, including those governing relationships among HPSM and federal and state regulatory agencies, participating providers, and Contractors. The Compliance Program is designed to ensure operational accountability and that HPSM's operations and the practices of All Employees

comply with applicable contractual requirements, ethical standards, and laws.

This Program was initially approved by HPSM's Chief Executive Officer (CEO) and HPSM's Governing Body, the San Mateo Health Commission/San Mateo Community Health Authority (Commission). It is reviewed annually by HPSM's Compliance Committee and the San Mateo Health Commission.

Key Elements of Compliance Program

The following are elements critical to HPSM's Compliance Program. Detailed descriptions of each area can be found below.

I. *Standards of Conduct, Policies and Procedures:* The Compliance Program outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to All Employees. HPSM compliance staff reviews new and modified standards on a regular basis, develops Policies and Procedures, and implements plans to meet contractual and legal obligations.

II. *Oversight:* The Compliance Program reflects a formal commitment of HPSM's Governing Body, the San Mateo Health Commission, which adopted this program. HPSM's Chief Government Affairs and Compliance Officer, together with the Compliance Committee, oversees the Compliance Program's implementation, under the direction of the CEO. The Chief Government Affairs and Compliance Officer and the Compliance Committee have the oversight and reporting roles and responsibilities set forth in this Compliance Program.

III. *Effective Training and Education:* The Compliance Program incorporates training and education relating to standards and risk areas, as well as continuing specialized education focused on the operations of HPSM's departments and its programs. HPSM communicates its standards and procedures by requiring Employees to participate in trainings upon hire as well as annual trainings.

IV. *Effective Lines of Communication:* HPSM has formal and routine mechanisms of communication available to All Employees, Providers, and Members. HPSM promotes communication through a variety of meetings and processes.

V. *Well Publicized Disciplinary Standards:* The Compliance Program encourages a consistent approach related to the reporting of compliance issues and adherence to compliance policies. It requires that standards and Policies and Procedures are consistently enforced through appropriate disciplinary mechanisms including, education, correction of improper behavior, discipline of individuals (suspension, financial penalties, sanctions, and termination), and disclosure/repayment if the conduct resulted in improper reimbursement.

VI. *Effective System for Routine Monitoring, Auditing, and Identification of Compliance Risks:* HPSM continues to implement monitoring and auditing reviews related to its operations and of those entities over which HPSM has oversight responsibilities. The Compliance Program and related Policies and Procedures address the monitoring and auditing processes in place to review the activities of HPSM, its providers, and Contractors. HPSM identifies risk areas through an operational risk assessment as well as by examining information collected from monitoring and auditing activities.

VII. *Procedures and Systems for Prompt Response to Compliance Issues:* Once an offense has been detected, HPSM is committed to taking all appropriate steps to respond appropriately to the offense and to prevent similar offenses from occurring. HPSM makes referrals to external agencies or law enforcement as appropriate for further investigation and follow-up.

APPLICABILITY

HPSM's Compliance Program applies to all HPSM products, including but not limited to: Medi-Cal, Medicare Parts C and D, HealthWorx and ACE.

CODE of CONDUCT

HPSM's Code of Conduct details the fundamental principles, values, and ethical framework for All Employees. The objective of the Code of Conduct is to articulate broad principles that guide All Employees in conducting their business activities in a professional, ethical, and legal manner. It is reviewed by the Compliance Committee annually. The Code provides guidelines for business decision-making and behavior whereas Compliance Policies and Procedures are specific and address identified areas of risk and operations.

The Code of Conduct and HPSM Policies and Procedures are available to all HPSM Employees from their time of hire via HPSM's intranet. As a condition of employment, HPSM Employees must certify within 14 calendar days of hire and annually thereafter that they have received, read, and will comply with HPSM's Code of Conduct. Commissioners will also certify that they have received, read, and will comply with these standards of conduct within 90 days of appointment and annually thereafter. All FDRs, including the Medicare Part D pharmacy benefits manager, are required to implement a Code of Conduct compliant with Chapter 21 of the Medicare Managed Care Manual, or utilize HPSM's Code of Conduct and disseminate it to their staff within 90 days of contracting with HPSM and annually thereafter. All managers are required to discuss the content of the Code of Conduct with Contractors under their immediate supervision during contract negotiations for the purpose of confirming the Contractors' understanding of the HPSM's Code of

Conduct. Contractors are encouraged to disseminate copies of HPSM's Code of Conduct to their employees, agents, and subcontractors that furnish items or services to HPSM and/or its members.

Review and Implementation of Standards

HPSM regularly reviews its business operations against new standards imposed by applicable contractual, legal, and regulatory requirements to ensure that All Employees operate under and comply with changing standards. HPSM develops Policies and Procedures to respond to changing standards and potential risk areas identified by HPSM, the OIG, CMS, DHCS, and DMHC. HPSM identifies risk areas through an operational risk assessment as well as by examining information collected from monitoring and auditing activities. These activities include internal reviews, contract monitoring, and external reviews of HPSM's operations by regulatory agencies. The Code of Conduct is reviewed annually by HPSM's Compliance Committee as are HPSM's compliance Policies and Procedures. Staff are informed of significant revisions annually, such as revisions that affect staff rights, responsibilities or job duties.

Compliance with Policies and Procedures

Policies and Procedures are written to help provide structure and guidance to the operations of the organization and ensure that HPSM stays current with contractual, legal, and regulatory requirements. HPSM Employees are responsible for ensuring that they comply with the Policies and Procedures relevant to their positions. At least annually, HPSM staff reviews and, as needed, updates Policies and Procedures. HPSM's Compliance Committee reviews and approves proposed changes and additions to HPSM's Compliance Policies and Procedures (a list of which can be found in Appendix B) and others as determined by the Leadership Team. Operational/Department Policies and Procedures are approved by HPSM Managers and Directors. These Policies and Procedures are set forth in HPSM's electronic Policies and Procedures Manual available to all employees through HPSM's intranet.

Compliance Policies and Procedures include the following:

- Commitment to comply with all federal and state standards
- Compliance expectations
- Guidance to employees and others on dealing with potential compliance issues
- Guidance on how to communicate compliance issues to appropriate staff
- Description of how potential compliance issues are investigated and resolved
- A commitment to non-intimidation and non-retaliation for good faith participation in the Compliance Program.

In addition, as part of HPSM's audit of FDRs, such as HPSM's pharmacy benefits manager, the FDRs must certify that as a condition of employment its employees must comply with written policies and

procedures and Code of Conduct.

Familiarity with Identified Standards

As indicated in the Code of Conduct, employees must be familiar with the standards related to potential risk areas for managed care organizations that relate to their job responsibilities.

OVERSIGHT

Governing Body

In its capacity as the Governing Body, the San Mateo Health Commission has the duty to assure that HPSM implements and monitors a Compliance Program governing HPSM's operations. The Chief Government Affairs and Compliance Officer reports to the Commission on a periodic basis, but no less than annually. Reports include review of activities of the Compliance Program, results of internal and external audits, and reporting of other compliance-related issues.

Chief Government Affairs and Compliance Officer

HPSM's Chief Government Affairs and Compliance Officer is responsible for developing and implementing Policies and Procedures and practices designed to ensure compliance with Federal and State health care programs, including the Medicare Programs. The Chief Government Affairs and Compliance Officer may only delegate tasks set forth in this Compliance Program to other HPSM Employees upon authorization from the CEO. The Chief Government Affairs and Compliance Officer's job description is available upon request to the Human Resources Department.

The Chief Government Affairs and Compliance Officer receives periodic training in compliance procedures and has the authority to oversee compliance and regularly reports on compliance activities to the Commission. Proper execution of compliance responsibilities and promotion of and adherence to the Compliance Program shall be factors in the annual performance evaluation of the Chief Government Affairs and Compliance Officer.

The Chief Government Affairs and Compliance Officer:

- Holds a full-time leadership level position at HPSM and reports directly to HPSM's CEO.
- Receives training in compliance issues and/or procedures at least annually.
- Has the necessary authority to oversee compliance.
- Serves as the Medicare Compliance Officer, in addition to Compliance Officer duties for all HPSM

programs
- Oversees compliance standards and procedures.
- Submits reports to the CEO, the Compliance Committee, and the Commission regarding compliance issues.
- Reports compliance issues involving the CEO directly to the Commission.

The Chief Government Affairs and Compliance Officer shall ensure that:
- The Code of Conduct and Policies and Procedures are developed, implemented, and distributed to All Employees.
- The Compliance Program is reviewed and updated if needed at least annually based on changes in HPSM's needs, regulatory requirements, and applicable law.
- HPSM Employee certifications confirming receipt, review, and understanding of the Code of Conduct are obtained at the time of hire (at new employee orientation) and annually thereafter.
- An appropriate education and training program that focuses on elements of the Compliance Program (including information on Medicare, Medi-Cal, and fraud, waste, and abuse) is implemented and provided to HPSM Employees and made available to Commissioners and Contractors, as appropriate. The Compliance Committee and the Commission are briefed on the status of compliance training.
- FDRs implement education and training for their staff involved in Medicare or Medi-Cal and that this training includes information about HPSM's Compliance Program.
- All data submitted to regulatory agencies are accurate and in compliance with reporting requirements.
- A work plan is developed to monitor the implementation and compliance with Medicare and Medi-Cal related Policies and Procedures.
- Marketing staff is aware of and follow the requirements for Medicare sales and marketing activities.
- Effective lines of communication are instituted, communication mechanisms such as telephone hotline calls are monitored, and complaints are investigated and treated confidentially (unless circumstances dictate the contrary) including any involving Medicare non-compliance or fraud.
- Inquiries and investigations with respect to any reported or suspected violation or questionable conduct including the coordination of internal investigations and investigations of FDRs are:
    - initiated timely and completed.
    - reported to the appropriate organization (DHCS, CMS or its designee, and/or law enforcement) as necessary
    - appropriate disciplinary actions and corrective action plans are implemented.
- Documentation is maintained for each report of potential non-compliance or fraud, waste, or abuse from any source including results and corrective action plans or disciplinary actions taken.
- Periodic reviews of the Participation Status Review process are completed with the Human Resources Department and other designated employees to ascertain that the process is conducted

in accordance with HPSM Policies and Procedures.
- Compliance software and electronic files are maintained to support implementation of the Compliance Program.
- Each of the requirements of the Compliance Program has been substantially accomplished.

Compliance Committee

The Compliance Committee is responsible for overseeing the Compliance Program, subject to the direction of the CEO and the ultimate authority of the Commission. The Compliance Committee is chaired by the Chief Government Affairs and Compliance Officer and meets on a quarterly basis. The Compliance Committee Charter identifies the responsibilities and membership of the Committee. HPSM maintains written minutes (as appropriate) of Compliance Committee meetings reflecting the reports made to the Committee and the Committee's decisions on issues raised (subject to applicable legal provisions concerning confidentiality.) The Compliance Committee Charter can be found in CP.001.

Managers / Supervisors

Managers/Supervisors must be available to discuss with each HPSM Employee under their direct supervision and every Contractor with whom they are the primary liaison:
- The content and procedures in this Compliance Program.
- The legal requirements applicable to Employees' and Contractors' job functions or contractual obligations, as applicable.
- That adherence to this Compliance Program is a condition of employment or contractual relationship.
- That HPSM shall take appropriate disciplinary action, including termination of employment or a Contractor's agreement with HPSM, for violation of the principles and requirements set forth in the Compliance Program and applicable law and regulations.

TRAINING

HPSM provides general and specialized compliance training and education, as applicable, to Commissioners and HPSM Employees to assist them in understanding the Compliance Program, including the Code of Conduct and Policies and Procedures relevant to their job functions. As a part of this process, all Commissioners and HPSM Employees are apprised of applicable state and federal laws, regulations, standards of ethical conduct and the consequences which shall follow from any violation of those rules or the Compliance Program.

Compliance and Fraud, Waste, and Abuse (FWA) Trainings

HPSM Employees are expected to complete compliance training within 14 calendar days of hire, and new Commissioners within 90 days of appointment to the HPSM Governing Body. HPSM Employees and Commissioners must complete compliance training annually thereafter.

New HPSM Employees receive a copy of the Code of Conduct during new hire compliance training and must attest that they have read and understood it. New Commissioners receive a copy of the Compliance Program and Code of Conduct upon appointment and annually thereafter.

Compliance trainings for HPSM Employees include information regarding:

- Health Insurance Portability and Accountability Act (HIPAA)
- Fraud, waste, abuse, and neglect including the False Claims Act~~, and~~ the Fraud Enforcement and Recovery Act, Anti-Kickback Statue, Stark Law, and Civil Monetary Penalties Law
- Compliance Program
- Code of Conduct
- Information on the confidentiality, anonymity, non-intimidation and non-retaliation for compliance-related questions or reports of potential non-compliance.
- Review of the disciplinary guidelines for non-compliant or fraudulent behavior.
- Review of potential conflicts of interest and HPSM's disclosure/attestation system.

HPSM Employees may receive additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Compliance training for Commissioners will focus on compliance and fraud, waste, and abuse.

Members of the Compliance Committee and other Leadership Team members are trained on how to respond appropriately to compliance inquiries and reports of potential non-compliance. This training also includes confidentiality, non-intimidation and non-retaliation against employees, and knowing when to refer the incident to the Chief Government Affairs and Compliance Officer.

Federal guidance specifically requires that all FDRs receive general compliance training, and in light of this requirement, FDRs are informed of their obligation to provide compliance training to their employees. HPSM receives confirmation that its FDRs conduct their own compliance training for staff and downstream entities in accordance with CMS guidance as part of the annual FDR audit. FDRs that have met the FWA certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the training and educational requirements for FWA.

Documentation

Documentation requirements related to the training and education program are addressed in the following manner:

- Core annual training material topics are available through a web-based tool. Core trainings include all-staff FWA, Compliance and HIPAA Privacy trainings. Confirmation of completion of assigned courses and post-test is documented through a web based tool and reviewed by the Chief Government Affairs and Compliance Officer to ensure staff completes assigned trainings.
- Supplemental annual trainings, such as manager training, are conducted in-person, with sign-in sheets retained as evidence of training participation.
- Documentation of trainings for Commissioners is captured through a web-based tool and reviewed by the Chief Government Affairs and Compliance Officer.

All Compliance Program training documents are retained in accordance with HPSM's Document Retention Policy.

EFFECTIVE LINES OF COMMUNICATION

Effective lines of communication are established ensuring confidentiality between the Chief Government Affairs and Compliance Officer, members of the Compliance Committee, HPSM managers and supervisors, HPSM Employees, Commissioners, and staff of FDRs. All Employees are encouraged to discuss compliance issues directly with their managers/supervisors or the Chief Government Affairs and Compliance Officer. All Employees are advised that they are required to report compliance concerns and suspected or actual misconduct and violations of law.

The Chief Government Affairs and Compliance Officer posts information such as the policies and procedures catalog (which includes the Code of Conduct as well as the Compliance Program) on HPSM's intranet, available to all HPSM Employees. Additional information can be posted as needed to update staff on changes in laws or regulations. The Chief Government Affairs and Compliance Officer also informs Commissioners of any relevant federal and state fraud alerts and policy letters, pending/new legislation reports, updates, and advisory bulletins as necessary.

Establishment and Publication of Reporting Hotlines

All Employees have an affirmative duty under the Compliance Program to report all violations, suspected violations, questionable conduct or practices by a verbal or written report to HPSM to a supervisor or the Chief Government Affairs and Compliance Officer. In the event any person wishes to remain anonymous, he/she may use HPSM's confidential hotline described below to report compliance concerns. The purpose of the hotline is to ensure that there is an effective line of communication for compliance issues between HPSM and its Commissioners, HPSM Employees, Contractors and/or members.

Compliance Hotline

HPSM has established a confidential Compliance Telephone Hotline (Compliance Hotline) for HPSM Commissioners, HPSM Employees, Contractors, Providers and Members and other interested persons to report any violations or suspected violations of law and/or the Compliance Program and/or questionable or unethical conduct or practices including, without limitation, the following:

- Incidents of fraud and abuse
- Criminal activity (fraud, kickback, embezzlement, theft, etc.)
- Conflict of interest issues
- Code of Conduct violations

HPSM currently uses a national hotline organization to administer its Compliance Hotline. The Compliance Hotline is accessible 24 hours a day, 365 days a year, excluding designated holidays (when callers will be routed to a voice mail message alerting them to call back during established hours of operation). A caller to the Compliance Hotline is initially greeted by a pre-recorded message that provides information regarding Compliance Hotline procedures and the caller's right to anonymity. Calls to the Compliance Hotline are not tape-recorded and will not be traced. The national hotline organization operator will ask the caller several questions relating to the reported issue, incident, etc. All reports are referred to HPSM's Chief Government Affairs and Compliance Officer and investigated. Follow-up calls may be scheduled; however, information regarding the investigation and status of any action taken relating to the report may not be available to the caller.

The compliance hotline information is as follows: TOLL FREE COMPLIANCE HOTLINE (844) 965-1241.

HPSM publicizes the Compliance Hotline by appropriate means of communication to Commissioners, HPSM Employees, and Contractors including, but not limited to: e-mail notice and/or posting in prominent common areas, as well as on HPSM's intranet.

Confidentiality, Non-Intimidation and Non-Retaliation

HPSM takes all reports of violations, suspected violations, questionable conduct or practices seriously. Verbal communications via the Compliance Hotline and written or verbal reports to managers or supervisors or anyone designated to receive such reports shall be treated as privileged and confidential to the extent permitted by applicable law and circumstances. The caller/author need not provide his/her name.

HPSM's "Open Door" policy encourages HPSM Employees to discuss issues directly with their managers,

supervisors, the Chief Government Affairs and Compliance Officer, other Leadership Team members, members of the Compliance Committee, or the CEO. These channels of discussion provide for confidentiality to the extent allowed by law.

HPSM maintains and supports a Non-Intimidation and Non -Retaliation policy which prohibits any retaliatory action against a Commission Member, HPSM Employee, or Contractor for making any verbal/written report in good faith. This includes qui tam relators who make a report under the federal or California False Claims Act.

Discipline shall not be increased because an Employee reported his or her own violation or misconduct. Prompt and complete disclosure may be considered a mitigating factor in determining an Employee's discipline. The non-tolerance for retaliation and intimidation is described in policy and reviewed in the annual compliance training. HPSM takes violations of the policy on non-intimidation and non-retaliation seriously; the Chief Government Affairs and Compliance Officer reviews disciplinary and/or other corrective actions for such violations with the Compliance Committee, as appropriate.

Although Commissioners and HPSM Employees are encouraged to report their own potential wrongdoing, they may not use any verbal or written report in an effort to insulate themselves from the consequences of their own violations or misconduct. Commissioners, HPSM Employees, and Contractors shall not prevent or attempt to prevent, a Commissioner, HPSM Employee, or Contractor from communicating via the Compliance Hotline or any other mechanism. If a Commissioner, HPSM Employee, or Contractor attempts such action, he or she is subject to disciplinary action.

DISCIPLINARY STANDARDS

Conduct Subject to Discipline

HPSM Employees may be subject to discipline up to and including termination for failing to participate in HPSM's Compliance efforts. All new and renewing contracts include a provision that clarifies that a contract can be terminated because of a violation. The following are examples of conduct subject to enforcement and discipline:

- Failure to perform any required obligation relating to the Compliance Program or applicable law, including conduct that results in violation of any Federal or state law relating to participation in Federal and/or State health care programs.
- Failure to report violations or suspected violations of the Compliance Program or applicable law to an appropriate person or through the Compliance Hotline.
- Conduct that leads to the filing of a false or improper claim or that is otherwise responsible for the filing of a claim in violation of federal or state law.

Enforcement and Discipline

HPSM maintains a "zero tolerance" policy towards any illegal conduct that impacts the operation, mission, or image of HPSM. Any employee or contractor engaging in a violation of laws or regulations (depending on the magnitude of the violation) may have their employment or contract terminated. HPSM shall accord no weight to a claim that any improper conduct was undertaken "for the benefit of HPSM". Illegal conduct is not for HPSM's benefit and is expressly prohibited.

The standards established in the Compliance Program must be fair and consistently enforced through disciplinary proceedings. These shall include the following:

- Prompt initiation of education to correct the identified problem.
- Disciplinary action, if any, as may be appropriate given the facts and circumstances of the investigation including oral or written reprimand, demotions, reductions in pay, and termination.

In determining the appropriate discipline or corrective action for any violation of the Compliance Program or applicable law, HPSM does not take into consideration a particular person's or entity's economic benefit to the organization.

All Employees should also be aware that violations of applicable laws and regulations could potentially subject them or HPSM to civil, criminal, or administrative sanctions and penalties. Further, violations could lead to HPSM's suspension or exclusion from participation in Federal and/or State health care programs. Documentation of all actions taken will be done by the Chief Government Affairs and Compliance Officer according to the guidelines set forth in the Compliance Program.

MONITORING and AUDITING

At the direction of the Chief Government Affairs and Compliance Officer and/or Compliance Committee, HPSM's Compliance and Operational staff perform auditing and monitoring functions for the organization to ensure compliance with applicable law and the Compliance Program. They report, investigate and, if necessary and appropriate, correct, any inconsistencies, suspected violations, or questionable conduct. The Chief Government Affairs and Compliance Officer develops an auditing work plan that is approved by the Compliance Committee that addresses risks, including, but not be limited to, areas of risk identified in the OIG's Annual Work Plan for Medicare Managed Care, Medicare Administration, and Medi-Cal. Focused audits are conducted based on audit reports from HPSM regulators including DHCS, DMHC, and CMS. In addition, the Chief Government Affairs and Compliance Officer develops auditing Policies and Procedures

that are reviewed by the Compliance Committee.

Monitoring is an on-going process to ensure processes are working as intended. On-going checking and measuring can be performed daily, weekly, or monthly, or on an ad hoc basis. Monitoring should be performed by department staff as well as compliance staff. Auditing is completed by independent compliance staff and is a more formal and objective approach to evaluate and improve the effectiveness of HPSM processes and to ensure oversight of delegated activities.

A risk assessment tool is used to conduct an assessment of HPSM's major compliance and FWA risk areas. This includes Medicare business operations, such as marketing, enrollment, appeals and grievances, benefit/formulary administration, transition policy, utilization management, accuracy of claims payments, and oversight of FDRs. The risk assessment is updated at least quarterly.

Oversight of Delegated Activities

HPSM delegates certain functions and/or processes to FDRs. These include:

- Provider credentialing and re-credentialing at select facilities and for pharmacists
- PBM Pharmaceutical claims processing and aspects in the administration and delivery of the Medicare Part D benefit
- Mental health benefits, including claims processing (for Medi-Cal, CareAdvantage, and HealthWorx lines of business)
- Transportation benefit for Medi-Cal and CareAdvantage
- Imaging of claims

Contractors are required to meet all contractual, legal, and regulatory requirements and comply with HPSM Policies and Procedures and other guidelines applicable to the delegated functions. HPSM maintains oversight of these delegated functions and will conduct annual audits of delegated entities.

Oversight of Non-Delegated Activities

HPSM maintains oversight responsibility of the following activities that are not delegated to Contractors:

- Quality Improvement Program for Medicare and Medi-Cal lines of business
- Grievances and Appeals processes
- Peer review process on specific, referred cases.
- Risk Management
- Pharmacy and drug utilization review as it relates to quality of care.
- Provider credentialing and re-credentialing, except as noted above

- Development of credentialing standards in specified circumstances
- Development of utilization standards
- Development of quality improvement standards
- Compliance

External Auditing for Pharmacy Benefits

As part of its work plan, HPSM developed a strategy to monitor and audit its pharmacy benefits manager and other entities that are involved in the administration or delivery of the pharmacy benefits, including Medicare Part D. HPSM seeks written assurances from its PBM that it has an adequate audit work plan in place that includes auditing of network pharmacies and reporting with respect to HPSM Members. HPSM receives audit reports on a regular basis. HPSM also seeks written assurances that the PBM has implemented corrective actions when appropriate. Contracts are amended as needed to ensure PBM compliance.

In addition, HPSM routinely generates a number of reports to aid in monitoring and oversight efforts. These reports include:

- Payment reports
- Drug utilization reports
- Physician prescribing reports
- Unusual utilization pattern reports

Finally, HPSM uses system edits to monitor the delivery of the prescription drug benefit. Examples of such edits are: controls on early refills, edits to prevent payment for excluded drugs, limits on the number of times a prescription can be refilled, and step therapy edits.

Internal Auditing

An annual auditing work plan is developed by the Compliance Department and includes:

- Internal audit schedule
- Audit report, including:
    - Audit objectives
    - Scope and methodology
    - Findings
    - Recommendations
- Audit staffing
- Approval, monitoring, and validation of corrective action plans

In developing the types of audits to include in the work plan, HPSM bases audits on the risk assessment to

determine which risk areas will most likely affect HPSM. The Compliance Committee has input into the priority of the monitoring and audit strategy. In determining risk areas, HPSM reviews the annual OIG work plan, the CMS Medicare Managed Care Manual and Prescription Drug Benefit Manual (Chapters 21 and 9, respectively), and resources developed by the industry that identify high risk areas in HPSM's programs and the health care industry.

The Chief Government Affairs and Compliance Officer, Compliance Committee, and business owners may ask the internal audit staff to conduct audits on specific topics not on the formal work plan should circumstances warranted such a review.

Finally, audits also may include follow up review of areas previously found non-compliant to determine if the corrective actions taken have fully addressed the underlying problem.

The work plan also includes a process for responding to all monitoring and audit results, including referral to appropriate agencies (e.g., CMS, the MEDIC, DHCS, law enforcement) when appropriate. All compliance actions taken will be tracked to evaluate the success of implementation efforts.

Compliance Program Effectiveness Audit

HPSM conducts annual effectiveness audits of its Compliance Program, the results of which are shared with the CEO, Compliance Committee and Commission. HPSM avoids self-policing through utilization of staff who do not report to the Chief Government Affairs and Compliance Officer or other managers in the Compliance Department, or by outsourcing the audit to external auditors.

The HPSM Compliance Department maintains less formal measures of compliance program effectiveness, including internal and external audit results and a dashboard of reported compliance issues.

Audit Review

The Chief Government Affairs and Compliance Officer submits regular reports of all auditing and corrective action activities to the Compliance Committee. When appropriate, HPSM informs the appropriate agency (e.g., DHCS, CMS or its designee including the appropriate MEDIC, or law enforcement) of aberrant findings.

PROMPT RESPONSE TO COMPLIANCE ISSUES

HPSM is committed to responding to compliance issues thoroughly and promptly and has developed policies to address the reporting of and responding to compliance issues. If an Employee becomes aware

of a violation, suspected violation or questionable or unethical conduct in violation of the Compliance Program or applicable law, the Employee must notify HPSM staff immediately. A Commissioner or Contractor should notify HPSM of a suspected violation or questionable unethical conduct by reporting the concern to the Chief Government Affairs and Compliance Officer or CEO. Any such reports of suspected violations may also be made to the Compliance Hotline.

The Chief Government Affairs and Compliance Officer refers compliance issues involving the CEO directly to the Commission. The CEO refers any issue that involves a Commissioner to the San Mateo Board of Supervisors.

HPSM maintains a Fraud, Waste and Abuse plan that defines the plan's approach to detecting, preventing, and deterring fraud, waste, and abuse. Significant fraud, waste and abuse issues are summarized to the Compliance Committee and a FWA Subcommittee of the Compliance Committee reviews potential cases of FWA to determine potential actions by HPSM, need for external assistance or determination that FWA has not occurred.

Reports of suspected or actual compliance violations, unethical conduct, fraud, abuse, or questionable conduct, whether made by Commissioners, Employees, Contractors, or third parties external to HPSM (including regulatory and/or investigating government agencies), in writing or verbally, formally or informally are investigated. These are subject to review and investigation by HPSM's Chief Government Affairs and Compliance Officer and/or the Compliance Committee, in consultation with legal counsel.

Self-Reporting

HPSM makes appropriate referrals to the CMS or the MEDIC; DHCS Medi-Cal Managed Care Division's (MMCD) Program Integrity Section; DHCS Audits and Investigations; DMHC; other agencies, as appropriate; or law enforcement for further investigation and follow-up of cases involving FWA, following the self-reporting section of the policy on Fraud, Waste, and Abuse.

Participation Status Review and Background Checks

HPSM does not hire, contract with, or retain on its behalf, any person or entity that is currently suspended, excluded or otherwise ineligible to participate in Federal and/or State health care programs; and/or has ever been excluded from participation in Federal and/or State health care programs based on a Mandatory Exclusion. HPSM maintains policies on participation status for All Employees and providers.

Participation Status Review

HPSM reviews Commissioners, HPSM Employees and Contractors against appropriate exclusion lists to

ensure that they are not excluded, suspended or otherwise ineligible to participate in Federal and/or State health care programs. HPSM requires that potential Commissioners, Employees and Contractors disclose their Participation Status as part of the employment/contracting/appointment process and when Commissioners, Employees, and Contractors receive notice of any suspension, exclusion, debarment or felony conviction during the period of employment, contract or appointment. HPSM also requires those delegated to complete provider credentialing and re-credentialing that comply with Participation Status Review requirements with respect to their relationships with participating providers and suppliers. This review is conducted prior to employment or contractual engagement of a person or entity and monthly thereafter according to Participation Status Review Policies and Procedures.

Background Checks

HPSM has implemented additional Policies and Procedures relating to background checks for specified potential or existing Employees or Contractors as may be required by law and/or deemed by HPSM to be otherwise prudent and appropriate.

Notice and Documentation

HPSM and its Employees comply with applicable federal and state laws governing notice and disclosure obligations relating to Participation Status Reviews and background checks. Employees responsible for conducting the Participation Status Reviews and/or background checks shall record and maintain the results of the reviews and notices/disclosures and shall provide periodic reports to the Chief Government Affairs and Compliance Officer.

DOCUMENTATION

The Chief Government Affairs and Compliance Officer has established and maintains an electronic filing system for all compliance-related documents. These tools are used to:

- Manage all Policies and Procedures.
- Organize and manage contracts.
- Organize and manage agendas, minutes, and meeting materials for Compliance Committee meetings and the FWA Committee.
- Document compliance with the Department of Health Care Services Medi-Cal contract.
- Organize audit materials for regulators and provide web access to materials to regulators.
- Document incidents of potential fraud.
- Document internal audits and those of delegated entities.
- Complete staff attestations.
- Maintain Compliance training records.

Document Retention

All of the documents to be maintained in the filing system described above are retained for ten (10) years from end of the fiscal year in which the HPSM Medicare or Medi-Cal contracts expire or are terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary).

APPENDIX A

GLOSSARY

Abuse means practices that are inconsistent with sound fiscal, business or medical/dental practice~~s~~, and result in unnecessary cost ~~to Federal and/or State health care programs~~, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Abuse also includes member practices that result in unnecessary cost to Medicare, Medi-Cal or other HPSM lines of business.

All Employees mean those HPSM Employees, interns, temporary employees, volunteers, Commissioners, contractors, or a First Tier, Downstream or Related Entity (FDR) who provide health or administrative services for an HPSM member.

Audit means a formal review of compliance with a particular set of internal (e.g., policies and procedures) or external (e.g., laws and regulations) standards used as base measures.

Centers for Medicare & Medicaid Services (CMS) means the Centers for Medicare & Medicaid Services, the operating component of the Department of Health and Human Services (DHHS) charged with administration of the Federal Medicare and Medicaid programs.

Code of Conduct means the statement setting forth the principles and standards governing HPSM's activities to which Commissioners, Employees, and Contractors are expected to adhere.

Commissioners mean the members of HPSM's Governing Body.

Compliance Committee means the committee designated by the CEO to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Program.

Compliance Program means the program (including, without limitation, Code of Conduct and Policies and Procedures) developed and adopted by HPSM to promote, monitor and ensure that HPSM's operations and practices and the practices of its Commissioners, Employees, Contractors, and FDRs comply with applicable law and ethical standards.

Contractor means any contractor, subcontractor, agent, or other person including FDRs which or who, on behalf of HPSM, furnishes or otherwise authorizes the furnishing of health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by HPSM.

Contractor Agreement means any agreement with a Contractor.

Department of Health Services (DHCS) means the California Department of Health Services, the State agency that oversees the Medi-Cal program.

Department of Managed Health Care (DMHC) means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 et seq.

Downstream Entity is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with an HPSM Medicare line of business below the level of the arrangement between HPSM and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

HPSM Employee(s) means any and all Employees of HPSM, including all Leadership Team members, managers, supervisors, and other employed personnel include temporary staff. Interns and volunteers are also included in this reference.

First Tier Entity means First Tier, Downstream or Related Entity. ***First Tier Entity*** means any party that enters into a written arrangement with HPSM to provide administrative services or health care services to HPSM members. ***Downstream Entity*** means any party that enters into a written arrangement with persons or entities below the level of the arrangement between HPSM and a first-tier entity. ***Related Entity*** means any entity related to HPSM by common ownership or control.~~is any party that enters into a written arrangement, acceptable to the Centers for Medicare and Medicaid Services (CMS), with HPSM to provide administrative services or health care services to a Medicare beneficiary~~.

FDR ~~is the term used to refer to~~means a first tier, downstream or related entity.

Federal and/or State Health Care Programs means "any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program" as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

Fraud means an intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit to itself, him/herself or some other person and includes any act that constitutes fraud under applicable Federal or State laws including, without limitation, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit.

Governing Body means the San Mateo Health Commission.

HPSM means the Health Plan of San Mateo, a County Organized Health System (COHS) created under California Welfare and Institutions Code Section 14087.5-14087.95 and San Mateo County Ordinance No.03067, as amended by Ordinance No. 04245.

HPSM Member means a beneficiary who is enrolled in one of HPSM's lines of business.

Manager / Supervisor means an Employee in a position representing HPSM who has one or more employees reporting directly to him or her. With respect to Contractors, the term "Supervisor" shall mean the HPSM Employee that is the designated liaison for that Contractor.

Mandatory Exclusion means an exclusion or debarment from Federal and/or State health care programs for any of the mandatory bases for exclusion identified in 42 U.S.C. § 1396a-7(a) and the implementing regulations including a conviction of a criminal offense related to the delivery of an item or service under Federal and/or State health care programs; and/or a felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service; related to health care fraud and/or related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

Medicare means both Part C (Parts A and B) and Part D of Medicare.

Medicare Drug Integrity Contractors (MEDICs) means a private organization contracted with CMS to assist in the management of CMS' audit, oversight, and anti-fraud and abuse efforts in the Medicare Part D benefit.

National Committee for Quality Assurance Standards for Accreditation of MCOs (NCQA Standards) means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Office of the Inspector General (OIG) means the Office of the Inspector General for the Department of Health and Human Services.

Participating providers and suppliers include all health care providers and suppliers (e.g. physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies etc.) that receive reimbursement from HPSM for items or services furnished to members.

Participation Status means whether a person or entity is currently suspended, excluded, or otherwise

ineligible to participate in Federal and/or State health care programs and/or was ever excluded from participation in Federal and/or State health care programs based on a Mandatory Exclusion.

Participation Status Review means the process by which HPSM reviews its Commissioners, Employees, Contractors, and HPSM direct providers to determine whether they are currently suspended, excluded, or otherwise ineligible to participate in Federal and/or State health care programs; and/or were ever excluded from participation in Federal and/or State health care programs based on a Mandatory Exclusion.

Policies and Procedures means the written policies and procedures regarding the operation of HPSM's Compliance Program and its compliance with applicable law, including those relating to Medicare and California's Medicaid program, Medi-Cal.

Related Entity means any entity related to HPSM by common ownership or control and (1) performs some of HPSM's management functions under contract or delegation, (2) furnishes services to Medicare beneficiaries under an oral or written agreement, or (3) leases property or sells materials to HPSM at a cost of more than $2500 during a contract period.

Waste means an overutilization or misuse of resources that result in unnecessary costs to the healthcare system, either directly or indirectly.

APPENDIX B

Compliance Policies and Procedures

Policy No.	Policy Title
CP.001	Compliance Committee Charter
CP.002	ACA Section 1557 Compliance
CP.003	Reporting Compliance Concerns
CP.004	Compliance Hotline
CP.005	Non-Retaliation & Non-Intimidation
CP.006	False Claims Act Compliance
CP.007	Distribution of Compliance Program Materials
CP.008	Internal Auditing
CP.009	Notification Process for Compliance Issues
CP.010	Civil Rights Obligations for Subcontractors
CP.011	Risk Assessment Development Process
CP.012	Medi-Cal Document and Data Certification
CP.013	Internal Monitoring
CP.014	Administrative Service Agreements
CP.015	Significant Network Changes
CP.016	Investigating & Reporting Fraud, Waste, Abuse, and Neglect
CP.017	Conflict of Interest for Committee Members
CP.018	Policy Filing Process

CP.019	Document Retention
CP.020	California Public Records Act Requests
CP.021	Delegation Oversight Activities and Responsibilities
~~CP.022~~	~~Delegation Oversight Subcommittee and Charter~~
CP.023	Pre-Delegation Review
~~CP.024~~	~~Data Sharing with Delegates~~
CP.025	Compliance Trainings and Attestations
CP.026	Code of Conduct
CP.027	Corrective Action Plan (CAP) Monitoring Process
CP.028	Delegation Monitoring and Auditing
CP.029	Oversight Responsibilities for Medicare Delegates (FDR)
CP.030	Oversight Responsibilities for Medi-Cal Delegates
HP.001	Privacy Program
HP.002	Minimum Necessary Use and Permitted Uses
HP.003	Verification Requirements
HP.004	Member Authorization
HP.005	Restriction Requests
HP.006	Confidential Communications
HP.007	Access Requests to PHI
HP.008	Amending PHI

HP.009	Accountings of Disclosures
HP.010	Privacy Incidents
HP.011	Breach Notification
HP.012	Safeguarding Sensitive Information
HP.013	Business Associates and Other Arrangements
HP.014	Notice of Privacy Practices
HP.100	HIPAA -HITECH Privacy and Security Glossary
HP.102	Security Management Process
HP.103	Workforce Security
HP.104	Security Awareness and Training
HP.105	Facility Security
HP.106	Workstation Server and Device Security
HP.107	Maintaining Confidentiality of ePHI
HP.108	Maintaining Integrity of ePHI
HP.109	Maintaining Availability of ePHI
HP.110	Data Backup & Disaster Recovery
HP.111	Physical Safeguards
HP.112	Disposal of Protected Health Information
HP.113	Security Incident & Data Compromise Procedure
HP.114	Acceptable Use Policy

HP.115	HPSM Wireless (WiFi) Access Policy
HP.116	HPSM Mobile Device Policy

INTRODUCTION

The Health Plan of San Mateo (HPSM) is committed to conducting its business operations in compliance with ethical standards, contractual obligations, and all applicable state and federal statutes, regulations and rules, including those pertaining to Medicare, Medi-Cal, and operations of health plans. HPSM's compliance commitment extends to its own internal business operations as well as its oversight and monitoring responsibilities relating to its business partners and delegated entities that enable HPSM to fully implement all aspects of the Medicare benefits as well as HPSM's other lines of business.

The comprehensive Compliance Program described here incorporates the fundamental elements of an effective compliance program identified by the U. S. Department of Health and Human Services' Office of Inspector General (OIG), CMS regulations, and the Medicare Managed Care Manual and Prescription Drug Benefit Manual. Following these guidelines and good business practice, HPSM's Compliance Program:

- Assures compliance with and conformity to all applicable federal and state laws governing HPSM
- Assures compliance with contractual obligations
- Utilizes prevention, detection, and correction tools for non-compliance
- Detects violations of ethical standards
- Combats fraud, waste, and abuse
- Ensures effective education and training of staff; and
- Involves HPSM's Commission and CEO in the Compliance Program.

The Compliance Program is a continually evolving process that will be modified and enhanced based on compliance monitoring, identification of areas of business or legal risk, and as a result of evaluation of the program.

For purposes of this Compliance Program, unless otherwise stated, the term "All Employees" applies to all HPSM Employees, temporary employees, interns, volunteers, Commissioners, Contractors, and First Tier, Downstream, and Related Entities (FDRs). The Glossary, found in Appendix A, further defines these and other key terms used throughout this Compliance Program.

THE COMPLIANCE PROGRAM

This document addresses the fundamental elements of a compliance program. The Compliance Program establishes HPSM principles, standards, and Policies and Procedures regarding compliance with applicable laws and regulations, including those governing relationships among HPSM and federal and state regulatory agencies, participating providers, and Contractors. The Compliance Program is designed to ensure operational accountability and that HPSM's operations and the practices of All Employees

comply with applicable contractual requirements, ethical standards, and laws.

This Program was initially approved by HPSM's Chief Executive Officer (CEO) and HPSM's Governing Body, the San Mateo Health Commission/San Mateo Community Health Authority (Commission). It is reviewed annually by HPSM's Compliance Committee and the San Mateo Health Commission.

Key Elements of Compliance Program

The following are elements critical to HPSM's Compliance Program. Detailed descriptions of each area can be found below.

I. *Standards of Conduct, Policies and Procedures:* The Compliance Program outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to All Employees. HPSM compliance staff reviews new and modified standards on a regular basis, develops Policies and Procedures, and implements plans to meet contractual and legal obligations.

II. *Oversight:* The Compliance Program reflects a formal commitment of HPSM's Governing Body, the San Mateo Health Commission, which adopted this program. HPSM's Chief Government Affairs and Compliance Officer, together with the Compliance Committee, oversees the Compliance Program's implementation, under the direction of the CEO. The Chief Government Affairs and Compliance Officer and the Compliance Committee have the oversight and reporting roles and responsibilities set forth in this Compliance Program.

III. *Effective Training and Education:* The Compliance Program incorporates training and education relating to standards and risk areas, as well as continuing specialized education focused on the operations of HPSM's departments and its programs. HPSM communicates its standards and procedures by requiring Employees to participate in trainings upon hire as well as annual trainings.

IV. *Effective Lines of Communication:* HPSM has formal and routine mechanisms of communication available to All Employees, Providers, and Members. HPSM promotes communication through a variety of meetings and processes.

V. *Well Publicized Disciplinary Standards:* The Compliance Program encourages a consistent approach related to the reporting of compliance issues and adherence to compliance policies. It requires that standards and Policies and Procedures are consistently enforced through appropriate disciplinary mechanisms including, education, correction of improper behavior, discipline of individuals (suspension, financial penalties, sanctions, and termination), and disclosure/repayment if the conduct resulted in improper reimbursement.

VI. *Effective System for Routine Monitoring, Auditing, and Identification of Compliance Risks:* HPSM continues to implement monitoring and auditing reviews related to its operations and of those entities over which HPSM has oversight responsibilities. The Compliance Program and related Policies and Procedures address the monitoring and auditing processes in place to review the activities of HPSM, its providers, and Contractors. HPSM identifies risk areas through an operational risk assessment as well as by examining information collected from monitoring and auditing activities.

VII. *Procedures and Systems for Prompt Response to Compliance Issues:* Once an offense has been detected, HPSM is committed to taking all appropriate steps to respond appropriately to the offense and to prevent similar offenses from occurring. HPSM makes referrals to external agencies or law enforcement as appropriate for further investigation and follow-up.

APPLICABILITY

HPSM's Compliance Program applies to all HPSM products, including but not limited to: Medi-Cal, Medicare Parts C and D, HealthWorx and ACE.

CODE of CONDUCT

HPSM's Code of Conduct details the fundamental principles, values, and ethical framework for All Employees. The objective of the Code of Conduct is to articulate broad principles that guide All Employees in conducting their business activities in a professional, ethical, and legal manner. It is reviewed by the Compliance Committee annually. The Code provides guidelines for business decision-making and behavior whereas Compliance Policies and Procedures are specific and address identified areas of risk and operations.

The Code of Conduct and HPSM Policies and Procedures are available to all HPSM Employees from their time of hire via HPSM's intranet. As a condition of employment, HPSM Employees must certify within 14 calendar days of hire and annually thereafter that they have received, read, and will comply with HPSM's Code of Conduct. Commissioners will also certify that they have received, read, and will comply with these standards of conduct within 90 days of appointment and annually thereafter. All FDRs, including the Medicare Part D pharmacy benefits manager, are required to implement a Code of Conduct compliant with Chapter 21 of the Medicare Managed Care Manual, or utilize HPSM's Code of Conduct and disseminate it to their staff within 90 days of contracting with HPSM and annually thereafter. All managers are required to discuss the content of the Code of Conduct with Contractors under their immediate supervision during contract negotiations for the purpose of confirming the Contractors' understanding of the HPSM's Code of

Conduct. Contractors are encouraged to disseminate copies of HPSM's Code of Conduct to their employees, agents, and subcontractors that furnish items or services to HPSM and/or its members.

Review and Implementation of Standards

HPSM regularly reviews its business operations against new standards imposed by applicable contractual, legal, and regulatory requirements to ensure that All Employees operate under and comply with changing standards. HPSM develops Policies and Procedures to respond to changing standards and potential risk areas identified by HPSM, the OIG, CMS, DHCS, and DMHC. HPSM identifies risk areas through an operational risk assessment as well as by examining information collected from monitoring and auditing activities. These activities include internal reviews, contract monitoring, and external reviews of HPSM's operations by regulatory agencies. The Code of Conduct is reviewed annually by HPSM's Compliance Committee as are HPSM's compliance Policies and Procedures. Staff are informed of significant revisions annually, such as revisions that affect staff rights, responsibilities or job duties.

Compliance with Policies and Procedures

Policies and Procedures are written to help provide structure and guidance to the operations of the organization and ensure that HPSM stays current with contractual, legal, and regulatory requirements. HPSM Employees are responsible for ensuring that they comply with the Policies and Procedures relevant to their positions. At least annually, HPSM staff reviews and, as needed, updates Policies and Procedures. HPSM's Compliance Committee reviews and approves proposed changes and additions to HPSM's Compliance Policies and Procedures (a list of which can be found in Appendix B) and others as determined by the Leadership Team. Operational/Department Policies and Procedures are approved by HPSM Managers and Directors. These Policies and Procedures are set forth in HPSM's electronic Policies and Procedures Manual available to all employees through HPSM's intranet.

Compliance Policies and Procedures include the following:

- Commitment to comply with all federal and state standards
- Compliance expectations
- Guidance to employees and others on dealing with potential compliance issues
- Guidance on how to communicate compliance issues to appropriate staff
- Description of how potential compliance issues are investigated and resolved
- A commitment to non-intimidation and non-retaliation for good faith participation in the Compliance Program.

In addition, as part of HPSM's audit of FDRs, such as HPSM's pharmacy benefits manager, the FDRs must certify that as a condition of employment its employees must comply with written policies and

procedures and Code of Conduct.

Familiarity with Identified Standards

As indicated in the Code of Conduct, employees must be familiar with the standards related to potential risk areas for managed care organizations that relate to their job responsibilities.

OVERSIGHT

Governing Body

In its capacity as the Governing Body, the San Mateo Health Commission has the duty to assure that HPSM implements and monitors a Compliance Program governing HPSM's operations. The Chief Government Affairs and Compliance Officer reports to the Commission on a periodic basis, but no less than annually. Reports include review of activities of the Compliance Program, results of internal and external audits, and reporting of other compliance-related issues.

Chief Government Affairs and Compliance Officer

HPSM's Chief Government Affairs and Compliance Officer is responsible for developing and implementing Policies and Procedures and practices designed to ensure compliance with Federal and State health care programs, including the Medicare Programs. The Chief Government Affairs and Compliance Officer may only delegate tasks set forth in this Compliance Program to other HPSM Employees upon authorization from the CEO. The Chief Government Affairs and Compliance Officer's job description is available upon request to the Human Resources Department.

The Chief Government Affairs and Compliance Officer receives periodic training in compliance procedures and has the authority to oversee compliance and regularly reports on compliance activities to the Commission. Proper execution of compliance responsibilities and promotion of and adherence to the Compliance Program shall be factors in the annual performance evaluation of the Chief Government Affairs and Compliance Officer.

The Chief Government Affairs and Compliance Officer:

- Holds a full-time leadership level position at HPSM and reports directly to HPSM's CEO.
- Receives training in compliance issues and/or procedures at least annually.
- Has the necessary authority to oversee compliance.
- Serves as the Medicare Compliance Officer, in addition to Compliance Officer duties for all HPSM

programs
- Oversees compliance standards and procedures.
- Submits reports to the CEO, the Compliance Committee, and the Commission regarding compliance issues.
- Reports compliance issues involving the CEO directly to the Commission.

The Chief Government Affairs and Compliance Officer shall ensure that:
- The Code of Conduct and Policies and Procedures are developed, implemented, and distributed to All Employees.
- The Compliance Program is reviewed and updated if needed at least annually based on changes in HPSM's needs, regulatory requirements, and applicable law.
- HPSM Employee certifications confirming receipt, review, and understanding of the Code of Conduct are obtained at the time of hire (at new employee orientation) and annually thereafter.
- An appropriate education and training program that focuses on elements of the Compliance Program (including information on Medicare, Medi-Cal, and fraud, waste, and abuse) is implemented and provided to HPSM Employees and made available to Commissioners and Contractors, as appropriate. The Compliance Committee and the Commission are briefed on the status of compliance training.
- FDRs implement education and training for their staff involved in Medicare or Medi-Cal and that this training includes information about HPSM's Compliance Program.
- All data submitted to regulatory agencies are accurate and in compliance with reporting requirements.
- A work plan is developed to monitor the implementation and compliance with Medicare and Medi-Cal related Policies and Procedures.
- Marketing staff is aware of and follow the requirements for Medicare sales and marketing activities.
- Effective lines of communication are instituted, communication mechanisms such as telephone hotline calls are monitored, and complaints are investigated and treated confidentially (unless circumstances dictate the contrary) including any involving Medicare non-compliance or fraud.
- Inquiries and investigations with respect to any reported or suspected violation or questionable conduct including the coordination of internal investigations and investigations of FDRs are:
    - initiated timely and completed.
    - reported to the appropriate organization (DHCS, CMS or its designee, and/or law enforcement) as necessary
    - appropriate disciplinary actions and corrective action plans are implemented.
- Documentation is maintained for each report of potential non-compliance or fraud, waste, or abuse from any source including results and corrective action plans or disciplinary actions taken.
- Periodic reviews of the Participation Status Review process are completed with the Human Resources Department and other designated employees to ascertain that the process is conducted

in accordance with HPSM Policies and Procedures.
- Compliance software and electronic files are maintained to support implementation of the Compliance Program.
- Each of the requirements of the Compliance Program has been substantially accomplished.

Compliance Committee

The Compliance Committee is responsible for overseeing the Compliance Program, subject to the direction of the CEO and the ultimate authority of the Commission. The Compliance Committee is chaired by the Chief Government Affairs and Compliance Officer and meets on a quarterly basis. The Compliance Committee Charter identifies the responsibilities and membership of the Committee. HPSM maintains written minutes (as appropriate) of Compliance Committee meetings reflecting the reports made to the Committee and the Committee's decisions on issues raised (subject to applicable legal provisions concerning confidentiality.) The Compliance Committee Charter can be found in CP.001.

Managers / Supervisors

Managers/Supervisors must be available to discuss with each HPSM Employee under their direct supervision and every Contractor with whom they are the primary liaison:
- The content and procedures in this Compliance Program.
- The legal requirements applicable to Employees' and Contractors' job functions or contractual obligations, as applicable.
- That adherence to this Compliance Program is a condition of employment or contractual relationship.
- That HPSM shall take appropriate disciplinary action, including termination of employment or a Contractor's agreement with HPSM, for violation of the principles and requirements set forth in the Compliance Program and applicable law and regulations.

TRAINING

HPSM provides general and specialized compliance training and education, as applicable, to Commissioners and HPSM Employees to assist them in understanding the Compliance Program, including the Code of Conduct and Policies and Procedures relevant to their job functions. As a part of this process, all Commissioners and HPSM Employees are apprised of applicable state and federal laws, regulations, standards of ethical conduct and the consequences which shall follow from any violation of those rules or the Compliance Program.

Compliance and Fraud, Waste, and Abuse (FWA) Trainings

HPSM Employees are expected to complete compliance training within 14 calendar days of hire, and new Commissioners within 90 days of appointment to the HPSM Governing Body. HPSM Employees and Commissioners must complete compliance training annually thereafter.

New HPSM Employees receive a copy of the Code of Conduct during new hire compliance training and must attest that they have read and understood it. New Commissioners receive a copy of the Compliance Program and Code of Conduct upon appointment and annually thereafter.

Compliance trainings for HPSM Employees include information regarding:

- Health Insurance Portability and Accountability Act (HIPAA)
- Fraud, waste, abuse, and neglect including the False Claims Act, the Fraud Enforcement and Recovery Act, Anti-Kickback Statue, Stark Law, and Civil Monetary Penalties Law
- Compliance Program
- Code of Conduct
- Information on the confidentiality, anonymity, non-intimidation and non-retaliation for compliance-related questions or reports of potential non-compliance.
- Review of the disciplinary guidelines for non-compliant or fraudulent behavior.
- Review of potential conflicts of interest and HPSM's disclosure/attestation system.

HPSM Employees may receive additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Compliance training for Commissioners will focus on compliance and fraud, waste, and abuse.

Members of the Compliance Committee and other Leadership Team members are trained on how to respond appropriately to compliance inquiries and reports of potential non-compliance. This training also includes confidentiality, non-intimidation and non-retaliation against employees, and knowing when to refer the incident to the Chief Government Affairs and Compliance Officer.

Federal guidance specifically requires that all FDRs receive general compliance training, and in light of this requirement, FDRs are informed of their obligation to provide compliance training to their employees. HPSM receives confirmation that its FDRs conduct their own compliance training for staff and downstream entities in accordance with CMS guidance as part of the annual FDR audit. FDRs that have met the FWA certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the training and educational requirements for FWA.

Documentation

Documentation requirements related to the training and education program are addressed in the following manner:

- Core annual training material topics are available through a web-based tool. Core trainings include all-staff FWA, Compliance and HIPAA Privacy trainings. Confirmation of completion of assigned courses and post-test is documented through a web based tool and reviewed by the Chief Government Affairs and Compliance Officer to ensure staff completes assigned trainings.
- Supplemental annual trainings, such as manager training, are conducted in-person, with sign-in sheets retained as evidence of training participation.
- Documentation of trainings for Commissioners is captured through a web-based tool and reviewed by the Chief Government Affairs and Compliance Officer.

All Compliance Program training documents are retained in accordance with HPSM's Document Retention Policy.

EFFECTIVE LINES OF COMMUNICATION

Effective lines of communication are established ensuring confidentiality between the Chief Government Affairs and Compliance Officer, members of the Compliance Committee, HPSM managers and supervisors, HPSM Employees, Commissioners, and staff of FDRs. All Employees are encouraged to discuss compliance issues directly with their managers/supervisors or the Chief Government Affairs and Compliance Officer. All Employees are advised that they are required to report compliance concerns and suspected or actual misconduct and violations of law.

The Chief Government Affairs and Compliance Officer posts information such as the policies and procedures catalog (which includes the Code of Conduct as well as the Compliance Program) on HPSM's intranet, available to all HPSM Employees. Additional information can be posted as needed to update staff on changes in laws or regulations. The Chief Government Affairs and Compliance Officer also informs Commissioners of any relevant federal and state fraud alerts and policy letters, pending/new legislation reports, updates, and advisory bulletins as necessary.

Establishment and Publication of Reporting Hotlines

All Employees have an affirmative duty under the Compliance Program to report all violations, suspected violations, questionable conduct or practices by a verbal or written report to HPSM to a supervisor or the Chief Government Affairs and Compliance Officer. In the event any person wishes to remain anonymous, he/she may use HPSM's confidential hotline described below to report compliance concerns. The purpose of the hotline is to ensure that there is an effective line of communication for compliance issues between HPSM and its Commissioners, HPSM Employees, Contractors and/or members.

Compliance Hotline

HPSM has established a confidential Compliance Telephone Hotline (Compliance Hotline) for HPSM Commissioners, HPSM Employees, Contractors, Providers and Members and other interested persons to report any violations or suspected violations of law and/or the Compliance Program and/or questionable or unethical conduct or practices including, without limitation, the following:

- Incidents of fraud and abuse
- Criminal activity (fraud, kickback, embezzlement, theft, etc.)
- Conflict of interest issues
- Code of Conduct violations

HPSM currently uses a national hotline organization to administer its Compliance Hotline. The Compliance Hotline is accessible 24 hours a day, 365 days a year, excluding designated holidays (when callers will be routed to a voice mail message alerting them to call back during established hours of operation). A caller to the Compliance Hotline is initially greeted by a pre-recorded message that provides information regarding Compliance Hotline procedures and the caller's right to anonymity. Calls to the Compliance Hotline are not tape-recorded and will not be traced. The national hotline organization operator will ask the caller several questions relating to the reported issue, incident, etc. All reports are referred to HPSM's Chief Government Affairs and Compliance Officer and investigated. Follow-up calls may be scheduled; however, information regarding the investigation and status of any action taken relating to the report may not be available to the caller.

The compliance hotline information is as follows: TOLL FREE COMPLIANCE HOTLINE (844) 965-1241.

HPSM publicizes the Compliance Hotline by appropriate means of communication to Commissioners, HPSM Employees, and Contractors including, but not limited to: e-mail notice and/or posting in prominent common areas, as well as on HPSM's intranet.

Confidentiality, Non-Intimidation and Non-Retaliation

HPSM takes all reports of violations, suspected violations, questionable conduct or practices seriously. Verbal communications via the Compliance Hotline and written or verbal reports to managers or supervisors or anyone designated to receive such reports shall be treated as privileged and confidential to the extent permitted by applicable law and circumstances. The caller/author need not provide his/her name.

HPSM's "Open Door" policy encourages HPSM Employees to discuss issues directly with their managers,

supervisors, the Chief Government Affairs and Compliance Officer, other Leadership Team members, members of the Compliance Committee, or the CEO. These channels of discussion provide for confidentiality to the extent allowed by law.

HPSM maintains and supports a Non-Intimidation and Non -Retaliation policy which prohibits any retaliatory action against a Commission Member, HPSM Employee, or Contractor for making any verbal/written report in good faith. This includes qui tam relators who make a report under the federal or California False Claims Act.

Discipline shall not be increased because an Employee reported his or her own violation or misconduct. Prompt and complete disclosure may be considered a mitigating factor in determining an Employee's discipline. The non-tolerance for retaliation and intimidation is described in policy and reviewed in the annual compliance training. HPSM takes violations of the policy on non-intimidation and non-retaliation seriously; the Chief Government Affairs and Compliance Officer reviews disciplinary and/or other corrective actions for such violations with the Compliance Committee, as appropriate.

Although Commissioners and HPSM Employees are encouraged to report their own potential wrongdoing, they may not use any verbal or written report in an effort to insulate themselves from the consequences of their own violations or misconduct. Commissioners, HPSM Employees, and Contractors shall not prevent or attempt to prevent, a Commissioner, HPSM Employee, or Contractor from communicating via the Compliance Hotline or any other mechanism. If a Commissioner, HPSM Employee, or Contractor attempts such action, he or she is subject to disciplinary action.

DISCIPLINARY STANDARDS

Conduct Subject to Discipline

HPSM Employees may be subject to discipline up to and including termination for failing to participate in HPSM's Compliance efforts. All new and renewing contracts include a provision that clarifies that a contract can be terminated because of a violation. The following are examples of conduct subject to enforcement and discipline:

- Failure to perform any required obligation relating to the Compliance Program or applicable law, including conduct that results in violation of any Federal or state law relating to participation in Federal and/or State health care programs.
- Failure to report violations or suspected violations of the Compliance Program or applicable law to an appropriate person or through the Compliance Hotline.
- Conduct that leads to the filing of a false or improper claim or that is otherwise responsible for the filing of a claim in violation of federal or state law.

Enforcement and Discipline

HPSM maintains a "zero tolerance" policy towards any illegal conduct that impacts the operation, mission, or image of HPSM. Any employee or contractor engaging in a violation of laws or regulations (depending on the magnitude of the violation) may have their employment or contract terminated. HPSM shall accord no weight to a claim that any improper conduct was undertaken "for the benefit of HPSM". Illegal conduct is not for HPSM's benefit and is expressly prohibited.

The standards established in the Compliance Program must be fair and consistently enforced through disciplinary proceedings. These shall include the following:

- Prompt initiation of education to correct the identified problem.
- Disciplinary action, if any, as may be appropriate given the facts and circumstances of the investigation including oral or written reprimand, demotions, reductions in pay, and termination.

In determining the appropriate discipline or corrective action for any violation of the Compliance Program or applicable law, HPSM does not take into consideration a particular person's or entity's economic benefit to the organization.

All Employees should also be aware that violations of applicable laws and regulations could potentially subject them or HPSM to civil, criminal, or administrative sanctions and penalties. Further, violations could lead to HPSM's suspension or exclusion from participation in Federal and/or State health care programs. Documentation of all actions taken will be done by the Chief Government Affairs and Compliance Officer according to the guidelines set forth in the Compliance Program.

MONITORING and AUDITING

At the direction of the Chief Government Affairs and Compliance Officer and/or Compliance Committee, HPSM's Compliance and Operational staff perform auditing and monitoring functions for the organization to ensure compliance with applicable law and the Compliance Program. They report, investigate and, if necessary and appropriate, correct, any inconsistencies, suspected violations, or questionable conduct. The Chief Government Affairs and Compliance Officer develops an auditing work plan that is approved by the Compliance Committee that addresses risks, including, but not be limited to, areas of risk identified in the OIG's Annual Work Plan for Medicare Managed Care, Medicare Administration, and Medi-Cal. Focused audits are conducted based on audit reports from HPSM regulators including DHCS, DMHC, and CMS. In addition, the Chief Government Affairs and Compliance Officer develops auditing Policies and Procedures

that are reviewed by the Compliance Committee.

Monitoring is an on-going process to ensure processes are working as intended. On-going checking and measuring can be performed daily, weekly, or monthly, or on an ad hoc basis. Monitoring should be performed by department staff as well as compliance staff. Auditing is completed by independent compliance staff and is a more formal and objective approach to evaluate and improve the effectiveness of HPSM processes and to ensure oversight of delegated activities.

A risk assessment tool is used to conduct an assessment of HPSM's major compliance and FWA risk areas. This includes Medicare business operations, such as marketing, enrollment, appeals and grievances, benefit/formulary administration, transition policy, utilization management, accuracy of claims payments, and oversight of FDRs. The risk assessment is updated at least quarterly.

Oversight of Delegated Activities

HPSM delegates certain functions and/or processes to FDRs. These include:

- Provider credentialing and re-credentialing at select facilities and for pharmacists
- PBM Pharmaceutical claims processing and aspects in the administration and delivery of the Medicare Part D benefit
- Mental health benefits, including claims processing (for Medi-Cal, CareAdvantage, and HealthWorx lines of business)
- Transportation benefit for Medi-Cal and CareAdvantage
- Imaging of claims

Contractors are required to meet all contractual, legal, and regulatory requirements and comply with HPSM Policies and Procedures and other guidelines applicable to the delegated functions. HPSM maintains oversight of these delegated functions and will conduct annual audits of delegated entities.

Oversight of Non-Delegated Activities

HPSM maintains oversight responsibility of the following activities that are not delegated to Contractors:

- Quality Improvement Program for Medicare and Medi-Cal lines of business
- Grievances and Appeals processes
- Peer review process on specific, referred cases.
- Risk Management
- Pharmacy and drug utilization review as it relates to quality of care.
- Provider credentialing and re-credentialing, except as noted above

- Development of credentialing standards in specified circumstances
- Development of utilization standards
- Development of quality improvement standards
- Compliance

External Auditing for Pharmacy Benefits

As part of its work plan, HPSM developed a strategy to monitor and audit its pharmacy benefits manager and other entities that are involved in the administration or delivery of the pharmacy benefits, including Medicare Part D. HPSM seeks written assurances from its PBM that it has an adequate audit work plan in place that includes auditing of network pharmacies and reporting with respect to HPSM Members. HPSM receives audit reports on a regular basis. HPSM also seeks written assurances that the PBM has implemented corrective actions when appropriate. Contracts are amended as needed to ensure PBM compliance.

In addition, HPSM routinely generates a number of reports to aid in monitoring and oversight efforts. These reports include:

- Payment reports
- Drug utilization reports
- Physician prescribing reports
- Unusual utilization pattern reports

Finally, HPSM uses system edits to monitor the delivery of the prescription drug benefit. Examples of such edits are: controls on early refills, edits to prevent payment for excluded drugs, limits on the number of times a prescription can be refilled, and step therapy edits.

Internal Auditing

An annual auditing work plan is developed by the Compliance Department and includes:

- Internal audit schedule
- Audit report, including:
    - Audit objectives
    - Scope and methodology
    - Findings
    - Recommendations
- Audit staffing
- Approval, monitoring, and validation of corrective action plans

In developing the types of audits to include in the work plan, HPSM bases audits on the risk assessment to

determine which risk areas will most likely affect HPSM. The Compliance Committee has input into the priority of the monitoring and audit strategy. In determining risk areas, HPSM reviews the annual OIG work plan, the CMS Medicare Managed Care Manual and Prescription Drug Benefit Manual (Chapters 21 and 9, respectively), and resources developed by the industry that identify high risk areas in HPSM's programs and the health care industry.

The Chief Government Affairs and Compliance Officer, Compliance Committee, and business owners may ask the internal audit staff to conduct audits on specific topics not on the formal work plan should circumstances warranted such a review.

Finally, audits also may include follow up review of areas previously found non-compliant to determine if the corrective actions taken have fully addressed the underlying problem.

The work plan also includes a process for responding to all monitoring and audit results, including referral to appropriate agencies (e.g., CMS, the MEDIC, DHCS, law enforcement) when appropriate. All compliance actions taken will be tracked to evaluate the success of implementation efforts.

Compliance Program Effectiveness Audit

HPSM conducts annual effectiveness audits of its Compliance Program, the results of which are shared with the CEO, Compliance Committee and Commission. HPSM avoids self-policing through utilization of staff who do not report to the Chief Government Affairs and Compliance Officer or other managers in the Compliance Department, or by outsourcing the audit to external auditors.

The HPSM Compliance Department maintains less formal measures of compliance program effectiveness, including internal and external audit results and a dashboard of reported compliance issues.

Audit Review

The Chief Government Affairs and Compliance Officer submits regular reports of all auditing and corrective action activities to the Compliance Committee. When appropriate, HPSM informs the appropriate agency (e.g., DHCS, CMS or its designee including the appropriate MEDIC, or law enforcement) of aberrant findings.

PROMPT RESPONSE TO COMPLIANCE ISSUES

HPSM is committed to responding to compliance issues thoroughly and promptly and has developed policies to address the reporting of and responding to compliance issues. If an Employee becomes aware

of a violation, suspected violation or questionable or unethical conduct in violation of the Compliance Program or applicable law, the Employee must notify HPSM staff immediately. A Commissioner or Contractor should notify HPSM of a suspected violation or questionable unethical conduct by reporting the concern to the Chief Government Affairs and Compliance Officer or CEO. Any such reports of suspected violations may also be made to the Compliance Hotline.

The Chief Government Affairs and Compliance Officer refers compliance issues involving the CEO directly to the Commission. The CEO refers any issue that involves a Commissioner to the San Mateo Board of Supervisors.

HPSM maintains a Fraud, Waste and Abuse plan that defines the plan's approach to detecting, preventing, and deterring fraud, waste, and abuse. Significant fraud, waste and abuse issues are summarized to the Compliance Committee and a FWA Subcommittee of the Compliance Committee reviews potential cases of FWA to determine potential actions by HPSM, need for external assistance or determination that FWA has not occurred.

Reports of suspected or actual compliance violations, unethical conduct, fraud, abuse, or questionable conduct, whether made by Commissioners, Employees, Contractors, or third parties external to HPSM (including regulatory and/or investigating government agencies), in writing or verbally, formally or informally are investigated. These are subject to review and investigation by HPSM's Chief Government Affairs and Compliance Officer and/or the Compliance Committee, in consultation with legal counsel.

Self-Reporting

HPSM makes appropriate referrals to the CMS or the MEDIC; DHCS Medi-Cal Managed Care Division's (MMCD) Program Integrity Section; DHCS Audits and Investigations; DMHC; other agencies, as appropriate; or law enforcement for further investigation and follow-up of cases involving FWA, following the self-reporting section of the policy on Fraud, Waste, and Abuse.

Participation Status Review and Background Checks

HPSM does not hire, contract with, or retain on its behalf, any person or entity that is currently suspended, excluded or otherwise ineligible to participate in Federal and/or State health care programs; and/or has ever been excluded from participation in Federal and/or State health care programs based on a Mandatory Exclusion. HPSM maintains policies on participation status for All Employees and providers.

Participation Status Review

HPSM reviews Commissioners, HPSM Employees and Contractors against appropriate exclusion lists to

ensure that they are not excluded, suspended or otherwise ineligible to participate in Federal and/or State health care programs. HPSM requires that potential Commissioners, Employees and Contractors disclose their Participation Status as part of the employment/contracting/appointment process and when Commissioners, Employees, and Contractors receive notice of any suspension, exclusion, debarment or felony conviction during the period of employment, contract or appointment. HPSM also requires those delegated to complete provider credentialing and re-credentialing that comply with Participation Status Review requirements with respect to their relationships with participating providers and suppliers. This review is conducted prior to employment or contractual engagement of a person or entity and monthly thereafter according to Participation Status Review Policies and Procedures.

Background Checks

HPSM has implemented additional Policies and Procedures relating to background checks for specified potential or existing Employees or Contractors as may be required by law and/or deemed by HPSM to be otherwise prudent and appropriate.

Notice and Documentation

HPSM and its Employees comply with applicable federal and state laws governing notice and disclosure obligations relating to Participation Status Reviews and background checks. Employees responsible for conducting the Participation Status Reviews and/or background checks shall record and maintain the results of the reviews and notices/disclosures and shall provide periodic reports to the Chief Government Affairs and Compliance Officer.

DOCUMENTATION

The Chief Government Affairs and Compliance Officer has established and maintains an electronic filing system for all compliance-related documents. These tools are used to:

- Manage all Policies and Procedures.
- Organize and manage contracts.
- Organize and manage agendas, minutes, and meeting materials for Compliance Committee meetings and the FWA Committee.
- Document compliance with the Department of Health Care Services Medi-Cal contract.
- Organize audit materials for regulators and provide web access to materials to regulators.
- Document incidents of potential fraud.
- Document internal audits and those of delegated entities.
- Complete staff attestations.
- Maintain Compliance training records.

Document Retention

All of the documents to be maintained in the filing system described above are retained for ten (10) years from end of the fiscal year in which the HPSM Medicare or Medi-Cal contracts expire or are terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary).

APPENDIX A

GLOSSARY

Abuse means practices that are inconsistent with sound fiscal, business or medical/dental practice, and result in unnecessary cost, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Abuse also includes member practices that result in unnecessary cost to Medicare, Medi-Cal or other HPSM lines of business.

All Employees mean those HPSM Employees, interns, temporary employees, volunteers, Commissioners, contractors, or a First Tier, Downstream or Related Entity (FDR) who provide health or administrative services for an HPSM member.

Audit means a formal review of compliance with a particular set of internal (e.g., policies and procedures) or external (e.g., laws and regulations) standards used as base measures.

Centers for Medicare & Medicaid Services (CMS) means the Centers for Medicare & Medicaid Services, the operating component of the Department of Health and Human Services (DHHS) charged with administration of the Federal Medicare and Medicaid programs.

Code of Conduct means the statement setting forth the principles and standards governing HPSM's activities to which Commissioners, Employees, and Contractors are expected to adhere.

Commissioners mean the members of HPSM's Governing Body.

Compliance Committee means the committee designated by the CEO to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Program.

Compliance Program means the program (including, without limitation, Code of Conduct and Policies and Procedures) developed and adopted by HPSM to promote, monitor and ensure that HPSM's operations and practices and the practices of its Commissioners, Employees, Contractors, and FDRs comply with applicable law and ethical standards.

Contractor means any contractor, subcontractor, agent, or other person including FDRs which or who, on behalf of HPSM, furnishes or otherwise authorizes the furnishing of health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by HPSM.

Contractor Agreement means any agreement with a Contractor.

Department of Health Services (DHCS) means the California Department of Health Services, the State agency that oversees the Medi-Cal program.

Department of Managed Health Care (DMHC) means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 et seq.

Downstream Entity is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with an HPSM Medicare line of business below the level of the arrangement between HPSM and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

HPSM Employee(s) means any and all Employees of HPSM, including all Leadership Team members, managers, supervisors, and other employed personnel include temporary staff. Interns and volunteers are also included in this reference.

First Tier Entity means First Tier, Downstream or Related Entity. ***First Tier Entity*** means any party that enters into a written arrangement with HPSM to provide administrative services or health care services to HPSM members. ***Downstream Entity*** means any party that enters into a written arrangement with persons or entities below the level of the arrangement between HPSM and a first-tier entity. ***Related Entity*** means any entity related to HPSM by common ownership or control..

FDR means a first tier, downstream or related entity.

Federal and/or State Health Care Programs means "any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program" as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

Fraud means an intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit to itself, him/herself or some other person and includes any act that constitutes fraud under applicable Federal or State laws including, without limitation, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit.

Governing Body means the San Mateo Health Commission.

HPSM means the Health Plan of San Mateo, a County Organized Health System (COHS) created under California Welfare and Institutions Code Section 14087.5-14087.95 and San Mateo County Ordinance No.03067, as amended by Ordinance No. 04245.

HPSM Member means a beneficiary who is enrolled in one of HPSM's lines of business.

Manager / Supervisor means an Employee in a position representing HPSM who has one or more employees reporting directly to him or her. With respect to Contractors, the term "Supervisor" shall mean the HPSM Employee that is the designated liaison for that Contractor.

Mandatory Exclusion means an exclusion or debarment from Federal and/or State health care programs for any of the mandatory bases for exclusion identified in 42 U.S.C. § 1396a-7(a) and the implementing regulations including a conviction of a criminal offense related to the delivery of an item or service under Federal and/or State health care programs; and/or a felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service; related to health care fraud and/or related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

Medicare means both Part C (Parts A and B) and Part D of Medicare.

Medicare Drug Integrity Contractors (MEDICs) means a private organization contracted with CMS to assist in the management of CMS' audit, oversight, and anti-fraud and abuse efforts in the Medicare Part D benefit.

National Committee for Quality Assurance Standards for Accreditation of MCOs (NCQA Standards) means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Office of the Inspector General (OIG) means the Office of the Inspector General for the Department of Health and Human Services.

Participating providers and suppliers include all health care providers and suppliers (e.g. physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies etc.) that receive reimbursement from HPSM for items or services furnished to members.

Participation Status means whether a person or entity is currently suspended, excluded, or otherwise ineligible to participate in Federal and/or State health care programs and/or was ever excluded from participation in Federal and/or State health care programs based on a Mandatory Exclusion.

Participation Status Review means the process by which HPSM reviews its Commissioners, Employees, Contractors, and HPSM direct providers to determine whether they are currently suspended, excluded, or otherwise ineligible to participate in Federal and/or State health care programs; and/or were ever excluded from participation in Federal and/or State health care programs based on a Mandatory Exclusion.

Policies and Procedures means the written policies and procedures regarding the operation of HPSM's Compliance Program and its compliance with applicable law, including those relating to Medicare and California's Medicaid program, Medi-Cal.

Related Entity means any entity related to HPSM by common ownership or control and (1) performs some of HPSM's management functions under contract or delegation, (2) furnishes services to Medicare beneficiaries under an oral or written agreement, or (3) leases property or sells materials to HPSM at a cost of more than $2500 during a contract period.

Waste means an overutilization or misuse of resources that result in unnecessary costs to the healthcare system, either directly or indirectly.

APPENDIX B

Compliance Policies and Procedures

Policy No.	Policy Title
CP.001	Compliance Committee Charter
CP.002	ACA Section 1557 Compliance
CP.003	Reporting Compliance Concerns
CP.004	Compliance Hotline
CP.005	Non-Retaliation & Non-Intimidation
CP.006	False Claims Act Compliance
CP.007	Distribution of Compliance Program Materials
CP.008	Internal Auditing
CP.009	Notification Process for Compliance Issues
CP.010	Civil Rights Obligations for Subcontractors
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Health Plan of San Mateo
Policy & Procedure Manual

Procedure: CP.009		Title: Notification Process for Compliance Issues	Original Effective Date: 02/24/2017
Revision: 7~~5~~	Last Reviewed /Revised: ~~09/17/2024~~08/04/2025	Dept: Compliance	Page 1 of 4

Approval By: Compliance Committee	**Date:** ~~11/09/2024~~
Approval By: San Mateo Health Commission	Date:
Annual Review Date: 10/01/~~2025~~2026	
Authored by: Chief Government Affairs and Compliance Officer	
Pursuant To: ☒ DHCS Contract Exhibit A, Attachment III, Provisions 1.3.1(F), (I), (K)-(L) ☐ Health and Safety (H&S) Code ☒ CFR 42 CFR 422.503(b)(4)(vi); 42 CFR 423.504(b)(4)(vi) ☐ APL / DPL	☐ W & I Code ☐ California Title # ☐ Organization Need ☒ Other Medicare Managed Care Guide Chapter 21, Section 50.4; Medicare Prescription Drug Benefit Manual Chapter 9, Section 50.4
Departments Impacted: All	

Policy:

This policy documents the Health Plan of San Mateo's (HPSM) procedure for notifying the appropriate party or parties of compliance issues, including the Chief Government Affairs and Compliance Officer, Compliance Committee, Chief Executive Officer, the Finance/Compliance Committee, and~~/or~~ the Commission.

Scope

This procedure applies to (check all that apply):

☒ All LOBs/Entire Organization	☐ CCS	☐ Medi-Cal Expansion
		☐ Medi-Cal Adults
☐ ACE	☐ HealthWorx	☐ Medi-Cal Children
☐ CA-DSNP	☐ Medi-Cal	☐ Other (specify)

Responsibility and Authority

- The Chief Government Affairs and Compliance Officer is responsible for implementing a Compliance Program to ensure that HPSM services are provided in accordance with all applicable federal, state, and county laws and regulations.

Definitions

Compliance issue means any ~~incident involving noncompliant~~non-compliance, including FWA or incident involving~~,~~ unethical~~,~~ or illegal behavior individuals or entities affiliated with HPSM. ~~For the purposes of this policy, "compliance issue" includes issues regarding privacy or FWA.~~

Employee means any full or part-time permanent HPSM employee, temporary employee, intern, volunteer, co-located county staff working at HPSM, or consultant working for HPSM.

Procedure: CP.009		Title: Notification Process for Compliance Issues	Original Effective Date: 02/24/2017
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Noncompliance means the failure to meet regulatory or legal requirements as stipulated in federal and state contracts, whether intentional or accidental.

Subcontractor means any entity or person under contract with HPSM which or who, on behalf of HPSM, furnishes or otherwise authorizes the furnishing of health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by HPSM. This includes First Tier, Downstream and Related Entities (FDR).

Procedure

1.0 Requirements

1.1 HPSM employees and subcontractors are required to report any suspected or known incidents of fraud, waste and abuse, privacy and~~/or~~ other non-compliance.

2.0 General Reporting of Compliance Issues

2.1 All compliance issues are reviewed by the Chief Government Affairs and Compliance Officer.

~~2.1.1 Compliance issues identified per CP.027 are included for review.~~

2.2 Quarterly, ~~all~~ compliance ~~issues are~~issue performance and trends are shared with the Compliance Committee.

2.2.1 The Chief Executive Officer is a standing member of the Compliance Committee.

2.2.2 Subject Matter Experts, including leadership and other key staff serve as standing members or are invited to the Compliance Committee to discuss compliance issues as needed.

2.3 At least twice a year, compliance issue statistics are shared with the Finance/Compliance Committee.

~~2.3~~2.4 At least ~~A~~annually, ~~compliance issue statistics are shared with the Commission~~the Commission is given an annual compliance report.

~~2.4~~2.5 Specific compliance issues are presented to the Commission, through the Finance/Compliance Committee per this Section.~~at the request of the Chief Government Affairs and Compliance Officer, Compliance Committee, or the Chief Executive Officer~~.

~~2.4.1~~2.5.1 These issues include, but are not limited to:

~~2.4.1.1~~2.5.1.1 Confirmed cases of fraud, waste and abuse~~;~~

~~2.4.1.2~~2.5.1.2 Privacy breaches~~;~~

~~2.4.1.3~~2.5.1.3 Notices of Non-Compliance or other formal regulatory agency action against HPSM~~;~~

~~2.4.1.4~~2.5.1.4 Other incidents of significant non-compliance (see Section 3.0)~~;~~

~~2.4.1.5~~2.5.1.5 Cases involving law enforcement; and

~~2.4.1.6~~2.5.1.6 Incidents involving potential for, or the assessment of civil monetary penalties~~.~~

Procedure: CP.009		Title: Notification Process for Compliance Issues	Original Effective Date: 02/24/2017
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3.0 Disclosures of Significant Non-Compliance

3.1 Certain incidents of significant non-compliance may warrant disclosure to the Commission.

3.1.1 Issues that pose a risk to members, providers or HPSM.

3.1.1.1 Risks to members may include, but are not limited to issues impacting the health of a group of members such as timely access to care or quality of care;

3.1.1.2 Risks to providers may include, but are not limited to issues impacting the financial stability of providers;

3.1.1.3 Risks to HPSM include, but are not limited to issues impacting HPSM's reputational, financial, legal, or operational health.

3.2 The Chief Government Affairs and Compliance Officer, Compliance Committee, and/or CEO may determine when an issue, not otherwise defined in Sections 2.4 and 3.1 requires disclosure to the Finance/Compliance Committee or the Commission.

4.0 Timing of Disclosures

4.1. Cases defined as a breach, fraud or non-compliance may be discussed with:

4.1.1. The CEO at a regular CEO and Chief Government Affairs and Compliance Officer one-on-one meeting;

4.1.2. The Compliance Committee, at the quarterly meeting following receipt of the issue unless an ad hoc meeting is called; and

4.1.3. The ~~Commission~~Finance/Compliance Committee, at the regularly scheduled meeting following receipt of an issue unless an ad hoc meeting is called.

4.2. Prior to disclosure to the ~~Commission~~Finance/Compliance Committee, all issues meeting disclosure criteria per Sections 2.4 or 3.1 of this policy shall be reported first to the Compliance Committee for review.

4.2.1. Cases identified for disclosure by the Compliance Committee will be reported at the next meeting of the Finance/Compliance Committee

4.2.2. The CEO or Chief Government Affairs and Compliance~~CC~~ Officer may determine any issue to require immediate notification to the Commission, either through a regularly scheduled meeting of the Commission or the Finance/Compliance Committee.

4.2.2.1. Such decisions shall be disclosed to the Compliance Committee at the next scheduled Compliance Committee meeting, or through ~~an email~~email notification, after consultation with legal counsel.~~.~~

5.0. Voluntary Self-Disclosure

5.1. Self-disclosure is a voluntary practice where HPSM, absent a request from a health care oversight agency, discloses a compliance issue to one or more health care oversight agencies and/or the Commission.

5.2. Self-disclosure demonstrates:

5.2.1. That HPSM has a functioning Compliance Program;

5.2.2. That HPSM is dedicated to operating a compliant managed care organization;

5.2.3. That HPSM is a partner in the delivery of health care services with the health care oversight agency; and

5.2.4. That HPSM places a high value on transparency and cooperation.

5.3. Self-disclosure to a health care oversight agency may be made by the Chief Government Affairs and Compliance Officer or the CEO.

5.3.1. If self-disclosure is to the HHS OIG, HPSM will follow the reporting instructions in the Self-Disclosure Protocol (SDP):

https://oig.hhs.gov/compliance/self-disclosure-info/files/Provider-Self-Disclosure-Protocol.pdf

6.0. Records

6.1 All compliance issue related records are maintained in accordance with HPSM policy CP.019.

Related Documentation

- CP.000 Compliance Program
- CP.003 Reporting Compliance Concerns
- CP.004 Compliance Hotline
- CP.016 Investigating and Reporting Fraud, Waste, Abuse and Neglect
- CP.019 Document Retention
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- CP.027 Corrective Action Plan Monitoring Process

Attachments

- None

Log of Revisions	
Revision Number	Revision Date
0	02/17/2017
1	03/15/2017
2	12/26/2017
3	02/19/2019
4	12/17/2019
5	06/02/2023
6	09/17/2024
7	08/04/2025

Health Plan of San Mateo
Policy & Procedure Manual

Procedure: CP.009		Title: Notification Process for Compliance Issues	Original Effective Date: 02/24/2017
Revision: 7	Last Reviewed /Revised: 08/04/2025	Dept: Compliance	Page 1 of 4

Approval By: Compliance Committee	**Date:** 08/18/2025
Approval By: San Mateo Health Commission	**Date:**
Annual Review Date: 10/01/2026	
Authored by: Chief Government Affairs and Compliance Officer	
Pursuant To: ☒ DHCS Contract Exhibit A, Attachment III, Provisions 1.3.1(F), (I), (K)-(L) ☐ Health and Safety (H&S) Code ☒ CFR 42 CFR 422.503(b)(4)(vi); 42 CFR 423.504(b)(4)(vi) ☐ APL / DPL	☐ W & I Code ☐ California Title # ☐ Organization Need ☒ Other Medicare Managed Care Guide Chapter 21, Section 50.4; Medicare Prescription Drug Benefit Manual Chapter 9, Section 50.4
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2.2.2 Subject Matter Experts, including leadership and other key staff serve as standing members or are invited to the Compliance Committee to discuss compliance issues as needed.

2.3 At least twice a year, compliance issue statistics are shared with the Finance/Compliance Committee.

2.4 At least annually, the Commission is given an annual compliance report.

2.5 Specific compliance issues are presented to the Commission, through the Finance/Compliance Committee per this Section..

2.5.1 These issues include, but are not limited to:

2.5.1.1 Confirmed cases of fraud, waste and abuse

2.5.1.2 Privacy breaches

2.5.1.3 Notices of Non-Compliance or other formal regulatory agency action against HPSM

2.5.1.4 Other incidents of significant non-compliance (see Section 3.0)

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4.1.1. The CEO at a regular CEO and Chief Government Affairs and Compliance Officer one-on-one meeting;

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4.1.3. The Finance/Compliance Committee, at the regularly scheduled meeting following receipt of an issue unless an ad hoc meeting is called.

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5.2. Self-disclosure demonstrates:

5.2.1. That HPSM has a functioning Compliance Program;

5.2.2. That HPSM is dedicated to operating a compliant managed care organization;

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5.2.3. That HPSM is a partner in the delivery of health care services with the health care oversight agency; and

5.2.4. That HPSM places a high value on transparency and cooperation.

5.3. Self-disclosure to a health care oversight agency may be made by the Chief Government Affairs and Compliance Officer or the CEO.

5.3.1. If self-disclosure is to the HHS OIG, HPSM will follow the reporting instructions in the Self-Disclosure Protocol (SDP):

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- CP.027 Corrective Action Plan Monitoring Process

Attachments

- None

Log of Revisions	
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0	02/17/2017
1	03/15/2017
2	12/26/2017
3	02/19/2019
4	12/17/2019
5	06/02/2023
6	09/17/2024
7	08/04/2025

HEALTH PLAN of SAN MATEO

CODE OF CONDUCT

~~2024~~2025

Table of Contents

A Message from the Chief Executive Officer

The Health Plan of San Mateo (HPSM) values the contribution of all employees, Commissioners, Committee Members, and Contracted Business Partners toward the goal of providing the highest possible quality of services to its members and providers. This *Code of Conduct* is created in accordance with state and federal requirements to provide guidance in following the ethical, legal, regulatory, and procedural principles that are necessary for maintaining high standards. This document serves as a guide for complying with HPSM's internal policies and procedures as well as all applicable laws and regulations.

This *Code of Conduct*, approved by the San Mateo Health Commission, applies to all HPSM staff, including employees, temporary staff and interns, as well as Commissioners, Committee Members, and Contracted Business Partners. In this document, the word *employee* encompasses all four groups unless otherwise stated.

The consequences for HPSM organizationally of failing to comply with this *Code of Conduct* can be serious, including member, financial, and reputational harm. Failure to comply may result in disciplinary actions up to and including termination.

Although this document was designed to provide overall guidance, it does not address every situation. Please refer to HPSM Policies and Procedures on HPSM's Intranet or in HPSM's Human Resources (HR) Policy Manual if additional direction is needed.

If there is no specific HPSM policy, this *Code of Conduct* becomes the policy. If a policy conflicts with this *Code of Conduct*, the *Code of Conduct* takes precedence. Questions or issues regarding this document or a policy should be discussed first with the immediate supervisor. If additional guidance is needed, one should go through the chain of authority up to and including HPSM's Chief Government Affairs and Compliance Officer, other members of the Leadership Team, or the Chief Executive Officer. Any issues may also be reported confidentially and anonymously by using HPSM's compliance hotline at 1-844-965-1241.

Thank you for your commitment to HPSM and your dedication to serve our members, providers, and our community partners in an ethical, professional manner using the high standards which are embodied in this *Code of Conduct*.

Sincerely,

Pat Curran
Chief Executive Officer

Introduction

The Health Plan of San Mateo (HPSM) is a local non-profit health care plan that offers health coverage and a provider network to San Mateo County's underserved population. We currently serve more than ~~130~~150,000 County residents.

The County Board of Supervisors established the San Mateo Health Commission in 1986 to address and resolve the issues of poor access to physicians, an uncoordinated health care system endured by the county's growing population of Medi-Cal patients. In 1987, the Commission founded the Health Plan of San Mateo to provide access to a stable and comprehensive network of providers, and a benefits program that promotes preventive care with staff devoted to ensuring Medi-Cal patients receive high quality, coordinated health care.

Our Mission

To ensure that San Mateo County's underserved residents have access to high-quality care services and supports so they can live the healthiest lives possible.

Our Vision

We believe that ***Healthy is for everyone*** and work to continually advocate for our members health, especially those disproportionally impacted by health inequities, and meet the highest quality of care standards.

Our Values

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

Commitments

This *Code of Conduct* is intended to help both the Health Plan of San Mateo as a whole and individual employees stay true to the following commitments.

To HPSM Members
HPSM is committed to delivering quality, affordable health care by providing its members access to a network of credentialed health care providers, customer service staff, and a grievance and appeal process for timely problem resolution.

To HPSM Providers
HPSM is dedicated to providing efficient network management resources for its contracted providers, honoring contractual obligations, delivering quality health services, and bringing efficiency and cost-effectiveness to health care.

To HPSM Community Partners
HPSM is dedicated to advocating for healthcare needs of San Mateo County with a commitment to addressing challenges of access for the underserved.

To HPSM Contracted Business Partners
HPSM is committed to managing contractor and supplier relationships in a fair and reasonable manner. The selection of Contracted Business Partners, e.g. vendors, contractors, suppliers, and First-tier, Downstream, and Related entities (FDRs), is based on objective criteria including quality, technical excellence, price, delivery, adherence to schedules, service, and maintenance of adequate sources of staff and supply. HPSM will not communicate confidential information given to us by its suppliers unless directed to do so by the supplier or by law.

Code of Conduct

All HPSM employees, Commissioners, Committee Members, and Contracted Business Partners are responsible for following these standards.

1. Privacy and Confidentiality

1.1. Respect the privacy of members, providers, and co-workers by safeguarding their information from physical damage, maintaining member health information and business documents in a safe and protected manner, and following HPSM's record retention policies.

1.2. Protect the privacy of HPSM members' protected health information (PHI) according to federal and state requirements.

1.3. When using, disclosing, or requesting PHI, limit the information to the minimum amount needed to accomplish the work. Do not share or request more PHI than is necessary.

1.4. Only share medical, business, or other confidential information when such release is supported by a legitimate clinical or business purpose and is in compliance with HPSM policies and procedures, and applicable laws and regulations.

1.5. Whenever it becomes necessary to share confidential information outside HPSM for legitimate business purposes, release PHI only after obtaining a signed business associate agreement or a completed Authorization to Release Information Form.

1.6. Exercise care to ensure that confidential information, such as salary, benefits, payroll, personnel files, and information on disciplinary matters is carefully maintained and managed.

1.7. Do not discuss confidential member, provider, contractor, or employee information in any public area, such as elevators, hallways, stairwells, restrooms, lobbies, or eating areas.

1.8. Do not divulge, copy, release, sell, loan, alter, or destroy any confidential information except as authorized for HPSM business purposes or as required by law.

2. Security of Electronic Information

2.1. Practice good workstation security, which includes locking up offices and file cabinets; disposing of all paperwork in appropriate shredding receptacles; and covering all PHI or locking the computer if stepping away from the desk.

2.2. Practice good work-from-home (WFH) security, which includes following HPSM's guidance on WFH protections for PHI and equipment.

2.3. Take appropriate and reasonable measures to protect against the loss or theft of electronic media (e.g., laptops, flash drives, CDs/DVDs, photocopier hard drives, etc.) and against unauthorized access to electronic media that may contain member protected health information. Maintain and monitor security, data back-up, and storage systems.

2.4. Maintain computer passwords and access codes in a confidential and responsible manner. Only allow authorized persons to have access to computer systems and software on a "need-to-know" basis.

2.5. Do not share passwords or allow access to information to Contracted Business Partners, unless authorized to do so.

2.6. Transmit electronic confidential information securely in encrypted form.

3. Workplace Conduct

3.1. Respect the dignity of every employee, provider, member, and visitor while providing high-quality services and treating one another with respect and courtesy.

3.2. Communicate openly and honestly and respond to one another in a timely manner. Share information and ask questions freely.

3.3. Be civil and comply with existing policies about the treatment of colleagues, non-harassment, and respect in the workplace.

3.4. Conduct HPSM business with high standards of ethics, integrity, honesty, and responsibility, and act in a manner that enhances our standing in the community.

3.5. Support and observe a workplace free of alcohol, drugs, smoking, harassment, and violence.

3.6. Do not act in any way that will harm HPSM.

4. Use of Social Media

4.1. Do not engage in activity on social media sites that violates HPSM's mission, vision and values.

4.2. As an employee, when one's connection to HPSM is apparent, the employee must make it clear that the posting is on behalf of the individual and not HPSM.

4.3. Protect members' confidentiality and protected health information at all times. Do not write or say anything that violates HPSM's privacy, security, or confidentiality policies. Never post any information that can be used to identify an HPSM member's identity or health condition.

4.4. Maintain the confidentiality of HPSM business information and do not discuss this information on social media sites.

4.5. Always seek official approval from the Leadership Team before posting an official statement about HPSM. Only designated staff may speak on behalf of HPSM.

4.6. Employees may not use HPSM email addresses or phone numbers for personal use of social media.

5. Adhering to Laws and Regulations

5.1. Follow all state and federal laws and regulations, including reporting requirements.

5.2. Do not knowingly make any false or misleading statements, verbal or written, to government agencies, government officials or auditors.

5.3. Do not conceal, destroy, or alter any documents.

5.4. Do not give or receive any form of payment, kickback, or bribe or other inducements to members, providers, or others in an attempt to encourage the referral of members to use a particular facility, product, or service.

5.5. Avoid inappropriate discussions regarding business issues.

6. Safety

6.1. Comply with established safety policies, standards, and training programs to prevent job-related hazards and ensure a safe environment for members, providers, employees, and visitors.

6.2. Wear an HPSM badge at all times while in HPSM offices and when representing HPSM offsite.

6.3. Not share or lend an HPSM employee badge to any other individual, including visitors, other HPSM staff or co-located San Mateo County staff to access secured areas in HPSM offices. Badges are issued on a per-individual basis and may only be used by the individual who was issued that badge.

7. Conflict of Interest

7.1. Avoid actual, apparent, or potential conflicts between one's own interests and the interests of HPSM. Comply with all legal requirements concerning conflicts of interest and incompatible activities. Complete all disclosure documentation as required.

7.2. Act in the best interest of HPSM whenever functioning as an agent of HPSM in dealings with contractors, providers, members, or government agencies. This includes those acts formalized in written contracts as well as everyday business relationships with business partners, members, and government officials.

7.3. As an HPSM employee, do not directly or indirectly participate in, or have a significant interest in, any business that competes with or is a supplier to HPSM. Only engage with a competitor or supplier if participation is disclosed to HPSM in advance and agreed to in writing by the Chief Executive Officer (CEO). This standard also applies to members of one's immediate family.

7.4. As an HPSM employee, do not engage in outside employment or self-employment that may conflict with the work of HPSM. Adhere to HPSM's Outside Employment/Self-Employment Policy, which can be found in the Human Resources Policy Manual/Employee Handbook.

7.5. As an HPSM employee, do not accept gifts and other benefits with a total value of more than $50.00 from any individuals, businesses, or organizations doing business with HPSM.

7.6. As an HPSM employee, do not accept cash or cash equivalents (gift certificates, gift cards, checks or money orders) in any amount from any individuals, businesses, or organizations doing business with HPSM.

8. Protecting Assets

8.1. Protect HPSM's assets and the assets of others entrusted to HPSM, including information and physical and intellectual property, against loss, theft, and misuse. Assets include money, equipment, office supplies, business contacts, provider and claims data, business strategies, financial reports, member utilization data, and data systems.

8.2. Take measures to prevent any unexpected loss or damage of equipment, supplies, materials, or services. Adhere to established policies regarding the disposal of HPSM properties.

8.3. Ensure the accuracy of all records and reports, including financial statements and reported hours worked.

8.4. Report expenses consistent with and justified by job responsibilities. Adhere to established policies and procedures governing record management and comply with HPSM's destruction policies and procedures.

8.5. Do not modify, destroy, or remove electronic communications resources (e.g., computers, phones, fax machines, etc.) that are owned by HPSM without proper authorization.

8.6. Do not install or attach any mobile or remote devices or equipment to an HPSM electronic communications resource without approval.

8.7. Use HPSM property and resources appropriately for the best interests of our members and HPSM and in accordance with HPSM's Acceptable Use Policy.

8.8. Follow all laws regarding intellectual property, which includes patents, trademarks, marketing, and copyrights. Do not copy software unless it is specifically allowed in the license agreement and authorized by the Chief Information Officer.

9. Participating in the Compliance Program

9.1. Report any potential instances of fraud, waste or abuse or any suspected violations of the *Code of Conduct* or law to the Chief Government Affairs and Compliance Officer, any member of HPSM management ~~or Human Resources staff~~. HPSM management ~~and Human Resources~~ staff are required to report suspected FWA and violations of the *Code of Conduct* to the Chief Government Affairs and Compliance Officer. Concerns can also be reported anonymously through the Compliance

Commented [IJ1]: Deletions to remove potential for confusion around reporting FWA and other non-compliance.

Hotline (844-965-1241).

9.2. Cooperate fully with investigational efforts.

9.3. Act in accordance with HPSM's commitment to high standards of ethics and compliance.

10. Employment Practices

10.1. Conduct business with high standards of ethics, integrity, honesty, and responsibility. Act in a manner that enhances our standing in the community.

10.2. Employ and contract with employees and business partners who have not been sanctioned by any regulatory agency and who are able to perform their designated responsibilities.

10.3. Provide equal employment opportunities to prospective and current employees, based solely on merit, qualifications, and abilities.

10.4. Do not discriminate in employment opportunities or practices on the basis of race, color, religion, sex, national origin, ancestry, age, physical or mental disability, sexual orientation, veteran status, or any other status protected by law.

10.5. Conduct a thorough background check of employees and evaluate the results to assure that there is no indication that an employee may present a risk for HPSM.

10.6. Acts of intimidation, retaliation or reprisal against any employee who in good faith reports suspected violations of law, regulations, HPSM's *Code of Conduct*, or policies will not be tolerated.

10.7. Provide an open-door communications policy and foster a work environment in which ethical and compliance concerns are welcomed and addressed to ensure that the highest quality of care and service is provided.

10.8. Provide appropriate training and orientation so that employees can perform their duties and meet the needs of our members, providers, and the communities we serve.

11. Resolving Issues and Concerns

11.1 Protect the identity of people who call the Compliance Hotline, if they identify themselves, to the fullest extent possible or as permitted by law.

11.2 Evaluate and respond to allegations of wrongdoing, concerns and/or inquiries made to the Compliance Hotline in an impartial manner. All allegations will be thoroughly investigated and verified before any action is taken.

11.3 Take appropriate measures to identify operational vulnerabilities and to detect, prevent, and control fraud, waste, and abuse throughout the organization.

11.4 Report, as appropriate, actual or suspected violations of law and policy to the state or federal oversight agency or to law enforcement.

12. HPSM Committee Member Responsibilities

12.1 Members of HPSM Committees ~~members~~ will not discriminate in decision-making/recommendations in their respective committees on the basis of race, color, religion, sex national origin, ancestry, age, physical or mental disability, sexual orientation, veteran status, or any other status protected by law.

Commented [IJ2]: Text added for clarity around which committees are affected

HEALTH PLAN of SAN MATEO

CODE OF CONDUCT

2025

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A Message from the Chief Executive Officer

The Health Plan of San Mateo (HPSM) values the contribution of all employees, Commissioners, Committee Members, and Contracted Business Partners toward the goal of providing the highest possible quality of services to its members and providers. This *Code of Conduct* is created in accordance with state and federal requirements to provide guidance in following the ethical, legal, regulatory, and procedural principles that are necessary for maintaining high standards. This document serves as a guide for complying with HPSM's internal policies and procedures as well as all applicable laws and regulations.

This *Code of Conduct*, approved by the San Mateo Health Commission, applies to all HPSM staff, including employees, temporary staff and interns, as well as Commissioners, Committee Members, and Contracted Business Partners. In this document, the word *employee* encompasses all four groups unless otherwise stated.

The consequences for HPSM organizationally of failing to comply with this *Code of Conduct* can be serious, including member, financial, and reputational harm. Failure to comply may result in disciplinary actions up to and including termination.

Although this document was designed to provide overall guidance, it does not address every situation. Please refer to HPSM Policies and Procedures on HPSM's Intranet or in HPSM's Human Resources (HR) Policy Manual if additional direction is needed.

If there is no specific HPSM policy, this *Code of Conduct* becomes the policy. If a policy conflicts with this *Code of Conduct*, the *Code of Conduct* takes precedence. Questions or issues regarding this document or a policy should be discussed first with the immediate supervisor. If additional guidance is needed, one should go through the chain of authority up to and including HPSM's Chief Government Affairs and Compliance Officer, other members of the Leadership Team, or the Chief Executive Officer. Any issues may also be reported confidentially and anonymously by using HPSM's compliance hotline at 1-844-965-1241.

Thank you for your commitment to HPSM and your dedication to serve our members, providers, and our community partners in an ethical, professional manner using the high standards which are embodied in this *Code of Conduct*.

Sincerely,

Pat Curran
Chief Executive Officer

Introduction

The Health Plan of San Mateo (HPSM) is a local non-profit health care plan that offers health coverage and a provider network to San Mateo County's underserved population. We currently serve more than 150,000 County residents.

The County Board of Supervisors established the San Mateo Health Commission in 1986 to address and resolve the issues of poor access to physicians, an uncoordinated health care system endured by the county's growing population of Medi-Cal patients. In 1987, the Commission founded the Health Plan of San Mateo to provide access to a stable and comprehensive network of providers, and a benefits program that promotes preventive care with staff devoted to ensuring Medi-Cal patients receive high quality, coordinated health care.

Our Mission

To ensure that San Mateo County's underserved residents have access to high-quality care services and supports so they can live the healthiest lives possible.

Our Vision

We believe that ***Healthy is for everyone*** and work to continually advocate for our members health, especially those disproportionally impacted by health inequities, and meet the highest quality of care standards.

Our Values

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

Commitments

This *Code of Conduct* is intended to help both the Health Plan of San Mateo as a whole and individual employees stay true to the following commitments.

To HPSM Members
HPSM is committed to delivering quality, affordable health care by providing its members access to a network of credentialed health care providers, customer service staff, and a grievance and appeal process for timely problem resolution.

To HPSM Providers
HPSM is dedicated to providing efficient network management resources for its contracted providers, honoring contractual obligations, delivering quality health services, and bringing efficiency and cost-effectiveness to health care.

To HPSM Community Partners
HPSM is dedicated to advocating for healthcare needs of San Mateo County with a commitment to addressing challenges of access for the underserved.

To HPSM Contracted Business Partners
HPSM is committed to managing contractor and supplier relationships in a fair and reasonable manner. The selection of Contracted Business Partners, e.g. vendors, contractors, suppliers, and First-tier, Downstream, and Related entities (FDRs), is based on objective criteria including quality, technical excellence, price, delivery, adherence to schedules, service, and maintenance of adequate sources of staff and supply. HPSM will not communicate confidential information given to us by its suppliers unless directed to do so by the supplier or by law.

Code of Conduct

All HPSM employees, Commissioners, Committee Members, and Contracted Business Partners are responsible for following these standards.

1. Privacy and Confidentiality

1.1. Respect the privacy of members, providers, and co-workers by safeguarding their information from physical damage, maintaining member health information and business documents in a safe and protected manner, and following HPSM's record retention policies.

1.2. Protect the privacy of HPSM members' protected health information (PHI) according to federal and state requirements.

1.3. When using, disclosing, or requesting PHI, limit the information to the minimum amount needed to accomplish the work. Do not share or request more PHI than is necessary.

1.4. Only share medical, business, or other confidential information when such release is supported by a legitimate clinical or business purpose and is in compliance with HPSM policies and procedures, and applicable laws and regulations.

1.5. Whenever it becomes necessary to share confidential information outside HPSM for legitimate business purposes, release PHI only after obtaining a signed business associate agreement or a completed Authorization to Release Information Form.

1.6. Exercise care to ensure that confidential information, such as salary, benefits, payroll, personnel files, and information on disciplinary matters is carefully maintained and managed.

1.7. Do not discuss confidential member, provider, contractor, or employee information in any public area, such as elevators, hallways, stairwells, restrooms, lobbies, or eating areas.

1.8. Do not divulge, copy, release, sell, loan, alter, or destroy any confidential information except as authorized for HPSM business purposes or as required by law.

2. Security of Electronic Information

2.1. Practice good workstation security, which includes locking up offices and file cabinets; disposing of all paperwork in appropriate shredding receptacles; and covering all PHI or locking the computer if stepping away from the desk.

2.2. Practice good work-from-home (WFH) security, which includes following HPSM's guidance on WFH protections for PHI and equipment.

2.3. Take appropriate and reasonable measures to protect against the loss or theft of electronic media (e.g., laptops, flash drives, CDs/DVDs, photocopier hard drives, etc.) and against unauthorized access to electronic media that may contain member protected health information. Maintain and monitor security, data back-up, and storage systems.

2.4. Maintain computer passwords and access codes in a confidential and responsible manner. Only allow authorized persons to have access to computer systems and software on a "need-to-know" basis.

2.5. Do not share passwords or allow access to information to Contracted Business Partners, unless authorized to do so.

2.6. Transmit electronic confidential information securely in encrypted form.

3. Workplace Conduct

3.1. Respect the dignity of every employee, provider, member, and visitor while providing high-quality services and treating one another with respect and courtesy.

3.2. Communicate openly and honestly and respond to one another in a timely manner. Share information and ask questions freely.

3.3. Be civil and comply with existing policies about the treatment of colleagues, non-harassment, and respect in the workplace.

3.4. Conduct HPSM business with high standards of ethics, integrity, honesty, and responsibility, and act in a manner that enhances our standing in the community.

3.5. Support and observe a workplace free of alcohol, drugs, smoking, harassment, and violence.

3.6. Do not act in any way that will harm HPSM.

4. Use of Social Media

4.1. Do not engage in activity on social media sites that violates HPSM's mission, vision and values.

4.2. As an employee, when one's connection to HPSM is apparent, the employee must make it clear that the posting is on behalf of the individual and not HPSM.

4.3. Protect members' confidentiality and protected health information at all times. Do not write or say anything that violates HPSM's privacy, security, or confidentiality policies. Never post any information that can be used to identify an HPSM member's identity or health condition.

4.4. Maintain the confidentiality of HPSM business information and do not discuss this information on social media sites.

4.5. Always seek official approval from the Leadership Team before posting an official statement about HPSM. Only designated staff may speak on behalf of HPSM.

4.6. Employees may not use HPSM email addresses or phone numbers for personal use of social media.

5. Adhering to Laws and Regulations

5.1. Follow all state and federal laws and regulations, including reporting requirements.

5.2. Do not knowingly make any false or misleading statements, verbal or written, to government agencies, government officials or auditors.

5.3. Do not conceal, destroy, or alter any documents.

5.4. Do not give or receive any form of payment, kickback, or bribe or other inducements to members, providers, or others in an attempt to encourage the referral of members to use a particular facility, product, or service.

5.5. Avoid inappropriate discussions regarding business issues.

6. Safety

6.1. Comply with established safety policies, standards, and training programs to prevent job-related hazards and ensure a safe environment for members, providers, employees, and visitors.

6.2. Wear an HPSM badge at all times while in HPSM offices and when representing HPSM offsite.

6.3. Not share or lend an HPSM employee badge to any other individual, including visitors, other HPSM staff or co-located San Mateo County staff to access secured areas in HPSM offices. Badges are issued on a per-individual basis and may only be used by the individual who was issued that badge.

7. Conflict of Interest

7.1. Avoid actual, apparent, or potential conflicts between one's own interests and the interests of HPSM. Comply with all legal requirements concerning conflicts of interest and incompatible activities. Complete all disclosure documentation as required.

7.2. Act in the best interest of HPSM whenever functioning as an agent of HPSM in dealings with contractors, providers, members, or government agencies. This includes those acts formalized in written contracts as well as everyday business relationships with business partners, members, and government officials.

7.3. As an HPSM employee, do not directly or indirectly participate in, or have a significant interest in, any business that competes with or is a supplier to HPSM. Only engage with a competitor or supplier if participation is disclosed to HPSM in advance and agreed to in writing by the Chief Executive Officer (CEO). This standard also applies to members of one's immediate family.

7.4. As an HPSM employee, do not engage in outside employment or self-employment that may conflict with the work of HPSM. Adhere to HPSM's Outside Employment/Self-Employment Policy, which can be found in the Human Resources Policy Manual/Employee Handbook.

7.5. As an HPSM employee, do not accept gifts and other benefits with a total value of more than $50.00 from any individuals, businesses, or organizations doing business with HPSM.

7.6. As an HPSM employee, do not accept cash or cash equivalents (gift certificates, gift cards, checks or money orders) in any amount from any individuals, businesses, or organizations doing business with HPSM.

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9.1. Report any potential instances of fraud, waste or abuse or any suspected violations of the *Code of Conduct* or law to the Chief Government Affairs and Compliance Officer, any member of HPSM management. HPSM management staff are required to report suspected FWA and violations of the *Code of Conduct* to the Chief Government Affairs and Compliance Officer. Concerns can also be reported anonymously through the Compliance Hotline (844-965-1241).

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10.4. Do not discriminate in employment opportunities or practices on the basis of race, color, religion, sex, national origin, ancestry, age, physical or mental disability, sexual orientation, veteran status, or any other status protected by law.

10.5. Conduct a thorough background check of employees and evaluate the results to assure that there is no indication that an employee may present a risk for HPSM.

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Health Plan of San Mateo
Policy & Procedure Manual

Procedure: CP.026		Title: Code of Conduct	Original Effective Date: 01/15/2015
Revision: 6	Last Reviewed /Revised: ~~01/04/24~~08/04/2025	Dept: Compliance	Page 1 of 5

Approval By: Compliance Committee	**Date:** ~~02/07/2024~~
Approval By: San Mateo Health Commission	**Date:** ~~03/13/2024~~
Annual Review Date: ~~01/01/2025~~04/01/2026	
Authored by: Chief Government Affairs and Compliance Officer	
Pursuant To: ☒ DHCS Contract Provision Exhibit A, Attachment III, Section 1.3 ☐ Health and Safety (H&S) Code ☒ CFR 42 CFR 438.608(a); 42 CFR 422.503(b)(4)(vi)(A); 42 CFR 422.504(b)(4)(vi)(A) ☐ APL / DPL	☐ W & I Code ☐ California Title # ☐ Organization Need ☒ Other Medicare Managed Care Guide Chapter 21, Sections 50.1.3; Medicare Prescription Drug Benefit Manual Chapter 9, Section 50.1.3
Departments Impacted: All	

Policy:

To document Health Plan of San Mateo's (HPSM) procedure for communicating the organization's Code of Conduct.

Scope

This procedure applies to (check all that apply):

☒ All LOBs/Entire Organization	☐ CCS	☐ Medi-Cal Expansion
		☐ Medi-Cal Adults
☐ ACE	☐ HealthWorx	☐ Medi-Cal Children
☐ CA-DSNP	☐ Medi-Cal	☐ Other (specify)

Responsibility and Authority

- The Chief Government Affairs and Compliance Officer is responsible for implementing a Compliance Program to ensure that HPSM services are provided in accordance with all applicable federal, state, and county laws and regulations.

Definitions

Code of Conduct means the statement setting forth the principles and standards governing HPSM's activities to which Commissioners, Employees, and Contractors are expected to adhere.

Commissioners mean the members of HPSM's Governing Body, the San Mateo Health Commission.

Committee Members means those individuals who are members of the Commission-appointed Committees of HPSM.

Subcontractor means any subcontractor, agent, or other person which or who, on behalf of HPSM, furnishes or

otherwise authorizes the furnishing of health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by HPSM.

Downstream Entity means any party that enters into a written arrangement, acceptable to the Centers for Medicare and Medicaid Services (CMS), with persons or entities involved with an HPSM Medicare line of business below the level of the arrangement between HPSM and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

First Tier Entity means any party that enters into a written arrangement, acceptable to the Centers for Medicare and Medicaid Services, with HPSM to provide administrative services or health care services to a Medicare beneficiary.

Related Entity means any entity related to HPSM by common ownership or control and (1) performs some of HPSM's management functions under contract or delegation, (2) furnishes services to Medicare beneficiaries under an oral or written agreement, or (3) leases property or sells materials to HPSM at a cost of more than $2500 during a contract period.

Procedure

1.0 Development of Code of Conduct

1.1 The Code of Conduct is a document which provides a statement of the principles and values by which HPSM operates.

1.2 The Code of Conduct is developed by the Chief Government Affairs and Compliance Officer with review and input from HPSM Senior Management and the Compliance Committee.

1.3 Approval of the initial development of the Code of Conduct is obtained from the San Mateo Health Commission (SMHC), HPSM's governing body.

2.0 Review of the Code of Conduct

2.1 The Code of Conduct is reviewed on an annual basis by the Compliance Committee, which includes HPSM's Leadership Team.

2.2 The full Code of Conduct is taken to the San Mateo Health Commission for review and approval on an annual basis.

3.0 Distribution of the Code of Conduct

3.1 HPSM Employees

3.1.1 New Hire:

3.1.1.1 The Code of Conduct is distributed to new employees of HPSM according to Policy CP.025 (New Hire Trainings and Attestations).

3.1.1.2 New employees receive a copy of the Code of Conduct during New Hire Compliance Training.

3.1.1.3 Employees complete an Acknowledgement Form attesting that they have received the Code of Conduct, understand it, and commit to comply with it.

3.1.1.4 The Acknowledgement Form is maintained in HPSM's online training system for compliance reporting.

3.1.2 Annual review:

3.1.2.1 All HPSM Employees undergo an annual review of the Code of Conduct.

3.1.2.2 The annual review is an online review during HPSM's Annual Compliance Training.

3.1.2.3 The online training system tracks completion of the review for compliance reporting.

3.2 San Mateo Health Commissioners

3.2.1 Newly appointed

3.2.1.1 The Code of Conduct is distributed to new Commissioners of the SMHC within 90 days of appointment.

3.2.1.2 New Commissioners receive a copy of the Code of Conduct during New Commissioner Orientation.

3.2.1.3 They complete a Code of Conduct Acknowledgement Form attesting that they have received the Code of Conduct, understand it, and commit to comply with it.

3.2.1.4 The Code of Conduct Acknowledgement Form is entered into a tracking system for ease of compliance reporting.

3.2.1.5 The original of the Acknowledgement Form is kept by the Clerk of the Commission.

3.2.2 Annual Review

3.2.2.1 The Code of Conduct is distributed to all Commissioners of the SMHC on an annual basis.

3.2.2.2 The SMHC reviews and approves the Code of Conduct, which is reflected in the minutes of the Commission.

3.3 Members of Committees of the San Mateo Health Commission

3.3.1 Newly appointed

3.3.1.1 The Code of Conduct is distributed to new Committee Members within 90 days of appointment.

Procedure: CP.026		Title: Code of Conduct	Original Effective Date: 01/15/2015
Revision: 6	Last Reviewed /Revised: ~~01/04/24~~08/04/2025	Dept: Compliance	Page 4 of 5

3.3.1.2 New Committee Members receive a copy of the Code of Conduct.

3.3.1.3 They complete a Code of Conduct Acknowledgement Form attesting that they have received the Code of Conduct, understand it, and commit to comply with it.

3.3.1.4 The Code of Conduct Acknowledgement Form is entered into a tracking system for ease of compliance reporting.

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3.3.2 Annual Review

3.3.2.1 The Code of Conduct is distributed to all Committee Members of the SMHC on an annual basis.

3.3.2.2 They complete a Code of Conduct Acknowledgement Form attesting that they have received the Code of Conduct, understand it, and commit to comply with it.

3.3.2.3 The Code of Conduct Acknowledgement Form is entered into a tracking system for ease of compliance reporting.

3.3.2.4 The original of the Acknowledgement Form is kept by the Clerk of the Commission.

3.4 FDRs, Vendors, and Subcontractors

3.4.1 FDRs, Vendors, and Subontractors, receive a copy of HPSM's Code of Conduct attached to their contracts with HPSM.

3.4.2 FDRs receive a copy of the Code of Conduct on an annual basis, and must attest that they have:

3.4.2.1 received the Code of Conduct, understand it, and commit to comply with it, and

3.4.2.2 shared it with their employees and any downstream entities.

Related Documentation

- CP.023 Oversight of FDRs
- CP.025 Compliance Trainings and Attestations

Attachments

- HPSM Code of Conduct
- Code of Conduct Acknowledgement Form

Procedure: CP.026		Title: Code of Conduct	Original Effective Date: 01/15/2015
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Revision Number	Revision Date
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1	02/11/2016
2	12/07/2016
3	12/01/2017
4	11/09/2018
5	11/09/2021
6	01/04/2024

Health Plan of San Mateo
Policy & Procedure Manual

Procedure: CP.026		Title: Code of Conduct	Original Effective Date: 01/15/2015
Revision: 6	Last Reviewed /Revised: 08/04/2025	Dept: Compliance	Page 1 of 5

Approval By: Compliance Committee	**Date:** 08/18/2025
Approval By: San Mateo Health Commission	**Date:**
Annual Review Date: 04/01/2026	
Authored by: Chief Government Affairs and Compliance Officer	
Pursuant To: ☒ DHCS Contract Provision Exhibit A, Attachment III, Section 1.3 ☐ Health and Safety (H&S) Code ☒ CFR 42 CFR 438.608(a); 42 CFR 422.503(b)(4)(vi)(A); 42 CFR 422.504(b)(4)(vi)(A) ☐ APL / DPL	☐ W & I Code ☐ California Title # ☐ Organization Need ☒ Other Medicare Managed Care Guide Chapter 21, Sections 50.1.3; Medicare Prescription Drug Benefit Manual Chapter 9, Section 50.1.3
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Procedure

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- 1.1 The Code of Conduct is a document which provides a statement of the principles and values by which HPSM operates.
- 1.2 The Code of Conduct is developed by the Chief Government Affairs and Compliance Officer with review and input from HPSM Senior Management and the Compliance Committee.
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2.0 Review of the Code of Conduct

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- 2.2 The full Code of Conduct is taken to the San Mateo Health Commission for review and approval on an annual basis.

3.0 Distribution of the Code of Conduct

- 3.1 HPSM Employees
  - 3.1.1 New Hire:
    - 3.1.1.1 The Code of Conduct is distributed to new employees of HPSM according to Policy CP.025 (New Hire Trainings and Attestations).

3.1.1.2 New employees receive a copy of the Code of Conduct during New Hire Compliance Training.

3.1.1.3 Employees complete an Acknowledgement Form attesting that they have received the Code of Conduct, understand it, and commit to comply with it.

3.1.1.4 The Acknowledgement Form is maintained in HPSM's online training system for compliance reporting.

3.1.2 Annual review:

3.1.2.1 All HPSM Employees undergo an annual review of the Code of Conduct.

3.1.2.2 The annual review is an online review during HPSM's Annual Compliance Training.

3.1.2.3 The online training system tracks completion of the review for compliance reporting.

3.2 San Mateo Health Commissioners

3.2.1 Newly appointed

3.2.1.1 The Code of Conduct is distributed to new Commissioners of the SMHC within 90 days of appointment.

3.2.1.2 New Commissioners receive a copy of the Code of Conduct during New Commissioner Orientation.

3.2.1.3 They complete a Code of Conduct Acknowledgement Form attesting that they have received the Code of Conduct, understand it, and commit to comply with it.

3.2.1.4 The Code of Conduct Acknowledgement Form is entered into a tracking system for ease of compliance reporting.

3.2.1.5 The original of the Acknowledgement Form is kept by the Clerk of the Commission.

3.2.2 Annual Review

3.2.2.1 The Code of Conduct is distributed to all Commissioners of the SMHC on an annual basis.

3.2.2.2 The SMHC reviews and approves the Code of Conduct, which is reflected in the minutes of the Commission.

3.3 Members of Committees of the San Mateo Health Commission

3.3.1 Newly appointed

3.3.1.1 The Code of Conduct is distributed to new Committee Members within 90 days of appointment.

3.3.1.2 New Committee Members receive a copy of the Code of Conduct.

3.3.1.3 They complete a Code of Conduct Acknowledgement Form attesting that they have received the Code of Conduct, understand it, and commit to comply with it.

3.3.1.4 The Code of Conduct Acknowledgement Form is entered into a tracking system for ease of compliance reporting.

3.3.1.5 The original of the Acknowledgement Form is kept by the Clerk of the Commission.

3.3.2 Annual Review

3.3.2.1 The Code of Conduct is distributed to all Committee Members of the SMHC on an annual basis.

3.3.2.2 They complete a Code of Conduct Acknowledgement Form attesting that they have received the Code of Conduct, understand it, and commit to comply with it.

3.3.2.3 The Code of Conduct Acknowledgement Form is entered into a tracking system for ease of compliance reporting.

3.3.2.4 The original of the Acknowledgement Form is kept by the Clerk of the Commission.

3.4 FDRs, Vendors, and Subcontractors

3.4.1 FDRs, Vendors, and Subontractors, receive a copy of HPSM's Code of Conduct attached to their contracts with HPSM.

3.4.2 FDRs receive a copy of the Code of Conduct on an annual basis, and must attest that they have:

3.4.2.1 received the Code of Conduct, understand it, and commit to comply with it, and

3.4.2.2 shared it with their employees and any downstream entities.

Related Documentation

- CP.023 Oversight of FDRs
- CP.025 Compliance Trainings and Attestations

Attachments

- HPSM Code of Conduct
- Code of Conduct Acknowledgement Form

Procedure: CP.026		Title: Code of Conduct	Original Effective Date: 01/15/2015
Revision: 6	Last Reviewed /Revised: 08/04/2025	Dept: Compliance	Page 5 of 5

Log of Revisions	
Revision Number	Revision Date
0	01/15/2015
1	02/11/2016
2	12/07/2016
3	12/01/2017
4	11/09/2018
5	11/09/2021
6	01/04/2024

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DRAFT

Agenda Item: 4.3

Date: September 10, 2025

HEALTH PLAN OF SAN MATEO
COMMUNITY ADVISORY COMMITTEE MEETING
Meeting Minutes
Wednesday, July 16, 2025
801 Gateway Blvd. – 1st Floor Boardroom
South San Francisco, CA 94080

Committee Members Present: Rob Fucilla, Kathryn Greis, Ligia Andrade-Zuniga, Marmi Bermudez, Amira Elbeshbeshy, Jill Dawson, Kay Lee, Ana Giulia Serra

Committee Members Absent: Kathryn Greis , Angela Valdez, Hazel Carillo, Ana Avendano Ed.D. , Lizelle Lirio de Luna

Staff Present: Megan Noe, Amy Scribner, Kiesha Williams, Luarnie Bermudo, Mykaila Shannon, Charlene Barairo, Mackenzie Munoz, Michelle Heryford, Veronica Alvarez

1.0 **Call to Order/Introductions:** The meeting was called to order by Amira Elbeshbeshy at 12:07 pm, a quorum was met.

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

3.0 **Approval of Meeting Minutes for April 16, 2025:** The minutes for April 16, 2024, were approved as presented. **Fucilla / Williams MSP**

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

5.0 **HPSM Operational Reports and Updates:**

5.1 **Introduction of new CAC Members: Ana Giulia:** Community Health Advocate with San Mateo County Health Coverage Unit, focusing on the Brazilian Portuguese-speaking community. **Jill Dawson**: Health Services Manager for Aging and Disability Services, overseeing in-home supportive services, enhanced care management, and community supports, serving approximately 9,000 people**. Ankita Tandel represents Lizelle Lirio de Luna**: Acting Director for Family Health Services (representing Liselle), overseeing WIC, home visiting programs, and CCS. **Kay Lee**: Executive Director of Burlingame Adult Day Healthcare, serving older adults with various health conditions, aiming to rebuild the network within the county, and the current board president of the California Association for Adult Day Services.

5.2 **Leadership Report:** Amy Scribner reports:

- Monitoring federal-level changes, some expected, some unexpected.
- Unexpected changes regarding Planned Parenthood took effect immediately on July 4th.

- A 14-day stay is in place to allow continued services.
- The team met with local Planned Parenthood; ~3,800 members receive primary care there.
- Monitoring closely and developing a course of action. Potential vote on Friday.
- State budget approval pending federal-level updates, expected in September.

5.3 Health Ed. Programs & Plan Marketing Materials:

- Overview of programs categorized by focus areas: preventive care, risk reduction, healthy lifestyle, and chronic condition management.
- Communication channels: HPSM website, social media, member newsletters, member mailers, outreach calls, and community events.
- Feedback requested on new member materials:

    - 7 to 11 well visit mailer
    - "Wow Baby" package (materials and resources from First5)
    - Cancer screening reminder letters
    - Diabetes management package (newsletter, 90-day medicine supply info, statin medicine info)

    - QR code and email link provided for feedback survey.
    - HPSM website updates in progress for diabetes, tobacco, mental health, and child health, aligning content with member newsletters.

- **Open Discussion:**

    - **Marmi Bermudez:** Issues encountered with newborn automatic enrollment in Medi-Cal. Suggests education for pregnant moms on the process and simplified flyer detailing the referral process.
    - **Robert Fucilla:** Most members are over 65 and not friendly with computer services and QR codes. Phone and Mail still needs to be first and foremost.
    - **Anna Giulia:** How many languages will the material be provided on? My parents are like Portuguese monolingual clients from Health plan and they did receive the cancer screening and they're a little bit freaked out and are more concerned.

        - Materials are translated into threshold languages (English, Spanish, Chinese, Tagalog).
        - Considering adding Portuguese as a threshold language (goal of implementation at the end of Q1 2026).
        - Language taglines are included in all materials, indicating how to request in other languages.

- **Amy Scribner:** If members want materials in a different language, they can call the call center to update their system.
- Update spoken language in our system so that our call center will actually speak to that member in that spoken language.
- **Question:** Are there any internal tracking as far as like members not picking up the phone, hang ups and things like that?

    - Internal systems log the outcome of each outreach call.

- **Ligia Andrade- Zuniga:** People don't know that they can receive just like one pamphlet or one piece of information that may not be available in their language, like in Portuguese or another language that is not one of the, you know, more broadly spoken here in the county.

    - Member services educates new members on services and benefits, using LanguageLine as needed. Members can request information in another language (verbally and in the member evidence of coverage).

- **Jill Dawson:** How many folks are using the TTY line?
- **Joy Dienla:** member newsletter reaches all households in our membership.

- **Member Newsletter:**

    - Four mailings annually with timely and well-planned messaging.
    - Incorporates call center feedback and website links.
    - Four thematic issues in 2025: Regulatory, Support to Stay Healthy, Kids (0-12 & 13-21), and Benefit messaging.
    - Includes graphics, easy-to-read formatting, and clear contact information.
    - Teen newsletter features youth-friendly language.
    - QR code planned for teen newsletter to download contact information.
    - Invitation to be added to the mailing list (email marketing@hpsm.org with language preference).

        - **Amira:** Visibility is also important and the campus is at San Mateo County. The new link building will be built. It would be great to see like an HBSM health education corner somewhere in the hospital.
        - Testing out some of the numbers in the past several months and trying to get some specific services for her clients but she hasn't had any success with the phone numbers

        - Share feedback with the communications workgroup to ensure numbers allow messages and that callbacks are handled appropriately.

    - Members of the CAC to be added to the mailing list for the newsletter.

- **CAC Recruitment Campaign**

    - Building a campaign to promote transparency and accountability.
    - Involves studying the audience, creating key messages, visual assets, communication channels, and engaging community partners.
    - Call to action to be provided at the end.

Action Items:

- **MacKenzie:**
    - Provide email addresses to Joy for mailing list.
- **Amy Scribner/Charlene:**
    - Review newborn automatic enrollment process and create a simplified flyer detailing the referral process.
    - Share data with Jill Dawson regarding TTY line use.
- **Communications Workgroup:**
    - Ensure phone numbers in materials allow messages and review callback procedures.
    - Add CAC members to the mailing list for the member newsletter.
    - Create an HPSM org chart.

- **Mailing Address Request:** Participants will receive a request for their mailing addresses to receive materials via mail.
- **Material Feedback:** Materials are considered fantastic and proactive.
- **Phone Number Concerns:** Some phone numbers listed in the materials do not allow messages or callbacks. A specific number (2060 for case management and integrated care) has not resulted in any call backs.
    - **Action Item:** Communications workgroup to review phone numbers, ensure message capabilities, and understand callback procedures.
- **Internal Communications:** Request for an HPSM Org chart to better navigate the organization.
    - **Action Item:** Discuss internally within work group.
- **Material Visibility:** Suggestion to increase visibility of materials in physical locations like San Mateo County campus, Ron Robinson Health Center, and the South San Francisco Clinic.
    - **Action Item:** Follow up regarding health education corner.

Newsletter Distribution: Encourage broader distribution of the HPSM newsletter to HSA benefits analysts and hospital staff

5.4 Grievance & Appeals Report:

- **Membership:** Slight increase in overall membership.
- **Grievance Volume:** Increased for Care Advantage, Medical, Healthworks, and ACE.
- **Complaint Rates:** Outside of the goal for most programs. Medical is very close to the goal.
- **Care Advantage Grievances:** Primarily related to customer service and transportation. No specific trends in access issues.
- **Timeliness:** Resolution timeliness is above goal at 97.5%.
- **PCP Changes:** Number increased from Quarter 1 but still lower than 2024.
- **Types of Grievances (Care Advantage):** Customer service, quality of care, and billing.
- **Types of Appeals (Care Advantage):** Prescription drugs, DME, and ancillary services.
- **Types of Grievances (Medi-Cal):** Customer service, quality of care, and billing.
- **Types of Appeals (Medi-Cal):** DME, other services, therapy, and specialists.
    - **Customer Service:** Applicable to providers and HPSM.
    - **Quality of Care:** Focused on provider groups.

Action Item: Distribute G&A report to the group after the meeting

5.5 Provider Service Report: CAC PS Update

- Contracts team successfully added HERS Breast Cancer Foundation to our network, expanding access to high-quality breast orthotics and prosthetics services in the Bay Area. (8 months contracting discussion and negotiation). HERS is a nonprofit organization that has served the community since 1998, offering post-surgical products such as customizable breast prostheses, specialty bras, compression garments, wigs, and services are delivered by Certified Breast Care Specialists. Their clinics locate in Fremont, San Leandro, and Livermore. Journey Health, our first in-network CHW provider in-network partnering with Stanford for care navigation and social support.
- Clarity Pediatrics, recently joined HPSM Behavioral Health network. Clarity Pediatrics provides non-medication ADHD therapy for youth, offering our youth members an alternative treatment option for ADHD, supporting those who are not yet ready to pursue medication therapy. Aside from providing youth therapies, they also provide Parent Behavioral Training (PBT) to further support families and youth in managing their ADHD. They work closely with many of our partners.
- BH Provider-Mills Perinatal provides comprehensive, specialized care for expectant mothers and their families, with a focus on delivering the highest standards of perinatal and maternal behavioral healthcare. Their team works closely with providers, OB's, and pediatric specialist to ensure that our members have access to Perinatal education, support groups and BH therapies through pregnancy and beyond. They are outreaching to our partners at the provider level to

ensure that our network knows that this service is available to our members. We are working with PHM on getting the word out to our Provider Network.
- Grants deployed across PCP network (10-15 grants so far)
- Rate increase across network deployed as of July 1st.

5.6 Member Services Report:

- **Membership:** Serving 152,000 members across all lines of business. Slight increase in Medi-Cal members (0.37%).
- **Medi-Cal Redeterminations:** Minimal terminations since January 2025 (6.43% determination rate).
- **Medi-Cal Welcome:** Facilitated 1,537 primary care assignments.
- **Staffing Update:** All Customer Service Navigator positions have been filled. Hired a second quality monitoring analyst.
- **Phone System:** Advancing the development of more 59 phone systems models. Working on workforce management implementation and finalizing reporting capabilities.
- **Pediatric Health Risk Assessments:** Completed 55 HRAs.
- **Community Events:** Participated in events, including the Health and Wellness Health Fair.

5.7 CareAdvantage Report:

- **Membership:** Positive membership growth. Enrolled 305 and disenrolled 222.
- **Disenrollment Reasons:** Death, relocation, and plan changes.
- **Default Enrollment Pilot:** 24% of Q2 enrollments are due to default enrollment. 77% retention rate.
- **Community Presence:** CareAdvantage Medicare specialists present in the community.
- **Call Center Updates:** Top 5 reasons for incoming calls are bills, Part B benefits, provider network information, transportation, and authorizations.
- **Transportation Reminder:** Members must call 48 hours in advance to schedule rides.
- **CMS Monitoring:** Completed the 2025 CMS Prospective Call center monitoring.
- **Staffing Update:** CareAdvantage Navigator Spanish speaking position is filled, and they are fully staffed.

6.0 New Business: There was no new business.

7.0 Adjournment: The meeting was adjourned at 1:34 pm by Amira Elbeshbeshy.

Respectfully submitted:

V. Alvarez

V. Alvarez

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Draft

FINANCE/COMPLIANCE COMMITTEE MEETING
Meeting Summary
August 18, 2025, 12:30 pm

Agenda Item: 4.4
Date: Sept. 10, 2025

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: Bill Graham, Manuel Santamaria, Mike Callagy

Members absent: Si France, M.D.

Staff present: Trent Ehrgood, Pat Curran, Ian Johansson, Amy Scribner, Cheryl Serafino, Michelle Heryford

1.0 **Call to Order –** The meeting was called to order by Commissioner Graham at 12:34 pm. A quorum was met.

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

3.0 **Approval on Consent Agenda –** The consent agenda was approved as presented. **Callagy/Graham MSP**

4.0 **Approval of Meeting Summary for May 5, 2025 –** The meeting summary for May 5, 2025, was approved as presented. **Callagy/Santamaria M/S/P**

5.0 **Preliminary Financial Report for the 6-month period ending June 30, 2025** – HPSM CFO, Trent Ehrgood, walked the group through the financial report for Q2. He compared Q1 and Q2 noting that they almost look identical, however if you look at revenue, you will see the risk corridor the Department of Health Care Services (DHCS) has carried over for the population with unsatisfactory immigration status (UIS). If DHCS pays more than needed, HPSM is required to give a portion of that back. Originally this was going to be enforced only in 2024, however they decided to carry it through to 2025 as well. This was unknown when they were working on the budget. That makes the revenue for Q2 look a lot lower, but it still ends with a $15M surplus due to favorable prior year adjustments. Mr. Ehrgood went over the prior year (PY) and current year (CY) net income for Q1 and Q2. PY

for Q1 reflects -$810K, but there were pass-through dollars of around $167M for hospital directed payments so the PY portion for Q1 was almost zero. In Q2, the $16.7 million in favorable adjustments to PY, which is the sum of a few different and unrelated things; they include various favorable prior year adjustments for Medicare risk adjustment revenue, claim liability adjustments, provider incentive true ups for 2024, and reinsurance recoveries. Q2 for current year (CY) is almost breakeven for two reasons. The $13 million risk corridor is for the first six months of 2025, and the provider rate increases. The first round of approved provider rate increases went into effect in April of this year for physician professional services. The second phase went into motion in June for hospital outpatient services. Approximately $4.5M in provider rate increases were paid in Q2, this is something that was intentionally not in the budget. HPSM can expect a smaller margin in the next two quarters due to the provider rate increases and the risk corridor.

Mr. Ehrgood went over enrollment projections; actual average membership compared to the actual budgeted average. He pointed out that they anticipated the Medi-Cal population to be flat with a small erosion, but instead they are seeing slight growth every month in the immigrant population. This appears to be due to efforts by the County and community organizations in convincing this population to enroll in Medi-Cal. This is also due to those who are coming off ACE and qualify for Medi-Cal benefits instead.

Mr. Ehrgood reviewed the major drivers of the budget variance, noting the risk corridor which was not originally included in the budget. There is also $6.6M in health care costs, this is the per member per month amount and it is quite a bit higher than budget. This reflects the provider rate increases, because it was not in the budget it creates a budget variance. Now that they know what the rate increases look like they will be able to build it to next year's budget. He also noted the DSNP MDP, which is the manufacturer discount program for the Medicare line of business (LOB). CMS is negotiating with participating manufacturers to bring down costs with this new program that started in 2025. As a result, CMS is giving less money in premiums because they know that HPSM will be getting certain drugs at a discount. This is a budget variance because CMS deducted this from capitation revenue in error. Those monies will be coming back next quarter.

Healthcare costs by category show a big variance for physician services and hospital outpatient. This is where the provider rate increases are showing up. Between now and the end of the year the variance will get bigger. He also highlighted the Strategic

Investment line, which is where primary care grants are recorded. Distribution of these monies for capacity building has started and was not part of the budget.

The CY year to date (YTD) surplus/deficits by LOB displays what the budget was from a bottom-line perspective versus the actual in terms of surplus and deficit. Last quarter, the blue columns, which is actual, and the orange line which is the budget were almost in the same place. Now the traditional Medi-Cal (MC) and the adult expansion (MCE) population is affected by the risk corridor, which means a smaller surplus. Everything else is close to budget, except for the DSNP, which is the CareAdvantage line. It is the only one that was budgeted to have a loss, and it is a larger loss than anticipated for now.

He went over the tangible net equity or reserves. The committed equity started out with $137M for the provider rate increases, primary care capacity building and the baby bonus program. That money is starting to be spent; the balance now is $130M. The burn rate for provider rate increases will eventually be around $8M per quarter once the primary care portion ramps up.

Pat commented on the reserve graph, highlighting additional investments the Commission may want to consider, while still retaining appropriate levels of reserves to weather potential periods of operational losses.

The financial report was approved as presented. **Santamaria/Callagy MSP**

6.0 Compliance Case Discussion – HPSM Government Affairs and Compliance Officer Ian Johansson opened by discussing the contents of the quarterly Compliance report contained in the consent agenda. New additions include agency actions and external audit reports. He noted that while these items are on the consent agenda, he is always available to answer any questions the Committee might have. Mr. Johansson then went over the Compliance Case Discussion. The first case involved Notices of Non-Compliance (NONC) that occurred in January, April, and July of 2025. NONC were issued by the Centers for Medicare and Medicaid Services (CMS) for various Medicare Part D issues. The three NONCs to date are related to services HPSM receives from its pharmacy benefits manager (PBM), SS&C. A root cause analysis discovered that the departure of key subject matter experts at SS&C has led to issues with adherence to Medicare Part D requirements. Corrective action in response to the January NONC involved creating a new service level

agreement (SLA) with SS&C. HPSM has strengthened internal processes as a result of this and continues to monitor adherence issues with SS&C. NONCs are the lowest form of corrective action that CMS can issue. They do not require documented corrective actions, but CMS does have a points scale where they assign points to compliance actions they issue. This also plays a role in determining when a health plan is selected for a program audit.

Mr. Johansson provided an update regarding a Model of Care (MOC) correction action plan. HPSM has been working with an outside consulting firm to perform a mock audit of our CareAdvantage program. This effort started in 2023 and continued through 2024 and 2025. The MOC speaks to how HPSM does care coordination for CareAdvantage members. There are many different components to this, including a health risk assessment (HRA) and an individualized care plan (ICP), which is based on information from the HRA. There is also a discussion with the member and their interdisciplinary care team (ICT). What they discovered in 2024 is that there was a backlog of care plans. The ICPs were going beyond the due date and the number was growing. This coincided with HPSM's launch of Care Plan 2.0, our plan to in-source ICP work from an external vendor. In November of 2024, the projected completion date to correct this issue was March 1, 2025. CMS had indicated concern with the progress to-date. HPSM has committed additional resources/staffing to speed up the project. At that time, they anticipated being compliant by June 30, 2025. HPSM officially closed the backlog at the end of May and CMS is now monitoring care plan completions monthly. HPSM developed an internal compliance metric; the threshold is 95%. 99% of ICPs were completed timely in the month of June and 100% were completed timely for the month of July. If this trend continues for the remainder of the year, CMS will no longer continue to monitor them.

Lastly, he went over the results of the Compliance Program Effectiveness Survey. This survey goes out to staff every year to measure how well the Compliance Program has performed in the prior year. The survey has been ongoing for 10 years now. The 2024 results were similar to the 2023 results; there were no major shifts. Participation is high and continues to trend positively. He also noted the qualifying questions for interaction with teams which include Compliance, the National Committee for Quality Assurance (NCQA) Program Manager and the Policy Implementation Unit (PIU). These questions asked staff if they felt supported by those teams in doing their work and the scores were very high, but there were some that went down a point or two from the previous year. This

was mainly due to staff not knowing or interacting with those in these positions. Next year's qualifier question will ask staff if they have worked with these departments or individuals in the past year. If the answer is yes, it will prompt follow-up questions.

There was a question about American Logistics Company (ALC), the non-medical medical transportation (NMT) vendor used by HPSM. This was based on information that was included in the packet. ALC provides rides to members who need NMT transportation with one of their drivers or through Uber. Mr. Johansson replied that the report highlights the number of fraud cases that have been referred to the Compliance Department for investigation. They have received a variety of grievances from members about the vehicles and/or the drivers. The fraud referrals are mostly internal. He did note that they are seeing an increased trend over the last year about members who have used the transportation benefit for an inappropriate purpose or instances where someone has used a member's identity to obtain a ride. He explained that the 50% figure refers to the fact that half of the cases received are related to transportation issues. There are no cost figures to report at this time. HPSM has acknowledged that they are working on how to deal with the runaway costs and the fact that it is often used in ways that were not intended. There is an internal work group dedicated to mitigating the costs and ensuring members are using the benefit appropriately.

7.0 Other Business – There was no other business.

8.0 Adjournment – The meeting was adjourned at 1:41 pm by Commissioner Graham.

Respectfully submitted:

M. Heryford

M. Heryford
Clerk to the Commission

Financial Update

Presentation to Finance/Compliance Committee

August 4, 2025

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2025 Budget by Quarter

HealthPlan OF SAN MATEO
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	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.

Q2 2025 Preliminary Financial Results

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	Q1 (Jan-Mar)	Q2 (Apr-Jun)	YTD Total	YTD Budget	Budget Variance
Operating Revenue:					
Capitation	467,129,448	304,195,903	771,325,351	595,089,057	176,236,294
UIS Risk Corridor		(13,050,000)	(13,050,000)	-	(13,050,000)
Total Operating Revenue	467,129,448	291,145,903	758,275,351	595,089,057	163,186,294
Healthcare cost	421,376,041	247,736,332	669,112,373	493,667,647	(175,444,726)
Administrative expenses	17,731,830	17,871,955	35,603,785	39,577,652	3,973,867
MCO Tax	20,555,697	18,921,401	39,477,098	40,016,079	538,981
Income/(loss) from operations	7,465,880	6,616,215	14,082,095	21,827,679	(7,745,584)
Non-operating revenue	9,545,895	9,359,070	18,904,965	19,654,250	(749,285)
Net income/(loss)	17,011,775	15,975,285	32,987,060	41,481,929	(8,494,869)

YTD June 2025 – PY/CY

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	YTD by PY/CY			Current Year YTD		
	Prior Year	Current Year	Total	Current Year	Budget	CY Variance
Operating Revenue:						
Capitation	172,826,233	598,499,118	771,325,351	598,499,118	595,089,057	3,410,061
UIS Risk Corridor		(13,050,000)	(13,050,000)	(13,050,000)	-	(13,050,000)
Total Operating Revenue	172,826,233	585,449,118	758,275,351	585,449,118	595,089,057	(9,639,939)
Healthcare cost	156,854,124	512,258,249	669,112,373	512,258,249	493,667,647	(18,590,602)
Administrative expenses	-	35,603,785	35,603,785	35,603,785	39,577,652	3,973,867
MCO Tax	-	39,477,098	39,477,098	39,477,098	40,016,079	538,981
Income/(loss) from operations	15,972,109	(1,890,014)	14,082,095	(1,890,014)	21,827,679	(23,717,693)
Non-operating revenue	9,281	18,895,684	18,904,965	18,895,684	19,654,250	(758,566)
Net income/(loss)	15,981,390	17,005,670	32,987,060	17,005,670	41,481,929	(24,476,259)

Net Income PY/CY by Quarter

	Prior Year (PY)		Current Year (CY)		Total
Q1 Net Income	(810,506)	[1]	17,822,281	[3]	17,011,775
Q2 Net Income	16,791,896	[2]	(816,611)	[4]	15,975,285
YTD Net Income	15,981,390		17,005,670		32,987,060

- [1] PY Q1 recorded $167M pass through dollars (revenue and expense) for 2nd half 2023 hospital directed payments that net to zero.
- [2] PY Q2 recorded various favorable prior year adjustments, including Medicare risk adjustment revenue, claim liability adjustments, provider incentive true-up for 2024, and reinsurance recoveries.
- [3] CY Q1 net income of $17M in alignment with projections in budget.
- [4] CY Q2 recorded estimate for UIS risk corridor (for Jan-Jun) totaling $13M, and recognized increased claim cost for provider rate increases that went into effect in Q2 totaling $4.5M.

Average Membership

Variance to Budget

LOB	Avg. Actual	Avg. Budget	Variance	% Var
Medi-Cal	75,375	74,692	683	0.9%
Medi-Cal Expansion	55,798	53,239	2,559	4.8%
Whole Child Model	1,108	1,069	39	3.6%
Medi-Cal Full Duals	8,796	7,632	1,164	15.2%
Sub-total Medi-Cal	141,077	136,632	4,445	3.3%
Medicare D-SNP	8,240	8,326	(85)	-1.0%
HealthWorx	1,317	1,286	31	2.4%
Total at Risk	150,633	146,244	4,390	3.0%
+ ACE	961	1,237	(276)	-22.3%
Grand Total	151,594	147,481	4,114	2.8%

Budget Variance by Major Drivers

favorable/(unfavorable)

		YTD Mar	YTD Jun		Revenue	Expense
1	Prior year adjustments not in the budget	(810,510)	15,981,386			
	Current year variances:					
2	Membership higher than budget	1,321,547	3,180,828	<<	14,436,160	(11,255,332)
3a	Revenue: Yield PMPM variance to budget	(4,188,327)	(7,699,698)			
3b	Revenue: UIS Risk Corridor	-	(13,050,000)			
3c	Revenue: DSNP MDP adj.		(1,366,236)			
4	Revenue: Maternity supplemental payment	298,759	(359,409)			
5	Healthcare cost: CY PMPM variance to budget	(1,793,469)	(6,665,362)			
6	Healthcare cost: directed payments	(1,057,344)	(995,079)			
7	Healthcare cost: strategic investments	(1,820,000)	(530,780)			
8	ECM (rev-exp variance)	1,415,457	(1,973,401)	<<	(2,829,352)	855,951
9	Administrative cost variance to budget	3,631,918	3,973,867			
10	MCO Tax variance (rev-exp variance)	(2,142)	1,767,576	<<	1,228,595	538,981
11	Non-op revenue (*CY portion) variance to budget*	(426,548)	(758,562)			
	Total current year	(2,620,150)	(24,476,257)			
	Total consolidated budget variance	**(3,430,660)**	**(8,494,870)**			

Healthcare Cost

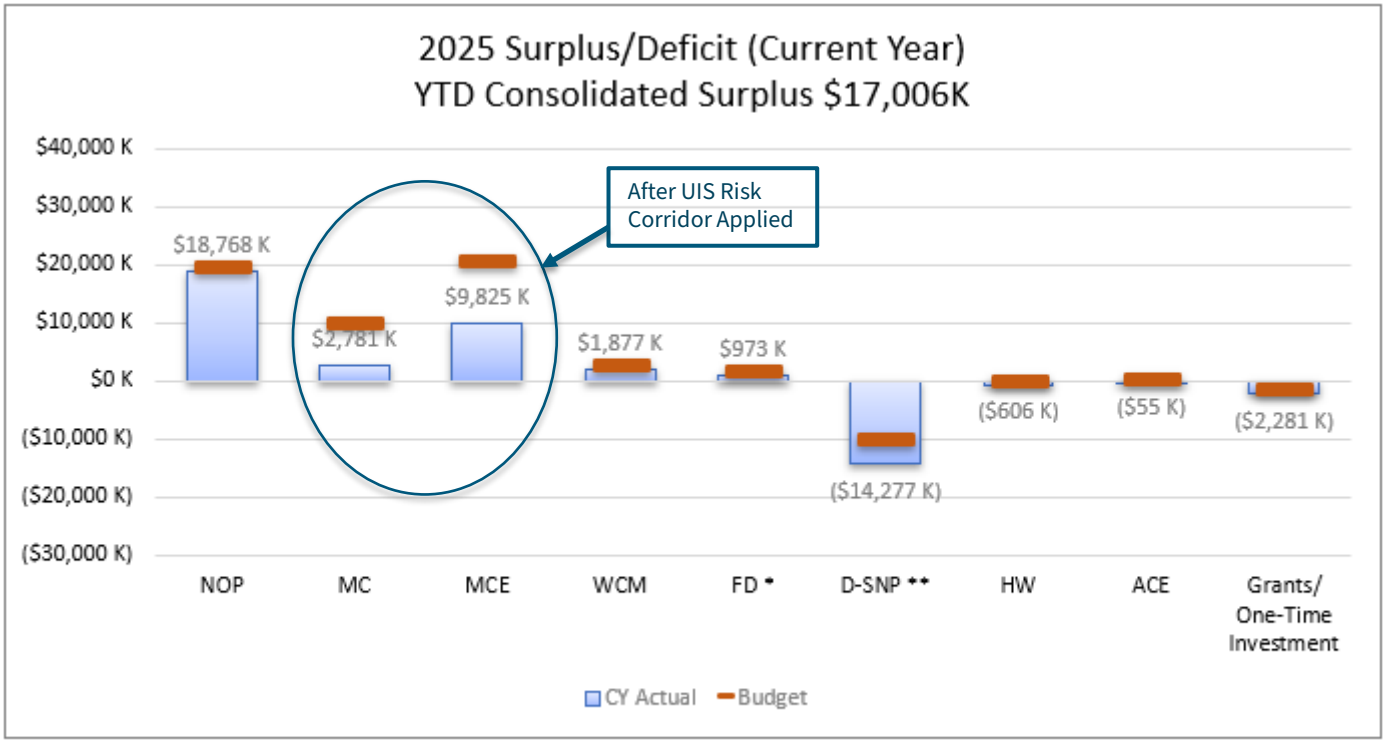
Detail by Category of Service

HealthPlan OF SAN MATEO
Healthy is for everyone

		YTD Actual					
		Total	Prior Year	Current Year	YTD Budget	Variance	% Var.
1	Provider Capitation	14,911,928	1,257,222	13,654,706	13,218,583	(436,123)	-3.3%
2	Hospital Inpatient	102,061,529	1,199,882	100,861,646	97,922,569	(2,939,077)	-3.0%
3	LTC/SNF	83,583,623	(500,000)	84,083,623	84,609,157	525,534	0.6%
4	Pharmacy	31,956,088	(1,249,130)	33,205,218	35,896,647	2,691,429	7.5%
5	Physician FFS	53,759,576	(1,636,393)	55,395,969	50,924,572	(4,471,397)	-8.8%
6	Hospital Outpatient	60,335,307	(1,298,392)	61,633,699	57,806,463	(3,827,236)	-6.6%
7	Other Medical Claims (incl. Other HC Serv)	60,315,185	(1,470,769)	61,785,954	59,057,022	(2,728,932)	-4.6%
8	Directed Payments	192,835,323	167,298,548	25,536,774	24,541,695	(995,079)	-4.1%
9	Long Term Support Services	1,257,812	20,610	1,237,202	866,183	(371,019)	-42.8%
10	CPO/In-lieu of Services	7,530,846	500,000	7,030,846	6,086,077	(944,769)	-15.5%
11	Dental	26,128,214	(1,500,000)	27,628,214	25,382,878	(2,245,336)	-8.8%
12	ECM	1,599,795	(13,412)	1,613,207	2,469,158	855,951	34.7%
13	Provider Incentives	7,886,294	(1,283,086)	9,169,381	7,948,750	(1,220,631)	-15.4%
14	Supplemental Benefits (D-SNP)	2,163,802	-	2,163,802	1,563,853	(599,950)	-38.4%
15	Transportation	9,448,839	-	9,448,839	9,450,503	1,664	0.0%
16	Strategic Investments (one-time grants)	2,280,780	-	2,280,780	1,750,000	(530,780)	-30.3%
17	Indirect Health Care Benefits	(2,196,226)	(4,477,841)	2,281,615	797,008	(1,484,607)	-186.3%
18	UMQA	13,253,656	6,884	13,246,773	13,376,528	129,755	1.0%
	Total Healthcare Cost	669,112,373	156,854,124	512,258,249	493,667,647	(18,590,602)	-3.8%

provider rate increase

CY YTD Surplus/Deficit by LOB

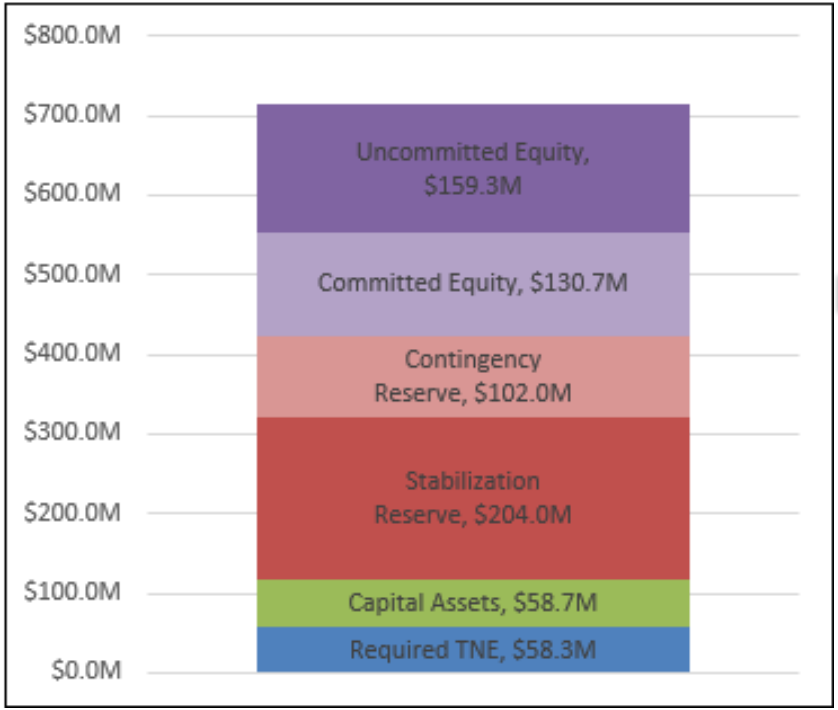


* FD includes M-Cal portion of D-SNP

** D-SNP includes Medicare portion only

Tangible Net Equity (TNE)

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



Committed Equity:

	Funding	Spend	Balance
Provider	$100.0M	$5.3M	$94.7M
Primary Care	$30.0M	$0.8M	$29.2M
Baby Bonus	$7.0M	$0.2M	$6.8M
	$137.0M	$6.3M	$130.7M

Q2 2025 Summary

- Q2 included several prior-year favorable adjustments, including Medicare risk adjustment revenue, claim liability adjustments, provider incentive expense true-up, and reinsurance recoveries totaling $16.7M.

- Q2 results specific to 2025 (current year) is approximately break-even ($816K loss) due to two items:

    1. UIS risk corridor estimate recorded in Q2 totaling $13M and covers Jan-Jun 2025.
    2. The cost of provider rate increases that went into effect totaled around $4.5M in Q2.

- The UIS risk corridor and provider rate increases will continue throughout the year, which means 2025 will end up a much smaller surplus than originally forecasted in the budget.

Health Plan of San Mateo
Consolidated Balance Sheet
June 30, 2025 and Prior Quarter

	Current QE	Prior QE	PY 12/31
ASSETS			
Current Assets			
Cash and Equivalents	$ 665,392,847	$ 643,945,837	$ 680,831,174
Investments	192,014,703	190,058,582	188,123,682
Capitation Receivable from the State	198,493,269	171,192,849	123,514,831
Capitation Receivable from CMS	60,312,673	58,652,342	58,652,342
Other Receivables	18,790,889	60,342,489	23,047,898
Prepaids and Other Assets	15,179,438	10,892,225	11,732,301
Total Current Assets	1,150,183,820	1,135,084,323	1,085,902,228
Capital Assets, Net	58,421,345	58,692,248	58,729,818
Assets Restricted As To Use	300,000	300,000	300,000
Other Assets & Outflows	16,486,062	16,486,062	16,486,062
Total Assets & Deferred Outflows	$ 1,225,391,227	$ 1,210,562,634	$ 1,161,418,109
LIABILITIES			
Current Liabilities			
Medical Claims Payable	91,173,675	98,871,169	88,948,893
Provider Incentives	13,892,818	15,036,302	11,243,576
Amounts Due to the State	214,751,913	199,665,913	202,037,523
Accounts Payable and Accrued Liabilities	176,813,892	184,205,606	163,416,247
SBITA Liability	4,378,929	4,378,929	4,378,929
Total Current Liabilities	501,011,227	502,157,919	470,025,168
Other Liabilities & Inflows	11,391,997	11,391,997	11,391,997
Total Liabilities & Deferred Inflows	$ 512,403,224	$ 513,549,916	$ 481,417,165
NET POSITION			
Invested in Capital Assets	58,421,345	58,692,248	58,729,818
Restricted By Legislative Authority	300,000	300,000	300,000
Unrestricted			
Stabilization/Contingency Reserve	305,977,900	305,977,900	305,977,900
Committed/Uncommitted Reserve	348,288,758	332,042,570	314,993,225
Net Position	712,988,003	697,012,718	680,000,944
Total Liabilities & Net Position	$ 1,225,391,227	$ 1,210,562,634	1,161,418,109
Change in Net Position	$ 32,987,060	$ 17,011,774	-

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Health Plan of San Mateo
Consolidated Statement of Revenue & Expense
for the Period Ending June 30, 2025

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	YTD Actual	YTD Budget	YTD Variance	% Var
OPERATING REVENUE							
Capitation and Premiums							
Medi-cal (includes Offsets)	$ 229,183,470	$ 235,724,185	$ (6,540,715)	$ 638,349,564	$ 471,632,595	$ 166,716,969	35.3%
HealthWorx	2,371,749	2,313,295	58,453	4,738,417	4,626,591	111,826	2.4%
Medicare (includes CA-CMC)	59,590,685	59,203,218	387,466	115,187,370	118,829,871	(3,642,501)	-3.1%
Total Operating Revenue	291,145,904	297,240,699	(6,094,795)	758,275,351	595,089,057	163,186,294	27.4%
OPERATING EXPENSE							
Healthcare Expense							
Provder Capitation	7,286,698	6,605,234	(681,464)	14,911,928	13,218,583	(1,693,345)	-12.8%
Hospital Inpatient	51,981,715	48,887,477	(3,094,238)	102,061,529	97,922,569	(4,138,959)	-4.2%
LTC/SNF	40,792,768	42,249,472	1,456,704	83,583,623	84,609,157	1,025,534	1.2%
Pharmacy	15,006,494	17,887,238	2,880,744	31,956,088	35,896,647	3,940,558	11.0%
Medical	98,081,856	96,051,284	(2,030,572)	367,245,391	192,329,753	(174,915,638)	-90.9%
Long Term Support Services	649,732	432,255	(217,477)	1,257,812	866,183	(391,629)	-45.2%
CPO/In-lieu of Services	4,400,722	3,036,832	(1,363,890)	7,530,846	6,086,077	(1,444,769)	-23.7%
Dental Expense	12,945,231	12,872,745	(72,485)	26,128,214	25,382,878	(745,336)	-2.9%
Enhanced Care Management	840,943	1,234,358	393,415	1,599,795	2,469,158	869,362	35.2%
Provider Incentives	3,350,988	3,974,375	623,387	7,886,294	7,948,750	62,456	0.8%
Supplemental Benefits	1,488,461	779,140	(709,321)	2,163,802	1,563,853	(599,950)	-38.4%
Transportation	5,313,223	4,721,160	(592,062)	9,448,839	9,450,503	1,664	0.0%
Other Provider HC	460,780	-	(460,780)	2,280,780	1,750,000	(530,780)	-30.3%
Indirect Health Care Expenses	(1,671,981)	398,298	2,070,279	(2,196,226)	797,008	2,993,234	375.6%
UMQA, Delegated and Allocation	6,808,704	6,781,363	(27,341)	13,253,656	13,376,528	122,872	0.9%
Total Healthcare Expense	247,736,332	245,911,232	(1,825,100)	669,112,373	493,667,647	(175,444,726)	-35.5%
Administrative Expense							
Salaries and Benefits	16,296,804	16,747,600	450,796	32,616,493	32,860,585	244,092	0.7%
Staff Training and Travel	63,804	178,100	114,296	135,734	330,200	194,466	58.9%
Contract Services	4,606,376	4,879,025	272,649	8,228,076	9,706,150	1,478,074	15.2%
Office Supplies and Equipment	1,851,957	2,551,142	699,185	3,821,951	5,359,775	1,537,824	28.7%
Occupancy and Depreciation	862,623	1,038,000	175,377	1,690,129	2,035,800	345,671	17.0%
Postage and Printing	416,019	680,725	264,706	969,022	1,355,550	386,528	28.5%
Other Administrative Expense	343,411	462,237	118,827	939,030	889,075	(49,955)	-5.6%
UM/QA Allocation	(6,569,038)	(6,572,926)	(3,888)	(12,796,647)	(12,959,483)	(162,836)	-1.3%
Total Admin Expense	17,871,955	19,963,904	2,091,948	35,603,786	39,577,652	3,973,866	10.0%
Premium Taxes	18,921,401	20,008,040	1,086,638	39,477,098	40,016,079	538,981	1.3%
Total Operating Expense	284,529,688	285,883,175	1,353,487	744,193,257	573,261,378	(170,931,879)	-29.8%
Net Income/Loss from Operations	6,616,215	11,357,524	4,741,308	14,082,094	21,827,679	7,745,585	35.5%
NONOPERATING REV AND (EXP)							
Interest Income, Net	8,950,056	9,300,000	(349,944)	18,106,857	18,900,000	(793,143)	-4.2%
Rental Income, Net	345,265	318,222	27,043	670,609	626,750	43,858	7.0%
Third Party Administrator Revenue	63,750	63,750	-	127,500	127,500	-	-
Net Nonoperating Rev and (Exp)	9,359,070	9,681,972	(322,901)	18,904,965	19,654,250	(749,285)	-3.8%
Net Income/(Loss)	$ 15,975,286	21,039,495	(5,064,210)	$ 32,987,060	$ 41,481,930	$ (8,494,870)	-20.5%
Admin exp as % of Net Rev (adj for Tax)	*6.57%*	*7.20%*		*4.95%*	*7.13%*		
Medical Loss Ratio (adj for Tax)	*91.00%*	*88.70%*		*93.09%*	*88.94%*		

Health Plan of San Mateo
ALL LOB UNITS Statement of Revenue & Expense
for the Period Ending June 30, 2025

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Medi-Cal Capitation	$ 245,209,578	$ 238,122,854	$ 7,086,724	3.0%	$ 656,316,184	$ 476,433,553	$ 179,882,632	37.8%
MC Supplemental Cap	3,285,975	3,407,322	(121,347)	-3.6%	7,983,754	6,815,289	1,168,465	17.1%
HealthWorx Premium	2,371,749	2,313,295	58,453	2.5%	4,738,417	4,626,591	111,826	2.4%
CareAdvantage Premiums	59,590,685	59,203,218	387,466	0.7%	115,187,370	118,829,871	(3,642,501)	-3.1%
MC Cap Offset	(19,312,083)	(5,805,991)	(13,506,093)	-232.6%	(25,950,374)	(11,616,246)	(14,334,128)	-123.4%
Total Operating Revenue	291,145,904	297,240,699	(6,094,795)	-2.1%	758,275,351	595,089,057	163,186,294	27.4%
OPERATING EXPENSE								
Provider Capitation	7,286,698	6,605,234	(681,464)	-10.3%	14,911,928	13,218,583	(1,693,345)	-12.8%
Hospital Inpatient	51,981,715	48,887,477	(3,094,238)	-6.3%	102,061,529	97,922,569	(4,138,959)	-4.2%
LTC/SNF	40,792,768	42,249,472	1,456,704	3.4%	83,583,623	84,609,157	1,025,534	1.2%
Pharmacy	15,006,494	17,887,238	2,880,744	16.1%	31,956,088	35,896,647	3,940,558	11.0%
Physician Fee for Service	26,401,876	25,435,125	(966,751)	-3.8%	53,759,576	50,924,572	(2,835,004)	-5.6%
Hospital Outpatient	30,018,049	28,864,789	(1,153,260)	-4.0%	60,335,307	57,806,463	(2,528,844)	-4.4%
Other Medical Claims	30,055,869	27,073,959	(2,981,910)	-11.0%	60,276,295	54,225,656	(6,050,639)	-11.2%
Other HC Services	482	2,414,813	2,414,331	100.0%	38,889	4,831,366	4,792,477	99.2%
Directed Payments	11,605,579	12,262,598	657,018	5.4%	192,835,323	24,541,695	(168,293,627)	-685.7%
Long Term Support Services	649,732	432,255	(217,477)	-50.3%	1,257,812	866,183	(391,629)	-45.2%
CPO/In-lieu of Services	4,400,722	3,036,832	(1,363,890)	-44.9%	7,530,846	6,086,077	(1,444,769)	-23.7%
Dental Expense	12,945,231	12,872,745	(72,485)	-0.6%	26,128,214	25,382,878	(745,336)	-2.9%
Enhanced Care Management	840,943	1,234,358	393,415	31.9%	1,599,795	2,469,158	869,362	35.2%
Provider Incentives	3,350,988	3,974,375	623,387	15.7%	7,886,294	7,948,750	62,456	0.8%
Supplemental Benefits	1,488,461	779,140	(709,321)	-91.0%	2,163,802	1,563,853	(599,950)	-38.4%
Transportation	5,313,223	4,721,160	(592,062)	-12.5%	9,448,839	9,450,503	1,664	0.0%
Other Provider HC	460,780	-	(460,780)	-	2,280,780	1,750,000	530,780	30.3%
Indirect Health Care Expenses	(1,671,981)	398,298	2,070,279	519.8%	(2,196,226)	797,008	2,993,234	375.6%
UMQA (Allocation & Delegated)	6,808,704	6,781,363	27,341	0.4%	13,253,656	13,376,528	(122,872)	-0.9%
Total Health Care Expense	247,736,332	245,911,232	(1,825,100)	-0.7%	669,112,373	493,667,647	(175,444,726)	-35.5%
G&A Allocation	17,871,955	19,963,903	2,091,948	10.5%	35,603,785	39,577,652	3,973,867	10.0%
Premium Tax	18,921,401	20,008,040	1,086,638	5.4%	39,477,098	40,016,079	538,981	1.3%
Total Operating Expense	284,529,688	285,883,175	1,353,487	0.5%	744,193,256	573,261,378	(170,931,878)	-29.8%
NONOPERATING REVENUE AND EXPENSE								
Interest Income, Net	8,950,056	9,300,000	(349,944)	-3.8%	18,106,857	18,900,000	(793,143)	-4.2%
Rental Income, Net	345,265	318,222	27,043	8.5%	670,609	626,750	43,858	7.0%
Third Party Administrator Revenue	63,750	63,750	-	-	127,500	127,500	-	-
Total Nonoperating Revenue and Expenses	9,359,070	9,681,972	(322,901)	-3.3%	18,904,965	19,654,250	(749,285)	-3.8%
Net Income/(Loss)	$ 15,975,286	$ 21,039,495	(5,064,209)	-24.1%	$ 32,987,060	$ 41,481,930	$ (8,494,869)	-20.5%
Medical Loss Ratio (adj MCO)	91.00%	88.70%			93.09%	88.94%		
Member Counts	481,060	467,173	13,887	3.0%	959,007	934,837	24,170	2.6%

Health Plan of San Mateo
Medi-Cal UNITS Statement of Revenue & Expense
for the Period Ending June 30, 2025

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Medi-Cal Capitation	$ 245,209,578	$ 238,122,854	$ 7,086,724	3.0%	$ 656,316,184	$ 476,433,553	$ 179,882,632	37.8%
MC Supplemental Cap	3,285,975	3,407,322	(121,347)	-3.6%	7,983,754	6,815,289	1,168,465	17.1%
HealthWorx Premium	-	-	-	-	-	-	-	-
CareAdvantage Premiums	-	-	-	-	-	-	-	-
MC Cap Offset	(19,312,083)	(5,805,991)	(13,506,093)	-232.6%	(25,950,374)	(11,616,246)	(14,334,128)	-123.4%
Total Operating Revenue	229,183,470	235,724,185	(6,540,715)	-2.8%	638,349,564	471,632,595	166,716,969	35.3%
OPERATING EXPENSE								
Provider Capitation	5,690,490	5,365,572	(324,918)	-6.1%	11,308,937	10,733,521	(575,416)	-5.4%
Hospital Inpatient	38,445,512	33,043,887	(5,401,625)	-16.3%	72,300,516	66,124,702	(6,175,815)	-9.3%
LTC/SNF	37,799,996	38,508,148	708,152	1.8%	76,797,756	77,099,751	301,995	0.4%
Physician Fee for Service	20,864,430	19,786,406	(1,078,024)	-5.4%	42,734,650	39,589,830	(3,144,820)	-7.9%
Hospital Outpatient	21,775,857	21,266,804	(509,054)	-2.4%	44,526,237	42,558,833	(1,967,404)	-4.6%
Other Medical Claims	24,297,975	20,929,424	(3,368,551)	-16.1%	48,706,842	41,893,832	(6,813,010)	-16.3%
Other HC Services	482	2,414,813	2,414,331	100.0%	38,897	4,831,366	4,792,469	99.2%
Directed Payments	11,605,579	12,262,598	657,018	5.4%	192,835,323	24,541,695	(168,293,627)	-685.7%
Long Term Support Services	649,732	432,255	(217,477)	-50.3%	1,257,812	866,183	(391,629)	-45.2%
CPO/In-lieu of Services	4,343,610	2,961,880	(1,381,730)	-46.7%	7,388,066	5,935,638	(1,452,429)	-24.5%
Dental Expense	12,945,231	12,872,745	(72,485)	-0.6%	26,128,214	25,382,878	(745,336)	-2.9%
Enhanced Care Management	835,637	1,234,358	398,721	32.3%	1,895,567	2,469,158	573,590	23.2%
Provider Incentives	2,892,781	3,679,628	786,847	21.4%	7,133,340	7,359,256	225,916	3.1%
Transportation	5,301,567	4,706,060	(595,507)	-12.7%	9,435,136	9,420,194	(14,941)	-0.2%
Indirect Health Care Expenses	(1,968,778)	323,888	2,292,666	707.9%	(2,162,764)	647,711	2,810,475	433.9%
UMQA (Allocation & Delegated)	4,953,364	5,089,651	(136,286)	-2.7%	9,948,176	10,040,620	(92,444)	-0.9%
Total Health Care Expense	190,433,465	184,878,118	(5,555,348)	-3.0%	550,272,706	369,495,168	(180,777,539)	-48.9%
G&A Allocation	12,667,923	14,020,353	1,352,430	9.6%	25,074,025	27,794,798	2,720,773	9.8%
Premium Tax	18,921,401	20,008,040	1,086,638	5.4%	39,477,098	40,016,079	538,981	1.3%
Total Operating Expense	222,022,789	218,906,511	(3,116,279)	-1.4%	614,823,830	437,306,045	(177,517,785)	-40.6%
NONOPERATING REVENUE AND EXPENSE								
Net Income/(Loss)	$ 7,160,681	$ 16,817,675	(9,656,994)	-57.4%	$ 23,525,735	$ 34,326,551	$ (10,800,816)	-31.5%
Medical Loss Ratio (adj MCO)	90.57%	85.70%			91.88%	85.61%		
Member Counts	449,297	434,437	14,860	3.4%	895,479	869,185	26,294	3.0%

Health Plan of San Mateo
CareAdvantage Units Statement of Revenue & Expense
for the Period Ending June 30, 2025

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Medi-Cal Capitation	-	-	-	-	-	-	-	-
MC Supplemental Cap	-	-	-	-	-	-	-	-
HealthWorx Premium	-	-	-	-	-	-	-	-
CareAdvantage Premiums	59,590,685	59,203,218	387,466	0.7%	115,187,370	118,829,871	(3,642,501)	-3.1%
MC Cap Offset	-	-	-	-	-	-	-	-
Total Operating Revenue	59,590,685	59,203,218	387,466	0.7%	115,187,370	118,829,871	(3,642,501)	-3.1%
OPERATING EXPENSE								
Provider Capitation	1,596,208	1,239,662	(356,546)	-28.8%	3,602,991	2,485,062	(1,117,929)	-45.0%
Hospital Inpatient	13,132,362	15,476,077	2,343,715	15.1%	28,958,584	31,062,843	2,104,259	6.8%
LTC/SNF	2,992,772	3,741,324	748,552	20.0%	6,785,867	7,509,406	723,539	9.6%
Pharmacy	14,056,062	17,081,507	3,025,445	17.7%	30,169,679	34,285,185	4,115,506	12.0%
Physician Fee for Service	4,948,523	5,215,922	267,398	5.1%	10,135,263	10,469,149	333,886	3.2%
Hospital Outpatient	7,832,282	7,222,770	(609,513)	-8.4%	15,103,834	14,497,198	(606,636)	-4.2%
Other Medical Claims	5,606,027	5,977,849	371,822	6.2%	11,277,622	11,998,453	720,832	6.0%
Other HC Services	0	-	0	-	(8)	-	8	-
CPO/In-lieu of Services	57,112	74,952	17,840	23.8%	142,780	150,440	7,660	5.1%
Enhanced Care Management	5,306	-	(5,306)	-	(295,772)	-	295,772	-
Provider Incentives	452,854	290,622	(162,232)	-55.8%	743,476	581,244	(162,232)	-27.9%
Supplemental Benefits	1,488,461	779,140	(709,321)	-91.0%	2,163,802	1,563,853	(599,950)	-38.4%
Transportation	11,656	15,100	3,444	22.8%	13,703	30,308	16,605	54.8%
Indirect Health Care Expenses	282,089	66,657	215,432	323.2%	(62,575)	133,792	196,366	146.8%
UMQA (Allocation & Delegated)	1,776,025	1,623,799	152,226	9.4%	3,123,920	3,201,957	(78,037)	-2.4%
Total Health Care Expense	54,237,739	58,805,381	4,567,642	7.8%	111,863,166	117,968,890	6,105,724	5.2%
G&A Allocation	4,916,315	5,622,583	706,268	12.6%	9,887,761	11,146,549	1,258,788	11.3%
Total Operating Expense	59,154,054	64,427,964	5,273,910	8.2%	121,750,927	129,115,439	7,364,513	5.7%
NONOPERATING REVENUE AND EXPENSE								
Net Income/(Loss)	$ 436,631	$ (5,224,746)	5,661,377	-108.4%	$ (6,563,556)	$ (10,285,568)	$ 3,722,012	-36.2%
Medical Loss Ratio (adj MCO)	91.02%	99.33%			97.11%	99.28%		
Member Counts	25,052	25,167	(115)	-0.5%	49,863	50,514	(651)	-1.3%

Health Plan of San Mateo
HealthWorx Statement of Revenue & Expense
for the Period Ending June 30, 2025

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Medi-Cal Capitation	-	-	-	-	-	-	-	-
MC Supplemental Cap	-	-	-	-	-	-	-	-
HealthWorx Premium	2,371,749	2,313,295	58,453	2.5%	4,738,417	4,626,591	111,826	2.4%
CareAdvantage Premiums	-	-	-	-	-	-	-	-
MC Cap Offset	-	-	-	-	-	-	-	-
Total Operating Revenue	2,371,749	2,313,295	58,453	2.5%	4,738,417	4,626,591	111,826	2.4%
OPERATING EXPENSE								
Hospital Inpatient	403,841	367,513	(36,328)	-9.9%	802,429	735,025	(67,403)	-9.2%
Pharmacy	950,432	805,731	(144,701)	-18.0%	1,786,409	1,611,462	(174,948)	-10.9%
Physician Fee for Service	588,922	432,797	(156,126)	-36.1%	889,663	865,594	(24,070)	-2.8%
Hospital Outpatient	409,909	375,216	(34,693)	-9.2%	705,237	750,432	45,195	6.0%
Other Medical Claims	151,866	166,685	14,819	8.9%	291,831	333,370	41,539	12.5%
Other HC Services	-	-	-	-	0	-	0	-
Provider Incentives	5,354	4,125	(1,229)	-29.8%	9,479	8,250	(1,229)	-14.9%
Indirect Health Care Expenses	14,708	7,753	6,955	89.7%	29,113	15,506	13,607	87.8%
UMQA (Allocation & Delegated)	79,315	67,914	11,401	16.8%	181,560	133,950	47,610	35.5%
Total Health Care Expense	2,604,347	2,227,733	(376,614)	-16.9%	4,695,721	4,453,589	(242,132)	-5.4%
G&A Allocation	211,807	260,948	49,141	18.8%	459,647	517,319	57,672	11.1%
Total Operating Expense	2,816,154	2,488,681	(327,473)	-13.2%	5,155,368	4,970,908	(184,460)	-3.7%
NONOPERATING REVENUE AND EXPENSE								
Net Income/(Loss)	$ (444,406)	$ (175,386)	(269,020)	153.4%	$ (416,951)	$ (344,317)	$ (72,634)	21.1%
Medical Loss Ratio (adj MCO)	109.81%	96.30%			99.10%	96.26%		
Member Counts	3,952	3,858	94	2.4%	7,899	7,716	183	2.4%

Health Plan of San Mateo
ACE Statement of Revenue & Expense
for the Period Ending June 30, 2025

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Medi-Cal Capitation	-	-	-	-	-	-	-	-
MC Supplemental Cap	-	-	-	-	-	-	-	-
HealthWorx Premium	-	-	-	-	-	-	-	-
CareAdvantage Premiums	-	-	-	-	-	-	-	-
MC Cap Offset	-	-	-	-	-	-	-	-
Total Operating Revenue	-	-	-	-	-	-	-	-
OPERATING EXPENSE								
Total Health Care Expense	-	-	-	-	-	-	-	-
G&A Allocation	75,910	60,020	(15,890)	-26.5%	182,352	118,986	(63,366)	-53.3%
Total Operating Expense	75,910	60,020	(15,890)	-26.5%	182,352	118,986	(63,366)	-53.3%
NONOPERATING REVENUE AND EXPENSE								
Third Party Administrator Revenue	63,750	63,750	-	-	127,500	127,500	-	-
Total Nonoperating Revenue and Expenses	63,750	63,750	-	-	127,500	127,500	-	-
Net Income/(Loss)	$ (12,160)	$ 3,730	(15,890)	-426.0%	$ (54,852)	$ 8,514	$ (63,366)	-744.3%
Medical Loss Ratio (adj MCO)	-	-			-	-		
Member Counts	2,759	3,711	(952)	-25.7%	5,766	7,422	(1,656)	-22.3%

DRAFT

AGENDA ITEM: 4.5

DATE: September 10, 2025

SAN MATEO HEALTH COMMISSION
Meeting Minutes
July 9, 2025 – 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor Boardroom
South San Francisco, CA 94080
-or-
17907 Holli Blue Rd, Champion, Michigan

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

1. **Call to order/roll call**
   The meeting was called to order at 12:35 p.m. by Commissioner Graham, Chair. A quorum was present.

   Commissioner Speier joined the meeting via teleconference link from an alternate location in Michigan, which was posted on the agenda and available to the public.

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

3. **Approval of Agenda:** The agenda was approved as presented. Motion: Tai (Second: Mueller). A roll call vote was taken. **M/S/P.**

4. **Consent Agenda:** The consent agenda was approved as presented. Motion: Tai (Second: Mueller). A roll call vote was taken. **M/S/P.**

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

   5.1 Approval of RFP contract for Practice Transformation: Luarnie Bermudo, Director of Provider Services reviewed a recent request for proposal that HPSM underwent to find a vendor to help with practice transformation efforts. Funding will come from a portion of the reserves that were recently approved by the Commission for investments in primary care. Ms.

Bermudo provided a recap of HPSMs strategic plan and investment criteria. Miriam Sheinbein, M.D., HPSM Medical Director, spoke about HPSMs primary care investment goal to better allocate resources, promote a robust and thriving workforce, improve population health, and enhance the care experience. In Phase I they worked to establish the foundational pieces of the strategy. They are now moving to Phase 2, where they will dive deeper into understanding HPSM's primary care network and catalyzing change. This includes launching practice transformation services. They are also developing a model of how they will deploy the $30M that the Commission approved. As they continue this program, they will continue to monitor the metrics of success in advancing the four primary care investment goals.

Practice transformation efforts will span three years and will involve assessments of the entire PCP provider network, provide targeted coaching for select providers within the network and offer other interventions that align with HPSM's requirements and scope. Dr. Sheinbein explained that practice assessments are standardized tools, which are developed to collect and analyze the attributes and characteristics of the practice delivering care. Assessments for primary care practices are organized around principles of primary care and the degree of attainment of each of these components such as team-based care, access and engagement, care coordination and population health capabilities. They are validated to measure concepts associated with high quality primary care practice. The vendor chosen to help with this is the Population Health Learning Center (PHLC). This decision was based on their expertise and experience. PHLC has a unique partnership with UCSF and deep relationships with providers, plans, and regulators across California. They also considered PHLC's value alignment, quality practice coaches, customizable options and how they are data and evaluation driven. They requested $6M from the Primary Care Capacity Fund to work with PHLC. The funding will facilitate the launch of the practice transformation efforts across HPSMs entire network. PHLC will deploy practice assessments across the network, practice coaching and peer learning as part of the scope of work. There were questions about how the monies would be dispersed. Ms. Bermudo noted that this will be based on performance measures, depending on how well they do in achieving those metrics, they may get $6M or they may get less. In response to a question about whether there were maximum or minimum coaching hours. Ms. Bermudo said they specifically looked for a vendor who could provide the maximum high touch hours. Ms. Bermudo responded to a question about how receptive providers will be for this help and which providers they are targeting. They are working now on how to incentivize the network of providers and will depend on PHLC to identify and make recommendations.

Commissioner Callagy motioned to approve the contract for Practice Transformation with PHLC. (Second: Andrade-Zuniga). A roll call vote was taken. **M/S/P.**

5.2 Update on State and Federal Budgets: Ian Johansson, HPSM Chief Government Affairs and Compliance Officer, provided an update on recent decisions made by the State and Federal Governments as it pertains to healthcare. He noted the passing of the California budget on June 27th. On July 4th President Trump signed the One Big Beautiful Bill Act (OBBBA) into law. There is still uncertainty about whether California will need to reopen the 2025-26 budget to reflect OBBBA cuts.

What did not pass in the California budget:

- Elimination of long-term care (LTC) and In Home Supportive Services (IHSS) for those with Unsatisfactory Immigrant Status (UIS).
- Increasing the MLR for managed care plans to 90%
- Asset test reduction to $2,000 for individuals and $3,000 for couples
- Elimination of acupuncture.

What did not pass in OBBA:

- Expansion federal matching (FMAP) penalty for UIS coverage.
- Prohibition of payment for gender affirming care.

Mr. Johannson also went over cuts in the California budget which include a variety of cuts in coverage for members with UIS which will be implemented in 2026 and 2027. There will also be an elimination of Prop 56 payments for dental in July of 2026 and the elimination of the workforce and quality incentive program (WQIP) in December of 2025. California will draw down $13.5B in reserves to deal with these issues.

Impacts to Medicaid at the Federal level include a required $35 copay for services starting in October of 2028, the implementation of work requirements starting in December of 2026 and requirements for redetermination every 6 months starting in December of 2026. Mr. Johansson also went over some of the more technical aspects in cuts to Medicaid in the OBBBA which includes postponing rules for Medicare Savings Programs and eligibility streamlining. This is currently in effect. It also removes certain groups from the “qualified immigrant” definition, which also affects Medicare, starting in October 2026 and limits retroactive coverage effective December 2026. There are also changes in provider tax rules, reducing allowable limit for State Directed Payments and prohibiting payments to “prohibited entities” such as Planned Parenthood for one year. These are all currently in effect. Mr. Johansson provided a timeline for the cuts, noting that there are big impacts to benefits in 2026 and to funding in 2028. He reminded them this is based on current information. If the State comes back and reopens its budget the window could change. Additionally, in January when the Governor proposes the 2026-2027 budget, there should be more clarity about any additional cuts the State needs to make to balance the budget starting in the July 2026 budget cycle. Mr. Johannson spoke about some of the effects on California and HPSM due to these changes. HPSM will evaluate decision-making over the

next two months, consider which decisions need to be made for the 2026 budget year, monitor the State for direction, and continue discussions with the Commission in September.

Pat Curran, HPSM CEO, took this time to touch on the work and eligibility requirements. He reminded the group that it is still unknown how this will be implemented. There are many moving parts that will affect both members and providers. He noted the importance of the investment criteria that HPSM has in place to understand how to prioritize investments.

He also advised the group that Planned Parenthood provides primary care to 3,700 HPSM members, as well as family planning and reproductive health services to additional HPSM members. There will be a need to evaluate and speak with them about how they and the State are going to approach the recent changes. Commissioner Speier noted that subsidies provided in the Affordable Care Act will drop, which means many people will either go without health care or become eligible for Medicaid. Mr. Curran noted that HPSM does not have a product with Covered California, but he did acknowledge the potential expiration of the Advanced Premium Tax Credit (APTC). During COVID this allowed people to get affordable coverage with Covered California. This will expire at the end of the year. It is unknown what will happen to those individuals. Commissioner Speier wondered if it would be advantageous to pursue a campaign to get UIS adults into the system before they are locked out in January 2026. Mr. Johannson agreed that it would be a great opportunity to ensure that they continue to qualify for full scope coverage. Commissioner Andrade-Zuniga asked if the Commission would consider releasing a statement to reiterate their support for the community. Similar actions have been taken recently by sibling organizations. Mr. Curran advised the group that the statement would need to be an agenda item and discussed at an upcoming meeting. He also stressed the importance of continuing to provide supportive one on one interactions with members and those in the community. Mr. Curran assured the Commission that in the next few months they will try to determine if there are decisions that need to be made as an organization prior to drafting the 2026 budget.

6. **Report from Chief Executive Officer:** Pat Curran, HPSM CEO, shared his thoughts during the discussion in Item 5.2.

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

8. **Adjournment:** The meeting was adjourned at 1:45 pm by Commissioner Graham.

Submitted by:

M. Heryford

M. Heryford, Clerk of the Commission

Primary Care Investments: Practice Transformation Update

Luarnie Bermudo, Director of Provider Services

Dr. Miriam Sheinbein, Medical Director

San Mateo Health Commission

July 2025

HealthPlan OF SAN MATEO
Healthy is for everyone

Objectives for today

HealthPlan OF SAN MATEO
Healthy is for everyone

- **Recap** of HPSM's Strategic Plan, investing in the future and oversight.
- Recap of **investment criteria:**
  - Primary Care Investments
- Primary Care Investment **Goals**
- **Deep dive** into Practice Transformation
- **Allocation** Proposal
- Recap of **things to come**

HPSM's 2024-2028 Strategic Plan

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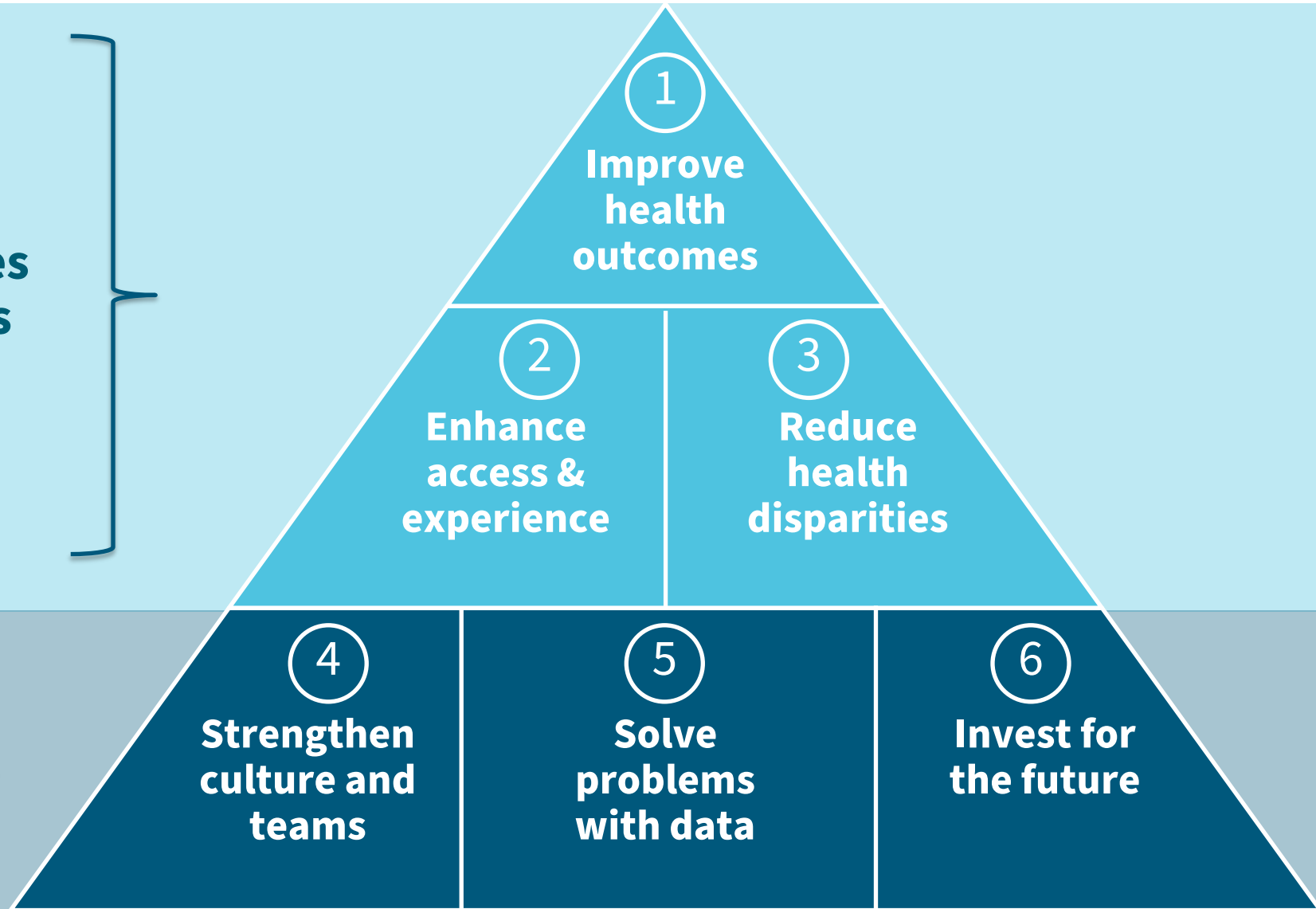
HPSM 2024-2028 Strategic Plan:

Area of Focus 1:

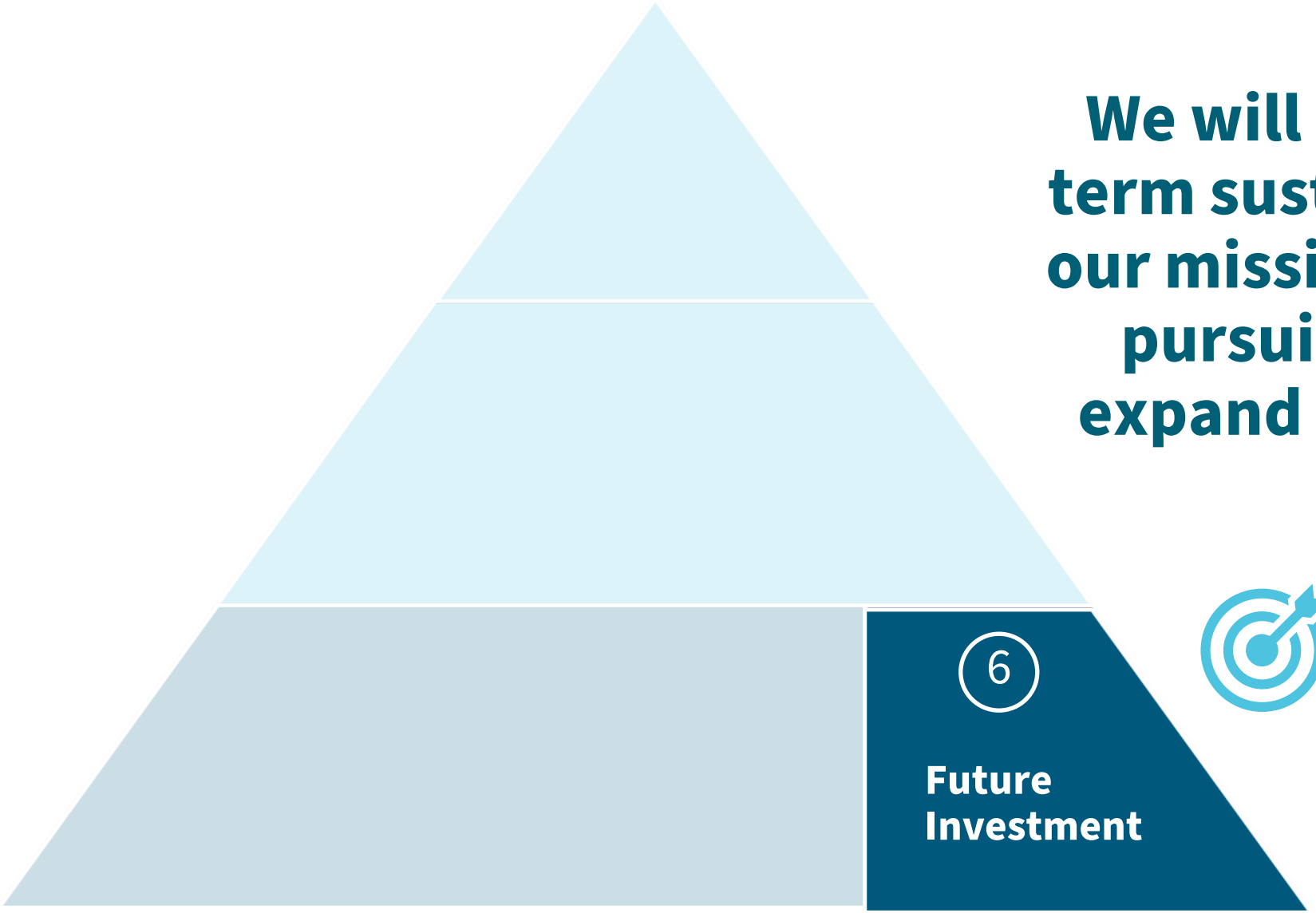
Better Health Care Experiences and Outcomes for all Members

Area of Focus 2:

Thriving Organizational Capacity and Resilience



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.

Ensuring effective oversight

In May 2024, SMHC approved **investment criteria** for the Provider Investment Fund ($100M) and Primary Care Investments ($30M)

SMHC approved the following **oversight processes**:

1. Obtain Commission approval by vote for:
   - Vendor expenditures following our existing purchasing policies
   - Bundles of one-time provider investments
2. Report out on progress on Provider Investments and Primary Care Investments every 6-12 months, including HPSM progress on implementing network rate changes based upon approved criteria

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HPSM Investment Criteria

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Does this investment:

- ❑ **Meaningfully impact member access** to high-quality care, services and supports in alignment with our mission.
- ❑ Support our members' journey to the **best possible health outcomes**, including equitable outcomes and a positive member experience
- ❑ **Leverage HPSM's unique strengths** including our unique capabilities, resources, relationships and role within the health care ecosystem.
- ❑ Support strong **stewardship of our financial resources**.
- ❑ Address threats and opportunities that **impact HPSM's long-term organizational health**
- ❑ Have defined metrics for **measurable progress** we can realistically make within an appropriate time frame.

Network dashboard: top priority needs

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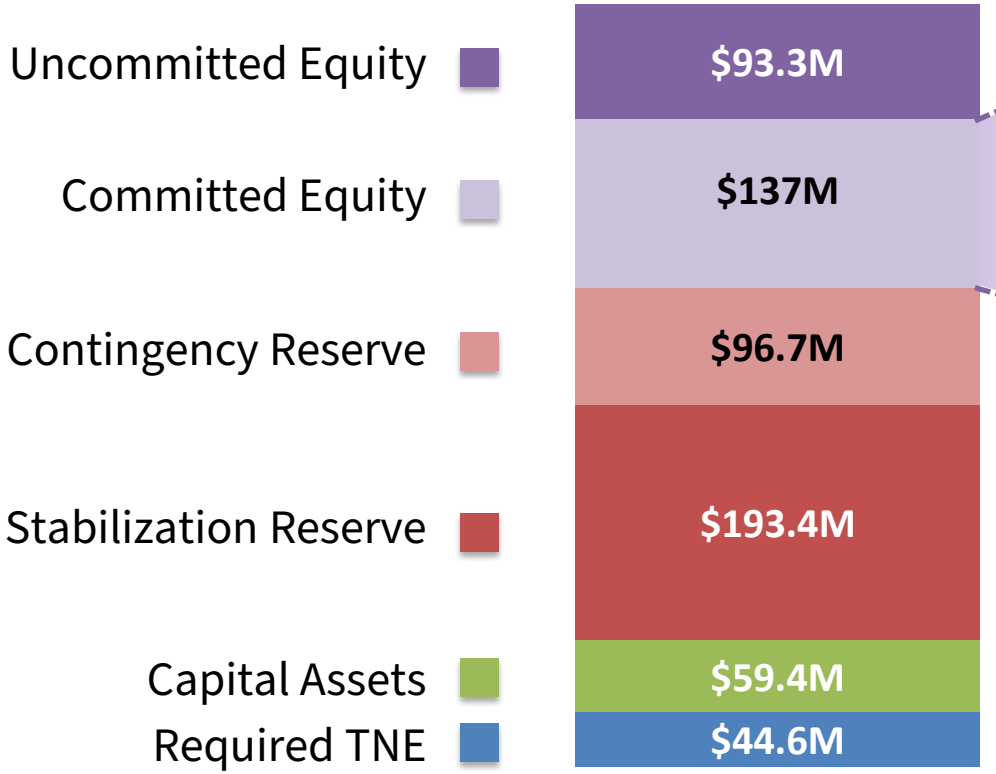
X Axis: **HPSM Member Access Priority**

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**

Primary Care Investment Update

Committed TNE as of EOY 2024



Committed Equity:

A	Provider	$100M
B	**Primary Care**	**$30M**
C	Baby Bonus	$7M

Based upon last audited financials: December 2023

Objectives for today

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Primary Care Investment Goals

Strategically invest in primary care, to:

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1. Better allocate resources: to address chronic underinvestment, support the implementation of advanced primary care, and shift from a focus on *volume* to *value*.

2. Promote a robust and thriving workforce: fortify a diverse primary care workforce in San Mateo County to increase capacity, bandwidth, and joy.

3. Improve population health: support our network to be more population focused, in order to achieve better, more equitable health outcomes for our members.

4. Enhance the care experience for members and families, so that they are satisfied, engaged in their care, and healthy.

Phase 1

Establish the Foundational Pieces of the Strategy:

- Defined primary care **investment criteria** and **metrics of success** to measure effectiveness in advancing our four primary care investment goals
- Developed methodology for calculating **Primary Care Spend**
- Reignited the **Provider Advisory Group**
- Designed a **Primary Care Grants program**
- Launched an RFP for **Practice Transformation** services

Objectives for today

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Healthy is for everyone

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- Recap of **things to come**

Phase 2

Dive deeper into understanding our primary care network and catalyzing change:

- Launch **Practice Transformation** services
  - Network-Wide Practice **Assessments** and analysis
  - Deployment of Practice **Coaches**
- Deploy **Primary Care Provider Grants**
- Propose an evidence- and value-based **Primary Care Payment** model
- Continue to monitor **metrics of success** in advancing our four primary care investment goals

Primary Care Practice Transformation

- **What is Practice Transformation?**
- **RFP launched:** In 2024 as a request for proposal to identify a vendor who would work in partnership with HPSM and HPSM's primary care network on Practice Transformation.
  - Complete **assessments** for the entire PCP provider network
  - Provide targeted **coaching** for select providers within the network
  - Offer other **practice transformation interventions** that align with our requirements and scope

Quintuple Aim

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Better Use of Resources

1. Measure/Report/Increase Primary Care Spend
2. Pay for Advanced Primary Care
3. Test Alternative Payment Models
4. Align with Other Payers
5. Offer Practice Supports

Better Population Health

1. Increase Network Population Health Management Capabilities
2. Improve Data Transparency
3. Support Data Integration & Interoperability
4. Improve Performance & Reduce Disparities

Better Work

1. Invest in Workforce Development
2. Bolster the 3Rs: Recruitment, Retention, and Resilience
3. Promote Team-Based Care that Increases PCP Capacity
4. Enhance Staff Diversity, Inclusion, and Belonging

Better Care Experience

1. Uplift member voices
2. Enhance Community Partnerships for more Coordinated, Integrated and Comprehensive Care
3. Improve Access
4. Increase Engagement

Primary Care Practice Transformation

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- **Chosen Vendor:** Population Health Learning Center (PHLC)
- **Vendor Background:**
  - **Expertise & Experience** in primary care with strong clinical leadership, partnership with UCSF, and deep relationships with providers, plans and regulators across California.
  - **Value alignment** emphasizing equity, outcomes, and sustainability.
  - **Quality Practice Coaches** with 10+ years of coaching experience; and include QI and SME coaches.
  - **Customizable options** offering combinations of coaching and peer learning.
  - **Data and evaluation driven** ensuring we can compare our data across our network and California.

Objectives for today

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- **Recap** of HPSM's Strategic Plan, investing in the future and oversight.
- Recap of **investment criteria:**
  - Primary Care Investments
- Primary Care Investment **Goals and Metrics**
- **Deep dive** into Practice Transformation
- **Allocation** Proposal
- Recap of **things to come**

Proposed Allocation

Request to approve **allocation of (do not exceed) $6 Million** from **$30,000,000 Primary Care Capacity Fund** to be dispersed to Population Health Learning Center over the next 3 years.

- Funding will facilitate the launch of Practice Transformation efforts across the network by selected vendor, Population Health Learning Center.
- PHLC will deploy Practice Assessment, Practice Coaching, and peer learning as part of the agreement.

Objectives for today

HealthPlan OF SAN MATEO
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- Primary Care Investment **Goals and Metrics**
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- **Allocation** Proposal
- Recap of **things to come**

Next steps

- Launch **Practice Transformation in Q3 2025**.
- Continue primary care **communication campaign.**
- **Update SMHC** on progress and impact.
- Bring SMHC bundled **Primary Care Provider Grants** and additional approval of dollars in the coming months.

Questions?

Appendix

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Primary Care Investment Goals

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Prioritization considerations:

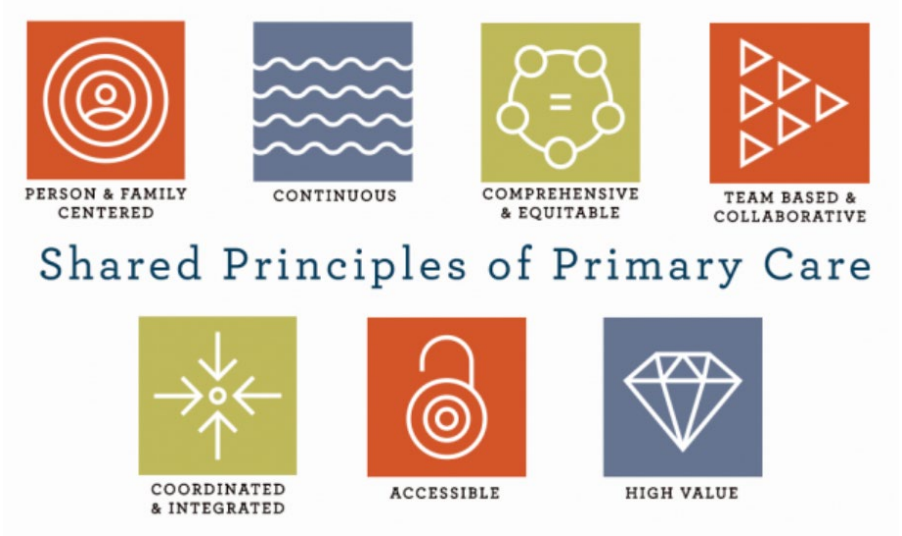
- The degree to which the opportunity advances our four investment goals relative to the size of the investment/grant.
- The appropriateness of HPSM as the funder, do-er, or convener
- Appropriateness of the request by the specific provider

Either/or (not both):

- For project support: test something that is net-new; aligned with the concepts of piloting, evaluating, and sharing lessons learned
- For general operational support: financial stability of the investment for HPSM and sustainability for the providers implementing new solutions

Timeline of Practice Transformation

- Timeline
  - Q3 2025 Initiate Practice Assessments
  - Q1 2026 Deploy Coaching
  - Q1 2028 Gather Data
  - Q2 2028 Evaluation



Primary Care Investment Metrics

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Goal	Primary Metric(s)	Secondary Metric(s)
Better Use of Resources	Increase PC spend by 30% (proportional to number of members)	Monitor proportion of reimbursement earned through VBP. Monitor rates in comparison to Medicare.
Better Work	Right-size primary care panels to 1200 members per primary care team.	Monitor provider well-being.
Better Population Health	Each primary care organization will show tiered improvement* on the following applicable clinical (HEDIS) metrics**: Well Child Visits; Breast Cancer Screening; Depression Screening and Follow Up; HbA1C>9 Close disparity gaps for well-child visits and immunizations at a statistically significant level.	Increase data transparency, integration and interoperability.
Better Care Experience	Increase members with a usual source of primary care.	

* Tier 1: at or above 90th percentile: stay or exceed; Tier 2: between 50th and 90th percentile: greater than 25% gap closure to 90th percentile; Tier 3: below 50th% percentile: exceed 50th percentile
** minimum denominator of 30 members per component rate

Practice Transformation Scope and Metrics

Vendor agreement structured with both at-risk and bonus fee components based on several key metrics:

- **Practice Assessment Completion**: The volume of HPSM member lives assigned to primary care practices with whom a robust practice assessment has been completed.
- **Practice Coaching Engagement**: The rate of practices successfully enrolled in a practice coaching intervention among those identified through practice assessments as an optimal candidate for practice coaching.
- **Practice Coaching Maintenance**: The rate of practices enrolled in a practice coaching intervention who achieve a minimum engagement threshold with coach during the Active Intervention.
- **Coaching Cohort HEDIS Improvement**: The percent improvement to the overall rate of compliance in up to four key health outcome metrics among practices enrolled in coaching.

2025-2027 Provider Investments

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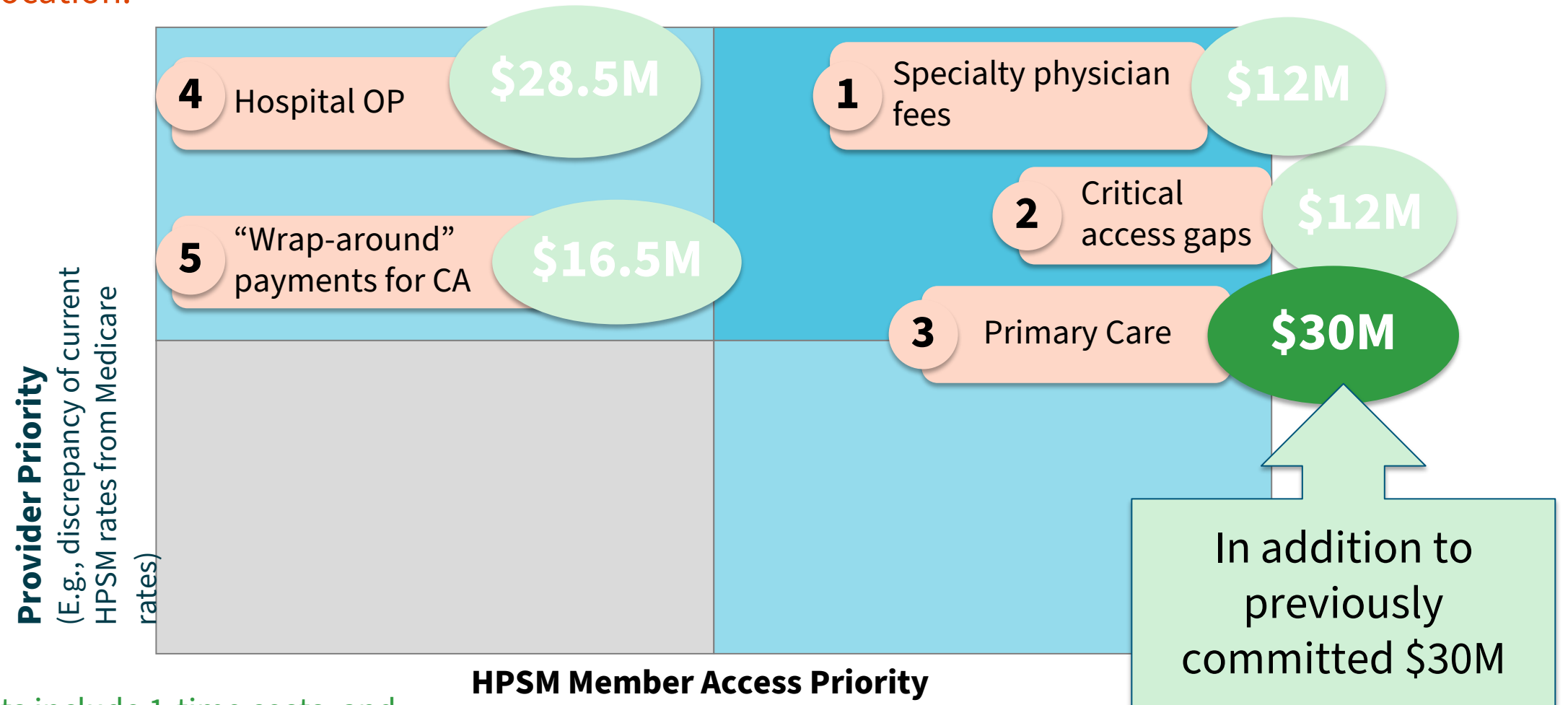
Cost allocation:



Total costs include 1-time costs, and the cost of network rate increases over **three years 2025-2027**

Primary Care Investment Metrics

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Investment Goal:	Primary Metric:
1 **Better Use of Resources**	**Increase primary care spend** by 30% per capita
2 **Better Work**	**Right-size primary care panels** to 1200 members per primary care team.
3 **Better Population Health**	Show tiered **improvement on prioritized HEDIS metrics:** WCV, BCS, DSF, HBD **Close disparity gaps** for well-child visits and immunizations
4 **Better Care Experience**	Increase the percent of members with a **usual source of primary care**

2025 Health Policy Update

July 9, 2025

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What we know

- California passed its 2025-26 budget on June 27th
- President Trump signed the One Big Beautiful Bill Act (OBBBA) into law on July 4th

What we don’t know

- When California will need to reflect OBBBA cuts in the budgeting process
  - Will California need to re-open the 2025-26 budget?

Good news – What didn't pass

- California Budget
  - Elimination of LTC and IHSS for UIS
  - Increasing the MLR for managed care plans to 90%
  - Asset test reduction to $2,000 for individuals, and $3,000 for couples
  - Elimination of acupuncture
- OBBBA
  - Expansion federal matching (FMAP) penalty for UIS coverage
  - Prohibition of payment for gender affirming care

Cuts in the California Budget

- Cuts to coverage for members with Unsatisfactory Immigration Status (UIS) **[mm/yy]**
  - Enrollment freeze for ages 19 and up **[01/26]**
  - $30 monthly premium for ages 19 to 59 **[07/27]**
  - 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 California Budget

- Other cuts
  - Eliminates Prop 56 payments for dental **[07/26]**
  - Eliminates Workforce and Quality Incentive Program (WQIP) **[12/25]**
- Withdraws $13.5 billion out of reserves

Medicaid Cuts in the OBBBA

- Requires $35 copay for services **[10/28]**
  - Exempts primary care, mental health, substance use disorder services, and services provided by FQHCs and RHCs
- Implements work requirements **[12/26*]**
  - Exempts parents with children up to age 13, medically frail
  - *States may receive a good faith extension up to 12/28
- Requires redetermination every six (6) months **[12/26]**

Medicaid Cuts in the OBBBA

- Postpones rules for Medicare Savings Programs and eligibility streamlining **[in effect]**
  - May result in eligible individuals losing coverage
- Removes certain groups from "qualified immigrant" definition (*also affects Medicare*) **[10/26]**
  - Shrinks the non-citizen group eligible for Medicaid
- Limits retroactive coverage **[12/26]**
  - 30 days for expansion Medicaid, 60 days for traditional Medicaid

Medicaid Cuts in the OBBBA

- Changes provider tax rules **[in effect*]**
  - *Gives states three (3) years to comply with “broad-based and uniform” requirement
  - *Reduces safe harbor limit from 6% to 3.5% starting 2028 (0.5%/year)
- Reduces allowable limit for State Directed Payments **[in effect*]**
  - Limits payment to the Medicare rate
  - *Begins reducing grandfathered payments 10% each year in 2028
- Prohibits payment to “prohibited entities” for one year **[in effect]**
  - The “Planned Parenthood” provision; in effect July 4, 2025

Timeline of cuts*

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2025	2026	2027	2028
• Ban on payment to prohibited entities • Provider tax rule (3-year window start) • Elimination of WQIP	• Work Requirements • 6-month redeterminations • Immigrant eligibility • UIS enrollment freeze • UIS PPS cut • UIS dental cut • Prop 56 dental cut	• Retroactive coverage • UIS premiums	• $35 copays • Work Requirements (with delay) • Provider tax reduction start • Provider tax rule (end of window) • State directed payment reduction start

Effects on HPSM (from January)

- Less federal funding = pressure on CA budget
- California would need to consider changes to Medi-Cal
  - Continue coverage of undocumented individuals?
  - Change/restrict Medi-Cal eligibility?
  - Change/restrict Medi-Cal benefits?
- As of January 2025, it's unclear which, if any Medicaid proposals can make it through Congress

Effects 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

What do we do, now?

- Evaluate decision making over the next two months
- Consider which decisions need to be made for the 2026 Plan budget
- Monitor for direction from the State
- Continue the discussion with the Commission in September

Questions?

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MEMORANDUM

AGENDA ITEM: 5.1

DATE: September 10, 2025

DATE: September 3, 2025

TO: San Mateo Health Commission

FROM: Patrick Curran, CEO

RE: Approval of $7.5 Million in Primary Care Investment Grants

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Recommendation:

HPSM recommends that the San Mateo Health commission approve a block allocation of $7,500,000 from the Primary Care Investment Fund to support Primary Care Provider Grants.

Background:

During the September 2023 HPSM Commission meeting, the San Mateo Health Commission (SMHC) approved the allocation of $30,000,000 of HPSM reserves over the subsequent five years for strategic investment to address the primary care crisis and to promote Advanced Primary Care in San Mateo County, to achieve better and more equitable health outcomes for our members.
Then in May 2024, the San Mateo Health Commission approved the Provider Investment Fund, a strategy to invest in the HPSM provider network more broadly to enhance access to high-quality, member-centered care throughout the HPSM Provider Network. As part of the established oversight process, HPSM is required to bundle one-time provider investments for commission approval.

In February 2025, the Health Commission approved a $300,000 capacity investment for the San Mateo Medical Center's Innovation Center, focusing on primary care engagement and access. in March of 2025, HPSM commission approved the disbursement of $2.5 million from the primary care investment funds for the Primary Care Provider Grants.

Building on the enthusiasm and momentum of the Primary Care Provider Grants, among our network of primary care providers, we are now prepared to deploy our next round of Primary Care Provider Grants. These grants are available to all HPSM-contracted primary care practices. Grantees are required to detail how the funding will improve primary care provider capacity, team bandwidth and satisfaction and increase access for HPSM members. Funding availability extends through 2028, and grants are awarded to organizations rather than individuals.

Four Flexible Primary Care Grant Options:

1. **Primary Care Team Expansion:** Hire and integrate new interprofessional team members.
2. **Core Team Stabilization:** Recruit and retain Primary Care Providers and Medical Assistants.
3. **Provider Sabbatical:** Retain providers by enhancing resilience through sabbaticals.
4. **Custom Pilot Program:** Design pilots and programs that enhance primary care teams' capacity, bandwidth, and joy.

Discussion and Fiscal Impact:

We are requesting the approval of $7,500,000 from the $30,000,000 allocated for Primary Care Investments for the deployment of Primary Care Provider Grants. Grants will be deployed across four flexible primary care grant options, as described above.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF $7.5 IN PRIMARY CARE INVESTMENTS GRANTS

RESOLUTION 2025 -

RECITAL: WHEREAS,

A. HPSM has developed a Provider Investment Fund and Primary Care Investment Strategy to support providers through payment rate changes and one-time investments;
B. HPSM recognizes that the stability and viability of its provider network is critical to member access;
C. HPSM has criteria in place to fund primary care capacity pilots in the community to meet the needs of HPSM members.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission authorizes the Chief Executive Officer to approve the disbursement of $7,500,000 from the $30,000,000 Primary Care Investment Fund to Primary Care Grantees across the network, as part of the four Primary Care Provider Grants developed by HPSM.
2. HPSM will monitor progress of the Primary Care Investment Grants and provide periodic reports to the San Mateo Health Commission as part of its ongoing updates on its Primary Care Investment Program.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 10th day of September 2025, 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: 5.2

DATE: September 10, 2025

Meeting Materials are not included for

Item 5.2 – Update on HPSMs Investing for the Future/Goal 6 Efforts

AGENDA ITEM: 5.3

DATE: September 10, 2025

Meeting Materials are not included for

Item 5.3 – Update on Baby Bonus Program

MEMORANDUM

AGENDA ITEM: 6.0

DATE: September 10, 2025

DATE: September 3, 2025

TO: San Mateo Health Commission

FROM: Patrick Curran

RE: CEO Report – September 2025

State Budget

The latest information we are receiving indicates that there is no significant support to have a special session this fall to address potential state budget shortfalls. The legislature has had hearings to assess the impact of HR1 on the state budget over this fiscal year (July 2025 through June 2026). There may be targeted budget changes, but it appears unlikely there will be further Medi-Cal reductions. If that is the case, the next official announcement will be the initial budget for 2026-27 that the Governor's office will release in January 2026.

As a reminder, here are the main changes in the final state budget that affect HPSM and our members in 2026:

- No new enrollment of members age 19 and older in the Unsatisfactory Immigration Status (UIS) category beginning January 1, 2026. For existing members in that category who lose coverage, there is a three-month period that they can re-enroll.
- Eliminates dental coverage for all members age 19 and older in the UIS category beginning July 1, 2026.

Federal Medicaid Policy

After the passage of HR1 in July, much of our work has involved assessing the potential impact, both short-term and long-term, on Medi-Cal. The main change which immediately affected HPSM and our members was the prohibition of Planned Parenthood from federal programs. That prohibition is paused pending litigation, and HPSM is working with Planned Parenthood Mar Monte (PPMM) on a transition of members, since PPMM provided primary care to approximately 3,700 members and is discontinuing primary care services. They continue to provide reproductive health services to the community at their Redwood City location.

Most other aspects of HR1 take effect in 2027 or later. Some, including provider taxes, have uncertain timelines. These taxes, which include the MCO Tax, are critical funding sources for Medi-Cal. HR1 allows for a three-year transition to ensure these funding sources comply with updated federal rules, but reductions could begin sooner. We will keep the Health Commission updated as we learn more.