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THE SAN MATEO HEALTH COMMISSION
Regular Meeting
September 9, 2026 - 12:30 p.m. Pacific Time
Health Plan of San Mateo
Boardroom
801 Gateway Blvd., 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/vIggjEMZDFQ?feature=share
Please note that while there is an opportunity to provide public comment in person, there is no means of doing so via the Live Stream link.

AGENDA

1. **Call to Order/Roll Call**
2. **Public Comment/Communication**
3. **Approval of Agenda***
4. **Consent Agenda***
   - 4.1 Approval of Annual Compliance Program
   - 4.2 Draft Finance/Compliance Committee Meeting Minutes – August 24, 2026
   - 4.3 Approval of San Mateo Health Commission Meeting Minutes from August 12, 2026
5. **Specific Discussion/Action Items**
   - 5.1 SMC Human Services Agency presentation and discussion
     Claire Cunningham, Agency Director
   - 5.2 PHCC Immigration Justice Presentation
     Ana Avendaño, Executive Director, El Concilio of San Mateo County
     Judith Guerrero, Executive Director, Coastside Hope
   - 5.3 Appointment of Chief Executive Officer *
6. **Report from the CEO**
7. **CLOSED SESSION**
   7.1 CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION (Government Code Section 54956.9(d)(2)) (1 case)
8. **Report on Action Taken in Closed Session**
9. **Other Business**
10. **Adjournment**

**Items for which Commission action is requested.*

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

MEMORANDUM

AGENDA ITEM: 4.1

DATE: September 9, 2026

DATE: September 2, 2026

TO: San Mateo Health Commission

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

RE: Annual Approval of the Compliance Program, Code of Conduct, and CP.009

Recommendation

Approve HPSM Compliance Policy CP.000 Compliance Program, Compliance Policy CP.009 Notification Process for Compliance Issues, and CP.026 the 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) defines the kinds of compliance-related information shared with the internal Compliance Committee, Finance-Compliance Committee, and 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 one minor change with an update to the policy catalog. The program document was reviewed and approved by the Compliance Committee on August 18, 2026. It is hereby submitted to the Commission for its annual review and approval.

Notification Process for Compliance Issues

The Notification Process for Compliance Issues had no substantive changes. The policy was reviewed and approved by the Compliance Committee on August 18, 2026. It is hereby submitted to the Commission for review and approval.

Code of Conduct

The Code of Conduct had no substantive changes. The Code of Conduct was reviewed and approved by the Compliance Committee on August 18, 2026. 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.

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

RESOLUTION 2026 -

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.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

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

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 9th day of September, 2026 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, 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
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.023	Pre-Delegation Review
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
CP.031	Enforcement Actions Administrative and Monetary Sanctions
CP.032	NCQA Accreditation Compliance
HP.001	Privacy Program
HP.002	Minimum Necessary ~~Use and Permitted Uses~~
HP.003	Verification Requirements
HP.004	Member Authorization
HP.005	Right to Request Restriction ~~Requests~~of PHI Use and Disclosure
HP.006	~~Confidential Communications~~Individuals Right to Request Alternate or Confidential Methods of Communications of PHI
HP.007	Individual Right of Access ~~Requests to~~ PHI

HP.008	Individual's Right to Request Amendment of ~~Amending~~ PHI
HP.009	Plan Member Right to Request Accountings of Disclosures
HP.010	~~Privacy Incidents~~Breach Analysis and Notification Policy
HP.011	~~Breach Notification~~ Designated Record Sets
HP.012	~~Safeguarding Sensitive Information~~Personal Representatives
HP.013	Business Associate~~s and Other Arrangements~~ Agreements
HP.014	Notice of Privacy Practices
HP.015	General Use and Disclosure of PHI
HP.016	Use and Disclosure of PHI – Judicial, Administrative, and Law Enforcement
HP.017	Use and Disclosures of De-Identified PHI and Limited Data Sets
HP.018	Fundraising
HP.019	Uses and Disclosures of PHI via Email and Fax
HP.020	Use and Disclosure of PHI – Gender Affirming Care and Abortion Related Services Restrictions
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
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.023	Pre-Delegation Review
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
CP.031	Enforcement Actions Administrative and Monetary Sanctions
CP.032	NCQA Accreditation Compliance
HP.001	Privacy Program
HP.002	Minimum Necessary
HP.003	Verification Requirements
HP.004	Member Authorization
HP.005	Right to Request Restriction of PHI Use and Disclosure
HP.006	Individuals Right to Request Alternate or Confidential Methods of Communications of PHI
HP.007	Individual Right of Access PHI
HP.008	Individual's Right to Request Amendment of PHI

HP.009	Plan Member Right to Request Accountings of Disclosures
HP.010	Breach Analysis and Notification Policy
HP.011	Designated Record Sets
HP.012	Personal Representatives
HP.013	Business Associate Agreements
HP.014	Notice of Privacy Practices
HP.015	General Use and Disclosure of PHI
HP.016	Use and Disclosure of PHI – Judicial, Administrative, and Law Enforcement
HP.017	Use and Disclosures of De-Identified PHI and Limited Data Sets
HP.018	Fundraising
HP.019	Uses and Disclosures of PHI via Email and Fax
HP.020	Use and Disclosure of PHI – Gender Affirming Care and Abortion Related Services Restrictions
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

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~~05/~~2025~~2026	Dept: Compliance	Page 1 of 4

Approval By: Compliance Committee	**Date:** ~~08/18/2025~~08/18/2026
Approval By: San Mateo Health Commission	**Date:** ~~09/10/2025~~
Annual Review Date: 10/01/~~2026~~2027	
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 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 non-compliance, including FWA or incident involving unethical or illegal behavior individuals or entities affiliated with HPSM.

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
Revision: 7	Last Reviewed /Revised: 08/~~0405~~/~~2025~~2026	Dept: Compliance	Page 2 of 4

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 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.

2.2 Quarterly, compliance 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.

2.4 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)

2.5.1.5 Cases involving law enforcement; and

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

3.0 Disclosures of Significant Non-Compliance

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

Procedure: CP.009		Title: Notification Process for Compliance Issues	Original Effective Date: 02/24/2017
Revision: 7	Last Reviewed /Revised: 08/~~0405~~/~~2025~~2026	Dept: Compliance	Page 3 of 4

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.

4.2 Prior to disclosure to the 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 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 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, disclosures 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

Procedure: CP.009		Title: Notification Process for Compliance Issues	Original Effective Date: 02/24/2017
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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
- CP.026 Code of Conduct
- 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
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Approval By: Compliance Committee	**Date:** 08/18/2026
Approval By: San Mateo Health Commission	**Date:**
Annual Review Date: 10/01/2027	
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 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
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HEALTH PLAN of SAN MATEO

CODE OF CONDUCT

~~2025~~

Last Reviewed: August 2026

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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 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. 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).

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

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 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

Last Reviewed: August 2026

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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.

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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.

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. 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).

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 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.

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~~05/~~2025~~2026	Dept: Compliance	Page 1 of 5

Approval By: Compliance Committee	**Date:** ~~08/18/2025~~ 08/18/2026
Approval By: San Mateo Health Commission	**Date:** ~~09/10/2025~~
Annual Review Date: ~~04~~08/01/~~2026~~2027	
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.

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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).

Procedure: CP.026		Title: Code of Conduct	Original Effective Date: 01/15/2015
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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
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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

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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
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

Health Plan of San Mateo
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Approval By: Compliance Committee	**Date:** 08/18/2026
Approval By: San Mateo Health Commission	**Date:**
Annual Review Date: 08/01/2027	
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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- 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.

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3.3 Members of Committees of the San Mateo Health Commission

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Procedure: CP.026		Title: Code of Conduct	Original Effective Date: 01/15/2015
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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.

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4	11/09/2018
5	11/09/2021
6	01/04/2024

Agenda Item: 4.2
Date: September 9, 2026

Financial Update

Presentation to Finance/Compliance Committee

August 24, 2026

HealthPlan OF SAN MATEO
Healthy is for everyone

2026 Budget by Quarter

HealthPlan OF SAN MATEO
Healthy is for everyone

	Q1	Q2	Q3	Q4	Total
Operating revenue	299,573,148	296,443,328	288,448,766	285,595,419	**1,170,060,662**
Healthcare cost	270,677,271	268,980,101	259,955,637	258,070,259	**1,057,683,268**
Administrative expenses	22,497,497	21,770,436	22,113,235	22,176,211	**88,557,379**
MCO Tax	20,124,411	20,124,411	20,124,411	20,124,411	**80,497,644**
Income/(loss) from operations	(13,726,031)	(14,431,619)	(13,744,517)	(14,775,462)	**(56,677,629)**
Non-operating revenue	9,018,222	8,728,205	8,428,205	8,128,205	**34,302,837**
Net income/(loss)	(4,707,809)	(5,703,414)	(5,316,312)	(6,647,257)	**(22,374,792)**

Q2 2026 Preliminary Financial Results

HealthPlan OF SAN MATEO
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	Q1 (Jan-Mar)	Q2 (Apr-Jun)	YTD Total	YTD Budget	Budget Variance
Operating Revenue:					
Capitation	293,191,466	286,895,800	580,087,266	595,863,488	(15,776,222)
TPA Fees	63,750	63,750	127,500	152,988	(25,488)
Total Operating Revenue	293,255,216	286,959,550	580,214,766	596,016,476	(15,801,710)
Healthcare cost	268,462,889	290,259,992	558,722,881	539,657,372	(19,065,509)
Administrative expenses	17,551,563	19,140,679	36,692,242	44,267,933	7,575,691
MCO Tax	16,856,886	19,674,035	36,530,921	40,248,822	3,717,901
Income/(loss) from operations	(9,616,122)	(42,115,156)	(51,731,278)	(28,157,651)	(23,573,627)
Non-operating revenue	8,185,451	7,888,101	16,073,552	17,746,427	(1,672,875)
Net income/(loss)	(1,430,671)	(34,227,055)	(35,657,726)	(10,411,224)	(25,246,502)

YTD June 2026 – PY/CY

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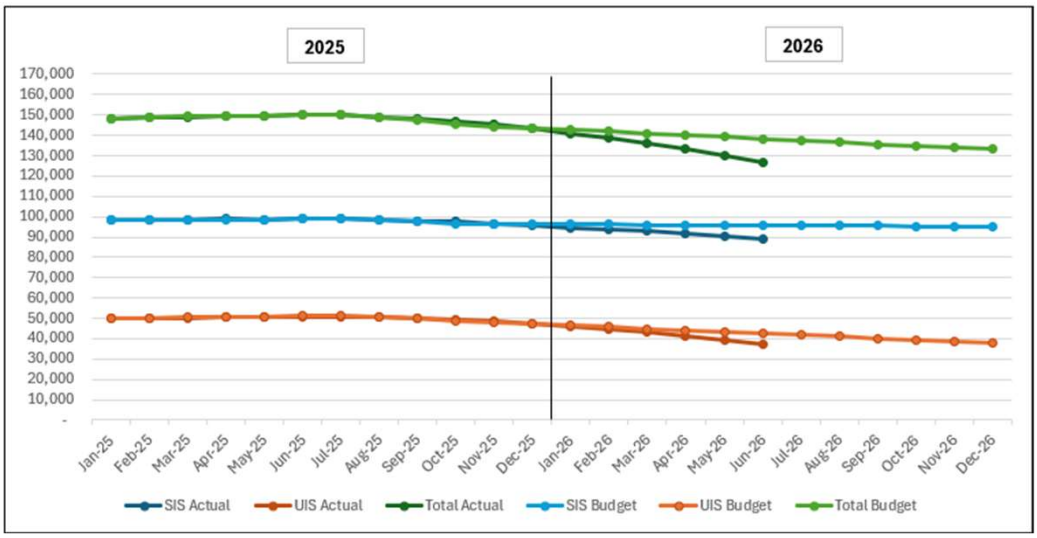
	YTD by PY/CY			Current Year YTD		
	Prior Year	Current Year	Total	Current Year	Budget	CY Variance
Operating Revenue:						
Capitation	11,438,884	568,648,382	580,087,266	568,648,382	595,863,488	(27,215,106)
TPA Fees	-	127,500	127,500	127,500	152,988	(25,488)
Total Operating Revenue	11,438,884	568,775,882	580,214,766	568,775,882	596,016,476	(27,240,594)
Healthcare cost	(829,199)	559,552,080	558,722,881	559,552,080	539,657,372	(19,894,708)
Administrative expenses	-	36,692,242	36,692,242	36,692,242	44,267,933	7,575,691
MCO Tax	(2,946,177)	39,477,098	36,530,921	39,477,098	40,248,822	771,724
Income/(loss) from operations	15,214,260	(66,945,538)	(51,731,278)	(66,945,538)	(28,157,651)	(38,787,887)
Non-operating revenue	(2,280)	16,075,832	16,073,552	16,075,832	17,746,427	(1,670,595)
Net income/(loss)	15,211,980	(50,869,706)	(35,657,726)	(50,869,706)	(10,411,224)	(40,458,482)

Average Membership
Variance to Budget

LOB	Avg. Actual	Avg. Budget	Variance	% Var
Medi-Cal	67,460	70,770	(3,309)	-4.7%
Medi-Cal Expansion	48,688	51,267	(2,579)	-5.0%
Whole Child Model	1,028	1,056	(28)	-2.6%
Medi-Cal Full Duals	8,634	9,103	(469)	-5.2%
Sub-total Medi-Cal	125,810	132,195	(6,385)	-4.8%
Medicare D-SNP	8,367	8,490	(123)	-1.4%
HealthWorx	1,315	1,315	-	0.0%
Total at Risk	135,492	142,000	(6,508)	-4.6%
+ ACE	1,549	2,701	(1,152)	-42.7%
Grand Total	137,041	144,701	(7,660)	-5.3%

Medi-Cal Membership by Month



Budget Variance by Major Drivers

favorable/(unfavorable)

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		YTD Mar	YTD Jun		Revenue	Expense
1	Prior year adjustments not in the budget	11,851,609	15,211,979			
	Current year variances:					
2	Membership lower than budget (*budget reset*)	(626,840)	(2,017,173)	<<	(20,046,945)	18,029,771
3	Revenue: Yield PMPM variance to budget	(481,940)	(2,017,286)			
3b	Revenue: ACE TPA Fee	-	(25,488)			
4	Revenue: Maternity supplemental payment	(2,979,207)	(3,196,309)			
5	Healthcare cost: CY PMPM variance to budget	(8,266,774)	(36,779,961)			
6	Healthcare cost: CY directed payments	565,331	930,564			
7	Healthcare cost: strategic investments	(300,000)	(1,959,603)			
8	ECM (rev-exp variance)	(363,154)	(166,811)	<<	(51,332)	(115,479)
9	Administrative cost variance to budget	5,273,177	8,063,604			
10	Administrative cost: strategic investments	(327,243)	(487,914)			
11	MCO Tax variance (rev-exp variance)	(234,882)	(1,131,511)	<<	(1,903,235)	771,724
12	Non-op revenue (*CY portion) variance to budget*	(832,939)	(1,670,595)			
	Total current year	(8,574,471)	(40,458,482)			
	Total consolidated budget variance	**3,277,138**	**(25,246,503)**			

Healthcare Cost

Detail by Category of Service

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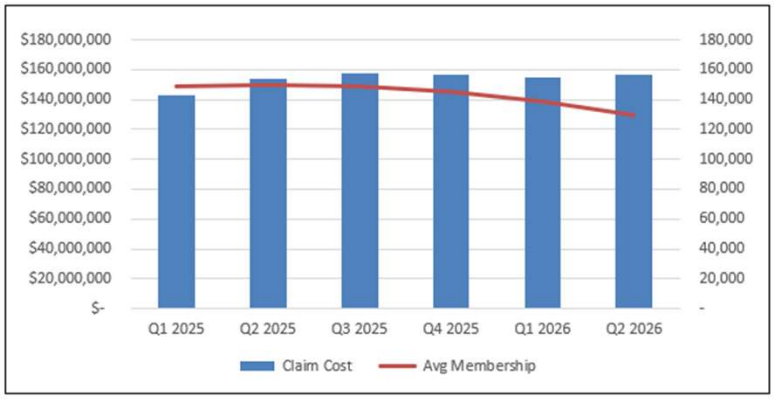
		YTD Actual					
		Total	Prior Year	Current Year	YTD Budget	Variance *	% Var.
1	Provider Capitation	15,572,345	1,081,230	14,491,114	14,673,788	182,673	1.2%
2	Hospital Inpatient	106,213,316	(26,668)	106,239,983	103,421,145	(2,818,839)	-2.7%
3	LTC/SNF	96,913,631	1,242,848	95,670,783	94,347,613	(1,323,169)	-1.4%
4	Pharmacy	30,444,644	(754,314)	31,198,958	37,251,783	6,052,825	16.2%
5	Physician FFS	62,632,010	67,649	62,564,362	58,870,930	(3,693,432)	-6.3%
6	Hospital Outpatient	69,708,728	162,265	69,546,463	65,871,059	(3,675,404)	-5.6%
7	Other Medical Claims (incl. Other HC Serv)	74,087,624	(166,659)	74,254,283	65,834,597	(8,419,686)	-12.8%
8	Directed Payments	27,441,089	4,133,367	23,307,722	24,238,285	930,564	3.8%
9	Long Term Support Services	1,292,582	-	1,292,582	1,286,311	(6,271)	-0.5%
10	CPO/In-lieu of Services	10,752,733	171,596	10,581,137	7,678,953	(2,902,184)	-37.8%
11	Dental	33,445,021	(651,000)	34,096,021	34,098,252	2,231	0.0%
12	ECM	2,990,411	670,421	2,319,990	2,204,511	(115,479)	-5.2%
13	Provider Incentives	8,328,609	21,132	8,307,477	8,444,000	136,523	1.6%
14	Supplemental Benefits (D-SNP)	926,360	-	926,360	1,804,214	877,853	48.7%
15	Transportation	3,946,521	(12,750)	3,959,271	4,655,672	696,401	15.0%
16	Strategic Investments (one-time grants)	1,959,603	-	1,959,603	-	(1,959,603)	100.0%
17	Indirect Health Care Benefits	(3,673,546)	(6,764,034)	3,090,488	1,057,643	(2,032,845)	-192.2%
18	UMQA	15,741,200	(4,285)	15,745,484	13,918,615	(1,826,869)	-13.1%
	Total Healthcare Cost	558,722,881	(829,199)	559,552,080	539,657,372	(19,894,709)	-3.7%

* Budget variance is net of 1) favorable variance due to lower members, and 2) unfavorable due to higher cost PMPM

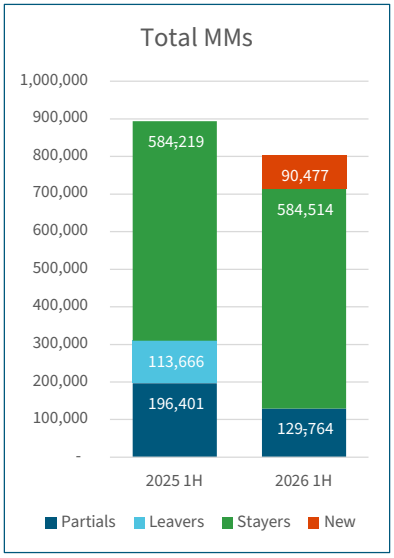
Medi-Cal Claim Cost Trend

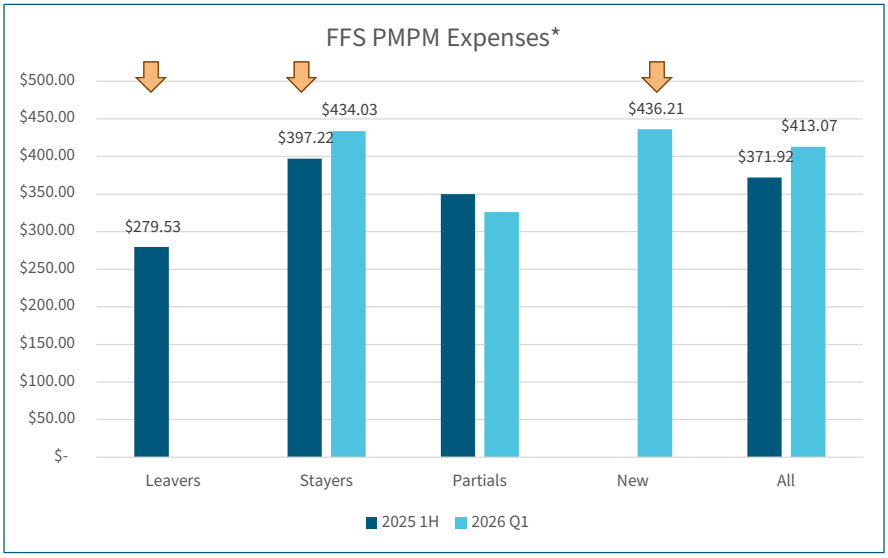
Includes: Hospital IP, LTC/SNF, Physician FFS, Hospital OP, Other Medical



Enrollment & Acuity Mix Comparisons

Member Months (MMs): Jan – Jun (1H) 2025 vs. Jan – June (1H) 2026
Fee For Service (FFS) Expenses: Jan – Jun (1H) 2025 vs. Jan – Mar (Q1) 2026





** FFS represents ~90% of HPSM's Medi-Cal healthcare cost*

2026 Re-Forecast

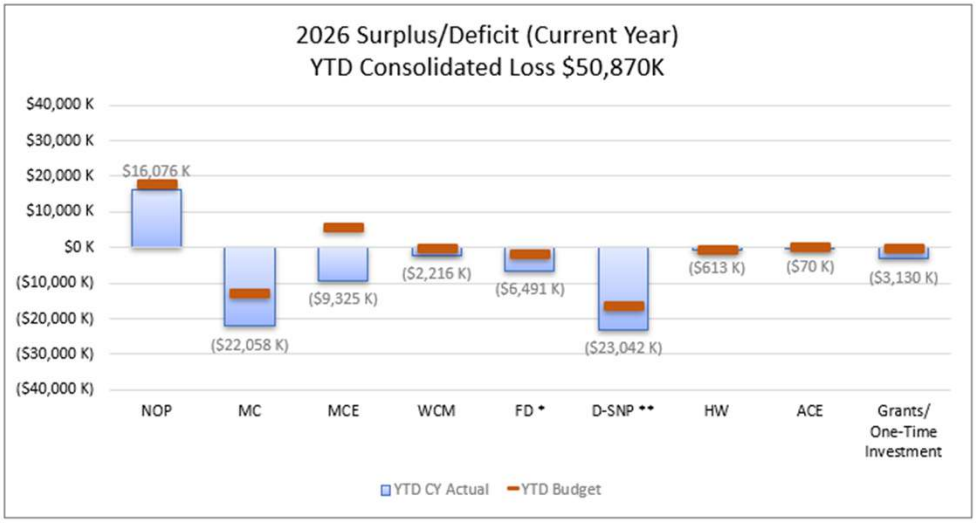
		First Half of Year			Second Half of Year			
		2026 Q1	2026 Q2	1H	2026 Q3	2026 Q4	2H	Total
1	Medi-Cal (1H restated)	(15,288,098)	(24,802,219)	**(40,090,317)**	(26,298,674)	(28,168,100)	**(54,466,774)**	**(94,557,091)**
2	CareAdvantage (1H restated)	(6,495,095)	(16,546,715)	**(23,041,810)**	(7,659,245)	(8,642,943)	**(16,302,188)**	**(39,343,998)**
3	HealthWorx	(256,505)	(356,901)	**(613,407)**	(350,000)	(350,000)	**(700,000)**	**(1,313,407)**
4	ACE	(32,238)	(37,417)	**(69,655)**	(35,000)	(35,000)	**(70,000)**	**(139,655)**
5	Corp: Interest Income	7,853,334	7,545,951	**15,399,285**	7,300,000	7,100,000	**14,400,000**	**29,799,285**
6	Corp: Rental Income	331,948	344,599	**676,547**	516,189	520,290	**1,036,479**	**1,713,026**
7	Corp: Strategic Investment	(974,268)	(2,156,083)	**(3,130,351)**	(1,000,000)	(1,000,000)	**(2,000,000)**	**(5,130,351)**
	Total (current year)	(14,860,921)	(36,008,785)	**(50,869,707)**	(27,526,730)	(30,575,753)	**(58,102,483)**	**(108,972,190)**
	PY Adjustments	11,851,610	3,360,370	**15,211,980**	-	-	-	**15,211,980**
	Grand Total	(3,009,311)	(32,648,415)	**(35,657,727)**	(27,526,730)	(30,575,753)	(58,102,483)	**(93,760,210)**

2026 Re-Forecast

with Budget Variance

		Actual		Forecast				
		2026 Q1	2026 Q2	2026 Q3	2026 Q4	Total	Budget	Variance
1	Medi-Cal (1H restated)	(15,288,098)	(24,802,219)	(26,298,674)	(28,168,100)	**(94,557,091)**	(20,345,211)	(74,211,880)
2	CareAdvantage (1H restated)	(6,495,095)	(16,546,715)	(7,659,245)	(8,642,943)	**(39,343,998)**	(33,563,378)	(5,780,619)
3	HealthWorx	(256,505)	(356,901)	(350,000)	(350,000)	**(1,313,407)**	(1,412,113)	98,706
4	ACE	(32,238)	(37,417)	(35,000)	(35,000)	**(139,655)**	9,073	(148,728)
5	Corp: Interest Income	7,853,334	7,545,951	7,300,000	7,100,000	**29,799,285**	33,000,000	(3,200,715)
6	Corp: Rental Income	331,948	344,599	516,189	520,290	**1,713,026**	1,302,837	410,189
7	Corp: Strategic Investment	(974,268)	(2,156,083)	(1,000,000)	(1,000,000)	**(5,130,351)**	(1,366,000)	(3,764,351)
	Total (current year)	(14,860,921)	(36,008,785)	(27,526,730)	(30,575,753)	**(108,972,190)**	(22,374,791)	(86,597,398)
	PY Adjustments	11,851,610	3,360,370	-	-	**15,211,980**		
	Grand Total	(3,009,311)	(32,648,415)	(27,526,730)	(30,575,753)	**(93,760,210)**		

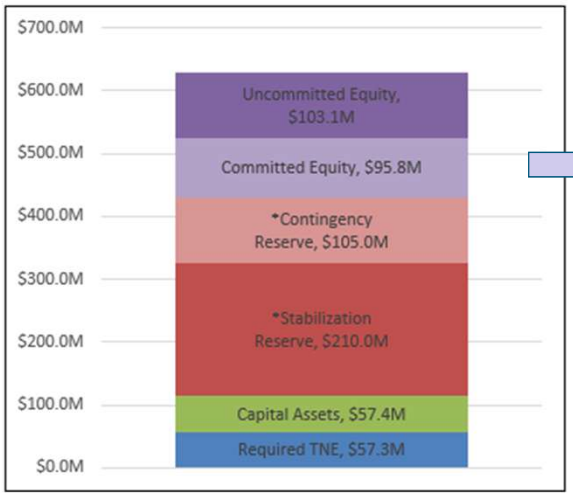
CY YTD Surplus/Deficit by LOB



* FD includes M-Cal portion of D-SNP
** D-SNP includes Medicare portion only

Tangible Net Equity (TNE)

Balance at 6/30/2026 = $628.6M
Uncommitted portion = $103.1M



Committed Equity:

	Funding	Spend	Balance
Provider	$100.0M	$33.3M	$66.7M
Primary Care	$30.0M	$6.6M	$23.4M
Baby Bonus	$7.0M	$1.3M	$5.7M
	$137.0M	$41.2M	$95.8M

* Contingency and Stabilization Reserve amounts are fixed based on historical operating cost.

Q2 2026 Summary

Two significant things are driving larger losses so far this year.

1. With the Medi-Cal LOB, the driver is the increased acuity of the population based on the changing membership mix (leavers versus stayers). This dynamic will continue through the remainder of the year. There is possible relief from either 1) retro acuity adjustment applied to 2026 rates, or 2) additional revenue from the UIS risk corridor. These will be evaluated as more information is available.

2. With the CareAdvantage LOB, the driver is the increased Medicare provider rate that CMS applied to one of our contracted hospitals. This seems to be temporary and should not continue through the remainder of the year. However, this will add approximately $10M in added cost this year (most of this was recorded in Q2).

Q2 2026 Summary

continued . . .

- Cost related to provider rate increases is estimated to be around $15M for the first half of 2026. This cost is contributing to the YTD loss, but is not impacting financial results compared to budget, as these expenses are included in the budget.
- Cost related to capacity building grants and practice transformation is around $3M for the first half of 2026, which is not included in the budget, and does contribute to the budget variance.
- The large prior year favorable adjustments are mostly due to timing with normal lag in maternity revenue and benefits from reinsurance recoveries. We also picked-up more 2025 Medicare risk adjustment revenue in Q2.

Questions?

HealthPlan OF SAN MATEO
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Health Plan of San Mateo
Consolidated Balance Sheet
June 30, 2026 and Prior Quarter

	Current QE	Prior QE	PY 12/31
ASSETS			
Current Assets			
Cash and Equivalents	$641,541,498	$768,707,670	$701,567,502
Investments	192,196,137	190,326,390	188,433,422
Capitation Receivable from the State	203,195,207	200,805,703	297,404,828
Capitation Receivable from CMS	61,216,264	62,514,089	59,518,905
Other Receivables	15,485,667	19,372,437	11,508,105
Prepaids and Other Assets	17,158,820	13,725,485	16,721,322
Total Current Assets	1,130,793,593	1,255,451,775	1,275,154,085
Capital Assets, Net	57,381,433	57,372,699	57,617,587
Assets Restricted As To Use	300,000	300,000	300,000
Other Assets & Outflows	17,382,504	17,382,504	17,382,504
Total Assets & Deferred Outflows	$1,205,857,531	$1,330,506,978	$1,350,454,176
LIABILITIES			
Current Liabilities			
Medical Claims Payable	98,978,284	99,381,946	94,383,660
Provider Incentives	18,543,827	15,826,788	18,489,882
Amounts Due to the State	235,990,188	236,128,075	235,240,774
Accounts Payable and Accrued Liabilities	207,589,036	300,186,917	321,925,936
SBITA Liability	1,645,058	1,645,058	1,645,058
Total Current Liabilities	562,746,392	653,168,784	671,685,310
Other Liabilities & Inflows	14,464,495	14,464,495	14,464,495
Total Liabilities & Deferred Inflows	$577,210,888	$667,633,279	$686,149,805
NET POSITION			
Invested in Capital Assets	57,381,433	57,372,699	57,617,587
Restricted By Legislative Authority	300,000	300,000	300,000
Unrestricted			
Stabilization/Contingency Reserve	398,947,600	398,947,600	398,947,600
Committed/Uncommitted Reserve	172,017,610	206,253,400	207,439,184
Net Position	628,646,643	662,873,699	664,304,370
Total Liabilities & Net Position	$1,205,857,531	$1,330,506,978	$1,350,454,176
Change in Net Position	($35,657,727)	($1,430,671)	

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Unit: HPALL

Health Plan of San Mateo
Consolidated Statement of Revenue Expense
for the Period Ending June 30, 2026

	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)	$219,754,027	$231,886,737	($12,132,710)	$450,987,015	$467,358,575	($16,371,560)	-3.5%
HealthWorx	2,709,447	2,720,275	(10,827)	5,433,525	5,440,550	(7,024)	-0.1%
Medicare (includes CA-CMC)	64,432,326	61,747,079	2,685,247	123,666,726	123,064,364	602,362	0.5%
Third Party Administrator Fees	63,750	89,238		127,500	152,988		
Total Operating Revenue	286,959,550	296,443,328	(9,483,778)	580,214,766	596,016,476	(15,801,710)	-2.7%
OPERATING EXPENSE							
Healthcare Expense							
Provder Capitation	7,511,937	7,280,556	(231,382)	15,572,345	14,673,788	(898,557)	-6.1%
Hospital Inpatient	52,904,924	51,402,162	(1,502,762)	106,213,316	103,421,145	(2,792,171)	-2.7%
LTC/SNF	50,503,350	47,167,003	(3,336,347)	96,913,631	94,347,613	(2,566,017)	-2.7%
Pharmacy	15,149,452	18,687,356	3,537,903	30,444,644	37,251,783	6,807,139	18.3%
Medical	119,676,975	106,713,049	(12,963,926)	233,869,451	214,814,871	(19,054,580)	-8.9%
Long Term Support Services	684,372	644,624	(39,748)	1,292,582	1,286,311	(6,271)	-0.5%
CPO/In-lieu of Services	5,289,907	3,846,311	(1,443,597)	10,752,733	7,678,953	(3,073,780)	-40.0%
Dental Expense	17,706,996	17,125,490	(581,506)	33,445,021	34,098,252	653,231	1.9%
Enhanced Care Management	1,233,782	1,095,679	(138,103)	2,990,411	2,204,511	(785,901)	-35.6%
Provider Incentives	4,249,813	4,222,000	(27,813)	8,328,609	8,444,000	115,391	1.4%
Supplemental Benefits	407,413	905,257	497,844	926,360	1,804,214	877,853	48.7%
Transportation	2,029,847	2,310,770	280,923	3,946,521	4,655,672	709,151	15.2%
Other Provider HC	1,659,603		(1,659,603)	1,959,603		(1,959,603)	
Indirect Health Care Expenses	3,992,551	523,547	(3,469,005)	(3,673,546)	1,057,643	4,731,189	447.3%
UMQA, Delegated and Allocation	7,259,070	7,056,298	(202,773)	15,741,200	13,918,615	(1,822,584)	-13.1%
Total Healthcare Expense	290,259,992	268,980,101	(21,279,892)	558,722,881	539,657,372	(19,065,509)	-3.5%
Administrative Expense							
Salaries and Benefits	17,049,094	18,048,450	999,356	33,991,939	35,435,260	1,443,321	4.1%
Staff Training and Travel	78,758	174,850	96,092	191,582	330,423	138,841	42.0%
Contract Services	4,130,921	5,558,675	1,427,754	8,294,723	10,552,908	2,258,185	21.4%
Office Supplies and Equipment	2,650,660	2,580,988	(69,672)	4,891,150	5,538,210	647,060	11.7%
Occupancy and Depreciation	1,033,148	1,039,800	6,652	1,957,311	2,037,600	80,289	3.9%
Postage and Printing	647,936	665,000	17,064	1,136,860	1,329,500	192,640	14.5%
Other Administrative Expense	710,218	538,718	(171,500)	1,641,514	2,517,055	875,542	34.8%
UM/QA Allocation	(7,137,625)	(6,822,245)	(315,380)	(15,412,837)	(13,445,824)	(1,967,013)	-14.6%
Total Admin Expense	19,163,110	21,784,236	2,621,126	36,692,243	44,295,133	7,602,890	17.2%
Premium Taxes	19,674,035	20,124,411	450,376	36,530,921	40,248,822	3,717,900	9.2%
Total Operating Expense	329,097,137	310,888,747	(18,208,390)	631,946,045	624,201,327	(7,744,719)	-1.2%
Net Income/Loss from Operations	(42,137,587)	(14,445,419)	27,692,168	(51,731,279)	(28,184,850)	23,546,429	-83.5%
NONOPERATING REV AND (EXP)							
Interest Income, Net	7,545,951	8,400,000	(854,049)	15,399,453	17,100,000	(1,700,547)	-9.9%
Rental Income, Net	364,580	328,205	36,375	674,099	646,427	27,672	4.3%
Net Nonoperating Rev and (Exp)	7,910,531	8,728,205	(817,674)	16,073,552	17,746,427	(1,672,875)	-9.4%
Net Income/(Loss)	($34,227,056)	($5,717,214)	($28,509,842)	($35,657,727)	($10,438,423)	($25,219,304)	241.6%
Admin exp as % of Net Rev (adj for Tax)	*7.17%*	*7.88%*		*6.75%*	*7.97%*		
Medical Loss Ratio (adj for Tax)	*108.60%*	*97.34%*		*102.77%*	*97.10%*		

Health Plan of San Mateo
ALL LOB UNITS Statement of Revenue Expense
for the Period Ending June 30, 2026

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Medi-Cal Capitation	$217,567,153	$230,175,498	($12,608,345)	-5.5%	$448,343,869	$463,913,864	($15,569,995)	-3.4%
MC Supplemental Cap	4,753,011	4,815,666	(62,655)	-1.3%	8,857,824	9,716,837	(859,013)	-8.8%
HealthWorx Premium	2,709,447	2,720,275	(10,827)	-0.4%	5,433,525	5,440,550	(7,024)	-0.1%
CareAdvantage Premiums	64,432,326	61,747,079	2,685,247	4.3%	123,666,726	123,064,364	602,362	0.5%
MC Cap Offset	(2,566,137)	(3,104,427)	538,290	17.3%	(6,214,678)	(6,272,126)	57,447	0.9%
Third Party Administrator Fees	63,750	89,238	(25,488)	-28.6%	127,500	152,988	(25,488)	-16.7%
Total Operating Revenue	286,959,550	296,443,328	(9,483,778)	-3.2%	580,214,766	596,016,476	(15,801,710)	-2.7%
OPERATING EXPENSE								
Provider Capitation	7,511,937	7,280,556	(231,382)	-3.2%	15,572,345	14,673,788	(898,557)	-6.1%
Hospital Inpatient	52,904,924	51,402,162	(1,502,762)	-2.9%	106,213,316	103,421,145	(2,792,171)	-2.7%
LTC/SNF	50,503,350	47,167,003	(3,336,347)	-7.1%	96,913,631	94,347,613	(2,566,017)	-2.7%
Pharmacy	15,149,452	18,687,356	3,537,903	18.9%	30,444,644	37,251,783	6,807,139	18.3%
Physician Fee for Service	33,057,153	29,214,854	(3,842,299)	-13.2%	62,632,010	58,870,930	(3,761,080)	-6.4%
Hospital Outpatient	37,097,768	32,709,618	(4,388,150)	-13.4%	69,708,728	65,871,059	(3,837,669)	-5.8%
Other Medical Claims	37,433,460	32,758,357	(4,675,103)	-14.3%	74,019,225	65,834,597	(8,184,628)	-12.4%
Other HC Services	25,100		(25,100)		68,399		(68,399)	
Directed Payments	12,063,494	12,030,220	(33,274)	-0.3%	27,441,089	24,238,285	(3,202,803)	-13.2%
Long Term Support Services	684,372	644,624	(39,748)	-6.2%	1,292,582	1,286,311	(6,271)	-0.5%
CPO/In-lieu of Services	5,289,907	3,846,311	(1,443,597)	-37.5%	10,752,733	7,678,953	(3,073,780)	-40.0%
Dental Expense	17,706,996	17,125,490	(581,506)	-3.4%	33,445,021	34,098,252	653,231	1.9%
Enhanced Care Management	1,233,782	1,095,679	(138,103)	-12.6%	2,990,411	2,204,511	(785,901)	-35.6%
Provider Incentives	4,249,813	4,222,000	(27,813)	-0.7%	8,328,609	8,444,000	115,391	1.4%
Supplemental Benefits	407,413	905,257	497,844	55.0%	926,360	1,804,214	877,853	48.7%
Transportation	2,029,847	2,310,770	280,923	12.2%	3,946,521	4,655,672	709,151	15.2%
Other Provider HC	1,659,603		(1,659,603)		1,959,603		1,959,603	
Indirect Health Care Expenses	3,992,551	523,547	(3,469,005)	-662.6%	(3,673,546)	1,057,643	4,731,189	447.3%
UMQA (Allocation & Delegated)	7,259,070	7,056,298	(202,773)	-2.9%	15,741,200	13,918,615	(1,822,584)	-13.1%
Total Health Care Expense	290,259,992	268,980,101	(21,279,892)	-7.9%	558,722,881	539,657,372	(19,065,509)	-3.5%
G&A Allocation	19,140,679	21,770,436	2,629,757	12.1%	36,692,242	44,267,933	7,575,691	17.1%
Premium Tax	19,674,035	20,124,411	450,376	2.2%	36,530,921	40,248,822	3,717,900	9.2%
Total Operating Expense	329,074,707	310,874,947	(18,199,759)	-5.9%	631,946,045	624,174,127	(7,771,918)	-1.2%
NONOPERATING REVENUE AND EXPENSE								
Interest Income, Net	7,545,951	8,400,000	(854,049)	-10.2%	15,399,453	17,100,000	(1,700,547)	-9.9%
Rental Income, Net	342,150	328,205	13,945	4.2%	674,099	646,427	27,672	4.3%
Total Nonoperating Revenue and Expenses	7,888,101	8,728,205	(840,104)	-9.6%	16,073,552	17,746,427	(1,672,875)	-9.4%
Net Income/(Loss)	($34,227,055)	($5,703,414)	($28,523,641)	500.1%	($35,657,727)	($10,411,223)	($25,246,503)	242.5%
Medical Loss Ratio (adj MCO)	108.60%	97.34%			102.77%	97.10%		5.8%
Member Counts	427,362	458,025	(30,663)	-6.7%	872,444	919,142	(46,698)	-5.1%

Report: 335 LOB By Source Qtrly, Unit: MCUNITS

Health Plan of San Mateo
Medi-Cal UNITS Statement of Revenue Expense
for the Period Ending June 30, 2026

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Medi-Cal Capitation	$217,567,153	$230,175,498	($12,608,345)	-5.5%	$448,343,869	$463,913,864	($15,569,995)	-3.4%
MC Supplemental Cap	4,753,011	4,815,666	(62,655)	-1.3%	8,857,824	9,716,837	(859,013)	-8.8%
HealthWorx Premium								
CareAdvantage Premiums								
MC Cap Offset	(2,566,137)	(3,104,427)	538,290	17.3%	(6,214,678)	(6,272,126)	57,447	0.9%
Total Operating Revenue	219,754,027	231,886,737	(12,132,710)	-5.2%	450,987,015	467,358,575	(16,371,560)	-3.5%
OPERATING EXPENSE								
Provider Capitation	5,933,942	5,686,423	(247,519)	-4.4%	12,330,164	11,496,483	(833,681)	-7.3%
Hospital Inpatient	31,811,942	34,290,984	2,479,042	7.2%	66,314,775	69,315,613	3,000,838	4.3%
LTC/SNF	45,318,214	43,264,462	(2,053,751)	-4.7%	87,711,854	86,569,695	(1,142,159)	-1.3%
Physician Fee for Service	26,000,845	22,880,321	(3,120,524)	-13.6%	49,984,955	46,241,843	(3,743,112)	-8.1%
Hospital Outpatient	23,595,257	23,571,325	(23,932)	-0.1%	47,949,062	47,654,377	(294,684)	-0.6%
Other Medical Claims	29,885,754	26,074,545	(3,811,209)	-14.6%	60,099,131	52,512,312	(7,586,820)	-14.4%
Other HC Services	25,397		(25,397)		68,697		(68,697)	
Directed Payments	12,063,494	12,030,220	(33,274)	-0.3%	27,441,089	24,238,285	(3,202,803)	-13.2%
Long Term Support Services	684,372	644,624	(39,748)	-6.2%	1,292,582	1,286,311	(6,271)	-0.5%
CPO/In-lieu of Services	4,999,507	3,765,249	(1,234,258)	-32.8%	10,402,937	7,517,394	(2,885,543)	-38.4%
Dental Expense	17,706,996	17,125,490	(581,506)	-3.4%	33,445,021	34,098,252	653,231	1.9%
Enhanced Care Management	1,229,988	1,095,679	(134,309)	-12.3%	2,845,897	2,204,511	(641,387)	-29.1%
Provider Incentives	3,890,462	3,855,389	(35,073)	-0.9%	7,595,386	7,710,777	115,391	1.5%
Transportation	1,999,225	2,295,254	296,028	12.9%	3,902,347	4,624,748	722,402	15.6%
Indirect Health Care Expenses	3,451,286	434,512	(3,016,774)	-694.3%	(3,048,575)	880,125	3,928,700	446.4%
UMQA (Allocation & Delegated)	5,195,325	5,246,064	50,739	1.0%	11,531,586	10,350,514	(1,181,073)	-11.4%
Total Health Care Expense	213,792,005	202,260,540	(11,531,465)	-5.7%	419,866,908	406,701,241	(13,165,667)	-3.2%
G&A Allocation	12,760,845	14,926,005	2,165,160	14.5%	25,107,327	30,350,490	5,243,163	17.3%
Premium Tax	19,674,035	20,124,411	450,376	2.2%	36,530,921	40,248,822	3,717,900	9.2%
Total Operating Expense	246,226,885	237,310,956	(8,915,929)	-3.8%	481,505,157	477,300,552	(4,204,604)	-0.9%
NONOPERATING REVENUE AND EXPENSE								
Net Income/(Loss)	($26,472,859)	($5,424,219)	($21,048,639)	388.0%	($30,518,141)	($9,941,977)	($20,576,164)	207.0%
Medical Loss Ratio (adj MCO)	106.85%	95.51%			101.31%	95.22%		6.4%
Member Counts	391,354	417,721	(26,367)	-6.3%	804,378	843,507	(39,129)	-4.6%

Report: 335 LOB By Source Qtrly, Unit: CAUNITS

Health Plan of San Mateo
CareAdvantage Units Statement of Revenue Expense
for the Period Ending June 30, 2026

	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	$64,432,326	$61,747,079	$2,685,247	4.3%	$123,666,726	$123,064,364	$602,362	0.5%
MC Cap Offset								
Total Operating Revenue	64,432,326	61,747,079	2,685,247	4.3%	123,666,726	123,064,364	602,362	0.5%
OPERATING EXPENSE								
Provider Capitation	1,577,995	1,594,133	16,138	1.0%	3,242,181	3,177,305	(64,876)	-2.0%
Hospital Inpatient	20,931,963	16,783,709	(4,148,254)	-24.7%	39,460,861	33,450,594	(6,010,267)	-18.0%
LTC/SNF	5,185,137	3,902,541	(1,282,595)	-32.9%	9,201,777	7,777,918	(1,423,858)	-18.3%
Pharmacy	14,365,933	17,660,730	3,294,797	18.7%	28,727,395	35,198,532	6,471,137	18.4%
Physician Fee for Service	6,509,579	5,743,586	(765,992)	-13.3%	11,601,880	11,447,194	(154,686)	-1.4%
Hospital Outpatient	12,995,165	8,606,403	(4,388,762)	-51.0%	20,787,283	17,152,901	(3,634,381)	-21.2%
Other Medical Claims	7,298,058	6,513,786	(784,272)	-12.0%	13,494,751	12,982,233	(512,517)	-3.9%
Other HC Services	(298)		298		(298)		298	
CPO/In-lieu of Services	290,400	81,062	(209,338)	-258.2%	349,796	161,559	(188,237)	-116.5%
Enhanced Care Management	3,794		(3,794)		144,514		(144,514)	
Provider Incentives	197,351	349,111	151,760	43.5%	409,223	698,223	289,000	41.4%
Supplemental Benefits	407,413	905,257	497,844	55.0%	926,360	1,804,214	877,853	48.7%
Transportation	30,622	15,516	(15,106)	-97.4%	44,175	30,924	(13,251)	-42.8%
Indirect Health Care Expenses	522,754	79,261	(443,493)	-559.5%	(664,023)	157,971	821,994	520.3%
UMQA (Allocation & Delegated)	2,016,288	1,728,688	(287,600)	-16.6%	4,055,120	3,407,327	(647,793)	-19.0%
Total Health Care Expense	72,332,154	63,963,784	(8,368,369)	-13.1%	131,780,994	127,446,895	(4,334,099)	-3.4%
G&A Allocation	5,497,500	6,086,366	588,866	9.7%	9,700,204	12,375,997	2,675,793	21.6%
Total Operating Expense	77,829,654	70,050,151	(7,779,503)	-11.1%	141,481,198	139,822,892	(1,658,306)	-1.2%
NONOPERATING REVENUE AND EXPENSE								
Net Income/(Loss)	($13,397,327)	($8,303,072)	($5,094,256)	-61.4%	($17,814,472)	($16,758,529)	($1,055,944)	-6.3%
Medical Loss Ratio (adj MCO)	112.26%	103.59%			106.56%	103.56%		2.9%
Member Counts	25,517	25,860	(343)	-1.3%	50,884	51,540	(656)	-1.3%

Report: 335 LOB By Source Qtrly, Unit: HWSM

Health Plan of San Mateo
HealthWorx Statement of Revenue Expense
for the Period Ending June 30, 2026

	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	$2,709,447	$2,720,275	($10,827)	-0.4%	$5,433,525	$5,440,550	($7,024)	-0.1%
CareAdvantage Premiums								
MC Cap Offset								
Total Operating Revenue	2,709,447	2,720,275	(10,827)	-0.4%	5,433,525	5,440,550	(7,024)	-0.1%
OPERATING EXPENSE								
Hospital Inpatient	161,019	327,469	166,450	50.8%	437,679	654,937	217,258	33.2%
Pharmacy	783,520	1,026,626	243,106	23.7%	1,717,249	2,053,251	336,002	16.4%
Physician Fee for Service	546,729	590,947	44,217	7.5%	1,045,176	1,181,893	136,717	11.6%
Hospital Outpatient	507,346	531,890	24,544	4.6%	972,383	1,063,780	91,397	8.6%
Other Medical Claims	249,648	170,026	(79,622)	-46.8%	425,343	340,052	(85,291)	-25.1%
Provider Incentives	162,000	17,500	(144,500)	-825.7%	324,000	35,000	(289,000)	-825.7%
Indirect Health Care Expenses	18,511	9,773	(8,738)	-89.4%	39,052	19,547	19,505	99.8%
UMQA (Allocation & Delegated)	47,457	81,546	34,088	41.8%	154,493	160,775	6,282	3.9%
Total Health Care Expense	2,476,231	2,755,776	279,545	10.1%	5,115,376	5,509,236	393,860	7.1%
G&A Allocation	284,687	312,957	28,270	9.0%	516,808	636,367	119,559	18.8%
Total Operating Expense	2,760,918	3,068,734	307,816	10.0%	5,632,184	6,145,602	513,419	8.4%
NONOPERATING REVENUE AND EXPENSE								
Net Income/(Loss)	($51,470)	($348,459)	$296,988	-85.2%	($198,659)	($705,053)	$506,394	-71.8%
Medical Loss Ratio (adj MCO)	91.39%	101.31%			94.14%	101.26%		-7.0%
Member Counts	3,945	3,945			7,890	7,890		

Report: 335 LOB By Source Qtrly, Unit: ACSM

Health Plan of San Mateo
ACE Statement of Revenue Expense
for the Period Ending June 30, 2026

	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								
Third Party Administrator Fees	$63,750	$89,238	($25,488)	-28.6%	$127,500	$152,988	($25,488)	-16.7%
Total Operating Revenue	63,750	89,238	(25,488)	-28.6%	127,500	152,988	(25,488)	-16.7%
OPERATING EXPENSE								
Total Health Care Expense								
G&A Allocation	101,167	109,298	8,131	7.4%	197,155	222,245	25,090	11.3%
Total Operating Expense	101,167	109,298	8,131	7.4%	197,155	222,245	25,090	11.3%
NONOPERATING REVENUE AND EXPENSE								
Net Income/(Loss)	($37,417)	($20,060)	($17,357)	86.5%	($69,655)	($69,257)	($398)	0.6%
Medical Loss Ratio (adj MCO)								
Member Counts	6,546	10,499	(3,953)	-37.6%	9,292	16,205	(6,913)	-42.7%

HealthPlan OF SAN MATEO
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DRAFT

FINANCE/COMPLIANCE COMMITTEE MEETING

Meeting Summary

August 24, 2026, 12:30 pm

Agenda Item: 4.2

Date: September 12, 2026

County Executive Conference Room, 500 County Center, Redwood City, CA 94063
-or-
Health Plan of San Mateo-Boardroom 801 Gateway Blvd, South San Francisco, CA 94080

Members: Bill Graham, Mike Callagy, Manuel Santamaria, Shabnam Gaskari

Staff present: Pat Curran, Trent Ehrgood, Colleen Murphy, Ian Johansson, Katie-Elyse Turner, Cheryl Serafino, Michelle Heryford

1.0 **Call to Order:** The meeting was called to order by Commissioner Graham at 12:42 pm. A quorum was met.

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

3.0 **Approval of Consent Agenda:**

3.1 Compliance Regulatory Report for Q3

The consent agenda was approved as presented. **Callagy/Gaskari M/S/P**

4.0 **Approval of Meeting Summary for May 4, 2026:** The meeting summary for May 4, 2026 was approved as presented. **Gaskari/Callagy M/S/P**

5.0 Preliminary Financial Results for the 6-month period ending June 30, 2026: HPSM CFO Trent Ehrgood, reviewed the financial results for Q2. Second-quarter results showed a $34M loss compared with a $1.4M first-quarter loss, producing a reported first-half loss of $35M. After removing approximately $15M of favorable prior-year adjustments, including maternity reimbursement timing, $6M in reinsurance recoveries, and $5M in Medicare Advantage risk-adjustment revenue, the current-year loss was approximately $50M versus a $10M budgeted loss. The principal driver was higher healthcare cost per member rather than membership decline alone.

Membership was substantially below budget. The budget assumed a total December-to-December decline of about 7.4%, including a 1.2% decline in SIS membership and a 20% decline in UIS membership. Current trends indicated an approximately 21% total decline, with SIS down about 13% and UIS down about 39% to 40%. Medi-Cal membership peaked at approximately 150,000 lives around June or July 2025. Mr. Ehrgood is projecting approximately 112,000 total Medi-Cal lives by December 2026, of which approximately 83,000 are SIS. This means we will start 2027 with approximately 83,000 Medi-Cal lives.

Of the approximately $40M current-year unfavorable variance, about $36M was attributed to higher healthcare costs on a per member per month (PMPM) basis. Lower membership would have reduced revenue by approximately $20M and expenses by approximately $18M, creating a net unfavorable membership effect of about $2M; however, higher average costs per member more than offset that benefit. Mr. Ehrgood explained that healthcare spending remained relatively flat while membership declined, causing average cost PMPM to rise. The pattern reflects the loss of lower-acuity or low-utilization members while higher-acuity members remain enrolled; new members also had average costs similar to, or higher than, those who stayed.

The group discussed the asset limit, which is currently $130,000 for an individual and $195,000 for a couple, with an additional allowance for household members. The income limit is state-driven, while work requirements are federal, both are expected to reduce enrollment. HPSM will work to obtain an estimate of how the upcoming lower asset limit, work requirements, and related eligibility changes could affect membership, using improved data sharing with the County Human Services Agency when possible.

Next, Mr. Ehrgood shared a recent analysis comparing average cost per member between leavers, stayers, and joiners. This highlighted the fact that lower acuity members have been leaving, and higher acuity members have stayed. It also highlighted that members that have newly joined have similar higher average cost as the stayers. The Department of Health Care Services (DHCS) and Mercer received the plan's leavers, stayers, and joiners' analysis and requested additional detail. HPSM expects DHCS to increase rates for the remaining SIS population in 2027 as acuity rises but believes the adjustment may not fully close the gap until a later year. HPSM CEO Pat Curran announced that the September Commission meeting will focus on re-enrollment and membership. Claire Cunningham, Director of the Human Services Agency, is expected to explain the county's enrollment process and current experience, with discussion of how the plan and county can improve coordination, data sharing, and outreach.

Mr. Ehrgood shared some re-forecasting for 2026. Based on results through June and current trends, Mr. Ehrgood projected approximately $108M of current-year loss, compared with a budgeted loss of approximately $22M. The projection assumed a second-half loss of about $58M and did not include additional prior-year adjustments, which were expected to be smaller and could be favorable or unfavorable. Medi-Cal loss increased from approximately $15M in the first quarter to $24M in the second quarter. Mr. Ehrgood extended the higher cost trend into the second half and projected an approximately $94M current-year Medi-Cal loss, while noting that the estimate could be worse depending on the enrollment and acuity trend.

CareAdvantage incurred an unexpected $10M second-quarter cost increase related to a temporary Centers for Medicare and Medicaid Services (CMS) hospital payment-rate factor affecting Seton Hospital. CMS calculates Medicare hospital inpatient case rates through a facility-specific grouper that incorporates hospital cost factors. Seton's cost factor increased substantially for a temporary period of approximately four months, mainly affecting inpatient rates and to a lesser extent outpatient rates. The unusual factor was linked to a temporary cost event involving retroactive wage payments associated with labor negotiations. The loss was partly offset by approximately $5M in pharmacy savings, resulting in an overall projected CareAdvantage budget variance of approximately $5M unfavorable for the year.

Mr. Ehrgood reviewed reserve levels, which are at $628.6M as of 6/30/2026. Of this amount, the Uncommitted balance is $103.1M and the Committed balance is $95.8M. Based on the projected losses, the Uncommitted balance will decrease to $63M, and the Committed balance will decrease to $77M. The Committed decrease is from planned expenses, including provider rate increases and primary care capacity building. The Uncommitted decrease is due to excessive losses above the committed amounts. HPSM leadership has indicated that primary-care investment remains a strategic priority and should not be immediately withdrawn; its continuation may be reconsidered in a year or two based on financial conditions.

There was a question about the decrease in cash and liabilities on the balance sheet. HPSM Controller Francine Lester explained that the decline was primarily associated with approximately $44M paid to the state for a risk-corridor obligation. These funds were already earmarked as due to the state and does not represent a new operating loss.

Commissioner Santamaria had a question about the DHCS and Department of Managed Health Care (DMHC) audits and the basis for disagreeing with the interest payment findings. Mr. Ehrgood explained that providers must receive interest when claims are paid late under applicable definitions. The audit findings appeared to involve refining system treatment under the definitions rather than a significant exposure. There was an instance related to Planned Parenthood where HPSM was forbidden to make payment. When DHCS finally cleared them for payment, HPSM was under the assumption that it would not constitute interest because the delay was the result of the DHCS directive. Commissioner Santamaria expressed concern about the boilerplate non-emergency medical transportation (NEMT) contract language, the absence of enforcement provisions, and open corrective actions from 2025. Mr. Johansson will address these questions and concerns offline with Mr. Santamaria and appropriate staff.

Administrative cost reduction work is underway, with staff input being gathered and recommendations being developed for the 2027 budget. The review will cover staffing and non-staffing costs, including vendor expenses, and will create a menu of potential reductions that can be sequenced as membership trends become clearer. HPSM Leadership has met with CIOs and COOs from other local health plans to review automation approaches, including internally developed tools and purchased solutions. Potential applications include automating routine work so staff can focus on more

complex activities. Program work will examine pharmacy management, utilization management, optional benefits, lower-value services, negotiated pricing, and ways to reduce avoidable utilization. They will emphasize targeting interventions that preserve member access and help members receive care before conditions become emergencies.

HPSM intends to avoid indiscriminate immediate cuts while the magnitude and duration of the enrollment decline remain uncertain. Management will identify immediate actions and preserve flexibility for later decisions, recognizing that DHCS administrative funding may increase as a percentage of revenue while the organization reduces its own administrative cost base.

The financial report was approved as presented. **Santamaria/Gaskari M/S/P**

6.0 Other Business – There was no other business.

7.0 Adjournment – The meeting was adjourned at 2:00 pm by Commissioner Graham.

Respectfully submitted:

M. Heryford

M. Heryford
Clerk to the Commission

DRAFT

SAN MATEO HEALTH COMMISSION
Special Meeting Minutes
(Gov't Code section 54956)
August 12, 2026 – 10:00 a.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor Boardroom
South San Francisco, CA 94080

AGENDA ITEM: 4.3

DATE: September 9 , 2026

Commissioners' Present:	Alpa Sanghavi, M.D.	Manny Santamaria, Vice Chair
	Bill Graham	Shabnam Gaskari
	Noelia Corzo	Ligia Andrade Zuniga
	Kenneth Tai, M.D.	Michael Callagy
	Amira Elbeshbesh	Jackie Speier
Counsel:	Kristina Paszek	

1. **Call to Order/Roll Call**
   The Special meeting was called to order at 10:04 a.m. by Commissioner Graham, Chair. A quorum was present.

2. **Public Comment/Communication**: There were no public comments.

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

4. **CLOSED SESSION:**
   4.1 Public Employment Appointment (Gov't Code section 54957)
   Title: Chief Executive Officer

5. **Report on Action Taken in Closed Session:** There was no report.

6. **Adjournment:** The meeting was adjourned at 12:31 pm by Commissioner Graham.

Submitted by:

M. Heryford

M. Heryford, Clerk of the Commission

DRAFT

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

AGENDA ITEM: 4.3.1

DATE: September 9 , 2026

Commissioners' Present:	Alpa Sanghavi, M.D.	Manny Santamaria, Vice Chair
	Bill Graham	Shabnam Gaskari
	Noelia Corzo	Ligia Andrade Zuniga
	Kenneth Tai, M.D.	Michael Callagy
	Amira Elbeshbesh	Jackie Speier
Counsel:	Kristina Paszek	

1. **Call to order/roll call**
   The Special meeting was called to order at 12:54 p.m. by Commissioner Graham, Chair. A quorum was present.

2. **Public Comment/Communication**: There were no public comments.

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

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

5. **CLOSED SESSION:**
   5.1 Public Employment Appointment (Gov't Code section 54957)
   Title: Chief Executive Officer
   5.2 Conference with Labor Negotiators (Gov't Code section 54957.6)
   Designated Representative: Commission Chair
   Unrepresented Employee: Chief Executive Officer

6. **Report on Action Taken in Closed Session:** There was no report.

7. **Adjournment:** The meeting was adjourned at 2:48 pm by Commissioner Graham.

Submitted by:

M. Heryford

M. Heryford, Clerk of the Commission

AGENDA ITEM: 5.1

DATE: September 9, 2026

Meeting materials are not included for Item 5.1 –

SMC Human Services Agency presentation and discussion

Agenda Item: 5.2

Date: September 9, 2026

Immigrant Health in San Mateo County

Emergent Findings & Recommendations

Presented by the San Mateo County Public Health Community Collaborative

Who We Are

The Public Health Community Collaborative (PHCC) is a cross-sector initiative focused on advancing health equity through community-informed research and policy advocacy. Established in 2023, the collaborative also seeks to build trust and strengthen relationships between County Health and community partners.

Redwood City Together – A Healthy Community Partnership

Center for Independence of Individuals with Disabilities – Serving San Mateo County

El Concilio of San Mateo County

East Palo Alto

¡Levantar!

ALAS

Healthways

Taulama

Siena Youth Center of the St. Francis Center

San Mateo County Health – All together better.

Instituto Multicultural – Multicultural Institute

Coastside Hope – Neighbors Helping Neighbors

Recommendations

Short-term: *currently underway*

To **expand protocol for immigration response** to include guidance for staff working in public spaces AND **implement a training** for front-facing staff

Long-term:

To **elevate and share existing community, social service, resources** and make **investments to retain or expand existing mental health resources** for immigrant communities

Introduction

Amid increasing federal enforcement activity and restrictions on public benefits, many individuals are experiencing heightened barriers to healthcare access and overall wellbeing.

These challenges call for informed, proactive responses from local county and health leadership.

Introduction

2025: At least **153** detentions in San Mateo County

2026 (Jan–Aug): At least **76** detentions in San Mateo County

News stories of ICE in hospitals

Objective

By sharing these findings, **we aim to support collaborative, proactive solutions that protect and promote the health of disproportionately impacted communities across San Mateo County.**

Existing Literature

Immigration status is a social determinant of health.

Migration experience

Family separations

Deportation proceedings

Exclusions from healthcare

San Mateo County:

- ALAS' 2022-2024 Latine Community Wellbeing Assessment

Our Data

How have our San Mateo County immigrant communities' health and wellbeing been affected by recent federal policy changes and heightened enforcement activity?

Qualitative

Focus groups – 37 participants

Provider Interviews – 3 participants

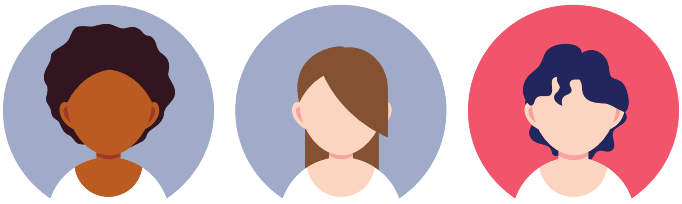
Quantitative

Community Survey – 41 responses

Provider Survey – 22 responses

100+ unique individuals

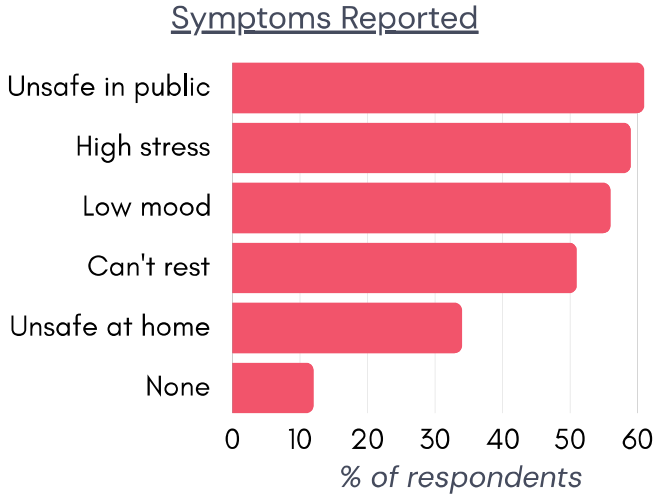
Community Survey



1 in 3 people
avoided going to the doctor for fear of ICE

Community Survey

50%
reported a drastic decrease in wellbeing.



Focus Groups

"**Traveling** [from Half Moon Bay] all the way to San Mateo or Stanford for a **medical appointment** is risky."

"I left my job out of that fear."

"Hospitals should have **signage** in all areas about how to respond to ICE for both patients and staff."

"I only feel safe at home and at church. I know my church has a **safety protocol**."

Provider Perspectives

"We got a couple emails and **talked about protocol once** in the clinic. I'd say we were ***informed*** on legal best practice more than *trained*."

"Clients also are **delaying** their physical health needs **appointments** out of fear of potential detainment."

"I wish I knew what is the county's plan to ensure people continue to be able to access care."

Other Themes

- Medi-cal eligibility changes
- Youth mental health impacts
- Related needs

The work continues...

We must act to strengthen patient trust.

Our goal is for all county health staff to **sign up for upcoming web and in-person trainings** from OCA.

For more information:
sofiaraquel@el-concilio.org | dlee1@smcgov.org

Recommendations

Short-term: *currently underway*

To **expand protocol for immigration response** to include guidance for staff working in public spaces AND **implement a training** for front-facing staff

Long-term:

To **elevate and share existing community, social service, resources** and make **investments to retain or expand existing mental health resources** for immigrant communities

Thank You

For your attention

AGENDA ITEM: 5.3

DATE: September 9, 2026

Meeting materials are not included for Item 5.3 – Appointment of Chief Executive Officer

MEMORANDUM

AGENDA ITEM: 6.0

DATE: September 9, 2026

DATE: September 2, 2026

TO: San Mateo Health Commission

FROM: Patrick Curran

RE: CEO Report – September 2026

HPSM Financial Projections

The Finance/Compliance Committee met on Monday, August 24th. Please note the presentation for that meeting, which is included in the Consent Agenda section of this packet. I want to specifically highlight our financial performance based on the first and second quarters.

We have been experiencing losses in 2026, which we expected and budgeted for. However, due to the membership losses and the cost profile of the remaining members, our financial losses are higher than expected. We discussed the reasons for that at the Committee meeting, and I want to thank our Finance/Compliance Committee members for their active participation and insightful questions.

There are four take-away messages for the entire Health Commission that are important to highlight. We will discuss these in more detail first at Finance/Compliance Committee and then at the Health Commission as we continue our budget development for 2027:

- The trends we are seeing will likely result in losses much higher than we originally budgeted for 2026. This is primarily due to the cost profile of remaining Medi-Cal members being far higher than the cost experience of members no longer with HPSM.
- We are already in discussions with DHCS about our 2027 rates and are submitting information about these cost trends. *A key determinant for our 2027 budget will be how much of this cost experience DHCS will incorporate into our 2027 rates*.
- These patterns of positive income during membership growth and negative income during membership declines are normal for health plans, especially with Medi-Cal. These are the times that our strong financial reserves are important, as they provide stability for our members and providers.
- We are also evaluating our administrative costs and health care costs as part of our budget process to propose short- and long-term strategies for managing our costs.

Membership Trends

As mentioned above, we are experiencing continued decreases in membership. Claire Cunningham, Agency Director for the San Mateo County Human Services Agency (HSA), will present to the Health Commission at our September 9th meeting to discuss the process for Medi-Cal new and re-enrollment in San Mateo County. A key element of this presentation will be for the Health Commission to understand the role of HSA, as well as other community organizations, including HPSM, in this process.

UIS Transition

As a reminder, due to a decision that the state finalized during the recent stage budget process, DHCS will transition all HPSM members with Unsatisfactory Immigration Status (UIS) to the state's Medi-Cal FFS delivery system on January 1, 2027.

DHCS has distributed policy guidance regarding this transition and will continue to do so over the next few weeks. HPSM staff are hard at work to facilitate this transition, with the goal of supporting members during the transition, as well as ensuring that providers have appropriate information about members to facilitate ongoing care.

AGENDA ITEM: 7.0

DATE: September 9, 2026

CLOSED SESSION for Item 7.0 –

CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION (Government Code Section 54956.9(d)(2)) (1 case)