Health Plan of San Mateo
Healthy is for everyone

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THE SAN MATEO HEALTH COMMISSION
Regular Meeting
March 13, 2024 - 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., Boardroom
South San Francisco, CA 94080

AGENDA

1. **Call to Order/Roll Call**
2. **Public Comment/Communication**
3. **Approval of Agenda**
4. **Consent Agenda***
   - 4.1 Report from Finance/Compliance Committee
   - 4.2 Quality Improvement and Health Equity Committee Minutes, 2023
   - 4.3 Approval of 2024 Compliance Program and 2024 Code of Conduct
   - 4.4 Approval of Amendment to Agreement with Compliance Strategies
   - 4.5 Approval of Amendment to Agreement with Independent Living Systems
   - 4.6 Approval of Agreement with County of San Mateo dba San Mateo County Health for Rate Range Intergovernmental Transfer (IGT) Funding for Calendar Year 2022
   - 4.7 Approval of San Mateo Health Commission Meeting Minutes from January 10, 2024 and February 14, 2024
5. **Specific Discussion/Action Items**
   - 5.1 Approval of 2024 HPSM Budget*
   - 5.2 Annual Compliance Report for 2023
   - 5.3 Introduction to Baby Bonus Project
6. **Report from Chief Executive Officer**
7. **Other Business**
8. **Adjournment**

**Items for which Commission action is requested.*

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

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AGENDA ITEM: 4.1

DATE: March 13, 2024

M E M O R A N D U M

Date: March 1, 2024
To: San Mateo Health Commission
From: Trent Ehrgood, Chief Financial Officer

Subject: **Financial report for the twelve-month period ending December 31, 2023**

Preliminary 2024 Financial Results All Lines of Business

Q4 2023 preliminary financial result for all lines of business is a surplus of $33.3M, with a YTD total surplus of $119.2M compared to the YTD budget surplus of $71.8M.

These financial statements are preliminary pre-audit and include some year-end true-ups recorded in Q4. Additional adjustments will be made as part of the final audited financials. More favorable results are expected.

Disenrollment from the Medi-Cal redetermination process started in July 2023. HPSM is observing approximately 2,100 disenrollments per month, which represents approximately 20% of members up for redetermination.

The MCO tax was approved by CMS, retro to April 2023. DHCS incorporated funding for this in updated 2023 rates, so both revenue and expense related to the MCO tax was added in Q4.

Attached is the presentation given at the Finance/Compliance Committee meeting on February 26th. Detailed Statements of Revenue and Expense on a consolidated basis, as well as for each line of business, are provided after the presentation slides.

Financial Update

Presentation to Finance/Compliance Committee

February 26, 2024

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2023 Budget by Quarter

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	Q1	Q2	Q3	Q4	Total
Capitation revenue	261,147,663	262,315,895	258,630,867	262,606,215	**1,044,700,640**
Healthcare cost	229,730,036	231,739,217	231,991,085	230,759,457	**924,219,795**
Administrative expenses	14,539,248	15,119,497	15,638,239	15,936,131	**61,233,114**
MCO Tax	-	-	-	-	-
Income/(loss) from operations	16,878,379	15,457,182	11,001,543	15,910,627	**59,247,731**
Non-operating revenue	3,123,606	3,129,344	3,135,081	3,140,819	**12,528,849**
Net income/(loss)	20,001,985	18,586,525	14,136,624	19,051,445	**71,776,580**

Q4 2023 Preliminary Financial Results

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	Q1 (Jan-Mar)	Q2 (Apr-Jun)	Q3 (Jul-Sep)	Q4 (Oct-Dec)	YTD Total	YTD Budget	Budget Variance
Capitation revenue	347,808,745	267,913,752	308,146,113	359,287,305	1,283,155,915	1,044,700,640	238,455,275
Healthcare cost	306,446,093	230,581,070	282,077,507	251,557,502	1,070,662,172	924,219,795	(146,442,377)
Administrative expenses	13,925,006	14,024,061	16,029,675	26,719,853	70,698,595	61,233,114	(9,465,481)
MCO Tax	-	-	-	57,553,727	57,553,727	-	(57,553,727)
Income/(loss) from operations	27,437,646	23,308,621	10,038,931	23,456,223	84,241,421	59,247,731	24,993,690
Non-operating revenue	6,922,184	9,053,586	9,114,261	9,877,415	34,967,446	12,528,849	22,438,597
Net income/(loss)	34,359,830	32,362,207	19,153,192	33,333,638	119,208,867	71,776,580	47,432,287

YTD December 2023 – PY/CY

Preliminary pre-audit

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	YTD by PY/CY			Current Year YTD		
	Prior Year	Current Year	Total	Current Year	Budget	CY Variance
* Capitation revenue	137,856,230	1,145,299,685	1,283,155,915	1,145,299,685	1,044,700,640	100,599,045
Healthcare cost	142,377,121	928,285,051	1,070,662,172	928,285,051	924,219,795	(4,065,256)
Administrative expenses	-	70,698,595	70,698,595	70,698,595	61,233,114	(9,465,481)
MCO Tax		57,553,727	57,553,727	57,553,727	-	(57,553,727)
Income/(loss) from operations	(4,520,891)	88,762,312	84,241,421	88,762,312	59,247,731	29,514,581
Non-operating revenue	(50)	34,967,496	34,967,446	34,967,496	12,528,849	22,438,647
Net income/(loss)	(4,520,941)	123,729,808	119,208,867	123,729,808	71,776,580	51,953,228

* *Note: $7.5M CMC 2022 w/h revenue listed as Current Year, since it is included in the CY budget.*

Average Membership

Variance to Budget

LOB	Avg. Actual	Avg. Budget	Variance	% Var
Medi-Cal	77,366	75,278	2,088	2.8%
Medi-Cal Expansion	52,459	49,233	3,227	6.6%
Whole Child Model	1,373	1,405	(32)	-2.3%
Medi-Cal Full Duals	10,105	9,447	657	7.0%
Medicare D-SNP	8,522	9,100	(578)	-6.4%
HealthWorx	1,212	1,199	13	1.0%
Total at Risk	151,036	145,663	5,373	3.7%
+ ACE	21,458	23,912	(2,454)	-10.3%
Grand Total	172,494	169,575	2,919	1.7%

Adjustments Recorded in Q4

- CMC withhold revenue for 2022 $7.5M (+ revenue)
- Additional Medicare risk adjustment and Part-D revenue (+ revenue)
- DHCS incentive revenue and expense (+ revenue; + HC cost)
- MCO tax retro to April 2023 (+ revenue; + MCO tax exp)
- Estimated global cap refund from Kaiser for 2022 (- HC cost)
- True-up to Part-D pharmacy rebate estimates (+ HC cost)
- Strategic investment to Seton (+ Admin cost).

Pending Adjustments
(will be reflected in final audited financials)

- Update Medi-Cal rates to SIS/UIS back to 19/20 BP (+ revenue)
- Estimated Medi-Cal revenue acuity adjustment (- revenue)
- Adjustments to prior year directed payments (- HC cost)
- Estimated global cap refund from Kaiser for 2023 (- HC cost)
- Misc. admin cost accrual adjustments, including year-end pension plan valuation.

DHCS Incentive Programs

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				A	B	C	D	E	F	G
				Funding Opportunity		Revenue	Expense		Reported Net Income	
	Program	Start	End	Statewide Funding	HPSM Max Potential	YTD Received	Paid or Committed	Balance	Booked in 2022	Booked in 2023
1	Behavior Health Integration Prog. (BHIIP)	Jan-21	Dec-22	$ 190,000,000	$ 1,880,227	$ 1,089,169	$ 889,169	$ 200,000	$ 200,000	$ -
2	Vaccine Incentive Program	Sep-21	Dec-22	$ 250,000,000	$ 2,713,266	$ 1,834,692	$ 1,096,690	$ 738,002	$ 738,002	$ -
3	Student Behavior Health Incentive Prog. (SBHIP)	Jan-22	Dec-24	$ 389,000,000	$ 4,406,197	$ 3,088,875	$ 2,753,875	$ 335,000	$ -	$ 335,000
4	CalAIM Incentive Program (IPP)	Jan-22	Dec-24	$ 1,500,000,000	$ 17,279,780	$ 9,258,343	$ 2,806,253	$ 6,452,090	$ -	$ 6,452,090
5	Housing and Homeless Incentieve Progg (HHIP)	Jan-22	Dec-23	$ 1,288,000,000	$ 14,981,079	$ 5,617,905	$ 2,158,000	$ 3,459,905	$ -	$ 3,459,905
	Total			$ 3,617,000,000	$ 41,260,549	$ 20,888,983	$ 9,703,987	$ 11,184,996	$ 938,002	$ 10,246,995

	CY 2022	CY 2023
Revenue	2,532,934	18,356,050
Expense	1,594,932	8,109,055
Net	938,002	10,246,995

Healthcare Cost

Detail by Category of Service

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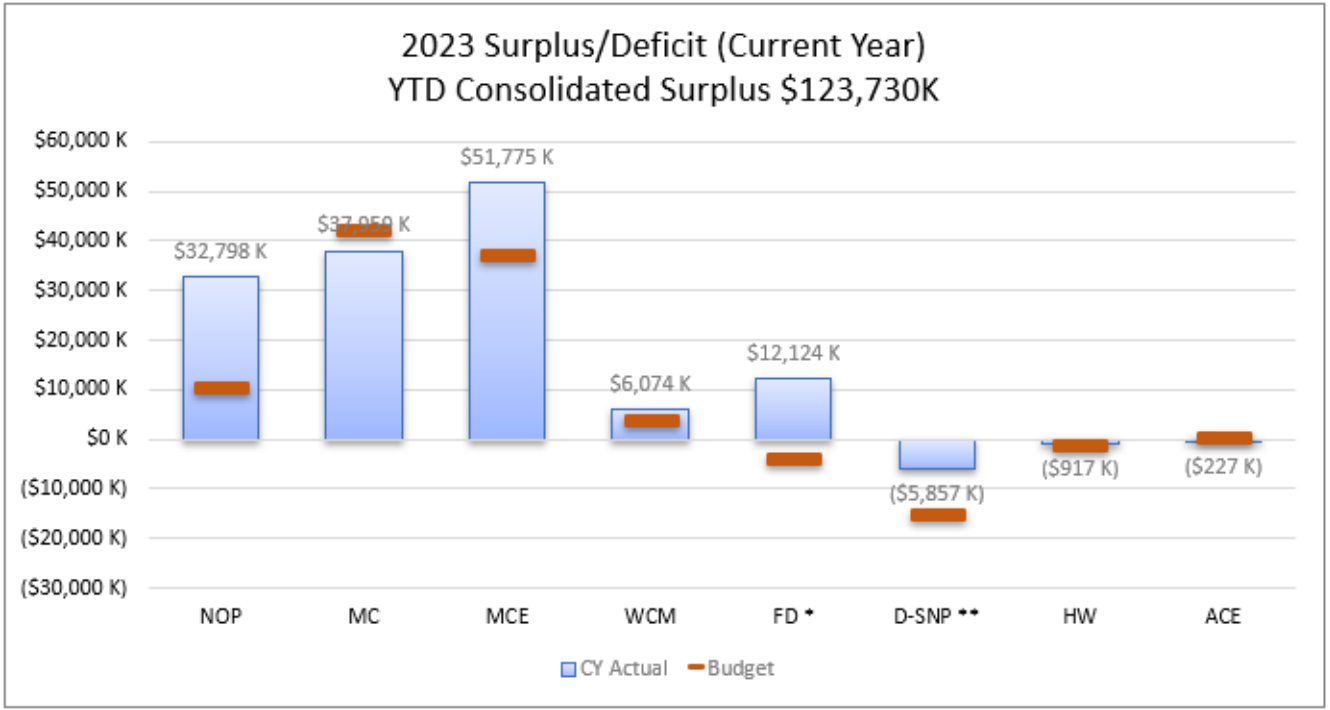
	YTD Actual					
	Total	Prior Year	Current Year	YTD Budget	Variance	% Var.
Provider Capitation	72,736,191	(4,284,537)	77,020,727	71,900,483	(5,120,244)	-7.1%
Hospital Inpatient	195,273,692	(832,026)	196,105,718	193,397,088	(2,708,630)	-1.4%
LTC/SNF	167,100,235	744,946	166,355,289	176,084,029	9,728,740	5.5%
Pharmacy	61,532,745	501,036	61,031,710	62,332,504	1,300,794	2.1%
Physician FFS	79,465,244	116,574	79,348,670	79,439,205	90,535	0.1%
Hospital Outpatient	95,988,243	138,113	95,850,129	96,024,323	174,193	0.2%
Other Medical Claims	90,528,805	415,770	90,113,036	89,718,049	(394,986)	-0.4%
Other HC Services	5,392,096	(260,164)	5,652,260	6,624,903	972,643	14.7%
Directed Payments	205,641,797	145,662,624	59,979,173	62,120,507	2,141,334	3.4%
Long Term Support Services	2,400,207	878,931	1,521,276	2,364,059	842,783	35.6%
CPO/In-lieu of Services	8,757,949	325,389	8,432,560	6,630,100	(1,802,461)	-27.2%
Dental	24,679,736	(51,352)	24,731,088	20,984,583	(3,746,505)	-17.9%
ECM	3,038,857	117,890	2,920,967	7,864,854	4,943,887	62.9%
Provider Incentives	20,678,110	(1,187,158)	21,865,269	10,830,250	(11,035,019)	-101.9%
Supplemental Benefits (D-SNP)	2,058,744	-	2,058,744	4,255,073	2,196,329	51.6%
Transportation	13,073,721	(518)	13,074,239	10,552,800	(2,521,439)	-23.9%
Indirect Health Care Benefits	1,619,481	90,494	1,528,987	817,570	(711,417)	-87.0%
UMQA	20,696,318	1,108	20,695,211	22,279,416	1,584,206	7.1%
Total Healthcare Cost	1,070,662,172	142,377,121	928,285,051	924,219,795	(4,065,256)	-0.4%

CY YTD Surplus/Deficit by LOB



* FD includes M-Cal portion of D-SNP

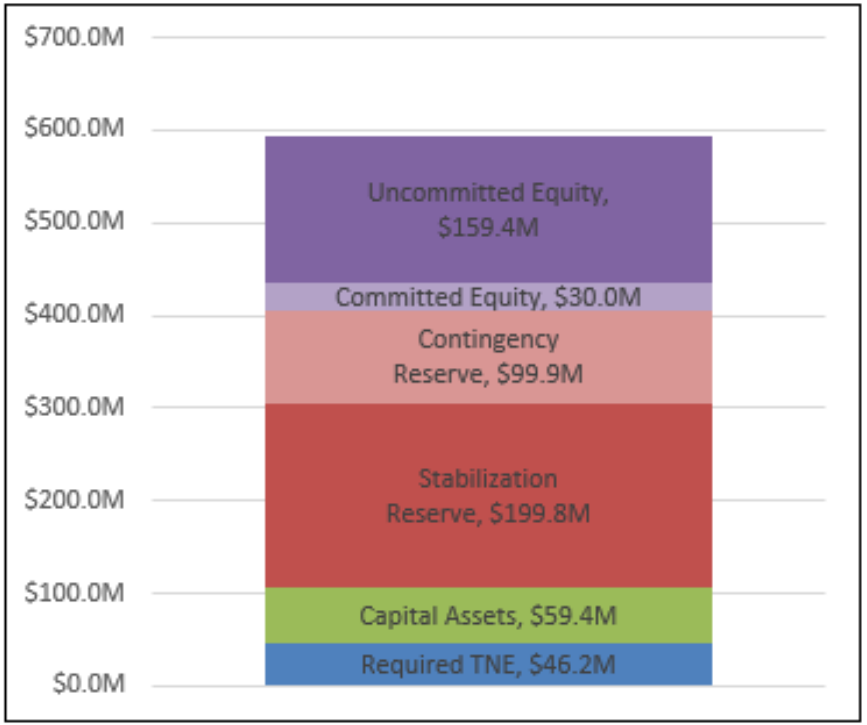
** D-SNP includes Medicare portion only

*** D-SNP include $7.5M PY w/h revenue

**** Excludes $10M strategic investment (NOP)

Tangible Net Equity (TNE)

At 12/31/23 Pre-Audit TNE = $594.7M
Uncommitted portion = $159.4M



Q4 2023 Summary

- The preliminary Q4 surplus of $33.3M includes several year-end adjustments. Additional adjustments will be made as part of the final audited financials. More favorable results are expected.
- December marks the sixth month of disenrollment from the start of the Medi-Cal redetermination process. HPSM is observing approximately 2,100 members disenrolled each month.
- Q4 adjustments include revenue and expenses related to DHCS sponsored incentive programs. This added $10.2M to the bottom line (and to reserves). The expectation is that these funds will be used in subsequent years, creating expenses in future years, thus drawing down on reserves.

Health Plan of San Mateo
Consolidated Balance Sheet
December 31, 2023 and November 30, 2023

	Current Month	Prior Month	PY 12/31
ASSETS			
Current Assets			
Cash and Equivalents	$ 552,675,606	$ 531,980,344	$ 409,879,878
Investments	185,724,686	185,724,686	180,739,480
Capitation Receivable from the State	212,896,630	156,179,115	157,581,748
Capitation Receivable from CMS	75,192,823	52,794,502	44,229,778
Other Receivables	11,021,802	11,083,277	10,394,960
Prepaids and Other Assets	9,847,467	9,923,158	9,462,156
Total Current Assets	1,047,359,014	947,685,082	812,288,000
Capital Assets, Net	59,364,273	59,497,436	60,977,606
Assets Restricted As To Use	300,000	300,000	300,000
Other Assets & Outflows	10,196,136	10,196,136	10,196,136
Total Assets & Deferred Outflows	$ 1,117,219,423	$ 1,017,678,654	$ 883,761,742
LIABILITIES			
Current Liabilities			
Medical Claims Payable	76,163,330	73,547,744	69,446,973
Provider Incentives	11,255,574	10,980,772	12,737,495
Amounts Due to the State	182,415,650	181,104,752	174,363,272
Accounts Payable and Accrued Liabilities	241,756,237	163,748,778	140,794,240
Total Current Liabilities	511,590,792	429,382,046	397,341,979
Other Liabilities & Inflows	10,917,265	10,917,265	10,917,265
Total Liabilities & Deferred Inflows	$ 522,508,057	$ 440,299,311	$ 408,259,244
NET POSITION			
Invested in Capital Assets	59,364,273	59,497,436	60,977,606
Restricted By Legislative Authority	300,000	300,000	300,000
Unrestricted			
Stabilization Reserve	191,796,300	191,796,300	154,531,300
Unrestricted Retained Earnings	343,250,793	325,785,607	259,693,592
Net Position	594,711,366	577,379,343	475,502,498
Total Liabilities & Net Position	$ 1,117,219,423	$ 1,017,678,654	883,761,742
Change in Net Position	$ 119,208,868	$ 101,876,845	0

Health Plan of San Mateo
Consolidated Statement of Revenue & Expense
for the Period Ending December 31, 2023

	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)	$ 262,425,043	$ 198,099,324	$ 64,325,719	$1,021,761,700	$ 815,418,780	$ 206,342,920	25.3%
HealthWorx	1,747,125	1,722,047	25,077	6,957,387	6,883,884	73,503	1.1%
Medicare (includes CA-CMC)	76,759,088	62,784,844	13,974,244	236,080,778	222,397,976	13,682,802	6.2%
Medi-Cal Incentives	18,356,050	-		18,356,050	-	-	-
Total Operating Revenue	359,287,305	262,606,215	96,681,090	1,283,155,915	1,044,700,640	238,455,275	22.8%
OPERATING EXPENSE							
Healthcare Expense							
Provder Capitation	15,215,388	17,564,691	2,349,304	72,736,191	71,900,483	(835,708)	-1.2%
Hospital Inpatient	44,242,064	48,332,540	4,090,475	195,273,692	193,397,088	(1,876,604)	-1.0%
LTC/SNF	43,757,289	44,753,828	996,539	167,100,235	176,084,029	8,983,794	5.1%
Pharmacy	19,515,704	16,293,188	(3,222,516)	61,532,745	62,332,504	799,758	1.3%
Medical	96,577,990	82,217,352	(14,360,638)	477,016,185	333,926,987	(143,089,198)	-42.9%
Long Term Support Services	1,329,401	593,270	(736,130)	2,400,207	2,364,059	(36,148)	-1.5%
CPO/In-lieu of Services	2,602,535	1,665,554	(936,981)	8,757,949	6,630,100	(2,127,850)	-32.1%
Dental Expense	7,620,001	5,222,618	(2,397,383)	24,679,736	20,984,583	(3,695,153)	-17.6%
Enhanced Care Management	827,585	1,899,514	1,071,928	3,038,857	7,864,854	4,825,996	61.4%
Provider Incentives	11,840,024	2,617,571	(9,222,454)	20,678,110	10,830,250	(9,847,861)	-90.9%
Supplemental Benefits	500,932	1,097,218		2,058,744	4,255,073	-	-
Transportation	3,502,494	2,664,477	(838,017)	13,073,721	10,552,800	(2,520,921)	-23.9%
Indirect Health Care Expenses	(652,729)	197,839	850,568	1,619,481	817,570	(801,911)	-98.1%
UMQA, Delegated and Allocation	4,678,824	5,639,797	960,973	20,696,318	22,279,416	1,583,098	7.1%
Total Healthcare Expense	251,557,503	230,759,457	(20,798,046)	1,070,662,172	924,219,795	(146,442,378)	-15.8%
Administrative Expense							
Salaries and Benefits	13,940,373	13,041,293	(899,081)	50,769,846	49,836,020	(933,826)	-1.9%
Staff Training and Travel	73,917	87,250	13,334	194,274	428,400	234,126	54.7%
Contract Services	3,618,226	4,325,100	706,874	15,719,596	17,537,400	1,817,804	10.4%
Office Supplies and Equipment	1,863,167	1,921,325	58,158	7,202,503	6,911,300	(291,203)	-4.2%
Occupancy and Depreciation	813,430	1,027,497	214,067	3,453,722	3,930,000	476,278	12.1%
Postage and Printing	503,185	702,725	199,540	1,943,334	2,745,900	802,566	29.2%
Other Administrative Expense	10,462,479	411,088	(10,051,391)	11,783,638	1,864,700	(9,918,938)	-531.9%
UM/QA Allocation	(4,554,925)	(5,580,146)	(1,025,221)	(20,368,320)	(22,020,606)	(1,652,286)	-7.5%
Total Admin Expense	26,719,851	15,936,130	(10,783,721)	70,698,594	61,233,114	(9,465,480)	-15.5%
Premium Taxes	57,553,727	-	(57,553,727)	57,553,727	-	(57,553,727)	-
Total Operating Expense	335,831,082	246,695,587	(89,135,494)	1,198,914,493	985,452,908	(213,461,585)	-21.7%
Net Income/Loss from Operations	23,456,224	15,910,628	(7,545,596)	84,241,422	59,247,732	(24,993,690)	142.2%
Interest Income, Net	9,061,346	2,250,000	6,811,346	31,557,814	9,000,000	22,557,814	250.6%
Rental Income, Net	320,232	296,834	23,398	1,231,687	1,187,337	44,350	3.7%
Third Party Administrator Revenue	495,822	593,984	(98,162)	2,169,056	2,341,512	(172,457)	-7.4%
Miscellaneous Income	15	-	(15)	8,889	-	8,889	-
Net Non-operating Revenue	9,877,415	3,140,819	6,736,597	34,967,446	12,528,849	22,438,597	179.1%
Net Income/(Loss)	$ 33,333,639	19,051,446	14,282,193	$ 119,208,868	$ 71,776,581	$ 47,432,287	-66.1%
Admin exp as % of Net Rev (adj for Tax)	*8.86%*	*6.07%*		*5.77%*	*5.86%*		
Medical Loss Ratio (adj for Tax)	*73.31%*	*82.21%*		*70.58%*	*82.52%*		

Health Plan of San Mateo
ALL LOB UNITS Statement of Revenue & Expense
for the Period Ending December 31, 2023

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Medi-Cal Capitation	$ 267,833,355	$ 192,927,523	$ 74,905,832	38.8%	$1,036,359,341	$ 793,833,655	$ 242,525,686	30.6%
MC Supplemental Cap	2,741,240	5,171,800	(2,430,560)	-47.0%	12,774,593	21,585,125	(8,810,532)	-40.8%
HealthWorx Premium	1,747,125	1,722,047	25,077	1.5%	6,957,387	6,883,884	73,503	1.1%
CareAdvantage Premiums	76,759,088	62,784,844	13,974,244	22.3%	236,080,778	222,397,976	13,682,802	6.2%
MC Cap Offset	(8,149,553)	-	(8,149,553)	-	(27,372,234)	-	(27,372,234)	-
Medi-Cal Incentives	18,356,050	-		-	18,356,050	-	18,356,050	-
Total Operating Revenue	359,287,305	262,606,215	96,681,090	36.8%	1,283,155,915	1,044,700,640	238,455,275	22.8%
OPERATING EXPENSE								
Provider Capitation	15,215,388	17,564,691	2,349,304	13.4%	72,736,191	71,900,483	(835,708)	-1.2%
Hospital Inpatient	44,242,064	48,332,540	4,090,475	8.5%	195,273,692	193,397,088	(1,876,604)	-1.0%
LTC/SNF	43,757,289	44,753,828	996,539	2.2%	167,100,235	176,084,029	8,983,794	5.1%
Pharmacy	19,515,704	16,293,188	(3,222,516)	-19.8%	61,532,745	62,332,504	799,758	1.3%
Physician Fee for Service	19,141,923	19,718,093	576,170	2.9%	79,465,244	79,439,205	(26,039)	0.0%
Hospital Outpatient	23,474,825	23,721,603	246,778	1.0%	95,988,243	96,024,323	36,080	0.0%
Other Medical Claims	22,919,456	22,306,113	(613,343)	-2.7%	90,528,805	89,718,049	(810,756)	-0.9%
Other HC Services	673,198	1,609,390	936,193	58.2%	5,392,096	6,624,903	1,232,807	18.6%
Directed Payments	30,368,589	14,862,152	(15,506,436)	-104.3%	205,641,797	62,120,507	(143,521,290)	-231.0%
Long Term Support Services	1,329,401	593,270	(736,130)	-124.1%	2,400,207	2,364,059	(36,148)	-1.5%
CPO/In-lieu of Services	2,602,535	1,665,554	(936,981)	-56.3%	8,757,949	6,630,100	(2,127,850)	-32.1%
Dental Expense	7,620,001	5,222,618	(2,397,383)	-45.9%	24,679,736	20,984,583	(3,695,153)	-17.6%
Enhanced Care Management	827,585	1,899,514	1,071,928	56.4%	3,038,857	7,864,854	4,825,996	61.4%
Provider Incentives	11,840,024	2,617,571	(9,222,454)	-352.3%	20,678,110	10,830,250	(9,847,861)	-90.9%
Supplemental Benefits	500,932	1,097,218	596,286	54.3%	2,058,744	4,255,073	2,196,329	51.6%
Transportation	3,502,494	2,664,477	(838,017)	-31.5%	13,073,721	10,552,800	(2,520,921)	-23.9%
Indirect Health Care Expenses	(652,729)	197,839	850,568	429.9%	1,619,481	817,570	(801,911)	-98.1%
UMQA (Allocation & Delegated)	4,678,824	5,639,797	960,973	17.0%	20,696,318	22,279,416	1,583,098	7.1%
Total Health Care Expense	251,557,503	230,759,457	(20,798,046)	-9.0%	1,070,662,172	924,219,795	(146,442,378)	-15.8%
G&A Allocation	26,719,853	15,936,131	(10,783,722)	-67.7%	70,698,595	61,233,114	(9,465,481)	-15.5%
Premium Tax	57,553,727	-	(57,553,727)	-	57,553,727	-	(57,553,727)	-
Total Operating Expense	335,831,083	246,695,588	(89,135,495)	-36.1%	1,198,914,495	985,452,909	(213,461,586)	-21.7%
NON-OPERATING REVENUE								
Interest, Net	9,061,346	2,250,000	6,811,346	302.7%	31,557,814	9,000,000	22,557,814	250.6%
Rental Income, Net	320,232	296,834	23,398	7.9%	1,231,687	1,187,337	44,350	3.7%
Third Party Administror Revenue	495,822	593,984	(98,162)	-16.5%	2,169,056	2,341,512	(172,457)	-7.4%
Miscellaneous Income	15	-	15	-	8,889	-	8,889	-
Total Non-Operating	9,877,415	3,140,819	6,736,597	214.5%	34,967,446	12,528,849	22,438,597	179.1%
Net Income/(Loss)	$ 33,333,637	$ 19,051,445	14,282,192	75.0%	$ 119,208,866	$ 71,776,580	$ 47,432,287	66.1%
Medical Loss Ratio (adj MCO)	92.70%	93.14%			104.97%	94.06%		
Member Counts	524,634	520,157	4,477	0.9%	2,172,188	2,144,095	28,093	1.3%

Health Plan of San Mateo
Medi-Cal UNITS Statement of Revenue & Expense
for the Period Ending December 31, 2023

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Medi-Cal Capitation	$ 267,833,355	$ 192,927,523	$ 74,905,832	38.8%	$1,036,359,341	$ 793,833,655	$ 242,525,686	30.6%
MC Supplemental Cap	2,741,240	5,171,800	(2,430,560)	-47.0%	12,774,593	21,585,125	(8,810,532)	-40.8%
HealthWorx Premium	-	-	-	-	-	-	-	-
CareAdvantage Premiums	-	-	-	-	-	-	-	-
MC Cap Offset	(8,149,553)	-	(8,149,553)	-	(27,372,234)	-	(27,372,234)	-
Medi-Cal Incentives	18,356,050	-		-	18,356,050	-	18,356,050	-
Total Operating Revenue	280,781,093	198,099,324	82,681,769	41.7%	1,040,117,750	815,418,780	224,698,970	27.6%
OPERATING EXPENSE								
Provider Capitation	13,787,206	16,083,798	2,296,592	14.3%	67,613,246	66,335,139	(1,278,107)	-1.9%
Hospital Inpatient	29,105,432	31,512,145	2,406,714	7.6%	131,720,891	128,685,331	(3,035,560)	-2.4%
LTC/SNF	40,670,981	42,297,260	1,626,278	3.8%	154,663,422	166,696,489	12,033,068	7.2%
Pharmacy	(70,126)	-	70,126	-	(121,015)	-	121,015	-
Physician Fee for Service	14,152,867	14,052,459	(100,407)	-0.7%	58,187,623	57,991,552	(196,070)	-0.3%
Hospital Outpatient	16,991,745	16,601,651	(390,094)	-2.3%	67,560,728	69,070,651	1,509,923	2.2%
Other Medical Claims	17,708,590	16,010,551	(1,698,040)	-10.6%	68,521,032	65,930,591	(2,590,441)	-3.9%
Other HC Services	676,744	1,609,390	932,646	58.0%	5,395,643	6,624,903	1,229,261	18.6%
Directed Payments	30,368,589	14,862,152	(15,506,436)	-104.3%	205,641,797	62,120,507	(143,521,290)	-231.0%
Long Term Support Services	1,329,401	593,270	(736,130)	-124.1%	2,400,207	2,364,059	(36,148)	-1.5%
CPO/In-lieu of Services	2,233,576	1,665,554	(568,022)	-34.1%	8,388,990	6,630,100	(1,758,891)	-26.5%
Dental Expense	7,620,001	5,222,618	(2,397,383)	-45.9%	24,679,736	20,984,583	(3,695,153)	-17.6%
Enhanced Care Management	611,585	1,632,197	1,020,611	62.5%	2,246,857	6,828,183	4,581,326	67.1%
Provider Incentives	11,518,101	2,367,098	(9,151,003)	-386.6%	19,887,379	9,858,902	(10,028,477)	-101.7%
Transportation	3,502,494	2,664,477	(838,017)	-31.5%	13,073,721	10,552,800	(2,520,921)	-23.9%
Indirect Health Care Expenses	(477,557)	141,398	618,955	437.7%	1,496,453	595,137	(901,316)	-151.4%
UMQA (Allocation & Delegated)	3,439,663	4,081,867	642,204	15.7%	15,252,995	16,131,363	878,369	5.4%
Total Health Care Expense	193,169,290	171,397,885	(21,771,405)	-12.7%	846,609,704	697,400,292	(149,209,412)	-21.4%
G&A Allocation	7,396,910	10,292,143	2,895,233	28.1%	37,012,241	39,546,609	2,534,368	6.4%
Premium Tax	57,553,727	-	(57,553,727)	-	57,553,727	-	(57,553,727)	-
Total Operating Expense	258,119,928	181,690,028	(76,429,900)	-42.1%	941,175,673	736,946,901	(204,228,771)	-27.7%
NON-OPERATING REVENUE								
Total Non-Operating	-	-	-	-	-	-	-	-
Net Income/(Loss)	$ 22,661,165	$ 16,409,296	6,251,869	38.1%	$ 98,942,077	$ 78,471,879	$ 20,470,199	26.1%
Medical Loss Ratio (adj MCO)	100.16%	93.54%			108.97%	92.58%		
Member Counts	436,308	414,488	21,820	5.3%	1,796,776	1,732,980	63,796	3.7%

Health Plan of San Mateo
CareAdvantage Units Statement of Revenue & Expense
for the Period Ending December 31, 2023

	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	76,759,088	62,784,844	13,974,244	22.3%	236,080,778	222,397,976	13,682,802	6.2%
MC Cap Offset	-	-	-	-	-	-	-	-
Total Operating Revenue	76,759,088	62,784,844	13,974,244	22.3%	236,080,778	222,397,976	13,682,802	6.2%
OPERATING EXPENSE								
Provider Capitation	1,428,182	1,480,893	52,711	3.6%	5,122,928	5,565,345	442,417	7.9%
Hospital Inpatient	14,961,352	16,468,167	1,506,815	9.1%	62,795,449	63,294,586	499,136	0.8%
LTC/SNF	3,086,308	2,456,568	(629,740)	-25.6%	12,436,813	9,387,539	(3,049,273)	-32.5%
Pharmacy	18,962,028	15,595,364	(3,366,663)	-21.6%	59,431,771	59,603,984	172,213	0.3%
Physician Fee for Service	4,672,966	5,336,559	663,593	12.4%	20,087,140	20,132,175	45,035	0.2%
Hospital Outpatient	5,866,820	6,703,747	836,927	12.5%	26,623,097	25,289,892	(1,333,205)	-5.3%
Other Medical Claims	5,105,159	6,183,071	1,077,912	17.4%	21,592,907	23,337,773	1,744,867	7.5%
Other HC Services	(3,546)	-	3,546	-	(3,546)	-	3,546	-
CPO/In-lieu of Services	368,959	-	(368,959)	-	368,959	-	(368,959)	-
Enhanced Care Management	216,000	267,317	51,317	19.2%	792,000	1,036,670	244,670	23.6%
Provider Incentives	321,923	250,473	(71,450)	-28.5%	790,732	971,348	180,616	18.6%
Supplemental Benefits	500,932	1,097,218	596,286	54.3%	2,058,744	4,255,073	2,196,329	51.6%
Indirect Health Care Expenses	(222,222)	54,997	277,220	504.1%	43,813	213,282	169,468	79.5%
UMQA (Allocation & Delegated)	1,183,189	1,502,248	319,058	21.2%	5,226,578	5,928,298	701,720	11.8%
Total Health Care Expense	56,448,050	57,396,623	948,573	1.7%	217,367,385	219,015,964	1,648,579	0.8%
G&A Allocation	8,579,997	4,867,249	(3,712,748)	-76.3%	20,553,521	18,701,957	(1,851,564)	-9.9%
Total Operating Expense	65,028,047	62,263,872	(2,764,175)	-4.4%	237,920,906	237,717,921	(202,985)	-0.1%
NON-OPERATING REVENUE								
Total Non-Operating	-	-	-	-	-	-	-	-
Net Income/(Loss)	$ 11,731,041	$ 520,972	11,210,069	2151.8%	$ (1,840,128)	$ (15,319,945)	$ 13,479,818	-88.0%
Medical Loss Ratio (adj MCO)	73.54%	91.42%			92.07%	98.48%		
Member Counts	25,671	28,308	(2,637)	-9.3%	103,378	109,780	(6,402)	-5.8%

Health Plan of San Mateo
HealthWorx Statement of Revenue & Expense
for the Period Ending December 31, 2023

	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	1,747,125	1,722,047	25,077	1.5%	6,957,387	6,883,884	73,503	1.1%
CareAdvantage Premiums	-	-	-	-	-	-	-	-
MC Cap Offset	-	-	-	-	-	-	-	-
Total Operating Revenue	1,747,125	1,722,047	25,077	1.5%	6,957,387	6,883,884	73,503	1.1%
OPERATING EXPENSE								
Provider Capitation	-	-	-	-	17	-	(17)	-
Hospital Inpatient	175,281	352,227	176,946	50.2%	757,351	1,417,172	659,820	46.6%
Pharmacy	623,802	697,824	74,021	10.6%	2,221,989	2,728,519	506,530	18.6%
Physician Fee for Service	316,090	329,075	12,985	3.9%	1,190,481	1,315,477	124,996	9.5%
Hospital Outpatient	616,260	416,205	(200,055)	-48.1%	1,804,417	1,663,779	(140,638)	-8.5%
Other Medical Claims	105,707	112,492	6,785	6.0%	414,867	449,685	34,819	7.7%
Other HC Services	0	-	0	-	0	-	0	-
Indirect Health Care Expenses	47,051	1,445	(45,607)	-3157.1%	79,215	9,151	(70,064)	-765.6%
UMQA (Allocation & Delegated)	55,971	55,682	(289)	-0.5%	216,746	219,755	3,009	1.4%
Total Health Care Expense	1,940,163	1,964,949	24,787	1.3%	6,685,083	7,803,539	1,118,456	14.3%
G&A Allocation	86,365	179,540	93,175	51.9%	736,999	689,866	(47,133)	-6.8%
Total Operating Expense	2,026,528	2,144,490	117,962	5.5%	7,422,082	8,493,405	1,071,323	12.6%
NON-OPERATING REVENUE								
Total Non-Operating	-	-	-	-	-	-	-	-
Net Income/(Loss)	$ (279,403)	$ (422,442)	143,039	-33.9%	$ (464,695)	$ (1,609,520)	$ 1,144,825	-71.1%
Medical Loss Ratio (adj MCO)	111.05%	114.11%			96.09%	113.36%		
Member Counts	3,647	3,600	47	1.3%	14,542	14,391	151	1.0%

Health Plan of San Mateo
ACE Statement of Revenue & Expense
for the Period Ending December 31, 2023

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Medi-Cal Capitation	-	-	-	-	-	-	-	-
MC Supplemental Cap	-	-	-	-	-	-	-	-
HealthWorx Premium	-	-	-	-	-	-	-	-
CareAdvantage Premiums	-	-	-	-	-	-	-	-
MC Cap Offset	-	-	-	-	-	-	-	-
Total Operating Revenue	-	-	-	-	-	-	-	-
OPERATING EXPENSE								
Total Health Care Expense	-	-	-	-	-	-	-	-
G&A Allocation	656,581	597,199	(59,382)	-9.9%	2,395,834	2,294,682	(101,152)	-4.4%
Total Operating Expense	656,581	597,199	(59,382)	-9.9%	2,395,834	2,294,682	(101,152)	-4.4%
NON-OPERATING REVENUE								
Third Party Administror Revenue	495,822	593,984	(98,162)	-16.5%	2,169,056	2,341,512	(172,457)	-7.4%
Total Non-Operating	495,822	593,984	(98,162)	-16.5%	2,169,056	2,341,512	(172,457)	-7.4%
Net Income/(Loss)	$ (160,759)	$ (3,215)	(157,544)	4900.4%	$ (226,779)	$ 46,830	$ (273,609)	-584.3%
Medical Loss Ratio (adj MCO)	-	-			-	-		
Member Counts	59,008	73,761	(14,753)	-20.0%	257,492	286,944	(29,452)	-10.3%

HEALTH PLAN OF SAN MATEO
STATEMENT OF CASH FLOWS - DIRECT & INDIRECT METHOD

FOR THE CURRENT PERIOD December 31, 2023

	CURRENT MONTH 12/31/2023	CURRENT YEAR YEAR-TO-DATE 2023
CASH FLOW PROVIDED BY OPERATING ACTIVITIES		
Group/Individual Premiums/Capitation	-	-
Title XVIII - Medicare Premiums	(178,908,586)	18,256,050
Title XIX - Medicaid Premiums	311,693,598	1,220,657,976
Investment and Other Revenues	1,969,749	2,240,169
Medical and Hospital Expenses	(97,168,211)	(1,063,145,111)
Administration Expenses	(19,498,836)	(63,003,395)
NET CASH PROVIDED BY OPERATING ACTIVITIES	**18,087,714**	**115,005,689**
CASH FLOW PROVIDED BY INVESTING ACTIVITIES		
Proceeds from Restricted Cash and Other Assets	-	-
Proceeds from Investments	-	-
Proceeds for Sales of Property, Plant and Equipment	-	-
Payments for Restricted Cash and Other Assets	-	-
Payments for Investments	-	-
Payments for Property, Plant and Equipment	(0)	(0)
Interest and Other Income Received	2,607,550	27,790,040
NET CASH PROVIDED BY INVESTING ACTIVITIES	**2,607,549**	**27,790,039**
CASH FLOW PROVIDED BY FINANCING ACTIVITIES:		
Principal payments under capital lease obligations	-	-
NET CASH PROVIDED BY FINANCING ACTIVITIES	**-**	**-**
NET INCREASE (DECREASE) IN CASH	**20,695,263**	**142,795,728**
CASH AND CASH EQUIVALENTS AT THE BEGINNING OF THE MONTH/PRIOR YEAR	**531,980,343**	**409,879,878**
CASH AND CASH EQUIVALENTS AT THE END OF THE MONTH	**552,675,606**	**552,675,607**
RECONCILIATION OF NET OPERATING INCOME TO NET CASH FROM OPERATING ACTIVITIES:		
Operating Income	14,070,419	84,241,422
	-	-
Depreciation and Amortization	133,163	1,613,333
Decrease (Increase) in Receivables	(78,400,306)	(84,712,568)
Decrease (Increase) in Prepaid Expenses	75,692	(385,311)
Decrease (Increase) in Net Pension/Inflows and Outflows	-	-
Decrease (Increase) in Affiliate Receivables	-	-
Increase (Decrease) in Amts due to State of CA	(1,310,898)	8,052,378
Increase (Decrease) in Accounts Payable	80,629,256	100,961,998
Increase (Decrease) in Medical Claims Payable	(1,397,815)	2,183,576
Increase (Decrease) in Incurred But Not Reported	4,013,401	4,532,782
Increase (Decrease) in Provider Risk Sharing	274,802	(1,481,921)
Increase (Decrease) in Unearned Premium	-	-
Aggregate Write-Ins for Adjustments to Net Income	-	-
TOTAL ADJUSTMENTS	**4,017,295**	**30,764,267**
NET CASH PROVIDED BY OPERATING ACTIVITIES	**18,087,713**	**115,005,689**
DETAILS OF WRITE-INS AGGREGATED FOR ADJUSTMENTS TO NET INCOME		
Unrealized (Gain)/Loss on Equity Securities	-	-
(Gain)/Loss on Sale of Assets	-	-
Prior Period Rent Expense	-	-
Realized (Gain)/Loss on Investment	-	-
TOTALS	**-**	**-**

Draft

FINANCE/COMPLIANCE COMMITTEE MEETING

Meeting Summary

February 26, 2024, 12:30 pm

Criminal Justice Training Center, 400 County Center, Redwood City, CA 94064

-or-

Health Plan of San Mateo -Boardroom 801 Gateway Blvd, South San Francisco, CA 94080

Member's present: Mike Callagy, Bill Graham, George Pon, Barbara Miao, Si France, M.D.

Members absent:

Staff present: Trent Ehrgood, Pat Curran, Francine Lester, Chris Esguerra, M.D., Katie-Elyse Turner, Ian Johansson, Corinne Burgess, Michelle Heryford

1.0 Call to Order – The meeting was called to order by Commissioner Graham at 12:30 pm. A quorum was met.

1.1 Introduction of new committee member – Barbara Miao: Committee Chairperson Bill Graham, introduced the committee's newest member, Barbara Miao. Ms. Miao is a Commissioner on the San Mateo Health Commission.

2.0 Public Comment – There was no public comment.

3.0 Approval of Meeting Summary for December 4, 2023 – The meeting summary for December 4, 2023, was approved as presented. **Callagy/Pon M/S/P**

4.0 Preliminary Financial report for the twelve-month period ending December 31, 2023 – HPSM CFO, Trent Ehrgood reviewed the financials for Q4 of 2023. He reviewed the 2023 budget by quarter, a $71M projected surplus was what was anticipated. The preliminary year-end results is a $119M surplus. Each quarter has consistently turned out a surplus of about $30M. The Finance department are currently working on additional adjustments, which they will record through the financial audit process, this will make the $119M even more favorable. Mr. Ehrgood pointed out that revenue in Q4 of 2023 was quite a bit higher, that is partly due to the MCO tax reinstated by the Department of Health Care Services (DHCS) in December. HPSM recorded funding to offset the taxes for 2023, which only goes back to April, not quite a years' worth. There were also close to $20M in true-ups and pick-ups for the CareAdvantage (CA) line, including prior-year withholds, money that HPSM has to earn after the fact, as well as risk adjustment revenue, some for current year and some for the prior year. There was also some Part D reconciliation related to CA and about $18M

in DHCS incentive revenue. Administrative expenses in Q4 are significantly higher than previous quarters due to the $10M grant to Seton Hospital, which was previously approved by the Commission.

Mr. Ehrgood went over membership differences. HPSM's budget assumed a decline would occur starting in May but the first disenrollments did not happen until July due to the extension of the public health emergency. This is one reason why they ended up with slightly more members than forecasted. Since July, approximately 2,100 members have been disenrolled each month.

Mr. Ehrgood went over adjustments recorded in Q4, which include the CMC withhold revenue for 2022, additional Medicare risk adjustment and Part D revenue, DHCS incentive revenue and expense, MCO tax retroactive to April 2023, the estimated global cap refund from Kaiser for 2022, true ups to the Part D pharmacy rebate estimates, and the strategic investment to Seton. Pending adjustments, which will be reflected in the final audited financials, include an update to the Medi-Cal rates to satisfactory immigration status (SIS)/unsatisfactory immigration status (UIS) back to the 19/20 bridge period (BP), an estimated Medi-Cal revenue acuity adjustment, adjustments to prior year directed payments, the estimated global cap refund from Kaiser for 2023, miscellaneous admin cost accrual adjustments, and the year-end pension plan valuation.

Mr. Ehrgood explained the various DHCS Incentive Programs a little further, noting the funding opportunities, revenue, expense and reported net income. He noted that these dollars are significant but time limited, once the program is done, it's done. The main takeaway is that the timing of recognizing revenue and expenses will not align in the same year as directed payments do. In 2023, HPSM recorded $18M in revenue, which is the amount earned by HPSM; but only $8M in expense, which is how much has been earned by community-based organizations so far. The $10M difference will contribute to the bottom line and temporarily add to HPSM's reserves. Use of these funds in subsequent years will add expense in that year, thus drawing down reserves. The Committee expressed the importance of tracking how these funds are used, and managing perceptions so it doesn't look like HPSM is just keeping these funds.

Mr. Ehrgood went over healthcare costs compared to budget. He highlighted that HPSM is $11M overbudget for Provider Incentives but explained this is where the $8M in DHCS incentive expenses is recorded. He also noted that $205M in directed payments flowed

through in 2023, the prior year $145M number will likely become smaller when they complete the final version of the financial statement.

Mr. Ehrgood highlighted the current year's YTD surplus/deficit by line of business (LOB). He explained that this is expected to get closer to break even and they anticipate much smaller surpluses in 2024, which will be highlighted with the budget discussion. The preliminary financial report was approved as presented. **Callagy/France MSP**

5.0 2024 Proposed Budget – Mr. Ehrgood updated the Committee on HPSMs proposed 2024 budget. He mentioned that DHCS backed off a little from the drastic rate reductions shared at the December Committee meeting. Revised versions are projecting a surplus of $30M for the year. A quick look shows a billion dollars in revenue, $951M in healthcare costs, $76M in administrative expenses and $52M for the MCO tax. They should end up with a margin from operations of approximately $5M, quite close to break even. Adding $25M in non-operating income, mostly earnings on the cash reserves, is how they will get to a $30M overall surplus. He put that in perspective by looking over the historical net income/(loss) for the last 10 years, noting that in 2019 and 2020 HPSM dipped into small negatives, and 2022 and 2023, each with surplus over $100M.

Mr. Ehrgood reviewed budget assumptions around membership, revenue, health care costs and administrative costs. Membership will take a drastic drop in the first half of 2024. This is partly due to continued disenrollment for MC related to the redetermination process, and also the loss of members due to the Kaiser direct contract. MC membership for SIS shows a drop in January mostly due to Kaiser, and an increase for UIS due to the ACE members who transitioned to MC. Remaining ACE membership is at around 2,000. CA membership dipped slightly during 2023, but they did receive a bump in January 2024 due to active marketing and outreach. HW membership has been flat at about 1,200 and is what is expected for the rest of the year through 2024.

The breakdown of the budget by LOB shows that not all have projected surpluses, some have losses. He explained how membership and revenue are different, noting that the Medicare membership is 6% of the entire membership, but they represent 21% of the revenue for 2024. Mr. Ehrgood compared preliminary 2023 healthcare costs to the 2024 budget. Most noteworthy, TRI gets baked into provider capitation explaining the increase there. Directed payments go down because of the elimination of a portion of prop 56, which gets baked into other line items. Global capitation goes down to zero because that

is what was paid to Kaiser. The administrative budget for 2024 has increased, as HPSM will now have close to 400 employees. Reserve levels will be over $600M at the end of 2024. The budget was approved as presented. **Miao/Pon MSP**

6.0 Compliance Discussion – HPSM, Chief Government Affairs and Compliance Officer, Ian Johansson noted that the rebranding of the committee from the Finance/Executive committee to the Finance/Compliance committee allows the group an opportunity to rethink the Compliance information and topics brought before the group. Items brought to this Committee and the San Mateo Health Commission (SMHC) are largely governed by CP009, a policy developed after a Centers for Medicare & Medicaid Services (CMS) audit in 2016. What this policy seeks to do is clarify when certain compliance issues, mostly noncompliance, gets disclosed at various levels of the organization, the Commission, and to external regulatory agencies like CMS and the Department of Health Care Services (DHCS), for example. He would also like to bring more government affairs information to the group. Perhaps items related to the budget or bills that are before the Legislature that could have an effect on HPSM. He would like to take a framework for these updates to the full Commission by the end of the year. He noted that policy CP009 has been around for years but has never been approved by the full Commission. Going forward he'd also like to include a written report, similar to the CEO report, as well as a dashboard with compliance and government affairs metrics.

Mr. Johansson reviewed recent Compliance Cases. Medication Therapy Management (MTM) vendor, Sinfonia Rx went out of business on October 20, 2023. They gave notice only 2 days prior on October 18, 2023, CMS was notified on October 19th. HPSM's pharmacy director, Ming Shen immediately went to work to obtain a new vendor, which he was able to do within a month. MedWatchers began services on November 22, 2023. Efforts to ensure necessary approvals were completed in late 2023.

The second case involved a vendor Independent Living Systems (ILS), they provide health risk assessments (HRA) and individualized care plan (ICP) services for HPSM under the Medicare program and also for a portion of the Medi-Cal population. During an invoice audit, HPSM staff had identified work product that HPSM was billed for, it was for a member who is deceased, and the billing date occurred after the date of expiration. They conducted an ad hoc audit, followed up with ILS leadership and confirmed that one of their employees had falsified documentation. The individual admitted to committing this act in interviews with ILS management, and HPSM immediately notified CMS on October

12th, 2023. After confirming the activity, they submitted a detailed documentation request to ILS's leadership. They also worked with an external firm that has subject matter expertise in auditing and Medicare, to perform a broader audit of activities which were subcontracted with ILS. That audit was completed this month. They are waiting for the formal findings. Early results show that there were subpar execution of contracted services by ILS, not rising to the level of potential fraud, waste, or abuse. Starting this year HPSM will be performing these services in-house with their own staff under a project called Care Plan 2.0. The relationship with this vendor will cease at the end of March.

The third case involved vendor, NationsBenefits. They provide an over the counter (OTC) and grocery benefit for CA members. In 2023, HPSM performed a delegation oversight audit of this vendor to ensure they were performing services according to the contract. This was prompted because monitoring data showed that NationsBenefits were struggling with the call center compliance piece of the contact. Audit results revealed that there were quality of service issues with their call center and their administration of the benefits under the contract. HPSM notified CMS about this in February 2024, not only about the issues but also about NationsBenefits efforts to improve their service quality after receiving the results.

7.0 **HPSM Investment Fund Update**: There was not enough time to address this item. It will be added to the agenda for the Finance/Compliance Meeting scheduled for March 25, 2024.

8.0 **Other Business –** There was no other business.

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

Respectfully submitted:

M. Heryford

M. Heryford

Assistant Clerk to the Commission

AGENDA ITEM: 4.2

DATE: March 13, 2024

QUALITY IMPROVEMENT COMMITTEE MEETING

March 15, 2023, 6:00 p.m. – 7:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd.
South San Francisco CA 94080

Voting Committee Members	Specialty	Present (Yes or Excused)
Kenneth Tai, M.D.	PCP (Internal Medicine)	Y
Jaime Chavarria, M.D.	PCP (Family Medicine)	N*
Maria Osmena, M.D.	PCP (Pediatric)	Excused
Jeanette Aviles, M.D.	SMMC Physician (Internal Medicine)	Y
Non-voting HPSM Members	**Title**	**Present (Yes or Excused)**
Chris Esguerra, M.D.	CMO (Psy)	Excused
Nicole Ford	QI Director	Y
Richard Moore, M.D.	Sr. Medical Director (IM)	Y
Miriam Sheinbein	Medical Director (FM)	Y
Talie Cloud	Population Health Specialist	N*

*On teleconference

1. Call to Order
   The meeting was called to order by Nicole Ford.

2. Public Comment/Communication
   No public comment or communication for discussion at this meeting.

3. Approval of Agenda
   Motion to approve. Approved by the QIC members.

4. Consent Agenda:
   4.1 QIC Minutes from December 21, 2022
   4.2 UMC Minutes from January 23, 2023
   4.3 CQC Minutes from February 27, 2023
   4.4 Dental Advisory Group minutes from Jan 20, 2023, and Feb 17, 2023

   Motion to approve. Approved by the QIC members.

5. Approval of the 2022 QI Program Evaluation, 2023 QI Program Description and 2023 QI Work Plan
   Ms. Ford presented a high-level overview of the QI Program documents.
   - Clinical Quality Measures = above the HPL on four of the measures such as diabetes measures for poor control. Three measures were below the MPL that were identified by DHCS (50th percentile across all Medicaid plans). Cervical Cancer Screening and Well Child Visits for six or more within the first 15 months of life and an additional two visits within the 15 to 30 months of life.
   - All Quality Withhold Measures for CareAdvantage CalMediConnect = passed with three are HEDIS measures. 1) Plan All-Cause Readmissions, 2) Controlling High Blood Pressure, and 3) follow up after hospitalization for mental illness.

     Comment from Dr. Tai with what was the target?

Comment from Ms. Ford: For the Controlling High Blood Pressure measures, the benchmark is 71%. We did not meet the benchmark but passed the withhold measure by meeting the gap improvement metric with sufficient improvement from prior year results.

- HEDIS Outcome Survey (HOS) Metrics for 2022 (reported last year)/collected prior year) = Improving Bladder Control, Reducing Fall Risks, and Physical Activity in Older Adults where HPSM's performance overall was very good in our region as well as nationally compared to other contracts in California.
- Potential Quality Issue (PQI) Monitoring = completed 42 PQI/Quality of Care Reviews from 1/12022 to 12/31/2022.
- Facility Site Review (FSR) and Medical Record Review (MRR) = due to staffing shortages and with the pandemic, there was a lack of certified site review nurse(s), HPSM was only able to conduct one site review in 2022. Of the one facility site review completed in 2022, the FSR score was 73% and of the one medical record review completed in 2022, the MRR score was 93%. HPSM is now able to catch up in the following year with the certified site review nurses to conduct site reviews. HPSM is collaborating with SFHP and SCHP where we can share reviews of shared provider offices.
- Quality Program Changes (contract change) = previously a Medicare Medicaid plan with quality withhold monitoring, which changed to a D-SNP/Dual Eligible Special Needs plan in 01/01/2023. Continue to report on HOS and CAHPS clinical measures for D-SNP. HPSM is rated on quality with the STARs program based on other plans.
- Initial Health Assessment (IHA) is now called the Initial Health Appointment, and the Staying Healthy Assessment requirement/Initial Health and Behavioral Assessment questionnaire was removed from IHA. A visit/encounter with a primary care provider within the first 120 days after enrollment with HPSM is still required.

  Comment from Ms. Ford from last DHCS audit, we received a CAP due to not meeting the requirement of an visit within the first 120 days of enrollment.
  Comment from Dr. Tai whether the Plan has documentation in terms of the initial appointment refusal after three or more attempts to contact the member, the Plan is complying.
  Comment from Ms. Ford, where HPSM currently does not have a mechanism to systematically capture these refusal attempts. Perhaps providers could provide a code to help identify on a regular basis.
  Comment from Dr. Moore if the member should drop out temporarily out of the system, how is it measured in our system?
  Comment from Ms. Ford, where if there was an assessment within the prior 12 months, count as an initial health appointment.
  Recommendation by Ms. Ford if we have a record of the visit within the first 12-month period, we might be able to document it in the Patient Engagement Report. Lastly, DHCS would still require a response from the Plan to hold providers compliance with these clinical measurements.

- Other areas of focus for 2023 with Cervical Cancer Screening = below the MPL. With the general health promotion, HPSM sends monthly reminders to members, e.g., on their birthdays.
- Continuing with our CCS measure for adult and family practice as part of HPSM P4P benchmark program, target member outreach from our Care Management team. CM team

would identify those barriers for members to get their cervical cancer screening appointments.

Comment from Dr. Aviles, what is the target?
Comment from Ms. Ford needs to provide the benchmark target to the committee later.

Comment from Dr. Sheinbein where HPSM has an article in the Provider Newsletter as well as on the web page specifically those with disabilities in how to access care.
Comment from Ms. Ford, we are exploring member incentives.

- Well Care Visits for six visits within the 13-months of life, which is a benchmark for our pediatric and family practice measure for P4P. A strategy to try to link new baby to mom for visits to capture on the claim since new babies are not assigned to HPSM yet. This measure was previously a hybrid measure for chart review but now HPSM is measured under the full population. Looking for ways to capture the data for any missing visits.

- We have an action plan for the SWOT analysis such as engaging with family health services to connect members to their pediatrician or primary care provider for these visits. The Well Child Visit for HEDIS is the number of visits within the 1st 15 month-period.

  Comment from Dr. Tai, what is the number of births? Could the Plan invest in a coordinator or a panelist to track to ensure the mother is seen within the 1st 15 months for the Well Child Visit? Perhaps emphasize as part of ongoing education for the 1st six-month visit from the Plan.
  Comment from Dr. Sheinbein, we have about 1,000 births per year.
  Comment from Ms. Ford, where we have a Baby and Me Program to increase timely prenatal and post-partum visits. An incentive program for members to do timely prenatal care in the first trimester and post-partum care.
  The next round of DHCS required Performance Improvement Projects (PIP) are staring this year. DHCS has chosen the topic areas. As many of the other MCPs struggle with the W30 measure, DHCS has chose this as the clinical PIP topic with the focus of reducing the disparity for Black/African American identifying members state-wide.

- The other PIP topic chosen by DHCS is for Plans work on building an infrastructure of linking members to mental health services and coordinating those services through Behavioral Health. HPSM is planning to focus on connecting members who have an ER visits with primary diagnosis of mental ill to behavioral health services for follow-up care. The specific intervention is still in development, but initial focus is notifying the treating behavioral health provider of the ED visit for members with established behavioral health services or coordinating follow-up with a behavioral health provider post ED discharge to initiate treatment.

  Comment from Dr. Tai, where it is difficult to get the data from specialty mental health providers to primary care providers due to protected confidentiality practices.

6. Consumer Assessment of Healthcare Providers and Systems (CAHPS) 2022 Results
   Not discussed.
   Recommended Actions: CAHPS results will be sent out to the committee before next meeting.
   Follow- up: CAHPS 2022 Results presentation sent to committee members on 6/15/23.

7. Meeting time and location
   Discussed if potentially the third Thursday on a quarterly basis could be another option for the QIC members to attend onsite/in-person at 801 Gateway location. Also, working out the details if HPSM staff could attend remotely or not. QIC is a public-held meeting at HPSM location and if teleconferencing is potentially permitted at another public site, it must be posted and open to the public.

8. Adjournment: **next meeting June 22, 2023**

QUALITY IMPROVEMENT COMMITTEE MEETING

June 22, 2023, 6:00 p.m. – 7:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd.
South San Francisco CA 94080

Voting Committee Members	Specialty	Present (Yes or Excused)
Kenneth Tai, M.D.	PCP (Internal Medicine)	Excused
Jaime Chavarria, M.D.	PCP (Family Medicine)	Yes
Maria Osmena, M.D.	PCP (Pediatric)	Excused
Jeanette Aviles, M.D.	SMMC Physician (Internal Medicine)	Yes
Non-voting HPSM Members	**Title**	**Present (Yes or Excused)**
Chris Esguerra, M.D.	CMO (Psy)	Excused
Nicole Ford	QI Director	Yes
Richard Moore, M.D.	Sr. Medical Director (IM)	Yes
Miriam Sheinbein	Medical Director (FM)	By Remote
Marisa Cardarelli	Dental Benefits Manager	Excused
Talie Cloud	Population Health Specialist	Yes

1. Call to Order
   The meeting was called to order by Nicole Ford and Dr. Jeanette Aviles.

2. Public Comment/Communication
   No public comment or communication for discussion at this meeting.

3. Approval of Agenda
   Motion to approve. Approved by the QIC members.

4. Consent Agenda:
   4.1 QIC Minutes from March 15, 2023
   4.2 UMC Minutes from April 24, 2023
   4.3 CQC Minutes from May 22, 2023
   4.4 Dental Advisory Group minutes from Jan 20, 2023, Feb 17, 2023, Mar 17, 2023, Apr 21, 2023, May 19, 2023, and Jun 16, 2023
   Motion to approve. Approved by the QIC members.

5. Unfinished Business
   5.1 Approval of the 2022 QI Program Evaluation, 2023 QI Program Description and 2023 QI Work Plan
   Motion to approve. Approved by the QIC members.

6. Dental Services Update
   No presentation for this QIC Meeting; however, the presentation will be available to the committee. If there are any questions, Ms. Cardarelli will be available at the next QIC Meeting.
   Recommended Actions: Distribute Dental Services Update presentation to committee members prior to next meeting.
   Follow-up: Dental Services Update presentation provided to committee members on 9/14/23.

7. HEDIS/MCAS Results Measurement Year 2022

Health Effectiveness Data Information Set

- Performance metrics that assess the effectiveness and access/availability of care.
- Measured and reported annually: submitted mid-June for prior calendar year's membership and services.
- All submissions require passing NCQA audit prior to reporting.
- Compared across health plans nationally.
- Most measures based on claims, and pharmacy data (Administrative), some require the use of medical record review as well (Hybrid). Plans can also use supplemental data sources (laboratory, EMR, registry, and HIE data feeds) with auditor approval to measure evidence of care.

Benchmarks

- CareAdvantage Cal MediConnect (CMC): CMS core Quality Withhold measures; Can meet benchmark or gap improvement target to pass measure (10% improvement); moving CMS STARS for D-SNP starting MY2023/RY2024.
- Starting January 2023, transitioned to D-SNP that is under the STAR Program. Based on STAR ratings measurement, which includes cut points based on specific rates. Different STARs have different weights/measures, which are measured, and the Plan would receive the STAR rating based on performance.
- Medi-Cal: minimum performance level is the lower 50th percentile and high-performance level is the upper 90th percentile; based on prior year's HEDIS reporting from all NCQA's national Medicaid plans; DHCS requires plans to perform above MPL for a mandatory set of HEDIS measures.

  Comment from Ms. Ford where STARs, CMS uses the current year to set the cut rates.
  Comment from Dr. Aviles where the cut rates are not curved: Plans are not limited to how many STARs such as one, two, or three STARs?
  Comment from Ms. Ford where the cut points are based on overall performance by the Plan. The maximum STARs = 5.

HEDIS MY2022/RY2023

- 3 submissions to NCQA: 1) CareAdvantage Cal MediConnect, 2) Medi-Cal State, and 3) Medi-Cal NCQA Accreditation.
- Added 4 new supplemental data sources in addition to established EMR feeds from large volume PCPs: EMR feeds from PAMF/Sutter and Dignity Health; Encounters from BHRS; matrix in-home assessments data files.
- Collected and reviewed 4,000 medical records.
- Reused charts collected from Risk Adjustment Project.
- Vendor for data analytics and medical record abstraction, HPSM staffed oversight and project management.

  Comment from Dr. Chavarria where the collected medical records are HPSM patients? Ms. Ford: Yes, these are EMR feeds for HPSM patients.
  Comment from Dr. Aviles if the EMR feeds are based on eligibility from another provider on HPSM patients? Ms. Ford: HPSM would submit eligibility in terms of their assigned members. Providers are billing HPSM for the services.

MY2022/RY2023 Results Summary

- CareAdvantage CMC: passed 2 of 3 HEDIS quality withhold measures.
- Medi-Cal: 3 measures above HPL; Childhood Immunization Status; Immunizations for Adolescents; Prenatal and Postpartum Care; 1 measure below MPL (Well Child Visits in the 1st 30 months of life; 6 or more well-child visits in 1st 15 months of life).

MY2021/RY2022 MCAS – MPL

- Controlling high blood pressure
- Comprehensive diabetes care – HbA1c poor control
- Childhood immunization status
- Immunizations for adolescents
- Breast cancer screening
- Cervical cancer screening
- Chlamydia screening in women
- Prenatal and postpartum care – postpartum care
- Prenatal and postpartum care – timeliness of prenatal care
- Child and adolescent well care visits
- Lead screening in children
- Well child visits in the 1st 30 months of life (6 or more well child visits in 1st 15 months of life and 2 or more well child visits in 15 to 30 months of life).

  Comment from Dr. Aviles where there was an increase in cervical cancer screening rate. Comment from Ms. Ford where this was one of the measures under MPL last year, which HPSM is now above MPL. Note: several measures are reported but we are not held accountable by the MPL. Colorectal Cancer Screening was added to the Medicaid LOB (administrative measure and not a hybrid measure), which will be reported to the State. Colorectal Cancer Screening reporting for Medicare allows for the hybrid methodology, using medical records.

MY2022/RY2023 MCAS – no MPL

- Ambulatory care: emergency department visits per 1,000 member months
- Follow up care for children prescribed attention deficit/hyperactivity disorder medications – initiation phase.
- Follow up care for children prescribed attention deficit/hyperactivity disorder medications – continuation and maintenance phase.
- Plan All Cause Readmissions (observed rate (lower is better) and observed to expected ratio)
- Metabolic monitoring for children and adolescents on Antipsychotics – blood glucose and cholesterol testing.
- Asthma Medication Ratio
- Antidepressant Medication Management – effective acute phase treatment
- Antidepressant Medication Management – effective continuation phase treatment
- Diabetes Screening for people with Schizophrenia or bipolar disorder who are using Antipsychotic medications.
- Colorectal cancer screening

MY2021/RY2022 MCAS – no MPL

- Follow up after emergency department visit for alcohol and other drug abuse or dependence (7 day follow up and 30 day follow up).
- Follow up after emergency department visit for mental illness (7 day follow and 30 day follow up).
- Adults access to preventive ambulatory health services
- Pharmacotherapy for Opioid Use Disorder
- Prenatal Immunization status
- Postpartum depression screening and follow up (screening and follow up)
- Depression screening and follow up for adolescents and adults (screening and follow up)
- Depression remission or response for adolescents and adults
- Developmental screening (ages 1 – 3 yrs.)
- Contraceptive care: postpartum women ages 15 – 44 most or moderate effective contraception – 60 days.
- Contraceptive care: all women ages 15 – 44 most or moderately effective contraception
- Topical fluoride for children (1 – 20 yrs.)
- Dental or oral health services
- Dental services
- Oral health services

Comment from Dr. Chavarria if there is a follow up with a behaviorist within the 7 to 30 days of the ED visit/discharge?
Comment from Ms. Ford, yes for the Medi-Cal LOB. The services are billed directly to the State where the data would not be available to HPSM. BHRS is now providing all encounter data to HPSM, which allows HPSM to use the data for reporting purposes.
Comment from Dr. Sheinbein where some of the non-NCQA measures (part of the CMS core sets for Topical fluoride for children/dental or oral health services/dental services/oral health services) report directly to the State. Note: these are currently on the proposed list to move from no MPL for 2024 reporting.
Comments from Drs. Aviles and Sheinbein for contraceptive care – moderately effective contraception. What is the definition of the eligible age population that are required to be on contraceptive care?
Comment from Dr. Sheinbein where the measures and/or methodology are due to CMS where it is administrative, which does not specify the calculation of the MPL. In addition, follow up in the Topical Fluoride for children for DQA measure 1 to 21 years old.
Comment from Ms. Cloud where most or moderately effective if oral birth control or the implant is highly effective. Based on studies, this measure would assume that all people will want/need birth control.
Comment from Ms. Ford to provide the specific benchmark and the slide deck to the group.

Well Child Visits in 1st 30 months of life.

- The percentage of members who had the following number of well child visits with a PCP. Two rates are reported: W15: 6 or more well child visits in the 1st 15 months. Children who turned 15 months old during the measurement year; W30: 2 or more well child

visits. Age 15 months – 30 months. Children who turned 30 months old during the measurement year.

- Area of focus for 2023: MC benchmark P4P payment measure; continue to investigate potential data gaps and procure additional data capture; engaging family health services to assist with member barriers to visits; exploring a member incentive; DHCS Clinical PIP topic -reducing disparity for the Hispanic/Latino population.

W30 Race/Ethnicity Stratification

- American Indian & Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian & Other Pacific Islander
- White
- Some Other Race
- Unknown
- Two or More Races
- Total

Comment from Dr. Aviles in looking at the W30 Race/Ethnicity Stratification, shows the Hispanic population is worse in their early days whereas the Black population is showing the opposite? For this population, are they covered in other ways?
Comment from Ms. Cloud that within the County for the Black-Identifying population, only 100 births this past year, which is relatively consistent. Overall, the County experiences similar proportions of racial ethnicity of live births/ children. Fifty percent of HPSM membership is under 21 years of age.
Comment from Ms. Ford the Black-identifying population is showing better with a smaller population (9 in W15). Note: there are 900 – 1,000 live births and for this measurement year, around 1,200 across the Plan.
Comment from Dr. Chavarria would this be beneficial to have a record of where the population resides? HPSM could provide the data.
Comment from Dr. Moore that this is based on the National Census for 2023, white population = 48, Asian population = 29, and Black African American = 2.3 in San Mateo County.

Cervical Cancer Screening

- Percentage of women ages 21 – 64 with Medi-Cal who received a pap test in the last 3 years, or women ages 30 – 64 had cervical high risk human papillomavirus testing performed or cervical cytology co-testing within the last 5 years.
- Areas of focus for 2023: general health promotion to members; MC benchmark P4P payment measure; targeted member outreach to Black identifying members and/or members with developmental disabilities and managed GGRC.

Comments from Dr. Aviles if Redetermination will affect the membership of the adult population for those not receiving a screening with the Redetermination process issue?
Comment from Ms. Ford there will be an overall decrease in adult membership for this measurement if current population loose Medi-Cal coverage. Note: in 2024, the undocumented who are eligible for Medi-Cal (ACE population) will increase the eligible

population for this measure. HPSM is also targeting the Black Identifying population and the developmentally disabled population is managed by Golden Gate Regional Center.

Breast Cancer Screening

- The percentage of women 50 – 74 years of age who had a mammogram to screen for breast cancer.
- Performance improvement project in 2022 with direct member outreach calls to Black women who had not had a screening in the last 2 years to decrease the disparity among Black/African American Medi-Cal members.

  Comment from Dr. Aviles for Dr. Chavarria if Ravenswood is targeting mammograms annually or yearly? Yes, annually. Also, captures in the data for two years and targets two years for metric.
  Comment from Ms. Cloud where Ravenswood used to have a Cervical Cancer Screening Program Assistant handling outreach call, but the person left the program.
  Comment from Dr. Chavarria that there is a dedicated staff at Ravenswood.
  Comment from Dr. Moore if the age has dropped to 40 years of age?
  Comment from Dr. Sheinbein that USPSTF has not officially changed their guidelines, which are in the final draft.

Diabetes Care

- The percentage of CMC members 18 – 75 years of age with diabetes who had each of the following tests or results with the measurement year: HbA1C. 9% HbA1C, 8%; eye exam; BP, 140/90
- P4P incentives to PCPs for ensuring that diabetic members have their HbA1C monitored & achieve control.
- Leveraging other encounters with CMC members to collect & monitor HbA1C and BP through home-based assessments and HomeAdvantage programs.

  Comment from Dr. Aviles what were the number of recorded patients in 2022 – smaller or larger than 2021 or 2023?
  Comment from Ms. Ford where HPSM would collect sample measures because of hybrid measure. We would capture diabetes diagnosis for the population by looking at two separate dates of service with diabetes diagnosis over the last two years.
  Comment from Dr. Moore there will be a Provider newsletter and mailings to members on ways to improve their diabetes through Medication Adherence (90-day supply).
  Comment from Dr. Chavarria where there are opportunities for pharmacies/doctors to remind patients their refills are available for pick up.

Controlling High Blood pressure

- The percentage of members 18 – 85 years of age with hypertension whose blood pressure was controlled during the measurement year, using latest BP value in the measurement year.
- CMS Core Measure Benchmark = 71% starting RY2021 (56% prior years)
- Measure rotated: 2020 measured rated, 2019 rate reported for 2020 submission due to COVID19 response.
- With RY2021, BP measured with digital monitor by member can be used. Home digital BP monitors CMC formulary in 2021, and Medi-Cal Rx June 1, 2022.

Comment from Dr. Aviles where we only work with two pharmacies for blood pressure cuffs due to the complexity with billing issues in NDC codes for all LOB.

CBP Race/Ethnicity Stratification

- American Indian & Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian & Other Pacific Islander
- White
- Some Other Race
- Unknown
- Two or More Races
- Total

Follow up after hospitalization for mental illness.

- Percentage of CareAdvantage CMC mental health discharges with subsequent outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner.
- CMS Core Measure Benchmark for a follow up within 30 days = 56%
- Worked with BHRS to report qualifying follow up services to include in HEDIs reporting.

Comment from Dr. Aviles if telehealth services would count for encounter data?
Comment from Ms. Ford yes, but not with the billing piece due to CMS does not count.

Plan all Cause Readmissions

- Percentage of acute inpatient and observation stays with an unplanned acute inpatient and observation stay for any diagnosis within 30 days of the initial hospital discharge for members ages 18 – 64 for Medi-Cal or 18 + for CMC.
- Lower rates are better.
- Measure changes for RY2020: admissions from outlier members (4+ admissions) excluded.
- CMS Core Measure Benchmark = observed to expected ratio (O/E), 1.0 (risk adjusted).

CMS STAR Ratings Estimate

- Medication Review
- Pain Assessment
- HbA1c control < 8.0%
- Statin Therapy Total
- Medication Reconciliation (a significant decrease from prior year – hybrid measure). Recently changed vendor for our HomeAdvantage Program in February 2022. The new vendor is not reporting Medication Reconciliation with post-discharge care and/or is not sending us the data, which is possibly the reason for the decrease in our rates for this measure

<u>Recommend Actions</u>: Continue with planned interventions in areas of focus for 2023.

8. Adjournment: **next meeting September 21, 2023**

QUALITY IMPROVEMENT COMMITTEE MEETING

September 21, 2023, 6:00 p.m. – 7:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd.
South San Francisco CA 94080

Voting Committee Members	Specialty	Present (Yes or Excused)
Kenneth Tai, M.D.	PCP (Internal Medicine)	Yes
Jaime Chavarria, M.D.	PCP (Family Medicine)	Yes
Maria Osmena, M.D.	PCP (Pediatric)	Excused
Jeanette Aviles, M.D.	SMMC Physician (Internal Medicine)	Yes
Non-voting HPSM Members	**Title**	**Present (Yes or Excused)**
Nicole Ford	QI Director	Yes
Miriam Sheinbein	Medical Director (Family Medicine)	Yes
Janet Davidson	Utilization Review Management Manager	Yes
Talie Cloud	Population Health Specialist	Yes
Samareen Shami	Population Health Manager	Yes

1. Call to Order
   The meeting was called to order by Dr. Kenneth Tai.

2. Public Comment/Communication
   No public comment or communication for discussion at this meeting.

3. Approval of Agenda
   Motion to approve. Approved by the QIHEC members.

4. Consent Agenda:
   4.1 QIHEC Minutes from June 22, 2023
   4.2 UMC Minutes from July 24, 2023
   4.3 CQC Minutes from August 21, 2023
   4.4 Dental Advisory Group minutes from
   - June 16, 2023
   - July 21, 2023
   - August 18, 2023
   - September 15, 2023

   Motion to approve. Approved by the QIHEC members.

5. QIHEC Reporting Structure
   Ms. Ford reported there has been a change in the naming structure to include a more in-depth focus on the health equity side for quality measurement and review. In addition, the reporting structure for other sub-committees (Utilization Management/Dental Advisory/Pharmacy & Therapeutics/CCS Clinical Advisory/Peer Review/Physician Advisory) will report to QIHEC.
   Recommended Actions: None.

6. Clinical Practice Guidelines Review for 2023

The guidelines were updated to include new additions and links from 2013 recommendations. The requirement for having the guidelines is not specific to comprehensive clinical practice; however, HPSM is required to maintain a list of evidence-based guidelines. There is valuable and helpful to have specific guidelines for some of these important metrics, such as for billing, claims, documentation purposes. The guidelines are focused on conditions based on metrics.

- Asthma
- Behavioral Health
- Cancer Screening
- Cardiovascular and Circulatory Guidelines (new)
- Chronic Pain and Prescribing Controlled Substances (new)
- COPD (new)
- Dental (new)
- Diabetes
- Gastroenterology (new)
- Gender Affirming Care (new)
- Immunization Schedules
- Obesity
- Pediatrics
- STD and Other Infectious Disease Guidelines
- Tobacco Cessation Resources (new)

Comment from Dr. Tai where there could be providers who will use the clinical evidenced-based guidelines as resources. NEMS uses UpToDate for resources. The guidelines would be beneficial for new providers coming into practice as part of their orientation for resource-use to be helpful.
Comment from Dr. Chavarria where Epoch and UpToDate highlight these care gaps; however, the guidelines are also useful resource tools.
Comment from Dr. Aviles if the guidelines will be available on the website as well as available to the external network? Comment from Dr. Sheinbein - Search/navigate under HPSM Provider Network for Clinical Guidelines 2023.

Approval of Clinical Practice Guidelines Review.
Motion to approve. Approved by the QIHEC members.
Recommended Actions: Post approved clinical practice guidelines to HPSM external website for use by network providers.

7. Prior Authorization List Review

Ms. Davidson reported one of the goals is to improve the prior authorization experience for providers. The goal is to improve and enhance the prior authorization list capability on the HPSM website by researching other commercial plans like HPSM. There was inspiration with the S.F. Health Plan website with their search tool capabilities. HPSM Marketing Manager will be working with the vendor who helped create the SFHP website to mirror with HPSM website. The focus is to give providers the opportunity to enter multiple codes at 1X to search for additional information on prior authorization process. The PA list will be linked to the Provider Portal as well. For NCQA requirement, there will be a member page available for members' access as well. Lastly, we appreciate feedback from this committee and their staff.

Recommended Actions: None currently. HPSM will continue to seek feedback and guidance from the committee to improve usability of prior authorization lists.

8. Population Needs Assessment (PNA) Results 2023 - Our goals today.
    - Present on HPSM Member demographics and broad focus areas.
    - Characterize disparities and social determinants of health for our member are facing.
    - Get feedback and input from QIHEC members on clinical considerations that may help us better understand our membership characteristics.
    - What is the PNA (goals)
        - Identify member health needs and health disparities.
        - Assess health outcomes and resources available.
        - Evaluate the health experiences of HPSM subpopulations.
        - Implement targeted strategies for PHM program/services gaps through an Action Plan.
        - Combine requirements of PHM 2.
    - Demographics – 2022 HPSM Membership (173,439)
    - The bulk of the focus is Medi-Cal LOB.
    - Race
        - Largest populations are Hispanic/Latino, Other and Asian or PI.
        - Little shift in racial makeup since 2019.
        - Now, we have some de-aggregated racial data for the Asian and Pacific Islander subgroup.
        - Among Asian and PI subgroup, Filipino and Chinese ae the largest groups.
    - Language
        - Medi-Cal represents 81% of HPSM's member population or 141,291 people.
        - Threshold languages * are Spanish, Chinese (Mandarin/Cantonese), and Tagalog.
        - 63,691 (45.1%) members prefer a language other than English.
        - *Threshold languages have certain requirements for language assistance services.
    - Age
        - Shift in population where largest age group is now 22 – 64.
        - Steady increase in overall membership to 141,000 from 124,000 last year. Partly due to the ACE eligibility shift to Medi-Cal.
    - Medi-Cal Subpopulations Assessed
        - Perinatal Health
        - Child and Youth Health
        - Adult Preventative Health
        - Chronic Conditions
        - Members with LEP
        - SDOH
        - Behavioral Health
        - Health Disparities
    - Social Determinants of Health (HPSM Medi-Cal Members 2022)
        - Social determinants of health (SDOH) are the social and economic conditions of a community that influence the quality and length of life of its residents.
        - 3.31% of all HPSM Medi-Cal members had 1 or more SDOH claims.
        - There was a 43% increase in SDOH claims from 2021 to 2022.
        - Most common SDOH category is housing and economic circumstances with 3,498 members (61% of those with SDOH claims).

Comment from Dr. Tai if this is through a survey and/or a focus group? The majority are Asian/Hispanic/Caucasian/PI/Black? If members don't fit into a specific category → Other? The data is from the State; however, is the data internally from HPSM HIM team?
Comment from Ms. Ford where the application has ethnicity and a subgroup of origination as a separate field. HPSM cannot track multiple races. Also, receiving race/ethnicity data from CMS and from providers for the dual's eligible population. The State's data overrides the other data from other sources.
Comment from Ms. Cloud where there has been an improvement in receiving additional data while working with our internal teams. Other health plans have requested additional data from DHCS for better improvement and tracking purposes.
Comment from Dr. Chavarria where does the race data come from - State? Comment from Ms. Shami – from the State and it is based on member selection on the reported data.
Comment from Dr. Chavarria when did adults transition from ACE to Medi-Cal? Comment from Dr. Sheinbein - May 20, 2022. Some members will remain in the ACE program due to the requirements, which is slightly different from ACE and Medi-Cal.
Comment from Ms. Shami is through claims data (demographic data). In addition, we have incorporated CAHPS surveys, member experience work, disparity data, quality metrics, etc. Our HIM team updates the health risk stratification report. Many of the codes under SDOH are recommended by DHCS to be the top codes for HPSM to verify.
Comment from Dr. Sheinbein if these categories are comprehensive and are these broadly included in SDOH or being captured from claims? Comment from Ms. Shami - captured from claims. The guidance is from DHCS.
Comment from Dr. Aviles if NEMS is doing SDOH assessments? Comment from Dr. Tai - Yes.

- ECM and CS Services (HPSM Medi-Cal Members 2022)
    - In 2022, 927 (.7%) unique members received ECM and/or CS services.
    - Housing Navigation (n=81) and Housing Tenancy and Sustaining Services (n=81) were the most utilized CS services.
- Who is accessing services?
    - 50% are older adults or people with disabilities.
    - English language speakers represent 55% of the overall MC population but 82% of members who receive CS or ECM services.
    - Services provided (CS = 88 members and ECM = 670 members) (Total = 927 members)
- What are Health Disparities?
    - Age
    - Gender
    - Social orientation
    - Race
    - Education
    - Disability status
    - Sex
    - Language
- Measuring Health Disparities
    - Review overall membership level data associated with metrics for chronic disease management and preventative care access.
    - Stratify member data by demographics variables to identify metric rates for subpopulation.

    - Check statistical significance of metric rates for subgroups. Identify positive deviants and disparate subgroups.
    - Deep analysis of disparate subgroups to determine which characteristics impact across multiple variables and metrics.
    - Develop targeted action plan based on summary of findings by our PH team.
- Disparities Analysis (HPSM Medi-Cal Members 2022)
    - Some examples,
    - Black Identified population faces number of disparities across the board.
    - Black Identified population could have problems with access issue.
    - An overall snapshot to look at statistical analysis.
- Disparities Analysis Summary (HPSM Medi-Cal Members 2022)
    - Age (young adults (aged 17 to 21) and adults (aged 22 to 50) have significantly lower rate of PCP visitation).
    - Gender (the male subgroup has disproportionately low rates of well visits and diabetes care rates).
    - Race/Ethnicity (the Black Identifying subgroup experiences disparities in diabetes and well child visits. The Asian or Pacific Islander subgroup experiences disparities in blood pressure control. The Caucasian subgroup experiences a high volume of disparities, including in blood pressure control, diabetes management, cervical cancer screening, well visits, and child and adolescent immunizations).
    - Spoken Language (The English language population experiences the highest volume of disparities. Members speaking non-threshold languages experience disparities in cancer screenings, well visits, and perinatal care. Non-threshold language speaking subgroups with disparities include Korean, other/unknown, Portuguese, and Russian subgroups).
    - Disability Status (People with Disabilities experience a high volume of disparities including in cancer screening and chronic condition management for conditions like asthma, diabetes, and hypertension.
- Action Plan Items from Population Health Management
    - Perinatal Health
    - Child and Youth Health
    - Adult Preventative Health
    - Chronic Condition Management

Comment from Ms. Shami where the data/metrics are either HEDIS metrics and/or are tracked by HPSM to look at the demographics for any disparities. The focus of areas is age, race, sex, disability status, and language whereas no good data on gender or sexual orientation. Also, we do not have good data to code education data. We are working closely with providers and through our internal portal to gather gender, sexual orientation, and education data.
Comment from Dr. Tai where the English language population is identified as the highest volume of disparities?
Comment from Ms. Shami where the English language population does not identify the specific race/ethnicity/subgroup, but it is the overall preference in English. Perhaps during the Medi-Cal expansion, many members were placed in Medi-Cal and were not used to having health insurance. Members were not accessing their primary care.
Comment from Dr. Sheinbein if the Caucasian English-speaking subgroup experience most disparities? Comment from Ms. Shami - Yes, there are significant high disparities in this group. For example, The Persian group who speak English are placed in the Caucasian subgroup.

Recommended Actions: None.

9. Health Outcome Survey (HOS) Results
   To be shared and discussed with the committee at the next meeting if time permits.
   Recommended Actions: Distribute HOS results to committee if not presented at next meeting.

10. Adjournment: **next meeting December 21, 2023**

MEMORANDUM

AGENDA ITEM: 4.3

DATE: March 13, 2024

DATE: February 20, 2024

TO: San Mateo Health Commission

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

RE: Approval of 2024 Compliance Program; and 2024 Code of Conduct

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Recommendation

Approve HPSM Compliance Program document for 2024 and Code of Conduct document for 2024.

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 defines the practices and policies that demonstrate HPSM's compliance with state and federal health care compliance requirements.

The 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 with all applicable laws and regulations.

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 substantive changes for 2024, reflecting the termination of the delegated relationship between the Health Plan of San Mateo and Kaiser Foundation Health Plan. Other minor changes were made for clarification of processes and practices. The program document was reviewed and approved by the Compliance Committee on February 7, 2024. It is hereby submitted to the Commission for its annual review and approval.

Code of Conduct

The Code of Conduct had one substantive change for 2024, which is the inclusion of a requirement for staff to adhere to work-from-home (WFH) guidance provided by HPSM. The Code of Conduct was reviewed and approved by the Compliance Committee on February 7, 2024. 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.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF
2024 COMPLIANCE PROGRAM and
2024 CODE OF CONDUCT

RESOLUTION 2024 -

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; and the Code of Conduct serves as a guide for complying with HPSM's internal policies and procedures as well as with all applicable laws and regulations
C. These documents have been reviewed by the Compliance Committee and are submitted for Commission's review and approval for 2024.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves the attached 2024 Compliance Program and 2024 Code of Conduct documents for the Health Plan of San Mateo.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of March 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chair

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

INTRODUCTION

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

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

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

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

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

THE COMPLIANCE PROGRAM

This document addresses the fundamental elements of a compliance program. The Compliance Program establishes HPSM principles, standards, and Policies and Procedures regarding compliance with applicable laws and regulations, including those governing relationships among HPSM and federal and state regulatory agencies, participating providers, and Contractors. The Compliance Program is designed

to ensure operational accountability and that HPSM's operations and the practices of All Employees comply with applicable contractual requirements, ethical standards, and laws.

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

Key Elements of Compliance Program

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

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

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

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

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

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

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

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

APPLICABILITY

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

CODE of CONDUCT

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

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

to discuss the content of the Code of Conduct with Contractors under their immediate supervision during contract negotiations for the purpose of confirming the Contractors' understanding of the HPSM's Code of Conduct. Contractors are encouraged to disseminate copies of HPSM's Code of Conduct to their employees, agents, and subcontractors that furnish items or services to HPSM and/or its members.

Review and Implementation of Standards

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

Compliance with Policies and Procedures

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

Compliance Policies and Procedures include the following:

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

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

Familiarity with Identified Standards

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

OVERSIGHT

Governing Body

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

Chief Government Affairs and Compliance Officer

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

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

The Chief Government Affairs and Compliance Officer:

- Holds a full-time leadership level position at HPSM and reports directly to HPSM's CEO.
- Receives training in compliance issues and/or procedures at least annually.

- Has the necessary authority to oversee compliance.
- Serves as the Medicare Compliance Officer, in addition to Compliance Officer duties for all HPSM programs
- Oversees compliance standards and procedures.
- Submits reports to the CEO, the Compliance Committee, and the Commission regarding compliance issues.
- Reports compliance issues involving the CEO directly to the Commission.

The Chief Government Affairs and Compliance Officer shall ensure that:

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

- Periodic reviews of the Participation Status Review process are completed with the Human Resources Department and other designated employees to ascertain that the process is conducted in accordance with HPSM Policies and Procedures.
- Compliance software and electronic files are maintained to support implementation of the Compliance Program.
- Each of the requirements of the Compliance Program has been substantially accomplished.

Compliance Committee

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

Managers / Supervisors

Managers/Supervisors must be available to discuss with each HPSM Employee under their direct supervision and every Contractor with whom they are the primary liaison:

- The content and procedures in this Compliance Program.
- The legal requirements applicable to Employees' and Contractors' job functions or contractual obligations, as applicable.
- That adherence to this Compliance Program is a condition of employment or contractual relationship.
- That HPSM shall take appropriate disciplinary action, including termination of employment or a Contractor's agreement with HPSM, for violation of the principles and requirements set forth in the Compliance Program and applicable law and regulations.

TRAINING

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

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

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

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

Compliance trainings for HPSM Employees include information regarding:

- Health Insurance Portability and Accountability Act (HIPAA)
- Fraud, waste, abuse, and neglect including the False Claims Act and the Fraud Enforcement and Recovery Act
- 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 Prescription Drug Benefit Manual (Chapter 9), 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 practices, and result in unnecessary cost to Federal and/or State health care programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

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 is any party that enters into a written arrangement, acceptable to the Centers for Medicare and Medicaid Services (CMS), with HPSM to provide administrative services or health care services to a Medicare beneficiary.

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

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

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

Governing Body means the San Mateo Health Commission.

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

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

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

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

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

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

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

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

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

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

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

excluded from participation in Federal and/or State health care programs based on a Mandatory Exclusion.

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

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

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

APPENDIX B

Compliance Policies and Procedures

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

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

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

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

Health Plan of San Mateo
Policy & Procedure Manual

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

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

Policy:

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

Scope

This procedure applies to (check all that apply):

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

Responsibility and Authority

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

Definitions

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

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

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

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

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

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

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

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

Procedure

1.0 Development of Code of Conduct

- 1.1 The Code of Conduct is a document which provides a statement of the principles and values by which HPSM operates.
- 1.2 The Code of Conduct is developed by the Chief Government Affairs and Compliance Officer with review and input from HPSM Senior Management and the Compliance Committee.
- 1.3 Approval of the initial development of the Code of Conduct is obtained from the San Mateo Health Commission (SMHC), HPSM's governing body.

2.0 Review of the Code of Conduct

- 2.1 The Code of Conduct is reviewed on an annual basis by the Compliance Committee, which includes HPSM's Leadership Team.
- 2.2 The full Code of Conduct is taken to the San Mateo Health Commission for review and approval on an annual basis.

3.0 Distribution of the Code of Conduct

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

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

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

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

3.1.2 Annual review:

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

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

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

3.2 San Mateo Health Commissioners

3.2.1 Newly appointed

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

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

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

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

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

3.2.2 Annual Review

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

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

3.3 Members of Committees of the San Mateo Health Commission

3.3.1 Newly appointed

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

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

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

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

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

3.3.2 Annual Review

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

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

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

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

3.4 FDRs, Vendors, and Subcontractors

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

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

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

3.4.2.2 shared it with their employees and any downstream entities.

Related Documentation

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

Attachments

- HPSM Code of Conduct
- Code of Conduct Acknowledgement Form

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

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

HEALTH PLAN of SAN MATEO

CODE OF CONDUCT

2024

Table of Contents

A Message from the Chief Executive Officer

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

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

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

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

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

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

Sincerely,

Pat Curran
Chief Executive Officer

Introduction

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

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

Our Mission

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

Our Vision

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

Our Values

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

Commitments

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

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

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

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

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

Code of Conduct

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

1. Privacy and Confidentiality

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

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

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

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

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

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

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

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

2. Security of Electronic Information

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

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

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

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

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

2.6. Transmit electronic confidential information securely in encrypted form.

3. Workplace Conduct

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

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

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

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

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

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

4. Use of Social Media

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

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

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

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

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

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

5. Adhering to Laws and Regulations

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

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

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

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

5.5. Avoid inappropriate discussions regarding business issues.

6. Safety

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

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

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

7. Conflict of Interest

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

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

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

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

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

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

8. Protecting Assets

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

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

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

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

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

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

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

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

9. Participating in the Compliance Program

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

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. Committee Member Responsibilities

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

MEMORANDUM

AGENDA ITEM: 4.4

DATE: March 13, 2024

DATE: February 20, 2024

TO: San Mateo Health Commission

FROM: Pat Curran, Chief Executive Officer
Ian Johansson, Chief Compliance Officer

RE: Approval of Amendment to Agreement with Compliance Strategies

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Recommendation

Authorize the Chief Executive Officer to execute an amendment to the agreement with Compliance Strategies to provide Medicare audit and consulting services through December 31, 2024. This amendment increases the expenditure for services by $100,000.

Background

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

HPSM has not been audited by CMS since 2016, and recently transitioned from the Cal MediConnect (CMC) program to the Exclusively Aligned Enrollment (EAE) Dual-Eligible Special Needs Plan (EAE D-SNP) program in 2022. These factors create a heightened risk for a CMS audit, when it occurs, due to changes in regulatory requirements and a higher chance HPSM will be selected for audit in 2024. CMS audits are incredibly intensive activities, lasting approximately 10 weeks beginning to end. Compliance Strategies consulting helps ensure HPSM can respond to a CMS audit, accurately and timely.

Compliance Strategies is also providing HPSM with consulting services in the areas of model of care, grievances and appeals, and an audit of an HPSM vendor. To perform these services well, and to minimize burden on HPSM staff, Compliance Strategies services helps ensure compliance with CMS requirements and timely completion of required activities.

In November 2023, the Commission approved $445,000 for Medicare consulting services provided by Compliance Strategies. Work performed to-date has identified the need for additional support in several operational areas, necessitating an increase in the overall approved contract amount.

Fiscal Impact

The fiscal impact of this recommendation is an additional $100,000, for a total amount not to exceed $545,000. The increase of $100,000 will be used for additional support for operational areas related to Medicare gap analysis and mock audit work being performed by Compliance Strategies. As noted in the original approval recommendation from November 2023, HPSM will be conducting a request for proposal for Medicare consulting services later in 2024.

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF AMENDMENT TO AGREEMENT WITH COMPLIANCE STRATEGIES

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. HPSM has not been audited by CMS since 2016, and the change in the Medicare duals model requires significant changes to HPSM's Medicare operations;
B. HPSM has a higher chance of being selected by CMS for a Medicare compliance audit in 2024;
C. HPSM has operational support needs for Medicare in the areas of compliance, vendor oversight, grievances and appeals, and model of care; and
D. HPSM will pursue a standing Medicare operational support agreement through the RFP process at the conclusion of the approved agreement with Compliance Strategies.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission authorizes the Chief Executive Officer to execute an amendment to the agreement with Compliance Strategies for services through December 31, 2024; and
2. Approves the Compliance Strategies amendment for an increase of $100,000 for an amount not to exceed $545,000.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of March 2024 by the following votes:

AYES:
NOES:
ABSTAINED:
ABSENT:

_____
George Pon, Chair

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

MEMORANDUM

AGENDA ITEM:	**4.5**
DATE:	**March 13, 2024**

DATE: February 20, 2024

TO: San Mateo Health Commission

FROM: Pat Curran, Chief Executive Officer
Amy Scribner, Chief Health Officer
Leilani Llorente-San Gabriel , Manager, Clinical Oversight and Monitoring

RE: Amendment to Agreement with Independent Living Systems (ILS)

Recommendation

Authorize the Chief Executive Officer to execute an amendment to the agreement with Independent Living Systems (ILS), increasing the amount by $360, 000 for a total amount not to exceed of $11, 000,000. The agreement term remains the same, October 1, 2017, through March 31, 2024.

Background and Discussion

HPSM has contracted with ILS since October 2017 to conduct Health Risk Assessments (HRAs) and Individualized Care Plans (ICPs) for members of CareAdvantage Cal MediConnect (CA CMC) and Seniors and Persons with Disabilities receiving Medi-Cal services until December 31, 2022. Effective January 1, 2023, HPSM transitioned to a dual eligible special needs plan or D-SNP plan where HRAs and ICPs continue to be a requirement under CMS.

The HRA is a survey used to identify and stratify member needs, facilitate program referrals, and inform the member's ICP. These activities are conducted when Care Advantage members enroll in HPSM and annually thereafter and are primarily telephonic. All assessment findings and referrals are sent to HPSM's Integrated Care Management team for any needed follow-up.

As part of HPSM's evolving comprehensive, whole person care management requirements under CMS's Medicare Part C and Star Ratings as well as the state's CalAIM program, HPSM initiated the transition of Health Risk Assessments and Individualized Care Planning from ILS to in-plan operations. Effective January 1, 2024, HPSM launched Care Plan 2.0 (CP 2.0) to bring these services in-house. Moving away from outsourcing to in-plan operations enables HPSM to leverage real-time data to optimize outreach and care planning efforts while creating a more seamless experience for members through assessment, development, and maintenance of their care plans.

These additional funds will ensure a seamless transition, with ILS maintaining appropriate staffing to complete contract close out of all deliverables and requirements between January 1, 2024 – March 31, 2024. Beginning April 1, 2024, HPSM will be solely responsible for the entire end to end process.

Fiscal Impact

This amendment increases the agreement by $360,000 for transition, a total amount of the seven year contract not to exceed of $11, 000,000 until the end of the agreement on March 31, 2024.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF AN AMENDMENT TO AGREEMENT
WITH INDEPENDENT LIVING SYSTEMS

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has contracted with Independent Living Systems (ILS) to provide Health Risk Assessment (HRAs) and Individualized Care Plan (ICPs) services for many HPSM members since October 2017;
B. ILS has demonstrated effective telephonic case management capabilities to identify potential and unmet member needs; and
C. ILS as a partner to help HPSM meet quality and performance measures for Medicare Advantage Part C and Part D ratings as well as CalAIM initiatives and services.
D. HPSM has implemented a transition plan which moves Health Risk Assessments and Individualized Care Planning to be done in-plan by HPSM staff starting January 1, 2024, and transitioning entirely by April 1, 2024.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves an amendment to the agreement with Independent Living Systems, increasing the agreement amount by $360,000 for a total amount not to exceed $11, 000, 000, until the end of the agreement through March 31, 2024;
2. Authorizes the Chief Executive Officer to execute said amendment.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of March 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

MEMORANDUM

AGENDA ITEM: 4.6

DATE: March 13, 2024

DATE: March 6, 2024

TO: San Mateo Health Commission

FROM: Pat Curran, Chief Executive Officer
Trent Ehrgood, Chief Financial Officer

RE: Agreement with County of San Mateo dba San Mateo County Health for Rate Range Intergovernmental Transfer (IGT) Funding for Calendar Year 2022.

Recommendation

Approve an agreement with San Mateo County Health to provide additional funding related to IGTs for Calendar Year 2022.

Background and Discussion

Federal Medicaid law allows local public entities such as counties to transfer permissible public funds to the State Medicaid agency (the Department of Health Care Services) to be used as the nonfederal share of Medicaid expenditures, which are then eligible for federal matching funds. San Mateo County has used this mechanism to increase funding for San Mateo Medical Center (SMMC) and San Mateo County Health for many years. County funds transferred to the State have funded the nonfederal share of Medi-Cal managed care capitation payment increases paid by the State to HPSM. The federal Medicaid program matches these funds, and the entire amount is paid to HPSM through increased Medi-Cal capitation. HPSM has then paid the entire amount to SMMC or the San Mateo Conty Health.

Since 2005, when San Mateo County and HPSM began implementing IGTs, the Commission has approved agreements with San Mateo Medical Center (SMMC) or San Mateo County Health to allow increased reimbursement to the hospital and San Mateo County Health.

Starting in 2017, the supplemental IGT provides for additional funding related to the Medi-Cal Managed Care Rate Ranges. The available IGT amount is the difference between the Medi-Cal managed care plan's contracted capitation rates and the top of the plan's actuarially sound rate range, as determined by the Department of Health Care Services.

This agreement provides for the payment to the San Mateo County Health of the total amount of the increased capitation due to the rate range IGT. In return, the San Mateo County Health agrees to remain a participating provider in the Plan, maintain current emergency room licensure status, maintain current surgery suites, and maintain the provision of mental health and substance use services and community-based services.

Fiscal Impact

Since this is a pass-through arrangement, there is no fiscal impact to HPSM. The term of the agreement is January 1, 2022, through December 31, 2022, which is the rating period for which the funds are derived from. This will be a new agreement for the 2022 rating period, instead of amending the older agreement, which has been the case in recent years.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF AGREEMENT WITH SAN MATEO COUNTY HEALTH RELATED TO MEDI-CAL MANAGED CARE RATE RANGES FOR THE CY 2022 INTERGOVERNMENTAL TRANSFER FUNDING

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. Since 2005, the San Mateo Health Commission has approved participation in Intergovernmental Transfer (IGT) Funding with the federal government of matching funds paid to HPSM in order to increase payment to the San Mateo Medical Center (SMMC) or the San Mateo County Health;

B. This agreement related to the Base Rate IGT for CY 2022 will make provision for the payment to the County Health System of the total amount of the increased capitation due to the Medi-Cal Managed Care Rate Ranges IGT.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission authorizes the Chief Executive Officer to execute the agreement with San Mateo County Health for additional funding related to the Medi-Cal Managed Care Rate Ranges IGT for Calendar Year 2022.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of March 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

DRAFT

AGENDA ITEM: 4.7

DATE: January 10. 2023

SAN MATEO HEALTH COMMISSION
Meeting Minutes
January 10, 2024 – 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor Boardroom
South San Francisco, CA 94080

Commissioners Present:	Jeanette Aviles	Raymond Mueller
	Michael Callagy	George Pon, R. Ph., Chair
	David J. Canepa	Manuel Santamaria
	Si France, M.D.,	Kenneth Tai, M.D.
	Barbara Miao	Ligia Andrade Zuniga
Commissioners Absent:	Bill Graham, Vice-Chair	
Counsel:	Kristina Paszek	
Staff Presenting:	Pat Curran, Trent Ehrgood.	

1. **Call to order/roll call**
   The meeting was called to order at 12:30 p.m. by Commissioner Pon, Chair. A quorum was present.

2. **Public Comment**
   No public comments were made at this time.

3. **Approval of Agenda**
   Commissioner Aviles moved to approve the agenda as presented (Second: Zuniga) **M/S/P.**

4. **Approval of Consent Agenda**
   Commissioner Aviles moved to approve the consent agenda as presented (Second: Zuniga) **M/S/P.**

5. **Specific Discussion/Action Items**

   5.1 Election of Officers

   Mr. Curran introduced the election of the officers for 2024. Commissioner Pon and Commissioner Graham have served as Chair and Vice-Chair respectively each for one year and are eligible to continue for another one-year term.

   Commissioner Zuniga moved to elect George Pon as the Chair of the Commission; and, Bill Graham as the Vice-Chair of the Commission (Second: Santamaria). **M/S/P**.

The positions of Clerk and Assistant Clerk of the Commission are filled by non-commissioners.

Commissioner Zuniga moved to elect Corinne Burgess as Clerk of the Commission; and Michelle Heryford, Assistant Clerk of the Commission (Second: Miao). **M/S/P**

5.3 Approval of Revised HPSM Financial Reserve Policy

Mr. Curran introduced the recommendation of a revision to the HPSM Financial Reserve Policy. This has been reviewed at the Finance/Compliance Committee and is recommended for approval. The recommendation is to approve a one month Contingency Reserve as an additional layer in the Reserve Policy above the Stabilization Reserve, which was established in 2016 and consists of two months of operating expenses.

Mr. Curran reported that the Governor's budget was released earlier that day and by all indication reflects lean years to come. In preparation for potentially difficult financial years ahead, the recommendation of this additional contingency reserve is to give a buffer between the Department of Managed Health Care's (DMHC) Tangible Net Equity requirement, HPSM's self-determined Stabilization Reserve, and the uncommitted reserve amount to sustain short term reductions in reserve levels due to future operating losses. He reminded the commission of the recently approved $30M of reserves committed to the effort towards investments in our Primary Care initiatives that are currently being developed to provide support to our primary care providers and services. With our current strong reserves, and the future budget challenges, this is the right time to structure our reserves to prepare for leaner years to come and invest in our community.

Touching on the Strategic Plan that was approved by the Commission, Mr. Curran talked about HPSM's proactive approach of investing from our reserves to ensure long-term sustainability and to advance our mission by evaluating and pursuing opportunities to expand. This does not change the amount of reserves or mean that there is less available for us to do our work, and all approvals will continue to come to the commission as they do now.

He further explained that, in the future, staff will come back to the commission with strategic investments in our provider network, our community and other innovative programs to support members. He described some ideas regarding provider and community investments being developed by staff. Another reason for this focus is the new Department of Health Care Services (DHCS) contract which requires health plans to develop

a Community Investment Fund. Setting up this fund anticipates this requirement. We are working on various ideas and areas of focus to invest in the community. Mr. Curran further described how the plan will continue to look at how reserves will be allocated in the future.

Commissioner Aviles asked how much the state is expecting HPSM to place in the Community Investment Fund and if the losses will match the contingency amount. Mr. Curran stated the state requirement for community investment will be approximately 7.5% of annual net income and we would propose to invest far more that. As far as future plan losses are concerned, it is difficult to predict but historically losses have not approached the amount proposed in the Contingency Reserve in any one year or multiple years combined.

Commissioner Canepa asked what we can expect in the coming years, as there has been quite a swing over the past several years in losses and surpluses and reserve levels. Mr. Curran stated that the next three to four years are likely to be challenging for the state. Discussion ensued on the calculations and the amounts within the reserve categories. Mr. Ehrgood noted that having just received the rates from DHCS we now know what the revenue side is and now will be evaluating what we project our health care costs will be. Discussion moved to where the reserve funds are held.

Commissioner France moved approval of the Revised Reserve Policy to add the Contingency Reserve equal to one month operating expenses. (Second: Tai). **M/S/P.**

6. **Report from Chief Executive Officer**

Mr. Curran introduced touched on:

- The Governor's budget has just been released and staff will be analyzing this, tracking the legislative process, and the budget items over the next few months.
- The commission will not have a regular meeting in February but will hold a study session regarding CalAIM.
- The Speier Foundation is working on the Baby Bonus Project, which is a guaranteed income concept for parents with newborns to evaluate the potential impact on infant health. We are in discussions with a broad stakeholder group about what role the health plan may play.

7. **Other Business**

No other business was discussed at this time.

8. **Closed Session**

The commission moved into closed session at 1

9. **Report out on Closed Session**

The commission reconvened at 1:58pm. County Deputy Attorney, Kristina Paszek reported that the commission did not take action in closed session.

10. Adjournment

The meeting was adjourned at 2:00 pm

Submitted by:
C. Burgess

C. Burgess, Clerk of the Commission

DRAFT

SAN MATEO HEALTH COMMISSION
Special Meeting Minutes
CalAIM Study Session
February 14, 2024 – 11:30 a.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor Boardroom
South San Francisco, CA 94080

Commissioners Present:	Jeanette Aviles	Manuel Santamaria
	Bill Graham, Vice-Chair	Kenneth Tai, M.D
	Raymond Mueller	Ligia Andrade Zuniga
	George Pon, R. Ph., Chair	
Commissioners Absent:	Michael Callagy, David J. Canepa, Si France, M.D. Barbara Miao	
Counsel:	Kristina Paszek	
Staff Presenting:	Amy Scribner, Samareen Shami, Courtney Sage, Kate Arsenault, Dayani Waas.	
Guests Presenting:	Mary McGrath, Mike Delrosario, Melissa Wagner.	

1. **Call to order/roll call**
   The meeting was called to order at 11:30 a.m. by Commissioner Pon, Chair. A quorum was present.

2. **Public Comment**
   A member of the public addressed the commission with concerns and issues related to privacy and HIPAA regulations. They noted that there have been situations that have been reported to the Compliance Department and the Grievances and Appeals Department. This member of the public stressed education on HIPAA policy for adherence to regulations.

Presentation:

The study session was covered by Amy Scribner, HPSM Chief Health Officer and other presenters. The presentation is attached to these minutes:

- **CalAIM Transformation Overview**
- **Population Needs Assessment and Equity Goals**
- **Enhance Care Management and Community Supports**
- **Spotlight on New Partnerships**

Adjournment

The meeting was adjourned at 2:30 pm

Submitted by:
C. Burgess

C. Burgess, Clerk of the Commission

Agenda for the Day

HealthPlan OF SAN MATEO
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- CalAIM Transformation Overview
- HPSM's Population Needs Assessment (PNA) and Health Equity Goals
- Enhanced Care Management (ECM) and Community Supports (CS)
- Spotlight on New Partnerships
  - Schools
  - Justice

CalAIM Transformation

ADDRESS PHYSICAL AND MENTAL HEALTH NEEDS

IMPROVE AND INTEGRATE CARE

BE A CATALYST FOR EQUITY AND JUSTICE

WORK TO BUILD A HEALTHIER STATE

Addressing Social Drivers of Health

What is Enhanced Care Management aka ECM?

- ECM is a Medi-Cal benefit to support comprehensive in person care management for enrollees with complex needs that most often engage several delivery systems to access care (e.g. primary and specialty care, dental, mental health, substance use disorder (SUD), and long-term services an/or supports (LTSS).

What are Community Supports?

- Community Supports are cost effective alternatives to traditional medical services or settings. Community Supports are intended to address social drivers of health for members. *Community Supports are optional for plans to implement.*

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite
7. Day Habilitation Programs
8. Nursing Facility Transition
9. Diversion to Assisted Living Facilities such as RCFE & Adult Residential Facilities
10. Personal Care/Homemaker Services (beyond IHSS)
11. Home Modifications
12. Meal/Medically Tailored Meals
13. Sobering Centers
14. Asthma Remediation

A Population Based Approach

Population Health Service

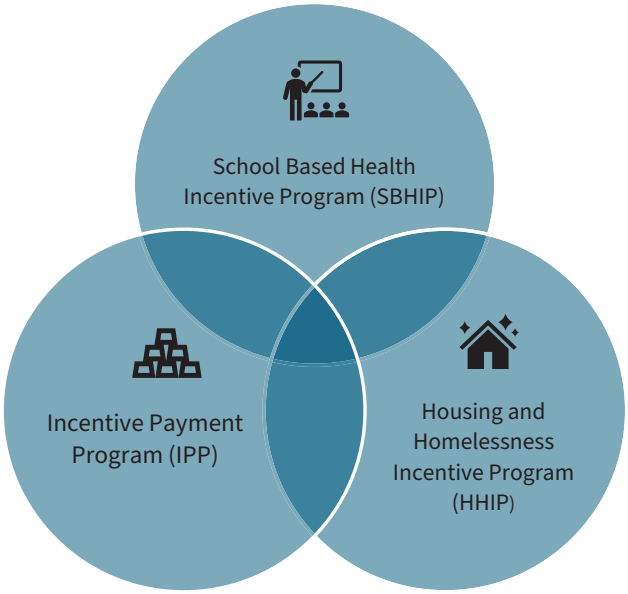
- Population Needs Assessment 2023
  - At least 1 shared goal with County Community Health Needs Assessment
- Risk stratification
  - Currently have locally, but statewide focus
- Transitional Care Services
  - Currently have locally, but statewide focus and services for all risk levels, not just high risk
- Focus on health outcomes/quality and health equity
- Community Health Workers
  - Potential HPSM workforce investment and deployment

Behavioral Health

- Criteria for Specialty Mental Health
- No Wrong Door and Co-occurring Treatment
- Behavioral Health in Schools
- Payment Reform
- Standardized Screening and Transition Tools
- MOU standardization

Infrastructure and Capacity Infusions

Incentives



SBHIP:

1. County Office of Education (CoE)
2. Redwood City School District
3. South San Francisco Unified

IPP:

1. Capacity Development ECM
2. Capacity Development CS
3. Data Sharing/Technology Infrastructure

HHIP:

1. Data Sharing
2. Street Medicine
3. Continuum of Care (CoC) partnership

Incentives (continued)

Providing Access and Transforming Health (PATH) and California Infrastructure, Transition, Expansion and Development (PATH) Initiatives	JI focus for County jails and systems
Capacity and Infrastructure Transition, Expansion and Development (CITED)	Payments directly from DHCS to potential and current ECM and CS providers

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And more….

Other Aspects

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New benefits	Doula, Community Health Worker (CHW), Dyadic Care, Transitional Care Services (TCS)
Health Equity focus – NCQA accreditation	
Statewide Managed Long-Term Care, Major Organ Transplant	HPSM has had these for several years
Integrated Care for Duals Members	CMC to D-SNP
Dental Integration with P4P	HPSM has special pilot status for integration and has gone above and beyond CalAIM dental

Build on success and focus on optimization

Successes

- 1,110 unique members have received an ECM service
- 508 unique members have received a Community Support
- 287 members have received both services
- Streamlining of processes to alleviate some administrative burden for providers
- ECM in Primary Care and CCS where members are already getting services
- More accurate capture of member conditions and needs
- Improvements in data sharing

Optimization

- Justice population integration
- PHM integration and deployment
- Optimization of ECM and expansion of CS
  - Asthma remediation?
  - Caregiver services expansion
  - Recuperative Care in Menlo Park?*
  - Housing investments?
- Improve partnerships and expand capacity
  - Convenings with ECM and CS providers
  - Cross County/Plan collaborations and data sharing
  - Pilots for ECM and CS

What is the PNA?

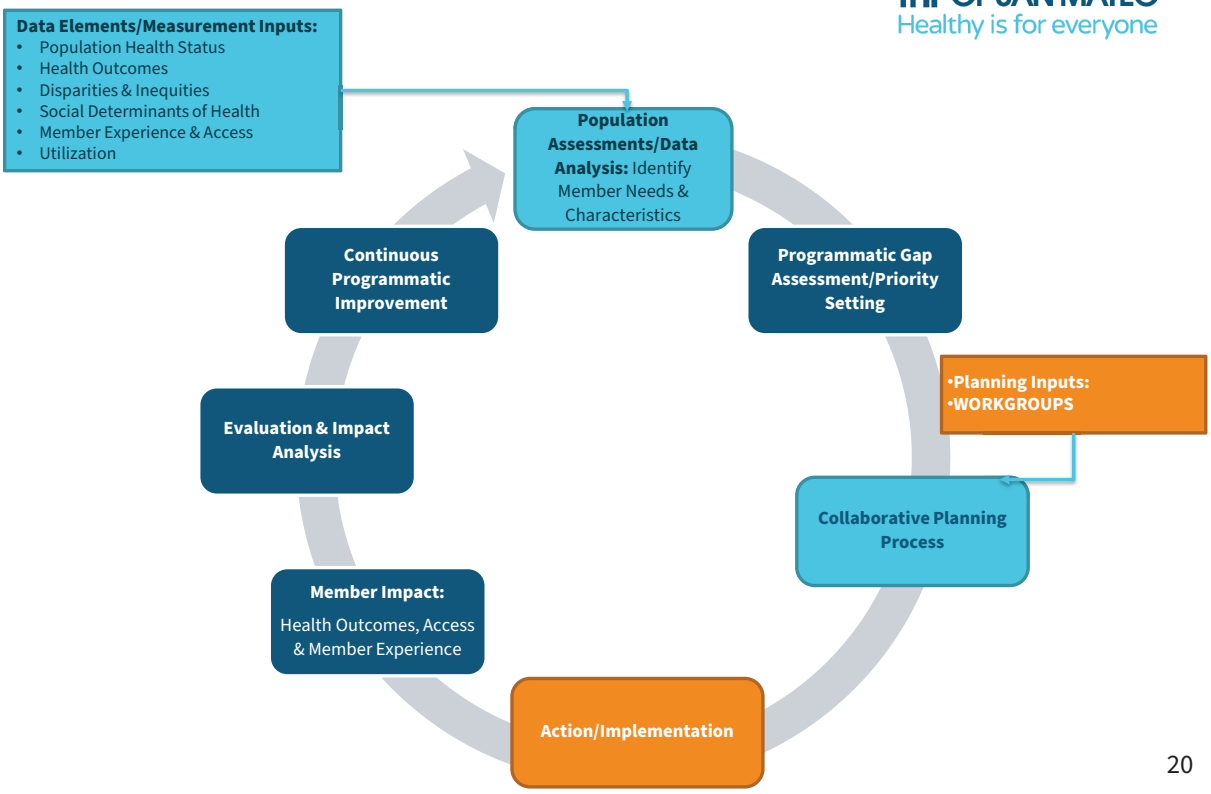
Timing:
Annual*

Today's Focus Population:
Medi-Cal

Goals

- **Identify** member health needs and health disparities
- **Assess** health outcomes and resources available
- **Evaluate** the health experiences of HPSM subpopulations
- **Implement** targeted strategies for PHM program/services gaps through an Action Plan
- **Guide** PHM strategy and collaboration with county on key focus areas
- *DHCS is implementing a change to the PNA to allow for more collaboration between the PNA and the CHA/CHIP process

PHM Strategy -How does the PNA inform our work?



Demographics

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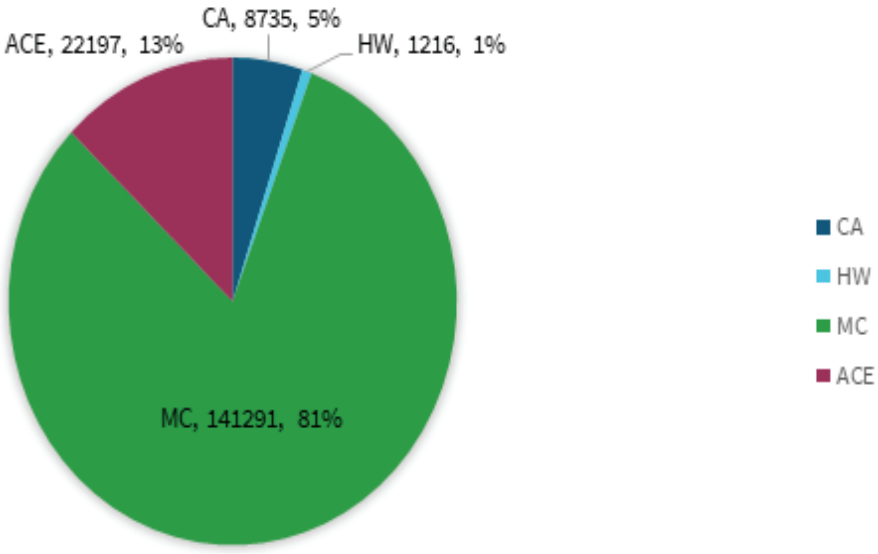
2022 HPSM Membership



Total Membership: 173,439

Race

Race/Ethnicity	Member Count	% of Membership
Hispanic	61906	44%
Other	25193	18%
Asian or Pacific Islander	24665	17%
Caucasian	16171	11%
Not Provided	9703	7%
Black	3328	2%
Native Hawaiian	230	0%
Alaskan Native or American Indian	195	0%
Grand Total	**141291**	**100.0%**

Race/Ethnicity	Member Count
Filipino	9596
Chinese	7986
Asian or Pacific Islander	3576
Asian Indian	1122
Vietnamese	873
Korean	500
Samoan	482
Japanese	345
Cambodian	107
Guamanian	40
Laotian	31
Amerasian	7
Total in AAPI Population	**24665**

- Largest populations are Hispanic/Latino, Other, and Asian or PI
- Little shift in racial makeup since 2019
- Now, we have some de-aggregated racial data for the Asian and Pacific Islander subgroup
- Among Asian and PI subgroup, Filipino and Chinese are the largest groups

Language

- Medi-Cal represents 81% of HPSM's member population or 141,291 people
- Threshold Languages* are Spanish, Chinese (Mandarin/Cantonese), and Tagalog
- 63,691 (45.1%) members prefer a language other than English.

Category	Language	Count	% of membership
Threshold Languages		**135902**	**96%**
	English	77600	55%
	Spanish	50668	36%
	Chinese (Mandarin/Cantonese)	5459	4%
	Tagalog	2175	2%
Non-threshold Languages		**5389**	**4%**
	Portuguese	1082	1%
	Arabic	1073	1%
	Russian	781	1%
	Vietnamese	420	0%
	Farsi	265	0%
	Unknown/Other	1089	1%
	<200 in Category	679	1%
Grand Total		**141291**	**100%**

**Threshold Languages have certain requirements for language assistance services*

Medi-Cal Subpopulation Analysis

Perinatal Health

Child and Youth Health

Adult Preventive Health

Chronic Conditions

Members with LEP

SDOH and Behavioral Health

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Perinatal Health

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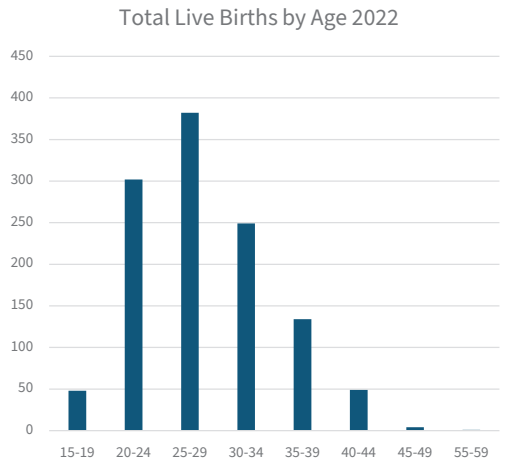
Perinatal Population

HPSM Medi-Cal Members, 2022

Total Live Births: 1169

1% of All Medi-Cal members



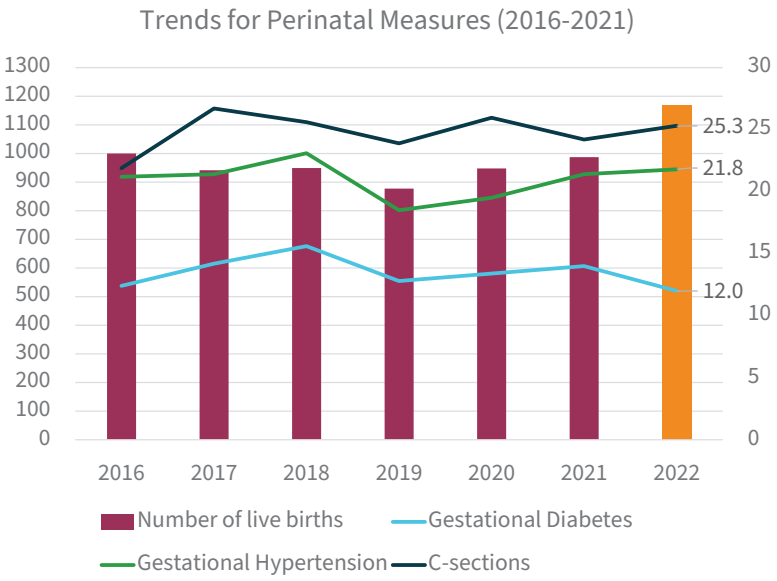
Race/Ethnicity	Member Count	Percentage of Total
HISPANIC	532	45.51%
OTHER	281	24.04%
NO VALID DATA REPORTED	179	15.31%
WHITE	56	4.79%
FILIPINO	40	3.42%
BLACK	26	2.22%
CHINESE	23	1.97%
ASIAN OR PACIFIC ISLANDER	16	1.37%
ASIAN INDIAN	3	0.26%
VIETNAMESE	3	0.26%
SAMOAN	3	0.26%
HAWAIIAN	2	0.17%
AMERASIAN	1	0.09%
CAMBODIAN	1	0.09%
Grand Total	**1169**	**100.00%**

Rate in teen pregnancy dropped from 6% to 4% in both 2021 and 2022

Most pregnant people are Hispanic, followed by White and Asian/PI. About 44% of pregnant people speak Spanish.

Perinatal Population

HPSM Medi-Cal Members, 2022



- Other identified disparities
  - Prenatal and Postpartum Care for our youngest members
  - Average gestational diabetes rate was 12%. This is a slight decrease from 14% in 2021. Members identifying as Filipino (20%) and Chinese (39%) have the highest rates.
  - C-section disparities

SDOH and CAL-AIM

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Social Determinants of Health

HPSM Medi-Cal Members, 2022

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- 3.31% of all HPSM Medi-Cal members had 1 or more SDOH claims.
- There was a 43% increase in SDOH claims from 2021 to 2022
- Most common SDOH category is housing and economic circumstances with 3498 members.

SDOH Category	Member Count	% of those with SDOH claims	% of MC Pop
Education & literacy	400	6.98%	0.28%
Occupational exposure to risk factors	5	0.09%	0.00%
Primary support group, including family circumstances	1074	18.73%	0.76%
Employment and unemployment	123	2.15%	0.09%
Housing and economic circumstances	**3498**	**61.00%**	2.48%
Psychosocial circumstances	402	7.01%	0.28%
Other psychosocial circumstances	40	0.70%	0.03%
Social environment	206	3.59%	0.15%
Upbringing	389	6.78%	0.28%

Health Disparities

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What are Health Disparities?

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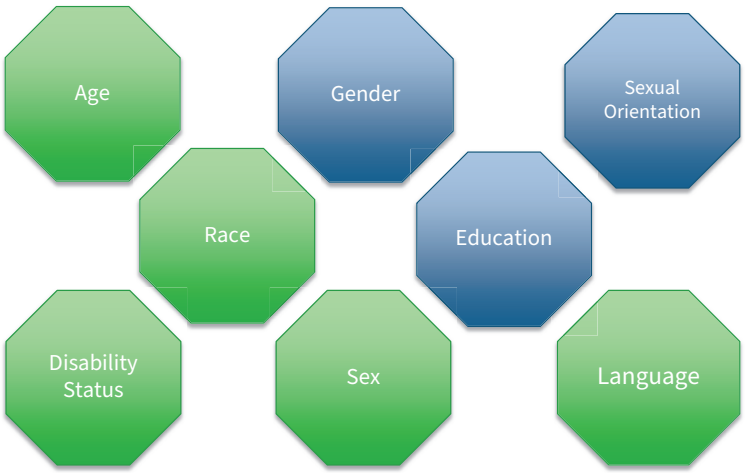

Measuring Health Disparities

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Step 1: Review overall membership level data associated with metrics for chronic disease management and preventive care access

Use overall population rate for each metric as comparison to identify disparities

Step 2: Stratify member data by demographic variables to identify metric rates for subpopulations

Age
Gender
Language
Race/ethnicity
Disability status

Step 3: Check statistical significance of metric rates for subgroups. Identify positive deviants and disparate subgroups.

Step 4: Deep analysis of disparate subgroups to determine which characteristics intersect across multiple variables and metrics.

Step 5: Develop targeted Action Plan based on summary of findings

Targeted Action Plan

- What do we know about factors that influence disparities in these subgroups? Explore key drivers.
- How might we impact these disparities? Identify interventions and strategies that target factors relevant to subgroup with disparity.

Disparities Analysis

HPSM Medi-Cal Members, 2022

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2022 HEDIS Disparities Data

Sub-Group	Chronic Condition Management						Adult Preventive Health			Child and Youth Health				Perinatal Health			
Age	AMR	CBP	HBD-A1C>9*	EED	KED	BPD	BCS	CCS	AAP	W30-2+	W30-6+	WCV	CIS-10	IMA	PDS-30 day FU	PND-30 day FU	PPC-PN	PPC-PP
0 to 2																		
3 to 6												67.84%						
7 to 11												52.51%						
12 to 16												54.26%						
17 to 21			80.95%	38.10%	19.67%				53.14%			35.02%			3.15%	2.27%	60.74%	
22 to 50		49.05%	45.59%	48.41%	47.19%	52.79%		49.13%	57.45%			28.09%						
51 to 64		56.61%	36.85%		60.70%	59.68%		43.48%	70.66%									
65 to 74			33.06%	68.01%	62.19%		39.9%		73.76%									
75+		41.60%							71.90%									
Gender	AMR	CBP	HBD-A1C	EED	KED	BPD	BCS	CCS	AAP	W30-2+	W30-6+	WCV	CIS-10	IMA	PDS-30 day FU	PND-30 day FU	PPC-PN	PPC-PP
Female		55.97%	37.05%	62.90%		60.28%			71.10%			52.54%						
Male		50.93%	41.31%	53.89%		53.63%			51.70%			49.78%						
Race/Ethnicity	AMR	CBP	HBD-A1C	EED	KED	BPD	BCS	CCS	AAP	W30-2+	W30-6+	WCV	CIS-10	IMA	PDS-30 day FU	PND-30 day FU	PPC-PN	PPC-PP
American Indian/Alaskan Native								33.33%										
Asian or Pacific Islander	87.25%	49.45%	34.42%			53.50%	48.25%								19.32%	27.63%		
Black					47.40%					40.74%		42.11%						
Caucasian		48.87%		46.37%	48.53%	49.43%		43.11%	59.24%			44.37%	31.25%	37.11%				73.02%
Hispanic		59.71%		62.27%	60.85%	62.66%	39.70%					52.19%	53.08%		6.50%	7.42%		
Native Hawaiian									52.42%									
Not Provided					50.40%		50.60%	50.23%	66.88%			43.81%						78.75%
Other Race/Ethnicity					52.97%		49.17%	50.68%	64.12%	59.86%								
Language	AMR	CBP	HBD-A1C	EED	KED	BPD	BCS	CCS	AAP	W30-2+	W30-6+	WCV	CIS-10	IMA	PDS-30 day FU	PND-30 day FU	PPC-PN	PPC-PP
THRESHOLD																		
Chinese			22.75%		67.83%		55.63%	56.41%	67.22%	88.24%		63.92%						
English		50.06%		53.11%	51.26%	50.86%	48.09%		61.16%	61.84%		47.95%	37.49%		17.24%	19.59%	79.87%	81.36%
Spanish		61.53%		64.98%	63.44%	65.29%	39.11%			73.73%		53.17%	57.14%		2.75%	2.80%	63.85%	90.48%
Tagalog		41.50%							72.04%									
NON-THRESHOLD			30.71%					43.67%		55.56%		48.30%	33.85%				48.48%	
Arabic			22.58%						66.60%									
Armenian																		
Bengali, Bangla																		
Burmese																		
Cambodian																		
Farsi																		
French																		
Gujarati																		
Hebrew																		
Hindi																		
Hmong																		
Ilocano																		
Indonesian																		
Italian																		
Japanese																		
Korean							22.22%	22.86%	45.31%									
Lao																		
Nepali																		
Other/Unknown								39.13%	74.31%									
Polish																		
Portuguese							34.65%	37.26%		52.38%								
Punjabi, Panjabi																		
Russian								32.20%	52.45%			36.59%						
Samoan																		
Sign Language																		
Thai																		
Tongan																		
Turkish																		
Urdu																		
Vietnamese			16.00%				60.66%	64.71%	72.20%									
Other Status	AMR	CBP	HBD-A1C	EED	KED	BPD	BCS	CCS	AAP	W30-2+	W30-6+	WCV	CIS-10	IMA	PDS-30 day FU	PND-30 day FU	PPC-PN	PPC-PP
People with Disabilities (PWD)	62.79%	46.59%		47.88%	42.61%	48.46%		35.15%	79.79%									
Older Adults		48.59%	34.23%	66.48%	60.94%		38.59%		73.94%									
People with SDOH Code			34.35%				55.82%		89.84%			74.00%					59.77%	
Overall Rate	77.76%	53.70%	39.06%	58.65%	56.96%	57.15%	44.87%	47.15%	62.17%	67.50%	40.37%	51.12%	46.88%	45.49%	11.00%	12.06%	72.23%	85.39%

PNA Action Plan

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Action Plan Areas from the PNA

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Perinatal Health

- Higher rates of gestational diabetes among API members
- Lower rates of prenatal and postpartum visits for teens
- Low rates of depression screenings among all pregnant people

Child and Youth Health

- Lower rates of compliance in well visits for black identifying members ages 3-21.
- Low rates of well visit compliance in the first 30 months of life

Adult Preventive Health

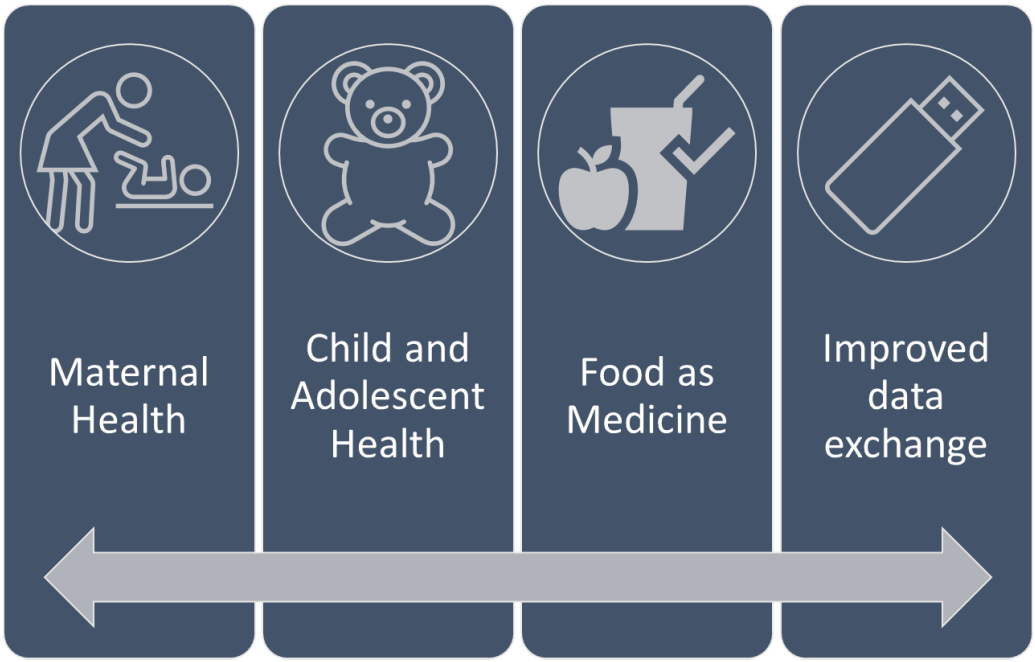
- Significant disparities in cervical cancer screening for people with disabilities
- Low cancer screening rates overall
- Only 62% of Adult HPSM MC members had a preventive visit in the past year .

Chronic Condition Management

- Increase in hypertension rate in overall population.
- Disparities in hypertension among those who speak Tagalog & those between 22-50 and 75+ years old.
- Lower A1C control in members between 17-21 and 22-50 .

County Collaborations on Findings

- Areas that we are currently collaborating with the county include:



What does required changes to the PNA mean for HPSM?

- HCS requires HPSM like all MCPs are required to work closely and collaborate with their counties in the CHA and CHIP process.
- HPSM's Pop Health team has already shared the PNA priority areas with CHA/CHIP leaders and there are many areas of alignment
- HPSM leaders are involved in 3 focus areas identified by the county which are SDOH, Behavioral Health and Access.
- As part of the PNA process, we will be required to meet regularly with the county and align around DHCS Bold Goals if possible.
- MCPs may need to commit resources – staffing, admin support etc.
- Another areas that will greatly benefit both sides is PHM Service

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Gale Carino, Director on Integrated Care

Dayani Waas, Program Manager, Integrated Services/SDOH

TC Nguyen, Program Manager, Community Care Partnerships

ECM Care Delivery

- ECM is a comprehensive care management service offered to our highest needs and most vulnerable members.
- ECM is provided through a person-centered approach to address the complex medical and social needs of our members such as housing and food insecurity.
- ECM provides a pathway for eligible members to access Community Supports, LTSS and other needed services to address their SDOH needs while supporting coordination of their medical and health care needs.
- ECM appoints a Lead Care Manager who works in collaboration with the member and their caregivers, family, and care team to coordinate a person-centered care plan to address the unique needs of the member.

ECM Populations of Focus (POF)

To be eligible for ECM, our Medi-Cal members must meet at least one of the populations of focus.

ECM Populations of Focus		Adults	Children & Youth
1a	Individuals Experiencing Homelessness: *Adults without Dependent Children/Youth Living with Them Experiencing Homelessness*	✓	
1b	Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization (*Formerly "High Utilizers"*)	✓	✓
3	Individuals with Serious Mental Health and/or SUD Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	✓
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	✓

ECM POF Implementation

January 2022:

Adults with medical issues who are experiencing homelessness

Adults at risk for avoidable hospital or ED utilization

Adults with one or more serious mental health or substance use disorder needs

4 Total ECM Providers upon launch

January 2023:

Adults living in the community at risk for long term care institutionalization

Adult nursing facility residents transitioning to the community

July 2023:

Children and youth up to age 21 POFs

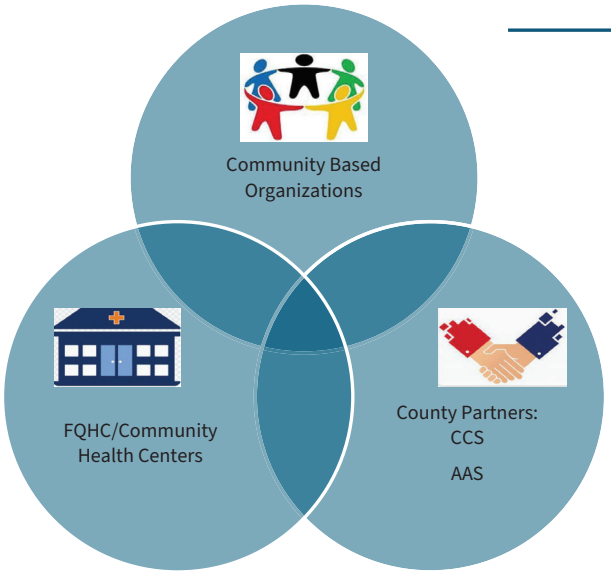
January 2024:

Birth equity

Individuals transitioning from incarceration

9 Total ECM Providers to include FQHCs

ECM Providers



CBOs:

1. Institute on Aging
2. Bridges to Wellness
3. Upward Health
4. Healthcare In Action

County Partners:

5. Aging and Adult Services (AAS - ECM)
6. California Childrens Services (CCS - ECM)

FQHCs:

7. North East Medical Services
8. Ravenswood Family Health Center
9. Gardner Health Services

For a detailed listing of our ECM Providers and the POFs they serve, visit our CalAIM Provider Webpage.

Community Supports Services

HealthPlan OF SAN MATEO
Healthy is for everyone

- Medically Appropriate Services Alternative
- Specific Eligibility Criteria
- Multiple Service Providers
- Whole Person Care Approach
- Continued Partnerships
- 9 of 14 Community Support Services Offered

Community Supports (CS) Services & Providers

HealthPlan OF SAN MATEO
Healthy is for everyone

Housing Navigation	Housing Tenancy	Housing Deposits	Home Modifications	Medically Tailored Meals
• Brilliant Corners • Mental Health Association*	• Brilliant Corners, • MidPen* • Mental Health Association	• Brilliant Corners • Mental Health Association*	• Brilliant Corners • Institute on Aging	• Mom's Meals

Community Supports (CS) Services & Providers

HealthPlan OF SAN MATEO
Healthy is for everyone

Respite Care

- Aging and Adult Services

Personal Care and Homemaker Services

- Aging and Adult Services

Nursing Facility Transition/Diversion to Assisted Living Facilities

- Institute on Aging

Community Transition Services/NF Transition to a Home

- Institute on Aging
- Aging and Adult Services

CS Provider Network

HealthPlan OF SAN MATEO
Healthy is for everyone

Jan 22
Launch
9 CS Services,
4 Total Providers

Aug 22
Added Housing Provider

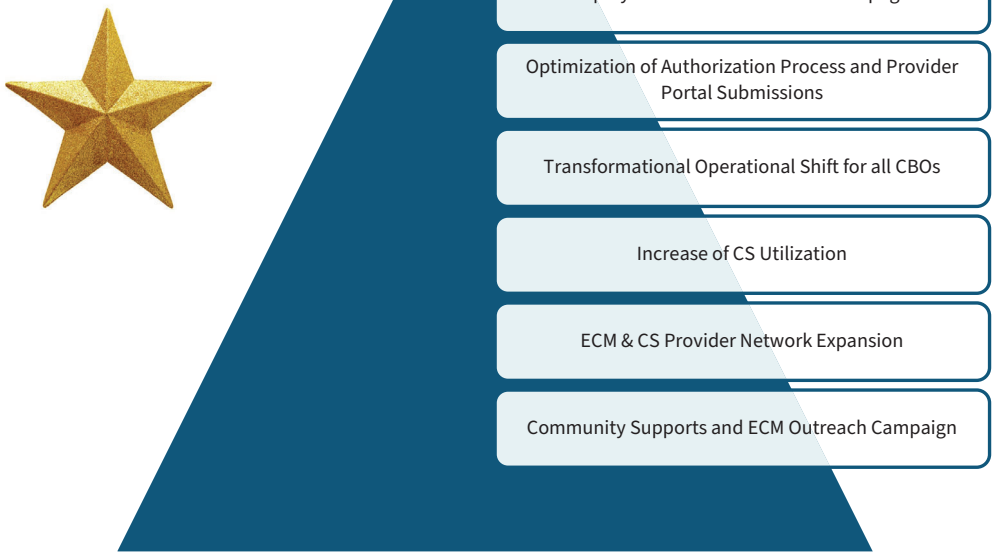
5 Total Providers

Jan 23
Added Housing Provider

6 Total Providers

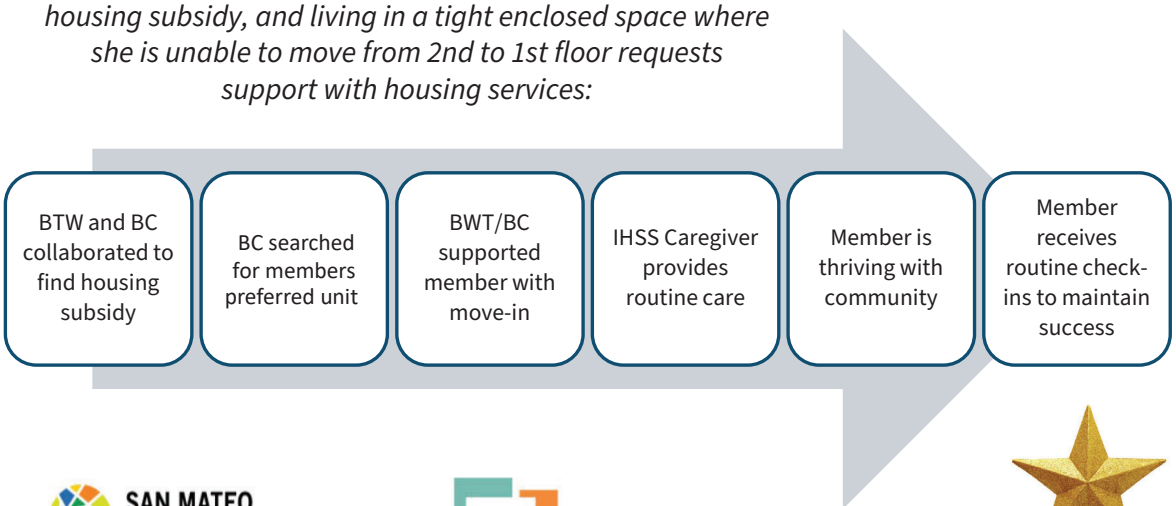
2024
CS Providers/Service Expansion + CHW Network

Accomplishments



Member Success Story

57-year old, female member, with mobility challenges, no housing subsidy, and living in a tight enclosed space where she is unable to move from 2nd to 1st floor requests support with housing services:



2024 and beyond

Implementation of JI POF

Continue development of JI Provider Network.

Continue to develop relationships with key stakeholders

Expansion of CS

Adding to CS offerings to meet service gaps; expanding CS provider network to meet service demands.

CHW Network Expansion

Exploring community partnerships to enhance CHW network.

Improve access to CHW services developing a referral pathway.

Identifying target populations for CHW integration.

Spotlight:
HPSM and County Office of Education

Health Plan of San Mateo

Courtney Sage, Director of Behavioral Health

San Mateo County Office of Education

Mary McGrath, Executive Director of Safe and Supportive schools

Importance of Mental Health Services in Schools

- Schools are invested in mental health services for students, mostly funded through 1x grants.
- Schools are a trusted resource for kids and families
- Schools have daily access to kids and know a lot about their well-being and needs
- Majority of HPSM school age youth are attending SM County Public Schools
- Kids are spending about half of their day in school.
- Busy parents often have limits on the available hours in the day to connect their kids to services.

Importance of the SBHIP partnership

SBHIP:3 year program (2022-2024) where HPSM, 3 School districts, and BHRS implement up to 4 project plans to support mental health service infrastructure within the school system

Development of a Statewide Multi-Payer School-Linked Fee Schedule (CYBHI fee schedule) and School-Linked Behavioral Health Provider Network

Through a Third Party Administrator, MCP's will reimburse school-linked providers for the provision of specified outpatient mental health and substance use disorder (SUD) services furnished to students 25 years of age or younger at a schoolsite.

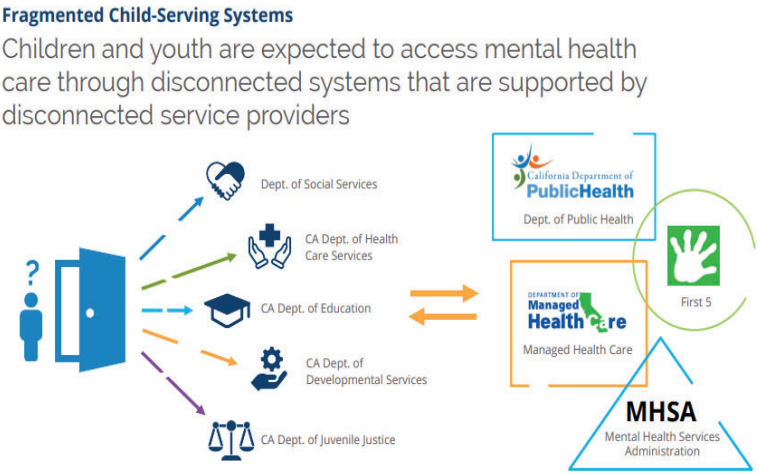
Equity

Access

Right Service, Right time

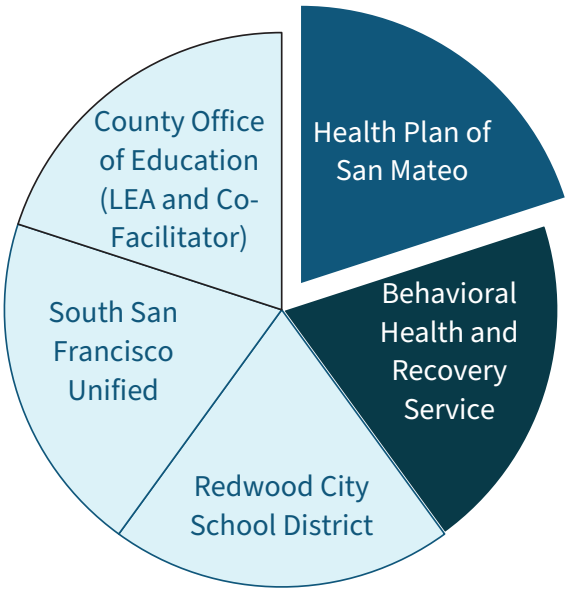
Statewide System challenge-CYBHI

While State level organizations work on larger system change (CYBHI), HPSM focuses on local partnership approach through SBHIP and beyond



https://cachildrenstrust.org/wp-content/uploads/2020/02/CCT-Overview-Jan2020-v2.pdf

SBHIP PARTNERS



Project plans selected

Wellness Centers

IT infrastructure:

- Referrals
- Claims
- Data

Substance use Prevention and Treatment

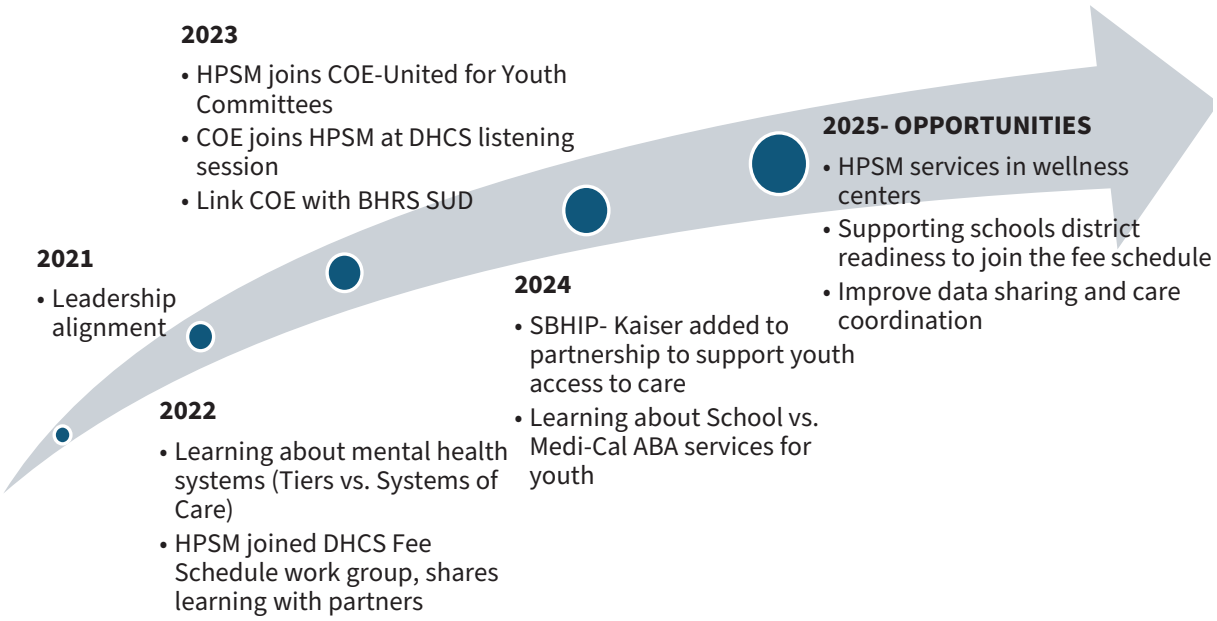
Workforce Enhancement

SPOTLIGHT ON PROJECT PLAN

Creating a sustainable funding pathway for Mental Health Services in Schools through IT Infrastructure:

- Schools already have staff and partnering CBO's providing mental health services
- SBHIP partnering schools do not have technology to support claims, and data
- Currently mental health services (non-IEP) at schools are either not available at schools, or are being funded with grants and other time limited funds
- Using HPSM expertise to support COE in decision making on procurement of a system.
  - Focus on developing strong data and care coordination infrastructure
- HPSM will be able to receive direct reimbursement for mental health services

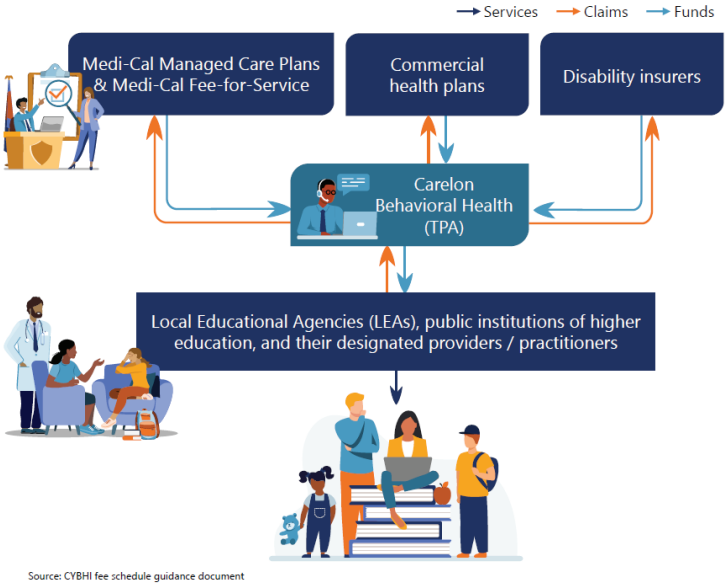
Partnership Development: **HPSM and SMCOE**



What's working well?

- HPSM highlighting school perspective in DHCS meetings
- Adapting together with changing DHCS guidance
- Demystifying insurance systems and billing for Schools, and Medi-Cal Enrollment
- Sharing Claims and insurance system knowledge to support decision making on IT Infrastructure

TPA



Source: CYBHI fee schedule guidance document

To support LEAs and managed care plans in operationalizing the CYBHI fee schedule, the State has **contracted with Carelon Behavioral Health**

Carelon will be responsible for:

- Provider network management
- Claims administration and payment remittance
- Payer and provider supports

See details to follow

7

Thank you!

Questions?

Spotlight:
HPSM and Corrections/Justice

Health Plan of San Mateo

Kate Arsenault, Housing and Homelessness Program Manager

San Mateo County Sheriff's Office

Melissa Wagner, Program Services Manager

San Mateo County Health

Mike del Rosario, Director of Correctional Health Services

Rationale for Providing Justice-Involved Services

Under CalAIM, California is providing additional Medicaid funds to cover services for people who are incarcerated, 90-days before release.

The intent of the demonstration is to **build a bridge to community-based care for justice-involved Medi-Cal members.**

This demonstration is **part of California's comprehensive initiative to improve physical and behavioral health care for the justice-involved population.**

With its 1115 demonstration, California will directly test and evaluate its expectation that **providing targeted pre-release services to Medi-Cal-eligible individuals will avert the unnecessary use** of inpatient hospitals, psychiatric hospitals, nursing homes, emergency departments and other forms of costly and inefficient care that otherwise would be paid for by Medi-Cal.

* Images borrowed from DHCS

State Goals for the Reentry Initiative

With the implementation of this initiative, DHCS hopes to achieve the following:

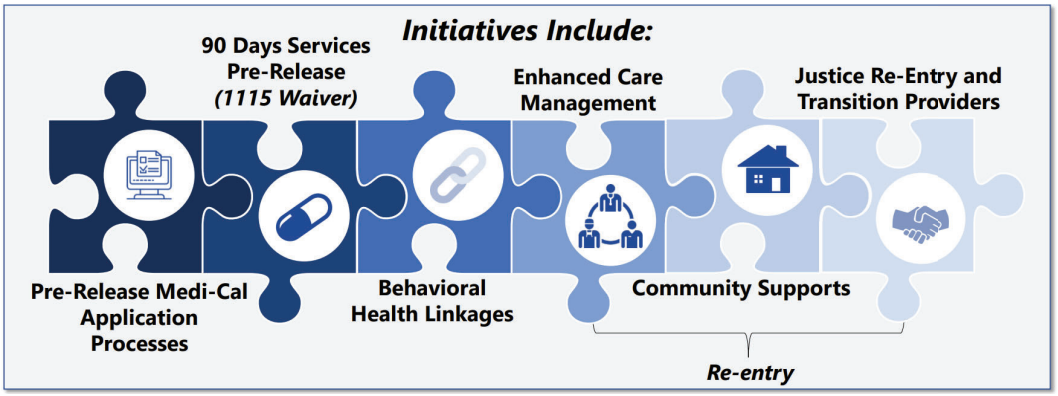
Advance health equity

Improve health outcomes

Serve as a model for the rest of the nation

Integrated Services: Building a Seamless Puzzle

CalAIM justice-involved initiative supports JI individuals by providing key services pre-release, enrolling them in Medi-Cal coverage, and connecting them with behavioral health, social services, and other providers that can support their re-entry.

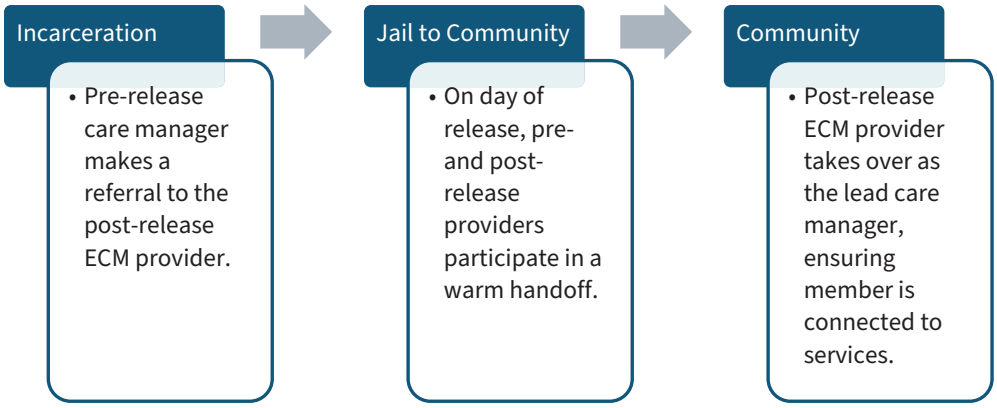


Covered Pre-Release Services

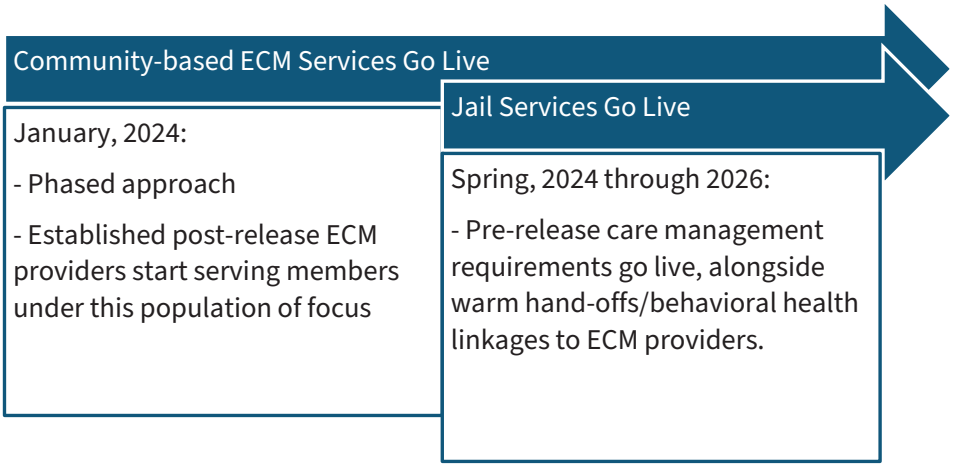
The pre-release services authorized under the Justice-Involved Reentry Initiative include the following services currently covered under DHCS's Medicaid and CHIP State Plans.

- Reentry case management services;
- Physical and behavioral health clinical consultation services provided through telehealth or in-person
- Laboratory and radiology services;
- Medications and medication administration;
- Oral Health;
- Medication Addiction Treatment (MAT), including coverage for MAT counseling; and
- Services provided by community health workers with lived experience.

Care Transition Process



Timeline



San Mateo Co. In-Custody Facilities

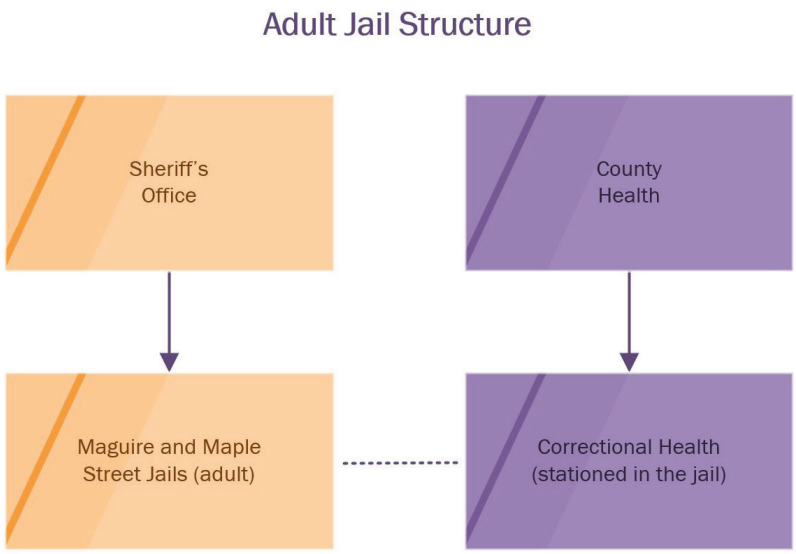
Adult Facilities

- Maguire Correctional Facility, Redwood City
  - Main Jail
    - All Warm Handoffs would happen from here
- Maple Street Jail, Redwood City

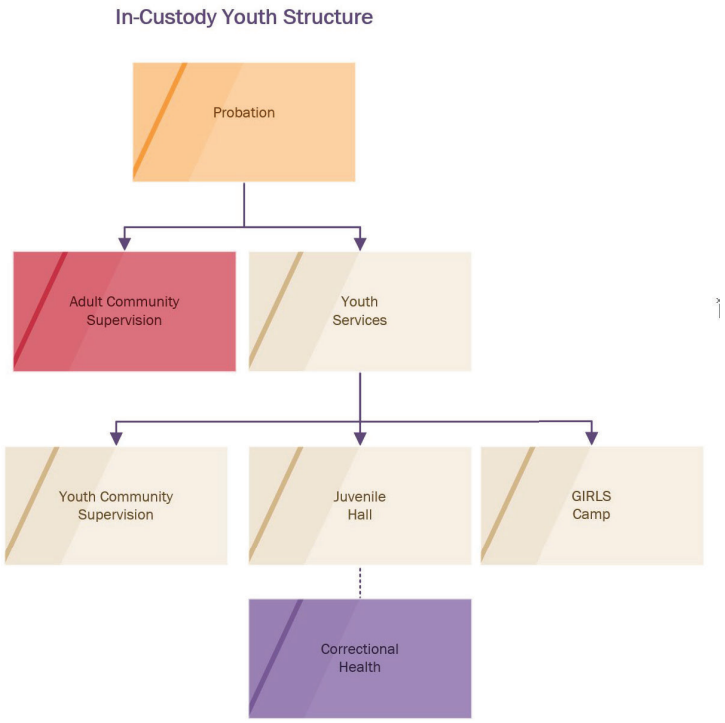
Youth Facilities

- Juvenile Hall
- G.I.R.L.S. Camp: Gaining Independence and Reclaiming Lives Successfully

San Mateo Co. In-Custody Facilities



San Mateo Co. In-Custody Facilities



Adult Facility Data

Correctional Health:

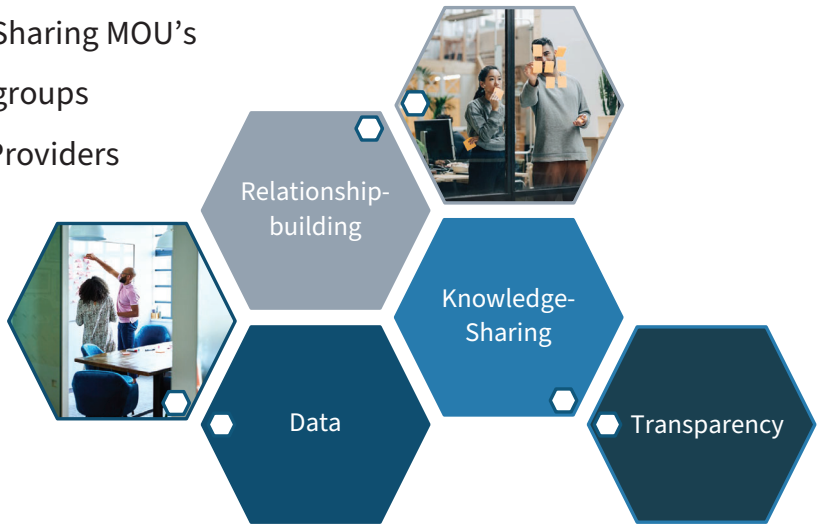
- December 2023: 19% of people booked were experiencing homelessness
- Average # of bookings per month: 1004
- Almost equal number gets released per month
- Average number of bookings per day: 34
- Approximately 30% are receiving mental health treatment
- Average number of new bookings identified with SUD and going through withdrawal: 200 per month
- 78% of people in jail stay under 20-days

HPSM Member Matching:

- 3,800 active and inactive members matched with 2022 to 2023 correctional health data

Current Work

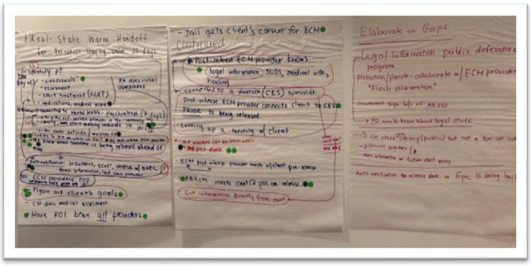
- Strengthening our partnerships through working towards common goals
  - Tour of the Jail
  - Data Sharing MOU's
  - Workgroups
  - ECM Providers

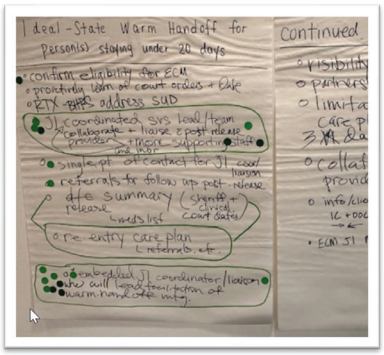


Workgroups

Goal: Warm Handoff to Post-release ECM Provider

- What happens to a person when they enter jail?
- Mapped out what data is collected and where it is stored.
- Embedded a referral process for ECM
- Created an "Ideal" Warm Handoff





What is working well

- Line of Sight into Members who have been Incarcerated
- Connecting Members to Additional Services
- Co-developed workflows
- Regular meetings
- Strengthening our relationships with Stakeholders
- Data-Sharing and Analysis

Thank you!

Questions?

MEMORANDUM

AGENDA ITEM: 5.1

DATE: March 13, 2024

DATE: March 6, 2024

TO: San Mateo Health Commission

FROM: Pat Curran, CEO
Trent Ehrgood, CFO

RE: HPSM 2024 Budget

Proposed 2024 Budget

Attached is a slide deck with the 2024 budget overview. HPSM is forecasting a surplus of $30.2M with anticipated total revenues (operating and non-operating revenue) of $1,109M and total expenses (including MCO tax) of $1,079M.

DHCS has indicated that they will be adjusting the 2024 Medi-Cal rates later this year, mostly to adjust for estimates related to funding the Targeted Rate Increase (TRI), which is additional funding for physician services. This version of the budget does not include any estimates for this potential change.

Finance Committee Review

The Commission's Finance/Compliance Committee reviewed the proposed budget in more detail at their meeting on Monday, February 26, 2024, and recommended approval.

This version of the budget is slightly different from the one reviewed at Finance/Compliance with a minor correction to the membership projection calculations, and a minor shift between Admin cost and UMQA cost. The net surplus decreased by a small amount from $30.6M to $30.2M.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF ADOPTION OF OPERATING BUDGET
FOR 01/01/2024 - 12/31/2024

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. The Finance Committee has reviewed details and assumptions for the budget for CFY 2024; and

B. The Committee recommends approval of the budget, which is based on current available financial information;

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves the operating budget for CFY 2024 as presented and attached.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 13th day of March 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

2024 Operating Budget

HPSM Commission

March 13, 2024

HealthPlan OF SAN MATEO
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Financial Summary and Outlook for 2024

HealthPlan OF SAN MATEO
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- HPSM has benefited from two years in a row with larger than normal surpluses of over $100M each. The main driver of these surpluses is lower than expected healthcare cost, and increased number of members with other health coverage. 2022 and 2023 Medi-Cal rates that did not anticipate either of these.
- Medi-Cal rates for 2024 are more in alignment with this lower cost experience, which is driving a much lower projected surplus in 2024. Medi-Cal rates are not final, and we expect adjusted rates later in 2024 – likely a slight decrease.
- Interest income on HPSM's cash reserves is contributing to the projected surplus, both from increased reserve levels and continued higher interest rates.
- Membership changes impacting 2024 include the Kaiser direct contract with DHCS, changes to Medi-Cal eligibility criteria, and the Medi-Cal redetermination process.

Proposed 2024 Budget

HealthPlan OF SAN MATEO
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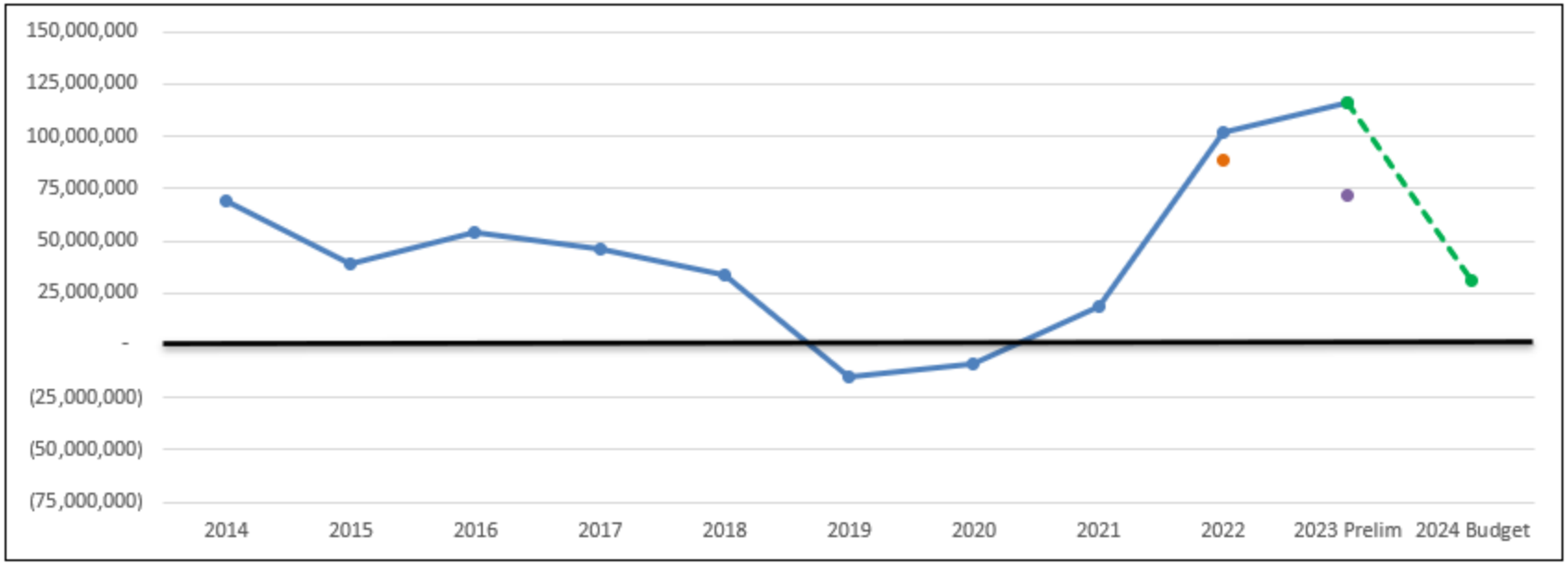
OPERATING REVENUES:	
Capitation & Premium Revenue	$ 1,083,587,950
HEALTH CARE EXPENSE:	
Inpatient Services	216,487,987
Outpatient/Professional	341,203,069
SNF/LTC	174,399,371
Pharmacy	64,012,525
Directed Payments	45,001,564
ECM, CS, CBAS, Dental	48,321,188
UMQA/Transportation/Other	42,030,393
Provider Incentives	17,914,000
Total Health Care Expenses	**949,370,097**
ADMINISTRATIVE EXPENSES	**76,887,449**
MCO Tax	**52,588,105**
Net Gain from Operations	**4,742,299**
NON-OPERATING REVENUES:	
Interest	**24,000,000**
Rental Income	**1,263,105**
TPA Fees/Other	**214,336**
Total Non-Operating Revenue	**25,477,441**
PROJECTED SURPLUS	**$ 30,219,740**

Historical Net Income/(Loss)

Ten-year trend – **Restated** w/ 2024 budget



Budget Assumptions - Membership

- Disenrollment from the Medi-Cal redetermination process started in July 2023. HPSM is observing approximately 2,100 disenrollments per month. The budget assumes this rate of decline through June 2024, then flattens out.
- Kaiser's direct contract with DHCS resulted in approximately 14,000-member loss from HPSM effective 1/1/24.
- The elimination of immigration status as a criterion for Medi-Cal enrollment, resulted in approximately 18,000 new Medi-Cal members effective 1/1/24, mostly a shift from the ACE program.
- CareAdvantage membership has had a slight decrease over 2023, but due to successful marketing and outreach, the CareAdvantage membership observed a net increase in enrollment effective 1/1/24.
- HealthWorx membership is expected to remain steady at approximately 1,200 members.

Membership Trends 2020-2024

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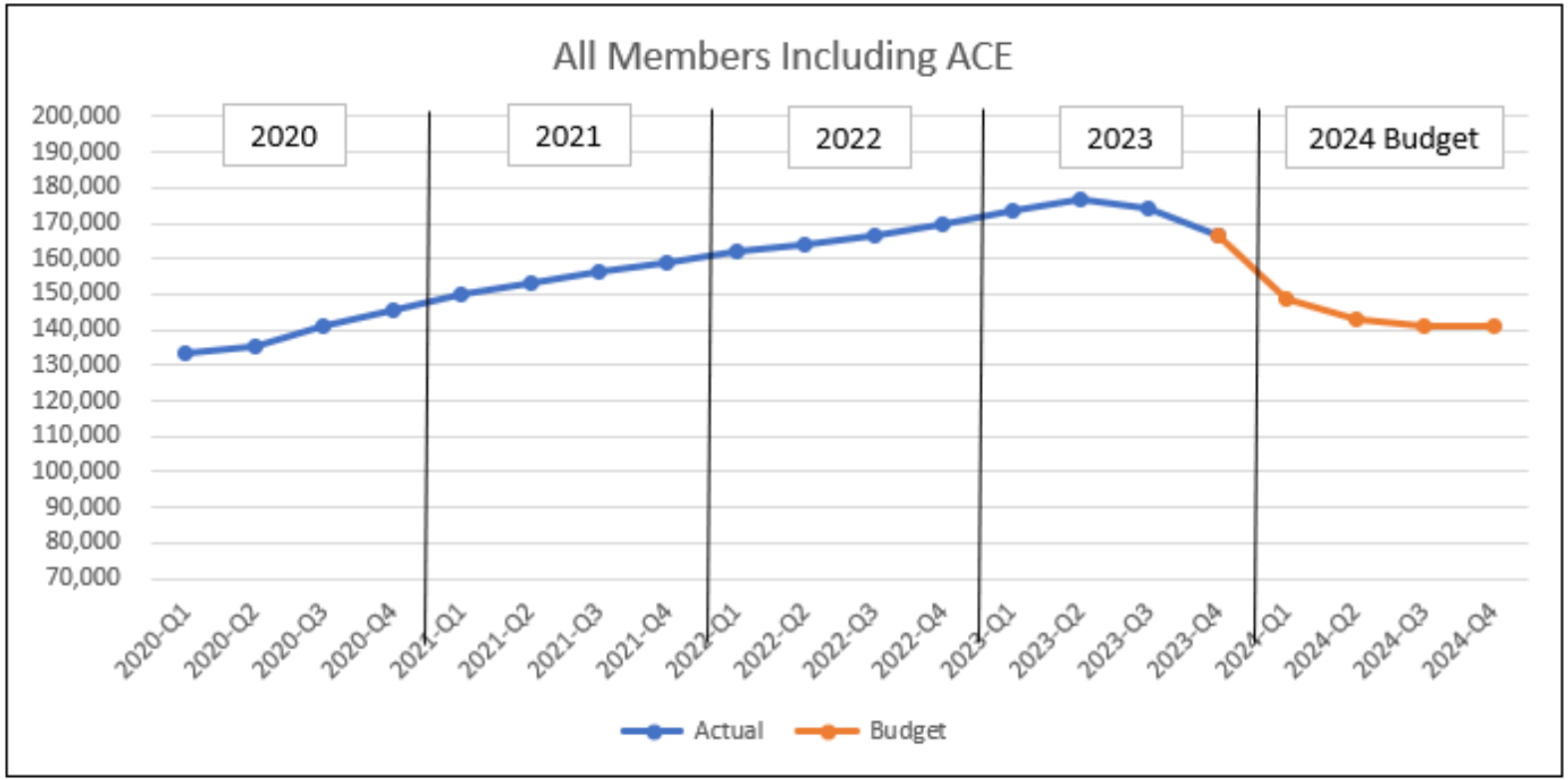
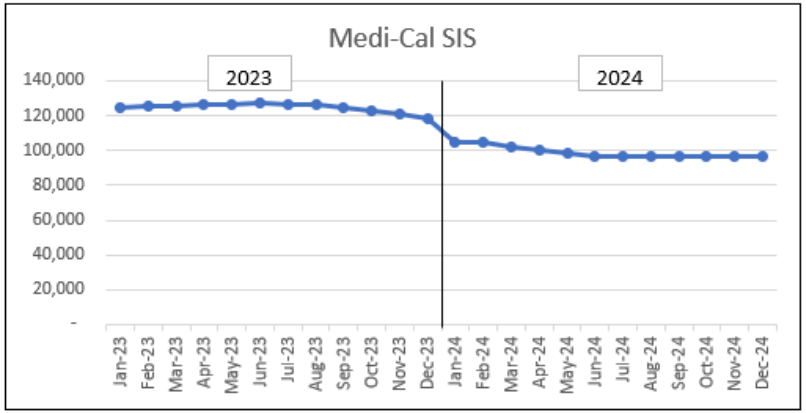
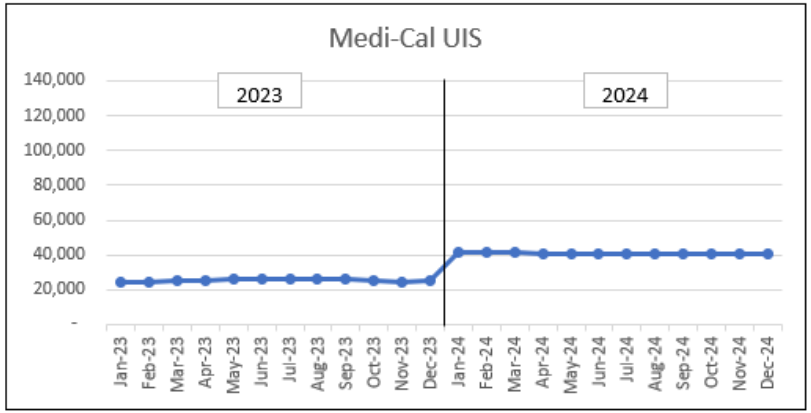
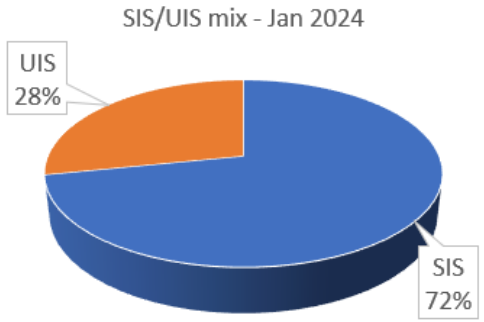
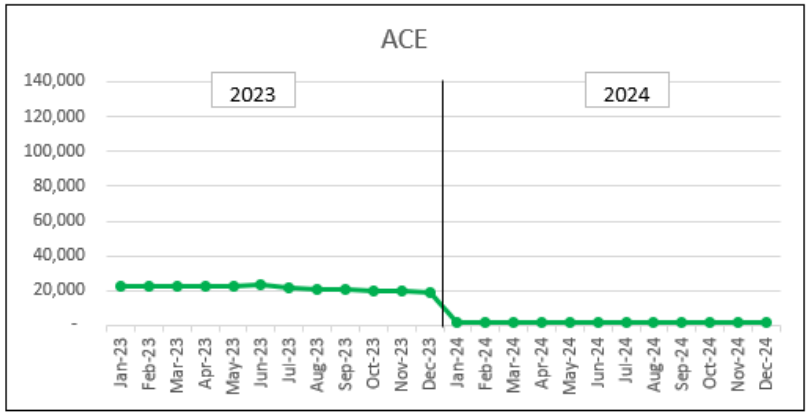


Medi-Cal Membership – SIS/UIS









2024 Budget Summary by LOB

HealthPlan OF SAN MATEO
Healthy is for everyone

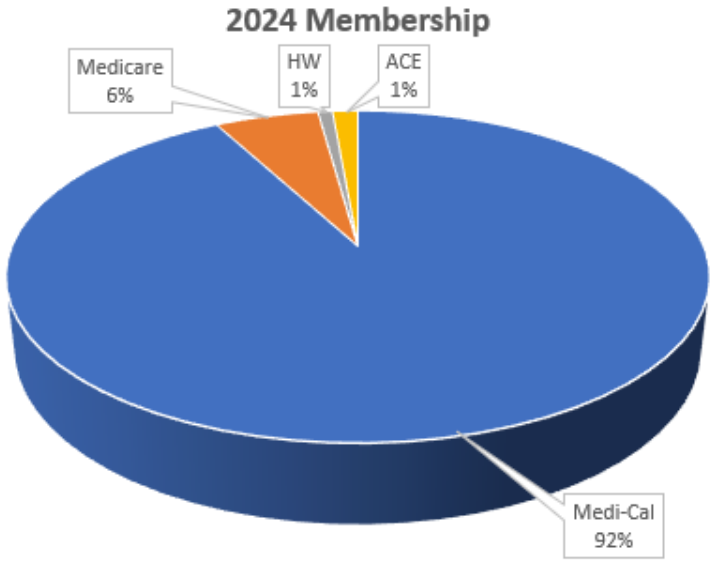
	Medi-Cal (non-duals)	Medi-Cal Duals (MC+DSNP)	MCE	WCM	CareAdvantage D-SNP	HealthWorx	ACE	HPSM *	Total
Operating Revenue	$352,097 K	$190,540 K	$276,432 K	$26,867 K	$230,052 K	$7,601 K			$1,083,588 K
Health Care Expense	$299,572 K	$163,060 K	$226,995 K	$26,434 K	$225,858 K	$7,451 K			$949,370 K
Admin	$23,978 K	$8,552 K	$19,239 K	$2,111 K	$21,897 K	$900 K	$210 K		$76,887 K
MCO Tax	$27,678 K	$5,682 K	$18,797 K	$431 K	$0 K	$0 K	$0 K		$52,588 K
Other Income	$0 K	$0 K	$0 K	$0 K	$0 K	$0 K	$214 K	$25,263 K	$25,477 K
Net Profit/(Loss)	$870 K	$13,245 K	$11,401 K	($2,109 K)	($17,704 K)	($750 K)	$4 K	$25,263 K	$30,220 K
MLR	92.3%	88.2%	88.1%	100.0%	98.2%	98.0%			92.1%
Average Membership	73,443	15,078	49,877	1,142	8,624	1,215	2,101		143,370
Revenue PMPM	$ 399.51	$ 1,053.06	$ 461.86	$ 1,959.78	$ 2,222.98	$ 521.40	$ 8.50		

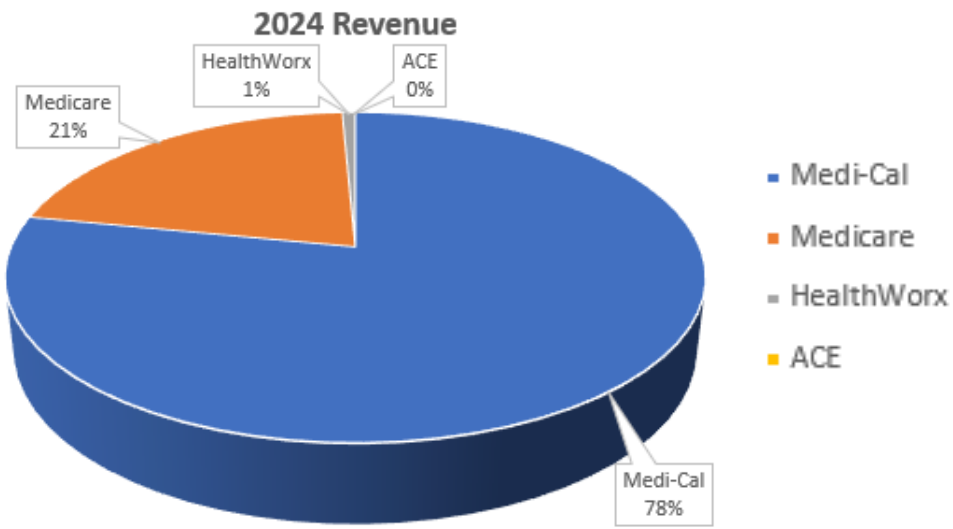
* *Interest Income & Rent Income*

Profit Margin Summary:

Medi-Cal	2.8%
Medicare	-7.7%
HealthWorx	-9.9%
Consolidated	2.8%

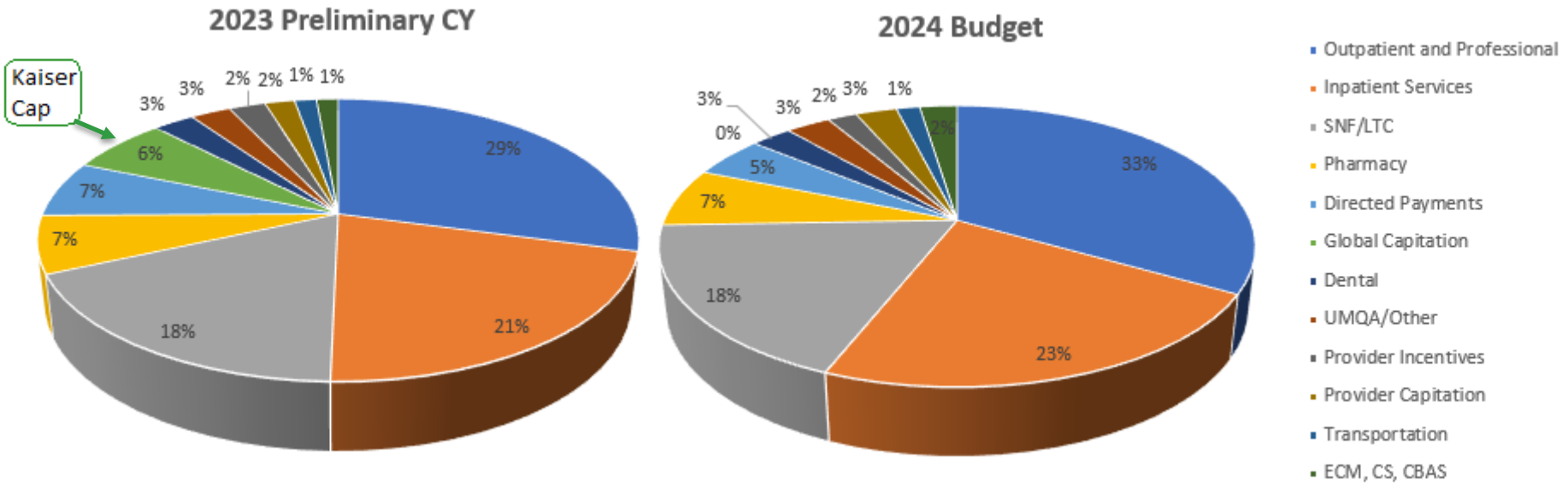
Membership and Revenue by Source





2024 Total Operating Revenue: $1,084M

Healthcare Cost by Expense Category



2024 Total Medical Expenses: $949M including UM/QA

Administrative Budget

2023 to 2024 Budget Change

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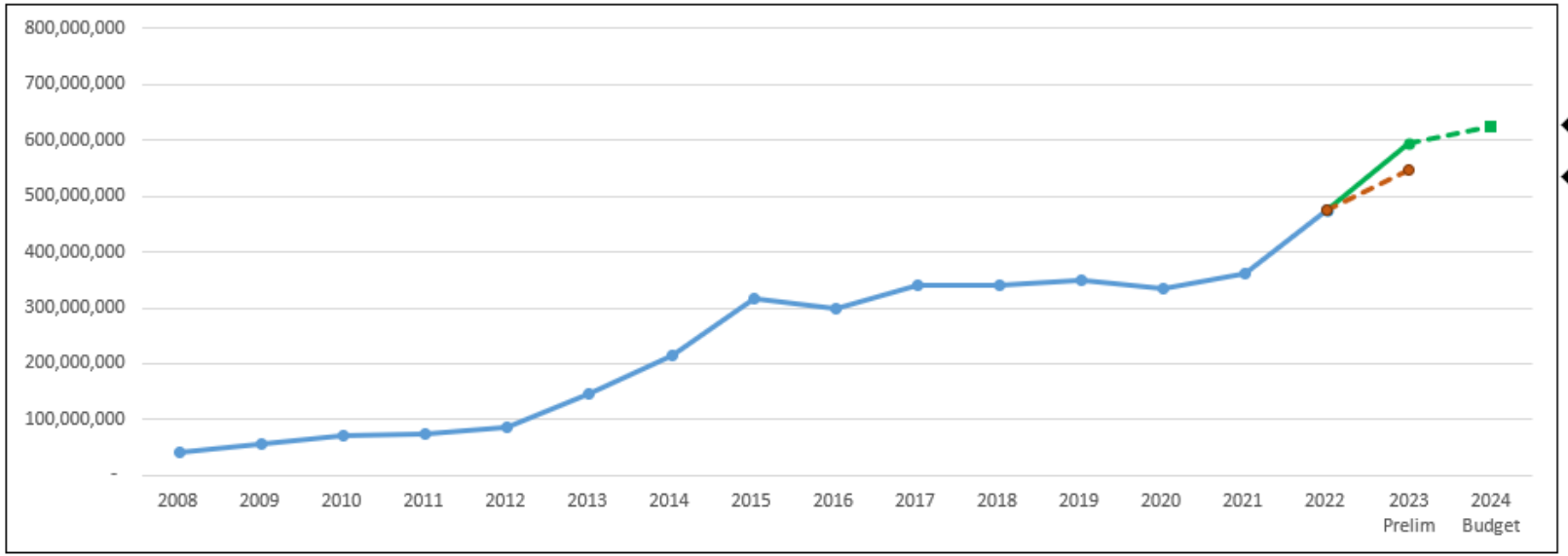
Expense Category	2023 Budget	2024 Budget	Change	% Chng.	2024 % of Total
Salaries, Benefits, Training, Travel	50,264,420	60,481,530	10,217,110	20%	61%
Consulting & Outside Services	17,537,400	19,134,100	1,596,700	9%	19%
Computer Maintenance & Support	5,434,000	7,020,000	1,586,000	29%	7%
Occupancy, Deprec. & Amort.	3,930,000	4,503,300	573,300	15%	5%
Postage, Delivery & Printing	2,745,900	2,300,000	(445,900)	-16%	2%
Office Expenses	1,477,300	2,273,670	796,370	54%	2%
Other Admin Expenses	1,864,700	3,699,925	1,835,225	98%	4%
Sub-Total	83,253,720	99,412,525	16,158,805	19%	100%
UM/QA Allocation (to HC Cost)	(22,020,606)	(22,525,076)	(504,470)	2%	
Total Admin Expense	61,233,114	76,887,449	15,654,335	26%	
FTE's	354	405	51	14%	

Projected Tangible Net Equity (TNE)



- This illustration is prior to any investments from strategic use of reserves.

Thank you

HealthPlan OF SAN MATEO
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AGENDA ITEM: 5.2

DATE: March 13, 2024

2023 Annual Compliance Report

Ian Johansson

Chief Government Affairs & Compliance Officer

March 13, 2024

HealthPlan OF SAN MATEO

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Background

- Status & Activities
  - Report provides a summary of HPSM's Compliance efforts
  - Enables you to:
    - To be knowledgeable about the Compliance Program
    - To exercise reasonable oversight

Our Goal

- To establish a culture of compliance at HPSM that helps the organization and its employees “do the right thing” *for our members, providers, and community*
- Achieved through *maintaining a compliance program, that*:
  - Educates our employees
  - Identifies and resolves compliance issues and risks
  - Provides opportunities to engage our staff, *our Commission*, and stakeholders

Agenda

- 2023 - Year in review
  - Major activities & status
- 2024 – Outlook
  - Known major activities
  - Opportunity to give input to Commission reporting

2023 Year in Review

- External review activity
  - Two (2) external reviews
    - NCQA Resurvey
    - Department of Health Care Services (DHCS) Medical Audit
- Other Major Activity
  - Received 2021 DMHC Routine Medical Survey report
  - Received approval of 2024 DHCS Contract Operational Readiness
  - CareAdvantage gap analysis kick-off

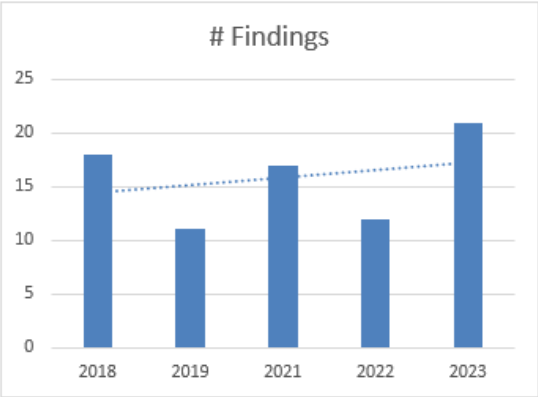
2023 DHCS Audit

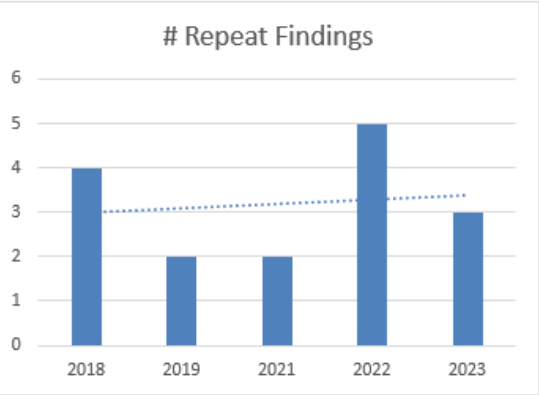
DHCS Audit Results Summary - Last Five Audits

Summary

Year	# Findings	# Repeat Findings
2018	18	4
2019	11	2
2021	17	2
2022	12	5
2023	21	3

5-year average	16	3





2023 DHCS Audit

- Repeat findings:
  - Written consent from the member for appeals filed by a provider
  - Ownership and Control Disclosure reviews
  - Delegation of Provider Training

2024 Forecasting

- CareAdvantage gap analysis & mock audit work
- NCQA Full Survey
- 2021 DMHC Audit Corrective Action Plan execution (CAP)
- 2023 DHCS Audit Corrective Action Plan execution (CAP)
- 2024 DHCS Annual Medical Audit
- CMS Compliance Program Effectiveness (CPE) audit OR Utilization Management Targeted audit

Commission Reporting

- Project kick-off to revisit compliance reporting to the Finance/Compliance Committee and Commission
  - First discussion held at February Finance/Compliance Committee meeting
- Goals
  - Provide the Commission with an opportunity for input into the design of compliance and government affairs reporting and discussions
  - Develop a framework with the Finance/Compliance Committee for presentation to the full Commission by Q4 2024

MY2023 Compliance Survey

- Survey completion expected by end of Q1 2024
- Survey re-tooled to provide additional opportunities for input
  - No modification to questions asked
- Presentation to Commission in Q2 2024 of results and trends

Questions?

- Contact me
  - ian.johansson@hpsm.org
- Hotline available 24/7
  - 844-965-1241

Thank You

HealthPlan OF SAN MATEO
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AGENDA ITEM: 5.3

DATE: March 13, 2024

Meeting materials are not included

for Item – 5.3
Introduction to Baby Bonus Program

MEMORANDUM

AGENDA ITEM: 6.0

DATE: March 13, 2024

DATE: March 5, 2024

TO: San Mateo Health Commission

FROM: Patrick Curran

RE: CEO Report – March 2024

Managed Care Organization (MCO) Tax

The five-year $19 billion managed care tax proposed by the state was approved by the Centers for Medicare and Medicaid Services (CMS) in 2023 and there will likely be a California ballot initiative in November 2024 to make the tax permanent.

For the services already approved in 2024, we are now implementing specific rates for more than 700 codes related to primary care and preventive services, as well behavioral health and maternity services. We have received some information about the types of provider rate increases the Department of Healthcare Services (DHCS) is proposing for 2025 and beyond. They are soliciting feedback from various stakeholders, and we are working through our statewide association, LHPC, to comment on these proposed increases.

Investment Funds

The MCO Tax payment increases mentioned above will serve as an important consideration as we continue to explore how we can support our provider network. We are developing a framework for both a provider and community investment fund and will discuss it at the Finance/Compliance Committee in late March. We plan to devote a significant portion of the May Health Commission meeting to our provider investment strategy.

State Budget

The Legislative Analyst Office (LAO) released an update to its preliminary budget estimate for the upcoming fiscal year (July 2024 through June 2025). At this point the Governor's office and the LAO have both released estimates about the budget deficit that differ by up to $24B, with the Governor's budget being more optimistic based upon its calculation of tax revenue.

As discussed previously, the upcoming budget does not include any reductions to either who is covered by Medi-Cal or what services are covered by Medi-Cal. In fact, the upcoming budget

assumes all undocumented individuals continue to qualify for Medi-Cal coverage, and the state is fully funding its CalAIM initiatives. However, it is important in our planning to forecast that the state's budget in 2025 may involve program cuts.

CalAIM Study Session

Thanks to all the Health Commissioners who spent time on February 14th at our CalAIM study session. HPSM staff presented an overview of the program, as well as the member demographic and health outcome data we use to develop and implement programs. Staff also highlighted our Enhanced Care Management (ECM) benefit, our Community Supports (CS) programs, our work with the justice-involved population, and our partnership with schools. We will continue to bring updates on these programs to future Health Commission meetings.

Baby Bonus Project

Based on the initial work done by the Jackie Speier Foundation, there is a community effort to embark upon a program called the Baby Bonus Project. It envisions providing basic monetary assistance to low-income families of newborns and evaluating the impact on child development and health outcomes. Similar programs that have provided funding in communities across the country are often called Guaranteed Basic Income or Universal Basic Income.

We are involved in the Steering Group, which includes First Five San Mateo County, the Jackie Speier Foundation, San Mateo County Health, and Lucille Packard Children's Hospital, to evaluate what role HPSM might play in this proposed program. We will discuss the concept and the approach HPSM is taking at our March Health Commission meeting.