HealthPlan OF SAN MATEO
Healthy is for everyone

801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080
tel 650.616.0050
fax 650.616.0060
tty 800.735.2929 or dial 7-1-1
www.hpsm.org

THE SAN MATEO HEALTH COMMISSION and
THE SAN MATEO COMMUNITY HEALTH AUTHORITY
Regular Meeting
June 12, 2019 - 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor, 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/Executive Committee
   - 4.2 CMC Advisory Committee Minutes, April 2019
   - 4.3 Pharmacy & Therapeutics Committee Minutes, May 2019
   - 4.4 Approval of Amendment to Agreement with Regents of University of California
   - 4.5 Ratification of Amendment to Agreement with MCG
   - 4.6 Approval of San Mateo Health Commission Meeting Minutes from May 8, 2019
5. **Specific Discussion/Action Items**
   - 5.1 Update on Long Term Care Collaborative
   - 5.2 Update on Strategic Plan Metrics
6. **Report from Chairman/Executive Committee**
7. **Report from Chief Executive Officer**
8. **Other Business**
9. **Adjournment**

**Items for which Commission action is requested.*

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

HealthPlan OF SAN MATEO

AGENDA ITEM: 4.1

DATE: June 12, 2019

M E M O R A N D U M

Date: June 12, 2019
To: San Mateo Health Commission
From: Trent Ehrgood, Chief Financial Officer

Subject: Financial Report for the 4-month Period Ending April 30, 2019

Preliminary 2019 Financial Results All Lines of Business

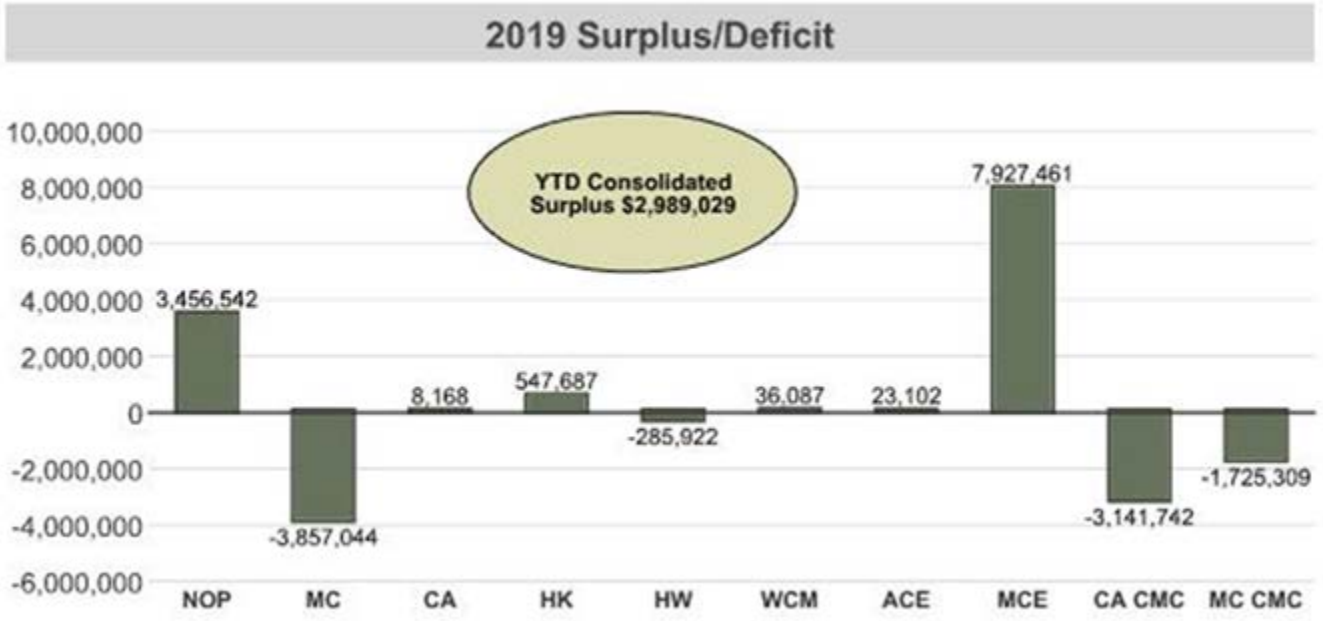
The preliminary financial result for all lines of business for the month of April is a deficit of $498,842. Year-to-date (YTD), the Plan has a surplus of $2,989,030. The table below shows the three month trend, and YTD compared to budget.

	Monthly Trend			Year-To-Date		
	Feb	Mar	Apr	Actual	Budget	Variance
Operating Revenue	63,326,278	73,084,479	70,572,093	273,659,470	260,523,670	13,135,800
Healthcare Expenses	55,808,281	60,929,948	63,015,218	237,748,012	232,729,543	5,018,469
Administrative Expenses	3,466,931	4,369,994	4,171,771	16,388,512	17,504,265	(1,115,753)
Premium Taxes	5,143,506	5,172,789	5,206,984	20,730,264	18,189,070	2,541,194
Operating Income/(Loss)	(1,092,440)	2,611,748	(1,821,880)	(1,207,318)	(7,899,208)	6,691,890
Non-Operating Revenue	951,589	1,039,908	1,323,038	4,196,348	3,292,451	903,897
Net Income/(Loss)	(140,851)	3,651,656	(498,842)	2,989,030	(4,606,757)	7,595,787

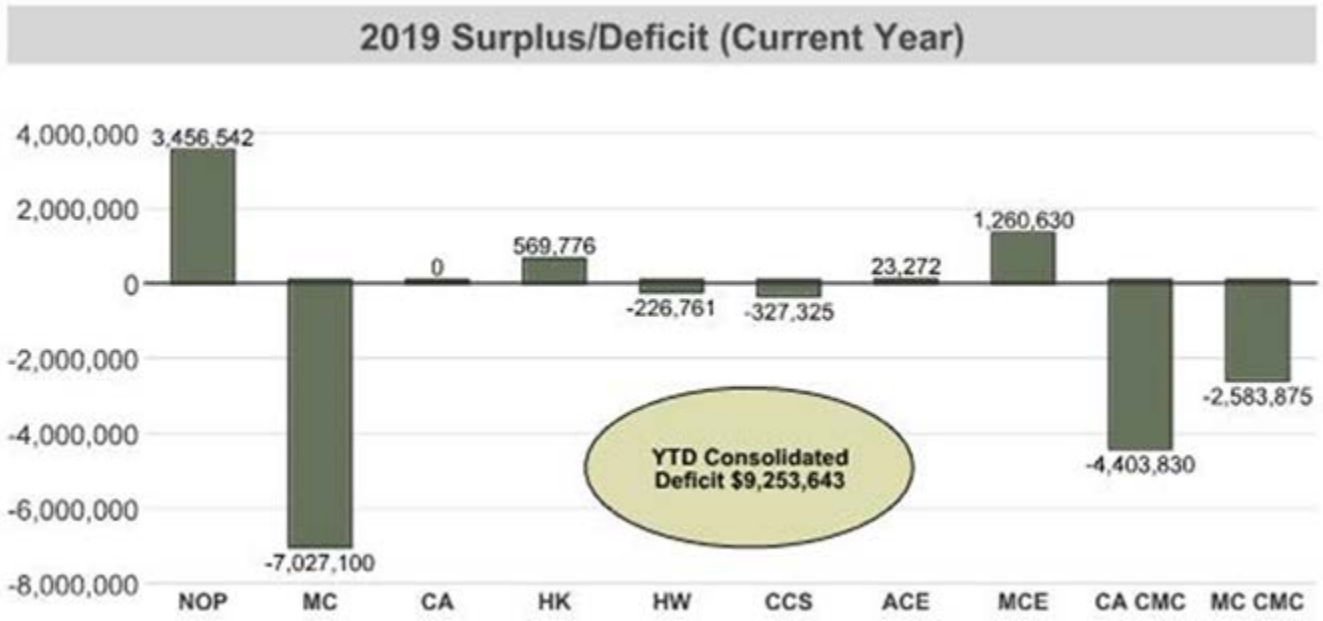
The table below separates prior year (PY) and current year (CY) transactions. The first four months include $12.2M in favorable prior year transactions. The remaining current year transactions results in a YTD deficit of $9.3M, compared to the YTD budget deficit of $4.6M.

	YTD by PY/CY			Current Year YTD		
	Prior Year	Current Year	Total	Current Year	Budget	CY Variance
Operating Revenue	10,274,599	263,384,871	273,659,470	263,384,871	260,523,670	2,861,201
Healthcare Expenses	(1,875,599)	239,623,611	237,748,012	239,623,611	232,729,543	6,894,068
Administrative Expenses	-	16,388,513	16,388,513	16,388,513	17,504,265	(1,115,752)
Premium Taxes	(97,673)	20,827,936	20,730,263	20,827,936	18,189,070	2,638,866
Operating Income/(Loss)	12,247,871	(13,455,189)	(1,207,318)	(13,455,189)	(7,899,208)	(5,555,981)
Non-Operating Revenue	(5,198)	4,201,546	4,196,348	4,201,546	3,292,451	909,095
Net Income/(Loss)	12,242,673	(9,253,643)	2,989,030	(9,253,643)	(4,606,757)	(4,646,886)

The graph below shows the YTD Preliminary Financial Results by line of business combining current year and prior year transactions. YTD consolidated surplus is $2.99M.

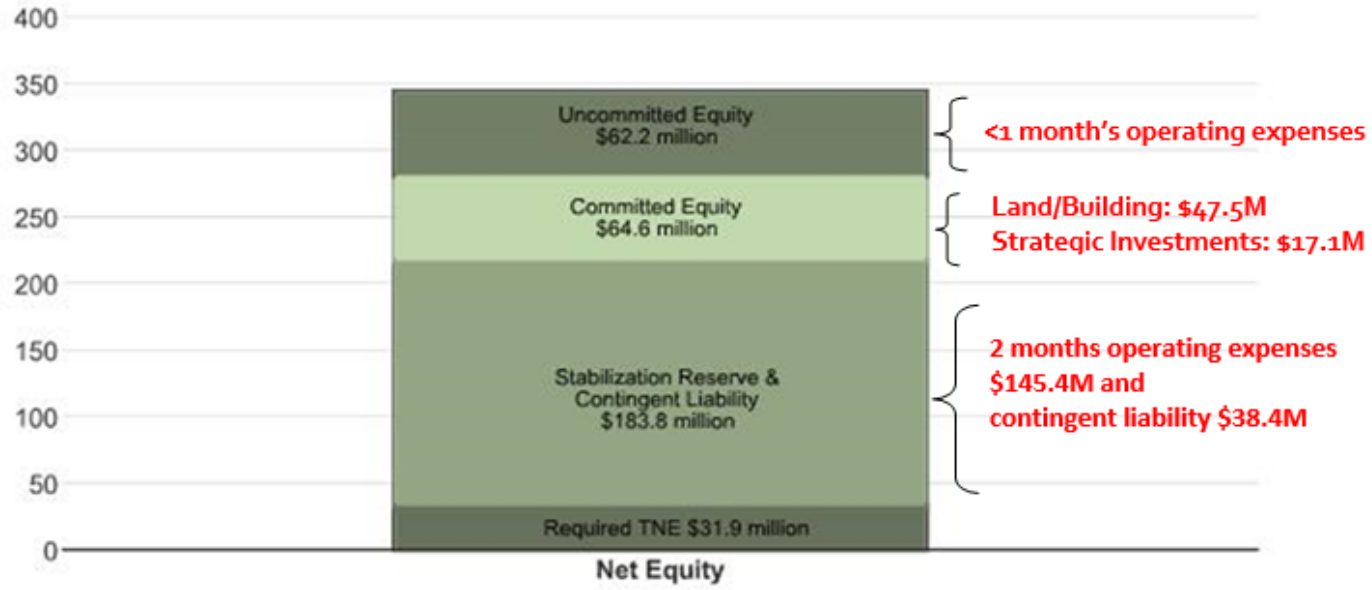


The graph below shows the YTD Preliminary Financial Results excluding prior period transactions. Prior period adjustments are typically due to updated rates or member counts from DHCS and adjustments to prior year medical costs, as necessary. Current Year consolidated deficit is $9.25M.



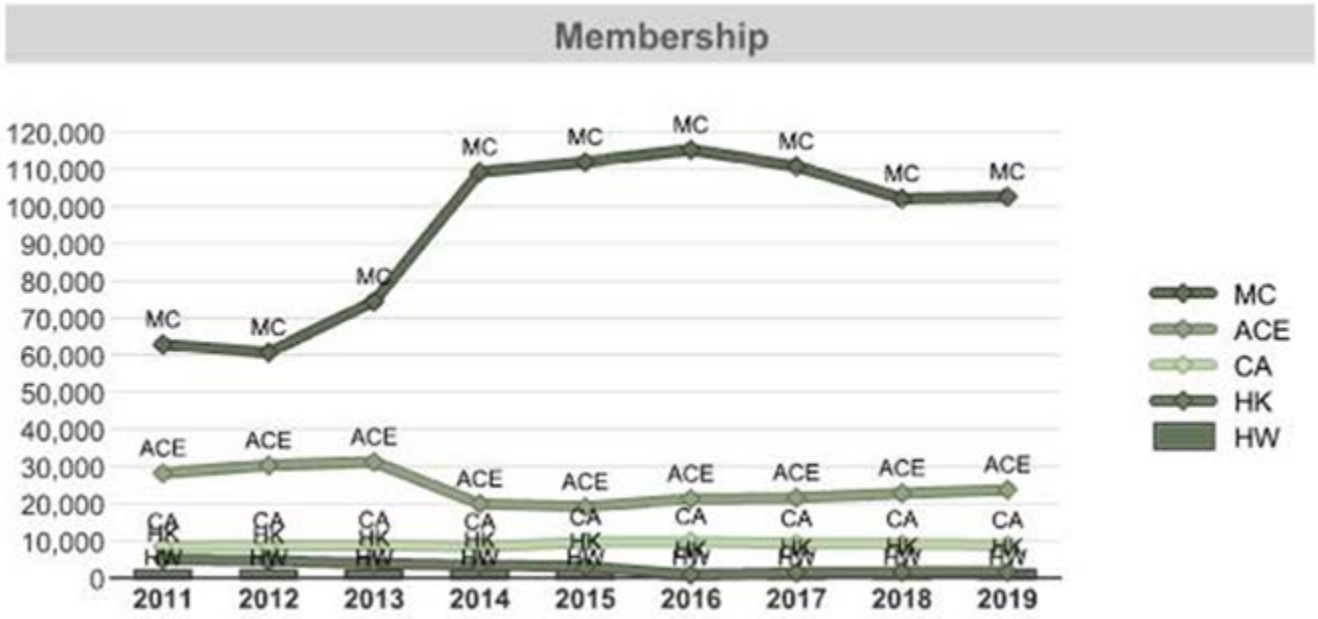
Stabilization Reserve and Tangible Net Equity (TNE)

The financial protocol requires us to have a minimum Stabilization Reserve of two month's operating expenses. As of April 30, 2019, our required TNE was $31.9 million and our stabilization reserve (plus the contingent liability related to the State audit report on potential aid code discrepancies impacting eligibility back to 2014) was $183.8 million. Our current net equity is $342.5 million of which $62.2 million is uncommitted.



Membership

Total membership at the end of April 2019 stands at 137,994. *A known data issue is overstating the ACE Participant count by approximately 1,700.



HIGHLIGHTS BY LINE OF BUSINESS (LOB)

Below are the highlights by major LOB of the current year performance compared to budget. The highlighted column represents current year only, excluding prior year adjustments. Detailed Statements of Revenue and Expense on a consolidated basis, as well as for every line of business, are provided beginning on page 15.

MEDI-CAL (MC)

	YTD Actual	Current Year	YTD Budget	Variance	% Var.
Membership	277,359	277,359	279,172	(1,813)	*-0.6%*
Operating Revenue	**$105,779 K**	**$103,644 K**	**$102,347 K**	**$1,297 K**	***1.3%***
Healthcare Costs	**$90,612 K**	**$91,578 K**	**$86,309 K**	**$5,269 K**	***6.1%***
Administrative Expenses	$5,363 K	$5,363 K	$5,479 K	-$116 K	*-2.1%*
Premium Tax	$13,661 K	$13,729 K	$12,275 K	$1,454 K	*11.8%*
Total Expenses	$109,636 K	$110,671 K	$104,063 K	$6,607 K	*6.3%*
Net Surplus/(Loss)	**-$3,857 K**	**-$7,027 K**	**-$1,716 K**	**-$5,311 K**	*309.4%*
MLR (Net of Premium Tax)	*98.4%*	*101.9%*	*95.8%*	*-6.0%*	

Current Year Performance

MC Revenue Drivers:

- Revenue is above budget by $1.3M, or 1.3%. The PMPM yield is now running higher than budget due to favorable retro adjustments. This is offset slightly due to the lower than budget membership.

MC Healthcare Expense:

- Healthcare cost is running $5.3M over budget, or 6.1%. The primary drivers are hospital inpatient, LTC, and Physician FFS cost. Keep in mind, there are still lots of IBNR estimates built into these numbers.

Medi-Cal Expansion (MCE)

	YTD Actual	Current Year	YTD Budget	Variance	% Var.
Membership	128,815	128,815	126,016	2,799	*2.2%*
Operating Revenue	**$70,905 K**	**$63,841 K**	**$58,283 K**	**$5,558 K**	***9.5%***
Healthcare Costs	**$52,825 K**	**$52,400 K**	**$49,681 K**	**$2,719 K**	***5.5%***
Administrative Expenses	$3,509 K	$3,509 K	$4,013 K	-$504 K	*-12.6%*
Premium Tax	$6,643 K	$6,672 K	$5,491 K	$1,181 K	*21.5%*
Total Expenses	$62,977 K	$62,581 K	$59,184 K	$3,396 K	*5.7%*
Net Surplus/(Loss)	**$7,927 K**	**$1,261 K**	**-$901 K**	**$2,162 K**	*-239.9%*
MLR (Net of Premium Tax)	*82.2%*	*91.7%*	*94.1%*	*2.4%*	

Current Year Performance

MCE Revenue Drivers:

- Revenue is above budget by $5.6M, or 9.5%, due to above budget membership (2.2%), and also higher yield PMPM (7.2%).

MCE Healthcare Expense Trends:

- Healthcare cost is above budget by $2.7M, which is due to the higher membership, and also higher PMPM cost (spread across hospital IP, hospital OP, LTC, Rx and physician FFS).

Whole Child Model, WCM (previously CCS)

	YTD Actual	Current Year	YTD Budget	Variance	% Var.
Membership	7,050	7,050	7,400	(350)	*-4.7%*
Operating Revenue	**$12,225 K**	**$12,183 K**	**$12,582 K**	**-$400 K**	***-3.2%***
Healthcare Costs	**$11,039 K**	**$11,360 K**	**$11,386 K**	**-$27 K**	***-0.2%***
Administrative Expenses	$731 K	$731 K	$893 K	-$162 K	*-18.2%*
Premium Tax	$420 K	$420 K	$333 K	$87 K	*26.0%*
Total Expenses	$12,189 K	$12,510 K	$12,612 K	-$102 K	*-0.8%*
Net Surplus/(Loss)	**$36 K**	**-$327 K**	**-$30 K**	**-$297 K**	*990.9%*
MLR (Net of Premium Tax)	*93.5%*	*96.6%*	*93.0%*	*-3.6%*	

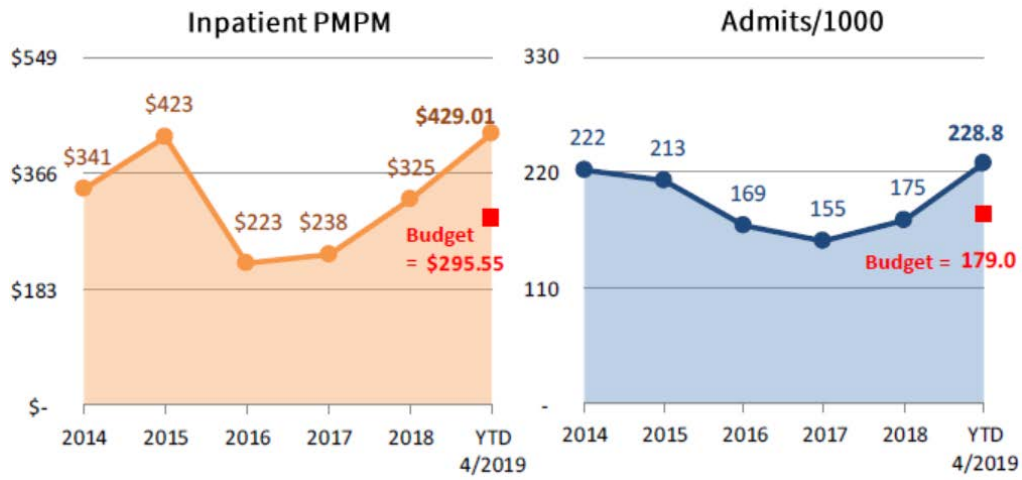
Current Year Performance

WCM Revenue Drivers:

- Revenue is below budget by $400K, or -3.2%, mostly due to lower than budget membership, offset slightly by higher yield PMPM.

WCM Healthcare Expense Trends:

- In total, healthcare cost is running close to budget; however, hospital inpatient is over budget significantly (45%), which is offset by the lower membership and lower budget cost in other areas.
- See Inpatient graphs below, from focus reports, showing high inpatient cost PMPM and high admit rate.



CAREADVANTAGE (MC + CA Combined)

See detail reports attached for separate P&L by insurance product (MC and CA).

	YTD Actual	Current Year	YTD Budget	Variance	% Var.
Membership	35,272	35,272	36,212	(940)	-2.6%
Operating Revenue	**$82,036 K**	**$81,027 K**	**$84,690 K**	**-$3,662 K**	**-4.3%**
Healthcare Costs	**$80,994 K**	**$82,106 K**	**$83,302 K**	**-$1,197 K**	**-1.4%**
Administrative Expenses	$5,909 K	$5,909 K	$6,079 K	-$170 K	-2.8%
Premium Tax	$0 K	$0 K	$0 K	$0 K	0.0%
Total Expenses	$86,903 K	$88,015 K	$89,381 K	-$1,367 K	-1.5%
Net Surplus/(Loss)	**-$4,867 K**	**-$6,988 K**	**-$4,692 K**	**-$2,296 K**	48.9%
MLR (Net of Premium Tax)	*98.7%*	*101.3%*	*98.4%*	*-3.0%*	

Current Year Performance

CMC Revenue Drivers:

- Revenue is below budget by $3.7M due to lower than budget membership (-2.6%) and lower yield PMPM (mostly on the CMS side).

CMC Healthcare Expense Trends:

- Healthcare cost is below budget by $1.2M, or -1.4%. This is mostly due to the lower membership but offset by slightly higher cost PMPM (-1.2%). Lots of noise between cost categories at this point (Hospital OP is running $1M over, and Other Medical is running $1M under).

HEALTHWORX, HEALTHY KIDS, ACE

HealthWorx:

- YTD performance through April shows a deficit of $286K, compared to budget deficit of $139K. Membership is running close to budget. The shortfall is due to healthcare cost running 7.5% higher than budget.

Healthy Kids:

- YTD performance through April shows a surplus of $548K, compared to budget surplus of $450K. Membership is running close to budget. The improvement is due to higher revenue yield, offset by slightly over budget on healthcare cost.

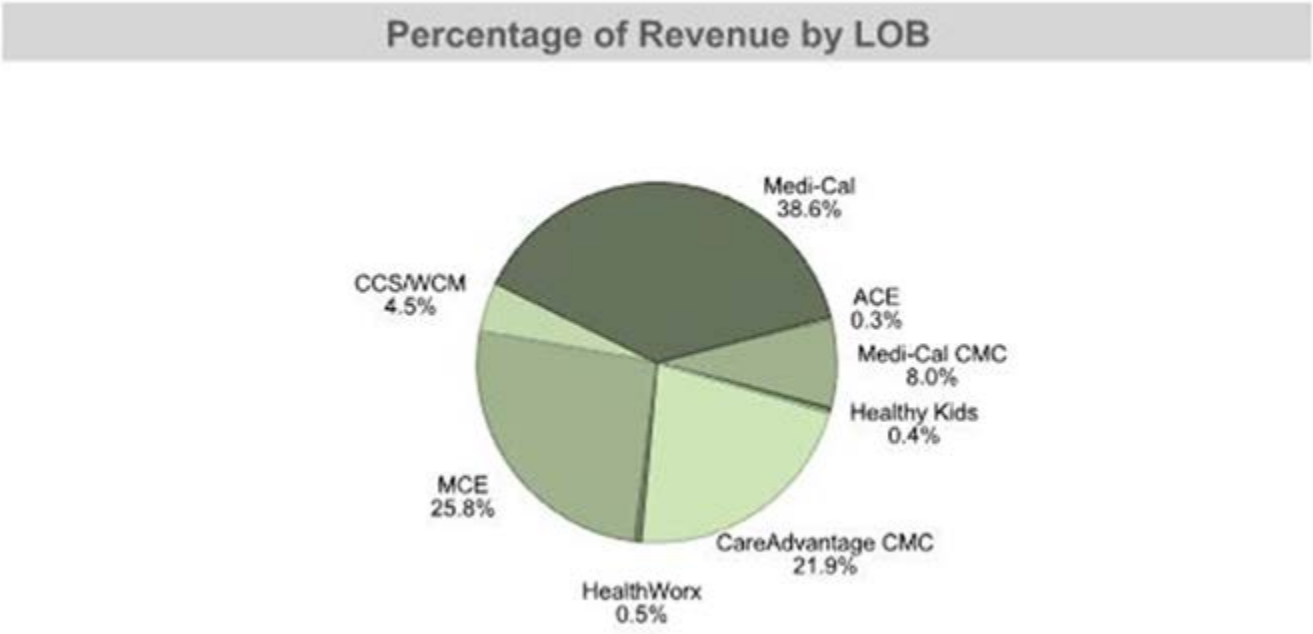
ACE:

- YTD performance through April shows a surplus of $23K, compared to a budget surplus of 63K. ACE membership is running 14% under budget.

HIGHLIGHTS OF ADDITIONAL METRICS

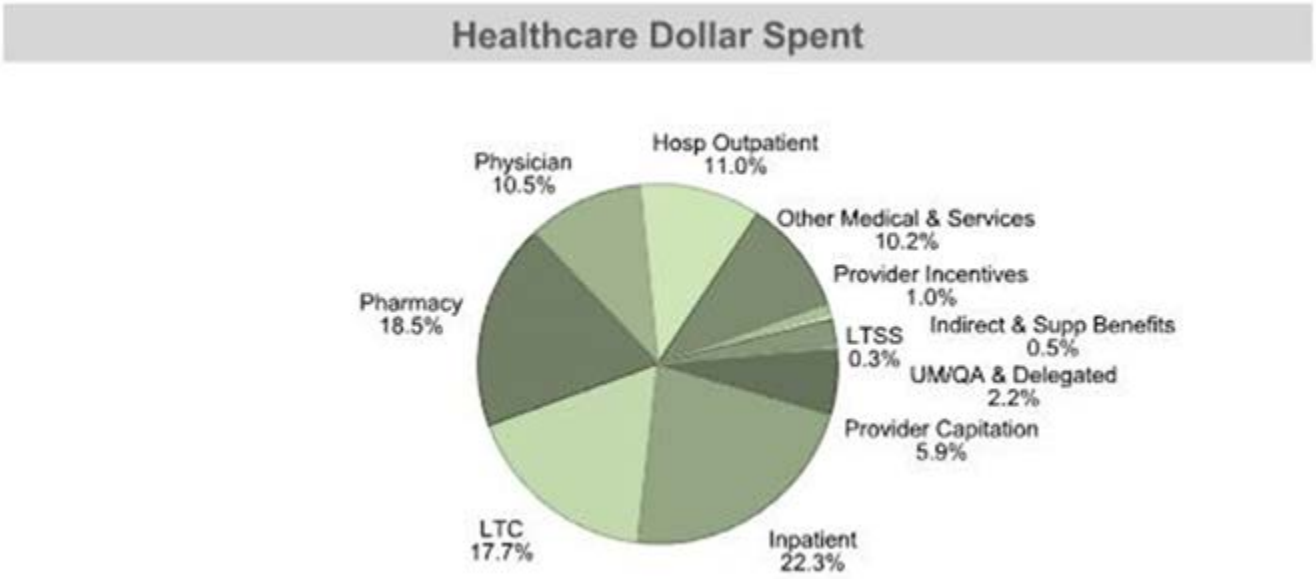
Revenue

Below is a depiction of revenue by each line of business in 2019. The largest share of HPSM revenue comes from the Medi-Cal Lines of Business: classic Medi-Cal, Medi-Cal Expansion, CCS/Whole Child Model and Medi-Cal CMC.



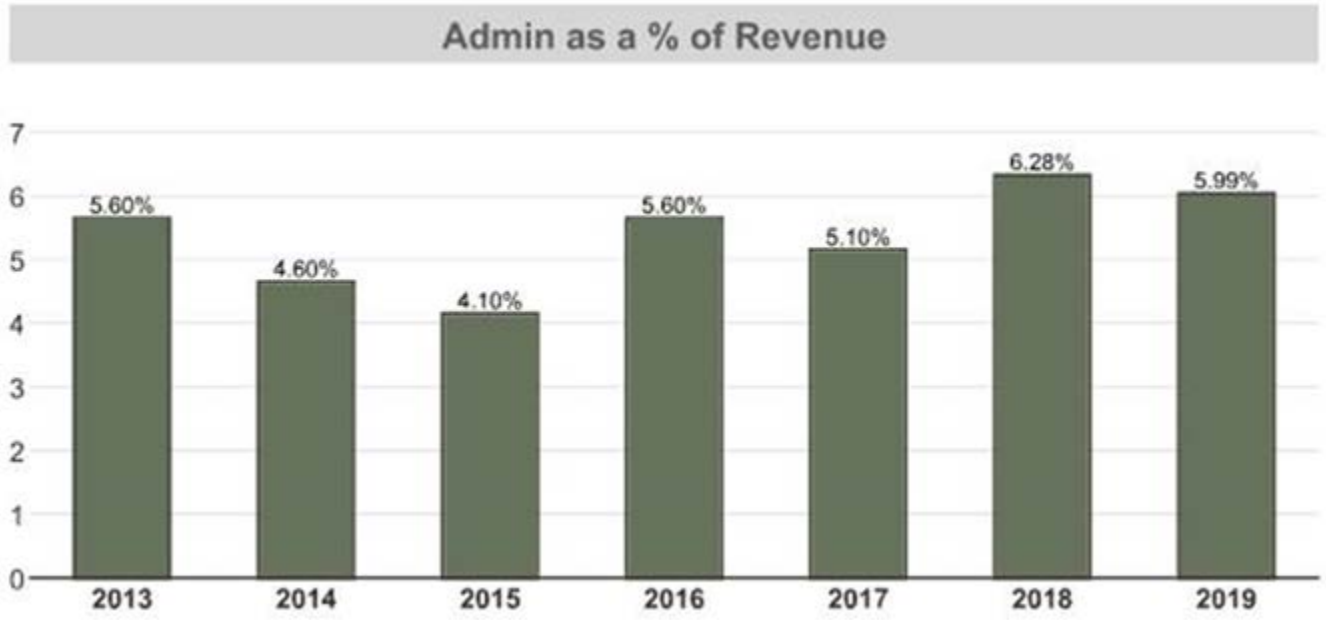
HealthCare Expenses

The graph below reflects how healthcare dollars are being spent in 2019.



Administrative Expenses

Administrative expenses are expressed as a percentage of net revenue received. The administrative expense percentage for 2019 is slightly lower than prior year. The percentage jump in 2018 was due to the transition of IHSS (financial) responsibility back to the State; therefore, resulting in lowered revenues.

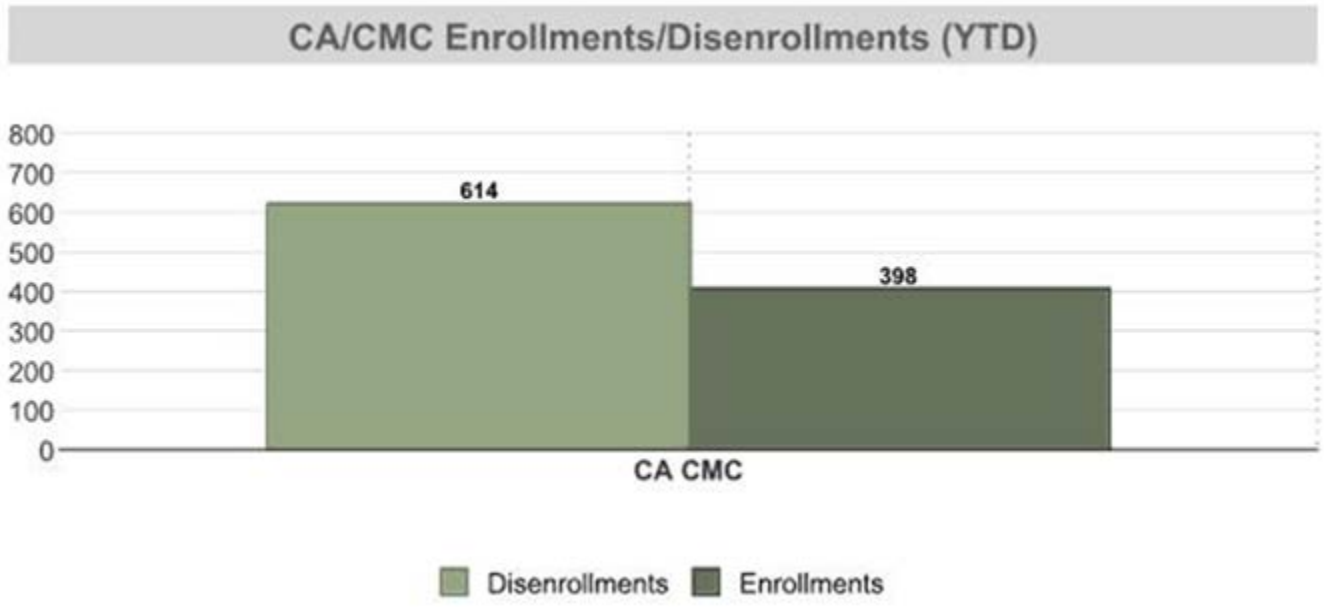


Investment and Interest

Total interest earned in April was $1,047,109, and $3,099,812 year to date.

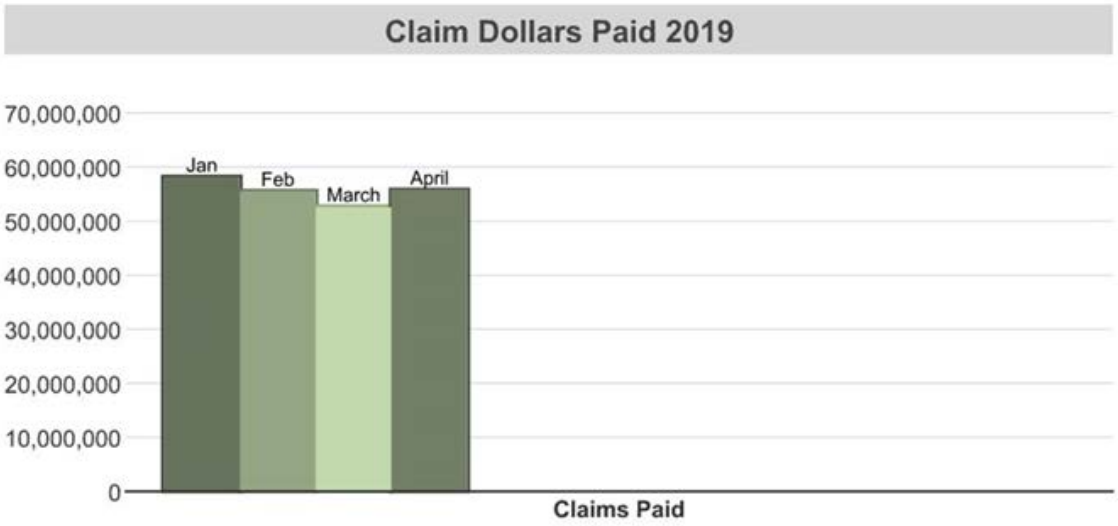
CMC Enrollment/Disenrollment

The YTD disenrollments were higher than enrollments at the end of April 2019. The graph does not reflect the work of the CA Outreach Unit who have saved 553 members (YTD) from being disenrolled. The CA Unit helps restore Medi-Cal eligibility or helps member restore SSI benefits.



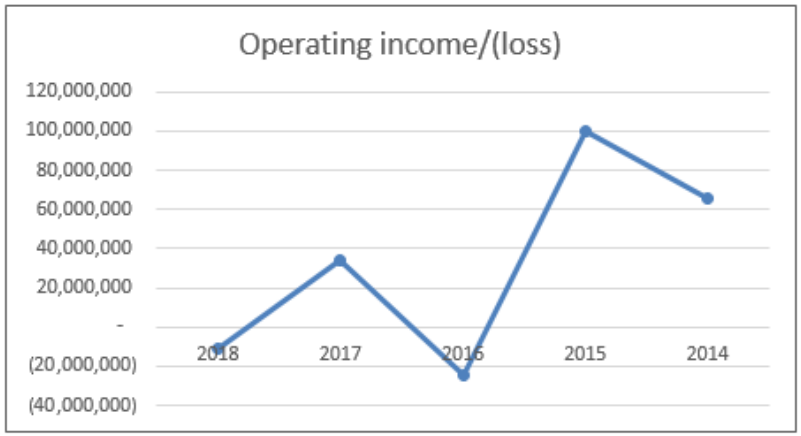
CLAIMS

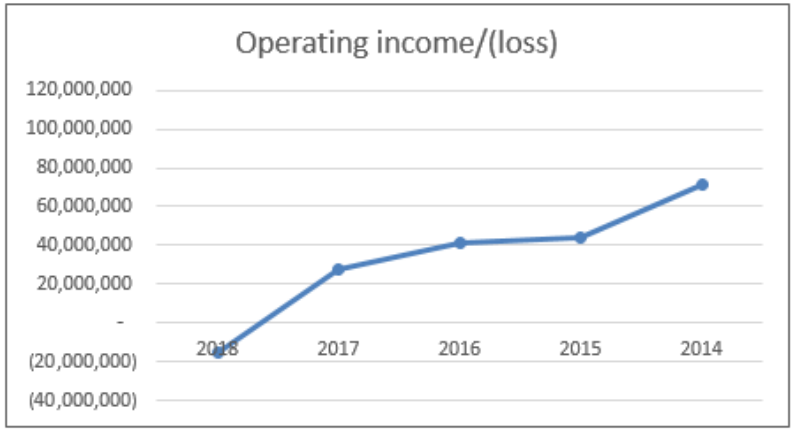
In the month of March, the Health Plan paid a total of 377,939 claims representing $55,463,034 worth of services to our members with 98.04% of those claims being paid within 30 days.



Five Year Trend Analysis

With Restated View by Date of Service

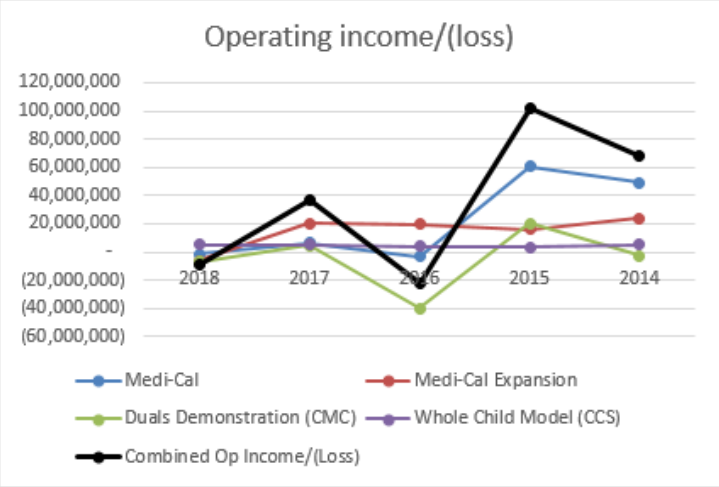


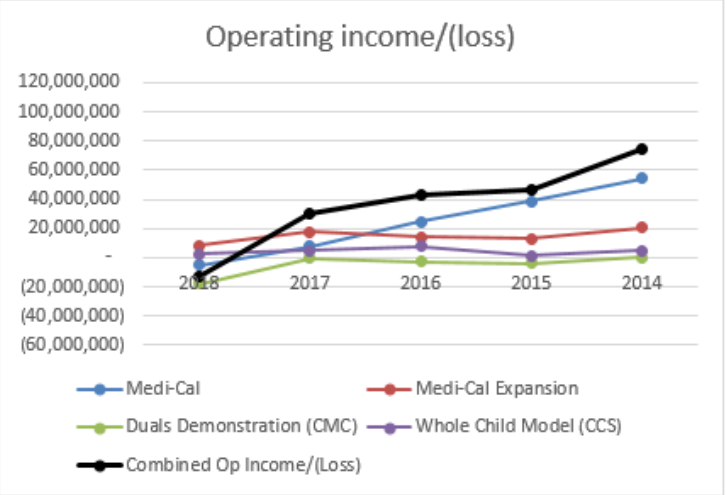


	Audited (from MultiView)					Restated BY DOS				
	2018	2017	2016	2015	2014	2018	2017	2016	2015	2014
Total Net Revenue	**$770,854 K**	**$906,421 K**	**$792,292 K**	**$910,959 K**	**$728,883 K**	**$782,222 K**	**$851,876 K**	**$862,685 K**	**$856,887 K**	**$752,293 K**
Total Health Care Expenses	$673,014 K	$764,432 K	$733,932 K	$737,400 K	$596,312 K	$688,116 K	$720,216 K	$737,449 K	$740,780 K	$621,039 K
G&A Allocation Expense	$48,399 K	$46,764 K	$44,590 K	$36,365 K	$33,072 K	$48,399 K	$46,764 K	$44,589 K	$36,365 K	$33,072 K
MCO Tax	$60,747 K	$57,409 K	$27,635 K	$983 K	$287 K	$60,747 K	$57,299 K	$27,745 K	($0 K)	$0 K
AB78 Sales Tax	($290 K)	$3,381 K	$10,272 K	$36,043 K	$33,421 K	$0 K	$53 K	$12,012 K	$35,508 K	$26,626 K
Total Operating Expense	**$781,870 K**	**$871,986 K**	**$816,429 K**	**$810,791 K**	**$663,092 K**	**$797,263 K**	**$824,331 K**	**$821,796 K**	**$812,654 K**	**$680,737 K**
Operating income/(loss)	**($11,017 K)**	**$34,435 K**	**($24,137 K)**	**$100,168 K**	**$65,791 K**	**($15,041 K)**	**$27,545 K**	**$40,889 K**	**$44,233 K**	**$71,557 K**
Total Non-operating Revenue	**$11,290 K**	**$7,390 K**	**$3,801 K**	**$3,263 K**	**$3,376 K**	**$11,290 K**	**$7,390 K**	**$3,801 K**	**$3,263 K**	**$3,376 K**
Net Income (Loss)	**$273 K**	**$41,824 K**	**($20,337 K)**	**$103,431 K**	**$69,167 K**	**($3,751 K)**	**$34,934 K**	**$44,690 K**	**$47,496 K**	**$74,932 K**

Net Income/(Loss) by Line-of-Business

With Restated View by Date of Service





Line of Business	2018 average membership	Audited (from MultiView) 2018	2017	2016	2015	2014	Restated BY DOS 2018	2017	2016	2015	2014
Operating income/(loss) by LOB:											
Medi-Cal	73,366	($1,254 K)	$6,589 K	($2,981 K)	$60,885 K	$49,154 K	($5,264 K)	$7,619 K	$24,739 K	$38,593 K	$54,632 K
Medi-Cal Expansion	33,846	($6,288 K)	$20,472 K	$19,607 K	$15,761 K	$23,725 K	$8,133 K	$17,653 K	$14,297 K	$12,768 K	$20,427 K
Duals Demonstration (CMC)	9,014	($6,658 K)	$4,389 K	($40,208 K)	$20,308 K	($2,784 K)	($18,091 K)	($280 K)	($2,543 K)	($3,971 K)	($50 K)
Whole Child Model (CCS)	1,690	$5,052 K	$4,887 K	$3,679 K	$3,423 K	$5,128 K	$2,240 K	$4,964 K	$7,829 K	$1,076 K	$4,623 K
HealthWorkx	1,102	($894 K)	($1,019 K)	($694 K)	($397 K)	($726 K)	($999 K)	($988 K)	($669 K)	($357 K)	($773 K)
Healthy Kids	1,513	$1,136 K	$793 K	$144 K	($125 K)	($228 K)	$1,112 K	$872 K	$90 K	($125 K)	($345 K)
ACE	23,034	$49 K	$121 K	$23 K	$450 K	$614 K	$49 K	$121 K	$23 K	$450 K	$614 K
Healthy Family (closed)		$0 K	$0 K	($0 K)	$0 K	$200 K	$0 K	$0 K	$0 K	$0 K	$11 K
D-SNP (closed)		$58 K	$412 K	($1,647 K)	$1,866 K	($6,889 K)	$0 K	($210 K)	($816 K)	($2,197 K)	($5,181 K)
Sub-total	143,565	($8,797 K)	$36,645 K	($22,077 K)	$102,171 K	$68,193 K	($12,819 K)	$29,751 K	$42,950 K	$46,237 K	$73,959 K
Corp-(non-operating revenue)	-	$9,071 K	$5,180 K	$1,740 K	$1,260 K	$974 K	$9,071 K	$5,180 K	$1,740 K	$1,260 K	$974 K
Combined net income/(loss)	143,565	$273 K	$41,824 K	($20,337 K)	$103,431 K	$69,167 K	($3,748 K)	$34,931 K	$44,690 K	$47,496 K	$74,932 K

Health Plan of San Mateo

Fiscal Year 2019

Statistical and Financial Summary
April-19

Month				Operating Margin	Year-to-Date			
Actual	Budget		Variance		Actual	Budget		Variance
71,895,131	65,415,244	▲	$6,479,887	Total Revenue	277,855,818	263,816,121	▲	$14,039,697
63,015,218	57,664,287	▲	$5,350,931	Total Health Care Costs	237,748,012	232,729,543	▲	$5,018,469
4,171,771	4,401,567	▼	($229,796)	Total Operational Admin Expenses	16,388,513	17,504,265	▼	($1,115,752)
5,206,984	4,547,268	▲	$659,716	Total MCO & AB78 Tax	20,730,264	18,189,070	▲	$2,541,194
(498,842)	($1,197,878)	▲	$699,036	Total Current Year Surplus (Deficit)	$2,989,029	($4,606,757)	▲	$7,595,786
5.8%				Admin Costs as a % of Revenue	5.9%			

Month			Membership	Year-to-Date		
Current	Prior	Variance		Current MM's	Budget MM's	Variance
100,966	101,082	(116)	Medi-Cal	406,563	405,188	1,375
8,857	8,875	(18)	CareAdvantage CMC	35,633	36,576	(943)
1,698	1,743	(45)	CCS	7,050	7,400	(350)
1,157	1,156	1	HealthWorx	4,623	4,580	43
1,571	1,595	(24)	Healthy Kids	6,303	6,080	223
23,745	23,554	191	ACE	93,882	109,940	(16,058)
137,994 *	138,005 *	(11)	Total*	554,054 *	569,764 *	(15,710)

* Total does not include Medi-cal CMC members, who in theory are the same as the CA CMC membership

Health Plan of San Mateo
Consolidated Balance Sheet
April 30, 2019 and March 31, 2019

	Current Month	Prior Month
ASSETS		
Current Assets		
Cash and Equivalents	$ 266,896,435	$ 302,273,791
Investments	163,951,510	162,973,491
Capitation Receivable from the State	77,229,154	45,093,754
Other Receivables	39,669,969	37,013,250
Prepaids and Other Assets	6,673,837	7,761,191
Total Current Assets	554,420,905	555,115,477
Capital Assets, Net	69,138,854	69,375,146
Net Pension Asset	-	-
Assets Restricted As To Use	300,000	300,000
Total Assets	623,859,760	624,790,623
Deferred Outflows of Resources	3,508,821	3,508,821
Total Assets & Deferred Outflows	$ 627,368,581	$ 628,299,444
LIABILITIES		
Current Liabilities		
Medical Claims Payable	72,403,584	70,106,369
Provider Incentives	5,076,854	4,657,313
Amounts Due to the State	112,084,980	99,833,760
Accounts Payable and Accrued Liabilities	92,877,351	108,277,348
Total Current Liabilities	282,442,769	282,874,790
Net Pension Liability	914,189	914,189
Deferred Inflows of Resources	1,502,453	1,502,453
Total Liabilities & Deferred Inflows	$ 284,859,411	$ 285,291,432
NET POSITION		
Invested in Capital Assets	69,138,854	69,375,146
Restricted By Legislative Authority	300,000	300,000
Unrestricted		
Stabilization Reserve	145,368,000	145,368,000
Unrestricted Retained Earnings	127,702,315	127,964,866
Net Position	342,509,170	343,008,012
Total Liabilities & Net Position	$ 627,368,581	$ 628,299,444
Change in Net Position	$ 2,989,029	$ 3,487,871

Health Plan of San Mateo
Consolidated Statement of Revenue & Expense
for the Period Ending April 30, 2019

	Current Month	Year to Date	Annual Budget	Unexpended Budget	% of Budget
OPERATING REVENUES					
Capitation and Premiums					
Medi-cal (includes MCE & Offsets)	$ 44,595,961	$ 173,825,327	$ 473,499,993	$ 299,674,666	36.7%
CareAdvantage	-	24,213	-	(24,213)	-
Healthy Kids	296,919	1,202,985	3,447,360	2,244,375	34.9%
HealthWorx	371,075	1,487,139	4,417,348	2,930,209	33.7%
Whole Child Model	5,288,218	15,083,980	37,746,771	22,662,791	40.0%
CA Cal MediConnect	14,757,307	60,137,972	194,811,369	134,673,397	30.9%
MC Cal MediConnect	5,262,612	21,897,854	65,055,876	43,158,022	33.7%
Total Operating Revenue	70,572,093	273,659,470	778,978,717	505,319,248	35.1%
OPERATING EXPENSES					
Health Care Expense					
Provder Capitation	3,488,752	13,998,236	41,478,015	27,479,779	33.8%
Hospital Inpatient	13,642,189	52,993,990	143,997,383	91,003,393	36.8%
Long Term Care	10,788,073	41,990,175	119,263,529	77,273,354	35.2%
Pharmacy	11,698,347	43,884,471	134,730,733	90,846,262	32.6%
Medical	21,723,142	75,186,583	215,061,794	139,875,211	35.0%
Long Term Support Services	178,324	803,226	2,488,083	1,684,857	32.3%
Provider Incentives	353,608	2,338,469	4,321,597	1,983,128	54.1%
Total Health Care Supplemental Benefits	509,038	1,892,075	6,275,741	4,383,666	30.2%
Total Indirect Health Care Expenses	(1,197,904)	(658,982)	848,062	1,507,044	-77.7%
Other Medical	(688,866)	1,233,093	7,123,802	5,890,709	17.3%
UMQA, Delegated and Allocation	1,831,650	5,319,769	19,652,662	14,332,894	27.1%
Total Health Care Expenses	63,015,218	237,748,012	688,117,598	450,369,586	34.6%
Administrative Expense					
Salaries and Benefits	2,995,139	11,991,791	37,140,000	25,148,208	32.3%
Staff Training and Travel	19,579	67,828	363,550	295,722	18.7%
Contract Services	1,717,566	5,777,339	20,032,200	14,254,861	28.8%
Office Supplies and Equipment	463,871	1,680,828	6,643,000	4,962,172	25.3%
Occupancy and Depreciation	400,203	1,581,257	5,324,000	3,742,743	29.7%
Postage and Printing	141,263	472,579	1,737,400	1,264,821	27.2%
Other Administrative Expense	239,847	396,955	1,676,100	1,279,145	23.7%
UM/QA Allocation	(1,805,696)	(5,580,064)	(19,406,620)	(13,826,556)	28.8%
Total Admin Expense	4,171,771	16,388,513	53,509,630	37,121,117	30.6%
Premium Taxes	5,206,984	20,730,264	54,567,210	33,836,946	38.0%
Total Operating Expense	72,393,973	274,866,788	796,194,438	521,327,649	34.5%
Net Income/Loss from Operations	(1,821,880)	(1,207,319)	(17,215,721)	(16,008,402)	7.0%
NON-OPERATING REVENUES					
Interest Income, Net	1,047,109	3,099,812	6,000,000	2,900,188	51.7%
Rental Income, Net	92,920	356,670	1,073,883	717,213	33.2%
Third Party Administrator Revenue	184,833	739,806	2,803,470	2,063,664	26.4%
Miscellaneous Income	(1,823)	60	-	(60)	-
Net Non-operating Revenues	1,323,038	4,196,348	9,877,353	5,681,005	42.5%
CHANGES IN NET ASSETS	$ (498,842)	$ 2,989,029	$ (7,338,368)	$ (10,327,397)	-40.7%

Health Plan of San Mateo
HPSM Statement of Revenue & Expense
for the Period Ending April 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
Total Operating Revenue	-	-	-	-	-	-	-
OPERATING EXPENSE							
Total Health Care Expense	-	-	-	-	-	-	-
G & A Allocation Expense	-	-	-	-	-	-	-
Total Operating Expense	-	-	-	-	-	-	-
NON-OPERATING REVENUE							
Interest, Net	1,047,109	500,000	209.4%	3,099,812	2,000,000	1,099,812	155.0%
Rental Income, Net	92,920	89,490	103.8%	356,670	357,961	(1,291)	99.6%
Miscellaneous Income	45	-	-	60	-	60	-
Total Non-Operating	1,140,074	589,490	193.4%	3,456,542	2,357,961	1,098,581	146.6%
Net Income/(Loss)	$ 1,140,074	$ 589,490	193.4%	$ 3,456,542	$ 2,357,961	$ 1,098,581	146.6%
Medical Loss Ratio	-	-		-	-		
Member Counts	-	-	-	-	-	-	-

Health Plan of San Mateo
Medi-Cal Statement of Revenue & Expense
for the Period Ending April 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
State Capitation	$ 45,153,646	$ 25,256,247	178.8%	$ 159,201,634	$ 102,346,672	$ 56,854,962	155.6%
BHT Capitation	238,933	-	-	1,512,075	-	1,512,075	-
HepC Capitation	121,478	-	-	689,049	-	689,049	-
MC Cap Offset	(19,679,362)	-	-	(55,623,330)	-	(55,623,330)	-
Total Operating Revenue	25,834,695	25,256,247	102.3%	105,779,428	102,346,672	3,432,756	103.4%
OPERATING EXPENSE							
Provider Capitation	1,396,263	1,453,596	96.1%	5,648,193	5,837,958	(189,765)	96.8%
Hospital Inpatient	5,343,880	3,715,017	143.9%	17,764,095	15,253,219	2,510,876	116.5%
Long Term Care	6,160,051	5,572,749	110.5%	24,227,171	22,582,623	1,644,548	107.3%
Pharmacy	3,534,354	3,155,685	112.0%	12,283,986	12,691,290	(407,304)	96.8%
Physician Fee for Service	3,019,076	2,201,077	137.2%	9,593,629	8,919,491	674,138	107.6%
Hospital Outpatient	2,589,295	2,086,801	124.1%	8,750,502	8,456,409	294,093	103.5%
Other Medical Claims	2,139,913	1,784,146	119.9%	7,231,822	7,229,952	1,870	100.0%
Other HC Services	571,183	433,599	131.7%	1,767,475	1,757,087	10,389	100.6%
Directed Payments	630,540	-	-	630,540	-	630,540	-
Long Term Support Services	72,633	75,810	95.8%	292,150	307,207	(15,056)	95.1%
Provider Incentives	153,810	158,155	97.3%	1,170,544	640,897	529,648	182.6%
Health Care Supplmntl Benefits	337,850	161,645	209.0%	766,474	655,039	111,435	117.0%
Indirect Health Care Expenses	(1,304,852)	33,511	-3893.8%	(850,429)	135,797	(986,226)	-626.3%
UMQA (Allocation & Delegated)	559,896	460,555	121.6%	1,336,254	1,842,220	(505,966)	72.5%
Total Health Care Expense	25,203,891	21,292,346	118.4%	90,612,408	86,309,188	4,303,220	105.0%
G & A Allocation Expense	1,453,909	1,377,784	105.5%	5,363,470	5,479,206	(115,736)	97.9%
Premium Tax	3,135,527	3,068,685	102.2%	13,660,594	12,274,740	1,385,854	111.3%
Total Operating Expense	29,793,327	25,738,815	115.8%	109,636,472	104,063,134	5,573,338	105.4%
NON-OPERATING REVENUE							
Total Non-Operating	-	-	-	-	-	-	-
Net Income/(Loss)	$ (3,958,632)	$ (482,568)	820.3%	$ (3,857,044)	$ (1,716,462)	$ (2,140,582)	224.7%
Medical Loss Ratio	111.03%	95.97%		98%	95.82%		
Member Counts	69,695	69,193	100.7%	277,359	279,172	(1,813)	99.4%

Health Plan of San Mateo
HealthWorx Statement of Revenue & Expense
for the Period Ending April 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
HealthWorx Premium	371,075	368,112	100.8%	1,487,139	1,472,449	14,690	101.0%
Total Operating Revenue	371,075	368,112	100.8%	1,487,139	1,472,449	14,690	101.0%
OPERATING EXPENSE							
Hospital Inpatient	12,456	59,135	21.1%	268,196	236,541	31,655	113.4%
Pharmacy	176,342	109,414	161.2%	574,850	437,656	137,194	131.4%
Physician Fee for Service	77,606	80,924	95.9%	339,685	323,695	15,990	104.9%
Hospital Outpatient	70,309	79,986	87.9%	309,143	319,943	(10,800)	96.6%
Other Medical Claims	17,555	20,529	85.5%	75,917	82,115	(6,198)	92.5%
Other HC Services	(1)	-	-	(1)	-	(1)	-
Health Care Supplmntl Benefits	90	-	-	374	-	374	-
Indirect Health Care Expenses	3,400	583	583.2%	14,154	2,332	11,822	606.9%
UMQA (Allocation & Delegated)	7,161	10,528	68.0%	29,062	42,112	(13,050)	69.0%
Total Health Care Expense	364,918	361,098	101.1%	1,611,379	1,444,393	166,986	111.6%
G & A Allocation Expense	26,878	32,206	83.5%	121,499	128,078	(6,579)	94.9%
Premium Tax	11,361	9,733	116.7%	40,183	38,930	1,253	103.2%
Total Operating Expense	403,157	403,037	100.0%	1,773,061	1,611,402	161,659	110.0%
NON-OPERATING REVENUE							
Total Non-Operating	-	-	-	-	-	-	-
Net Income/(Loss)	$ (32,082)	$ (34,925)	91.9%	$ (285,922)	$ (138,952)	$ (146,969)	205.8%
Medical Loss Ratio	101.45%	100.76%		111%	100.76%		
Member Counts	1,157	1,145	101.1%	4,623	4,580	43	100.9%

Health Plan of San Mateo
Healthy Kids Statement of Revenue & Expense
for the Period Ending April 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
Healthy Kids Premium	296,919	287,280	103.4%	1,202,985	1,149,120	53,865	104.7%
Total Operating Revenue	296,919	287,280	103.4%	1,202,985	1,149,120	53,865	104.7%
OPERATING EXPENSE							
Hospital Inpatient	(18,296)	19,868	-92.1%	37,729	79,472	(41,743)	47.5%
Pharmacy	22,027	22,828	96.5%	139,973	91,311	48,662	153.3%
Physician Fee for Service	28,771	34,697	82.9%	143,477	138,788	4,689	103.4%
Hospital Outpatient	18,525	23,493	78.9%	91,777	93,972	(2,195)	97.7%
Other Medical Claims	9,805	9,584	102.3%	39,990	38,337	1,653	104.3%
Other HC Services	5,185	-	-	20,629	-	20,629	-
Health Care Supplmntl Benefits	36,132	37,233	97.0%	148,347	148,931	(583)	99.6%
Indirect Health Care Expenses	4,718	700	674.4%	19,509	2,798	16,711	697.2%
UMQA (Allocation & Delegated)	1,335	3,323	40.2%	8,661	13,292	(4,631)	65.2%
Total Health Care Expense	108,201	151,725	71.3%	650,093	606,901	43,192	107.1%
G & A Allocation Expense	5,676	10,166	55.8%	38,147	40,427	(2,280)	94.4%
Premium Tax	(114,974)	12,920	-889.9%	(32,942)	51,680	(84,622)	-63.7%
Total Operating Expense	(1,097)	174,811	-0.6%	655,298	699,008	(43,710)	93.8%
NON-OPERATING REVENUE							
Miscellaneous Income	(1,868)	-	-	-	-	-	-
Total Non-Operating	(1,868)	-	-	-	-	-	-
Net Income/(Loss)	$ 296,148	$ 112,469	263.3%	$ 547,687	$ 450,112	$ 97,575	121.7%
Medical Loss Ratio	26.27%	55.30%		53%	55.30%		
Member Counts	1,509	1,520	99.3%	6,303	6,080	223	103.7%

Health Plan of San Mateo
CareAdvantage Statement of Revenue & Expense
for the Period Ending April 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
CareAdvantage Premium	-	-	-	24,213	-	24,213	-
Total Operating Revenue	-	-	-	24,213	-	24,213	-
OPERATING EXPENSE							
Hospital Inpatient	-	-	-	17,495	-	17,495	-
Pharmacy	11	-	-	84	-	84	-
Physician Fee for Service	-	-	-	(89)	-	(89)	-
Hospital Outpatient	-	-	-	(1,760)	-	(1,760)	-
Other Medical Claims	-	-	-	314	-	314	-
Total Health Care Expense	11	-	-	16,045	-	16,045	-
G & A Allocation Expense	-	-	-	-	-	-	-
Total Operating Expense	11	-	-	16,045	-	16,045	-
NON-OPERATING REVENUE							
Total Non-Operating	-	-	-	-	-	-	-
Net Income/(Loss)	$ (11)	-	-	$ 8,168	-	$ 8,168	-
Medical Loss Ratio	-	-		66%	-		
Member Counts	-	-	-	-	-	-	-

Health Plan of San Mateo
ACE Statement of Revenue & Expense
for the Period Ending April 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
Total Operating Revenue	-	-	-	-	-	-	-
OPERATING EXPENSE							
Total Health Care Expense	-	-	-	-	-	-	-
G & A Allocation Expense	164,501	219,076	75.1%	716,704	871,227	(154,523)	82.3%
Total Operating Expense	164,501	219,076	75.1%	716,704	871,227	(154,523)	82.3%
NON-OPERATING REVENUE							
Third Party Administror Revenue	184,833	233,623	79.1%	739,806	934,490	(194,684)	79.2%
Total Non-Operating	184,833	233,623	79.1%	739,806	934,490	(194,684)	79.2%
Net Income/(Loss)	$ 20,332	$ 14,546	139.8%	$ 23,102	$ 63,263	$ (40,161)	36.5%
Medical Loss Ratio	-	-		-	-		
Member Counts	23,913	27,385	87.3%	93,882	109,300	(15,418)	85.9%

Health Plan of San Mateo
CCS Statement of Revenue & Expense
for the Period Ending April 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
CCS Capitation	5,288,218	3,145,564	168.1%	15,083,980	12,582,257	2,501,723	119.9%
BHT Capitation	-	-	-	15,928	-	15,928	-
MC Cap Offset	(2,306,526)	-	-	(2,874,650)	-	(2,874,650)	-
Total Operating Revenue	2,981,692	3,145,564	94.8%	12,225,258	12,582,257	(356,999)	97.2%
OPERATING EXPENSE							
Provider Capitation	50,034	54,113	92.5%	207,281	208,125	(844)	99.6%
Hospital Inpatient	717,155	545,789	131.4%	3,024,938	2,187,085	837,853	138.3%
Long Term Care	80,893	77,700	104.1%	330,635	310,800	19,835	106.4%
Pharmacy	597,314	748,240	79.8%	2,424,241	2,992,959	(568,718)	81.0%
Physician Fee for Service	271,287	171,296	158.4%	680,132	685,185	(5,053)	99.3%
Hospital Outpatient	547,754	490,684	111.6%	1,591,835	1,962,736	(370,901)	81.1%
Other Medical Claims	464,479	380,504	122.1%	1,315,786	1,522,017	(206,231)	86.5%
Other HC Services	78,208	44,495	175.8%	468,315	177,982	290,334	263.1%
Directed Payments	21,564	-	-	21,564	-	21,564	-
Provider Incentives	3,656	3,861	94.7%	25,995	15,446	10,549	168.3%
Health Care Supplmntl Benefits	36,593	6,115	598.4%	55,889	24,461	31,428	228.5%
Indirect Health Care Expenses	(6,828)	1,285	-531.3%	(305,037)	5,141	(310,178)	-5933.8%
UMQA (Allocation & Delegated)	389,996	323,584	120.5%	1,197,463	1,294,337	(96,874)	92.5%
Total Health Care Expense	3,252,107	2,847,667	114.2%	11,039,037	11,386,273	(347,236)	97.0%
G & A Allocation Expense	201,439	224,549	89.7%	730,565	892,990	(162,425)	81.8%
Premium Tax	186,918	83,250	224.5%	419,570	333,000	86,570	126.0%
Total Operating Expense	3,640,464	3,155,465	115.4%	12,189,171	12,612,263	(423,092)	96.7%
NON-OPERATING REVENUE							
Total Non-Operating	-	-	-	-	-	-	-
Net Income/(Loss)	$ (658,772)	$ (9,901)	6653.6%	$ 36,087	$ (30,006)	$ 66,093	-120.3%
Medical Loss Ratio	116.36%	92.99%		94%	92.95%		
Member Counts	1,722	1,850	93.1%	7,050	7,400	(350)	95.3%

Health Plan of San Mateo
MCE Statement of Revenue & Expense
for the Period Ending April 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
MCE Capitation	34,759,792	14,310,193	242.9%	111,324,801	58,283,485	53,041,316	191.0%
MC Cap Offset	(13,692,000)	-	-	(40,420,180)	-	(40,420,180)	-
Total Operating Revenue	21,067,792	14,310,193	147.2%	70,904,621	58,283,485	12,621,136	121.7%
OPERATING EXPENSE							
Provider Capitation	1,418,271	1,335,517	106.2%	5,639,015	5,429,891	209,124	103.9%
Hospital Inpatient	3,066,575	2,585,770	118.6%	11,010,007	10,520,800	489,206	104.7%
Long Term Care	741,045	661,428	112.0%	3,150,539	2,693,908	456,631	117.0%
Pharmacy	3,471,989	3,072,375	113.0%	13,115,497	12,513,371	602,126	104.8%
Physician Fee for Service	1,724,955	1,460,219	118.1%	6,637,349	5,947,273	690,076	111.6%
Hospital Outpatient	1,873,435	1,719,713	108.9%	7,443,135	7,004,160	438,974	106.3%
Other Medical Claims	770,424	765,799	100.6%	3,060,885	3,118,997	(58,112)	98.1%
Other HC Services	1	-	-	0	-	0	-
Directed Payments	573,760	-	-	573,760	-	573,760	-
Long Term Support Services	1,798	2,162	83.2%	7,153	8,804	(1,650)	81.3%
Provider Incentives	83,224	84,068	99.0%	638,031	342,398	295,633	186.3%
Health Care Supplmntl Benefits	(12,170)	163,615	-7.4%	351,773	666,383	(314,611)	52.8%
Indirect Health Care Expenses	93,309	25,277	369.1%	398,021	102,951	295,069	386.6%
UMQA (Allocation & Delegated)	252,383	332,897	75.8%	800,297	1,331,589	(531,291)	60.1%
Total Health Care Expense	14,058,998	12,208,841	115.2%	52,825,461	49,680,524	3,144,937	106.3%
G & A Allocation Expense	891,437	1,009,136	88.3%	3,508,839	4,013,157	(504,318)	87.4%
Premium Tax	1,988,152	1,372,680	144.8%	6,642,860	5,490,720	1,152,140	121.0%
Total Operating Expense	16,938,587	14,590,657	116.1%	62,977,160	59,184,401	3,792,759	106.4%
NON-OPERATING REVENUE							
Total Non-Operating	-	-	-	-	-	-	-
Net Income/(Loss)	$ 4,129,205	$ (280,464)	-1472.3%	$ 7,927,461	$ (900,916)	$ 8,828,376	-879.9%
Medical Loss Ratio	73.69%	94.37%		82%	94.10%		
Member Counts	32,280	31,129	103.7%	128,815	126,016	2,799	102.2%

Health Plan of San Mateo
CA CMC Statement of Revenue & Expense
for the Period Ending April 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
CA Cal MediConnect Premium	14,757,307	15,812,304	93.3%	60,137,972	63,093,327	(2,955,355)	95.3%
Total Operating Revenue	14,757,307	15,812,304	93.3%	60,137,972	63,093,327	(2,955,355)	95.3%
OPERATING EXPENSE							
Provider Capitation	622,991	629,384	99.0%	2,501,145	2,462,903	38,242	101.6%
Hospital Inpatient	4,320,650	4,969,401	87.0%	19,945,440	20,223,552	(278,113)	98.6%
Pharmacy	3,811,239	4,034,215	94.5%	14,926,811	16,097,088	(1,170,276)	92.7%
Physician Fee for Service	1,662,378	1,726,292	96.3%	6,409,019	6,833,555	(424,536)	93.8%
Hospital Outpatient	1,694,082	1,475,872	114.8%	6,577,521	5,888,937	688,584	111.7%
Other Medical Claims	1,465,449	1,846,363	79.4%	5,701,694	7,367,250	(1,665,556)	77.4%
Other HC Services	0	-	-	0	-	0	-
Provider Incentives	112,777	116,258	97.0%	503,411	463,885	39,526	108.5%
Health Care Supplmntl Benefits	(179,728)	81,555	-220.4%	2,861	325,415	(322,555)	0.9%
Indirect Health Care Expenses	12,349	9,583	128.9%	64,800	38,239	26,561	169.5%
UMQA (Allocation & Delegated)	495,286	455,003	108.9%	1,657,712	1,820,011	(162,299)	91.1%
Total Health Care Expense	14,017,473	15,343,925	91.4%	58,290,414	61,520,834	(3,230,420)	94.8%
G & A Allocation Expense	1,241,522	1,370,091	90.6%	4,989,300	5,448,614	(459,314)	91.6%
Total Operating Expense	15,258,995	16,714,017	91.3%	63,279,714	66,969,449	(3,689,734)	94.5%
NON-OPERATING REVENUE							
Total Non-Operating	-	-	-	-	-	-	-
Net Income/(Loss)	$ (501,687)	$ (901,713)	55.6%	$ (3,141,742)	$ (3,876,122)	$ 734,379	81.1%
Medical Loss Ratio	94.99%	97.04%		97%	97.51%		
Member Counts	8,853	9,119	97.1%	35,633	36,416	(783)	97.9%

Health Plan of San Mateo
Medi-Cal CMC Statement of Revenue & Expense
for the Period Ending April 30, 2019

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
MC Cal MediConnect Capitation	5,262,612	5,412,430	97.2%	21,897,854	21,596,360	301,494	101.4%
Total Operating Revenue	5,262,612	5,412,430	97.2%	21,897,854	21,596,360	301,494	101.4%
OPERATING EXPENSE							
Provider Capitation	1,193	-	-	2,603	-	2,603	-
Hospital Inpatient	199,770	198,633	100.6%	926,090	792,575	133,515	116.9%
Long Term Care	3,806,083	3,563,049	106.8%	14,281,830	14,217,068	64,762	100.5%
Pharmacy	85,071	127,806	66.6%	419,029	509,964	(90,935)	82.2%
Physician Fee for Service	277,965	301,257	92.3%	1,129,230	1,202,058	(72,828)	93.9%
Hospital Outpatient	316,146	295,999	106.8%	1,294,161	1,181,077	113,084	109.6%
Other Medical Claims	803,494	716,033	112.2%	3,289,148	2,857,073	432,075	115.1%
Other HC Services	0	-	-	(2)	-	(2)	-
Long Term Support Services	103,893	127,806	81.3%	503,922	509,964	(6,042)	98.8%
Provider Incentives	141	-	-	489	-	489	-
Health Care Supplmntl Benefits	290,271	75,953	382.2%	566,357	303,064	263,292	186.9%
Indirect Health Care Expenses	-	315	-	-	1,259	(1,259)	-
UMQA (Allocation & Delegated)	125,594	51,832	242.3%	290,319	207,327	82,991	140.0%
Total Health Care Expense	6,009,619	5,458,683	110.1%	22,703,175	21,781,429	921,746	104.2%
G & A Allocation Expense	186,409	158,560	117.6%	919,988	630,565	289,423	145.9%
Total Operating Expense	6,196,028	5,617,243	110.3%	23,623,163	22,411,995	1,211,169	105.4%
NON-OPERATING REVENUE							
Total Non-Operating	-	-	-	-	-	-	-
Net Income/(Loss)	$ (933,416)	$ (204,814)	455.7%	$ (1,725,309)	$ (815,635)	$ (909,674)	211.5%
Medical Loss Ratio	114.19%	100.85%		104%	100.86%		
Member Counts	8,695	9,017	96.4%	34,911	36,008	(1,097)	97.0%

Draft

FINANCE/EXECUTIVE COMMITTEE MEETING
Meeting Summary – April 29, 2019
Criminal Justice Training Room (CJTR), 400 County Center, First Floor, Redwood City, CA 94063

Teleconference location: Health Plan of San Mateo Boardroom, 801 Gateway Blvd., South San Francisco, CA 94080

Member's present: Don Horsley, Mike Callagy, Si France, M.D.

Member's absent: Bill Graham, David Canepa

Staff present: Maya Altman, Trent Ehrgood, Lia Vedovini, Francine Lester, Ian Johansson, Dr. Susan Huang, Katie-Elyse Turner, Chris Baughman, Pat Curran, Michelle Heryford

1.0 Call to Order – The meeting was called to order at 12:33 pm by Don Horsley.

2.0 Public Comment – There was no public comment at either location.

3.0 Approval of Meeting Summary – The minutes were approved as presented. **M/S/P**

4.0 Preliminary Financial and Operational Report for the period ending March 31, 2019 Mr. Ehrgood opened by going over the new layout of the packet. He has introduced a new front page that will have a rolling three-month trend, and a view that reflects the differences between current year and prior year transactions. He went on to review the financial report. The preliminary financial result for all lines of business for the month of March is a surplus of $3,651,656. YTD, the Plan has a surplus of $3,487,872. The first quarter included $9.2M in favorable prior year transactions. The remaining current year transactions results in a YTD deficit of $5.7M, compared to the YTD budget deficit of $3.4M.

Mr. Ehrgood emphasized the significance of estimates and timing differences, and how this can change the true results of a given calendar year. In fact, he noted that just three months in, assumptions in the budget have already changed considerably. He noted that while it's important to understand trends and estimates it's also important to look back at how adjustments and true ups affect HPSM's real historical trend. He also mentioned he will bring information on our recent five-year trends to the next meeting.

Mr. Ehrgood went over the surplus/deficit graphs, and said he moved them to the same page to help one easily note comparisons. Going forward he will include percentages of each variance as a tool to help determine financial impact. He went over highlights by line-of business, noting WCM inpatient admissions were up in March, which is historically a high utilization month. There was a question about why healthcare costs are going up in some areas and not others. Mr. Ehrgood noted that there is a lot of volatility in this LOB, this is a small cohort where the entire population is sick.

He also went over the MC-CMC and CA-CMC lines of business. He is proposing combining the two reports and looking at them together to see how the population is performing as a whole. He asked for feedback. The group was receptive to the idea. They will give it a try at the next meeting, if the committee feels there is information missing, he will go back to separate reports.

There was a small problem with slide 12 that was recently identified; it understated the Medi-Cal budget member months and will be corrected. There was a question on the annual return of the reserves, Trent said our cash surplus is invested very conservatively, and currently earns approximately between 2- 2.5%. They are moving around some of the cash reserves to take advantage of maximum returns.

Mr. Ehrgood noted that both the detail TNE calculation page and the investment by account pages has been removed from the packet, noting this level of detail was probably not necessary.

Mr. Ehrgood concluded with a few takeaways in a Past, Present, Future format.

- First, is the importance of historical trends (the Past), and how this helps us understand how we got here, and how to course correct, keeping in mind the significance of estimates and timing differences, and the effect this has on our view of historical trends.
- Second, is monitoring current year results (the Present), and being mindful of prior year adjustments included in current year results.
- Last is the importance of continued forecasting efforts (the Future), noting that the budget is one point of comparison, that quickly becomes outdated. Continued re-forecasting is important tool for long term planning, like implications of the pharmacy carve out, as an example.

There was a question about the pharmacy carve out from Supervisor Horsley. Ms. Altman briefly went over the proposal by Governor Newsom. There were questions about how that would affect HPSM members. Ms. Altman noted that while HPSM and other Health Plans are not keen on the pharmacy changes, they are not coming out vocally against it yet and are instead seeking alternatives.

There was a question about an increase in audits. There was agreement that there may be more State ordered audits around pediatrics going forward. The report was approved as presented. **M/S/P**

5.0 San Mateo Health Commission Agenda – Ms. Altman went over the SMHC agenda, there are no changes.

6.0 Other Business – There was no other business.

7.0 Adjournment – The meeting was adjourned at 1:31 pm by Supervisor Horsley. M/S/P

Respectfully submitted:

M. Heryford

M. Heryford
Assistant Clerk to the Commission

AGENDA ITEM: 4.2

DATE: June 12, 2019

DRAFT

Health Plan of San Mateo
Cal MediConnect Advisory Committee
Meeting Minutes
Friday, April 26, 2019 – 10:00 a.m.
Health Plan of San Mateo
801 Gateway Blvd., Boardroom
South San Francisco, CA 94080

Committee Members Present: Gay Kaplan, Lisa Mancini, Teresa Guingona Ferrer, Ligia Andrade Zuniga, Pete Williams, Claire Day, Janet Hogan, and Kirsten Irgens-Moller.

Committee Members Absent: Christina Kahn, Nancy Keegan, Evelina Chang, Tricia Berke Vincent, Beverly Karnatz, Sharolyn Kriger, and Diane Prosser.

Staff Present: Maya Altman, Pat Curran, Adrienne Lebsack, Gabrielle Ault-Riche, Katie-Elyse Turner, and Susan Huang, M.D.

Guests Present: Michael Grimes, Nina Rhee, Jill Dawson.

1. Call to Order

The meeting was called to order at 10:00 a.m. by Gay Kaplan.

2. Public Comment

There was no additional public comment at this time.

3. Approval of Minutes

The minutes for the January 18, 2019 meeting were approved as presented. **M/S/P.**

4. Ombudsman Services (LTC) Report

Ms. Irgens-Moller, Regional Coordinator for Ombudsman Services of San Mateo County, advocating for the rights of residents in long-term care facilities, reported they have been seeing out of county people due to SNFs in San Francisco declining to accept Medi-Cal. People are struggling to transfer from San Francisco Health Plan to HSPM. Ms. Altman stated that this is not under HPSM control and likely under the responsibility of Human Services at the County. Ms. Ault-Riche asked that information on these cases be sent to her to review but that Human Services is responsible for inter-county transfers. Ms. Mancini was concerned by this because she stated there is a lack of Medi-Cal beds in San Mateo County and wondered what is happening in San Francisco. Ms. Irgens-Moller stated it is her understanding that all the Kindred facilities are transitioning into Medicare/rehab, short-term only and not accepting new Medi-Cal patients. She will look into this further.

The other concern Ms. Irgens-Moeller raised was related to Seton and if the new buyer will be committed to continuing to serve the Medi-Cal population. Ms. Altman stated that the status on Verity is that the court recently approved the new buyer. Next, the Attorney General will need to

approve the sale and public hearings will be scheduled. There were commitments made in 2015 that would need to be kept and she does not expect much to change at this point. She did note, however, they have said they would reduce the cancer service of which they do not have much. Mr. Curran added that the status of the sub-acute unit and Coastside long term care have been topics of discussion. There is no indication of any change but is really important to us.

Ms. Irgens-Moller commented that Seton staff are being told they need to start "correcting the payment mix." Ms. Altman said there have been discussions about them serving more Medicare with a goal to increase services provided at Coastside but expressed concern about preserving the mix. Ms. Altman said HPSM provided funding to reopen the Skilled Nursing Facility Unit on the 9th floor of Seton and part of the agreement was Seton taking on HPSM patients. They are full and have a lot of HPSM patients.

Ms. Irgens-Moller stated that the ongoing difficulty in discharges is another concern. It is hard to figure out what to do with people who don't have resources who are leaving nursing homes. Ms. Altman stated that HPSM is in the process of implementing a recuperative care program and is doing as much as possible through the Community Care Settings Program (CCSP). San Mateo County is having the same problem of losing Board and Care facilities having lost three last week in San Bruno and South San Francisco. Ms. Altman reported that IOA has been contracting with some new ones but overall the picture is grim.

Ms. Mancini suggested presenting recent data on the CCSP to get a better overall picture. She reported that they learned recently that one of their low income motels, Bel-Mateo Hotel will be closing. For years, this has been a place where they could house folks for a short period of time and get them stabilized at a lower rate and is another lost housing resource.

Ms. Irgens-Moller concluded that the Ombudsman groups at the state level will be meeting soon to lobby for much needed support.

5. Legal Aid Report

Representatives from Legal Aid were unable to attend this meeting. They will give a report at the next meeting.

6. Grievances and Appeals Report

Ms. Ault-Riche reported on Q4 of 2018:

- Rate of Complaints per 1,000 members for CMC has been well within the goal range of 21.3 per thousand for CMC members.
- Timeliness of Complaint Resolution shows that Grievances and Appeals are up due again to staffing issues. The goal is 95% but the last quarter resulted in 75% of grievances and 87% of Medical appeals resolved on time. In the last month, staff has cleared up a significant backlog. Currently, they have two nurse positions open.
- Volume and Types of Complaints: Appeals have remained steady and grievances have gone down throughout the year.

- Types of Grievances are consistent with past quarters; they are not seeing any unusual trends or problems for members.
- **Resolutions Within 24 Hours of Receipt**: Prescription Drug issues have remained steady (being resolved while the member is generally still at the pharmacy); resolution of issues related to Medical Supplies has gone down significantly from a total of 75 in the first quarter of the year to 9 at the last quarter of the year.
- **Types of Appeals** has remained consistent as well as the Rate of Overturned Appeals
    i. **Part C (Medical Services)**: the overturned appeals rate is 25%
    ii. **Part D (Prescription Drugs):** still high at 67% - this is primarily due to incomplete information. The Pharmacy Unit has less time to chase information. Staff continues to keep watch on this though due to the tight timeframes, the expectation is that this is normal.
- **Overturned Appeals by Provider Type** – the types of services that tend to be overturned are pharmacy, ancillary and home health. The initial decisions on Physical Therapy and Specialist appeals are generally upheld which means we are receiving the information needed to make the correct decision the first time.
- **PCP Changes** indicate that of the 75 members across all lines of business who requested to change their PCP during the quarter were for a total of 30 different providers and half of those were clinics. Also, providers with five or more members requesting a switch were from clinics. There is generally more concern when multiple members move from an individual provider rather than a clinic. This activity is consistent with previous quarters.

Ms. Kaplan asked if there is a trend in the type of drugs that are involved with the appeals. Ms. Ault-Riche said she would research this. Ms. Kaplan asked if there is a trend in reasons related to PCP changes. Ms. Ault-Riche responded that of the 75 changes, 26 switched because they could not get an appointment with their current PCP; 43 switched because of what they felt was poor service.

7. Updates and Discussion

- **Education Topics (taken out of sequence)**

Ms. Katie-Elyse Turner explained that, as a CMC plan, staff have a monthly call with CMS and DHCS to report on the CMC program regarding grievances and appeals, enrollment, marketing issues; this usually includes a monthly discussion topic identified by CMS. CMS sends questions for their selected topic to staff in advance which relate to various CMC benefits, plan processes or overall reporting across the Plans. Through this process, Plans receive information on what CMS identifies as best practices or trends. Ms. Turner presented an overview of the topics discussed at these meetings over the past quarter. She plans to give a similar report as educational topics at these CMC meetings going forward. In Q1 2019, the topics discussed were MSSP, Quality of Care in nursing facilities, and CAHPS scores. Her presentation with the outline of this information is attached:

MSSP

In January, CMS and DHCS were interested in MSSP particularly around participation, referrals and how integrated MSSP works. She noted that HPSM is the only CMC Plan that has integrated its program with the County systems.

Multipurpose Senior Services Program (MSSP) is an intensive home-based case management program with the goal of helping members stay in the community. Members eligible for MSSP are those who have a nursing facility level need of care, are already living in the community, and need some case management support to stay in their home. San Mateo County Health's Partners for Independence (PFI) is the newly re-branded agency which administers this program (previously called CCI-IHSS Unit). Ricky Kot is the manager of this unit and will join this meeting in the future. Key to this program is the Interdisciplinary Care Team (ICT) that works with members to develop individualized care plans (ICP). CMS and DHCS were interested in the process for intake and referrals.

Ms. Altman added that the MSSP Site Association sent a letter to DHCS to suggest that ongoing MSSP integration efforts not move forward and that MSSP be carved out of CMC. HPSM and LHPC plans have drafted letters to make a case to keep MSSP integration within the Plans moving forward. Ms. Turner noted that MSSP has been an integrated program at HPSM since 2014 and it would take a lot of work to unravel. Ms. Kaplan asked why they would want to fragment programs again. Ms. Altman was unsure how this would be beneficial. The message HPSM and the LHPC plans would like to send is that this program is worth working on and it is possible for integration to be successful.

There was a question about where the referrals come from. Ms. Turner stated the biggest referral source right now is the Health Risk Assessment process and the Care Planning process that staff administers. The assessment is a 50 question telephonic assessment and the care plan generates follow up items that go to the Care Coordination Team. They work with the PFI team to make the referral.

Quality of Care in Nursing Facilities

In February, CMS and DHCS asked about how the Plan was improving quality of care in nursing facilities and the overall quality of our facility network. Ms. Turner listed Post-Acute Care Pilot; Long Term Care Collaborative; and, Integration of LTSS into the Model of Care as initiatives for improving quality. Dr. Huang touched on these programs:

- Post-Acute Care (PAC) Pilot is a program through Landmark Health which provides care in the skilled nursing facilities for patients transitioning out of the hospital and also for long term care.

- Long Term Care Collaborative is an initiative that Pat Curran has been working on with 11 network facility administrators and staff to consider process improvements and quality improvement within nursing facilities. Reporting around some of the quality

measures and discussion about best practices is being shared, as well as performance. Within this is a payment sub group to discuss how to better support these network facilities. Staff shortages and effectively managing the members to get them back into the community continue to be a challenge. Staff is working more closely with providers on integrated discharge planning.

- Integration of LTSS into the model of care is in line with MSSP integration and the availability of CBAS centers. These programs promote the deinstitutionalization of members and support placement in the community. More supports around them are needed, not only housing but also intensive case management and social aspects.

- Related to quality of network, Dr. Huang noted that a pilot was started this year for staff to visit the facilities to review the active census of our members, sample a number of charts looking at the MDS and Acute sections to see how we can support the facilities in their discharge planning process.

  Ms. Kaplan asked about the lack of places for people to go upon discharge. Dr. Huang said staff are working on multiple mechanisms to place members into the community such as with housing subsidy vouchers, some set-aside units and possibly subsidizing the cost for assisted living facilities as well as Board and Care. Ms. Altman stated that the problem with assisted living in San Francisco and San Mateo County areas is that Board and Cares are shutting down and it's hard to stay in front of that, however, given the market forces, we are doing all that we can. Subsidized housing seems to be the best option for people who can live independently but the timing is always an issue.

  Ms. Irgens-Moller asked if the Plan is working with shelters. Dr. Huang stated we are not but Ms. Altman stated that the Plan has just been approved by the commission to work with a vendor on recuperative care for homeless members who are coming out of the hospital and still need some medical care. The biggest challenge is the permanent housing of course.

- In March, CMS and DHCS were interested in our 2018 CAHPS survey results and interventions. This survey was discussed in detail at our October meeting. Ms. Turner reviewed some of the results from Q2 2018 noting that overall, respondents were very satisfied with their health plan and drug plan. Improvements focused on "getting needed care" and "overall health care quality". Our Care Coordination Composite score was 5% above other CA MMP plans. Interventions were member-focused events and outreach communications; launching a member experience workgroup; hiring a Quality Improvement Specialist; and, building staff awareness of member-facing surveys and all the communications. The CAHP survey is currently out and we anticipate getting this year's results for member experience in the last six months of 2018 sometime in September or October.

- **CMC Updates and Dashboards (taken out of sequence)**
  Ms. Turner reviewed a few charts related to CMC (attached):
  - Charts related to LTSS Utilization were presented for IHSS, MSSP, NFs, and CBAS. These charts showed that overall utilization has been going up. This is good news for IHSS and MSSP. Nursing Facility utilization going up is not desirable. CBAS utilization has been stable in terms of the number of CMC members engaged.
  - Health Risk Assessment (HRA) chart shows the activities related to these assessments with detail indicating the percentage of HRAs complete within 90 days, the percentage of members who were unwilling to participate or those who were unable to be located broken down by quarter from 2016 through 2018. The number of HRAs completed in the 3rd and 4th quarter of 2018 dipped and the percentage of members unwilling to participate and who were unable to be located went up. Compared to the average CMC plan in California, we are a little bit below the 62% benchmark for HRAs completed in 90 days of enrollment. HRAs are a bit challenging for us due to the length of the HRA form itself.
  - Individualized Care Plan Completion chart indicates that high risk members percentage is at 82% compared to the State average of 69%; and, the low risk members is also at 82% compared to the State average of 71%. This is a good indication that we are doing a good job of completing the individualized care plans. Our numbers have been going up and we are well above the State average.

- **IHSS Update**
  Ms. Mancini introduced Nina Rhee who manages the IHSS program and Jill Dawson, Supervisor for the IHSS unit. In January, the group discussed having open discussions about IHSS at this CMC Advisory Committee. One of the areas we talked about was Protected Supervision and fair hearings.

  Ms. Rhee stated that there are 5,200 IHSS recipients, which is a wide population that includes seniors and people with disabilities. Protected supervision is available to safeguard against accidents or hazards by observing or monitoring the behaviors of non-self-directing, confused, mentally impaired or mentally ill persons (as defined by the State). Ms. Rhee continued to describe some of the process the social workers go through in determining and recommending protective services for a person. The assessment can take up to two hours to determine if a person is able to be directed. The goal is to keep people in their homes as safely as possible. Unfortunately when people hear the term protective supervision they think this is 24/7 care but it is not and they informed exactly what IHSS can provide. If they feel they have not been assessed accurately, they are encouraged to go through the State Fair Hearing process. Information on how to file a Fair Hearing is included on the notices that go to recipients. She noted that while there has been as slight increase in the number of State Fair Hearings, the percentage of people who are served with authorized hours for protective supervision is not really changing and remains constant at about 9%.

When reassessments take place, the same questions are asked but at this point they are looking to see if anything has changed since the last assessment. Is this a good time to consider protective services or, if they already have authorized protective service hours, are they still needed.

To give an idea of the type of IHSS recipient who might need protected supervision, Ms. Dawson gave an example of an individual who had a massive stroke and was able to recover well physically however, the cognitive functions changed dramatically. This left the person unable to work or deal with safety awareness. This person began wandering away from the home; started smoking and not managing this safely in the home; and, the spouse was unable to stay home to provide the needed care. Since applying for IHSS and having the specifics of protective services explained they have been able to stabilize the right kind of support to help the person stay safely in the home. A question about the requirement to receive protected services related to other programs was asked. Ms. Dawson explained it is not a requirement to be connected to some other program (like CBAS) but the social worker would help to determine if this was desired they could include that in the care plan.

A question was asked how an individual using the registry is matched with a person who would be able to provide the appropriate type of care. Ms. Hogan explained that the registry is restricted to specific criteria: gender, regular IHSS approved tasks, location, and language. Protected Services is for a maximum of nine hours a day so the provider would also have to be available for that within their schedule. It is the client's choice and they are responsible for training and scheduling the providers. Ms. Zuniga asked if there could be another leg to this process where there could be assistance for the clients in interviewing or how to approach these issues. She is concerned that people do not know how to handle it from the employer side. Ms. Rhee stated this is one of the more challenging areas is managing the provider portion. On the social work side they try to provide education with printed material, etc. For some consumers, managing providers is just too much and they get a lot of phone calls about this. Ms. Hogan stated that the registry is solely a referral service and are restricted to that, however, they have hired three social workers to hopefully help in these areas and whether or not the client needs the social worker to support them in the hiring process. They will also go out and meet with new providers and the clients when they hire a new provider to cover the logistics, the paperwork, timesheets, review the tasks that have been approved so there is a clear understanding of the relationship from the beginning. Ms. Day from the Alzheimer's Association stated they do help clients with some of this process as well and some of the questions they should be asking.

Ms. Rhee added that, as they get requests, they have been doing more outreach presenting at a variety of events recently in the community. These have been well received.

8. Other State/CMS Updates

Ms. Altman reported:

- Cal MediConnect has been extended to 2022 by CMS. There are a few changes: the quality withhold will increase to 4% as of 2020; there will be a disenrollment penalty for Plans that have a large number of voluntary CMC disenrollments; and they will increase the savings between the Plans and the State and Federal Government for profitable CMC plans.

- We are making progress with the State in building understanding of the programs that offer "In lieu of" services which give us the flexibility to design a care plan that is suited to the consumer and helps them to live safely and independently. The State is showing interest and we hope there will be more movement in this direction coming.

- The Governor's proposal in his executive order includes pulling pharmacy services out of the Medicaid Managed Care Plans and we would no longer manage the benefit. Part of the proposal is to do bulk purchasing for pharmaceuticals and pull this responsibility from the Plans. Most of our pharmacy benefit is for Medicaid so approximately 50% of our appeals are related to pharmacy which would result in all of those issues being handled at the State level. The governor will need a legislative appropriation to implement to hire staff, a PBM, etc., though the Order is set to go into effect in 2021. HPSM is working with internally and with our CA plan peers to develop alternatives that will meet the Governor's goals while letting us continue to manage the benefit.

9. Adjournment

The meeting adjourned at 11:28 p.m.

Respectfully submitted:

C. Burgess

C. Burgess
Clerk of the Commission

CMC Discussion & Updates

CMC Advisory Committee

26 April 2019

HealthPlan OF SAN MATEO
Healthy is for everyone

Updates & Discussion

HealthPlan OF SAN MATEO
Healthy is for everyone

- Q1 CMS-DHCS Discussion Topics
  - MSSP
  - Quality of Care in NFs
  - CAHPS
- CMC Dashboards
  - LTSS Utilization
  - HRAs & ICPs

Q1 CMS-DHCS Discussion Topics

Multipurpose Senior Support Program (MSSP)

- CMS-DHCS interested in MSSP referrals, participation, and plan-provider partnership
- Intensive case management and purchase of services with goal of supporting members to reside in the community
  - Home-based and provided by county CCI team (SW and/or PHN)
  - Member follows an ICP, which is developed in partnership with ICT
- HPSM has one of the highest rates of MSSP participation among CMC plan peers
  - Q1 2018: 7.1 members/k (tied for 2nd of 9 plans)
  - Q2 2018: 7.4 members/k (4th of 9 plans)
- Referrals: HPSM Care Coordination or County CCI
  - All 18+ CMC & MC members eligible
  - Must meet nursing facility level of care need

Quality of Care in Nursing Facilities

- CMS-DHCS interested in how HPSM is improving QOC for in NFs and the overall quality of the facility network
- Quality of Care
  - Post Acute Care (PAC) Pilot – Landmark Health
  - Long Term Care (LTC) Collaborative w/ 11 network facilities
  - Integrating LTSS into the model of care (MSSP, CBAS, CCSP, WPC)
- Quality of Network
  - SNF Payment Model Re-design (through LTC Collaborative)
  - SNF Chart Review – pilot to identify members for referral to CCSP

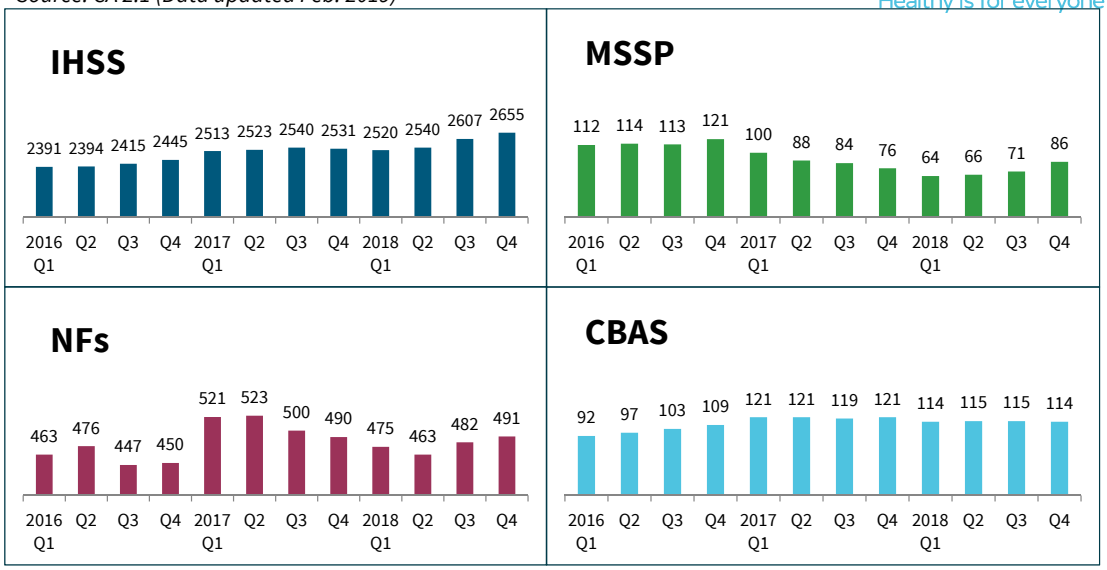
Consumer Assessment of Healthcare Providers and Systems (CAHPS)

- CMS-DHCS interested in 2018 CAHPS results interpretation & interventions
  - CMC Advisory Committee discussed 2018 CAHPS results in Oct. 2018
  - 2018 survey administered in English and Spanish in Q2 2018 with a 33.1% response rate (~265 respondents)
- Results
  - Overall, respondents are very satisfied with their health plan and drug plan; both aligned with CA MMPs
  - Opportunity for improvement in “getting needed care” and “overall health care quality”
  - “Care Coordination Composite” score is 5% above CA MMP average
- Interventions
  - Member-focused events & refreshing outreach communications
  - Launched Member Experience Workgroup & hired QI specialist w/ member focus
  - Building staff awareness of member-facing surveys (in-service training)

CMC Dashboards

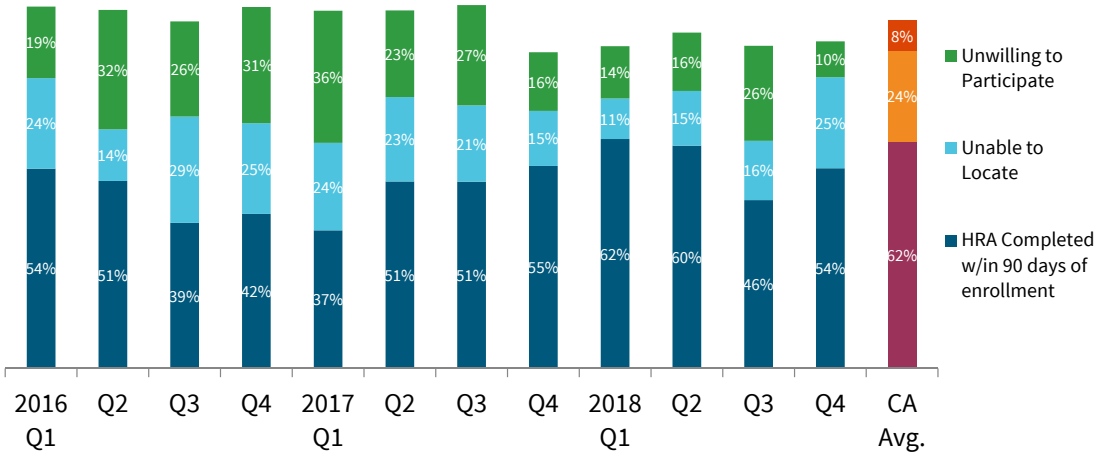
LTSS Utilization Among CMC Enrollees

Source: CA 2.1 (Data updated Feb. 2019)



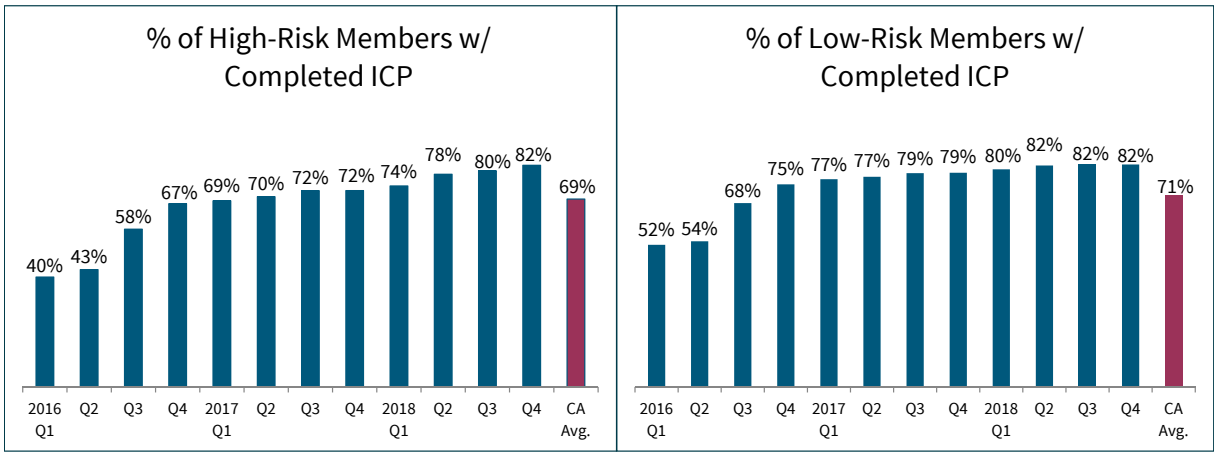
Health Risk Assessment (HRA) Completion

Source: Core 2.1 (Data updated Feb. 2019) & CA Average from Q4 2018 NORC



Individualized Care Plan (ICP) Completion

Source: Core 3.2 (Data updated Feb. 2019) & CA Avg. from Q4 2018 NORC



Thank You

DRAFT

AGENDA ITEM: 4.3

DATE: June 12, 2019

PHARMACY & THERAPEUTICS (P&T) COMMITTEE
Meeting Summary
Wednesday, May 8, 2019, 7:00-9:00 a.m.
SMMC – Alcove Room
222 West 39th Avenue, 2nd Floor
San Mateo, CA 94403

Members Present: Barbara Liang, Gary Horne, George Pon, Lena Osher, Rukhsana Siddiqui and Niloofar Zabihi

Members Absent: Jack Tayan, Jaime Chavarria, Jonathan Han, and Varsha Gadgil

Staff Present: Andrew Yau, Biyan Feng, Jasmine Le-Thi, Karla Cruz-McKernan, Kelly Chang, Matthew Lee, Ming Shen and Richard Moore.

Staff Absent: None

Guest Present: Gabrielle Ng (Pharmacy Intern)

1. **Call to Order**

2. **Approval of Meeting Minutes**
   Meeting minutes for February 13, 2019 P&T meeting reviewed and approved as presented.

3. **Approval of Agenda**
   The proposed agenda for the meeting was approved as presented.

4. **Old Business**
   None.

5. **New Business**
   Andrew reviewed the Executive Summary with the Committee, outlining the topics for discussion.

   5.1 Consent Agenda
   Andrew discussed updates to the CMC Coverage Request and Redetermination Policy to reflect new guidance from CMS requiring only 1 outreach attempt and a new limit on tolling to no more than 14 days due to the absence of a Physician Supporting Statement (PSS). Updates were also made to the Transition Process Policy to align with current regulatory requirements and to reflect present day-operations.

   5.2 Coverage Policies
   Andrew discussed updates to the Utilization Management Exception Policy which outlines the Plan's ability to place quantity limit restrictions on non-formulary drugs.

An update to the Nutritional Supplements for Medical Conditions Policy was also made, removing length-for-age and stature-for-age as measurements used to assess appropriateness of nutritional supplementation in infants and children. In addition, the Policy was updated to indicate that the Plan will cover all types of nutritional supplements when medically necessary.

5.3 New Drugs to Market

5.3.1 New Protected Drug Class

Andrew discussed new protected drug class drugs launched which included Elzonris, Infugem, Prograf Packets, Sympazan, and Dovato. All were recommended to be added to the CMC formulary. For Medicaid, Dovato was recommended to be added with a QL, consistent with the Plan's comprehensive coverage of antiretrovirals for HIV.

5.3.2 New Non-Protected Class

12 new non-protected class drugs were launched. Based on a number of different factors, Andrew recommended not adding any of these new products to the formulary.

5.4 New Indications | FDA – Approved Indications

Andrew presented the new FDA-approved indications. The prior authorization criteria for Hemlibra updated to allow for its use in those with hemophilia A with or without factor VIII inhibitors. In addition, the prior authorization criteria for Dupixent updated to reflect its new indication for use in those over the age of 12. Absent from the update is Dupixent's new indication for asthma, pending a drug class review.

5.5 CMS Required Formulary Changes (CMC)

Matt presented changes to the 2020 CMC formulary. As a result of anticipated issues that CMS may have regarding the Plan's 2020 formulary, the prior authorization criteria for Orencia and Kineret updated to require trial and failure of 2 prerequisite drugs (Humira and Enbrel) instead of 3. This aligns with the prior authorization criteria currently in place for the 2019 formulary.

5.6 Oncology Formulary Changes Update

Andrew recommended removal of Trexall and Rheumatrex from the formulary in favor of generic formulary methotrexate tablets. In addition, a number of oncology drugs were recommended to be added to the Medi-Cal formulary due to their presence on DHCS' Contract Drug List (CDL) in order to meet regulatory requirements. Lastly, a new coverage criteria for Lupron was proposed due to its use for non-cancer related indications (e.g. endometriosis).

Gary had a question regarding whether there were any differences between Trexall/Rheumatrex versus methotrexate. Andrew said he conducted a primary literature search and did not find any meaningful differences and that was why the recommendation was made.

5.7 Formulary Considerations
Jasmine discussed formulary changes to the following drugs: Aimovig, chlordiazepoxide, Foracare test strips and lancets, lamotrigine ODT, pimecrolimus cream, Proair HFA, albuterol HFA, kristalose packets, aripiprazole, celecoxib, fluticasone cream/ointment, Gilenya, Myrbetriq, Namzaric, Prevident, and sodium fluoride tablets. Jasmine also recommended changes to the prior authorization criteria for Xifaxan, excluding members concurrently taking the drug with laxatives when used for the treatment of IBS-D. Lastly, the coverage criteria for Repatha recommended to be updated to reflect LDL goals outlined by current guideline recommendations.

Jasmine went on to discuss recommended changes to the quantity limits on short-acting opioids. In order to mitigate potential opioid abuse, the Plan wants to implement a non-extended day's supply restriction on short-acting opioids for the Medicare line of business, aligning with the Medicaid formulary.
George had a question regarding the reason why high quantities of short-acting opioids would be prescribed since these agents are typically used for breakthrough pain. Jasmine responded by stating some patients have cancer or may have difficulty weaning off short-acting opioids. Ming added that opioid use in San Mateo County is trending down rather than up. Despite this, the Plan would like to be proactive in placing further restrictions on opioids in order to prevent the potential for misuse and abuse.

5.8 Substance Use Disorder (SUD) Drugs
Ming presented formulary changes to substance use disorder (SUD) drugs which are a carved-out benefit to State via FFS Medi-Cal (as it is for all other counties in California). In the past, HPSM has agreed to cover the SUD drugs through a pilot with the county in order to promote member access. However, due to various circumstances, the Plan is proposing to transition the payment of these drugs back to State. Ming requested for conditional approval for this change with a tentative and non-committal date of implementation due to the need to ensure a proper transition and to minimize member disruption.

In contrast, in order to promote member access, it was recommended to expand coverage of SUD drugs for the HW and HK lines of business with the formulary status of SUD drugs to align with CMC.

5.9 DESI/Unapproved Drugs
Andrew gave a brief history on the Drug Efficacy Study Implementation (DESI) program. DESI drugs are identified and classified based on Covered Outpatient Drug (COD) codes which CMS uses to identify whether a drug is reimbursable under Medicaid. Consistent with both State and Federal guidelines, the Plan recommended excluding all non-FDA approved drugs from coverage with certain exceptions.

Examples of such drugs which are not FDA-approved include Alcortin A, Donnatal, and hydrocortisone suppositories.

Dr. Moore asked if there was any information regarding which injectable drugs were not FDA-approved as this information may be useful for decisions rendered in the Utilization Management Department. Andrew said he would provide a list from CMS' website to the Utilization Management Department in the near future.

5.9 Drug Class Reviews

5.10.1 Agents for Hemorrhoids

Matt gave a brief overview of agents used for the treatment of hemorrhoids. The Plan recommended the removal of hydrocortisone suppositories from formulary since they are considered a less-than-effective DESI drug (a drug deemed by the FDA to lack substantial evidence of efficacy). In lieu of the hydrocortisone suppositories, the plan will be adding various other agents to the formulary for the treatment of hemorrhoids. These include local anesthetics, topical astrigents, bulk forming laxatives, and topical vasoactives.

Gary asked about the effective date for these formulary changes. Andrew answered that the implementation date would likely be within 2 months; similar to all other P&T recommended formulary changes. Dr. Moore asked whether docusate would remain on the formulary since primary literature does not support its efficacy. Ming felt that due to its low cost and high member impact, the Plan would like to keep the docusate on the formulary.

5.10.2 Anti-Obesity Drugs

Jasmine presented a drug class review on anti-obesity drugs. Preferred agents will be Alli OTC, phentermine, and diethylpropion which will be added to the formulary with a prior authorization requirement. For all other options, members must have documentation that they have tried and failed (or have a contraindication) to any two of the preferred formulary options. In addition, consistent with guideline recommendations, documentation of lifestyle modifications including meal planning, physical activity, and behavioral counseling will be required prior to approval of all agents. Initial approval will be for 3 months and 12 months for renewals. For renewals, documentation must be provided that the member has lost ≥5% of initial body weight.

5.10.3 Prenatal Vitamins

Andrew presented a drug class review on prenatal vitamins. Andrew recommended the removal of Code 1 requirements for all prenatal vitamins. In addition, preference on the formulary will be given to prenatal vitamins which are the most cost-effective, with higher cost prenatal vitamins removed from formulary due to lack of benefit compared to the lower cost formulations. As part of the transition, all existing utilizers will be grandfathered for a year to prevent member disruption.

5.10.4 Antiandrogens

Andrew presented a drug class review on antiandrogens for the treatment of castrate resistant prostate cancer. Based on clinical guideline recommendations, data from primary literature, and cost; the Plan recommends favoring generic abiraterone 250 mg over Xtandi, Zytiga 500 mg, and Yonsa. No changes were recommended for Erleada due to similar cost and efficacy compared to Xtandi for the treatment of non-metastatic castrate-resistant prostate cancer.

5.10.5 Long-acting Opioids

Andrew presented a drug class review on long-acting opioids. Buprenorphine patches were recommended to be added to formulary (for CMC and HW/HK only since the drug is carved out to the State for Medi-Cal) along with tramadol ER to provide safe options for the treatment of chronic pain. Code 1 removed for fentanyl patches and oxycodone ER tablets to prevent barriers to care. Andrew recommended that Oxycontin brand name be added to the CMC formulary with a prior authorization requirement in order to allow for short-term approvals as a result of generic drug shortages.
George asked why there was shortage on oxycodone ER. Andrew responded by saying he does not know but noted that the shortage has been an ongoing issue for past 2 years.

George motioned for approval of the recommended formulary changes and Gary seconded with the committee unanimously approving with no objections.

5.11 Drug Monograph

5.11.1 Spravato

Rukhsana presented a monograph for Spravato (Esketamine), a nasal spray used concurrently with an oral antidepressant which must be administered in a healthcare setting. Side effects of concern include elevation in blood pressure, potential street abuse, and psychological effects. For this reason, the drug has a REMS requirement. Rukhsana recommended adding the Spravato to the Medicare formulary with PA and QL requirement since it is a protected class drug and therefore requires mandatory formulary placement per CMS regulations. For all other lines of business, the drug was recommended to remain non-formulary due to the abundance of other formulary options available for the treatment of depression, with requests approved on a case-by-case basis.

6. Other Business/Announcements

None.

7. Adjournment

The meeting adjourned at 8:55 am.
Next scheduled meeting: July 10, 2019 in the Alcove Room.

MEMORANDUM

AGENDA ITEM: 4.4

DATE: June 12, 2019

DATE: June 3, 2019

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: Approval of Amendment to Agreement with Regents of University of California

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Recommendation

Approve an amendment to the agreement with Regents of University of California for the services of Clarissa Kripke, M.D., and her colleagues at UCSF, who provide services to HPSM members with developmental disabilities (DD). This amendment extends the agreement one year through June 30, 2020, and increases the annual agreement by $331,188 for this additional one year term.

Background

Beginning in 2005, as part of the sequential closure of several State operated Developmental Centers for consumers with developmental disabilities, an increasing number of DD clients were placed in community facilities in San Mateo County. This deinstitutionalization effort culminated in 2008 with the closure of Agnews Developmental Center in San Jose but has continued. HPSM is responsible for ensuring coordination of medical services for HPSM DD clients who often need enhanced or specialized services. The Plan works closely with Golden Gate Regional Center (GGRC) to ensure medical services are coordinated with the social services and support provided by the Regional Center, including but not limited to those adult residential facilities and DD group homes that are part of GGRC's system of medical and supportive services.

Discussion

Dr. Kripke is a licensed Family Practitioner who also serves as the Director of the Office of Developmental Primary Care in the Department of Family and Community Medicine at UCSF. As such she is an expert in the provision of care for DD consumers. HPSM has contracted with UCSF for Dr. Kripke's services since 2007, and she has provided consultative patient care services for DD clients in various group homes throughout San Mateo County. Dr. Kripke also provides ongoing primary care services at the group homes, and coordination of the unique needs of the DD clients in conjunction with Golden Gate Regional Center, DD group home administrators, HPSM's Care Coordination Unit, and the consumers' families. By addressing the specialized needs of these clients with comprehensive case management and primary care services, HPSM has been able to improve quality of care and reduce inappropriate hospital and emergency room utilization for HPSM DD clients. Dr. Kripke's practice is a single-provider practice with one cross-covering physician for approximately 103 DD patients, 75 of those patients being HPSM members. Her services include frequent direct clinical services, with on call services 24/7. This agreement has been amended to account for the increase in the cost of Dr. Kripke's practice, which includes salary support for Dr. Kripke.

Fiscal Impact

This amendment extends the current agreement one year, through June 30, 2020, and increases the agreement amount by $331,188 – a 2.8% increase compared to the amount spent in the prior year.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION and
THE SAN MATEO COMMUNITY HEALTH AUTHORITY

IN THE MATTER OF APPROVAL OF AMENDMENT TO AGREEMENT WITH THE REGENTS OF UNIVERSITY OF CALIFORNIA FOR SERVICES PROVIDED BY CLARISSA KRIPKE, M.D.

RESOLUTION 2019 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has previously entered into an agreement with the Regents of University of California for the ongoing services provided by Dr. Clarissa Kripke for developmentally disabled clients since the closing of Agnews Developmental Center in 2007;

B. The agreement is due to expire and both parties wish to continue the agreement to provide these services.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves this amendment to extend the agreement with the Regents of University of California for the services provided by Clarissa Kripke, M.D. and her colleagues as outlined in the attached memorandum through June 30, 2020 and increase the dollar amount by $331,188; and

2. Authorizes the Chief Executive Officer to sign said amendment.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of June 2019 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
David Canepa, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

MEMORANDUM

AGENDA ITEM: 4.5

DATE: June 12, 2019

DATE: June 3, 2019

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: Ratify an Amendment to the Agreement with MCG for Care Guidelines

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Recommendation

Ratify an amendment to the agreement with MCG to provide behavioral health clinical guidelines in an amount not to exceed $2,770,496, an increase of $86,448. The term of the agreement, which is due to expire at the end of 2022, remains the same.

Background

HPSM is required to use evidence based clinical guidelines to ensure uniform standards are applied throughout its utilization management program. The guidelines used by HPSM cover inpatient and surgical care, ambulatory care, chronic care, home care, general recovery and recovery facility care. These guidelines provide the basis for HPSM's clinical professionals to provide a standard and consistent review of care delivered by HPSM providers, especially the Plan's hospital providers. Clinical guidelines are critical to help reduce inappropriate care, control its associated costs and employ care pathways to support continuing proactive management of patients. In 2005, HPSM first contracted with MCG to provide evidence based clinical guidelines. In 2009, HPSM implemented a three year agreement renewal with MCG to continue providing these services. In 2012, the Commission approved waiving the RFP process and HPSM amended the agreement with MCG to add an additional five years.

In 2015, HPSM staff recognized the need for additional utilization management tools for management and authorization for home health care, and proposed adding home care guidelines to the MCG contract. Use of these guidelines leads to higher quality care and lower costs by ensuring use of comprehensive treatment plans for health care provided in members' homes.

The costs of the MCG agreement are directly associated with HPSM's number of covered lives. In 2015, the cost of the agreement with MCG was based on 100,000 covered lives. HPSM is required to notify MCG if the number of covered lives exceeds those stated in the agreement.

As such, in November 2015, HPSM notified MCG that covered lives increased to 140,000 and the Commission approved an increase of $115,000 to cover the additional lives.
The current MCG agreement includes guidelines for:

- Chronic care;
- Ambulatory care;
- Inpatient and surgical care;
- General recovery care;
- Recovery facility;
- Home care; and an
- Interrater reliability module.

In March 2018, the Commission approved an amendment authorizing an additional five year term with MCG, and added $1.6 million to the agreement to cover costs for the additional five years.

Discussion

This amendment adds behavioral health clinical guidelines to the agreement. In early 2019, NCQA released its first accreditation report for HPSM. While the organization did very well overall, we failed a must pass item – timely and appropriate utilization management (UM) for behavioral health services. At that time, behavioral health UM was provided by County Behavioral Health and Recovery Services (BHRS) as HPSM's subcontractor for providing behavioral health services for HPSM members needing mild to moderate services funded by Medi-Cal. BHRS also subcontracts with HPSM for services provided to the Plan's dually eligible members in CareAdvantage. As a result of the NCQA findings, HPSM and BHRS agreed that UM responsibility for HPSM funded Medi-Cal and Medicare services should be shifted to HPSM staff. This was done effective May 2019, in time for an NCQA audit focused on behavioral health to be performed later in 2019.

With HPSM taking on responsibility for this aspect of utilization management, staff needs to use care guidelines specifically tailored for behavioral health services. Due to critical timing issues, the amendment with MCG has already been executed, and we are requesting ratification of that amendment.

Fiscal Impact

This amendment adds behavioral health clinical guidelines for the remaining term of the agreement, which extends through December 31, 2022. The cost associated with the amendment is $86,448, bringing the total fiscal obligation of the agreement to $2,770,496.

DRAFT

RESOLUTION OF THE

SAN MATEO HEALTH COMMISSION and
THE SAN MATEO COMMUNITY HEALTH AUTHORITY

IN THE MATTER OF RATIFYING AN AMENDMENT TO AGREEMENT WITH MCG FOR BEHAVIORIAL HEALTH CARE GUIDLINES

RESOLUTION 2019 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission previously entered into an agreement with MCG for care guidelines required to ensure uniform standards are applied in its utilization management (UM) program;
B. MCG has provided these services for HPSM since 2005;
C. HPSM has added behavioral health to its UM program as of May 2019; and
D. HPSM's CEO signed an amendment to the agreement with MCG authorizing the purchase of behavioral health UM care guidelines in May 2019.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission ratifies the signing of an amendment to the agreement with MCG for behavioral health care guidelines, at an additional cost of $86,448 for the remaining term, for a new not to exceed contract amount of $2,770,495.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of June, 2019 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
David Canepa, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

DRAFT

SAN MATEO HEALTH COMMISSION and
SAN MATEO COMMUNITY HEALTH AUTHORITY
Commission Meeting Minutes
May 8, 2019 – 12:30 p.m.
Health Plan of San Mateo - Boardroom
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

AGENDA ITEM: 4.6

DATE: June 12, 2019

Commissioners Present:	Jeanette Aviles, M.D.	Don Horsley
	Michael Callagy	George Pon, R.Ph.
	David J. Canepa, Chair	Kenneth Tai, M.D.
	Si France, M.D.	Ligia Andrade Zuniga, Vice-Chair
	Bill Graham	
Commissioners Absent:	Teresa Guingona Ferrer	
Counsel:	Kristina Paszek	
Staff Present:	Maya Altman, Chris Baughman, Corinne Burgess, Pat Curran, Trent Ehrgood, Nicole Ford, Liss Ieong, Ian Johansson, Francine Lester, Colleen Murphey, Kati Phillips, Sophie Scheidlinger, Vicki Simpson, Katie-Elyse Turner, and Eben Yong.	

1. **Call to order/roll call**
   The meeting was called to order at 12:30 pm by Commissioner Canepa. A quorum was present.

2. **Public Comment**
   There was no public comment.

3. **Approval of Agenda**
   Commissioner Callagy moved approval of the Agenda as presented. **M/S/P**

4. **Approval of Consent Agenda**
   The Consent Agenda was approved as presented. **M/S/P**

5. **Specific Discussion/Action Items**

   5.1 Discussion/Action on Approval of Quality Improvement (QI) Documents: 2018 QI Program Evaluation; 2019 QI Program Description; and, 2019 QI Work Plan

   Ms. Altman introduced Nicole Ford, Quality Improvement Director, to present the quality documents for approval by the Commission. Ms. Ford described the purpose of each document and reviewed her presentation, highlighting 2018 accomplishments; areas of focus for 2019; and new reporting requirements which affect reporting year 2020. A copy of her presentation is attached.

   In 2018, HPSM had no measures below the minimum performance levels set by DHCS. HPSM ranked fifth among the Medi-Cal health plans in its score for the Managed Care Accountability Set (MCAS). HPSM also just learned that the Plan earned back 100% of the

quality withholds for contract year 2017 CMC quality measures. Other 2018 accomplishments include implementation of a Population Health Management Strategy and the Quality team work with the entire organization to achieve NCQA Plan Accreditation.

Key areas of focus for 2019 include: Timely access to prenatal care; Asthma medication adherence; Cervical Cancer Screening; and preparation for the new MCAS measures and reporting methodology for the 2020 reporting year. Of significance is the new minimum performance level, which moves from the 25th percentile of performance among Medicaid plans nationally to the 50th percentile. HPSM will be challenged to meet these new requirements; the Plan has been above the 25th percentile for several measures but has not exceeded the 50th percentile mark. DHCS has also stated it will impose financial sanctions on plans that do not meet these minimum performance levels.

Commissioner Zuniga expressed concern about access for people with disabilities, in particular for services such as cervical cancer screenings. The developmentally disabled population also has difficulties. Ms. Ford responded that staff is focusing on education efforts with providers, although there is more to be done.

Ms. Ford reviewed the proposed measures for Reporting Year 2020. She presented a chart outlining measures for RY 2020, showing previous year scores and the Plan's preliminary rates so far in 2019. DHCS will calculate some measures using encounter data, thereby eliminating chart reviews done previously by HPSM staff. Currently, staff collects all the data and submits it to NCQA, which conducts audits to ensure the Plan is appropriately measuring and reporting the data. In the future, DHCS will perform measurement and calculations from encounters HPSM submits to the State, placing even more importance on accurate encounter data from providers. DHCS is also expanding facility site review and medical record review requirements. HPSM Nurse Auditors visit provider offices to ensure appropriate screening and documentation by providers and that facilities meet state required standards.

DHCS oversight will also be stricter. Beginning next year, plans will incur immediate financial sanctions for any measure that fails to reach the 50th percentile benchmark. If providers do not pass the facility site review, plans must impose corrective action plans; ultimately, if there is no improvement, plans will be prohibited from assigning new members until providers come into compliance. Ultimately, plans must terminate providers that continue to fail site reviews after multiple attempts.

Ms. Altman noted that these new requirements represent a significant burden for HPSM's providers, especially smaller practices. However, HPSM's new pay for performance program aligns well with the new measures. Commissioner Aviles also commented on the challenges these requirements will present for providers who will also have to ensure new services are well documented. She also noted that there may be negative impacts on patients, who may not want to participate in all the new screenings or other activities.

Commissioner Horsley moved approval of the quality improvement documents as presented. **M/S/P.**

5.2 Presentation on Community Care Settings Program

Ms. Altman introduced Luarnie Bermudo, Program Manager, who presented an update for the Community Care Settings Program (CCSP). CCSP has been operating for a few years, has garnered national attention, and has been replicated by the Inland Empire Health Plan. A commercial plan in Los Angeles is also considering replicating CCSP. Ms. Altman and Ms. Bermudo recently attended an opening of a new affordable senior housing facility, Rotary Terrace in South San Francisco, which includes eight units for HPSM CSSP participants who have transitioned from nursing facilities to independent living. To date, CCSP has helped 262 members either move from long term care or avoid entering long term care by finding alternative housing in the community.

Ms. Bermudo provided background about CCSP and why HPSM decided to develop the program five years ago. There were nursing facility shortages for Medi-Cal members and the potential closure of one of the largest long term care facilities serving Medi-Cal enrollees. With the advent of Cal MediConnect in 2014 there were new opportunities to support members with additional community based services and help them avoid institutions like nursing homes. Plan staff worked with stakeholders and developed an RFP to find community partners that had the appropriate experience and expertise to help create new programs.

CCSP's goal is to support community living by helping people in nursing facilities who do not need to be there transition back into the community. CCSP achieves this by providing housing retention services through Brilliant Corners and intensive transitional case management through the Institute on Aging. Challenges include access to affordable housing, shortages of Residential Care Facilities for the Elderly (RCFE's), and the psycho---social issues faced by many of HPSM's members.

Besides case management, IOA contracts with RCFEs, where approximately 70% of CCSP participants are placed. Supporting these facilities, particularly smaller ones, has been challenging given the cost pressures in the Bay Area. Brilliant Corners (BC) provides housing retention services through access to independent housing and project based Section 8 vouchers provided through a partnership with the County Housing Authority. BC helps members search for housing and serves as a liaison with landlords.

Ms. Altman explained that CCSP is a strategic investment approved and funded by the Commission in part from Plan reserves. One time intergovernmental funding has also contributed to the program. Staff leverages other funding programs such as California Community Transitions (CCT), a federally funded program operated through the State and also focused on nursing home transitions to other settings. Other programs used include

the State's Assisted Living Waiver and Whole Person Care (WPC) funding. Finally, HPSM is advocating for the State to recognize and credit health plan spending on non-medical services such as services in provided in Assisted Living settings. Currently, these services are not included as Medicaid benefits; yet without these services, the State would be spending much more paying for nursing home stays. There are some indications that the State will eventually adopt more flexible rate setting that awards plans for investments in innovations that reduce costs for the State over the long term.

CCSP costs and savings are evaluated twice a year by Moss-Adams. To date, we have transitioned 262 members: 74 SNF diversions; 108 LTC residents moved to the community; and 80 community diversions. The community diversion population category continues to grow. Overall cost savings for the first six months of 2018 was 36%, or $3.77 million. LTC and SNF costs were reduced by 97%.

After members transition 93% are staying in the community and not returning to long term care facilities. Members and stakeholders report high satisfaction with the program with 95% of members stating they would recommend this program to family and friends; and 91% indicate improved quality of life due to the program. Overall members and stakeholders say CCSP staff are strong advocates for clients, are knowledgeable about community based resources, and are easy to work with.

Ms. Bermudo concluded by summarizing lessons learned. She closed with a story about a member who had been independent until suffering major injuries in an accident. Unable to work, he also experienced other complex medical issues and lost his housing. After enrolling in CCSP, the member left a long term care facility to transition back into the community. With case management provided by IOA, the member was able to live safely and successfully in the community.

Commissioners Canepa and France both expressed their appreciation to staff for the work with the quality program and CCSP.

5.3 Presentation on External Audit & Compliance Survey Results

Ms. Altman introduced Ian Johansson, Chief of Compliance, who reviewed his presentation, attached.

The California Department of Health Care Services and the Department of Managed Health Care conducted audits in 2018. Medi-Cal results: 19 findings; 2 findings in dispute; and 4 repeat findings. Cal MediConnect (CMC) results: 9 findings. There were no findings in dispute or repeat findings.

There were higher than usual findings in the Medi-Cal audit; the number of repeat findings stayed the same. Comparing results from 2015 to 2018, the number of repeat findings

dropped between 2015 and 2016 but stayed somewhat steady thereafter. Overall performance improved, however. DMHC conducts a routine medical survey audit every three years, in 2018 resulting in ten findings and two repeat findings. Overall there was a reduction in the number of findings compared to 2015.

Participation rose in the 2018 staff compliance survey; however, fear of retaliation among staff remained higher than desired. Staff had conducted training on this subject prior to the survey. Compliance staff will continue education efforts. Survey results also indicate staff would like to know more about what the compliance team does, what issues are reported, and what happens once issues are reported. Compliance is planning training on these subjects in tandem with the Chief HR Officer and the new Learning and Development Manager.

Commissioner Graham asked if the employee survey surfaced any results related to the fear of retaliation evident in the compliance survey. Ms. Simpson, Chief Human Resources Officer, responded that no evidence supporting these results were arose in the employee survey. On the contrary, the employee survey results indicate staff trusts leadership and management.

6. Report from Chairman/Executive Committee

Commissioner Canepa had nothing to report.

7. Report from CEO

Ms. Altman reported the Governor's May budget revision will be released within the next couple of days. More detail on the proposed pharmacy carve out is expected, including estimated savings from this action. LHPC, the public plan state association, is developing an alternative proposal for meeting the Governor's goals without carving the pharmacy benefit out of the plans. LHPC has also commissioned a report to examine what has happened in other states that have implemented similar carve-outs. This report will be released soon. Finally, plan pharmacy staff has developed stories about how they help members access their medications today. Ms. Altman shared a member story from Dr. Shen, HPSM's Pharmacy Director. The member's elderly mother was unable to find a medication for her son, who suffered from a mental illness. When HPSM pharmacy staff heard about the situation, they called all the local pharmacies, searched pharmacy claims, and were finally able to locate a pharmacy that had the medication in stock. HPSM staff provided a taxi ride for the mother to travel to the pharmacy that same day. Finally, pharmacy staff identified a few other members who were on the same medication and ensured a plan was in place to make the medication available when these members need it. This is an example of local plan service that will be difficult if not impossible to provide at the state level.

Commissioner Canepa asked about LA County's support for the Governor's pharmacy proposal. Ms. Altman explained that LA County is supporting the Governor's proposal for bulk purchasing of pharmaceuticals; this is distinct from the pharmacy carve out proposal. Commissioner Pon

expressed concern about the Governor's carve out proposal; it will have a severe impact on pharmacy services for HPSM members if it is implemented.

Other Business
There was no other business discussed at this time.

8. Closed Session:
9.1 PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

The Commission moved to closed session at 1:30pm

9. Reconvene Open Session
The Commission reconvened in open session at 1:44p.m. Commissioner Canepa reported that the Commission reviewed and discussed the performance of Maya Altman, Chief Executive Officer. The Commission unanimously agreed that Ms. Altman's performance throughout 2018 was stellar and commended her for the organization's accomplishments.

10. Action on 2019 Compensation and Performance Goals for Chief Executive Officer
Commissioner Horsley moved approval of a 10% salary increase for Ms. Altman and to accept the 2019 Performance Goals as presented. Kristina Paszek clarified that the resolution is for a 10% increase for a new base salary of $413,600 in addition to the current car allowance. **M/S/P.**

11. Adjournment
The meeting was adjourned at 1:46 p.m.

Respectfully submitted:

C. Burgess

C. Burgess
Clerk of the Commission

ATTACHMENT 1 TO
SMHC MINUTES FOR MAY 8, 2019

Quality Improvement Program 2018-2019

San Mateo Health Commission

May 8, 2019

HealthPlan OF SAN MATEO
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QI Program Overview

HealthPlan OF SAN MATEO
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Essential Functions	Priority Areas
Safety of Care, Access to Care & Quality of Services	Clinical Guidelines Annual Review
	Facility Site Review (FSR)
	Medical Record Review (MMR)
	Potential Quality Issues (PQI) Monitoring
	Physical Accessibility Reviews (PAR)
	Serving Seniors & Persons with Disabilities (SPD)
	Healthcare Effectiveness Data and Information Set (HEDIS) Reporting
	Nurse Advice Line (NAL)
Quality of Clinical Care Improvement Activities/ Population Health Management	Asthma Medication Ratio (AMR)/Adherence
	Cervical Cancer Screening (CCS)
	Breast Cancer Screening (BCS)
	Controlling High Blood Pressure
	Timeliness of Prenatal & Postpartum Care (PPC)
	Initial Health Assessment (IHA) Completion
	Reducing 30 Day - Plan All Cause Readmissions (PCR)
	Individualized Care Plan (ICP)/Health Risk Assessment (HRA) Completion
Member Experience & Outcomes	Health Outcomes Survey (HOS)
	Consumer Assessment of Healthcare Providers & Systems (CAHPS)
Serving a Diverse Membership/ Culturally & Linguistically Appropriate Services (CLAS) Program	CLAS Committee
	CLAS Staff Trainings
	Language Assistance Program (LAP)
	Provider & Member Education
Health Education/ Wellness & Prevention	Weight Watchers pilot
	Health Education Materials/Health Literacy/Readability
	Health Education Classes Evaluation
	Smoking Tobacco Prevention & Cessation
	Diabetes Prevention Program (DPP)
NCQA Health Plan Accreditation	HEDIS & CAHPS Reporting and tracking
	Quality Management & Improvement (QI) Standards
	Population Health Management (PHM) Standards: 1 - 4, 5(F), 6

2018 QI Accomplishments

- No measures below minimum performance level for DHCS Managed Care Accountability Set (MCAS)
- 7 Measures at high performance level (top 10% of Medicaid plans nationally)
- 5th highest performing Medi-Cal plan on the MCAS
- All CMS Core CareAdvantage Cal-MediConnect HEDIS quality withhold measure above required benchmarks
- Implementation of a Population Health Management Strategy
- QI team efforts in NCQA Plan Accreditation

2019 Focus Areas

- Increase **Timely prenatal care (PPC)** (within 42 days of enrollment or during the first trimester) from 83.88% (HEDIS 2018) to 87.06% (75th percentile).
- Increase the Medi-Cal **Asthma Medication Ratio (AMR)** rate of 58.15% (HEDIS 2018) to 62.3% (50th percentile).
- Increase the **Cervical Cancer Screening (CCS)** rate from 59.95% (HEDIS) to 60.1% (50th percentile).
- Prepare for proposed new MCAS measures and reporting methodology for proposed RY2020:
  - Early child and adolescent well-care visits
  - Follow-up on attention deficit/hyperactivity disorder medication
  - Timely and complete encounter submission to plan from providers
- Prepare for proposed expanded Facility Site Review and Medical Record Review requirements

Proposed RY2020 MCAS

Measure	50th Percentile	RY 2018 Rate	Prelim RY2019 Rate
Adult BMI Assessment*	88.56	49.35 (A)	57.57 (A)
Asthma Medication Ratio	62.28	58.56	58.03
Controlling High Blood Pressure*	58.64	70.08	64.23
Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)* (lower is better)	38.2	36.19	35.02
Comprehensive Diabetes Care - HbA1c Testing*	87.83	91.2	92.06
Follow-Up Care for Children Prescribed ADHD Medication - Continuation &Maintenance Phase	57.09	24.39	19.23
Follow-Up Care for Children Prescribed ADHD Medication -Initiation Phase	45	22.6	23.46
Antidepressant Medication Management - Effective Acute Phase Treatment	51.73	67.41	65.50
Antidepressant Medication Management - Effective Continuation Phase Treatment	36.4	48.40	48.72
Adolescent Well-Care Visits*	54.57	49.0 (A)	50.74(A)
Childhood Immunization Status –Combo 10*	35.28	54.40	60.0
Immunizations for Adolescents –Combo 2*	31.87	55.47	52.83
Well-Child Visits in the First 15 Months of Life – 6+ Visits*	66.23	19.05 (A)	20.14(A)
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*	73.89	74.43	76.01
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI*	75.55	86.44	78.82
Breast Cancer Screening	58.04	62.80	63.05
Cervical Cancer Screening*	60.1	59.95	69.85
Chlamydia Screening in Women	56.07	66.85	64.34
Prenatal and Postpartum Care – Postpartum Care*	65.21	75.59	82.55
Prenatal and Postpartum Care – Timeliness of Prenatal Care*	83.21	83.88	85.67
Plan All Cause Readmissions (PCR)	?	15.19	15.03

Measure new to MCAS for RY2020

*Hybrid measure (chart review + admin & sup data): Plan reports via HEDIS
Non-Hybrid measures DHCS will calculate with encounters received only
(A) Administrative Rate only (no sampling or chart review done)

Note: Uncertain what benchmark DHCS will use for PCR at this time, total observed readmission rate provided.
For Prelim RY2019 rates hybrid measures may improve before reporting, non-hybrid measures will not

New DHCS Monitoring Process

- Current
  - Required QI work if MCPs below MPL on measures
  - 3 Quality Corrective Action Plan (CAP) triggers for MCPs with sustained poor performance
  - Multi-year CAPs with milestones
  - Sanctions if CAP milestones are not met
- Future
  - Any MCP not meeting the MPL on any of the required measures will do required QI work with immediate sanctions
  - Three Quality Oversight Tiers, including two levels of CAPs
  - CAPs are re-evaluated annually
  - Possibility of progressive sanctions for sustained poor performance

Proposed Expanded FSR & MRR

11 new Facility Site Review elements, 49 new Medical Record Review elements
Selection of new MRR elements:

Pediatric Preventative	Adult Preventative
Autism Spectrum Disorder Screening	Alcohol Misuse: Screening and Behavioral Counseling
Psychosocial/behavioral assessment	Tobacco use counseling and interventions
Depression Screening	Depression Screening
Adverse Childhood Event (pending policy)	Osteoporosis Screening
Sexual activity risk assessment for adolescents	BRCA risk assessment and genetic counseling/testing
Intimate Partner Violence Screening women of reproductive age	Breast Cancer Preventive Medication
Contraceptive Care	Sexually Transmitted Infections Counseling
Folic Acid Supplement	HIV Screening
Hepatitis B Screening	Hepatitis B Screening
HIV Screening	Hepatitis C Screening
Fluoride Varnish, Fluoride Supplementation, and Dental Home	Intimate Partner Violence Screening
Newborn Blood Screening including bilirubin	Diabetic Screening and Comprehensive Diabetic Care
Anemia Screening	Adverse Event Screening (pending policy)
Lipid Screening	Lung Cancer Screening
Alcohol Misuse Screening and Behavioral Counseling	Skin Cancer Behavioral Counseling
Tobacco Prevention and Cessation Services	Abdominal Aneurysm Screening
Skin Cancer Behavior Counseling	Fall Prevention
Immunization Registry Reporting	Folic Acid Supplementation
	Immunization Registry Reporting

Thank You

ATTACHMENT 2 TO
SMHC MINUTES FOR MAY 8, 2019

Community Care Settings Program (CCSP) Commission Update

HPSM Commission Meeting

May 8, 2019

Agenda

- Background
- How did we get here?
- Case Management Strategy
- Housing Strategy
- Funding
- Outcomes and Evaluation
- Lessons Learned
- Member Story

Background

Goal: Support Community Living

How did we get here?

- Opportunities and Challenges
  - Address Community Needs
  - Leverage Reforms
  - Build or Buy assessment
  - Inefficient health care systems (Barriers)

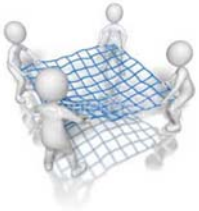
How did we get here?

- 01/2013 –RFI process
- 8/2013 – RFP for Intensive Case Management/Housing Services
- 9/2014 – First enrollees served/intake
- 6/2016 – First 100 enrollees transitioned
- 1/2017 – Integrate with Whole Person Care
- 8/2018 –Enroll 26 Theresa Rodriguez clients
- 9/2018 – New Core Meeting Model
- 09/2018- Support to RCFEs
- 10/2018- 8 new set aside units- Human Good
- 1/2019 – On-Going integration internally and externally
- 4/2021 – 10 set aside units Arroyo Gardens- MidPen

Building community awareness and alignment is key…it takes time

Case Management and Housing Strategy

- Case Management delivered by Institute on Aging
  - Phased Approach- Implementation, stabilization and transition
    - Intensive Case Management , Moderate Case Management and Banked Case Management
  - Contracts with Residential Care Facilities for the Elderly (RCFEs)- IOA
- Housing Retention Services by Brilliant Corners
  - Independent Housing and Housing Retention Services- Brilliant Corners
  - Housing Search, unit repairs and modifications, lease arrangements, owner-resident liaison



Funding

- HPSM Strategic Investment
- Sustainability efforts
  - Leveraging Whole Person Care spend and match
  - California Community Transitions (CCT), Assisted Living Waiver (ALW), and Home and Community Based Alternatives (HCBA) Waiver

Evaluation

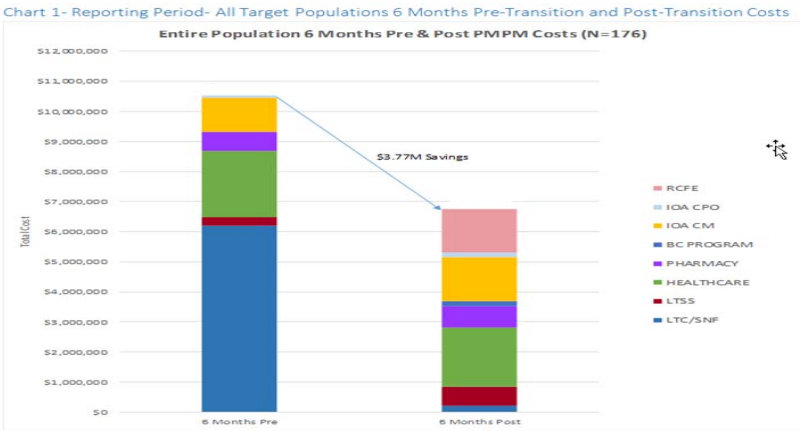
- Semi-Annual Program Evaluation by Moss Adams
- Quarterly Operations Reports
- Bi-Weekly Dashboards
- Annual Satisfaction Surveys
  - Client Satisfaction
  - Stakeholder Satisfaction

Program Outcomes

- Total Transitions to date: 262

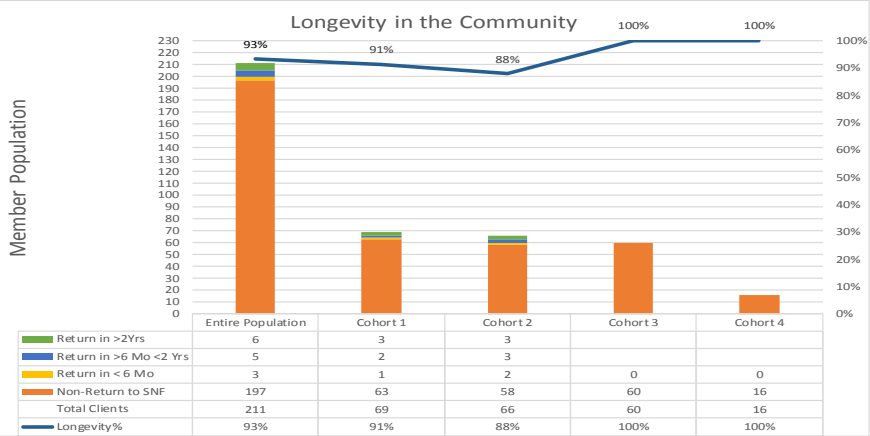
Population	SNF Diversions	LTC Residents	Community Diversions
# of members served	74	108	80

Q1 and Q2- 2018 Program Outcomes



36% overall cost savings and 97% decline LTC/SNF post transition costs

Longevity in the Community



93% of all members are staying in the community

2018 Client and Stakeholder Satisfaction

- Members report high satisfaction with the program:
  - 95% would recommend the service to their family or friends
  - 85% felt satisfied or very satisfied with the services provided
  - 79% felt that their CCSP care manager had the knowledge and skills needed to help them
- Providers and stakeholders are also satisfied:
  - 85% felt that CCSP staff are strong advocates for their clients
  - 92% felt that staff are knowledgeable about community based resources
  - 83% felt that CCSP staff are easy to work and collaborate with
  - 46% felt that the amount of time it was taking to transition someone out of a nursing facility was “just right”, 39% felt that the amount of time was “too long”, and 15% felt that it was “too fast”

Members and stakeholders report high satisfaction

Keys to Success and Lessons Learned

- Serving as single coordinated entity
- Filling systemic gaps and breaking down barriers to support transitions or community longevity
- Leveraging and coordinating an array of services
- Maintaining organizational alignment in an evolving landscape
- Focused, flexible housing approach

Member Success Story

- **Before CCSP:** Eric was involved in a terrible car accident in 2014, leaving him confined to a wheelchair for more than a year. In July of 2015, he got admitted to the hospital for worsening lower extremity weakness and inability to walk and needed to recover in a skilled nursing facility. During this time he had several other complex medical needs, which included glaucoma and had also lost his housing unit.
- **Enrolled** in CCSP in September 2015, as HPSM UM unit knew he could benefit from the supportive services and housing retention services to safely transition back into the community.
- **CCSP:** IOA provided intensive case management and developed a joint plan of care to support the member to successfully live in the community (e.g. pcp engagement, IHSS, BHRS, and other supports). Brilliant corners provided housing location and retention services and helped Eric move into a studio apartment in Redwood City.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ATTACHMENT 3 TO
SMHC MINUTES FOR MAY 8, 2019

2018 External Audit & Compliance Survey Results

Ian Johansson, Chief Compliance Officer

May 8, 2019

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Background

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- Status & Activities
  - Annual and trended view of HPSM performance in externally facing audits with regulatory agencies at the State and Federal level
  - Enables Commissioners:
    - To be knowledgeable about areas of improvement, and
    - To exercise reasonable oversight with respect to HPSM performance to contractual and regulatory standards

Our Goal

- To establish a culture of compliance at HPSM that helps the organization and its employees “do the right thing”

- Achieved through:
  - Maintaining and implementing a Compliance Program
  - Educating our employees
  - Identifying and resolving compliance risks
  - Providing opportunities to engage our staff and stakeholders

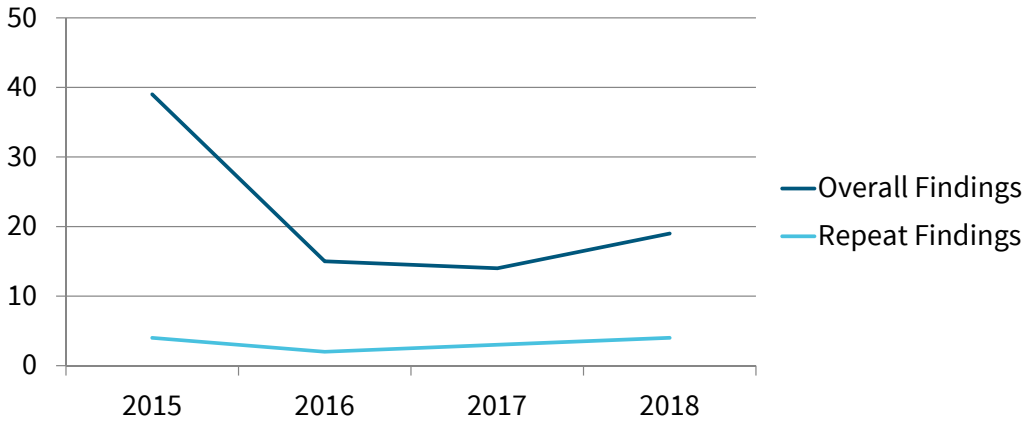
Agenda

- Review for 2018 and trended:
  - Department of Health Care Service (DHCS) audit performance
  - Department of Managed Health Care (DHCS) audit performance
  - Compliance Survey results

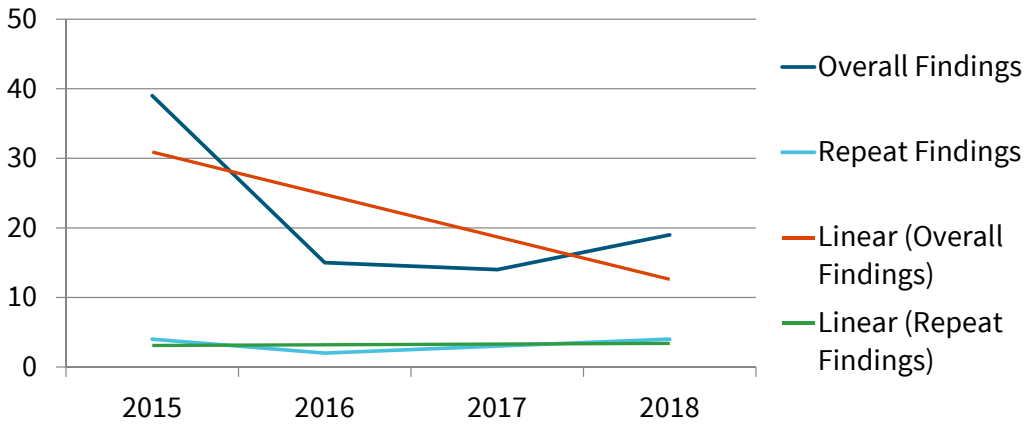
2018 DHCS Audit Results

- Medi-Cal Audit
  - 19 findings
  - 2 findings in dispute
  - 4 repeat findings
- Cal MediConnect Audit
  - 9 findings
  - 0 findings in dispute
  - 0 repeat findings

2015-2018 DHCS Performance



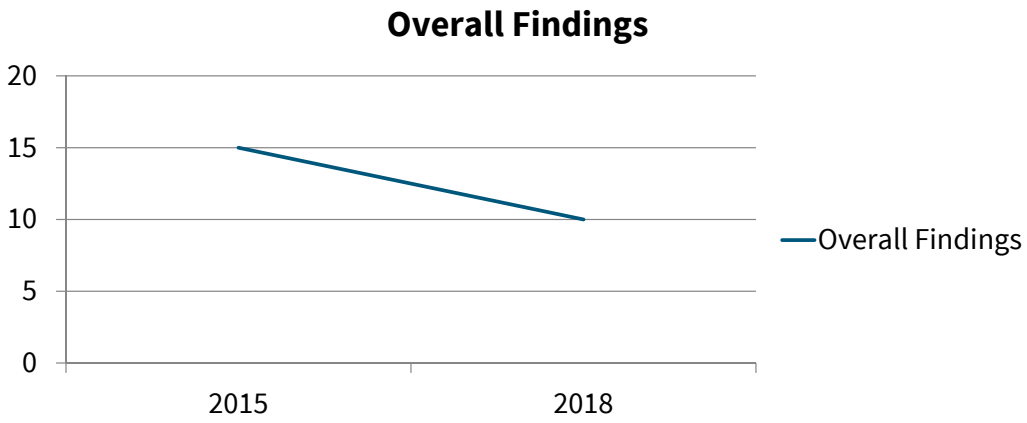
2015-2018 DHCS Trended



2018 DMHC Audit Results

- Routine Medical Survey Audit
  - 10 findings
  - 2 repeat findings

2015-2018 DMHC Trended



Compliance Survey Results

Background

- Annual Employee Survey
  - One measure of the health of HPSM's Compliance Program
  - Conducted anonymously (via web-based survey)
  - 5th year of the survey
  - Results factor into current year compliance activities designed to improve program outcomes

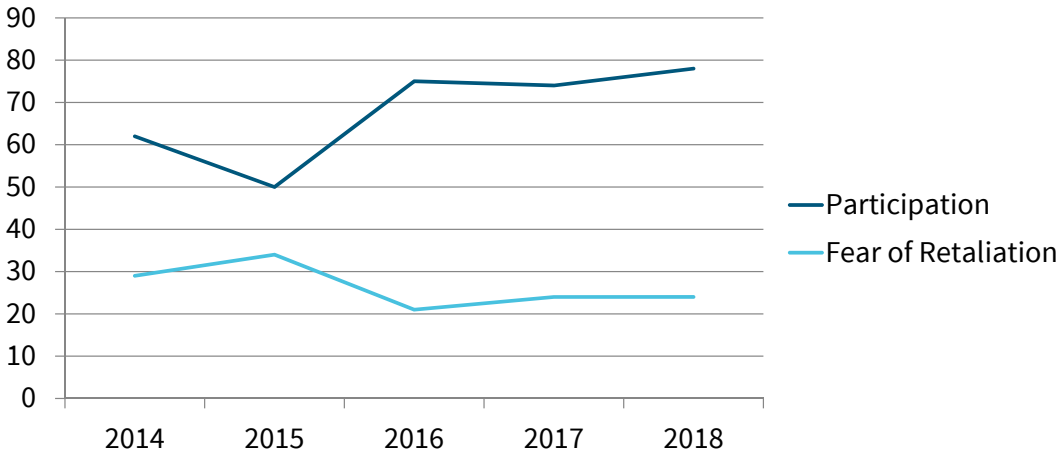
Background

- 2 focus areas from CY2018 survey
  - ↑ Participation
  - ↑ Fear of Retaliation

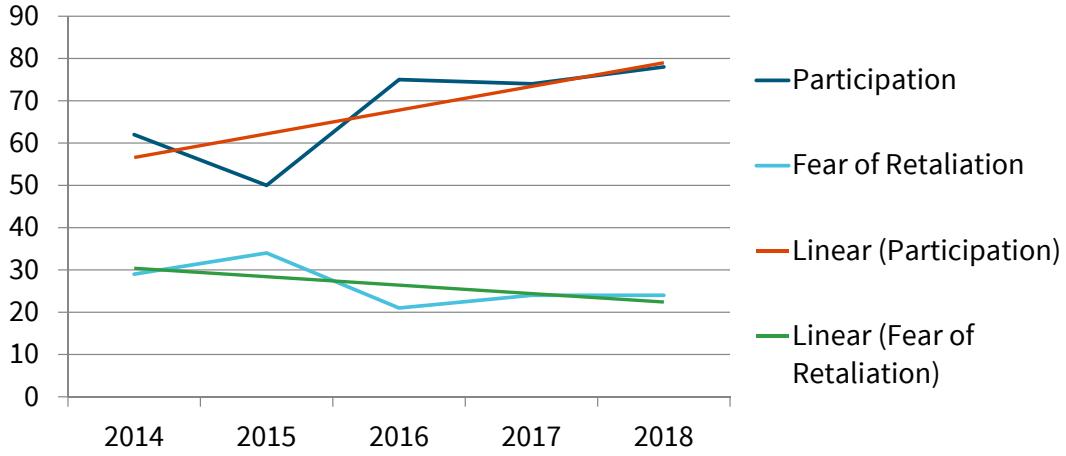
Plan, Do, Study, Act (PDSA)

- Fear of Retaliation
  - Plan: Train HPSM staff on retaliation and intimidation
  - Do: Trained Claims, Health Services and Customer Support
  - Study: Conducted CY2019 survey; rate unchanged CY18 – CY19
  - Act: Train all staff; evaluate data; identify new interventions

2014-2018 Key Indicators



2014-2018 Key Indicator Trends



2018 Performance v. 5yr Average

	2018	AVG
Participation Rate	**78%**	↑ 10
Familiar with Compliance Program	**98%**	=
I know where to view a copy of HPSM's Code of Conduct	**99%**	↑ **2**
I know where to locate HPSM's P&Ps	**96%**	↓ **1**
I am aware of the P&P that relate to my job	**98%**	↑ **1**
The name of HPSM's Compliance Officer is	**100%**	↑ **1**
I know where the Compliance Officer's office is located	**98%**	↑ **3**
I would feel comfortable reporting to Compliance Officer	**99%**	↑ **1**
Observed workplace behavior that felt violated Code or policy, law	**12%**	=
If YES to previous, did not report it	**4.19%**	↑**0.19**
Do you know about HPSM's policy on non-retaliation and non-intimidation?	**97%**	↑ **2**
Fear of retaliation would prevent me from reporting	**24%**	↓ **2**
Confident compliance will ensure concern is addressed timely	**97%**	↑ **1**
Confident compliance will ensure concern is addressed confidentially	**98%**	↑ **2**

Assessment

- Overall: Positive results
- Need to continue:
  - Efforts to improve participation rate
  - Efforts to reduce percentage of staff who fear retaliation

Questions?

- Contact me @
  - 650-616-2151
  - ian.johansson@hpsm.org
  - 3rd floor
- Hotline available 24/7
  - 800-826-6762

Thank You

AGENDA ITEM: 5.1

DATE: June 12, 2019

Meeting materials are not included

for Item 5.1 – Update on Long Term Care Collaborative

AGENDA ITEM: 5.2

DATE: June 12, 2019

Meeting materials are not included

for Item 5.2 – Update on Strategic Plan Metrics

MEMORANDUM

AGENDA ITEM: 7.0

DATE: June 12, 2019

DATE: June 5, 2019

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: CEO Report

State Budget Update

Since the last Commission meeting in May, the Governor released his revised May Budget and the State Assembly and Senate have adopted their own budget language. The Budget Conference Committee had its initial meeting last week. The Legislature must approve a new State Budget by mid-June.

Outstanding items that remain to be resolved include:

- **Managed Care Organization (MCO) Tax.** The current MCO tax, which brings about $1.5 billion in federal funding to the State, is due to expire by the end of June. The Governor did not include a proposal for a new tax in his May Revise, saying it was too risky to seek federal approval for such a tax at this time. Both legislative houses adopted an MCO tax with different revenue amounts. The Conference Committee will have to negotiate with the Administration to determine if the MCO tax will be part of the budget and what the dollar amount might be. While HPSM pays this tax currently (and would assumedly pay a renewed tax), the tax amounts are mostly offset through Medi-Cal capitation paid to the Plan.

- **Medi-Cal Expansion for the Undocumented.** The Assembly approved the Governor's proposal to expand coverage to young adults up to age 26. The Senate approved this expansion but added an expansion of coverage to undocumented seniors age 65 and over, and also voted to expand young adult coverage each year by one year of age, beginning with eligibility for individuals age 26 in January 2021. The Conference Committee will have to determine the scope of the expansion.

- **Individual Mandate.** The Senate approved general fund subsidies for policies sold through Covered California for qualifying individuals and adopted trailer bill language relating to the individual mandate to buy health insurance. The Assembly approved general fund subsidies and chose to defer the individual mandate issue to the policy bill process instead of the budget. The Conference Committee will determine the level of funding for subsidies and if the individual mandate should be part of the budget.

- **Optional Benefits.** Both the Assembly and the Senate restored Medi-Cal optional benefits that were cut several years ago during the recession. The May Revise proposed restoring optical benefits funding only. The Assembly and Senate each included different benefits to be restored. The Conference Committee will have to determine the list of benefits to be restored and a funding source. Some of the other optional benefits include audiology, incontinence creams, podiatry, and speech therapy. HPSM has continued to provide many of these services despite the State Medi-Cal reductions.

The Governor's May Revise included an estimated savings figure for his pharmacy proposals, including the carve-out of the pharmacy benefit from Medi-Cal managed care. Total savings are estimated to be $393 million per year, beginning in 2022-23 (the carve-out is supposed to become effective in January 2021). The Administration also released detail on the fiscal estimate that identifies some of the major assumptions behind the estimate. However, the Administration did not request any legislative action or appropriation related to the proposal.

Local Health Plans of California (LHPC), HPSM's state association of public health plans, released a report about the pharmacy carve out proposal in May (a summary is attached). The consultant team that authored the report found that costs actually rose in every state that transitioned the pharmacy benefit to fee for service. The authors conclude that a pharmacy carve-out in California would increase net pharmacy expenses by 19.4%, or $2.2 billion, over five years. The report also includes vignettes from public plans about the on the ground services provided to members to ensure they have access to and take medications appropriately, services that would suffer if the benefit is transferred to fee for service. Finally, LHPC joined a coalition that includes public hospitals, safety net clinics, and other 340B entities to propose trailer bill language calling for: 1) a public stakeholder process related to the carve-out; 2) a comprehensive fiscal analysis of the costs and savings to the Medi-Cal program; and 3) a comprehensive transition plan. This language has been adopted by both the Assembly and Senate. We expect there to be further discussion about the pharmacy proposal after the state budget is adopted in mid-June.

Cal MediConnect (CMC) Update

HPSM recently learned that the Plan earned back 100% of the CMC quality withhold for 2017. The total withhold was $6.1 million, so this is a significant achievement. HPSM exceeded the benchmark for nine out of ten measures, for a score of 90% (plans must score at least 80% to receive the withhold). Measures include: all-cause readmissions; follow up after hospitalization for a mental illness; controlling blood pressure; medication adherence for diabetes medications; quality of encounter data; and reduction in ER use for seriously mentally ill members and those with substance use disorders. Other measures relate to process, e.g., are member care goals documented and percentage of members who have a care coordinator and at least one care team contact.

The most recent evaluation of the CMC program was also released in May and highlights San Mateo County as a high performing county in several areas. A press release describing the evaluation data is attached.

New Commissioner

Barbara Miao, HPSM's newest Commissioner, was appointed by the Board of Supervisors on June 4, 2019. She is filling the "public at large" seat. Barbara was the Chief Financial Officer for the Indian Health Center in San Jose for many years. She is a long time resident of San Mateo County and has family members who are or have been HPSM members. Please join me in welcoming her to the Commission.

Dental Integration

HPSM staff continues to explore the feasibility of adding dental benefits to the Plan's responsibilities. We have completed operational and financial feasibility studies that will be presented at the next community stakeholder meeting later this week. Our intention is to come to the Commission for a final decision at the August Commission meeting.

REPORT SUMMARY

"Assessment of Medi-Cal Pharmacy Benefits Policy Options"

The Menges Group

Policymakers are considering moving Medi-Cal to a pharmacy "carve-out" – that is, shifting the pharmacy benefit out of managed care to instead be administered by the state in fee-for-service (FFS). The carve-out proposal is motivated, in part, by the potential for the state to collect more drug manufacturer rebates. A report by The Menges Group provides strong evidence that a pharmacy benefit carve-out will not achieve its intended cost savings and will have an adverse impact on the integrated, whole-person approach to care the Medi-Cal program has embraced. The Menges Group reaches these conclusions through detailed cost analysis of the experience of 13 states that moved between a Medicaid pharmacy carve-in and carve-out (and vice versa) and using publicly available Medicaid pharmacy claims data.

Key Findings

➢ A Medi-Cal Pharmacy Carve-Out Would Increase Net Pharmacy Expenditures 19.4% Over Five Years

- The proposed carve-out would increase Medi-Cal costs by an estimated ***$149 million in the first year*** and by ***$2.2 billion over five years*** (SFY2020-2024) (Table 1).
- Enrollee continuity of care protections may initially slow cost growth, but by Year 3 and beyond, estimated annual net cost increase for a carve-out is 23.85%.
- Carve-out costs are primarily attributable to (1) the state's increased reliance on brand-name and other costlier drugs to secure more manufacturer rebates (2) higher dispensing fees and (3) decreased ability to promptly make modifications to the formulary to address emerging dynamics such as price changes, patent expirations, and new drug introductions.

Table 1

Year	Net Overall Medi-Cal Cost Increase Due to Carve-Out ($ millions)	Net State-Fund Cost Increase Due to Carve-Out ($ millions)
SFY2020	$149	$51
SFY2021	$344	$117
SFY2022	$555	$189
SFY2023	$577	$196
SFY2024	$600	$204
5 Year Total	**$2,227**	**$757**

➢ Across the Nation, Pharmacy Benefit Carve-In States Outperform Carve-Out States

- A key metric demonstrating this performance is that the states that carved in the pharmacy benefit experienced a *1.3% decrease* in net cost per prescription across the entire FFY2011-FFY2017 timeframe, after factoring in drug manufacturer rebates.
- States that continued to carve out the pharmacy benefit experienced an *14.3% increase* in net cost in the same timeframe.
- States that have been the most successful at collecting drug manufacturer rebates have been the least successful at controlling net costs (i.e., maximizing use of generics).
- Optimizing front-end drug mix is more impactful than securing back-end rebates.

Because the net cost of a brand drug is 8.9 times higher than the average generic, managing the front-end drug mix on a formulary is more impactful than securing back-end rebates.

➢ A Medi-Cal Pharmacy Carve-Out Would be Detrimental to Clinical Integration, Health Outcomes

- Prescription drug benefits are central to the integrated health services Medi-Cal enrollees receive. Health plans' existing access to real-time prescription drug data is essential to discerning individuals' health needs, comorbidities, new diagnoses, and treatment patterns.
- Under a carve-out, the state would provide plans with a pharmacy file – a daily data feed – which is not the same as real-time pharmacy data.
- The carve-out would compromise the availability of real-time pharmacy data, eroding integrated care management programs and clinical outcomes.

Uses of Real-Time Pharmacy Data

Allow providers and prescribers to monitor for drug cross-reactivity.

Provide enrollees' medication profile during time-sensitive care transitions.

Resolve Customer Service inquiries.

Support enrollees in tobacco cessation, opioid overutilization, polypharmacy, disease management, case management, and HEDIS programs.

Identify fraud, waste and abuse.

Recommendations

The Menges Group offers the following recommendations:

1. Keep the current Medi-Cal pharmacy benefit carved in unless compelling, objective evidence demonstrates that a carve-out will produce large scale cost savings without eroding access, care management resources, and enrollees' clinical outcomes.
2. Because the state's cost-saving assumptions have not been supported with data and information and are at odds with other carve-out states' experiences, further analysis should be disclosed and discussed prior to implementing a carve-out.
3. California could look to achieve near-term fiscal savings under the existing pharmacy carve-in by increasing pharmacy cost transparency to identify savings opportunities and devise tailored solutions.

University of California
San Francisco

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Media Contacts:
Carrie Graham, University of California 510-847-2719
Mari Nicholson, The SCAN Foundation 562-308-2804
Norman Williams, Department of Health Care Services 916-440-7660

Since 2018, Cal MediConnect enrollees are reporting higher levels of satisfaction, confidence and continuity of care; but there are differences by county, race, language, and disability.

New look at Cal MediConnect polling results: differences by county, race, language and disability between 2015 – 2018.

In June 2018, the University of California, San Francisco completed the 2018 wave of the Cal MediConnect (CMC) Rapid Cycle Polling Project, a tracking survey that included over 2,900 interviews with older adults and people with disabilities who were dually eligible for Medicare and Medi-Cal. CMC health plans integrate all Medicare and Medi-Cal benefits, including long-term services and supports (LTSS), in seven California counties. Since 2015, almost 10,000 CMC enrollees were surveyed about their experiences with the program.

Beneficiaries were asked about their confidence and satisfaction with health care, and problems encountered. Previous analyses report beneficiary experiences over the 4-year survey, including changes over time and comparisons with the non-CCI groups. In this analysis, researchers analyzed data from CMC beneficiaries and compared by several member characteristics including: county, race, language, and disability (need for long-term services and support).

Results indicate several differences that can inform policy makers and CMC health plans moving forward.

COUNTY

San Mateo County exceeds other Cal MediConnect (CMC) counties in some enrollees experiences: CMC enrollees in San Mateo were the most likely to: 1) report having a personal doctor, 2) had the highest percent of enrollees saying they still have the same doctor they had before the transition to CMC, and 3) were the most likely to say they were satisfied with their choice of doctors.

San Mateo County's CMC program is part of what is called a "County Organized Health System" model. Unlike other counties where there are two or more CMC plans to choose from, San Mateo county has a single plan. Despite this, San Mateo county seems to exceed other counties in many key areas of enrollee satisfaction.

San Mateo and San Bernardino counties enrollees reported the highest satisfaction in choice of hospitals.

Riverside and San Bernardino Counties did the best in making sure their non-English speaking CMC enrollees received interpreter services. Less than 8% of non-English speaking enrollees in Riverside and San Bernardino Counties reported that their health plan failed to provide interpreter services.

Average number of monthly IHSS hours differed significantly by county. Orange County had the lowest average of 72 IHSS hours, while San Mateo and Santa Clara Counties provided an average of over 100 hours. But there were no significant difference by county in unmet needs for personal care.

RACE

Cal MediConnect enrollees confidence navigating health care differed by race: White and Black CMC enrollees were significantly more likely than Latinos or Asians to say they were "very" or "somewhat confident" in knowing how to manage their health conditions.

Asian enrollees were least likely to say they knew whom to call with questions about their health coverage, compared to other races.

Latinos had the lowest satisfaction with choice of doctors and hospitals in 2018 (only 25% were very satisfied).

There are key areas where experiences with CMC differed by race. White and Black enrollees were more likely to know how to navigate their plan and get the assistance they needed. Asian enrollees were more likely to have problems with communication, transportation, and unmet needs for long-term services and supports.

Asian enrollees reported the most continuity with providers, with 98% saying they had a personal doctor and 75% reporting they had the same doctor as before enrolling in CMC.

While Asian CMC enrollees were most likely to report they had a care manager from the CMC plan, Latino and Black CMC enrollees who had a single care manager were most likely to say that the single care manager improved their care "a lot."

White CMC enrollees were most likely to report problems such as: having a misunderstanding about health care services or coverage, being denied a treatment, and having a doctor not available through the plans network.

Asian CMC enrollees were most likely to report problems such as: not getting an interpreter, transportation barriers, trouble communicating with providers, and having unmet needs for personal or routine care.

LANGUAGE

There were major differences by language in CMC enrollees' confidence managing health care in all years. In 2018, English-speaking CMC enrollees were more confident they knew how to manage their health conditions, knew who to call if they had a health need or questions about their health, and were very confident they could get their questions answered, compared to Spanish speakers and Chinese speakers.

Chinese-speaking CMC enrollees reported more continuity with past providers compared to English and Spanish speakers. In 2018, 75% of Chinese speakers reported they had the same doctor as before enrolling in the program, compared to 63% of English speakers and 57% of Spanish speakers.

English-speaking CMC enrollees were the most likely to be "very satisfied" with most aspects of their health care, including: choice of hospitals, information from the plan explaining benefits, ability to call a provider 24/7, amount of time spent with providers, wait time for appointments, and provider coordination.

English speakers were the most likely to have a single care manager. Furthermore, English and Spanish speakers were most likely to say their single care manager has improved their care "a lot" (at least 60% of English and Spanish speakers, compared to only 30% of Chinese speakers).

English-speaking CMC enrollees were the most likely to report the following problems:

- Had a misunderstanding about health care services or coverage
- Health plan denied treatment or referral for another service recommended by a doctor
- A doctor you were seeing was not available through the plan

Chinese-speaking CMC enrollees were the most likely to report the following problems:

- Doctor did not speak your language or there was not an interpreter available
- Transportation problems kept you from getting needed health care

DISABILITY

In 2018, CMC enrollees with no LTSS needs were more likely to feel "very confident" that they know how to manage their health conditions.

Respondents were separated into three different categories based on their self-reported need for long-term services and supports (LTSS), including: 1) No need for LTSS; 2) needs assistance with routine tasks; and 3) needs assistance with personal care (enrollees with the most significant needs for assistance with bathing, dressing, eating, etc).

CMC enrollees with personal care needs were slightly less likely to feel very confident that they could get their questions answered, compared to those with no needs or just routine needs.

CMC enrollees with personal care needs were more likely than those with no LTSS needs and those with only routine needs to experience the following problems with their health care services:

- Having a misunderstanding about their health care services
- Health plan denied treatment or referral for another service recommended by a doctor
- [For non-English interviews] Doctor did not speak your language or there was not an interpreter available for you when you visited your doctor or other health care professional
- Transportation problems kept you from getting needed health care
- A doctor you were seeing was not available through your plan
- You had trouble communicating with a doctor or health care provider because of a speech, hearing, or other disability

While only about a third of CMC enrollees with personal care needs reported having a care manager (34%), this is significantly higher than those with routine needs (28%) and those with no LTSS needs (21%).

While only about a third of CMC enrollees with personal care needs reported having a personal care plan (32%), this is more than those with routine needs (29%) and those with no LTSS need (24%).

"We are pleased that polls continue to show that Cal MediConnect members, overall, are satisfied with their care and choice of doctors and confident about navigating their care," said Jennifer Kent, Director of the California Department of Health Care Services. "At the same time, this latest analysis provides a wealth of data that will allow us to explore areas where we can work with our plan partners to improve access to care, and ensure all Cal MediConnect members have the same high-quality experience."

"These results show that Cal MediConnect enrollees have improved access to care to meet their individualized needs while experiencing greater confidence and satisfaction with their care," said Bruce Chernof, President and CEO of The SCAN Foundation. "Although important challenges still exist and must be addressed, enrollee voices are telling us that integrating Medicare and Medi-Cal can work in California."

About the Survey

The results reported in this release come from a large-scale tracking survey of dually eligible Medicare and Medi-Cal beneficiaries in California, conducted in 2017 and 2018 by University of California on behalf of The SCAN Foundation and the California Department of Health Care Services (DHCS). Earlier waves in 2015 and 2016 were conducted by Field Research Corporation.

All surveys were conducted by means of telephone interviews with stratified random samples of CMC enrollees and opt-outs across California counties participating in the Cal MediConnect demonstration. In 2015, the survey included five counties (Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara). In 2016, two additional CMC counties (San Mateo and Orange) were added to the survey.

Each survey also included interviews with samples of dual eligible beneficiaries in non-CMC counties. In 2015 and 2016, those counties were San Francisco and Alameda. In 2017, the non-CMC comparison counties were expanded to include nine counties where the demonstration was not implemented.

To enable the study to compare the opinions of dual eligible beneficiaries who were either unable or found it difficult to complete the telephone interview themselves, the survey offered those chosen to participate the option of naming another individual who assisted them in making their health care decisions to complete the survey on their behalf (i.e., proxy).

The 2018 survey was administered to 2,961 dual eligible beneficiaries or their proxies. Of those, 1,775 were CMC enrollees, 781 were CMC opt-outs, and 405 were beneficiaries from non-CMC counties.

Over the course of the six survey waves across the four years, a total of 17,460 dually eligible beneficiaries were interviewed, including: 9,671 CMC enrollees, 4,966 opt-outs, and 2,823 beneficiaries in non-CMC counties. Each survey was administered in four languages and dialects – English, Spanish, Cantonese, and Mandarin. Up to eight attempts were made to reach and complete an interview with each randomly selected dual eligible beneficiary or their proxy on different days and times of day during the interviewing period. The allocation of interviews for each survey was stratified by county and within the CMC counties, between enrollees and those who had opted out of the program. After the completion of interviewing, weights were applied to return these stratified sample allocations to population estimates of the share of beneficiaries in each county as reported by DHCS.