HealthPlan OF SAN MATEO
Healthy is for everyone

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**THE SAN MATEO HEALTH COMMISSION**
**Regular Meeting**
**April 12, 2023 - 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
   - 4.2 CMC Advisory Committee Minutes, January 2023
   - 4.3 Consumer Advisory Committee, January 2023
   - 4.4 CCS Clinical and Family Advisory Committee, February 2023
   - 4.5 Physician Advisory Group, December 2022
   - 4.6 Waive Request for Proposal and Ratify Amendment to Agreement with Periscope Consulting
   - 4.7 Approval of Amendment to Agreement with County of San Mateo for ACE Third Party Administrator Agreement
   - 4.8 Approval of 2023 Compliance Program and 2023 Code of Conduct.
   - 4.9 Approval of Amendment to Agreement with AccessNurse
   - 4.10 Approval of San Mateo Health Commission Meeting Minutes from February 8, 2023
5. **Specific Discussion/Action Items**
   - 5.1 Audited Financial Statements for the Twelve-Month Period Ending December 31, 2022*
   - 5.2 Approval on Updated Purchasing Policy*
   - 5.3 Update on Strategic Planning Process
   - 5.4 Update on Primary Care Investments
   - 5.5 Update on Modular RFP
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.

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**AGENDA ITEM: 4.1**

**DATE: April 12, 2023**

**M E M O R A N D U M**

Date: February 21, 2023
To: San Mateo Health Commission
From: Trent Ehrgood, Chief Financial Officer

Subject: **Financial report for the twelve-month period ending December 31, 2022**

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## Preliminary 2022 Financial Results All Lines of Business

Q4 2022 preliminary financial result for all lines of business is a surplus of $48.4M, with a year-to-date (YTD) surplus of $115.0M, compared to the YTD budget surplus of $6.2M.

The fourth quarter includes a revenue accrual of $7.4M, which represents 75% of the 2021 Cal Medi-Connect (CMC) quality withhold. The monthly revenue for CMC is reduced by 4%, and this amount must be earned back based on achieving certain quality metrics. This item is included in the 4th quarter of the 2022 budget, so is not a budget variance, but does speak for the increase in revenue for this quarter.

Besides the extra CMC revenue noted above, the 4th quarter is somewhat consistent with previous quarters in 2022, where lower nursing home utilization, and higher portion of members with other health coverage, are causing overall lower healthcare cost.

Other items contributing to the favorable budget variance include 1) lower admin cost, 2) favorable net MCO tax impact, and 3) higher interest earnings on cash reserves.

Attached is presentation material to guide the discussion for our committee meeting on February 27th. Detailed Statements of Revenue and Expense on a consolidated basis, as well as for each line of business, are provided after the presentation slides.

# Financial Update

## Presentation to Finance/Executive Committee

February 27, 2023

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# 2022 Budget by Quarter

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| | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|
| Capitation revenue | 218,766,277 | 224,472,838 | 227,978,299 | 232,448,093 | **903,665,508** |
| Healthcare cost | 208,887,076 | 212,854,235 | 212,907,179 | 210,843,150 | **845,491,640** |
| Administrative expenses | 13,447,987 | 14,306,963 | 14,132,881 | 14,393,740 | **56,281,572** |
| MCO Tax | - | - | - | - | - |
| Income/(loss) from operations | (3,568,786) | (2,688,361) | 938,239 | 7,211,203 | **1,892,295** |
| Non-operating revenue | 1,167,874 | 1,103,321 | 1,057,001 | 1,034,985 | **4,363,181** |
| Net income/(loss) | (2,400,911) | (1,585,040) | 1,995,240 | 8,246,188 | **6,255,477** |

# Q4 2022 Financial Results (pre-audit)

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| | Q1 (Jan-Mar) | Q2 (Apr-Jun) | Q3 (Jul-Sep) | Q4 (Oct-Dec) | YTD Total | YTD Budget | Budget Variance |
|---|---|---|---|---|---|---|---|
| Capitation revenue | 236,366,221 | 234,552,138 | 234,499,360 | 261,775,935 | 967,193,654 | 903,665,508 | 63,528,146 |
| Healthcare cost | 192,369,679 | 197,852,311 | 186,497,781 | 195,268,941 | 771,988,712 | 845,491,640 | 73,502,928 |
| Administrative expenses | 12,764,669 | 13,389,361 | 13,616,529 | 13,247,131 | 53,017,690 | 56,281,572 | 3,263,882 |
| MCO Tax | 9,160,100 | 9,160,100 | 10,076,110 | 10,076,110 | 38,472,420 | - | (38,472,420) |
| Income/(loss) from operations | 22,071,773 | 14,150,366 | 24,308,940 | 43,183,753 | 103,714,832 | 1,892,296 | 101,822,536 |
| Non-operating revenue | 1,197,234 | 1,640,611 | 3,289,395 | 5,207,436 | 11,334,676 | 4,363,181 | 6,971,495 |
| Net income/(loss) | 23,269,007 | 15,790,977 | 27,598,335 | 48,391,189 | 115,049,508 | 6,255,477 | 108,794,031 |

# YTD December 2022 – PY/CY (pre-audit)

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| | YTD by PY/CY | | | Current Year YTD | | |
|---|---|---|---|---|---|---|
| | Prior Year | Current Year | Total | Current Year | Budget | CY Variance |
| Capitation revenue | 5,947,539 | 961,246,115 | 967,193,654 | 961,246,115 | 903,665,508 | 57,580,607 |
| Healthcare cost | (13,234,622) | 785,223,334 | 771,988,712 | 785,223,334 | 845,491,640 | 60,268,306 |
| Administrative expenses | - | 53,017,690 | 53,017,690 | 53,017,690 | 56,281,572 | 3,263,882 |
| MCO Tax | - | 38,472,420 | 38,472,420 | 38,472,420 | - | (38,472,420) |
| Income/(loss) from operations | 19,182,161 | 84,532,671 | 103,714,832 | 84,532,671 | 1,892,296 | 82,640,375 |
| Non-operating revenue | (3,390) | 11,338,066 | 11,334,676 | 11,338,066 | 4,363,181 | 6,974,885 |
| Net income/(loss) | 19,178,771 | 95,870,737 | 115,049,508 | 95,870,737 | 6,255,477 | 89,615,260 |

| | | YTD 09/22 | YTD 12/22 |
|---|---|---|---|
| M-Care risk adj rev. | Rev | 1,400,000 | 2,380,000 |
| M-Cal COA adjustments | Rev | 1,580,000 | 2,250,000 |
| M-Cal supplemental rev. | Rev | 1,250,000 | 1,300,000 |
| PY IBNR adj. | HC Cost | 9,230,000 | 15,660,000 |
| PY reinsurance recoveries | HC Cost | 850,000 | 845,000 |
| Recovery paid to DHCS (APL) | HC Cost | (1,650,000) | (109,000) |
| Misc. other | HC Cost | (510,000) | (327,000) |
| Provider incentive adj | HC Cost | - | (2,820,000) |
| | | 12,150,000 | 19,179,000 |

# Average Membership

## Variance to Budget

| LOB | Avg. Actual | Avg. Budget | Variance | % Var |
|---|---|---|---|---|
| Medi-Cal | 74,932 | 72,661 | 2,271 | 3.1% |
| Medi-Cal Full Duals | 8,274 | 7,791 | 483 | 6.2% |
| Medi-Cal Expansion | 47,537 | 45,416 | 2,121 | 4.7% |
| Whole Child Model | 1,393 | 1,381 | 12 | 0.8% |
| Cal Medi Connect | 8,781 | 8,840 | (59) | -0.7% |
| HealthWorx | 1,200 | 1,228 | (28) | -2.2% |
| Total at Risk | 142,116 | 137,318 | 4,799 | 3.5% |
| + ACE | 23,518 | 22,277 | 1,241 | 5.6% |
| Grand Total | 165,634 | 159,595 | 6,039 | 3.8% |

# Budget Variance by Major Drivers

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| | | YTD Dec | | Revenue | Expense |
|---|---|---|---|---|---|
| 1 | Prior year adjustments not in the budget | 19,178,772 | | | |
| | **Current year variances:** | | | | |
| 2 | Membership higher than budget | 2,379,802 | << | 21,152,886 | (18,773,084) |
| 3 | Revenue yield PMPM higher than budget | 16,027,873 | | | |
| 3.5 | Revenue refund (CCI $8.7M, ECM $13.6M risk corridors) | (22,300,000) | | | |
| 6 | Healthcare cost PMPM lower than budget | 79,357,508 | | | |
| 7 | Administrative cost under budget | 3,263,882 | | | |
| 8 | MCO Tax variance | 3,911,309 | << | 42,383,730 | (38,472,420) |
| 9 | Non-op revenue (*CY portion) over budget* | 6,974,885 | | | |
| | Total current year | 89,615,259 | | | |
| | **Total consolidated budget variance** | **108,794,031** | | | |

# Healthcare Cost

## Detail by Category of Service

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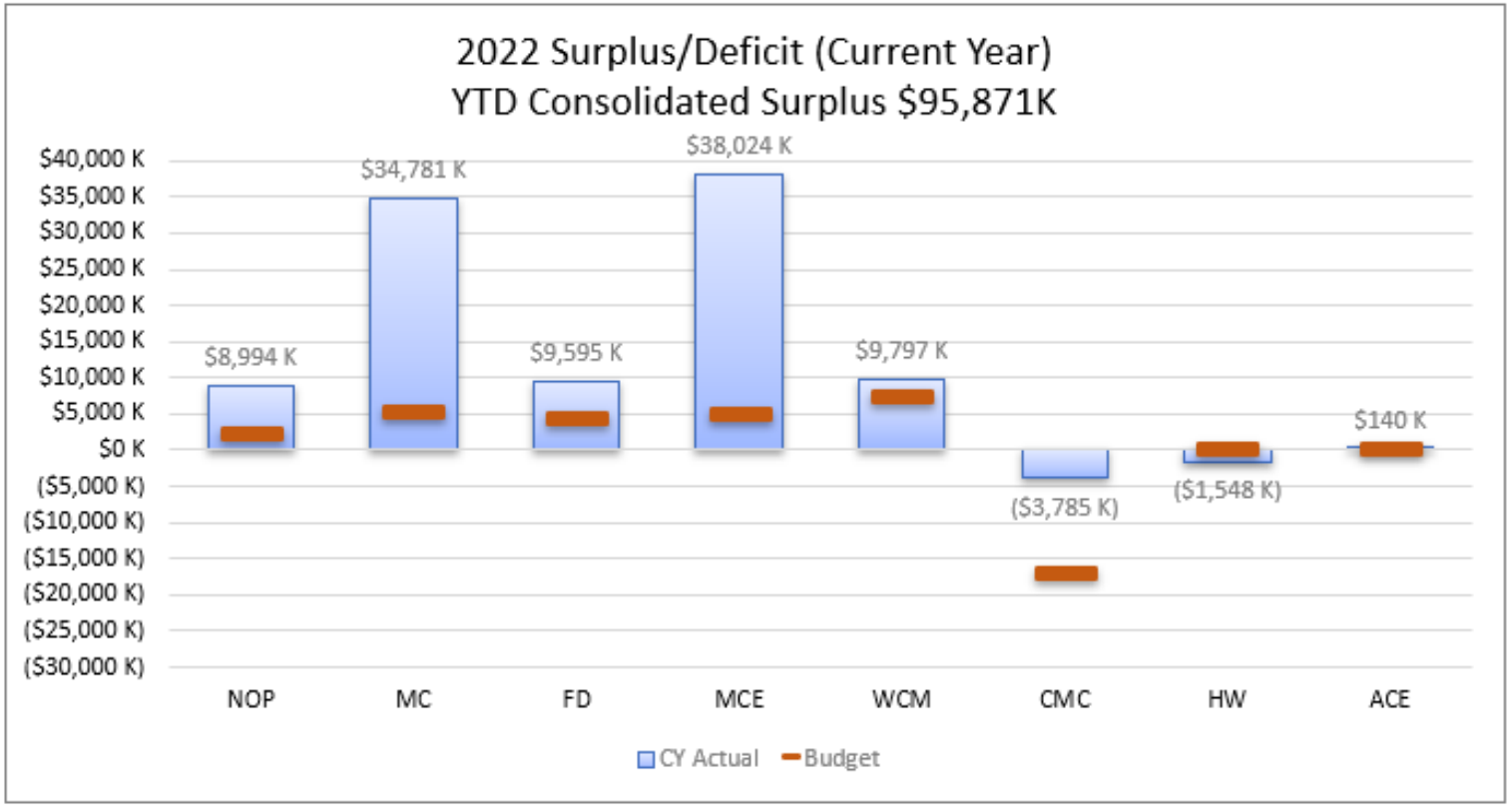
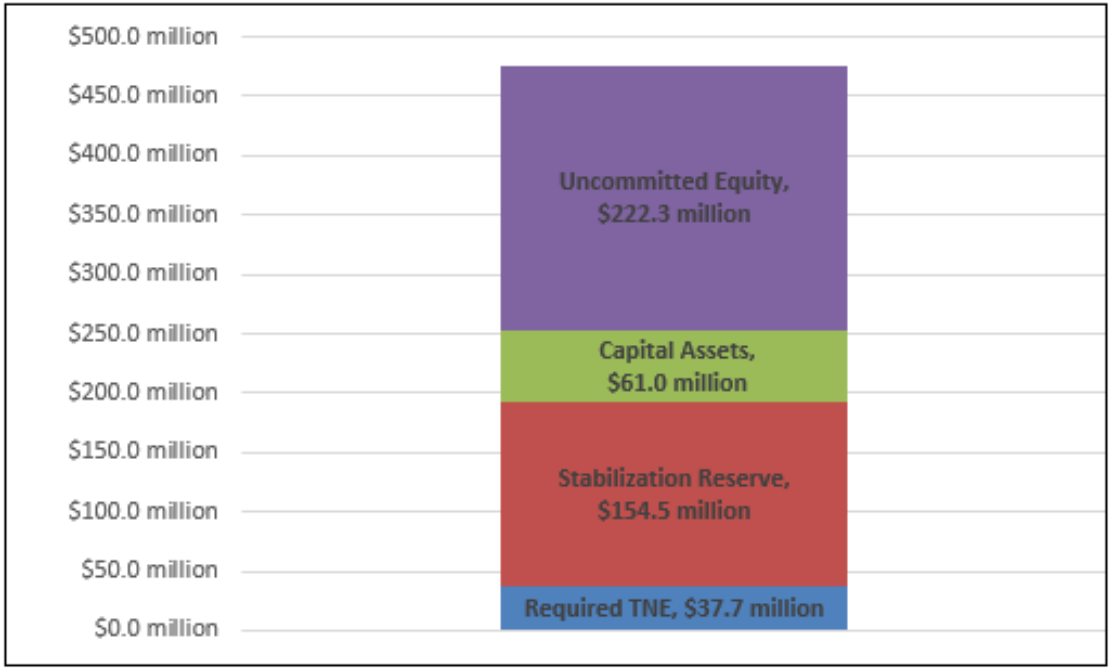
| | | YTD Actual | | | | | |
|---|---|---|---|---|---|---|---|
| | | Total | Prior Year | Current Year | YTD Budget | Variance | % Var. |
| | Provider Capitation | 48,625,317 | 166,118 | 48,459,200 | 52,786,443 | 4,327,244 | 8.2% |
| | Hospital Inpatient | 160,450,966 | (10,505,548) | 170,956,514 | 193,512,272 | 22,555,758 | 11.7% |
| | LTC/SNF | 157,527,789 | (1,718,010) | 159,245,798 | 175,850,777 | 16,604,979 | 9.4% |
| | Pharmacy | 54,428,826 | (1,364,227) | 55,793,053 | 60,381,449 | 4,588,395 | 7.6% |
| | Physician FFS | 70,749,513 | (648,390) | 71,397,904 | 78,644,167 | 7,246,264 | 9.2% |
| | Hospital Outpatient | 86,067,227 | (605,099) | 86,672,326 | 87,413,390 | 741,064 | 0.8% |
| | Other Medical Claims | 82,451,183 | (814,000) | 83,265,183 | 83,997,133 | 731,950 | 0.9% |
| | Other HC Services | 6,588,176 | 109,262 | 6,478,914 | 5,848,924 | (629,990) | -10.8% |
| | Directed Payments | 29,249,489 | 67,629 | 29,181,860 | 28,900,812 | (281,048) | -1.0% |
| | Long Term Support Services | 2,140,621 | (9,153) | 2,149,774 | 3,182,891 | 1,033,117 | 32.5% |
| New | CPO/In-lieu of Services | 6,062,328 | (39,635) | 6,101,963 | 4,279,637 | (1,822,327) | -42.6% |
| New | Dental | 16,064,027 | - | 16,064,027 | 17,803,262 | 1,739,235 | 9.8% |
| New | ECM | 2,385,391 | - | 2,385,391 | 13,131,536 | 10,746,145 | 81.8% |
| | Provider Incentives | 18,884,786 | 2,819,544 | 16,065,242 | 9,215,592 | (6,849,649) | -74.3% |
| | Transportation | 9,285,746 | 14,532 | 9,271,214 | 6,987,239 | (2,283,975) | -32.7% |
| | Indirect Health Care Benefits | 2,394,393 | (706,263) | 3,100,656 | 2,844,162 | (256,493) | -9.0% |
| | UMQA | 18,632,933 | (1,383) | 18,634,316 | 20,711,954 | 2,077,638 | 10.0% |
| | Total Healthcare Cost | 771,988,712 | (13,234,622) | 785,223,334 | 845,491,640 | 60,268,306 | 7.1% |

# CY YTD Surplus/Deficit by LOB



# Tangible Net Equity (TNE)

At 12/31/22 Pre-Audit TNE = $475.5M
Uncommitted portion = $222.3M



# Health Plan of San Mateo
## Consolidated Balance Sheet
## December 31, 2022 and November 30, 2022

| | Current Month | Prior Month | PY 12/31 |
|---|---|---|---|
| **ASSETS** | | | |
| **Current Assets** | | | |
| Cash and Equivalents | $ 409,879,878 | $ 394,861,105 | $ 257,910,849 |
| Investments | 180,739,480 | 180,739,480 | 179,148,167 |
| Capitation Receivable from the State | 133,818,401 | 129,708,597 | 162,771,179 |
| Other Receivables | 76,696,607 | 60,880,810 | 84,001,861 |
| Prepaids and Other Assets | 8,301,288 | 7,115,797 | 6,930,906 |
| Total Current Assets | 809,435,655 | 773,305,789 | 690,762,962 |
| **Capital Assets, Net** | 60,977,606 | 61,032,733 | 62,881,892 |
| **Net Pension Asset** | 2,373,317 | 2,373,317 | 2,373,317 |
| **Assets Restricted As To Use** | 300,000 | 300,000 | 300,000 |
| Total Assets | 873,086,578 | 837,011,840 | 756,318,171 |
| **Deferred Outflows of Resources** | 2,351,463 | 2,351,463 | 2,351,463 |
| Total Assets & Deferred Outflows | $ 875,438,041 | $ 839,363,303 | $ 758,669,634 |
| **LIABILITIES** | | | |
| **Current Liabilities** | | | |
| Medical Claims Payable | 69,446,973 | 70,639,758 | 82,630,315 |
| Provider Incentives | 12,737,495 | 9,710,955 | 9,095,674 |
| Amounts Due to the State | 174,363,272 | 170,762,372 | 153,300,138 |
| Accounts Payable and Accrued Liabilities | 140,440,291 | 138,037,573 | 150,243,004 |
| Total Current Liabilities | 396,988,030 | 389,150,657 | 395,269,131 |
| **Net Pension Liability** | - | - | - |
| **Deferred Inflows of Resources** | 3,022,421 | 3,022,421 | 3,022,421 |
| Total Liabilities & Deferred Inflows | $ 400,010,451 | $ 392,173,078 | $ 398,291,552 |
| **NET POSITION** | | | |
| Invested in Capital Assets | 60,977,606 | 61,032,733 | 62,881,892 |
| Restricted By Legislative Authority | 300,000 | 300,000 | 300,000 |
| Unrestricted | | | |
| Stabilization Reserve | 154,224,200 | 155,842,200 | 178,301,800 |
| Unrestricted Retained Earnings | 259,925,784 | 230,015,291 | 118,894,390 |
| **Net Position** | 475,427,590 | 447,190,225 | 360,378,082 |
| Total Liabilities & Net Position | $ 875,438,041 | $ 839,363,303 | 758,669,634 |
| Change in Net Position | $ 115,049,508 | $ 86,812,143 | 0 |

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# Health Plan of San Mateo
## Consolidated Statement of Revenue & Expense
## for the Period Ending December 31, 2022

| | Current Qtr Actual | Current Qtr Budget | Current Qtr Variance | YTD Actual | YTD Budget | YTD Variance | % Var |
|---|---|---|---|---|---|---|---|
| **OPERATING REVENUE** | | | | | | | |
| Capitation and Premiums | | | | | | | |
| Medi-cal (includes Offsets) | $ 196,287,221 | $ 175,544,500 | $ 20,742,720 | $ 746,601,350 | $ 693,666,154 | $ 52,935,196 | 7.6% |
| HealthWorx | 1,596,299 | 1,618,040 | (21,741) | 6,318,612 | 6,465,577 | (146,965) | -2.3% |
| Medicare (includes CA-CMC) | 61,359,482 | 55,285,553 | 6,073,929 | 211,740,758 | 203,533,776 | 8,206,982 | 4.0% |
| Medi-Cal Incentives | 2,532,934 | - | | 2,532,934 | - | - | - |
| Total Operating Revenue | 261,775,935 | 232,448,093 | 29,327,842 | 967,193,654 | 903,665,508 | 63,528,146 | 7.0% |
| **OPERATING EXPENSE** | | | | | | | |
| Healthcare Expense | | | | | | | |
| Provder Capitation | 12,304,332 | 13,160,286 | 855,954 | 48,625,317 | 52,786,443 | 4,161,126 | 7.9% |
| Hospital Inpatient | 43,347,483 | 48,034,456 | 4,686,973 | 160,450,966 | 193,512,272 | 33,061,306 | 17.1% |
| LTC/SNF | 39,571,480 | 43,599,381 | 4,027,901 | 157,527,789 | 175,850,777 | 18,322,988 | 10.4% |
| Pharmacy | 12,476,516 | 15,091,662 | 2,615,146 | 54,428,826 | 60,381,449 | 5,952,622 | 9.9% |
| Medical | 64,680,595 | 71,106,402 | 6,425,807 | 275,105,588 | 284,804,426 | 9,698,838 | 3.4% |
| Long Term Support Services | 536,505 | 794,740 | 258,234 | 2,140,621 | 3,182,891 | 1,042,269 | 32.7% |
| CPO/In-lieu of Services | 1,553,240 | 1,070,114 | (483,125) | 6,062,328 | 4,279,637 | (1,782,691) | -41.7% |
| Dental Expense | 4,155,812 | 4,438,510 | 282,699 | 16,064,027 | 17,803,262 | 1,739,235 | 9.8% |
| Enhanced Care Management (ECM) | 635,509 | 3,310,185 | 2,674,676 | 2,385,391 | 13,131,536 | 10,746,145 | 81.8% |
| Provider Incentives | 7,486,799 | 2,298,173 | (5,188,626) | 18,884,786 | 9,215,592 | (9,669,194) | -104.9% |
| Transportation | 2,830,682 | 1,860,447 | (970,236) | 9,285,746 | 6,987,239 | (2,298,507) | -32.9% |
| Indirect Health Care Expenses | 917,035 | 709,350 | (207,685) | 2,394,393 | 2,844,162 | 449,770 | 15.8% |
| UMQA, Delegated and Allocation | 4,772,952 | 5,369,445 | 596,493 | 18,632,933 | 20,711,954 | 2,079,020 | 10.0% |
| Total Healthcare Expense | 195,268,941 | 210,843,150 | 15,574,209 | 771,988,712 | 845,491,640 | 73,502,929 | 8.7% |
| Administrative Expense | | | | | | | |
| Salaries and Benefits | 11,065,546 | 11,910,110 | 844,564 | 43,318,332 | 45,116,550 | 1,798,218 | 4.0% |
| Staff Training and Travel | 48,262 | 52,383 | 4,121 | 186,351 | 335,200 | 148,849 | 44.4% |
| Contract Services | 3,261,008 | 4,179,550 | 918,542 | 13,985,140 | 16,794,300 | 2,809,160 | 16.7% |
| Office Supplies and Equipment | 1,817,249 | 1,735,133 | (82,116) | 6,303,678 | 6,783,600 | 479,922 | 7.1% |
| Occupancy and Depreciation | 971,658 | 1,143,706 | 172,047 | 4,035,227 | 4,379,800 | 344,573 | 7.9% |
| Postage and Printing | 587,896 | 466,000 | (121,896) | 2,124,811 | 1,799,000 | (325,811) | -18.1% |
| Other Administrative Expense | 216,084 | 219,863 | 3,779 | 1,435,478 | 1,553,400 | 117,922 | 7.6% |
| UM/QA Allocation | (4,720,573) | (5,313,002) | (592,429) | (18,371,327) | (20,480,278) | (2,108,951) | -10.3% |
| Total Admin Expense | 13,247,132 | 14,393,743 | 1,146,611 | 53,017,690 | 56,281,572 | 3,263,882 | 5.8% |
| Premium Taxes | 10,076,110 | - | (10,076,110) | 38,472,420 | - | (38,472,420) | - |
| Total Operating Expense | 218,592,182 | 225,236,893 | 6,644,711 | 863,478,822 | 901,773,212 | 38,294,390 | 4.2% |
| Net Income/Loss from Operations | 43,183,753 | 7,211,201 | (35,972,552) | 103,714,832 | 1,892,296 | (101,822,536) | 5480.9% |
| Interest Income, Net | 4,181,345 | 250,000 | 3,931,345 | 7,637,164 | 1,000,000 | 6,637,164 | 663.7% |
| Rental Income, Net | 305,489 | 293,970 | 11,519 | 1,199,096 | 1,175,881 | 23,215 | 2.0% |
| Third Party Administrator Revenue | 565,781 | 491,015 | 74,766 | 2,343,595 | 2,187,301 | 156,294 | 7.1% |
| Miscellaneous Income | 9,433 | - | (9,433) | 9,433 | - | 9,433 | - |
| Grant Income | 145,388 | - | (145,388) | 145,388 | - | 145,388 | - |
| **NON-OPERATING REVENUE** | | | | | | | |
| Net Non-operating Revenue | 5,207,436 | 1,034,985 | 4,172,451 | 11,334,676 | 4,363,181 | 6,971,495 | 159.8% |
| Net Income/(Loss) | $ 48,391,189 | 8,246,186 | 40,145,003 | $ 115,049,508 | $ 6,255,477 | $ 108,794,031 | -1739.2% |
| *Admin exp as % of Net Rev (adj for Tax)* | *5.26%* | *6.19%* | | *5.71%* | *6.23%* | | |
| *Medical Loss Ratio (adj for Tax)* | *75.05%* | *87.60%* | | *79.97%* | *90.36%* | | |

# Health Plan of San Mateo
## HPSM Statement of Revenue & Expense
## for the Period Ending December 31, 2022

| | Current Qtr Actual | Current Qtr Budget | Current Qtr Variance | % Var | YTD Actual | YTD Budget | YTD Var Fav/(Unfav) | % Var |
|---|---|---|---|---|---|---|---|---|
| **OPERATING REVENUE** | | | | | | | | |
| Total Operating Revenue | - | - | - | - | - | - | - | - |
| **OPERATING EXPENSE** | | | | | | | | |
| Total Health Care Expense | - | - | - | - | - | - | - | - |
| Total Operating Expense | - | - | - | - | - | - | - | - |
| **NON-OPERATING REVENUE** | | | | | | | | |
| Interest, Net | 4,181,345 | 250,000 | 3,931,345 | 1572.5% | 7,637,164 | 1,000,000 | 6,637,164 | 663.7% |
| Rental Income, Net | 305,489 | 293,970 | 11,519 | 3.9% | 1,199,096 | 1,175,881 | 23,215 | 2.0% |
| Miscellaneous Income | 9,433 | - | 9,433 | - | 9,433 | - | 9,433 | - |
| Grant Income | 145,388 | - | 145,388 | - | 145,388 | - | 145,388 | - |
| Total Non-Operating | 4,641,655 | 543,970 | 4,097,685 | 753.3% | 8,991,082 | 2,175,881 | 6,815,201 | 313.2% |
| **Net Income/(Loss)** | $ 4,641,655 | $ 543,970 | 4,097,685 | -753.3% | $ 8,991,082 | $ 2,175,881 | $ 6,815,201 | -313.2% |
| Medical Loss Ratio (adj MCO) | - | - | | | - | - | | |
| Member Counts | - | - | - | - | - | - | - | - |

# Health Plan of San Mateo
## Medi-Cal Statement of Revenue & Expense
## for the Period Ending December 31, 2022

| | Current Qtr Actual | Current Qtr Budget | Current Qtr Variance | % Var | YTD Actual | YTD Budget | YTD Var Fav/(Unfav) | % Var |
|---|---|---|---|---|---|---|---|---|
| **OPERATING REVENUE** | | | | | | | | |
| MC Capitation | $ 83,935,259 | $ 65,407,067 | $ 18,528,192 | 28.3% | $ 343,713,360 | $ 259,373,369 | $ 84,339,991 | 32.5% |
| Supplemental Capitation | 2,829,874 | 2,551,241 | 278,633 | 10.9% | 9,750,678 | 10,204,966 | (454,287) | -4.5% |
| BHT Capitation | 2,011,874 | 1,745,025 | 266,850 | 15.3% | 8,280,491 | 6,980,099 | 1,300,392 | 18.6% |
| HepC Capitation | - | - | - | - | 69,892 | - | 69,892 | - |
| MC Cap Offset | (7,260,185) | - | (7,260,185) | - | (51,137,304) | - | (51,137,304) | - |
| Medi-Cal Incentives | 1,904,740 | - | | - | 1,904,740 | - | 1,904,740 | - |
| Total Operating Revenue | 83,421,562 | 69,703,333 | 13,718,229 | 19.7% | 312,581,856 | 276,558,434 | 36,023,423 | 13.0% |
| **OPERATING EXPENSE** | | | | | | | | |
| Provider Capitation | 6,140,037 | 6,366,432 | 226,395 | 3.6% | 24,656,441 | 25,551,119 | 894,678 | 3.5% |
| Hospital Inpatient | 15,699,036 | 16,250,113 | 551,077 | 3.4% | 49,936,677 | 64,727,580 | 14,790,903 | 22.9% |
| LTC/SNF | 8,135,266 | 7,329,177 | (806,089) | -11.0% | 29,001,263 | 29,600,776 | 599,514 | 2.0% |
| Pharmacy | 131,442 | - | (131,442) | - | (393,983) | - | 393,983 | - |
| Physician Fee for Service | 6,256,760 | 6,569,764 | 313,004 | 4.8% | 24,282,313 | 26,641,721 | 2,359,408 | 8.9% |
| Hospital Outpatient | 6,623,515 | 7,073,794 | 450,279 | 6.4% | 25,717,920 | 28,392,107 | 2,674,187 | 9.4% |
| Other Medical Claims | 6,375,974 | 5,879,765 | (496,208) | -8.4% | 24,729,233 | 23,703,613 | (1,025,620) | -4.3% |
| Other HC Services | (116,672) | 1,427,326 | 1,543,998 | 108.2% | 6,618,151 | 5,728,447 | (889,703) | -15.5% |
| Directed Payments | 3,984,770 | 4,722,610 | 737,840 | 15.6% | 18,238,255 | 18,931,298 | 693,044 | 3.7% |
| Long Term Support Services | 103,597 | 143,388 | 39,791 | 27.8% | 435,705 | 575,474 | 139,769 | 24.3% |
| CPO/In-lieu of Services | 309,462 | 213,859 | (95,602) | -44.7% | 925,284 | 831,024 | 94,260 | 11.3% |
| Dental Expense | 2,320,511 | 2,925,040 | 604,529 | 20.7% | 9,785,807 | 11,739,392 | (1,953,585) | -16.6% |
| Enhanced Care Management (ECM) | 159,740 | 1,292,177 | 1,132,437 | 87.6% | 577,466 | 5,058,695 | (4,481,229) | -88.6% |
| Provider Incentives | 2,149,959 | 1,157,054 | (992,905) | -85.8% | 7,175,648 | 4,643,735 | (2,531,913) | -54.5% |
| Transportation | 925,109 | 499,684 | (425,424) | -85.1% | 2,747,491 | 1,951,157 | 796,334 | 40.8% |
| Indirect Health Care Expenses | 513,722 | 346,501 | (167,221) | -48.3% | 2,872,179 | 1,390,651 | (1,481,528) | -106.5% |
| UMQA (Allocation & Delegated) | 1,200,494 | 1,413,023 | 212,529 | 15.0% | 4,033,342 | 5,417,982 | 1,384,640 | 25.6% |
| Total Health Care Expense | 60,912,720 | 63,609,708 | 2,696,989 | 4.2% | 231,339,190 | 254,884,772 | 23,545,581 | 9.2% |
| G&A Allocation | 3,752,874 | 4,212,715 | 459,841 | 10.9% | 14,054,853 | 16,457,885 | 2,403,032 | 14.6% |
| Premium Tax | 5,636,894 | - | (5,636,894) | - | 21,745,919 | - | (21,745,919) | - |
| Total Operating Expense | 70,302,488 | 67,822,423 | (2,480,065) | -3.7% | 267,139,962 | 271,342,657 | 4,202,694 | 1.5% |
| **NON-OPERATING REVENUE** | | | | | | | | |
| Total Non-Operating | - | - | - | - | - | - | - | - |
| **Net Income/(Loss)** | $ 13,119,074 | $ 1,880,910 | 11,238,164 | -597.5% | $ 45,441,894 | $ 5,215,777 | $ 40,226,117 | -771.2% |
| Medical Loss Ratio (adj MCO) | 82.54% | 97.89% | | | 84.86% | 98.94% | | |
| Member Counts | 230,740 | 217,255 | 13,485 | 6.2% | 899,180 | 871,931 | 27,249 | 3.1% |

# Health Plan of San Mateo
## Full Duals Statement of Revenue & Expense
## for the Period Ending December 31, 2022

| | Current Qtr Actual | Current Qtr Budget | Current Qtr Variance | % Var | YTD Actual | YTD Budget | YTD Var Fav/(Unfav) | % Var |
|---|---|---|---|---|---|---|---|---|
| **OPERATING REVENUE** | | | | | | | | |
| MC Capitation | $ 25,710,519 | $ 22,074,242 | $ 3,636,277 | 16.5% | $ 98,767,796 | $ 89,121,489 | $ 9,646,307 | 10.8% |
| MC Cap Offset | (1,994,000) | - | (1,994,000) | - | (7,921,000) | - | (7,921,000) | - |
| Medi-Cal Incentives | 86,148 | - | | - | 86,148 | - | 86,148 | - |
| Total Operating Revenue | 23,802,667 | 22,074,242 | 1,728,425 | 7.8% | 90,932,944 | 89,121,489 | 1,811,455 | 2.0% |
| **OPERATING EXPENSE** | | | | | | | | |
| Provider Capitation | 17,642 | - | (17,642) | - | 110,949 | - | (110,949) | - |
| Hospital Inpatient | 120,786 | 370,528 | 249,742 | 67.4% | 1,162,680 | 1,495,952 | 333,272 | 22.3% |
| LTC/SNF | 14,241,381 | 16,437,473 | 2,196,093 | 13.4% | 58,399,172 | 66,363,866 | 7,964,695 | 12.0% |
| Pharmacy | 9,155 | - | (9,155) | - | (38,388) | - | 38,388 | - |
| Physician Fee for Service | 184,994 | 291,245 | 106,252 | 36.5% | 1,048,738 | 1,214,131 | 165,393 | 13.6% |
| Hospital Outpatient | 217,340 | 134,316 | (83,024) | -61.8% | 879,355 | 546,976 | (332,378) | -60.8% |
| Other Medical Claims | 1,330,725 | 1,600,449 | 269,725 | 16.9% | 6,571,988 | 6,517,904 | (54,084) | -0.8% |
| Other HC Services | (453) | (463) | (10) | 2.1% | (6,822) | (1,870) | 4,952 | -264.8% |
| Directed Payments | 104,395 | 1,158 | (103,237) | -8915.8% | 399,138 | 4,675 | (394,463) | -8437.9% |
| Long Term Support Services | 167,755 | 180,632 | 12,877 | 7.1% | 587,664 | 735,131 | 147,467 | 20.1% |
| CPO/In-lieu of Services | 252,438 | 275,812 | 23,374 | 8.5% | 1,278,685 | 1,113,549 | 165,135 | 14.8% |
| Dental Expense | 338,717 | 206,821 | (131,896) | -63.8% | 891,784 | 835,011 | 56,773 | 6.8% |
| Enhanced Care Management (ECM) | 121,200 | 316,385 | 195,185 | 61.7% | 428,808 | 1,277,356 | (848,548) | -66.4% |
| Provider Incentives | 1,878,851 | - | (1,878,851) | - | 2,867,448 | - | (2,867,448) | - |
| Transportation | 267,521 | 130,843 | (136,678) | -104.5% | 933,454 | 531,779 | 401,675 | 75.5% |
| Indirect Health Care Expenses | - | 37,580 | 37,580 | 100.0% | 42 | 151,722 | 151,680 | 100.0% |
| UMQA (Allocation & Delegated) | 283,305 | 267,070 | (16,235) | -6.1% | 1,143,031 | 1,022,748 | (120,283) | -11.8% |
| Total Health Care Expense | 19,535,751 | 20,249,850 | 714,099 | 3.5% | 76,657,725 | 81,808,931 | 5,151,206 | 6.3% |
| G&A Allocation | 590,254 | 817,619 | 227,365 | 27.8% | 2,571,211 | 3,194,148 | 622,937 | 19.5% |
| Premium Tax | 633,984 | - | (633,984) | - | 2,369,088 | - | (2,369,088) | - |
| Total Operating Expense | 20,759,989 | 21,067,469 | 307,480 | 1.5% | 81,598,024 | 85,003,079 | 3,405,055 | 4.0% |
| **NON-OPERATING REVENUE** | | | | | | | | |
| Total Non-Operating | - | - | - | - | - | - | - | - |
| **Net Income/(Loss)** | $ 3,042,678 | $ 1,006,774 | 2,035,904 | -202.2% | $ 9,334,920 | $ 4,118,410 | $ 5,216,510 | -126.7% |
| Medical Loss Ratio (adj MCO) | 84.70% | 91.74% | | | 86.95% | 91.80% | | |
| Member Counts | 25,969 | 23,158 | 2,811 | 12.1% | 99,288 | 93,497 | 5,791 | 6.2% |

# Health Plan of San Mateo
## HealthWorx Statement of Revenue & Expense
## for the Period Ending December 31, 2022

| | Current Qtr Actual | Current Qtr Budget | Current Qtr Variance | % Var | YTD Actual | YTD Budget | YTD Var Fav/(Unfav) | % Var |
|---|---|---|---|---|---|---|---|---|
| **OPERATING REVENUE** | | | | | | | | |
| HealthWorx Premium | 1,596,299 | 1,618,040 | (21,741) | -1.3% | 6,318,612 | 6,465,577 | (146,965) | -2.3% |
| Medi-Cal Incentives | 6,252 | - | | - | 6,252 | - | 6,252 | - |
| Total Operating Revenue | 1,602,550 | 1,618,040 | (15,490) | -1.0% | 6,324,864 | 6,465,577 | (140,714) | -2.2% |
| **OPERATING EXPENSE** | | | | | | | | |
| Provider Capitation | 24 | - | (24) | - | 95 | - | (95) | - |
| Hospital Inpatient | 264,534 | 193,568 | (70,966) | -36.7% | 1,379,700 | 759,676 | (620,024) | -81.6% |
| Pharmacy | 660,452 | 626,539 | (33,913) | -5.4% | 2,619,655 | 2,476,458 | (143,197) | -5.8% |
| Physician Fee for Service | 282,309 | 288,065 | 5,756 | 2.0% | 1,174,926 | 1,173,178 | (1,747) | -0.1% |
| Hospital Outpatient | 412,936 | 263,842 | (149,094) | -56.5% | 1,603,263 | 1,094,789 | (508,474) | -46.4% |
| Other Medical Claims | 95,560 | 101,024 | 5,463 | 5.4% | 416,425 | 401,475 | (14,949) | -3.7% |
| Other HC Services | - | - | - | - | 0 | - | 0 | - |
| Provider Incentives | 3,041 | - | (3,041) | - | 3,041 | - | (3,041) | - |
| Indirect Health Care Expenses | 10,648 | 9,448 | (1,200) | -12.7% | 42,490 | 37,754 | (4,736) | -12.5% |
| UMQA (Allocation & Delegated) | 42,172 | 41,108 | (1,064) | -2.6% | 154,215 | 157,486 | 3,271 | 2.1% |
| Total Health Care Expense | 1,771,677 | 1,523,593 | (248,083) | -16.3% | 7,393,809 | 6,100,816 | (1,292,993) | -21.2% |
| G&A Allocation | 151,054 | 124,721 | (26,333) | -21.1% | 594,569 | 487,243 | (107,326) | -22.0% |
| Total Operating Expense | 1,922,731 | 1,648,314 | (274,416) | -16.6% | 7,988,378 | 6,588,059 | (1,400,319) | -21.3% |
| **NON-OPERATING REVENUE** | | | | | | | | |
| Total Non-Operating | - | - | - | - | - | - | - | - |
| **Net Income/(Loss)** | $ (320,181) | $ (30,274) | (289,906) | 957.6% | $ (1,663,515) | $ (122,482) | $ (1,541,033) | 1258.2% |
| Medical Loss Ratio (adj MCO) | 110.55% | 94.16% | | | 116.90% | 94.36% | | |
| Member Counts | 3,633 | 3,687 | (54) | -1.5% | 14,402 | 14,733 | (331) | -2.2% |

# Health Plan of San Mateo
## Healthy Kids Statement of Revenue & Expense
## for the Period Ending December 31, 2022

| | Current Qtr Actual | Current Qtr Budget | Current Qtr Variance | % Var | YTD Actual | YTD Budget | YTD Var Fav/(Unfav) | % Var |
|---|---|---|---|---|---|---|---|---|
| **OPERATING REVENUE** | | | | | | | | |
| Total Operating Revenue | - | - | - | - | - | - | - | - |
| **OPERATING EXPENSE** | | | | | | | | |
| Pharmacy | - | - | - | - | (66) | - | 66 | - |
| Physician Fee for Service | (19) | - | 19 | - | (19) | - | 19 | - |
| Hospital Outpatient | (12) | - | 12 | - | (12) | - | 12 | - |
| Other Medical Claims | (5) | - | 5 | - | (5) | - | 5 | - |
| Indirect Health Care Expenses | - | - | - | - | 46 | - | (46) | - |
| Total Health Care Expense | (35) | - | 35 | - | (55) | - | 55 | - |
| Total Operating Expense | (35) | - | 35 | - | (55) | - | 55 | - |
| **NON-OPERATING REVENUE** | | | | | | | | |
| Total Non-Operating | - | - | - | - | - | - | - | - |
| **Net Income/(Loss)** | $ 35 | - | 35 | - | $ 55 | - | $ 55 | - |
| Medical Loss Ratio (adj MCO) | - | - | | | - | - | | |
| Member Counts | - | - | - | - | - | - | - | - |

# Health Plan of San Mateo
## CareAdvantage Statement of Revenue & Expense
## for the Period Ending December 31, 2022

| | Current Qtr Actual | Current Qtr Budget | Current Qtr Variance | % Var | YTD Actual | YTD Budget | YTD Var Fav/(Unfav) | % Var |
|---|---|---|---|---|---|---|---|---|
| **OPERATING REVENUE** | | | | | | | | |
| Total Operating Revenue | - | - | - | - | - | - | - | - |
| **OPERATING EXPENSE** | | | | | | | | |
| UMQA (Allocation & Delegated) | 35,133 | - | (35,133) | - | 35,133 | - | (35,133) | - |
| Total Health Care Expense | 35,133 | - | (35,133) | - | 35,133 | - | (35,133) | - |
| G&A Allocation | (63,336) | - | 63,336 | - | 92,875 | - | (92,875) | - |
| Total Operating Expense | (28,203) | - | 28,203 | - | 128,008 | - | (128,008) | - |
| **NON-OPERATING REVENUE** | | | | | | | | |
| Total Non-Operating | - | - | - | - | - | - | - | - |
| **Net Income/(Loss)** | $ 28,203 | - | 28,203 | - | $ (128,008) | - | $ (128,008) | - |
| Medical Loss Ratio (adj MCO) | - | - | | | - | - | | |
| Member Counts | - | - | - | - | - | - | - | - |

# Health Plan of San Mateo
## Medi-Cal Advantage Statement of Revenue & Expense
## for the Period Ending December 31, 2022

| | Current Qtr Actual | Current Qtr Budget | Current Qtr Variance | % Var | YTD Actual | YTD Budget | YTD Var Fav/(Unfav) | % Var |
|---|---|---|---|---|---|---|---|---|
| **OPERATING REVENUE** | | | | | | | | |
| Total Operating Revenue | - | - | - | - | - | - | - | - |
| **OPERATING EXPENSE** | | | | | | | | |
| Total Health Care Expense | - | - | - | - | - | - | - | - |
| Total Operating Expense | - | - | - | - | - | - | - | - |
| **NON-OPERATING REVENUE** | | | | | | | | |
| Total Non-Operating | - | - | - | - | - | - | - | - |
| Medical Loss Ratio (adj MCO) | - | - | | | - | - | | |
| Member Counts | - | - | - | - | - | - | - | - |

# Health Plan of San Mateo
## ACE Statement of Revenue & Expense
## for the Period Ending December 31, 2022

| | Current Qtr Actual | Current Qtr Budget | Current Qtr Variance | % Var | YTD Actual | YTD Budget | YTD Var Fav/(Unfav) | % Var |
|---|---|---|---|---|---|---|---|---|
| **OPERATING REVENUE** | | | | | | | | |
| Total Operating Revenue | - | - | - | - | - | - | - | - |
| **OPERATING EXPENSE** | | | | | | | | |
| Total Health Care Expense | - | - | - | - | - | - | - | - |
| G&A Allocation | 510,197 | 535,890 | 25,693 | 4.8% | 2,204,044 | 2,143,560 | (60,484) | -2.8% |
| Total Operating Expense | 510,197 | 535,890 | 25,693 | 4.8% | 2,204,044 | 2,143,560 | (60,484) | -2.8% |
| **NON-OPERATING REVENUE** | | | | | | | | |
| Third Party Administror Revenue | 565,781 | 491,015 | 74,766 | 15.2% | 2,343,595 | 2,187,301 | 156,294 | 7.1% |
| Total Non-Operating | 565,781 | 491,015 | 74,766 | 15.2% | 2,343,595 | 2,187,301 | 156,294 | 7.1% |
| **Net Income/(Loss)** | $ 55,584 | $ (44,875) | 100,459 | 223.9% | $ 139,551 | $ 43,741 | $ 95,810 | -219.0% |
| Medical Loss Ratio (adj MCO) | - | - | | | - | - | | |
| Member Counts | 62,519 | 57,767 | 4,753 | 8.2% | 282,214 | 267,326 | 14,888 | 5.6% |

# Health Plan of San Mateo
## CCS Statement of Revenue & Expense
## for the Period Ending December 31, 2022

| | Current Qtr Actual | Current Qtr Budget | Current Qtr Variance | % Var | YTD Actual | YTD Budget | YTD Var Fav/(Unfav) | % Var |
|---|---|---|---|---|---|---|---|---|
| **OPERATING REVENUE** | | | | | | | | |
| WCM Capitation | 10,943,192 | 8,480,058 | 2,463,134 | 29.0% | 41,307,302 | 33,912,047 | 7,395,255 | 21.8% |
| Supplemental Capitation | - | - | - | - | (19,361) | - | (19,361) | - |
| BHT Capitation | 144,777 | 143,309 | 1,468 | 1.0% | 613,557 | 573,237 | 40,321 | 7.0% |
| MC Cap Offset | (388,377) | - | (388,377) | - | (5,986,679) | - | (5,986,679) | - |
| Medi-Cal Incentives | 39,719 | - | | - | 39,719 | - | 39,719 | - |
| Total Operating Revenue | 10,739,311 | 8,623,367 | 2,115,944 | 24.5% | 35,954,538 | 34,485,283 | 1,469,255 | 4.3% |
| **OPERATING EXPENSE** | | | | | | | | |
| Provider Capitation | 100,047 | 142,330 | 42,283 | 29.7% | 659,181 | 569,181 | (90,000) | -15.8% |
| Hospital Inpatient | 1,710,972 | 2,422,531 | 711,559 | 29.4% | 7,063,156 | 9,640,339 | 2,577,183 | 26.7% |
| LTC/SNF | 363,062 | 362,750 | (312) | -0.1% | 1,559,194 | 1,450,652 | (108,542) | -7.5% |
| Pharmacy | (7,076) | - | 7,076 | - | (46,493) | - | 46,493 | - |
| Physician Fee for Service | 343,835 | 524,175 | 180,340 | 34.4% | 1,682,223 | 2,054,752 | 372,529 | 18.1% |
| Hospital Outpatient | 589,264 | 795,897 | 206,632 | 26.0% | 3,604,148 | 3,182,838 | (421,310) | -13.2% |
| Other Medical Claims | 940,331 | 871,317 | (69,014) | -7.9% | 3,516,515 | 3,525,869 | 9,354 | 0.3% |
| Other HC Services | 101,463 | 71,479 | (29,985) | -41.9% | 203,510 | 285,846 | 82,336 | 28.8% |
| Directed Payments | 162,446 | 163,854 | 1,408 | 0.9% | 643,626 | 655,257 | 11,631 | 1.8% |
| CPO/In-lieu of Services | - | 524 | 524 | 100.0% | - | 2,097 | (2,097) | -100.0% |
| Dental Expense | 48,909 | 54,300 | 5,390 | 9.9% | 195,765 | 217,146 | (21,381) | -9.8% |
| Enhanced Care Management (ECM) | - | 12,793 | 12,793 | 100.0% | - | 51,158 | (51,158) | -100.0% |
| Provider Incentives | 11,900 | 21,209 | 9,309 | 43.9% | 95,753 | 84,815 | (10,939) | -12.9% |
| Transportation | 23,006 | 21,342 | (1,664) | -7.8% | 73,226 | 77,062 | (3,835) | -5.0% |
| Indirect Health Care Expenses | 7,431 | 7,259 | (172) | -2.4% | (398,523) | 29,028 | 427,551 | 1472.9% |
| UMQA (Allocation & Delegated) | 676,273 | 934,143 | 257,870 | 27.6% | 3,571,751 | 3,717,466 | 145,714 | 3.9% |
| Total Health Care Expense | 5,071,863 | 6,405,900 | 1,334,037 | 20.8% | 22,423,034 | 25,543,505 | 3,120,472 | 12.2% |
| G&A Allocation | 341,214 | 443,454 | 102,240 | 23.1% | 1,429,052 | 1,732,418 | 303,366 | 17.5% |
| Premium Tax | 112,612 | - | (112,612) | - | 412,341 | - | (412,341) | - |
| Total Operating Expense | 5,525,689 | 6,849,354 | 1,323,665 | 19.3% | 24,264,427 | 27,275,923 | 3,011,497 | 11.0% |
| **NON-OPERATING REVENUE** | | | | | | | | |
| Total Non-Operating | - | - | - | - | - | - | - | - |
| **Net Income/(Loss)** | $ 5,213,623 | $ 1,774,013 | 3,439,610 | -193.9% | $ 11,690,111 | $ 7,209,360 | $ 4,480,751 | -62.2% |
| Medical Loss Ratio (adj MCO) | 48.47% | 75.72% | | | 64.25% | 75.51% | | |
| Member Counts | 4,200 | 4,144 | 56 | 1.4% | 16,710 | 16,572 | 138 | 0.8% |

# Health Plan of San Mateo
## MCE Statement of Revenue & Expense
## for the Period Ending December 31, 2022

| | Current Qtr Actual | Current Qtr Budget | Current Qtr Variance | % Var | YTD Actual | YTD Budget | YTD Var Fav/(Unfav) | % Var |
|---|---|---|---|---|---|---|---|---|
| **OPERATING REVENUE** | | | | | | | | |
| MCE Capitation | 67,361,396 | 52,250,694 | 15110702 | 28.9% | 275,323,932 | 208,682,438 | 66,641,494 | 31.9% |
| AIDS Capitation | 469 | - | 469 | - | 469 | - | 469 | - |
| Supplemental Capitation | 633,466 | 337,354 | 296,112 | 87.8% | 2,176,236 | 1,349,417 | 826,819 | 61.3% |
| HepC Capitation | - | - | - | - | (69,892) | - | (69,892) | - |
| MC Cap Offset | (8,440,958) | - | (8,440,958) | - | (44,974,249) | - | (44,974,249) | - |
| Medi-Cal Incentives | 478,296 | - | | - | 478,296 | - | 478,296 | - |
| Total Operating Revenue | 60,032,669 | 52,588,048 | 7,444,621 | 14.2% | 232,934,792 | 210,031,855 | 22,902,937 | 10.9% |
| **OPERATING EXPENSE** | | | | | | | | |
| Provider Capitation | 5,356,018 | 5,566,874 | 210,856 | 3.8% | 20,283,912 | 22,231,257 | 1,947,345 | 8.8% |
| Hospital Inpatient | 13,181,834 | 12,201,800 | (980,035) | -8.0% | 43,877,836 | 50,667,436 | 6,789,600 | 13.4% |
| LTC/SNF | 4,290,219 | 4,416,410 | 126,192 | 2.9% | 15,315,052 | 17,573,374 | 2,258,322 | 12.9% |
| Pharmacy | (284,014) | - | 284,014 | - | (1,143,223) | - | 1,143,223 | - |
| Physician Fee for Service | 5,238,058 | 6,330,896 | 1,092,838 | 17.3% | 20,979,471 | 25,050,517 | 4,071,046 | 16.3% |
| Hospital Outpatient | 6,293,906 | 7,172,923 | 879,018 | 12.3% | 28,069,039 | 28,749,292 | 680,253 | 2.4% |
| Other Medical Claims | 4,230,497 | 4,752,744 | 522,247 | 11.0% | 16,534,822 | 18,980,036 | 2,445,214 | 12.9% |
| Other HC Services | (54,105) | (40,941) | 13,163 | -32.2% | (226,483) | (163,499) | 62,984 | -38.5% |
| Directed Payments | 1,986,418 | 2,330,515 | 344,097 | 14.8% | 9,419,551 | 9,309,581 | (109,969) | -1.2% |
| Long Term Support Services | 2,028 | 4,094 | 2,066 | 50.5% | 3,243 | 16,350 | 13,106 | 80.2% |
| CPO/In-lieu of Services | 100,476 | 24,781 | (75,695) | -305.5% | 221,077 | 98,961 | 122,116 | 123.4% |
| Dental Expense | 994,631 | 911,838 | (82,792) | -9.1% | 3,634,792 | 3,641,416 | (6,624) | -0.2% |
| Enhanced Care Management (ECM) | 112,870 | 1,688,830 | 1,575,960 | 93.3% | 437,592 | 6,744,327 | (6,306,735) | -93.5% |
| Provider Incentives | 2,016,221 | 641,986 | (1,374,235) | -214.1% | 4,885,446 | 2,563,766 | (2,321,680) | -90.6% |
| Transportation | 937,164 | 702,826 | (234,338) | -33.3% | 3,222,632 | 2,605,039 | 617,592 | 23.7% |
| Indirect Health Care Expenses | 290,029 | 218,585 | (71,444) | -32.7% | 825,473 | 872,915 | 47,442 | 5.4% |
| UMQA (Allocation & Delegated) | 885,049 | 1,041,188 | 156,139 | 15.0% | 3,082,361 | 3,989,480 | 907,119 | 22.7% |
| Total Health Care Expense | 45,577,299 | 47,965,350 | 2,388,052 | 5.0% | 169,422,594 | 192,930,250 | 23,507,656 | 12.2% |
| G&A Allocation | 2,814,126 | 3,145,756 | 331,630 | 10.5% | 10,787,253 | 12,289,353 | 1,502,100 | 12.2% |
| Premium Tax | 3,692,620 | - | (3,692,620) | - | 13,945,072 | - | (13,945,072) | - |
| Total Operating Expense | 52,084,044 | 51,111,106 | (972,938) | -1.9% | 194,154,919 | 205,219,603 | 11,064,684 | 5.4% |
| **NON-OPERATING REVENUE** | | | | | | | | |
| Total Non-Operating | - | - | - | - | - | - | - | - |
| **Net Income/(Loss)** | $ 7,948,625 | $ 1,476,942 | 6,471,683 | -438.2% | $ 38,779,874 | $ 4,812,252 | $ 33,967,621 | -705.9% |
| Medical Loss Ratio (adj MCO) | 83.85% | 95.44% | | | 80.84% | 96.12% | | |
| Member Counts | 151,455 | 136,471 | 14,984 | 11.0% | 570,446 | 544,996 | 25,450 | 4.7% |

# Health Plan of San Mateo
## CA CMC Statement of Revenue & Expense
## for the Period Ending December 31, 2022

| | Current Qtr Actual | Current Qtr Budget | Current Qtr Variance | % Var | YTD Actual | YTD Budget | YTD Var Fav/(Unfav) | % Var |
|---|---|---|---|---|---|---|---|---|
| **OPERATING REVENUE** | | | | | | | | |
| CA Cal MediConnect Premium | 61,359,482 | 55,285,553 | 6,073,929 | 11.0% | 211,740,758 | 203,533,776 | 8,206,982 | 4.0% |
| Total Operating Revenue | 61,359,482 | 55,285,553 | 6,073,929 | 11.0% | 211,740,758 | 203,533,776 | 8,206,982 | 4.0% |
| **OPERATING EXPENSE** | | | | | | | | |
| Provider Capitation | 690,531 | 1,084,650 | 394,119 | 36.3% | 2,914,578 | 4,434,886 | 1,520,308 | 34.3% |
| Hospital Inpatient | 11,499,013 | 16,025,460 | 4,526,448 | 28.2% | 54,025,832 | 63,930,960 | 9,905,128 | 15.5% |
| LTC/SNF | 1,727,162 | 2,608,796 | 881,633 | 33.8% | 8,372,628 | 10,407,366 | 2,034,737 | 19.6% |
| Pharmacy | 11,805,461 | 14,259,351 | 2,453,890 | 17.2% | 52,757,046 | 57,080,692 | 4,323,646 | 7.6% |
| Physician Fee for Service | 4,570,411 | 4,859,185 | 288,773 | 5.9% | 18,452,767 | 19,342,277 | 889,510 | 4.6% |
| Hospital Outpatient | 5,114,182 | 5,642,447 | 528,265 | 9.4% | 22,654,532 | 22,263,236 | (391,295) | -1.8% |
| Other Medical Claims | 5,888,217 | 5,361,777 | (526,440) | -9.8% | 21,367,942 | 21,366,329 | (1,613) | 0.0% |
| Other HC Services | (6) | - | 6 | - | 0 | - | 0 | - |
| Enhanced Care Management (ECM) | 241,699 | - | (241,699) | - | 941,525 | - | 941,525 | - |
| Provider Incentives | (340,322) | 477,924 | 818,245 | 171.2% | 1,344,165 | 1,923,276 | 579,112 | 30.1% |
| Indirect Health Care Expenses | 95,205 | 88,340 | (6,865) | -7.8% | (947,314) | 355,501 | 1,302,816 | 366.5% |
| UMQA (Allocation & Delegated) | 1,435,122 | 1,374,156 | (60,965) | -4.4% | 5,796,880 | 5,262,700 | (534,180) | -10.2% |
| Total Health Care Expense | 42,726,674 | 51,782,085 | 9,055,411 | 17.5% | 187,680,581 | 206,367,224 | 18,686,643 | 9.1% |
| G&A Allocation | 4,486,241 | 4,198,960 | (287,281) | -6.8% | 18,529,459 | 16,403,849 | (2,125,610) | -13.0% |
| Total Operating Expense | 47,212,915 | 55,981,046 | 8,768,131 | 15.7% | 206,210,040 | 222,771,073 | 16,561,033 | 7.4% |
| **NON-OPERATING REVENUE** | | | | | | | | |
| Total Non-Operating | - | - | - | - | - | - | - | - |
| **Net Income/(Loss)** | $ 14,146,567 | $ (695,493) | 14,842,060 | 2134.0% | $ 5,530,719 | $ (19,237,297) | $ 24,768,015 | 128.7% |
| Medical Loss Ratio (adj MCO) | 69.63% | 93.66% | | | 88.64% | 101.39% | | |
| Member Counts | 26,390 | 26,410 | (20) | -0.1% | 105,583 | 106,280 | (697) | -0.7% |

# Health Plan of San Mateo
## Medi-Cal CMC Statement of Revenue & Expense
## for the Period Ending December 31, 2022

| | Current Qtr Actual | Current Qtr Budget | Current Qtr Variance | % Var | YTD Actual | YTD Budget | YTD Var Fav/(Unfav) | % Var |
|---|---|---|---|---|---|---|---|---|
| **OPERATING REVENUE** | | | | | | | | |
| MC Cal MediConnect Capitation | 21,369,913 | 22,555,510 | (1,185,596) | -5.3% | 78,506,122 | 83,469,094 | (4,962,972) | -5.9% |
| MC Cap Offset | (570,000) | - | (570,000) | - | (1,800,000) | - | (1,800,000) | - |
| Medi-Cal Incentives | 17,780 | - | | - | 17,780 | - | 17,780 | - |
| Total Operating Revenue | 20,817,693 | 22,555,510 | (1,737,817) | -7.7% | 76,723,902 | 83,469,094 | (6,745,192) | -8.1% |
| **OPERATING EXPENSE** | | | | | | | | |
| Provider Capitation | 34 | - | (34) | - | 162 | - | (162) | - |
| Hospital Inpatient | 871,309 | 570,456 | (300,853) | -52.7% | 3,005,084 | 2,290,328 | (714,756) | -31.2% |
| LTC/SNF | 10,814,390 | 12,444,775 | 1,630,384 | 13.1% | 44,880,481 | 50,454,743 | 5,574,263 | 11.0% |
| Pharmacy | 161,097 | 205,773 | 44,675 | 21.7% | 674,277 | 824,299 | 150,022 | 18.2% |
| Physician Fee for Service | 587,467 | 758,688 | 171,221 | 22.6% | 3,129,094 | 3,167,590 | 38,497 | 1.2% |
| Hospital Outpatient | 755,939 | 792,787 | 36,848 | 4.6% | 3,538,982 | 3,184,151 | (354,831) | -11.1% |
| Other Medical Claims | 2,043,153 | 2,365,764 | 322,611 | 13.6% | 9,314,263 | 9,501,908 | 187,645 | 2.0% |
| Other HC Services | (164) | - | 164 | - | (180) | - | 180 | - |
| Directed Payments | 137,166 | - | (137,166) | - | 548,920 | - | (548,920) | - |
| Long Term Support Services | 263,125 | 466,625 | 203,501 | 43.6% | 1,114,009 | 1,855,936 | 741,927 | 40.0% |
| CPO/In-lieu of Services | 890,864 | 555,138 | (335,726) | -60.5% | 3,637,283 | 2,234,006 | 1,403,277 | 62.8% |
| Dental Expense | 453,044 | 340,511 | (112,532) | -33.0% | 1,555,878 | 1,370,297 | 185,581 | 13.5% |
| Provider Incentives | 1,767,149 | - | (1,767,149) | - | 2,513,285 | - | (2,513,285) | - |
| Transportation | 677,882 | 505,751 | (172,131) | -34.0% | 2,308,943 | 1,822,202 | 486,741 | 26.7% |
| Indirect Health Care Expenses | - | 1,638 | 1,638 | 100.0% | - | 6,591 | 6,591 | 100.0% |
| UMQA (Allocation & Delegated) | 215,405 | 298,756 | 83,351 | 27.9% | 816,220 | 1,144,091 | 327,871 | 28.7% |
| Total Health Care Expense | 19,637,860 | 19,306,663 | (331,197) | -1.7% | 77,036,701 | 77,856,143 | 819,442 | 1.1% |
| G&A Allocation | 664,507 | 914,625 | 250,118 | 27.3% | 2,754,374 | 3,573,116 | 818,742 | 22.9% |
| Total Operating Expense | 20,302,367 | 20,221,288 | (81,079) | -0.4% | 79,791,075 | 81,429,259 | 1,638,184 | 2.0% |
| **NON-OPERATING REVENUE** | | | | | | | | |
| Total Non-Operating | - | - | - | - | - | - | - | - |
| **Net Income/(Loss)** | $ 515,327 | $ 2,334,222 | (1,818,895) | -77.9% | $ (3,067,173) | $ 2,039,835 | $ (5,107,008) | -250.4% |
| Medical Loss Ratio (adj MCO) | 94.96% | 85.60% | | | 101.13% | 93.28% | | |
| Member Counts | 26,277 | 26,255 | 22 | 0.1% | 105,157 | 105,885 | (728) | -0.7% |

# Health Plan of San Mateo
## ALL LOB UNITS Statement of Revenue & Expense
## for the Period Ending December 31, 2022

| | Current Qtr Actual | Current Qtr Budget | Current Qtr Variance | % Var | YTD Actual | YTD Budget | YTD Var Fav/(Unfav) | % Var |
|---|---|---|---|---|---|---|---|---|
| **OPERATING REVENUE** | | | | | | | | |
| MC Capitation | $ 109,645,778 | $ 87,481,309 | $ 22,164,469 | 25.3% | $ 442,481,156 | $ 348,494,858 | $ 93,986,298 | 27.0% |
| MCE Capitation | 67,361,396 | 52,250,694 | 15110702 | 28.9% | 275,323,932 | 208,682,438 | 66,641,494 | 31.9% |
| WCM Capitation | 10,943,192 | 8,480,058 | 2,463,134 | 29.0% | 41,307,302 | 33,912,047 | 7,395,255 | 21.8% |
| AIDS Capitation | 469 | - | 469 | - | 469 | - | 469 | - |
| Supplemental Capitation | 3,463,340 | 2,888,596 | 574,745 | 19.9% | 11,907,554 | 11,554,383 | 353,171 | 3.1% |
| BHT Capitation | 2,156,652 | 1,888,334 | 268,318 | 14.2% | 8,894,048 | 7,553,335 | 1,340,713 | 17.7% |
| HealthWorx Premium | 1,596,299 | 1,618,040 | (21,741) | -1.3% | 6,318,612 | 6,465,577 | (146,965) | -2.3% |
| CA Cal MediConnect Premium | 61,359,482 | 55,285,553 | 6,073,929 | 11.0% | 211,740,758 | 203,533,776 | 8,206,982 | 4.0% |
| MC Cal MediConnect Capitation | 21,369,913 | 22,555,510 | (1,185,596) | -5.3% | 78,506,122 | 83,469,094 | (4,962,972) | -5.9% |
| MC Cap Offset | (18,653,520) | - | (18,653,520) | - | (111,819,233) | - | (111,819,233) | - |
| Medi-Cal Incentives | 2,532,934 | - | | - | 2,532,934 | - | 2,532,934 | - |
| Total Operating Revenue | 261,775,935 | 232,448,093 | 29,327,842 | 12.6% | 967,193,654 | 903,665,508 | 63,528,146 | 7.0% |
| **OPERATING EXPENSE** | | | | | | | | |
| Provider Capitation | 12,304,332 | 13,160,286 | 855,954 | 6.5% | 48,625,317 | 52,786,443 | 4,161,126 | 7.9% |
| Hospital Inpatient | 43,347,483 | 48,034,456 | 4,686,973 | 9.8% | 160,450,966 | 193,512,272 | 33,061,306 | 17.1% |
| LTC/SNF | 39,571,480 | 43,599,381 | 4,027,901 | 9.2% | 157,527,789 | 175,850,777 | 18,322,988 | 10.4% |
| Pharmacy | 12,476,516 | 15,091,662 | 2,615,146 | 17.3% | 54,428,826 | 60,381,449 | 5,952,622 | 9.9% |
| Physician Fee for Service | 17,463,815 | 19,622,019 | 2,158,203 | 11.0% | 70,749,513 | 78,644,167 | 7,894,654 | 10.0% |
| Hospital Outpatient | 20,007,070 | 21,876,006 | 1,868,936 | 8.5% | 86,067,227 | 87,413,390 | 1,346,163 | 1.5% |
| Other Medical Claims | 20,904,452 | 20,932,841 | 28,389 | 0.1% | 82,451,183 | 83,997,133 | 1,545,950 | 1.8% |
| Other HC Services | (69,937) | 1,457,400 | 1,527,337 | 104.8% | 6,588,176 | 5,848,924 | (739,252) | -12.6% |
| Directed Payments | 6,375,195 | 7,218,136 | 842,941 | 11.7% | 29,249,489 | 28,900,812 | (348,677) | -1.2% |
| Long Term Support Services | 536,505 | 794,740 | 258,234 | 32.5% | 2,140,621 | 3,182,891 | 1,042,269 | 32.7% |
| CPO/In-lieu of Services | 1,553,240 | 1,070,114 | (483,125) | -45.1% | 6,062,328 | 4,279,637 | 1,782,691 | 41.7% |
| Dental Expense | 4,155,812 | 4,438,510 | 282,699 | 6.4% | 16,064,027 | 17,803,262 | (1,739,235) | -9.8% |
| Enhanced Care Management (ECM) | 635,509 | 3,310,185 | 2,674,676 | 80.8% | 2,385,391 | 13,131,536 | (10,746,145) | -81.8% |
| Provider Incentives | 7,486,799 | 2,298,173 | (5,188,626) | -225.8% | 18,884,786 | 9,215,592 | (9,669,194) | -104.9% |
| Transportation | 2,830,682 | 1,860,447 | (970,236) | -52.2% | 9,285,746 | 6,987,239 | 2,298,507 | 32.9% |
| Indirect Health Care Expenses | 917,035 | 709,350 | (207,685) | -29.3% | 2,394,393 | 2,844,162 | 449,770 | 15.8% |
| UMQA (Allocation & Delegated) | 4,772,952 | 5,369,445 | 596,493 | 11.1% | 18,632,933 | 20,711,954 | 2,079,020 | 10.0% |
| Total Health Care Expense | 195,268,941 | 210,843,150 | 15,574,209 | 7.4% | 771,988,712 | 845,491,640 | 73,502,929 | 8.7% |
| G&A Allocation | 13,247,131 | 14,393,740 | 1,146,609 | 8.0% | 53,017,690 | 56,281,572 | 3,263,882 | 5.8% |
| Premium Tax | 10,076,110 | - | (10,076,110) | - | 38,472,420 | - | (38,472,420) | - |
| Total Operating Expense | 218,592,182 | 225,236,890 | 6,644,709 | 3.0% | 863,478,822 | 901,773,212 | 38,294,391 | 4.2% |
| **NON-OPERATING REVENUE** | | | | | | | | |
| Interest, Net | 4,181,345 | 250,000 | 3,931,345 | 1572.5% | 7,637,164 | 1,000,000 | 6,637,164 | 663.7% |
| Rental Income, Net | 305,489 | 293,970 | 11,519 | 3.9% | 1,199,096 | 1,175,881 | 23,215 | 2.0% |
| Third Party Administror Revenue | 565,781 | 491,015 | 74,766 | 15.2% | 2,343,595 | 2,187,301 | 156,294 | 7.1% |
| Miscellaneous Income | 9,433 | - | 9,433 | - | 9,433 | - | 9,433 | - |
| Grant Income | 145,388 | - | 145,388 | - | 145,388 | - | 145,388 | - |
| Total Non-Operating | 5,207,436 | 1,034,985 | 4,172,451 | 403.1% | 11,334,676 | 4,363,181 | 6,971,495 | 159.8% |
| **Net Income/(Loss)** | $ 48,391,190 | $ 8,246,189 | 40,145,001 | -486.8% | $ 115,049,508 | $ 6,255,477 | $ 108,794,032 | -1739.2% |

Health Plan of San Mateo
ALL LOB UNITS Statement of Revenue & Expense
for the Period Ending December 31, 2022

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Medical Loss Ratio (adj MCO) | 79.60% | 93.61% | | | 85.83% | 96.65% | | |
| Member Counts | 531,183 | 495,147 | 36,036 | 7.3% | 2,092,980 | 2,021,220 | 71,760 | 3.6% |

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

**FOR THE CURRENT PERIOD December 31, 2022**

| | CURRENT MONTH 12/31/2022 | CURRENT YEAR YEAR-TO-DATE 2022 |
|---|---|---|
| **CASH FLOW PROVIDED BY OPERATING ACTIVITIES** | | |
| Group/Individual Premiums/Capitation | - | - |
| Title XVIII - Medicare Premiums | 28,840,323 | 214,273,692 |
| Title XIX - Medicaid Premiums | 55,176,297 | 786,997,848 |
| Investment and Other Revenues | 365,760 | 1,512,778 |
| Medical and Hospital Expenses | (63,810,449) | (788,363,101) |
| Administration Expenses | (7,000,390) | (70,235,390) |
| **NET CASH PROVIDED BY OPERATING ACTIVITIES** | **13,571,541** | **144,185,826** |
| **CASH FLOW PROVIDED BY INVESTING ACTIVITIES** | | |
| Proceeds from Restricted Cash and Other Assets | - | - |
| Proceeds from Investments | - | - |
| Proceeds for Sales of Property, Plant and Equipment | - | - |
| Payments for Restricted Cash and Other Assets | - | - |
| Payments for Investments | - | - |
| Payments for Property, Plant and Equipment | (125,689) | (257,127) |
| Interest and Other Income Received | 1,572,922 | 8,040,330 |
| **NET CASH PROVIDED BY INVESTING ACTIVITIES** | **1,447,233** | **7,783,203** |
| **CASH FLOW PROVIDED BY FINANCING ACTIVITIES:** | | |
| Principal payments under capital lease obligations | - | - |
| **NET CASH PROVIDED BY FINANCING ACTIVITIES** | **-** | **-** |
| **NET INCREASE (DECREASE) IN CASH** | **15,018,773** | **151,969,029** |
| **CASH AND CASH EQUIVALENTS AT THE BEGINNING OF THE MONTH/PRIOR YEAR** | **394,861,105** | **257,910,849** |
| **CASH AND CASH EQUIVALENTS AT THE END OF THE MONTH** | **409,879,879** | **409,879,878** |
| **RECONCILIATION OF NET OPERATING INCOME TO NET CASH FROM OPERATING ACTIVITIES:** | | |
| Operating Income | 26,250,873 | 103,714,832 |
| | - | - |
| Depreciation and Amortization | 180,816 | 2,161,413 |
| Decrease (Increase) in Receivables | (19,512,030) | 37,961,065 |
| Decrease (Increase) in Prepaid Expenses | (1,185,491) | (1,370,382) |
| Decrease (Increase) in Net Pension/Inflows and Outflows | - | - |
| Decrease (Increase) in Affiliate Receivables | - | - |
| Increase (Decrease) in Amts due to State of CA | (3,600,900) | 21,063,134 |
| Increase (Decrease) in Accounts Payable | 9,604,518 | (9,802,713) |
| Increase (Decrease) in Medical Claims Payable | 37,174 | (3,731,516) |
| Increase (Decrease) in Incurred But Not Reported | (1,229,959) | (9,451,826) |
| Increase (Decrease) in Provider Risk Sharing | 3,026,540 | 3,641,821 |
| Increase (Decrease) in Unearned Premium | - | - |
| Aggregate Write-Ins for Adjustments to Net Income | - | - |
| **TOTAL ADJUSTMENTS** | **(12,679,332)** | **40,470,994** |
| **NET CASH PROVIDED BY OPERATING ACTIVITIES** | **13,571,541** | **144,185,826** |
| **DETAILS OF WRITE-INS AGGREGATED FOR ADJUSTMENTS TO NET INCOME** | | |
| Unrealized (Gain)/Loss on Equity Securities | - | - |
| (Gain)/Loss on Sale of Assets | - | - |
| Prior Period Rent Expense | - | - |
| Realized (Gain)/Loss on Investment | - | - |
| **TOTALS** | **-** | **-** |

# FINANCE/EXECUTIVE COMMITTEE MEETING
## Meeting Summary – February 27, 2023
### Teleconference Meeting

Important notice regarding COVID-19: Based on guidance from the California Department of Public Health and the California Governor's Office, in order to minimize the spread of the COVID-19 virus, the meeting was conducted via online meeting/teleconference. Members of the public were invited to submit public comment via email to the Assistant Clerk to the Commission in advance of the meeting and were also able to access the meeting using the web and teleconference information provided on the meeting notice.

**Member's present**: M.D, Mike Callagy, Ligia Andrade-Zuniga, Bill Graham, George Pon

**Members absent**: Si France, M.D.

**Staff present**: Trent Ehrgood, Pat Curran, Chris Esguerra, M.D., Ian Johannson, Chris Baughman, Francine Lester, Colleen Murphey, Carl Smith, Jr., Christine Lopez, Amy Scribner, Daria Keener, Eben Yong, Lia Vedovini, Michelle Heryford

**1.0** **Call to Order –** The meeting was called to order by Commissioner Graham at 12:32 pm.

**2.0** **Public Comment –** There was no public comment either virtually or via email.

**3.0** **Approval of Meeting Summary for December 5, 2022 –** There was a correction to the meeting summary for December 5, 2022. Ligia Andrade-Zuniga was listed as absent; however, she was in fact in attendance. The meeting summary was approved as corrected. **Pon/Callagy second. A roll call vote was unanimous.**

**4.0** **Adopt a resolution finding that, as a result of the continuing COVID-19 pandemic state of emergency, meeting in person would present imminent risks to the health or safety of attendees –** The Committee moved to adopt a resolution finding that, as a result of the continuing COVID-19 pandemic state of emergency, meeting in person would present imminent risks to the health or safety of attendees. **Callagy/Graham second. A roll call vote was unanimous.**

**5.0** **Name Chair of Finance/Executive Committee –** The Committee nominated Commissioner Bill Graham to lead the Finance/Executive Committee meeting, effective immediately. **Pon/Callagy second. A roll call vote was unanimous.**

**6.0 Discussion: Review Committee Charter, Cadence, Location –** The Committee reviewed the Finance/Executive Committee meeting charter and discussed upcoming changes for the Finance/Executive Committee meetings. Now that the public health emergency (PHE) has been lifted, Committees are expected to meet in person. The Committee chose to go back to meeting at the co-locations used prior to the PHE. Commissioners and members of the public will be able to attend meetings at either the HPSM offices at 801 Gateway in South San Francisco or at the Criminal Justice Training Room at 444 County Center in Redwood City effective March 2023. The Committee was asked to verify with County Counsel that it is in fact okay to have two locations for this public meeting.

**7.0 Preliminary Financial Summary for the period ending December 31, 2022** – Mr. Ehrgood reviewed Q4 of 2022. The budget for 2022 was for a surplus of $6.2M. He reminded the group that Q4 is usually the more favorable of the four quarters because of the Cal MediConnect (CMC) withhold revenue. Actual results for the year is a $115M surplus compared to $6.2M in the budget. He showed a breakdown of prior year versus current year, for which $19M of the overall $115M surplus was for prior year adjustments. There were three revenue and five healthcare cost items that were the main drivers of prior year adjustments. Most noteworthy is the Incurred But Not Reported (IBNR) adjustments, those numbers have changed the most. The prior year IBNR adjustment has been a growing number. This adjustment is intentionally spread out to make sure that it is valid and in the fourth quarter HPSM releases the remaining true ups to prior year's claims expense. There will always be variances in the claim's liability estimate.

He spoke briefly about membership. Because of the PHE, enrollment kept growing. There are about 4,800 more members (excluding ACE) than was assumed in the budget, which is about a 3.5% difference. The fact that HPSM has more members actually creates a budget variance through more revenue and more expense. Because HPSM has a margin on membership this year, the extra revenue is higher than the extra expense. He then went over other drivers of the overall favorable budget variance. He explained how HPSM received a higher yield on incoming revenue premiums which equated to $16M and how they have to give back some of the

revenue, approximately $22.3M, through risk corridors. The Coordinated Care Initiative (CCI) and Enhanced Care Management (ECM) benefits both have risk corridors. CCI is related to long term care (LTC), and HPSM had to return money for this benefit because the actual number of members in LTC was lower than anticipated. In addition, DHCS assumed a certain number of members would engage in the ECM benefit, but it too was less than anticipated. Mr. Ehrgood reported that Administrative costs are running about $3.2M better than budget.

The MCO tax was not included in the budget, which usually has zero impact on the bottom line. There is an expense for the MCO tax, and funding for that comes through rates. The funding was bigger this time around because of the increase in membership. The MCO tax alone contributed $3.9M, favorable to the bottom line. He also reported on non-operating revenue. HPSM has a $6.9M favorable variance to non-operating revenue, mostly higher interest income on cash reserves.

Mr. Ehrgood went over healthcare cost variances in more detail. He broke down these costs into two parts, current and prior year adjustments. He noted that most of the prior year adjustments are fee for service claim based for inpatient services. This is an area where HPSM expected higher cost cases last year that didn't play out, partly from lower utilization and partly from members having other health coverage.

Mr. Ehrgood also went over the surplus and deficits by line of business. The line with the most significant change is Cal-MediConnect, it was budgeted for a $17 or $18M deficit. Throughout the year, the actuals have been negative and closer to budget, and in the fourth quarter the addition of withhold revenue, which are booked in the last quarter, improved that line as did additional revenue from the Part D pharmacy benefit.

Lastly, he reviewed the reserve balances, the total at the end of 2022 was $475M with uncommitted equity in the $220M range. The Committee briefly discussed using some of the reserves in the near future to help support investments to grow and improve services for the membership, particularly around PCPs and support for the provider

community. The Committee also discussed HPSM's policy on investing cash reserves. **Callagy/Pon second. A roll call vote was unanimous.**

**8.0 Discussion: HPSM Purchasing Policy –** Mr. Ehrgood briefly went over the HPSM purchasing policy. He would like to ask the Commission to consider increasing the dollar limit requiring Commission approval from the current threshold of $100K to $250K. Mr. Ehrgood included the thresholds used by other sister plans. HPSM has the smallest cut-off at $100K. He would also like to add an exception which would be for claim recovery vendors that are paid on a commission basis. He explained how HPSM uses recovery vendors to comb through claims expenses to look for opportunities where maybe HPSM paid something that was not ultimately their financial responsibility. A good example would be if someone has other health coverage, HPSM is not always privy to this information. These vendors have national information about people's coverage and will come to HPSM and notify them if someone actually is covered by a commercial plan. That becomes a savings to HPSM, so they pay those vendors a commission if they find something. He reiterated they only get paid if they find something. Mr. Ehrgood went over the items requiring approval last year and this move would only have affected a handful of requests. The ultimate goal is to make better use of everyone's time by eliminating smaller expense items coming to Commission for approval. The Committee agreed to bring this item to the full Commission at the April meeting. There will be another opportunity to discuss this at the March 27th meeting if needed.

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

**10.0 Adjournment –** The meeting was adjourned at 1:22 pm by Commissioner Bill Graham.

Respectfully submitted:

*M. Heryford*

M. Heryford
Assistant Clerk to the Commission

**DRAFT**

**RESOLUTION OF THE**
**SAN MATEO HEALTH COMMISSION**
**FINANCE/EXECUTIVE COMMITTEE**

**IN THE MATTER OF APPROVAL OF TELECONFERENCE MEETING PROCEDURES PURSUANT TO AB 361 (BROWN ACT PROVISIONS)**

**RECITAL: WHEREAS,**

A. In the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, the San Mateo County Board of Supervisors recently found that meeting in person would present imminent risk to the health or safety of attendees of public meetings and accordingly directed staff to continue to agendize its public meetings only as online teleconference meetings; and
B. The Board of Supervisors strongly encouraged other legislative bodies of the County of San Mateo that are subject to the Brown Act to make a similar finding and avail themselves of teleconferencing until the risk of community transmission has further declined; and
C. The San Mateo Health Commission and its Committees must make such a finding under AB 361 in order to continue to conduct its meetings as online teleconference meetings.

**NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:**

1. The Finance/Executive Committee of the San Mateo Health Commission hereby finds that in the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, meeting in person would present imminent risk to the health or safety of attendees of public meetings for the reasons set forth in Resolution No. 078447 of the San Mateo County Board of Supervisors and subsequent resolutions made pursuant to AB 361; and
2. The San Mateo Health Commission directs staff to continue to agendize its meetings only as online teleconference meetings; and
3. The San Mateo Health Commission further directs staff to present, within 30 days, an item for its consideration regarding whether to make renewed findings required by AB 361 in order to continue to meet remotely.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 27th day of February 2023 by the following votes:

AYES: France, Graham, Horsely, Andrade-Zuniga

NOES: 0

ABSTAINED: 0

ABSENT: 1

ATTEST: 0

BY: *Michelle Heryford*
Michelle Heryford
Assistant Clerk to the Commission

**AGENDA ITEM:** 4.2

**DATE:** April 12, 2023

**DRAFT**

# Health Plan of San Mateo
# CareAdvantage Advisory Committee
# Friday, January 27, 2023 – 11:30 a.m.
# Meeting Summary
# -Virtual Meeting via Microsoft Teams-

Important notice regarding COVID-19: Based on guidance from the California Department of Public Health and the California Governor's Office, in order to minimize the spread of the COVID-19 virus, Health Plan of San Mateo offices were closed for this meeting, and the meeting was conducted via online meeting/teleconference. Members of the public were invited to submit public comment via email to the Clerk in advance of the meeting and were also able to access the meeting using the web and teleconference information provided on the meeting notice.

**Committee Members Present:** Amira Elbeshbeshy Claire Day, Gay Kaplan, Dr. Darlene Yee-Melichar, Beverly Karnatz, Jill Dawson, Bernie Mellott, Nina Rhee, Pete Williams, Ricky Kot, Ligia Andrade Zuniga.

**Committee Members Absent:** Lisa Mancini.

**Staff Present:** Pat Curran, Karla Rosado-Torres, Chris Esguerra, M.D., Karen Sturdevant, Megan Noe.

**1. Call to Order / Introductions**

The meeting was called to order at 11:30 a.m. by Karla Rosado-Torres. Beverly Karnatz introduced Donovan Fernandez, Service Coordinator at Hillcrest Gardens in Daly City.

**2. Public Comment**

There were no public comments received via email prior to the meeting or made at this time.

**3. Approval of Minutes**

The minutes for October 28, 2022, were presented for approval. Motion to approve: Zuniga / Second: Yee. Minutes were approved as presented.

**4. Adopt a resolution finding that, as a result of continuing COVID-19 pandemic state of emergency, meeting in person would present imminent risks to the health or safety of attendees**

In accordance with AB 361, a resolution for approval was presented finding that meeting in person would present imminent health risk due to COVID-19.

Motion to approve: Zuniga; Second: Elbeshbeshy. All in attendance were in favor. The resolution is attached to these minutes as part of the record.

## 5. State/CMS Updates

Mr. Curran touched on the sad events that have taken place in Half Moon Bay with the shootings. He explained that HPSM staff are in contact with the county to look at the ways to best support the community, our members and employees. The county is providing some behavioral health services for the community and other initiatives are in place and being planned.

Ms. Elbeshbeshy state that Legal Aid has worked with the county to provide support in Half Moon Bay. They were asked about mental health and behavioral health services specifically for people on ACE and restricted Medi-Cal. Dr. Esguerra stated that the access number for the county is the best way to get these services. ACE is covered and their calls will be routed to where they need to go, which includes restricted Medi-Cal.
Mr. Curran reported that the state officially ended the public health emergency as of the end of February. This means that our public meetings such as this group will return to being held in person. We are exploring ideas around meeting remotely as we have become a bit accustomed, but for now, beginning March 1st, all public meetings will resume meeting in person.

Another state update is that many health plans throughout California will transition to or begin serving dual eligible beneficiaries for their Medi-Cal coverage beginning January 1, 2023. This is a big transition for California, as many dual eligible beneficiaries were receiving their Medi-Cal benefits directly through the state FFS program. Members will still have their primary coverage as Medicare. This does not affect San Mateo County as we have been covering these beneficiaries for many years.

Mr. Curran stated that he will be picking up where Maya Altman left off on serving on the Master Plan on Aging participation. He reported that the governor's budget in January did not include major cuts in terms of benefits or services for Seniors and Persons with Disabilities (SPD), but there were no new programs or enhancements. The Master Plan on Aging may bring awareness to things like long term care and some of the experiences during the pandemic with access to care and services provided in nursing facilities.

Dr. Yee asked about other areas of the budget and if any other funding might make its way to Health and Human Services. Mr. Curran was unaware of any other movement in this direction.

## 6. HPSM Updates

### a. D-SNP Transition Update – Karla Rosado-Torres

Ms. Karla Rosado-Torres, HPSM Director of Medicare, gave an update on the D-SNP transition. She reported the following:

- During enrollment period that began at the end of 2022, we experienced a 99.8 retention rate meaning that we kept most of our Cal MediConnect members and transitioning them into the D-SNP
- We gained 94 new members during the enrollment period.
- New benefits began in January for Over-The-Counter (OTC) items that offers members $90 on a quarterly basis; we also offer a healthy foods benefit, which provides $65 quarterly for those who qualify.
- The bid submitted to CMS was approved. This is the annual process to determine our costs and member benefits for the program.
- Marketing and branding campaigns are being planned, and staff will become more involved in the community, participating in events and health fairs.

**b. End of Public Health Emergency - Update**.

Ms. Karla Rosado-Torres explained the renewal process for members now that the public health emergency will end on February 28, 2023.

- Members will start receiving notices to renew their Medi-Cal in April 2023.
- For CareAdvantage members, there is a four-month deeming period.
- HPSM and HSA will be communicating when members report they have not received their renewal packet so HPSM can reach out to help them, make sure they are aware of the renewal timeframes and when they have to submit their documents.
- It was encouraged that if anyone on this committee has contact with members to urge them to make sure their contact information is up to date so they don't miss any important notices or their renewal packet. And that they should fill it out and send their packets back as soon as possible, even if they don't have all the complete information, so they don't miss the deadlines.

**7. Discussion Topics:**

a. Member Advisory Committee
   i. **Ideal candidate**
   ii. **Recruitment efforts**

Ms. Rosado Torres introduced Teresa Kopp who has worked with HPSM in the Population Health team on health equity. Ms. Kopp expressed the importance of direct member and community input when it comes to health equity and member engagement in our committees.

Ms. Kopp explained that in 2023, D-SNP plans must establish and maintain one or more member advisory committees that engages member input. Elements discussed were:

- Criteria for participation
    - Collective conversations with Community Groups and members, possibly quarterly and in person.
    - Active Members or Care Givers
    - Able to commit at least one to two hours per month (not in person)
    - With the strong interest of diversity, language and resources around translation comes in to play; maybe language specific meetings launched over time.
    - Passion for patient centered care for individuals and populations with chronic conditions
    - Related to languages questions were raised about sign language and other technologies for multiple language translations and hearing disabilities
    - Discussion ensued on the variety of language needs and vendor support and technologies that may be out the to help with the varying language needs and having various options to get member input.
- How to define reasonable representation
- Recruitment plan (process)
    - Demographics:  Line of Business
    - When and how to gather information from people – outreach materials
    - Do we want to have an application
        - Do we want to gather demographic information within the application (or would that be perceived as discriminatory
        - Should there be an interview stage
        - An approach shared was that some of this "application" and selection process may scare people away however, if the purpose of these committees is to truly solicit feedback it may be those willing to go through this type of process may be more likely to participate in the meetings.
        - The thought of what calling the process something less threatening such as "information session" as part of an onboarding stage.
        - Discussion on outreach and materials for members developed by marketing that will be easily understood.
        - Getting the word out through referral of people who would be interested as opposed to putting it out through a member newsletter.

- Timelines for forming this committee
    - By April to have 5 additional members on this committee bring the member percentage to 43%

- Conversation ensued on the process for recruiting and whether or not the current committee would be involved in the process. This has not yet been determined.
- Consideration of residents from a assisted living facility and the possibility of transportation
- Question if this would be solely members on this committee
- Question about holding hybrid meetings. Mr. Curran stated this is something they are looking into with relation to Brown Act requirements.

Ms. Rosado-Torres concluded that staff would prepare something to send to the committee through email for input on these processes in the near future.

**8. CCI Ombudsperson Report (Legal Aid)**

Ms. Elbeshbeshy reported:

- Public Health Emergency ending will also end the Medi-Cal continuous coverage requirement. They anticipate this to cause confusion because it has been three years since members have had to do any paperwork. The continuous coverage requirement will end on March 31st.
- DHCS is meeting with counties weekly over the next several months to update contact information, sharing FAQs, etc.
- The asset elimination is set to take place January 2024. If people are having trouble proving their assess or finding the verification who may be just over the asset limit, they may be disenrolled. She asked the committee to share this with Legal Aid.

**9. LTC Ombudsperson Report**

Ms. Bernadette "Bernie" Mellott, who is the new Executive Director of Ombudsman Services of San Mateo County, was present for the meeting but had to leave before getting to this agenda item. No report given at this time.

**10. Questions about reports distributed prior to meeting.**

**a. Health Risk Assessment/Care Plan Completion and LTSS Utilization Dashboard**
**b. Grievance & Appeals Report**
**c. Call Center & Enrollment Report**
**d. IHSS Utilization Report**

There were no questions about the submitted reports at this time.

Ms. Elbeshbeshy took this time to further reported on an issue they see related to Long Term Care Share of Cost referrals noting that there is not much they can do to help, however, they do offer training for staff with "PowerShell" which may be helpful.

**11. Other Discussion Topics**.

**12. Adjournment**

The meeting adjourned at 12:54 p.m.

Respectfully submitted:

*C. Burgess*

C. Burgess, Clerk of the Commission

**RESOLUTION OF THE**
**CareAdvantage Advisory Committee**

**IN THE MATTER OF APPROVAL OF TELECONFERENCE MEETING PROCEDURES PURSUANT TO AB 361 (BROWN ACT PROVISIONS)**

**RECITAL: WHEREAS,**

A. In the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, the San Mateo County Board of Supervisors recently found that meeting in person would present imminent risk to the health or safety of attendees of public meetings and accordingly directed staff to continue to agendize its public meetings only as online teleconference meetings; and
B. The Board of Supervisors strongly encouraged other legislative bodies of the County of San Mateo that are subject to the Brown Act to make a similar finding and avail themselves of teleconferencing until the risk of community transmission has further declined; and
C. The Committees of the San Mateo Health Commission must make such a finding under AB 361 in order to continue to conduct meetings as online teleconference meetings.

**NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:**

1. The CareAdvantage Advisory Committee hereby finds that in the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, meeting in person would present imminent risk to the health or safety of attendees of public meetings for the reasons set forth in Resolution No. 078447 of the San Mateo County Board of Supervisors and subsequent resolutions made pursuant to AB 361; and
2. The CareAdvantage Advisory Committee continues to agendize its meetings only as online teleconference meetings; and presents this item, within 30 days, for its consideration regarding whether to make renewed findings required by AB 361 in order to continue to meet remotely.

PASSED, APPROVED, AND ADOPTED by the CMC Advisory Committee this 27th day of January 2023 by the following votes:

AYES: Elbeshbeshy, Day, Kaplan, Yee-Melichar, Karnatz, Dawson, Mellott, Rhee, Williams, Zuniga.

NOES: -0-

ABSTAINED: -0-

ATTEST:

BY: C. Burgess _____

D. Burgess, Clerk

DRAFT

# HEALTH PLAN OF SAN MATEO
# CONSUMER ADVISORY COMMITTEE MEETING
## Meeting Minutes
## Wednesday, January 18, 2023
## **Virtual Teleconference**

**Agenda Item: 4.3**
**Date: April 12, 2023**

Important notice regarding COVID-19: Based on guidance from the California Department of Public Health and the California Governor's Office, in order to minimize the spread of the COVID-19 virus, the meeting was conducted via online meeting/teleconference. Members of the public were invited to submit public comment via email to the Assistant Clerk to the Commission in advance of the meeting and were also able to access the meeting using the web and teleconference information provided on the meeting notice.

**Committee Members Present:** Amira Elbeshbeshy, Ricky Kot, Angela Valdez, Gloria Flores-Garcia, Robert Fucilla, Marmi Bermudez

**Committee Members Absent:** Mary Pappas, Hazel Carrillo, Cynthia Pascual, Ortensia Lopez, Judy Garcia

**Guests:** Ana Avendano, M.D.

**Staff Present:** Amy Scribner, Megan Noe, Carolyn Thon, Keisha Williams, Karla Rosado-Torres, Charlene Barairo, Luarnie Bermudo, Samareen Shami, Talie Cloud, Sarah Munoz, Chris Esguerra, M.D., Kiesha Williams, April Watson, Richard Moore, M.D., Michelle Heryford

**1.0 Call to Order/Introductions:** The meeting was called to order by Ms. Elbeshbeshy at 12:00 pm, a quorum was met.

**2.0 Public Comment:** There was no public comment, either virtually or via email.

**3.0 Approval of Meeting Minutes for October 19, 2022:** The minutes from the October 19, 2022, meeting was approved by the committee. **Fucilla/Flores-Garcia second**. **A roll call vote was unanimous.**

**4.0 Approval of Teleconference Meeting Procedures Pursuant to AB 361:** The committee moved to continue the practice of virtual meetings pursuant to AB361 which was signed by Governor Newsom in October 2021. **Fucilla/Bermudez second**. **A roll call vote was unanimous.**

**5.0 HPSM Operational Reports and Updates:**

**5.1 CEO Update:** Chief Executive Officer, Pat Curran provided an update on the redetermination process for members who have Medi-Cal. Redetermination is

scheduled to commence on April 1, 2023. Members will start to receive letters requiring them to submit documentation for coverage. HPSM is concerned about the impact, though data seems to indicate that up to 15% of members have other health coverage (OTC) which should help to lessen the amount of those who might lose their coverage. He also spoke of a provision starting in January for all eligible California residents aged 26-45 regardless of documentation status, that could be eligible for Medi-Cal. In San Mateo county this could impact about 20K people.

**5.2 CMO Update:** Chief Medical Officer, Dr. Chris Esguerra spoke to the group about the change HPSM recently underwent on January 1st, 2023, which shifted Cal-Mediconnect (CMC) to the D-SNP program. He explained that under CMC, the pharmacy piece was fully integrated even on the Medi-Cal side. As of January 1st, the State will administer it. There have been issues with members not being able to locate their Medi-Cal ID card which is now required. Up until recently CareAdvantage (CA) members were able to use one card issued by HPSM for all their needs. HPSM is doing their best to minimize the disruption. Members are able to call HPSM with any concerns or issues they may encounter. They are also helping members with the new Over The Counter (OTC) benefit and the new Nations grocery benefit, assisting them in activating cards and with any other questions or concerns they may have about this new benefit. There was a question about the Part D pharmacy benefit still being administered by HPSM, Dr. Esguerra confirmed that the Medi-Cal Part D pharmacy is still through HPSM.

**5.3 Population Needs Assessment:** Population Health Manager, Samareen Shami went over the results of the Population Needs Assessment (PNA) for 2021, which were received in 2022. The survey encompasses the entire HPSM population. The goals are to identify member health needs as well as health disparities. They also strive to make the data meaningful and actionable. They evaluate health education activities, culturally and linguistically appropriate services (CLAS) as well as population health management activities, CalAIM and any other available resources that they feel are important to members. Ms. Shami went over the demographics, the Medi-Cal population largely identifies as Hispanic, Latino and Asian or Pacific islander, the threshold languages for this group are Spanish, Chinese, Mandarin, Cantonese, and Tagalog. CareAdvantage members largely identify as Asian of Pacific Islander, followed by Hispanic and Caucasian. 78% of these Members prefer English or Spanish, followed by 12% preferring Chinese. The majority of the Members in this population are older, over the age of 75

which is expected from this group. Population Health Specialist, Talie Cloud reviewed results for older persons and those with disabilities. She also spoke briefly about adult preventive health, chronic conditions and social determinants of health and behavioral health within the Medi-Cal membership. Older adults and people with disabilities represent about 12% of HPSM's Medi-Cal population. This population is fairly complex and there's a greater percentage of members that have more than one chronic condition compared to the rest of the population. Chronic conditions include things like diabetes, obesity, asthma, tobacco use, etc. that can lead to a more complex care experience. People with disabilities experience incredibly high incidences of severe and persistent mental illness. Within the persons with disability population, they've been carefully monitoring mental health and behavioral health data to make sure they're providing those members with access to the resources and support they need. They are aware that there are large disparities or health differences when it comes to breast and cervical cancer screenings and are working to remedy that. They are also working on developing additional programming so that they can address the high rates of essential hypertension, obesity, and diabetes. They are also monitoring tobacco use and have access to tobacco cessation resources for Members that are interested. Some of the initiatives they are working on to provide preventive care are reminder letters, phone calls, and home testing solutions. Ms. Shami also pointed out that those identifying as Asian and Pacific Islander who had live births in 2020 and 2021 faced higher rates of gestational diabetes. They would like to add programming that specifically targets that population. There were questions about how they follow up with the information provided in the survey. Ms. Shami went over the efforts made by different departments to address concerns found in the survey; they are also looking at ways to support Providers.

**5.4** **Health Education Update:** Health Promotion Supervisor, Sarah Munoz provided a Health education update on projects they engaged in in 2022. They launched a topic specific newsletter about diabetes and tobacco cessation programs. Newsletters were sent to members and are also available on the website. They continued their COVID-19 communications, and their annual flu campaign which starts in September and includes information about the flu vaccine. Going forward for 2023 they will include cancer screenings and well-visits for babies and teens. Ongoing programs include baby and me, Diabetes prevention, asthma management, diabetes management,

hypertension management resources, nutrition services and tobacco cessation resources. This year they will also do an assessment of nutrition support and diabetes management while they look for opportunities for improvement.

**5.5** **Provider Services (PS**): Director of Provider Services, Luarnie Bermudo went over recent contracts and services. She announced that last year at this time HPSM had 78 providers in the dental network. They now have 315 dental providers in the network. They will have their second in person on-site hospital and skilled nursing facility (SNF) collaborative coming soon. This is a new iteration of the work that HPSM has been doing with nursing facilities around value-based payment and partnering with hospitals. They also hope to identify measures to not only support Providers, but also to identify metrics in support of the member population. Ms. Bermudo announced two new provider types. Doulas and Community Health workers are brand new benefits to HPSM. More information will come. She also spoke about Non-Emergency Medical Transportation (NEMT). HPSM has recently increased their rates for the Provider network. One of the major NEMT providers recently closed shop due to financial constraints so they are working very closely with the existing network to support them and ensure access to transportation services for HPSM members.

**5.6** **Member Services (MS) Report:** Director of Member Services, Kiesha Williams reviewed the Member Services (MS) Call Center and Enrollment Report for Q4. The current enrollment for all LOBs is 172,232. They are expecting a decline once the PHE ends. She did not have metrics for Call Center performance at the moment. They introduced a new cloud-based system last April and are still working out some technical difficulties. The call monitoring goal is 95%, they exceeded that with 98%. Emails met the service level goal of 95% for responsiveness. The Call Center continues to operate remotely. HPSM is experiencing high call volumes. Calls are longer as members have many questions about dental, PCP changes and demo updates. At the end of 2022 they hired 4 new call center representatives. They are currently looking for a Call Center Supervisor and a Call Center Manager.

**5.7** **CareAdvantage (CA) Enrollment and Call Center Report:** CareAdvantage Manager Charlene Barairo reviewed the CareAdvantage (CA) Enrollment and Call Center Report. Like the Member Services team they are having problems reporting their call center stats. Last quarter for CA they processed 199 members, 156 new ones and 43 enrolled members. They also dis-enrolled 164 members, the number one reason being death,

followed by a move out of the County. She also shared a table that highlighted the health plans some dis-enrolled members have moved to. All Cal-Mediconnect (CMC) members have transitioned to the D-SNP plan as of 1/1/2023. Call monitoring goals were met at 95% for the year. During the Medi-Cal deeming period they enrolled 93 members into the D-SNP program.

**5.8 Grievance and Appeals (G&A) Report:** Chief Health Officer, Amy Scribner reviewed the Grievance and Appeals (G&A) report. Targets were met for all LOBs except CMC. Timeliness goals for all LOBs were exceeded in Q4. She went over CA appeals and grievances. The top three grievances for the CA line is billing, customer service and quality of care. Most appeals were for prescription drugs, there were also some for durable medical equipment (DME). There is a high number of overturned decisions. They may need to look at the UM side to see why they are so many denied claims. For Medi-Cal the results were similar. This line had the same top three grievances as the CA line. The majority of appeals were for Other Services/Therapy, DME and Imaging. NCQA rates for BH grievances were higher than targeted, access for Behavioral Health Therapy (BHT) was not met. However, rates for all non-BHT were on target. They are working with vendor Magellan to help with access for children. This will be an area of focus for the next quarter. There were 55 Provider changes, which is a decrease from Q3, the top reasons cited are difficulty in obtaining an appointment, and poor service. There was one case of provider and patient incompatibly.

**6.0 New Business:** Director of Population Health, Megan Noe announced that the next CAC meeting scheduled for April 19, 2023, will be held in person at the HPSM Boardroom at 801 Gateway Blvd in South San Franciso. There was a question about there being a virtual option. At the moment there is not, however, HPSM leadership is consulting with County Counsel Kristina Paszek on the matter. Ms. Noe also announced that there will be a new Population Health Program Manager starting soon. They are considering reviewing the current CAC committee recruitment strategy and are looking for suggestions for the committee makeup going forward. They would also like to change the content of the meeting. They discussed sending reports to be reviewed in advance via email instead of providing a full delve at the meeting. This would allow them to free up time for thematic subjects that interest committee members. She shared the thematic subjects with the group and asked them to consider the changes for future meetings. The feedback from the committee was good. The members liked

the idea of sending reports out prior and keeping discussions at meetings about the thematic items she listed. One of the concerns expressed was that more HPSM members need to actively participate on the committee.

**7.0 Adjournment:** The meeting was adjourned at 1:29 pm by Ms. Elbeshbeshy.

Respectfully submitted:

*M. Heryford*

M. Heryford
Assistant Clerk to the Commission

**DRAFT**

**CCS CLINICAL ADVISORY COMMITTEE**
**Thursday, February 23, 2023 – 12:00 p.m.**
**Meeting Summary**
**-Virtual Meeting via Microsoft Teams-**

**AGENDA ITEM: 4.4**

**DATE: April 12, 2023**

Important notice regarding COVID-19: Based on guidance from the California Department of Public Health and the California Governor's Office, in order to minimize the spread of the COVID-19 virus, Health Plan of San Mateo offices were closed for this meeting, and the meeting was conducted via online meeting/teleconference. Members of the public were invited to submit public comment via email to the Clerk in advance of the meeting and were also able to access the meeting using the web and teleconference information provided on the meeting notice.

| | |
|---|---|
| **Members Present:** | Laurie Soman, Stephanie Smith, Grace Chen, M.D. |
| **Members Excused:** | Leticia Acevedo, Sofia Verstraete, M.D., Michelle deBlank, Yumi Mitsuya, M.D., Brian Lee, M.D., Carol Elliott, Lee Sanders, M.D. |
| **San Mateo County Members present:** | Anand Chabra, M.D., Susanna Flores, Lianna Chen. |
| **San Mateo County Members Excused:** | Jenn McLean, Marsha Aleman, Lizelle Lirio de Luna. |
| **HPSM Members Present:** | Cynthia Cooper, M.D., Tejasi Khatri, Samareen Shami, Amanda Epperson. |
| **HPSM Members Excused:** | Amy Scribner, Chris Esguerra, M.D. |

1. **Call to Order / Introductions:** The meeting was called to order at 12:04 p.m. by Dr. Cynthia Cooper. Introductions were made.

2. **Public Comment:** There were no public comments received via email prior to the meeting or made at this time.

3. **Adopt a resolution finding that, as a result of the continuing COVID-19 pandemic state of emergency, meeting in person would present imminent risks to the health or safety of attendees**

   Dr. Cooper described the action to be taken in compliance with AB 361, allowing the committee to continue meeting virtually. Motion to approve: Laurie Soman / Second: Stephanie Smith. All who were present voted in favor. A copy of this resolution is attached to these minutes.

4. **Approval of Minutes:** Motion to approve the minutes from the December 8, 2022, meeting by Stephanie Smith / Second: Laurie Soman; All were in favor.

5. **Youth/Young Adult Advisory Committee Report Out**
   Ms. Chen reported that the committee will meet in the following week. This will be an open discussion meeting at this time. They will also discuss the members experiences with job searching and the Department of Rehabilitation.

6. **Importance of Blood Screening in Young Children – Amanda Epperson**
Dr. Cooper introduced Amanda Epperson who is the Program Manager for Child and Youth Health at HPSM in the Population Health Department. Ms. Epperson shared her presentation and reported on the following:

- Ms. Epperson shared information on trends in California which was released in October 2022.
- This has been a priority due to low testing rates. In 1986 lead exposure was the most significant childhood environmental health problem in the state prompting the development of the California Childhood Lead Poisoning Prevention program (CLPP).
- Between 2010 and 2020, California children under the age of 6 years old who tested positive for lead at the reference value of 5.0 dropped by more than half.
- No level of lead in blood is safe. CDC updated their reference value to 3.5 but California continues to use the reference value of 5.0. Any patients who are incoming refugees are to be tested at 3.5 reference value.
- Lead testing is very important because lead does not affect all children equally.
- Data suggests that lead screening declined during the COVID-19 pandemic by over 50% in some states. Due to the pandemic 28% fewer children under the age of six were tested in 2020 compared to 2019.
- Magellan Diagnostics recalled all three Lead Care Test Kits in 2021 but as of October 14, 2022 all three testing kits have resumed distribution. During this time period, venous blood draw testing was required. Magellan has launched an online screening education video to help providers perform and document this testing.
- Data for San Mateo County in 2020 indicated 98.86% of 4,428 under the age of 6 tested in San Mateo County had blood lead values under the reference value of 4.5; 55 had a reference value above 4.5; and, 12 had a reference value above 9.5
- A map reference of California showed the levels of various counties and the value references for blood lead. One area that stans out is Humboldt County which may have been affected by the earthquake there and housing conditions of older dwellings and lead content.
- HEDIS (Healthcare Effectiveness Data and Information Set) Measure which is the standardized performance measures developed by the National Committee of Quality Assurance (NCQA) to measure health plan performance. Blood lead testing is covered under Medicaid under EPSDT (Early and Periodic Screening ,Diagnostic and Treatment) now called Medi-Cal for Kids and Teens. Under EPSDT, there is a specific requirement for screening of a percentage of children 2 years of age are to have blood test before their 2nd birthday. HPSM is working on their population health assessment needs now and a higher rate indicated better performance.
- HPSM current activities include:
    - Monthly notifications to providers for their patients for screenings due and overdue

- Newsletter and fax blast announcements to providers about availability of the test kits
- Sign ups through the Well Baby program. This is an outreach and education work in collaboration with the San Mateo County Family Home Visiting Program

Ms. Soman asked if HPSM is performing the lead screening program instead of CHDP. She explained that CHDP has been responsible for educating providers and ensuring they are doing these screenings. Dr. Chabra stated that the county has a program that is not part of CHDP but is adjacent and will continue working with providers and works with HSPM. CHDP's role with providers we are not supposed to duplicate what the plan is doing and then CHDP does a lot less since it is more the health plan's responsibility. There is a little overlap but more on the health plan side.

Dr. Chabra stated that SMMC is back to doing the capillary blood test screening. He wonders what other providers are talking about this. Ms. Smith will have to check into this with the pediatricians. Ms. Epperson will also check in with other providers to find out more about this procedure.

Ms. Soman asked about what the health plan may be doing under CalAIM Community Supports related to lead abatement or home modifications. Ms. Epperson answered that whenever there is a child who tests above a certain percentage, they are assigned a case manager from the state Lead Poising Prevention Branch and they are responsible for any changes and identifying any other possible exposures to lead. The health plan doesn't have any responsibility in this area. All of the test results are reported to the state.

**Child & Youth Health (Areas of Focus)**

- Well Child Visits
- Preventative Screenings
- Oral Health as a new benefit including two new HEDIS measures: Oral Evaluation and the Topical Fluoride for Children
- Behavioral Health – AC HIP Health Initiative Program
- Teen to Adult Transition

**Well Child Visits**

- HSPM is below MPL
- 2019 California State Auditor report found that roughly half of all children under the age of 21 enrolled in Medi-Cal were not receiving all preventative services. Another nationwide report said that CMS should have more accountability and oversight over the EPSDT benefit. Changes were put out in March 2022 to require more well child visits and more preventative screening.

HPSM is performing the MPL right now at 25.73%. She is looking into an incentive program in addition to the well-baby incentive. She will target which the well visits are being missed the most and the most preventative screenings can be done in one visit. She is also looking identifying a variety of disparities: among black identifying members; among members 17 to 21 years of age; and among mail members.

Ms. Epperson asked for incentive ideas and any barriers that committee members may be aware of.

Ms. Shami explained the metrics described are those that fall under HEDIS. These metrics use to see how the health plan is doing to access in general. The Well Visit rates among health plans in California is quite low. Nationally the rates are higher and there must be a reason why California is lower. These minimum performance levels are at the 50th percentile. She explained the different measures and stated we are wondering why these measures are have a challenge, what are the reasons. This a focus area for the health plan. These well child visits effect overall all types of screenings and checks.

Dr. Chabra asked if we are confident that we are getting the data on the visits even if it is a provider under the capitated rate. Ms. Shami stated it does seem that they are. They have found there could be some issues with appointment availability. There may be some room there for improvement with member assignments. And, they are trying to figure out a way to help members to get to all the visits that are required. Dr. Cooper asked if the immunizations are happening at these visits. Ms. Shami stated that the immunizations are happening and our immunization rates are not that bad.

Dr. Chabra stated that there may be something with the scheduling of appointments and if they don't get it in the right timing the measure suffers. There are a number of variables including staffing for provider offices. Dr. Chen concurred that capacity is an issue especially with the increase in births. She added that they review vaccination records at every visit at the county. So they may be getting vaccines at those times and may not be a well child visit. She noted that the six month visit is another area where they may not be getting the immunization because the child must be six months old and the timing has to be precise and if they get it a seven months, it backs it up.

Ms. Shami asked if a mailer or handout that is well framed for what has to happen with well-child visit and immunizations, when they are needed and that are informative, if that would help? Dr. Chen thought it may as many patients do as when the next immunization or visit is due. Dr. Chen mentioned the influx of children that are seen at certain times (5 years and 11 years) because it is a school requirement. Possibly reminders from schools that their children should be seen annually for medical and dental. Ms. Shami stated that this is a good resource and they are aligning with schools.

Dr. Chen shared that her office have opening up the schedule for the next

calendar year which seems to be helpful so parents can schedule their next well child check one year out. They do have to make a lot of effort to remind them about the appointment and this seems to be successful. This involves a lot of phone calls. There is an auto call that prompts them to confirm and then a person calling to confirm closer to the visit. Dr. Chabra added that this process has been successful in approving attendance for Medical Therapy appointments as well.

Dr. Chen commented on young adults and getting them in for the CHDPs. They try hard give them these children at age 17 information regarding transition to adulthood but there still seems to be a big drop off of these kids finding an adult medical home to be connected with or in attending an adult provider. She wishes there was a more productive way of helping them in this shift to adulthood. Ms. Epperson is passionate about this focus area and is working on. Dr. Chen stated that in particular children with special needs. She suggested a list of providers that will take young adults.

Dr. Cooper mentioned that the CCS program has a system for helping the children who are aging out of CCS to go from their pediatric provider to and adult provider. Ms. Flores talked about what CCS staff does to help them prepare to take over their own health care and that they are working on ramping that up. The challenge is find those providers who will take these new patients.

**7. Other Business**

No other business was discussed at this time.

**8. 2023 Meeting Dates:**

**June 22, 2023**
**September 28, 2023**
**December 14, 2023**

**9. Adjournment/Closing Remarks**

The meeting adjourned at 1:02 p.m.

**RESOLUTION OF THE**
**CCS CLINICAL ADVISORY COMMITTEE**

## IN THE MATTER OF APPROVAL OF TELECONFERENCE MEETING PROCEDURES PURSUANT TO AB 361 (BROWN ACT PROVISIONS)

**RECITAL: WHEREAS,**

A. In the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, the San Mateo County Board of Supervisors recently found that meeting in person would present imminent risk to the health or safety of attendees of public meetings and accordingly directed staff to continue to agendize its public meetings only as online teleconference meetings; and
B. The Board of Supervisors strongly encouraged other legislative bodies of the County of San Mateo that are subject to the Brown Act to make a similar finding and avail themselves of teleconferencing until the risk of community transmission has further declined; and
C. The Committees of the San Mateo Health Commission must make such a finding under AB 361 in order to continue to conduct meetings as online teleconference meetings.

**NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:**

1. The CCS Clinical Advisory Committee hereby finds that in the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, meeting in person would present imminent risk to the health or safety of attendees of public meetings for the reasons set forth in Resolution No. 078447 of the San Mateo County Board of Supervisors and subsequent resolutions made pursuant to AB 361; and
2. The CCS Clinical Advisory Committee continues to agendize its meetings only as online teleconference meetings; and presents this item, within 30 days, for its consideration regarding whether to make renewed findings required by AB 361 in order to continue to meet remotely.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 23rd day of February 2023 by the following votes:

AYES: Chabra, Chen, Soman, Smith.
NOES: -0-
ABSTAINED: -0-

ATTEST:

BY: C. Burgess
C. Burgess, Clerk

**DRAFT**

# CCS FAMILY ADVISORY COMMITTEE MEETING
## Thursday, February 23, 2023 – 6:00 p.m.
## Meeting Summary
## -Virtual Meeting via Microsoft Teams-

Important notice regarding COVID-19: Based on guidance from the California Department of Public Health and the California Governor's Office, in order to minimize the spread of the COVID-19 virus, Health Plan of San Mateo offices were closed for this meeting, and the meeting was conducted via online meeting/teleconference. Members of the public were invited to submit public comment via email to the Clerk in advance of the meeting and were also able to access the meeting using the web and teleconference information provided on the meeting notice.

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| **Members Present:** | Lianna Chen, Stephanie Gradek, Miguel Sr. Bejar Arias, Leticia Acevedo, Doris Dablo, Gladis Gomez, Roberta Zarate |
| **Members Excused:** | Stephanie Bayless, Faviola Morales, Rocio Jimenez, Rocia Salas, Nyla Dowden, Miguel Sr. and Claudia Pina, Amabilia Espinoza, Christina Marquez, Bianca Ortiz, Sylvia Ixcoy, Esperanza Zamora, Stephanie Smith, Sonia Valenzuela |
| **San Mateo County Members present:** | Anand Chabra, M.D., Susana Flores. |
| **San Mateo County Members Excused:** | Lizelle Lirio de Luna, Marsha Aleman, Jennifer McLean |
| **HPSM Members Present:** | Amy Scribner, Tejasi Khatri, Cynthia Cooper, M.D., Amanda Epperson |
| **HPSM Members Excused:** | Pat Curran, Miriam Sheinbein, M.D., Leslie Wong. |

**Guests:**

1. **Welcome/Introductions:** The meeting was called to order at 6:04 p.m. by Tejasi Khatri. Introductions for all in attendance were made.

2. **Public Comment:**
   There were no other public comments received via email or made at this time.

3. **Adopt a resolution finding that, as a result of the continuing COVID-19 pandemic state of emergency, meeting in person would present imminent risks to the health or safety of attendees.**

   Ms. Khatri explained the need for the group to approve the resolution to continue meeting virtually as required for AB 361. Motion to adopt the resolution: Chabra / Second: Gradek. All were in favor. A Copy of the resolution approving is attached to these minutes.

## 4. Approval of Minutes

Ms. Khatri noted that the minutes to the September 22, 2022, meeting were sent with the meeting materials for review. Motion to approve minutes as presented: Gradek / Second: Flores.

## 5. Youth Advisory Committee Update

Ms. Chen reported that the youth advisory is scheduled to for the following week. The meeting structure has been temporarily changed while the CCS Social Worker is out. Their meeting will be a 30 minute open discussion around their experiences with job searching and Department of Rehabilitation.

## 6. Blood Lead Screening

Ms. Khatri introduced Amanda Epperson, HPSM Program Manager for Child and Youth Health. Ms. Epperson reviewed her presentation touching on the following points:

- Ms. Epperson shared information on trends in California which was released in October 2022.
- She expressed the importance of blood lead screening which dates back to 1986 when lead exposure was the most significant childhood environmental health problem in the state.
- This led to the development of the California Childhood Lead Poisoning Prevention program.
- Between 2010 and 2020, the rate of children under the age of 6 years old who tested positive for lead poisoning was decrease by more than half.
- CDC has stated that no level of lead in blood is safe making screening very important.
- Lead is hard to detect even those with high levels and health impacts do not appear until high levels have accumulated. She reviewed some of the impacts including brain and nervous system damage; learning and behavior problems; slowed growth and development; and hearing and speech problems.
- She reviewed how younger children can be exposed at a higher rate due to the way they put everything in their mouths, chewing on toys, etc. They also absorb lead more easily than adults and is more dangerous to them.
- She shared data on the areas of exposure which include lead paint, in the soil, dust and water, housing-related exposures.
- Non-housing related exposure includes cosmetics and spiritual products; food, spice, drink; pottery and utensils.
- Due to the pandemic 28% fewer children under the age of six were tested in 2020 compared to 2019.
- Recall of test kits by Magellan Diagnostics in 2021 created a shortage and some had to have a sample directly from the child's vein which was more invasive. In October 2022, all three testing products resumed distribution.
- In San Mateo County in 2020 resulted in 98.86% of children under age of six test at reference value of 4.5 with 43 children between 4.5 to 9.5 reference levels.

- For HPSM, blood lead testing is a HEDIS measure and came in at the "below minimum performance level". This is measured by the percentage of children 2 years old who have had one or more blood test by their 2nd birthday.
- Staff is working on new strategies and interventions to increase these rates
- HPSM current activities include:
    - Monthly notifications to providers for their patients for screenings due and overdue
    - Newsletter and fax blast announcements to providers about availability of the test kits
    - Sign ups through the Well Baby program. This is an outreach and education work in collaboration with the San Mateo County Family Home Visiting Program

In conclusion of the presentation, there was discussion about the type of candies, wrappers, ceramics from other countries that may come from manufacturers who do not test their products for lead. And, the kinds of impacts on health that this exposure can cause.

**7. Discussion Topics for Family Feedback**

One of the members asked about who to contact now that Mr. Eckstein, Social Worker, has retired. Ms. Flores stated that they are in the process of hiring to fill this position. Ms. Aleman will be returning from leave soon and that will help. Right now, the Senior Community Workers are helping to support our members, and the child's public health nurse or the child's pediatrician are other resources for support.

One of the members noted the need to support in the loss of their family member and Ms. Flores was able to share the resources to help for this type of need. She added that the case manager could also help in this type of situation. There was more discussion around reassignment to other counties and to keep the case manager informed of these changes and that services should be continued without interruption. Dr. Chabra added that it is important to contact Human Services Agency to make sure their Medi-Cal gets transferred to the new county.

**8. Meeting Dates for 2023**

Ms. Khatri explained that our next meeting is scheduled for June, however we are still trying to figure out if our meetings will need to be in person or if there is a way to continue virtually. Once we know how we can proceed, we will send out an email notification at least 45 days prior to the date. We will likely send out a survey regarding preferred location if the meeting needs to be in person.

**June 22, 2023**
**September 28, 2023**
**December 14, 2023**

**9. Adjournment/Closing Remarks**

The meeting was adjourned at 6:40 p.m.

**RESOLUTION OF THE**
**CCS FAMILY ADVISORY COMMITTEE**

**IN THE MATTER OF APPROVAL OF TELECONFERENCE MEETING PROCEDURES PURSUANT TO AB 361 (BROWN ACT PROVISIONS)**

**RECITAL: WHEREAS,**

A. In the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, the San Mateo County Board of Supervisors recently found that meeting in person would present imminent risk to the health or safety of attendees of public meetings and accordingly directed staff to continue to agendize its public meetings only as online teleconference meetings; and
B. The Board of Supervisors strongly encouraged other legislative bodies of the County of San Mateo that are subject to the Brown Act to make a similar finding and avail themselves of teleconferencing until the risk of community transmission has further declined; and
C. The Committees of the San Mateo Health Commission must make such a finding under AB 361 in order to continue to conduct meetings as online teleconference meetings.

**NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:**

1. The CCS Family Advisory Committee hereby finds that in the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, meeting in person would present imminent risk to the health or safety of attendees of public meetings for the reasons set forth in Resolution No. 078447 of the San Mateo County Board of Supervisors and subsequent resolutions made pursuant to AB 361; and
2. The CCS Family Advisory Committee continues to agendize its meetings only as online teleconference meetings; and presents this item, within 30 days, for its consideration regarding whether to make renewed findings required by AB 361 in order to continue to meet remotely.

PASSED, APPROVED, AND ADOPTED by the CCS Family Advisory Committee this 23rd day of February 2023 by the following votes:

AYES: Chen, Gradek, Bejar-Arias, Acevedo, Dablo, Gomez, Zarate.

NOES: -0-

ABSTAINED: -0-

ATTEST:

BY: C. Burgess
C. Burgess, Clerk

**Agenda Item: 4.5**

**Date: April 12, 2023**

**OPEN SESSION-PHYSICIAN ADVISORY GROUP (PAG)**
**Meeting Minutes**
**December 13, 2022 7:30 a.m.**
**Virtual Meeting due to Public Emergency**

**Important notice regarding COVID-19:** Based on guidance from the California Department of Public Health and the California Governor's Office, in order to minimize the spread of the COVID-19 virus, the meeting was conducted via online meeting/teleconference. Members of the public were invited to submit public comment via email to nina.nguyen@hpsm.org in advance of the meeting and were also able to access the meeting using the web and teleconference information provided on the meeting notice.

| Voting Committee Members | Specialty | Present (Yes or Excused) |
|---|---|---|
| Janet Chaikind, MD, Committee Chair | Pediatrics | Yes |
| Leland Luna, MD | Family Practice | Yes |
| Vincent Mason, MD | Pediatrics | Excused |
| Tom Stodgel, MD | Obstetrics and Gynecology | Yes |
| Kenneth Tai, MD | Internal Medicine | Yes |
| Randolph Wong, MD | General Surgery | Delegated Dr. Moore as Proxy |
| **Non-voting HPSM Staff Members** | **Title** | **Present (Yes or Excused)** |
| Luarnie Bermudo | Director of Provider Services | Excused |
| Carolyn Brown, DDS | Dental Director | Yes |
| Marisa Cardarelli | Dental Benefits Manager | Excused |
| Harnoor Chahal | Quality Improvement Clinical Manager | Excused |
| Cynthia Cooper, MD | Medical Director | Excused |
| Pat Curran | Chief Executive Officer | Yes |
| Paul Dela Cruz | Credentialing Specialist | Yes |
| Chris Esguerra, MD | Chief Medical Officer | Excused |
| Scott Fogle | Program Manager, Provider Services | Excused |
| Nicole Ford | Director of Quality | Excused |
| Jenny Hu | Provider Network Liaison | Excused |
| Daniel Le | Contract Supervisor | Excused |
| Treschere Lowery | Credentialing Specialist | Yes |
| Richard Moore, MD | Senior Medical Director | Yes |
| Colleen Murphey | Chief Operating Officer | Excused |
| Nina Nguyen | Provider Operations Manager | Yes |
| Jo Quach | NCQA Program Manager | Excused |
| Clarissa Rivera-Loo | Provider Network Liaison | Yes |
| Karla Rosado-Torres | Director of Medicare | Yes |
| Miriam Sheinbein, MD | Medical Director | Excused |
| Manila Shrestha | Provider Data Steward | Yes |
| April Watson | Provider Network Manager/ Interim Provider Services Director | Yes |

| | Item(s) | Discussion | Action | Responsible Parties | Due Date |
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| 1 | **Call to Order** | Dr. Janet Chaikind called the meeting to order at 7:35 am. A quorum was present. | Quorum was present | J. Chaikind | N/A |
| 2 | **Public Comment** | None | N/A | N/A | N/A |
| 3 | **Approval of virtual meeting – AB361** | | | | |
| 3 | **Meeting Agenda and Meeting Minutes** | Agenda and Minutes disseminated to committee.<br><br>Agenda for today's meeting and Minutes from the October 2022 PAG Committee Meeting were approved. | Agenda approved; Minutes from October 2022 PAG Approved. | PAG | N/A |
| 4 | **HPSM Announcements** | 1. Pat gave an update on the state public health emergency-Brown Act exclusions which will officially then come to the end of the middle of February. Commission is very clear So we've announced at our health commission meeting that our first meeting will be the first meeting after the end of February which actually is April because there's no March meeting. Per the Commission, we'll be returning to in person meetings. However, our county counsel is researching to see what types of flexibilities will exist. And if it isn't allowed, or if there's a permutation of it, we'll we'll come back and explain what the options are because some of the flexibilities have been working for PAG/PRC. The Federal Public Health Emergency has not ended and there has not been an announcement. So currently, the current thinking is that the earliest the end of the public health emergency at the | N/A | Pat Curran | N/A |

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| | | federal level would be April 15 2023.<br><br>2. The difference is that the Federal Public Health Emergency ending would mean the start of Redeterminations meaning the pause they made on people needing to re-determine their medical benefits that ends and they would start what would be a 12 to 14 month process for people to have to renew their coverage for medical and so that should mean probably will mean people losing coverage. Hopefully, that's because they have other coverage, because if they still qualify, they would certainly continue to participate in Medi-Cal. So that process we're anticipating if it starts, if the end the public health emergency in April would start in May and June, which is a little bit later than we thought so it will either be April or it will be July.<br><br>3. A brief 2022 highlights review. We implemented some major programs. We started the first series of programs related to Calaim for community support, housing or transition programs, food programs. Then Enhanced Care Management (ECM), which was actually mainly a transition of Whole Person Care program that was done through the county- a big program implementation. ECM model of care idea is for more services face-to-face in the community for members in July of 2023 will apply to | | | |

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| | | children and youth so that will greatly expand who is possible to cover under those services.<br><br>4. The other big implementation was dental which Dr. Brown and Marisa spearheaded as well. We successfully implemented the first integrated dental program and faced a lot of challenges especially with access for adults. But thanks to the efforts of a lot of people in this group, and the organization and in the community. We're making a lot of progress. And to that end, as we move forward and 2023 what we notified the Health Commission is few areas of emphasis for us and potential investment and PACE program exploration whether it is an opportunity to maybe partner with another organization to implement Pace. As this would be a three-, four- or five-year venture, but with this Pace exploration meaning the community investing in dental capacity.<br><br>5. To that end, we are taking a proposal tomorrow to the Health Commission, and now to proposing for to help support NEMS hiring an oral surgeon which was a huge area of access challenge for us, so supporting our FQHC partners and we'd love to do more dental capacity, especially with FQHC. So that's the first and what we hope will be several. Then the third is just acknowledging the workforce challenges and | | | |

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| | | inflation and all of that and of course we can't solve the whole workforce challenge for the healthcare system. But I think the one thing that impacts so importantly many areas is in primary care and what additional investments and support for primary care in 2023. It's difficult for primary care to recruit and hire, especially in the Bay Area. So we're very aware of that it's a challenge that cannot be solved overnight. | | | |
| 6 | **Health Services Announcements** | 1. Dr. Moore reminded on voting motions and order as Health Plan members are not voting members.<br><br>2. We are revamping our peer to peer process. It's been pretty strict and haven't had the opportunity to overturn a decision based on a peer to peer conversation and we are in the process of it's all written in compliance to approve it. We are allowing more time for a peer to peer and we can actually bypass the appeals process, if enough information is obtained. We could do a full approval and we would allow up to 60 days after a denial letter went out. Majority of time denials stem from not enough clinical information was submitted or no information was submitted.<br><br>3. And then there's just the other big-ticket item are MRIs. Most of the time not enough information is submitted to justify an MRI, the lumbar, low back MRIs for low back pain, which we see so many of and coverage criteria really dictates that there is a at least | | Dr. Richard Moore | N/A |

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| | | four weeks and some conservative treatment rather than presenting to the office with low back pain and ordering a lumbar MRI. So more to follow on the peer-to-peer process but it's exciting that we will be able to reduce some of the provider burden by reducing the number of pills that patients have to go through. | | | |
| 7 | **Provider Services Announcements** | 1. April gave an update on NEMT network that is requiring significant level of resources time and attention that's related to some DHCS requirements. NEMT is an interesting network, with small number of providers. Most of them are small family run businesses. They run on very thin margins and don't have a lot of infrastructure. So we're trying to support them as best we can, with minimal impact to members but it's definitely been just a big area of focus.<br><br>2. Other provider types are community health workers, street medicine, so we'll have more to report out, as currently there are more of the planning work at this point, We're also continuing to recruit and grow our behavioral health provider network as we see the demand continuing to grow for that ensure no surprise to anybody there.<br><br>3. And then the last point is, yeah, we have some really good work related to primary care and trying to support primary care. So one thing I'll call out is that we're really, | N/A | April Watson | N/A |

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| | | really excited that NEMS expanded capacity and in North County clinics and so kind of opened up an expanded care there for our members in that geography which is terrific. We're also in an intense planning mode for an 18 month pilot that you might have heard about, that we're doing with Palo Alto Medical Foundation. It's going to start early next year. It's really an expanded primary care model with a focus on mostly the older adult population. This is going to be for our Care Advantage population. And just really excited to be partnering with them on the implementation of this really pretty innovative care model. | | | |
| 7 | **Adjournment** | The meeting was adjourned to the Peer Review Committee (PRC) closed session. | N/A | N/A | N/A |

**Next Meeting for the Physician Advisory Group: 02/14/2023 at 7:30 am**

**RESOLUTION OF THE**
**PHYSICIAN ADVISORY GROUP**

**IN THE MATTER OF APPROVAL OF TELECONFERENCE MEETING PROCEDURES PURSUANT TO AB 361 (BROWN ACT PROVISIONS)**

**RECITAL: WHEREAS,**

A. In the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, the San Mateo County Board of Supervisors recently found that meeting in person would present imminent risk to the health or safety of attendees of public meetings and accordingly directed staff to continue to agendize its public meetings only as online teleconference meetings; and
B. The Board of Supervisors strongly encouraged other legislative bodies of the County of San Mateo that are subject to the Brown Act to make a similar finding and avail themselves of teleconferencing until the risk of community transmission has further declined; and
C. The San Mateo Health Commission must make such a finding under AB 361 in order to continue to conduct its meetings as online teleconference meetings.

**NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:**

1. The Physician Advisory Group of the San Mateo Health Commission hereby finds that in the interest of public health and safety, as affected by the state of emergency caused by the spread of COVID-19, meeting in person would present imminent risk to the health or safety of attendees of public meetings for the reasons set forth in Resolution No. 078447 of the San Mateo County Board of Supervisors and subsequent resolutions made pursuant to AB 361; and
2. The Physician Advisory Group of the San Mateo Health Commission directs staff to continue to agendize its meetings only as online teleconference meetings; and
3. The Physician Advisory Group of the San Mateo Health Commission further directs staff to present, within 30 days, an item for its consideration regarding whether to make renewed findings required by AB 361 in order to continue to meet remotely.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission's Physician Advisory Group this 13th day of December 2022 by the following votes:

AYES: Drs. Chaikind, Luna, Stodgel, Tai.

NOES: -0-

ATTEST:

BY: Nina Nguyen cn=Nina Nguyen, o=Health Plan of San Mateo, ou=Provider Operations Manager, email=nina.nguyen@hpsm.org, c=US 2022.12.13 14:23:03 -08'00'

Nina Nguyen, Provider Operations Mgr.

**MEMORANDUM**

**AGENDA ITEM: 4.6**

**DATE: April 12, 2023**

**DATE:** March 15, 2023

**TO:** San Mateo Health Commission

**FROM:** Chris Esguerra, M.D, Chief Medical Officer
Janet Davidson, Utilization Review Manager

**RE:** Waive Request for Proposal (RFP) Process and Ratify Amendment to the Agreement with Periscope Consulting Group

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## Recommendation

Waive RFP process and ratify an amendment to the agreement with Periscope Consulting Group f/k/a DME Consulting Group, Inc. This amendment extends the contract three years, through December 31, 2025, and increases the agreement by $1 million for a new total amount not to exceed $2 million.

## Background and Discussion

HPSM has contracted with Periscope consulting Group f/k/a DME Consulting Group to conduct in home assessments and submit written recommendations for members' durable medical equipment (DME) for many years. However, the Consulting Group's services have been limited to a few equipment areas. In 2017, HPSM expanded the services to engage members earlier in the process to improve service timeliness; Plan staff also expanded the use of this vendor to cover additional categories of equipment. These changes led to improved durable medical equipment services for members.

Based on a comprehensive home assessment, DME Consulting can make impartial recommendations based on member needs rather than relying only on recommendations from the equipment supplier or the prescribing physician, who is unlikely to be familiar with the patient's home environment.

Due to the unique nature of the services provided, the existing relationships developed between Periscope Consulting Group and HPSM, DME vendors and network providers, it is in the members' best interest to extend the agreement with Periscope Consulting Group. Therefore, a waiver of the RFP process is requested.

## Fiscal Impact

The estimated expense for the three-year extension of the agreement is $1 million based upon the average number of monthly assessments performed by Periscope Consulting Group. The new term is through December 31, 2025 and the new agreement maximum is $2 million.

**DRAFT**

**RESOLUTION OF THE**
**SAN MATEO HEALTH COMMISSION**

**IN THE MATTER TO WAIVE REQUEST FOR PROPOSAL PROCESS AND RATIFY AN AMENDMENT TO THE AGREEMENT WITH PERISCOPE CONSULTING GROUP**

**RESOLUTION 2023 -**

**RECITAL: WHEREAS,**

A. Periscope Consulting Group, f/k/a DME Consulting Group, Inc. performs evaluation services for HPSM members to ensure the most appropriate equipment is being provided to members through comprehensive home assessments;

B. The agreement was due to expire on December 31, 2022 necessitating an amendment to continue these services.

C. Due to the unique nature of these services and the existing relationships with HPSM, DME vendors, and participating providers, it is in the members' best interest to extend the current agreement with Periscope Consulting Group.

**NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:**

1. The San Mateo Health Commission waives the request for proposal process and ratifies an amendment to extend the agreement with DME Consulting Group, Inc. through December 31, 2025; and
2. Approves an increase in the contract of $1 million for a new not to exceed amount of $2 million.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of April 2023 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

**MEMORANDUM**

**AGENDA ITEM: 4.7**

**DATE: April 12, 2023**

**DATE:** April 3, 2023

**TO:** San Mateo Health Commission

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

**RE:** Approval of Amendment to Agreement with County of San Mateo for Third Party Administrative Services for the ACE Program

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## Recommendation

Authorize the Chief Executive Officer to execute an amendment to the agreement with the County of San Mateo to extend the Third-Party Administrator (TPA) services HPSM provides for the ACE Program for another 18 months through September 2024.

## Background and Discussion

HPSM began administering ACE (Access and Care for Everyone) in February 2008. The ACE program is San Mateo County's local version of the State Coverage Initiative, which was intended to offer counties the opportunity to develop innovative programs for expanding access to the uninsured.

The ACE program has been successful by creating a program that is simple, transparent, and easy to use for participants. The addition of medical management has helped control cost, while improving outcomes, especially for participants that suffer from chronic conditions. The program has also created better awareness of cost and utilization for the County.

To qualify for ACE, individuals must reside in San Mateo County, be 19 or older without other health insurance coverage, ineligible for coverage through Medicare, Medi-Cal, or other insurance, and have incomes below 200% of the federal poverty level.

The number of participants covered under the ACE program was around 22,000 prior to the pandemic, then grew to around 27,000 during the pandemic. In April 2022, ACE participation dropped by around 6,000 (to around 21,000) after undocumented residents age 50 and older became eligible for Medi-Cal. The Governor's 2023/2024 budget includes proposed funding that will expand Medi-Cal coverage to undocumented residents even further to include ages 26 through 49. This will cause another shift in coverage from ACE to Medi-Cal, bringing projected ACE membership down to an estimated 4,000 based on current projections.

There is uncertainty with this program, mostly because of the potential large shift in eligibility of undocumented residents, who will likely qualify for coverage through regular Medi-Cal starting

in January 2024. Once this happens, then HPSM leadership will work with County Health to evaluate the future of this program.

The current contract ends March 31, 2023. The reason for the 18-month extension is to allow sufficient time in 2024 to evaluate the program after the expected January 2024 shift in eligibility from ACE to Medi-Cal.

**Financial Impact**

The TPA fee structure will remain unchanged, which is $8.50 per participant per month for the first 22,000 participants, and $4.25 per participant per month for participant count over 22,000. Current annual TPA revenue is around $2.2M, which covers HPSM's cost to administer the program. The County has financial responsibility for all healthcare costs, so HPSM has no insurance risk for this program.

**RESOLUTION OF THE**
**SAN MATEO HEALTH COMMISSION**

**IN THE MATTER OF APPROVAL OF AMENDMENT TO THE AGREEMENT WITH COUNTY OF SAN MATEO FOR THIRD PARTY ADMINISTRATOR SERVICES FOR THE ACE PROGRAM**

**RESOLUTION 2023 -**

**RECITAL: WHEREAS,**

A. The San Mateo Health Commission has previously entered into an agreement with the County of San Mateo for the Health Plan of San Mateo to be the third-party administrator for the ACE Program;

B. The San Mateo Health Commission has renewed this TPA arrangement over the years, with the current agreement expiring March 31, 2023;

C. Both parties wish to extend the TPA arrangement for another 18 months through September 2024.

**NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:**

1. The San Mateo Health Commission approves the amendment to extend the agreement with San Mateo County for Third Party Administrator Services for the ACE Program through September 2024; and

2. The San Mateo Health Commission authorizes the Chief Executive Officer to execute said amendment.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of April 2023 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

**MEMORANDUM**

**AGENDA ITEM: 4.8**

**DATE: April 12, 2023**

**DATE:** March 15, 2023

**TO:** San Mateo Health Commission

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

**RE:** Approval of 2023 Compliance Program; and 2023 Code of Conduct

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## Recommendation

Approve HPSM Compliance Program document for 2023 and Code of Conduct document for 2023.

## Background

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

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

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

## Discussion

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

## Compliance Program

The Compliance Program document did not have any substantive changes for 2023. The program document was reviewed and approved by the Compliance Committee on February 6, 2023. It is hereby submitted to the Commission for its annual review and approval.

## Code of Conduct

The Code of Conduct had no substantive changes and was reviewed and approved by the Compliance Committee on February 6, 2023. It is hereby submitted to the Commission for its annual review and approval.

## Fiscal Impact

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

**DRAFT**

**RESOLUTION OF THE**
**SAN MATEO HEALTH COMMISSION**

**IN THE MATTER OF APPROVAL OF**
**2023 COMPLIANCE PROGRAM and**
**2023 CODE OF CONDUCT**

**RESOLUTION 2023 -**

**RECITAL: WHEREAS**,

A. The San Mateo Health Commission and the Health Plan of San Mateo values the contribution of all employees, commissioners, committee members, and contracted business partners toward the goal of providing the highest possible quality of services to its members and providers; and
B. The Compliance Program describes how HPSM ensures compliance with all applicable laws and regulations; and the Code of Conduct serves as a guide for complying with HPSM's internal policies and procedures as well as with all applicable laws and regulations
C. These documents have been reviewed by the Compliance Committee and are submitted for Commission's review and approval for 2023.

**NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:**

1. The San Mateo Health Commission approves the attached 2023 Compliance Program and 2023 Code of Conduct documents for the Health Plan of San Mateo.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of April, 2023 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chair

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

*INTRODUCTION*

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

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

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

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

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

*THE COMPLIANCE PROGRAM*

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

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

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

**Key Elements of Compliance Program**

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

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

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

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

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

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

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

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

## *APPLICABILITY*

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

## *CODE of CONDUCT*

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

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

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

**Review and Implementation of Standards**

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

**Compliance with Policies and Procedures**

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

Compliance Policies and Procedures include the following:

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

In addition, as part of HPSM's audit of FDRs, such as HPSM's pharmacy benefits manager, the FDRs must

certify that as a condition of employment its employees must comply with written policies and procedures and Code of Conduct.

**Familiarity with Identified Standards**

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

*OVERSIGHT*

**Governing Body**

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

**Chief Compliance Officer**

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

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

*The Chief Compliance Officer:*

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

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

*The Chief Compliance Officer shall ensure that:*

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

- Compliance software and electronic files are maintained to support implementation of the Compliance Program.
- Each of the requirements of the Compliance Program has been substantially accomplished.

**Compliance Committee**

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

**Managers / Supervisors**

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

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

*TRAINING*

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

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

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

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

Compliance trainings for HPSM Employees include information regarding:

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

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

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

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

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

**Documentation**

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

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

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

*EFFECTIVE LINES OF COMMUNICATION*

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

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

*Establishment and Publication of Reporting Hotlines*

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

**Compliance Hotline**

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

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

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

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

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

**Confidentiality, Non-Intimidation and Non-Retaliation**

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

HPSM's "Open Door" policy encourages HPSM Employees to discuss issues directly with their managers, supervisors, the Chief Compliance Officer, other Leadership Team members, members of the Compliance

Committee, or the CEO. These channels of discussion provide for confidentiality to the extent allowed by law.

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

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

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

*DISCIPLINARY STANDARDS*

**Conduct Subject to Discipline**

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

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

**Enforcement and Discipline**

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

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

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

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

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

*MONITORING and AUDITING*

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

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

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

*Oversight of Delegated Activities*

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

- Provider credentialing and re-credentialing at select facilities and for pharmacists
- PBM Pharmaceutical claims processing and aspects in the administration and delivery of the Medicare Part D benefit
- Mental health benefits, including claims processing and oversight of the grievance and appeals processes (for Medi-Cal, CareAdvantage, and HealthWorx lines of business)
- Transportation benefit for Medi-Cal and CareAdvantage CMC
- Grievances and appeals to Kaiser Permanente for those members assigned to Kaiser
- Imaging of claims

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

*Oversight of Non-Delegated Activities*

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

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

- Development of utilization standards
- Development of quality improvement standards
- Compliance

*External Auditing for Pharmacy Benefits*

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

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

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

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

*Internal Auditing*

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

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

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

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

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

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

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

*Compliance Program Effectiveness Audit*

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

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

***Audit Review***

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

## *PROMPT RESPONSE TO COMPLIANCE ISSUES*

HPSM is committed to responding to compliance issues thoroughly and promptly and has developed policies to address the reporting of and responding to compliance issues. If an Employee becomes aware of a violation, suspected violation or questionable or unethical conduct in violation of the Compliance

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

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

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

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

**Self-Reporting**

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

**Participation Status Review and Background Checks**

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

*Participation Status Review*

HPSM reviews Commissioners, HPSM Employees and Contractors against appropriate exclusion lists to ensure that they are not excluded, suspended or otherwise ineligible to participate in Federal and/or State health care programs. HPSM requires that potential Commissioners, Employees and Contractors

disclose their Participation Status as part of the employment/contracting/appointment process and when Commissioners, Employees, and Contractors receive notice of any suspension, exclusion, debarment or felony conviction during the period of employment, contract or appointment. HPSM also requires those delegated to complete provider credentialing and re-credentialing that comply with Participation Status Review requirements with respect to their relationships with participating providers and suppliers. This review is conducted prior to employment or contractual engagement of a person or entity and monthly thereafter according to Participation Status Review Policies and Procedures.

*Background Checks*

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

*Notice and Documentation*

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

*DOCUMENTATION*

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

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

**Document Retention**

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

APPENDIX A

GLOSSARY

**Abuse** means practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to Federal and/or State health care programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

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

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

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

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

**Commissioners** mean the members of HPSM's Governing Body.

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

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

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

**Contractor Agreement** means any agreement with a Contractor.

**Department of Health Services (DHCS)** means the California Department of Health Services, the State

agency that oversees the Medi-Cal program.

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

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

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

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

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

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

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

**Governing Body** means the San Mateo Health Commission/San Mateo Community Health Authority.

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

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

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

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

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

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

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

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

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

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

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

Exclusion.

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

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

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

APPENDIX B

Compliance Policies and Procedures

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

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

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

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

# HEALTH PLAN of SAN MATEO

# CODE OF CONDUCT

2023

# Table of Contents

# A Message from the Chief Executive Officer

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

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

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

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

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

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

Sincerely,

Pat Curran
Chief Executive Officer

# Introduction

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

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

## Our Mission

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

## Our Vision

***Healthy is for everyone*** *and we fight to make that happen.*

## Our Values

- **Advocate** for the health and well-being of our members and other underserved residents of San Mateo County.
- **Partner** with providers and community organizations to overcome local challenges faced by members and providers.
- **Give** individual and personal attention to our members by being culturally and linguistically responsive to their unique needs.
- **Support** our providers by ensuring they receive timely payment for their services and by reducing administrative obstacles.
- **Strive** to be good stewards of public resources by focusing on the efficient use of services and funds.
- **Act** with the highest standards of ethics integrity and transparency.
- **Embrace** a work atmosphere that encourages employee growth and commitment to HPSM's mission.

# Commitments

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

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

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

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

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

# Code of Conduct

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

## 1. Privacy and Confidentiality

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

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

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

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

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

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

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

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

## 2. Security of Electronic Information

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

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

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

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

2.5. Transmit electronic confidential information securely in encrypted form.

## 3. Workplace Conduct

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

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

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

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

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

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

## 4. Use of Social Media

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

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

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

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

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

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

## 5. Adhering to Laws and Regulations

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

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

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

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

5.5. Avoid inappropriate discussions regarding business issues.

## 6. Safety

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

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

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

## 7. Conflict of Interest

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

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

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

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

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

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

## 8. Protecting Assets

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

claims data, business strategies, financial reports, member utilization data, and data systems.

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

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

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

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

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

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

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

## 9. Participating in the Compliance Program

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

9.2. Cooperate fully with investigational efforts.

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

## 10. Employment Practices

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

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

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

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

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

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

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

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

## 11. Resolving Issues and Concerns

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

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

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

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

## 12. Committee Member Responsibilities

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

**MEMORANDUM**

**AGENDA ITEM: 4.9**

**DATE: April 12, 2023**

**DATE:** March 1, 2023

**TO:** San Mateo Health Commission

**FROM:** Amy Scribner, Population Health Officer

**RE:** Approval of Amendment to Agreement with AccessNurse

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**Recommendation:**

Authorize the Chief Executive Officer to execute an amendment to the agreement with AccessNurse, formerly known as TeamHealth Medical Call Center, to increase the contract maximum by $281,250 for a total contract maximum amount of $1,415,076 for services to fulfill regulatory requirements for telephone triage services through September 30, 2023.

**Background:**

HPSM is required by the Department of Managed Health Care to provide or arrange for the provision of telephone triage services for its 173,000 members, 24 hours/7 days per week/365 days a year. In its three way Cal MediConnect contract with the Centers for Medicare and Medicaid Services and the Department of Health Care Services, HPSM is also required to ensure that members have access to telephone medical advice from a licensed professional during after-hours. In November 2017, the Commission approved a two-year agreement with AccessNurse to replace Envolve People, Inc. to perform telephone triage services. AccessNurse was selected through an RFP process that included nine bidding vendors. Since going live in February 2018, AccessNurse's customer service has been excellent. The firm provides regular and timely reporting, is responsive to staff inquiries, and quickly investigates and resolves any call quality issues that arise. Starting January 2019, HPSM added outbound welcome calls to new Medi-Cal members and ACE participants to AccessNurse's scope of services. These calls help orient new members to HPSM and remind members to select a primary care physician.

**Discussion:**

HPSM is currently contracted with AccessNurse for both Nurse Advice line services and new member outreach calls which is due to expire on September 30, 2023, and also currently has an open Request for Proposal (RFP) for both services. A projection calculation indicated that an increase of $281,250 is needed to carry these services through the end of the contract term due to an increase in the number of nurse advice line calls.

**Fiscal Impact:**

HPSM is currently contracted with AccessNurse through September 30, 2023. The request to increase the contract maximum by $281,250 brings the total six-year contract maximum to $1,415.076.

**DRAFT**

**RESOLUTION OF THE**
**SAN MATEO HEALTH COMMISSION**

**IN THE MATTER OF APPROVAL OF**
**AMENDMENT TO AGREEMENT WITH ACCESSNURSE**

**RESOLUTION 2023 -**

**RECITAL: WHEREAS,**

A. HPSM is required by the Department of Managed Health Care, the Centers for Medicare and Medicaid Services, and the Department of Health Care Services to provide or arrange for the provision of telephone triage services for its 173,000 members, 24 hours/7 days per week/365 days a year;
B. The San Mateo Health Commission has previously approved an agreement with AccessNurse f/k/a TeamHealth Medical Call Center that is set to expire September 30, 2023;
C. A request for proposal was performed in 2017 for these services that resulted in the selection of AccessNurse; and
D. In order to continue services, add $281,250 to the contract maximum.

**NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:**

1. The San Mateo Health Commission approves the addition of $281,250 to the contract maximum for a total contract maximum of $1,415,076; and
2. Authorizes the Chief Executive Officer to execute said amendment.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of April, 2023 by the following votes:

AYES:
NOES:
ABSTAINED:
ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

**DRAFT**

**SAN MATEO HEALTH COMMISSION**
**Meeting Minutes**
**February 8, 2023 – 12:30 p.m.**

**AGENDA ITEM: 4.10**

**DATE: April 12, 2023**

****BY VIDEOCONFERENCE ONLY****

Important notice regarding COVID-19: Based on guidance from the California Department of Public Health and the California Governor's Office, in order to minimize the spread of the COVID-19 virus, Health Plan of San Mateo offices were closed for this meeting, and the meeting was conducted via online meeting/teleconference. Members of the public were invited to submit public comment via email to the Clerk in advance of the meeting or express public comment throughout the meeting and were able to access the meeting using the web and teleconference information provided on the meeting notice.

| | | |
|---|---|---|
| Commissioners Present: | Jeanette Aviles | Raymond Mueller |
| | Michael Callagy | George Pon, R. Ph., Chair |
| | Si France, M.D. | Manny Santamaria |
| | Bill Graham, Vice-Chair | Kenneth Tai, M.D. |
| | Barbara Miao | Ligia Andrade Zuniga |
| Commissioners Absent: | David J. Canepa. | |
| Counsel: | Kristina Paszek | |
| Guest: | Janet Williams | |
| Staff Present: | Brandy Armenta, Chris Baughman, Luarnie Bermudo, Corinne Burgess, Pat Curran, Trent Ehrgood, Chris Esguerra, M.D., Nicole Ford, Francine Lester, Rob Lindley, Leilani Llorente-San Gabriel, Sandy Medlin, Colleen Murphey, Courtney Sage, Amy Scribner, Carl Smith, Jr., Lia Vedovini, and Eben Yong. | |

1. **Call to order/roll call**
   The meeting was called to order at 12:34 p.m. by Commissioner Graham, Vice-Chair. A quorum was present.

2. **Public Comment**
   No public comments were received via email in advance of the meeting nor were any verbal public comments made at this time. The clerk of the commission instructed those with public comment on using the raise hand feature in Teams to indicate their desire to make public comment.

Mr. Curran recognized the recent shooting that took place in Half Moon Bay, the victims and their families with concern and condolences, as well as appreciation for our public officials in supporting the community around this sad incident.

**3. Approval of Agenda**

Motion to approve the agenda as presented: **Callagy / Second: Miao**

**Verbal roll call vote was taken:**

Yes: 10 – Aviles, Callagy, France, Graham, Miao, Mueller, Pon, Santamaria, Tai, Zuniga.
No: 0

**4. Approval of Consent Agenda**

Motion to approve the Consent Agenda as presented: **Callagy / Second: Miao**

**Verbal roll call vote was taken:**

Yes: 10 – Aviles, Callagy, France, Graham, Miao, Mueller, Pon, Santamaria, Tai, Zuniga.
No: 0

**5. Specific Discussion/Action Items**

**5.1 Updated HPSM Values and IDEA Presentation**

Mr. Curran introduced Janet Williams and Sandy Medlin, who presented an update on the work being done on the HPSM Value Statement and IDEA (Inclusion, Diversity, Equity and Accessibility) Group. A copy of the presentation is attached to these minutes.

Janet Williams talked about the journey for HPSM, which started around the end of 2021 with the CLAS Committee efforts to determine cultural priorities and held learning sessions for staff. This led to an assessment process with focus groups, digital surveys, reflection sessions and giving opportunities for staff to provide input. This process led to the next steps of the Inclusion and Diversity Committee (IDC), which has brought us where we are now with the IDEA Group. She gave a broad overview of the IDEA Group, which has three components: A core IDEA group, as well as two task forces, each with external orientation related to members. She explained the focus of each group, which includes internal HPSM practices, one task force on Reproductive Health and one on LGBTQIA+. The Reproductive Health task force is reviewing services related to materials around HIV/AIDS, contraception, STD/STIs, abortion, and safe sex practices. The LGBTQIA+ task force is working on reviewing and updating member materials and services for LGBTQIA+ members and inclusive language for all our member materials. The IDEA Group has 21 members, and the task forces have 8-10 members that do cross-intersect in membership yet operate as three separate entities.

Sandy Medlin, Claims Call Center Manager, and IDEA Group lead, described the operating guidelines, vision and mission of the group. She explained how the group starts each of its

meetings by reflecting on the vision, mission, and operating guidelines of the IDEA Group. Next, Ms. Medlin reviewed the work the IDEA group did in updating the health plan's Value Statements using "HEALTHY" as an acronym (as outlined in attached presentation).

Ms. Williams described other activities with the IDEA Group. She spoke about an initial internal survey done over two years ago and another that will be conducted soon, with the IDEA Group reviewing the differences between the two. They expect to identify key themes and make recommendations to leadership. She described an ongoing conversation around what is meant when we talk about diversity, equity, including or belonging and how is this operationalized at HPSM. This group will work to define these terms in a way that everyone may be able to embrace them. Lastly, the IDEA Group will recommend modifications as needed to foundational documents of the organization, such as HR policies. Ms. Williams expressed her appreciation for the amazing, committed group involved in this work.

Commissioner Pon thanked all for the great presentation. Commissioner France commended Ms. Williams and the work that is being done in this effort and inspiring work.

Mr. Curran added that the refresh of the organizational values is of great importance and very aspirational. These values will be used during recruitment and onboarding of staff and will guide all our interactions internally and externally. The group did a great job framing these values; now our goal will be to live up to them.

## 5.2 Approval of Updated HPSM Operating Budget for 2023

Mr. Ehrgood, Chief Financial Officer, reviewed his presentation, which is attached to these minutes. Mr. Ehrgood explained that the changes in the 2023 budget were due to updated rates received shortly after the initial budget was presented to the commission. He noted that the organization now has one billion dollars of revenue. Notable items in the revised budget include:

- Minor changes in membership
- DHCS's 10% bump for long term care during pandemic will continue post-pandemic. This added $13 million in revenue and will also be an increase in expenses.
- The Enhanced Care Management (ECM) funding will be reduced by about $6 million based on lower participation, which is reflected in the reduced expense projections.
- Other increases are due to slightly higher membership numbers.
- Kaiser was expected to take on Whole Child Model in 2023 but this is not going to happen, so the provider capitation was reduced and shifted back to how it is currently budgeted.
- A new line item of Directed Payments was included in the revised budget, which reflects an accounting methodology change. This represents pass-through dollars.

This will be recognized as gross revenue rather than net revenue to be more in alignment with the way that DHCS does their reporting.

- The main net increase for the 2023 budget is higher funding for the Medi-Cal line of business.
- Review of membership from year to year indicates a proposed slight increase of .7% in Medi-Cal members per month and other lines are proposed to remain flat.
- Review of the budget summary by line of business and the difference between the original budget and the revised budget indicates minor changes only.
- The original estimate for 2022 was about an $80 million surplus. The staff is in the process of finalizing the year-end closing and when this is done it might be slightly higher.

Commissioner Miao asked what the optimal percentage for the medical loss ratio (MLR) is. Mr. Ehrgood replied that would be in the 90-92% range with 8% in administrative costs and maybe a 2% margin. He added that there will be new MLR reporting starting 2024 where if the MLR is lower than 85% the health plan will have to give back a portion of the premiums.

Commissioner Miao asked why the membership for Medi-Cal has remained flat. Mr. Ehrgood stated that it is not that they remain flat but that there have not been any redeterminations causing people to lose their Medi-Cal. As redeterminations start up again, we will likely see a drop if people no longer qualify for Medi-Cal and lose their coverage. We expect to see that decline beginning mid-year of 2023 and into mid-year 2024.

Commissioner Tai asked if the MLR is by different payer mix. Mr. Ehrgood confirmed this is only on the Medi-Cal line of business.

Motion to approve the Updated HPSM Operating Budget for 2023 as presented:
**Tai / Second: Miao**

**Verbal roll call vote was taken:**
Yes: 10 – Aviles, Callagy, France, Graham, Miao, Mueller, Pon, Santamaria, Tai, Zuniga.
No: 0

## 5.3 Approval of Dental Capacity Funding

Mr. Curran reviewed the background of Dental Capacity as an area of our strategic investment for 2023. He talked about the previous funding that the commission approved to NEMS for the hiring of an oral surgeon to increase access, and the other many

approaches to increase access, capacity and broaden participation in the dental program. Work with the San Mateo Dental Society advancing an orthodontic pilot are in place, as well as work with both dental schools.

The upcoming Navigation Center is part of a larger initiative which will include a dental clinic.

San Mateo County is engaging the University of the Pacific (UOP) to staff two dental operatory rooms, and we will pay them to see our members using the normal claims process. This dental capacity funding of $125,000 would be used for implementation costs to set up the dental clinic, with the hope that it will be self-sustaining.

Commissioner Callagy expressed his appreciation for this opportunity to partner with the health plan on this clinic, which he believes is the first if not only one of its kind in Northern California. This on-site clinic in the navigation center will provide both medical and dental services, and is made possible by a donation of $1 million from a philanthropic organization or individual who is very excited about this venture. The County believes this partnership will result in serving the unhoused, . He described the Navigation Center's capacity, which consists of 240 individual rooms that could house possible up to 270 people (including couples) and will create a model that we hope will be emulated around the state.

Commissioner Mueller concurred with Commissioner Callagy's statement and stated that this partnership reinforces the amazing work being done and his gratitude for the opportunity. Mr. Curran concluded that we are making a huge qualitative impact in interacting with members and getting them access with so many access points with this multi-pronged strategy. We are making progress in improving dental access for our members, but we have a long way to go.

Motion to approve the Dental Capacity Funding as presented: Pon / Second: Zuniga

**Verbal roll call vote was taken:**

Yes: 10 – Aviles, Callagy, France, Graham, Miao, Mueller, Pon, Santamaria, Tai, Zuniga.
No: 0

### 5.4 Presentation on School Behavioral Health Incentive Program

Mr. Curran introduced Courtney Sage of HPSM and Mary McGrath of the San Mateo County Office of Education to present on the School Behavioral Health Incentive Program (SBHIP) and the partnership that is part of the CalAIM Initiative.

Ms. Sage explained that SBHIP is a three-year incentive program involving three school districts in San Mateo County and BHRS. It will be spread out through four project plans.

DHCS will provide up to $4.4 million, which is based on the project attaining certain milestones.

The goal of the projects is to increase the number of students with Medi-Cal who receive mental health services and to strengthen relationships between local education agencies (school districts, Office of Education) and the mental health plans (BHRS and MCPs such as HPSM). The hope is to address health equity gaps.

Ms. McGrath explained how 24 school districts met with HPSM staff and explained the goals of SBHIP and this infrastructure incentive program. Redwood City School District, South San Francisco School District, and the San Mateo County Office of Education, which has its own Court and Community Program, were selected for this project. She stated how this project will give us a wide sampling of how these projects can take place for students K-12 who have significant mental health and behavioral concerns, as well as those who are incarcerated.

Ms. Sage continued the presentation noting the DHCS, DMHC and CDPHP's interest in supporting youth mental health as part of the CalAIM as a vision for the Children and Youth Behavioral Health Initiative. There is concern about having the workforce to handle the needs as we ramp up the benefits for this investment of $4.4 billion to enhance, expand and redesign this system. HPSM in coming years will be required to pay for mental health services affiliated with schools.

Ms. Sage stated that they began monthly meetings in 2022 and performed a needs assessment that was submitted to the state, creating four project plans that are currently under review by the state. In 2023, the plan is to continue these monthly meetings, as well as prepare progress reports leading up to the point when payment for services will begin and go through to the end of 2024.

Ms. McGrath described the projects:

- The two school districts will work on Wellness Centers:
    - Redwood City will create a district Wellness Center, making it a one-stop shop for transportation, health care, mental health care, and enrollment for Medi-Cal. They will occupy a school that is not currently being used and turn half of the school into a district Wellness Center.
    - South San Francisco will have Wellness Centers in each of their high schools staffed with Wellness Counselors, therapists, and access to other services. There will be substance use prevention and treatment specialists on campus to work with students and families.

- Another SBHIP project is working with the kids coming out of various venues of incarceration and back to their home schools. They will follow up with students for up to six months to make sure their services and other supports continue.
- The project is also intended to build the infrastructure for communications between the health plan and the schools to expedite referrals.

Ms. Sage reflected on the work that is yet to be done in the future for this benefit, the partnership, shared work to support our children in the community, of which many are HPSM members. The goal is to link students to services in our network.

Commissioner Santamaria asked how to access more information on the Wellness Centers and how they are being funded. Ms. Sage stated that the proposals are currently being reviewed by the state. Ms. McGrath added that the San Mateo Office of Education is co-funding and would share more information about funding with him.

Commissioner Zuniga mentioned that the substance abuse issue is a problem and is hindering mental health services. When kids are placed in treatment centers, there is no transition plan for them when going home or going back into the community. They end up back in detention centers or even on the streets. She asked if there is a plan to address these issues. Ms. McGrath replied that this is the bigger issue and they have begun discussions around this issue.

**6. Report from Chairman/Executive Committee**

There were no comments or reports from the Executive Committee at this time.

**Report from Chief Executive Officer**

Mr. Curran reported that the commission will not hold a meeting in March and our next meeting in April will be in person. He noted that topics of discussion will include our Strategic Investments and planning process.

**Other Business**

No other business was discussed at this time.

**7. Adjournment:** The meeting was adjourned at 1:35 p.m.

Respectfully submitted:

*C. Burgess*

C. Burgess, Clerk of the Commission

Inclusion
Diversity
Equity
Accessibility
GROUP

# HPSM DEI Journey

**CLAS Committee**
- Priorities
- Learning Sessions
- Analysis
- PNA
- Resources

**PD Assessments**
- Interviews
- Focus Groups
- Digital Survey
- Data Reflection Sessions

**Action Pathways**
- Organize: Steering Committee
- **IDC**
- **Task Forces**



HealthPlan OF SAN MATEO
Healthy is for everyone

Inclusion
Diversity
Equity
Accessibility
GROUP

# Three Groups; One Mission

## Task Force

IDEA

Internal

External

Reproductive Health

Updated HIV/AIDS, Contraception, STD/STIs, abortion, safe sex practices

LGBTQIA+

Updated member materials & services for trans, queer members; inclusive language

**Inclusion**
**Diversity**
**Equity**
**Accessibility**
**GROUP**

**VISION:** A culture where everyone feels respected, safe, and a sense of belonging to bring their most authentic selves to work.

**MISSION:** To ensure an inclusive and equitable organizational culture by enhancing shared language and interactions with each other and our broader community.

## OPERATING GUIDELINES:

| | | | | | |
|---|---|---|---|---|---|
| Respect, support and trust one another | Maintain awareness of diverse experiences and processing through active and reflective listening | Correct with compassion; be open and receptive to feedback | Remember people's good intentions and address problems with trust and respect | **INTENT** is the action we aim to achieve; **IMPACT** is how our actions are received | What's said here stays here; what's learned here leaves here |

**Inclusion**
**Diversity**
**Equity**
**Accessibility**
**GROUP**

HealthPlan OF SAN MATEO
Healthy is for everyone

# Our **HEALTHY** Values

**Inclusion**
**Diversity**
**Equity**
**Accessibility**
**GROUP**

# Our VALUES

*HPSM has been keeping San Mateo County **HEALTHY** for over 35 years:*

**H**ealth Care that puts members at the center of everything we do.

**E**quitable access to quality services and supports for all members.

**A**dvocacy for members disproportionately impacted by health inequities.

**L**ocal health care based in San Mateo County provided in partnership with community resources.

**T**ransparency and accountability achieved through local governance.

**H**onesty is the core of our service to members, providers, business partners and the community.

**Y**ou - because HEALTHY is for everyone!

HealthPlan OF SAN MATEO
Healthy is for everyone

**Inclusion**
**Diversity**
**Equity**
**Accessibility**
**GROUP**

# So, What's Next?

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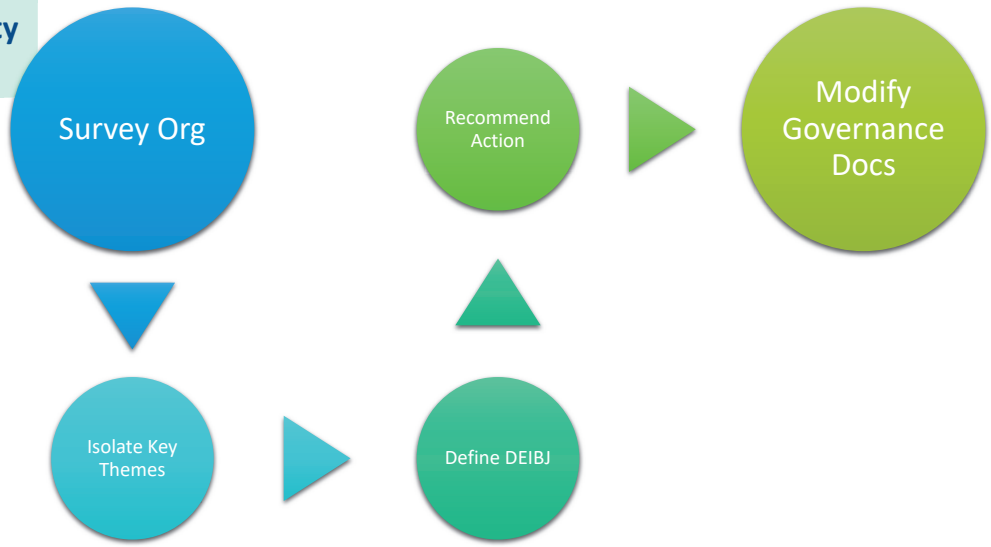



PROGRESSIVE DISCOVERIES

Agenda Item:
Date: February 8, 2023

# 2023 Revised Operating Budget

HPSM Commission

February 8, 2023

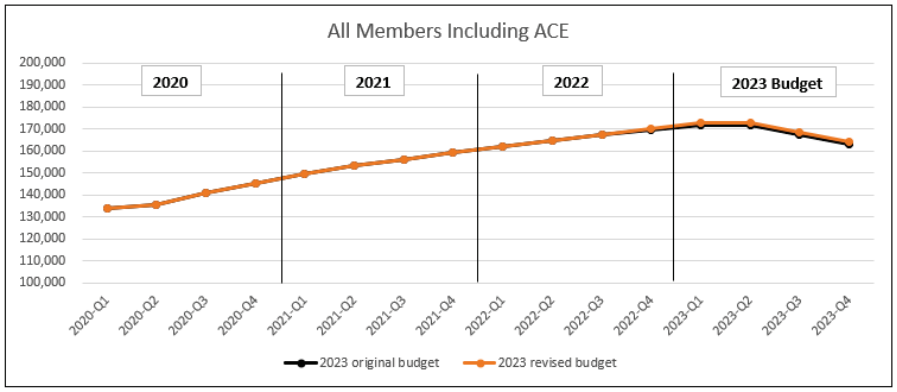
HealthPlan OF SAN MATEO
Healthy is for everyone

## Proposed 2023 Budget

HealthPlan OF SAN MATEO
Healthy is for everyone

| | Original | Revised | Change |
|---|---|---|---|
| **OPERATING REVENUES:** | | | |
| **Capitation & Premium Revenue** | **$ 970,028,246** | **$ 1,044,700,640** | **$ 74,672,394** |
| **HEALTH CARE EXPENSE:** | | | |
| Professional & OP Svs FFS | $ 312,668,764 | $ 315,757,938 | $ 3,089,174 |
| Inpatient Services | $ 200,537,367 | 202,784,628 | $ 2,247,260 |
| SNF & Long Term Care | $ 153,177,668 | 166,696,489 | $ 13,518,821 |
| Provider Capitation (Incl. Kaiser) | $ 74,609,645 | 71,900,483 | $ (2,709,162) |
| Pharmacy | $ 62,332,503 | 62,332,503 | $ - |
| MLTSS (CBAS, ECM, CS) | $ 23,556,389 | 16,859,012 | $ (6,697,377) |
| Directed Payments (VRR) | | 33,403,779 | $ 33,403,779 |
| UM / QA Costs | $ 22,020,606 | 22,020,606 | $ - |
| Dental | $ 20,837,251 | 20,984,583 | $ 147,332 |
| Provicer Incentive Pool | $ 10,814,970 | 10,830,250 | $ 15,280 |
| Reinsurance/Other | $ 643,207 | 649,523 | $ 6,317 |
| **Total Health Care Expenses** | **$ 881,198,370** | **$ 924,219,795** | **$ 43,021,424** |
| **ADMINISTRATIVE EXPENSES** | $ 61,233,114 | **$ 61,233,114** | $ - |
| **Net Gain from Operations** | **$ 27,596,761** | **$ 59,247,731** | **$ 31,650,970** |
| **NON-OPERATING REVENUES:** | | | |
| **Interest** | $ 9,000,000 | $ 9,000,000 | $ - |
| **Rental Income** | $ 1,187,337 | $ 1,187,337 | $ - |
| **ACE TPA Fees** | $ 2,341,512 | $ 2,341,512 | $ - |
| **Total Non-Operating Revenue** | **$ 12,528,849** | **$ 12,528,849** | **$ -** |
| **PROJECTED SURPLUS** | **$ 40,125,610** | **$ 71,776,580** | **$ 31,650,970** |

# Membership Trends 2020-2023




| 2023 Avg Membership | Original | Revised | Change | % Change |
|---|---|---|---|---|
| Medi-Cal | 134,241 | 135,364 | 1,123 | 0.8% |
| Medicare | 9,148 | 9,148 | - | 0.0% |
| Other (HW, ACE) | 25,111 | 25,111 | - | 0.0% |
| | 168,501 | 169,623 | 1,123 | 0.7% |

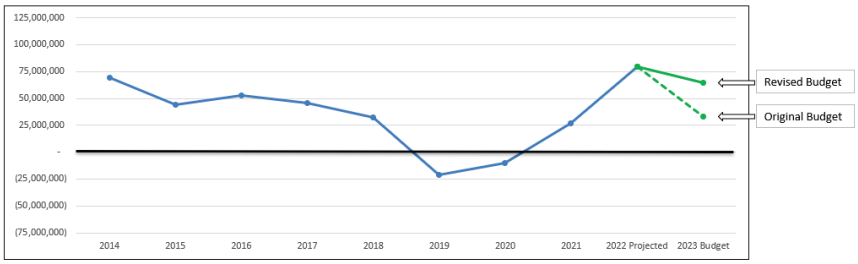
# 2023 Budget Summary by LOB (revised)

| | Medi-Cal (non-duals) | Medi-Cal (duals) | MCE | WCM | D-SNP | HealthWorx | ACE | HPSM * | Total |
|---|---|---|---|---|---|---|---|---|---|
| Operating Revenue | $328,179 K | $97,403 K | $259,774 K | $34,339 K | $318,121 K | $6,884 K | | | $1,044,701 K |
| Health Care Expense | $269,618 K | $100,221 K | $209,214 K | $28,754 K | $308,610 K | $7,804 K | | | $924,220 K |
| Admin | $16,693 K | $3,203 K | $13,628 K | $1,894 K | $22,830 K | $690 K | $2,295 K | | $61,233 K |
| Other Income | | | | | | | $2,342 K | $10,187 K | $12,529 K |
| **Net Profit/(Loss)** | $41,868 K | ($6,020 K) | $36,932 K | $3,691 K | ($13,319 K) | ($1,610 K) | $47 K | $10,187 K | $71,777 K |
| Change from Original | $7,161 K | $3,160 K | $14,816 K | $391 K | $6,009 K | $114 K | $0 K | $0 K | $31,651 K |
| MLR | 82% | 103% | 81% | 84% | 97% | 113% | | | 88% |
| Average Membership | 75,278 | 9,447 | 49,233 | 1,405 | 9,148 | 1,199 | 23,912 | | 169,623 |
| Revenue PMPM | $ 363.30 | $ 859.17 | $ 439.70 | $ 2,036.71 | $ 2,897.81 | $ 478.35 | $ 8.16 | | |

* *Interest Income & Rent Income*

# Historical Net Income/(Loss)

## Nine-year trend – **Restated** w/ 2023 budget




| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 Projected | 2023 Budget* |
|---|---|---|---|---|---|---|---|---|---|---|
| Revenue: | | | | | | | | | | |
| Capitation | $753,161 K | $852,378 K | $877,035 K | $864,840 K | $812,636 K | $766,740 K | $796,627 K | $908,345 K | $934,920 K | $1,044,701 K |
| +/- CMC w/h revenue | | | | | | | | $7,000 K | $7,000 K | ($7,000 K) |
| Revenue | $753,161 K | $852,378 K | $877,035 K | $864,840 K | $812,636 K | $766,740 K | $796,627 K | $915,345 K | $941,920 K | $1,037,701 K |
| Healthcare Cost | $627,748 K | $739,952 K | $743,533 K | $722,195 K | $682,804 K | $718,711 K | $734,006 K | $807,164 K | $779,534 K | $924,220 K |
| Administrative Exp. | $33,072 K | $36,365 K | $44,589 K | $46,764 K | $48,399 K | $50,566 K | $48,544 K | $51,475 K | $53,027 K | $61,233 K |
| Premium Tax | $26,648 K | $35,332 K | $39,770 K | $57,351 K | $60,747 K | $31,242 K | $31,144 K | $34,808 K | $37,862 K | $0 K |
| Operating Income/(Loss) | $65,694 K | $40,729 K | $49,143 K | $38,529 K | $20,686 K | ($33,779 K) | ($17,068 K) | $21,898 K | $71,498 K | $52,248 K |
| Non-Operating Revenue | $3,376 K | $3,263 K | $3,801 K | $7,390 K | $11,288 K | $12,688 K | $6,903 K | $4,580 K | $8,174 K | $12,529 K |
| **Net Income/(Loss)** | $69,070 K | $43,992 K | $52,943 K | $45,919 K | $31,973 K | ($21,091 K) | ($10,165 K) | $26,477 K | $79,672 K | $64,777 K |

** 2023 restated = $71.8M 2023 budget less $7.0M 2022 CMC w/h revenue budgeted in 2023 = $64.8M restated.*

# Thank you

# School Behavioral Health and Student Behavioral Health Incentive Program (SBHIP)

## January 2023

HPSM: Courtney Sage, HPSM, Director of Behavioral health
SMCOE Mary McGrath, , Executive Director of Safe and Supportive schools

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## What is SBHIP?

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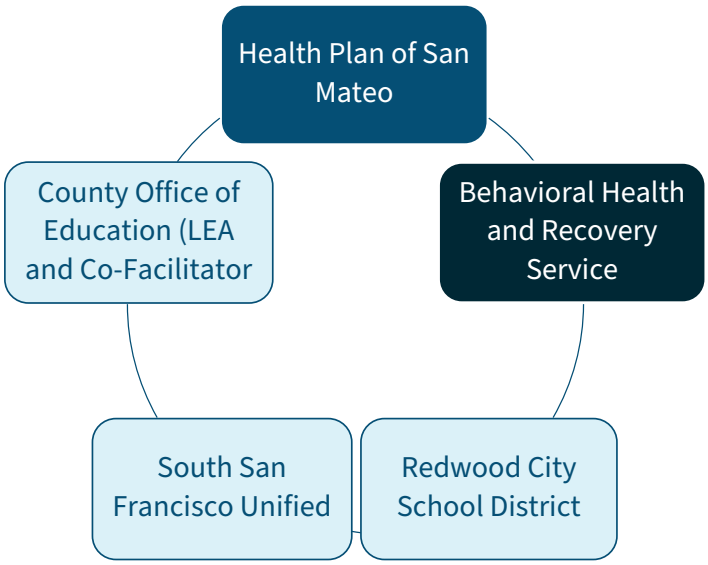
- 3 year incentive program where HPSM, 3 School districts, and BHRS will implement up to 4 project plans
  - Access to up to $4.4 million from DHCS based on project plan milestones
    - Increase number of TK-12 students with Medi-cal receiving services
    - Strengthen relationships between LEA's, COE's, and MHP's and MCP's
    - Address health equity gap, inequalities and disparities in access

# SBHIP PARTNERS






# Why Is DHCS Funding SBHIP Now?

- Children and Youth Behavioral (CYBHI): "announced in July 2021 with a $4.4B investment to enhance, expand and redesign the systems that support behavioral health for children and youth."
  - SBHIP: Incentive program with Managed Care Plans, School Districts and Mental Health Plans to prepare infrastructure for new benefit
  - School Based MH Benefit: Starting 1/1/ 2024 DHCS and DMHC will regulate that MCP's and commercial plans will be required to cover school linked mental health services.

## SBHIP Timeline

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| 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|
| • Monthly partnership meetings<br>• Needs Assessment<br>• Project plan (up to 4 plans across all partners) | • Implement and evaluate project plans<br>• Quarterly Partnership meetings<br>• Bi-quarterly project plan submissions | • Implement and evaluate project plans<br>• Bi-quarterly submissions (1 in 2024)<br>• Project outcome milestone | • **SBHIP ends**<br>• Established relationship and process to serve students with mental health needs |

January 2024 MCP's responsible for school-based services, DHCS guidance and definitions pending



## Project plans selected

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**Wellness Centers**

**IT infrastructure:**

- Referrals
- Claims
- Data

**Substance use Prevention and Treatment**

**Workforce Enhancement**

- Peer Support (SSFUSD)
- Promotores (RCSD)
- Enhancement of school transition support (SMCOE)

## Project Plan Participants and Funds

| Project Plans | Maximum SBHIP funds | SSFUSD | RCSD | SMCOE |
|---|---|---|---|---|
| BH Wellness Centers | $1,762,478 | ✓ | ✓ | |
| Substance Use disorder | $881,239.40 | ✓ | | ✓ |
| Expand Workforce | $881,239.40 | ✓ | ✓ | ✓ |
| IT Systems | $881,239.40 | ✓ | ✓ | ✓ |



## 2024 Benefit Readiness and beyond

- Support schools to link students to available services and bill HPSM
  - Utilize school mental health staff or partner with local agencies
  - Link students to HPSM network
- Build on partnership and project plan learning
  - Expand to non-SBHIP districts
  - Enhance referral process
  - Improve data sharing and care coordination
- HPSM Benefit extends to higher education students

Thank you!

Questions?

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# CYBHI

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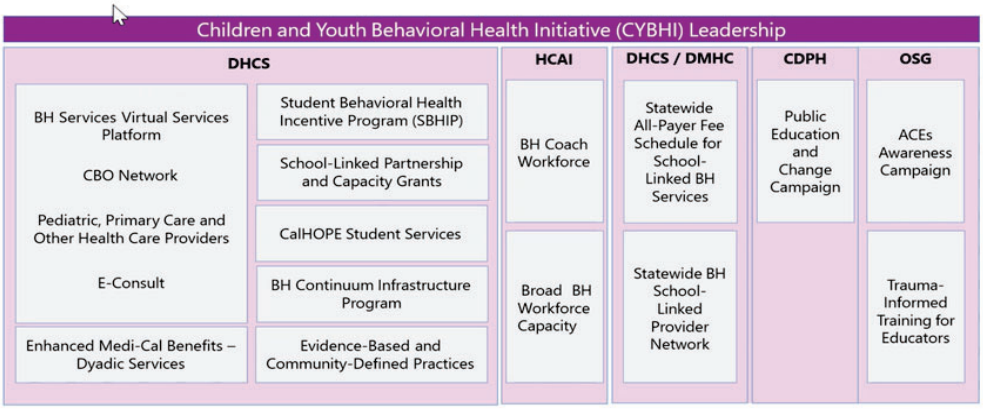
**Overview of CYBHI Workstreams**

DRAFT as of April 1, 2022




Source: California Health and Human Services Agency, DHCS, DMHC, HCAI, CDPH, OSG

**AGENDA ITEM: 5.1**

**DATE: April 12, 2023**

**MEMORANDUM**

**DATE:** April 3, 2023

**TO:** San Mateo Health Commission

**FROM:** Patrick Curran, Chief Executive Officer
Trent Ehrgood, Chief Financial Officer

**RE:** Approval of Audited Financial Statements for Period Ending December 31, 2022

---

## Recommendation

Approve HPSM's 2022 final audited financial statements.

## Background information

HPSM's auditors, Moss Adams, completed their annual audit of HPSM's 2022 financial statements in March 2023. Moss Adams presented reports to the Finance/Executive Committee on March 27th, including details of their audit process, and results of their findings. Two separate reports, described below, are included in this packet for Commission review.

## Communication to Commissioners

The first report is the required communication to the Commission and includes a description of the audit scope and any findings resulting from the audit.

## Report of Independent Auditors and Financial Statements with Supplementary Information

The second report is the full set of audited financial statements with footnotes. The auditors issued an unmodified opinion (which is good). There were no audit adjustments, but management included some proposed adjustments to refine estimates based on more recent information. The final audited financial result is a surplus of $115.1M for the year, which is better than the budget surplus of $6.2M.

**DRAFT**

**RESOLUTION OF THE**
**SAN MATEO HEALTH COMMISSION**

**IN THE MATTER OF ACCEPTANCE OF THE AUDIT REPORT FOR FISCAL YEAR ENDING DECEMBER 31, 2022**

**RESOLUTION 2023 -**

**RECITAL: WHEREAS,**

A. Moss-Adams, LLP, a firm of accountants has conducted an audit of the San Mateo Health Commission financial statements for the fiscal year ending December 31, 2022; and

B. The San Mateo Health Commission has reviewed the resulting report submitted by Moss-Adams, LLP.

**NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:**

1. The San Mateo Health Commission formally accepts the audit report for the fiscal year ended December 31, 2022 as presented by Moss-Adams, LLP.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of April 2023 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chair

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
CHIEF DEPUTY COUNTY COUNSEL

Communications to the Commissioners

**San Mateo Health Commission**
**(d.b.a. Health Plan of San Mateo)**

December 31, 2022

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# Communications to the Commissioners



To the Commissioners
San Mateo Health Commission
(d.b.a. Health Plan of San Mateo)

We have audited the financial statements of the business-type activities and the aggregate remaining fund information of San Mateo Health Commission d.b.a. Health Plan of San Mateo (a stand-alone government entity appointed by the San Mateo County Board of Supervisors) as of and for the year ended December 31, 2022 and have issued our report thereon dated _____, 2023. Professional standards require that we provide you with the following information related to our audit.

## Our Responsibility Under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated December 13, 2019, and amendment dated December 2, 2021, we are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS). As part of an audit conducted in accordance with U.S. GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit.

An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of San Mateo Health Commission d.b.a. Health Plan of San Mateo's internal control over financial reporting. Accordingly, we considered San Mateo Health Commission d.b.a. Health Plan of San Mateo's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

The supplementary information was subject to certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves.

## Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you on December 14, 2022.

## Significant Audit Findings and issues

### *Qualitative Aspects of Accounting Practices*

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by San Mateo Health Commission d.b.a. Health Plan of San Mateo are described in Note 1 to the financial statements. During fiscal year 2022, San Mateo Health Commission d.b.a. Health Plan of San Mateo adopted GASB 87, *Leases*, under the restrospective approach, and GASB 97, *Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans – an amendment of GASB Statements No. 14 and No. 84, and a supersession of GASB Statement No. 32* for the fiscal year 2022. We noted no transactions entered into by San Mateo Health Commission d.b.a. Health Plan of San Mateo during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transaction occurred.



### *Significant Accounting Estimates*

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the financial statements were:

- Management's estimate of the liability for incurred but unreported claims expense is based on historical claims experience and known activity subsequent to year end. We evaluated the key factors and assumptions used to develop the incurred but unreported claims expense in determining that they are reasonable in relation to the financial statements taken as a whole.
- Management's estimate of the capitation receivable and revenue for eligible program beneficiaries is based upon a historical experience methodology using contracted rates and member counts. We evaluated the key factors and assumptions used to develop the capitation receivable in determining that they are reasonable in relation to the financial statements taken as a whole.
- Management recorded an estimated amount due to the State of California. The estimated payable for eligible Medi-Cal program beneficiaries is based upon estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. We evaluated the key factors and assumptions used to develop the estimated net realizable amounts. We found management's basis to be reasonable in relation to the financial statements taken as a whole.
- Management's estimate of the fair market values of investments in the absence of readily-determinable fair values is based on information provided by the fund managers. We have gained an understanding of management's estimate methodology and examined the documentation supporting this methodology. We found management's process to be reasonable.

- Management's estimate of the net pension asset is actuarially determined using assumptions on the long-term rate of return on pension plan assets, the discount rate used to determine the present value of benefit obligations, and the rate of compensation increases. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the financial statements taken as a whole.
- Management's estimates of the discount rate, useful lives, lease terms related to the lease assets and deferred inflow of resources. We have gained an understanding of management's key factors and assumptions and examined the documentation supporting the estimates. We found management's basis to be reasonable in relation to the financial statements taken as a whole.



***Financial Statement Disclosures***

The disclosures in the financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the financial statements were medical claims payable and capitation revenue.

***Significant Unusual Transactions***

We encountered no significant unusual transactions during our audit of San Mateo Health Commission d.b.a. Health Plan of San Mateo's financial statements.

***Significant Difficulties Encountered in Performing the Audit***

Professional standards require us to inform you of any significant difficulties encountered in performing the audit. No significant difficulties were encountered during our audit of the entity's financial statements.

***Disagreements with Management***

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. No such disagreements arose during the course of our audit.

***Circumstances that Affect the Form and Content of the Auditor's Report***

There may be circumstances in which we would consider it necessary to include additional information in the auditor's report in accordance with U.S. GAAS. There were no circumstances that affected the form and content of the auditor's report.

***Corrected and Uncorrected Misstatements***

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. There were no corrected and uncorrected misstatements, whose effects, as determined by management were material, both individually or in the aggregate, to the financial statements taken as a whole

***Management Representations***

We have requested certain representations from management that are included in the management representation letter dated _____, 2023.

***Management Consultation with Other Independent Accountants***

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to San Mateo Health Commission d.b.a. Health Plan of San Mateo's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

***Other Significant Audit Findings or Issues***

We are required to communicate to you other findings or issues arising from the audit that are, in our professional judgment, significant and relevant to your oversight of the financial reporting process. There were no such items identified.

This information is intended solely for the use of the Commissioners and management of San Mateo Health Commission d.b.a. Health Plan of San Mateo, and is not intended to be, and should not be, used by anyone other than these specified parties.

San Francisco, California
_____, 2023

Report of Independent Auditors and
Financial Statements with Supplementary Information

# San Mateo Health Commission
# (d.b.a. Health Plan of San Mateo)

December 31, 2022 and 2021

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# Table of Contents

# Management's Discussion and Analysis

# San Mateo Health Commission
# (d.b.a. Health Plan of San Mateo)
## Management's Discussion and Analysis
## December 31, 2022, 2021, and 2020



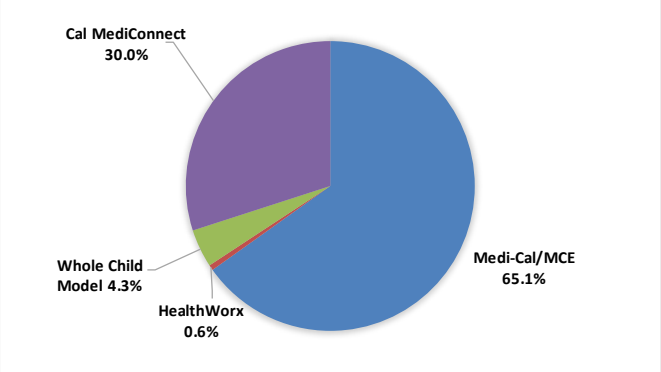
Our discussion and analysis of the San Mateo Health Commission, (d.b.a. Health Plan of San Mateo) ("HPSM" or the "Commission"), provides an overview of the Commission's financial activities for the years ended December 31, 2022, 2021, and 2020. Please read it in conjunction with the Commission's audited financial statements and accompanying notes, which begin on page 16.

**FINANCIAL HIGHLIGHTS – PROPRIETARY FUND**

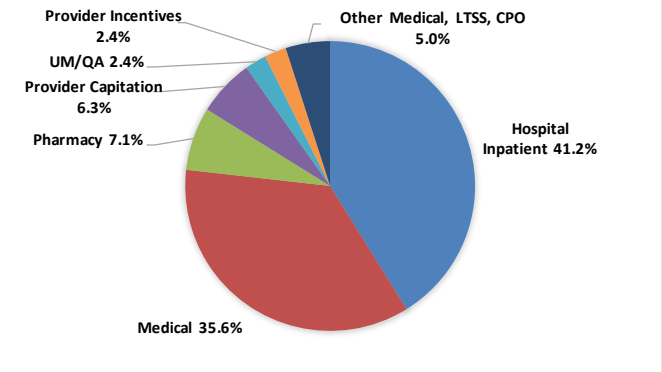
***Overview of Financial Results***

- Net surplus of $115,124,416 in 2022, net surplus of $27,108,819 in 2021 and net deficit of $14,749,370 in 2020.
- Net operating revenues increased by $37,505,229 (4.03%) in 2022, increased by $123,505,694 (15.29%) in 2021, and increased by $26,791,049 (3.43%) in 2020.
- Healthcare expenses decreased by $50,260,047 (6.11%) in 2022, increased by $72,731,595 (9.70%) in 2021, and increased by $46,272,980 (6.58%) in 2020.

2022 Percentage of Revenue by LOB




2022 Healthcare Dollar Spent




- Member months increased by 9.96% in 2022, increased by 11.02% in 2021, and increased by 2.37% in 2020.
- In 2022, membership for Medi-Cal increased by 10.88%, HealthWorx by 0.54%, Whole Child Model by 3.48%, and Cal MediConnect by 6.20%. Increases are due to a continuation of the Governor's executive order to suspend disenrollment during the public health emergency.
- In 2021, membership for Medi-Cal increased by 11.96%, HealthWorx by 5.01%, Whole Child Model by 4.43%, and Cal MediConnect by 1.49%. Increases are due to the Governor's executive order to suspend disenrollment during the pandemic.
- In 2020, membership for Medi-Cal increased by 4.46% while the remaining lines showed declining membership: Whole Child Model by 23.05% due to realignment into the Medi-Cal program, Cal MediConnect by 2.22%, and HealthWorx by 1.52%.

## USING THIS ANNUAL REPORT

This annual report consists of a series of financial statements. The statements of net position, the statements of revenues, expenses, and changes in net position, and the statements of cash flows provide information about the activities of the Commission as a whole. Additionally, certain required supplemental information contains information regarding the Commission's budget and how actual operating results compare to the budget adopted by the Commission.



## THE STATEMENTS OF NET POSITION AND THE STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

### *HPSM'S NET POSITION*

HPSM's net position is the difference between its assets and liabilities as reported in the statements of net position on page 16. HPSM's net position increased by $115,124,416 in 2022, increased by $27,108,819 in 2021, and decreased by $14,749,370 in 2020.

| | 2022 | 2021 (As restated) | 2020 |
|---|---|---|---|
| CURRENT ASSETS | $ 812,288,000 | $ 691,859,336 | $ 579,567,247 |
| CAPITAL ASSETS, NET | 60,977,607 | 62,881,892 | 64,961,169 |
| NET PENSION ASSET | - | 2,373,317 | 1,463,514 |
| LEASE RECEIVABLE - NONCURRENT | 2,858,362 | 4,019,229 | - |
| ASSETS RESTRICTED AS TO USE | 300,000 | 300,000 | 300,000 |
| DEFERRED OUTFLOWS OF RESOURCES | 7,337,774 | 2,351,463 | 3,279,910 |
| Total assets and deferred outflows of resources | $ 883,761,743 | $ 763,785,237 | $ 649,571,840 |
| CURRENT LIABILITIES | | | |
| Medical claims payable | $ 100,748,474 | $ 101,141,724 | $ 124,710,273 |
| Providers incentives payable | 12,737,495 | 9,095,674 | 4,870,000 |
| Amounts due to the State of California | 174,363,272 | 153,300,138 | 116,444,159 |
| Accounts payable and accrued liabilities | 109,492,738 | 131,731,595 | 66,857,397 |
| Total liabilities | 397,341,979 | 395,269,131 | 312,881,829 |
| NET PENSION LIABILITY | 5,069,872 | - | - |
| DEFERRED INFLOWS OF RESOURCES | | | |
| Deferred inflows of resources - leases | 3,935,529 | 5,115,602 | - |
| Deferred inflows of resources - pension | 1,911,864 | 3,022,421 | 3,420,747 |
| Total deferred inflows of resources | 5,847,393 | 8,138,023 | 3,420,747 |
| Total liabilities and deferred inflows of resources | $ 408,259,244 | $ 403,407,154 | $ 316,302,576 |
| NET POSITION | | | |
| Invested in capital assets | $ 60,977,607 | $ 62,881,892 | $ 64,961,169 |
| Restricted by legislative authority | 300,000 | 300,000 | 300,000 |
| Unrestricted | 414,224,892 | 297,196,191 | 268,008,095 |
| Total net position | $ 475,502,499 | $ 360,378,083 | $ 333,269,264 |

***CURRENT ASSETS***

Current assets increased $120,428,664 (17.41%) from 2021 to 2022, which includes an increase of $153,560,342 (35.13%) in cash and investments, due to more timely payment of final rates from DHCS along with increased membership resulting in higher capitation received as compared to healthcare expenses paid. HPSM intentionally holds a greater cash position due to the uncertainty of rate increases/cuts and cash flow from the State of California (the State), a decrease of $37,935,062 (15.82%) in Medi-Cal and CareAdvantage capitation receivables due to more timely payment of capitation from DHCS including payment on retro rates especially for the , and an increase of $4,803,384 (31.91%) in other accounts receivable, prepaids and other assets, and lease receivable - current due in part to an increase in interest receivable as related to higher interest rates coupled with an increase in other healthcare receivables for expected pharmacy rebates

Current assets increased $112,292,089 (19.38%) from 2020 to 2021, which includes an increase of $55,984,646 (14.69%) in cash and investments, due to the prior year timing difference of State capitation payments. HPSM intentionally holds a greater cash position due to the uncertainty of rate increases/cuts and cash flow from the State of California; an increase of $57,874,894 (31.82%) in Medi-Cal and CareAdvantage capitation receivables due to timing differences of State capitation payments including the Private Hospital Directed Payments, and a decrease of $1,567,451 (9.43%) in other accounts receivable and prepaids and other assets due primarily to a decrease in reinsurance recoveries and recoveries from Kaiser.

Current assets increased $40,775,182 (7.57%) from 2019 to 2020, which includes a decrease of $40,754,019 (9.66%) in cash and investments, due to lower interest rates and a timing difference on State capitation payments; an increase of $81,000,503 (80.30%) in Medi-Cal and CareAdvantage capitation receivables due to timing differences of State capitation payments including the Hospital Quality Assurance Fee ("HQAF"), and an increase of $528,698 (3.29%) in other accounts receivable and prepaids and other assets due to an increase in prepaid hardware/software expenses.

***CAPITAL ASSETS, NET***

Capital assets decreased by $1,904,285 (3.03%) in 2022, by $2,079,277 (3.20%) in 2021 and by $$2,056,678 (3.72%) in 2020 due to depreciation and amortization expense combined with no substantial capital expenditures within the years.

***ADOPTION OF GASB NO. 87***

The Commission adopted Governmental Accounting Standards Board (GASB) Statement GASB No. Statement 87 *Leases* (GASB 87), as of January 1, 2021. The Commission evaluated contracts that were formerly accounted for as operating leases to determine whether they meet the definition of a lease as defined in GASB 87. As lessor, the Commission's adoption of GASB 87 resulted in recognition of lease receivable and deferred inflow of $5,115,602 as of December 31, 2021. The impact to beginning net position was not significant. See Note 8 in the notes to the financial statement.

***NET PENSION LIABILITY (ASSET)***

Net pension liability (asset) represents the excess (deficit) value of pension assets above the projected liability, under GASB No. 68, *Accounting and Financial Reporting for Pensions* ("GASB 68"). Net pension liability was $5,069,872 at December 31, 2022, a decrease of $7,443,189 (313.62%) from a net pension asset of $2,373,317 at December 31, 2021. Net pension asset was $2,373,317 at December 31, 2021, an increase of $909,803 (62.17%) from $1,463,514 at December 31, 2020.

***DEFERRED OUTFLOWS OF RESOURCES***

Deferred outflows of resources represent the difference between projected and actual retirement investment earnings that are deferred under GASB 68. Deferred outflows of resources increased to $7,337,774 as of December 31, 2022, decreased to $2,351,463 as of December 31, 2021, and increased to $3,279,910 as of December 31, 2020.

***PROVIDERS INCENTIVES PAYABLE***

Incentives payable to providers increased by $3,641,821 (40.04%) in 2022, increased by $4,225,674 (86.77%) in 2021, and decreased by $1,609,966 (24.85%) in 2020. HPSM uses a pay for performance-based incentive model for primary care physicians ("PCP"). The change in year-end balances each year is a function of timing differences between the expense accrual during the performance year, and payments made in the subsequent year. See Note 6 for more information on the Provider Incentive Program.

***ACCOUNTS PAYABLE AND ACCRUED LIABILITIES***

Accounts payable and accrued liabilities decreased by $22,238,857 (16.88%) from 2021 to 2022, increased by $64,874,198 (97.03%) from 2020 to 2021, and decreased by $9,464,753 (12.40%) from 2019 to 2020. The 2022 decrease is due primarily to timely receipt and distribution of directed payments to providers and hospitals. The 2021 increase is due primarily to the delay in Directed Payments to hospitals bringing that account liability to $87,554,465. This increase was slightly offset by a payout of the Managed Care Organization ("MCO") liability from the prior year bringing the balance to $0. The decrease in 2020 is due to a preliminary payment of the Intergovernmental Transfer ("IGT") at year-end reducing the Directed Payments liability.

***AMOUNTS DUE TO THE STATE OF CALIFORNIA***

Amounts due to the State of California increased by $21,063,134 (13.74%) in 2022, increased by $36,855,979 (31.65%) in 2021, and increased by $16,880,795 (16.95%) in 2020. The 2022 increase is due to continued overpayments by the State for long-term care and risk-based programs such as Enhanced Care Management (ECM). The 2021 increase is due to overpayments by the State related to long-term care. The increase in 2020 is primarily due to capitation overpayments by the State related to long-term care.

***DEFERRED INFLOWS OF RESOURCES***

Deferred inflows of resources represent changes in assumptions and the difference between expected and actual experience in 2022, 2021 and 2020 that are deferred under GASB 68, as well as deferred inflow resulting from adoption of GASB 87. Deferred inflows of resources decreased $2,290,630 (28.15%) to $5,847,393 as of December 31, 2022, increased $4,717,276 (138%) to $8,138,023 as of December 31, 2021, and increased $513,117 (17.65%) to $3,420,747 as of December 31, 2020.



| | 2022 | 2021 | 2020 |
|---|---|---|---|
| OPERATING REVENUES | | | |
| Capitation and premiums | | | |
| Medi-Cal | $ 631,154,588 | $ 598,298,004 | $ 489,076,148 |
| Healthy Kids | - | - | 54,432 |
| HealthWorx | 6,318,612 | 6,288,171 | 5,708,304 |
| Whole Child Model | 41,307,302 | 41,807,003 | 31,942,772 |
| Cal MediConnect | 290,246,880 | 285,128,975 | 281,234,803 |
| Net operating revenues | 969,027,382 | 931,522,153 | 808,016,459 |
| OPERATING EXPENSES | | | |
| Health care expenses | | | |
| Hospital inpatient | 317,978,754 | 325,930,565 | 337,280,939 |
| Medical | 275,105,588 | 249,498,616 | 214,014,110 |
| Pharmacy | 54,571,077 | 145,372,661 | 130,024,464 |
| Primary care physician capitation | 48,979,266 | 50,974,992 | 41,528,597 |
| Utilization management and quality assessment allocation | 18,613,364 | 17,833,608 | 17,856,597 |
| Provider incentives | 18,884,786 | 14,456,891 | 3,846,845 |
| Long-term support services | 2,140,621 | 8,014,071 | 3,025,895 |
| Dental | 16,064,027 | - | - |
| Transportation | 9,285,746 | 5,592,959 | 4,892,340 |
| Care Plan Options/In-lieu of Services | 6,062,328 | 2,533,725 | 2,662,603 |
| Enhanced care management | 2,385,391 | - | - |
| Other medical - reinsurance, etc. - net of reinsurance recoveries | 2,394,393 | 2,517,300 | (5,138,597) |
| Total health care expenses | 772,465,341 | 822,725,388 | 749,993,793 |
| General and administrative | 54,383,580 | 51,474,667 | 48,544,008 |
| MCO tax | 38,472,420 | 34,808,380 | 31,144,340 |
| Total operating expenses | 865,321,341 | 909,008,435 | 829,682,141 |
| Income (loss) from operations | 103,706,041 | 22,513,718 | (21,665,682) |
| NONOPERATING REVENUE | | | |
| Net interest and investment income | 7,750,108 | 1,090,668 | 3,453,443 |
| Other revenue | 154,821 | 6,060 | 170 |
| Rental income, net | 1,169,852 | 1,194,644 | 1,152,620 |
| Third-party administrator fees | 2,343,594 | 2,303,729 | 2,310,079 |
| Total nonoperating revenue | 11,418,375 | 4,595,101 | 6,916,312 |
| Changes in net position | 115,124,416 | 27,108,819 | (14,749,370) |
| NET POSITION, beginning of year | 360,378,083 | 333,269,264 | 348,018,634 |
| NET POSITION, end of year | $ 475,502,499 | $ 360,378,083 | $ 333,269,264 |

**OPERATING REVENUES**

HPSM's overall operating revenues increased by $37,505,229 (4.03%) in 2022, increased by $123,505,694 (15.29%) in 2021, and increased by $26,791,049 (3.43%) in 2020.

***The primary components for the increased revenues in 2022 are:***

- Growth in membership (for all lines of business) resulted in $62.9 million in increased revenue;
- The Medi-Cal pharmacy carveout, effective January 2022, resulted in approximately $93.0 million in reduced revenue;
- New rates (effective January 2022) for Medi-Cal (including Full Duals, MCE and Whole Child Model) resulted in approximately $26.4 million increased revenue. This includes a $22.3 million offset for the Coordinated Care Initiative (CCI) member mix risk corridor and ECM risk corridor;
- New rates (effective January 2022) for Cal MediConnect resulted in approximately $7.0 million increased revenue;
- Funding for dental integration and the new ECM benefit, both effective January 2022, resulted in approximately $18.4 million in additional revenue;
- Funding for directed payments increased by $9.6 million due to increased membership and the addition of Prop 56 for dental. Funding for MCO tax increased by about $3.7 million from increased membership;
- Funding for Medi-Cal Incentive programs, which is new in 2022, resulted in approximately $2.5 million in revenues.

***The primary components for the increased revenues in 2021 are:***

- Growth in membership (for all lines of business) resulted in $59.2 million in increased revenue;
- New rates (effective January 2021) for Medi-Cal (including Full Duals, MCE and Whole Child Model) resulted in approximately $49.3 million increased revenue. This includes an $8.7m offset for the CCI member mix risk corridor;
- New rates (effective January 2021) for Cal MediConnect resulted in approximately $7.9 million increased revenues;
- New rates for HealthWorx resulted in $0.3 million increased revenue;
- Funding for directed payments and MCO tax increase by about $6.8 million.

***The primary components for the increased revenues in 2020 are:***

- Growth in Medi-Cal membership resulted in $12.8 million in increased revenue; while a decrease in Cal MediConnect membership resulted in $5.1 million in decreased revenue;
- The lower Medi-Cal 18-month bridge period rates that went into effect July 1, 2019, carried into 2020, resulted in overall lower revenue in 2020 compared to 2019, which was offset by prior year rate adjustments for long-term care for an overall net increase of $5.8 million;
- New rates (effective January 2020) for Cal MediConnect resulted in approximately $8.2 million in increased revenues;
- New rates for HealthWorx resulted in $1.4 million increased revenue;
- Funding for directed payments increase by about $3.9 million.

**INTEREST AND INVESTMENT INCOME**

Net interest and investment income was $7,750,108 in 2022, $1,090,668 in 2021, and $3,453,443 in 2020. The average rate of return for the investments was 2.8% in 2022, 0.31% in 2021, and 0.59% in 2020.

**OPERATING EXPENSES**

***Healthcare Expenses***

Overall healthcare expenses decreased $50,260,047 (6.11%) from 2021 to 2022 due to:

- Membership growth for all lines of business in 2022 resulted in higher cost of $47.2 million;
- Inpatient cost on a per member basis decreased by about $9.0 million, mostly credits to prior year overstated IBNR;
- Net pharmacy cost decreased by approximately $93 million due to the Medi-Cal pharmacy carveout; separate from this pharmacy cost increased by approximately $2.1 for Cal MediConnect and HealthWorx lines-of-business.
- Outpatient and professional medical cost on a per member basis decreased in 2022 by $10.3 million;
- Overall long-term care cost decreased by $17.4 million, partly from the timing of large prior year adjustments. There is a total of $40 million in prior year rates adjustments that goes back to 2016, of which $30 million was recognized in 2020, and another $10 million was recognized in 2021, and zero in 2022. This contributed a $10 million decrease to the overall year-over-year change in long-term care cost from 2021 to 2022;
- The addition of dental integration and the ECM benefit, both effective January 2022, resulted in approximately $18.5 million in additional healthcare cost;

- Directed payments increased by about $8.5 million from the addition of Prop 56 for dental and increased membership.

- Other cost increased from the prior year by about $3.1 million, provider incentives, UM/QA and prior year adjustments.

Overall healthcare expenses increased $72,731,595 (9.70%) from 2020 to 2021 due to:

- Membership growth for all lines of business in 2021 resulted in higher cost of $61.7 million;

- Inpatient cost on a per member basis decreased by about $18.7 million due to lower hospitalization;

- Net pharmacy cost on a per member basis increased by $3.1 million;

- Outpatient and professional medical cost on a per member basis increased in 2021 by $20.9 million, which is a return to previous levels after the large decrease in 2020 due to the pandemic;

- Overall long-term care cost decreased by $14.4 million, partly from the timing of large prior year adjustments. There is a total of $40 million in prior year rates adjustments that goes back to 2016, of which $30 million was recognized in 2020, and another $10M is recognized in 2021. This contributed a $20 million decrease to the overall year over year change in long-term care cost;

- Other cost increased from the prior year by about $20.6 million, including directed payments, provider incentives, UM/QA and prior year adjustments.

Overall healthcare expenses increased $46,272,980 (6.58%) from 2019 to 2020 due to:

- Medi-Cal membership growth in 2020 resulted in higher cost of $14.1 million, which is offset by a decline in Cal MediConnect membership resulting in lower cost of $4.9 million;

- Both Inpatient and Pharmacy cost on a per member basis increased by about $9 million combined mostly due to higher unit cost;

- Outpatient and professional medical cost on a per member basis decreased in 2020 by $17.4 million, which was mostly due to lower utilization from canceled procedures due to the pandemic;

- Overall long-term care cost increased by $42 million, which includes $30 million in rate adjustments that goes back four years to 2017, for which there is offsetting revenue;

- Directed payments increased from the prior year by about $3.5 million.

**General and Administrative ("G&A") Expenses**

Total G&A expenses were $54,383,580 in 2022, $51,474,667 in 2021, and $48,544,008 in 2020. The increase from 2021 to 2022 is due primarily to an increase in staffing costs. Specifically a $3.3 million increase in employee benefits expense. The increase from 2020 to 2021 is due to an increase in salary and employee benefit costs along with an increase in printing and mailing costs to members as a result of the State taking over pharmacy benefits for MediCal members (originally effective April 1, 2021, but delayed until January 1, 2022). The decrease from 2019 to 2020 is lower than normal operating costs (for the building) due to the shelter-in-place order, in addition to intentionally keeping open positions vacant in an effort to control costs.

**MCO Tax**

In 2009, Assembly Bill ("AB") No. 1422 ("AB1422") was passed by the legislature and signed by Governor Schwarzenegger. The bill provided that MCO would be subject to a gross premium tax on Medi-Cal capitation revenues. For revenues pertaining to June 30, 2013, and prior, the tax rate was 2.35%. In June 2013, Senate Bill ("SB") No. 78 ("SB 78") reauthorized the MCO premium tax through the State of California's fiscal year 2016. Beginning July 1, 2013 through June 30, 2016, the rate is equal to the state sales and use tax rate of 3.9375%. On March 1, 2016, SB X2-2 established a new MCO provider tax, to be administered by Department of Healthcare Service ("DHCS"), effective July 1, 2016 through June 30, 2019. On April 3, 2020, CMS approved a waiver for the broad-based and uniformity requirements related to the State of California's MCO tax, effectively renewing the program effective January 1, 2020. The effective date range for this approval is January 1, 2020 through December 31, 2022. The tax was assessed by the DHCS on licensed healthcare service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate healthcare service plans ("AHCSP"), as defined, except as excluded by the bill. This bill established applicable taxing tiers and per enrollee amounts for the 2016-2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. HPSM paid $38,472,420 in 2022, $34,808,380 in 2021, and $31,144,340 in 2020 for MCO taxes. HPSM's tax liability of $10,076,110 as of December 31, 2022, $0 as of December 31, 2021, and $8,244,090 as of December 31, 2020, is included in accounts payable and accrued liabilities in the statements of net position.

| | 2022 Actual | 2022 Budgeted | Variance |
|---|---|---|---|
| REVENUES | | | |
| Medi-Cal | $ 631,154,588 | $ 498,005,761 | $ 133,148,827 |
| HealthWorx | 6,318,612 | 5,961,427 | 357,185 |
| Whole Child Model | 41,307,302 | 27,588,696 | 13,718,606 |
| Cal MediConnect | 290,246,880 | 267,245,244 | 23,001,636 |
| Total revenues | 969,027,382 | 798,801,128 | 170,226,254 |
| HEALTH CARE EXPENSES | | | |
| Hospital inpatient | 317,978,754 | 348,266,932 | (30,288,178) |
| Medical | 275,105,588 | 236,732,716 | 38,372,872 |
| Pharmacy | 54,571,077 | 76,448,712 | (21,877,635) |
| Primary care physician capitation | 48,979,266 | 46,626,001 | 2,353,265 |
| Utilization management (UM) and quality assessment (QA) allocation | 18,613,364 | 19,659,994 | (1,046,630) |
| Provider incentives | 18,884,786 | 6,447,033 | 12,437,753 |
| Long-term support services | 2,140,621 | 3,228,828 | (1,088,207) |
| Dental | 16,064,027 | - | 16,064,027 |
| Transportation | 9,285,746 | 6,392,784 | 2,892,962 |
| Care Plan Options/In-lieu of Services | 6,062,328 | - | 6,062,328 |
| Enhanced Care Management | 2,385,391 | - | 2,385,391 |
| Other medical - dental, reinsurance, etc. - net of reinsurance recoveries | 2,394,393 | 1,093,699 | 1,300,694 |
| Total health care expenses | 772,465,341 | 744,896,699 | 27,568,642 |
| ADMINISTRATIVE EXPENSES | | | |
| Salaries and fringe benefits | 44,664,653 | 41,041,910 | 3,622,743 |
| Contract services | 14,171,491 | 17,903,200 | (3,731,709) |
| Office supplies and maintenance | 6,303,678 | 6,589,050 | (285,372) |
| Occupancy, equipment, and depreciation expense | 4,035,227 | 4,581,500 | (546,273) |
| Postage and printing | 2,124,811 | 1,552,300 | 572,511 |
| Other administrative expenses | 1,435,478 | 1,302,575 | 132,903 |
| UMQA healthcare allocation | (18,351,758) | (19,469,270) | 1,117,512 |
| Total administrative expenses | 54,383,580 | 53,501,265 | 882,315 |
| MCO tax | 38,472,420 | 36,109,946 | 2,362,474 |
| Total expenses | 865,321,341 | 834,507,910 | 30,813,431 |
| Income (loss) from operations | 103,706,041 | (35,706,782) | 139,412,823 |
| NONOPERATING INCOME (LOSS) | | | |
| Net interest and investment income | 7,750,108 | 2,000,000 | 5,750,108 |
| Other revenue and rental income | 1,324,673 | 1,141,318 | 183,355 |
| Third-party administrator fees | 2,343,594 | 2,494,002 | (150,408) |
| Total nonoperating income | 11,418,375 | 5,635,320 | 5,783,055 |
| Net income (loss) | 115,124,416 | (30,071,462) | 145,195,878 |
| Net position at beginning of year | 360,378,083 | 360,378,083 | - |
| Net position at end of year | $ 475,502,499 | $ 330,306,621 | $ 145,195,878 |

**FINANCIAL HIGHLIGHTS – FIDUCIARY FUND**

The table below is a summarized comparison of the assets, liabilities and fiduciary net position of the Health Plan of San Mateo Retirement Plan Fund as of December 31, and the changes in fiduciary net position for the years ended December 31:

| | 2022 | 2021 | 2020 |
|---|---|---|---|
| TOTAL ASSETS | $ 29,280,931 | $ 33,150,125 | $ 28,734,252 |
| TOTAL LIABILITIES | - | - | - |
| TOTAL FIDUCIARY NET POSITION | 29,280,931 | 33,150,125 | 28,734,252 |
| TOTAL ADDITIONS, NET | (2,860,008) | 5,160,572 | 5,576,765 |
| TOTAL DEDUCTIONS | 1,009,186 | 744,699 | 1,228,597 |
| (DECREASE) INCREASE IN FIDUCIARY NET POSITION | (3,869,194) | 4,415,873 | 4,348,168 |
| FIDUCIARY NET POSITION - BEGINNING OF YEAR | 33,150,125 | 28,734,252 | 24,386,084 |
| FIDUCIARY NET POSITION - END OF YEAR | $ 29,280,931 | $ 33,150,125 | $ 28,734,252 |

Total fiduciary fund net position as of December 31, 2022, decreased by $3,869,194 from December 31, 2021, due to an decrease in fair value of investments.

Total fiduciary fund net position as of December 31, 2021, increased by $4,415,873 from December 31, 2020, due to an increase in fair value of investments.

Total fiduciary fund net position as of December 31, 2020, increased by $4,348,168 from December 31, 2019, due to an increase in fair value of investments.

MOSSADAMS



# Report of Independent Auditors

The Commissioners
San Mateo Health Commission
(d.b.a. Health Plan of San Mateo)

## Report on the Audit of the Financial Statements

### *Opinion*

We have audited the financial statements of the business-type activities and the aggregate remaining fund information of San Mateo Health Commission d.b.a. Health Plan of San Mateo (a stand-alone government entity appointed by the San Mateo County Board of Supervisors), as of and for the years ended December 31, 2022 and 2021, and the related notes to the financial statements, which collectively comprise San Mateo Health Commission d.b.a. Health Plan of San Mateo's financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements present fairly, in all material respects, the respective financial position of the business-type activities and aggregate remaining fund information of San Mateo Health Commission d.b.a. Health Plan of San Mateo as of December 31, 2022 and 2021, and the respective changes in net position and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

### *Basis for Opinion*

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of San Mateo Health Commission d.b.a. Health Plan of San Mateo and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

### *Responsibilities of Management for the Financial Statements*

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about San Mateo Health Commission d.b.a. Health Plan of San Mateo's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

***Auditor's Responsibilities for the Audit of the Financial Statements***

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of San Mateo Health Commission d.b.a. Health Plan of San Mateo's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about San Mateo Health Commission d.b.a. Health Plan of San Mateo's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

***Emphasis of Matter – New Accounting Standard***

As discussed in Note 1 to the financial statements, the San Mateo Health Commission adopted Government Accounting Standards Board No. 87, *Leases*, as of January 1, 2021. Our opinion is not modified with respect to this matter.

***Other Matters***

*Required Supplementary Information*

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 1 through 11 and the supplementary schedule of changes in the net pension asset liability and related ratios, supplementary schedule of contributions, and supplementary schedule of investment returns – Health Plan of San Mateo Retirement Plan on pages 45 through 47 be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.



San Francisco, California
_____, 2023

# Financial Statements

# San Mateo Health Commission
# (d.b.a. Health Plan of San Mateo) – Proprietary Fund
## Statements of Net Position
## December 31, 2022 and 2021



| | 2022 | 2021 (As restated) |
|---|---|---|
| **ASSETS AND DEFERRED OUTFLOWS** | | |
| CURRENT ASSETS | | |
| Cash and cash equivalents | $ 409,879,878 | $ 257,910,849 |
| Investments | 180,739,480 | 179,148,167 |
| Capitation receivable from the State of California | 157,581,748 | 191,263,823 |
| CareAdvantage receivable | 44,229,778 | 48,482,765 |
| Other accounts receivable | 8,378,505 | 6,713,030 |
| Prepaids and other assets | 10,317,744 | 7,244,329 |
| Lease receivable - current | 1,160,867 | 1,096,373 |
| Total current assets | 812,288,000 | 691,859,336 |
| CAPITAL ASSETS, NET | | |
| Nondepreciable | 15,667,814 | 15,667,814 |
| Depreciable, net of accumulated depreciation and amortization | 45,309,793 | 47,214,078 |
| Total capital assets, net | 60,977,607 | 62,881,892 |
| NET PENSION ASSET | - | 2,373,317 |
| LEASE RECEIVABLE - NONCURRENT | 2,858,362 | 4,019,229 |
| ASSETS RESTRICTED AS TO USE | 300,000 | 300,000 |
| Total assets | 876,423,969 | 761,433,774 |
| DEFERRED OUTFLOWS OF RESOURCES | 7,337,774 | 2,351,463 |
| Total assets and deferred outflows of resources | $ 883,761,743 | $ 763,785,237 |
| **LIABILITIES AND DEFERRED INFLOWS** | | |
| CURRENT LIABILITIES | | |
| Medical claims payable | $ 100,748,474 | $ 101,141,724 |
| Providers incentives payable | 12,737,495 | 9,095,674 |
| Amounts due to the State of California | 174,363,272 | 153,300,138 |
| Accounts payable and accrued liabilities | 109,492,738 | 131,731,595 |
| Total current liabilities | 397,341,979 | 395,269,131 |
| NET PENSION LIABILITY | 5,069,872 | - |
| DEFERRED INFLOWS OF RESOURCES | | |
| Deferred inflows of resources - leases | 3,935,529 | 5,115,602 |
| Deferred inflows of resources - pension | 1,911,864 | 3,022,421 |
| Total deferred inflows of resources | 5,847,393 | 8,138,023 |
| Total liabilities and deferred inflow of resources | $ 408,259,244 | $ 403,407,154 |
| **NET POSITION** | | |
| Invested in capital assets | $ 60,977,607 | $ 62,881,892 |
| Restricted by legislative authority | 300,000 | 300,000 |
| Unrestricted | 414,224,892 | 297,196,191 |
| Total net position | $ 475,502,499 | $ 360,378,083 |

See accompanying notes.

# San Mateo Health Commission
# (d.b.a. Health Plan of San Mateo) – Proprietary Fund
## Statements of Revenues, Expenses, and Changes in Net Position
## Years Ended December 31, 2022 and 2021



| | 2022 | 2021 |
|---|---|---|
| OPERATING REVENUES | | |
| Capitation and premiums | | |
| Medi-Cal | $ 631,154,588 | $ 598,298,004 |
| HealthWorx | 6,318,612 | 6,288,171 |
| Whole Child Model ("WCM") | 41,307,302 | 41,807,003 |
| Cal MediConnect | 290,246,880 | 285,128,975 |
| Net operating revenues | 969,027,382 | 931,522,153 |
| OPERATING EXPENSES | | |
| Healthcare expenses | | |
| Hospital inpatient | 317,978,754 | 325,930,565 |
| Medical | 275,105,588 | 249,498,616 |
| Pharmacy | 54,571,077 | 145,372,661 |
| Primary care physician capitation | 48,979,266 | 50,974,992 |
| Utilization management (UM) and quality assessment (QA) allocation | 18,613,364 | 17,833,608 |
| Provider incentives | 18,884,786 | 14,456,891 |
| Long-term support services | 2,140,621 | 8,014,071 |
| Dental | 16,064,027 | - |
| Transportation | 9,285,746 | 5,592,959 |
| Care plan options/In-lieu of Services | 6,062,328 | 2,533,725 |
| Enhanced care management | 2,385,391 | - |
| Other medical - reinsurance, etc. - net of reinsurance recoveries | 2,394,393 | 2,517,300 |
| Total health care expenses | 772,465,341 | 822,725,388 |
| General and administrative | | |
| Salaries and fringe benefits | 44,664,653 | 39,758,976 |
| Contract services | 14,171,491 | 15,748,538 |
| Office supplies and maintenance | 6,303,678 | 6,091,313 |
| Occupancy, equipment, and depreciation expense | 4,035,227 | 3,974,113 |
| Postage and printing | 2,124,811 | 2,195,107 |
| Other administrative expenses | 1,435,478 | 1,328,346 |
| UMQA healthcare allocation | (18,351,758) | (17,621,726) |
| Total general and administrative expenses | 54,383,580 | 51,474,667 |
| MCO tax | 38,472,420 | 34,808,380 |
| Total operating expenses | 865,321,341 | 909,008,435 |
| Income from operations | 103,706,041 | 22,513,718 |
| NONOPERATING REVENUE | | |
| Net interest and investment income | 7,750,108 | 1,090,668 |
| Other revenue | 154,821 | 6,060 |
| Rental income | 1,169,852 | 1,194,644 |
| Third-party administrator fees | 2,343,594 | 2,303,729 |
| Total nonoperating revenue | 11,418,375 | 4,595,101 |
| Changes in net position | 115,124,416 | 27,108,819 |
| NET POSITION, beginning of year | 360,378,083 | 333,269,264 |
| NET POSITION, end of year | $ 475,502,499 | $ 360,378,083 |

See accompanying notes.

# San Mateo Health Commission
# (d.b.a. Health Plan of San Mateo) – Proprietary Fund
## Statements of Cash Flows
## Years Ended December 31, 2022 and 2021



| | 2022 | 2021 |
|---|---|---|
| CASH FLOWS FROM OPERATING ACTIVITIES | | |
| Capitation and premium revenues | $ 988,481,448 | $ 985,825,202 |
| Healthcare expenses | (773,982,336) | (837,962,095) |
| General and administrative expenses | (71,864,760) | (96,942,517) |
| Other | 1,512,776 | 297,291 |
| Net cash provided by operating activities | 144,147,128 | 51,217,881 |
| CASH FLOWS FROM INVESTING ACTIVITIES | | |
| Proceeds from sale and maturities of investments | 8,124,029 | 3,534,896 |
| Payments for purchase of capital assets | (302,128) | (182,898) |
| Net cash provided by investing activities | 7,821,901 | 3,351,998 |
| Net increase in cash and cash equivalents | 151,969,029 | 54,569,879 |
| CASH AND CASH EQUIVALENTS, beginning of year | 257,910,849 | 203,340,970 |
| CASH AND CASH EQUIVALENTS, end of year | $ 409,879,878 | $ 257,910,849 |
| RECONCILIATION OF INCOME FROM OPERATIONS TO NET CASH PROVIDED BY OPERATING ACTIVITIES | | |
| Income from operations | $ 103,706,041 | $ 22,513,718 |
| Adjustment to reconcile income from operations to net cash provided by operating activities: | | |
| Depreciation and amortization | 2,161,413 | 2,262,175 |
| Loss on disposal of assets | 45,000 | - |
| Changes in operating assets and liabilities: | | |
| Capitation receivable from the State of California | 33,682,075 | (31,989,906) |
| CareAdvantage receivable | 4,252,987 | (25,884,988) |
| Other accounts receivable | (569,102) | 2,096,576 |
| Prepaids and other assets | (2,550,455) | 212,686 |
| Net pension asset (liability) | 1,346,321 | (379,682) |
| Medical claims payable | (393,250) | (23,568,549) |
| Providers incentives payable | 3,641,821 | 4,225,674 |
| Amounts due to the State of California | 21,063,134 | 36,855,979 |
| Accounts payable and accrued liabilities | (22,238,857) | 64,874,198 |
| Net cash provided by operating activities | $ 144,147,128 | $ 51,217,881 |

See accompanying notes.

# San Mateo Health Commission
# (d.b.a. Health Plan of San Mateo) – Health Plan of San Mateo Retirement Plan
## Statements of Fiduciary Net Position
## December 31, 2022 and 2021



| | 2022 | 2021 |
|---|---|---|
| ASSETS | | |
| Cash and cash equivalents | $ 971,764 | $ 874,320 |
| Investments, at fair value | | |
| Mutual funds | 5,187,975 | 5,885,732 |
| Pooled, common, and collective trusts | 23,122,460 | 26,390,073 |
| Total investments, at fair value | 28,310,435 | 32,275,805 |
| Net pending trades | (10,313) | - |
| Interest and dividends receivable | 9,045 | - |
| Total assets | $ 29,280,931 | $ 33,150,125 |
| NET POSITION RESTRICTED FOR PENSIONS | $ 29,280,931 | $ 33,150,125 |

See accompanying notes.

# San Mateo Health Commission
# (d.b.a. Health Plan of San Mateo) –
# Health Plan of San Mateo Retirement Plan
## Statements of Changes in Fiduciary Net Position
## Years Ended December 31, 2022 and 2021



| | 2022 | 2021 |
|---|---|---|
| ADDITIONS | | |
| Employer contributions | $ 2,095,537 | $ 1,948,733 |
| Investment income | | |
| Net (depreciation) appreciation in fair value of investments | (5,120,881) | 3,142,188 |
| Dividends | 140,504 | 65,519 |
| Interest | 24,832 | 4,132 |
| Total investment (loss) income | (4,955,545) | 3,211,839 |
| Total additions, net | (2,860,008) | 5,160,572 |
| DEDUCTIONS | | |
| Benefits paid to participants | 1,009,186 | 744,699 |
| (DECREASE) INCREASE IN NET POSITION | (3,869,194) | 4,415,873 |
| NET POSITION RESTRICTED FOR PENSIONS | | |
| Beginning of year | 33,150,125 | 28,734,252 |
| End of year | $ 29,280,931 | $ 33,150,125 |

See accompanying notes.

**Note 1 – Description of Operations and Summary of Significant Accounting Policies**

**Basis of organization** – The San Mateo Health Commission (the Commission) (d.b.a. Health Plan of San Mateo) (HPSM) was formed and organized by the Board of Supervisors of San Mateo County (the County) under an ordinance pursuant to Section 14087.51 of the Welfare and Institutional Code as a Health Insuring Organization (HIO). The majority of HPSM's revenues are generated from a contract with the State of California Medi-Cal Program and a three-way contract between HPSM, the State of California, and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Demonstration Program (Cal MediConnect). HPSM is included in the County of San Mateo's basic financial statements as a discretely presented component unit.

HPSM is responsible for managing a capitated prepaid healthcare system for residents of the County who are eligible for services under the Medi-Cal Program. The California Legislature authorized the prepaid system in March 1986 and HPSM began operations on December 1, 1987, under a contract with the State of California (the State). HPSM has an executed contract with the State for the period of January 1, 2009 through December 31, 2023.

CMS originally approved the State's request for HPSM to operate under a federal Medicaid freedom of choice waiver in November of 1987. The 1915(b) waiver allows for mandatory participation by Medi-Cal eligible San Mateo County residents in HPSM. Effective November 1, 2010, CMS transitioned all existing California 1915(b) waivers, including HPSM's, into the State's 1115(a) waiver. CMS renewed the State's 1115(a) waiver and 1915(b) waiver for November 1, 2010 through December 31, 2026.

The eleven commissioners of HPSM (Commissioners) are appointed by the County Board of Supervisors. The current Commissioners include two members of the San Mateo County Board of Supervisors, the County Manager or his designee, a physician, four public members (a beneficiary or representative of a beneficiary served by the Commission, a representative of the senior and/or minority communities in San Mateo County, a representative of the business community in San Mateo County, and a public member at large), a representative of the San Mateo Medical Center physicians that serve members of HPSM, a representative of a hospital located in San Mateo County that serves members of HPSM, and a pharmacist.

HPSM acquired a license under the Knox-Keene Healthcare Services Plan Act of 1975, as amended (the Act) on July 31, 1998, and is regulated by the State's Department of Healthcare Services (DHCS) and California Department of Managed Healthcare (DMHC). For the HealthWorx program, HPSM contracted with the San Mateo Public Authority for coverage of the In-Home Support Services (IHSS) employees as of August 1, 2001, and the City of San Mateo for Non-Merit Part-Time and Library Per Diem employees as of January 1, 2009. The current HealthWorx contracts are for the following periods: (1) IHSS – July 1, 2014 to December 31, 2023 and (2) the City of San Mateo – January 1, 2009 to December 31, 2023. The renewal is currently in process.

Effective September 1, 2007, HPSM entered into an agreement with the County of San Mateo to provide third-party administrator (TPA) services to administer the benefits of their indigent care program (ACE). The current agreement ends March 31, 2023. The renewal is currently in process.

Effective April 1, 2014, HPSM entered into a three-way contract with CMS and the State of California for Cal MediConnect. The Cal MediConnect demonstration program promotes coordination of care to seniors and people with disabilities who are dually eligible for both Medi-Cal and Medicare. The agreement results in a third Medi-Cal contract and a second Medicare contract. The contract period was through December 31, 2022 at which time the demonstration program ended.

In September 2022, HPSM entered into an agreement with the CMS and became a MediCareAdvantage Organization (MAO) under the commercial name CareAdvantage. As an MAO, HPSM provides medical services to its dual eligible members. The service contract for fiscal year 2023 became effective on January 1, 2023 through December 31, 2023, and may be renewed for successive one-year periods.

Health Plan of San Mateo Retirement Plan Fund accounts for the assets of the employee benefit plan held by HPSM in a trustee capacity. See Note 10.

**Accounting standards** – Pursuant to Governmental Accounting Standards Board (GASB) Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, HPSM's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989.

**Proprietary fund accounting** – HPSM utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis and financial statements are prepared using the economic resources measurement focus.

**Cash and cash equivalents** – Cash and cash equivalents are stated at cost which approximates current market value due to their short-term nature. All highly-liquid investments with original maturities of three months or less when purchased are considered cash equivalents.

**Investments** – Investments include mutual funds, pooled, common and collective trusts, debt obligations of the U.S. Government and its agencies, certificates of deposits, and money markets as permitted by the California Government Code for Investments. All short-term investments with a maturity of three months or less at the date of purchase are considered to be cash equivalents. These investments are carried at fair market value. The fair values of investments are based on quoted market prices. Changes in fair value of investments are included in net interest and investment income in the statements of revenues, expenses, and changes in net position.

**Lease receivable** – The Commission's lease receivable is measured at the present value of lease payments expected to be received during the lease term. Under the lease agreement, the Commission may receive variable lease payments that are dependent upon the lessee's revenue. The variable payments are recorded as an inflow of resources in the period the payment is received. The deferred inflow of resources is recorded at the initiation of each lease in an amount equal to the initial recording of the lease receivable. The deferred inflows of resources are amortized on an effective interest method basis over the term of each lease.

**Capital assets** – Capital assets include property and equipment which are stated at cost. Depreciation is provided on the straight-line basis over the asset's estimated useful lives which are as follows:

| | |
|---|---|
| Leasehold improvements | 5 years |
| Building and improvements | 39 years |
| Furniture and equipment | 3 to 7 years |



Leasehold improvements are amortized over the life of the improvement or the lease term, whichever is shorter. Upon retirement or disposal of capital assets, any gain or loss is included in results of operations in the period disposed.

Capital assets of $9,000 or more are depreciated over their useful lives. Leasehold improvements of $9,000 or more are amortized over the term of the related lease or their estimated useful lives.

HPSM evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

**Assets restricted as to use** – HPSM is required by the California DMHC to restrict cash of $300,000 as of December 31, 2022 and 2021, for the payment of member claims in the event of its insolvency.

**Medical claims payable** – HPSM contracts with various providers, including physicians and hospitals, to provide certain healthcare products and services to enrolled Medi-Cal, CareAdvantage, HealthWorx, Whole Child Model, and Cal MediConnect beneficiaries. The cost of the healthcare products and services provided or contracted for is accrued in the period in which it is provided to a member and includes an estimate of the cost of services that have been incurred but not yet reported. The estimate for reserves for claims is based on projections of hospital and other costs using historical studies of claims paid. Estimates are monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions.

**Amounts due to the State of California** – When HPSM is made aware of changes to the State rate structure, such as rate decreases, risk corridors or program reconciliations, that significantly impact the financial outlook, an accrual for the estimated change is recorded. Such estimates are subject to the impact of changes in the regulatory environment and are subject to third party review. At the end of December 31, 2022 and 2021, HPSM had the following included in Amounts due to the State of California in the accompanying statements of net position:

| | 2022 | 2021 |
|---|---|---|
| Risk corridor | $ 50,836,024 | $ 28,519,224 |
| Medi-Cal Expansion (MCE) medical loss ratio (MLR) reserve | 3,666,077 | 3,666,077 |
| Overpayments | 119,861,171 | 121,114,837 |
| Total | $ 174,363,272 | $ 153,300,138 |

*Risk corridor* – HPSM's contract with DHCS is subject to various risk corridors. The Coordinated Care Initiative (CCI) demonstration program for full-dual members has multiple risk corridors that triggered liabilities. A medical loss ratio (MLR) risk corridor for the first two years (July 2014 through June 2016) resulted in an estimated return of premiums of $19,789,224 as of December 31, 2022 and 2021. A separate member mix risk corridor triggered an additional return of premiums of $8,720,000 and $8,730,000 for calendar year 2022 and 2021, respectively, recorded as a reduction to capitation and premium revenue as of December 31, 2022.

CalAIM risk corridor reserve – Effective January 1, 2022, California launched a multi-year initiative called California Advancing and Innovating Medi-Cal (CalAIM) to improve the quality of life and health outcomes of the Medi-Cal managed care population through the implementation of broad delivery system, program, and payment reforms across the Medi-Cal program. CalAIM initiatives include the delivery of new Enhanced Care Management (ECM) benefits. DHCS has implemented two-sided risk corridors on ECM services as of January 1, 2022, under which managed care plans are fully at risk for losses up to 95% and gains over 105% on applicable ECM services. Managed care plans will owe a remittance to the State or be owed a payment from the State if gains or losses exceed 5 percent of the applicable ECM rates received. The CalAIM risk corridor reflects the potential amount due to the State for ECM gains in excess of the 105% risk corridor. During the years ended December 31, 2022 and 2021, the reduction of premium revenue related to CalAIM risk corridors was $13,596,800 and $0, respectively.

*Medi-Cal Expansion (MCE) medical loss ratio (MLR) reserve* – Effective with the enrollment of the Adult Expansion Population per the Affordable Care Act on January 1, 2014, HPSM is subject to DHCS requirements to meet a minimum of 85% medical loss ratio for this population. Specifically, HPSM will be required to expend at least 85% of the Medi-Cal capitation revenue received for this population on allowable medical expenses as defined by DHCS. In the event HPSM expends less than the 85% requirement, HPSM will be required to return to DHCS the difference between the minimum threshold and the actual allowed medical expenses. The original 85% MLR requirement was for January 2014 through June 2016, a 30-month period. In 2018, HPSM made a payment to the State of $109 million related to the original reporting periods of January 2014 – June 2016. In 2019, HPSM made a payment to DHCS in the amount of $15 million related to July 1, 2016 – June 30, 2017. As of December 31, 2022 and 2021, HPSM estimated a remainder liability of $3,666,077, relating to reporting period July 1, 2016 – June 30, 2017. There are no estimated liabilities for DHCS between the minimum threshold and the actual allowed medical expenses for the reporting period July 2017 to June 2022.

*Overpayments* – DHCS pays HPSM based on the most recent CMS approved rates for the various Medi-Cal programs. HPSM records revenue using the anticipated final rates and records a liability for the excess payment received. DHCS has begun recouping overpayments in the current fiscal year.

**Accounts payable and accrued liabilities** – included in accounts payable and accrued liabilities on the statements of net position are the following:

| | 2022 | 2021 |
|---|---|---|
| Intergovernmental (IGT) and Directed Payments payable | $ 44,769,137 | $ 87,554,463 |
| MCO tax payable | 10,076,110 | - |
| Hospital Quality Assurance Fee (HQAF) payable | 27,635,926 | 24,921,566 |
| Other program payable | 16,300,271 | 7,556,901 |
| Accounts payable and accrued expenses | 7,760,809 | 6,971,318 |
| Other healthcare liabilities | 2,950,485 | 4,727,347 |
| Total | $ 109,492,738 | $ 131,731,595 |



*IGT payable* – Welfare and Institutions Code provides for an IGT program relating to the Medi-Cal managed care capitation rates and the capitation rate ranges. Governmental funding agencies, defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, are eligible to transfer the non-federal share of the available IGT amounts. The IGT is used to fund the non-federal share of increases in Medi-Cal managed care actuarially sound capitation rates.

*Directed payments payable* – Beginning with the July 1, 2017, rating period, the DHCS has implement managed care Directed Payments: 1) Private Hospital Directed Payment (PHDP); 2) Designated Public Hospital Enhanced Payment Program (EPP-FFS and EPP-CAP); and 3) Designated Public Hospital Quality Incentive Pool (QIP). (1) For PHDP, the Department will direct Managed Care Plans (MCP) to reimburse private hospitals as defined in WIC 14169.51, based on actual utilization of contracted services. The enhanced payment is contingent upon hospitals providing adequate access to service, including primary, specialty, and inpatient (both tertiary and quaternary) care. The total funding available for the enhanced contracted payments are limited to a predetermined amount (pool). (2) For EPP-FFS and EPP–Capitated Pools, the Department has directed MCPs to reimburse California's 21 Designated Public Hospitals (DPH) for network contracted services delivered by DPH systems, enhanced by either a uniform percentage or dollar increment based on actual utilization of network contracted services. (3) For QIP, the Department has directed the MCPs to make QIP payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to the delivery of services under the MCP contracts and increase the amount of funding tied to quality outcomes. To receive QIP payments the DPH and University of California hospitals must achieve specified improvement targets, which grow more difficult through year-over-year improvement or sustained high performance requirements. The total funding available for the QIP payments will be limited to a predetermined amount (pool).

*HQAF payable* – Established by Assembly Bill (AB) 1653 (AB1653), the HQAF program allows additional draw down of federal funding to be used for increased payments to general acute care hospitals for inpatient services rendered to Medi-Cal beneficiaries. DHCS provides increased capitation payments to Medi-Cal managed healthcare plans who in turn expend 100 percent of any increased capitation payments on hospital services. In April 2011, SB90 was signed into law, which extended the HQAF through June 30, 2011. SB335, signed into law in September 2011, extended the HQAF portion of Senate Bill (SB) SB90 for an additional 30 months through December 31, 2013. The payments were received and distributed in a manner prescribed as a pass through to revenue. SB239, signed into law October 8, 2013, extended the program for an additional 36 months from January 1, 2014 through December 31, 2016. In November of 2016, California approved Proposition 52, which made SB239 permanent and also created HQAF V. The program period for HQAF V is from January 1, 2017 through June 30, 2019. An extension of the program known as HQAF VI, covering July 1, 2019 – December 31, 2021 was approved by the CMS in February 2020. An additional extension known as HQAF VII was approved in September 2022 covering calendar year 2022.

*Other program payable* – HPSM holds and administers funds to certain other entities who partner on programs to enhance the Community Care Settings Pilot (CCSP) and further HPSM's mission to ensure access to high-quality, affordable healthcare for San Mateo County's underserved residents.

In 2021 and 2022, DHCS implemented several State sponsored incentive programs related to behavior health integration, COVID vaccines, student behavior health, enhanced care management, community supports, and housing and homelessness. In 2022, $2,532,934 in revenue and $1,594,932 in incentive expense was recognized. Unearned incentives included within other program payable include $4,368,881 and $0 in funds received but not yet earned as of December 31, 2022, and 2021, respectively, related to these programs.

**Net position** – Net position is classified as invested in capital assets, restricted by legislative authority or unrestricted. Invested in capital assets represents investments in building, furniture, and equipment, net of depreciation. Restricted net position consists of noncapital net position that must be used for a particular purpose, as specified by state regulatory agency, grantors, or contributors external to HPSM. Unrestricted net position consists of net position that does not meet the definition of restricted or invested in capital assets. The Commission, at its discretion, from time-to-time designates portions of unrestricted net position for the establishment of a stabilization reserve.

**Capitation and premium revenues** – The State of California pays HPSM capitation revenue retrospectively on an estimated basis each month. Capitation revenue is recognized as revenue in the month the beneficiary is eligible for Medi-Cal services. These estimates are continually reviewed, and adjustments to the estimates are reflected currently in the Statements of revenues, expenses, and changes in net position. Eligibility of beneficiaries is determined by the County of San Mateo Department of Human Services and validated by the State of California. The State of California provides HPSM the validated monthly eligibility file of program beneficiaries who are continuing, newly added or terminated from the program in support of capitation revenue for the respective month.

CMS pays HPSM capitation revenue each month. Capitation revenue is recognized in the month the beneficiary is eligible for Medicare services. Eligibility of members is determined by CMS.

The County of San Mateo and the City of San Mateo each pay HPSM HealthWorx premiums by the first of the month of coverage. The County of San Mateo pays HPSM Healthy Kids quarterly premiums prospectively based on the quarter's estimated member months. Subsequent to the end of the quarter, HPSM submits an adjustment invoice for the difference between the actual versus the estimated quarterly membership. Eligibility of members is determined by the San Mateo County Public Authority and the City of San Mateo.



**Premium deficiencies** – HPSM performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency is recorded. Management determined that no premium deficiency reserves were needed at December 31, 2022 and 2021.

**Healthcare expenses** – The cost of healthcare rendered to eligible beneficiaries is estimated and recognized as expense in the month in which the services are rendered. These estimates are continually reviewed, and adjustments to the estimates are reflected currently in the Statements of revenues, expenses, and changes in net position.

**MCO tax** – In November 2009, DHCS implemented AB1422 or MCO premium tax. This program imposes an assessment on HPSM's revenue. DHCS uses this assessment to obtain matching federal funds, which is used to sustain enrollment in the Healthy Families program. Effective with California SB78 and beginning July 1, 2012, HPSM was required to pay a gross premium tax on Medi-Cal revenue. For July 1, 2013 through June 30, 2016, the tax rate increased to 3.9375%. Beginning July 1, 2016, a new methodology for determining the annual tax liability was instituted by the State. MCO tax expense was $38,472,420 and $34,808,380 for the years ended December 31, 2022 and 2021, respectively. As of December 31, 2022 and 2021, $10,076,110 and $0, respectively, was accrued. These amounts are included in accounts payable and accrued liabilities on the statements of net position.

**Operating revenues and expenses** – HPSM's primary operating revenue is derived from capitation. As defined by GASB Codification Section P80, *Proprietary Fund Accounting and Financial Reporting*, all operating revenues are considered program revenues since they are charges for services provided and program-specific operating grants. The primary operating revenue is derived from capitation and other sources in support of providing healthcare services to its members. Operating expenses are all expenses incurred to provide such healthcare services. Nonoperating revenues and expenses consist of those revenues and expenses that are related to financing and investing activities, result from net investment income, changes in the fair value of investments, and administrative fees relating to providing Third Party Administrator claims processing services for the County of San Mateo's Section 17,000 participants.

**Income taxes** – HPSM operates under the purview of Internal Revenue Code (IRC) Section 115, and corresponding California Revenue and Taxation Code provisions. As such, it is not subject to federal income or state franchise taxes.

**Use of estimates** – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. Management also discloses contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period based on these estimates and assumptions such as medical claims payable including incurred but not reported liability, capitation receivable from the State of California and CareAdvantage receivable, amounts due to the State of California including MLR and risk corridor, fair market value of investments, and net pension (liability) asset. Ultimate results may differ from those estimates.



**Concentrations of risk** – Financial instruments potentially subjecting HPSM to concentrations of risk consist primarily of bank demand deposits in excess of Federal Deposit Insurance Corporation (FDIC) insurance thresholds. HPSM believes no significant concentration of credit risk exists with these cash accounts.

HPSM's business could be impacted by external price pressure on new and renewal business, additional competitors entering HPSM's markets, federal and state legislation, and governmental licensing regulations of HMOs and insurance companies. External influences in these areas could have the potential to adversely impact HPSM's operations in the future.

HPSM is highly dependent upon the State of California for its revenues. A significant portion of accounts receivable and revenue are from the State of California. Loss of the contracts with the State of California due to nonrenewal or legislative decisions that impact program funding or result in discontinuation could materially affect the financial position of HPSM.

**New accounting pronouncements** – In June 2017, the GASB issued Statement No. 87, *Leases* (GASB 87), which is effective for financial statements for periods beginning after December 15, 2019. GASB 87 increases the usefulness of financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. GASB 87 also establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance*, which deferred the effective date of GASB 87 to fiscal years beginning after June 15, 2021. As lessor, the Commission's adoption of GASB 87 resulted in recognition of lease receivable and deferred inflow of $5,115,602 as of December 31, 2021. The impact to beginning net position was not significant. See Note 8.

In June 2020, the GASB issued Statement No. 97, *Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans – an amendment of GASB Statements No. 14 and No. 84, and a supersession of GASB Statement No. 32* (GASB 97). GASB 97 amends the criteria for reporting governmental fiduciary component units – separate legal entities included in a government's financial statements. GASB 97 clarifies rules related to reporting of fiduciary activities under Statements No. 14 and No. 84 for defined contribution plans and to enhance the relevance, consistency, and comparability of the accounting and financial reporting of IRC Code section 457 plans that meet the definition of a pension plan. HPSM adopted GASB 97 for the fiscal year 2022 and the adoption had no material impact to the financial statements.



**Note 2 – Cash and Cash Equivalents, Investments, and Assets Restricted as to Use**

**Cash and cash equivalents investments** – Cash and cash equivalents and investments as of December 31, 2022 and 2021 consist of the following:

| | 2022 | 2021 |
|---|---|---|
| Cash on hand | $ 500 | $ 500 |
| Cash deposits | 204,039,217 | 54,514,718 |
| Cash equivalents | 205,840,161 | 203,395,631 |
| Investments | 180,739,480 | 179,148,167 |
| Total cash and cash equivalents and investments | $ 590,619,358 | $ 437,059,016 |

**Assets restricted as to use** – Assets restricted as to use consist of $300,000 of certificates of deposits as of December 31, 2022 and 2021.

The current investment policy of HPSM states the chief financial officer/treasurer has the authority to invest or reinvest HPSM's surplus funds not required for immediate necessities in such a manner as to provide maximum return with adequate protection of the funds. Return on invested funds is secondary to safety of principal and liquidity. The Commission may invest in obligations of the U.S. Treasury and other U.S. agencies, bankers' acceptances, commercial paper from issuing corporations of $500 million and of the highest letter, and numerical rating as provided by Moody's Investors Service, Inc., or Standard & Poor's Corporation, certificates of deposits, repurchase agreements, and the State Treasurer's Local Agency Investment Fund. No more than 10% of funds invested can be instruments of any single institution other than securities issued by the U.S. Government and its affiliated agencies. Additional restrictions are placed on the concentration of investments and the days until maturity. The following table also identifies certain provisions that address interest rate risk, credit risk, and concentration risk.

| Authorized Investment Type | Maximum Maturity | Maximum Specified Percentage Portfolio | Maximum Investment in One Issuer |
|---|---|---|---|
| U.S. Treasury Obligations | None | None | None |
| U.S. Agencies | None | None | None |
| Bankers' Acceptances | 270 days | 40% | 30% |
| Commercial Paper | 180 days | 10% | None |
| Negotiable Certificates of Deposits | 2 years | 30% | None |
| Repurchase Agreements | 10 days | None | None |
| State Operating Funds and Reserves | 75% of holdings - 4.5 years with no single purchase greater than 6 years<br>25% of holdings - month to month | None | None |



**State Treasurer's Local Agency Investment Fund** – HPSM has an investment in the State Treasurer's Local Agency Investment Fund (LAIF). The investment in LAIF is carried at fair value, which approximates amortized cost. Generally, the investments in LAIF are available for withdrawal on demand. The investment in LAIF does not meet the criteria for risk categorization.

LAIF has an equity interest in the State of California Pooled Money Investment Account (PMIA). PMIA funds are on deposit with the State's Centralized Treasury System and are managed in compliance with the California Government Code (the Code) according to a statement of investment policy that sets forth permitted investment vehicles, liquidity parameters, and maximum maturity of investments. These investments consist of U.S. government securities, securities of federally-sponsored agencies, U.S. corporate bonds, interest-bearing time deposits in California banks, prime-rated commercial paper, bankers' acceptances, negotiable certificates of deposit, and repurchase and reverse repurchase agreements. The PMIA policy limits the use of reverse repurchase agreements subject to limits of no more than 10% of PMIA. The PMIA does not invest in leveraged products or inverse floating rate securities. The PMIA cash and investments are recorded at amortized cost, which approximates fair value.

**County of San Mateo Pooled Fund** – HPSM also has an investment in the County of San Mateo Pooled Fund (CSMPF). The investment in CSMPF is carried at fair value, which approximates amortized cost.

CSMPF funds are on deposit with the County's Treasurer and are managed in compliance with the Code, according to a statement of investment policy, developed by the Treasurer, reviewed and approved annually by the County Treasury Oversight Committee and the County Board of Supervisors.

The investment policies of the CSMPF are similar to those of the PMIA.

The amounts invested in LAIF and CSMPF are considered investments in an external investment pool and earn interest based on the blended rate of return earned by the entire portfolio in the pool. As HPSM does not own identifiable investment securities of the pool but participates as a shareholder of the pool, these investments are not individually identifiable and were not required to be categorized under GASB Statement No. 62 Section C20, *Cash Deposits with Financial Institutions*.

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A fair value hierarchy is also established which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

**Level 1** – Quoted prices in active markets for identical assets or liabilities.

**Level 2** – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in active markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

**Level 3** – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

HPSM's equity in the investment pool is determined by the dollar amount of HPSM's deposits, adjusted for withdrawals and distributed investment income. Investment income is determined on an amortized cost basis. Interest payments, accrued interest, accreted discounts, amortized premiums, and realized gains and losses, net of administrative fees, are apportioned to pool participants every quarter. This method differs from the fair value method used to value investments in these financial statements as unrealized gains or losses are not apportioned to pool participants.

Per CSMPF's investment policy, any request to withdraw funds shall be subject to the consent of the Treasurer and shall be released at no more than 12.5% per month, based on the month-end balance of the prior month. In accordance with California Government Code 27136 et seq, and 27133(h) et seq, these requests are subject to the Treasurer's consideration of the stability and predictability of the pooled investment fund, or the adverse effect on the interests of the other depositors in the pooled investment fund.

Investments and assets restricted as to use not subject to fair value hierarchy as of December 31:

| | 2022 | 2021 |
|---|---|---|
| Certificate of deposits | $ 300,000 | $ 300,000 |
| San Mateo County Pooled Fund | 107,941,540 | 106,831,321 |
| Local Agency Investment Fund | 72,797,940 | 72,316,846 |
| Total investments and assets restricted as to use | $ 181,039,480 | $ 179,448,167 |

There were no investments subject to fair value hierarchy as of December 31, 2022 and 2021.

The custodial credit risk, interest rate, credit risk, and concentration of credit risk under GASB Statement No. 62 Section C20, *Cash Deposits with Financial Institutions*, at December 31, 2022 and 2021 were as follows:



**Custodial credit risk** – Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, HPSM will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The Code requires financial institutions to secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under State Law. As of December 31, 2022 and 2021, deposits exposed to custodial credit risk as they were uninsured, and the collateral held by the pledging bank not in HPSM's name were $409,879,878 and $257,910,849, respectively.

Custodial credit risk for investments is the risk that, in the event of the failure of the counterparty to a transaction, HPSM will not be able to recover the value of its investments or collateral securities that are in the possession of another party. As of December 31, 2022 and 2021, HPSM did not hold investments exposed to custodial credit risk.

**Interest rate risk** – Changes in market interest rates will adversely affect the fair value of an investment. In accordance with its investment policy, HPSM manages the risk of market value fluctuations due to overall changes in the general level of interest rates by limiting the weighted average maturity of its portfolio to no more than five years.

The weighted average maturity in years for the $300,000 certificates of deposit included in assets restricted as to use was 0.47 and 0.31 as of December 31, 2022 and 2021, respectively. The weighted average maturity in years for the portfolio was 0.47 and 0.31 as of December 31, 2022 and 2021, respectively.

**Credit risk** – Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of rating by a nationally recognized statistical rating organization. Per GASB Statement No. 62 Section C20, *Cash Deposits with Financial Institutions*, unless there is information to the contrary, obligations of the U.S. Government or obligations explicitly guaranteed by the U.S. Government are not considered to have credit risk and do not require disclosure of credit quality. Presented below is the minimum rating required by (where applicable) the California Government Code or HPSM's investment policy and the actual rating as of year-end for each investment type.

Ratings as of December 31, 2022 and 2021 for the certificates of deposit were A-1.

**Concentration of credit risk** – The investment policy of HPSM contains certain limitations on the amount that can be invested in any one issuer and is listed in the table above. There are no investments in any one issuer (other than U.S. Treasury securities, mutual funds, and external investment pools) that represent 5% or more of the total HPSM's investments at December 31, 2022 and 2021.

**Note 3 – Capitation Receivable From the State of California**

HPSM receives capitation from the State based upon the monthly capitation rate of each aid code (Medi-Cal category of eligibility). The State makes monthly payments based on actual members for the current month and changes for the prior 12 months.

HPSM estimates the current and prior years' capitation receivable based on the State's most current actual member counts by aid code. Currently, HPSM records the current year capitation receivable based on the most current actual member counts by aid code. The amounts are trued up on a monthly basis.



**Note 4 – Capital Assets**

Capital asset activity for the fiscal year ended December 31, 2022 was as follows:

| | Beginning Balance | Increases | Decreases | Ending Balance |
|---|---|---|---|---|
| Furniture and equipment | $ 14,395,875 | $ 149,951 | $ (184,195) | $ 14,361,631 |
| Building improvements | 23,087,261 | 152,177 | - | 23,239,438 |
| Building | 31,810,055 | - | - | 31,810,055 |
| Land | 15,667,814 | - | - | 15,667,814 |
| Total capital assets | 84,961,005 | 302,128 | (184,195) | 85,078,938 |
| Less: accumulated depreciation and amortization | 22,079,113 | 2,161,413 | (139,195) | 24,101,331 |
| Capital assets, net | $ 62,881,892 | $ (1,859,285) | $ (45,000) | $ 60,977,607 |

Capital asset activity for the fiscal year ended December 31, 2021 was as follows:

| | Beginning Balance | Increases | Decreases | Ending Balance |
|---|---|---|---|---|
| Furniture and equipment | $ 14,271,900 | $ 123,975 | $ - | $ 14,395,875 |
| Building improvements | 23,028,338 | 58,923 | - | 23,087,261 |
| Building | 31,810,055 | - | - | 31,810,055 |
| Land | 15,667,814 | - | - | 15,667,814 |
| Total capital assets | 84,778,107 | 182,898 | - | 84,961,005 |
| Less: accumulated depreciation and amortization | 19,816,938 | 2,262,175 | - | 22,079,113 |
| Capital assets, net | $ 64,961,169 | $ (2,079,277) | $ - | $ 62,881,892 |

Depreciation and amortization expense for capital assets for the years ended December 31, 2022 and 2021 was $2,161,413 and $2,262,175, respectively.

**Note 5 – Medical Claims Payable**

The cost of healthcare services is recognized in the period in which it is provided and includes an estimate of the cost of services that have been incurred but not yet reported.

HPSM contracts with various providers, including physicians and hospitals, to provide certain healthcare products and services to enrolled Medi-Cal, Health Worx, WCM, IHSS, Cal MediConnect, and CareAdvantage beneficiaries. The cost of the healthcare products and services provided or contracted for is accrued in the period in which it is provided to a member and includes an estimate of the cost of services that have been incurred but not yet reported. The estimate for reserves for claims is based on projections of hospital and other costs using historical studies of claims paid. Estimates are monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions.

Activity for medical claims payable for the years ended December 31 is summarized as follows:

| | 2022 | 2021 |
|---|---|---|
| Balance at beginning of period | $ 101,141,724 | $ 124,710,273 |
| Incurred | | |
| Current year | 695,379,487 | 726,170,101 |
| Prior year | (13,240,375) | 3,668,064 |
| | 682,139,112 | 729,838,165 |
| Paid related to | | |
| Current year | 606,139,862 | 642,936,442 |
| Prior year | 76,392,500 | 110,470,272 |
| Total paid | 682,532,362 | 753,406,714 |
| Balance at end of period | $ 100,748,474 | $ 101,141,724 |

Medical claims payable decreased by $0.4 million in comparison to the previous year. $13.2 million of this decrease is in the general medical claims payable reserves and is due to the changes between actual payments for medical services and estimated amounts in previous years. This is offset by an increase of $15.4 million from the accruals and payments of State directed Proposition 56 supplemental payments.

Amounts incurred related to prior years represent changes from previously estimated liabilities. Liabilities at any year-end are continuously reviewed and re-estimated as information regarding actual claims payments and expected payment trends become known. Negative amounts reported for incurred related to prior years result from claims being adjudicated and paid for amounts less than originally estimated.

**Note 6 – Incentives Payable to Provider**

In October 2019, HPSM implemented a new quality incentive program with nursing facilities that provide skilled and/or long-term care services to HPSM members for meeting targeted quality measures. The program is designed to improve outcomes by incentivizing member access and high-quality care. The first measurement period is in 2020, with the first payments from results starting in 2021.

**Note 7 – Reserve for Stabilization and Minimum Tangible Net Equity**

The Commission, at its discretion, from time to time designates portions of net position for the establishment of certain reserves. These reserves are Board designated and unrestricted. They are available to satisfy the unreserved net position.

As a limited license plan under the Act, HPSM is required to maintain a minimum level of tangible net equity. On November 9, 2016, the San Mateo Health Commission approved a change to the stabilization reserve from 250% of the minimum tangible net equity (TNE) as defined by the DMHC regulation to two (2) months of operating expenses. As of December 31, 2022 and 2021, the stabilization reserve was $154,531,300 and $178,301,779, respectively.

As of December 31, 2022, the minimum TNE was $37,414,103. Total net position as of December 31, 2022, was $475,502,499, which exceeds the minimum tangible net equity by $438,088,396 and is 1,271% of TNE.

As of December 31, 2021, the minimum TNE was $43,302,105. Total net position as of December 31, 2021, was $360,378,083, which exceeds the minimum tangible net equity by $317,075,978 and is 832% of TNE.

**Note 8 – Leases**

HPSM is a lessor for noncancellable leases of office space with lease terms through March 31, 2026. For the years ended December 31, 2022 and 2021, HPSM recognized $1,169,852, included in lease revenue released from the deferred inflows of resources related to the office lease included in rental income on the statements of revenues, expenses, and changes in net position. No inflows of resources were recognized in the year related to termination penalties or residual value guarantees during fiscal years ended December 31, 2022 and 2021.

**Note 9 – Deferred Compensation Fund**

HPSM contributes an amount equal to 7.5% of gross salary on behalf of the employee to an IRC Section 457 deferred compensation plan per Internal Revenue Service (IRS) regulations in lieu of social security. In July 2016, HPSM held a vote of its employees to determine for themselves whether or not to participate in social security effective October 1, 2016. Employees who voted to participate in social security would no longer receive the 7.5% of gross salary contribution. Those voting not to participate would continue to receive the contributions in lieu of social security.

All HPSM employees may participate in this deferred compensation plan under which employees are permitted to defer a portion of their annual salary until future years. For the years ended December 31, 2022 and 2021, HPSM contributed $713,894 and $724,863, respectively. The deferred compensation plan is administered by the International City Managers Association and the funds are invested under the terms of a trust agreement. The amounts are not available to employees until termination, retirement, death, or unforeseeable emergency.

The market value of the investments held equals the liability to plan participants under the deferred compensation plan. The deferred compensation investments consisted of various participant directed uninsured investments.

The assets in the plan are not available to pay the liabilities of HPSM. Therefore, the respective assets and liabilities are not reflected in the statements of net position of HPSM.



**Note 10 – Health Plan of San Mateo Retirement Plan – Fiduciary Fund**

Effective January 1, 1994, HPSM established the Health Plan of San Mateo Employee Retirement Plan (the Plan). The Plan is a single-employer defined benefit pension (cash balance) plan administered by HPSM. Eligible HPSM employees become members of the Plan on the first day of employment. HPSM has the authority to amend or terminate the Plan at any time and for any reason by action of its Commission. The Plan does not issue a stand-alone financial report.

Under the Plan, participants' account balances are credited with contributions equal to 10% of their annual compensation, plus interest of 5% on an annual basis effective January 1, 2005. Benefits are payable in the form of a single-sum payment upon termination or can be deferred through optional payment forms. Participants earn a vested right to accrued benefits upon completion of three years of service and upon death, permanent disability, or employer termination of the Plan. Contributions to the Plan are made by HPSM as no contributions are permitted by participants.

**Summary of Significant Accounting Policies**

**Basis of accounting** – The Plan fiduciary financial statements are prepared using the accrual basis of accounting. HPSM's contributions are recognized in the period in which contributions are made. Benefits are recognized when due and payable in accordance with the terms of the Plan.

**Investments** – The Plan's investments are reported at fair value, including certain investments held in pooled, common and collective trusts which are maintained for the collective investments are reinvestments of monies contributed to the funds.

**Mutual funds** – Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are open-end mutual funds that are registered with the U.S. Securities and Exchange Commission. These funds are required to publish their daily net asset value (NAV) and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded.

**Pooled, common, and collective trusts** – Units held in pooled investment accounts are valued using the NAV practical expedient of the pooled investment account as reported by the account managers. The NAV is based on the fair value of the underlying assets owned by the pooled investment account, minus its liabilities, and then divided by the number of units outstanding. The NAV of a pooled investment account is calculated based on a compilation of primarily observable market information. The funds invested in the Wells Fargo collective trusts are discretionary accounts managed by Wells Fargo; as a participant of those collective trusts, the Plan purchases and redemption of units from each fund are based on unit values as of the valuation date. Purchases and redemption of units may occur on a daily basis with no redemption fees or other restrictions. Further, the funds do not distribute their investment income to participants, but rather reinvest their investment income back into their respective funds.



Investments by fair value level include the following as of December 31:

| Description | Level 1 | Level 2 | Level 3 | 2022 |
|---|---|---|---|---|
| Investments by fair value level | | | | |
| Mutual funds | $ 5,187,975 | $ - | $ - | $ 5,187,975 |
| Total investments subject to fair value hierarchy | $ 5,187,975 | $ - | $ - | 5,187,975 |
| Investments not subject to fair value hierarchy | | | | |
| Pooled, common, and collective trusts - at NAV | | | | 23,122,460 |
| Total investments | | | | $ 28,310,435 |

| Description | Level 1 | Level 2 | Level 3 | 2021 |
|---|---|---|---|---|
| Investments by fair value level | | | | |
| Mutual funds | $ 5,885,732 | $ - | $ - | $ 5,885,732 |
| Total investments subject to fair value hierarchy | $ 5,885,732 | $ - | $ - | 5,885,732 |
| Investments not subject to fair value hierarchy | | | | |
| Pooled, common, and collective trusts - at NAV | | | | 26,390,073 |
| Total investments | | | | $ 32,275,805 |

**Plan description** – Participant data for the Plan, as of the measurement date for the year indicated, is as follows:

| | 2022 | 2021 |
|---|---|---|
| Retired and beneficiaries | 13 | 12 |
| Inactive | 59 | 49 |
| Active | 304 | 293 |
| Total participants | 376 | 354 |

All employees are eligible to participate, except for the following: leased employees, nonresident aliens, temporary employees, and individuals designated by the employer as ineligible to participate in the Plan.

**Retirement dates are either** – Normal – first of the month following or coincident with attainment of age 65. Deferred – first of any month following actual retirement after age 65. Early – any age prior to age 65 following completion of at least 3 years of vesting service.

**Benefits at normal retirement** – Each participant will receive an accumulated credit account determined as the sum of the following:

a) Effective January 1, 1994, 10% of compensation received as an employee prior to the effective date;

b) Effective January 1, 1994, investment credits that would have been credited to the account prior to the effective date if it had been in place;

c) For each year starting on or after January 1, 1994, 10% of compensation earned during the plan year; and

d) For each year starting on or after January 1, 1994, an investment credit determined as the Investment Crediting Rate applied to the Accumulated Credit Account at the start of the year, plus the Investment Crediting Rate applied for half a year to the compensation credit for the year.

Investment credits under d) will be pro-rated for the length of participation in the year of payment.

**Contribution** – HPSM agrees to maintain and contribute funds to the Plan in an amount sufficient to pay the vested accrued benefits of participating members and the beneficiaries when the benefits become due. Members do not make contributions. The Finance Committee makes contributions based on the established funding policy.

**Rate of return** – For the years ended December 31, 2022 and 2021, the actual rate of return on the Plan's investments, net of investment expenses, was 0.31% and 0.59%, respectively.

The following table summarizes changes in pension asset for the year ended December 31, 2022:

| | Total Pension Liability | Plan Fiduciary Net Pension | Net Pension (Asset) Liability |
|---|---|---|---|
| Balance at December 31, 2021 | $ 30,776,808 | $ 33,150,125 | $ (2,373,317) |
| Changes during the year | | | |
| Service cost at beginning of year: | 2,014,298 | - | 2,014,298 |
| Interest | 2,422,173 | - | 2,422,173 |
| Differences between expected and actual experience | 146,710 | - | 146,710 |
| Changes in assumptions | - | - | - |
| Benefit payments | (1,009,186) | (1,009,186) | - |
| Contributions | - | 2,095,537 | (2,095,537) |
| Net investment income | - | (4,955,545) | 4,955,545 |
| Net change in total pension liability (asset) | 3,573,995 | (3,869,194) | 7,443,189 |
| Balance at December 31, 2022 | $ 34,350,803 | $ 29,280,931 | $ 5,069,872 |
| Total pension liability | | | $ 34,350,803 |
| Plan fiduciary net position | | | 29,280,931 |
| Net pension liability | | | $ 5,069,872 |
| Plan fiduciary net position as a percentage of the total pension liability | | | 85.24% |
| Covered payroll as of December 31, 2022, actuarial valuation | | | $ 28,063,764 |
| Net pension liability as a percentage of covered payroll | | | 18.07% |

The following table summarizes changes in pension asset for the year ended December 31, 2021:

| | Total Pension Liability | Plan Fiduciary Net Pension | Net Pension (Asset) Liability |
|---|---|---|---|
| Balance at December 31, 2020 | $ 27,270,738 | $ 28,734,252 | $ (1,463,514) |
| Changes during the year: | | | |
| Service cost at beginning of year | 1,850,939 | - | 1,850,939 |
| Interest | 2,156,704 | - | 2,156,704 |
| Differences between expected and actual experience | 243,072 | - | 243,072 |
| Changes in assumptions | 54 | - | 54 |
| Benefit payments | (744,699) | (744,699) | - |
| Contributions | - | 1,948,733 | (1,948,733) |
| Net investment income | - | 3,211,839 | (3,211,839) |
| Net change in total pension liability (asset) | 3,506,070 | 4,415,873 | (909,803) |
| Balance at December 31, 2021 | $ 30,776,808 | $ 33,150,125 | $ (2,373,317) |
| Total pension liability | | | $ 30,776,808 |
| Plan fiduciary net position | | | 33,150,125 |
| Net pension (asset) | | | $ (2,373,317) |
| Plan fiduciary net position as a percentage of the total pension liability | | | 107.71% |
| Covered payroll as of December 31, 2021, actuarial valuation | | | $ 27,278,649 |
| Net pension (asset) as a percentage of covered payroll | | | -8.70% |

The following table summarizes the actuarial assumptions used to determine net pension liability and plan fiduciary net position as of December 31, 2022 and 2021:

| | |
|---|---|
| | Contributions related to the actuarially determined contributions made for the plan year |
| Valuation date: | January 1 to December 31 |
| Actuarial cost method: | Entry age normal actuarial cost method |
| Amortization method: | Level dollar, closed amortization |
| Asset valuation method: | Market value |
| Actuarial assumptions: | |
| Projected salary increases | 5.00% |
| Mortality | Pri-2012 total dataset table for males and females, with future mortality improvements projected on a fully generational basis using projection scale MP-2021. |
| Discount rate | 7.50% |

The following table summarizes the sensitivity of net pension asset to changes in the discount rates as of December 31:



| | 1% Decrease (6.50%) | Current Discount Rate (7.50%) | 1% Increase (8.50%) |
|---|---|---|---|
| Net pension liability (asset) as of December 31, 2022 | $ 7,237,919 | $ 5,069,872 | $ 3,134,492 |

| | 1% Decrease (6.50%) | Current Discount Rate (7.50%) | 1% Increase (8.50%) |
|---|---|---|---|
| Net pension liability (asset) as of December 31, 2021 | $ (388,718) | $ (2,373,317) | $ (4,143,955) |

Components of pension cost included in salaries and fringe benefits and deferred outflows and deferred inflows of resources, as calculated under the requirements of Accounting and Financial Reporting for Pensions (GASB 68), are as follows:

| | 2022 | 2021 |
|---|---|---|
| Service cost | $ 2,014,298 | $ 1,850,939 |
| Interest cost | 2,422,173 | 2,156,704 |
| Projected earnings on plan investments | (2,526,261) | (2,199,404) |
| Current period difference between expected and actual experience | 24,824 | 39,848 |
| Current period effect of changes in assumptions | - | 9 |
| Current period difference between projected and actual investment earnings | 1,496,361 | (202,487) |
| Current period recognition of prior years' deferred outflows of resources | 1,121,020 | 1,131,716 |
| Current period recognition of prior years' deferred inflows of resources | (1,110,557) | (1,208,274) |
| Total pension cost | $ 3,441,858 | $ 1,569,051 |

| | 2022 | 2021 |
|---|---|---|
| Deferred outflows of resources as of December 31 | | |
| Difference between expected and actual experience | $ 1,339,314 | $ 1,793,306 |
| Actual earnings on Defined Benefit Plan investments | 4,081,656 | - |
| Changes in assumptions | 13,015 | 19,269 |
| Total | $ 5,433,985 | $ 1,812,575 |

| | 2022 | 2021 |
|---|---|---|
| Deferred inflows of resources as of December 31 | | |
| Changes in assumptions | $ 8,075 | $ 10,906 |
| Difference between projected and actual investment earnings | - | 2,472,627 |
| | $ 8,075 | $ 2,483,533 |

Deferred outflows of resources as of December 31, 2022 consist of $1,903,789 of deferred inflows from difference between projected and actual investment earnings, presented in a consolidated format per GASB 68.

Deferred inflows of resources as of December 31, 2022 consist of $538,888 of deferred outflows from difference between projected and actual investment earnings, presented in a consolidated format per GASB 68.

Amount reported as deferred outflows of resources and deferred inflows of resources to pension will be recognized in pension expense are as follows:

| Year Ending December 31, | |
|---|---|
| 2023 | $ 875,905 |
| 2024 | 1,308,693 |
| 2025 | 1,614,741 |
| 2026 | 1,599,997 |
| 2027 | 26,574 |
| | $ 5,425,910 |

**Note 11 – Medical Reinsurance (Stop-Loss Insurance)**

HPSM has entered into certain reinsurance (stop-loss) agreements with third parties to limit its losses on individual claims. Under the terms of these agreements, the third parties will reimburse HPSM certain proportions of the cost of each member's annual healthcare services in excess of specified deductibles ($425,000 for all lines of business for all healthcare expenses excluding pharmacy), limited to $2,000,000 in aggregate over all contract years per member.

Stop-loss insurance premiums of $9,036,238 and $6,917,887 are included in other medical expense in 2022 and 2021, respectively.

In 2022 and 2021, there is a total of $6,952,941 and $4,599,277, respectively, included in recoveries.

**Note 12 – Professional Liability Insurance**

HPSM maintains insurance coverage for professional liability and errors and omissions insurance. The policy is an occurrence-based policy and designed specifically for health maintenance organizations to provide comprehensive professional liability insurance and errors and omissions insurance for HPSM employees and certain covered physicians. There have been no reductions in coverage or any claims that have exceeded coverage in any of the past three years.

**Note 13 – Commitments and Contingencies**

In the ordinary course of business, HPSM is a party to claims and legal actions by enrollees, providers, and others. After consulting with legal counsel, HPSM's management is of the opinion that any liability that may ultimately be incurred as a result of claims or legal actions will not have a material effect on the financial position or results of operations of HPSM.



**Note 14 – Healthcare Reform**

There are various proposals at the federal and state levels that could, among other things, significantly change member eligibility, payment rates or benefits. The ultimate outcome of these proposals, including the potential effects of or changes to health care reform that will be enacted cannot presently be determined.

## Supplementary Information

# San Mateo Health Commission
# (d.b.a. Health Plan of San Mateo)
## Supplementary Schedule of Changes in the
## Net Pension Liability (Asset) and Related Ratios



| | 2022 | 2021 | 2020 | 2019 |
|---|---|---|---|---|
| Total pension liability | | | | |
| Service cost at beginning of year | $ 2,014,298 | $ 1,850,939 | $ 1,760,865 | $ 1,555,503 |
| Interest | 2,422,173 | 2,156,704 | 1,841,604 | 1,654,496 |
| Changes of benefit terms | - | - | - | - |
| Differences between expected and actual experience | 146,710 | 243,072 | 1,514,965 | 561,651 |
| Changes in assumptions | - | 54 | (15,143) | 37,351 |
| Benefit payments | (1,009,186) | (744,699) | (1,228,597) | (1,800,659) |
| Net change in total pension liability | 3,573,995 | 3,506,070 | 3,873,694 | 2,008,342 |
| Total pension liability beginning of fiscal year | 30,776,808 | 27,270,738 | 23,397,044 | 21,388,502 |
| Total pension liability end of fiscal year (a) | $ 34,350,803 | $ 30,776,808 | $ 27,270,738 | $ 23,396,844 |
| Plan fiduciary net pension | | | | |
| Contributions | $ 2,095,537 | $ 1,948,733 | $ 1,772,346 | $ 1,613,011 |
| Net investment income | (4,955,545) | 3,211,839 | 3,804,419 | 4,099,419 |
| Benefit payments | (1,009,186) | (744,699) | (1,228,597) | (1,800,659) |
| Net change in Plan fiduciary net position | (3,869,194) | 4,415,873 | 4,348,168 | 3,911,771 |
| Plan fiduciary net position beginning of year | 33,150,125 | 28,734,252 | 24,386,084 | 20,474,313 |
| Plan fiduciary net position end of fiscal year (b) | $ 29,280,931 | $ 33,150,125 | $ 28,734,252 | $ 24,386,084 |
| Net pension liability (asset) end of fiscal year | | | | |
| Plan's net pension liability (asset) (a) - (b) | $ 5,069,872 | $ (2,373,317) | $ (1,463,514) | $ (989,240) |
| Plan fiduciary net position as a percentage of the total pension liability | 85.24% | 107.71% | 105.37% | 104.23% |
| Covered employee payroll | $ 28,063,764 | $ 27,278,649 | $ 26,690,439 | $ 23,367,767 |
| Net pension liability (asset) as a percentage of covered payroll | 18.07% | -8.70% | -5.48% | -4.23% |

# San Mateo Health Commission
# (d.b.a. Health Plan of San Mateo)
## Supplementary Schedule of Contributions



| | 2022 | 2021 | 2020 | 2019 | 2018 |
|---|---|---|---|---|---|
| Actuarial determined contribution | $ 2,095,537 | $ 1,948,733 | $ 1,772,346 | $ 1,613,011 | $ 1,396,529 |
| Contributions related to actuarially determined contribution | $ 2,095,537 | $ 1,948,733 | $ 1,772,346 | $ 1,613,011 | $ 1,396,529 |
| Contribution deficiency (excess) | $ - | $ - | $ - | $ - | $ - |
| Covered payroll | $ 28,063,764 | $ 27,278,649 | $ 26,690,439 | $ 23,367,767 | $ 23,367,767 |
| Contribution as % of covered payroll | 7.47% | 7.14% | 6.64% | 6.90% | 5.98% |
| Contributions made during the fiscal year | $ 2,095,537 | $ 1,948,733 | $ 1,772,346 | $ 1,613,011 | $ 1,396,529 |

| | 2017 | 2016 | 2015 | 2014 | 2013 |
|---|---|---|---|---|---|
| Actuarial determined contribution | $ 1,313,247 | $ 1,164,095 | $ 1,437,466 | $ 1,367,854 | $ 1,321,835 |
| Contributions related to actuarially determined contribution | $ 1,313,247 | $ 1,164,095 | $ 1,459,445 | $ 1,333,194 | $ 1,361,858 |
| Contribution deficiency (excess) | $ - | $ - | $ (21,979) | $ 34,660 | $ (40,023) |
| Covered payroll | $ 20,084,266 | $ 18,167,831 | $ 16,535,874 | $ 15,989,836 | $ 14,768,660 |
| Contribution as % of covered payroll | 6.54% | 6.41% | 8.83% | 8.34% | 9.22% |
| Contributions made during the fiscal year | $ 1,313,247 | $ 1,164,095 | $ 1,459,445 | $ 1,333,194 | $ 1,361,858 |

# San Mateo Health Commission
# (d.b.a. Health Plan of San Mateo)
## Supplementary Schedule of Investment Returns –
## Health Plan of San Mateo Retirement Plan Fund



| Years Ended December 31, | Rate of return |
|---|---|
| 2022 | -14.71% |
| 2021 | 10.95% |
| 2020 | 15.43% |
| 2019 | 22.21% |
| 2018 | -5.05% |

**AGENDA ITEM: 5.2**

**DATE: April 12, 2023**

**MEMORANDUM**

**DATE:** April 3, 2023

**TO:** San Mateo Health Commission

**FROM:** Patrick Curran, Chief Executive Officer
Trent Ehrgood, Chief Financial Officer

**RE:** Purchasing Policy Change

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## Recommendation

Approve changes to HPSM's Purchasing Policy effective July 1, 2023.

## Background information

HPSM's purchasing policy is reviewed by management annually. The policy has various internal controls for approving administrative expenses, including authority limits for different levels of management, and a threshold for expenses requiring HPSM's Commission approval.

The purchasing policy is being adjusted in various ways to improve efficiencies, while still maintaining strong internal controls. Authority limits for different levels of management are being adjusted as well, to increase authority and accountability.

Besides adjustments to management authority levels, we are proposing to increase the level requiring Commission approval from $100,000 to $250,000, and to add one exclusion for claim recovery vendors paid on a contingency basis. The Finance/Executive Committee discussed this at their February meeting and supports these changes.

**DRAFT**

**RESOLUTION OF THE**
**SAN MATEO HEALTH COMMISSION**

**IN THE MATTER OF APPROVING CHANGES TO HPSM'S PURCHASING POLICY**

**RESOLUTION 2023 -**

**RECITAL: WHEREAS,**

A. HPSM's purchasing policy is reviewed and updated by management annually to ensure strong internal controls; and

B. HPSM management is recommending the limit requiring Commission approval to be raised from $100,000 to $250,000; and

C. HPSM management is recommending the addition of an exclusion for claim-related recoveries that are paid on a contingency basis.

**NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:**

1. The San Mateo Health Commission approves changes to HPSM's purchasing policy by increasing the limit requiring Commission approval to $250,000 and adding an exclusion for claim recovery vendors.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of April 2023 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chair

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
CHIEF DEPUTY COUNTY COUNSEL

**AGENDA ITEM:** 5.3

**DATE:** April 12, 2023

# Meeting materials are not included

# for Item 5.3 – Update on Strategic Planning Process

**AGENDA ITEM:** 5.4

**DATE:** April 12, 2023

# Meeting materials are not included

# for Item 5.4 – Update on Primary Care Investments

**AGENDA ITEM:** 5.5

**DATE:** April 12, 2023

# Meeting materials are not included

# for Item 5.5 – Update on Modular RFP

**MEMORANDUM**

**AGENDA ITEM: 7.0**

**DATE: April 12, 2023**

**DATE:** April 4, 2023

**TO:** San Mateo Health Commission

**FROM:** Patrick Curran

**RE:** CEO Report – April 2023

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**Medi-Cal Redeterminations**

Beginning April 1st, the state renewed the Medi-Cal redetermination process for more than 15 million beneficiaries statewide. The state suspended redeterminations during the public health emergency. Over the next year, members will need to recertify their eligibility for Medi-Cal, including all 140,000 HPSM members. We are working closely with San Mateo County Health and San Mateo County Human Services Agency to facilitate this process and ensure that qualified members retain coverage. The first date that members could lose coverage is July 1, 2023.

**State Budget and Legislative Process**

The California legislature is now conducting hearings on bills for inclusion in the final June budget. We are following many healthcare-related bills through our lobbyist in Sacramento and through LHPC, our statewide association. There are two bills of particular interest to us at this time, one that we are supporting and one that we are opposing:

- SB311 – This bill was introduced by Senator Eggman and would require the State Department of Healthcare Services (DHCS) to enter into an agreement with the Centers for Medicare and Medicaid Services (CMS) to pay the Part A Medicare premium for qualified beneficiaries. HPSM is supporting this bill because it would expand Medicare coverage for those individuals who qualify but who cannot afford or cannot navigate the system to qualify for full Medicare benefits in addition to their Medi-Cal benefits.
- AB1230 – This bill was introduced by Assemblymember Valencia and would require that DHCS contract with Medicare special needs plans which are designated as Fully Integrated Dual Eligible Special Needs Plans (so-called FIDE SNPs) and Highly Integrated Dual Eligible Special Needs Plans (so-called HIDE SNPs). HPSM is opposing this bill. Similar to the state's direct contract with Kaiser, this bill would further undermine the County Organized Health System (COHS) model by allowing any Medicare plan to offer a FIDE or HIDE SNP and require the state to contract with that plan for Medi-Cal services, which means that the members would no longer have Medi-Cal coverage through HPSM.

We will keep the Health Commission informed about these bills and others that may affect our members.

**Managed Care Organization (MCO) Tax**

The state of California has historically received federal approval to place a "tax" on managed care organizations. This mechanism of taxing all health plans actually results in enhanced federal funding and a redistribution of dollars to help fund the Medi-Cal program through a complex financing formula. The state discontinued this tax in 2022 but is now proposing to re-establish the tax.

There are two separate bodies of work taking place related to this MCO tax. The Governor included a reinstatement of this tax in the January budget proposal, and DHCS is working with CMS to obtain necessary approvals. In addition, there is a group of provider and plan organizations which are proposing to place an initiative on the November 2024 ballot, which would permanently establish an MCO tax and devote the funding specifically to Medi-Cal, with an emphasis on provider payment rates.

HPSM supports these MCO tax initiatives, as they both offer opportunities to enhance and solidify funding for the Medi-Cal program, which will be important over the long-term due to inevitable state budget fluctuation. We will update the Health Commission regarding the progress of both tax-related proposals over the next few months.

**Medicare DSNP and PACE**

We plan on having two main focus topics at our Health Commission meeting in May. We will give an update on our evaluation work of PACE (Program of All-Inclusive Care for the Elderly) and potential next steps, as well as follow up on the primer given by Dr. Chris Esguerra on our Medicare Dual Special Needs Plan (DSNP). We will talk about how our Medicare plan continues to evolve, as well as give an update on conversations with other local plans regarding a potential collaboration on a regional DSNP model.