HealthPlan OF SAN MATEO
Healthy is for everyone

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THE SAN MATEO HEALTH COMMISSION
Regular Meeting
December 11, 2024 - 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., Boardroom
South San Francisco, CA 94080

This meeting of the San Mateo Health Commission will be held in the Boardroom at 801 Gateway Blvd., South San Francisco. Members of the public wishing to view this meeting remotely may access the meeting via YouTube Live Stream using this link: https://youtube.com/live/5NGV1tPt85Y?feature=share Please note that while there will be an opportunity to provide public comment in person, there is no means for doing so via the Live Stream link.

AGENDA

1. **Call to Order/Roll Call**
2. **Public Comment/Communication**
3. **Approval of Agenda**
4. **Consent Agenda***
   - 4.1 Finance Report
   - 4.2 Community Advisory Meeting Minutes, October 2024
   - 4.3 Waive Request for Proposal and Approval of Amendment to Extend Pharmacy Benefit Management Services with SS&C Health
   - 4.4 Waive Request for Proposal and Approval of Amendment to Agreement with Previon Solutions, LLC for Part D Mailing Services
   - 4.5 Waive Request for Proposal and Approval of Amendment to Agreement with Wider Circle for the Connect for Life Program
   - 4.6 Waive Request for Proposal and Approve Amendment to Agreement with UG2 Engineering
   - 4.7 Approval of Agreement with Lahlouh, Inc., and Amendments to Agreements with Clarity Software Solutions, and FolgerGraphics, Inc.
   - 4.8 Waive Request for Proposal Process and Approval of Agreement with Lussier Data Architects, LLC
   - 4.9 Waive Request for Proposal Process and Approval of Agreement with Legal Aid Society of San Mateo County
   - 4.10 San Mateo Health Commission Meeting Dates for 2025
   - 4.11 Approval of San Mateo Health Commission Meeting Minutes from November 13, 2024
5. **Specific Discussion/Action Items**
   - 5.1 Resolution of Appreciation for George Pon, Commissioner*
   - 5.2 Approval of 2025 HPSM Budget*
6. **Report from Chief Executive Officer**
7. **Other Business**
8. **Adjournment**

**Items for which Commission action is requested.*

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

HealthPlan OF SAN MATEO

AGENDA ITEM: 4.1

DATE: Dec 11, 2024

M E M O R A N D U M

Date: October 28, 2024
To: San Mateo Health Commission
From: Trent Ehrgood, Chief Financial Officer

Subject: **Financial report for the nine-month period ending September 30, 2024**

Preliminary 2024 Financial Results All Lines of Business

Q3 2024 preliminary financial results for all lines of business is a surplus of $20.4M, with a YTD total surplus of $65.5M, compared to the YTD budget surplus of $22.1M.

There is a pending revenue adjustment related to the transitioning populations this year. This revenue adjustment will be recorded in Q4 which will lower Medi-Cal revenue and decrease the cumulative surplus to a smaller number for the year. Rough estimates now show 2024 potentially ending with a surplus between $40M to $50M. This is still higher than the budget of $30M, but lower than current trends.

The pending revenue adjustment will be a refund of premium dollars to DHCS as an offset to the lower-than-expected utilization with the newly transitioned membership. The refund will be calculated in the form of a risk corridor.

Attached is presentation material to guide the discussion for our committee meeting on November 4th. Additional material will be added during the meeting to illustrate the pending adjustments mentioned above. Detailed Statements of Revenue and Expense on a consolidated basis, as well as for each line of business, are provided after the presentation slides.

Financial Update

Presentation to Finance/Compliance Committee

November 4, 2024

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2024 Budget by Quarter

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	Q1	Q2	Q3	Q4	Total
Capitation revenue	278,251,545	270,376,856	267,479,774	267,479,774	**1,083,587,950**
Healthcare cost	244,457,413	236,785,413	234,094,216	234,033,056	**949,370,098**
Administrative expenses	20,450,626	18,544,037	19,096,791	18,795,995	**76,887,449**
MCO Tax	13,688,653	13,108,437	12,895,507	12,895,507	**52,588,105**
Income/(loss) from operations	(345,148)	1,938,970	1,393,260	1,755,217	**4,742,299**
Non-operating revenue	6,363,016	6,371,475	6,371,475	6,371,475	**25,477,441**
Net income/(loss)	6,017,868	8,310,445	7,764,735	8,126,691	**30,219,739**

Q3 2024 Preliminary Financial Results

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	Q1 (Jan-Mar)	Q2 (Apr-Jun)	Q3 (Jul-Sep)	YTD Total	YTD Budget	Budget Variance
Capitation revenue	375,040,869	293,423,415	329,754,669	998,218,953	816,108,176	182,110,777
Healthcare cost	329,717,779	251,707,268	274,271,117	855,696,164	715,337,042	(140,359,122)
Administrative expenses	18,967,270	17,184,266	17,785,367	53,936,903	58,091,454	4,154,551
MCO Tax	15,238,091	10,827,926	27,992,478	54,058,495	39,692,598	(14,365,897)
Income/(loss) from operations	11,117,729	13,703,955	9,705,707	34,527,391	2,987,082	31,540,309
Non-operating revenue	9,649,216	10,635,452	10,717,259	31,001,927	19,105,966	11,895,961
Net income/(loss)	20,766,945	24,339,407	20,422,966	65,529,318	22,093,048	43,436,270

YTD September 2024 – PY/CY

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	YTD by PY/CY			Current Year YTD		
	Prior Year	Current Year	Total	Current Year	Budget	CY Variance
Capitation revenue	152,751,671	845,467,282	998,218,953	845,467,282	816,108,176	29,359,106
Healthcare cost	149,235,007	706,461,157	855,696,164	706,461,157	715,337,042	8,875,885
Administrative expenses	-	53,936,903	53,936,903	53,936,903	58,091,454	4,154,551
MCO Tax	(228,035)	54,286,530	54,058,495	54,286,530	39,692,598	(14,593,932)
Income/(loss) from operations	3,744,699	30,782,692	34,527,391	30,782,692	2,987,082	27,795,610
Non-operating revenue	6,352	30,995,575	31,001,927	30,995,575	19,105,966	11,889,609
Net income/(loss)	3,751,051	61,778,267	65,529,318	61,778,267	22,093,048	39,685,219

Average Membership

Variance to Budget

LOB	Avg. Actual	Avg. Budget	Variance	% Var
Medi-Cal	75,453	73,805	1,648	2.2%
Medi-Cal Expansion	53,365	50,344	3,021	6.0%
Whole Child Model	1,152	1,145	8	0.7%
Medi-Cal Full Duals	7,522	7,000	521	7.4%
Sub-total Medi-Cal	137,492	132,294	5,198	3.9%
Medicare D-SNP	8,341	8,380	(40)	-0.5%
HealthWorx	1,245	1,216	29	2.4%
Total at Risk	147,078	141,890	5,188	3.7%
+ ACE	1,483	2,104	(622)	-29.5%
Grand Total	148,561	143,994	4,566	3.2%

Budget Variance by Major Drivers

favorable/(unfavorable)

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		YTD Jun	YTD Sep		Revenue	Expense
1	Prior year adjustments not in the budget	(494)	3,751,047			
	Current year variances:					
2	Membership higher than budget	1,684,940	3,634,395	<<	20,658,034	(17,023,639)
3	Revenue: Yield PMPM variance to budget	(803,152)	(3,505,262)			
4	Revenue: Maternity supplemental payment	670,030	1,497,562			
5	Healthcare cost: PMPM variance to budget	17,445,382	16,704,602			
6	Healthcare cost: directed payments	(744,666)	1,627,671			
7	ECM (rev-exp variance)	884,012	2,060,618	<<	(5,506,633)	7,567,251
8	Administrative cost variance to budget	2,843,127	4,154,551			
9	MCO Tax variance (rev-exp variance)	1,248,684	1,621,473	<<	16,215,406	(14,593,933)
10	Non-op revenue (*CY portion) variance to budget*	7,550,177	11,889,614			
	Total current year	30,778,533	39,685,224			
	Total consolidated budget variance	**30,778,039**	**43,436,271**			

Healthcare Cost

Detail by Category of Service

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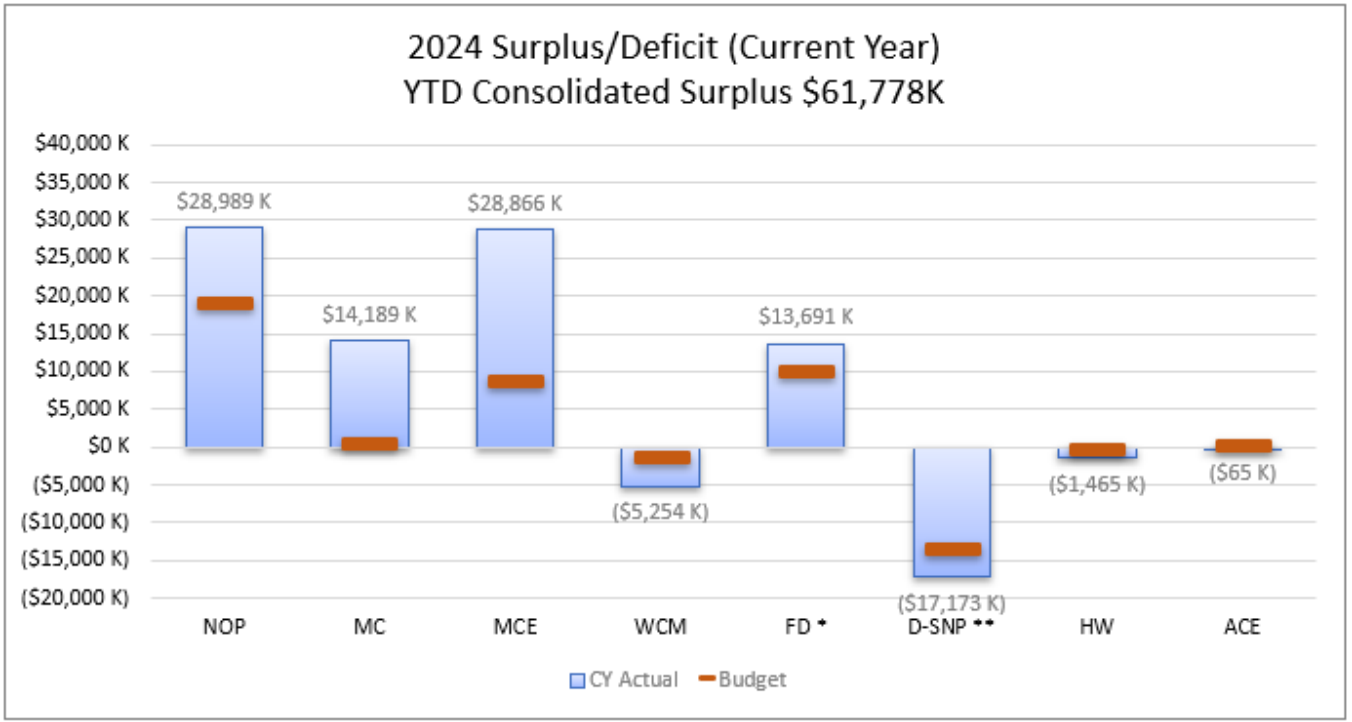
	YTD Actual					
	Total	Prior Year	Current Year	YTD Budget	Variance	% Var.
Provider Capitation	20,269,994	104,064	20,165,930	19,389,825	(776,105)	-4.0%
Hospital Inpatient	141,931,910	(1,990,000)	143,921,910	163,111,185	19,189,275	11.8%
LTC/SNF	120,768,273	(2,280,000)	123,048,273	131,408,409	8,360,136	6.4%
Pharmacy	50,558,126	(58,436)	50,616,562	48,010,893	(2,605,669)	-5.4%
Physician FFS	74,100,156	(497,018)	74,597,174	73,253,681	(1,343,492)	-1.8%
Hospital Outpatient	87,315,274	(656,970)	87,972,245	80,867,611	(7,104,634)	-8.8%
Other Medical Claims	79,102,177	(313,208)	79,415,384	79,069,500	(345,884)	-0.4%
Other HC Services	6,825,210	143,091	6,682,120	4,824,986	(1,857,134)	-38.5%
Directed Payments	190,314,317	157,989,388	32,324,930	33,952,601	1,627,671	4.8%
Long Term Support Services	1,261,334	-	1,261,334	1,163,058	(98,276)	-8.4%
CPO/In-lieu of Services	8,844,978	440,000	8,404,978	6,837,814	(1,567,165)	-22.9%
Dental	28,232,721	(60,000)	28,292,721	19,196,384	(9,096,337)	-47.4%
ECM	1,857,092	189,218	1,667,875	9,235,126	7,567,251	81.9%
Provider Incentives	12,748,169	(963,372)	13,711,541	13,508,500	(203,040)	-1.5%
Supplemental Benefits (D-SNP)	1,918,136	-	1,918,136	2,248,582	330,446	14.7%
Transportation	12,899,758	(403)	12,900,161	10,970,561	(1,929,600)	-17.6%
Indirect Health Care Benefits	(321,039)	(2,808,611)	2,487,572	1,222,200	(1,265,372)	-103.5%
UMQA	17,069,575	(2,736)	17,072,312	17,066,127	(6,185)	0.0%
Total Healthcare Cost	855,696,164	149,235,007	706,461,157	715,337,042	8,875,885	1.2%

CY YTD Surplus/Deficit by LOB

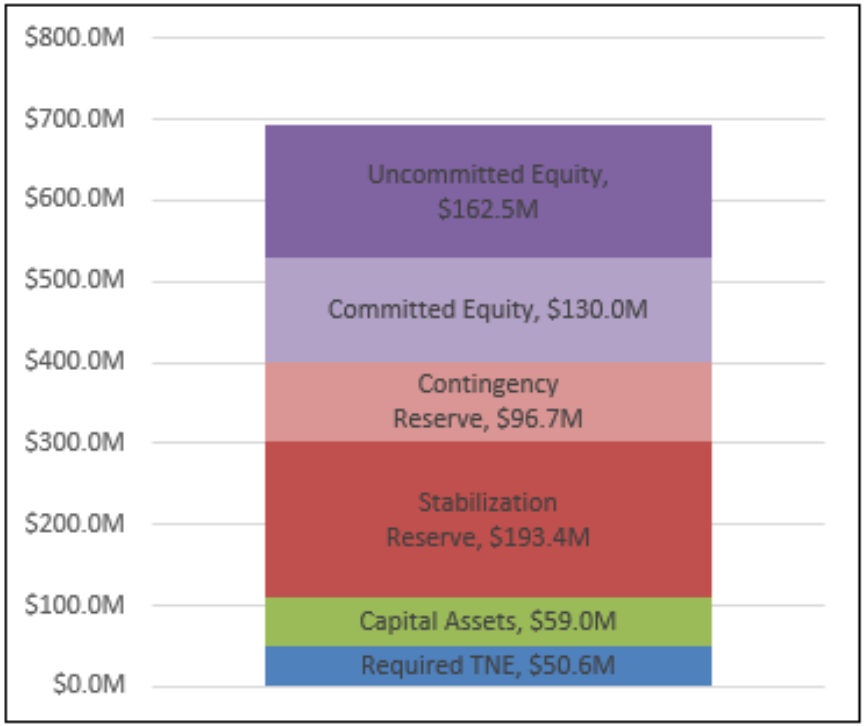


* FD includes M-Cal portion of D-SNP
** D-SNP includes Medicare portion only

Tangible Net Equity (TNE)

At 9/30/24 Pre-Audit TNE = $692.2M

Uncommitted portion = $162.5M



Q3 2024 Summary

- DHCS published final Medi-Cal rates for 2024, resulting in an annual revenue decrease for 2024 of around $5M retro to Jan 1st. Nine months worth of this ($3.7M) was recorded in September.
- The 2024 Medi-Cal rate adjustment was offset by a favorable adjustment to 2023 claim cost estimates (IBNR) totaling around $2.5M.
- Overall, the primary driver of the current year surplus is lower healthcare cost. This will be offset with a risk corridor (see next item).
- A pending revenue adjustment related to the transitioning populations will be recorded in Q4 and will lower Medi-Cal revenue and decrease the cumulative surplus for the year. This will be an offset to the lower utilization with this population that was the main driver of this year's surplus.

Q3 2024 Summary

Continued . . .

- Below are pending adjustments that will be recorded in Q4:
  1) Medi-Cal UIS risk corridor (reduce revenue)
  2) Remaining TRI provider rate adjustments for PCP Cap and WCM (increase expense)
  3) Kaiser global cap adjustment for 2023 annual reconciliation (reduce PY expense)

- Current estimates now show 2024 potentially ending with a surplus between $40M to $50M as a result of the UIS risk corridor. This is still higher than the budget of $30M, but lower than current trends.

Questions?

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FINANCE/COMPLIANCE COMMITTEE MEETING

Meeting Summary

November 4, 2024, 12:30 pm

County Executive Conference Room, 500 County Center, Redwood City, CA 94064

-or-

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

Member's present: Bill Graham, George Pon, Si France, M.D.

Members absent: Mike Callagy

Staff present: Trent Ehrgood, Pat Curran, Francine Lester, Ian Johansson, Michelle Heryford

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

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

3.0 **Approval of Meeting Summary for March 25, 2024 –** The meeting summary for August 26, 2024, was approved as presented. **Pon/Graham M/S/P**

4.0 **Preliminary Financial Report for the 9-month period ending September 30, 2024** – CFO, Trent Ehrgood reviewed the financial report for the 9-month period ending September 30, 2024. He advised the committee of a pending adjustment that is relatively significant and will reduce the surplus for the year to something much smaller than what is trending so far. This has to do with the unsatisfactory immigration status (UIS) risk corridor. HPSM was unaware of this until it was mentioned at a recent conference by the CFO of a sister plan. He reminded the group that in January of this year, the state lifted the immigration status as a criteria for qualifying for Medi-Cal for those in the 26 to 49 age group. They had already done this for the 50 and above age group a couple years ago. When HPSM received draft rates for 2024 in late 2023, they noticed the rates for that population had been drastically reduced. There was a lot of push back from other plans. As a result, the State backed off and didn't decrease them by as much. What they did not notice at the time was that they inserted a risk corridor to protect the State if they

overshot the rates. The risk corridor works for both sides, if they don't give the Plan enough, they'll give you more, if they give the Plan too much, you have to give some back. It's rare to have this at the population level, it usually occurs at the program or benefit level. It was not stated in the rate package, the only mention of it was in a rate certification letter to CMS, a 130-page procedural document that the State submits for rate approval. The necessary adjustments will be recorded in Q4. The revenue adjustment could be around $10M a quarter, or $40M for the year.

Mr. Ehrgood reviewed the 2024 budget by quarter. They originally projected a $30M surplus. Without the UIS risk corridor adjustment HPSM has a $65M surplus through the third quarter, and the fourth quarter would be similar to past quarters with about $20M. That comes to about $80M for the year, minus the $40M for the risk corridor, which will bring the surplus to around $40 to $45M for the year. This risk corridor could be potentially impactful for next year if it still applies. Though it is not part of the 2025 draft rate package, there is suspicion that it will probably apply for next year. He went over how much of the $65 million is for the current year versus prior year. About $61M is from 2024, the rest of the $3.7M relates to prior year adjustments. Claims estimates for 2023 were too conservative and makes up most of that $3.7M.

HPSM membership was expected to decline some due to redetermination, which it has. However, the decline has been less than expected, which is why they are running slightly higher than budgeted. He went over the budget variance by major drivers and noted that the State finally submitted their final rates for 2024, they anticipated a big decrease of approximately $10-$15M for 2024 but it ended up being equivalent to a $5M decrease. Mr. Ehrgood reviewed healthcare costs by category of service showing the adjustments to the prior year versus the expenses for the current year. He noted that hospital inpatient and long-term care skilled nursing is actually positive. These expenses were much lower than expected due to lower utilization from the UIS transitioning population.

The current year surplus/deficit by line of business notes that Medi-Cal was expected to be closer to break even, but there is a big surplus of $14M, this is due to low utilization of the UIS population. The same thing is occurring with the expansion population. He also pointed out the impact of the non-operating revenue. It's reported separately because it is not specific to the individual populations but is contributing towards the surplus because interest rates have remained high, which means more income.

He discussed the medical loss ratio (MLR) calculation. The MLR is the percentage of revenue that is used for health care costs. He showed numbers from Q2 for illustrative purposes. HPSMs revenue for Medi-Cal was $202M and health care cost was $177M, which means HPSM is spending almost 88% of their revenue on healthcare costs. He broke it down to take a look at the satisfactory immigration status (SIS) and the UIS populations separately. The SIS population has an MLR of 94.4%, while the UIS population has a MLR of 72.5%. A good place is 90% - 91%, which ensures that administrative costs are covered. The risk corridor that will be applied in 2024 is only going to apply to two cohorts – the UIS adult and the UIS adult expansion populations, which has a MLR of 65.8% and where the majority of the surplus is. "All other" UIS, which includes children, seniors, persons with disabilities and institutionalized members has a high MLR at 98%. Which means that HPSM is spending almost all of that revenue on health care costs. It leaves almost nothing for administrative costs. He explained how it is not detrimental to HPSM this year because they have enough surplus in other areas to land in a positive place overall. Though it appears that the rates will be decreasing a little bit, both on the SIS and UIS for next year. The risk corridor may be carried forward for another year, and if that happens HPSM may end up with the SIS being really tight or negative and the UIS being somewhat positive. They are still working on forecasting for next year.

He went over Tangible Net Equity, showing how reserve levels have accumulated. HPSM is close to $700M in reserves. That number will decrease slightly in Q4 as part of the year end close by recording the UIS risk corridor. The financial report was approved as presented.
France/Pon MSP

5.0 Compliance Report – Compliance Disclosures - Chief Government Affairs and Compliance Officer, Ian Johansson reviewed Compliance disclosures. He spoke about delegation oversight, which involves the model of care. Model of care (MOC) is a requirement for HPSMs Medicare program to ensure that the Plan is appropriately managing the complex conditions of the Medicare Advantage population. Up until March of 2024, HPSM outsourced some of the activities of the MOC to an organization called Independent Living Systems (ILS). At the February Commission meeting it was reported that there was potential fraud, waste and abuse identified with work conducted by ILS employees. As a result, they engaged a consulting firm, Compliance Strategies, to conduct a targeted audit. Their report identified numerous deficiencies with adherence to their contractual and regulatory requirements. Because the contract between HPSM and ILS was slated to term at the end of March, they opted not to engage in corrective actions with

ILS. Though HPSM did provide ILS with a report of the findings. Because of the low performance by not only ILS, but also the prior vendor, HPSM decided to bring these tasks in-house. On January 1, 2024, HPSM initiated the CarePlan 2.0 Project and began performing health risk assessments (HRA) and individualized care plan (ICP) work. Between January 1, 2024 – March 31, 2023, ILS' work was phased out. In June of 2024, HPSM initiated a program-wide gap analysis and mock audit of Medicare operations in Q3 of 2023. The audit reviewed HPSMs HRA, ICP and interdisciplinary care team (ICT) activities. They completed the audit report in June of 2024 and non-compliance was identified with CMS standards. HRAs were compliant with CMS standards. ICPs were non-compliant with timeliness and completeness standards. A backlog of 1,811 overdue ICPs were identified. CMS was advised of this non-compliance in August of 2024. HPSM is providing regular updates to CMS on its corrective action. They are revising processes to be more efficient with ICPs and ICT completion and are in the process of hiring both temporary and full-time staff to meet timeliness and completion standards. When they first created the corrective action plan, they anticipated that they would be compliant by November 30th, 2024. They now realize they will not meet that deadline; the new projected date is March 1, 2025. They will continue to provide updates to CMS and this committee.

6.0 Other Business – There was no other business.

7.0 Adjournment – The meeting was adjourned at 1:42 pm by Commissioner Graham.

Respectfully submitted:

M. Heryford

M. Heryford

Assistant Clerk to the Commission

DRAFT

HEALTH PLAN OF SAN MATEO
COMMUNITY ADVISORY COMMITTEE MEETING
Meeting Minutes
Wednesday, October 16, 2024
801 Gateway Blvd. – 1st Floor Boardroom
South San Francisco, CA 94080

AGENDA ITEM: 4.2

DATE: December 11, 2024

Committee Members Present: Rob Fucilla, Ricky Kot, Ana Avendano Ed.D., Kathryn Greis, Ligia Andrade-Zuniga, Marmi Bermudez

Committee Members Absent: Angela Valdez, Amira Elbeshbeshy, Hazel Carillo

Staff Present: Megan Noe, Amy Scribner, Karla Mendoza-Pina, Charlene Barairo, Luarnie Bermudo, Talie Cloud, Mackenzie Munoz, Corinne Burgess, Michelle Heryford

1.0 Call to Order/Introductions: The meeting was called to order by Ms. Greis at 12:04 pm, a quorum was met.

2.0 Public Comment: There was no public comment.

3.0 Approval of Meeting Minutes for April 17, 2024, and August 20, 2024: The minutes for April 17, 2024, and August 20, 2024, were approved as presented. **Andrade-Zuniga/Kot MSP**

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

5.0 HPSM Operational Reports and Updates:

5.1 CEO Update: Chief Health Officer Amy Scribner, reported on behalf of CEO Pat Curran. HPSM staff has been busy completing an audit for the Department of Health Care Services (DHCS) and are awaiting the results. On October 1st, ABA services transitioned from vendor Magellan to HPSM. So far, the transition is going well. Members are getting matched with ABA providers in a timely fashion.

5.2 CMO Update: There was no report.

5.3 Population Needs Assessment (PNA): Population Health Program Specialist, Talie Cloud went over the results of the PNA for both the Medi-Cal (MC) and CareAdvantage (CA) lines of business (LOB). She went over membership demographics, reported on health disparities and the action plan for 2024-2025. She noted the importance of addressing disparities in chronic condition management, cancer screening, and access to care.

Demographics show that membership as of January 2024 is approximately 150K. The most common race and ethnicities are Hispanic along with Asian/Pacific Islander. Threshold languages include Spanish, Chinese, Tagalog, and English. The top non-threshold languages are Portuguese, Russian and Arabic. About 50% of HPSM membership speaks English and 41% speaks Spanish. There are disparities in chronic condition management, which includes diabetes care, and blood pressure control. Younger populations have lower rates of colon cancer screening as well as access and engagement with care. In terms of gender, male members have lower rates of diabetes care management, colon cancer screening and access and engagement with care. The Caucasian population had the greatest volume of disparities. The Black identifying population also has a large number of disparities in blood pressure control, diabetes care, colon cancer screening, and access and engagement with care. There are also some disparities in well-child visits for certain sub-populations for Black identifying members. She also went over disparities by area, they appear to be particularly concentrated in South San Francisco and East Palo. HPSMs disabled membership have lower rates of blood pressure control, diabetes management and lower rates of cervical cancer screening.

She explained how the data is reviewed and used to be most impactful in addressing these disparities. The action plan for 2024-2025 includes perinatal health, child and youth health, adult preventive health, and chronic condition management. She provided example interventions for each of the areas mentioned above. The group discussed problems with access for disabled members. There was a request to provide breakdowns and compositions of the membership in the next survey.

5.4 **Member Experience Survey Overview:** Program Manager, Member Experience and Engagement Mackenzie Moniz went over the results of the CAHPS, Timely Access, CareAdvantage Member Experience and the Medi-Cal Member Experience surveys that were completed by HPSM members for 2023 and 2024. She highlighted the top performing measures and the bottom performing areas in each. All of the survey results were sent to committee members in advance.

5.5 **Provider Services (PS) Report:** Director of Provider Services, Luarnie Bermudo provided an update of the dental collaborative with Sequoia Healthcare District. HSPM is collaborating with eight dental providers who are not yet a part of the network. They are excited about the program and hope to have these providers eventually join the

network. PS has onboarded two new endodontists as well as two new general dentists in San Bruno and Redwood City. There are also three new pediatric dentists and an oral surgeon in San Mateo. They are currently processing two Registered Dental Hygienists in Alternative Practice (RDHPs). They are also in talks with Sonrisas to get a mobile unit funded in Pescadero to help increase dental access on the coast.

Behavioral Health Therapy (BHT) services, specifically ABA services for young members with autism, was brought in house on October 1st. Ms. Bermudo noted the addition of Clarity Pediatrics to the network. They contracted with this group specifically for their ADHD behavioral parenting training sessions. Their hope is that in addition to offering training sessions for families impacted by ADHD, they will also support PCPs and offer medication management. PS is also working with some contracted providers to see if there is an opportunity for HPSM to offer one-time capacity funds to build out their workforce in an effort to increase access.

HPSM has contracted with Breathe California, specific to community support (CS) aspects around asthma remediation. Two of HPSMs CBAS providers, Golden Castle and Avenidas, have contracted to provide enhanced care management (ECM) services. HPSM continues to look for non-emergency transportation (NEMT) providers that provide gurney transport, as well as those who can assist members that have more than two steps at their front door. A challenge as these transports require that there be two drivers present. Lastly, Ms. Bermudo noted that San Mateo Medical Center (SMMC) is going through a massive transition and are close to launching Epic, a software system primarily used as an electronic health record (EHR) system. It helps healthcare providers manage patient information, including medical history, appointments, prescriptions, and test results. This centralized system improves efficiency and communication. Their go live date is November 2nd through November 16th. They are expecting a 25% reduction in patient visits at that time as they will be prioritizing urgent visits only. The schedule should be back to normal the week of November 18th.

5.6 **Member Services Report:** Member Services Manager, Karla Mendoza-Pina went over the Member Services (MS) report for Q3 on behalf of Director of Member Services, Keisha Williams. She went over membership numbers for all LOBs. There are no call metrics to report this quarter as a new phone system was implemented in September. They hope to share Q4 data at the next meeting. The MS email address has been updated. CA, MS, and G&A now have their own email addresses. They have hired a full-time staff member who can speak Spanish and Portuguese. They have also hired two MS representatives; they will start the second week of November. There are two openings for MS staff as a result of promotions. They hope to fill those positions soon and are looking for a call center supervisor as well.

5.7 CareAdvantage Enrollment and Call Center Report: CA Manager, Charlene Barairo reviewed the CA report for Q3. She went over CA membership which is at 8,367. They enrolled 184 members in Q3, 153 are new and 31 re-enrolled. 261 members were dis-enrolled. The Medicare annual enrollment period started on October 15th and goes until December 7th. HPSM is holding an event on Saturday, October 19th called "All Aboard CareAdvantage" to help those who are interested in joining CareAdvantage. Any enrollments received during the Medicare enrollment period will be effective January 1, 2025. In 2025 they will go back to monthly enrollment. Enrollment in 2024 was done on a quarterly basis. Default enrollment, formerly known as seamless enrollment, has been postponed as they await approval from Centers for Medicare & Medicaid Services (CMS). This is for HPSM Medi-Cal members who will be newly eligible for Medicare parts A and B. They won't have to complete an enrollment application; instead, they will be automatically enrolled. They will be notified 60 and 30 days prior and can opt out then if they choose. They can also opt out 90 days after their effective date of enrollment.

The department has fully transitioned to the new phone system and will be able to provide Q4 reports at the next meeting. The top three reasons for member calls in Q3 2024 were balance billing, inquiries on Parts C and D benefits, and supplemental benefit inquiries. There are new benefits for CareAdvantage members starting January 1, 2025, they include a medical alert device, they will also offer transportation to the gym for those who choose to take advantage of the fitness benefit. They are offering 12 one way or 6 round trip rides. There will also be an increase to the OTC benefit, which will go up to $95 per quarter and the grocery benefit will increase to $70 per quarter. The OTC and grocery benefit will now roll over if there is a balance at the end of the quarter. They will also remind members to use their balances if they have one. These benefits are only for those with certain chronic conditions.

5.8 Grievance and Appeals Report: Chief Health Officer, Amy Scribner reviewed the G&A report for Q3. Membership is stabilizing, it had been decreasing in prior months. The volume of G&A has increased, it was noted that complaints going straight to grievance caused a spike and they continue to be on an upward trend. Rates of complaints per thousand members was outside the goal for all LOB's, except for the CCS whole child model. MC was slightly above goal. CA grievances are very high. They have looked into some of the trends around customer service, which tend to be complaints against the staff at provider offices, from front desk staff to medical assistants. Timeliness goals are set at 95%. They were above the goal for pharmacy and medical at 98%. PCP changes have actually decreased from prior quarters of 2024. The top grievances for CA is customer service, quality of care and billing. For CA appeals its prescription drugs, followed by durable medical equipment (DME) and other services/therapy. The top grievances on the MC side is customer service, quality of care and billing. The top

three appeals for MC is other service/therapy, DME and specialists. They will continue to look into why there is an increase in G&A's overall.

5.9 2025 Meeting Dates – The proposed meeting dates for 2025 were shared. They will occur quarterly, the dates are January 15, April 16, July 18, and October 15, 2025. Invitations will be sent for the new dates to all committee members.

6.0 New Business: There was no new business.

7.0 Adjournment: The meeting was adjourned at 1:38 pm by Ms. Greis.

Respectfully submitted:

M. Heryford

M. Heryford

Assistant Clerk to the Commission

MEMORANDUM

AGENDA ITEM: 4.3

DATE: December 11, 2024

DATE: November 26, 2024

TO: San Mateo Health Commission

FROM: Pat Curran, Chief Executive Officer

RE: Waive Request for Proposal and Approval of Amendment to Agreement with SS&C Health for Pharmacy Benefit Management Services

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Recommendation:

Approve a waiver of the request for proposal (RFP) process and authorize the Chief Executive Officer to execute an amendment to extend the agreement with SS&C Health for Pharmacy Benefit Management (PBM) services. The amendment will extend services for one year through December 31, 2025.

Background and Discussion:

Pharmacy benefit management services are a necessary component to the provision of the pharmacy benefit to health plan beneficiaries. PBM services include but are not limited to the following: pharmacy claims processing and payment transactions, formulary development and maintenance, pharmacy network contracting and management, a 24/7 pharmacy help desk call center, drug rebate negotiations and collections, and regulatory compliance support to state and federal requirements pertaining to the pharmacy benefit.

SS&C Health (f/k/a DST Pharmacy Solutions, and prior to that, Argus Health Systems) has served as HPSM's contracted PBM for pharmacy benefit services since they were originally selected through the completion of an RFP process back in 2012. HPSM's current service agreement with SS&C Health is set to term December 31, 2024. SS&C has been a longstanding vendor partner of HPSM's, providing vital and satisfactory pharmacy benefit management services to enable HPSM to offer pharmacy benefit coverage to our members.

It's worth noting that many other local health plans have either recently or are currently undergoing the RFP and PBM implementation process to start new D-SNP lines of business beginning in 2026, leading to an overly impacted schedule for PBM implementation resources. As such, the notion of considering a PBM transition for an established D-SNP plan would neither be considered practical nor in the best interests of HPSM and its members.

All things considered, staff recommends waiving the request for proposal process and moving forward with the proposed amendment to extend PBM services with SS&C Health through December 31, 2025 in the amount of $800,000.

Fiscal Impact:

The amendment will extend our agreement with SS&C Health through December 31, 2025. SS&C Health has offered to keep administrative rates generally the same as our previous arrangement by maintaining the same rates for core administrative expenses associated with prescription claims processing, asking for slight inflationary increases to secondary administrative expenses, while offering slight improvements to prescription drug reimbursement rates. As mentioned in the most recent memo regarding SS&C Health in 2021, the total fiscal impact is heavily dependent on actual prescription drug utilization, as the primary administrative expense is tied to paid prescription claim volume. Additionally, increasing state and federal requirements that are to take effect in 2025, such as provisions of the Inflation Reduction Act, may result in increased administrative costs associated with operating those requirements. A previous 2021 memo regarding PBM services had estimated administrative expenses falling between $900,000 to $1.5 million annually in 2021, given the uncertainty from the pharmacy carve-out transition for Medi-Cal Rx. Our current estimate for direct administrative expenses in 2025 is an upper threshold of $800,000.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL TO WAIVE
REQUEST FOR PROPOSAL PROCESS AND APPROVE
THE AMENDMENT TO AGREEMENT TO WITH SS&C HEALTH

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. HPSM has a need to maintain pharmacy benefit management (PBM) services for the provision of the pharmacy benefit to health plan beneficiaries.
B. SS&C Health has been a longstanding vendor partner that enables HPSM to provide pharmacy benefit coverage services.
C. SS&C Health has in good faith offered a reasonable amendment proposal to HPSM where both parties desire to extend services one year through December 31, 2025.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the request for proposal process and approves the amendment to the agreement to extend the term one year through December 31, 2025 in an amount not to exceed $800,000; and
2. Authorizes the Chief Executive Officer to execute said amendment.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of December 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

MEMORANDUM

AGENDA ITEM: 4.4

DATE: December 11, 2024

DATE: December 11, 2024

TO: San Mateo Health Commission

FROM: Pat Curran, Chief Executive Officer
Chris Esguerra, M.D., Chief Medical Officer
Ming Shen, Director of Pharmacy

RE: Waive Request for Proposal Process and Approval of Amendment to Agreement with Previon Solutions, LLC for Part D Mailing Services

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Recommendation:

Waive Request for Proposal process and authorize the Chief Executive Officer to execute an amendment to agreement with Previon Solutions, LLC to extend the agreement for one year from January 1, 2025 to December 31, 2025 in an amount not to exceed $385,000 for the term.

Background and Discussion:

As a Part D sponsor, HPSM must meet state and Centers for Medicare and Medicaid Services (CMS) communication and mailing requirements regarding Medicare Part D benefits and services provided to HPSM Medicare beneficiaries. In addition to other standard required mailings, Part D mailing requirements are complex in nature and involve communications with member-specific details such as Explanation of Benefit (EOB) mailings that provide each member with individualized details on benefit utilization.

Due to the nature and complexity of Part D mailing requirements, staff is requesting the continuation of the agreement with Previon Solutions, LLC as its vendor for Part D and requests a waiver of the request for proposal process. In 2022, the Commission approved $360,000 annually towards Part D printing and mailing services associated with Previon for 2023 and 2024.

HPSM estimates printing and mailing obligations for Part D EOBs to remain relatively stable in 2025, inclusive of alternative format needs such as large print. As such, HPSM anticipates future annual costs changes to be mostly based on annual inflationary increases.

Fiscal Impact:

We are estimating 2025 expenditures for Part D mailing services to come in at around $385,000, which would be a $25,000 increase from 2024 to cover service costs. This assumes demand for alternative format needs will remain relatively stable. Actual costs are utilization based, dependent on membership and the number of individuals that utilize the Part D benefit large print format materials.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF WAIVE REQUEST FOR PROPOSAL
AND APPROVAL OF AMENDMENT TO AGREEMENT
WITH PREVION SOLUTIONS, LLC

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission is required to meet Part D mailing requirements as a Part D sponsor operating a Medicare line of business

B. The Health Plan of San Mateo has an existing agreement with Previon Solutions, LLC to provide printing and mailing services;

C. Previon Solutions, LLC, has demonstrated the capability to support Part D mailing requirements over the years, including the recent increased demand in large print activity.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the request for proposal process and authorizes the Chief Executive Officer to execute an amendment to the agreement to with Previon Solutions, LLC to increase the agreement by $385,000 and extend the term for one year from January 1, 2025 to December 31, 2025 to cover Part D printing and mailing services.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of December, 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

MEMORANDUM

AGENDA ITEM: 4.5

DATE: December 11, 2024

DATE: November 8, 2024

TO: San Mateo Health Commission

FROM: Chris Esguerra MD, Chief Medical Officer
Eunice Salonga, CareAdvantage Program Manager

RE: Waive Request for Proposal Process and Approval of Amendment to Agreement with Wider Circle for the Connect for Life Program for 2025

Recommendation:

Waive Request for Proposal process and approve an amendment to the existing agreement with Wider Circle to provide their "Connect For Life" Program to Health Plan of San Mateo's (HPSM) CareAdvantage D-SNP members in an amount not to exceed $485,000 and extend the term for another year. And, to authorize the Chief Executive Officer to execute this amendment with Wider Circle.

Background:

HPSM has been working with Wider Circle since 2017 offering services to its members to decrease social isolation and loneliness among older adults through community integration. The "Connect for Life" Program was provided through small group facilitated meetings focused on healthy living, movement and socialization. Participants graduated from the six-week program and then participated in larger monthly groups to maintain their new social connections. All groups are supported by a trained Wider Circle facilitator and a network of peers known as Wider Circle Ambassadors.

This program began in 2017 with a pilot of fifty (50) HPSM members in three sites focused on building connections among Medicare eligible older adults living in the community. Based on the success of the pilot program, the Commission approved expansion of the program to 500 members in 2018. In June 2020, the Commission further approved expansion of the program to cover emergency response and screenings due to COVID. Wider Circle completed 4,271 welfare check calls and supported 16,634 peer buddy calls. The current agreement with Wider Circle is due to expire on December 31, 2024. Based on the expertise and success of this program, staff recommends continuing this agreement with Wider Circle and waiving the request for proposal process.

Discussion:

In this continuation of our agreement, Wider Circle will provide member engagement services to assist with closing care gaps and improve the member experience. As a technology-enabled, peer-based community health organization, Wider Circle is equipped to help restore the community support network critical for addressing social challenges in members' lives. Working with our internal team to reach members, Wider Circle will assist with closing gaps related to several State and Federal required measures (i.e., CMS Star Ratings measures) as well as helping members create social connections within their community.

Fiscal Impact:

This amendment includes a performance bonus provision for the following measures:

- Annual Wellness Visit (AWV) Performance
- Retention Performance
- Member Experience Performance

In order to begin implementation of this program, staff is requesting approval of a one year extension through December 31, 2025 for an amount not to exceed $485,000 for administrative costs.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF WAIVE REQUEST FOR PROPOSAL
AND APPROVAL OF AMENDMENT TO AGREEMENT WITH
WIDER CIRCLE FOR CONNECT FOR LIFE PROGRAM

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has previous entered into an agreement with Wider Circle for the "Connect for Life" program focused on decreasing social isolation;
B. The Duals Special Needs Program began on January 1, 2023 with new requirements and measures which will affect our STAR ratings related to our rates;
C. The current agreement with Wider Circle is due to expire on December 31, 2024; and
D. Staff recommends amending the agreement for the CareAdvantage population for the D-SNP program for the "Connect for Life" Program.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the request for proposal process and approves the amendment to the agreement with Wider Circle in an amount not to exceed $485,000 for the extended term of January 1, 2025 through December 31, 2025 for the "Connect for Life" Program; and
2. Authorizes the Chief Executive Officer to execute said amendment.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of December 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

MEMORANDUM

AGENDA ITEM: 4.6

DATE: December 11, 2024

DATE: November 15, 2024

TO: San Mateo Health Commission

FROM: Trent Ehrgood, Chief Financial Officer
Oz Bubakar, Facilities Manager

RE: Waive Request for Proposal and Approve Amendment to the Agreement with UG2 Engineering to provide Engineering Services to HPSM

Recommendation:

Approve a waiver for the RFP process and an amendment to extend the term of the agreement with UG2 Engineering by three years and increase the contract maximum amount by $700,000 for a total new not to exceed amount of $1,350,000.00 from January 1, 2023 through December 31, 2026 authorize the Chief Executive Officer to execute said Amendment.

Background:

In 2015 HPSM purchased a five-floor building at 801 Gateway, South San Francisco, which resulted in the need of services that HPSM had previously not required. One of these services is engineering and maintenance. Services include minor repairs of boilers, heater pumps, valves, compressors, and coordination of building/capital improvements. HPSM also requested a full-time engineer to be on site. The Facility/Administrative Services staff interviewed three companies to review our needs and submit pricing. The companies interviewed were ABM Engineering, Able, and CBRE Engineering. Cost comparisons of services offered by each company were similar. Able Engineering had provided the engineering and maintenance services to the previous building owners. Because of this they knew the building equipment and had relationships with the vendors that support that equipment. In December 2015, the commission ratified a three-year agreement with Able to provide Engineering Services in the amount of $678,000. In March 2018 the commission approved an amendment extending the agreement until December 31, 2020 increasing the not to exceed amount to $1,549,740. In January 2021, you approved a 2 year agreement with Able through December 2022 to continue providing Engineering services to HPSM.

In September 2021 HPSM received notice that Able Engineering had been acquired by ABM Engineering. While the notice had been extended there was no action by ABM to interact with HPSM. Because of this HPSM staff looked at alternatives and received information regarding engineering services from ABM, GSH and UG2. All Peninsula/San Francisco Union Building Engineers belong to Local 39 and as such the wages paid and benefits given are the same by all companies. The only price variable is the markup by the company contracted with. Current cost comparisons of the local engineering companies are very similar. After review,

based on local references, management support and cost, it was determined that UG2 Engineering would best meet the needs of HPSM.

Discussion

After the initial term with UG2 Engineering, they have been consistent and valuable partner for the past 2 years. The firm has local contacts and discounts with variety of vendors that HPSM utilizes and performed physical survey of the building , making recommendations for capital and building improvements.

Term and Fiscal Impact:

The amendment to the agreement increases the contract maximum by $700,000 for a total maximum of $1,350,000. The new term of the agreement is extended through December 31, 2026. Monies have been approved in the 2025 budget and a request for funds will be made in future budgets for the subsequent years of the agreement.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF WAIVING THE REQUEST FOR PROPOSAL PROCESS AND APPROVE AN AMENDMENT TO THE AGREEMENT WITH UG2 ENGINEERING, INC.

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. In September of 2021 Able Engineering was acquired by ABM and San Mateo Health Commission approved an agreement with UG2 Engineering for HPSM at its offices at 801 Gateway Blvd., South San Francisco;

B. Staff requests a waiver of the Request for Proposal process and authority to extend the existing agreement for an additional 2 years with UG2 Engineering.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the Request for Proposal process and approves an amendment to the agreement with UG2 Engineering Services, Inc. for a term beginning January 1, 2023 through December 31, 2026 in an amount not to exceed $1,350,000; and

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

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of December 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

MEMORANDUM

AGENDA ITEM: 4.7

DATE: December 11, 2024

DATE: November 27, 2024

TO: San Mateo Health Commission

FROM: Pat Curran, Chief Executive Officer
Trent Ehrgood, Chief Financial Officer
Oz Bubakar, Facilities Manager

RE: Approval of Agreement with Lahlouh, Inc. and Amendments to Agreements with FolgerGraphics, and Clarity Software Solutions (Print and Mailing Services Vendors)

Recommendation

Authorize the Chief Executive Officer to execute agreement with our new print and mailing vendor, Lahlouh, Inc. and amendments to the agreements with our existing vendors, Folger Graphics, Clarity Software Solutions. The total print and mailing budget to be allocated among the vendors is for a not to exceed amount of $1,500,000 for a term ending December 31, 2025.

Background and Discussion

HPSM performs a large volume of print and mailing services to meet State and the Centers for Medicare and Medicaid Services (CMS) requirements for printed hard copies of important informing materials to be mailed to the Plan's 160,000 members and more than 900 providers.

HPSM handles the printing, packaging and mailing of materials through a combination of internal staff resources and contracted vendors. Many years ago, HPSM invested in a small number of large, high-volume printers to handle print jobs that are more efficiently done internally, especially simple letter notices about key program changes. HPSM Administrative staff print and process these materials.

HPSM has been using multiple print and mailing vendors allowing more flexibility to choose the vendor that best fits timeline and delivery requirements as well as cost considerations. This approach also permits HPSM to obtain competitive pricing for certain print jobs. In 2020, the Commission approved $1,737,400 for printing services provided by Folgers, KPLLC and Clarity which was identified through an RFP.

HPSM currently conducted an RFQ process specifically for mailing and printing and Lahlouh, Inc. was selected to be added to our pool of our print and mailing vendors.

Due to new programs including Cal-AIM, Dental, Pharmacy and D-SNP, as well as some unexpected mailing mandates from the State, the cost of contracted printing increased significantly. While departments actively worked together to anticipate these costs to HPSM, the costs were much higher than anticipated. We are asking the Commission to approve an agreement with Lahlouh, Inc. and amendments to the current agreements for Folger Graphics, Inc. and Clarity Software Solutions, Inc.

Fiscal Impact

We are estimating the 2025 expenditures with vendors for print and processing to be $1,500,000. These amendments will be with Clarity Software Solutions, Inc., and FolgerGraphics, Inc. and the new agreement with Lahlouh, Inc. all term ending December 31, 2025.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF AGREEMENT WITH LAHLOU, INC. AND AMENDMENTS TO AGREEMENTS WITH FOLGER GRAPHICS, INC. AND CLARITY SOFTWARE SOLUTIONS, LLC. FOR PRINT AND MAILING SERVICES

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. HPSM does a large volume of print and mailing services to meet requirements from the State and the Centers for Medicare and Medicaid Services (CMS) to mail printed hard copies of important informing materials to members and providers; and

B. Multiple print and mailing vendors give HPSM more flexibility to choose the vendor that best fits timeline and delivery requirements as well as cost considerations, and allows HPSM to obtain competitive pricing for certain print jobs; and

C. HPSM has been using FolgerGraphics and Clarity for these services and has identified a new vendor, Lahlouh, Inc through an RFQ process.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves an agreement with Lahlou Inc. and amendments to the agreements with FolgerGraphics and Clarity Software Solutions for total amount not to exceed $1,500,000 for the term ending December 31, 2025; and
2. Authorizes the Chief Executive Officer to execute said new agreement and amendments, respectively.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of December 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

AGENDA ITEM: 4.8

DATE: December 11, 2024

MEMORANDUM

DATE: November 27, 2024

TO: San Mateo Health Commission

FROM: Pat Curran, Chief Executive Officer
Eben Yong, Chief Information Officer

RE: Waive Request for Proposal Process and Approve a two year Agreement with Lussier Data Architects, Inc. (LDA)

Recommendation:

Waive the Request for Proposal process and approve a two-year agreement with Lussier Data Architects, Inc. (LDA) They will continue to provide ongoing full-service software development and reporting services in an amount not to exceed $720,000 and to authorize the Chief Executive Officer to execute said Agreement.

Background:

LDA has provided software development and reporting services to Health Plan of San Mateo (HPSM) since March 2006 and is the developer of HPSM's claims data warehouse (Claims Statistics Database), the main reporting, workflow and auditing tool for the claims management system (HEALTHsuite). The Claims Statistics Database is a valuable tool for the organization in managing claims related data and reporting to external agencies. Claims Statistics Database integrates additional critical data sources including the document imaging system, the off-site claims processing service, legacy Customer Service system (Everest) and New System MedHOK, and the Medicare carrier file for other healthcare coverage. Claims Statistics Database has been custom designed to address HPSM's specific needs and allows staff to create ad-hoc workflows and reports that contribute to increased productivity.

In addition to the Claims Statistics Database referenced above, LDA has also created and continues to manage other operations systems utilized by HPSM daily, such as Authorizations Statistics Database, Letter Generator, Data Mart, and HPSM's Intranet. LDA has become embedded with every HPSM department as a trustworthy resource and is relied upon to upgrade current systems, or develop new ones, based on requests from respective Business Owners/Department Leads.

As of December 2024, LDA continues to provide additional software development and maintenance to address a myriad of regulatory issues to support HPSM in meeting its statutory obligations as well as the development of several tools to help increase productivity in HPSM's day to day activities. These projects include:

Admin / Facilities
Vendor Contract Management Database

Business Systems Integration
Geo-Mapping Database Application
DP Datamart

CareAdvantage
Automated Enrollment/Disenrollment and OEV Letter Process
CareAdvantage Member Workflow and Reporting Database

Claims Department:
Pharmacy Pricing Database and User-Interface
Suspended Claims Database and User-Interface
Reinsurance Database and User-Interface
Automated PNF (Provider Not Found) Letter Process
Automated Misdirected Claim Letter Process
Continued Daily Management of Claims Statistics Database

Compliance
Policy Database

Finance
Finance Database Server Upgrade
Reinsurance Database and User-Interface

Grievance & Appeals
External Case Review
MedHOK integration

Health Services
Authorizations Statistics Database – Inpatient Webform Revision of Functionality
PCP Admit and Discharge Automated Letter Process
Continued Daily Management of Letter Generator
Continued Daily Management of Authorizations Statistics Database
Health Risk Assessment Database
Referral Management Database

Marketing & Communications
Large Print Letters
Cover Page Configuration

Member Services
Kaiser and HealthWorx Automated Letter Process

IT
eFax Database reporting and integration with other systems
MedHOK integration with other existing HPSM systems
Microsoft Access conversion to MS SQL Server
HPSM Intranet Releases: v2.0, v2.1
Evaluation and Consolidation of Resources (Utilized Servers, Databases)
Service Desk Plus Interoperability
Data Extract Optimization

Provider Services
Provider Contracts Database and User-Interface
Provider Services Department Correspondence Tracking (Call Log Database)
Continued Daily Management of Provider Portal
LOA Pipeline
Provider Intake

LDA has been a consistent and valued partner of HPSM and is viewed as more than a consulting firm. Its staff has been responsive in developing innovative solutions to HPSM's rapidly changing needs. LDA will continue to work with HPSM to add new features and expand the operational and reporting capabilities of the many tools already delivered and in daily use in addition to creating new applications and data systems to support organizational business and regulatory requirements.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF WAIVE REQUEST FOR PROPOSAL AND APPROVAL OF AGREEMENT WITH LUSSIER DATA ARCHITECHTS INC., LLC

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. Lussier Data Architects, Inc. (LDA) has provided software development and reporting services to Health Plan of San Mateo (HPSM) since March 2006;
B. LDA has delivered excellent application and support services to HPSM;
C. The current contract is due to expire on December 31, 2024; and
D. Ongoing development and professional services are needed.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the Request for Proposal process;
2. Approves a two-year agreement with Lussier Data Architects, Inc. for January 1, 2025 through December 31, 2026 in an amount not to exceed $720,000 for the term; and
3. Authorizes the Chief Executive Officer to execute said agreement.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of December 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

MEMORANDUM

AGENDA ITEM: 4.9

DATE: December 11, 2024

DATE: November 27, 2024

TO: San Mateo Health Commission

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

RE: Waive Request for Proposal Process and Approve Agreement with the Legal Aid Society of San Mateo County

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Recommendation

Waive the RFP process and approve a three-year agreement with the Legal Aid Society of San Mateo County in an amount not to exceed $697,700; and authorize the Chief Executive Officer to execute said agreement.

Background and Discussion

The Legal Aid Society of San Mateo County has provided advocacy services for HPSM members since 2008. The member advocacy program includes:

- Providing advice, representation, and referral services for HPSM members;
- Educating members, staff, and staff of partner agencies that serve HPSM members about legal issues that impact health and health care coverage;
- Addressing systemic issues that impact HPSM members, including the timely processing of Medi-Cal applications and renewals; and
- Statewide advocacy to benefit HPSM members.

HPSM serves a disproportionately elderly and disabled population. Retention of health coverage through Medi-Cal and/or Medicare is crucial to HPSM members receiving necessary ongoing medical and behavioral health care. Since 2008, HPSM has referred over 1,540 members to Legal Aid (81 referrals between August 2023 to July 2024). Please note that there were fewer referrals in 2020-2022 given the State's hold on negative actions for member eligibility. We anticipate that the number of referrals may continue to increase due to potential risk of immigration challenges for

undocumented Medi-Cal members. Legal Aid has provided members with assistance in meeting or eliminating Medi-Cal Share of Cost, maintaining Medi-Cal coverage, and resolving inappropriate Medi-Cal, Medicare and/or SSI terminations.

Legal Aid has also been instrumental in statewide advocacy which has benefited HPSM members, including efforts to require counties to evaluate beneficiaries on Share of Cost Medi-Cal for full coverage under Medi-Cal expansion.

In June 2015, DHCS implemented a two-month deeming period for CareAdvantage Cal MediConnect (CA CMC) members that lose Medi-Cal eligibility. The deeming period allowed members to remain enrolled in CA CMC for up to two months while attempts are made to restore Medi-Cal coverage. If Medi-Cal is not restored, the member will be disenrolled at the end of the two-month deeming period. HPSM staff will continue to refer CA CMC members to Legal Aid to help get their Medi-Cal restored before the end of the two-month deeming period. This prevents a break in coverage, especially since many members temporarily lose Medi-Cal due to administrative errors or confusion about documentation requirements. Legal Aid received 121 calls related to Medicare/Medi-Cal in FY 23-24.

In 2016, the agreement with the Legal Aid Society of San Mateo County was amended to add a Conservatorship Project to the scope of service. The Conservatorship Project provides free legal services to HPSM's most vulnerable families and parents seeking conservatorship for their adult children. The young adult who is the proposed conservatee must be at least 17 ½ years old and have severe cognitive disabilities that make the young adult incapable of consenting to medical care, as documented by medical providers. The conservatorships must be uncontested.
Since 2019, Legal Aid has received 243 conservator referrals from HPSM.

HPSM has been very satisfied with the caliber of the services provided by Legal Aid. Staff at Legal Aid are responsive, professional, and well respected in the healthcare community, in addition to understanding the local landscape. Due to the high level of service and the fact that there are no viable alternative vendors to provide this service, staff requests a waiver of the RFP process.

Fiscal Impact

The current agreement with Legal Aid expired July 31, 2024, with an annual amount not to exceed $210,300. We are recommending a 5% rate increase per year for the next three years. The term of the new three-year agreement is August 1, 2024 through July 31, 2027, in an amount not to exceed $697,700.00.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF WAIVING THE REQUEST FOR PROPOSAL PROCESS AND APPROVING AN AGREEMENT WITH LEGAL AID SOCIETY OF SAN MATEO COUNTY

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. The Health Plan of San Mateo has previously entered into an agreement with the Legal Aid Society of San Mateo County;
B. Legal Aid provides a valuable and unique service that directly benefits HPSM members:
C. Since 2008, HPSM has referred 1,540 members to Legal Aid; and
D. Staff recommends these services continue under a new three-year agreement.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the RFP process and approves a three-year agreement with the Legal Aid Society of San Mateo County beginning August 1, 2024 through July 31, 2027 in an amount not to exceed $697,700; and
2. Authorizes the Chief Executive Officer to execute said agreement.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of December 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chair

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

AGENDA ITEM: 4.10

DATE: December 11, 2024

MEMORANDUM

DATE: December 3, 2024

TO: San Mateo Health Commission

FROM: Pat Curran, Chief Executive Officer

RE: Commission Meeting Schedule for 2024

The San Mateo Health Commission meetings are held on the 2nd Wednesday of the month at 12:30 p.m. The meetings will be held at the Health Plan of San Mateo, 801 Gateway Blvd., 1st Floor Boardroom, South San Francisco. Below are the meeting dates planned for 2025, unless notified otherwise.

Please note there will be no meeting scheduled for the months of May and August in 2025:

January 8, 2025
February 12, 2025
March 12, 2025
April 9, 2025
June 11, 2025
July 9, 2025
September 10, 2025
October 8, 2025
November 12, 2025
December 10, 2025

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF SAN MATEO HEALTH COMMISSION
MEETING DATES FOR 2025

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission meets on the 2nd Wednesday of the month at 12:30 p.m.; and

B. The Commission wishes to adopt a schedule for 2025 for its scheduled meetings.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission adopts the schedule to meet on the 2nd Wednesday of each month at 12:30 pm with the exception of May and August 2025.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of December 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

DRAFT

AGENDA ITEM: 4.11

DATE: December 11, 2024

SAN MATEO HEALTH COMMISSION
Meeting Minutes
November 13, 2024 – 12:30 a.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor Boardroom
South San Francisco, CA 94080

Commissioners Present:	Jeanette Aviles, M.D.,	Manuel Santamaria
	Bill Graham, Vice-Chair	Kenneth Tai, M.D.
	George Pon, R. Ph., Chair	Ligia Andrade Zuniga
Commissioners Absent:	David J. Canepa, Michael Callagy, Si France, M.D., Raymond Mueller	
Counsel:	Kristina Paszek	
Staff Presenting:	Pat Curran, Colleen Murphey, Luarnie Bermudo, Amy Scribner, John Okonne, Nicole Ford, Megan Noe, Samareen Shami.	

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

2. **Public Comment**
   There were no public comments at this time.

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

4. **Consent Agenda**
   Consent Agenda was approved as presented. Motion: Aviles (Second: Graham) **M/S/P.**

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

   5.1 Provider Capacity Investments

   Mr. Patrick Curran introduced Colleen Murphey, Chief Operating Officer, and Luarnie Bermudo, Director of Provider Services, who presented the recommendation to the commission related to a block of provider capacity investments. Their presentation is attached to these minutes.

   They explained how this recommendation was developed in line with the 2024-2028 Strategic Plan and focused on goal 2 and goal 6: Enhance Access and Experience and Investing for the Future, respectively. They reviewed the background of previous commission approval for a commitment for a Provider Investment Fund which included a directive to continue working on provider rate increases and the commission direction for HPSM to "bundle" potential one-time provider investments that meet our criteria.

Presented for consideration was a recommendation to provide funding in the amount of $47,000 to Ted's Pharmacy, who serves about 10% of HPSM members but prescribes over 90% of antipsychotic injectable prescriptions and over 20% of behavioral health prescriptions. The investment aims to help Ted's Pharmacy continue providing free prescription deliveries due to rising costs. This funding will support up to 65 CareAdvantage members with access to these injectable antipsychotic medications.

Also in this block of one-time proposed investments was the recommendation to fund $140,000 for two behavioral health treatment providers, Adapt and Aces, to increase access to services for young members impacted by autism. Each provider will receive $70,000 to double their caseload by the year 2025 and maintain it for at least three years. This is a one-time Behavioral Health Treatment (BHT) investment in workforce and cultural concordance. This funding would increase access by an estimated 10% in BHT for members.

Lastly, this block of funding would include funding in the amount of $400,000 for Sonrisas, a high-volume dental provider, to expand dental access in the south coast side area via mobile dentistry units equipped with new technology and equipment to serve members with mobility challenges. This includes $300,000 for two operatories in a dental RV, $25,000 for enhancing their outreach data management system, and $75,000 for a 3D Panoramic Dental X-ray machine. This would increase access by reaching up to 200 new members, with each member receiving about five visits annually.

The total amount of this recommendation for a one-time capacity block funding is $587,000 for these HPSM contracted providers: Ted's Pharmacy, Adapt, ACES and Sonrisas.

Commissioner Tai asked about the $400,000 for Sonrisas after the 200 members in the first year. It was explained that this will cover approximately 200 members per year for 5 years.

Commission Pon asked about the sustainability of these programs. It was clarified that the current investments are one-time funding, and future funding will be evaluated based on the success and impact of the programs. Staff emphasized the importance of aligning the investments with the strategic plan. They discussed how these investments address access challenges and support the strategic goals of advancing high-quality care and investing for the future.

Commissioner Graham inquired about the selection process for the providers receiving investments. It was explained that Ted's Pharmacy was chosen in partnership with BHRS due to its unique role in prescribing essential medications. For BHT services, providers were selected based on their ability to offer culturally concordant care and extended hours. It was further explained that staff will present a more formal approach for primary care capacity investment in January. The structure of the program presented in January can be expanded to additional provider categories.

Commissioner Zuniga moved approval of the recommendation to fund these one-time provider capacity investments as stated for a total amount of $587,000 as described. Second: Tai. **M/S/P.**

5.2 Population Needs Assessment and Health Outcomes Updates

Mr. Curran introduced Amy Scribner, Chief Health Officer, who then introduced the speakers: Nicole Ford, Director of Quality Improvement, Megan Noe, Director of Population Health, John Okonne, Director of Medicare, and Samareen Shami, Population Health Manager. Their presentation is attached to these minutes.

Amy Scribner first gave an overview, such as the focus areas of the strategic plan around goal 1 and goal 3: Improve health outcomes and reduce health disparities. Ms. Scribner and Ms. Ford provided a breakdown of the membership demographics and highlighted the importance of understanding the differences and similarities across lines of business. Medi-Cal is the health plan's largest population, followed by CareAdvantage, ACE and HealthWorks.

The population needs assessment uses various report cards to measure health outcomes, including the NCQA health plan rating, and Medicare star ratings. These tools help in understanding the health experiences and gaps within the member population. The presentation highlighted the differences in demographics and health experiences across lines of business.

Ms. Ford covered the information relating to the NCQA rating which is the assessment nationally of health plans' clinical quality and member satisfaction annually. The plans across the country are categorized into three categories: Private/Commercial, Medicare Advantage (non D-SNP), and Medicaid. This rating is based on clinical quality metrics called HEDIS (Healthcare Effectiveness Data and Information Set) and patient experience. NCQA gives plans an overall rating of 0-5 stars. She explained the overall rating methodology, stating that there are about 47 measures in total in calculating this star rating and how the comparison among plans work. She further explained the domains of the measurements and how they are calculated to determine the overall rate. Ms. Ford was pleased to report for the 2024 NCQA Health Plan Rating, HPSM received a 4.5 Star out of 5 rating, which is the highest rating for Medicaid plans across all Medicaid plans for 2024 and for 2023.

Mr. Okonne spoke specifically about the CareAdvantage D-SNP star ratings which is published annually by CMS (Centers for Medicare and Medicaid Services). He explained the star ratings of 1-5 with 5 stars being Excellent. This year HPSM received its first Medicare star rating since the Cal MediConnect program ended. This rating is based on a comparison of Medicare Advantage plans across the nation. He explained that for Medicare, the star rating cycle is a two-year cycle. For 2025, this consists of the measurement year (MY), which is 2023, and collected in 2024, which then becomes the star rating for 2025. He further explained the four levels of the framework to arrive at the CMS star rating. Of note, the measures are not weighted equally, are grouped by nine different domains, then are summarized into Part C (Medical Plan) and Part D (Drug Plan – then leading to the overall star rating.

Mr. Okonne explained the five different parts of the Part C Domain: Staying Healthy; Managing Chronic Conditions; Member Experience with Health Plan; Member Complaints and Changes in the Health Plan's Performance; and Health Plan Customer Service. The domains for Part D, which is the Drug Plan, are similar to Part C. However, there are only four parts of the Part D domain: Drug Plan Customer Service; Member Complaints; Member Experience; and Drug Safety and Accuracy of Drug Pricing.

Mr. Okonne explained that the star ratings are a regulatory requirement since we are participating in the Duals Special Needs Program. We are held accountable by CMS. The star ratings are used by members and potential members in making their health plan selection decisions. The other important factor of our star rating is that it is tied to our funding. High-performing health plans receiving 4+ stars receive a 5% Quality Bonus Payment, which is reinvested to provide even more supplemental benefits for our members.

Lastly, Mr. Okonne reviewed our CMS star rating results and how we were able to obtain our star rating. He broke this down by the overall rating, as well as the specific Part C and Part D ratings, which all resulted in a 3 star rating, which is very good for the first measurement year. He covered the reasons why the health plan was able to reach this level. In closing, he reviewed the areas of opportunity to improve in future years including work on pharmacy MTM program, continuing to drive CAHPS interventions that are member, provider and staff focused, and to close any HEDIS measure gaps.

Megan Noe, Director of Population Health, and Samareen Shami, Manager of Population Health Management, presented on the Population Needs Assessment (PNA). Ms. Noe reviewed the work that the PNA sets out to inform and reviewed the health disparities identified in the population needs assessment, including disparities in diabetes management, primary care engagement, and cancer screenings. The areas of focus for their report today covered Member Demographics, Engagement with Care, Chronic Condition Prevalence, and Health Disparities. These are the areas where the health plan integrates the bulk of the health outcomes related to HEDIS and stars measures across the access to care, preventive care and chronic condition management domains. The presentation covered the PNA from January 2024 and is performed annually.

Ms. Noe reviewed the race and ethnicity categories as well as the preferred languages for our 150,000 members. More than half of our membership identifies as Hispanic, followed by Asian or Pacific Islander. The highest language preferences continue to include English, Spanish, Chinese and Tagalog. Around half of the membership prefers a non-English language, and this is continuing to increase. We are seeing an increase in Portuguese, Arabic and Vietnamese speaking populations. These shifts are important when implementing or designing improvement strategies and target approaches.

Regarding Primary Care Engagement, we see that less than half of the Medi-Cal members visited a primary care provider, whereas on the CareAdvantage side, almost all members visited a primary care provider during the previous year. Looking at chronic condition prevalence on the Medi-Cal side, we have around 36% of members that have one or more chronic conditions and for the CareAdvantage population, approximately 94% have a

chronic condition, with a majority of members having more than one. Geographically, the cities with the highest Medi-Cal membership are San Mateo, followed by Redwood City and Daly City. For the CareAdvantage population nearly 1/4 of our members live in Daly City, followed by San Mateo and then South San Francisco.

Ms. Shami emphasized the importance of addressing these disparities through data-driven interventions and community collaboration. Disparities identified were in diabetes management, primary care engagement, and cancer screenings. These disparities were observed across different demographic groups, including age, race, and language preference. By analyzing data on race, ethnicity, language, sex, age, and disability status, the team aims to design targeted interventions to improve health outcomes for specific demographic groups. Additionally, community collaboration is crucial in addressing health disparities. The team works with various community partners, advisory councils, and health districts to align goals and activities, involving internal work groups, ensuring that interventions are informed by community needs and perspectives and leveraging qualitative inputs to inform improvement strategies.

- **Internal Work Groups:** These groups focus on maternal and child health, chronic conditions, and adult preventive health. These groups analyze data from the population needs assessment and prioritize interventions based on identified gaps and disparities.

- **Advisory Councils:** These groups provide valuable insights and feedback on the PNA. These councils include representatives from various community organizations and help ensure that the assessment and subsequent interventions are aligned with community priorities.

- **Qualitative Inputs:** In addition to quantitative data, qualitative inputs from community members and stakeholders are used to inform improvement strategies. This approach helps in understanding the underlying factors contributing to health disparities and designing more effective interventions.

6. Report from Chief Executive Officer

Mr. Curran reviewed the forecast of the intentions of our next few commission meetings, noting future agenda topics to include the budget discussion in December, provider investments in January, and policy updates in February, leading to a retreat in April.

7. Other Business

There was no other business discussed at this time.

8. Closed Session

The commission moved to closed session at 1:38 pm to discuss:

CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION (Government Code Section 54956.9(d)(1))
West Sacramento Nursing and Rehabilitation Center v. Health Plan of San Mateo (Case No. 24-CIV-05925, Superior Court for the County of San Mateo)

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

9. Reconvene Open Session (and report on closed session)

The commission reconvened at 2:00 pm. Ms. Paszek reported that no action was taken in closed session.

10. Adjournment

The meeting adjourned at 2:01 pm.

Submitted by:

C. Burgess

C. Burgess, Clerk of the Commission

San Mateo Health Commission

5.1 Provider Capacity Investments

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2024-2028 Strategic Plan

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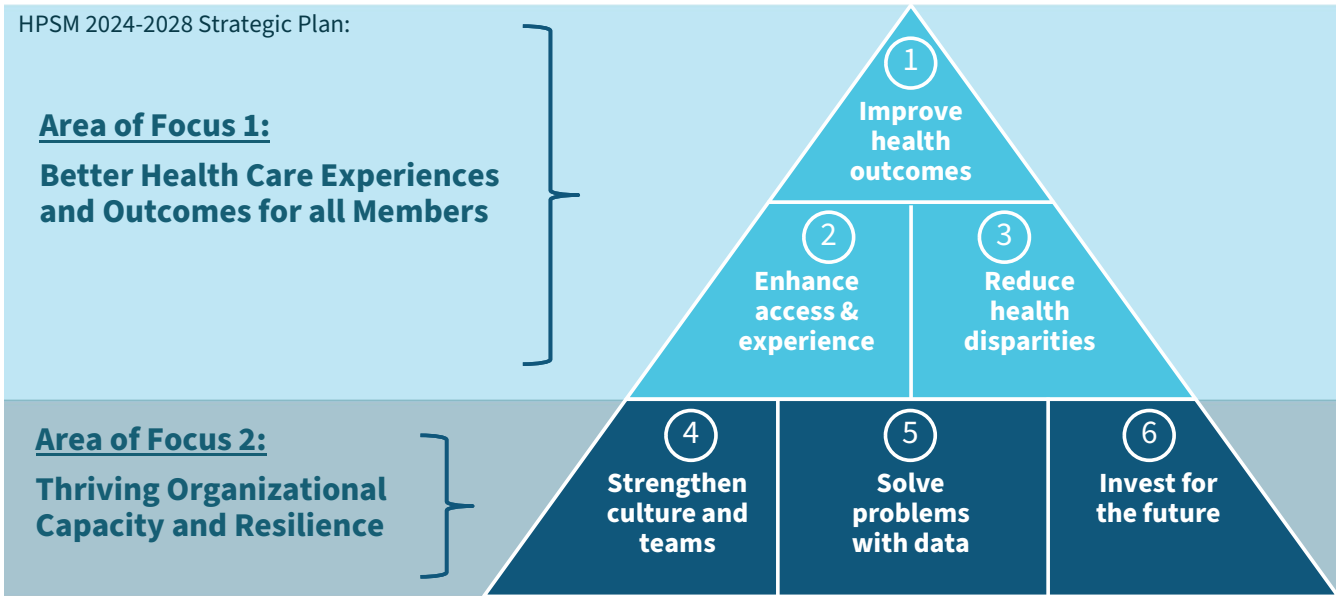
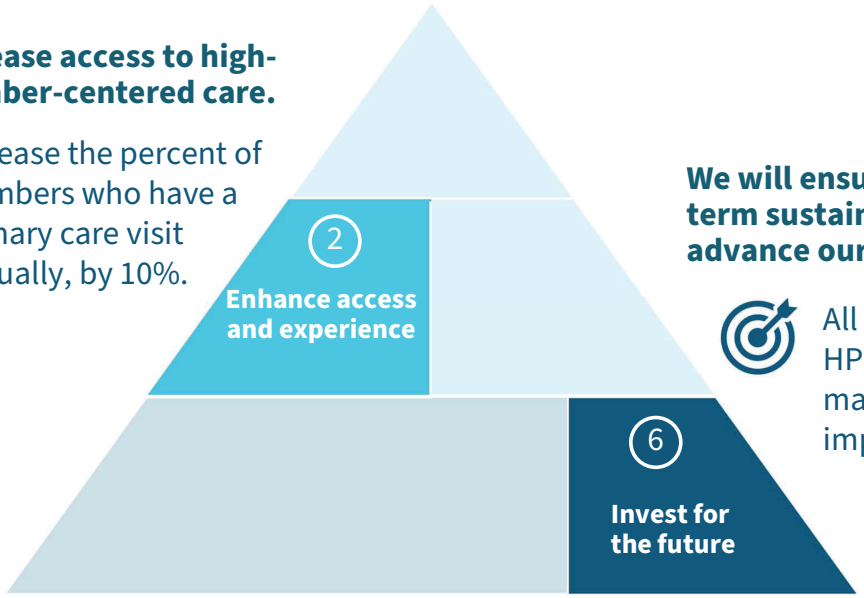


A Focus on Goal 2 and Goal 6

We will increase access to high-quality member-centered care.

Increase the percent of members who have a primary care visit annually, by 10%.



We will ensure HPSM's long-term sustainability to advance our mission

All investments of HPSM reserves were made applying our impact criteria.

Recap

- At our 5/8/2024 Commission meeting, SMHC approved a strategy to direct our investments, within the reserve funds that SMHC committed to the **Provider Investment Fund**.
- This included a directive to continue the work on provider rate increases, which we are providing an update on in **January 2025.**
- Additionally, SMHC provided direction for **HPSM "bundle" potential one-time provider investments** that meet our criteria, and bring these for SMHC approval on a rolling basis.

Proposed One-Time Investments

- **Ted's Pharmacy:** Free Rx deliveries for CA Members engaged with BHRS.

$47,000
Support for up to 65 CA members, >90% of injectable antipsychotic Rxs, and >20% of all BH drugs Rxs

- **Adapt: A Behavioral Collective Inc.: Enhance and ACES** Behavioral Health Treatment (BHT) investment in workforce and cultural concordance.

$140,000 ($70,000 each)

Est. 10% increase in BHT access for members

- **Sonrisas:** Increase dental access in the south coast via mobile dentistry units, technology & equipment.

$400,000

Reach up to 200 members on the south coast or with mobility challenges

Request

- Request block approval of total one-time capacity funds in the amount of **$587,000** funding HPSM contracted providers: Ted's Pharmacy, Adapt, ACES and Sonrisas.
- Funds will be used to increase access to:
  - Pharmacy services for D-SNP members
  - BHT services for young members impacted by autism
  - Dental services for members on the coast, and improve accessibility to dental diagnostic services

San Mateo Health Commission

5.2 Population Needs Assessment and Health Outcomes Updates

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2024-2028 Strategic Plan

HealthPlan OF SAN MATEO
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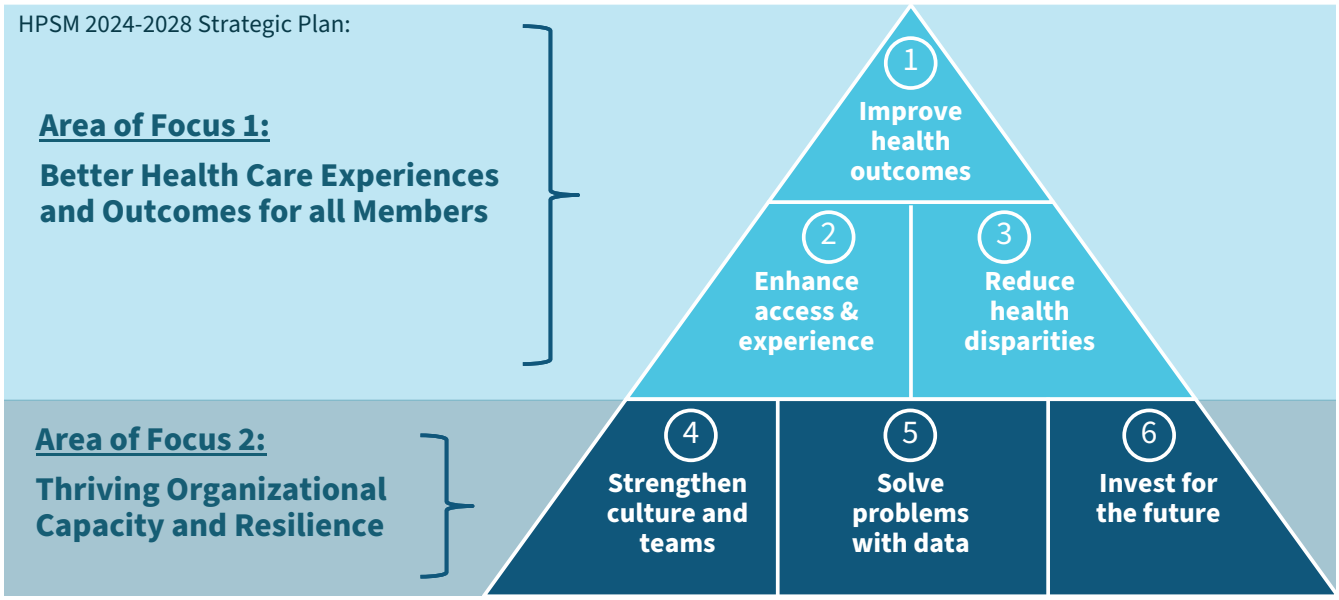

Our themes today

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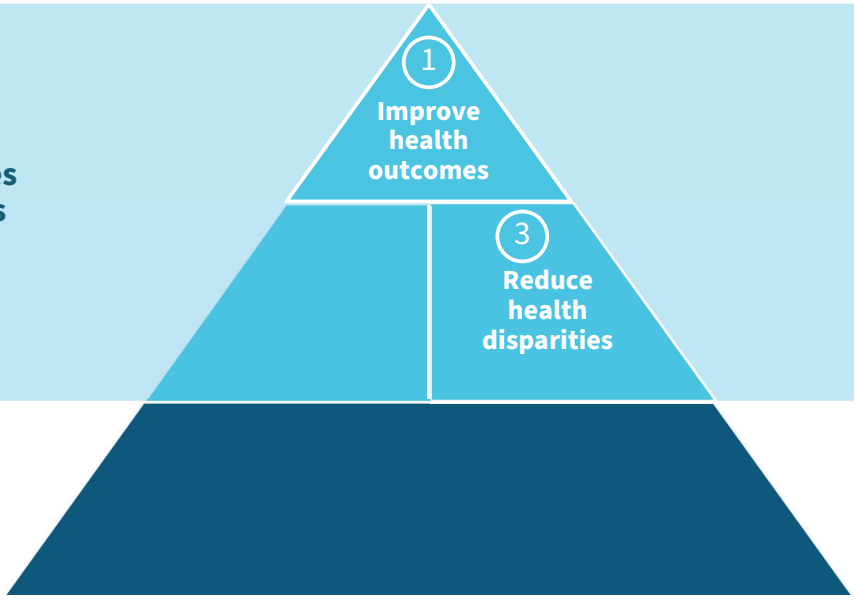
Area of Focus 1:

Better Health Care Experiences and Outcomes for all Members



How we measure outcomes

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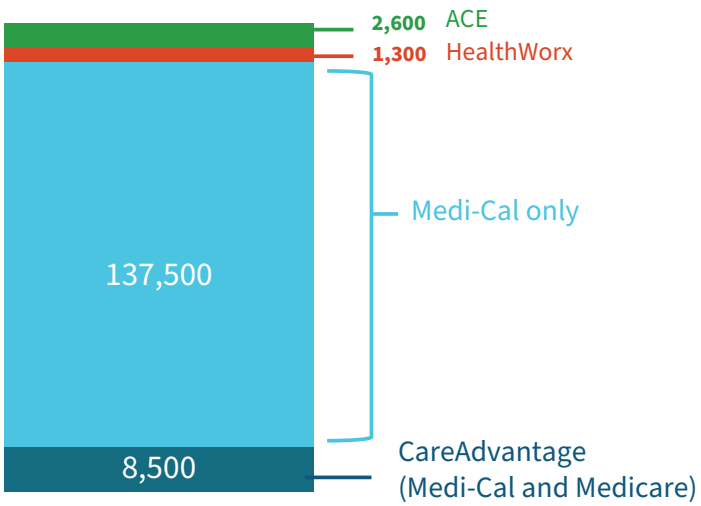
HPSM Members

Not to scale



How we measure outcomes

HealthPlan OF SAN MATEO
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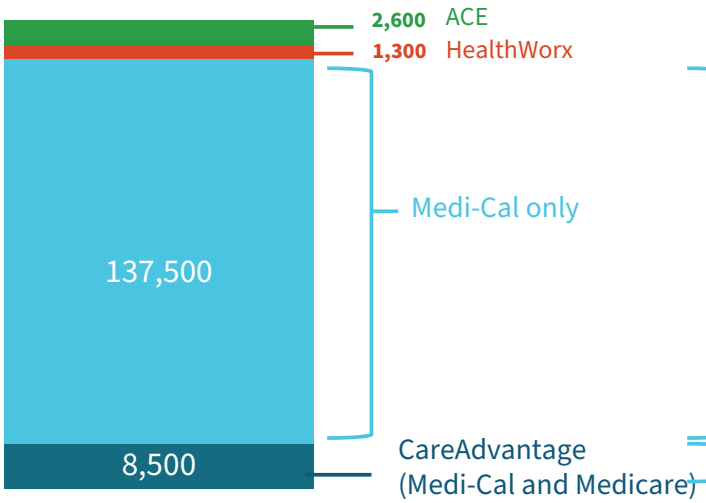
HPSM Members

Not to scale



Outcomes Methodology

Not to scale

NCQA Health Plan Rating & accreditations

Medicare Stars rating

Population Needs Assessment

How we measure outcomes

HealthPlan OF SAN MATEO
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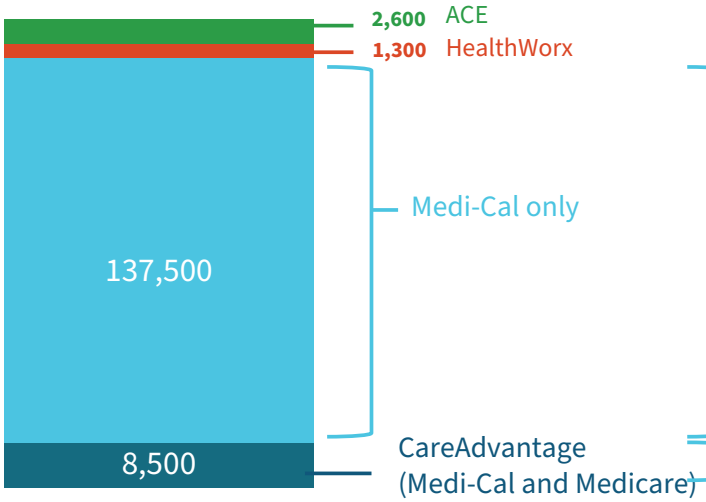
HPSM Members

Not to scale



Outcomes Methodology

Not to scale

NCQA Health Plan Rating & accreditations

Medicare Stars rating

Population Needs Assessment

2024 NCQA Health Plan Rating

Presented by Nicole Ford, Director of Quality Improvement

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NCQA Health Plan Rating

HealthPlan OF SAN MATEO
Healthy is for everyone

- A rigorous assessment of health plans' clinical quality and member satisfaction
- Health plans are rated in 3 categories: Private/Commercial, Medicare Advantage (not supplemental or Special Needs), and Medicaid
- Ratings are based on measures of clinical quality from NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) and patient experience from Consumer Assessment of Healthcare Providers and Systems (CAHPS) that are collected and submitted by health plans annually
- Overall rating calculated on a 0–5 scale in half-points (5 is highest), displayed as Stars and rounded to the nearest half-point

Rating Methodology

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Overall score is a weighted average of all measures

Each measure is assigned a score on a 1 to 5 scale. Measure performance is determined by plan submitted rate for each measure compared to the 10th, 33.33rd, 66.67th and 90th measure percentiles for **all** submitting health plans.

Additional 0.5 Star for NCQA Health Plan Accreditation status

Measure Rates and Percentiles

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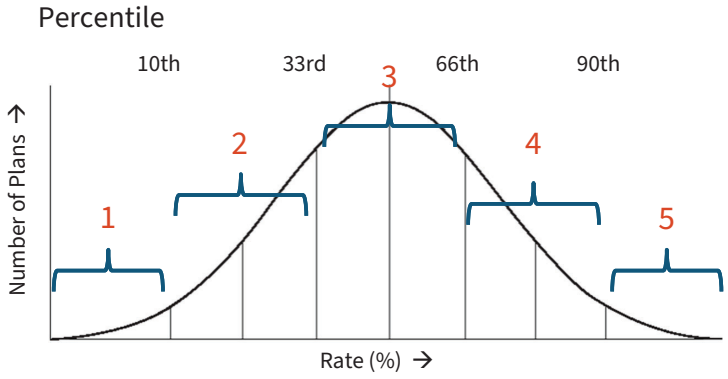
Result:

Measure Rate: $\frac{\text{Service or Result}}{\text{Eligible Population}} = \frac{1{,}008}{1{,}628} = 61.92\%$

Performance:

How does this rate compare to that of all the other plans?



NCQA HPR Domains

Patient Experience

- Source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- 5 measures, weighted at 1.5x each
- Example Measures: Getting Care Quickly, Rating of Primary Care Doctor

Prevention & Equity

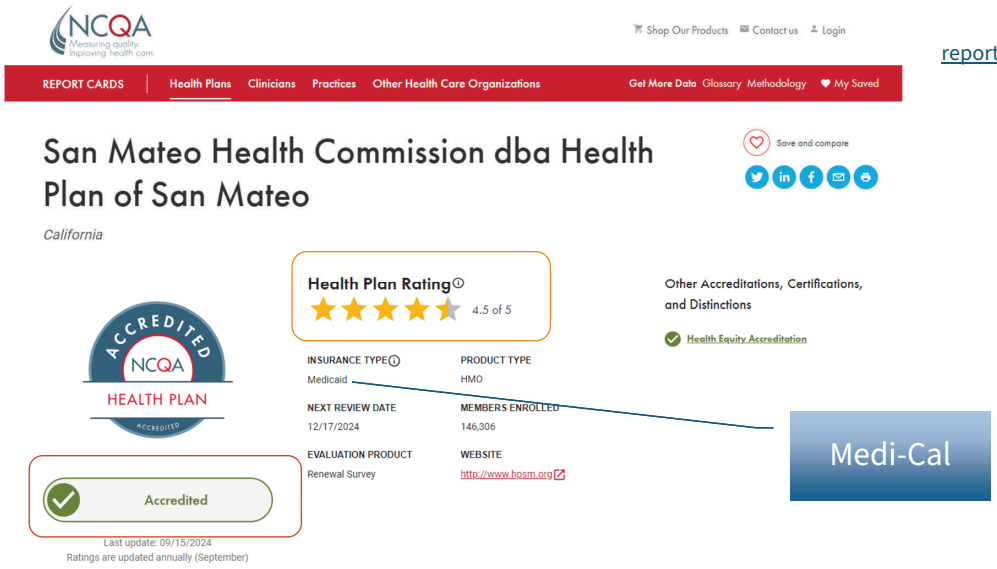
- Source: Health Effectiveness Data Information Set (HEDIS)
- 14 measures, 2 weighted 3x
- Example Measures: Child Immunizations, Breast Cancer Screening, Post Partum Care
- Equity Measure is plan's ability to collect race and ethnicity of members from direct sources (i.e. member, state/CMS)

Treatment

- Source: HEDIS
- 28 measures, 3 weighted 3x
- Example Measures: Hemoglobin A1c Control for Patients With Diabetes, Controlling High Blood Pressure, Asthma Medication Ratio, Follow-up after ED visit for Mental Illness

HPSM's 2024 NCQA Health Plan Rating

reportcards.ncqa.org/health-plans



What does our rating mean?

- Comparative performance for health plans
- Medicaid: 4.5 highest rating
  - 14 plans of 201 with a numeric rating
  - Only 2 Medi-Cal plans
- Only 5 plans (3 Commercial and 2 Medicare) received a 5.0 Star Rating out of 1,019

Questions?

How we measure outcomes

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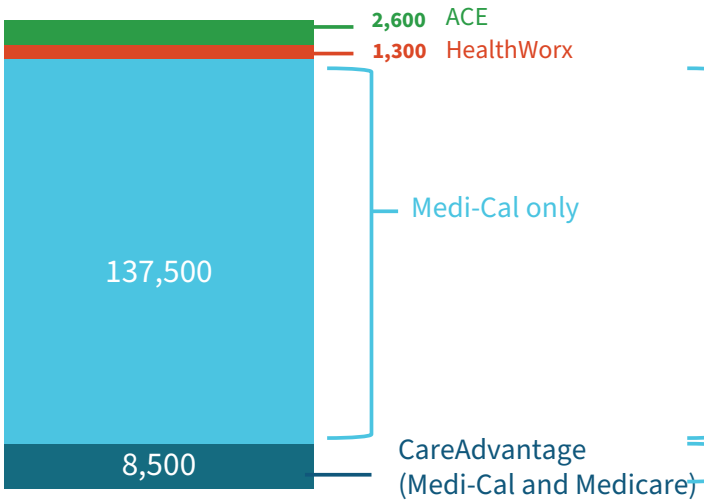
HPSM Members

Not to scale



Outcomes Methodology

Not to scale

NCQA Health Plan Rating & accreditations

Medicare Stars rating

Population Needs Assessment

The CMS Medicare Star Ratings Program

Presented by John Okonne, Director of Medicare

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Objectives

✓	**Educate Health Commission**	*Provide an overview of the Medicare Star Rating framework*
✓	**Report Results**	*Announce HPSM's first ever Medicare Star Ratings results*

Agenda

- Lesson 1*: What* are Medicare Star Ratings?
- Lesson 2: *Why* are Medicare Star Ratings Important?
- Lesson 3: *How* did we Perform?

Lesson 1:
What are Medicare Star Ratings?

Medicare Star Ratings 101 Refresher / Overview

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What are Medicare Star Ratings?

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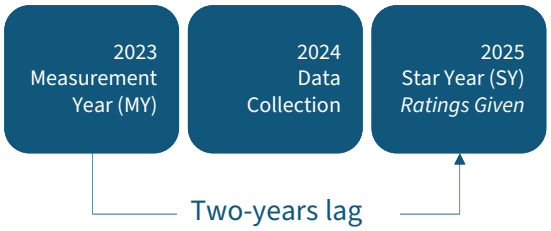
- Measures the quality of CareAdvantage/DSNP* health and drug services
- Based on a scale of 1 to 5 stars (with 5 stars being the highest rating)^
- HPSM receives its first Medicare Star Ratings in “Star Year” (SY) 2025

*Dual-eligible Special Needs Plan (DSNP): Members who qualify for both Medicare and Medicaid
^Compares our performance against all 3,959 (KFF, 2024) Medicare Advantage plans which allows for side-by-side evaluation

What are Medicare Star Ratings?

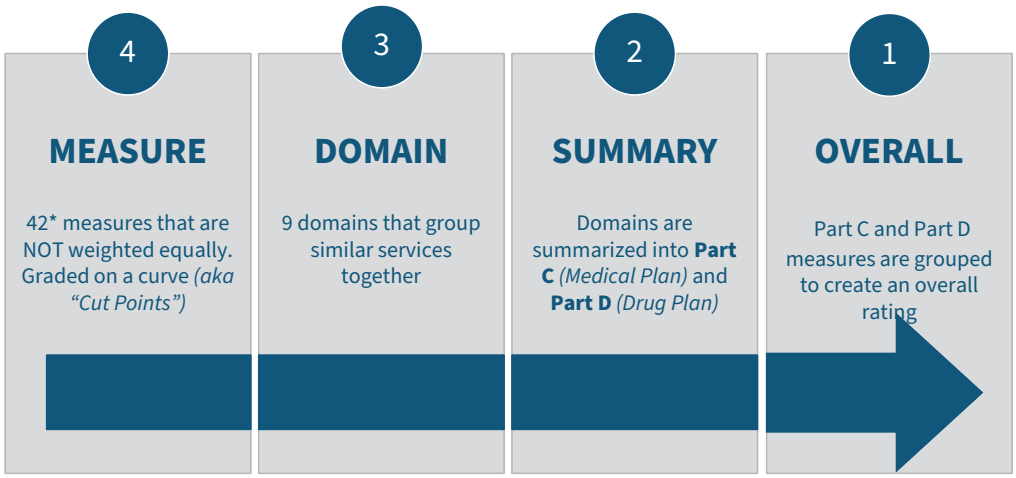
Star Rating Cycle Two-years Lag



- The *Star Rating Cycle* consists of MY, Data Collection, and SY
- Two-years lag between performance period and rating period
- Measure Year (MY) 2023 performance dictates our Star Year (SY) 2025 Star Ratings

What are Medicare Star Ratings?

Four Levels of the CMS Star Ratings Framework



*Five Type of Measures: "Outcome" reflect improvements; "Intermediate Outcomes" reflect actions taken (EX: Blood Sugar Controlled); "Access"; "Patient Experience"; "Process"; *"Quality Improvement"*. Aligns with the CSM "Meaningful Measures" framework.

What are Medicare Star Ratings?

There are 5 Part C Domains

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Staying Healthy: Screenings, Tests, & Vaccines	Managing Chronic (Long Term) Conditions	Member Experience with Health Plan	Member Complaints and Changes in the Health Plan's Performance	Health Plan Customer Service
				
• Maintain a healthy lifestyle by conducting regular **screenings**, tests, and vaccines. • Ex: "Breast Cancer Screening"	• High-risk patients with multiple chronic conditions are at risk for **readmission**. • Ensure **timely and proper follow-up** post-discharge. • Ex: "Transitions of Care"	• How well the health plan **coordinates care** and how members rate the health plan. • Ex: "Getting Appointments and Care Quickly"	• How often members **file complaints** and changes in performance based on these complaints • Ex: "Members Choosing to Leave the Plan"	• Timely decision on **appeals** … • Availability of **interpreter** services and **TTY** • Ex: "Call Center – Foreign Language Interpreter and TTY Availability"

What are Medicare Star Ratings?

There are 4 Part D Domains

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Drug Plan Customer Service	Member Complaints and Changes in the Drug Plan's Performance	Member Experience with the Drug Plan	Drug Safety and Accuracy of Drug Pricing
			
• Availability of interpreter services and TTY • Ex: "Call Center – Foreign Language Interpreter and TTY Availability"	• How often members file complaints and changes in performance based on these complaints • Ex: "Members Choosing to Leave the Plan"	• How easy it is for members to get their prescriptions filled. • Ex: "Getting Needed Prescription Drugs"	• Compares **prices members pay** for their drugs to the drug prices the plan provided for the Medicare.gov Plan Finder (MPF) Website … • Ex: "MPF Price Accuracy"

Lesson 2:
Why are Medicare Star Ratings Important?

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Why are Medicare Star Ratings Important?

The Business Case & Value Proposition

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Regulatory

- **Transition from CMC to DSNP**: CMS to hold Plans accountable using these set of Star measures.
- **Denial of New Applications or Service-area Expansion**: Two consecutive years of < 3 Star Ratings (any combination of a Part C, D Summary Rating, or Overall)
- **Low Performing Plans**: At risk of CMS contract termination …

Membership

- **A Useful Yardstick that is Published Publicly, in CMS Plan Finder**: CMS encourages members and their care givers use this quality information to make health decision and decide their plan selection during Annual Enrollment Period (AEP) – as such may **impact membership retention and growth**

Financial

- **Don't Leave Money on the Table**: High performing (4+) health plans receive a 5% Quality Bonus Payment (QBP)
- **Ensures More Competitive Product**: Bonus payout is reinvested to provide more supplemental benefits. 4+ Star Rating could enable the CareAdvantage product line to break-even

Lesson 3:
How did we Perform in MY2023 / SY2025?

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MY2023 / SY2025 Star Ratings Result

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KEY DRIVERS:

- ✓ **Strong "Customer Service" Results** *including timely appeals decisions and reviews; timely TTY and Interpreter / foreign language services*
- ✓ **Low Member Complaints** *in CMS Complaint Tracking Module (CTM) for both Part C and D.*
- ✓ **Excellent Performance in Staying Health** *perfect score in Annual Flu Vaccine and Monitoring Physical Activity, boosts Staying Health domain.*

OPPORTUNITY AREAS:

- **Double Down on Pharmacy** *especially in the areas of MTM* Program Completion Rate for CMR and Medication Adherence*
- **Continue to Drive Comprehensive CAHPS Interventions** *that are Member, Provider and Staff focused.*
- **Close HEDIS Measure Gaps** *(Care for Older Adults, Care Management / SNP, TOC).*

*Medication Therapy Management
^Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Questions?

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How we measure outcomes

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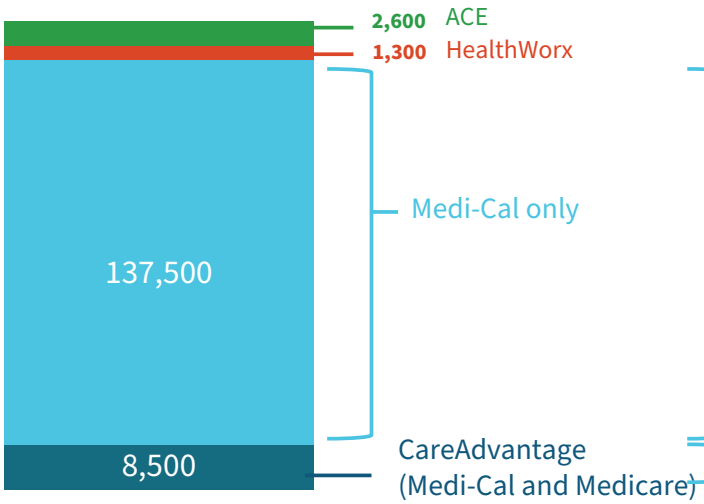
HPSM Members

Not to scale



Outcomes Methodology

Not to scale

NCQA Health Plan Rating & accreditations

Medicare Stars rating

Population Needs Assessment

Improving Population Health: A review of Population Needs Assessment (PNA)

Megan Noe, Director of Population Health

Samareen Shami, Population Health Management (PHM) Manager

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Agenda

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1. 2024 Population Needs Assessment (PNA) Results – Member Demographics & Characteristics
2. HPSM's Collaborative Approach to Population Assessments & Action Planning

2024 Population Needs Assessment

Components of the Population Needs Assessment (PNA)

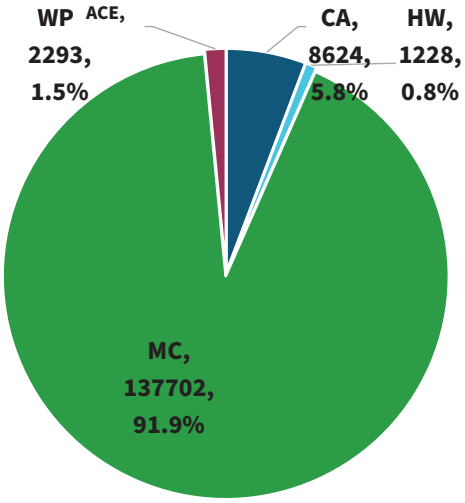
Membership Demographics & Characteristics

- Member Demographics
- Engagement with Care
- Chronic Condition Prevalence
- Healthcare Disparities
- Program Enrollment
- Behavioral Health
- Social Determinants of Health

Subpopulation Analysis

- Perinatal
- Children & Adolescents
- General Adults
- Older Adults
- Members who receive Behavioral Health services
- People with Disabilities
- Members with Limited English Proficiency (LEP)

HPSM Membership across all LOBs



Total Membership: 149,847
PNA Data as of January 2024

San Mateo County ACE Program
Locally funded health care program for low-income adults who do not qualify for other health insurance; HPSM serves as the third-party administrator.

CareAdvantage D-SNP
Health insurance program for people with both Medicare and Medi-Cal.

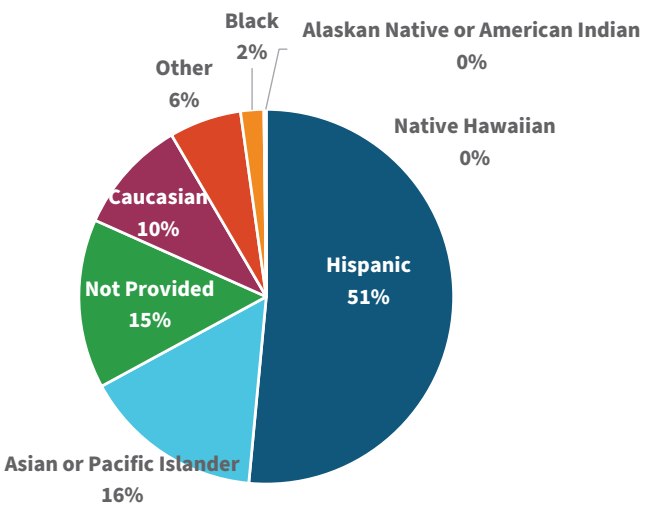
HealthWorx
Health insurance program for In-Home Services and Support (IHSS) providers and eligible employees of San Mateo County.

Medi-Cal
State and federally funded health insurance program for low-income individuals and families.

Demographics

HPSM Total Membership across all LOB's

Race/Ethnicity



Preferred Language

Language	Count	% of Membership
Predominant Language Groups	**143,526**	**96%**
English	74412	50%
Spanish	61996	41%
Chinese (Mandarin/Cantonese)	5690	4%
Tagalog	1955	1%
Emerging Language Groups	**5,794**	**5%**
Portuguese	1396	1%
Russian	1141	1%
Other/Unknown	928	0.6%
Arabic	845	0.6%
Vietnamese	392	0.3%
<300 in Category	1092	0.7%
Grand Total	**149,847**	**100%**

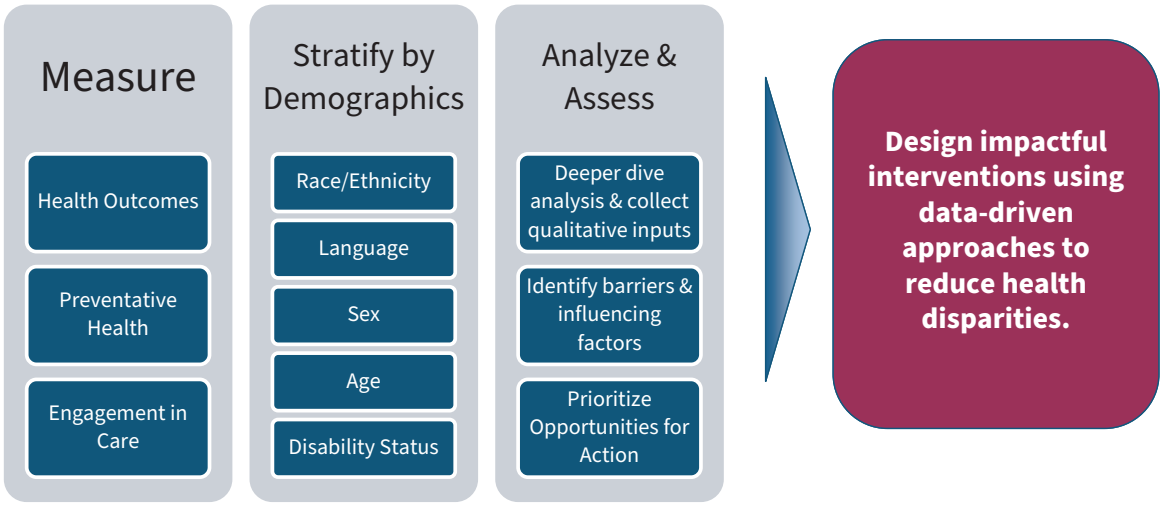
How do HPSM member populations differ by LOB?

	Medi-Cal	Care Advantage
Demographics	Majority of HPSM Medi-Cal members are between 22 - 50 years old, prefer English or Spanish, and identify as Hispanic or Latino.	CareAdvantage members tend to be between 66 - 80 years old, prefer English, and identify as Asian or Pacific Islander.
Primary Care Engagement	Less than ½ of HPSM Medi-Cal members visited a primary care provider last year.	Almost all HPSM CareAdvantage members visited a primary care provider last year.
Chronic Conditions	36% of HPSM Medi-Cal members have 1 or more chronic conditions.	94% of HPSM CareAdvantage members have a chronic condition, and a majority have more than one.
Geography	Most members live in San Mateo, Redwood City & Daly City.	Similar geographic distribution with a quarter of members living in Daly City, followed by San Mateo & South San Francisco.

37

HPSM's Collaborative Approach to Population Assessments & Action Planning

Process to assess for disparities



Health Disparities Analysis At A Glance

HPSM Members, 2024 PNA

Demographic Variable	Disparities	
	Subgroup	Metric
Age	17 – 21	Diabetes Management, Primary Care Engagement
Gender	Male	Diabetes Care, adult preventative care
Race/Ethnicity	Caucasian	Chronic condition management (diabetes & hypertension), preventative care and pediatric well visits
	Black	Diabetes & Hypertension management, preventative care
Spoken Language	English	Most disparities out of any language subgroup, 14 total
	Arabic	Newly identified disparity pediatric well visits
Other Disparities	South San Francisco	Diabetes Management, preventative care
	People with Disabilities	Diabetes & Hypertension management, Cancer Screenings

Collaborative Approach to Improving Health Outcomes and Health Equity

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Internal Workgroups

Parternships with PCPs and Advisory Councils

Community Partners

(e.g. MCAH related, Office of Diversity & Equity, PRIDE Center)

Health DIstricts

County CHA/CHIP process. Steering Committee, workgroups etc.

Priority Areas & Partnerships for 2024/2025

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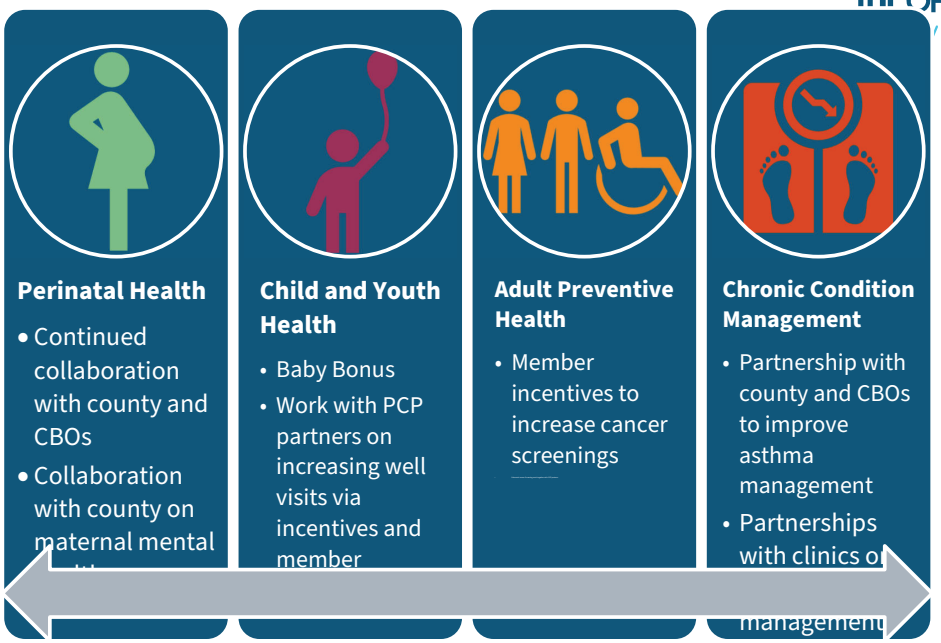

Perinatal Health

- Continued collaboration with county and CBOs
- Collaboration with county on maternal mental

Child and Youth Health

- Baby Bonus
- Work with PCP partners on increasing well visits via incentives and member

Adult Preventive Health

- Member incentives to increase cancer screenings

Chronic Condition Management

- Partnership with county and CBOs to improve asthma management
- Partnerships with clinics o

management

Thank you!

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AGENDA ITEM: 5.1

DATE: December 11, 2024

MEMORANDUM

DATE: November 21, 2024

TO: San Mateo Health Commission

FROM: Patrick Curran, Chief Executive Officer

RE: Resolution of Appreciation for George G. Pon

George Pon's contributions to the San Mateo Health Commission have been invaluable. He has served on the Commission for twelve years, including most recently as Commission Chair from 2022 to 2024. He has also been a member of the Pharmacy Review Committee since 2005.

George Pon's leadership has always been enthusiastic and committed. He cares deeply about the Health Plan of San Mateo and its mission to provide the highest quality health care for our members. The attached resolution expresses the Commission's and staff's sincere gratitude to George Pon for his dedication to the Health Plan of San Mateo.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPRECIATION OF
GEORGE G. PON, COMMISSIONER

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. George G. Pon has served as the pharmacist representative on the San Mateo Health Commission since 2013; and

B. George G. Pon has served most recently as Chair of the Commission from 2022 to 2024; and

C. George G. Pon has participated in the Pharmacy Review Committee since 2005, and provided strong and effective leadership for the Health Plan of San Mateo's pharmacy services; and

D. George G. Pon has been a passionate advocate for both members and providers; and

E. George G. Pon has provided devoted leadership on behalf of the San Mateo Health Commission and the Health Plan of San Mateo; and

F. George G. Pon's insights and counsel will be missed by the San Mateo Health Commission and HPSM staff.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission and staff wish to express their sincere appreciation and gratitude to George G. Pon for his leadership and service to the Health Plan of San Mateo, its staff, providers and members.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of December 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
Bill Graham, Vice-Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

MEMORANDUM

AGENDA ITEM: 5.2

DATE: December 11, 2024

DATE: December 4, 2024

TO: San Mateo Health Commission

FROM: Pat Curran, CEO
Trent Ehrgood, CFO

RE: Approval of HPSM 2025 Budget

Proposed Draft 2025 Budget

Attached is a slide deck with the 2025 budget overview. HPSM is forecasting a surplus of $17.6M with anticipated total revenues (operating and non-operating revenue) of $1,042M and total expenses of $1,024M.

This version of the budget is based on draft Medi-Cal rates received in October. DHCS is planning to publish final prospective rates in late December. The final rates will have adjustments to base rates and added funding for pass-through expense items like directed payments and the MCO tax. Management plans to update the 2025 budget after the first of the year with final Medi-Cal rates, and layer in related pass-through expenses. Approval of the final budget will be made at the January 2025 Commission meeting.

Earlier in 2024, the Commission approved strategic use of reserves for provider rate increases and investments in primary care. These expenses are not included in this budget. These items will be added expenses as they occur and will be separately reported.

The Finance/Compliance Committee was not able to meet and review the budget in advance of the Commission meeting but are aware of the major drivers and assumptions that contribute toward this forecast.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF ADOPTION OF OPERATING BUDGET
FOR 01/01/2025 - 12/31/2025

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. The draft 2025 budget is projecting a surplus of $17M, which includes draft Medi-Cal rates; and

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

C. Management will bring a revised budget in January 2025 incorporating final Medi-Cal rates;

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves the operating budget for CFY 2025 as presented and attached.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 11th day of December 2024 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

Agenda Item: 5.2
Date: December 11, 2024

HPSM 2025 Operating Budget

San Mateo Health Commission

December 11, 2024

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Financial Summary and Outlook for 2025

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- HPSM has benefited from several years with larger than normal surpluses. 2022 and 2023 were over $100M each, and 2024 is projected to be around $35M.
- Draft 2025 Medi-Cal base rates decreased from 2024 by about 4%. Final prospective rates are expected to be delivered in late-December. The budget will be updated with final rates.
- HPSM is projecting an overall surplus in 2025 of $17M. However, at an operating level, we are projecting a loss of $20M, which is offset by non-operating revenue of $38M, mostly earnings on cash reserves.
- The Medicare line-of-business is the primary contributor to the operating loss and the challenge is mostly with the Part-D benefit.
- The demands of Managed Care Plans continue to increase, including administration of new benefits and increased reporting to regulators.

Proposed 2025 Budget

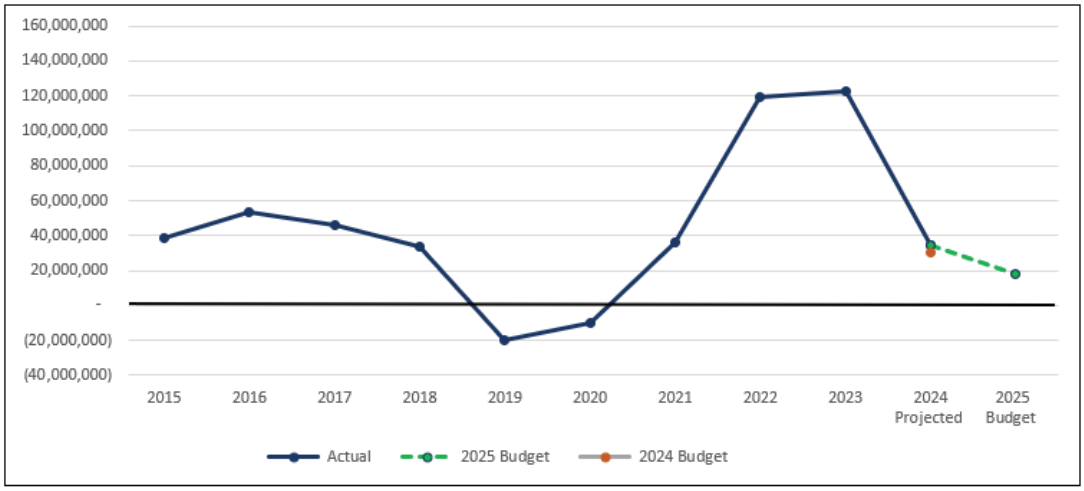
OPERATING REVENUES:	
Capitation & Premium Revenue (net)	1,003,897,017
HEALTH CARE EXPENSE:	
Inpatient Services	195,259,257
Outpatient/Professional	361,142,650
SNF/LTC	168,779,553
Pharmacy	71,304,611
Directed Payments	7,624,785
Dental	51,735,199
ECM, CS, CBAS	18,785,025
UMQA/Transportation/Other	50,745,084
Provider Incentives	15,897,500
Total Health Care Expenses	**941,273,664**
ADMINISTRATIVE EXPENSES	**83,122,618**
MCO Tax	-
Net Loss from Operations	**(20,499,265)**
NON-OPERATING REVENUES:	
Interest	**36,600,000**
Rental Income	**1,263,194**
TPA Fees	**255,000**
Total Non-Operating Revenue	**38,118,194**
PROJECTED SURPLUS	**$ 17,618,928**

2024 Forecast and 2025 Budget Compare

		2024 Forecast	2025 Budget
	OPERATING REVENUES:		
	Capitation & Premium Revenue	$1,126,383,572	$1,009,288,962
Revenue adjustments	Medi-Cal Incentive Revenue	-	-
	Medi-Cal ECM Corridor	(7,265,261)	(5,391,946)
	Medi-Cal UIS Risk Corridor	(46,300,000)	-
	Total Revenue	1,072,818,310	1,003,897,017
	HEALTH CARE EXPENSE:		
	Inpatient Services	190,939,510	195,259,257
	Outpatient/Professional	355,247,644	361,142,650
	SNF/LTC	162,151,022	168,779,553
	Pharmacy	67,770,903	71,304,611
	Directed Payments	43,068,010	7,624,785
	Dental	40,006,092	51,735,199
	ECM, CS, CBAS	15,609,626	18,785,025
	UMQA/Transportation/Other	44,493,328	50,745,084
	Provider Incentives	15,172,435	15,897,500
	Total Health Care Expenses	**934,458,570**	**941,273,664**
	ADMINISTRATIVE EXPENSES	**72,463,038**	**83,122,618**
	MCO Tax	**71,699,038**	-
	Net Loss from Operations	**(5,802,337)**	**(20,499,265)**
	NON-OPERATING REVENUES:		
	Interest	**40,062,574**	**36,600,000**
	Rental Income	**1,263,105**	**1,263,194**
	TPA Fees	**255,000**	**255,000**
	Total Non-Operating Revenue	**41,580,679**	**38,118,194**
	PROJECTED SURPLUS	**$ 35,778,342**	**$ 17,618,928**

Historical Net Income/(Loss)

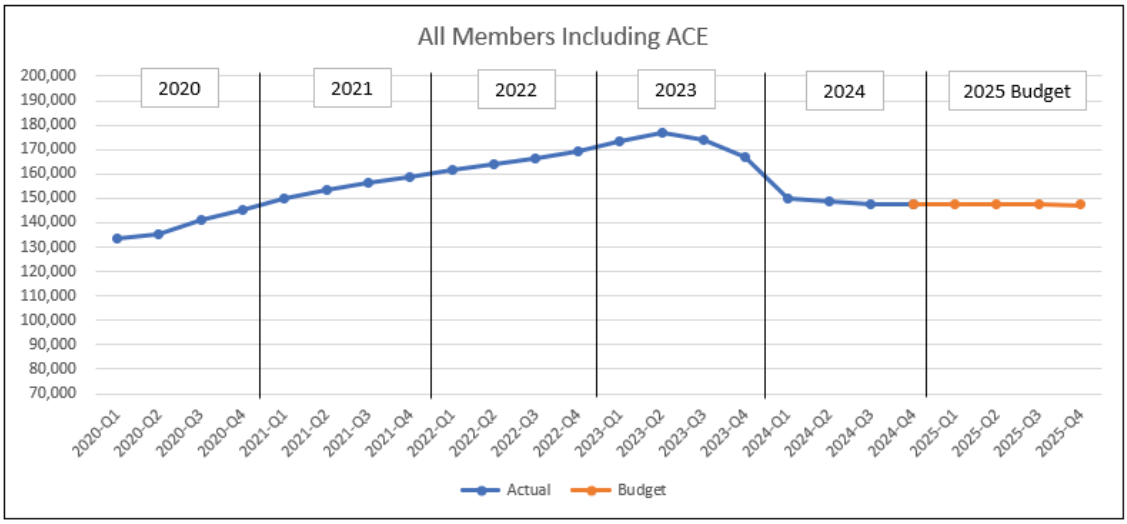
Ten-year trend – **Restated** w/ 2025 budget



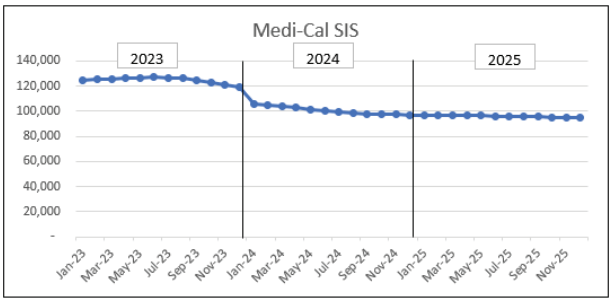
Budget Assumptions - Membership

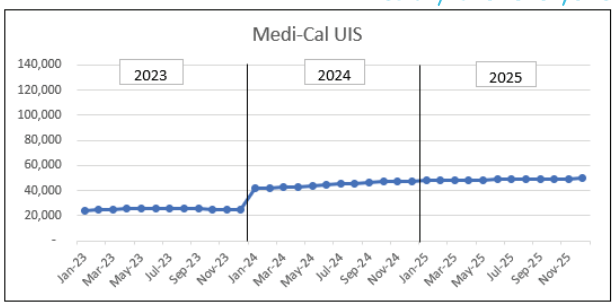
- Medi-Cal membership is projected to be relatively stable through 2025. The dust has settled after much change with transitioning populations, including a full cycle of redetermination, Kaiser's transition to a direct contract with DHCS, and lifting immigration status for ages 26 to 49.
- CareAdvantage membership is projected to have similar trends in 2025 as prior years, which is a bump at the beginning of the year from open enrollment, and then a small decline throughout the year. However, new default enrollment, which starts in 2025, will likely reduce the small decline throughout the year.
- HealthWorx membership is expected to remain steady at approximately 1,300 members.

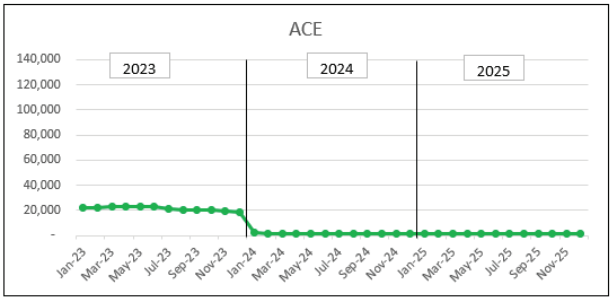
Membership Trends 2020-2025



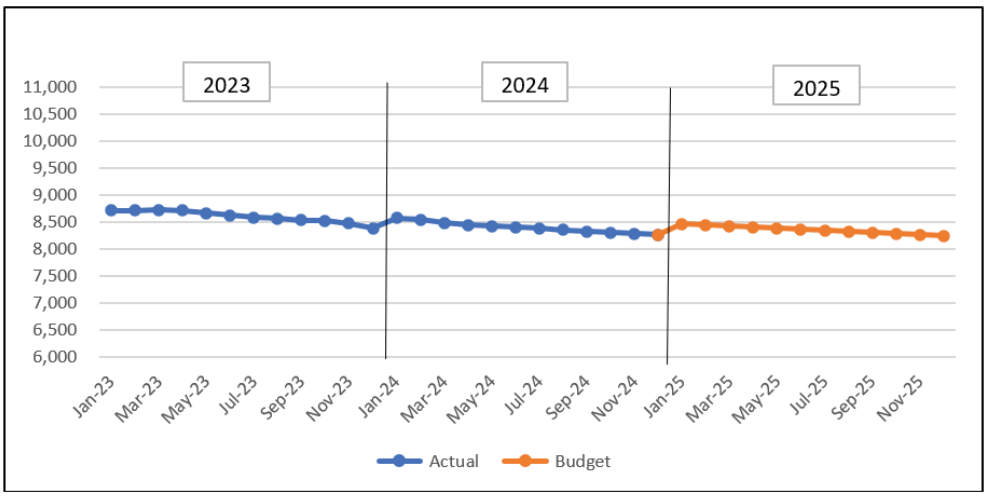
Medi-Cal Membership – SIS/UIS/ACE



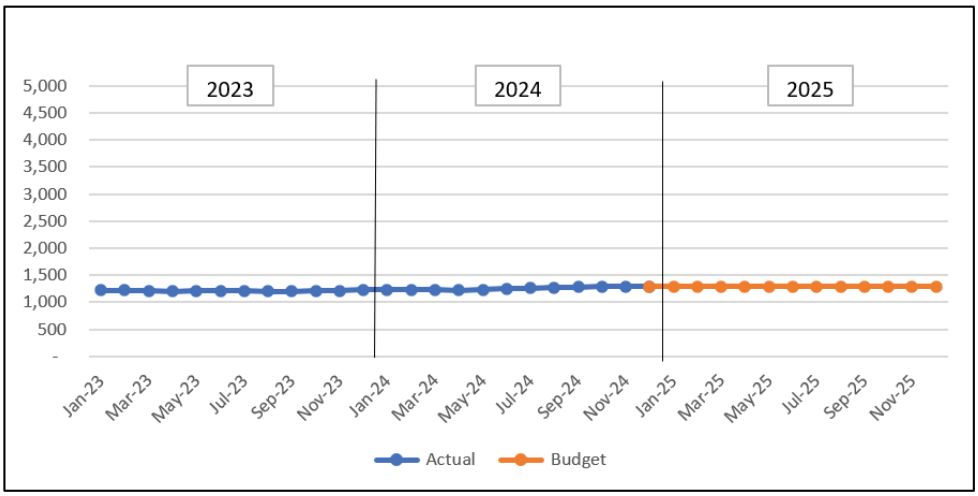




CareAdvantage Membership



HealthWorx Membership



2025 Budget Summary by LOB

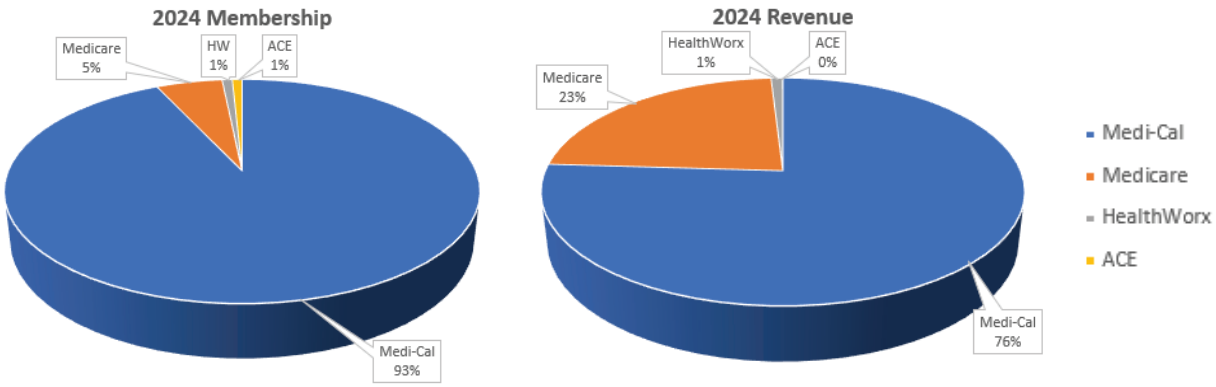
2025 Budget	Medi-Cal (non-duals)	Medi-Cal Duals (MC+DSNP)	MCE	WCM	CareAdvantage D-SNP	HealthWorx	ACE	HPSM Non-Op *	Total
Operating Revenue	$320,817 K	$165,940 K	$251,962 K	$24,069 K	$231,856 K	$9,253 K			$1,003,897 K
Health Care Expense	$285,960 K	$166,206 K	$221,006 K	$24,768 K	$234,422 K	$8,911 K			$941,274 K
Admin	$25,839 K	$9,959 K	$20,391 K	$2,187 K	$23,410 K	$1,086 K	$250 K	$0 K	$83,123 K
MCO Tax	$0 K	$0 K	$0 K	$0 K	$0 K	$0 K			$0 K
Other Income		$0 K					$255 K	$37,863 K	$38,118 K
Net Profit/(Loss)	$9,018 K	($10,224 K)	$10,564 K	($2,886 K)	($25,977 K)	($745 K)	$5 K	$37,863 K	$17,619 K
MLR	89.1%	100.2%	87.7%	102.9%	101.1%	96.3%			93.8%
Average Membership	74,686	15,804	53,219	1,057	8,359	1,286	1,237		147,476
Revenue PMPM	$ 357.96	$ 874.99	$ 394.54	$ 1,897.62	$ 2,311.44	$ 599.61	$ 17.18		

** Interest Income & Rent Income*

Profit Margin Summary:

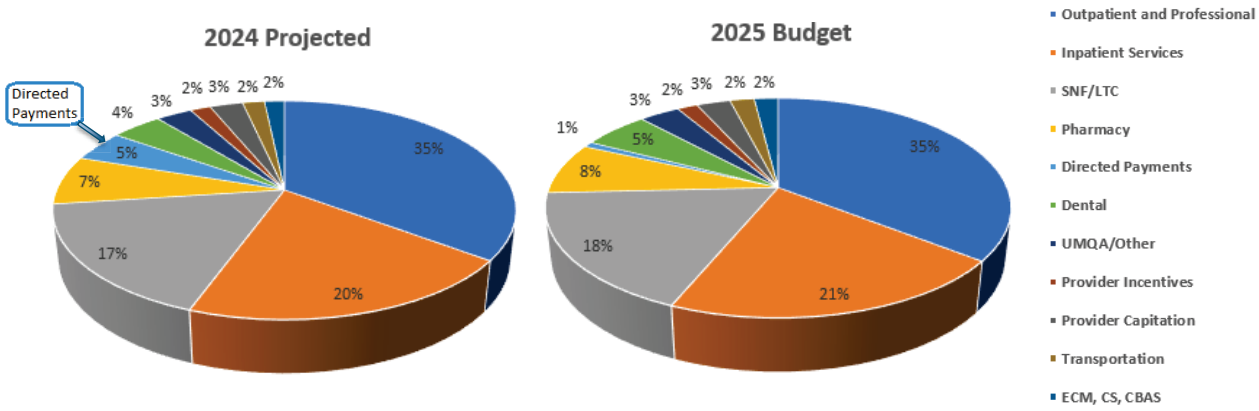
Medi-Cal	0.8%
Medicare	-11.2%
HealthWorx	-8.0%
Consolidated	1.8%

Membership and Revenue by Source



2025 Total Operating Revenue: $1,004M

Healthcare Cost by Expense Category



2025 Total Medical Expenses: $941M including UM/QA

ACE

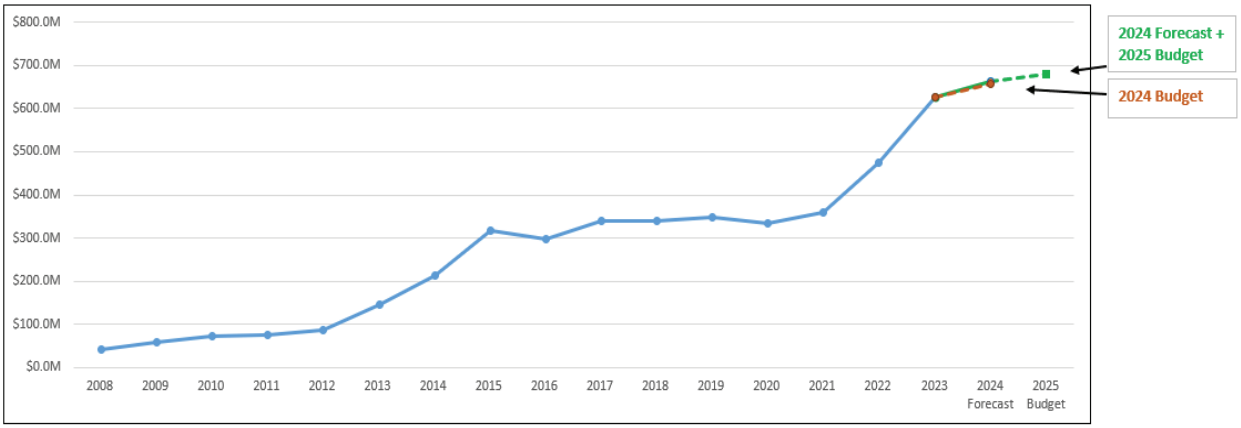
- Third Party Agreement (TPA) with SM County.
- Historical membership was around 26K. In May of 2022 approximately 6K members aged 50 and over became eligible for Medi-Cal; and then in January of 2024, members aged 26 through 49 also became eligible for Medi-Cal. Current enrollment is now around 1,200.
- The TPA fee changed from $8.50 PMPM to a flat fee of $255K per year due to the low membership.

Administrative Budget

2024 to 2025 Budget Change

Expense Category	2024 Budget	2025 Budget	Change	% Chng.	2025 % of Total
Salaries, Benefits, Training, Travel	60,481,530	68,296,630	7,815,100	13%	62%
Consulting & Outside Services	19,134,100	19,362,400	228,300	1%	18%
Computer Maintenance & Support	7,020,000	7,864,900	844,900	12%	7%
Occupancy, Deprec. & Amort.	4,503,300	4,176,100	(327,200)	-7%	4%
Postage, Delivery & Printing	2,300,000	2,758,100	458,100	20%	3%
Office Expenses	2,273,670	2,595,200	321,530	14%	2%
Other Admin Expenses	3,699,925	4,414,300	714,375	19%	4%
Sub-Total	99,412,525	109,467,630	10,055,105	10%	100%
UM/QA Allocation (to HC Cost)	(22,525,076)	(26,345,012)	(3,819,936)	17%	
Total Admin Expense	76,887,449	83,122,618	6,235,169	8%	
FTE's	405	431	26	6%	

Projected Tangible Net Equity (TNE)



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

Thank You

HealthPlan OF SAN MATEO
Healthy is for everyone

MEMORANDUM

AGENDA ITEM: 6.0

DATE: December 11, 2024

DATE: December 3, 2024

TO: San Mateo Health Commission

FROM: Patrick Curran

RE: CEO Report – December 2024

As we close out the year, it is a good time to reflect and celebrate the accomplishments of the organization and the actions taken by this Health Commission in 2024 to further our mission and vision. Here are some highlights:

- **Care Plan and HRA Transition** – Starting in 2024, we began transitioning in-house the major tasks of performing Health Risk Assessments (HRAs) and care plans for all our Medicare members and certain Medi-Cal members.
- **NCQA** – HPSM received 4.5 Stars in the NCQA quality ranking in 2024. We were one of only two Medi-Cal plans in California to attain that level, which is also the highest of any Medicaid plan in the country.
- **DHCS Quality Standards** – HPSM was one of the few plans in the state to have no measures below the minimum performance level, receiving no monetary sanctions from the state. HPSM continued to show improvement in several categories.
- **Member Transitions** – HPSM successfully worked in collaboration with our county and state partners to conclude the year-long Medi-Cal redetermination process. We also worked with the county to transition more than 15,000 individuals aged 26-49 who were part of the ACE program and qualified for full Medi-Cal coverage as of January 1, 2024.
- **Provider Investments** – The Health Commission approved a provider investment strategy with several components, building on the prior approval of investment in primary care. We will bring an update on this investment strategy to the January 2025 Health Commission meeting.
- **Baby Bonus** – The Health Commission approved a $7M investment in this program, which is an innovative collaboration with community partners. A rigorous clinical trial accompanies the program to test the impact of both income support for newborn families as well as enhanced care coordination services.
- **Medicare Enrollment Pilot** – HPSM was one of only three plans in California selected to enroll Medi-Cal members who newly qualify for Medicare directly into our CareAdvantage product. It is a testament to the trust and confidence the state has in HPSM.

- **IDEA Group** – We started our third cohort of employees in the Inclusion, Diversity, Equity and Accessibility (IDEA) Group. More than twenty staff are participating in up to four projects to help make HPSM a more inclusive organization. This group will begin recruiting for its next cohort in 2025.
- **Behavioral Health Therapy (BHT)** – In October, we completed our transition in-house to administer this benefit, which provides services for children with conditions on the autism spectrum. We had previously contracted with Magellan, an external organization, to provide this service.

This is only a partial list of the important work that takes place here at HPSM every day. It is due to the skill, passion, and dedication of each employee, as well as the leadership and commitment of each of you, our Health Commissioners, that inches us closer to our vision that Healthy is for Everyone.