HealthPlan OF SAN MATEO
Healthy is for everyone

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THE SAN MATEO HEALTH COMMISSION
Regular Meeting
June 14, 2023 - 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor Boardroom
South San Francisco, CA 94080

AGENDA

1. **Call to Order/Roll Call**
2. **Public Comment/Communication**
3. **Approval of Agenda**
4. **Consent Agenda***
   - 4.1 Finance Committee Report
   - 4.2 Pharmacy & Therapeutics Minutes, January 2023
   - 4.3 Approval of San Mateo Health Commission Meeting Minutes from May 10, 2023
5. **Specific Discussion/Action Items**
   - 5.1 Presentation on Provider Workforce
   - 5.2 Presentation on Workforce Development
6. **Report from Chairman/Executive Committee**
7. **Report from Chief Executive Officer**
8. **Other Business**
9. **Adjournment**

**Items for which Commission action is requested.*

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

Agenda Item: 4.1

Date: June 14, 2023

M E M O R A N D U M

Date: June 8, 2023
To: San Mateo Health Commission
From: Trent Ehrgood, Chief Financial Officer
Subject: **Financial report for the three-month period ending March 31, 2023**

Preliminary 2023 Financial Results All Lines of Business

Q1 2023 preliminary financial result for all lines of business is a surplus of $34.4M, compared to the YTD budget surplus of $20.0M.

We continue to have lower than average utilization, which is keeping medical expenses lower than projected. The reinstatement of the Medi-Cal redetermination processes, which will start in Q2 2023, will result in disenrollment of certain Medi-Cal members starting in Q3 2023. The expectation is that the low utilizers and/or members who obtained other health covers in recent years will be the ones most impacted by the redetermination process. As this happens, the average cost per member will rise, thus closing the surplus gap we have experienced in the past few years.

Starting in 2023, DHCS created a blended rate for SPD/LTC (separately for duals and non-duals), which includes an assumption of members residing in a nursing home. In 2023, there is no longer a member mix risk corridor, which means there will be inherent revenue risk if the number of members residing in a nursing home is different than what was assumed in the Medi-Cal rates.

Attached is presentation material which guided the discussion for our Finance/Executive Committee meeting on May 8th. Detailed Statements of Revenue and Expense on a consolidated basis, as well as for each line of business, are provided after the presentation slides.

Financial Update

Presentation to Finance/Executive Committee

May 8, 2023

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2023 Budget by Quarter

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

Q1 2023 Financial Results

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	YTD Total	YTD Budget	Budget Variance
Capitation revenue	347,808,745	261,147,663	86,661,082
Healthcare cost	306,446,093	229,730,036	(76,716,057)
Administrative expenses	13,925,006	14,539,248	614,242
MCO Tax	-	-	-
Income/(loss) from operations	27,437,646	16,878,379	10,559,267
Non-operating revenue	6,922,184	3,123,606	3,798,578
Net income/(loss)	34,359,830	20,001,985	14,357,845

YTD March 2023 – PY/CY

	YTD by PY/CY			Current Year YTD		
	Prior Year	Current Year	Total	Current Year	Budget	CY Variance
Capitation revenue	88,290,598	259,518,147	347,808,745	259,518,147	261,147,663	(1,629,516)
Healthcare cost	86,619,810	219,826,283	306,446,093	219,826,283	229,730,036	9,903,753
Administrative expenses	-	13,925,006	13,925,006	13,925,006	14,539,248	614,242
MCO Tax			-	-	-	-
Income/(loss) from operations	1,670,788	25,766,858	27,437,646	25,766,858	16,878,379	8,888,479
Non-operating revenue	-	6,922,184	6,922,184	6,922,184	3,123,606	3,798,578
Net income/(loss)	1,670,788	32,689,042	34,359,830	32,689,042	20,001,985	12,687,057

		YTD Mar/'23
M-Cal COA mix/directed pmt.	Rev	973,000
M-Cal supplemental rev.	Rev	862,000
Misc. other	HC Cost	(164,000)
		1,671,000

Average Membership

Variance to Budget

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LOB	Avg. Actual	Avg. Budget	Variance	% Var
Medi-Cal	77,424	76,796	628	0.8%
Medi-Cal Expansion	52,458	51,807	651	1.3%
Whole Child Model	1,394	1,421	(27)	-1.9%
Medi-Cal Full Duals	9,780	9,591	189	2.0%
Medicare D-SNP	8,646	8,813	(167)	-1.9%
HealthWorx	1,217	1,197	19	1.6%
Total at Risk	150,919	149,626	1,293	0.9%
+ ACE	22,678	23,237	(559)	-2.4%
Grand Total	173,596	172,863	734	0.4%

Budget Variance by Major Drivers

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		YTD Mar		Revenue	Expense
1	Prior year adjustments not in the budget	1,670,792			
	Current year variances:				
2	Membership higher than budget	199,095	<<	304,968	(105,873)
3	Revenue: Yield PMPM variance to budget	2,708,608			
4	Revenue: Maternity supplemental payment	(3,987,235)			
5	Revenue: ECM Risk Corridor	(1,201,400)			
6	Healthcare cost PMPM variance to budget	10,555,168			
7	Administrative cost variance to budget	614,243			
8	Non-op revenue (*CY portion) variance to budget*	3,798,574			
	Total current year	12,687,054			
	Total consolidated budget variance	**14,357,845**			

Healthcare Cost

Detail by Category of Service

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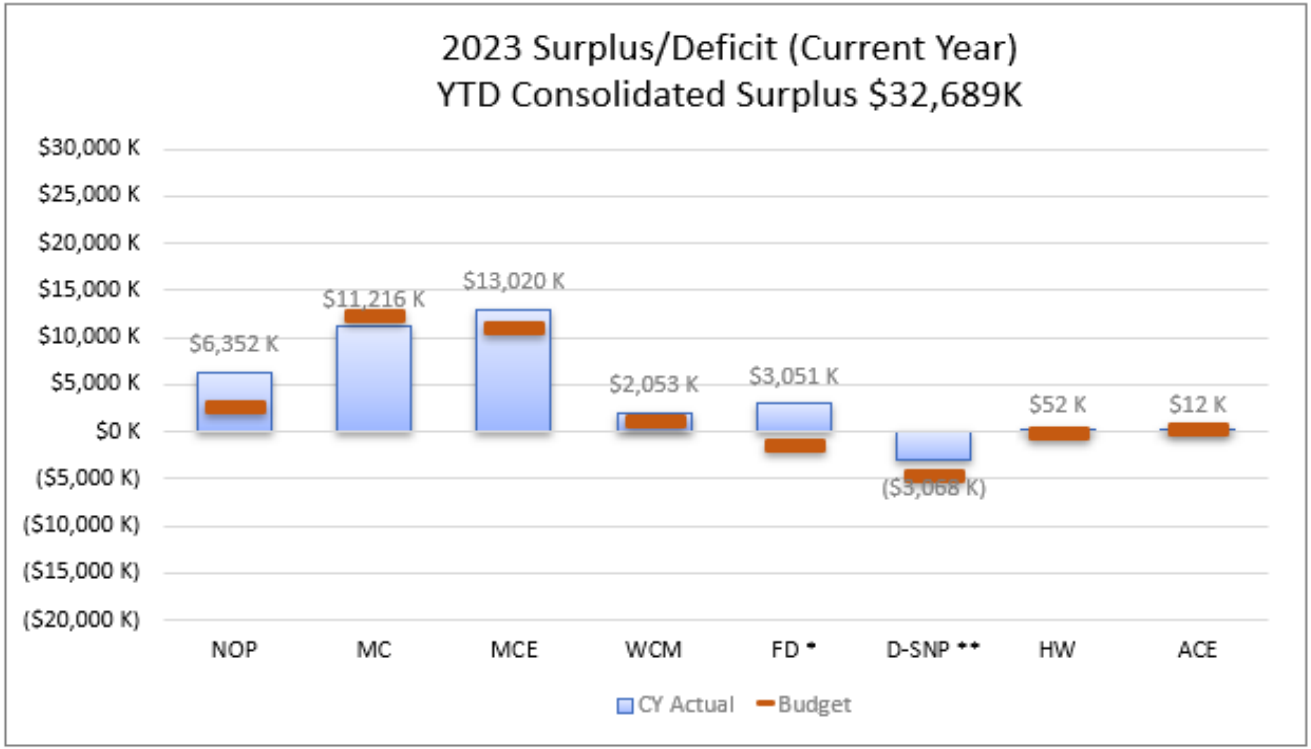
		YTD Actual					
		Total	Prior Year	Current Year	YTD Budget	Variance	% Var.
	Provider Capitation	16,903,868	177,297	16,726,571	18,024,414	1,297,843	7.2%
	Hospital Inpatient	50,726,016	-	50,726,016	50,325,661	(400,355)	-0.8%
	LTC/SNF	39,224,097	-	39,224,097	40,924,851	1,700,754	4.2%
	Pharmacy	14,293,044	(5,683)	14,298,726	14,878,296	579,570	3.9%
	Physician FFS	17,903,343	-	17,903,343	19,848,165	1,944,823	9.8%
	Hospital Outpatient	21,834,958	-	21,834,958	24,031,383	2,196,425	9.1%
	Other Medical Claims	21,342,896	244	21,342,652	22,586,452	1,243,800	5.5%
	Other HC Services	1,677,972	(154,096)	1,832,068	1,684,868	(147,201)	-8.7%
	Directed Payments	102,951,486	86,456,388	16,495,098	15,949,555	(545,543)	-3.4%
	Long Term Support Services	371,113	-	371,113	585,607	214,494	36.6%
	CPO/In-lieu of Services	1,753,811	-	1,753,811	1,640,530	(113,282)	-6.9%
	Dental	4,555,813	-	4,555,813	5,170,047	614,235	11.9%
	ECM	738,948	138,948	600,000	2,004,549	1,404,549	70.1%
	Provider Incentives	3,287,313	-	3,287,313	2,760,165	(527,148)	-19.1%
New	Supplemental Benefits (D-SNP)	428,724	-	428,724	1,030,396	601,672	58.4%
	Transportation	2,554,578	(518)	2,555,096	2,573,892	18,796	0.7%
	Indirect Health Care Benefits	829,470	3,789	825,681	210,078	(615,603)	-293.0%
	UMQA	5,068,644	3,440	5,065,204	5,501,128	435,924	7.9%
	Total Healthcare Cost	306,446,093	86,619,810	219,826,284	229,730,036	9,903,752	4.3%

CY YTD Surplus/Deficit by LOB



* FD includes M-Cal portion of D-SNP

** D-SNP includes Medicare portion only

Balance Sheet

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	3/31/2023	12/31/2022
Assets:		
Cash and Investments	745,956,697	590,619,358
Capitation and other receivables	198,283,035	212,206,486
Other current assets	12,520,815	12,320,518
Capital assets	60,568,594	60,977,606
Other LT assets and deferred outflows	7,637,774	7,637,774
Total assets and deferred outflows	1,024,966,915	883,761,742
Liabilities:		
Medical claims payable	74,544,799	69,446,973
Provider incentives payable	15,502,920	12,737,495
Amounts due to the State of California	175,564,672	174,363,272
Accounts payable and accrued liabilities	238,574,932	140,794,240
Net pension liability and deferred outflows	10,917,265	10,917,265
Total liabilities	515,104,588	408,259,245
Net Position (reserves)	509,862,327	475,502,497

Cash Investments

	Description	% Yield Jun'22	% Yield Sep'22	% Yield Dec'22	% Yield Mar'23	Balance at 3/31/2023	% Total	Balance at 12/31/2022	% Total
1	Cash - WFB (MM sweep)	0.7%	2.0%	3.7%	3.6%	$ 356,385,489	48%	$ 204,039,717	35%
2	WFB Institutional Securities	1.2%	2.3%	3.7%	4.1%	$ 207,970,909	28%	$ 205,840,161	35%
3	SM County Pooled Fund	0.9%	1.5%	1.5%	2.0%	$ 108,422,065	15%	$ 107,941,540	18%
4	State Pooled Fund (LAIF)	0.4%	1.5%	1.4%	2.1%	$ 73,178,234	10%	$ 72,797,940	12%
						$ 745,956,697	100%	$ 590,619,358	100%

Monthly Cash Flow

Week 1	Week 2	Week 3	Week 4
+ CMS Cap Revenue			
	+ DHCS Cap Revenue		
- Provider Cap			
- Provider Claims	- Provider Claims	- Provider Claims	- Provider Claims
- AP	- AP	- AP	- AP
	- Payroll		- Payroll

Questions?

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Health Plan of San Mateo
Consolidated Balance Sheet
March 31, 2023 and February 28, 2023

	Current Month	Prior Month	PY 12/31
ASSETS			
Current Assets			
Cash and Equivalents	$ 564,356,398	$ 441,749,271	$ 409,879,878
Investments	181,600,299	181,600,299	180,739,480
Capitation Receivable from the State	141,629,751	162,958,847	157,581,748
Medicare Receivable	44,229,778	44,229,778	44,229,778
Other Receivables	12,423,506	11,340,139	10,394,960
Prepaids and Other Assets	12,520,815	12,432,143	12,320,518
Total Current Assets	956,760,547	854,310,477	815,146,362
Capital Assets, Net	60,568,594	60,706,067	60,977,606
Assets Restricted As To Use	300,000	300,000	300,000
Other Assets & Outflows	7,337,774	7,337,774	7,337,774
Total Assets & Deferred Outflows	$ 1,024,966,915	$ 922,654,318	$ 883,761,742
LIABILITIES			
Current Liabilities			
Medical Claims Payable	74,544,799	71,565,674	69,446,973
Provider Incentives	15,502,920	14,581,112	12,737,495
Amounts Due to the State	175,564,672	175,161,072	174,363,272
Accounts Payable and Accrued Liabilities	238,574,932	146,922,679	140,794,240
Total Current Liabilities	504,187,322	408,230,536	397,341,979
Other Liabilities & Inflows	10,917,265	10,917,265	10,917,265
Total Liabilities & Deferred Inflows	$ 515,104,587	$ 419,147,801	$ 408,259,244
NET POSITION			
Invested in Capital Assets	60,568,594	60,706,067	60,977,606
Restricted By Legislative Authority	300,000	300,000	300,000
Unrestricted			
Stabilization Reserve	211,014,800	154,531,300	154,531,300
Unrestricted Retained Earnings	237,978,934	287,969,150	259,693,592
Net Position	509,862,328	503,506,517	475,502,498
Total Liabilities & Net Position	$ 1,024,966,915	$ 922,654,318	883,761,742
Change in Net Position	$ 34,359,830	$ 28,004,019	0

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

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	YTD Actual	YTD Budget	YTD Variance	% Var
OPERATING REVENUE							
Capitation and Premiums							
Medi-cal (includes Offsets)	$ 293,779,051	$ 207,757,053	$ 86,021,998	$ 293,779,051	$ 207,757,053	$ 86,021,998	41.4%
HealthWorx	1,748,213	1,718,221	29,992	1,748,213	1,718,221	29,992	1.7%
Medicare (includes CA-CMC)	52,281,481	51,672,390	609,091	52,281,481	51,672,390	609,091	1.2%
Total Operating Revenue	347,808,745	261,147,663	86,661,082	347,808,745	261,147,663	86,661,082	33.2%
OPERATING EXPENSE							
Healthcare Expense							
Provder Capitation	16,903,868	18,024,414	1,120,546	16,903,868	18,024,414	1,120,546	6.2%
Hospital Inpatient	50,726,016	50,325,661	(400,355)	50,726,016	50,325,661	(400,355)	-0.8%
LTC/SNF	39,224,097	40,924,851	1,700,754	39,224,097	40,924,851	1,700,754	4.2%
Pharmacy	14,293,044	14,878,296	585,252	14,293,044	14,878,296	585,252	3.9%
Medical	165,710,656	84,100,423	(81,610,233)	165,710,656	84,100,423	(81,610,233)	-97.0%
Long Term Support Services	371,113	585,607	214,494	371,113	585,607	214,494	36.6%
CPO/In-lieu of Services	1,753,811	1,640,530	(113,282)	1,753,811	1,640,530	(113,282)	-6.9%
Dental Expense	4,555,813	5,170,047	614,235	4,555,813	5,170,047	614,235	11.9%
Enhanced Care Management	738,948	2,004,549	1,265,601	738,948	2,004,549	1,265,601	63.1%
Provider Incentives	3,287,313	2,760,165	(527,148)	3,287,313	2,760,165	(527,148)	-19.1%
Supplemental Benefits	428,724	1,030,396		428,724	1,030,396	-	-
Transportation	2,554,578	2,573,892	19,314	2,554,578	2,573,892	19,314	0.8%
Indirect Health Care Expenses	829,470	210,078	(619,392)	829,470	210,078	(619,392)	-294.8%
UMQA, Delegated and Allocation	5,068,644	5,501,128	432,484	5,068,644	5,501,128	432,484	7.9%
Total Healthcare Expense	306,446,093	229,730,036	(76,716,057)	306,446,093	229,730,036	(76,716,057)	-33.4%
Administrative Expense							
Salaries and Benefits	11,740,412	11,815,022	74,611	11,740,412	11,815,022	74,611	0.6%
Staff Training and Travel	32,748	120,925	88,177	32,748	120,925	88,177	72.9%
Contract Services	3,898,547	4,424,600	526,053	3,898,547	4,424,600	526,053	11.9%
Office Supplies and Equipment	1,770,513	1,695,958	(74,554)	1,770,513	1,695,958	(74,554)	-4.4%
Occupancy and Depreciation	773,440	939,626	166,186	773,440	939,626	166,186	17.7%
Postage and Printing	387,845	672,725	284,881	387,845	672,725	284,881	42.3%
Other Administrative Expense	323,029	302,637	(20,391)	323,029	302,637	(20,391)	-6.7%
UM/QA Allocation	(5,001,527)	(5,432,246)	(430,719)	(5,001,527)	(5,432,246)	(430,719)	-7.9%
Total Admin Expense	13,925,006	14,539,248	614,242	13,925,006	14,539,248	614,242	4.2%
Premium Taxes	0	-	0	0	-	0	-
Total Operating Expense	320,371,099	244,269,284	(76,101,815)	320,371,099	244,269,284	(76,101,815)	-31.2%
Net Income/Loss from Operations	27,437,645	16,878,379	(10,559,267)	27,437,645	16,878,379	(10,559,267)	162.6%
Interest Income, Net	6,048,851	2,250,000	3,798,851	6,048,851	2,250,000	3,798,851	168.8%
Rental Income, Net	303,528	296,834	6,694	303,528	296,834	6,694	2.3%
Third Party Administrator Revenue	569,806	576,772	(6,966)	569,806	576,772	(6,966)	-1.2%
Net Non-operating Revenue	6,922,184	3,123,606	3,798,578	6,922,184	3,123,606	3,798,578	121.6%
Net Income/(Loss)	$ 34,359,830	20,001,985	14,357,845	$ 34,359,830	$ 20,001,985	$ 14,357,845	-71.8%
Admin exp as % of Net Rev (adj for Tax)	*4.00%*	*5.57%*		*4.00%*	*5.57%*		
Medical Loss Ratio (adj for Tax)	*58.51%*	*81.86%*		*58.51%*	*81.86%*		

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

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Total Operating Revenue	-	-	-	-	-	-	-	-
OPERATING EXPENSE								
Total Health Care Expense	-	-	-	-	-	-	-	-
Total Operating Expense	-	-	-	-	-	-	-	-
NON-OPERATING REVENUE								
Interest, Net	6,048,851	2,250,000	3,798,851	168.8%	6,048,851	2,250,000	3,798,851	168.8%
Rental Income, Net	303,528	296,834	6,694	2.3%	303,528	296,834	6,694	2.3%
Total Non-Operating	6,352,378	2,546,834	3,805,544	149.4%	6,352,378	2,546,834	3,805,544	149.4%
Net Income/(Loss)	$ 6,352,378	$ 2,546,834	3,805,544	-149.4%	$ 6,352,378	$ 2,546,834	$ 3,805,544	-149.4%
Medical Loss Ratio (adj MCO)	-	-			-	-		
Member Counts	-	-	-	-	-	-	-	-

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

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
MC Capitation	$ 132,469,815	$ 79,632,126	$ 52,837,690	66.4%	$ 132,469,815	$ 79,632,126	$ 52,837,690	66.4%
Supplemental Capitation	1,770,386	3,791,197	(2,020,810)	-53.3%	1,770,386	3,791,197	(2,020,810)	-53.3%
BHT Capitation	191,237	-	191,237	-	191,237	-	191,237	-
MC Cap Offset	(3,369,507)	-	(3,369,507)	-	(3,369,507)	-	(3,369,507)	-
Total Operating Revenue	131,061,932	83,423,322	47,638,610	57.1%	131,061,932	83,423,322	47,638,610	57.1%
OPERATING EXPENSE								
Provider Capitation	6,371,963	6,233,532	(138,431)	-2.2%	6,371,963	6,233,532	(138,431)	-2.2%
Hospital Inpatient	15,227,727	15,426,061	198,334	1.3%	15,227,727	15,426,061	198,334	1.3%
LTC/SNF	8,374,253	8,098,669	(275,584)	-3.4%	8,374,253	8,098,669	(275,584)	-3.4%
Pharmacy	5,345	-	(5,345)	-	5,345	-	(5,345)	-
Physician Fee for Service	6,266,727	6,796,446	529,719	7.8%	6,266,727	6,796,446	529,719	7.8%
Hospital Outpatient	6,630,300	6,911,640	281,340	4.1%	6,630,300	6,911,640	281,340	4.1%
Other Medical Claims	6,368,124	6,681,252	313,128	4.7%	6,368,124	6,681,252	313,128	4.7%
Other HC Services	1,598,663	1,612,716	14,053	0.9%	1,598,663	1,612,716	14,053	0.9%
Directed Payments	56,635,625	8,432,219	(48,203,406)	-571.7%	56,635,625	8,432,219	(48,203,406)	-571.7%
Long Term Support Services	94,868	133,625	38,757	29.0%	94,868	133,625	38,757	29.0%
CPO/In-lieu of Services	371,679	258,314	(113,366)	-43.9%	371,679	258,314	113,366	43.9%
Dental Expense	2,594,124	3,075,403	481,280	15.6%	2,594,124	3,075,403	(481,280)	-15.6%
Enhanced Care Management	163,636	543,306	379,670	69.9%	163,636	543,306	(379,670)	-69.9%
Provider Incentives	1,391,882	1,063,742	(328,139)	-30.8%	1,391,882	1,063,742	(328,139)	-30.8%
Transportation	643,227	672,397	29,170	4.3%	643,227	672,397	(29,170)	-4.3%
Indirect Health Care Expenses	435,965	90,144	(345,821)	-383.6%	435,965	90,144	(345,821)	-383.6%
UMQA (Allocation & Delegated)	1,249,700	1,346,518	96,818	7.2%	1,249,700	1,346,518	96,818	7.2%
Total Health Care Expense	114,423,806	67,375,984	(47,047,822)	-69.8%	114,423,806	67,375,984	(47,047,822)	-69.8%
G&A Allocation	3,802,699	3,963,573	160,874	4.1%	3,802,699	3,963,573	160,874	4.1%
Premium Tax	2,903	-	(2,903)	-	2,903	-	(2,903)	-
Total Operating Expense	118,229,408	71,339,557	(46,889,851)	-65.7%	118,229,408	71,339,557	(46,889,851)	-65.7%
NON-OPERATING REVENUE								
Total Non-Operating	-	-	-	-	-	-	-	-
Net Income/(Loss)	$ 12,832,524	$ 12,083,766	748,758	-6.2%	$ 12,832,524	$ 12,083,766	$ 748,758	-6.2%
Medical Loss Ratio (adj MCO)	153.75%	89.85%			153.75%	89.85%		
Member Counts	232,273	230,727	1,546	0.7%	232,273	230,727	1,546	0.7%

Health Plan of San Mateo
Full Duals Statement of Revenue & Expense
for the Period Ending March 31, 2023

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
MC Capitation	$ 25,428,739	$ 24,433,154	$ 995,584	4.1%	$ 25,428,739	$ 24,433,154	$ 995,584	4.1%
Supplemental Capitation	-	288,603	(288,603)	-100.0%	-	288,603	(288,603)	-100.0%
MC Cap Offset	(174,000)	-	(174,000)	-	(174,000)	-	(174,000)	-
Total Operating Revenue	25,254,739	24,721,758	532,981	2.2%	25,254,739	24,721,758	532,981	2.2%
OPERATING EXPENSE								
Provider Capitation	2,861,617	4,612,771	1,751,153	38.0%	2,861,617	4,612,771	1,751,153	38.0%
Hospital Inpatient	328,467	321,523	(6,944)	-2.2%	328,467	321,523	(6,944)	-2.2%
LTC/SNF	14,377,650	14,732,315	354,665	2.4%	14,377,650	14,732,315	354,665	2.4%
Physician Fee for Service	283,011	316,268	33,257	10.5%	283,011	316,268	33,257	10.5%
Hospital Outpatient	246,530	234,281	(12,249)	-5.2%	246,530	234,281	(12,249)	-5.2%
Other Medical Claims	1,844,710	1,739,586	(105,124)	-6.0%	1,844,710	1,739,586	(105,124)	-6.0%
Other HC Services	(309)	(1,439)	(1,129)	78.5%	(309)	(1,439)	(1,129)	78.5%
Directed Payments	955,600	879,468	(76,133)	-8.7%	955,600	879,468	(76,133)	-8.7%
Long Term Support Services	103,897	141,395	37,498	26.5%	103,897	141,395	37,498	26.5%
CPO/In-lieu of Services	338,853	371,538	32,684	8.8%	338,853	371,538	(32,684)	-8.8%
Dental Expense	302,668	292,875	(9,793)	-3.3%	302,668	292,875	9,793	3.3%
Enhanced Care Management	99,750	508,596	408,846	80.4%	99,750	508,596	(408,846)	-80.4%
Provider Incentives	428,739	423,340	(5,399)	-1.3%	428,739	423,340	(5,399)	-1.3%
Transportation	264,915	238,446	(26,469)	-11.1%	264,915	238,446	26,469	11.1%
Indirect Health Care Expenses	-	276	276	100.0%	-	276	276	100.0%
UMQA (Allocation & Delegated)	245,842	249,971	4,129	1.7%	245,842	249,971	4,129	1.7%
Total Health Care Expense	22,681,942	25,061,209	2,379,267	9.5%	22,681,942	25,061,209	2,379,267	9.5%
G&A Allocation	695,093	760,530	65,437	8.6%	695,093	760,530	65,437	8.6%
Premium Tax	5,224	-	(5,224)	-	5,224	-	(5,224)	-
Total Operating Expense	23,382,258	25,821,739	2,439,480	9.4%	23,382,258	25,821,739	2,439,480	9.4%
NON-OPERATING REVENUE								
Total Non-Operating	-	-	-	-	-	-	-	-
Net Income/(Loss)	$ 1,872,480	$ (1,099,981)	2,972,462	270.2%	$ 1,872,480	$ (1,099,981)	$ 2,972,462	270.2%
Medical Loss Ratio (adj MCO)	93.36%	105.11%			93.36%	105.11%		
Member Counts	29,341	26,191	3,150	12.0%	29,341	26,191	3,150	12.0%

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

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
HealthWorx Premium	1,748,213	1,718,221	29,992	1.7%	1,748,213	1,718,221	29,992	1.7%
Total Operating Revenue	1,748,213	1,718,221	29,992	1.7%	1,748,213	1,718,221	29,992	1.7%
OPERATING EXPENSE								
Provider Capitation	17	-	(17)	-	17	-	(17)	-
Hospital Inpatient	198,852	367,147	168,295	45.8%	198,852	367,147	168,295	45.8%
Pharmacy	630,163	665,906	35,743	5.4%	630,163	665,906	35,743	5.4%
Physician Fee for Service	246,335	328,344	82,008	25.0%	246,335	328,344	82,008	25.0%
Hospital Outpatient	334,730	415,280	80,550	19.4%	334,730	415,280	80,550	19.4%
Other Medical Claims	87,097	112,242	25,144	22.4%	87,097	112,242	25,144	22.4%
Other HC Services	0	-	0	-	0	-	0	-
Indirect Health Care Expenses	10,816	4,818	(5,999)	-124.5%	10,816	4,818	(5,999)	-124.5%
UMQA (Allocation & Delegated)	51,738	54,216	2,478	4.6%	51,738	54,216	2,478	4.6%
Total Health Care Expense	1,559,748	1,947,952	388,204	19.9%	1,559,748	1,947,952	388,204	19.9%
G&A Allocation	137,401	163,802	26,401	16.1%	137,401	163,802	26,401	16.1%
Total Operating Expense	1,697,149	2,111,754	414,605	19.6%	1,697,149	2,111,754	414,605	19.6%
NON-OPERATING REVENUE								
Total Non-Operating	-	-	-	-	-	-	-	-
Net Income/(Loss)	$ 51,063	$ (393,534)	444,597	113.0%	$ 51,063	$ (393,534)	$ 444,597	113.0%
Medical Loss Ratio (adj MCO)	89.22%	113.37%			89.22%	113.37%		
Member Counts	3,650	3,592	58	1.6%	3,650	3,592	58	1.6%

Health Plan of San Mateo
Healthy Kids Statement of Revenue & Expense
for the Period Ending March 31, 2023

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Total Operating Revenue	-	-	-	-	-	-	-	-
OPERATING EXPENSE								
Indirect Health Care Expenses	35	-	(35)	-	35	-	(35)	-
Total Health Care Expense	35	-	(35)	-	35	-	(35)	-
Total Operating Expense	35	-	(35)	-	35	-	(35)	-
NON-OPERATING REVENUE								
Total Non-Operating	-	-	-	-	-	-	-	-
Net Income/(Loss)	$ (35)	-	(35)	-	$ (35)	-	$ (35)	-
Medical Loss Ratio (adj MCO)	-	-			-	-		
Member Counts	-	-	-	-	-	-	-	-

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

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
CareAdvantage Premium	52,281,481	51,672,390	609,091	1.2%	52,281,481	51,672,390	609,091	1.2%
Total Operating Revenue	52,281,481	51,672,390	609,091	1.2%	52,281,481	51,672,390	609,091	1.2%
OPERATING EXPENSE								
Provider Capitation	1,157,792	1,157,625	(167)	0.0%	1,157,792	1,157,625	(167)	0.0%
Hospital Inpatient	18,519,954	17,681,993	(837,961)	-4.7%	18,519,954	17,681,993	(837,961)	-4.7%
Pharmacy	13,602,761	14,212,390	609,629	4.3%	13,602,761	14,212,390	609,629	4.3%
Physician Fee for Service	4,426,425	4,641,243	214,818	4.6%	4,426,425	4,641,243	214,818	4.6%
Hospital Outpatient	5,602,199	5,830,295	228,096	3.9%	5,602,199	5,830,295	228,096	3.9%
Other Medical Claims	5,273,752	5,385,435	111,683	2.1%	5,273,752	5,385,435	111,683	2.1%
Enhanced Care Management	144,000	251,037	107,037	42.6%	144,000	251,037	(107,037)	-42.6%
Provider Incentives	235,209	235,219	10	0.0%	235,209	235,219	10	0.0%
Supplemental Benefits	428,724	1,030,396		-	428,724	1,030,396	(601,672)	-58.4%
Transportation	418,510	-	(418,510)	-	418,510	-	418,510	-
Indirect Health Care Expenses	91,276	51,648	(39,628)	-76.7%	91,276	51,648	(39,628)	-76.7%
UMQA (Allocation & Delegated)	1,300,559	1,462,461	161,903	11.1%	1,300,559	1,462,461	161,903	11.1%
Total Health Care Expense	51,201,160	51,939,742	738,582	1.4%	51,201,160	51,939,742	738,582	1.4%
G&A Allocation	4,069,310	4,440,610	371,300	8.4%	4,069,310	4,440,610	371,300	8.4%
Total Operating Expense	55,270,470	56,380,352	1,109,882	2.0%	55,270,470	56,380,352	1,109,882	2.0%
NON-OPERATING REVENUE								
Total Non-Operating	-	-	-	-	-	-	-	-
Net Income/(Loss)	$ (2,988,989)	$ (4,707,963)	1,718,974	36.5%	$ (2,988,989)	$ (4,707,963)	$ 1,718,974	36.5%
Medical Loss Ratio (adj MCO)	97.93%	100.52%			97.93%	100.52%		
Member Counts	26,179	26,584	(405)	-1.5%	26,179	26,584	(405)	-1.5%

Health Plan of San Mateo
MC-CA Statement of Revenue & Expense
for the Period Ending March 31, 2023

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Medi-Cal Advantage Capitation	22,076,373	22,590,157		-	22,076,373	22,590,157	(513,784)	-2.3%
Total Operating Revenue	22,076,373	22,590,157	(513,784)	-2.3%	22,076,373	22,590,157	(513,784)	-2.3%
OPERATING EXPENSE								
Hospital Inpatient	649,860	687,578	37,718	5.5%	649,860	687,578	37,718	5.5%
LTC/SNF	11,400,769	12,766,272	1,365,503	10.7%	11,400,769	12,766,272	1,365,503	10.7%
Pharmacy	65,274	-	(65,274)	-	65,274	-	(65,274)	-
Physician Fee for Service	849,918	1,059,597	209,679	19.8%	849,918	1,059,597	209,679	19.8%
Hospital Outpatient	1,006,448	1,074,348	67,900	6.3%	1,006,448	1,074,348	67,900	6.3%
Other Medical Claims	2,575,119	2,782,978	207,859	7.5%	2,575,119	2,782,978	207,859	7.5%
Other HC Services	0	-	0	-	0	-	0	-
Directed Payments	836,115	800,622	(35,493)	-4.4%	836,115	800,622	(35,493)	-4.4%
Long Term Support Services	168,128	310,586	142,458	45.9%	168,128	310,586	142,458	45.9%
CPO/In-lieu of Services	959,286	944,919	(14,367)	-1.5%	959,286	944,919	14,367	1.5%
Dental Expense	458,231	472,361	14,129	3.0%	458,231	472,361	(14,129)	-3.0%
Enhanced Care Management	72,000	-	(72,000)	-	72,000	-	72,000	-
Provider Incentives	219,731	219,737	6	0.0%	219,731	219,737	6	0.0%
Transportation	-	635,399	635,399	100.0%	-	635,399	(635,399)	-100.0%
Indirect Health Care Expenses	-	335	335	100.0%	-	335	335	100.0%
UMQA (Allocation & Delegated)	291,771	322,173	30,402	9.4%	291,771	322,173	30,402	9.4%
Total Health Care Expense	19,552,651	22,076,904	2,524,253	11.4%	19,552,651	22,076,904	2,524,253	11.4%
G&A Allocation	839,390	980,203	140,813	14.4%	839,390	980,203	140,813	14.4%
Total Operating Expense	20,392,041	23,057,107	2,665,067	11.6%	20,392,041	23,057,107	2,665,067	11.6%
NON-OPERATING REVENUE								
Total Non-Operating	-	-	-	-	-	-	-	-
Net Income/(Loss)	$ 1,684,333	$ (466,950)	2,151,283	460.7%	$ 1,684,333	$ (466,950)	$ 2,151,283	460.7%
Medical Loss Ratio (adj MCO)	92.05%	101.32%			92.05%	101.32%		
Member Counts	25,695	26,578	(883)	-3.3%	25,695	26,578	(883)	-3.3%

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

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Total Operating Revenue	-	-	-	-	-	-	-	-
OPERATING EXPENSE								
Total Health Care Expense	-	-	-	-	-	-	-	-
G&A Allocation	557,437	544,851	(12,586)	-2.3%	557,437	544,851	(12,586)	-2.3%
Total Operating Expense	557,437	544,851	(12,586)	-2.3%	557,437	544,851	(12,586)	-2.3%
NON-OPERATING REVENUE								
Third Party Administror Revenue	569,806	576,772	(6,966)	-1.2%	569,806	576,772	(6,966)	-1.2%
Total Non-Operating	569,806	576,772	(6,966)	-1.2%	569,806	576,772	(6,966)	-1.2%
Net Income/(Loss)	$ 12,369	$ 31,920	(19,551)	-61.3%	$ 12,369	$ 31,920	$ (19,551)	-61.3%
Medical Loss Ratio (adj MCO)	-	-			-	-		
Member Counts	68,033	69,711	(1,678)	-2.4%	68,033	69,711	(1,678)	-2.4%

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

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
WCM Capitation	13,466,763	8,560,573	4,906,190	57.3%	13,466,763	8,560,573	4,906,190	57.3%
Supplemental Capitation	10,226	122,135	(111,909)	-91.6%	10,226	122,135	(111,909)	-91.6%
BHT Capitation	26,309	-	26,309	-	26,309	-	26,309	-
MC Cap Offset	(607,812)	-	(607,812)	-	(607,812)	-	(607,812)	-
Total Operating Revenue	12,895,486	8,682,708	4,212,778	48.5%	12,895,486	8,682,708	4,212,778	48.5%
OPERATING EXPENSE								
Provider Capitation	120,019	106,239	(13,780)	-13.0%	120,019	106,239	(13,780)	-13.0%
Hospital Inpatient	1,652,475	2,189,519	537,044	24.5%	1,652,475	2,189,519	537,044	24.5%
LTC/SNF	348,393	435,823	87,430	20.1%	348,393	435,823	87,430	20.1%
Physician Fee for Service	394,732	493,314	98,582	20.0%	394,732	493,314	98,582	20.0%
Hospital Outpatient	832,858	1,122,294	289,436	25.8%	832,858	1,122,294	289,436	25.8%
Other Medical Claims	847,843	946,456	98,613	10.4%	847,843	946,456	98,613	10.4%
Other HC Services	138,602	120,217	(18,385)	-15.3%	138,602	120,217	(18,385)	-15.3%
Directed Payments	5,094,112	585,960	(4,508,152)	-769.4%	5,094,112	585,960	(4,508,152)	-769.4%
Dental Expense	62,031	62,122	92	0.1%	62,031	62,122	(92)	-0.1%
Enhanced Care Management	-	109,921	109,921	100.0%	-	109,921	(109,921)	-100.0%
Provider Incentives	22,654	15,853	(6,801)	-42.9%	22,654	15,853	(6,801)	-42.9%
Transportation	19,366	19,646	279	1.4%	19,366	19,646	(279)	-1.4%
Indirect Health Care Expenses	7,470	1,804	(5,667)	-314.1%	7,470	1,804	(5,667)	-314.1%
UMQA (Allocation & Delegated)	888,913	985,131	96,218	9.8%	888,913	985,131	96,218	9.8%
Total Health Care Expense	10,429,466	7,194,298	(3,235,168)	-45.0%	10,429,466	7,194,298	(3,235,168)	-45.0%
G&A Allocation	428,917	449,813	20,896	4.6%	428,917	449,813	20,896	4.6%
Premium Tax	(1,012)	-	1,012	-	(1,012)	-	1,012	-
Total Operating Expense	10,857,371	7,644,111	(3,213,260)	-42.0%	10,857,371	7,644,111	(3,213,260)	-42.0%
NON-OPERATING REVENUE								
Total Non-Operating	-	-	-	-	-	-	-	-
Net Income/(Loss)	$ 2,038,114	$ 1,038,597	999,518	-96.2%	$ 2,038,114	$ 1,038,597	$ 999,518	-96.2%
Medical Loss Ratio (adj MCO)	133.67%	88.85%			133.67%	88.85%		
Member Counts	4,182	4,242	(60)	-1.4%	4,182	4,242	(60)	-1.4%

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

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
MCE Capitation	105,093,699	67,000,439	38093260	56.9%	105,093,699	67,000,439	38,093,260	56.9%
Supplemental Capitation	416,995	1,338,669	(921,675)	-68.9%	416,995	1,338,669	(921,675)	-68.9%
MC Cap Offset	(3,033,940)	-	(3,033,940)	-	(3,033,940)	-	(3,033,940)	-
Total Operating Revenue	102,476,754	68,339,108	34,137,645	50.0%	102,476,754	68,339,108	34,137,645	50.0%
OPERATING EXPENSE								
Provider Capitation	6,323,108	5,914,248	(408,860)	-6.9%	6,323,108	5,914,248	(408,860)	-6.9%
Hospital Inpatient	14,148,681	13,651,839	(496,842)	-3.6%	14,148,681	13,651,839	(496,842)	-3.6%
LTC/SNF	4,723,032	4,891,773	168,741	3.4%	4,723,032	4,891,773	168,741	3.4%
Pharmacy	(10,999)	-	10,999	-	(10,999)	-	10,999	-
Physician Fee for Service	5,436,195	6,212,954	776,760	12.5%	5,436,195	6,212,954	776,760	12.5%
Hospital Outpatient	7,181,894	8,443,246	1,261,352	14.9%	7,181,894	8,443,246	1,261,352	14.9%
Other Medical Claims	4,346,251	4,938,502	592,251	12.0%	4,346,251	4,938,502	592,251	12.0%
Other HC Services	(58,982)	(46,626)	12,356	-26.5%	(58,982)	(46,626)	12,356	-26.5%
Directed Payments	39,429,935	5,251,287	(34,178,648)	-650.9%	39,429,935	5,251,287	(34,178,648)	-650.9%
Long Term Support Services	4,219	-	(4,219)	-	4,219	-	(4,219)	-
CPO/In-lieu of Services	83,992	65,759	(18,233)	-27.7%	83,992	65,759	18,233	27.7%
Dental Expense	1,138,760	1,267,286	128,526	10.1%	1,138,760	1,267,286	(128,526)	-10.1%
Enhanced Care Management	259,042	591,688	332,646	56.2%	259,042	591,688	(332,646)	-56.2%
Provider Incentives	989,098	802,274	(186,824)	-23.3%	989,098	802,274	(186,824)	-23.3%
Transportation	1,001,509	1,008,005	6,496	0.6%	1,001,509	1,008,005	(6,496)	-0.6%
Indirect Health Care Expenses	283,476	61,054	(222,422)	-364.3%	283,476	61,054	(222,422)	-364.3%
UMQA (Allocation & Delegated)	1,033,214	1,080,658	47,444	4.4%	1,033,214	1,080,658	47,444	4.4%
Total Health Care Expense	86,312,423	54,133,947	(32,178,476)	-59.4%	86,312,423	54,133,947	(32,178,476)	-59.4%
G&A Allocation	3,322,949	3,235,865	(87,084)	-2.7%	3,322,949	3,235,865	(87,084)	-2.7%
Premium Tax	(7,115)	-	7,115	-	(7,115)	-	7,115	-
Total Operating Expense	89,628,257	57,369,812	(32,258,445)	-56.2%	89,628,257	57,369,812	(32,258,445)	-56.2%
NON-OPERATING REVENUE								
Total Non-Operating	-	-	-	-	-	-	-	-
Net Income/(Loss)	$ 12,848,497	$ 10,969,296	1,879,201	-17.1%	$ 12,848,497	$ 10,969,296	$ 1,879,201	-17.1%
Medical Loss Ratio (adj MCO)	136.89%	85.81%			136.89%	85.81%		
Member Counts	157,373	153,966	3,407	2.2%	157,373	153,966	3,407	2.2%

Health Plan of San Mateo
CA CMC Statement of Revenue & Expense
for the Period Ending March 31, 2023

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Total Operating Revenue	-	-	-	-	-	-	-	-
OPERATING EXPENSE								
Provider Capitation	69,352	-	(69,352)	-	69,352	-	(69,352)	-
Pharmacy	621	-	(621)	-	621	-	(621)	-
Indirect Health Care Expenses	432	-	(432)	-	432	-	(432)	-
UMQA (Allocation & Delegated)	6,908	-	(6,908)	-	6,908	-	(6,908)	-
Total Health Care Expense	77,314	-	(77,314)	-	77,314	-	(77,314)	-
G&A Allocation	71,299	-	(71,299)	-	71,299	-	(71,299)	-
Total Operating Expense	148,613	-	(148,613)	-	148,613	-	(148,613)	-
NON-OPERATING REVENUE								
Total Non-Operating	-	-	-	-	-	-	-	-
Net Income/(Loss)	$ (148,613)	-	(148,613)	-	$ (148,613)	-	$ (148,613)	-
Medical Loss Ratio (adj MCO)	-	-			-	-		
Member Counts	-	-	-	-	-	-	-	-

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

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
MC Cal MediConnect Capitation	13,768	-	13,768	-	13,768	-	13,768	-
Total Operating Revenue	13,768	-	13,768	-	13,768	-	13,768	-
OPERATING EXPENSE								
Pharmacy	(121)	-	121	-	(121)	-	121	-
Other HC Services	0	-	0	-	0	-	0	-
Directed Payments	99	-	(99)	-	99	-	(99)	-
Enhanced Care Management	520	-	(520)	-	520	-	520	-
Transportation	207,051	-	(207,051)	-	207,051	-	207,051	-
Total Health Care Expense	207,550	-	(207,550)	-	207,550	-	(207,550)	-
G&A Allocation	510	-	(510)	-	510	-	(510)	-
Total Operating Expense	208,060	-	(208,060)	-	208,060	-	(208,060)	-
NON-OPERATING REVENUE								
Total Non-Operating	-	-	-	-	-	-	-	-
Net Income/(Loss)	$ (194,292)	-	(194,292)	-	$ (194,292)	-	$ (194,292)	-
Medical Loss Ratio (adj MCO)	1518.45%	-			1518.45%	-		
Member Counts	-	-	-	-	-	-	-	-

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

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
MC Capitation	$ 157,898,554	$ 104,065,280	$ 53,833,274	51.7%	$ 157,898,554	$ 104,065,280	$ 53,833,274	51.7%
MCE Capitation	105,093,699	67,000,439	38093260	56.9%	105,093,699	67,000,439	38,093,260	56.9%
WCM Capitation	13,466,763	8,560,573	4,906,190	57.3%	13,466,763	8,560,573	4,906,190	57.3%
Supplemental Capitation	2,197,607	5,540,604	(3,342,997)	-60.3%	2,197,607	5,540,604	(3,342,997)	-60.3%
BHT Capitation	217,546	-	217,546	-	217,546	-	217,546	-
CareAdvantage Premium	52,281,481	51,672,390	609,091	1.2%	52,281,481	51,672,390	609,091	1.2%
Medi-Cal Advantage Capitation	22,076,373	22,590,157		-	22,076,373	22,590,157	(513,784)	-2.3%
HealthWorx Premium	1,748,213	1,718,221	29,992	1.7%	1,748,213	1,718,221	29,992	1.7%
MC Cal MediConnect Capitation	13,768	-	13,768	-	13,768	-	13,768	-
MC Cap Offset	(7,185,259)	-	(7,185,259)	-	(7,185,259)	-	(7,185,259)	-
Total Operating Revenue	347,808,745	261,147,663	86,661,082	33.2%	347,808,745	261,147,663	86,661,082	33.2%
OPERATING EXPENSE								
Provider Capitation	16,903,868	18,024,414	1,120,546	6.2%	16,903,868	18,024,414	1,120,546	6.2%
Hospital Inpatient	50,726,016	50,325,661	(400,355)	-0.8%	50,726,016	50,325,661	(400,355)	-0.8%
LTC/SNF	39,224,097	40,924,851	1,700,754	4.2%	39,224,097	40,924,851	1,700,754	4.2%
Pharmacy	14,293,044	14,878,296	585,252	3.9%	14,293,044	14,878,296	585,252	3.9%
Physician Fee for Service	17,903,343	19,848,165	1,944,823	9.8%	17,903,343	19,848,165	1,944,823	9.8%
Hospital Outpatient	21,834,958	24,031,383	2,196,425	9.1%	21,834,958	24,031,383	2,196,425	9.1%
Other Medical Claims	21,342,896	22,586,452	1,243,556	5.5%	21,342,896	22,586,452	1,243,556	5.5%
Other HC Services	1,677,972	1,684,868	6,895	0.4%	1,677,972	1,684,868	6,895	0.4%
Directed Payments	102,951,486	15,949,555	(87,001,931)	-545.5%	102,951,486	15,949,555	(87,001,931)	-545.5%
Long Term Support Services	371,113	585,607	214,494	36.6%	371,113	585,607	214,494	36.6%
CPO/In-lieu of Services	1,753,811	1,640,530	(113,282)	-6.9%	1,753,811	1,640,530	113,282	6.9%
Dental Expense	4,555,813	5,170,047	614,235	11.9%	4,555,813	5,170,047	(614,235)	-11.9%
Enhanced Care Management	738,948	2,004,549	1,265,601	63.1%	738,948	2,004,549	(1,265,601)	-63.1%
Provider Incentives	3,287,313	2,760,165	(527,148)	-19.1%	3,287,313	2,760,165	(527,148)	-19.1%
Supplemental Benefits	428,724	1,030,396		-	428,724	1,030,396	(601,672)	-58.4%
Transportation	2,554,578	2,573,892	19,314	0.8%	2,554,578	2,573,892	(19,314)	-0.8%
Indirect Health Care Expenses	829,470	210,078	(619,392)	-294.8%	829,470	210,078	(619,392)	-294.8%
UMQA (Allocation & Delegated)	5,068,644	5,501,128	432,484	7.9%	5,068,644	5,501,128	432,484	7.9%
Total Health Care Expense	306,446,093	229,730,036	(76,716,057)	-33.4%	306,446,093	229,730,036	(76,716,057)	-33.4%
G&A Allocation	13,925,005	14,539,248	614,243	4.2%	13,925,005	14,539,248	614,243	4.2%
Premium Tax	0	-	0	-	0	-	0	-
Total Operating Expense	320,371,098	244,269,284	(76,101,815)	-31.2%	320,371,098	244,269,284	(76,101,815)	-31.2%
NON-OPERATING REVENUE								
Interest, Net	6,048,851	2,250,000	3,798,851	168.8%	6,048,851	2,250,000	3,798,851	168.8%
Rental Income, Net	303,528	296,834	6,694	2.3%	303,528	296,834	6,694	2.3%
Third Party Administror Revenue	569,806	576,772	(6,966)	-1.2%	569,806	576,772	(6,966)	-1.2%
Total Non-Operating	6,922,184	3,123,606	3,798,578	121.6%	6,922,184	3,123,606	3,798,578	121.6%
Net Income/(Loss)	$ 34,359,831	$ 20,001,985	14,357,845	-71.8%	$ 34,359,831	$ 20,001,985	$ 14,357,845	-71.8%
Medical Loss Ratio (adj MCO)	125.15%	93.69%			125.15%	93.69%		
Member Counts	546,726	541,591	5,135	0.9%	546,726	541,591	5,135	0.9%

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

FOR THE CURRENT PERIOD March 31, 2023

	CURRENT MONTH 3/31/2023	CURRENT YEAR YEAR-TO-DATE 2023
CASH FLOW PROVIDED BY OPERATING ACTIVITIES		
Group/Individual Premiums/Capitation	-	-
Title XVIII - Medicare Premiums	17,132,191	52,281,481
Title XIX - Medicaid Premiums	270,289,293	415,523,648
Investment and Other Revenues	111,816	425,531
Medical and Hospital Expenses	(161,627,638)	(295,645,785)
Administration Expenses	(5,091,148)	(23,354,749)
NET CASH PROVIDED BY OPERATING ACTIVITIES	**120,814,515**	**149,230,126**
CASH FLOW PROVIDED BY INVESTING ACTIVITIES		
Proceeds from Restricted Cash and Other Assets	-	-
Proceeds from Investments	-	-
Proceeds for Sales of Property, Plant and Equipment	-	-
Payments for Restricted Cash and Other Assets	-	-
Payments for Investments	-	-
Payments for Property, Plant and Equipment	-	-
Interest and Other Income Received	1,792,613	5,246,394
NET CASH PROVIDED BY INVESTING ACTIVITIES	**1,792,613**	**5,246,394**
CASH FLOW PROVIDED BY FINANCING ACTIVITIES:		
Principal payments under capital lease obligations	-	-
NET CASH PROVIDED BY FINANCING ACTIVITIES	**-**	**-**
NET INCREASE (DECREASE) IN CASH	**122,607,127**	**154,476,520**
CASH AND CASH EQUIVALENTS AT THE BEGINNING OF THE MONTH/PRIOR YEAR	**441,749,271**	**409,879,878**
CASH AND CASH EQUIVALENTS AT THE END OF THE MONTH	**564,356,398**	**564,356,398**
RECONCILIATION OF NET OPERATING INCOME TO NET CASH FROM OPERATING ACTIVITIES:		
Operating Income	1,549,494	25,086,273
	-	-
Depreciation and Amortization	137,474	409,012
Decrease (Increase) in Receivables	25,455,553	19,285,914
Decrease (Increase) in Prepaid Expenses	(88,672)	(200,298)
Decrease (Increase) in Net Pension/Inflows and Outflows	-	-
Decrease (Increase) in Affiliate Receivables	-	-
Increase (Decrease) in Amts due to State of CA	(403,600)	1,201,400
Increase (Decrease) in Accounts Payable	90,263,333	95,584,573
Increase (Decrease) in Medical Claims Payable	(7,284,668)	355,407
Increase (Decrease) in Incurred But Not Reported	10,263,793	4,742,419
Increase (Decrease) in Provider Risk Sharing	921,808	2,765,425
Increase (Decrease) in Unearned Premium	-	-
Aggregate Write-Ins for Adjustments to Net Income	-	-
TOTAL ADJUSTMENTS	**119,265,021**	**124,143,853**
NET CASH PROVIDED BY OPERATING ACTIVITIES	**120,814,515**	**149,230,126**
DETAILS OF WRITE-INS AGGREGATED FOR ADJUSTMENTS TO NET INCOME		
Unrealized (Gain)/Loss on Equity Securities	-	-
(Gain)/Loss on Sale of Assets	-	-
Prior Period Rent Expense	-	-
Realized (Gain)/Loss on Investment	-	-
TOTALS	**-**	**-**

Draft

FINANCE/EXECUTIVE COMMITTEE MEETING
Meeting Summary
May 8, 2023 – 12:30 pm
Criminal Justice Training Center, 400 County Center, Redwood City, CA 94064

-or-

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

Member's present: Mike Callagy, Bill Graham, George Pon

Members absent: Ligia Andrade-Zuniga, Si France, M.D.

Staff present: Trent Ehrgood, Pat Curran, Francine Lester, Corinne Burgess, Ben Fu, Michelle Nordstedt, Michelle Heryford

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

2.0 Public Comment – There was no public comment.

3.0 Approval of Meeting Summary for March 27, 2023 – The meeting summary was approved as presented. **Callagy/Pon second. M/S/P**

4.0 Preliminary Financial Summary for the 3-month period ending March 31, 2023 - Mr. Ehrgood started with a recap of the 2023 budget, which is a forecasted surplus of $71M for the year. He highlighted that the forecasted surplus decreases each quarter illustrating the expectation that HPSM will start moving back toward smaller margins. Q1 is already doing better than anticipated with a surplus of $34M. So far, they are seeing a continuation of the last couple of years where there has been excess funding relative to what HPSMs cost is. He broke down the $34M, there is over $80M in prior year's revenue and a similar number in healthcare costs, which are the hospital directed payments. They don't usually book these until they know what the exact amount is, and the funding comes through. It came through in March and because it's pass-through dollars it hits revenue and expense but does not have much impact on the bottom line, though it does create noise in terms of revenue and expense relative to budget. The net prior-year adjustment is $1.6M in terms of the bottom-line impact. Included in this overall prior year adjustment is a mixture of direct payments and aid code changes. When the aid code change happens, it creates retro revenue. The combination of these two things created the $973K in adjustments. There is also $862K in supplemental revenue flowing from the prior year. It is mostly related to maternity, HPSM gets paid differently for maternity, it is not built into the rates, it's more episodic and payment is always delayed.

Membership numbers are close to what was anticipated for Q1. Membership did grow a bit more than was assumed, there is a .9% budget variance. Mr. Ehrgood explained the overall $14M budget variance for the quarter; HPSMs $20M budget surplus is really a surplus of $34M. The main driver is healthcare costs, which is running under budget as they have for the last couple of years. Likely a reflection of low utilizing members expected to drop off once redeterminations occur. Though they did assume in the budget that they would see some growth in healthcare costs on a per member basis. He also explained the relatively new Enhanced Care Management (ECM) benefit. Funding for this was quite high compared to expense, HPSM is required to give back some of that revenue, which shows up as a negative because it is not assumed in the budget. Healthcare costs are running close to $10M under budget, which is across most categories of service. Admin costs are running about $600K under budget. Non-operating revenue is $3.7M higher than budgeted. He explained that non-operating revenue includes rent from the County as well as ACE TPA fees and interest income. Mr. Ehrgood also went over HPSMs earned interest over the past year. In Q1 of 2022 the average monthly interest was around $90K, in Q2 the monthly average was $250K, in Q3 that rose to $800K and was at $1.4M in Q4. For Q1 of 2023, the average is $2M. Bringing the total interest in Q1 to $6M.

Next, Mr. Ehrgood reviewed healthcare cost in more detail. Total healthcare expenses recorded for Q1 is $306M. The budget variance is spread out amongst many different areas, everything is running lower than normal because there are still low utilizing members. He pointed out the ECM line where the budget for Q1 was $2M, but HPSM has only recorded $600K so far. He also noted that the line for Indirect Health Care Benefits has a negative variance, this is mostly HPSM's reinsurance coverage for catastrophic coverage, this usually involves member cases that have extremely high expenses. That line item is usually the net of two numbers, the premium paid and the recoveries when members go over the threshold.

Mr. Ehrgood went over profitability compared to budget by line-of-business (LOB) for Q1. With the exception of traditional Medi-Cal, HPSM is running favorable to budget across all LOB's.

Lastly, he walked through a summarized balance sheet and went over the difference between HPSMs assets and liabilities, which is the reserves or retained earnings. The reserve level was at $475M at the end of 2022. It has increased since then by $34M. Also noteworthy is the line item - Amounts Due to the State of California, which is about $175M, this is where the State has overpaid HPSM for various reasons, including the risk corridors like the ECM risk corridor. These monies are set aside, it

is not recognized as revenue, it's not included in the reserves. Mr. Ehrgood then went over the 4 places where cash sits. They are in order of liquidity, 1) a deposit account with Wells Fargo, that has disbursements accounts tied to it, 2) an institutional securities account, which is similar to a money market account (MMA), also with Wells Fargo. 3) a pooled fund with San Mateo County and 4) a pooled account with the State of California. He noted that recent local banking failures has inspired them to look at opening accounts with other financial institutions in an effort to spread assets around, so they are not "all in one basket." Mr. Ehrgood also explained HPSMs monthly cash flow, and the typical transactions during each week of the month. He closed by reminding the group that starting in January of 2024 Kaiser will have a direct contract with the State. Today, some HPSM members are delegated to Kaiser and HPSM receives revenue from DHCS cap to pay the Kaiser capitation for those assigned members. In 2024 that will go away, as Kaiser will have a direct contract. As a result, HPSMs membership will be smaller; revenue and expenses will be smaller as well.

Callagy/Pon second. A roll call vote was unanimous.

5.0 Other Business – Mr. Curran provided the Committee with a preview of HPSMs Investment Framework which highlights investment parameters he plans to communicate to the Commission over the next few months, as well as DNSP model considerations. He reminded the group about the investments HPSM has made and/or planned so far in dental, primary care, and PACE.

Mr. Curran then went over some of the recent long-term strategic planning. There are six areas that came out on top during their discussions with external stakeholders. They are:

Investor/funder: Use reserves to financially support critical services and support not covered by health insurance (e.g., value-based payments, capacity building investments/grants)

Innovator: design and pilot new approaches to ensure timely access to care.

Policy advocate: use data to influence and inform local, state, and federal policies that aim to improve systemic issues that impact health outcomes.

Convener: unite community partners on specific topics (e.g., behavioral health, housing, access to care in school settings).

Technical Assistance Provider: provide support and resources to help community-based organizations with billing Medi-Cal.

Educator: develop and communicate health education messages.

He highlighted some opportunities and challenges. To start, HPSM is financially stable. It was noted that it is likely that State rate changes combined with member redeterminations will result in future financial challenges. There is also concern that Provider workforce challenges highlighted during the pandemic are now systemic. HPSM has a strong history of implementing innovative programs and establishing learning collaboratives and recognize that they have a unique opportunity as their financial stability and projected income for 2023 is strong.

Mr. Curran then highlighted the areas of planned investments, which now will include expansion of the DSNP, and addressing provider workforce issues. He plans to recommend dedicating 2023 earnings, which is projected to be around $75M, toward the different targeted investment areas. He will conduct more discussion sessions between now and the Commission meeting in July, where he will seek potential approval on committed funding.

6.0 Adjournment – The meeting was adjourned at 1:29 pm by Commissioner Bill Graham.

Respectfully submitted:

M. Heryford

M. Heryford
Assistant Clerk to the Commission

AGENDA ITEM: 4.2

DATE: June 14, 2023

PHARMACY & THERAPEUTICS (P&T) COMMITTEE
Meeting Summary
Thursday, January 26, 2023 – 7:30am to 9:30am
Health Plan of San Mateo
Virtual Meeting via Microsoft Teams

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

Members Present: Barbara Liang, Dr. Bryan Gescuk, George Pon, Dr. Lena Osher, Jonathan Han, Niloofar Zabihi, and Victor Armendariz

Members Absent: Jaime Chavarria, Rukhsana Siddiqui, and Varsha Gadgil

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

Staff Absent: Dr. Chris Esguerra, Laura Lo, Matthew Lee, and Dr. Miriam Sheinbein

1. **Call to Order**
   George Pon, P&T interim chair, started the meeting with a call to order.
2. **Covid-19 Resolution (AB 361)**
   George requested that the Committee vote on adopting a resolution finding that, because of the continuing COVID-19 pandemic and state of emergency, meeting in person would present imminent risks to the health or safety of attendees. The Committee members and HPSM staff present all agreed to continue to meet virtually.
3. **Public Comment**
   None
4. **Approval of Meeting Minutes**
   Dr. Lena Osher motioned for approval of the prior meeting minutes and Niloo seconded.
5. **Approval of Agenda**
   Barbara motioned for approval of the meeting agenda and Jonathan seconded.
6. **Old Business**
   None
7. **New Business**
   Due to the impending end of the public health emergency, Ming signaled that the next P&T meeting may be in person at San Mateo Medical Center or Health Plan of San Mateo's Boardroom. Ming added that he would explore teleconference options and will let the Committee members know once he has any updates.

7.1 Pharmacy Department Policy Updates

Andrew presented three updates to Pharmacy department policies. The first policy update was made to the Medical Drug Prior Authorization policy, to clarify that it only applies to drugs billed under the Plan's medical benefit. The second policy update was made to the Duplicate and Overlapping Prior Authorizations policy, to address how the Plan handles overlapping requests received under the outpatient pharmacy benefit. The third policy update was made to the Nutritional Supplements for Medical Conditions policy which addresses how the Plan covers nutritional supplements covered under the Plan's outpatient pharmacy benefit.

George asked about how the Plan pays for administration of nutritional supplementation. Andrew replied that for oral nutritional supplementation, no payment is provided since they are self-administered. For enteral and parental nutrition, the cost of administration is invoiced and paid by the Plan under the medical benefit via CPT code.

Niloo motioned for approval and Barbara seconded with the Committee approving with no objections.

7.2 New Drugs to Market

7.2.1 New Protected Class Drugs

Andrew introduced seven new protected class drugs that were recently approved including the following: Calquence tablets, Elahere, Imbruvica suspension, Imjudo, Lytgobi, Tecvayi and Zonisade oral susp. The recommendation was made to add Calquence tablets, Imbruvica suspension, and Lytgobi to the CA D-SNP and HealthWorx formularies. Zonisade was recommended for formulary addition to the CA D-SNP line of business only.

7.2.2 New Non-Protected Class Drugs

Andrew presented eleven non-protected class drugs. The recommendation was made to add Fylnetra and Kyzatrex to both the CA D-SNP and HealthWorx formularies. The remaining drugs were not recommended for formulary addition because they were either healthcare administered drugs or due to presence of more cost-effective formulary alternatives available. Drugs for rare diseases were also not recommended for formulary addition due to expected low utilization with requests approved on a case-by-cases basis.

George asked whether there were a lot of pegfilgrastim products on the formulary. Andrew responded that all pegfilgrastim products except for Neulasta were on the formulary. Andrew added that most providers have already shifted to using biosimilar products rather than the reference product. George questioned whether it was necessary to have so many biosimilar products on formulary. Andrew responded that the intent of covering so many biosimilars was not only to promote their utilization (since they are more cost-effective relative to the reference product), but also to acknowledge that different hospitals may prefer one biosimilar over another.

7.3 New FDA-Approved Indications

Andrew went over new FDA-approved indications for existing drugs on the market. Changes to the prior authorization criteria for Orkambi and Tymlos were recommended. Orkambi was newly approved for patients one year of age or older while Tymlos was newly approved for the treatment of osteoporosis in men with high risk for fracture.

7.4 CMS Required Formulary Changes

Andrew presented various changes to the formulary and prior authorization criteria in response to concerns from CMS.

George asked whether off-label usage of drugs is common and whether the Plan would continue to allow coverage of drugs for these indications. Andrew responded that Plans are permitted to cover drugs when used for off-label indications based on CMS regulations as long as those indications are “medically-accepted”. This means that the indication is listed in CMS-approved drug compendia.

7.5 Formulary Considerations

Andrew presented various formulary updates in response to staff and provider feedback as well as updates to guideline recommendations. Some of the changes included the following: removing Jatenzo from the CareAdvantage formulary, adding tinidazole to both the CareAdvantage and HealthWorx formularies, adding mifepristone to the HealthWorx formulary, removing Xyrem from the CareAdvantage formulary, adding benzonatate 150 mg to the CA formulary, removing Oxbryta 300 mg tablet for suspension from the CareAdvantage formulary, updating the prior authorization criteria for Nexletol and Repatha to account for AACE/ACE guidelines.

7.6 Pharmacy Drug Class Review 0:40

7.6.1 Idiopathic Pulmonary Fibrosis Agents

Ming presented a drug class review on idiopathic pulmonary fibrosis agents. He discussed data from a trial comparing pirfenidone (Esbriet) to nintedanib (OFEV).

The recommendation was made to prefer generic pirfenidone over nintedanib for idiopathic pulmonary fibrosis.

Andrew asked if there was any data regarding the safety and efficacy of switching from nintedanib to pirfenidone. Ming responded by saying he couldn’t find any. However, retrospective cohort studies failed to show significant differences between the two agents in all-cause mortality and respiratory related hospitalization with both agents demonstrating the ability to slow decline of IPF. Ming added that the Plan would allow members currently on OFEV to continue taking it and would only prefer pirfenidone for new starts.

Dr. Gescuk was concerned about preferring pirfenidone for indications outside of idiopathic pulmonary fibrosis, citing data that favors nintedanib over pirfenidone. Ming clarified that the proposed prior auth criteria only favors pirfenidone for IPF and

not other indications. Dr. Gescuk was amenable to this and agreed.

Medical Pharmacy Drug Class Reviews

7.7.1 Hyaluronic Acid Products

Biyan presented a drug class review on Hyaluronic Acid products for osteoarthritis. For HealthWorx, Medi-Cal, and ACE: It was recommended to prefer Hyalgan, Supartz, Visco-3, Euflexxa, Orthovisc, Synvisc and Synvisc-One due to their low cost relative to the other hyaluronic acid products on the market. For CareAdvantage, no preference was given due to regulatory constraints.

Andrew asked Dr. Moore if the requirement for continuing pain should be removed. Dr. Moore said that these products should only be used if a member experiences pain. Dr. Gescuk added that hyaluronic acid should not be used in a preventative manner but rather in response to pain. After a brief discussion, the Committee agreed that it was appropriate to leave that requirement as is.

Jasmine asked whether the Plan would try to transition members who are currently taking a non-preferred product to a preferred product once their existing authorization has expired. Dr. Moore responded by saying he sees no concerns with transitioning members to a preferred product.

George asked about repeat injections and whether the Plan sees a lot of requests for these. Biyan responded by saying repeat requests were common. Dr. Gescuk added that some orthopedists prefer viscosupplementation over intraarticular steroids. However, due to lack of data showing its superiority over intraarticular steroids, he normally prefers giving steroids first due to their low cost. He also finds that, based on his experience, patients have better overall response to intraarticular steroids.

A discussion ensued surrounding the requirement that members try and fail on an NSAID, acetaminophen, and intra-articular steroids. There were concerns that requiring all three would be overly cumbersome for members. Another question that arose was whether a topical NSAID would suffice rather than an oral. After a brief conversation, the Committee agreed to change the requirement in such a way as to allow either an oral or topical NSAID. In addition, instead of requiring members to meet all three criteria, members would only be required to meet two of them.

Barbara motioned approval of all the recommendations proposed and Dr. Osher seconded with the Committee approving with no objections.

7.7.2 Infliximab

Biyan presented a drug class review on infliximab products. In addition to Remicade, four other biosimilars were discussed, including Avsola, Inflectra, Ixifi and Renflexis. Remicade, Inflectra, and Renflexis were recommended to be preferred over Avsola and Ixifi for Medi-Cal, HealthWorx, and ACE lines of business due to cost. For CareAdvantage, no preference was given due to regulatory constraints.

Biyan reviewed new requirements for members who want to use infliximab above

FDA-approved dosages and frequency. These requirements include but are not limited to the following: requiring that the members show an initial response to therapy by week 16, documentation that prior loading doses and intervals were not above FDA-approved package labeling, and documentation of subsequent loss of response.

Andrew expressed concerns regarding the requirement of initial response by week 16, saying that the interval was too specific and not necessary. Jasmine worried for pediatric patients who may need a higher dose due to severe disease. Ming suggested pharmacists use their best clinical judgement for extreme cases, but otherwise, the Plan should try to abide by the new requirements which align with guideline recommendations. In addition, it was agreed that the 16-week requirement would be removed, with specific timeframe mentioned.

Jonathan motioned approval of all formulary changes proposed and Niloo seconded with the Committee approving with no objections.

8. **Other Business/Announcements**
   None
9. **Adjournment**
   George adjourned the meeting at 9:35am

RESOLUTION OF THE
PHARMACY & THERAPEUTICS (P&T) COMMITTEE
OF THE SAN MATEO HEALTH COMMISSION

IN THE MATTER OF APPROVAL OF TELECONFERENCE MEETING PROCEDURES PURSUANT TO AB361 (BROWN ACT PROVISION)

RECITAL: WHEREAS,

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

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

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

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 26th day of January 2023 by the following votes:

AYES: Armendariz, Liang, Gescuk, Han, Osher, Pon, and Zabihi

NOES: 0

ABSTAINED: 0

ATTEST:

BY: *Kelly Chang*
Kelly Chang, Clerk

DRAFT

SAN MATEO HEALTH COMMISSION
Meeting Minutes
May 10, 2023 – 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor Boardroom
South San Francisco, CA 94080

AGENDA ITEM: 4.3

DATE: June 14, 2023

Commissioners Present:	Michael Callagy David J. Canepa Barbara Miao Raymond Mueller	George Pon, R. Ph., Chair Manuel Santamaria Kenneth Tai, M.D.
Commissioners Absent:	Jeanette Aviles, Si France, M.D., Bill Graham, Vice-Chair, Ligia Andrade Zuniga.	
Counsel:	Kristina Paszek	
Staff Present:	Corinne Burgess, Pat Curran, Trent Ehrgood, Chris Esguerra, M.D., Ian Johansson, Richard Moore, M.D. Colleen Murphey, Courtney, Sage, Amy Scribner.	

1. **Call to order/roll call**
   The meeting was called to order at 12:32 p.m. by Commissioner Pon, Chair. A quorum was present.

2. **Public Comment**
   Mr. Curran announced that Judy Garcia, a long standing member of the Consumer Advisory Committee, since 1991, has passed away. She will be missed. No other public comments were made at this time.

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

4. **Approval of Consent Agenda**
   Commissioner Pon presented a correction to the April 12, 2023 minutes on item 5.2, *Approval of Update Purchasing Policy*, to strike the sentence referencing expenditures outlined in the annual budget would not need to be approved again by the commission (within first paragraph). The correction was duly noted as read. Mr. Curran added for clarity that any contract over $250,000 would be brought to the Commission for approval.

   Commissioner Canepa asked a question about the rates regarding Item 4.2, *Amendment #10 to Agreement with County of San Mateo dba San Mateo County Health for Rate Range Intergovernmental Transfer (IGT) Funding for Calendar Year 2021*. Mr. Ehrgood explained the IGT which is additional funding to the San Mateo Medical Center (SMMC) as a funding mechanism from the state through the health plan and to the SMMC as a public hospital serving Medi-Cal patients. This does not impact the health plan's bottom line.

Commissioner Canepa moved to approve the Consent Agenda including the minutes as corrected (Second: Callagy) **M/S/P.**

5. Specific Discussion/Action Items

5.1 Medicare D-SNP Update

[Commissioner Mueller arrived during the presentation}
Mr. Curran introduced Dr. Chris Esguerra, Chief Medical Office. Dr. Esguerra reviewed his presentation on CareAdvantage which is attached to these minutes.

CareAdvantage by Health Plan of San Mateo is the name of the new D-SNP program. The Centers for Medicare and Medicaid Services (CMS) run the Medicare program. This population is being heavily marketed by all health plans because these members have options – Original Medicare and Medicare Advantage. Under Medicare Advantage, there are two options: Special Needs Plans and Standard Medicare Advantage Plans. HPSM's plan is a Dual Special Needs Plan (D-SNP) for people who are eligible for both Medicare and Medi-Cal, and this is the population that has the most needs and support. The drivers of this program include the makeup of the membership, the revenue to support to program, and the quality metrics through STARS ratings which is determined annually.

Dr. Esguerra reviewed the demographics of the D-SNP membership within HPSM of 8,800 in CareAdvantage; 5,900 have original Medicare and 2,300 are with Kaiser. In San Mateo County, there are about 16,000 duals and he proposes that we can increase the number of CareAdvantage members. He compared our D-SNP with plans nationally noting that our plan is larger than 62% of D-SNPs nationally.

He reviewed the history of the health plan's experience with D-SNP, starting in 2006. In2014 Cal MediConnect began as a pilot program to take the place of the D-SNP and ended December 31, 2022. HPSM transitioned back to a D-SNP on January 1, 2023. The State is pushing for alignment of all plans to have a D-SNP. The commercial plans are reaching out in a way they didn't do in the past, creating competition for these dually eligible members during open enrollment.

The D-SNP participates in the STAR ratings program. HPSM does not have a rating for this year but will have one beginning in 2025 based on data from calendar year 2023. The bid process to CMS is an annual requirement which affects our rates for the following year. Supplemental benefits are a new benefit we implemented, which allows additional ways we can help our members. Another new area of emphasis for HPSM is the marketing and sales function. Dr. Esguerra also touched on the existing partnerships such as with San Mateo County Aging & Adult services and how we can promote CareAdvantage.

He spoke of the health plan's strengths in running a D-SNP and the partnerships we have already developed. The opportunities before us include working to improve our performance in the STARS program to achieve a 4-star rating. We will have a community presence in various clinics, San Mateo County Senior Fair, and the idea is to promote member growth.

Dr. Esguerra noted that by 2026 all other local plans will be required to have a D-SNP, and this process can be costly, with a potential to incur losses for 3-4 years based on feasibility studies some of the plans have performed. Many of our neighboring local plans have no experience running a D-SNP. This presents an opportunity for HPSM and other local plans to group together in innovative ways. Discussions of creating a regional "CareAdvantage" non-profit, which would be structured as a 501(c)(3), and would be locally operated could offer expansion to our D-SNP. This would require a Knox-Keene license with Department of Managed Health Care. HPSM would be the initial participant and other plans could join this entity. He talked about the governance, finance and operational aspects, noting that much would be delegated from the other plans to HPSM since we are already performing these functions, such as marketing and provider network. HPSM would be able to support this growth and enhance services for our members here in San Mateo County.

He reviewed the timeline, and preparation would need to take place between 2023 and 2026. HPSM has had conversations with neighboring plans and there are still a lot of questions to be answered. CMS and DHCS supportive of this regional plan idea. To CMS, this would look like a service area expansion in partnership with other plans. Since HPSM is already established, others who would join in with us would not have to go through the full process of establishing a D-SNP.

Commissioner Callagy asked how difficult it is to get to 5 Stars and what is the largest hurdle. Dr. Esguerra explained that moving up our Stars rating involves good data and information systems to capture the work being done by providers. We are in a request for proposal process to find the right data infrastructure partner to invest in that data gathering. Another important factor is how teams come together to organize the work. Our Population Health Management team has been working on the many aspects and measures of the Stars rating system. He suggested that getting to 4 Stars will be challenging but very possible.

Dr. Tai made a comment on the doubling of the Kaiser membership in the duals and suggested that we look at what services and benefits they are offering, to be proactive with keeping our members in the health plan. He asked about the legal structure and the cost involved in implementation. Dr. Esguerra explained that they are meeting soon to better establish the details of the process. Ian Johanssen, Chief Compliance Officer, already has the information of what it will take to submit the Knox-Keene application.
Commission Pon asked if the Star rating systems is the same as for hospitals. Dr. Esguerra stated that there are similarities, in that they both measure operational and member experience.

Commission Miao asked if we are taking on more risk by potentially adding other plans with more membership at the same time that we are trying to establish and improve our own Star rating. Dr. Esguerra said this is a note of concern. This is one of the risks that needs to be considered but the opportunity exists for all plans to work together on best practices, which could lift our Stars rating.

Commission Pon asked what it would mean to our members. Dr. Esguerra stated that we will keep our focus on San Mateo County, and we would be leveraging the operational pieces to run this regional D-SNP. Mr. Curran added that there will be more conversations in the next few months to fully understand the risks and the benefits of this concept.

Commissioner Canepa asked about the financial ramifications of Kaiser doubling their members. Dr. Tai gave some context on the annual revenue related to the 2,300 additional members, noting that there is a lot of revenue involved in the Medicare program.

Commissioner Mueller asked if this 501c3 structure could lead to other potential lines of business, such as those serving employers. Dr. Esguerra explained this is a possibility, yet they are currently focusing on CareAdvantage. This would tie into HealthWorx and the potential to grow and develop that program, but that would be a significant amount of work. Mr. Curran noted that there will be conversations about HealthWorx in the next two months and the challenges we have with that program, and the opportunities of how that program could evolve.

Commissioner Miao has heard in the news about a large number of plans jumping into this Medicare Advantage arena and then dropping out. Dr. Esguerra concurred that this is true and there are reports of plans who are possibly declaring bankruptcy. HPSM has been operating a D-SNP and has been financially and operationally stable.

5.2 PACE Update

Dr. Richard Moore, HPSM Senior Medical Director, reviewed his presentation, which is attached to these minutes. He touched on the following points regarding the possibility of having a PACE (Program of All-Inclusive Care for the Elderly) program in San Mateo County:

- HPSM would be a strategic investor with the entity that would run the PACE model.
- While the current basic PACE model may not be needed in San Mateo County, staff want to explore the possibility of an innovative model that would add value to the community.
- PACE is an insurance entity that covers all the benefits and services that a Medi-Cal and Medicare plan would offer through a PACE center.
- He reviewed the history of the model, which is listed in the attached presentation.
- Reasons to consider PACE:
    - There is an expectation of a surge of an aging population
    - We are already experiencing challenges with getting more Primary Care Physicians and Geriatricians into San Mateo County.
    - Growing needs for care, high cost for residential care, and an increase of people needing long term care.
    - Lack of long-term care beds in San Mateo County, resulting in placing members out of county for custodial care.

- The number of PACE centers in the country is 306 in 32 states; California has 20 PACE providers, with PACE programs in San Francisco, Santa Clara, Alameda and Contra Costa
- He reviewed the criteria for PACE enrollees. These patients would be in a nursing facility without this program. PACE would allow these members to live safely in the community with needed services.
- The average PACE patient has 20 medical conditions, is eligible for Medi-Cal, or dually eligible for Medicare and Medi-Cal.
- PACE Model of Care has 11 interdisciplinary team roles.
- Benefits of the PACE program embodies the "One Stop Shop" for the member having access to the right care in an integrated setting.
- Barriers include members having to change their PCP or other providers; relinquish their IHSS hours; excluding members with active mental health issues or unstable housing. These limitations and exclusions make it challenging to attain sustainable enrollment.

Next steps are to go out to request for proposal (RFP) in July 2023 seeking innovating ideas of how this would look in San Mateo County. He presented the questions that may be covered in the RFP.

Commissioner Callagy asked who might be likely to respond to the RFP. Dr. Moore explained the centers would provide the core services and would contract with the necessary additional services that would need to be provided. They expect there are 2 to 5 PACE centers that would be able to respond.

Commissioner Miao asked if members must disenroll from CareAdvantage and how many patients would be needed to break even. Dr. Esguerra confirmed they would need to disenroll, and it would take about 300 patients for a PACE program to become sustainable.

5.3 Compliance Program Education Session

Ian Johansson, Chief Compliance Officer, reviewed his presentation, which is attached to these minutes. His presentation reviewed the Compliance Program and the commission's oversight of the program.

Compliance is part of the culture at HPSM and is achieved through the Compliance Program, educating employees, identifying and resolving compliance risks, and engaging our staff and stakeholders. His presentation covers how the Compliance department assesses risks, handles compliance issues and how this information is reported to the Commission.

Review Risk Assessment Process

- Using an inside tool staff assess risks related to HR, utilization and other operational factors. Risk information comes through internal and external audits that are performed on a regular basis. Regulatory agencies publish areas of concern which allow staff to monitor operations in these areas before formal external audits are performed. Lastly, stakeholder input through our compliance hotline or other reporting of issues that are brought to our attention can be followed and resolved.
- This tool provides an opportunity to assess compliance risks across the organization. The Compliance Committee is made up of key staff and leadership and meets quarterly to review risks and determine s needed resources, and identifies any further action to mitigate risks.

Review Compliance Issue Process

- Mr. Johansson noted that we have not had a CMS audit since 2016. This leaves room for complacency within operational processes. In order to mitigate this, the compliance department surveys staff for their concerns and then engages consultants to help us prepare for the audit. He used the example of timeliness in prior authorizations as a risk area. If the timeliness dips below the threshold, staff opens an investigation to review the process and identifies the root cause, tracks and documents the resolution, and monitors progress to ensure compliance.

Reporting issues to the Commission

- Our policy on disclosure is mandated by CMS.
- All compliance issues are brought to the attention of the Chief Compliance Officer and the Compliance Committee, which recommends cases to be disclosed to the Commission. These include mandated issues of Fraud, Waste & Abuse, Privacy Breaches, and other issues that come under regulatory action and/or penalty.
- Reporting to the Commission on compliance activity and issues come through the external audit reports which are presented to the commission.
- Specific compliance issues involving fraud, waste and abuse; privacy; or, regulatory action are first disclosed at the Finance/Executive committee and are reported as soon as possible.

Mr. Johansson concluded his presentation by noting that more reporting will be brought to the commission at the August meeting, including the 2022 Compliance Program survey results; external audit activity update; and the NCQA Resurvey results. In November they will present the 2024 new State Contract and the requirements contained that will drive

activity going forward, as well as give an outlook on 2024 as a whole for potential risks or audits that we can expect.

5.4 HPSM Investment Framework

Mr. Curran noted that in the coming months the commission will be presented with a series of updates and presentations related to various initiatives to consider as ways of strategic investments over the next few years. He gave a preview of the current landscape, including the challenges and opportunities we are facing. The competitive environment and regulatory changes will create a number of challenges and some opportunities, such as expanding our Medicare plan as discussed earlier in this meeting, and timing will be important.

In 2022, three areas were identified as focal points to impact health outcomes, member experience, resource stewardship and equity innovation. These areas of focus are primary care, oral health, and PACE.

He reviewed the investments that the commission has already made in these three areas, noting the Orthopedic access pilot with San Mateo County and San Mateo Dental Society; NEMS funding to recruit an oral surgeon; and University of the Pacific start-up funding as Dental investments. In Primary Care, the commission has approved the implementation of a model for a pilot project (Grove model) with Sutter/PAMF.
Mr. Curran reviewed input by the commission on the roles and responsibilities HPSM should play to improve health outcomes by addressing social determinants of health. This includes investing in critical services and supports; innovative new approaches to timely access; policy advocacy through use of data; uniting community partners on priority topics, providing support to help community based organizations with Medi-Cal billing; and, education with health messages. He talked about the unique opportunities before us and how we can use our current financial stability to prepare for leaner times we expect to be facing in the future. The state budget revision is to be released soon and is expected to be gloomy, the reinstatement of redeterminations will have an affect on membership, and state rate considerations will be an issue. HPSM has a history of developing innovative programs. The lessons learned during the pandemic is that provider workforce challenges are now systemic. This is another area that will be an ongoing challenge that will affect access for our members.

He concluded on the general framework and next steps of what will be proposed to the commission in the next few months, dedicating our 2023 net income to potential one-time and ongoing investments to address the strategic areas noted.

Commissioner Canepa asked about reserves. Mr. Curran talked about the current reserves, the level of investments that will be proposed, which involves 2023 net income, and the stabilization reserves projected thereafter for the future potential leaner years to come. Commissioner Canepa talked about Seton Medical Center and the action by San Mateo County to provide funding during the transition to AHMC Healthcare. He expressed hope to see additional support from HPSM for the community. He stated that he looks forward to seeing how we might include this in the strategic investments.

6. **Report from Chairman/Executive Committee**
   There were no comments or reports from the Executive Committee at this time.

7. **Report from Chief Executive Officer**
   Mr. Curran had nothing additional to report.

8. **Other Business**
   No other business was discussed at this time.

9. **CLOSED SESSION**

   CONFERENCE WITH LEGAL COUNSEL – Existing Litigation (Gov't Code section 54956.9(d)(1)) Koval v. American Logistics LLC, Anas Ali Artimeh, Sultan Almakanin, Let's Move Limo LLC, Pacifica Linda Mar, Inc., Health Plan of San Mateo, San Mateo Health Commission, Does 1 to 100, 21-CIV-02032, Superior Court for the County of San Mateo

   CONFERENCE WITH LEGAL COUNSEL – Anticipated Litigation (Gov't Code section 54956.9(d)(2)) (3 cases)

   Commissioner Pon moved the meeting to closed session at 1:55pm

10. **Report Out on Closed Session**
    The meeting reconvened at 2:17pm. Kristina Paszek reported that there was no action taken in closed session.

11. **Adjournment**
    The meeting was adjourned at 2:18pm

Submitted by:
C. Burgess

C. Burgess, Clerk of the Commission

Attachment 1 to
SMHC Minutes 5-10-2023

CareAdvantage
by Health Plan of San Mateo

San Mateo Health Commission

May 2023

HealthPlan OF SAN MATEO
Healthy is for everyone

Medicare Primer

HealthPlan OF SAN MATEO
Healthy is for everyone

CMS Medicare Program

Original Medicare

Medicare Advantage

Special Needs Plans

Standard MA Plans

Fundamental Drivers

Membership

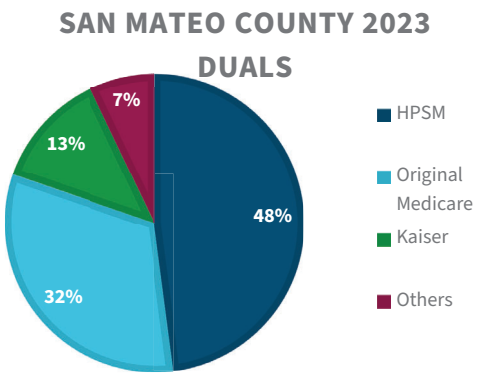
Revenue

Quality

CareAdvantage by HealthPlan OF SAN MATEO

Focusing on Dually Eligible Members

HealthPlan OF SAN MATEO
Healthy is for everyone



San Mateo County "Duals" ~16,000

~5900 remain with Original Medicare

~2300 went with Kaiser

~8800 with CareAdvantage

HPSM's CareAdvantage Program is larger than 62% of D-SNPs nationally

CareAdvantage by HealthPlan OF SAN MATEO

We are Now a D-SNP

HealthPlan OF SAN MATEO
Healthy is for everyone

2006 - 2016
- HPSM operated a D-SNP

2014 - 2022
- CMS Financial Alignment Initiative – Cal MediConnect
- Pilot ended 12/31/2022

2023
- Transition to D-SNP (H6019)

We continue to advocate for our CareAdvantage and other dually eligible members

Despite the push of aligned enrollment, we are competing with other plans

CareAdvantage by HealthPlan OF SAN MATEO

We are New Again (Somewhat)

HealthPlan OF SAN MATEO
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New (or New-ish)

- Contract ID H6019
- Stars Rating
- CMS Bid Process
- Supplemental Benefits
- Marketing and Sales

What we already do

- Operations (Claims, UM, Model of Care, Compliance, Appeals/Grievances, Member Services, Network, Pharmacy, Encounters/Revenue Capture)
- Partnerships

CareAdvantage by HealthPlan OF SAN MATEO

Our Strengths

Foundations

Partnerships

We are Local

CareAdvantage by HealthPlan OF SAN MATEO

Our Opportunities

Outcomes

Community Presence

Member Growth

CareAdvantage by HealthPlan OF SAN MATEO

Scaling Local – Regional D-SNP Model

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Healthy is for everyone

Challenge

Other local plans must have a D-SNP by 2026

Establishing a D-SNP is costly and breakeven may be by year 3 or 4

Opportunity

HPSM already has a D-SNP

Innovative way for local plans to work together to scale local

Care Advantage Structure

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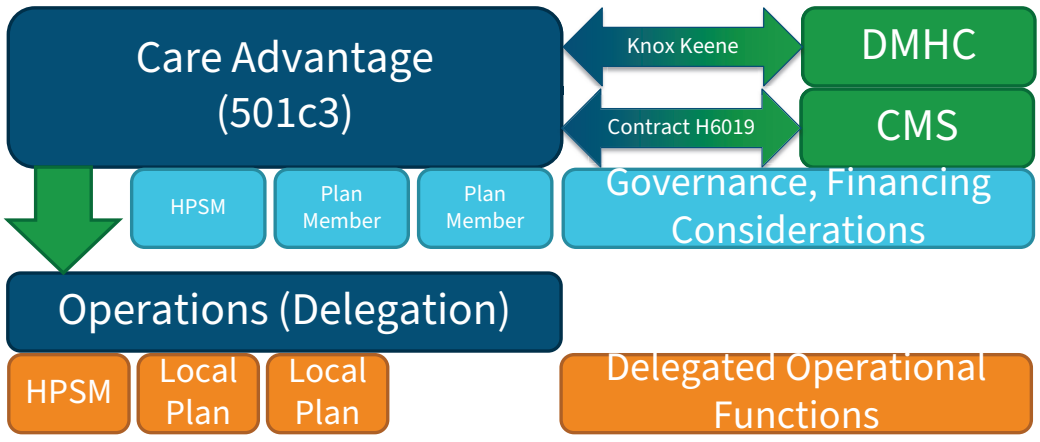
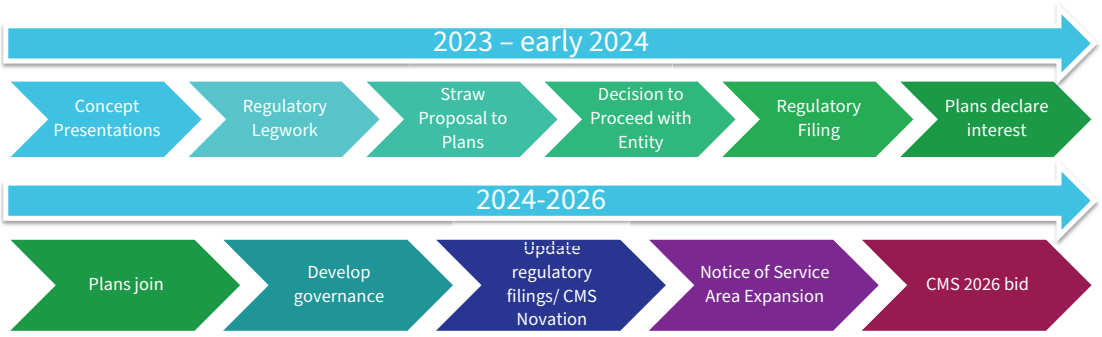
Regional Strategy, Locally Integrated



Regional D-SNP Model - Timeline



What is Next? (Timeline in more detail)

- Exploration of local plan interest and identification of regulatory barriers, if any: March 2023
- HPSM Commission approval to create subsidiary (based on results of initial exploration): August 2023
- Creation of LLC: September-October 2023
- Initiate filing Knox Keene License for new entity: November 2023
- Deadline for local plans to join: April 2024
- CMS and DMHC Service Area Expansion applications: November 2024
- CMS bid submission for newly expanded service area: June 2025
- DHCS demonstration of EAE: ?
- Go-live date for expanded service area: January 2026

Thank you

PACE Model Exploration

SAN MATEO HEALTH COMMISSION

May 10, 2023

HealthPlan OF SAN MATEO
Healthy is for everyone

PACE Exploration – Starting Point

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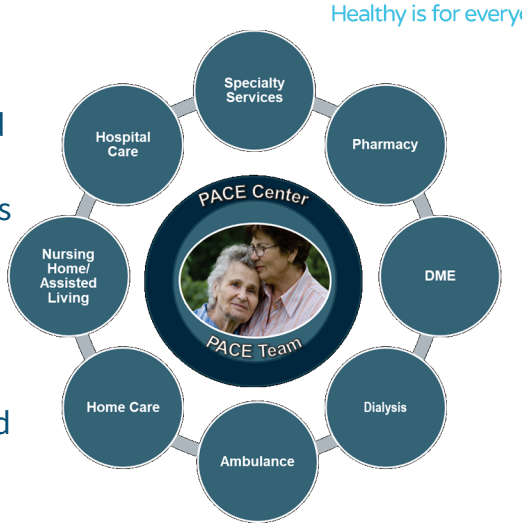
- HPSM's partnership is as a strategic investor.
- The current basic PACE model is not needed.
- Any PACE model must add value to the community and not replicate existing programs at HPSM or in the community.

What is PACE?

- **P**rogram of **A**ll-Inclusive **C**are for the **E**lderly
- A fully capitated, fully integrated, and comprehensive care program for adults age 55 or older living with chronic illnesses or disabilities.
- The PACE model is described by the CHCF as a cross between an HMO, a health care provider, and long-term care.

Provider Network

- PACE organizations are responsible for coordinating and providing comprehensive care to their enrolled participants.
- This all-inclusive care model includes all services normally covered by Medicare and Medicaid.
- The PACE team is responsible for managing and paying for services delivered by contracted providers such as hospitals, nursing homes and specialists.



History of PACE

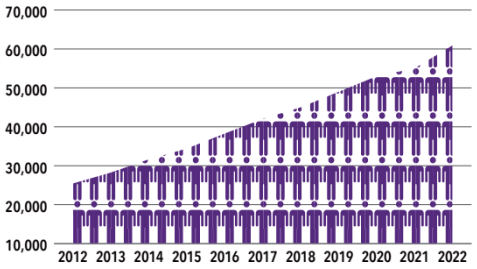
- In the 1970s, a community-based care model was designed to serve older residents in the Chinatown-North Beach community of San Francisco.
- 1983 - On Lok is allowed to test a new financing system in which a combination of Medicare and Medicaid (or private) funding pays the program a fixed amount each month for each person in the program becoming the first PACE.
- 1986 - Federal legislation extended the financing mechanism to 10 additional locations in the US.
- 1997 – The Balanced Budget Act established PACE as a permanent provider status creating important stability that promoted PACE replication and overall expansion of needed services to frail older adults.
- 2019 – Federal Register PACE Final Rule is published

Why Consider PACE

- In the next 30 years, there will be a significant increase in people needing long term care with a 3-fold rise in the number of people over age 85 years.
- With this surge in total numbers of older adults comes an increasing prevalence of functional dependence and cognitive impairment as well as greater complexity of medical care needs.
- The traditional approach to long-term care has been nursing facility care or in-home care provided by family caregivers.
- The drivers include the high cost of residential care, the role of Medicaid on nursing home financing, and the plateau in nursing home bed capacity.

PACE Centers

- As of June 2022 – 306 PACE centers in 32 states and the District of Columbia serving more than 61,000 older adults in the United States.
- California has 20 PACE providers.
- There are PACE programs in adjacent counties, including: San Francisco, Santa Clara, Alameda, and Contra Costa



PACE Goals

- Throughout the development and growth of PACE, the overarching goal has remained very clear.
- This comprehensive care model aims to provide high-quality, person-centered care that enables older people who are at-risk for nursing home placement to remain living in the home or community setting.
- Complementary to that goal are efforts to minimize the need for hospitalization and to control health care costs by intensive management through an interdisciplinary team.

PACE Enrollee Requirements

- PACE programs can only enroll the following individuals:
  - At least 55 years old
  - Living in a PACE service area
  - Certified by their state as needing nursing facility care
  - Able to live safely in the community with PACE services at the time of enrollment

PACE Participants - Nationwide

- Coverage:
  - 87% are dually eligible for Medicaid and Medicare
  - 13% are Medicaid-only
  - 0.5% pay a premium (Medicare-only or other)
- Average Age: 77
- 66% female; 34% male
- Average number of ADLs with which participants need assistance:
  - 1-2: 26%
  - 3-4: 24%
  - 5-6: 33%

PACE Participants - California

- 12,000 participants are enrolled in California:
- Average age is 76, with 33% over age 80.
- Participants have strong racial/ethnic diversity.
- Average 20 medical conditions
  - 64% have 3+ limitations in ADLs
  - 33% have Alzheimer's or related dementia.
- Coverage:
  - 100% of enrollees are eligible for Medi-Cal, with 75% dually eligible for Medicare and Medi-Cal and 25% Medi-Cal eligible only.

Model of Care

- Across ALL settings, PACE integrates and coordinates care for participants, including drugs, transportation and meals.
- 11 Interdisciplinary Team roles are mandated.
- An individualized care plan is developed to respond to all of the participant's needs – 24 hours a day, 7 days a week, 365 days a year.
- Ideally, a PACE center will include a mental health worker.

Chronic Conditions

- Top 5 Chronic Conditions:
  - Vascular Disease
  - Major Depressive, Bipolar and Paranoid Disorders
  - Diabetes with Chronic Complication(s)
  - Congestive Heart Failure
  - Chronic Obstructive Pulmonary Disease
- Average = 5.8 chronic conditions
- Note: 46% of participants diagnosed with dementia

Benefits of PACE

- Provide the entire continuum of medical care and long-term services and supports required by frail older adults.
- PACE covers all Medicare Parts A, B and D benefits, all Medicaid-covered benefits, and any other services or supports that are medically necessary to maintain or improve the health status of PACE program participants.
- Regular, “High-Touch” Care
- No prior authorizations – services are discussed and approved at the interdisciplinary team meeting

Barriers

- Members having to change their PCP, specialists, and other providers to those in the PACE program network.
- Members having to relinquish their IHSS hours, oftentimes provided by family members.
- Members with active mental health issues or unstable housing are excluded.
- Difficulty maintaining sufficient enrollment.
- Individuals who can obtain care through a variety of home-care arrangements and a community-based medical home, are likely to be less willing to change those arrangements.

PACE Exploration – Next Steps

- Solicit Request for Proposals (RFPs) – July 2023
- Provide bi-monthly updates to the Health Commission
- We want to see innovative/creative ideas from potential providers
  - What about a hybrid model?

PACE Exploration – Questions

- What is the role of your organization and what do you think the role of HPSM should be?
- What do you see as the value of having a PACE in San Mateo County?
- What will be the added benefits to our members?
  - For example, on-site mental health support, dentist, audiologist, and podiatrist
- What is the strategy to overcome enrollment barriers as previously presented?
- What are additional anticipated challenges for sustained success of a PACE?
- How will the program provide an inclusive and culturally competent workforce able to communicate and effectively work with persons of various ethnic groups and diverse backgrounds?
- What are creative organizational and delivery methods for meeting service needs of the PACE participants?

To cure, occasionally
To relieve, often
To comfort, always

-- Hippocrates (460 – 370 BCE)

Additional Slides

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6 Critical Success Factors for PACE

1. Sufficient Demand for PACE Services
2. Positive Market Factors
3. Strong State Support
4. Adequate Payment for PACE Services
5. Sustained Organizational Capacity and Commitment to PACE
6. Adequate Capitalization

- PACE Critical Success Factors White Paper, National Pace Association, March 2013

Changes to PACE. Federal Register 04/12/2023

- We proposed to establish at new § 460.70(a)(1) that, at minimum, except as provided for in § 460.70(a)(4), PACE organizations must have contracts in place for the following medical specialties: anesthesiology, audiology, cardiology, dentistry, dermatology, gastroenterology, gynecology, internal medicine, nephrology, neurosurgery, oncology, ophthalmology, oral surgery, orthopedic surgery, otorhinolaryngology, palliative medicine, plastic surgery, pharmacy consulting services, podiatry, psychiatry, pulmonary disease, radiology, rheumatology, general surgery, thoracic and vascular surgery, and urology.
- We solicited comment on whether CMS should include the following additional specialty services in the list of minimum required services: endocrinology, hematology, immunology, neurology, colorectal surgery, infectious disease, physical medicine and rehabilitation. Additionally, we solicited comment on whether the proposed list of medical specialties should include any types of behavioral health specialties in addition to psychiatry such as psychologists or licensed clinical social workers.

Attachment 3 to
SMHC Minutes 5-10-2023

Mitigating Risks & Compliance Issues

Ian Johansson, Chief Compliance Officer

May 10, 2023

HealthPlan OF SAN MATEO
Healthy is for everyone

Background

HealthPlan OF SAN MATEO
Healthy is for everyone

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

Our Goal

- To establish a culture of compliance at HPSM that helps the organization and its employees “do the right thing”
- Achieved through:
  - Maintaining and implementing a Compliance Program
  - Educating our employees
  - Identifying and resolving compliance risks
  - Providing opportunities to engage our staff and stakeholders

Agenda

- Review Risk Assessment Process
- Review Compliance Issue Process
- How and when do risks/issues come to the Commission?

What is risk assessment?

- A process to identify compliance risks and the potential impact those risks have on HPSM
- HPSM maintains a tool to aggregate compliance risks identified from:
  - Internal audits and monitoring
  - External audits
  - Regulatory agency areas of concern
  - Stakeholder input

What is it used for?

- Provides an opportunity to assess compliance risks across HPSM, and
  - Provide updates to the Compliance Committee on the scope of each risk
  - Determine if adequate resources are allocated to each risk
  - Identify additional risks, actions, or other information critical to risk mitigation

Risk Mitigation

- Effort(s) to resolve a compliance risk
- Can be broad efforts, or targeted
- Broad effort example:
  - Risk:
    - Readiness for a CMS Compliance Program Effectiveness (CPE) Audit
  - Mitigation:
    - Survey stakeholders for concerns and risk areas
    - Solicit consulting support to support business owners in resolving identified concerns

Risk Mitigation

- Targeted risk example:
  - Risk:
    - Timeliness for Organization Determinations (prior authorization) is below threshold
  - Mitigation:
    - Compliance issue investigation opened
    - Business owner contacted; root cause identified; resolution tracked and documented
    - Issue monitored to ensure compliance is maintained

Commission Disclosure

- HPSM maintains a policy on disclosure of compliance issues
- All compliance issues are disclosed to the:
  - The Chief Compliance Officer, and
  - The Compliance Committee
- The CEO, CCO, and the Compliance Committee can recommend a case be disclosed to the Commission
- Examples include:
  - Confirmed cases of fraud, waste, and abuse;
  - Confirmed privacy breaches;
  - Other compliance issues with regulatory action / penalty

Commission Disclosure

- Where disclosure is made:
  - External audit risks / issues are reported to at regular Commission meetings
  - Issues involving FWA, privacy, or regulatory action are disclosed at the Finance/Executive Committee
- Disclosure is made as soon as possible, given the status of the given investigation

2023 Update Schedule

- August
  - 2022 Compliance Program Survey results
  - External audit activity update
  - NCQA Resurvey results
- November
  - 2024 Contract
  - 2024 Outlook

Questions?

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

Thank You

HPSM Strategic Investment Program

San Mateo Health Commission

May 10, 2023

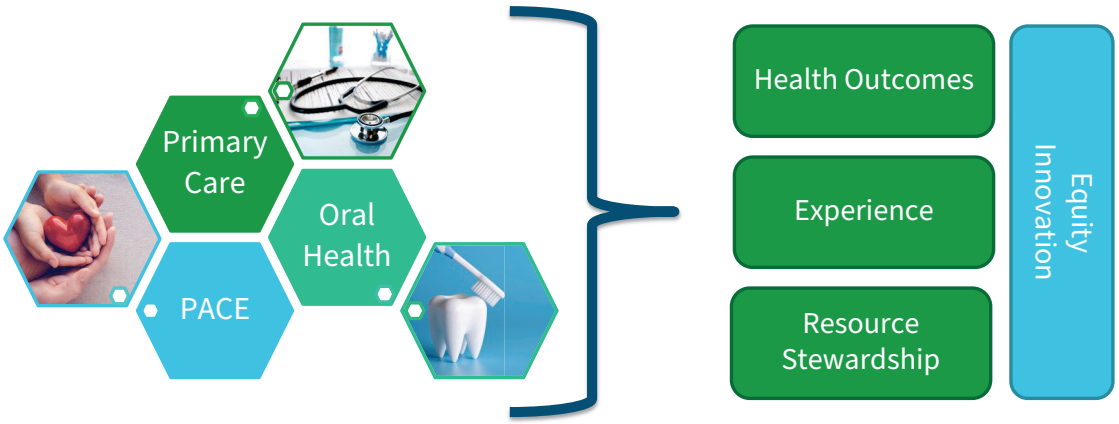
HealthPlan OF SAN MATEO
Healthy is for everyone

Current Landscape

HealthPlan OF SAN MATEO
Healthy is for everyone

	Challenges		Opportunities
Competition	Kaiser	Double down on our unfair advantage	Leveraging our "local"
	D-SNP		Executing on our mission
Local alone is not as salient	Relationship with DHCS	Relationships and reputation matter	Enhancing our Trusted Partner status
	Medi-Cal Procurement & 2024 Contract		Communicating our efforts and results
	Regional rates		Outcomes and Health Equity

Three Areas Identified in 2022



Investments made so far

- **Dental:**
  - Orthopedic access pilot in collaboration with San Mateo County and San Mateo Dental Society (Minimum impact on HPSM reserves)
  - NEMS funding to recruit and hire an oral surgeon to increase access to critical specialty dental services ($750K)
  - University of the Pacific start-up costs to develop a dental clinic at the San Mateo County Navigation Center ($125K)
- **Primary Care:**
  - Sutter/PAMF pilot to implement innovative model for HPSM Medicare members ($1.25M)
- **PACE:**
  - RFP process to identify potential operational partner to implement an innovative PACE program in San Mateo County (investment TBD: early 2024)

Strategic Planning Insights

HSPM Roles

Respondents were asked to rank the most important roles and responsibilities HPSM should play to improve health outcomes by addressing the social determinants of health aside from being a payor of medical, dental, and ancillary care. The potential roles HPSM could play/continue to play are listed below and ranked in order of most important to least important.

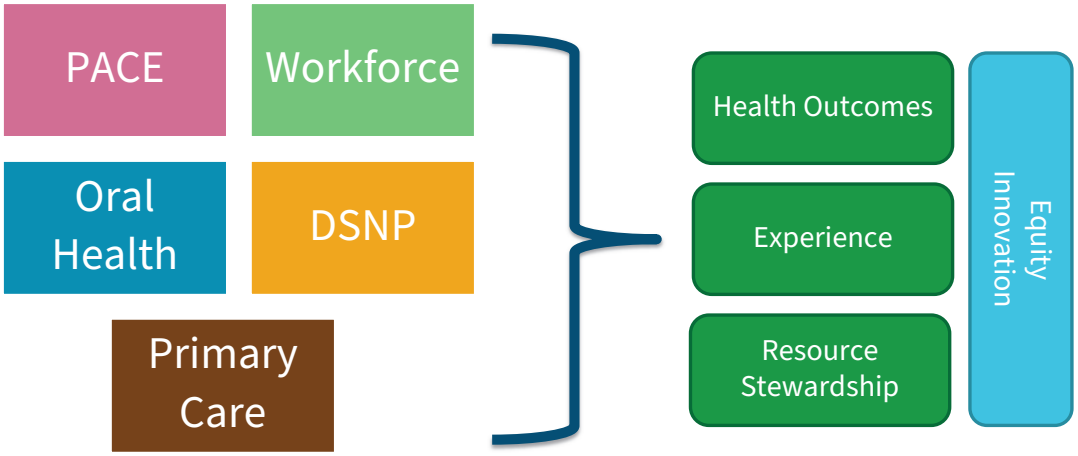
1. Investor/funder: use reserves to financially support critical services and supports not covered by health insurance (e.g., Value-Based Payment, Capacity Building investments/grants)
1. Innovator: design and pilot new approaches to ensure timely access to care
2. Policy advocate – use data to influence and inform local, state, and federal policies that aim to improve systemic issues that impact health outcomes
3. Convener - unite community partners on specific topics (e.g., behavioral health, housing, access to care in school settings)
4. Technical assistance provider – provide support and resources to help community-based organizations with billing Medi-Cal
5. Educator - develop and communicate health education messages

Unique Opportunity

- Strong financial stability and projected net income for 2023
- Likelihood that state rate changes combined with member redeterminations will result in future financial challenges
- History of HPSM implementing innovative programs and establishing learning collaboratives

What might significant HPSM investments look like to further access, health outcomes, and health equity for our members?

Areas of Opportunity - Updated



General Framework

- Investor/Funder: HPSM will dedicate the budgeted net income for 2023, approximately $75M, to explore both one-time funding and ongoing investment opportunities
- Convener and Technical Assistance: HPSM will build on its experience both locally and statewide to explore our role in facilitating system change (*Primary Care, Oral Health, Workforce*)
- Innovator and Policy Advocate: HPSM will explore expanding and implementing new lines of business consistent with our mission and state transformation (*Regional DSNP, PACE*)

Next Step - June Commission Meeting Discussion

- Strategic Plan Update and criteria for potential investments and program growth
- Presentation on Provider Workforce
- Updates on DSNP Model and Primary Care Investment exploration

AGENDA ITEM: 5.1

DATE: June 14, 2023

Meeting materials are not included

for Item 5.1 – Presentation on Provider Workforce

AGENDA ITEM: 5.2

DATE: June 14, 2023

Meeting materials are not included

for Item 5.2 – Presentation on Workforce Development

MEMORANDUM

AGENDA ITEM: 7.0

DATE: June 14, 2023

DATE: June 6, 2023

TO: San Mateo Health Commission

FROM: Patrick Curran

RE: CEO Report – June 2023

State Budget and Legislative Process

The California legislature is nearing its final approval of the annual budget and legislation. Of particular note is the increasing state budget shortfall, now projected to be $31.5 billion for the upcoming fiscal year (higher than the $22.5 billion deficit projected in January). However, there are no notable reductions in Medi-Cal funding or member benefits. The proposed coverage for all residents aged 26-49 regardless of documentation status is still included. That enhanced coverage would mean that as of January 1, 2024, all California residents who meet Medi-Cal eligibility requirements, regardless of documentation status, will be eligible for coverage. This could affect many current ACE participants, and HPSM and San Mateo County have a workgroup in place to implement this transition.

Managed Care Organization (MCO) Tax

As I reported in prior months, the state of California has historically received federal approval to place a "tax" on managed care organizations. This mechanism of taxing all health plans helps fund the Medi-Cal program through a complex financing formula. The state discontinued this tax in 2022 but is now proposing to re-establish the tax.

The final budget will include a significantly higher tax than was previously in place. There is also a coalition advancing a ballot initiative to make such a tax permanent and also designate how the funding would be used.

HealthWorx Program Evaluation

As mentioned in the February 2023 CEO Report, HPSM operates the HealthWorx program, which is licensed by the Department of Managed Health Care (DMHC) as a commercial health plan and serves approximately 1,200 members, most of whom are enrolled through San Mateo County's agreement with the union serving In-Home Supportive Services (IHSS) workers, as well as a small number of enrollees who are retirees from the City of San Mateo.

We will bring an update to the July meeting, which will include increasing our premium to San Mateo County by 20-30% due to higher medical costs and increasing administrative burden due to regulations from the Department of Managed Health Care (DMHC). Our proposal will be to use some of the increased premium to fund additional positions to address the regulatory burden, as well as consulting assistance to assist HPSM in evaluating longer term options for operating this local program.

Seton Medical Center Funding and AHMC Acquisition

At a March 10, 2020, special meeting of the San Mateo County Board of Supervisors, the main agenda item was discussion of proposed funding assistance to AHMC Healthcare, the potential buyer of Seton Medical Center and Seton Coastside. The motion made and approved by the Board of Supervisors was to appropriate $20 million in County funds with a request that Health Plan of San Mateo contribute $10 million of this amount subject to several conditions: (1) Closing of the transaction between Verity and AHMC and AHMC continuing to operate Seton Medical Center in Daly City as a full service hospital subject to the Attorney General's conditions: (2) Funds to be paid at a rate of $5 million per year over 4 years beginning at sale close; (3) Funds to be appropriate secured, as determined by staff/counsel; (4) AHMC continues to provide services that afford countywide public benefit; (5) Provision of satisfactory business plans and financials; (6) Negotiation of an appropriate form of agreement; and (7) Annual reporting in satisfaction of these conditions. As of May 2023, San Mateo County has made two $5 million payments to AHMC.

Since that meeting of the San Mateo County Board of Supervisors, the Health Commission has not acted on any request from San Mateo County or AHMC for HPSM funding to AHMC. HPSM recently received a proposal from AHMC, which we are now reviewing, requesting that HPSM contribute $10 million to AHMC. In light of the funding source, HPSM is engaging in discussions with AHMC regarding a potential HPSM investment, and in particular, how HPSM funding could be used to enhance access to care for HPSM members. We will bring a proposal for Health Commission consideration to the August or September meeting.