HealthPlan OF SAN MATEO
Healthy is for everyone

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REVISED

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

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

AGENDA

1. **Call to Order/Roll Call**
2. **Public Comment/Communication**
3. **Approval of Agenda**
4. **Consent Agenda***
   - 4.1 Report from Finance/Compliance
   - 4.2 Waive Request for Proposal and Approval of Amendment to Agreement with Cotiviti, Inc.
   - 4.3 Waive Request for Proposal and Approval of Amendment to Agreement with Certified Languages International
   - 4.4 Approval of San Mateo Health Commission Meeting Minutes from August 22, 2024
5. **Specific Discussion/Action Items**
   - 5.1 MCO Tax Update - See attached memo
   - 5.2 Update on HPSM Work Culture (2024 Company Initiative)
6. **Report from Chief Executive Officer**
7. **Identification of Designated Representative**
8. **CLOSED SESSION**
   - 8.1 Public Employee Performance Evaluation (Gov't Code section 54957)
     Title: Chief Executive Officer, Health Plan of San Mateo
   - 8.2 Conference with Labor Negotiators (Gov't Code section 54957.6)
     Agency designated representative: George Pon, San Mateo Health Commission
     Unrepresented employee: Chief Executive Officer, Health Plan of San Mateo
9. **Reconvene Open Session (and report on closed session)**
10. **Action on Compensation and Performance Goals for Chief Executive Officer***
11. **Other Business**
12. **Adjournment**

**Items for which Commission action is requested.*

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

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AGENDA ITEM: 4.1

DATE: Sept 11, 2024

M E M O R A N D U M

Date: August 19, 2024
To: Finance/Compliance Committee
From: Trent Ehrgood, Chief Financial Officer

Subject: **Financial report for the six-month period ending June 30, 2024**

Preliminary 2024 Financial Results All Lines of Business

Q2 2024 preliminary financial result for all lines of business is a surplus of $24.3M, with a YTD total surplus of $45.1M, compared to the YTD budget surplus of $14.3M.

The largest driver of the higher-than-expected surplus is lower healthcare cost. It is still not clear how utilization will eventually settle with all the transitioning membership. It's likely the ACE members that became eligible for Medi-Cal in 2024 are not fully utilizing services, which may be contributing to the lower utilization.

Medi-Cal membership is running a bit higher than expected in the first half of the year. As a reminder, disenrollment from the redetermination process started in July 2023. The volume of disenrolled members in the recent six months (Jan-Jun 2024) has been lower than the previous six months (Jul-Dec 2023). The 2024 budget assumed the same level of disenrollment.

Attached is presentation material to guide the discussion for our committee meeting on August 26th. Detailed Statements of Revenue and Expense on a consolidated basis, as well as for each line of business, are provided after the presentation slides.

Financial Update

Presentation to Finance/Compliance Committee

August 26, 2024

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2024 Budget by Quarter

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

Q2 2024 Preliminary Financial Results

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	Q1 (Jan-Mar)	Q2 (Apr-Jun)	YTD Total	YTD Budget	Budget Variance
Capitation revenue	375,040,869	293,423,415	668,464,284	548,628,401	119,835,883
Healthcare cost	329,717,779	251,707,268	581,425,047	481,242,826	(100,182,221)
Administrative expenses	18,967,270	17,184,266	36,151,536	38,994,663	2,843,127
MCO Tax	15,238,091	10,827,926	26,066,017	26,797,090	731,073
Income/(loss) from operations	11,117,729	13,703,955	24,821,684	1,593,822	23,227,862
Non-operating revenue	9,649,216	10,635,452	20,284,668	12,734,491	7,550,177
Net income/(loss)	20,766,945	24,339,407	45,106,352	14,328,313	30,778,039

YTD June 2024 – PY/CY

	YTD by PY/CY			Current Year YTD		
	Prior Year	Current Year	Total	Current Year	Budget	CY Variance
Capitation revenue	113,875,248	554,589,036	668,464,284	554,589,036	548,628,401	5,960,635
Healthcare cost	114,103,777	467,321,270	581,425,047	467,321,270	481,242,826	13,921,556
Administrative expenses	-	36,151,536	36,151,536	36,151,536	38,994,663	2,843,127
MCO Tax	(228,035)	26,294,052	26,066,017	26,294,052	26,797,090	503,038
Income/(loss) from operations	(494)	24,822,178	24,821,684	24,822,178	1,593,822	23,228,356
Non-operating revenue	-	20,284,668	20,284,668	20,284,668	12,734,491	7,550,177
Net income/(loss)	(494)	45,106,846	45,106,352	45,106,846	14,328,313	30,778,533

Average Membership

Variance to Budget

LOB	Avg. Actual	Avg. Budget	Variance	% Var
Medi-Cal	75,738	74,530	1,208	1.6%
Medi-Cal Expansion	53,386	51,278	2,108	4.1%
Whole Child Model	1,154	1,149	5	0.4%
Medi-Cal Full Duals	7,432	7,066	367	5.2%
Sub-total Medi-Cal	137,710	134,022	3,688	2.8%
Medicare D-SNP	8,372	8,406	(34)	-0.4%
HealthWorx	1,233	1,218	15	1.2%
Total at Risk	147,315	143,646	3,669	2.6%
+ ACE	1,583	2,111	(528)	-25.0%
Grand Total	148,898	145,757	3,142	2.2%

Budget Variance by Major Drivers

favorable/(unfavorable)

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		YTD Jun		Revenue	Expense
1	Prior year adjustments not in the budget	(494)			
	Current year variances:				
2	Membership higher than budget	1,684,940	<<	9,599,211	(7,914,271)
3	Revenue: Yield PMPM variance to budget	(803,152)			
4	Revenue: Maternity supplemental payment	670,030			
5	Healthcare cost: PMPM variance to budget	17,445,382			
6	Healthcare cost: directed payments	(744,666)			
7	ECM (rev-exp variance)	884,012	<<	(4,251,100)	5,135,112
8	Administrative cost variance to budget	2,843,127			
9	MCO Tax variance (rev-exp variance)	1,248,684	<<	745,646	503,038
10	Non-op revenue (*CY portion) variance to budget*	7,550,177			
	Total current year	30,778,533			
	Total consolidated budget variance	**30,778,039**			

Healthcare Cost

Detail by Category of Service

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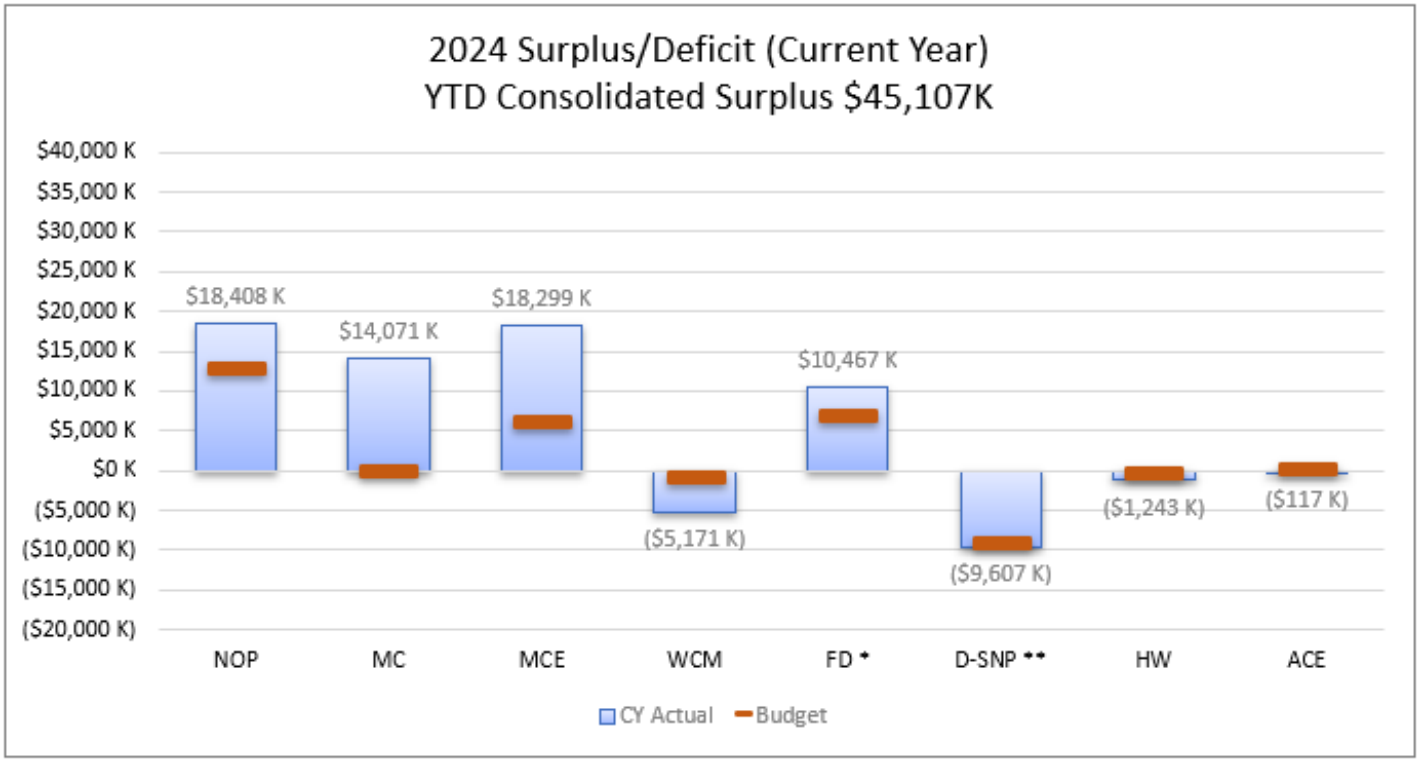
	YTD Actual					
	Total	Prior Year	Current Year	YTD Budget	Variance	*% Var.*
Provider Capitation	13,883,386	179,495	13,703,891	13,059,352	(644,539)	-4.9%
Hospital Inpatient	96,610,504	(150,000)	96,760,504	109,734,382	12,973,878	11.8%
LTC/SNF	79,190,808	(1,900,000)	81,090,808	88,417,447	7,326,639	8.3%
Pharmacy	32,206,596	(49,705)	32,256,301	32,009,261	(247,040)	-0.8%
Physician FFS	49,665,414	(417,041)	50,082,455	49,339,102	(743,354)	-1.5%
Hospital Outpatient	58,270,296	(523,712)	58,794,007	54,432,488	(4,361,519)	-8.0%
Other Medical Claims	50,789,838	(244,799)	51,034,637	53,200,137	2,165,501	4.1%
Other HC Services	5,066,554	590,654	4,475,900	3,247,059	(1,228,841)	-37.8%
Directed Payments	142,773,848	119,125,544	23,648,304	22,903,638	(744,666)	-3.3%
Long Term Support Services	816,173	-	816,173	781,683	(34,490)	-4.4%
CPO/In-lieu of Services	5,325,980	200,000	5,125,980	4,594,295	(531,685)	-11.6%
Dental	16,254,255	100,000	16,154,255	12,945,182	(3,209,073)	-24.8%
ECM	1,239,148	151,844	1,087,304	6,222,416	5,135,112	82.5%
Provider Incentives	9,152,242	-	9,152,242	9,103,001	(49,241)	-0.5%
Supplemental Benefits (D-SNP)	1,275,160	-	1,275,160	1,499,055	223,895	14.9%
Transportation	8,488,493	(403)	8,488,896	7,403,150	(1,085,746)	-14.7%
Indirect Health Care Benefits	(1,227,978)	(2,958,530)	1,730,552	824,036	(906,516)	-110.0%
UMQA	11,644,330	430	11,643,900	11,527,144	(116,756)	-1.0%
Total Healthcare Cost	581,425,046	114,103,777	467,321,269	481,242,826	13,921,557	2.9%

Healthcare Cost Comparison

Average Quarterly

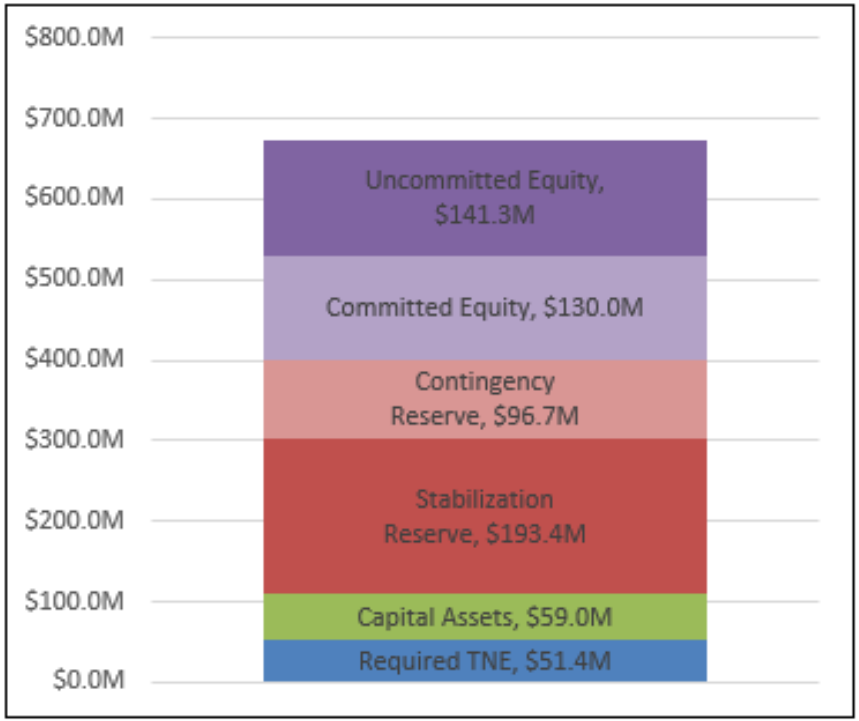
		2023 Actual (Jan-Dec) Qtr Avg	2024 Budget (Jan-Jun) Qtr Avg		2024 Actual (Jan-Jun) Qtr Avg	
1	Global Capitation	13,286,115	-	-100%	-	0%
2	Provider Capitation	4,451,966	6,529,676	47%	6,851,946	5%
3	Hospital Inpatient	49,049,990	54,867,191	12%	48,380,252	-12%
4	LTC/SNF	41,113,822	44,208,724	8%	40,545,404	-8%
5	Pharmacy	15,247,969	16,004,631	5%	16,128,151	1%
6	Physician FFS	19,793,111	24,669,551	25%	25,041,228	2%
7	Hospital Outpatient	23,908,048	27,216,244	14%	29,397,004	8%
8	Other Medical Claims	22,516,235	26,600,069	18%	25,517,318	-4%
9	Other HC Services	1,547,657	1,623,529	5%	2,237,950	38%
10	Directed Payments	16,024,593	11,451,819	-29%	11,824,152	3%
11	Long Term Support Services	380,319	390,841	3%	408,086	4%
12	CPO/In-lieu of Services	2,158,140	2,297,147	6%	2,562,990	12%
13	Dental	6,207,772	6,472,591	4%	8,077,127	25%
14	ECM	768,203	3,111,208	305%	543,652	-83%
15	Provider Incentives	5,466,317	4,551,501	-17%	4,576,121	1%
16	Supplemental Benefits (D-SNP)	514,686	749,527	46%	637,580	-15%
17	Transportation	3,268,459	3,701,575	13%	4,244,448	15%
18	Indirect Health Care Benefits	(350,717)	412,018	-217%	865,276	110%
19	UMQA	5,173,802	5,763,572	11%	5,821,950	1%
	Total Healthcare Cost	**230,526,488**	**240,621,413**	4%	**233,660,635**	-3%

CY YTD Surplus/Deficit by LOB



Tangible Net Equity (TNE)

At 6/30/24 Pre-Audit TNE = $671.8M
Uncommitted portion = $141.3M



Q2 2024 Summary

- The primary driver of the YTD surplus is lower healthcare cost.
- Some of the healthcare cost increases assumed in the budget have not materialized yet, but likely will as the year plays out. It's also likely the ACE members that became eligible for Medi-Cal are not fully utilizing services yet.
- DHCS is expected to publish adjusted 2024 Medi-Cal rates later this year. Final rates are expected to be slightly reduced retro to 1/1/2024 and will reduce the current year accumulated surplus.

Health Plan of San Mateo
Consolidated Balance Sheet
June 30, 2024 and May 31, 2024

	Current Month	Prior Month	PY 12/31
ASSETS			
Current Assets			
Cash and Equivalents	$ 634,443,454	$ 634,813,345	$ 552,675,606
Investments	184,246,683	184,246,683	185,724,686
Capitation Receivable from the State	93,474,867	91,939,887	185,457,468
Capitation Receivable from CMS	66,022,183	81,066,717	75,192,823
Other Receivables	19,848,736	18,511,122	17,269,702
Prepaids and Other Assets	9,989,307	10,537,820	9,914,698
Total Current Assets	1,008,025,230	1,021,115,572	1,026,234,983
Capital Assets, Net	59,019,581	59,146,407	59,364,273
Assets Restricted As To Use	300,000	300,000	300,000
Other Assets & Outflows	11,025,448	11,025,448	11,025,448
Total Assets & Deferred Outflows	$ 1,078,370,259	$ 1,091,587,426	$ 1,096,924,703
LIABILITIES			
Current Liabilities			
Medical Claims Payable	90,546,633	92,492,206	76,163,330
Provider Incentives	13,099,350	17,276,211	11,255,574
Amounts Due to the State	142,393,004	142,858,204	161,788,284
Accounts Payable and Accrued Liabilities	148,731,331	165,851,891	209,223,927
SBITA Liability	1,216,580	1,216,580	1,216,580
Total Current Liabilities	395,986,898	419,695,092	459,647,695
Other Liabilities & Inflows	10,619,040	10,619,040	10,619,040
Total Liabilities & Deferred Inflows	$ 406,605,938	$ 430,314,132	$ 470,266,735
NET POSITION			
Invested in Capital Assets	59,019,581	59,146,407	59,364,273
Restricted By Legislative Authority	300,000	300,000	300,000
Unrestricted			
Stabilization Reserve	293,838,200	363,923,100	376,750,900
Unrestricted Retained Earnings	318,606,540	237,903,788	190,242,796
Net Position	671,764,321	661,273,294	626,657,968
Total Liabilities & Net Position	$ 1,078,370,259	$ 1,091,587,426	1,096,924,703
Change in Net Position	$ 45,106,352	$ 34,615,326	0

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Health Plan of San Mateo
Consolidated Statement of Revenue & Expense
for the Period Ending June 30, 2024

	Current Qtr	Current Qtr	Current Qtr	YTD Actual	YTD Budget	YTD Variance	% Var
OPERATING REVENUE							
Capitation and Premiums							
Medi-cal (includes Offsets)	$ 233,177,072	$ 210,968,114	$ 22,208,958	$ 549,111,607	$ 429,793,189	$ 119,318,418	27.8%
HealthWorx	1,933,077	1,895,810	37,267	3,852,171	3,809,348	42,822	1.1%
Medicare (includes CA-CMC)	58,313,266	57,512,932	800,334	115,500,506	115,025,864	474,642	0.4%
Total Operating Revenue	293,423,414	270,376,856	23,046,558	668,464,284	548,628,401	119,835,882	21.8%
OPERATING EXPENSE							
Healthcare Expense							
Provder Capitation	7,978,101	6,414,693	(1,563,408)	13,883,386	13,059,352	(824,034)	-6.3%
Hospital Inpatient	47,931,648	54,007,411	6,075,763	96,610,504	109,734,382	13,123,878	12.0%
LTC/SNF	37,533,938	43,508,069	5,974,131	79,190,808	88,417,447	9,226,639	10.4%
Pharmacy	16,825,491	16,001,632	(823,859)	32,206,596	32,009,261	(197,335)	-0.6%
Medical	112,722,948	89,993,690	(22,729,258)	306,565,950	183,122,423	(123,443,526)	-67.4%
Long Term Support Services	415,310	385,356	(29,954)	816,173	781,683	(34,490)	-4.4%
CPO/In-lieu of Services	3,070,146	2,266,081	(804,065)	5,325,980	4,594,295	(731,685)	-15.9%
Dental Expense	8,911,034	6,344,503	(2,566,531)	16,254,255	12,945,182	(3,309,073)	-25.6%
Enhanced Care Management	586,312	3,054,412	2,468,100	1,239,148	6,222,416	4,983,268	80.1%
Provider Incentives	4,568,659	4,467,221	(101,438)	9,152,242	9,103,001	(49,241)	-0.5%
Supplemental Benefits	652,986	749,527		1,275,160	1,499,055	-	-
Transportation	4,443,508	3,624,302	(819,206)	8,488,493	7,403,150	(1,085,343)	-14.7%
Indirect Health Care Expenses	341,394	404,018	62,624	(1,227,978)	824,036	2,052,014	249.0%
UMQA, Delegated and Allocation	5,725,792	5,564,498	(161,294)	11,644,330	11,527,144	(117,186)	-1.0%
Total Healthcare Expense	251,707,268	236,785,413	(14,921,855)	581,425,046	481,242,826	(100,182,220)	-20.8%
Administrative Expense							
Salaries and Benefits	14,680,825	14,812,303	131,477	29,162,240	29,190,870	28,630	0.1%
Staff Training and Travel	90,704	147,825	57,121	173,537	262,400	88,863	33.9%
Contract Services	3,637,907	4,816,075	1,178,168	8,180,147	10,025,250	1,845,103	18.4%
Office Supplies and Equipment	2,393,995	2,302,497	(91,498)	4,309,370	4,957,068	647,698	13.1%
Occupancy and Depreciation	974,059	1,016,125	42,066	1,824,149	2,351,350	527,201	22.4%
Postage and Printing	527,359	566,925	39,566	1,191,023	1,127,950	(63,073)	-5.6%
Other Administrative Expense	373,193	359,806	(13,387)	2,529,488	2,429,463	(100,025)	-4.1%
UM/QA Allocation	(5,493,778)	(5,477,519)	16,259	(11,218,417)	(11,349,688)	(131,271)	-1.2%
Total Admin Expense	17,184,266	18,544,037	1,359,771	36,151,536	38,994,663	2,843,127	7.3%
Premium Taxes	10,827,926	13,108,437	2,280,511	26,066,018	26,797,090	731,072	2.7%
Total Operating Expense	279,719,460	268,437,886	(11,281,573)	643,642,600	547,034,579	(96,608,021)	-17.7%
Net Income/Loss from Operations	13,703,955	1,938,970	(11,764,985)	24,821,684	1,593,822	(23,227,861)	1557.4%
Interest Income, Net	10,282,334	6,000,000	4,282,334	19,569,875	12,000,000	7,569,875	63.1%
Rental Income, Net	317,341	318,129	(787)	631,179	626,847	4,332	0.7%
Third Party Administrator Revenue	35,777	53,346	(17,570)	83,615	107,644	(24,030)	-22.3%
Net Non-operating Revenue	10,635,452	6,371,475	4,263,978	20,284,669	12,734,491	7,550,178	59.3%
Net Income/(Loss)	$ 24,339,407	8,310,445	16,028,962	$ 45,106,352	$ 14,328,313	$ 30,778,039	-214.8%
Admin exp as % of Net Rev (adj for Tax)	*6.08%*	*7.21%*		*5.63%*	*7.47%*		
Medical Loss Ratio (adj for Tax)	*79.81%*	*87.68%*		*68.28%*	*87.83%*		

Health Plan of San Mateo
ALL LOB UNITS Statement of Revenue & Expense
for the Period Ending June 30, 2024

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Medi-Cal Capitation	$ 217,388,294	$ 212,221,454	$ 5,166,840	2.4%	$ 539,085,867	$ 432,380,924	$ 106,704,943	24.7%
MC Supplemental Cap	4,788,554	3,015,770	1,772,784	58.8%	8,478,710	6,153,784	2,324,926	37.8%
HealthWorx Premium	1,933,077	1,895,810	37,267	2.0%	3,852,171	3,809,348	42,822	1.1%
CareAdvantage Premiums	58,313,266	57,512,932	800,334	1.4%	115,500,506	115,025,864	474,642	0.4%
MC Cap Offset	11,000,224	(4,269,110)	15,269,334	-357.7%	1,547,030	(8,741,518)	10,288,548	-117.7%
Total Operating Revenue	293,423,414	270,376,856	23,046,558	8.5%	668,464,284	548,628,401	119,835,882	21.8%
OPERATING EXPENSE								
Provider Capitation	7,978,101	6,414,693	(1,563,408)	-24.4%	13,883,386	13,059,352	(824,034)	-6.3%
Hospital Inpatient	47,931,648	54,007,411	6,075,763	11.2%	96,610,504	109,734,382	13,123,878	12.0%
LTC/SNF	37,533,938	43,508,069	5,974,131	13.7%	79,190,808	88,417,447	9,226,639	10.4%
Pharmacy	16,825,491	16,001,632	(823,859)	-5.1%	32,206,596	32,009,261	(197,335)	-0.6%
Physician Fee for Service	25,867,416	24,233,948	(1,633,469)	-6.7%	49,665,414	49,339,102	(326,312)	-0.7%
Hospital Outpatient	32,203,850	26,765,359	(5,438,491)	-20.3%	58,270,296	54,432,488	(3,837,808)	-7.1%
Other Medical Claims	25,555,015	26,178,238	623,223	2.4%	50,789,838	53,200,137	2,410,300	4.5%
Other HC Services	2,932,083	1,596,863	(1,335,221)	-83.6%	5,066,554	3,247,059	(1,819,495)	-56.0%
Directed Payments	26,164,584	11,219,282	(14,945,302)	-133.2%	142,773,848	22,903,638	(119,870,210)	-523.4%
Long Term Support Services	415,310	385,356	(29,954)	-7.8%	816,173	781,683	(34,490)	-4.4%
CPO/In-lieu of Services	3,070,146	2,266,081	(804,065)	-35.5%	5,325,980	4,594,295	(731,685)	-15.9%
Dental Expense	8,911,034	6,344,503	(2,566,531)	-40.5%	16,254,255	12,945,182	(3,309,073)	-25.6%
Enhanced Care Management	586,312	3,054,412	2,468,100	80.8%	1,239,148	6,222,416	4,983,268	80.1%
Provider Incentives	4,568,659	4,467,221	(101,438)	-2.3%	9,152,242	9,103,001	(49,241)	-0.5%
Supplemental Benefits	652,986	749,527	96,541	12.9%	1,275,160	1,499,055	223,895	14.9%
Transportation	4,443,508	3,624,302	(819,206)	-22.6%	8,488,493	7,403,150	(1,085,343)	-14.7%
Indirect Health Care Expenses	341,394	404,018	62,624	15.5%	(1,227,978)	824,036	2,052,014	249.0%
UMQA (Allocation & Delegated)	5,725,792	5,564,498	(161,294)	-2.9%	11,644,330	11,527,144	(117,186)	-1.0%
Total Health Care Expense	251,707,268	236,785,413	(14,921,855)	-6.3%	581,425,046	481,242,826	(100,182,220)	-20.8%
G&A Allocation	17,184,266	18,544,037	1,359,771	7.3%	36,151,536	38,994,663	2,843,127	7.3%
Premium Tax	10,827,926	13,108,437	2,280,511	17.4%	26,066,018	26,797,090	731,072	2.7%
Total Operating Expense	279,719,460	268,437,886	(11,281,574)	-4.2%	643,642,600	547,034,579	(96,608,021)	-17.7%
NON-OPERATING REVENUE								
Interest, Net	10,282,334	6,000,000	4,282,334	71.4%	19,569,875	12,000,000	7,569,875	63.1%
Rental Income, Net	317,341	318,129	(787)	-0.2%	631,179	626,847	4,332	0.7%
Third Party Administror Revenue	35,777	53,346	(17,570)	-32.9%	83,615	107,644	(24,030)	-22.3%
Total Non-Operating	10,635,452	6,371,475	4,263,978	66.9%	20,284,669	12,734,491	7,550,178	59.3%
Net Income/(Loss)	$ 24,339,407	$ 8,310,445	16,028,962	192.9%	$ 45,106,352	$ 14,328,313	$ 30,778,039	214.8%
Medical Loss Ratio (adj MCO)	98.16%	96.24%			116.37%	96.46%		
Member Counts	470,656	453,177	17,479	3.9%	943,623	924,975	18,648	2.0%

Health Plan of San Mateo
Medi-Cal UNITS Statement of Revenue & Expense
for the Period Ending June 30, 2024

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Medi-Cal Capitation	$ 217,388,294	$ 212,221,454	$ 5,166,840	2.4%	$ 539,085,867	$ 432,380,924	$ 106,704,943	24.7%
MC Supplemental Cap	4,788,554	3,015,770	1,772,784	58.8%	8,478,710	6,153,784	2,324,926	37.8%
HealthWorx Premium	-	-	-	-	-	-	-	-
CareAdvantage Premiums	-	-	-	-	-	-	-	-
MC Cap Offset	11,000,224	(4,269,110)	15,269,334	-357.7%	1,547,030	(8,741,518)	10,288,548	-117.7%
Total Operating Revenue	233,177,072	210,968,114	22,208,958	10.5%	549,111,607	429,793,189	119,318,418	27.8%
OPERATING EXPENSE								
Provider Capitation	5,291,119	5,055,930	(235,189)	-4.7%	10,776,022	10,341,826	(434,196)	-4.2%
Hospital Inpatient	35,043,620	37,520,560	2,476,940	6.6%	65,822,540	76,758,513	10,935,973	14.2%
LTC/SNF	33,931,724	40,450,111	6,518,387	16.1%	71,853,251	82,301,532	10,448,281	12.7%
Pharmacy	(12,095)	-	12,095	-	(12,095)	-	12,095	-
Physician Fee for Service	20,077,650	18,762,574	(1,315,077)	-7.0%	38,800,457	38,393,376	(407,081)	-1.1%
Hospital Outpatient	23,714,149	19,321,557	(4,392,592)	-22.7%	43,027,928	39,540,384	(3,487,544)	-8.8%
Other Medical Claims	19,684,918	20,530,334	845,416	4.1%	39,637,479	41,903,291	2,265,812	5.4%
Other HC Services	2,932,083	1,596,863	(1,335,221)	-83.6%	5,066,554	3,247,059	(1,819,495)	-56.0%
Directed Payments	26,164,584	11,219,282	(14,945,302)	-133.2%	142,773,848	22,903,638	(119,870,210)	-523.4%
Long Term Support Services	415,310	385,356	(29,954)	-7.8%	816,173	781,683	(34,490)	-4.4%
CPO/In-lieu of Services	2,987,778	2,144,831	(842,947)	-39.3%	5,243,612	4,351,795	(891,817)	-20.5%
Dental Expense	8,911,034	6,344,503	(2,566,531)	-40.5%	16,254,255	12,945,182	(3,309,073)	-25.6%
Enhanced Care Management	706,312	2,856,201	2,149,890	75.3%	1,239,148	5,825,994	4,586,847	78.7%
Provider Incentives	4,193,668	4,092,275	(101,393)	-2.5%	8,402,260	8,352,937	(49,323)	-0.6%
Transportation	4,443,508	3,624,302	(819,206)	-22.6%	8,488,493	7,403,150	(1,085,343)	-14.7%
Indirect Health Care Expenses	185,636	330,994	145,359	43.9%	(1,226,018)	677,921	1,903,939	280.8%
UMQA (Allocation & Delegated)	4,341,121	4,182,823	(158,299)	-3.8%	8,727,272	8,664,547	(62,726)	-0.7%
Total Health Care Expense	193,012,120	178,418,497	(14,593,623)	-8.2%	465,691,179	364,392,826	(101,298,353)	-27.8%
G&A Allocation	12,597,118	12,994,914	397,796	3.1%	23,041,785	27,327,195	4,285,410	15.7%
Premium Tax	10,827,926	13,108,437	2,280,511	17.4%	26,066,018	26,797,090	731,072	2.7%
Total Operating Expense	216,437,164	204,521,847	(11,915,316)	-5.8%	514,798,982	418,517,111	(96,281,870)	-23.0%
NON-OPERATING REVENUE								
Total Non-Operating	-	-	-	-	-	-	-	-
Net Income/(Loss)	$ 16,739,908	$ 6,446,267	10,293,641	159.7%	$ 34,312,625	$ 11,276,078	$ 23,036,548	204.3%
Medical Loss Ratio (adj MCO)	98.38%	95.59%			122.46%	95.87%		
Member Counts	437,577	417,393	20,184	4.8%	875,828	853,261	22,567	2.6%

Health Plan of San Mateo
CareAdvantage Units Statement of Revenue & Expense
for the Period Ending June 30, 2024

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Medi-Cal Capitation	-	-	-	-	-	-	-	-
MC Supplemental Cap	-	-	-	-	-	-	-	-
HealthWorx Premium	-	-	-	-	-	-	-	-
CareAdvantage Premiums	58,313,266	57,512,932	800,334	1.4%	115,500,506	115,025,864	474,642	0.4%
MC Cap Offset	-	-	-	-	-	-	-	-
Total Operating Revenue	58,313,266	57,512,932	800,334	1.4%	115,500,506	115,025,864	474,642	0.4%
OPERATING EXPENSE								
Provider Capitation	2,686,982	1,358,763	(1,328,219)	-97.8%	3,107,364	2,717,526	(389,838)	-14.3%
Hospital Inpatient	12,470,123	16,254,901	3,784,777	23.3%	30,008,049	32,509,801	2,501,752	7.7%
LTC/SNF	3,602,214	3,057,957	(544,257)	-17.8%	7,337,557	6,115,915	(1,221,642)	-20.0%
Pharmacy	16,173,185	15,360,205	(812,979)	-5.3%	30,811,554	30,720,411	(91,143)	-0.3%
Physician Fee for Service	5,239,360	5,152,950	(86,410)	-1.7%	9,997,553	10,305,901	308,347	3.0%
Hospital Outpatient	8,182,258	6,962,711	(1,219,547)	-17.5%	14,468,081	13,925,423	(542,658)	-3.9%
Other Medical Claims	5,640,323	5,536,930	(103,394)	-1.9%	10,809,381	11,073,859	264,478	2.4%
Other HC Services	-	-	-	-	0	-	0	-
CPO/In-lieu of Services	82,368	121,250	38,882	32.1%	82,368	242,500	160,132	66.0%
Enhanced Care Management	(120,000)	198,211	318,211	160.5%	-	396,421	396,421	100.0%
Provider Incentives	356,490	356,489	(1)	0.0%	712,980	712,978	(2)	0.0%
Supplemental Benefits	652,986	749,527	96,541	12.9%	1,275,160	1,499,055	223,895	14.9%
Indirect Health Care Expenses	144,831	65,808	(79,023)	-120.1%	(24,207)	131,615	155,822	118.4%
UMQA (Allocation & Delegated)	1,303,428	1,334,042	30,614	2.3%	2,772,593	2,763,931	(8,662)	-0.3%
Total Health Care Expense	56,414,549	56,509,744	95,195	0.2%	111,358,433	113,115,335	1,756,902	1.6%
G&A Allocation	4,394,754	5,281,288	886,534	16.8%	10,667,544	11,104,323	436,779	3.9%
Total Operating Expense	60,809,303	61,791,032	981,729	1.6%	122,025,977	124,219,659	2,193,681	1.8%
NON-OPERATING REVENUE								
Total Non-Operating	-	-	-	-	-	-	-	-
Net Income/(Loss)	$ (2,496,037)	$ (4,278,100)	1,782,063	-41.7%	$ (6,525,471)	$ (9,193,795)	$ 2,668,324	-29.0%
Medical Loss Ratio (adj MCO)	96.74%	98.26%			96.41%	98.34%		
Member Counts	25,276	25,872	(596)	-2.3%	50,901	51,744	(843)	-1.6%

Health Plan of San Mateo
HealthWorx Statement of Revenue & Expense
for the Period Ending June 30, 2024

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Medi-Cal Capitation	-	-	-	-	-	-	-	-
MC Supplemental Cap	-	-	-	-	-	-	-	-
HealthWorx Premium	1,933,077	1,895,810	37,267	2.0%	3,852,171	3,809,348	42,822	1.1%
CareAdvantage Premiums	-	-	-	-	-	-	-	-
MC Cap Offset	-	-	-	-	-	-	-	-
Total Operating Revenue	1,933,077	1,895,810	37,267	2.0%	3,852,171	3,809,348	42,822	1.1%
OPERATING EXPENSE								
Hospital Inpatient	417,905	231,950	(185,955)	-80.2%	779,915	466,068	(313,847)	-67.3%
Pharmacy	664,401	641,426	(22,975)	-3.6%	1,407,137	1,288,850	(118,287)	-9.2%
Physician Fee for Service	550,406	318,424	(231,982)	-72.9%	867,404	639,825	(227,579)	-35.6%
Hospital Outpatient	307,443	481,091	173,648	36.1%	774,287	966,681	192,394	19.9%
Other Medical Claims	229,773	110,975	(118,799)	-107.1%	342,978	222,987	(119,991)	-53.8%
Other HC Services	0	-	0	-	0	-	0	-
Provider Incentives	18,501	18,457	(44)	-0.2%	37,002	37,086	84	0.2%
Indirect Health Care Expenses	10,927	7,216	(3,711)	-51.4%	22,247	14,500	(7,747)	-53.4%
UMQA (Allocation & Delegated)	81,242	47,634	(33,609)	-70.6%	144,465	98,667	(45,798)	-46.4%
Total Health Care Expense	2,280,599	1,857,172	(423,427)	-22.8%	4,375,434	3,734,665	(640,770)	-17.2%
G&A Allocation	213,332	217,174	3,842	1.8%	448,517	456,626	8,109	1.8%
Total Operating Expense	2,493,931	2,074,347	(419,584)	-20.2%	4,823,951	4,191,291	(632,660)	-15.1%
NON-OPERATING REVENUE								
Total Non-Operating	-	-	-	-	-	-	-	-
Net Income/(Loss)	$ (560,854)	$ (178,536)	(382,318)	214.1%	$ (971,780)	$ (381,943)	$ (589,838)	154.4%
Medical Loss Ratio (adj MCO)	117.98%	97.96%			113.58%	98.04%		
Member Counts	3,708	3,636	72	2.0%	7,397	7,306	91	1.2%

Health Plan of San Mateo
ACE Statement of Revenue & Expense
for the Period Ending June 30, 2024

	Current Qtr Actual	Current Qtr Budget	Current Qtr Variance	% Var	YTD Actual	YTD Budget	YTD Var Fav/(Unfav)	% Var
OPERATING REVENUE								
Medi-Cal Capitation	-	-	-	-	-	-	-	-
MC Supplemental Cap	-	-	-	-	-	-	-	-
HealthWorx Premium	-	-	-	-	-	-	-	-
CareAdvantage Premiums	-	-	-	-	-	-	-	-
MC Cap Offset	-	-	-	-	-	-	-	-
Total Operating Revenue	-	-	-	-	-	-	-	-
OPERATING EXPENSE								
Total Health Care Expense	-	-	-	-	-	-	-	-
G&A Allocation	(42,813)	50,661	93,474	184.5%	200,220	106,518	(93,702)	-88.0%
Total Operating Expense	(42,813)	50,661	93,474	184.5%	200,220	106,518	(93,702)	-88.0%
NON-OPERATING REVENUE								
Third Party Administror Revenue	35,777	53,346	(17,570)	-32.9%	83,615	107,644	(24,030)	-22.3%
Total Non-Operating	35,777	53,346	(17,570)	-32.9%	83,615	107,644	(24,030)	-22.3%
Net Income/(Loss)	$ 78,590	$ 2,685	75,904	2826.5%	$ (116,606)	$ 1,126	$ (117,732)	-10454.2%
Medical Loss Ratio (adj MCO)	-	-			-	-		
Member Counts	4,095	6,276	(2,181)	-34.8%	9,497	12,664	(3,167)	-25.0%

HealthPlan OF SAN MATEO
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Draft

FINANCE/COMPLIANCE COMMITTEE MEETING

Meeting Summary

August 26, 2024, 12:00 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: Si France, M.D.

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

1.0 **Call to Order –** The meeting was called to order by Commissioner Graham at 12:06 pm. A quorum was met.

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

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

4.0 **Preliminary Financial Report for the 6-month period ending June 30, 2024** – CFO, Trent Ehrgood reviewed the financial report. He reminded the Committee of the anticipated budget for 2024. At this point, HPSM is reporting a surplus of $45M compared to the first six-month budget of $14M. They are reporting $119M more in revenue and $100M more in expenses. This revenue and expense variance is mostly prior year hospital directed payments flowing through. He explained how the prior year adjustments balances' out to almost zero. Although prior year adjustments offset each other, there are several different unrelated adjustments. There is about $5.4M worth of prior-year Medicare risk adjustment revenue. These adjustments have a delayed reaction, sometime taking a year or two to be realized. It's often favorable but can go in either direction. There is about $12M negative adjustment that includes true-up to prior-year acuity adjustment, and small differences from the hospital directed payment transactions. There was also

$2.9M favorable incurred but not reported (IBNR) expense adjustment that relate to claims expenses that were overstated at year-end.

Mr. Ehrgood itemized what's making up the $30M budget variance so far this year. One of the drivers is membership. He noted that the favorable budget variance for the "total at risk" membership has been growing over time. HPSM has retained more Medi-Cal members then they thought they would in the budget. He reminded them that the disenrollment process started in July of 2023, HPSM observed approximately 2,000 members being disenrolled per month in the 6 months from July to December of 2023. They assumed this would be the trend for the six months in the beginning of 2024, but it ended up being smaller. The net decrease was not as big as it was in the first half. Part of what is driving that is the ACE membership, in January of 2024, most ACE members became eligible for Medi-Cal. There was a big block transfer at that time, but now they are observing a trickling of members who did not go through the process in January and who think that they are still eligible for ACE. If HPSM determines that they are eligible for Medi-Cal instead of ACE, they will make the transfer at that point. The shift is happening with smaller groups of people on a month-to-month basis. As of June, of this year the ACE membership is down to about 1,300. They expect it to be closer to 1,000 or less by the end of the year.

Mr. Ehrgood noted that lower healthcare cost is the biggest driver of the favorable budget variance. The next biggest favorable variance is non-operating revenue which is interest income. In the budget they assumed that interest rates would start to drop throughout the year, but they haven't yet. The combination of higher interest rates and higher surpluses have created more interest income. He shared a slide that compared the 2024 healthcare budget and actuals to 2023. In 2023, the average quarterly expense was $230M. What they expected is that the budget would go from $230M to $240M, a 4% increase. What they are really seeing is that it went from $230M to $233M, which is only a 1% increase. He went through some of the differences between 2023 and 2024 and noted that the global capitation, which is what was paid to Kaiser went away. 100% as those members are now under direct contract with the Department of Health Care Services (DHCS) and are no longer HPSM members. Provider capitation was assumed to grow by 47% to $6.5M, but instead it grew to $6.8M which is mostly just a function of having more members. Hospital inpatient (IP) was averaged at $49M per quarter last year, they assumed it would grow 12% to $54M but it actually decreased a bit to $48M, due to lower hospital admissions. He explained the primary assumptions used for the 2024 healthcare cost budget. One item

assumed in the budget were contractual changes, specifically negotiated higher rates for certain providers. A second was to bake in targeted rate increases (TRI), where DHCS gave HPSM more money for certain physicians and that number was added to the budget. They also estimated that their average cost per member would go up assuming that a lot of the disenrollment was going to be for members that were low utilizers. Lastly, they assumed that the ACE enrollees that moved to Medi-Cal would have the same utilization as everyone else because there was no indication otherwise.

There was a question about the decrease in hospital inpatient (IP) utilization. It was also noted that hospital outpatient (OP) associated costs tend to be higher. HPSM will look at the utilization metrics and data and do further analysis to try and determine why this is. Mr. Ehrgood noted that there was a big uptick in dental, a positive as more members are accessing oral care services that were not available before. Specific analysis is being done around dental to get a better idea of if there are unique members that are part of the growth, the same members doing more, or a combination of both.

Mr. Ehrgood went over the current year (CY) year-to-date (YTD) surplus/deficit by line of business (LOB). In all but one case the actuals are running higher than budget. The Whole Child Model (WCM) was estimated to be close to breakeven but is actually running a $5M deficit. This is mostly due to one rare, high-cost case. The MC and MCE lines-of-business have the highest surplus and is where the ACE members transitioned to.

He went over the tangible net equity (TNE) graph. They came up with a new way of calculating the stabilization reserve and the contingency reserve. Going forward this will be measured at the end of the year instead of monthly to avoid variability. He also noted that at the last meeting in March, the Committed section was $30M, reflecting the primary care investment approved by the Commission. At a more recent Commission meeting, the board authorized a provider investment pool of $100M bringing the Committed section to $130M. HPSM is close to making decisions now on how they plan to spend that money.

Mr. Ehrgood closed by informing the group that DHCS is expected to publish adjusted 2024 Medi-Cal rates later this year. Final rates are expected to be slightly reduced and retroactive to 1/1/2024 and will reduce the current year accumulated surplus. The financial report was approved as presented. **Callagy/Pon MSP**

5.0 Compliance Report – Oversight of Compliance Program - Chief Government Affairs and Compliance Officer Ian Johansson gave a presentation highlighting regulatory requirements titled "Oversight of Compliance Programs for Governing Bodies." The governing bodies include the San Mateo Health Commission (SMHC) and the Finance/Compliance Committee. This committee was renamed to give it more explicit authority on oversight of HPSMs compliance program. Mr. Johansson went over the regulatory requirements which come from two bodies, the Centers for Medicare, and Medicaid Services (CMS) and the Department of Health Care Services (DHCS).

Mr. Johansson noted that DHCS expects governing bodies to have oversight of implementation and monitoring of corrective action plans as it pertains to external audits. This is a new level of detail that was not brought to the Commission or any other committee at HPSM. He shared examples of reasonable oversight and went over the reporting structure as well as the functions and makeup of the internal Compliance Committee. He reviewed the current state and requirements they currently meet. He explained compliance policy (CP) 009, entitled "Notification Process for Compliance Issues" which was drafted in 2017, it details how compliance issues received by the compliance department are disclosed both internally to HPSM and externally to the Commission. He shared specific disclosures that must go to the Commission. These include: 1) HIPAA privacy incidents that result in a breach, 2) confirmed incidents of fraud, waste, and abuse, 3) government enforcement actions, which include warning letters and administrative and financial penalties, 4) incidents of significant non-compliance and 5) incidents involving law enforcement. He defined what is meant by "significant non-compliance." This would be things impacting timely access or quality of care, financial stability of providers or issues that may impact HPSMs reputational, financial, legal, or operational health. HPSM would expect regulatory action to occur as a result of any of these issues. These issues would likely lead to a discussion not only with the leadership team but also the Compliance committee where they would determine if it required disclosure to the Commission. The report up would be at the next scheduled Finance/Compliance committee meeting. If it is a significant issue, they would likely send notice to the Commission through HPSMs CEO. He outlined opportunities for improvement, including: (1) presentation of internal audit results, including audits of HPSMs delegated entities, and (2) audit results of the Compliance program. In the future they will also provide more timely disclosure of non-compliance cases. He proposed different methods of presenting the information with a dashboard and written report. In summary, while the existing program design meets many CMS and DHCS requirements,

gaps exist that can be remedied by provision of a dashboard and other reports, while also adding standardization to reporting.

Mr. Johannson reviewed current Compliance Case disclosures. In October of 2023 HPSM received a Notice of Non-Compliance for Call Center Monitoring regarding a 2023 accuracy and accessibility study on TTY functionality. It measured the plans' ability to provide interpreters for Limited English Proficient callers, TTY services for the hearing and speech impaired, and accurate Part C and/or Part D information. Part C TTY functionality measured at 68.75%, below the 80% threshold. The investigation did not reveal a clear root cause due to a low volume of calls combined with unclear causes of disconnect or wait time. The Medicare department continue to pursue methods to improve performance. HPSM and many other plans rely on the State of California TTY service, which makes it difficult for plans to solve for quality and consistency of service.

The second Compliance Case was an agency action in April 2024 regarding DHCS Managed Care Accountability Sanction (MCAS) for measurement year 2021. There was a failure to meet Minimum Performance Level (MPL). DHCS imposed a monetary sanction in the amount of $25,000 for quality measures below the MPL. HPSM had 3 measures below the MPL, two of which trended worse year over year. HPSM was not assessed a penalty for Measurement year 2022 or 2023.

The third item was a security incident in February 2024 involving Change Healthcare. This subsidiary of Optum and United Health Group experienced significant system and service disruptions due to a cybersecurity incident. Functionality continues to be impaired, in lesser ways compared to the initial onset of impacts. HPSM has initiated alternative solutions to impacted services and conducted outreach to its provider network. HPSM continues to monitor updates from Change; they continue to await communication as to whether HPSM data was impacted by this incident.

6.0 Other Business – There was no other business.

7.0 Adjournment – The meeting was adjourned at 1:23 pm by Commissioner Graham.

Respectfully submitted:

M. Heryford

M. Heryford

Assistant Clerk to the Commission

MEMORANDUM

AGENDA ITEM: 4.2

DATE: September 11, 2024

DATE: August 30, 2024

TO: San Mateo Health Commission

FROM: Pat Curran, Chief Executive Officer
Chris Esguerra, M.D., Chief Medical Officer

RE: Waive Request for Proposal and Approve Amendment to Agreement with Cotiviti, Inc.

Recommendation:

Approve a waiver for the RFP process and an amendment to extend the term of the agreement with Cotiviti, Inc. by three years, and increase the contract maximum by $993,000 for a total contract maximum amount not to exceed $3.018 million for Health Effectiveness Data Information Set (HEDIS) and Managed Care Accountability Set (MCAS) measure calculation, software and services. The new extended term will be from October 15, 2024 to October 14, 2027.

Background and Discussion:

HPSM is required to collect and report specific HEDIS measures for Medi-Cal and CareAdvantage contracts for the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). Starting in 2024, the California Department of Managed Health Care (DMHC) requires all health plans to collect a set of HEDIS measures for health equity and quality reporting for all members.

Cotiviti, Inc. formerly known as Verscend Technologies, Inc. and Verisk Health, Inc., has provided HPSM with HEDIS data analytics software since 2013. The Commission waived the RFP process and approved amendments extending the current agreement in November 2016, October 2019, and October 2021. In February 2019 HPSM added monthly HEDIS measure calculation and data extracts from Cotiviti for regular quality metric monitoring and to inform our provider value-based payment incentive programs.

Cotiviti is a widely used HEDIS software vendor. Several other Medi-Cal Managed Care plans, such as San Francisco Health Plan, Kaiser Foundation Health Plan North, Contra Costa Health Plan and Alameda Alliance for Health, also use Cotiviti's software for HEDIS data analytics.

In addition to HEDIS measures, the firm's software can calculate non-HEDIS CMS Core measures as well as custom build state-specified measures for required reporting. Starting with 2020 reporting, seven non-HEDIS CMS Core Set measures were added to the Managed Care Accountability Set (MCAS), a group of quality metrics required by DHCS. Three custom measures on long term care facilities were added to the MCAS starting with 2024 reporting. Cotiviti provides calculation and analysis of these seven CMS Core Set measures and three long term care facility measures along with the entire library of HEDIS measures with our required annual MCAS reporting as well as monthly, enabling HPSM to report and regularly monitor the full set of MCAS measures.

Cotiviti has provided excellent services over the past eleven years and has readily accommodated specialized HEDIS reporting and non-HEDIS measurement to enable full MCAS reporting and monthly monitoring. HPSM plans to conduct a request for quotation for HEDIS and clinical quality data analytics services no later than Q2 2025 to ensure competitive pricing for such services.

Fiscal Impact:

The annual average cost of this agreement is approximately $331,000. The amendment will extend the term of the agreement three years through October 14, 2027, and increase the contract maximum by $993,000, bringing the total contract maximum to $3.018 million for HEDIS and MCAS measure analytics services.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF WAIVE REQUEST FOR PROPOSAL PROCESS
AND APPROVAL OF AMENDMENT TO AGREEMENT WITH COTIVITY, INC.

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission is required to report HEDIS metrics to CMS, DMHC and the Managed Care Accountability Set to DHCS annually;
B. The San Mateo Health Commission has utilized Cotiviti, Inc. for HEDIS measure calculation and analysis since 2013;
C. Cotiviti, Inc. can provide full HEDIS and Managed Care Accountability Set measure calculation and analysis software and services;
D. Staff recommends the continued use of these services.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the request for proposal process and approves an extension of the agreement with Cotiviti, Inc. through October 14, 2027 and the addition of $993,000 for a total contract maximum of $3.018 million for data analytics services; and
2. Authorizes the Chief Executive Officer to execute said amendment.

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

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

MEMORANDUM

AGENDA ITEM: 4.3

DATE: September 11, 2024

DATE: August 30, 2024

TO: San Mateo Health Commission

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

RE: Waive Request for Proposal and Approve Amendment to Agreement with Certified Languages International (CLI)

Recommendation

Authorize the Chief Executive Officer to execute an amendment to the agreement with Certified Languages International (CLI), to extend the term and increase the contract maximum by $295,000 for a total contract maximum amount of $1,930,000 for services to fulfill regulatory requirements for telephonic & video remote interpreting services. The new term of the agreement will be from January 1, 2018, through March 31, 2025.

Background

Telephonic interpreter services are a key component for any health plan, especially one as culturally and linguistically diverse as HPSM. While health plans and health care providers hire bilingual staff, it is difficult to hire staff bilingual in all the languages that plan members speak. HPSM contracts for interpreter services to ensure adequate coverage for languages spoken in the service area.

In late 2013, HPSM experienced issues with the provider of telephonic interpreter services at that time, including dropped calls, misconnects, delays in connect times to an interpreter, and difficulties with interpreter availability. After several unsuccessful attempts to resolve these issues, staff began looking for other service providers. CLI was highly recommended by several health plans like HPSM and offered competitive pricing. In 2014, HPSM entered into a secondary agreement with CLI for telephonic interpreter services. In 2015, HPSM made CLI the exclusive vendor for telephonic interpreter services. The Commission approved an amendment in December 2015 to extend this agreement through 2016, and add the transcription of certain calls with

members related to Grievances and Appeals as a new service. Call transcripts are used for quality assurance and compliance monitoring. In December 2016, December 2018, and May 2021, the Commission waived the Request for Proposal process and approved amendments extending the current agreement. The current contract maximum is $1,635,000. HPSM is required to provide no cost interpreter services to members and has promoted the availability of these services to members and providers to ensure they are aware that HPSM members can communicate with their healthcare provider in their preferred language at no cost to the member or provider. Utilization of these services has steadily increased. Since 2021, utilization of telephonic interpreter services has increased, adding 1,000 extra calls per month. This increase highlights the importance of interpreters for our member population.

In 2020, CLI added video interpretation services, enabling the member and provider to see as well as hear the interpreter. Such visual cues can assist members with limited or reduced hearing ability in understanding the interpreter. CLI's video interpretation service replaced several in-person interpretation services, such as those for American Sign Language, that were suspended to reduce the spread of COVID-19.

Discussion

Current spending for this service has increased to about $390,000 per year. HPSM will continue to promote the availability of telephonic and video interpreter services to members and providers to ensure awareness of these services. With this promotion as well as the addition of the dental benefit in 2022, staff has seen higher utilization of interpretation services. Staff estimates that a $295,000 increase to the contract maximum will sufficiently fund interpretation services with CLI through March 31, 2025.

Certified Languages International has provided excellent service and value. HPSM is currently conducting an RFP for interpreter services which will go into effect prior to the next renewal. The current RFP process will ensure there is time to conduct a thorough evaluation of vendors and, if necessary, transition telephonic and video interpretation services to a new vendor without interrupting availability to members.

Fiscal Impact

The amendment increases the contract maximum amount by $295,000 for a total maximum of $1,930,000. The term of the agreement is extended through March 31, 2025.

DRAFT

RESOLUTION OF THE
SAN MATEO HEALTH COMMISSION

IN THE MATTER OF WAIVE REQUEST FOR PROPOSAL PROCESS AND APPROVE AN AMENDMENT TO THE AGREEMENT WITH CERTIFIED LANGUAGES INTERNATIONAL

RESOLUTION 2024 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has previously entered an agreement with Certified Languages International to provide telephonic interpretation services;

B. The contract is due to expire, and Staff recommends continuing this agreement through March 31, 2025, and adding $295,000 to the contract maximum, to allow time to conduct a thorough evaluation of vendors through an RFP.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission waives the RFP process and approves an amendment to the agreement with Certified Languages International to extend the term of the agreement through March 31, 2025, and increase the total contract maximum to $1,930,000; and

2. Authorizes the Chief Executive Officer to execute said amendment to the agreement.

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

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
George Pon, Chairperson

ATTEST:

APPROVED AS TO FORM:

BY: _____
C. Burgess, Clerk

_____
Kristina Paszek
DEPUTY COUNTY ATTORNEY

DRAFT

AGENDA ITEM: 4. 4

DATE: September 11, 2024

SAN MATEO HEALTH COMMISSION
Meeting Minutes
August 22, 2024 – 12:30 a.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor Boardroom
South San Francisco, CA 94080

Commissioners Present:	Michael Callagy	Manuel Santamaria
	David J. Canepa	Kenneth Tai, M.D.
	Bill Graham, Vice-Chair	Ligia Andrade Zuniga
	George Pon, R. Ph., Chair	

Commissioners Absent: Jeanette Aviles, M.D., Si France, M.D., Raymond Mueller.

Counsel: Kristina Paszek

Staff Presenting: Pat Curran, Chris Esguerra, M.D., Nicole Ford

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

2. **Public Comment**
   Commissioner Pon expressed his sympathies and condolences in the recent passing of Commissioner Barbara Miao. He reflected on her commitment to serving our members. Commissioner Canepa expressed it is a great loss to our commission. There were no other public comments at this time.

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

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

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

5.1 Quality Update

Dr. Chris Esguerra introduced Nicole Ford, Director of Quality Improvement, who presented an update on the quality improvement activities over the past year and HEDIS results for 2022-23. Her presentation is attached to these minutes. Highlights of her report:

- The Managed Care Accountability Set (MCAS) is the specific set of measures from the California Department of Health Care Services (DHCS) which consists of about 40 measures.
- This is related to member outcomes reported on the activity for 2023.
- DHCS has emphasized outcomes through these quality measures, and it is increasingly tied to how we are paid. Sanctions can be required if performances

levels are low, and our quality withhold is earned based on our performance.

- The MCAS is made up of measure from the Health Effectiveness Data Information Set (HEDIS), which is curated and maintained by the National Committee of Quality Assurance (NCQA) and is made up of mostly preventative care metrics.
- These measures are reported annually in June looking back to the prior year activity.
- Submissions are audited by a certified NCQA auditor, and all plans are measured in the same way for comparison across plans to create benchmarks for all plans.
- Data comes primarily from the claims for services provided and a small subset of measures are a sample from medical records.
- Pharmacy data used includes the type of medications prescribed, the quantity and, in some cases, the medication ratio between emergency medication and controlled medication.
- HPSM utilizes a vendor to calculate these metrics that goes through a rigorous audit process to ensure that data is being comprehensively calculated for each measure.
- The HEDIS submissions are submitted to CMS, DHCS, NCQA and DMHC for the various lines of business for our quality measure reporting.
- The MCAS takes all of the data and ranks this into performance level percentiles: Minimum performance level (MPL) is the lower 50th percentile and high performance level is the upper 90th percentile, based on the prior year's HEDIS reporting from all NCQA national Medicaid plans. We know beforehand where the benchmarks are, which is how we are able to measure where we are today based on last year's rates and performance levels.
- There are sanctions for measures that are below the 50th percentile.
- DMHC has a similar 50th percentile benchmark but uses the current year's data. We will have those results in September and know then if there are any sanctions, which would start January 1, 2027 for the HealthWorx and Medi-Cal lines of business.
- NCQA uses the 10th, 33.33rd, 66.67th and 90th measure percentile for a 1 to 5 star rating. Every year the percentile level changes nationally for all health plans.
- Medicare uses a star rating bonus program for our D-SNP for Part C HEDIS measures.
- Ms. Ford reviewed the Medical MCAS 2023/2024 Results: 12 out of 18 measures were improved from prior year; no measures were below the MPL; and 6 measures are above the high performance level: Childhood Immunization and Adolescent Immunizations; Breast Cancer Screening; Chlamydia Screening; Prenatal and Postpartum Care; and timely prenatal care. The measure that is a challenge is the Well-Child visit in the first 30 months of life.
- Ms. Ford reviewed the Breast Cancer Screening comparison over the past few years, noting that in 2024 we have experienced performance improvement in the number of women 50-74 that had a mammogram screening. This is due to direct member outreach calls to Black-identifying women who had not had a screening in the previous two years, to decrease the disparity among Black/African American identifying Medi-Cal members.
- Well-Child Visit comparison of 2021 to 2024 show challenges in the early years but has improved to above the 50 percentile in 2024.
- Prenatal Care comparisons show much improvement over the years.

Commissioner Callagy asked how staff can make such a difference in the scores. Dr. Esguerra stated it is a layering of the different types of intervention and many teams coming together for the various areas of the interventions. Another reason is the organization and way we approach the work as directed by the Population Health group led by Megan Noe. Another way is staff working with our providers and getting involved with them in their practices. Commissioner Graham touched on the relationship that HPSM has with providers, the trust and confidence providers have with the plan, which plays a critical role in these results.

Commissioner Santamaria asked if the Well Child Visits will improve with the implementation of the Baby Bonus Program. Dr. Esguerra is hopeful that it will improve our outcomes. Commissioner Santamaria raised the question about the number of measures and the types of measures which have been in place for several years. Dr. Esguerra explained that there is openness on the part of the state to look at these and for plans to give input. There is a group meeting soon with the state to have some of these discussions.

5.2 Compliance Program Update

Mr. Ian Johansson, Chief Government Affairs and Compliance Officer, gave an update on the annual Compliance survey results and some insight into the upcoming external audits coming for HPSM and staff activity preparing for them. His presentation is attached to these minutes. Highlights of his report:

- The annual staff compliance survey is an anonymous survey for all employees which began in 2015. It gives insight into the strength of HPSM's Compliance Program, allows direct communication with staff and Chief Compliance Officer, and the results are reported annually to the staff, Compliance Committee, and the Commission.
- Mr. Johansson reviewed the feedback and variances from year to year. New to the survey over the years was the addition of staff's ability to give feedback on each question to better understand their responses, to better understand why they felt a certain way about various questions, as well as adding some new questions with feedback from the Compliance Committee.
- In reviewing the results of the survey, Mr. Johansson talked about the questions that had either a decrease or an increase, as well as how we are trending historically.
- He noted that since the beginning of these surveys, HPSM has grown by about 150 employees.
- NCQA is a new area for staff so an education program will be rolled out to help them understand their specific role as it relates to NCQA.
- Many scores beat our 10-year averages, participation rate remained above our 80% target, and new questions received high marks.
- Survey results indicated opportunities in the areas of fear of retaliation, reports of observed violations not reported, and keeping participation above 80%.
- Future efforts include helping staff to know the Compliance Team and their roles; emphasizing compliance as a service, not a form of policing; more general routine messaging to staff; and coordination with HR on the issue of fear of retaliation scoring.

Commissioner Canepa asked about the approach we are planning to help with the fear of retaliation. Mr. Johansson stated that they will be working on communicating to staff, reaching out to gain trust and knowledge about the roles of compliance staff and that they are here to provide a service as well as working with Learning & Development Department on connecting with staff with understanding in this area.

Commissioner Santamaria asked about the type of observable violations that are not reported. Mr. Johansson gave an example of an email violation by a person's supervisor and the staff member knowing that if reported they would be implicated having been included on that email. This is an example where someone may not report it but it really is an educational opportunity. The survey gives staff the opportunity to report it as well.

Mr. Johansson reviewed the upcoming audits and surveys:

- Department of Managed Health Care (DMHC) – financial audit every three years.
- Department of Health Care Services (DHCS) – in document production and audit prep for this annual audit,
- DMHC follow up Medical Survey – preparing documentation for this audit that was performed in 2021.
- NCQA Survey – once every three years for the health plan's accreditation and will begin submitting evidence the first week of September; case review and interviews will take place in January 2025.
- Practice interviews are taking place now with compliance staff to prepare for interviews with DHCS state auditors.
- Once every three years our audit season is particularly heavy due to overlapping audits by different agencies.

Commissioner Pon had a need to excuse himself from the meeting at this time and asked for a motion to select a Chair Pro Tempore to take his place. Commissioner Canepa moved to select Commissioner Graham, Vice Chair, to continue the meeting as Chair Pro Tempore in Commissioner Pon's absence. Commissioner Callagy seconded the motion. **M/S/P.**

[Commissioners Pon and Commissioner Zuniga exited the meeting at this time]

Mr. Johansson continue his report noting that consultants are not used to collect the information for these audits except for the Medicare (CMS) audit. The CMS audit does not schedule on a regular cadence. We do not expect this in 2024, but it could be coming in 2025. We are currently undertaking a mock audit in preparation for the potential of this audit in the future.

Following these current audits, reporting will be coming first to the Finance/Compliance Committee with a review of any findings, trends, and corrective actions necessary. Following this, the results will be reported to the commission.

Beginning in the first quarter of 2025, Mr. Johansson will report on government affairs including the post elections results, the state initial January budget projection, and the legislative outlook with bills expected to come to the floor. Periodic updates will be presented throughout the year and impacts that could affect the health plan.

6. Report from Chief Executive Officer

Mr. Curran reviewed his written report touching on the audits as presented here today, the approval of the Baby Bonus Program recently, the Primary Care Investments Program, and the criterion for Provider Investments. Teams are at work on the initiatives and implementation of these programs. More updates will be coming in the future.

Mr. Curran thanked Nicole Ford and the team, emphasizing the immense amount of detailed reporting handled by the Quality Improvement staff. He noted another effort being led by Ms. Ford to educate employees on the complicated work that affects these measures, which is important because the reason we are here is to improve outcomes and health equity for our members.

Lastly, Mr. Curran touched on information that he will present at the September meeting related to the MCO Tax to give an overview of what that program is and how it has evolved. There is a ballot initiative, Measure 35, that is relevant to this MCO Tax.

7. Other Business

There was no other business discussed at this time.

8 . Adjournment

The meeting was adjourned at 1:40 pm

Submitted by:
C. Burgess

C. Burgess, Clerk of the Commission

Attachment 1
to August 22, 2024
SMHC Minutes

HEDIS/MCAS Measurement Year 2023/ Reporting Year 2024 Results

San Mateo Health Commission

August 22, 2024

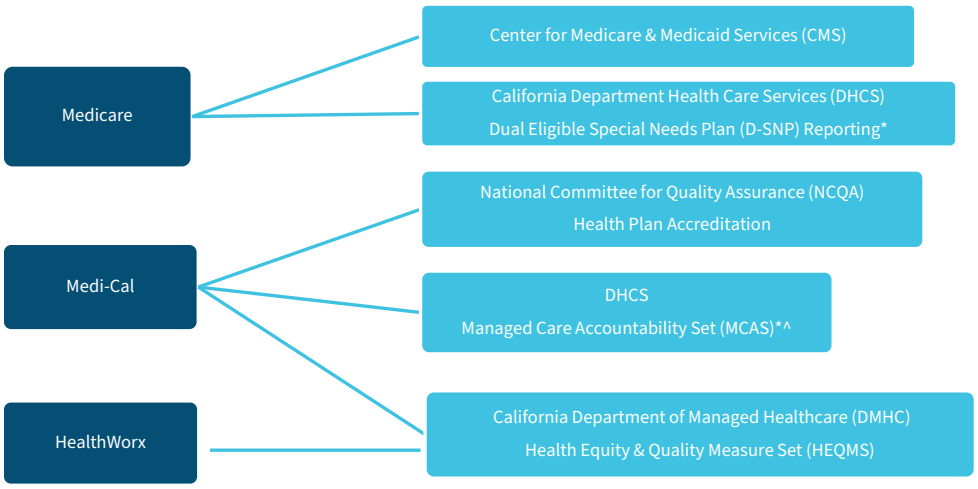
HealthPlan OF SAN MATEO
Healthy is for everyone

HEDIS

HealthPlan OF SAN MATEO
Healthy is for everyone

- **H**ealth **E**ffectiveness **D**ata **I**nformation **S**et
- Performance metrics that assess the effectiveness and access/availability of care
- Measured and reported annually:
  - Submitted mid-June (Reporting Year) for prior calendar year's membership and services (Measurement Year)
- All submissions require passing NCQA audit prior to reporting
- Compared across health plans nationally
- Most measures based on claims, and pharmacy data (Administrative), some require the use of medical record review as well (Hybrid). Plans can also use *supplemental* data sources (e.g. laboratory, EMR, registry, case management system, and HIE data feeds) with auditor approval to measure evidence of care.

HEDIS Submissions



*Includes HEDIS measures with custom race/ethnicity stratifications
^Includes non-HEDIS measures

Performance Benchmarks

- Medi-Cal MCAS:
  - Minimum performance level (MPL) is the lower 50th percentile and High performance level (HPL) is the upper 90th percentile
  - Based on prior year's HEDIS reporting from all NCQA's national Medicaid plans
  - DHCS requires plans to perform above MPL for a mandatory set of MCAS measures. DHCS mandates formal quality improvement work and may impose monetary sanctions for any measure under MPL.
- DMHC HEQMS:
  - NCQA national Medicaid HMO 50th percentile for the current reporting year for both Medi-Cal and Commercial submissions
  - DMHC may assess administrative penalties for not meeting benchmarks starting January 1, 2027
- NCQA Health Plan Accreditation Rating
  - Compares plan submitted rate to the 10th, 33.33rd, 66.67th and 90th measure percentiles for the current reporting year by National All Lines of Business submissions and assigns an individual measure rating on a 1 to 5 scale for each measure.
- Medicare:
  - CMS STARS bonus program for Medicare Advantage and D-SNP plans
  - Select HEDIS measures for Part C STARs rating
  - "Cut-points" for Star rating for each measure set with CMS's comparative methodology across all Medicare Advantage plans for the current reporting year

MY2023/RY2024 Results Summary

- Medi-Cal MCAS

  Of 18 measures total held to MPL:

  - Improved in 12 measures from prior year
  - No measures below MPL (50th percentile)
  - 6 measures above HPL (above 90th percentile):
    - Childhood Immunization Status –combination 10
    - Immunizations for Adolescents –combination 2
    - Breast Cancer Screening
    - Chlamydia Screening in Women
    - Prenatal and Postpartum Care – Postpartum Care
    - Prenatal and Postpartum Care – Timely Prenatal Care

MY2023/RY2024 MCAS – MPL

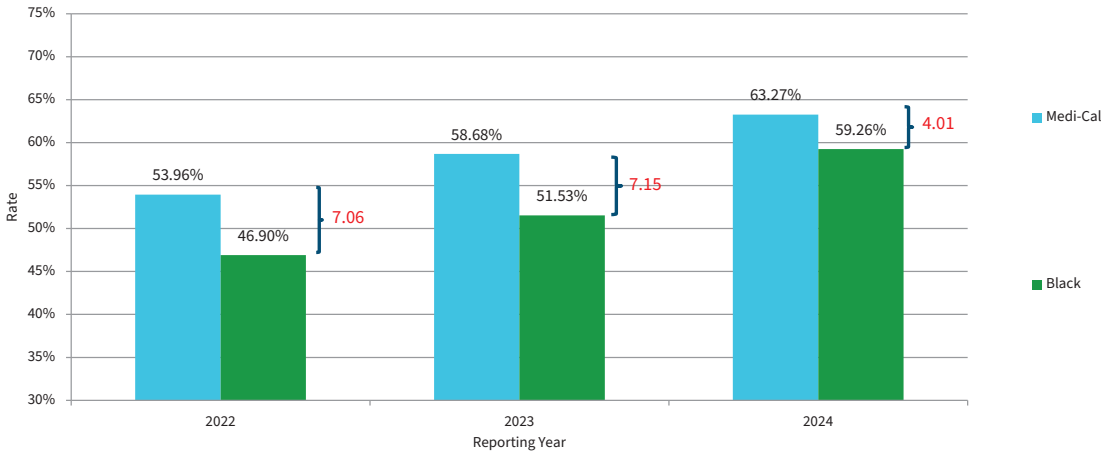
Abrev	Measure	50th Percentile MPL	MY2023	MY2022	MY2021	MY 2020
CBP	Controlling High Blood Pressure*	61.31	71.48	64.95	62.20	53.04
HBD>9	Hemoglobin A1c Control for Patients with Diabetes: Poor Control (>9.0%)* (lower is better)	37.96	30.77	34.43	28.78	37.23
AMR	Asthma Medication Ratio	65.61	75.18	77.44	69.56	70.06
CIS-10	Childhood Immunization Status –Combo 10*	30.90	54.03	54.50	54.85	61.56
IMA -2	Immunizations for Adolescents –Combo 2*	34.31	50.85	49.39	51.58	50.61
BCSE	Breast Cancer Screening	52.60	63.27	58.68	53.96	59.20
CCS	Cervical Cancer Screening*	57.11	61.22	61.69	57.61	58.91
CHL	Chlamydia Screening in Women	56.04	69.07	67.39	68.71	63.98
PPC -Post	Prenatal and Postpartum Care – Postpartum Care*	78.10	86.63	89.53	92.45	92.59
PPC-Pre	Prenatal and Postpartum Care – Timeliness of Prenatal Care*	84.23	91.28	90.70	89.31	90.0
WCV	Child and Adolescent Well-Care Visits (3-21 yrs)	48.07	54.81	52.00	56.92	48.80
LSC	Lead Screening in Children*	62.79	70.66	67.88	N/A	N/A
DEV^	Developmental Screening in the First Three Years of Life	34.70	56.07	53.15	43.02	24.24
FUM	Follow-Up After Emergency Department Visit for Mental Illness (30-Day Follow-Up)	54.87	64.43	69.70	27.72	N/A
FUA	Follow-Up After Emergency Department Visit for Substance Use (30-Day Follow-Up)	36.34	49.13	53.44	7.58	N/A
TFL-CH^	Topical Fluoride for Children	19.30	23.00	20.32	N/A	N/A
W30	Well-Child Visits in the First 30 Months of Life • 6 or more well-child visits in first 15 months of life • 2 or more well-child visits in 15 to 30 months of life	 58.38 66.76	 58.58 72.96	 49.62 72.38	 25.73 69.14	 20.03 76.94

*Hybrid measure (chart review + admin & sup data)
^Non-HEDIS measure

Under MPL (50th Percentile/CMS FFY 2022 state medians for non-HEDIS)
Above HPL (90th Percentile)

Breast Cancer Screening

The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

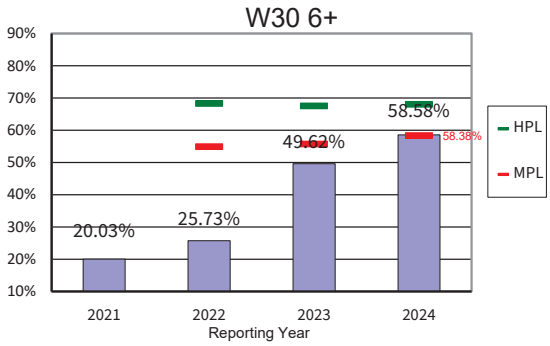


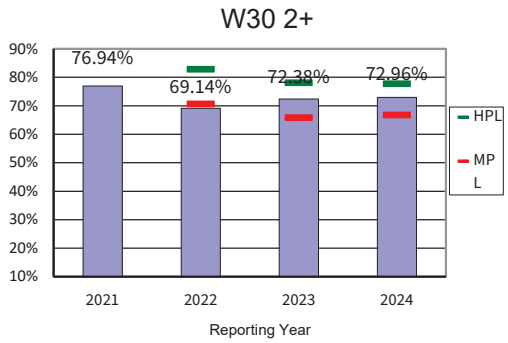
- Performance improvement project (PIP) in 2022 with direct member outreach calls to Black identifying women who had not had a screening in the last two years to decrease the disparity among Black/African American identifying Medi-Cal members.
- Multiple ongoing interventions to improve cancer screening rates for adult members in 2023 and continuing in 2024

Well-Child Visits in First 30 Months of Life

The percentage of members who had the following number of well-child visits with a PCP. Two rates are reported:

1. W30 6+ : Six or more well-child visits in the *first 15 Months*. Children who turned 15 months old during the measurement year.
2. W30 2+: Two or more well-child visits *Age 15 Months–30 Months*. Children who turned 30 months old during the measurement year.



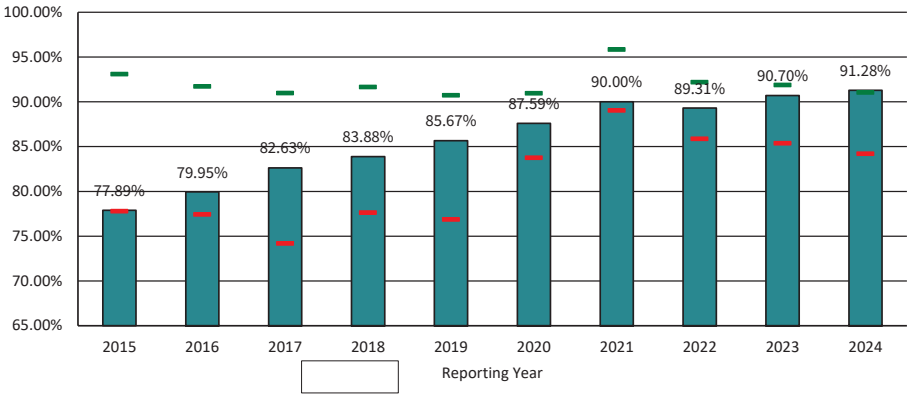


Area of Focus for 2023 and 2024

- MC benchmark P4P payment measure and included in Care Gaps P4P program
- Continue to investigate potential data gaps and procure additional data capture
- Engaging Family Health Services to assist with member barriers to visits
- DHCS Clinical PIP topic -reducing disparity for the Hispanic/Latino population
- DHCS Collaborative Sprint lead by Institute for Healthcare Improvement (IHI) to focus on improving child well visits

Prenatal Care

Percentage of Medi-Cal deliveries that received a prenatal care visit within the first trimester or 42 days of enrollment if the member became enrolled after the first trimester



- Baby+Me Program: Member incentives and outreach for timely initial prenatal care

Questions?

Appendix

HealthPlan OF SAN MATEO
Healthy is for everyone

MY2023/RY2024 MCAS – no MPL

HealthPlan OF SAN MATEO
Healthy is for everyone

Abbrev.	Measure	MY2023	MY 2022	MY 2021	MY 2020
FUA	Follow-Up After Emergency Department Visit for Substance Use (7-Day Follow-Up)	34.65	35.52	4.27	N/A
FUM	Follow-Up After Emergency Department Visit for Mental Illness (7-Day Follow-Up)	49.67	55.34	18.58	N/A
AAP	Adults' Access to Preventive/Ambulatory Health Services	68.76	67.59	N/A	N/A
POD	Pharmacotherapy for Opioid Use Disorder	18.62	26.03	N/A	N/A
PRS-E	Prenatal Immunization Status: Flu + Tdap	52.01	49.67	N/A	N/A
PDS-E	Postpartum Depression Screening and Follow Up • Screening • Follow-up	8.67 66.67	10.75 86.67	N/A	N/A
PND-E	Prenatal Depression Screening and Follow Up • Screening • Follow-up	9.65 64.71	11.91 47.06	N/A	N/A
DSF-E	Depression Screening and Follow-up for Adolescents and Adults • Screening • Follow-up	8.29 68.45	4.31 80.81	N/A	N/A
DRR-E	Depression Remission or Response for Adolescents and Adults • Follow-up • Remission • Response	37.97 7.17 16.03	0 0 0	N/A	N/A
CCP^	Contraceptive Care: Postpartum Women Ages 15-44 Most or moderately effective contraception – 90 days	57.16	48.92	52.41	50.17
CCW^	Contraceptive Care: All Women Ages 15-44 Most or moderately effective contraception	22.07	23.07	25.26	24.34

^Non-HEDIS measure All administratively collected measures;

MY2023/RY2024 MCAS – no MPL

HealthPlan OF SAN MATEO
Healthy is for everyone

Abbrev.	Measure	MY2023	MY 2022	MY 2021	MY 2020
AMB-ED	Ambulatory Care: Emergency Department (ED) Visits per 1,000 member months	43.33	44.76	38.63	36.99
ADD-Init	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications – Initiation Phase	52.59	50.82	24.35	22.88
ADD-C/M	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications – Continuation and Maintenance Phase	46.51	N/A	N/A	N/A
PCR	Plan All-Cause Readmissions (18-64 yr olds) • Observed rate (lower is better) • Observed to expected ratio	9.00 0.9271	8.53 0.8623	9.42 0.9597	9.64 0.9322
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing	37.35	31.51	42.55	35.64
AMM -AP	Antidepressant Medication Management - Effective Acute Phase Treatment	69.20	69.55	67.59	66.47
AMM -CP	Antidepressant Medication Management - Effective Continuation Phase Treatment	50.09	53.26	51.48	51.09
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.89	81.26	80.19	78.15
COLE	Colorectal Cancer Screening	49.91	47.82	N/A	N/A

All administratively collected measures;

Attachment 2
to August 22, 2024
SMHC Minutes

Compliance Survey Results and Upcoming Audits

Ian Johansson
Chief Government Affairs & Compliance Officer
August 22, 2024

HealthPlan OF SAN MATEO
Healthy is for everyone

Annual Compliance Survey

HealthPlan OF SAN MATEO
Healthy is for everyone

- Anonymous survey of HPSM staff
- Conducted since 2015
- Gives insight into health of HPSM's Compliance Program
- Enables direct communication between HPSM staff and the Chief Compliance Officer
- Results reported to All-Staff, Compliance Committee, and Commission

Changes to survey '23 → '24

- Feedback opportunity added to all questions
- New questions added to determine:
  - If staff knew their role in meeting regulatory requirements
  - If staff felt Compliance supported them in meeting those requirements
  - If staff felt the NCQA Program Manager supported them in meeting NCQA requirements

		Year	Average	2022	2023
		Participation Rate	72%	83%	81%
1	Familiar with Compliance Program	Agree	98%	99%	99%
2	I know where to view a copy of HPSM's Code of Conduct	Agree	97%	99%	97%
3	I know where to locate HPSM's P&Ps	Agree	97%	97%	97%
4	I am aware of the P&P that relate to my job	Agree	98%	100%	100%
5	The name of HPSM's Compliance Officer is	Agree	99%	99%	98%
6	I know how to contact the CO	Agree	96%	98%	99%
7	I would feel comfortable reporting to the Compliance Officer	Agree	97%	92%	99%
8	Observed workplace behavior that felt violated Code or policy, law	Agree	10%	6%	9%
9	If you observed a violation, did you report it?	YES	14	11	19
		NO	5	5	6
10	Do you know about HPSM's policy on non-retaliation and non-intimidation?	Agree	97%	98%	97%
11	Fear of retaliation would prevent me from reporting	Agree	24%	21%	22%
12	Confident compliance will ensure my concern is addressed timely	Agree	97%	97%	99%
13	Confident compliance will ensure my concern is addressed confidentially	Agree	98%	98%	100%
	NEW QUESTIONS				
14	I understand my role in meeting regulatory requirements	Agree	n/a	n/a	99%
15	The Compliance Department supports me in meeting regulatory requirements	Agree	n/a	n/a	99%
16	The NCQA Program Manager supports me in meeting regulatory requirements	Agree	n/a	n/a	97%

Positives / Improvements

- Overall, scores beat 10-year averages
- Participation rate remained above target
- Scores for “I would feel comfortable reporting to” improved in all categories
- New questions received high marks

Opportunities

- Fear of retaliation score below average, but remains above 20%
- Reports of observed a violation not reported to Compliance
- Keeping participation above 80%

Efforts underway

- Compliance Team "Road Show"
  - Helping teams get to know the Compliance Team and their roles
  - Emphasizing Compliance-as-a-Service
- More communication from Compliance to Staff
- Coordination with HR on fear of retaliation score

Upcoming Audits / Surveys

- Department of Managed Health Care (DMHC) Financial Audit
  - Triennial audit; underway
- Department of Health Care Services (DHCS) Medical Audit
  - Annual audit; to be performed in September
- Department of Managed Health Care (DMHC) Follow-Up Medical Survey
  - Follow up to 2021 survey; to be performed in December
- NCQA Survey
  - Triennial survey; evidence submission in December, case review in Q1 '25

Results reporting

- Audit and survey performance to be discussed at Finance/Compliance committee
  - Review of findings, trends, and corrective actions
- Opportunity for Finance/Compliance Committee to provide input
  - Identify information to report to full Commission
- Commission opportunity to request additional detail
- Audit / survey reports expected in 2025

CMS Audit

- Audit / survey reports expected in 2025
- Audit and survey performance to be discussed at Finance/Compliance committee
  - Review of findings, trends, and corrective actions
- Opportunity for Finance/Compliance Committee to provide input
  - Identify information to report to full Commission
- Commission opportunity to request additional detail

Government Affairs Reporting

- Beginning Q1 2025
- Look at state/federal policy landscape
  - Post-election results
  - January CA Budget
  - Legislative outlook

Questions?

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

Questions?

MEMORANDUM

AGENDA ITEM: 5.1

DATE: September 11, 2024

DATE: September 5, 2024

TO: San Mateo Health Commission

FROM: Patrick Curran, Chief Executive Officer

RE: MCO Tax Update – Measure 35 LAO Analysis

Attached as information to provide background for the update on the MCO Tax - Proposition 35, is the analysis from the Legislative Analyst's Office (LAO), California Legislature's Nonpartisan Fiscal and Policy Advisor. This will be discussed at our September Commission meeting.

LAO

PROPOSITION 35
Provides Permanent Funding for Medi-Cal Health Care Services. Initiative Statute.

ANALYSIS OF MEASURE

BACKGROUND

State Charges a Specific Tax on Health Plans. Since 2009, California typically has charged a specific tax on certain health plans, such as Kaiser Permanente. This tax is called the Managed Care Organization Provider Tax ("health plan tax"). The tax has worked differently over time. Currently, it charges plans based on the number of people to whom they provide health coverage, including those in Medi-Cal. The tax rate is higher for those in Medi-Cal compared to other kinds of health coverage. (Medi-Cal is a federal-state program that provides health coverage for low-income people. The federal government and the state share the cost of the program. By charging the health plan tax, the state can receive more federal funding.)

State Uses Tax for Two Purposes. The amount of revenue raised by the health plan tax has changed over time. Based on recent legislative action, we estimate the tax is expected to result in between $7 billion to $8 billion each year (annually) to the state. The state uses this money for two purposes.

- ***Paying for Existing Costs in Medi-Cal.*** Some revenue helps pay for existing costs in the Medi-Cal program. Using the tax revenue in this way allows the state to spend less money from the General Fund on Medi-Cal. (The General Fund is the account the state uses to pay for most public services, including education, health care, and prisons. Medi-Cal is expected to get around $35 billion from the General Fund this year.) In other words, the health plan tax revenue reduces costs to the state General Fund.
- ***Increasing Funding for Medi-Cal and Other Health Programs.*** Some of the revenue increases funding for Medi-Cal and other health programs. For example, the state is increasing Medi-Cal payments to doctors and other health care providers. This is a new use of health plan tax revenue. Some of these funding increases began in 2024, but most will begin in 2025 and 2026. Once they all begin in 2026, the increases likely would result in around $4 billion more for Medi-Cal annually.

Around half of this amount will come from the health plan tax. (The rest will come from increased federal funding.)

Tax Will End, Unless It Is Approved Again. The Legislature has not permanently approved this tax. Instead, it has approved it for a few years at a time. The federal government also must approve the tax. The tax was most recently approved in 2023. It will expire at the end of 2026, unless the Legislature and federal government approve it again.

PROPOSAL

Makes Existing Health Plan Tax Permanent. Proposition 35 makes the existing health plan tax permanent beginning in 2027. The state would still need federal approval to charge the tax. The tax would continue to be based on the number of people to whom health plans provide health coverage. The proposition allows the state to change the tax, if needed, to get federal approval, within certain limits.

Creates Rules on How State Uses Tax Revenue. In addition to making the health plan tax permanent, Proposition 35 creates rules on how to use the revenue. Generally, these rules require the state to use more of the revenue to increase funding for Medi-Cal and other health programs. The rules are different in the short term (in 2025 and 2026) and the long term (in 2027 and after). Proposition 35 also changes which Medi-Cal services and other health programs get funding increases compared to current law. Figure 1 shows these changes in the short term.

Figure 1

Proposition 35 Changes Which Services Get Funding Increases

Funding Increases in the Short Term (in 2025 and 2026)

	Current Law	Proposition 35[a]
Doctors and other related providers[b]	✓	✓
Specified hospital services		✓
Outpatient facilities		✓
Safety net clinics	✓	✓
Behavioral health facilities		✓
Reproductive health and family planning	✓	✓
Emergency medical transportation	✓	✓
Nonemergency medical transportation	✓	
Private duty nursing	✓	
Certain long-term supports	✓	
Community health workers	✓	[c]
Continuous Medi-Cal coverage for children up to five-years old	✓	
Medi-Cal workforce programs	✓	✓
Doctor postgraduate training programs		✓

[a] More services are eligible for funding increases in the long term (beginning in 2027).
[b] Current law and Proposition 35 include some differences over which related providers get funding increases.
[c] Eligible for funding increases in the long term (beginning in 2027), depending on how much money is raised by the health plan tax.

FISCAL EFFECTS

In Short Term, Three Key Fiscal Effects. In the short term (in 2025 and 2026), Proposition 35 would have the following key fiscal effects:

- ***No Change to State Tax Revenue.*** Proposition 35 does not change the existing temporary tax on health plans, which expires at the end of 2026. For this reason, the proposition would have no effect on state tax revenue over this period of time.
- ***Increased Funding for Health Programs.*** Proposition 35 would increase funding for Medi-Cal and other health programs. This is because the proposition requires the state to use more health plan tax revenue for funding increases. The total increase in funding likely would be between roughly $2 billion and $5 billion annually. About half of this amount would come from the tax on health plans. (Because the federal government shares the cost of Medi-Cal with the state, the rest of the funding increase would come from federal funds. Including all fund sources, Medi-Cal is expected to get over $150 billion this year.)
- ***Increased State Costs.*** Proposition 35 would increase state costs. This is because it reduces the amount of health plan tax revenue that can be used to help pay for existing costs in Medi-Cal. Instead, the state likely would have to use more money from the General Fund for this purpose. **The annual cost would be between roughly $1 billion to $2 billion in 2025 and 2026.** These amounts are between one-half of 1 percent and 1 percent of the state's total General Fund budget.

In Long Term, Unknown Fiscal Effects. In the long term (2027 and after), Proposition 35 makes the temporary tax on health plans permanent and creates new rules about how to spend the money. The fiscal effect of these changes depends on many factors. For example, the state could approve the tax in the future, as it has done in the past, even if the proposition is not passed by voters. Also, it is uncertain how large of a tax the federal government would approve in the future. Given these uncertain factors, the proposition's long-term effects on tax revenue, health program funding, and state costs are unknown.

Temporarily Increases State Spending Limit. The California Constitution has various rules that impact the state budget. One rule limits how much state tax revenue can be spent on any purpose annually. Voters may increase this limit for up to four years at a time. In line with these rules, Proposition 35 temporarily increases the limit by the size of the health plan tax for four years. After the temporary increase ends, the long-term effect of the proposition on the state's spending limit is uncertain. This is because it is unknown how Proposition 35 would affect state tax revenue in the future.

YES/NO STATEMENT

A **YES** vote on this measure means: An existing state tax on health plans that provides funding for certain health programs would become permanent. New rules would direct how the state must use the revenue.

A **NO** vote on this measure means: An existing state tax on health plans would end in 2027, unless the Legislature continues it. The new rules would not become law.

SUMMARY OF LEGISLATIVE ANALYST'S ESTIMATE OF NET STATE AND LOCAL GOVERNMENT FISCAL IMPACT

- In the short term, increased funding for Medi-Cal and other health programs between roughly $2 billion and $5 billion annually (including federal funds). Increased state costs between roughly $1 billion to $2 billion annually to implement funding increases.
- In the long term, unknown effect on state tax revenue, health program funding, and state costs. Fiscal effects depend on many factors, such as whether the Legislature would continue to approve the tax on health plans in the future if Proposition 35 is not passed by voters.

BALLOT LABEL

Fiscal Impact: Short-term state costs between roughly $1 billion and $2 billion annually to increase funding for certain health programs. Total funding increase between roughly $2 billion to $5 billion annually. Unknown long-term fiscal effects.

AGENDA ITEM: 5.2

DATE: September 11, 2024

Meeting materials are not included

for Item 5.2 – Update on HPSM Work Culture (2024 Company Initiative)

MEMORANDUM

AGENDA ITEM: 6.0

DATE: September 11, 2024

DATE: September 4, 2024

TO: San Mateo Health Commission

FROM: Patrick Curran

RE: CEO Report – September 2024

Transitional Rent

The state received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a transitional rent program. They are in the process of soliciting comments from stakeholders about the implementation of this program. Here is an overview:

What is transitional rent? Health plans serving Medi-Cal members, like HPSM, can pay for up to six months' rent for individuals who have certain medical conditions and who are unhoused. The state has drafted initial criteria for which members would qualify for this benefit and is seeking feedback from stakeholders this month.

When will it start? Health plans can voluntarily implement this transitional rent program starting in 2025 as one of its voluntary Community Supports through CalAIM. Effective January 1, 2026, all health plans must have a program in place so that members who qualify for transitional rent receive it as a Medi-Cal benefit.

How will it work? Most of the details regarding implementation will follow in the next few months, but it is likely to involve extensive coordination with county agencies, especially Behavioral Health and Recovery Services (BHRS). It will also likely build on the established relationships we have with housing entities, such as Brilliant Corners.

State and Internal Audits

As mentioned at our meeting last month, our teams are very busy right now and over the next few months with several state audits, follow-up from prior audits, new state reporting requirements, NCQA accreditation preparation, and "mock" audits for CareAdvantage, in which we are receiving consultant expertise to identify gaps in our Medicare program for future audit readiness. In addition to these program audits, DHCS also conducted focused audits on behavioral health and transportation, which we are responding to as well.

AGENDA ITEM: 7.0

DATE: September 11, 2024

Meeting materials are not included

for Item 7.0 – Identification of Designated Representative

AGENDA ITEM: **8.0**

DATE: **September 11, 2024**

There are no meeting materials for Item 8.0 – CLOSED SESSION

8.1 Public Employee Performance Evaluation (Gov't Code section 54957)
Title: Chief Executive Officer, Health Plan of San Mateo

8.2 Conference with Labor Negotiators (Gov't Code section 54957.6)
Agency designated representative: George Pon, San Mateo Health Commission
Unrepresented employee: Chief Executive Officer, Health Plan of San Mateo