HealthPlan OF SAN MATEO
801 Gateway Blvd., Suite 100 | South San Francisco, CA 94080
www.hpsm.org

THE SAN MATEO HEALTH COMMISSION and
THE SAN MATEO COMMUNITY HEALTH AUTHORITY
Regular Meeting
April 12, 2017 - 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor, Boardroom
South San Francisco, CA 94080

~ REVISED AGENDA ~

1. **Call to Order/Roll Call**
2. **Public Comment/Communication**
3. **Approval of Agenda**
4. **Consent Agenda***
   - 4.1 Finance Report
   - 4.2 CCS Family Sub Committee and DPAC Minutes, December 2016
   - 4.3 CMC Advisory Committee Minutes, January 2017
   - 4.4 Consumer Advisory Committee Minutes, March 2017
   - 4.5 Ratify Agreement with San Mateo County Health System for Intergovernmental Transfer Funding (IGT) for State FY 2015-16 and 2016-17
   - 4.6 Approval of Amendment to Agreement for Lussier Architect Technologies, Inc.
   - 4.7 Approval of San Mateo Health Commission Meeting Minutes from March 8, 2017
5. **Specific Discussion/Action Items**
   - 5.1 Discussion/Action on Audited Financial Statements for the Twelve-Month Period Ending December 31, 2016 by Moss-Adams, LLP.*
   - 5.2 Review of 2016 Financial Statements.
   - 5.3 Approval of Quality Improvement (QI) Documents: 2016 QI Program Evaluation; 2017 QI Program Description; and 2017 QI Work Plan.*
   - 5.4 California Children's Service Demonstration Project.
   - 5.5 Compliance Oversight Training and Compliance Program Effectiveness Survey Results.
   - 5.6 Discussion/Action on Approval of Agreement with Verity Health System.
6. **Report from Chairman/Executive Committee**
7. **Report from Chief Executive Officer**
8. **Adjournment**

**Items for which Commission action is requested.*

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

HealthPlan OF SAN MATEO

AGENDA ITEM: 4.1

DATE: April 12, 2017

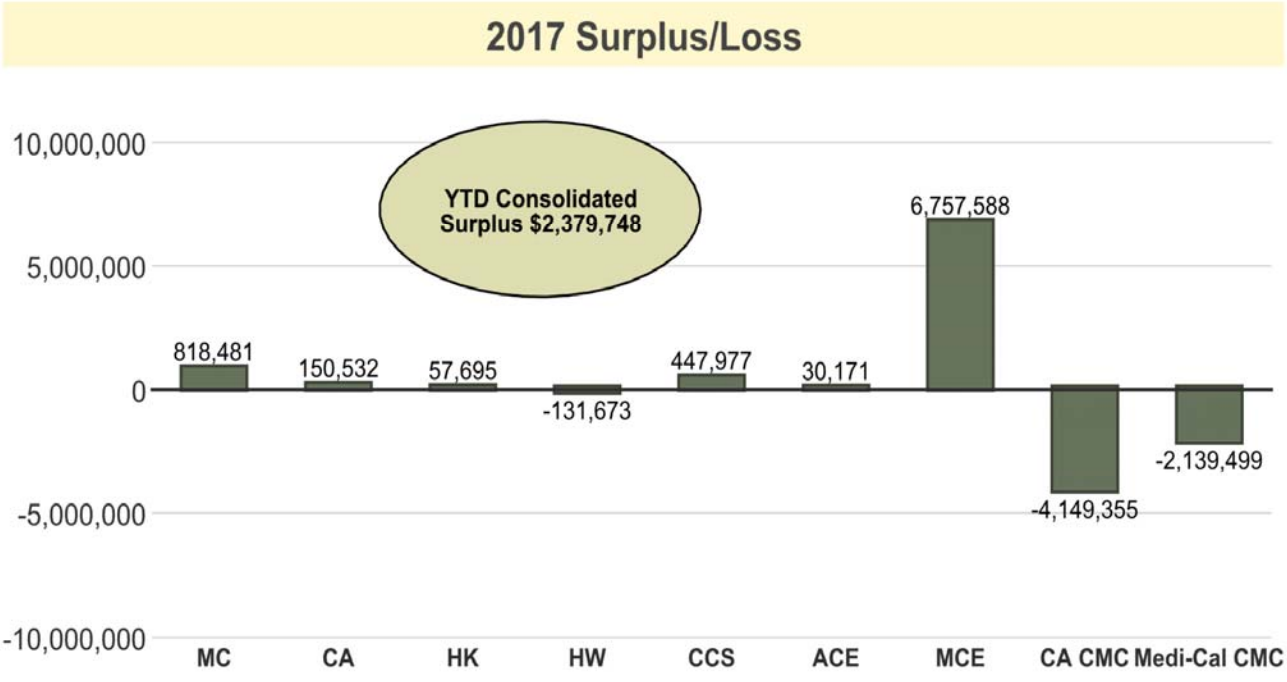
M E M O R A N D U M

Date: April 12, 2017
To: San Mateo Health Commission
From: Ron Robinson, Chief Financial Officer
Subject: Financial Report for the Two-Month Period Ending February 28, 2017

OVERVIEW OF FINANCIAL POSITION

Preliminary 2016 Financial Results All Lines of Business

The preliminary financial result for all lines of business for the month of February is a surplus of $3,066,594. Year-to-date the Plan has a surplus of $2,379,748. On page 11 is a Statistical and Financial Summary.

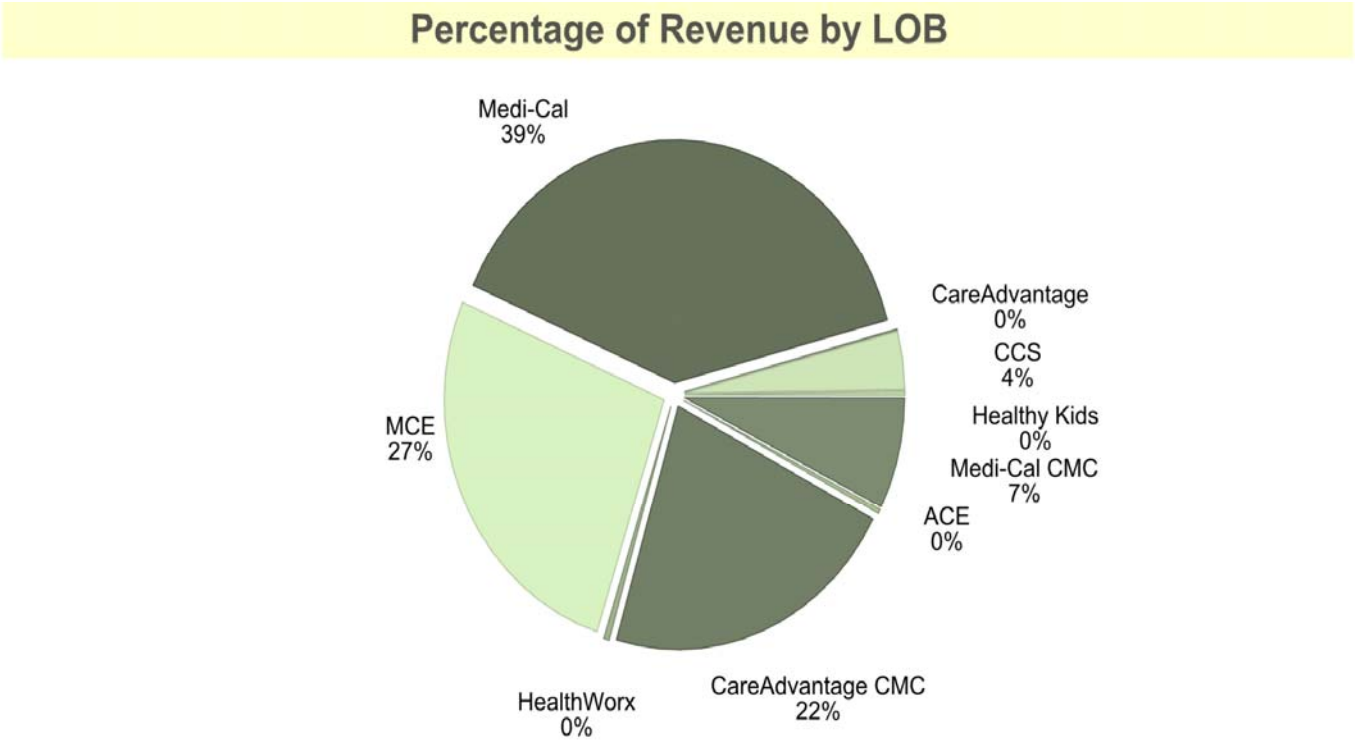


Membership

Below is a graph showing membership trends dating back to 2009. Total membership at the end of February, 2017 stands at 147,107, an increase of 59 members from the previous year. The increase in 2013 is a result of the Healthy Families transition to Medi-Cal and the 2014 increase is due to Medi-Cal expansion.

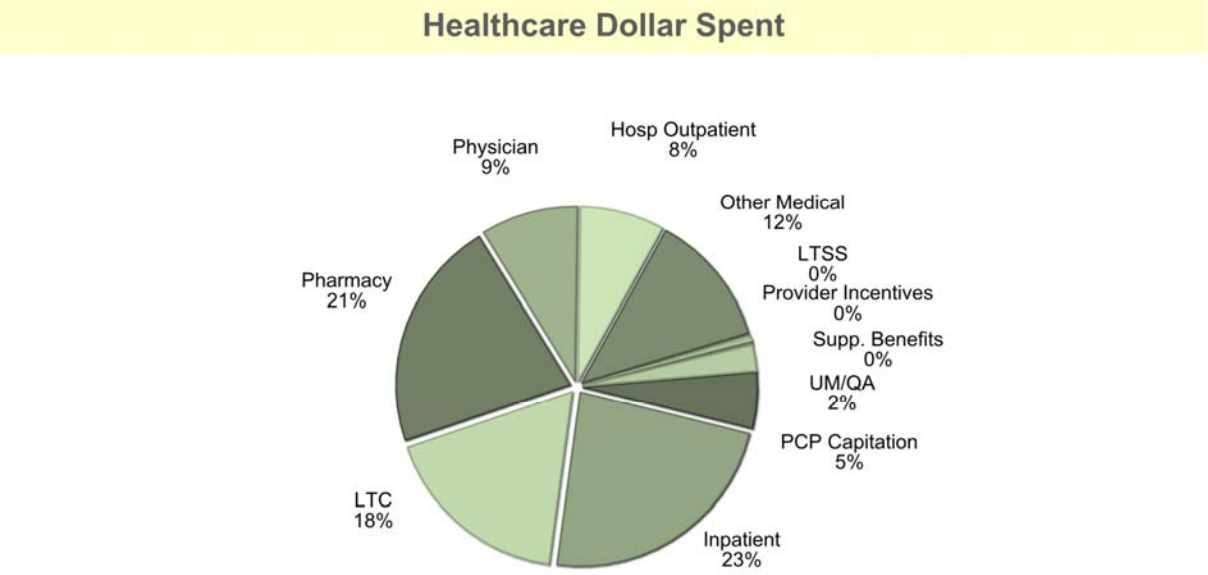
Revenue

Below is a depiction of revenue by each line of business for 2017. Medi-Cal Lines of Business continue to provide the largest share of HPSM revenue which includes Medi-Cal, Medi-Cal Expansion, CCS and Medi-Cal Cal MediConnect. Medi-Cal is followed by the CareAdvantage lines of business.



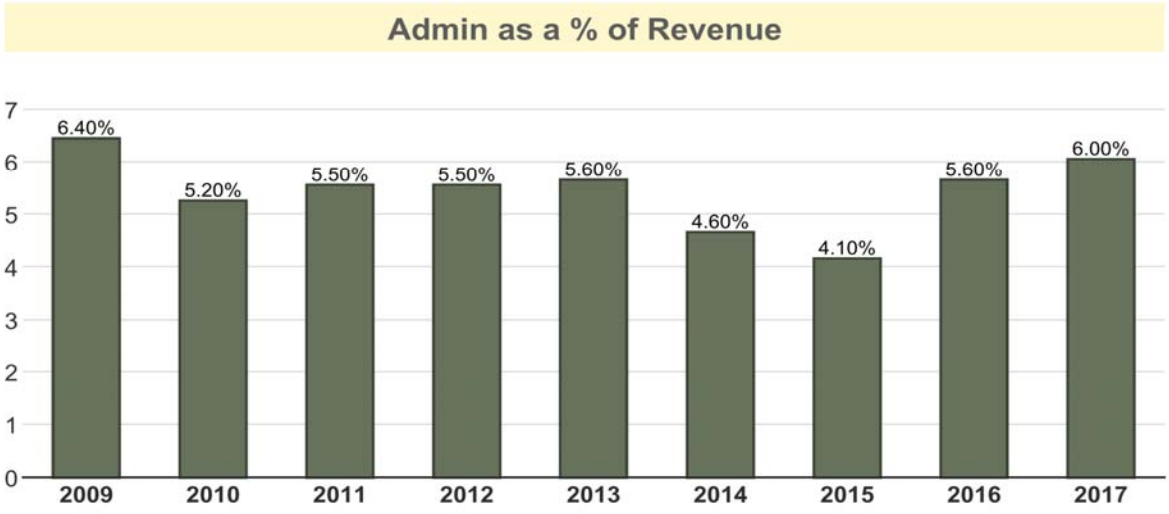
HealthCare Expenses

The graph below reflects how the healthcare dollar is being spent in 2017. Pharmacy and Inpatient are the largest driver of costs closely followed by Long Term Care expenses.



Administrative Expenses

Administrative expenses are expressed as a percentage of net revenue received. Administrative expenses are 6.0% of revenue for February, 2017. The following graph represents this percentage since 2009.

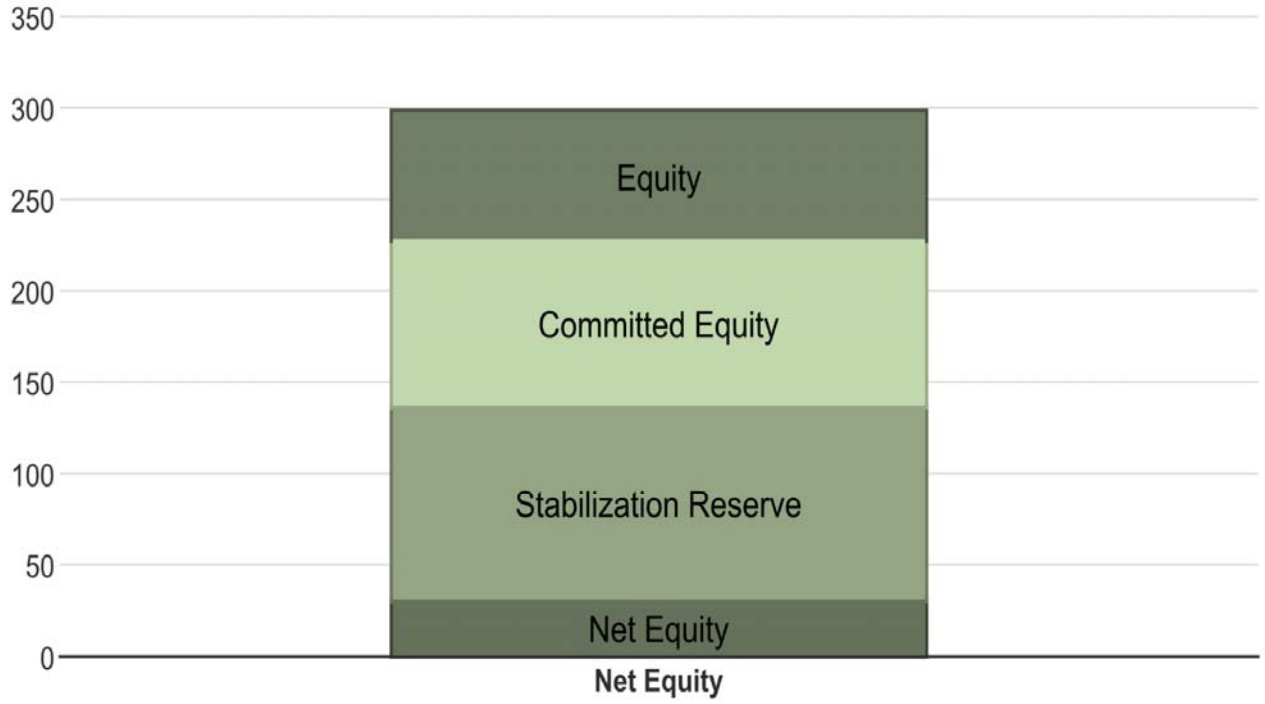


Investment and Interest

On page 12 is the Schedule of Investments. Total interest earned for February was $158,105 and $371,254 year to date.

Stabilization Reserve and Tangible Net Equity (TNE)

The TNE calculation is included on page 13. The financial protocol requires us to have a minimum Stabilization Reserve of two months operating expenses. As of February 28, 2017 our required TNE was $30.1 million and our stabilization reserve was $136.1 million. Our current net equity is $299.8 million of which $69.1 million is uncommitted.



MEDI-CAL (MC)

The Medi-Cal Statement of Revenue and expenses is included on page 17. Highlights are below:

Month Actual		Year - to - Date Actual	Budget
	REVENUES		
26,236,237	Capitation Revenue	52,098,563	60,067,141
(1,257,435)	MC Offset	(2,514,871)	(3,587,228)
24,978,802	**Total Revenue**	49,583,692	56,479,913
	EXPENSES		
19,585,735	**Total Health Care Costs**	40,230,535	49,928,833
1,353,186	**Administrative Expenses**	2,434,975	2,896,141
(14,338)	**SB78 Sales Tax**	8,906	0
3,085,058	**MCO Tax**	6,090,795	6,268,640
24,009,641	**TOTAL EXPENSES**	48,765,211	59,093,614
0	**Non-Operating Income**	0	0
969,161	**NET SURPLUS / (LOSS)**	**818,481**	**(2,613,701)**
78.4%	**Medical Loss Ratio**	81.1%	

Utilization:

	ACTUAL *YTD 2/17*	BUDGET *Annual 2017*
Hospital Inpatient Expense Total PMPM Expense	$47.45	$48.83
Physician, Outpatient & Other Medical Expense Total PMPM Expense	$70.42	$78.42
Pharmacy Expense (Excludes Drug Rebates) Total PMPM Expense	$42.25	$50.25

Medi-Cal has a surplus of $969,161 for the month of February and a year to date surplus of $818,481. Health care costs are trending lower than budgeted in all three main categories.

Additional Medi-Cal Programs

CCS

The CCS Pilot began in April of 2013. The CCS Statement of Revenue and Expenses is included as page 23 Highlights are below:

Month Actual		Year - to - Date Actual	Budget
	REVENUES		
2,440,915	Capitation Revenue	4,838,983	4,888,587
0	Cap Offset		
2,440,915	**Total Revenue**	4,838,983	4,888,587
	EXPENSES		
2,148,423	**Total Health Care Costs**	4,076,783	4,441,062
133,058	**Administrative Expenses**	249,819	344,944
(716)	**MCO Tax**	64,404	132,000
(60)	**AB78 Sales Tax**	1	0
2,280,705	**TOTAL EXPENSES**	4,391,007	4,918,006
0	**Non-Operating Income**	0	0
160,210	**NET SURPLUS / (LOSS)**	**447,976**	**(29,419)**
88.0%	**Medical Loss Ratio**	84.2%	

The pilot ended February with a surplus of $160,210 and a year to date surplus of $447,976

	ACTUAL *YTD 2/17*	BUDGET *Annual 2017*
Hospital Inpatient Expense Total PMPM Expense	$343.34	$290.38
Physician, Outpatient & Other Medical Expense Total PMPM Expense	$386.56	$435.54
Pharmacy Expense (Excludes Drug Rebates) Total PMPM Expense	$342.91	$375.33

Medi-Cal Expansion (MCE)

On January 1, 2014, Medi-Cal eligibility was expanded to those adults under 138% of poverty as a result of the Affordable Care Act. Those members that were in the Low Income Health Program (LIHP) automatically transitioned and we are also receiving members signing up through Covered California. As of February, there are 35,946 MCE members.

The MCE Statement of Revenue and Expenses is included as page 24. Highlights are below:

Month Actual		Year - to - Date Actual	Budget
	REVENUES		
17,289,680	Capitation Revenue	35,101,796	33,148,067
(753,815)	Medi-Cal Cap Offset	(1,504,731)	
16,535,865	**Total Revenue**	33,597,065	33,148,067
	EXPENSES		
11,491,578	**Total Health Care Costs**	23,769,245	26,497,592
780,176	**Administrative Expenses**	1,610,158	2,253,898
7,001	**MCO Tax**	1,429,136	2,937,120
4,891	**SB78 Sales Tax**	30,939	0
12,283,646	**TOTAL EXPENSES**	26,839,478	31,688,610
0	**Non-Operating Income**	0	0
4,252,219	**NET SURPLUS / (LOSS)**	**6,757,587**	**1,459,457**
69.5%	**Medical Loss Ratio**	70.7%	

The MCE line of business ended February with a surplus of $4.2 million and a year to date surplus of $6.7 million.

This line of business has an 85% Medical Loss Ratio requirement. If we fall below 85%, dollars will have to be paid back to the state. We are reserving (shown as Cap Offset) for the difference between actual expenses and the 85% MLR.

CAREADVANTAGE

The CareAdvantage Statement of Revenue and expenses is included on page 21.

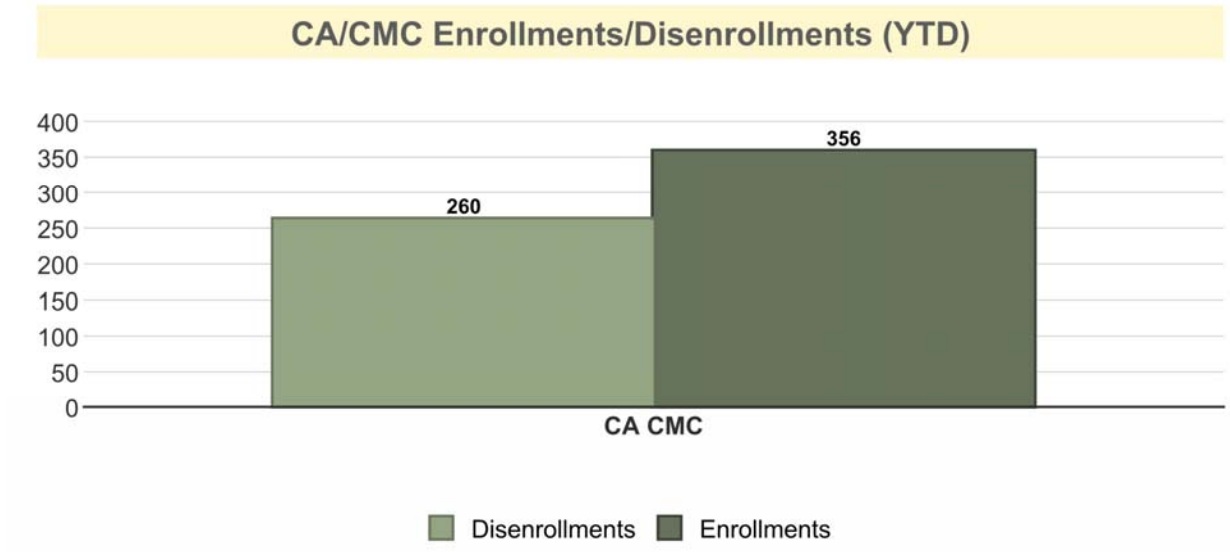
Highlights are below:

Month Actual		Year - to - Date Actual	Budget
	REVENUES		
199,147	Capitation Revenue	85,757	0
199,147	**Total Revenue**	85,757	0
	EXPENSES		
(77,654)	**Total Health Care Costs**	(88,232)	0
10,459	**Administrative Expenses**	23,456	0
(67,195)	**TOTAL EXPENSES**	(64,776)	0
0	**Non-Operating Income**	0	0
266,342	**NET SURPLUS / (LOSS)**	**150,533**	**0**

CareAdvantage ended as a D-SNP in December 2016. However, we will continue to see revenue and expenses as a result of retroactive activity.

Enrollment/Disenrollment

With the impending termination of CareAdvantage, the goal was to enroll as many eligible CareAdvantage members into Cal MediConnect as possible. Enrollments are higher than disenrollments as we begin 2017, however, the graph does not reflect the work of the CA Outreach Unit who have saved 227 members from being disenrolled. The CA Unit helps restore Medi-Cal eligibility or helps member restore SSI benefits.



CAREADVANTAGE CMC

Cal MediConnect began on April 1, 2014. There were 9,497 members as of February 28. The Statement of Revenue and Expenses is included on pages 25 and 26. Highlights are below:

Month Actual		Year - to - Date Actual	Budget
	REVENUES		
13,926,501	Capitation Revenue	27,572,355	30,358,332
13,926,501	**Total Revenue**	27,572,355	30,358,332
	EXPENSES		
14,027,358	**Total Health Care Costs**	29,164,858	31,166,568
1,337,494	**Administrative Expenses**	2,556,851	2,811,102
15,364,852	**TOTAL EXPENSES**	31,721,709	33,977,670
0	**Non-Operating Income**	0	0
(1,438,351)	**NET SURPLUS / (LOSS)**	**(4,149,354)**	**(3,619,338)**
100.7%	**Medical Loss Ratio**	105.8%	

Medi-Cal CMC

Month Actual		Year - to - Date Actual	Budget
	REVENUES		
4,951,302	Capitation Revenue	9,895,055	18,106,096
(282,297)	MC Offset	(564,595)	(1,079,439)
4,669,005	**Total Revenue**	9,330,460	17,026,657
	EXPENSES		
5,588,920	**Total Health Care Costs**	11,305,115	15,565,863
246,262	**Administrative Expenses**	351,927	269,791
0	**MCO Tax**		770,240
194,958	**SB78 Sales Tax**	(187,082)	0
6,030,140	**TOTAL EXPENSES**	11,469,960	16,605,894
0	**Non-Operating Income**	0	0
(1,361,135)	**NET SURPLUS / (LOSS)**	**(2,139,500)**	**420,763**
119.7%	**Medical Loss Ratio**	121.2%	

HEALTHWORX, HEALTHY KIDS, ACE

HealthWorx:

- Ended February with a $(131,673) deficit year to date.
- Statement of Revenue and Expenses on page 19.

Healthy Kids:

- Ended February with a $57,695 surplus year to date.
- Statement of Revenue and Expenses on page 20.

ACE:

- Ended February with a $30,171 surplus year to date.
- Statement of Revenue and Expenses on page 22.

CLAIMS

In the month of February the Health Plan paid a total of 340,981 claims representing $54,109,083 worth of services to our members with 94% of those claims being paid within 30 days.

Health Plan of San Mateo

Fiscal Year 2017

Statistical and Financial Summary
February-17

Month Actual	Month Budget		Month Variance	Operating Margin	Year-to-Date Actual	Year-to-Date Budget		Year-to-Date Variance
63,610,112	71,668,284	▼	($8,058,172)	Total Revenue	126,783,178	143,336,568	▼	($16,553,390)
53,210,380	64,217,005	▼	($11,006,625)	Total Health Care Costs	109,323,838	128,434,009	▼	($19,110,171)
4,056,726	4,361,900	▼	($305,174)	Total Operational Admin Expenses	7,627,800	8,658,217	▼	($1,030,417)
3,276,412	5,066,428	▼	($1,790,016)	Total MCO Tax	7,451,792	10,132,855	▼	($2,681,063)
3,066,594	($1,977,049)	▲	$5,043,643	Total Current Year Surplus (Deficit)	2,379,748	($3,888,513)	▲	$6,268,261
6.4%				Admin Costs as a % of Revenue	6.0%			

Month Current	Month Prior	Month Variance	Membership	Year-to-Date Current MM's	Year-to-Date Budget MM's	Year-to-Date Variance
112,386	112,564	(178)	Medi-Cal	148,203	230,144	(81,941)
0	0	0	CareAdvantage	0	0	0
9,477	9,585	(108)	CareAdvantage CMC	18,741	19,256	(515)
1,648	1,624	24	CCS	3,272	3,300	(28)
1,051	1,049	2	HealthWorx	2,100	2,102	(2)
987	935	52	Healthy Kids	1,922	1,212	710
21,558	21,399	159	ACE	42,957	42,914	43
147,107 *	144,786 *	59	Total*	198,454 *	279,672 *	(81,218)

* Total is minus the CareAdvantage as they are counted under MediCal also

HEALTH PLAN OF SAN MATEO

SCHEDULE OF INVESTMENTS AS OF 02/28/17

MATURITY or DIVIDEND DATE	BALANCE @ 1/1/16	DESCRIPTION SECURITY	CURRENT % RATE YIELD	VALUE AS OF 02/28/17	% VALUE OF TOTAL	INTEREST EARNED YTD 02/28/17	INTEREST EARNED CURRENT MONTH 02/28/17
SHORT-TERM INVESTMENTS							
3/31/2017	$58,951,795	**LAIF California State Fund**	0.753%	$59,051,660	9.49%	$102,290	$34,104
3/31/2017	$98,961,495	**County of San Mateo Pooled Fund**	0.909%	$99,191,162	15.94%	$159,910	$69,140
02/20/18							
02/10/18							
04/23/18	$300,000	**Knox Keene Bank Deposits**	0.157%	$300,000	0.05%	$74	$36
Various	$0	**Gov't Discount Notes***	0.000%	$0	0.00%	$0	$0
TOTAL	$158,213,290	Weighted Average, excluding gov't notes	0.849%	$158,542,822	25.47%	$262,274	$103,280
MONEY MARKET & CASH							
2/28/2017	$40,271,509	**Wells Fargo Institutional Securities**	0.416%	$40,297,866	6.47%	$26,357	$12,853
		All Other Cash Accounts		N/A		$82,623	$41,972
TOTAL					31.95%	$371,254	$158,105

TNE CALCULATION

As of 2/28/2017

Month # ***2***

			YTD As of 2/28/2017
A.	Minimum TNE Requirement	$	1,000,000
B.	Revenue		
	Annualized Premium Revenue:		
	Medicaid		98,221,887
	Medicare		27,658,111
	Total YTD		125,879,998
	Annualized		755,279,990
	@ 2% for the first $150 million		3,000,000
	Plus 1% of annualized premium revenue in excess of $150 million		6,052,800
	Total	$	9,052,800
C.	Healthcare Expenditures		
	Annualized, except capitated or managed hospital basis:		
	Total Medical & Hospital	$	109,323,838
	Less Inpatient Services Per Diem (includes LTC)		(32,780,903)
	Less Primary Prof Svcs - Capitated		(5,734,666)
	Less Write-Ins Other Capitated Med & Hosp Exp		(2,947,718)
	Total YTD		67,860,551
	Annualized		407,163,309
	@ 8% of first $150 million		12,000,000
	Plus 4% of annualized health care expenditures in excess of $150 million		10,286,532
	Total	$	22,286,532
	Plus annualized hospital expenditures, paid on managed hospital payment basis:		
	Inpatient Services Per Diem	$	32,780,903
	Annualized		196,685,416
	@ 4%	$	7,867,417
	Total Healthcare Expenditures	$	30,153,949
Net Equity		$	299,802,216
Required TNE (greater of A, B, or C)		**$**	**30,153,949**
TNE Excess		$	269,648,267
Committed Net Equity			
Stabilization Requirement (Equivalent)		$	136,100,000
Land and Building			47,477,869
Strategic Investment - approved			52,934,269
Strategic Investment - (incurred)			(5,908,725)
Uncommitted Net Equity		**$**	**69,198,803**

Health Plan of San Mateo
Consolidated Balance Sheet
February 28, 2017 and January 31, 2017

	Current Month	Prior Month
ASSETS		
Current Assets		
Cash and Equivalents	$ 461,369,932	$ 446,195,693
Investments	158,242,822	158,242,822
Capitation Receivable from the State	(114,974,034)	(112,614,378)
Other Receivables	(31,045,001)	(11,477,156)
Prepaids and Other Assets	6,788,634	6,939,048
Total Current Assets	480,382,354	487,286,029
Capital Assets, Net	75,553,106	75,836,349
Net Pension Asset	1,376,620	1,376,620
Assets Restricted As To Use	300,000	300,000
Total Assets	557,612,080	564,798,998
Deferred Outflows of Resources	1,082,648	1,082,648
Total Assets & Deferred Outflows	$ 558,694,728	$ 565,881,646
LIABILITIES		
Current Liabilities		
Medical Claims Payable	89,022,741	93,536,167
Provider Incentives	1,067,227	853,932
Amounts Due to the State	113,359,743	113,359,743
Accounts Payable and Accrued Liabilities	54,189,000	60,142,380
Total Current Liabilities	257,638,710	267,892,223
Deferred Inflows of Resources	1,253,802	1,253,802
Total Liabilities & Deferred Inflows	$ 258,892,512	$ 269,146,025
NET POSITION		
Invested in Capital Assets	75,553,106	75,836,349
Restricted By Legislative Authority	300,000	300,000
Unrestricted		
Stabilization Reserve	136,100,000	136,100,000
Unrestricted Retained Earnings	87,849,110	84,499,272
Net Position	299,802,216	296,735,621
Total Liabilities & Net Position	$ 558,694,728	$ 565,881,646
Change in Net Position	$ (17,956,844)	$ (21,023,439)

Health Plan of San Mateo
Consolidated Statement of Revenue & Expense
for the Period Ending February 28, 2017

	Current Month	Year to Date	Annual Budget	Unexpended Budget	% of Budget
OPERATING REVENUES					
Capitation and Premiums					
Medi-cal (includes MCE & Offsets)	$ 41,232,369	$ 82,616,164	$ 528,558,697	$ 445,942,534	15.6%
CareAdvantage	199,147	85,757	-	(85,757)	-
Healthy Kids	180,684	362,753	1,374,414	1,011,661	26.4%
HealthWorx	254,454	508,933	3,058,347	2,549,414	16.6%
CCS Pilot	2,440,915	4,838,983	29,331,522	24,492,539	16.5%
CA Cal MediConnect	13,926,501	27,572,355	182,149,992	154,577,637	15.1%
MC Cal MediConnect	4,951,302	9,895,055	108,636,578	98,741,523	9.1%
Total Operating Revenue	63,185,373	125,879,998	853,109,550	727,229,552	14.8%
OPERATING EXPENSES					
Health Care Expense					
PCP Capitation	2,845,107	5,734,666	41,907,312	36,172,647	13.7%
Hospital Inpatient	21,469,901	44,739,445	263,262,968	218,523,523	17.0%
Pharmacy	11,520,963	23,460,681	159,704,084	136,243,403	14.7%
Medical	15,807,911	31,844,520	204,789,406	172,944,886	15.6%
Long Term Support Services	193,545	395,447	74,533,299	74,137,851	0.5%
Provider Incentives	130,100	260,235	5,146,401	4,886,166	5.1%
Other Medical	(113,682)	240,741	3,320,440	3,079,699	7.3%
UMQA, Delegated and Allocation	1,356,535	2,648,104	17,974,630	15,326,526	14.7%
Total Health Care Expenses	53,210,380	109,323,838	770,638,539	661,314,701	14.2%
Administrative Expense					
Salaries and Benefits	2,605,806	5,210,324	36,285,400	31,075,076	14.4%
Staff Training and Travel	4,776	10,074	333,950	323,876	3.0%
Contract Services	1,684,376	2,477,742	20,419,650	17,941,908	12.1%
Office Supplies and Equipment	356,444	796,808	5,675,870	4,879,062	14.0%
Occupancy and Depreciation	450,955	908,027	5,830,100	4,922,073	15.6%
Postage and Printing	64,329	160,737	1,597,000	1,436,263	10.1%
Other Administrative Expense	84,307	389,479	1,800,780	1,411,301	21.6%
UM/QA Allocation	(1,194,266)	(2,325,391)	(17,974,630)	(15,649,239)	12.9%
Total Admin Expense	4,056,726	7,627,800	53,968,120	46,340,320	14.1%
MCO Tax	3,090,961	7,599,028	60,797,130	53,198,102	12.5%
AB78 Sales Tax	185,451	(147,236)	-	147,236	-
Total Operating Expense	60,543,518	124,403,430	885,403,789	761,000,359	14.1%
Net Income/Loss from Operations	2,641,856	1,476,568	(32,294,239)	(33,770,808)	-4.6%
NON-OPERATING REVENUES					
Interest Income, Net	158,105	371,254	1,000,000	628,746	37.1%
Rental Income, Net	83,058	166,518	986,292	819,774	16.9%
Third Party Administrator Revenue	183,490	365,050	2,188,614	1,823,565	16.7%
Miscellaneous Income	87	358	2,404	2,046	14.9%
Net Non-operating Revenues	424,739	903,179	4,177,310	3,274,130	21.6%
CHANGES IN NET ASSETS	$ 3,066,595	$ 2,379,748	$ (28,116,929)	$ (30,496,677)	-8.5%

Health Plan of San Mateo
HPSM Statement of Revenue & Expense
for the Period Ending February 28, 2017

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
Total Operating Revenue	-	-	-	-	-	-	-
OPERATING EXPENSE							
Total Health Care Expense	-	-	-	-	-	-	-
Total Operating Expense	-	-	-	-	-	-	-
NON-OPERATING REVENUE							
Interest, Net	158,105	83,333	189.7%	371,254	166,667	204,587	222.8%
Rental Income, Net	83,058	82,191	101.1%	166,518	164,382	2,136	101.3%
Miscellaneous Income	60	-	-	60	-	60	-
Total Non-Operating	241,222	165,524	145.7%	537,832	331,049	206,784	162.5%
Net Income/(Loss)	$ 241,222	$ 165,524	145.7%	$ 537,832	$ 331,049	$ 206,784	162.5%

Health Plan of San Mateo
Medi-Cal Statement of Revenue & Expense
for the Period Ending February 28, 2017

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
State Capitation	$ 25,685,325	$ 29,074,057	88.3%	$ 50,734,213	$ 58,148,114	$ (7,413,901)	87.3%
AIDS Capitation	-	-	-	236,622	-	236,622	-
LTC Capitation	-	-	-	25,903	-	25,903	-
BHT Capitation	-	214,158	-	-	428,316	(428,316)	-
HepC Capitation	550,913	745,355	73.9%	1,101,825	1,490,711	(388,886)	73.9%
MC Cap Offset	(1,257,435)	(1,793,614)	70.1%	(2,514,871)	(3,587,228)	1,072,357	70.1%
Total Operating Revenue	24,978,802	28,239,957	88.5%	49,583,692	56,479,913	(6,896,221)	87.8%
OPERATING EXPENSE							
PCP Capitation	1,445,929	1,505,477	96.0%	2,882,945	3,010,953	(128,008)	95.8%
Hospital Inpatient-Per Diem	2,942,974	956,482	307.7%	6,084,449	1,912,964	4,171,485	318.1%
Hospital Inpatient-FFS	579,317	2,869,446	20.2%	1,183,005	5,738,893	(4,555,887)	20.6%
LTC/SNF	5,043,665	5,776,177	87.3%	10,872,713	11,552,354	(679,640)	94.1%
Pharmacy	3,441,029	3,848,715	89.4%	6,930,757	7,697,431	(766,674)	90.0%
Physician Fee for Service	1,834,186	2,247,765	81.6%	3,652,968	4,495,531	(842,563)	81.3%
Hospital Outpatient	1,648,042	1,715,194	96.1%	3,281,250	3,430,388	(149,138)	95.7%
Other Medical Claims	2,055,541	2,204,498	93.2%	4,092,581	4,408,995	(316,415)	92.8%
Long Term Support Services	69,108	3,048,389	2.3%	135,068	6,096,777	(5,961,709)	2.2%
Provider Incentives	42,080	271,014	15.5%	84,202	542,027	(457,826)	15.5%
Health Care Supplmntl Benefits	14,052	-	-	28,564	-	28,564	-
Indirect Health Care Expenses	142,351	100,571	141.5%	292,919	201,141	91,778	145.6%
Total UM/QA	327,461	420,689	77.8%	709,115	841,379	(132,264)	84.3%
Total Health Care Expense	19,585,735	24,964,417	78.5%	40,230,535	49,928,833	(9,698,298)	80.6%
G & A Allocation Expense	1,353,186	1,448,071	93.5%	2,434,975	2,896,141	(461,166)	84.1%
MCO Tax	3,085,058	3,134,320	98.4%	6,090,795	6,268,640	(177,845)	97.2%
AB78 Sales Tax	(14,338)	-	-	8,906	-	8,906	-
Total Operating Expense	24,009,641	29,546,807	81.3%	48,765,212	59,093,614	(10,328,403)	82.5%
NON-OPERATING REVENUE							
Net Income/(Loss)	$ 969,161	$ (1,306,851)	-74.2%	$ 818,481	$ (2,613,701)	$ 3,432,182	-31.3%

Health Plan of San Mateo
Healthy Families Statement of Revenue & Expense
for the Period Ending February 28, 2017

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
Total Operating Revenue	-	-	-	-	-	-	-
OPERATING EXPENSE							
Total Health Care Expense	-	-	-	-	-	-	-
Total Operating Expense	-	-	-	-	-	-	-
NON-OPERATING REVENUE							

Health Plan of San Mateo
HealthWorx Statement of Revenue & Expense
for the Period Ending February 28, 2017

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
HealthWorx Premium	254,454	254,862	99.8%	508,933	509,725	(792)	99.8%
Total Operating Revenue	254,454	254,862	99.8%	508,933	509,725	(792)	99.8%
OPERATING EXPENSE							
Hospital Inpatient-Per Diem	21,667	39,232	55.2%	62,039	78,463	(16,424)	79.1%
Hospital Inpatient-FFS	11,065	9,759	113.4%	34,561	19,518	15,043	177.1%
Pharmacy	98,945	110,636	89.4%	203,945	221,273	(17,328)	92.2%
Physician Fee for Service	63,629	73,568	86.5%	124,712	147,136	(22,424)	84.8%
Hospital Outpatient	58,377	51,769	112.8%	114,418	103,537	10,882	110.5%
Other Medical Claims	16,825	15,694	107.2%	32,977	31,389	1,588	105.1%
Health Care Supplmntl Benefits	187	-	-	377	-	377	-
Indirect Health Care Expenses	1,827	1,440	126.9%	4,194	2,879	1,314	145.7%
Total UM/QA	4,173	8,098	51.5%	10,813	16,197	(5,384)	66.8%
Total Health Care Expense	276,694	310,196	89.2%	588,036	620,391	(32,355)	94.8%
G & A Allocation Expense	22,209	27,875	79.7%	44,703	55,751	(11,048)	80.2%
MCO Tax	(8)	7,883	-0.1%	7,868	15,765	(7,898)	49.9%
Total Operating Expense	298,896	345,954	86.4%	640,606	691,907	(51,300)	92.6%
NON-OPERATING REVENUE							
Net Income/(Loss)	$ (44,442)	$ (91,092)	48.8%	$ (131,673)	$ (182,182)	$ 50,509	72.3%

Health Plan of San Mateo
Healthy Kids Statement of Revenue & Expense
for the Period Ending February 28, 2017

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
Healthy Kids Premium	180,684	114,534	157.8%	362,753	229,069	133,684	158.4%
Total Operating Revenue	180,684	114,534	157.8%	362,753	229,069	133,684	158.4%
OPERATING EXPENSE							
Hospital Inpatient-Per Diem	92,811	48,372	191.9%	111,647	96,744	14,903	115.4%
Hospital Inpatient-FFS	1,440	-	-	1,924	-	1,924	-
Pharmacy	13,951	5,375	259.6%	22,883	10,751	12,133	212.9%
Physician Fee for Service	11,395	14,016	81.3%	29,544	28,032	1,512	105.4%
Hospital Outpatient	13,308	12,880	103.3%	34,502	25,761	8,742	133.9%
Other Medical Claims	8,657	8,497	101.9%	22,444	16,995	5,450	132.1%
Health Care Supplmntl Benefits	23,537	14,456	162.8%	46,198	28,913	17,285	159.8%
Indirect Health Care Expenses	1,681	851	197.4%	3,525	1,703	1,823	207.0%
Total UM/QA	2,545	2,401	106.0%	4,830	4,802	28	100.6%
Total Health Care Expense	169,325	106,850	158.5%	277,498	213,700	63,799	129.9%
G & A Allocation Expense	12,727	8,265	154.0%	21,032	16,529	4,503	127.2%
MCO Tax	(375)	4,545	-8.3%	6,825	9,090	(2,265)	75.1%
Total Operating Expense	181,677	119,659	151.8%	305,355	239,319	66,036	127.6%
NON-OPERATING REVENUE							
Miscellaneous Income	27	200	13.7%	298	401	(103)	74.3%
Total Non-Operating	27	200	13.7%	298	401	(103)	74.3%
Net Income/(Loss)	$ (966)	$ (4,925)	19.6%	$ 57,695	$ (9,849)	$ 67,545	-585.8%

Health Plan of San Mateo
CareAdvantage Statement of Revenue & Expense
for the Period Ending February 28, 2017

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
CareAdvantage Premium	199,147	-	-	85,757	-	85,757	-
Total Operating Revenue	199,147	-	-	85,757	-	85,757	-
OPERATING EXPENSE							
Health Care Supplmntl Benefits	1,195	-	-	2,512	-	2,512	-
Indirect Health Care Expenses	(77,670)	-	-	(89,317)	-	(89,317)	-
Total UM/QA	(1,179)	-	-	(1,427)	-	(1,427)	-
Total Health Care Expense	(77,654)	-	-	(88,232)	-	(88,232)	-
G & A Allocation Expense	10,459	-	-	23,456	-	23,456	-
Total Operating Expense	(67,195)	-	-	(64,776)	-	(64,776)	-
NON-OPERATING REVENUE							
Net Income/(Loss)	$ 266,342	-	-	$ 150,532	-	$ 150,532	-

Health Plan of San Mateo
ACE Statement of Revenue & Expense
for the Period Ending February 28, 2017

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
Total Operating Revenue	-	-	-	-	-	-	-
OPERATING EXPENSE							
Total Health Care Expense	-	-	-	-	-	-	-
G & A Allocation Expense	161,155	173,265	93.0%	334,879	346,531	(11,652)	96.6%
Total Operating Expense	161,155	173,265	93.0%	334,879	346,531	(11,652)	96.6%
NON-OPERATING REVENUE							
Third Party Administror Revenue	183,490	182,385	100.6%	365,050	364,769	281	100.1%
Total Non-Operating	183,490	182,385	100.6%	365,050	364,769	281	100.1%
Net Income/(Loss)	$ 22,335	$ 9,119	244.9%	$ 30,171	$ 18,238	$ 11,932	165.4%

Health Plan of San Mateo
CCS Pilot Statement of Revenue & Expense
for the Period Ending February 28, 2017

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
CCS Capitation	2,440,915	2,444,294	99.9%	4,838,983	4,888,587	(49,604)	99.0%
Total Operating Revenue	2,440,915	2,444,294	99.9%	4,838,983	4,888,587	(49,604)	99.0%
OPERATING EXPENSE							
PCP Capitation	35,262	36,633	96.3%	69,932	73,265	(3,333)	95.5%
Hospital Inpatient-Per Diem	533,486	335,393	159.1%	921,707	670,785	250,922	137.4%
Hospital Inpatient-FFS	118,963	143,740	82.8%	201,702	287,479	(85,778)	70.2%
LTC/SNF	49,440	66,000	74.9%	98,160	132,000	(33,840)	74.4%
Pharmacy	560,086	619,300	90.4%	1,121,990	1,238,600	(116,611)	90.6%
Physician Fee for Service	197,083	255,550	77.1%	405,001	511,101	(106,100)	79.2%
Hospital Outpatient	187,149	205,444	91.1%	384,758	410,888	(26,130)	93.6%
Other Medical Claims	233,425	257,653	90.6%	479,894	515,306	(35,412)	93.1%
Provider Incentives	742	6,536	11.4%	1,471	13,072	(11,601)	11.3%
Health Care Supplmntl Benefits	286	-	-	586	-	586	-
Indirect Health Care Expenses	4,408	2,510	175.6%	8,883	5,020	3,863	177.0%
Total UM/QA	228,095	291,773	78.2%	382,700	583,546	(200,845)	65.6%
Total Health Care Expense	2,148,423	2,220,531	96.8%	4,076,783	4,441,062	(364,280)	91.8%
G & A Allocation Expense	133,058	172,472	77.2%	249,819	344,944	(95,125)	72.4%
MCO Tax	(716)	66,000	-1.1%	64,404	132,000	(67,596)	48.8%
AB78 Sales Tax	(60)	-	-	1	-	1	-
Total Operating Expense	2,280,705	2,459,003	92.8%	4,391,006	4,918,006	(527,000)	89.3%
NON-OPERATING REVENUE							
Net Income/(Loss)	$ 160,210	$ (14,710)	-1089.2%	$ 447,977	$ (29,419)	$ 477,396	-1522.7%

Health Plan of San Mateo
MCE Statement of Revenue & Expense
for the Period Ending February 28, 2017

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
MCE Capitation	17,289,680	16,574,034	104.3%	35,101,796	33,148,067	1,953,729	105.9%
MC Cap Offset	(753,815)	-	-	(1,504,731)	-	(1,504,731)	-
Total Operating Revenue	16,535,865	16,574,034	99.8%	33,597,066	33,148,067	448,999	101.4%
OPERATING EXPENSE							
PCP Capitation	1,363,900	1,575,765	86.6%	2,701,357	3,151,530	(450,173)	85.7%
Hospital Inpatient-Per Diem	2,171,133	743,322	292.1%	4,397,482	1,486,643	2,910,839	295.8%
Hospital Inpatient-FFS	606,740	2,229,965	27.2%	1,284,288	4,459,930	(3,175,642)	28.8%
LTC/SNF	642,135	571,435	112.4%	1,200,039	1,142,871	57,168	105.0%
Pharmacy	3,028,231	3,708,453	81.7%	6,326,891	7,416,905	(1,090,014)	85.3%
Physician Fee for Service	1,097,588	1,357,766	80.8%	2,334,073	2,715,531	(381,459)	86.0%
Hospital Outpatient	983,632	1,069,273	92.0%	2,100,846	2,138,546	(37,700)	98.2%
Other Medical Claims	1,226,848	1,340,867	91.5%	2,620,308	2,681,735	(61,427)	97.7%
Long Term Support Services	8,983	144,838	6.2%	17,946	289,676	(271,730)	6.2%
Provider Incentives	26,317	129,628	20.3%	52,622	259,255	(206,633)	20.3%
Health Care Supplmntl Benefits	6,403	-	-	12,803	-	12,803	-
Indirect Health Care Expenses	62,388	50,087	124.6%	100,620	100,174	445	100.4%
Total UM/QA	267,280	327,398	81.6%	619,972	654,796	(34,824)	94.7%
Total Health Care Expense	11,491,578	13,248,796	86.7%	23,769,245	26,497,592	(2,728,347)	89.7%
G & A Allocation Expense	780,176	1,126,949	69.2%	1,610,158	2,253,898	(643,740)	71.4%
MCO Tax	7,001	1,468,560	0.5%	1,429,136	2,937,120	(1,507,984)	48.7%
AB78 Sales Tax	4,891	-	-	30,939	-	30,939	-
Total Operating Expense	12,283,646	15,844,305	77.5%	26,839,478	31,688,610	(4,849,132)	84.7%
NON-OPERATING REVENUE							
Net Income/(Loss)	$ 4,252,219	$ 729,729	582.7%	$ 6,757,588	$ 1,459,458	$ 5,298,130	463.0%

Health Plan of San Mateo
CA CMC Statement of Revenue & Expense
for the Period Ending February 28, 2017

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
Care Advantage CMC Premium	13,926,501	15,179,166	91.8%	27,572,355	30,358,332	(2,785,977)	90.8%
Total Operating Revenue	13,926,501	15,179,166	91.8%	27,572,355	30,358,332	(2,785,977)	90.8%
OPERATING EXPENSE							
PCP Capitation	-	374,402	-	80,400	748,804	(668,404)	10.7%
Hospital Inpatient-Per Diem	892,344	859,048	103.9%	1,928,551	1,718,095	210,456	112.3%
Hospital Inpatient-FFS	4,014,684	3,809,689	105.4%	8,728,277	7,619,378	1,108,899	114.6%
Pharmacy	4,253,386	4,861,587	87.5%	8,603,194	9,723,174	(1,119,980)	88.5%
Physician Fee for Service	1,297,513	1,517,524	85.5%	2,530,573	3,035,047	(504,474)	83.4%
Hospital Outpatient	1,044,887	1,090,371	95.8%	2,037,870	2,180,742	(142,872)	93.5%
Other Medical Claims	2,397,039	2,534,109	94.6%	4,675,006	5,068,218	(393,212)	92.2%
Provider Incentives	-	21,689	-	-	43,379	(43,379)	-
Health Care Supplmntl Benefits	95,305	91,567	104.1%	166,452	183,134	(16,681)	90.9%
Indirect Health Care Expenses	(389,635)	14,961	-2604.3%	(337,578)	29,923	(367,501)	-1128.2%
Total UM/QA	421,834	408,337	103.3%	752,112	816,674	(64,562)	92.1%
Total Health Care Expense	14,027,358	15,583,284	90.0%	29,164,858	31,166,568	(2,001,710)	93.6%
G & A Allocation Expense	1,337,494	1,405,551	95.2%	2,556,851	2,811,102	(254,251)	91.0%
Total Operating Expense	15,364,852	16,988,835	90.4%	31,721,709	33,977,671	(2,255,961)	93.4%
NON-OPERATING REVENUE							
Net Income/(Loss)	$ (1,438,351)	$ (1,809,669)	79.5%	$ (4,149,355)	$ (3,619,339)	$ (530,016)	114.6%

Health Plan of San Mateo
Medi-Cal CMC Statement of Revenue & Expense
for the Period Ending February 28, 2017

	Current Mo Actual	Current Mo Budget	% of Budget	Y-T-D Actual	Y-T-D Budget	Y-T-D Variance	% of Budget
OPERATING REVENUE							
Medi-Cal CMC Capitation	4,951,302	9,053,048	54.7%	9,895,055	18,106,096	(8,211,041)	54.7%
MC Cap Offset	(282,297)	(539,719)	52.3%	(564,595)	(1,079,439)	514,844	52.3%
Total Operating Revenue	4,669,005	8,513,329	54.8%	9,330,460	17,026,658	(7,696,197)	54.8%
OPERATING EXPENSE							
PCP Capitation	16	-	-	33	-	33	-
Hospital Inpatient-Per Diem	2,155	373	578.4%	3,684	745	2,939	494.4%
Hospital Inpatient-FFS	324,688	206,629	157.1%	524,785	413,259	111,527	127.0%
LTC/SNF	3,421,195	3,273,520	104.5%	7,100,431	6,547,040	553,391	108.5%
Pharmacy	125,336	154,607	81.1%	251,021	309,213	(58,193)	81.2%
Physician Fee for Service	381,470	309,270	123.4%	769,531	618,540	150,991	124.4%
Hospital Outpatient	273,071	217,820	125.4%	550,982	435,640	115,342	126.5%
Other Medical Claims	778,244	566,256	137.4%	1,570,282	1,132,512	437,770	138.7%
Long Term Support Services	115,455	3,015,007	3.8%	242,433	6,030,014	(5,787,581)	4.0%
Provider Incentives	60,961	-	-	121,940	-	121,940	-
Health Care Supplmntl Benefits	3	-	-	3	-	3	-
Indirect Health Care Expenses	-	260	-	-	520	(520)	-
Total UM/QA	106,327	39,189	271.3%	169,989	78,379	91,610	216.9%
Total Health Care Expense	5,588,920	7,782,931	71.8%	11,305,115	15,565,863	(4,260,748)	72.6%
G & A Allocation Expense	246,262	134,895	182.6%	351,927	269,791	82,136	130.4%
MCO Tax	-	385,120	-	-	770,240	(770,240)	-
AB78 Sales Tax	194,958	-	-	(187,082)	-	(187,082)	-
Total Operating Expense	6,030,140	8,302,947	72.6%	11,469,960	16,605,894	(5,135,934)	69.1%
NON-OPERATING REVENUE							
Net Income/(Loss)	$ (1,361,135)	$ 210,382	-647.0%	$ (2,139,499)	$ 420,764	$ (2,560,263)	-508.5%

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

FOR THE CURRENT PERIOD February 28, 2017

	CURRENT MONTH 2/28/2017	CURRENT YEAR YEAR-TO-DATE 2017
CASH FLOW PROVIDED BY OPERATING ACTIVITIES		
Group/Individual Premiums/Capitation	-	-
Title XVIII - Medicare Premiums	13,926,501	27,878,713
Title XIX - Medicaid Premiums	73,293,696	117,485,802
Investment and Other Revenues	(604,792)	(419,750)
Medical and Hospital Expenses	(57,894,717)	(108,376,780)
Administration Expenses	(13,866,599)	(20,330,654)
NET CASH PROVIDED BY OPERATING ACTIVITIES	**14,854,089**	**16,237,331**
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	-	(67,325)
Interest and Other Income Received	320,150	616,037
NET CASH PROVIDED BY INVESTING ACTIVITIES	**320,150**	**548,712**
CASH FLOW PROVIDED BY FINANCING ACTIVITIES:		
Principal payments under capital lease obligations	-	-
NET CASH PROVIDED BY FINANCING ACTIVITIES	**-**	**-**
NET INCREASE (DECREASE) IN CASH	**15,174,240**	**16,786,044**
CASH AND CASH EQUIVALENTS AT THE BEGINNING OF THE MONTH/PRIOR YEAR	**446,195,693**	**444,583,889**
CASH AND CASH EQUIVALENTS AT THE END OF THE MONTH	**461,369,933**	**461,369,933**
RECONCILIATION OF NET OPERATING INCOME TO NET CASH FROM OPERATING ACTIVITIES:		
Operating Income	2,641,855	1,476,568
	-	-
Depreciation and Amortization	283,243	564,776
Decrease (Increase) in Receivables	22,032,089	257,938,278
Decrease (Increase) in Prepaid Expenses	150,414	497,294
Decrease (Increase) in Net Pension Assets	-	-
Decrease (Increase) in Affiliate Receivables	-	-
Increase (Decrease) in Amts due to State of CA	-	(217,475,669)
Increase (Decrease) in Accounts Payable	(5,953,381)	(27,114,175)
Increase (Decrease) in Medical Claims Payable	(4,513,426)	66,513
Increase (Decrease) in Incurred But Not Reported	-	-
Increase (Decrease) in Provider Risk Sharing	213,295	283,745
Increase (Decrease) in Unearned Premium	-	-
Aggregate Write-Ins for Adjustments to Net Income	-	-
TOTAL ADJUSTMENTS	**12,212,234**	**14,760,763**
NET CASH PROVIDED BY OPERATING ACTIVITIES	**14,854,089**	**16,237,331**
DETAILS OF WRITE-INS AGGREGATED FOR ADJUSTMENTS TO NET INCOME		
Unrealized (Gain)/Loss on Equity Securities	-	-
(Gain)/Loss on Sale of Assets	-	-
Prior Period Rent Expense	-	-
Realized (Gain)/Loss on Investment	-	-
TOTALS	**-**	**-**

FINANCE/EXECUTIVE COMMITTEE MEETING
Meeting Summary
February 27 - 12:30 p.m.
Health Plan of San Mateo
801 Gateway Blvd., 1st Floor – Boardroom
South San Francisco, CA 94080

Members Present: Barbara Erbacher, Vincent Mason, M.D., John Ferrelli

Staff Present: Maya Altman, Pat Curran, Chris Baughman, Ian Johansson, Francine Lester, Khoa Nguyen, Rosie Rivera, Ron Robinson, Vicki Simpson, Lia Vedovini, Eben Yong

1.0 Call to Order

Commissioner Erbacher called the meeting to order at 12:32 p.m.

2.0 Public Comment

There was no public comment.

3.0 Approval of Meeting Summary for November 27, 2016

The minutes were approved as presented.

4.0 Preliminary Financial and Operational Report for the Twelve-Month Period Ending December 31, 2016

Ron Robinson reported the Health Plan has risk corridor and retroactive rate changes, going back three years. These losses will be recorded in 2016. As a result, the month of December ended in a deficit of $(57.7) million and YTD consolidated deficit of $(20.3) million.

Membership – Membership has remained relatively stable at about 148,000.

Revenue – The Medi-Cal lines of business continue to provide the largest share of revenue, followed by the CareAdvantage lines of business.

HealthCare Expenses –For the last several months pharmacy has become the highest expense and following by inpatient and long term care.

Administrative Expenses –Administrative expenses as of December are 5.6% of revenue.

Investment and Interest – Total interest earned for December was $120,159 and YTD $1.1million.

Stabilization Reserve and Tangible Net Equity (TNE) – The new reserve policy was approved in November, requiring the Plan to maintain two months operating expenses. The TNE requirement as of December 31, 2016 was $31.5 million; our stabilization reserve was $136.1 million; current net equity is $297.4 million of which $65.5 is uncommitted.

Medi-Cal – had a deficit of $(18.7) million for the month of December, mainly due to the Risk Corridor calculation reserve. YTD there was a deficit of $(3.0) million.

CCS – The month of December ended with a $(206,000) deficit and YTD $4.0 million surplus.

Medi-Cal Expansion (MCE) - ended the month of December with 36,442 members and a deficit of $(183,000) with a year to date of surplus of $19.4 million.

CareAdvantage – ended the month with a surplus of $179,000 and YTD deficit of (1.6) million. The D-SNP ended in 2016.

CareAdvantage Cal Medi-Connect – There were 9,408 members enrolled in the CA-CMC as of December 31, 2016. The program ended the month with a surplus of $8.2 million and YTD it has a deficit of $(9.0) million. This reflects the Part D Reconciliation and the final Risk Adjustment Reconciliation.

HealthWorx – ended the year with a $(697,000) deficit.

Healthy Kids – ended the year with a surplus of $143,000.

ACE – ended the year with a surplus of $22,792.

Claims – For the month of December the Health Plan paid a total of 349,241 claims, representing about $46 million worth of services to our members. 92% of these claims were paid within 30 days.

5.0 Report from Compliance Department

Mr. Johansson, Chief of Compliance, reviewed the results of the Independent Compliance Program Effectiveness (CPE) Audit. The CPE is an annual CMS requirement that measures whether HPSM's Compliance Program is meeting CMS' compliance requirements. It must be conducted by an external auditor. The results of the report are based on 2015 activity, and including the following findings:

Finding	Status
HPSM must improve Compliance Area policies and procedures	In progress.
HPSM must have the Code of Conduct reviewed and approved annually by the Commission.	Completed.
HPSM must improve its onboarding and annual training processes.	Completed.
HPSM must improve its risk assessment and auditing program.	Completed.
HPSM must improve fraud, waste and abuse (FWA) processes.	In progress.
HPSM must improve delegation (FDR) oversight process.	In progress.

The next audit is set for October 2017, the auditors will review all 2016 and the first half of 2017 compliance activities.

The 21st Century Cures Act – This legislation was passed and signed December 2016. It releases funding and authorizes grants to fight the opioid epidemic, fast-track drug approval process with the FDA, allows waiver of requirement for informed consent for testing new devices, funds medical research – including the "Cancer Moonshot" and provides funds for community mental health resources.

Regular Compliance Report -

As part of his regular compliance report, Mr. Johansson discussed three privacy breaches that occurred between August and November 2016.

- (August 2016) CCS staff sent documentation out to the wrong individual. Documentation was recovered and a breach letter mailed to affected member.
- (October 2016) Member ID card sent to the wrong address. ID recovered and breach letter was sent to affected party.
- (November 2016) Fax sent to wrong number. Reported by recipient. Staff error identified as cause. Recipient attested to shredding document and breach letter was sent.

6.0 San Mateo Health Commission Agenda

Ms. Altman reviewed the draft agenda for the March commission meeting.

7.0 Other Business

There was no other business discussed at this time.

8.0 Adjournment

Meeting adjourned at 1:11 p.m

AGENDA ITEM: 4.2

DATE: April 12, 2017

CCS FAMILY SUB-COMMITTEE MEETING
Thursday, December 15, 2016 – 6:00 p.m.
2000 Alameda de las Pulgas
San Mateo, CA 94403

Meeting Summary

Members Present:	Marilyn Wendt, Lianna Chen, Michael Stevens, and Stephanie Gradek.
Members Excused:	Cherisse Lunt, Floridalma Chilel, Alma Rodriguez, Maria Naso-Kerr, Damaris Britton, and Guadalupe Lara.
San Mateo County Members present:	Srija Srinivasan, Anand Chabra, M.D., Glenn Ibarrientos, Mitch Eckstein, Marsha Guevara, and Teresa Jurado.
San Mateo County Members Excused:	None.
HPSM Members Present:	Cynthia Cooper, M.D., Sophie Scheidlinger, and Hanh Pham.
HPSM Members Excused:	Maya Altman, Margaret Beed, M.D.
Guests Present:	Katie Joy Alsup, Kimberly Chu, and Simone Strunin.

1. **Call to Order:** The meeting was called to order at 6:00 p.m. by Teresa Jurado.

2. **Introductions**

3. **Public Comment:** There was no public comment at this time.

4. **Approval of Minutes:** The minutes from September 16, 2016 were approved as presented.

5. **Grievances and Appeals Report**
   Ms. Pham reviewed the Grievance and Appeals report for 2014 through 2016.
   - In 2016, a new reporting system was used which represents a change in the way that Grievances and Appeals are categorized. This report is a manual match.
   - The number of grievances has gone up which may be attributed to billing issues.
   - There has been a shift from appeals to grievances. For example, prescription drugs has grievances but no appeals, which may be an indicator that families are not being denied services related to prescriptions.

   Ms. Pham intends to include at the next meeting the report of a full year's worth of data. The Grievance and Appeals data will then be shared once a year every March.

   Mr. Eckstein commented that at times, CCS staff makes decisions that the family may not agree with but they may not want to complain or file a grievance. It was asked how staff might help those families that may be uncomfortable to report or disagree with the decision. Mr.

Ibarrientos said a member can file a grievance at any time and the only way staff can facilitate an issue is to hear about it. He expressed that he hopes families know that staff really wants to hear about their thoughts and issues, and that families will not be punished in any way for expressing concerns. CCS can only address issues and hopefully rectify the problem if they know about the issues from the family. Mr. Eckstein suggested that the person could initially contact someone else within CCS other than the person that made the decision, such as a social worker or other contacts they have within the agency. The question was asked if the PCPs are aware of the process because a member may comment to them about an issue they are experiencing. Staff present did affirm that the PCPs do contact them from time to time with issues from the members or families.

6. Youth/Young Adult Advisory Committee & Transitions Work

Lianna Chen reported:

- The Age Specific Pamphlets were finalized at the last Youth Advisory meeting
- The letters to accompany these pamphlets were reviewed, and both will be sent out to age appropriate Members.
- The next YAC meeting is scheduled for January 30th for North County and sometime in February in Redwood City.
- A two-sided cover letter was reviewed, and comments were shared about one side for the parent and the other side for the client being potentially ineffective in reaching both. Discussion came down to sending two separate mailings, with the parent version being sent first with a contact form that would allow the separate mailing to the client.

7. Private Duty Nursing

Ms. Pham reported on Private Duty Nursing:

- Staff has been working with providers on how to improve access for patients and HPSM is close to signing a contract to increase access in exchange for higher rates. Two other PDN providers are also considering this arrangement.
- The agreements will include a payment that is withheld unless better access is provided to members, such as providing 80% of the prescribed number of hours and getting them into nursing care in a timely fashion.
- Concern was raised about patients that lose their nursing while hospitalized. Ms. Pham stated this is covered in these service requirements.
- Mr. Ibarrientos reported that staff has begun meeting monthly about PDN clients so they do not fall through the cracks.

8. Incontinence Supplies

Ms. Pham reported on this issue:

- The policy and formulary for incontinence supplies is now finalized so it is much clearer to providers what is and what is not on the formulary. Ms. Pham brought samples for the group to see.

9. **Authorizations**

Ms. Pham reported on authorizations:

- In September 2016, the new prior authorization policy went into effect, and staff notified CCS providers that service code groupings would stop. This did cause a bit of confusion but staff were able to gather and submit codes to ensure they are now included on the PA list.
- Outreach to providers has taken place to inform them about these changes and webinars or workshops were offered. No takers at this point.

10. **Medical Home & Care Coordination (Pediatric Assessment – Care Coordination Timeline)**

Ms. Pham thanked the group for their participation in the one-on-one focus group sessions with Teresa to review the pediatric welcome survey. As much feedback as possible has been incorporated into the document. The nearly final draft was discussed and will be tested now with other families. CCS Staff is conducting phone calls with this survey to collect information and to get comments from families about the survey. They hope to get more feedback over the next two weeks and finalize the survey in January. Thereafter, this survey will be used with every family member beginning March or April. While this will be used for new members/ patients, the intent is to ask some of the questions (highlighted) annually to capture anything that may have changed. Ms. Pham stated that there is also the hope that we would be able to collect data over time to hopefully show that the active care coordination staff provides leads to a decrease in issues that families are having. This tool will allow staff to triage member's medical and psycho-social care coordination needs, and to assign that member to the appropriate staff person as well as balance the work load.

- The suggestion was made to time the survey to verify how long it really takes to complete.
- Another suggestion was to schedule phone appointments.

11. **2017 Meeting Schedule**

Ms. Pham reviewed the schedule for 2017. December meeting was moved to 12/14 (from 12/21). All were in favor of the rest of the dates.

12. **Health Plan of San Mateo CEO Remarks**

Ms. Altman was not present to give a report at this meeting.

Ms. Pham introduced Sophie Scheidlinger, the new Pediatric Health Manager for the health plan who will be working directly with Ms. Pham and will be taking on a lot more of the responsibilities for the CCS Pilot.

13. **Adjournment/Closing Remarks** with no further business at 6:50 p.m.

CCS DEMONSTRATION PROJECT
ADVISORY COMMITTEE
Thursday, December 16, 2016 – 7:00 p.m.
2000 Alameda de las Pulgas
San Mateo, CA 94403

Meeting Summary

Members Present:	Benjamin R. Mandac, M.D., Grace Chen M.D., Sherri Sager, Marilyn Wendt, Lianna Chen, Michelle Blakely, Michael Stevens, Tracey Fecher, Kate Stanford, Alma Rodriguez, and Brooke Heymach.
Members Excused:	Janet Chaikind, M.D.
San Mateo County Members present:	Anand Chabra, M.D., Glenn Ibarrientos, Marsha Guevara, Mitch Eckstein, Teresa Jurado, Katie Joy Alsup, Kim Chu, Simone Strunin and Srija Srinivasan.
San Mateo County Members Excused:	none
HPSM Members Present:	Cynthia Cooper, M.D., Sophie Scheidlinger, and Hanh Pham.
HPSM Members Excused:	Maya Altman and Margaret Beed, M.D.

1. **Call to order** at 7:05 p.m. by Hanh Pham.

2. **Introductions**
   Introductions were made include those joining by phone.

3. **Public Comment** – none.

4. **Approval of September 16, 2016 Minutes**
   The minutes for September 16, 2016 meeting were presented for review.

5. **Grievances and Appeals Report**
   Ms. Hanh reviewed the G&A Report which detailed the activity for 2014 through Q3 2016. In 2016, the G&A Department moved to a new reporting system. This report was a manual mapping from previous years to show the trends over time.

   - There was a major uptick in the number of grievances during the period mostly from billing issues. This would indicate that members are recognizing that they should not be billed and Ms. Hanh considered this information a positive.
   - There were more prescription drug grievances but no prescription drug appeals in 2016 so far. Ms. Hanh pointed out that this indicates that patients are not being denied medications that are necessary.
   - Dr. Chabra added that the report presented is for current CCS clients. There is a separate appeals process for program denials that he reviews for people who are not considered CCS eligible. There were only five cases this year which is a low number.

6. **Family Sub-Committee Report Out**

Ms. Jurado deferred this report as the information discussed at that meeting will also be presented here on this meeting agenda.

7. **Youth/Young Adult Advisory Committee Report Out & Transition Work**

Ms. Chen stated at the last meeting the group was given the age specific booklets that were finalized. Cover letters were developed to accompany these booklets to provide an introduction to the booklets.

The next Youth meetings are planned for January 30th in the North County and sometime in February for the Redwood City. The plan is to have a discussion to get insight and feedback on how clients can take ownership of their health.

8. **Authorizations**

Ms. Pham reported that there have been changes made on the process for authorizations within HPSM:

- September 1st a new prior authorization list was implemented indicating the codes that do or do not require prior authorization.
- The list was expanded to include the CCS population. Previously in CCS, everything required pre-authorization. The new list eliminates the prior authorization for certain codes/services.
- Ms. Pham reviewed the process HPSM implemented to create a list of services that require prior authorization. Dr. Chabra and Dr. Cooper reviewed all relevant codes to identify those which did or did not require prior authorization. Feedback from clinics indicated some confusion. Webinars were conducted to help educate staff and this training was offered to others. Staff continues to refine this list.
- Ms. Hanh explained that they are now on a quarterly update schedule and are working with the Provider Services Department to better communicate any major changes as they occur.
- Dr. Mandac asked where they could get the most up-to-date information or who to contact. Mr. Ibarrientos explained that the website has this most up-to-date information and that he, Sophie Scheidlinger, and Hanh Pham are also available to help with this information.
- Ms. Pham added that the health plan has been working with incontinence vendors on a policy and formulary. This has been finalized and sent to the incontinence vendors and PCPs. This information is also on our website.

9. **Value Based Purchasing (VBP)**

Ms. Pham reported that staff has been working on VBP contracts with the private duty nursing providers. The family sub-committee and other families had expressed difficulty getting private duty nursing. Staff is in the final negotiations with one of the major private duty nursing vendors to provide patients with better access in terms of getting at least 85% of their authorized hours and that they are able to handle 90% of patients referred to them and get them a nurse within a month of the referral. The vendor will receive a higher rate and the plan is to withhold 10-15% as an incentive payment for meeting these quality measures.

HPSM hopes to have the first contract signed by the end of the month and are working with two other vendors for a similar arrangement.

Ms. Sager commented that in the past there was no data to support the issue of needing more private duty nursing access. She hopes that the data can show that paying a higher rate is beneficial and this new approach will result in the data proving the need. Ms. Pham added that they have included a very strong reporting element to the agreements for this purpose and to represent the meeting of the quality measures.

Ms. Pham stated that the CCS leadership team meets monthly to review all the patient cases they are aware of who need private duty nursing to ensure that all the vendors are aware and that the nurses continue to follow up with the family for any changes in their needs. Dr. Chabra stated this is the way staff ensures that people are not overlooked and that they are actually getting the help they need. Ms. Pham added that they are also sending the cases out to every vendor so that everyone is working on the patient at the same time.

Srija Srinivasan asked how many members are in need of this service. Dr. Chabra and Ms. Pham explained there are 8-10 that are currently in need of this service and another 30 who are currently receiving these services. Of those receiving there is still a large gap in the number of hours of service they are receiving.

10. Medical Home & Care Coordination

- Pediatric Assessment
  Ms. Pham brought the groups attention to the welcome survey included in the meeting packet. She explained this is a tool staff would like to use when a patient first comes to the program and every year thereafter. This will assist in identifying needs and proactively addressing them. The CCS staff have begun using it with Members to see how it will work in a live environment with English and Spanish speaking patients. All members of the staff (not just the nurses) are testing this because the ultimate goal is to have a vendor take this over and perform this regularly for the health plan. Once the test is complete, staff will do one more round of revisions and will finalize it in mid-January.

- Care Coordination Timeline
  Ms. Pham reported that at that point in mid-January, HPSM staff will be working on configuring the MedHOK system for care coordination so that this software will be able to handle this survey, organize the needs, and make the appropriate assignments to staff. The goal is to go live with this process in March/April.

- PCP Communication
  Ms. Pham reported that the hope is that in the future staff will be able to send these care plans that are being generated from these surveys to the Primary Care Providers so they can have this conversation with the PCPs in terms of what health plan staff are doing with patients. Staff will be talking to PCPs to get feedback on the type of information and how much information they would like to see and confirm they are getting this information.

11. 2017 Meeting Schedule

Ms. Pham reviewed the 2017 schedule.

12. Health Plan of San Mateo CEO's Remarks

- Ms. Srinivasan commented on behalf of Maya Altman and Dr. Margaret Beed who are both out ill today, to express their appreciation for the group's effort in guiding the work on this committee.

13. Adjournment

The meeting adjourned at 7:45 p.m.

AGENDA ITEM: 4.3

DATE: April 12, 2017

Health Plan of San Mateo
Cal MediConnect Advisory Committee
Meeting Minutes
Friday, January 20, 2017 – 11:30 a.m.
San Mateo Health System
225 37th Avenue, Room 100
San Mateo, CA 94403

Committee Members Present: Danilyn Nguyen, Maureen Dunn, Gay Kaplan, Lisa Mancini, Christina Kahn, Ligia Andrade Zuniga.

Committee Members Absent: Susy Castoria, Sharolyn Kriger, Janet Hogan, Stephen Kaplan, Angie Pratt, Teresa Guingona Ferrer, Diane Prosser, Pete Williams.

Staff Present: Maya Altman, Chris Baughman, Melora Simon, Katie-Elyse Turner, Gabrielle Ault-Riche.

Guests Present: Rachelle Kast.

1. Call to Order

The meeting was called to order at 11:35 a.m. by Maya Altman. Ms. Altman informed the group that Teresa Guingona Ferrer will not be able to continue as chair and asked for a volunteer to serve as chair. Ms. Kaplan volunteered.

2. Public Comment

There was no public comment at this time.

3. Approval of Minutes

The minutes for the November 18, 2016 meeting were approved as presented. **M/S/P.**

4. Ombudsperson Report

Danilyn Nguyen from Legal Aid reported that she participated recently in a statewide Ombudsperson call. The CCI program is currently experiencing few overall problems. Most of the challenges noted related to Medi-Cal renewal issues.

5. Grievance and Appeals Report

Gabrielle Ault-Riche reported that HPSM has hired a new Grievance and Appeals Manager who will attend the next meeting, Tonya Walters. Ms. Ault-Riche reported on the following for Grievances and Appeals received in Q3 of 2016:

- Grievances were up from 83 to 113 for the quarter.
- The distribution of grievance types is similar to prior quarters with 40% in customer service, half of which are related to taxi rides; 22% in billing; 18% in quality; and 14% in access to care.
- Within the sub-categories, half of the the quality of care issues are related to treatment and one quarter were related to interpersonal issues between the provider and

member. Cases of clinical quality of care problems are rare but all potential quality issues are thoroughly investigated.

- Appeal rates are similar to past quarters with half related to medications and around one quarter for durable medical equipment issues.
- Resolutions within 24 hours have declined perhaps due to the increase in the number of grievances and greater complexity of grievances. Of those resolved within 24 hours, the majority were related to prescription drug access.
- The rate of complaints per thousand members for all lines of business increased which correlates with the number of grievances rising.
- Timeliness of complaint resolution data indicates that only 74% of grievances were resolved within the required regulatory timeframe. The CMS mandated percentage is 95% so this is an area of focus. Medical appeals and pharmacy appeals were closer to the 95% rate mandated by CMS at 94.6% and 91.6% respectively. While this is an improvement overall, the goal is to reach 100% for all categories.
- The number of requests for Primary Care Provider changes was relatively low.

6. Updates and Discussion

a. CCI and the Governor's Budget

Ms. Altman provided an update on the Governor's proposed budget, released on January 10, 2017:

- The CCI has been eliminated, which the Governor has the ability to do without legislative consent based on the "poison pill" included in the 2012 authorizing legislation.
- The poison pill language allowed the Governor to make a determination of whether the CCI has achieved cost savings with program elimination automatic if savings are insufficient.
- Savings have not been achieved because the original CCI legislation changed the State/County financial arrangement for IHSS in all 58 counties, not just the seven CCI counties; this arrangement shifted much of the financial liability that had been borne by the counties to the State and established a modest county maintenance of effort requirement.
- The Governor's Budget did acknowledge that the CCI program on its own did show promise and could achieve savings.
- As a result, the budget supported the continuation of Cal MediConnect for two years, with the stipulation that it no longer include IHSS services.
- The budget shifted all the financial responsibility the State had assumed under the CCI legislation back to the counties, a total savings for the State of $626 million per year which now becomes a cost to the counties.
- Besides the very large financial hit to the counties, Ms. Altman said she was concerned about the impact this change will have on the work HPSM and San Mateo County have done to reduce institutional nursing home care and help people at risk of nursing home stays remain in the community. IHSS services are critical for these efforts. The fear is that with such a large IHSS budget cut the County will be under pressure to reduce IHSS services.

- In addition, Ms. Altman said she believed this was a step backward from full integration of long term services and supports through one accountable entity, the health plan.
- There was some discussion about the new legislature's understanding of the program and Ms. Altman concurred that there will be a learning curve for new legislators and staff about the CCI and CMC programs.

b. IHSS Issues

At a previous meeting, Ms. Zuniga had asked to include this subject as a standing agenda item. At this time, with all that has been discussed at this meeting there are many unknown factors. She asked about the worst case scenario. Ms. Mancini noted that nothing is final yet. She then described how demand for IHSS services has increased and how the program has grown to meet that demand. Information about the need for this program is being shared with State decision makers.

Ms. Zuniga asked about the possibility of educating consumers about the new overtime rules and how to ensure providers meet the new requirements. Ms. Mancini responded that training for providers has been the focus; the Public Authority has tried to do some training for recipients as well, but it is difficult for consumers to get to trainings. Ms. Mancini said she would look into this further with her staff, possibly some materials could be developed. Ms. Zuniga also mentioned the need for information on how to go through a grievance process and empowerment on how to handle issues and manage their care. Ms. Kaplan stated this may be more feasible in small groups rather than on an individual basis. Another idea was to have parallel training, providers in one room and recipients in another.

A question was asked about recruitment of providers. Ms. Mancini stated that there is a registry within the Public Authority, with active efforts to recruit providers to join the registry.

c. CAHPS Data

Ms. Simon reported on the CAHPS Survey which is a national customer satisfaction survey administered to all Medicare beneficiaries enrolled in managed care plans. She reviewed the data in her presentation which was included in the meeting packet. The data compares HPSM's CMC program to other duals demonstration programs in California and nationally.

- 92% of members rated the health plan as a whole above seven in a ten point scale giving HPSM the third highest score in the nation (Bronze Medal).
- The results indicate an improvement of about 6% in the last year.
- Our members feel that their doctors communicate well with them.
- Members feel that their doctors provide high-quality care.
- Performance in customer service significantly improved over the last year.
- Members experienced fewer problems receiving their prescribed medications in 2016 but there is still room to improve.
- Members feel their doctors provide care coordination;
- Members feel they can get the care that they need; and

- An area needing improvement was quick access to care. This last year resulted in a decreased score for this measure.

Ms. Simon stated that the sample is about 260 people and it is hard to know if the percentages are statistically significant or not. However, the fact that 25% of those members surveyed feel that they cannot get care quickly will be something staff will work to improve.

There are two specific initiatives to work on access: the Clinical Partnership which is a collaborative working with a number of FQHCs, County providers and high-volume PCPs to enhance capacity/access/quality outcomes; and Member Access initiatives where if the providers come to us with ideas funding will be provided to help them to improve access and expand their panels for our members.

There was a question about how the survey was conducted. Ms. Turner responded that it is mailed and only translated into Spanish. Ms. Altman added that this has been a point of contention because HPSM and many other health plans have non-English speakers in many other languages besides Spanish.

d. Other State/CMS Updates

Ms. Altman reported that in December HPSM closed down its D-SNP, the dual eligible special needs plan that pre-dated CMC. The people that were left after the transition to CMC were those who were not eligible. We are now reapplying because of all the uncertainty surrounding CMC. Although the Governor supports its continuation, legislation is needed for the program to continue.

7. Adjournment

The meeting adjourned at 1:02 p.m.

Next meeting: March 17, 2017 at 11:30 a.m.
HPSM, 801 Gateway Blvd., Boardroom, South San Francisco

Respectfully submitted:

C. Burgess

C. Burgess
Clerk of the Commission

DRAFT

HEALTH PLAN OF SAN MATEO
CONSUMER ADVISORY COMMITTEE MEETING
Meeting Minutes
Thursday, March 2, 2017 – 12:00 p.m.
801 Gateway Blvd., 1st Floor Boardroom
South San Francisco, CA 94080

AGENDA ITEM: 4.4

DATE: April 12, 2017

Members Present: Barbara Erbacher, Judy Garcia, Ricky Kot, Vincent Merola, Danilyn Nguyen, Nicole Pollack,

Staff Present: Maya Altman, Gabrielle Ault-Riche, Charlene Bariero, Margaret Beed, M.D., Rhonda Bibbins, Nicole Ford, Karen Licavoli, David Ries, Rosie Rivera, Jose Santiago, Carolyn Thon, Tonya Walters

1.0 Call to Order

Ms. Nguyen called the meeting to order at 12:06 p.m.

2.0 Public Comment

There was no public comment.

3.0 Approval of Agenda

The Consumer Advisory Committee agenda was approved as presented.

4.0 Approval of Meeting Minutes for December 29, 2016

The minutes of the December 29, 2016 were approved as presented.

5.0 HPSM Operational Reports and Updates

5.1 CEO Update

Ms. Altman gave an update to the group:

- Health Plan received an Innovation Award from the Department of Health Care Services for work on Community Care Setting Pilot (CCSP).
- The Health Plan is monitoring the possibility of an ACA repeal, very closely.
- The County of San Mateo has written a letter in support of ACA that is going out to California representatives.

5.2 Medical Director

Dr. Beed reported:

- The HomeAdvantage program that went live in October of 2016, now has about 200 members enrolled in the program. The members are selected based on risk. Members who have 5 or more complex conditions and who pose the highest health risk, are prioritized. There is a pool of 2,500 potential members. The network consists of social workers, case workers and doctors who are working together to address members' issues.

- Ms. Pollack asked whether HomeAdvantage interferes or conflicts with Whole Person Care (WPC). Ms. Altman clarified that the distinction lies in member eligibility. Those who are eligible for WPC are mostly Medi-Cal members, not necessarily duals. Where HomeAdvantage is exclusively for duals.
- Ms. Nguyen asked if people could be served by multiple programs. Dr. Beed informed the group that it is possible for one person to be eligible and served by multiple programs, but they would not receive the same service from multiple programs. This is the type of overlap the Health Plan and partner agencies are attempting to avoid.

5.3 Member Services

Mr. Santiago verbally reviewed the written Members Services/CareAdvantage report and reported on the following:

- Enrollment is over 148,000 members, Medi-Cal enrollments continue to increase due to Medi-Cal expansion.
- Magellan Health will administer the Behavioral Health Therapy services.
- HPSM's Landmark program has been renamed HomeAdvantage.
- In October of 2016, HPSM mailed closure letters to 621 DSNP members.

5.4 Health Education Update

Ms. Licavoli provided an update on the Health Education, Diabetes/Weight Watcher's program. After a needs assessment survey identified that members wanted more information on weight management and healthy eating, the health education department bolstered the diabetes management classes and partnered with Weight Watcher's to give members options for weight management and nutrition.

Ms. Licavoli visited the sites that conduct the diabetes/weight management classes. The sites visited were: Fair Oaks, Seton, Mills-Peninsula and San Mateo Medical Center. Two of the sites offer classes in Spanish. The classes are mostly lecture but there are interactive activities, for example the trainer brings in samples of food portions. They also illustrate what grams of sugar look like, so that members are more aware of how much sugar is in the different foods they eat. On the member assessment forms, they enjoy this portion of the class.

There is also a Weight Watchers (WW) program, where HPSM provides 5 vouchers to eligible members to attend a WW class near them. To be eligible for the program, members must be over 18, with a BMI over 25, and be ready for the program. After attending 5 classes, members can send in proof of attendance and receive another 5 vouchers, for up to a total of 20 vouchers. The one drawback to the WW's program is that it does not provide classes in Spanish and this might dissuade some Spanish speaking members.

The program objective is to help members manage weight by learning healthy eating habits, portion control, and providing a support group. A measurement of success is whether the member can lose 5% of their weight during the program. For members who participated in the program, they lost the 5% and/or said they learned from the program.

There seems to be high interest but low participation. HPSM is launching a new incentive program to address this. For members who participate and meet the weight loss goal, they will receive a Target gift card. HPSM will target members who received referrals or called in about the program but never enrolled in the program. The results of the campaign will be shared at a future meeting.

6.0 Adjournment

The meeting was adjourned at approximately 1:00 pm.

Next meeting is in June 2017

AGENDA ITEM: 4.5

DATE: April 12, 2017

MEMORANDUM

DATE: March 31, 2017

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: Agreement with County of San Mateo dba San Mateo County Health System for Intergovernmental Transfer (IGT) Funding for State FY 2015-16 and FY 2016-17.

Recommendation

Ratify an agreement with San Mateo County Health System to provide additional funding related to IGTs for State Fiscal Years 2015-16 and 16-17.

Background and Discussion

Federal Medicaid law allows local public entities such as counties to transfer permissible public funds to the State Medicaid agency (the Department of Health Care Services) to be used as the nonfederal share of Medicaid expenditures, which are then eligible for federal matching funds. San Mateo County has used this mechanism to increase funding for San Mateo Medical Center (SMMC) and the San Mateo County Health System for many years. County funds transferred to the State have funded the nonfederal share of Medi-Cal managed care capitation payment increases paid by the State to HPSM. The federal Medicaid program matches these funds and the entire amount is paid to HPSM through increased Med-Cal capitation. HPSM has then paid the entire amount to SMMC or the Health System through quarterly supplemental payments.

Since 2005, when San Mateo County and HPSM began implementing IGTs, the Commission has approved agreements with San Mateo Medical Center (SMMC) or the Health System to allow increased reimbursement to the hospital and the Health System. For 2005-06 and 2006-07, the total amount paid to SMMC through this mechanism was $8 million per year, based on an IGT transfer amount of $4 million. For 2007-08, HPSM and the County requested and the State approved an IGT transfer of $5 million from the County, with a resulting $10 million increase to HPSM to be paid to SMMC. For 2008-09, HPSM and the County requested and the State approved an IGT transfer from the County with a resulting $18 million increase to HPSM to be paid to SMMC. In 2009, the IGT was again increased for a total of $28 million to be paid to SMMC. The additional $10 million was to cover a Long Term Care supplemental payment SMMC had historically received; this supplemental payment was eliminated when HPSM assumed payment responsibility for institutional Long Term Care and the IGT was

intended to replace it and hold SMMC financially harmless. In 2014-15, HPSM began paying all the IGT funding to the Health System.

Since these rates are included in our base rates and therefore must be actuarially sound and approved by CMS, DHCS and Mercer, the State's contracted actuarial firm, have worked with SMMC financial staff to reconcile uncompensated Medi-Cal costs to the amount of the base rate IGT for the last two State fiscal years. The total amount of the base rate IGT is still being finalized. This agreement provides for the payment to the County Health System of the total amount of the increased capitation due to the base rate IGT, minus the Managed Care Sales Tax, to be paid within 30 days of receipt by HPSM. In return, the County Health System agrees to remain a participating provider in the Plan, maintain current emergency room licensure status, maintain current surgery suites and maintain the provision of mental health and substance use services and community-based services.

DHCS recently and suddenly required HPSM and the San Mateo County Health System to submit an executed agreement covering FY 2015-16 and FY 2016-17 immediately, leaving no time for Commission approval prior to submission. Therefore we are requesting ratification of the agreement.

Fiscal Impact

Since this is a pass through arrangement, there is no fiscal impact to HPSM. The term of the agreement is July 1, 2015 through September 30, 2019.

DRAFT

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

IN THE MATTER TO RATIFY AGREEMENTS WITH SAN MATEO COUNTY HEALTH SYSTEM RELATED TO INTERGOVERNMENTAL TRANSFER FUNDING FOR 2015-16 and FY 2016-17

RESOLUTION 2017 -

RECITAL: WHEREAS,

1. Since 2005, the San Mateo Health Commission has approved participation in Intergovernmental Transfer (IGT) Funding with the federal government of matching funds paid to HPSM in order to increase payment to the San Mateo Medical Center (SMMC);

2. In 2009 the supplemental payment for Long Term Care was eliminated and HPSM assumed payment responsibility for these services with the intent that the IGT would replace it and hold SMMC financially harmless,;

3. In 2014-15, the total IGT began to be paid to the San Mateo County Health System. In return for this payment, the San Mateo County Health System agrees to remain a participating provider in the Plan, maintain current emergency room licensure status, current surgery suites, maintain the provision of mental health and substance use services; and, community-based services; and

4. Because DHCS suddenly and immediately required HPSM and the San Mateo County Health System to submit an executed agreement covering FY 2015-16 and FY 2016-17, staff requests the ratification of the signing of this agreement.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission ratifies the signing of the IGT Agreement with the San Mateo County Health System for State Fiscal Years 2015-16 and FY 2016-17 as outlined in the attached memorandum.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of April, 2017 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
John Ferrelli, Vice Chair

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

AGENDA ITEM: 4.6

DATE: April 12, 2017

MEMORANDUM

DATE: March 31, 2017

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer
Ron Robinson, Chief Financial Officer

RE: Approve an Amendment to the Agreement with Lussier Data Architects, Inc. (LDA)

Recommendation

Approve an amendment to the agreement with Lussier Data Architects, Inc. (LDA) to extend the agreement through December 31, 2018 for a total amount not to exceed of $854,000 for the thirty-four month long term; and authorize the Chief Executive Officer to execute said amendment.

Background and Discussion

LDA has provided software development and reporting services to HPSM since March 2006, and is the developer of HPSM's claims data warehouse (Claims Statistics Database), the main reporting, workflow and auditing tool for the claims management system. The Claims Statistics Database is an important tool for managing claims related data and reporting to external agencies. Claim Statistics Database integrates additional critical data sources including the document imaging system, the off-site claims processing service, the legacy customer service system, the new care management and grievance and appeals system, and the Medicare carrier file for other healthcare coverage. The Database has been custom designed to address HPSM's specific needs and allows staff to create ad-hoc workflows and reports that contribute to increased productivity.

In recent years, LDA has also created two other critical tools, Letter Generator which is responsible for the production, storage and maintenance of the majority of Health Services and Claims letters sent to both members and providers; and Authorizations Statistics Database, HPSM's authorization data warehouse, which has become the fundamental tool for managing authorizations, utilization workflow, and reporting for Health Services.

The Commission most recently approved an amended agreement with LDA in November 2016 for a two-year term and a total amount of $594,000. The agreement covers additional software development and maintenance to support HPSM in meeting its regulatory obligations as well as the creation of several tools to help increase day to day operational productivity. These projects include multiple initiatives in Claims, Finance, Provider Services, Health Services, and IT.

Two additional projects were added in 2016, Vendor Contract Management Database and HPSM Intranet infrastructure upgrade and redesign. As of the date of this memo, the HPSM Intranet infrastructure upgrade has been completed. The Vendor Contract Management Database is in beta phase and should be rolled out to all staff in April 2017. The first phase of the HPSM Intranet Redesign will be rolled out early in the first quarter of 2018 with additional phases to follow shortly thereafter. This contract extension allows for continued development of these projects as well as to bring the agreement terms in line with HPSM's fiscal calendar.

Fiscal Impact

The term of this agreement will change to March 1, 2016 through December 31, 2018, with a new not to exceed amount of $854,000. The original contract term was March 1, 2016 through February 28, 2017. This agreement adds $260,000 to the original contract maximum of $594,000 to cover services during the extended term.

DRAFT

RESOLUTION OF THE

SAN MATEO HEALTH COMMISSION and
THE SAN MATEO COMMUNITY HEALTH AUTHORITY

IN THE MATTER OF APPROVING AN AMENDMENT
TO THE AGREEMENT WITH
LUSSIER DATA ARCHITECTS, INC. (LDA)

RESOLUTION 2017 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission has previously approved an Agreement with LDA; and

B. Ongoing support and development services are needed to for an extended term that will align with HPSM's fiscal year.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission approves the Amendment to the current Agreement with LDA;

2. Authorizes the Chief Executive Officer to execute an Amendment to the Agreement with Lussier Data Architects, Inc. to increase the not to exceed amount to $854,000 and extend the term through December 31, 2018.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of April, 2017 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
John Ferrelli, Vice Chair

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

DRAFT

SAN MATEO HEALTH COMMISSION and
SAN MATEO COMMUNITY HEALTH AUTHORITY
Meeting Minutes
March 8, 2017 – 12:30 p.m.
Health Plan of San Mateo - Boardroom
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

AGENDA ITEM: 4.7

DATE: April 12, 2017

Commissioners Present:	Jeanette Aviles, M.D. David J. Canepa Barbara Erbacher, Chair John Ferrelli Teresa Guingona Ferrer	Don Horsley Vincent Mason, M.D. George Pon, R.Ph. Ligia Andrade Zuniga
Commissioners Absent:	Peggy Jensen	
Counsel:	Kristina Paszek	
Staff Present:	Maya Altman, Gabrielle Ault-Riche, Chris Baughman, Margaret Beed, M.D., Corinne Burgess, Pat Curran, Ian Johansson, Khoa Nguyen, Francine Lester, David Reis, Ron Robinson, Melora Simon, Vicki Simpson, and Katie-Elyse Turner	

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

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

3. **Approval of the Agenda**
   The agenda was approved as presented. **M/S/P.**

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

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

   5.1 Discussion/Action on Approval of Agreement with Seton Medical Center and Strategic Investment for Skilled Nursing Facility Capacity.

   County Counsel, Kristina Paszek announced that Commissioner Ferrelli is recusing himself from the discussion and exiting the room based on his affiliation with one of the parties involved in the proposed agreement. Commissioner Ferrelli exited the room at 12:34 pm.

   Ms. Altman explained the recommendation is to approve a one-time investment in Seton Medical Center not to exceed $611,000 for expansion of its Skilled Nursing Facility capacity. She explained that there has been a 25% loss of nursing home beds in this community over the past several years and no new operators are coming into the county due to high land, building, and operating costs. Health plan staff is having an increasingly difficult time finding

long term care placement for its Medicaid patients, particularly for those individuals who are homeless or who have behavioral issues. This is a growing issue in our neighboring counties, Santa Clara and San Francisco, as well. HPSM often has to place patients outside of the county, sometimes far from their families.

HPSM has responded to these issues with several strategies. The Duals Demonstration gives HPSM the flexibility to pay for alternatives to nursing home care such as we're doing through the Community Care Settings Pilot and the Landmark program (Home Advantage). But HPSM also needs to work on increasing nursing facility capacity for members whenever possible. The situation will only get worse with an aging population.

In its Strategic Plan, HPSM has committed to consideration of strategic investments to further HPSM goals. This proposed investment would come from uncommitted reserves with the goal of increasing access, quality and improved service delivery for our members. In the past 15 months, the Commission has approved similar strategic investments. Ms. Altman reviewed a chart showing the plan's reserves, the State required reserve level (Tangible Net Equity), the stabilization reserve level established by the Commission last fall, and committed and uncommitted reserve funding.

This investment involves an agreement that has been developed in concept with Seton Medical Center leadership. The investment will be structured as a forgivable loan based on meeting quality outcomes over a three year period, a structure similar to the recently approved County agreement with Seton Medical Center. Seton commits to increase skilled nursing facility capacity by 39 beds, timely access for HPSM members to those beds, and other quality metrics which are still being finalized (including reduction of avoidable readmissions, emergency department visits, falls, and infections). This agreement will be reviewed by County Counsel prior to execution.

Commissioner Horsley asked if funds would be used for renovation of the hospital. Ms. Altman stated that seismic upgrades may occur as a result of this funding. Mr. Curran added that the agreement is focused on delivery of results. There is flexibility in how funds may be used to accomplish those outcomes.

Commissioner Aviles concurred with the need for additional long term care beds. She wondered if the problem had more to do with costs or the lack of a labor force able to live in the Bay Area. Ms. Altman answered that both issues contribute to the problem. Commissioner Aviles also noted that 39 additional beds was only a small addition considering the scope of the problem. Ms. Altman agreed but argued that HPSM needs to seize opportunities to improve the situation whenever it can.

Commissioner Canepa thanked staff for this proposal and said this is a sound investment. He asked if there would be an increase in staffing and employment opportunities at Seton. Ms. Altman responded that these 39 beds have been in suspension for a number of years and she assumes there would have to be some addition in staff.

Commissioner Horsley moved approval of the agreement with Seton Medical Center for the development of additional skilled nursing facility capacity for an amount not to exceed $611,000. Commissioner Aviles seconded the motion. **M/S/P.**

[Commissioner Ferrelli returned to the meeting at this time]

6. **Report from Chairman/Executive Committee**
Commissioner Erbacher had nothing additional to report. Commissioner Horsley noted that it is International Women's Day.

7. **Report from Chief Executive Officer**
Ms. Altman reported that HPSM recently received a letter of termination and notice of intent to renegotiate terms from Sutter Health. The deadline for termination is July 31, 2017, with 150 days to reach agreement. Ms. Altman stated that in the past year we have now received two hospital termination letters, which we have never received at any time prior in her tenure at HPSM. This is another indication of changes in marketplace dynamics, with local hospital leadership shifting more and more to corporate entities for decision making about contracts. The termination includes Mills-Peninsula and PAMF Medical Foundation and CPMC and St. Luke's in San Francisco.

Ms. Altman provided an update on the attempt to repeal the Affordable Care Act. The House Republican leadership on Monday released a bill to repeal and replace the ACA, called the American Health Care Act (AHCA). This bill is being reviewed by the House Energy and Commerce Committee today. Anna Eshoo, one of San Mateo County's Congressional Representatives and a member of that Committee, is fighting hard against the bill, noting that among other things it has yet to be scored by the Congressional Budget Office. So we do not yet know how much the bill is going to cost or how many people would be covered under this proposal. The American Hospital Association, the American Medical Association, and AARP have all announced opposition to the AHCA, and it appears the sponsors are trying to move this bill very quickly through the committees and through Congress.

While we are still reviewing the bill, notable provisions include:

- Significant changes proposed for the Medicaid Expansion, which would stay in place until 2020. However, no new people could enroll beginning in 2020 and anyone who loses Medicaid eligibility for more than 30 days could not re-enroll. Considering the eligibility churn in Medicaid, this would reduce the expansion population markedly.
- Redetermination for Medicaid would be required every six months rather than annually, leading to additional losses in Medicaid eligibility among the Medicaid expansion population.
- HPSM has added 36,000 new enrollees through expansion; many of these members would eventually lose their insurance coverage under this bill.
- The biggest threat is the change in Medicaid financing; instead of the current open-ended entitlement, states would receive capped payments based on their number of Medicaid enrollees. This change would be very costly for California's Medicaid program.
- There are a number of changes to the individual marketplace that would impact Covered California and coverage in San Mateo County, including elimination of the individual

mandate or penalty for not getting insurance and the replacement of ACA income-based subsidies with age-based tax credits. Most affected will be older people who live in high cost areas like the Bay Area.

HPSM staff is working with its national and state associations, which have hired lobbyists with Republican connections, to attain the best possible leverage. Finally, the ACA has made substantial contributions to the California economy; in the public plans alone, billions have been paid out to doctors and hospitals as a result of the ACA.

Ms. Altman reported that there is nothing new related to the State budget since her written report. Counties are fighting the State shift of more IHSS financing to the counties. Budget hearings have begun but the IHSS issue is still in play.

Ms. Altman concluded her report with good news. The Health Plan of San Mateo received the 2016 Innovation Award from the Department of Health Care Services for the Plan's Community Care Settings Pilot.

8. Closed Session

Commissioner Erbacher announced that the Commission would move into a closed session to discuss the following topics.

8.1 CONFERENCE WITH LEGAL COUNSEL--ANTICIPATED LITIGATION. Significant exposure to litigation pursuant to Government Code Section 54956.9(d)(2) (1 case).

8.2 PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

The Commission moved to closed session at 12:52 p.m.

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

The Commission reconvened in open session at 1:40 p.m. Commissioner Erbacher reported that during closed session the Commission gave direction to counsel regarding anticipated litigation.

Commissioner Erbacher reported that the Commission reviewed and discussed the performance evaluation of the Chief Executive Officer.

10. Action on 2017 Compensation and Performance Goals for Chief Executive Officer

Commissioner Horsley moved approval of a 10% increase in the base compensation for the Chief Executive Officer, retroactive to January 1, 2017, and the retention of the current car allowance at $12,000 per year. In addition, the Commission will form a sub-committee to determine specific goals for the Chief Executive Officer related to a bonus payment; she will be paid up to 6% of the base salary upon the achievement of those goals. Commissioner Ferrelli seconded this motion. **M/S/P.**

11. Other Business

There was no other business at this time.

12. Adjournment

Commissioner Erbacher adjourned the meeting at 1:45 p.m.

Respectfully submitted:

C. Burgess

C. Burgess
Clerk of the Commission

AGENDA ITEM: 5.1

DATE: April 12, 2017

MEMORANDUM

DATE: April 5, 2017

TO: San Mateo Health Commission

FROM: Ron Robinson, Director of Finance
THROUGH: Maya Altman, Chief Executive Officer

RE: Audited Financial Statements for the Twelve-Month Period Ending December 31, 2016

Attached is the Draft Communication with Those Charged with Governance, Communication of Internal Control Related Matters and the Independent Auditor's Report and Financial Statements for December 31, 2015 and 2016. Representatives from Moss-Adams, LLP will attend and give a brief presentation.

These are for your review and approval.

RESOLUTION OF THE

SAN MATEO HEALTH COMMISSION and
THE SAN MATEO COMMUNITY HEALTH AUTHORITY

IN THE MATTER OF ACCEPTANCE OF THE
AUDIT REPORT FOR FISCAL YEAR ENDING DECEMBER 31, 2016

RESOLUTION 2017 -

RECITAL: WHEREAS,

A. Moss-Adams, LLP, a firm of accountants has conducted an audit of the San Mateo Health Commission financial statements for the fiscal year ending December 31, 2016; and

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

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission formally accepts the audit report for the fiscal year ended December 31, 2016 as presented by Moss-Adams, LLP.

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of April, 2017 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
John Ferrelli, Vice Chair

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

San Mateo Health Commission
and San Mateo Community Health Authority
(d.b.a. Health Plan of San Mateo)

Report of Independent Auditors

Chris Pritchard
Health Care Services Partner

Rianne Suico
Health Care Services Senior Manager

MOSS-ADAMS LLP
Certified Public Accountants | Business Consultants

AUDIT OBJECTIVES

- Opinion on whether the combined financial statements of Health Plan of San Mateo are *reasonably* stated and free of material misstatement in accordance with generally accepted accounting principles
- Consideration of internal controls
- Audit required by regulators

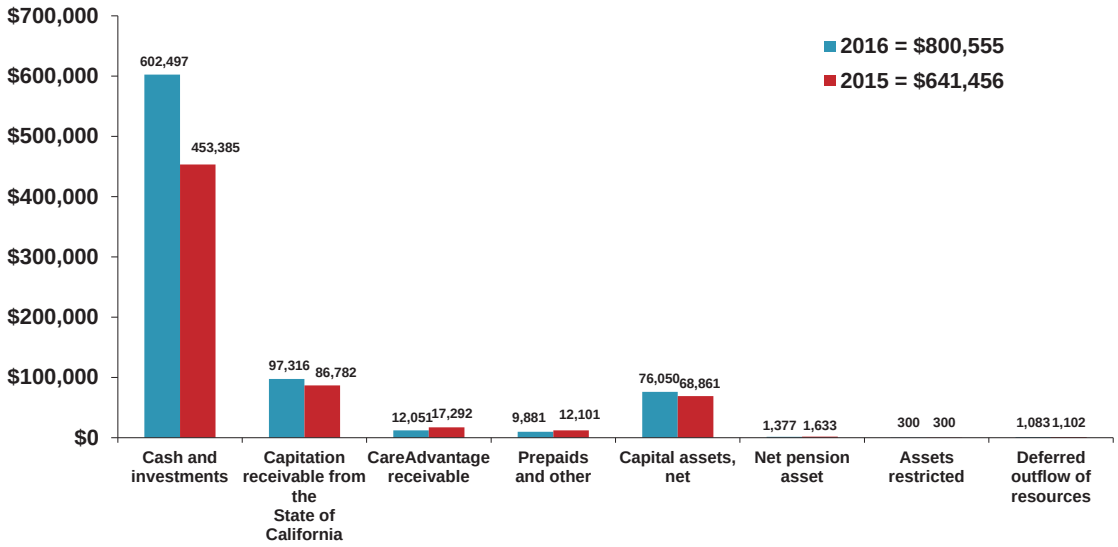
UNMODIFIED OPINION

Combined financial statements are fairly presented in accordance with generally accepted accounting principles.

COMBINED STATEMENTS OF NET POSITION

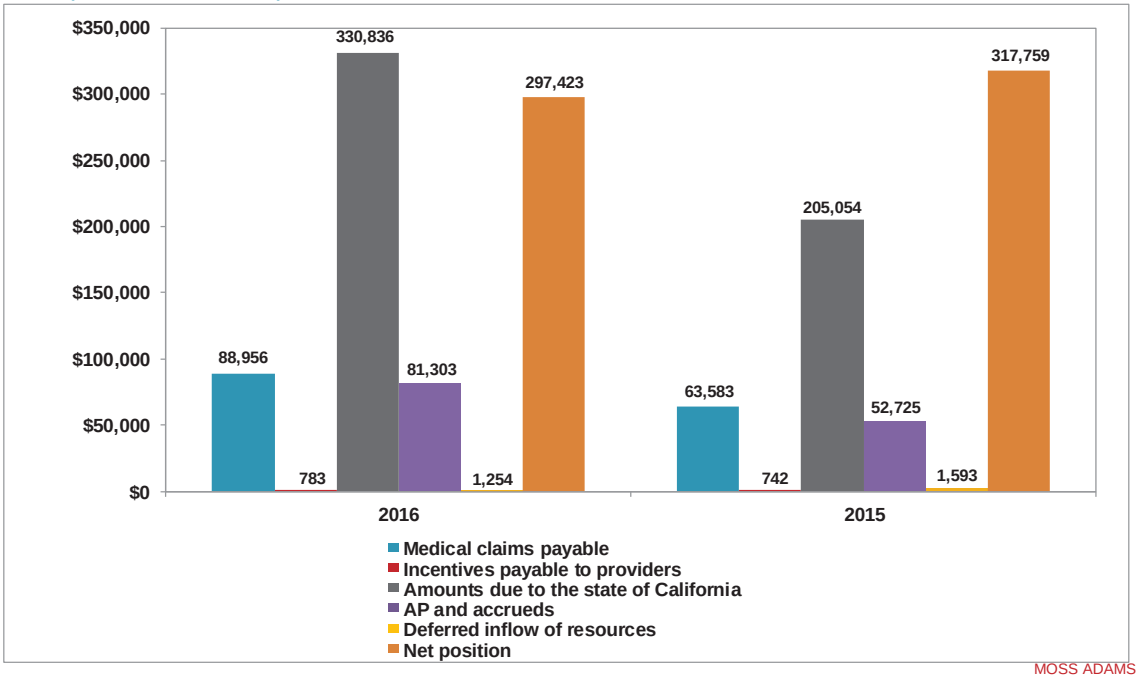
ASSET AND DEFERRED OUTFLOW OF RESOURCES COMPOSITION

(IN THOUSANDS)



LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION BALANCE

(IN THOUSANDS)

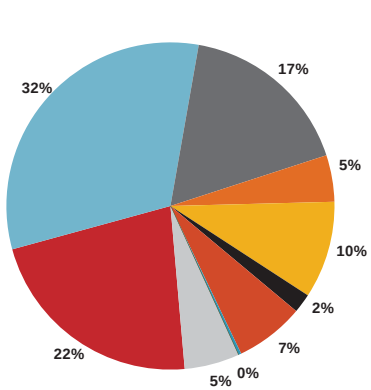


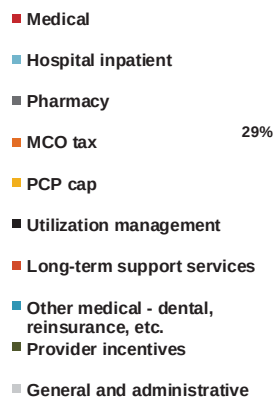
OPERATIONS

INCOME STATEMENTS
(IN MILLIONS)

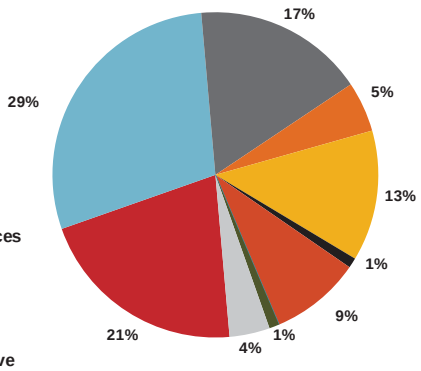
Total Operating Expenses

December 31, 2016
$ 816.4





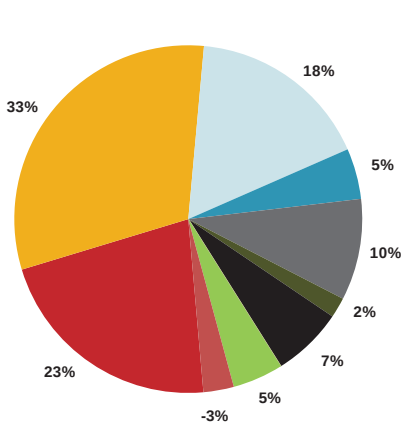
December 31, 2015
$ 810.8

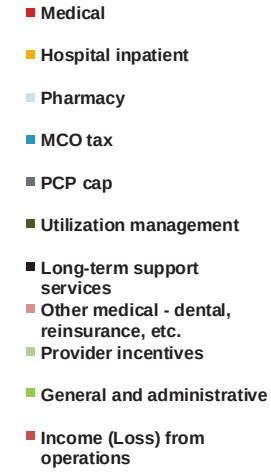


INCOME STATEMENTS (CONTINUED)
(IN MILLIONS)

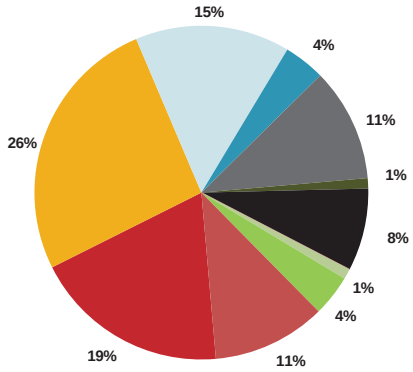
Total Operating Expenses as a % of Total Operating Revenues

December 31, 2016
$ 792.3

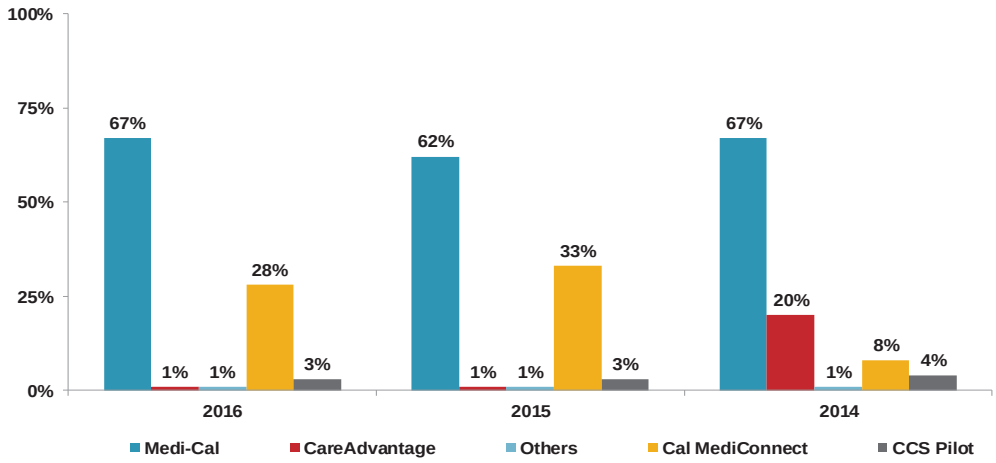




December 31, 2015
$911.0



REVENUE TREND



IMPORTANT BOARD COMMUNICATIONS

- Significant accounting policies – AU-C 260 (AU 380)
- Accounting estimates are reasonable
- No audit adjustments
- No issues discussed prior to our retention as auditors
- No disagreements with management

QUESTIONS

Communications with
Those Charged with Governance

San Mateo Health Commission and San Mateo Community Health Authority (d.b.a. Health Plan of San Mateo)

December 31, 2016

COMMUNICATIONS WITH THOSE CHARGED WITH GOVERNANCE

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

We have audited the combined financial statements of San Mateo Health Commission and San Mateo Community Health Authority (d.b.a. Health Plan of San Mateo) ("HPSM") as of and for the year ended December 31, 2016, and have issued our report thereon dated _____, 2017. Professional standards require that we advise you of the following matters relating to our audit.

OUR RESPONSIBILITY UNDER AUDITING STANDARDS GENERALLY ACCEPTED IN THE UNITED STATES OF AMERICA

As stated in our engagement letter dated September 21, 2016, our responsibility, as described by professional standards, is to form and express an opinion about whether the combined financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. Our audit of combined financial statements does not relieve you or management of your respective responsibilities.

Our responsibility is to plan and perform the audit in accordance with auditing standards generally accepted in the United States of America and to design the audit to obtain reasonable, rather than absolute, assurance about whether the combined financial statements are free from material misstatement. An audit of combined financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of HPSM's internal control over financial reporting. Accordingly, we considered HPSM's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

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

PLANNED SCOPE AND TIMING OF THE AUDIT

We performed the audit according to the planned scope and timing previously communicated to you.

SIGNIFICANT AUDIT FINDINGS AND ISSUES

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by HPSM are described in Note 1 to the combined financial statements. During the year, HPSM adopted Governmental Accounting Standards Board ("GASB") Statement No. 72, *Fair Value Measurement and Application*, GASB Statement No. 76, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments,* and GASB Statement No. 79, *Certain External Investment Pools and Pool Participants*. There have been no other accounting policies adopted and there were no changes in the application of existing policies during 2016. We noted no transactions entered into by HPSM during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the combined financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

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

- Management's estimate of the liability for incurred but unreported claims expense is based on historical claims experience and known activity subsequent to year end. We evaluated the key factors and assumptions used to develop the incurred but unreported claims expense in determining that it is reasonable in relation to the combined financial statements taken as a whole.

- Management's estimate of the capitation receivable for Medi-Cal and CareAdvantage program beneficiaries is based upon a historical experience methodology. We evaluated the key factors and assumptions used to develop the capitation receivable in determining that it is reasonable in relation to the combined financial statements taken as a whole.

- Management's estimate of the amounts payable to the State of California related to the Medi-Cal expansion medical loss ratio ("MLR") is based upon the difference between the minimum MLR threshold of 85% and the actual allowed medical expenses. We evaluated the key factors and assumptions used to develop the amounts payable to the State of California in determining that it is reasonable in relation to the combined financial statements taken as a whole.

- Management's estimate of the fair market values of investments in the absence of readily-determinable fair values is based on information provided by the fund managers. We have gained an understanding of management's estimate methodology and examined the documentation supporting this methodology. We found management's process to be reasonable.

- Management's estimate of the net pension asset is actuarially determined using assumptions on the long-term rate of return on pension plan assets, the discount rate used to determine the present value of benefit obligations, and the rate of compensation increases. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the financial statements taken as a whole.

Financial Statement Disclosures

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

Significant Difficulties Encountered During the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. None of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to the combined financial statements taken as a whole.

Disagreements with Management

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

Management Representations

We have requested certain representations from management that are included in the attached management representation letter dated _____, 2017.

Management's Consultations with Other Independent Accountants

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

Independence

We are required to disclose to those charged with governance, in writing, all relationships between the auditors and HPSM that in the auditor's professional judgment, may reasonably be thought to bear on our independence. We know of no such relationships and confirm that, in our professional judgment, we are independent of HPSM within the meaning of professional standards.

Other Significant Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as HPSM's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition of our retention.

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

San Francisco, California
_____, 2017

Report of Independent Auditors and
Combined Financial Statements

San Mateo Health Commission and San Mateo Community Health Authority (d.b.a. Health Plan of San Mateo)

December 31, 2016 and 2015

CONTENTS

MANAGEMENT'S DISCUSSION AND ANALYSIS

_____

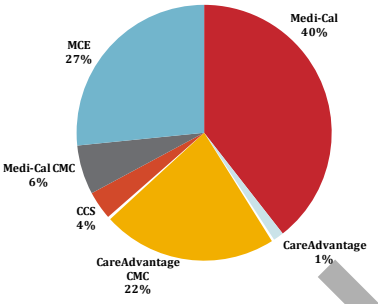
Our discussion and analysis of the San Mateo Health Commission and San Mateo Community Health Authority, (d.b.a. Health Plan of San Mateo) ("HPSM" or the "Commission"), provides an overview of the Commission's financial activities for the years ended December 31, 2016, 2015, and 2014. Please read it in conjunction with the Commission's audited combined financial statements and accompanying notes, which begin on page 11.

FINANCIAL HIGHLIGHTS

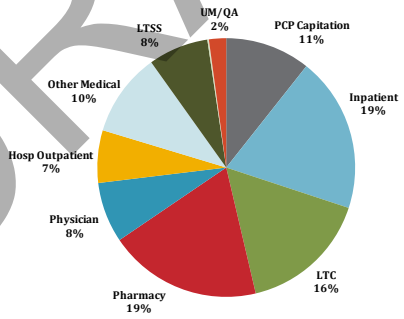
Overview of Financial Results

- Net deficit of $-20,336,592 in 2016, a net surplus of $103,430,837 in 2015, and $69,166,751 in 2014.
- Net operating revenues decreased by $-118,667,030 (-13.03%) in 2016, increased by $182,075,913 (24.98%) in 2015, and $224,965,937 (44.64%) in 2014.
- Healthcare expenses decreased by $-3,468,124 (-0.05%) in 2016, increased by $141,087,581 (23.66%) in 2015, and $180,251,947 (43.32%) in 2014.

Percentage of Revenue by LOB



Healthcare Dollar Spent



- Member months increased overall by 4.07% in 2016, by 7.56% in 2015, and 35.33% in 2014.
    - In 2016 Medi-Cal increased by 6.67% and the California Children's Services ("CCS") Pilot program also increased by 3.63%. The remaining programs all showed a decrease. HealthWorx decreased by 3.69%. Healthy Kids decreased by 42.83%, as the majority of the program transitioned to Medi-Cal. CareAdvantage decreased by 16.43%, as more members were reassigned to the Cal MediConnect program, which decreased by 6.00%.
    - In 2015 Medi-Cal increased by 9.15%. The CCS Pilot program increased by 5.51%, while Healthy Kids decreased 12.86%, as families continue to move to Medi-Cal and/or Covered California. HealthWorx had a slight increase of 1.93%. CareAdvantage decreased by 90.60%; however, most of the members were reassigned to the Cal MediConnect program, which increased by 381.64% as the program completed a full year of operation.
    - In 2014 Medi-Cal increased by 40.65% due to the addition of the Medi-Cal Expansion ("MCE") Program. CareAdvantage decreased by less than 1%, HealthWorx increased by 1.9%, Healthy Kids decreased by 14.45% due to many families moving into Medi-Cal and/or Covered California, the CCS Pilot increased by 43.73%, as the program completed its first full year. Additionally, the Cal MediConnect program began in April 2014, which had a slight positive impact on the total CareAdvantage membership.

USING THIS ANNUAL REPORT

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

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

HPSM's NET POSITION

HPSM's net position is the difference between its assets and liabilities as reported in the combined statements of net position on page 11. HPSM's net position decreased by $-20,336,592 in 2016, increased by $103,430,837 in 2015, and $69,166,751 in 2014.

	2016	2015	2014
CURRENT ASSETS	$ 721,744,741	$ 569,559,764	$ 404,724,383
CAPITAL ASSETS, NET	76,050,557	68,860,680	3,367,424
NET PENSION ASSET	1,376,620	1,633,028	-
ASSETS RESTRICTED AS TO USE	300,000	300,000	300,000
DEFERRED OUTFLOWS OF RESOURCES	1,082,648	1,102,454	-
Total assets and deferred outflows of resources	$ 800,554,566	$ 641,455,926	$ 408,391,807
CURRENT LIABILITIES			
Medical claims payable	$ 88,956,228	$ 63,583,454	$ 73,691,984
Provider incentives payable	783,482	742,344	362,082
Amounts due to the State of California	330,835,412	205,053,853	64,545,068
Accounts payable and other accrued liabilities	81,303,174	52,724,548	55,464,450
Total liabilities	501,878,296	322,104,199	194,063,584
DEFERRED INFLOWS OF RESOURCES	1,253,802	1,592,667	-
Total liabilities and deferred inflows of resources	$ 503,132,098	$ 323,696,866	$ 194,063,584
NET POSITION			
Invested in capital assets	$ 76,050,557	$ 68,860,680	$ 3,367,424
Restricted by legislative authority	300,000	300,000	300,000
Unrestricted	221,071,911	248,598,380	210,660,799
Total net position	$ 297,422,468	$ 317,759,060	$ 214,328,223

CURRENT ASSETS

Current assets increased $152,184,977 (26.72%) from 2015 to 2016. Included is an increase of $149,112,645 (32.89%) in cash and investments, HPSM intentionally holds a greater cash position due to the uncertainty of rate increases/cuts and cash flow from the State of California; an increase of $5,293,349 (5.09%) in Medi-Cal and CareAdvantage capitation receivables due to rate and risk score adjustments, and; a decrease of $-2,221,017 (-18.35%) in other accounts receivable and prepaids and other assets.

Current assets increased $164,835,381 (40.73%) from 2014 to 2015. Included is an increase of $132,297,970 (41.20%) in cash and investments, HPSM intentionally holds a greater cash position due to the uncertainty of rate increases/cuts and cash flow from the State of California; an increase of $33,020,242 (46.47%) in Medi-Cal and CareAdvantage capitation receivables due to rate and risk score adjustments and; a decrease of $-482,831 (-3.84%) in other accounts receivable and prepaids and other assets due to the close-out of our office lease and other prepaid expenses.

Current assets increased $152,710,912 (60.60%) from 2013 to 2014. Included is an increase of $139,935,951 (77.25%) in cash and investments; an increase of $7,715,748 (12.18%) in Medi-Cal and CareAdvantage receivables due to rate adjustments (recorded in 2014) back to July 2012; and an increase of $5,059,213 (67.23%) in other accounts receivable and prepaids and other assets due to an increase of funds on account with our pharmacy benefits manager and increased maintenance/support.

CAPITAL ASSETS

Capital assets increased by $7,189,877 (10.44%) in 2016, as renovations and upgrades to HPSM headquarters were completed. In 2015, capital assets increased by $65,493,256 (1,944.91%) due to the purchase (and renovation) of land, building, and parking structure located at 801 Gateway Blvd. in South San Francisco, which as of December 21, 2015, served as HPSM headquarters. Capital assets decreased by ($550,525) (-14.05%) in 2014, and decreased by ($198,161) (-4.81%) in 2013.

NET PENSION ASSET

Net pension asset represents the excess value of pension assets above the projected liability, under Governmental Accounting Standards Board ("GASB") Statement No. 68, *Accounting and Financial Reporting for Pensions* ("GASB 68"). Net pension asset decreased to $1,376,620 (-15.70%) at December 31, 2016, from $1,633,028 at December 31, 2015. Net Pension Assets were $0 at December 31, 2014. HPSM adopted GASB 68 reporting in 2015.

DEFERRED OUTFLOW

Deferred outflows of resources represent the difference between projected and actual retirement investment earnings that are deferred under GASB 68. Deferred outflows of resources decreased to $1,082,648 (-1.80%) as of December 31, 2016, from $1,102,454 as of December 31, 2105, when GASB 68 was adopted. Deferred outflows of resources were $0 at December 31, 2014.

INCENTIVES PAYABLE TO PROVIDERS

Incentives payable to providers increased by $41,138 (5.54%) in 2016, by $380,262 (105.02%) in 2015, and by $42,533 (13.31%) in 2014. HPSM uses a pay for performance based incentive model for primary care physicians ("PCP"). The model identifies key health quality performance indicators and pays physicians for performing or achieving them. The increase in 2016 (as well as 2014) is due to increased participation by physicians added to the network. The increase in 2015 is related to the timing of payments to providers.

ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

Accounts payable and accrued liabilities increased $28,578,626 (54.20%) from 2015 to 2016, decreased $2,739,902 (-4.94%) from 2014 to 2015, and increased $11,738,865 (26.85%) from 2013 to 2014. The 2016 changes consist of an increase in the hospital tax payable (SB239) from $5,192 to $13,769,847 due to a rate change for FY14/15; an increase in MCO tax payable from $0 to $13,750,306 due to reinstatement of the tax beginning in July 2016; an increase in Intergovernmental Transfer ("IGT") from $31,067,313 million to $46,600,985 million, due to a FY14/15 rate change; and a $10,088,147 million decrease of the SB78 Sales Tax, also related to State rate changes. The 2015 change is due to a payout of the 2014 hospital tax payable ("SB335"), which was partially offset by an increase in IGT from $22,117,500 million in 2014 to $31,067,313 million in 2015. The 2014 change is primarily due to an increase in the hospital tax payable (SB335), from $908,324 to $11,073,992.

AMOUNTS DUE TO THE STATE OF CALIFORNIA

Amounts due to the State of California increased $125,781,559 (61.34%) to $330,835,412 in 2016; increased $140,508,785 (217.69%) to $205,053,853 in 2015, and increased to $64,545,068 in 2014 from $0. The 2016 increase is primarily due to rate recasting back to April 2014 for the CCI Medi-Cal Dual and Cal MediConnect populations, as well as, the recording of a risk corridor related to the same period. The 2015 increase is due to State capitation rate changes for the SFY15/16 period, in addition to the medical loss ratio ("MLR") requirement associated with the Medi-Cal Expansion program. Managed Care Plans are required to spend 85% of premiums received on health care costs. The difference between the actual costs and 85% must be returned to the State. The 2014 increase is due exclusively to the MLR requirement associated with the Medi-Cal Expansion program.

DEFERRED INFLOW

Deferred inflows of resources represent changes in assumptions and the difference between expected and actual experience in 2016 that are deferred under GASB 68. Deferred inflows of resources decreased $-338,865 (-21.28%) to $1,253,802 as of December 31, 2016, from $1,102,454 as of December 31, 2105, when GASB 68 was adopted.

	2016	2015	2014
OPERATING REVENUES			
Capitation and premiums			
Medi-Cal	$ 528,489,927	$ 562,519,075	$ 489,962,825
CareAdvantage	10,472,394	9,349,509	140,964,121
Healthy Kids	2,587,982	3,845,225	4,414,170
Healthy Families	-	-	379
HealthWorx	3,027,381	3,101,981	3,482,218
CCS Pilot	26,747,540	31,698,482	30,043,374
Cal MediConnect	220,966,448	300,444,430	60,015,702
Net operating revenues	792,291,672	910,958,702	728,882,789
OPERATING EXPENSES			
Health care expenses			
Hospital inpatient	262,060,776	233,926,947	231,795,866
Medical	180,129,892	169,429,112	171,921,395
Pharmacy	139,078,731	137,389,812	106,255,970
Primary care physician capitation	78,470,754	103,014,815	63,034,529
Long-term support services	55,411,693	74,614,204	4,628,473
Utilization management and quality assessment allocation	15,851,353	11,824,758	10,839,246
Provider incentives	776,273	4,005,234	3,716,612
Other medical - dental, reinsurance, etc.	2,152,287	3,195,001	4,120,211
Total health care expenses	733,931,759	737,399,883	596,312,302
General and administrative	44,589,790	36,365,142	33,071,713
MCO tax	37,907,311	37,026,019	33,707,567
Total operating expenses	816,428,860	810,791,044	663,091,582
(Loss) income from operations	(24,137,188)	100,167,658	65,791,207
NONOPERATING REVENUE			
Net interest and investment income	1,010,944	605,126	389,872
Other	6,890	568,144	583,707
Rental income, net	728,856	86,310	-
Third party administration fees	2,053,906	2,003,599	2,401,965
Total nonoperating revenue	3,800,596	3,263,179	3,375,544
Changes in net position	(20,336,592)	103,430,837	69,166,751
NET POSITION, beginning of the year	317,759,060	214,328,223	145,161,472
NET POSITION, end of the year	$ 297,422,468	$ 317,759,060	$ 214,328,223

OPERATING REVENUES

HPSM's overall operating revenues decreased by $-118,667,030 (-13.03%) in 2016, increased by $182,075,913 (24.98%) in 2015, and $224,965,937 (44.64%) in 2014.

The primary components for the decreased revenues in 2016 are:

- Recasted rates back to April 2014 for the Coordinated Care Initiative ("CCI") dual population and Cal MediConnect resulting in approximately $89 million of decreased revenues;
- New rates (effective July 2016) for the MCE from $518.27 pmpm to $435.22 pmpm;
- Retro-rate adjustments for the CCS Pilot Program resulting in approximately $2 million of decreased revenues;
- Healthy Kids member conversion to Medi-Cal; and
- Projected Risk Corridor repayment to the State of approximately $20 million in revenue off-set (covers back to 2014)

The primary components for the increased revenues in 2015 are:

- Rate increases back to 2014 for the addition of Home and Community Based Services ("HCBS"), primarily In Home Services and Supports ("IHSS"), to our Medi-Cal contracts for Cal MediConnect and Coordinated Care Initiative (April 2014), and Special Needs Persons with Disabilities (July 2014), resulting in approximately $75 million of additional revenues;
- Rate increases back to July 2014 for Medi-Cal and Medi-Cal Expansion program ("MCE") due to a change in institutional member reimbursement methodology resulting in approximately $30 million of additional revenues;
- Full year operation of Cal MediConnect into the program; and
- Increased risk scores for CareAdvantage and Cal MediConnect programs.

The primary components for the increased revenues in 2014 are:

- Addition of MCE, which resulted in approximately 20,000 additional members per month;
- Addition of the Cal MediConnect ("CMC") program;
- Rate increases back to July 2013 for Medi-Cal; including Affordable Care Act ("ACA") section 1202 and Senate Bill ("SB") 78 (sales tax); and
- Rate increases back to April 2013 (program inception) for the CCS Pilot Program.

INTEREST AND INVESTMENT INCOME

Net interest and investment income was $1,010,944 in 2016, $605,126 in 2015, and $389,872 in 2014. The average rate of return for the investments was 0.736% in 2016, 0.557% in 2015, and 0.526% in 2014.

OPERATING EXPENSES

Health Care Expenses

Overall health care expenses decreased $-3,468,124 (-0.47%) from 2015 to 2016 due to:

- Reduction of the global capitation paid to County Health Services for the MCE population assigned to them; and

- Recording of IHSS expenses for 2016 (only) whereas 2015 had multiple years recorded.

Overall health care expenses increased by $141,087,581 (23.66%) from 2014 to 2015 due to:

- A 67% growth in MCE membership resulting in $72 million additional healthcare expenditures;
- Retro-inclusion of IHSS resulting in additional healthcare expenditures of approximately $72 million; and
- An increase in Pharmacy costs across all lines of business.

Overall health care expenses increased by $180,251,947 (43.32%) from 2013 to 2014 due to:

- The addition of the Medi-Cal Expansion program resulting in $100 million in health care expenditures, with approximately $49 million of these expenditures reimbursed through a global capitation arrangement with the County Health Department;
- The addition of the CMC program, resulting in additional Medicare expenditures of $37 million;
- Increased Medi-Cal membership, resulting in $30 million of additional healthcare expenditures (including expenditures for Medi-Cal covered services for CMC members);
- An increase in Pharmacy costs across all lines of business;
- Addition of Home and Community Based Services to our MediCal contract, primarily IHSS; and
- An increase in Utilization Management and Care Coordination costs due to expanded regulatory requirements associated with the CMC program.

General and Administrative ("G&A") Expenses

Total G&A expenses were $44,589,790 in 2016, $36,365,142 in 2015, and $33,071,713 in 2014. The increase from 2015 to 2016 is due increased outside services contracts for the CMS program audit and new and expanded community programs. We also experienced an increase in depreciation expense due to the new building. The increase from 2014 to 2015 is due to increased outside services contracts and software expense as we continue to build data infrastructure, annual rent increase, and other occupancy costs associated with the new offices. The increase from 2013 to 2014 is due to increased staffing for the addition of the MCE and CMC programs, annual rent increases, increased hardware and software costs associated with upgrading computer systems, increased Outside Services contracts, and increased printing and member packet processing for members. The increase from 2012 to 2013 is due to a contract with San Mateo County Family Health Services for service related to the CCS Pilot program. We also experienced increased salary and benefits costs, annual rent increase, additional minor equipment costs (including desks and computers) and increased software costs related to system upgrades.

The administrative expenses as a percentage of operating revenues were 5.63% in 2016, 3.99% in 2015, and 4.54% in 2014.

MCO Tax

In 2009, Assembly Bill No. 1422 ("AB1422") was passed by the legislature and signed by Governor Schwarzenegger. The bill provided that Medi-Cal Managed Care Organizations (MCO) would be subject to a gross premium tax on Medi-Cal capitation revenues. For revenues pertaining to June 30, 2013, and prior, the tax rate was 2.35%. For July 1, 2013 through June 30, 2016, the tax rate increased to 3.9375% and was paid as a sales tax to the Board of Equalization on capitation revenues received. Both taxes are processed through HPSM capitation payments received from the State so HPSM is held harmless.

Senate Bill X2 2 enacted a new MCO tax, effective for a taxing period of July 1, 2016 through June 30, 2019. The tax structure is based on enrollment between specified tiers that are taxed different tax rates. Additionally, the taxing rates and member month tiers vary between Medi-cal and Non-Medi-Cal lives. To calculate total tax liability DHCS used enrollment reported to DMHC from October 2014 through September 2015. As of December 31, 2016, HPSM's tax liability was $13,750,306, included in accounts payable and accrued liabilities in the combined statements of financial position.

The MCO taxes were $37,907,311, $37,026,019, and $33,707,567 for 2016, 2015, and 2014, respectively.

	Actual	Budgeted	Variance
REVENUES			
Medi-Cal	$ 528,489,927	$ 542,771,211	$ (14,281,284)
CareAdvantage	10,472,394	10,082,023	390,371
Healthy Kids	2,587,982	3,443,840	(855,858)
HealthWorx	3,027,381	30,554,470	(27,527,089)
CCS Pilot Program	26,747,540	30,698,156	(3,950,616)
Cal MediConnect	220,966,448	273,122,281	(52,155,833)
Total revenues	792,291,672	890,671,981	(98,380,309)
HEALTH CARE EXPENSES			
Hospital inpatient	262,060,776	254,550,815	7,509,961
Medical	180,129,892	183,999,052	(3,869,160)
Pharmacy	139,078,731	163,791,866	(24,713,135)
Primary care physician capitation	78,470,754	97,826,440	(19,355,686)
Long-term support services	55,411,693	53,637,959	1,773,734
Utilization management ("UM") and quality assessment ("QA") allocation	15,851,353	13,875,277	1,976,076
Other medical - dental, reinsurance, etc.	2,152,287	3,673,088	(1,520,801)
Provider incentives	776,273	4,256,551	(3,480,278)
Total health care expenses	733,931,759	775,611,048	(41,679,289)
ADMINISTRATIVE EXPENSES			
Salaries and fringe benefits	29,136,485	34,183,200	(5,046,715)
Contract services	16,350,206	15,036,900	1,313,306
Office supplies and maintenance	4,364,813	4,497,050	(132,237)
Occupancy, equipment and depreciation expense	5,653,786	5,958,100	(304,314)
Postage and printing	1,182,053	1,874,400	(692,347)
Other administrative expenses	1,698,167	1,335,150	363,017
Utilization management and quality assessment allocation	(13,795,720)	(13,875,277)	79,557
Total administrative expenses	44,589,790	49,009,523	(4,419,733)
MCO tax	37,907,311	27,966,519	9,940,792
Total expenses	816,428,860	852,587,090	(36,158,230)
(Loss) income from operations	(24,137,188)	38,084,891	(62,222,079)
NONOPERATING INCOME			
Net interest and investment income	1,010,944	500,000	510,944
Other	735,746	1,956,360	(1,220,614)
Third-party administrator fees	2,053,906	133,071	1,920,835
Total nonoperating income	3,800,596	2,589,431	1,211,165
Net (loss) income	(20,336,592)	40,674,322	(61,010,914)
Net position at the beginning of year	317,759,060	317,759,060	-
Net position at the end of year	$ 297,422,468	$ 358,433,382	$ (61,010,914)

REPORT OF INDEPENDENT AUDITORS

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

Report on the Financial Statements

We have audited the accompanying combined statements of net position of the San Mateo Health Commission (a stand-alone government entity appointed by the San Mateo County Board of Supervisors) (the "Commission") and San Mateo Community Health Authority (the "Health Authority"), collectively known as Health Plan of San Mateo ("HPSM") as of December 31, 2016 and 2015, and the related combined statements of revenues, expenses, and changes in net position, cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the combined financial position of the San Mateo Health Commission and the San Mateo Community Health Authority (d.b.a. Health Plan of San Mateo) as of December 31, 2016 and 2015, and the combined results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Required Supplementary Information

The accompanying Management's Discussion and Analysis on pages 1 through 9, and the accompanying supplemental pension and postretirement benefit information on page 30 and 31, are not required parts of the combined financial statements but are supplementary information required by the Governmental Accounting Standards Board who considers them to be an essential part of financial reporting for placing the combined financial statements in an appropriate operational, economic, or historical context. This supplementary information is the responsibility of HPSM's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the combined financial statements, and other knowledge we obtained during our audit of the combined financial statements. We do not express an opinion or provide any assurance on the supplementary information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

San Francisco, California
_____, 2017

COMBINED FINANCIAL STATEMENTS

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SAN MATEO HEALTH COMMISSION AND SAN MATEO COMMUNITY HEALTH AUTHORITY
(d.b.a. HEALTH PLAN OF SAN MATEO)
COMBINED STATEMENTS OF NET POSITION
December 31, 2016 and 2015

	2016	2015
ASSETS AND DEFERRED OUTFLOWS		
CURRENT ASSETS		
Cash and cash equivalents	$ 444,583,888	$ 346,260,730
Investments	157,913,290	107,123,803
Capitation receivable from the State of California	97,316,226	86,781,659
CareAdvantage receivable	12,050,562	17,291,780
Other accounts receivable	2,295,000	2,516,369
Prepaids and other assets	7,585,775	9,585,423
Total current assets	721,744,741	569,559,764
CAPITAL ASSETS, NET	76,050,557	68,860,680
NET PENSION ASSET	1,376,620	1,633,028
ASSETS RESTRICTED AS TO USE	300,000	300,000
Total assets	799,471,918	640,353,472
DEFERRED OUTFLOWS OF RESOURCES	1,082,648	1,102,454
Total assets and deferred outflows of resources	$ 800,554,566	$ 641,455,926
LIABILITIES AND DEFERRED INFLOWS		
CURRENT LIABILITIES		
Medical claims payable	$ 88,956,228	$ 63,583,454
Incentives payable to providers	783,482	742,344
Amounts due to the State of California	330,835,412	205,053,853
Accounts payable and accrued liabilities	81,303,174	52,724,548
Total current liabilities	501,878,296	322,104,199
DEFERRED INFLOWS OF RESOURCES	1,253,802	1,592,667
Total liabilities and deferred inflow of resources	$ 503,132,098	$ 323,696,866
NET POSITION		
Invested in capital assets	$ 76,050,557	$ 68,860,680
Restricted by legislative authority	300,000	300,000
Unrestricted	221,071,911	248,598,380
Total net position	$ 297,422,468	$ 317,759,060

See accompanying notes.

	2016	2015
OPERATING REVENUES		
Capitation and premiums		
Medi-Cal	$ 528,489,927	$ 562,519,075
CareAdvantage	10,472,394	9,349,509
Healthy Kids	2,587,982	3,845,225
HealthWorx	3,027,381	3,101,981
Child Care Services Pilot	26,747,540	31,698,482
Cal MediConnect	220,966,448	300,444,430
Net operating revenues	792,291,672	910,958,702
OPERATING EXPENSES		
Health care expenses		
Hospital inpatient	262,060,776	233,926,947
Medical	180,129,892	169,429,112
Pharmacy	139,078,731	137,389,812
Primary care physician capitation	78,470,754	103,014,815
Long-term support services	55,411,693	74,614,204
Utilization management ("UM") and quality assessment ("QA") allocation	15,851,353	11,824,758
Provider incentives	776,273	4,005,234
Other medical - dental, reinsurance, etc.	2,152,287	3,195,001
Total health care expenses	733,931,759	737,399,883
General and administrative		
Salaries and fringe benefits	29,136,485	25,595,871
Contract services	16,350,206	11,036,740
Office supplies and maintenance	4,364,813	4,290,266
Occupancy, equipment and depreciation expense	5,653,786	4,146,567
Postage and printing	1,182,053	1,796,368
Other administrative expenses	1,698,167	1,324,088
UM/QA Healthcare Allocation	(13,795,720)	(11,824,758)
Total general and administrative expenses	44,589,790	36,365,142
MCO tax	37,907,311	37,026,019
Total operating expenses	816,428,860	810,791,044
(Loss) income from operations	(24,137,188)	100,167,658
NONOPERATING REVENUE		
Net interest and investment income	1,010,944	605,126
Other revenue	6,890	568,144
Rental income, net	728,856	86,310
Third party administration fees	2,053,906	2,003,599
Total nonoperating revenue	3,800,596	3,263,179
(Decrease) increase in net position	(20,336,592)	103,430,837
NET POSITION, beginning of the year	317,759,060	214,328,223
NET POSITION, end of the year	$ 297,422,468	$ 317,759,060

See accompanying notes.

SAN MATEO HEALTH COMMISSION AND SAN MATEO COMMUNITY HEALTH AUTHORITY
(d.b.a. HEALTH PLAN OF SAN MATEO)
COMBINED STATEMENTS OF CASH FLOWS
Years Ended December 31, 2016 and 2015

	2016	2015
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation and premium revenues	$ 941,381,227	$ 1,017,522,294
Health care expenses	(698,719,079)	(746,193,865)
General and administrative expenses	(87,139,909)	(70,706,421)
Other	581,726	(4,705,697)
Net cash provided by operating activities	156,103,965	195,916,311
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from sale and maturities of investments	-	2,625,178
Payments for purchase of investments	(47,135,791)	-
Payments for purchase of capital assets	(10,645,016)	(66,845,651)
Net cash used for investing activities	(57,780,807)	(64,220,473)
Net increase in cash	98,323,158	131,695,838
CASH AND CASH EQUIVALENTS, beginning of year	346,260,730	214,564,892
CASH AND CASH EQUIVALENTS, end of year	$ 444,583,888	$ 346,260,730
RECONCILIATION OF INCOME FROM OPERATIONS TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
(Loss) income from operations	$ (24,137,188)	$ 100,167,658
Adjustment to reconcile (loss) income from operations to net cash provided by operating activities		
Depreciation	3,409,207	1,352,395
Loss on disposal of assets	45,930	-
Changes in operating assets and liabilities		
Capitation receivable from the State of California	(10,534,567)	(19,859,650)
CareAdvantage receivable	5,241,218	(13,160,592)
Other accounts receivable	221,369	368,686
Prepaids and other assets	2,146,550	150,014
Net pension asset	(62,651)	(1,142,815)
Medical claims payable	25,372,774	(10,108,530)
Incentives payable to providers	41,138	380,262
Amounts due to the State of California	125,781,559	140,508,785
Accounts payable and accrued liabilities	28,578,626	(2,739,902)
Net cash provided by operating activities	$ 156,103,965	$ 195,916,311

See accompanying notes.

NOTE 1 – DESCRIPTION OF OPERATIONS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

HPSM is responsible for managing a capitated prepaid health care system for residents of the County who are eligible for services under the Medi-Cal Program. The California Legislature authorized the prepaid system in March 1986 and HPSM began operations on December 1, 1987, under a contract with the State of California (the "State"). HPSM has an executed contract with the State for the period of January 1, 2009 through December 31, 2020.

The Centers for Medicare & Medicaid Services originally approved the State's request for HPSM to operate under a federal Medicaid freedom of choice waiver in November of 1987. The 1915(b) waiver allows for mandatory participation by Medi-Cal eligible San Mateo County residents in HPSM. Effective November 1, 2010, CMS transitioned all existing California 1915(b) waivers, including HPSM's 1915(b) waiver, into the State's 1115(a) waiver. CMS renewed the State's 1115(a) waiver for November 1, 2010 through December 31, 2020.

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

HPSM acquired a license under the Knox-Keene Health Care Services Plan Act of 1975, as amended (the "Act") on July 31, 1998, and is regulated by the State's Department of Health Care Services ("DHCS") and California Department of Managed Health Care ("DMHC"). For the HealthWorx program, HPSM contracted with the San Mateo Public Authority for coverage of the IHSS employees as of August 1, 2001, San Mateo County for coverage of San Mateo County Extra Help employees as of September 1, 2006, and the City of San Mateo for Non-Merit Part-Time and Library Per Diem employees as of January 1, 2009. The current HealthWorx contracts are for the following periods: (1) IHSS – July 1, 2014 to June 30, 2017, (2) Extra Help – September 1, 2011 to August 31, 2015 (now terminated), and (3) the City of San Mateo – January 1, 2009 to December 31, 2017. As a result of HealthWorx program's commercial status, members who have extinguished all available COBRA benefits are eligible for an Individual Coverage Plan ("ICP"). HPSM fully expects the above noted contracts, with the exception of Healthy Families and the San Mateo County Extra Help HealthWorx, to renew after the current contract end dates.

As of February 12, 2003, HPSM contracted with the County of San Mateo and the San Mateo County Children and Families First Commission for the Healthy Kids program. As of January 2004, the County of San Mateo is the sole contractor for Healthy Kids, as San Mateo County Children and Families First Commission is contracting directly with the County of San Mateo. This program covers children under the age of 19 with family income levels of 400% of poverty or lower, who do not qualify for Medi-Cal. The current Healthy Kids contract is for the period from January 1, 2010 to December 31, 2017.

In July 2005, DHCS implemented the Quality Improvement Fee ("QIF") program. This program imposed a 6% assessment from July 2005 through December 2007 and a 5.5% assessment effective January 1, 2008 through September 30, 2009, on the Commission's non Medicare revenue. In order to minimize the impact on HPSM, the Health Authority was created. Effective February 23, 2006, all non Medi-Cal programs were assigned to the Health Authority, thus reducing the resulting assessment levied on HPSM.

The Health Authority is a licensed health maintenance organization that operates in the County. The County's Board of Supervisors established the Health Authority in accordance with State of California Welfare and Institutions Code (the "Code") Section 14087.54. This legislation provides that the Health Authority is a public entity, separate and apart from the County, and is not considered to be an agency, division, or department of the County. Further, the Health Authority is not governed by, nor is it subject to, the Charter of the County and is not subject to the County's policies or operational rules. The Health Authority received its Knox-Keene license on February 23, 2006, and accounting separately for the Health Authority from HPSM became effective March 1, 2006.

In September 2005, HPSM entered into an agreement with the Centers for Medicare & Medicaid Services and became a MediCareAdvantage Organization ("MAO") under the commercial name CareAdvantage. As an MAO, HPSM provides medical services to its dual eligible members. The service contract for fiscal year 2006 became effective on January 1, 2006 through December 31, 2006, and was not renewed. Currently, the Medicare contract is for the period of January 1, 2016 to December 31, 2016, and will not renew for 2017. The contract terminated December 31, 2016, when the CareAdvantage program closed.

Effective September 1, 2007, HPSM entered into an agreement with the County of San Mateo to provide third party administrator ("TPA") services to administer the benefits of their indigent care program ("ACE"). The current agreement is for the period April 1, 2015 to March 31, 2018.

Effective April 1, 2013, HPSM entered into a second Medi-Cal contract (Plan #703) with the State of California. This contract covers the CCS Pilot Initiative. CCS Services were previously covered under the primary Medi-Cal contract. The current contract is for the period April 1, 2013 to March 31, 2017.

Effective April 1, 2014, HPSM entered into a three-way contract with CMS and the State of California for the Cal MediConnect Pilot program. The Cal MediConnect program promotes coordination of care to seniors and people with disabilities who are dually eligible for both Medi-Cal and Medicare. The agreement results in a third Medi-Cal contract and a second Medicare contract. The contract is through December 31, 2017.

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

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

Basis of combination – The accompanying combined financial statements as of December 31, 2016 and 2015, and for the years then ended, include the Commission and the Health Authority, collectively known as HPSM. The operations of the Health Authority are included from the date of its inception on February 1, 2006.

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

Investments – Investments include debt obligations of the U.S. Government and its agencies, certificates of deposits, and money markets as permitted by the California Government Code for Investments. These investments are carried at fair market value. The fair values of investments are based on quoted market prices. Changes in fair value of investments are included in net interest and investment income in the combined statements of revenues, expenses, and changes in net position.

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

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

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

Capital assets of $3,000 or more are depreciated over their useful life. Leasehold improvements of $3,000 or more are amortized over the term of the related lease or their estimated useful life.

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

Assets restricted as to use – HPSM is required by the California Department of Managed Health Care to restrict cash of $300,000 as of December 31, 2016 and 2015, for the payment of member claims in the event of its insolvency.

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

ACA Section 1202 – For calendar years 2013 and 2014, Section 1202 of the federal ACA, required Medicaid agencies to provide payment for certain primary care services delivered by eligible physicians consistent with Medicare rates. This program increases expected capitation revenue received from DHCS to offset the increased expenses paid to providers. As of December 31, 2016 and 2015, approximately $0 and $0, respectively, was accrued for the expected capitation revenue and claims expense.

Amounts due to the State of California – When HPSM is made aware of changes to the State rate structure, such as rate decreases, risk corridors or program reconciliations, that significantly impact the financial outlook, an accrual for the change is recorded.

- Risk corridor - Amendments to the State Medi-Cal contract established a two year risk corridor for the Coordinated Care Initiative. This impacts the Medi-Cal and Cal MediConnect lines of business. HPSM would be responsible or retain up to 1% of losses or gains. The State and HPSM would equally share any gains or losses between 1% and 2.5%. DHCS would be responsible or keep any gains or losses greater than 2.5%. As of December 31, 2016, a total of $19,789,224 is reflected on the combined statements of net position in amounts due to the State of California.

- MLR - Effective with the enrollment of the Medi-Cal Adult Expansion Population per ACA on January 1, 2014, HPSM is subject to DHCS requirements to meet a minimum 85% medical loss ratio for this population. Specifically, HPSM will be required to expend at least 85% of the Medi-Cal capitation revenue received for this population on allowable medical expenses as defined by DHCS. In the event HPSM expends less than the 85% requirement, HPSM will be required to return to DHCS the difference between the minimum threshold and the actual allowed medical expenses. For the year ended December 31, 2016, HPSM does not expect to meet the minimum threshold and recorded a $10.3 million reduction to Medi-Cal capitation revenue. Likewise, as of December 31, 2015, HPSM included an estimated return of funds $17 million. A total of $91 million is reflected on the combined statements of net position in amounts due to the State of California.

- Miscellaneous adjustments relating to IHSS reconciliation and Agnews totaling $3.3 million is reflected on the combined statements of net position in amounts due to the State of California.

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

- IGT payable – Welfare and Institutions Code provides for an IGT program relating to the Medi-Cal managed care capitation rates and the capitation rate ranges. Governmental funding agencies, defined as counties, cities, special purpose districts, state university teaching hospitals and other political subdivisions of the state, are eligible to transfer the non-federal share of the available IGT amounts. The IGT is used to fund the non-federal share of increases in Medi-Cal managed care actuarially sound capitation rates. As of December 31, 2016 and 2015, $46,600,985 and $31,067,313, respectively, were accrued for the expected payout.

- Assembly Bill ("AB") 1653 ("AB1653")/SB 335 ("SB335") Payable – On September 8, 2010, AB1653 established a Hospital Quality Assurance Fee ("HQAF") program allowing additional draw down of federal funding to be used for increased payments to general acute care hospitals for inpatient services rendered to Medi-Cal beneficiaries. DHCS provides increased capitation payments to Medi-Cal managed health care plans who in turn expend 100 percent of any increased capitation payments on hospital services. In April 2011, SB90 was signed into law, which extended the HQAF through June 30, 2011. SB335, signed into law in September 2011, extended the HQAF portion of SB90 for an additional 30 months through December 31, 2013. The payments were received and distributed in a manner prescribed as a pass through to revenue. SB239, signed into law October 8, 2013, extended the program for an additional 36 months from January 1, 2014 through December 31, 2016. As of December 31, 2016 and 2015, $13,769,847 and $5,192, respectively, were accrued for payments to the hospitals.

- Assembly Bill ("AB") 85 Payable – On June 27, 2013, Governor Brown signed into law AB85, that provides a mechanism for the state to redirect state health realignment funding to fund social service programs at the County level, as a result of the Medicaid Expansion afforded by the ACA. The redirected amount is determined according to respective formula options for California public hospitals, County Medical Services Programs ("CMSP") counties and Article 13 counties. For CMSP Counties, which San Mateo is one, AB85 outlines that 60% of health realignment that would otherwise been received will be redirected. As an offset to this redirection, 75% of the difference between the lower bound and upper bound rates for the Medi-Cal Expansion population will be paid to the County Hospital. As of December 31, 2016 and 2015, approximately $1,310,709 and $1,814,339 were accrued for related to AB85 for payment to the County of San Mateo Health System.

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

Capitation and premium revenues – The State of California pays HPSM capitation revenue retrospectively on an estimated basis each month. Capitation revenue is recognized as revenue in the month the beneficiary is eligible for Medi-Cal services. These estimates are continually reviewed, and adjustments to the estimates are reflected currently in the combined statements of revenues, expenses, and changes in net position. The Centers for Medicare & Medicaid Services pays HPSM capitation revenue each month. Capitation revenue is recognized in the month the beneficiary is eligible for Medicare services.

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

Premium deficiencies – HPSM performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency is recorded. Management determined that no premium deficiency reserves were needed at December 31, 2016 or 2015.

Health care expenses – The cost of health care rendered to eligible beneficiaries is estimated and recognized as expense in the month in which the services are rendered. These estimates are continually reviewed, and adjustments to the estimates are reflected currently in the combined statements of revenues, expenses, and changes in net position.

MCO Tax – In November 2009, DHCS implemented AB1422 or Managed Care Organization ("MCO") premium tax. This program imposes an assessment on HPSM's revenue. DHCS uses this assessment to obtain matching federal funds, which is used to sustain enrollment in the Healthy Families program. Effective with California SB78 and beginning July 1, 2012, HPSM was required to pay a gross premium tax on Medi-Cal revenue. For July 1, 2013 through June 30, 2016, the tax rate increased to 3.9375%. Beginning July 1, 2016, a new annual liability methodology for determining tax liability was instituted by the State. MCO tax expense was $37,907,312 and $37,026,019 for the years ended December 31, 2016 and 2015, respectively. As of December 31, 2016 and 2015, $-3,998,922 and $6,089,225, respectively, was accrued for the premium tax due on cash receipts. The 2016 credit is the result of premium overpayments (by the State to HPSM) due to retro-active rate adjustments, which are lower than the rates originally paid. These amounts are included on the combined statements of net position in accounts payable and accrued liabilities.

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

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

Use of estimates – The preparation of combined financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. Management also discloses contingent assets and liabilities at the date of the combined financial statements and the reported amounts of revenues and expenses during the reporting period based on these estimates and assumptions. Ultimate results may differ from those estimates.

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

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

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

New accounting pronouncements – The GASB issued GASB Statement No. 72, *Fair Value Measurement and Application* ("GASB No. 72"), which is effective for financial statements for periods beginning after June 15, 2015. GASB No. 72 requires disclosures to be made about fair value measurements, the level of fair value hierarchy, and valuation techniques. Governments should organize these disclosures by type of asset or liability reported at fair value. It also requires additional disclosures regarding investments in certain entities that calculate net asset value per share. HPSM has adopted this pronouncement and reflected the adoption as of the years ended December 31, 2016 and 2015.

In June 2015, the GASB issued GASB Statement No. 76, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments,* ("GASB 76") which is effective for financial statements for periods beginning after June 15, 2015. GASB 76 supersedes the requirements of GASB Statement No. 55, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments*. GASB 76 reduces the GAAP hierarchy to two categories of authoritative GAAP and addresses the use of authoritative and nonauthoritative literature in the event that the accounting treatment for a transaction or other event is not specified within a source of authoritative GAAP. HPSM has adopted this pronouncement and reflected the adoption as of the years ended December 31, 2016 and 2015. The adoption had no material impact to the combined financial statements for the fiscal year ended June 30, 2016.

The GASB issued GASB Statement No. 79, *Certain External Investment Pools and Pool Participants*, ("GASB No. 79"), which is effective for financial statements for periods beginning after June 15, 2015. GASB No. 79 addresses accounting and financial reporting for certain external investment pools and pool participants. Specifically, it establishes criteria for an external investment pool to qualify for making the election to measure all of its investments at amortized cost for financial reporting purposes. An external investment pool qualifies for that reporting if it meets all the applicable criteria established in GASB No. 79. The specific criteria address (1) how the external investment pool transacts with participants; (2) requirements for portfolio maturity, quality, diversification, and liquidity; and (3) calculation and requirements of shadow price. Significant noncompliance prevents the external investment pool from measuring all of its investments at amortized cost for financial reporting purposes. Professional judgment is required to determine if instances of noncompliance with the criteria establish by GASB No. 79 during the reporting period, individually or in the aggregate, were significant. HPSM has adopted this pronouncement and reflected the adoption as of the years ended December 31, 2016 and 2015.

The GASB issued GASB Statement No. 82, *Pension Issues – an amendment of GASB Statement No. 67, No. 68, and No. 73*, ("GASB No. 82"), which is effective for financial statements for periods beginning after June 15, 2016. GASB No. 82 addresses certain issues that have been raised with respect to GASB Statement No. 67, *Financial Reporting for Pension Plans,* No. 68, *Accounting and Financial Reporting for Pensions*, and No. 73, *Accounting and Financial Reporting for Pensions and Related Assets That Are Not within the Scope of GASB Statement 68 and Amendments to Certain Provisions of GASB Statements No. 67 and No. 68.* Specifically, GASB No. 82 addresses issues regarding (1) the presentation of payroll-related measures in required supplementary information, (2) the selection of assumptions and the treatment of deviations from the guidance in an Actuarial Standard of Practice for financial reporting purposes, and (3) the classification of payments made by employers to satisfy employee contribution requirements. The adoption of GASB No. 82 is effective for HPSM for the fiscal year ending December 31, 2018. The adoption is not expected to have a material impact on HPSM's combined financial statements.

Reclassifications – Certain financial statement reclassifications have been made to prior year balances for comparability purposes and had no impact on changes in net position or net position as previously reported.

NOTE 2 – CASH AND CASH EQUIVALENTS AND INVESTMENTS

Cash and cash equivalents and investments – Cash and cash equivalents and investments as of December 31, 2016 and 2015, consist of the following:

	2016	2015
Cash on hand	$ 500	$ 500
Cash deposits	404,311,879	306,076,521
Cash equivalents	40,271,509	40,183,709
Investments	158,213,290	107,423,803
Total cash and cash equivalents and investments	$ 602,797,178	$ 453,684,533

Included in investments as of December 31, 2016 and 2015, is $300,000 related to HPSM's Knox-Keene reserve requirement. This amount is included in assets restricted as to use in the combined statements of net position.

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

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

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

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

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

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

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

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

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

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

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

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

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

Per CSMPF's investment policy, the Treasurer will honor all requests to withdraw funds for normal cash flow purposes and apportionments. Any request to withdraw funds for purposes other than cash flow and apportionment, such as external investing, shall be subject to the consent of the Treasurer and will normally be released at 20% per month. In accordance with California Government Code 27136 et seq, and 27133 (h) et seq, these requests are subject to the Treasurer's consideration of the stability and predictability of the pooled investment fund, or the adverse effect on the interests of the other depositors in the pooled investment fund.

HPSM's investments by fair value level include the following as of December 31:

Description	Level 1	Level 2	Level 3	2016
Investments by fair value level				
Total investments subject to fair value hierarchy	$ -	$ -	$ -	$ -
Investments not subject to fair value hierarchy				
San Mateo County Pooled Fund				$ 98,961,495
Local agency investment fund				58,951,795
Total investments				$ 157,913,290

Description	Level 1	Level 2	Level 3	2015
Investments by fair value level				
Total investments subject to fair value hierarchy	$ -	$ -	$ -	$ -
Investments not subject to fair value hierarchy				
San Mateo County Pooled Fund				$ 63,389,320
Local agency investment fund				43,734,483
Total investments				$ 107,123,803

The custodial credit risk, interest rate, credit risk, and concentration of credit risk under GASB Statement No. 62 Section C20, *Cash Deposits with Financial Institutions*, at December 31, 2016 and 2015, were as follows:

Custodial credit risk – Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, HPSM will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The Code requires financial institutions to secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under State Law. As of December 31, 2016 and 2015, deposits exposed to custodial credit risk as they were uninsured, and the collateral held by the pledging bank not in HPSM's name were $444,583,889 and $346,260,730, respectively.

Custodial credit risk for investments is the risk that, in the event of the failure of the counterparty to a transaction, HPSM will not be able to recover the value of its investments or collateral securities that are in the possession of another party. As of December 31, 2016 and 2015, HPSM did not hold investments exposed to custodial credit risk.

Interest rate risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. In accordance with its investment policy, HPSM manages the risk of market value fluctuations due to overall changes in the general level of interest rates by limiting the weighted average maturity of its portfolio to no more than five years. The weighted average maturity in years for HPSM at December 31 was as follows:

As of December 31, 2016:

Investment Type	Fair Value	Weighted Average Maturity (Years)
Certificates of Deposit	$ 300,000	1.22
Local Agency Investment Fund	58,951,795	-
San Mateo County Pooled Fund	98,961,495	-
Total fair value	$ 158,213,290	
Portfolio weighted average maturity		1.22

As of December 31, 2015:

Investment Type	Fair Value	Weighted Average Maturity (Years)
Certificates of Deposit	$ 300,000	0.22
Local Agency Investment Fund	43,734,483	-
San Mateo County Pooled Fund	63,389,320	-
Total fair value	$ 107,423,803	
Portfolio weighted average maturity		0.22

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

Ratings as of December 31, 2016:

Investment Type	Fair Value	AAA	A-1
Certificates of Deposit	$ 300,000	$ -	$ 300,000
Total fair value	$ 300,000	$ -	$ 300,000

Ratings as of December 31, 2015:

Investment Type	Fair Value	AAA	A-1
Certificates of Deposit	$ 300,000	$ -	$ 300,000
Total fair value	$ 300,000	$ -	$ 300,000

Concentration of credit risk – The investment policy of HPSM contains certain limitations on the amount that can be invested in any one issuer and is listed in the table above. There are no investments in any one issuer (other than U.S. Treasury securities, mutual funds, and external investment pools) that represent 5% or more of the total HPSM's investments at December 31, 2015 and 2014.

NOTE 3 – CAPITATION RECEIVABLE FROM THE STATE OF CALIFORNIA

HPSM receives capitation from the State based upon the monthly capitation rate of each aid code (Medi-Cal category of eligibility). The State makes monthly payments based on actual members for the current month and changes for the prior twelve months.

HPSM estimates the current and prior years' capitation receivable based on the State's most current actual member counts by aid code. Currently, HPSM records the current year capitation receivable based on the most current actual member counts by aid code. The figures are trued-up on a monthly basis.

NOTE 4 – CAPITAL ASSETS

Capital asset activity for the fiscal year ended December 31, 2016, was as follows:

	Beginning Balance	Increases	Decreases	Ending Balance
Furniture and equipment	$ 13,055,514	$ 1,059,366	$ 217,450	$ 13,897,430
Building improvements	13,098,476	9,585,648	45,930	22,638,194
Building	31,810,055	-	-	31,810,055
Land	15,667,814	-	-	15,667,814
Total capital assets	73,631,859	10,645,014	263,380	84,013,493
Less accumulated depreciation and amortization for				
Furniture and equipment	4,771,179	3,409,207	217,450	7,962,936
Total accumulated depreciation	4,771,179	3,409,207	217,450	7,962,936
Capital assets, net	$ 68,860,680	$ 7,235,807	$ 45,930	$ 76,050,557

Capital asset activity for the fiscal year ended December 31, 2015, was as follows:

	Beginning Balance	Increases	Decreases	Ending Balance
Furniture and equipment	$ 8,752,938	$ 6,269,306	$ 1,966,730	$ 13,055,514
Leasehold improvements	949,210	-	949,210	-
Building and tenant improvements	-	13,098,476	-	13,098,476
Building	-	31,810,055	-	31,810,055
Land	-	15,667,814	-	15,667,814
Total capital assets	9,702,148	66,845,651	2,915,940	73,631,859
Less accumulated depreciation and amortization for				
Furniture and equipment	5,524,220	1,213,689	1,966,730	4,771,179
Leasehold improvements	810,504	138,706	949,210	-
Total accumulated depreciation	6,334,724	1,352,395	2,915,940	4,771,179
Capital assets, net	$ 3,367,424	$ 65,493,256	$ -	$ 68,860,680

Depreciation expense for capital assets for the years ended December 31, 2016 and 2015, was $3,409,207 and $1,352,395, respectively.

NOTE 5 – MEDICAL CLAIMS PAYABLE

The cost of health care services is recognized in the period in which it is provided and includes an estimate of the cost of services that have been incurred but not yet reported.

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

Activity for medical claims payable for the years ended December 31 is summarized as follows:

	2016	2015
Balance at the beginning of the period	$ 63,583,454	$ 73,691,984
Incurred		
Current year	588,860,765	559,253,812
Prior year	2,498,738	(12,495,538)
	591,359,503	546,758,274
Paid related to		
Current year	502,151,325	494,724,623
Prior year	63,835,404	62,142,181
Total paid	565,986,729	556,866,804
Balance at end of the period	$ 88,956,228	$ 63,583,454

NOTE 6 – PROVIDER INCENTIVES PAYABLE

As of January 1, 2008, HPSM's risk sharing agreement with care providers was replaced with a pay for performance based system. The program rewards primary care providers for their performance related to quality indicators including but not limited to submission of encounter data, asthma action plans, referral to an Obstetrician in the first trimester, effective treatment of diabetes patients, and maintenance of an open panel. Many of these are included in the capitation payment and others are reimbursed with claims submissions.

NOTE 7 – OPERATING LEASE OBLIGATIONS

HPSM entered into an operating lease agreement for their office space which provides for minimum annual rental payments expiring December 2015. HPSM leased 58,758 square feet of office space. The lease agreement ended December 31, 2015, with no extensions or renewals. There are no new lease agreements as HPSM occupies the building purchased in 2015.

Rental expense for operating lease for office space for the years ended December 31, 2016 and 2015, was $52,701 and $2,162,204, respectively, and is included in occupancy, equipment, and depreciation expense in the combined statements of revenues, expenses, and changes in net position.

NOTE 8 – RESERVE FOR STABILIZATION AND MINIMUM TANGIBLE NET EQUITY

The Commission, at its discretion, from time to time designates portions of net position for the establishment of certain reserves. These reserves are board designated and unrestricted. They are available to satisfy the unreserved net position.

As a limited license plan under Knox-Keene Health Care Services Plan Act of 1975 (the "Act"), HPSM is required to maintain a minimum level of tangible net equity. On November 9, 2016, the San Mateo Health Commission approved a change to the stabilization reserve from 250% of the minimum tangible net equity ("TNE") as defined by the Department of Managed Health Care regulation to two (2) months of operating expenses. As of December 31, 2016, the stabilization reserve of 250% was $136,100,000. As of December 31, 2015, stabilization reserve of 250% was $69,232,380.

As of December 31, 2016, the minimum TNE was $31,527,302. Total net position as of December 31, 2016, is $297,422,468, which exceeds the minimum tangible net equity by $265,895,166 and is 943% of TNE.

As of December 31, 2015, the minimum TNE was $27,692,952. Total net position as of December 31, 2015, is $317,759,060, which exceeds the minimum tangible net equity by $290,066,108 and is 1147% of TNE.

NOTE 9 – DEFERRED COMPENSATION FUND

HPSM contributes an amount equal to 7.5% of gross salary on behalf of the employee to an Internal Revenue Code Section 457 deferred compensation plan per Internal Revenue Service ("IRS") regulations in lieu of social security. In July 2016 HPSM held a vote of its employees to determine for themselves whether or not to participate in social security effective October 1, 2106. Employees who voted to participate in social security would no longer received the 7.5% of gross salary contribution. Those voting not to participate would continue to receive the contributions in lieu of social security.

All HPSM employees may participate in this deferred compensation plan under which employees are permitted to defer a portion of their annual salary until future years. For the years ended December 31, 2016 and 2015, HPSM contributed $1,361,928 and $1,378,750, respectively. The deferred compensation plan is administered by the International City Managers Association and the funds are invested under the terms of a trust agreement. The amounts are not available to employees until termination, retirement, death, or unforeseeable emergency.

The market value of the investments held equals the liability to plan participants under the deferred compensation plan. The deferred compensation investments consisted of various participant directed uninsured investments.

The assets in the plan are not available to pay the liabilities of HPSM. Therefore, the respective assets and liabilities are not reflected in the combined statements of net position of HPSM.

NOTE 10 – RETIREMENT PLAN

Effective January 1, 1994, HPSM established the Health Plan of San Mateo Employee Retirement Plan (the "Plan"). The Plan is a single-employer defined benefit pension (cash balance) plan administered by HPSM. Eligible HPSM employees become members of the Plan on the first day of employment. HPSM has the authority to amend or terminate the Plan at any time and for any reason by action of its Commission. The Plan does not issue a stand-alone financial report.

Under the Plan, participants' account balances are credited with contributions equal to 10% of their annual compensation, plus interest of 5% on an annual basis effective January 1, 2005. Benefits are payable in the form of a single sum payment upon termination or can be deferred through optional payment forms. Participants earn a vested right to accrued benefits upon completion of three years of service and upon death, permanent disability or employer termination of the Plan. Contributions to the Plan are made by HPSM as no contributions are permitted by participants.

Participant data for the Plan, as of the measurement date for the year indicated is as follows:

	2016	2015
Retired and beneficiaries	7	5
Inactive	37	35
Active	254	238
Total participants	298	278

Components of pension cost included in salaries and fringe benefits and deferred outflows and deferred inflows of resources as calculated under the requirements of GASB 68 are as follows:

	2016	2015
Pension cost		
Service cost	$ 1,187,234	$ 1,253,303
Interest cost	1,265,064	1,283,904
Projected earnings on plan investments	(1,341,363)	(1,307,391)
Current period effect of benefit changes	-	-
Current period difference between expected and actual experience	65,021	(80,706)
Current period effect of changes in assumptions	726	(258,159)
Current period difference between projected and actual investment earnings	(11,986)	275,613
Administrative expenses	-	-
Current period recognition of prior years' deferred outflows of resources	275,613	-
Current period recognition of prior years' deferred inflows of resources	(338,865)	-
Total pension cost	$ 1,101,444	$ 1,166,564

	2016	2015
Deferred outflows of resources as of December 31		
Difference between expected and actual experience	$ 300,397	$ -
Changes in assumptions	3,354	-
Difference between projected and actual investment earnings	778,897	1,102,454
Total	$ 1,082,648	$ 1,102,454

	2016	2015
Deferred inflows of resources as of December 31		
Difference between expected and actual experience	$ (298,615)	$ (379,321)
Changes in assumptions	(955,187)	(1,213,346)
Difference between projected and actual investment earnings	-	-
	$ (1,253,802)	$ (1,592,667)

Amount reported as deferred outflows of resources and deferred inflows of resources to pension will be recognized in pension expense are as follows:

Year Ended December 31,	
2017	$ (9,491)
2018	(9,491)
2019	(9,491)
2020	(183,444)
2021	40,763
Thereafter	-
	$ (171,154)

The following table summarizes changes in pension asset for the year ended December 31, 2016:

	Total Pension Liability	Plan Fiduciary Net Pension	Net Pension Asset
Balance at December 31, 2015	$ 16,110,081	$ 17,743,109	$ (1,633,028)
Changes during the year:			
Service cost at beginning of year	1,187,234	-	1,187,234
Interest	1,265,064	-	1,265,064
Changes of benefit terms	-	-	-
Differences between expected and actual experience	365,418	-	365,418
Changes in assumptions	4,080	-	4,080
Benefit payments	(875,405)	(875,405)	-
Contributions	-	1,164,095	(1,164,095)
Net investment income	-	1,401,293	(1,401,293)
Administrative expenses	-	-	-
Net change in total pension liability (asset)	1,946,391	1,689,983	256,408
Balance at December 31, 2016	$ 18,056,472	$ 19,433,092	$ (1,376,620)

Total pension liability	$ 18,056,472
Plan fiduciary net position	19,433,092
Net pension asset	$ (1,376,620)
Plan fiduciary net position as a percentage of the total pension asset	107.62%
Covered payroll as of December 31, 2016, actuarial valuation	$ 18,167,831
Net pension asset as a percentage of covered payroll	7.58%

The following table summarizes changes in pension liability for the year ended December 31, 2015:

	Total Pension Liability	Plan Fiduciary Net Pension	Net Pension Asset
Balance at December 31, 2014	$ 16,213,596	$ -	$ 16,213,596
Changes during the year:			
Service cost at beginning of year	1,253,303	17,063,530	(15,810,227)
Interest	1,283,904	-	1,283,904
Changes of benefit terms	-	-	-
Differences between expected and actual experience	(460,027)	-	(460,027)
Changes in assumptions	(1,471,505)	-	(1,471,505)
Benefit payments	(709,190)	(709,190)	-
Contributions	-	1,459,445	(1,459,445)
Net investment income	-	(70,676)	70,676
Administrative expenses	-	-	-
Net change in total pension liability (asset)	(103,515)	17,743,109	(17,846,624)
Balance at December 31, 2015	$ 16,110,081	$ 17,743,109	$ (1,633,028)

Total pension liability	$ 16,110,081
Plan fiduciary net position	17,743,109
Net pension asset	$ (1,633,028)
Plan fiduciary net position as a percentage of the total pension asset	110.14%
Covered payroll as of December 31, 2015, actuarial valuation	$ 16,535,874
Net pension asset as a percentage of covered payroll	9.88%

The following table summarizes the actuarial assumptions used to determine net pension liability and plan fiduciary net position as of December 31, 2016 and 2015:

	Contributions related to the actuarially determined contributions are made for the plan year
Valuation date:	January 1 to December 31
Actuarial cost method:	Entry age normal method
Amortization method:	Level percent of payroll
Asset valuation method:	Market value
Actuarial assumptions:	
Projected salary increases	5.00%
Mortality	Based on the RP-2014 Health Annuitant and Employee tables for males and females with generational projections from 2006 using projection scale MP-2016
Discount rate	7.50%

The following table summarizes the sensitivity of net pension asset to changes in the discount rates as of December 31:

	1% Decrease (6.50%)	Current Discount rate (7.50%)	1% Increase (8.50%)
Net pension asset as of December 31, 2016	$ (71,377)	$ (1,376,620)	$ (2,536,025)

	1% Decrease (6.50%)	Current Discount rate (7.50%)	1% Increase (8.50%)
Net pension asset as of December 31, 2015	$ (452,870)	$ (1,633,028)	$ (2,679,630)

NOTE 11 – MEDICAL REINSURANCE (STOP-LOSS INSURANCE)

HPSM has entered into certain reinsurance (stop-loss) agreements with third parties to limit its losses on individual claims. Under the terms of these agreements, the third parties will reimburse HPSM certain proportions of the cost of each member's annual health care services in excess of specified deductibles (for 2016 and 2015, $425,000 for all lines of business for all health care expenses excluding pharmacy), limited to $2,000,000 in aggregate over all contract years per member.

Stop-loss insurance premiums of $1,985,404 and $1,834,339 are included in other medical expense in 2016 and 2015, respectively. In 2016, there is a total of $1,874,019 in recoveries: Medi-Cal $275,115 and $445,750 for 2016 and 2015 dates of service; Cal MediConnect $139,271 and $536,853 for 2016 and 2015 dates of service; and CCS $241,678 and $235,352 for 2016 and 2015 dates of service. In 2015, there is a total of $1,065,919 in recoveries: Medi-Cal $620,082 and $100,569 for 2015 and 2014 dates of service; CareAdvantage $49,364 and $172,683 for 2015 and 2014 dates of service; Cal MediConnect $118,891 for 2014 dates of service; and HealthWorx $11,329 for 2014 dates of service. In 2014, there was a total of $555,304 in recoveries: Medi-Cal $91,141 and $409,758 for 2013 and 2014 dates of service; CareAdvantage $16,924 and $37,481 for 2013 and 2014 dates of service.

NOTE 12 – PROFESSIONAL LIABILITY INSURANCE

HPSM maintains insurance coverage for professional liability and errors and omissions insurance. The policy is an occurrence-based policy and designed specifically for health maintenance organizations to provide comprehensive professional liability insurance and errors and omissions insurance for HPSM employees and certain covered physicians. There have been no reductions in coverage or any claims that have exceeded coverage in any of the past three years.

NOTE 13 – COMMITMENTS AND CONTINGENCIES

In the ordinary course of business, HPSM is a party to claims and legal actions by enrollees, providers, and others. After consulting with legal counsel, HPSM's management is of the opinion that any liability that may ultimately be incurred as a result of claims or legal actions will not have a material effect on the financial position or results of operations of HPSM.

NOTE 14 – HEALTH CARE REFORM

The Patient Protection and Affordable Care Act ("PPACA") allowed for the expansion of Medicaid members in the State of California. Any further federal or state changes funding could have an impact on HPSM. With the changes in the executive branch, the future of PPACA and impact of future changes in Medicaid to HPSM is uncertain at this time.

SUPPLEMENTARY INFORMATION

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SAN MATEO HEALTH COMMISSION AND SAN MATEO COMMUNITY HEALTH AUTHORITY
(d.b.a. HEALTH PLAN OF SAN MATEO)
SUPPLEMENTARY SCHEDULE OF CHANGES IN THE NET PENSION ASSET AND RELATED RATIOS
December 31, 2016 and 2015

	2016	2015
Total pension liability		
Service cost at beginning of year	$ 1,187,234	$ 1,253,303
Interest	1,265,064	1,283,904
Changes of benefit terms	-	-
Differences between expected and actual experience	365,418	(460,027)
Changes in assumptions	4,080	(1,471,505)
Benefit payments	(875,405)	(709,190)
Net change in total pension liability	1,946,391	(103,515)
Total pension liability beginning of fiscal year	16,110,081	16,213,596
Total pension liability end of fiscal year (a)	$ 18,056,472	$ 16,110,081
Plan fiduciary net pension		
Contributions	$ 1,164,095	$ 1,459,445
Net investment income	1,401,293	(70,676)
Benefit payments	(875,405)	(709,190)
Administrative expenses	-	-
Other	-	-
Net change in Plan fiduciary net position	1,689,983	679,579
Plan fiduciary net position beginning of year	17,743,109	17,063,530
Plan fiduciary net position end of fiscal year (b)	$ 19,433,092	$ 17,743,109
Net pension asset end of fiscal year		
Plan's net pension asset (a) - (b)	$ (1,376,620)	$ (1,633,028)
Plan fiduciary net position as a percentage of the total pension asset	107.62%	110.14%
Covered payroll as of December 31, 2015, actuarial valuation	$ 18,167,831	$ 16,535,874
Net pension asset as a percentage of covered payroll	-7.58%	-9.88%

	2016	2015	2014	2013	2012
Actuarial determined contribution	$ 1,164,095	$ 1,437,466	$ 1,367,854	$ 1,321,835	$ 1,382,058
Contributions related to actuarially determined contribution	$ 1,164,095	$ 1,459,445	$ 1,333,194	$ 1,361,858	$ 1,440,249
Contribution deficiency (excess)	$ -	$ (21,979)	$ 34,660	$ (40,023)	$ (58,191)
Covered payroll	$ 18,167,831	$ 16,535,874	$ 15,989,836	$ 14,768,660	$ 13,203,459
Contribution as % of covered payroll	6.41%	8.83%	8.34%	9.22%	10.91%
Contributions made during the fiscal year	$ 1,164,095	$ 1,459,445	$ 1,333,194	$ 1,361,858	$ 1,440,249

	2011	2010	2009	2008	2007
Actuarial determined contribution	$ 1,192,417	$ 1,148,871	$ 1,175,390	$ 728,849	$ 491,648
Contributions related to actuarially determined contribution	$ 1,156,479	$ 1,124,362	$ 1,890,727	$ -	$ 604,671
Contribution deficiency (excess)	$ 35,938	$ 24,509	$ (715,337)	$ 728,849	$ (113,023)
Covered payroll	$ 12,680,263	$ 11,485,618	$ 10,190,445	$ 8,514,283	$ 7,323,431
Contribution as % of covered payroll	9.12%	9.79%	18.55%	0.00%	8.26%
Contributions made during the fiscal year	$ 1,156,479	$ 1,124,362	$ 1,890,727	$ -	$ 604,671

AGENDA ITEM: 5.2

DATE: April 12, 2017

No Meeting materials are included for Item 5.2 Review of 2016 Financial Statements

MEMORANDUM

AGENDA ITEM: 5.3

DATE: April 12, 2017

DATE: March 30, 2017

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer
Margaret Beed, Chief Medical Officer

RE: Quality Improvement Program Documents: 2016 Quality Improvement Program Evaluation, 2017 Quality Improvement Program Description, and 2017 Quality Improvement Work Plan

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Recommendation

Approve the attached HPSM quality documents for submission to DHCS: 2016 Quality Improvement Program; 2017 Quality Improvement Program Description; and 2017 Quality Improvement Work Plan.

Following is a summary of the 2016 Quality Improvement Program Evaluation and a brief description of the changes to the Quality Improvement Program Description and Work Plan. These documents are presented to the Commission for review as part of HPSM's standard quality oversight process.

Quality Improvement Program Evaluation

The 2016 Quality improvement (QI) Evaluation analyzes core clinical and service indicators to determine if the QI Program has achieved its key performance goals during the year. It is based on the 2016 QI Work Plan and provides guidance for the 2017 QI Program and Work Plan.

For the 2016 quality of care metrics, HPSM achieved one of its primary quality improvement goals of having no Health Effectiveness Data Information Set (HEDIS) measures below the minimum performance level (MPL) for Medi-Cal. This was accomplished by implementing quality improvement projects targeting the Medication Management for People with Asthma measure, improving the rate from 47.09% in 2015 (below the MPL of 47.88%) to 55.45% in 2016. Other ongoing quality improvement projects, such as the Prenatal Care Program, were effective in keeping Timely Prenatal and Postpartum Care rates above the MPL. HPSM had one measure above high performance level (HPL): Use of Imaging Studies for Low Back Pain. In addition, the 2016 rate for Control High Blood Pressure measure was the highest rate achieved to date for both the Medi-Cal and Cal MediConnect lines of business.

However, there was a noted decline in the rates for HbA1c control for our members with diabetes. HPSM will be targeting HbA1c control with its disease management program for Medi-Cal members with diabetes, set to launch in 2017.

To evaluate the quality of service and member experience, HSPM conducted the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for both Cal MediConnect and Medi-Cal lines of business. Overall, the results revealed opportunities for improvement in access related measures for both populations, particularly the Getting Care Quickly measures. HPSM performed well on the Rating of All Health Care and Ratings of Health Plan measures indicating that, despite some access issues, once members get in for care they rate their experience highly.

Every five years HPSM conducts a Group Needs Assessment (GNA) of its Medi-Cal membership. The 2016 GNA consisted of a mailed survey sent to a random sample of 4,000 Medi-Cal members or their guardians. Survey questions aimed to identify health education needs and gaps, accessibility and availability of cultural and linguistic services, improvements to existing services, and new approaches to address health disparities. Most survey respondents were aware that HSPM has free interpreter services, but indicated that their PCP spoke their language and/or they did not need or want an interpreter. Many respondents expressed not having enough appointment times as an important health concern, and many older adult respondents wanted help with getting an appointment with a specialist. The majority of respondents across all member age groups indicated that they wanted information on exercise, weight loss, healthy eating, healthy teeth and healthy aging. HPSM is including additional resources on these topics in its health education program.

Quality Improvement Program Description

The QI Program description details the structure, membership and responsibilities of the Quality Improvement committees as well as the operational committees that report to the Quality Improvement committees for oversight. It also outlines HPSM's process for monitoring and improving member safety, including procedures for identifying, researching and resolving quality of care issues

Minor changes were made to the 2016 QI Program Description to reflect changes in committee member title changes and reporting procedures. Specific objectives for 2017 were added for the health education program, culturally and linguistically appropriate services program, and all active quality improvement projects.

Quality Improvement Work Plan

The QI Work Plan is the operational and functional component of the QI Program that outlines the key activities for the upcoming year. It provides the detailed objectives, scope, timeline, deliverables and individual responsible for each activity.

Monitoring and improving timely access to care for our members will continue to be an area of focus for quality improvement in 2017. We also continue to work to improve targeted HEDIS measures such as Cervical Cancer Screenings, Plan All-Cause Readmissions, and Comprehensive Diabetes Care.

DRAFT

RESOLUTION OF THE

SAN MATEO HEALTH COMMISSION and
THE SAN MATEO COMMUNITY HEALTH AUTHORITY

IN THE MATTER OF APPROVAL OF
2016 QUALITY IMPROVEMENT PROGRAM EVALUATION
2017 QUALITY IMPROVEMENT PROGRAM DESCRIPTION
2017 QUALITY IMPROVEMENT WORK PLAN

RESOLUTION 2017 -

RECITAL: WHEREAS,

A. The San Mateo Health Commission is required by the State to review and approve the Quality Improvement Program Evaluation; the Quality Improvement Program Description; and, Quality Improvement Work Plan on an annual basis; and

B. These documents have been prepared by the Quality Staff and reviewed by the Quality Improvement Committee to be submitted to the Commission for approval.

NOW, THEREFORE, IT IS HEREBY RESOLVED AS FOLLOWS:

1. The San Mateo Health Commission adopts the following documents as attached:
    a. 2016 Quality Improvement Program Evaluation
    b. 2017 Quality Improvement Program Description
    c. 2017 Quality Improvement Work Plan

PASSED, APPROVED, AND ADOPTED by the San Mateo Health Commission this 12th day of April, 2017 by the following votes:

AYES:

NOES:

ABSTAINED:

ABSENT:

_____
John Ferrelli, Vice Chair

ATTEST:

BY: _____
C. Burgess, Clerk

APPROVED AS TO FORM:

_____
Kristina Paszek
DEPUTY COUNTY COUNSEL

2016 QUALITY IMPROVEMENT PROGRAM ANNUAL EVALUATION

_____ _____

Margaret Beed, M.D. Date

Chief Medical Officer

Health Plan of San Mateo

_____ _____

Barbara Erbacher Date

Chairperson

San Mateo Health Commission

TABLE OF CONTENTS

Introduction

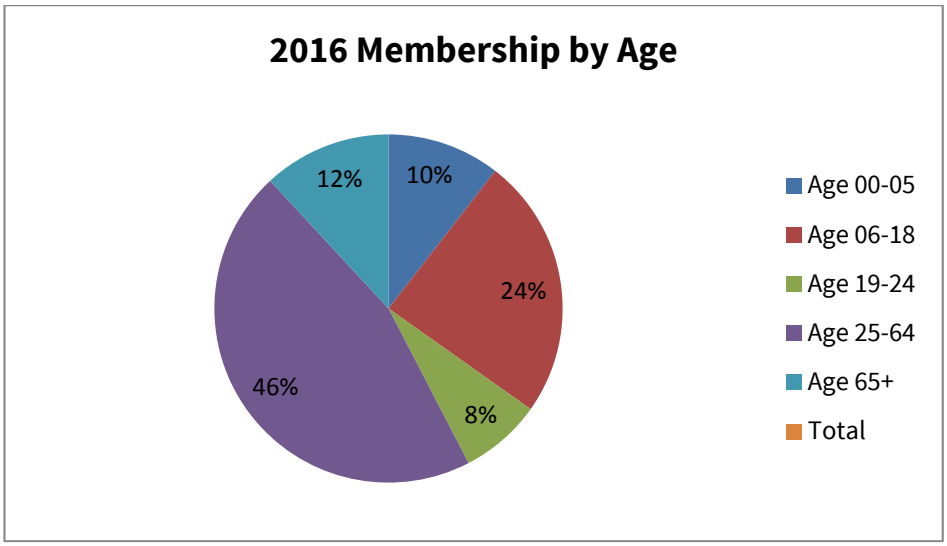
This program evaluation incorporates results from quality activities carried out in 2016. It should be noted that based on the HEDIS data collection and reporting schedule, HEDIS results discussed below are of services provided in 2015, which were then collected and analyzed in 2016.

HPSM MEMBERSHIP

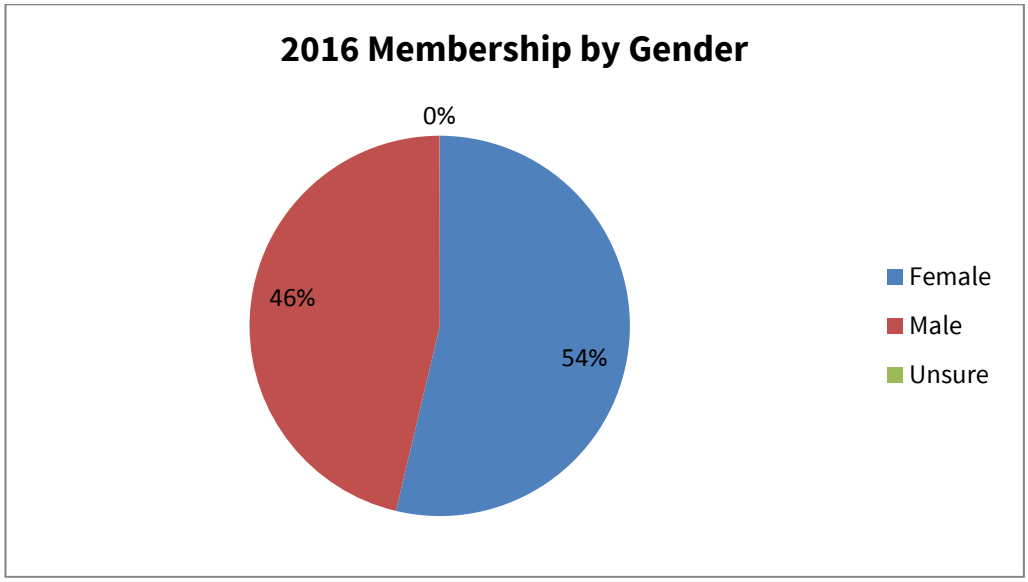
The following chart summarizes the membership in HPSM's current lines of business as of December 1, 2016:

Medi-Cal	CareAdvantage	Cal MediConnect	HealthWorx	Healthy Kids	ACE	**Total**
124,554 (Excluding members dually enrolled in CA or CMC)	400	9404	1050	836	21,269	**157,513**
79%	0.3%	6%	0.7%	0.5%	13.5%	**100.0%**

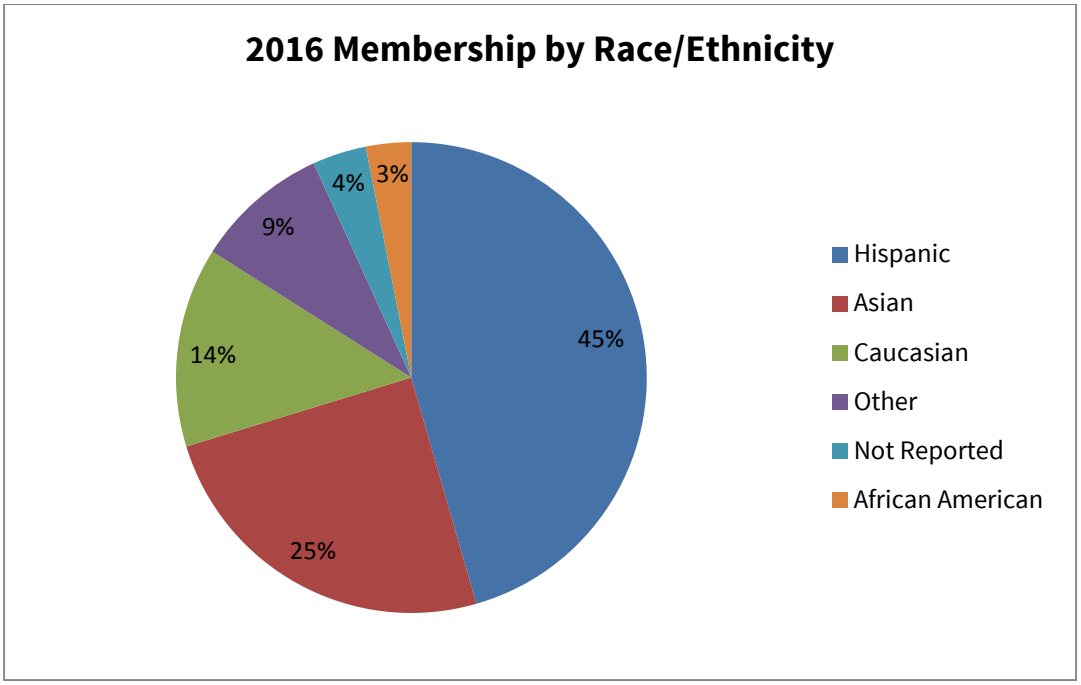
HPSM Membership by Age:



Membership by Gender:



Membership by Race/Ethnicity:



HEDIS RESULTS

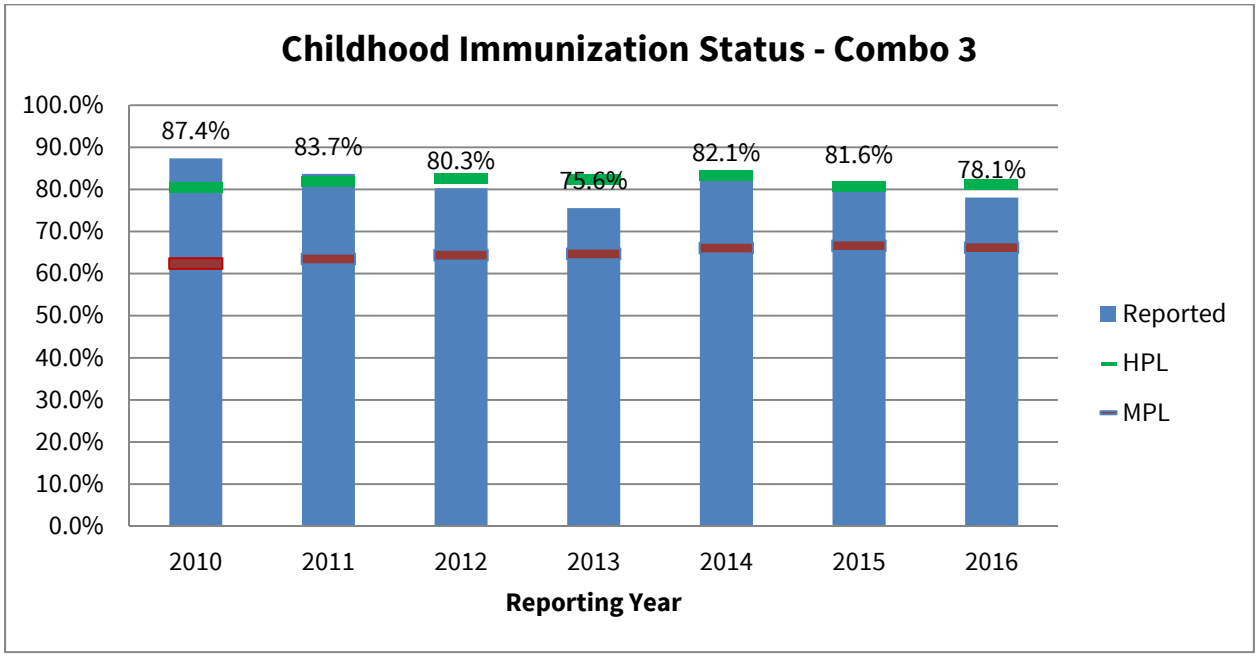
In 2016, HPSM was required to collect and report HEDIS measures for the Medi-Cal and CareAdvantage populations. The 2016 HEDIS results are the analysis of services provided in 2015. In 2014, the CareAdvantage population included members that moved into Cal MediConnect on January 1, 2015. In this evaluation, HSPM will report separate HEDIS results for the Cal MediConnect line of business in 2016. Individual HEDIS measures are selected by the Centers for Medicare and Medicaid Services (CMS) for CareAdvantage, the Department of Health Care Services Medi-Cal Managed Care Division (DHCS-MMCD) for Medi-Cal.

DHCS set a Minimum Performance Level (MPL) and a High Performance Level (HPL) for each required measure. Performance levels are based on prior year's HEDIS reporting from all National Committee of Quality Assurance (NCQA) national Medicaid plans. The MPL and HPL are the 25th and 90th percentiles respectively.

Below is a selection of HEDIS measures that are areas of focus for quality of improvement compared over the last five years. See the appendix for the full set of 2016 HEDIS results for Medi-Cal and CareAdvantage lines of business.

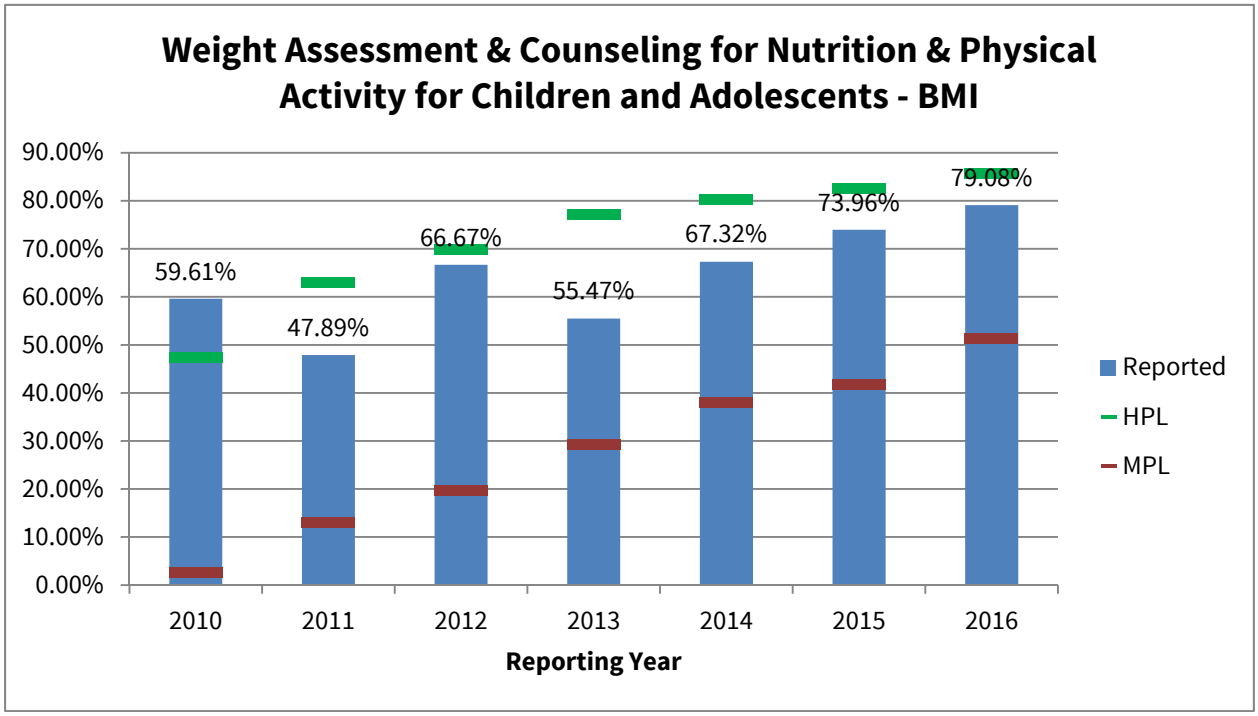
CHILDHOOD IMMUNIZATION STATUS

Combo 3: Percentage of children 2 years of age who receive a series of vaccines (# of injections) by their second birthday: Dtap (4), Hep B (3), PCV (4), IPV (3), HiB (3), MMR (1), VZV (1)



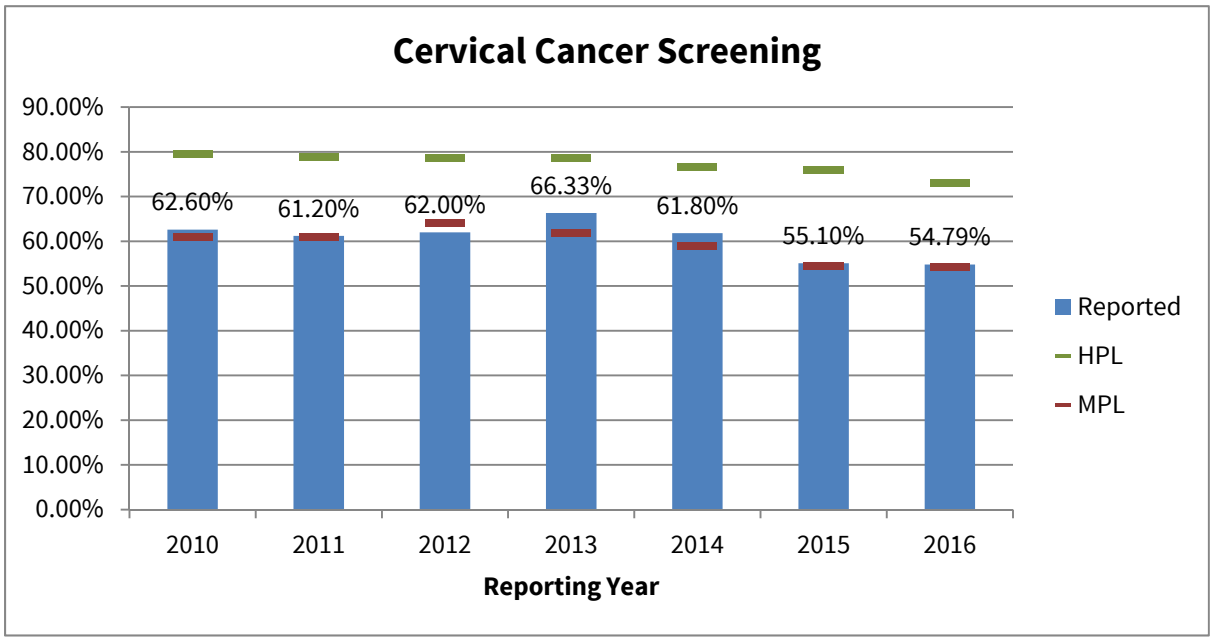
HPSM continues to perform well with our childhood immunizations, achieving a rate that is well above the minimum performance level for 2016, despite a slight drop from 81.6% in 2015 to 78.1% in 2016. We were able to achieve such results with excellent data capture. We receive immunization data directly through processing Child Health and Disability Prevention (CHDP) claims. We also receive data feeds from the California Immunization Registry (CAIR), which allows HPSM to track vaccines administered by providers outside of our network.

WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION & PHYSICAL ACTIVITY FOR CHILDREN AND ADOLESCENTS -BMI



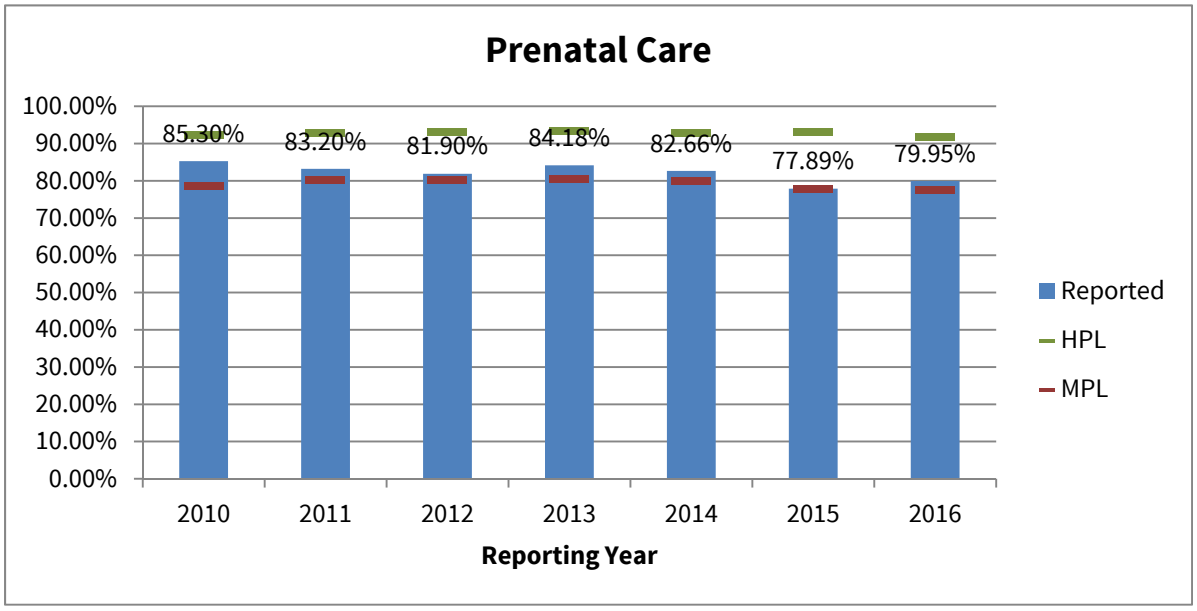
We continue to improve in the BMI Percentile measure, increasing again from 73.96% in 2015 to 79.08% in 2016. There was an increase in the Physical Activity Counseling measures from the 2015 rate of 61.98% to 68.62. Nutrition counseling increased also from 75.00% to 79.08.

CERVICAL CANCER SCREENING



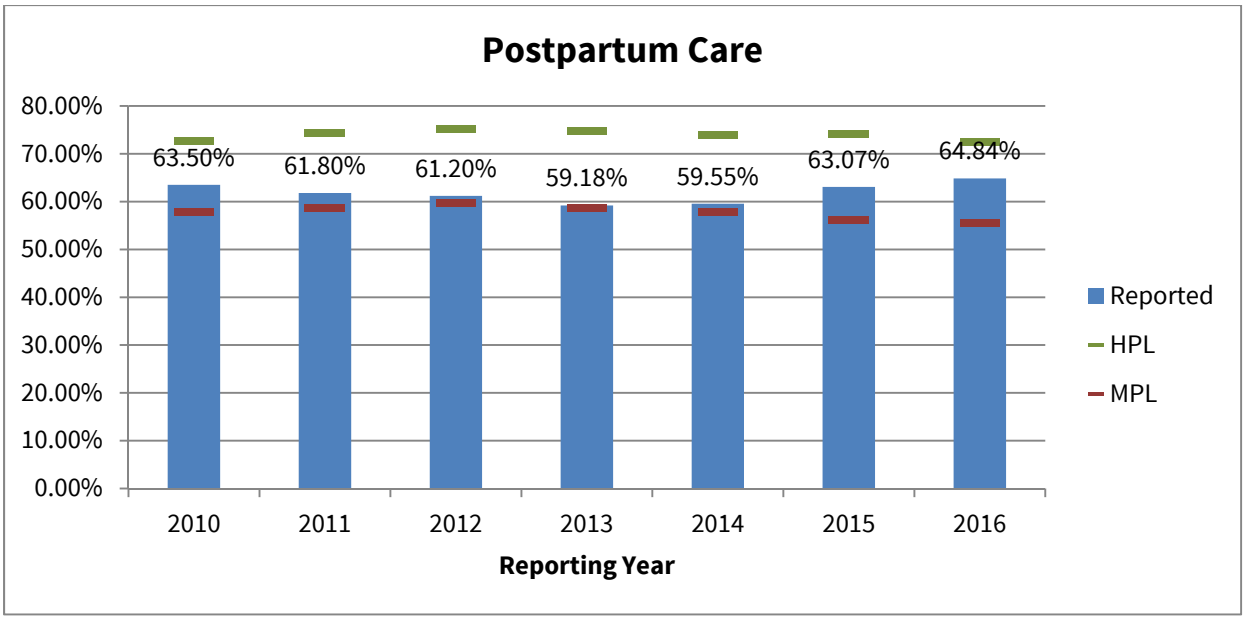
There was a slight decrease in rate from 55.10% in 2015 to 54.79% in 2016. However, our rate was still over the minimum performance level (MPL) of 54.33%. Efforts to improve cervical cancer screening rates are described below.

PRENATAL CARE



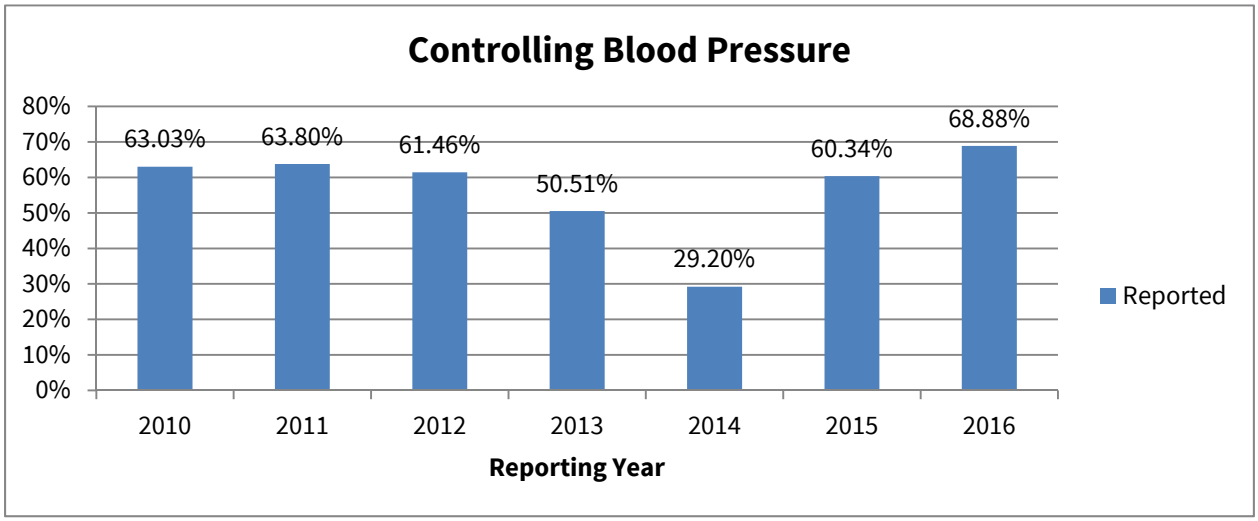
The timely prenatal care rate increased from 77.89% in 2015 to 79.95% in 2016, raising it above the MPL of 77.44%. There is a limited number of obstetric providers in San Mateo County who serve our pregnant Medi-Cal members making this a continued area of focus for QI interventions. Efforts to expand our OB provider network and increase timely access to prenatal care described below.

POSTPARTUM CARE



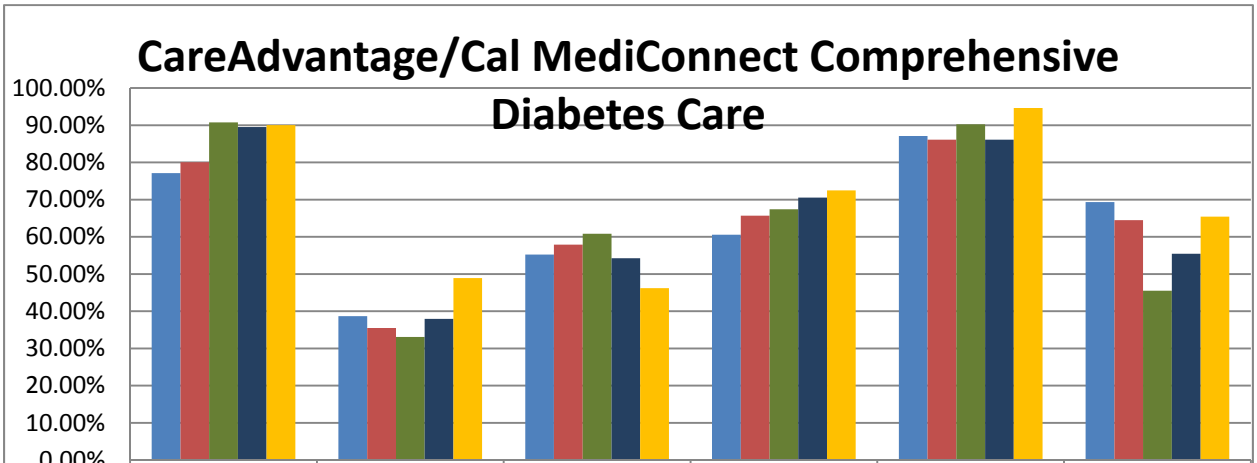
The timely postpartum care rate has steadily increased since 2013 and increased again from 63.07% in 2015 to 64.84% in 2016. We attribute this to our Prenatal and Postpartum Care Program, described below. We continue to work on improving our rate for this measure in 2017 and have selected it as our required Performance Improvement Program (PIP) for DHCS.

CONTROLLING HIGH BLOOD PRESSURE (CBP)



The Controlling High Blood Pressure rate increased again from 60.34% in 2015 to 68.88% in 2016. Reducing hypertension remains an area of focus for clinical care improvement for our CareAdvantage population. Improvement activities are described below.

COMPREHENSIVE DIABETES CARE (CDC)



	HbA1C Test	HbA1C >9%	HbA1C <8%	Eye Exam	Nephropathy Scn	BP <140/90
2012	77.13%	38.69%	55.23%	60.58%	87.10%	69.34%
2013	80.05%	35.52%	57.91%	65.69%	86.13%	64.48%
2014	90.75%	33.09%	60.83%	67.40%	90.27%	45.50%
2015	89.54%	37.96%	54.26%	70.56%	86.13%	55.47%
2016	90.02%	48.91%	46.23%	72.51%	94.65%	65.45%

All of the Comprehensive Diabetes Care measures improved for Medicare lines of business in 2016, with the exception of the measures for good HbA1c control. We continue to have P4P incentives for all of the diabetes measures with the exception of the blood pressure measure.

QUALITY IMPROVEMENT PROGRAMS

QUALITY OF CLINICAL CARE ACTIVITIES

Prenatal and Postpartum Care Program

PROGRAM DESCRIPTION

In 2016, HPSM's Quality Improvement Department continued enrolling pregnant women into HPSM's Prenatal & Postpartum Care (PPC) Program. The program focuses on promoting timely entry into prenatal care and timely postpartum care by providing gift card incentives. Program participants receive gift card incentives as they meet pregnancy milestones in their first, second, and third trimester as well as postpartum. Members are identified by the following data sources: prenatal ultrasound visits, first prenatal visit, prenatal vitamins, pregnancy diagnosis codes, and a recent delivery. Members are also identified through P4P Provider Referral Incentive Forms, OB Providers, Family Health Services, and Self-Referral. Once the member is identified as pregnant through the different data sources, the Health Promotion Coordinator conducts outbound calls to this list of members. If the member chooses to participate, the Health Promotion Coordinator enrolls and follows-up with

the member throughout her pregnancy. In addition, the Health Promotion Coordinator links the member to community programs related to their psycho-social wants or needs.

PROGRAM GOAL

The objective of the program is to increase enrollment in the Prenatal and Postpartum Care Program. High enrollment into HPSM prenatal program reflects higher rates of women getting timely prenatal and postpartum care.

METRICS

As of 2016, 854 members enrolled in HPSM's Prenatal and Postpartum Care Program, 204 attended their first trimester appointment, 114 attended their second trimester appointment, 143 attended their third trimester appointment, and 213 attended their postpartum appointment.

MAJOR ACCOMPLISHMENTS

- HPSM's HEDIS Timeliness of Prenatal Care rate improved 2.06% over the previous year from 77.89% to 79.95%.
- HPSM's HEDIS Postpartum Care rate improved 1.77% over the previous year from 63.07% to 64.84%.

PRENATAL & POSTPARTUM PROGRAM UPDATES

Member Incentive Increased

In 2016, HPSM increased the monetary incentive for participating in our Prenatal and Postpartum Program. To improve pregnant women's early utilization of prenatal care, we raised the Target gift card amount from $15 to $50 for members who visit their doctor during their first trimester (i.e., the initial 12 weeks of pregnancy). We will measure the impact of this intervention by comparing the number of participants who accessed early prenatal care before and after the incentive increase.

HPSM-FHS Partnership

In 2016, HPSM partnered with the County of San Mateo Family Health Services (FHS) to provide a monthly file of pregnant HPSM Medi-Cal members living in San Mateo County. FHS then reaches out to pregnant African American teens under 20 years of age and encourages them to visit their prenatal care provider during their first trimester. Such data sharing enables HPSM and FHS to work collaboratively on improving outcomes for this vulnerable population of expectant mothers and their babies.

Program Participant Survey

In 2016, HPSM surveyed members enrolled in our Prenatal and Postpartum Care Program about their experience with the program, gift selection and barriers to care. A total of 37 members responded to the survey (0.17% response rate, which represented 0.04% of pregnant HPSM members enrolled in the PPC Program). Key findings include:

- Most respondents are "satisfied" or "very satisfied" with the PPC Program.
- Most respondents like the gift choice selection.
- Many respondents had no problems with the program, but a few had problems receiving the gifts or forms in the mail and getting their providers to fill out the forms.
- Most respondents didn't have any issues attending their health care appointment, but many indicated childcare and transportation as barriers to attendance.
-

In response to these results, we plan to take the following actions:

- Improve the mailing of gifts, reminder forms and information for providers to fill out.

- Explore options for providing childcare and transportation to scheduled health care appointments.
- Consider conducting a telephone survey (instead of a written survey) to increase response rates.

Provider Secret Shopper Calls

In July of 2016, HPSM Quality Improvement (QI) Department conducted "Secret Shopper" telephone calls to contracted OB providers accepting new patients to assess for timely access around prenatal care. QI staff were provided a call script guide and instructed to act as newly pregnant (8-10 weeks) patients seeking an initial prenatal appointment (e.g. w/in ten business days or two calendar weeks from the time an appointment is requested to the appointment date). Key findings from the calls include:

- Decrease in the number of OB providers available to serve HPSM Medi-Cal members throughout the San Mateo County, especially in the Southern region, where a majority of pregnant members reside.
- Improved wait times to speak to a live representative and schedule an initial appointment compared to prior access study conducted in 2015 .

In response to these results, we have taken the following steps:

- Developed an internal prenatal and postpartum workgroup tasked with improving timely prenatal and postpartum care. The workgroup is composed of the Provider Services Manager, Medical Director, and Quality Improvement staff.
- Increased reimbursement rates to OB providers with the hopes of retaining the current network of providers.
- Explored contracting with OB providers in the area.
- Focused on expanding OB provider network in the South and Mid County areas of the county particularly in the central and south county where a majority of our pregnant members reside.

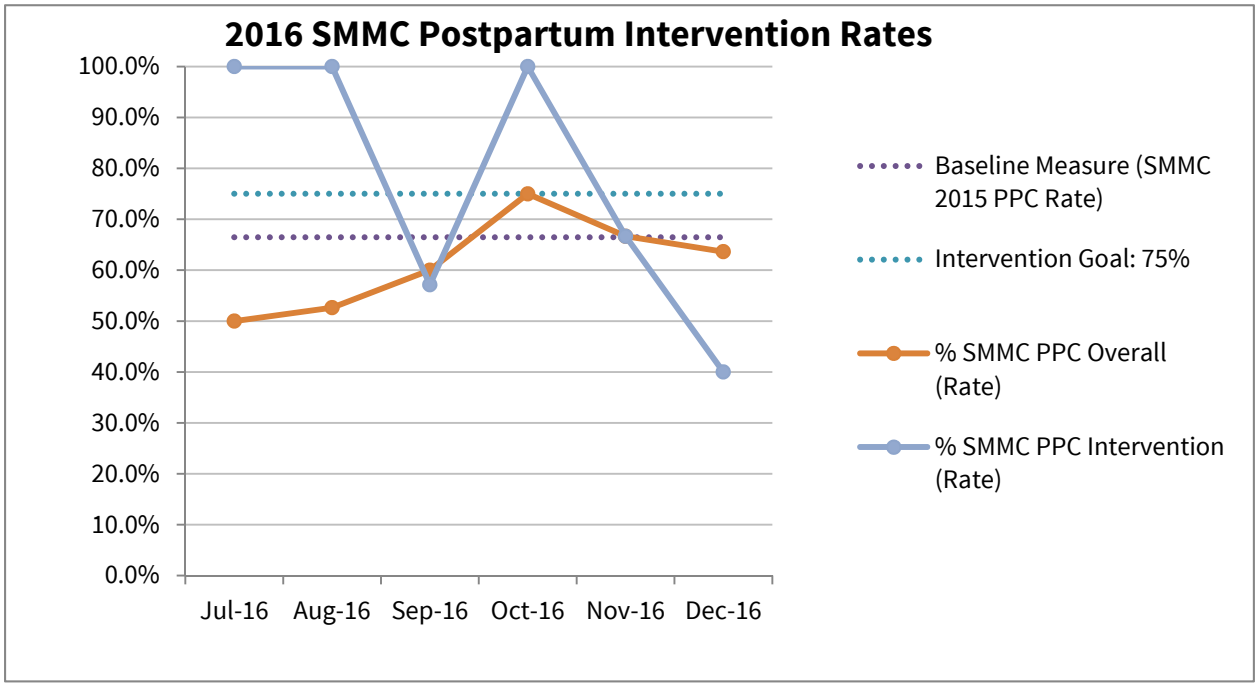
TEXT MESSAGING INTERVENTION (PERFORMANCE IMPROVEMENT PLAN (PIP)

The Postpartum Care (PPC) performance improvement plan (PIP) targets members that receive OB care at San Mateo Medical Centers (SMMC) because this provider sees the highest volume of HPSM Medi-Cal members. The PIP is aimed at improving the postpartum care rate of women who had a live birth and have SMMC as their OB care provider for timely postpartum care. The goal for this PIP is to improve timely (21-56 day post-delivery) postpartum care from 66.46% to 75% for all HPSM women who had a live birth delivery and received OB care from San Mateo Medical Center by June 30, 2017. Analysis of 2014 measurement year HEDIS data demonstrates that San Mateo Medical Center OB clinic has a compliance rate of 66.46%.Given that SMMC has the highest percentage in members, HPSM decided to focus on improving timely postpartum care at SMMC.

In 2016, the Health Plan collaborated with the state to begin a new performance improvement plan narrowing its focus on a specific intervention to improve timely postpartum visit rates. For this project, the Quality team collaborated with SMMC to develop health promotion text messaging content to encourage women to schedule and attend their postpartum visit. Through a collaborative effort between HPSM and SMMC a series of text messages were composed to reach out to women who are receiving care at SMMC and are due for a postpartum appointment. Text messaging content included reminding women to schedule a postpartum appointment, the significance of postpartum care after delivery and the PPC visit being a covered benefit. The project started in July 2016 and will continue through June 2017.

From July through December 2016 , 51 (56%) of the eligible population (SMMC members with recent deliveries) received a text message reminding them to attend their postpartum appointment. Of the 51 SMMC members, 38 (74.50%) members successfully received a reminder text message and attended their postpartum appointment.

Dashboard 1: Current SMMC Intervention rate



Despite the small number of participants in the intervention at this point, for women with an active cell phone number, they are demonstrating success in receiving the text message and subsequently attending their postpartum appointment within 3-8 weeks after delivery. The claim lag in data, or the delay between when services are rendered and when the claim for the services is received by the plan, could be a possible reason for lower compliance rates in October, November, and December. In the month of February and March of 2017 HPSM will run a report of the women in those months to assess if the low compliance rate was due to the claim lag.

Barriers/Issues with Text Messaging program

Following are the identified potential barriers that have made it challenging to reach the postpartum goal by 2017.

One of the challenges to this intervention is making sure the member's contact phone number is a cell phone number versus a land line phone number. The Health Promotion Coordinator verifies the telephone number for member's enrolled in HPSM Prenatal and Postpartum Care program throughout her pregnancy. In addition, the Health Promotion Coordinator works with the OB Clinic to obtain accurate phone numbers. Additionally, CareMessage uses software to check validity of the cell phone number.

Our monthly data analysis highlighted an improvement area that we had not previously explored internally related to the process to combine the CareMessage and Claims data for analysis. To avoid having to maintain two separate data sets, we worked with HPSM reporting team to merge the records for each data set into one new data set that contained all the information at the member detail level. The variable that was common to both data sets was the member ID. The Quality Specialist was able to have new data that showed the women who received a text message and of those, who also had postpartum claim during the 21-56 days post-delivery timeframe. As a result, a new process has been implemented to merge the two data sets on an ongoing basis.

Next Steps for Text Messaging program

1) Given the ease of using the CareMessage platform, uploading participant data, scheduling text message delivery, and downloading reports related to text message delivery status, participation and response rates, HPSM is considering expanding the intervention to additional provider groups. Expanding the reminder text messaging campaign would allow a concurrent member outreach PDSA cycle, increase sample size for more accurate analysis and for HPSM to better detect a difference in compliance between members that receive the intervention and those that don't.

2) Continue to analyze the data monthly to evaluate and determine if improvements are occurring in reaching out to these subgroups of assigned women.

3) Consider changing the time and days of when the text messages are sent to members to a later time in the afternoon or evening hour to see if the number of responses increases.

OB PROVIDER PAY-FOR-PERFORMANCE (P4P) INCENTIVE

HPSM continued to offers monetary incentives through the Pay for Performance (P4P) program to OB Practices that provide timely prenatal care to pregnant women early in their pregnancy (first 12 weeks) and after delivery during the postpartum period (3-8 weeks after delivery). The incentives are aligned with HEDIS technical specifications for prenatal and postpartum care measures. In addition, Primary Care Providers that refer a pregnant woman to an OB physician receive an incentive for each verification form received.

The following information summarizes incentive payments to OB providers from January through September 2016. It shows incentives and the total number of payments made to providers.

Incentive	**Total**
OB Visit by OB physician $100	241
Referrals by PCP to OB physicians$50	67
Postpartum exam by OB/GYN physician $50	491

PROGRAM BARRIERS/ISSUES

The challenges to achieving the objectives of this intervention are the following:

- Identifying pregnant HPSM members early in their pregnancy due to claims lag.
- Members enroll with HPSM late during their pregnancy.
- Identification of pregnant women and those women who have just delivered.
- Members do not perceive the urgency for postpartum care check-up.
- 1st Prenatal appointment happens after the first twelve weeks or 42 days from enrollment.
- Postpartum care happens before or after the 21-56 days recommendation.
- Shortage of OB providers accepting new HPSM Medi-Cal members.

ACTION PLAN FOR 2017

- HPSM will continue to identify members who are pregnant early in their pregnancy before their first trimester from the claims report, OB referrals and P4P referrals following the criteria of a positive pregnancy test result and first prenatal appointment.
- HPSM will continue working with the Provider Services department to address access issues in OB Provider network.
- HPSM will work with PCP office that offers pregnancy tests to send a referral list of members who are pregnant.

- Meet HSAG (Health Services Advisory Group) reporting requirements for process improvement project. The QI specialist will submit Mods 4 and 5 for final validation in August 2017.
- HPSM will reach out to delivering hospitals to receive a delivery report of recently delivered HPSM Medi-Cal members.
- HPSM will continue to conduct postpartum weekly reminder calls to members who are enrolled in the Prenatal and Postpartum Care program.
- HPSM will survey members who completed the prenatal and postpartum program to learn about their experience and ways to improve the program.
- HPSM will continue to offer gift card incentives to members that attend timely prenatal and postpartum care visits.
- HPSM will include information that explains the importance of the first trimester prenatal and postpartum visits in the member and provider newsletters.
- HPSM will continue to promote the Prenatal and Postpartum member incentive program, a free program that provides gift care incentives for timely prenatal and postpartum care.
- HPSM will conduct a telephone survey of OB/GYNs to learn more about perceived barriers.

Cervical Cancer Screening Outreach Project

PROGRAM DESCRIPTION

In 2016, HPSM's Quality Improvement Department implemented a targeted mailing to Medi-Cal members due for cervical cancer screening (CCS). The mailing consisted of a letter written to inform these women of their need to receive a routine Pap test and encourage them to schedule an appointment with their primary care provider (PCP), or gynecology practice. The letter, signed by HPSM's Chief Medical Director, included the name and phone number of their PCP (or Gyn), in addition to educational messages on the importance of receiving routine CCS until age 64. Three cohorts of women continuously enrolled in Medi-Cal, age 21 to 64, were identified for the targeted mailing. Women assigned to San Mateo Medical Center clinics constituted one cohort, women assigned to a PCP practice formed a separate cohort, and the third cohort consisted of women with "special member status". The latter are members who are not assigned to a specific HPSM PCP for primary care, and can go to any (and multiple) provider that accepts Medi-Cal patients.

PROGRAM GOAL

Improve the CCS screening rate among women, age 21 to 64, who are due for CCS and continuously enrolled in Medi-Cal.

METRICS

- Mail intervention letter to target population to prompt them to schedule and complete Pap test appointment with their PCP or Gyn.
- Target population completes CCS in response to intervention letter.

Intervention Population Members assigned to: Palo Alto Medical Foundation	**Count** 75	**Completed CCS** (as of November) 7

Solo PCPs	620	47
San Mateo Medical Center	503	57
Special Member Codes	508	
Total	**1706**	

PROGRAM UPDATE

The mailings to the three cohorts were implemented separately in July, August, and October. Collectively, 1706 women were mailed the intervention letter encouraging them to schedule a Pap test. At the time of this update (December), HPSM's Informatics team has received claims data that shows that 111 women have received a CCS test. To properly assess the CCS outcome for women in all three cohorts, HPSM Quality pulled the data in February 2017 to include updated claims data that includes the cohort of women in the October mailing. This is to allow the recommended 3 months from the mailing date of their outreach letter, for HPSM to receive a claim for CCS provided to women in this cohort.

PROGRAM BARRIERS/ISSUES

The challenges to achieving the objectives of this intervention are the following:

- **Non-deliverable addresses "returns":** some women in the target population did not receive their intervention letter due to bad addresses
- **Systems-related**
  - PCP or Gyn may not be able to offer appointment within desired timeframe
  - Woman does not receive an appointment reminder from PCP/Gyn, a practice known to reduce the chance of a "no show"
  - Woman may not have regular relationship with PCP who encourages CCS

- **Beliefs and attitudes among target group**
  - Scheduling an appointment for uncomfortable pelvic exam for preventive care is not a priority (personal/cultural).
  - Low perceived risk in older age group: women believe it's unnecessary to receive routine CCS for prevention after a certain age or after many years in a stable intimate relationship.

RECOMMENDED ACTION PLAN FOR 2017

If HPSM Quality decides to implement a targeted mailing to remind Medi-Cal members that they are due for CCS, following are suggestions that address the barriers/issues described above:

- **Clean member mailing data file prior to mailing:** Use the member data file provided by Informatics to cross-check mailing address data with Member Services and/or Marketing. The purpose would be to identify addresses that have previously been "returned" as non-deliverable. Remove these from the CCS mailing list.
- **Inform assigned PCPs of HSPM intervention letter project**: Prior to mailing letter to target population, contact assigned PCPs via email and include copy of intervention letter. Request their cooperation in advising staff of member calls to schedule CCS, and in promoting the benefits of preventive CCS to their female patients in the target age range.

- **Provide brief PCP training on addressing barriers to CCS among Medi-Cal women**: Identify PCPs with high volume assignment of women due for CCS, on their panel. Arrange to provide ½ hour in-service, or deliver a PPT, that addresses common attitudinal/perception barriers, including cultural considerations, that are relevant to target groups. Provide educational messages to use during clinic visits that inform women of the benefits of CCS. Include the benefits of establishing a regular primary care relationship with women, and implementing an appointment reminder system to help increase completion rate among women who make appointments for CCS.
- **Use a text message campaign to supplement intervention letter:** To reinforce the message in the intervention letter, schedule text messages to be sent to target population one week after mailing date of letter. Provide PCP phone number to call for CCS appointment.

CCS PROCESS IMPROVEMENT PROJECT (PIP)

The Cervical Cancer Screening PIP focuses on supporting Ravenswood Family Health Center (RFHC) in identifying all assigned Medi-Cal members who are due for a Pap test, for timely preventive care. It is a collaborative effort to create and test a safety net system for reaching out to women that have been previously excluded, or have not responded to the clinic's existing CCS recall/reminder system. HPSM's Quality Improvement Department provides RFHC a monthly file of new and currently assigned Medi-Cal female members, age 24 to 64, for whom HPSM does not have an administrative claim for cervical cancer screening within the past 3 to 5 years. The purpose in receiving this monthly file is twofold: 1) it enables RFHC Decision Support and Women's Health teams to identify both newly and currently assigned women that need to be contacted about scheduling an appointment and 2) allows RFHC's data staff to update the screening status of the women in the file, based on clinic data that confirms completion of CCS. In the long term, use of this monthly file will help increase Ravenswood's CCS rate.

METRICS

Goal: to increase the CCS rate among the target population at RFHC from 69% (2015 baseline) to 77% by June 30, 2017.

Objective: To increase the number of PCP and Pap appointments scheduled for women assigned to RFHC through a new process that identifies and reaches out to women previously excluded from RFHC's Pap recall reminder system, and women who have been previously included but have not responded.

Measurement month	**denominator**	**numerator (completed CCS)**		**CCS Rate**
		w/ HPSM Claim	RFHC CCS clinic data	
October 2016	1942	930	328	65%
November 2016	1954	949	315	65%
December 2016	1967	949		

PROJECT UPDATE

In October 2016, the project started with an initial test cycle of 3 months and will continue through June 2017. Subsequent cycles will serve to further test and make adjustments as needed to this proposed safety net system (intervention). HPSM provided RFHC a monthly file for October, November, and December. RFHC has updated the monthly files for October and November with clinic data and sent to HPSM Quality. In January 2017, HPSM Quality will review the member data added to the files by RFHC staff and assess how many women RFHC confirmed for previously receiving a reminder letter, or a phone call from clinic staff, to schedule an appointment with Women's Health or their PCP. HPSM's review will also include appointments that have been scheduled, or completed, for the women identified in the 3 month cycle.

PROJECT BARRIERS/ISSUES

Following are the project's potential barriers and issues which could make it challenging to reach the CCS goal by June 2017.

- RFHC may not have sufficient staff time to dedicate to phone outreach to women about scheduling appointments.
- RFHC may not be able to offer available CCS appointment within 2 - 3 weeks.
- Women who do not have a regular relationship with a RFHC PCP, may not respond to a reminder letter or phone call from RFHC to schedule an appointment, or complete a scheduled appointment.
- Women may not be motivated to schedule or keep an appointment for uncomfortable pelvic exam for preventive care, because it is not a priority (personal/cultural).

RECOMMENDED ACTION PLAN FOR 2017

- HPSM's Quality Improvement Department will continue to work with RFHC on implementing the test cycles for this process improvement project through June 2017. The assigned Quality Improvement (QI) Specialist will continue to receive from HPSM Informatics team, the monthly file of Medi-Cal women assigned to RFHC with updated CCS status, and forward to RFHC staff at the beginning of each month. At the end of each month, when RFHC sends back the monthly file with the added clinic data, the QI Specialist will review data before forwarding to HPSM Informatics to analyze and calculate the monthly CCS rate for RFHC.
- The QI Specialist will continually assess the need to make adjustments to expectations related to systems/process changes at RFHC, with input from RFHC staff. This assessment will be based on the review of appointments scheduled and completed for the women identified for outreach in the monthly files. The assessment will also include input from RFHC regarding staff resources to implement phone outreach on a regular basis, for women who don't respond to reminder letter.
- Meet Health Services Advisory Group (HSAG) reporting requirements for process improvement project. The QI specialist will submit Mods 4 and 5 for final validation in August 2017.

REDUCING 30-DAY READMISSIONS

PROGRAM DESCRIPTION

The performance improvement plan (PIP) targets readmissions from St. Francis Pavilion and St. Francis Heights because these two particular SNFs have the highest volume of index discharges and readmissions back into acute care. The PIP is aimed at reducing the readmission rate in the target population of members who have been discharged from an acute care facility to two of the high volume SNFs, St. Francis Pavilion and St. Francis Heights. The goal for this PIP is to decrease the rate of 30 day readmissions from two skilled nursing facilities (St. Francis Pavilion and St. Francis Heights) back to hospitals among all of HPSM's MMP population, from 22.3% to 16% by June 30, 2017. Data shows that the average age of these members are 77.2 years old and that they are being readmitted with diagnoses related to initial admission diagnosis indicating these facilities are not adequately rehabilitating members to be discharged back to their homes.

Simultaneously, HPSM's Care Coordination Department has continued to implement the Coleman Model intervention targeting the MMP population which focuses on high quality coordination of care to members discharged to a home or (self-care) environment. The Coleman Model intervention was implemented to achieve the goal of less disruption to members, improved coordination of care and better health outcomes. The

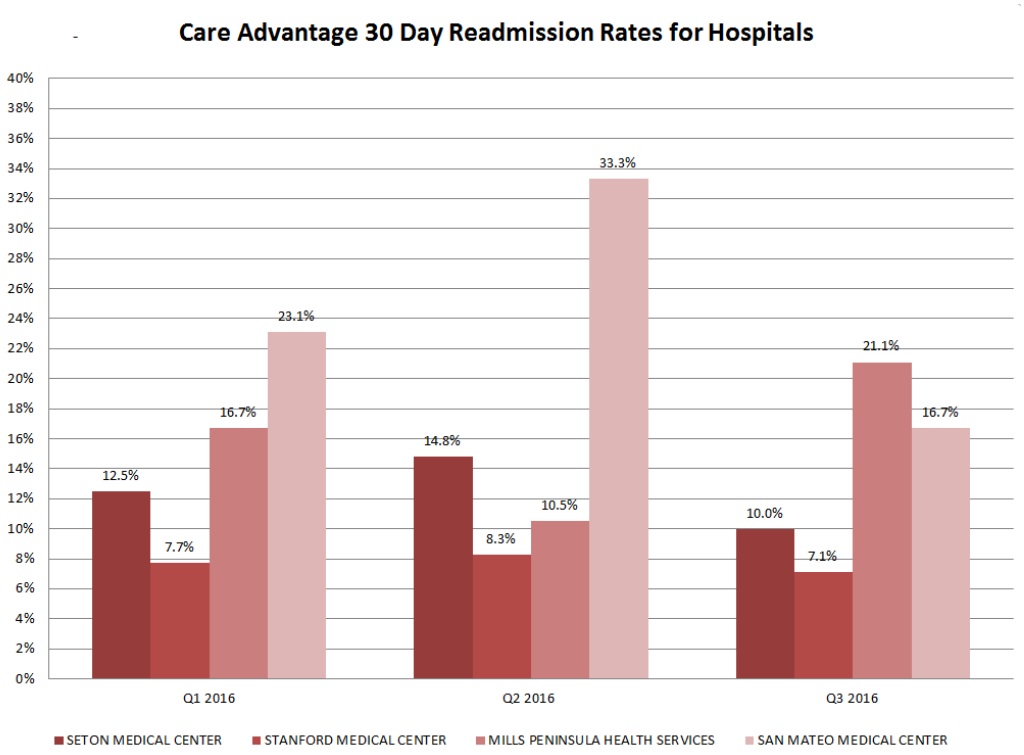
intervention helps to facilitate the discharge from the hospital as well as coordinating post discharge visits with the members PCP.

PROGRAM UPDATES

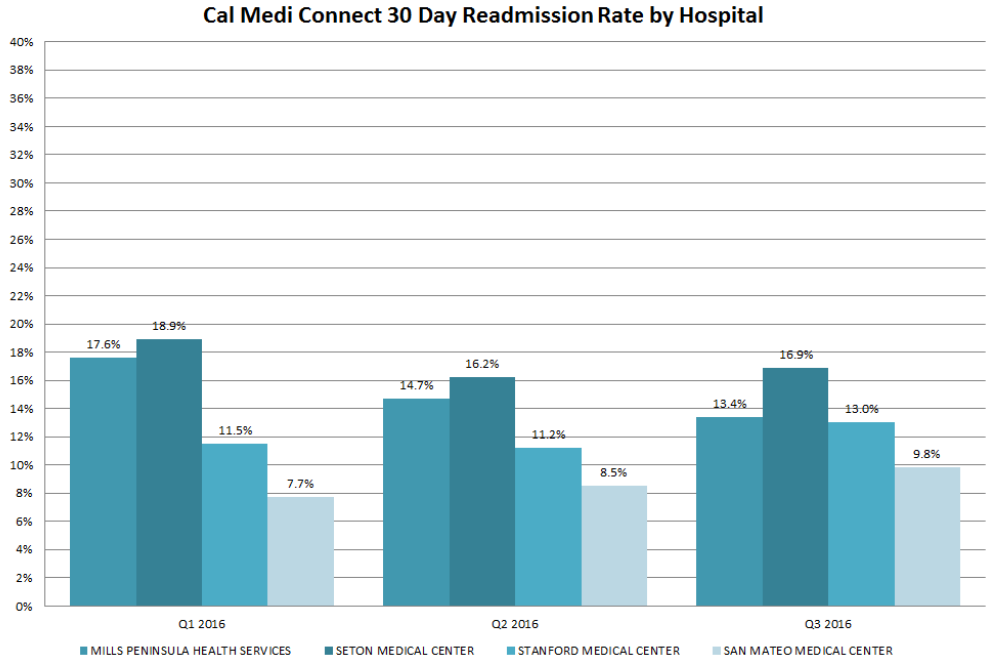
In 2016, the Health Plan collaborated with the state to begin a new performance improvement plan narrowing its focus on a specific intervention within the overall goal of reducing Plan All-Cause Readmission (PCR) rates. The Quality team analyzed potential areas of improvement and will target skilled nursing facilities as they represent the highest readmission rates back to an acute care facility in our Care Advantage and CalMediConnect population. The QI Specialist and QI Supervisor worked together with the stakeholders including partner skilled nursing facilities Administrators and Directors of Nursing, the health plan's skilled nursing facilities Care Coordination Manager and the health plan's Chief Medical Officer to analyze, plan and choose the intervention with the most impact to these two facilities. The intervention will test a communication tool used by clinical staff at St. Francis Pavilion and St. Francis Heights to relay complete and accurate information of the member's health status to the head clinician on shift. All data collection for this intervention will begin in January 2017.

PROGRAM METRICS

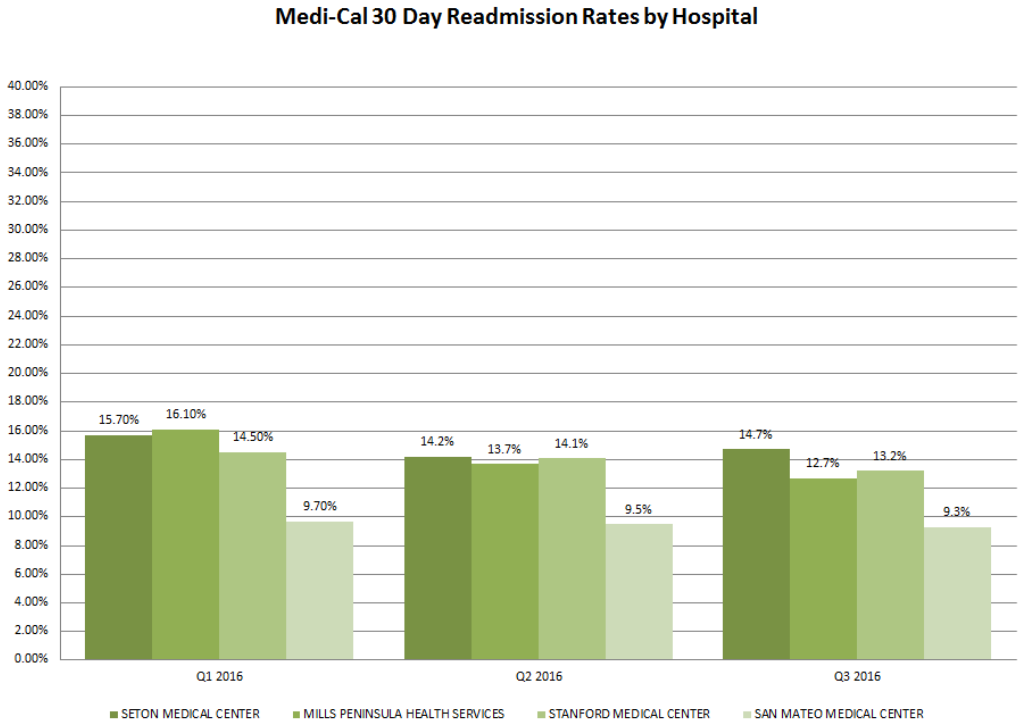
Data received from HPSM's Informatics team is claims sourced and will experience a three month lag from the last day of the previous quarter, therefore, current data is through 2016 Quarter 3. 2016 Quarter 4 will be provided in early 2017. Preliminary data from Q1-Q3 for our Care Advantage D-SNP population shows a decrease in admissions from 2016 Q1 and 2016 Q3. At this point, the cause for the decrease is unknown, but could be attributed to the number of members in the line of business. Current membership in the Care Advantage D-SNP line of business is 515 members. These members continue to represent the greatest need for care coordination as a majority of the members have a disability and are diagnosed with multiple co-morbidities. The top readmission diagnoses for this population are: complications from kidney failure, mental disorders and pneumonia from food inhalation.



For the Cal Medi Connect population (CareAdvantage MMP), readmissions have remained stable in the three quarters of data presented below. Current membership size is 9,349 members with most being readmitted to Seton Hospital. The performance improvement plan HPSM is implementing focuses on members discharged from Seton and admitted into a skilled nursing facility. This has been a focused area of improvement. Data has shown readmissions to Seton are higher in this population from a skilled nursing facility. Top readmission diagnoses in this population are sepsis, COPD and congestive heart failure.



The Medi-Cal population which accounts for most of our membership at 124,760 members has similar trends as our CalMediConnect population. Top readmit diagnoses in this population are sepsis, kidney failure and COPD.



HPSM's Care Coordination department continues to use the Coleman Model as a means of coordinating care for members identified as high risk for readmission and not discharged to a SNF. There are three transition coaches currently assigned to coordinating care of patients discharged from hospital back to home.

HEDIS 2016 rates for plan all cause readmissions defined as the percentage of Care Advantage or Care Advantage CalMediConnect members with an unplanned acute inpatient stay for any diagnosis within 30 days of the initial hospital discharge is 14.27% The rate has improved from HEDIS 2015 of 16.11%. The lower the number, the better the readmission rate.

Metrics	CY 2016
Total MMP Readmission Rate	15.25%
Total Eligible Population	1152
Number of unique members approached to enroll but did not complete intervention (LTF)	62
Readmission rate of members approached only (LTF)	23.1%
Number of unique enrollees who received intervention (members enrolled and had an in home visit)	117
Readmission rate of members enrolled and had an in home visit	21.5%

Number of enrollees eligible to receive intervention	827

HPSM uses the HEDIS Plan All Cause Readmissions (PCR) measure specifications to calculate rates for 30 Day Readmissions (a lower rate is better) and also used a baseline PCR rate of 14.27% (HEDIS CY 2015). There was an increase in the overall HEDIS PCR rate from 2015 (14.27%) to 2016 (15.25%). Despite the efforts of the Care Transitions (CT)/Coleman Model Intervention for the CMC population, the readmission rate for members enrolled in the intervention and received a home visit had a PCR rate of 21.5%. The population that enrolled but were lost to follow-up (LTF) and did not participate had a PCR rate of 23.1%. As a comparison group to the intervention population (those that received a home visit), we used the lost to follow up (LTF) group to compare readmission rates. Overall, the intervention group had a slightly better readmission rate than those that enrolled but did not participate, but the overall 2016 PCR rate did not improve and remains at 15.25%. The lack of improvement for the intervention population's PCR rate may be attributed to the percentage of members with multiple chronic conditions (25%) that put them at higher risk for hospitalizations and readmissions.

PROGRAM BARRIERS

The Care Transitions coaching went through a period of staffing shortage which impacted how many home visits could be conducted to members who were qualified to participate in the intervention. For half of 2016, there was only one care transitions coach versus the three that were allocated to the program. The one care transitions coach focused on San Mateo Medical Center discharges which showed a drop in the Medi-Cal and CMC population but a rise in the three quarters of data for the D-SNP population. Care Coordination has hired additional staff for Seton Medical Center in the second half of the year, but data is not available to date.

ACTION PLAN FOR 2017

Beginning in November 2016 and through June 2017, the performance improvement plan will be working with St. Francis Pavilion and St. Francis Heights skilled nursing facilities to measure how many SBAR forms are fully completed by nurses in a month's time. The second process measure evaluates if the SBAR form was addressed by the skilled nursing facilities MD or Director RN within the hour the form was filled out by the shift nurse. The SBAR tool (Situation, Background, Assessment and Recommendation) is a standardized communication tool used by clinical staff at both SNFs to record prompt and appropriate communication of changes in the member's health status. The Quality Improvement Specialist will continue to evaluate and analyze the impact of the SNF focused intervention.

The Care Transitions (CT)/Coleman Model Intervention will continue with the CT Coaches conducting calls and/or inpatient visits to enroll members in the program. In hopes of improving PCR rates for the intervention population, several changes will be made including risk stratification of the enrolled participants and a new process around the specific staff that will conduct the follow-up through a home visit. Going forward, the CT Coaches will now work only with members stratified as low risk for a readmission. Complex cases (defined as a member with 3-5 chronic and/or mental health conditions) will be coached by a Nurse Practitioner (NP) or will be referred directly to Landmark Health. These changes will allow for the intervention to better target each risk stratified subgroup and allocate the most appropriate staff to work with each risk level group. The health plan will measure these processes: number discharged to home, number discharged to SNF, number approached, number enrolled, number total intervention participants, number with a Landmark Health referral, and number of intervention participants by risk level. The outcome of the intervention will be measured by the PCR rates for the total intervention population as well as broken down by intervention risk level subgroups, enrolled members, home visit, and Landmark Health.

Controlling High Blood Pressure

PROGRAM DESCRIPTION

The Health Plan of San Mateo (HPSM) has partnered with a county clinic, Fair Oaks (FOHC), to provide care to a large volume of HPSM 's members. HPSM entered into collaboration with FOHC clinic staff to provide hypertension classes/clinics to members identified by HPSM beginning in 2015 through 2017. The target population is about 200 members with the following criteria: Care Advantage or CalMediConnect members, have had a diagnosis of hypertension identified through claims beginning January 2014, and whose primary care physician is based at FOHC.

Blood pressure monitors are provided to members served at their primary provider's office. Outreach is completed by the assigned clinical staff that leads the program. The members who enroll sign a contract verifying acceptance of blood pressure monitor and are taught how to take blood pressure in accordance to each individual's specific needs. The assigned clinician also educates members on signs and symptoms of hypertension, diet, proper medication adherence and use of the blood pressure monitor. The blood pressure monitors need to be connected to a gateway "cloud" device to upload the pressure readings via internet. Each blood pressure monitor has a connection with the county clinic's electronic medical record system as the primary care physician can view the patient's medical records along with readings to make treatment adjustments as necessary.

PROGRAM UPDATES

The pilot with Fair Oaks Health Center came to an end in October 2016 with the goal not achieved. Of the 200 patients identified with hypertension and in which Fair Oaks Health Center is the member's primary provider, the goal was to have blood pressure controlled in 50% patients (100 patients) by December 31, 2016.

HPSM has also partnered with North East Medical Services (NEMS) in 2016, a federally qualified health clinic in the northern part of the county to also participate in the pilot. Of the 55 Care Advantage members identified with hypertension and in which NEMS is the member's primary care provider, the goal is to have blood pressure controlled in 70% (39 patients) by December 31, 2017. Outreach to 55 identified Care Advantage members is to begin in January 2017. An additional 200 plus patients were identified as hypertensive and Medi-Cal insured. These members will be outreached to when NEMS has exhausted the outreach attempts to the Care Advantage members.

PROGRAM METRICS

As of the end of 2016, 21 members have enrolled in FOHC pilot program and of those 21 members, 12 (57.1%) members achieved their blood pressure goal (18–59 years old with BP less than 140/90 mm Hg., 60–85years old with diabetes diagnosis with BP less than 140/90 mm Hg., 60–85 years old with no diabetes diagnosis with BP less than 150/90 mm Hg) within four weekly blood pressure measurements. 1 member was lost to follow-up meaning that the member stopped participating in pilot and 8 members did not achieve blood pressure at the end of the pilot. The small number of members in the pilot was not anticipated for the year. We had anticipated that FOHC re-vamping their outreach approach would increase numbers.

HEDIS rates for 2016 show steady improvement in both the Medicare and Medi-Cal lines of business since HEDIS 2014 when HPSM had fallen under the minimal performance level for Medicare and Medi-Cal, respectively of 29.24% and 29.93%. The CBP measure for the Medi-Cal HEDIS 2016 was 68.88%, an increase from HEDIS 2015 of 61.80%. The CBP measure for Cal MediConnect HEDIS 2016 was 70.32% an increase from HEDIS 2015 of 60.34%

PROGRAM BARRIERS

The low numbers of participation at FOHC is a result of a few issues that were unforeseen at time of planning with the partner clinic. The pharmacist leading the project at FOHC was on leave for a period of 5 months which left a gap in the clinician leading the pilot. The lack of a replacement halted the program for that period of time. Upon the pharmacist's return, the clinic pushed blood pressure control as a priority which altered outreach efforts. Previous to the change, outreaching to patients from a list generated low interest and high no show rates. With the focus on blood pressure control, members were being referred by the provider to the pharmacist for education and induction into the pilot. Unfortunately, the priority focus did not increase participation as the clinic's other competing priorities took precedence. Although, the goal of 100 patients with controlled blood pressure was not achieved, a measured success was evident in how quickly members showed improvement when participating in the program. The evaluation of the barriers have helped the QI Specialist re-define the pilot's goals and identify appropriate partners for the pilot in the future.

ACTION PLAN FOR 2017

Implementation of the pilot at North East Medical Services in Daly City will begin in January 2017. Outreach will start with the 55 identified Care Advantage members and the remaining 200 plus members that were identified as Medi-Cal will be outreached to once Care Advantage members have all been outreached to.

The QI Specialist has worked with the lead physician and health educator to define how the pilot can best benefit the members and work into the workflows of the clinic. The adapted changes were a result of an evaluation on the barriers from the pilot at FOHC and the data measures that will provide an improved analysis of the pilot's progress.

The lead physician of the clinic and the clinic's health educator will train all front and back office staff on the procedures of notifying the health educator and physician that the member on the list is here for an appointment to coordinate care. The health educator will outreach to all identified members who are identified as hypertensive and seen in the clinic in the last year. When a member has an appointment to be seen by a physician, staff will notify the physician and the health educator to market the benefits of joining the pilot to the member. When the member agrees to participating in the pilot, the health educator will provide a BP (in the language of member's choice), record baseline BP, review medications and lifestyles with physician present and inform the member how to use and upload BP readings.

The QI Specialist will collect data on a quarterly basis from the clinic measuring the number of members that are participating in the pilot, length of time (in weeks) for a member to achieve controlled blood pressure, if the member is seen at least once by the health educator quarterly, if member is on hypertensive medications and if member is compliant.

The QI Specialist will continue to seek out providers and/or clinics that would be candidates in partnering in the pilot program in 2017.

IMPROVING A1C TESTING FOR CARE ADVANTAGE D-SNP MEMBERS PROJECT

PROGRAM DESCRIPTION

A pilot disease management program targeting HPSM's Care Advantage D-SNP population with diabetes was created in 2016. The program stemmed from the Centers of Medicaid and Medicare Services aligning health plan improvement projects to the common goal of improving care coordination within the MMP population. This initiative was linked to our HPSM's D-SNP population that historically has required additional care coordination efforts to help the members navigate their multiple conditions and needs.

PROGRAM UPDATES

A list of targeted members were identified as diagnosed with diabetes in the past year. The goal of the diabetes program was to increase HbA1c testing from HEDIS 2015 rates of 86.42% to the upper 95 percent confidence interval of 92.62% for HEDIS 2016. The letter was sent to members to encourage visits to their designated provider to complete a HbA1c lab test at least one time this year. For those who get tested, nothing further is implemented unless test indicates uncontrolled sugar levels. Case Managers worked with members to help members with an HbA1C value>8 and to find alternatives for those unable to get to labs. All members on the list were provided to case management with the following information: most current PCP assignment, HbA1c test date and value in 2016 if completed, demographics, assigned case manager and last PCP visit date.

PROGRAM METRICS

Care Coordination played a large role in the program planning and implementation. The Care Coordination Tech identified of the 120 members, 60 members had completed an HbA1C narrowing the list of members to outreach to 60 members (50%) of the cohort group.

Metrics	Count	Rate
Baseline # of members w/ dx of diabetes	120	
Total # of members w/ HbA1c done	60	50.0%
Total # of outreached members	60	50.0%

Over the course of 6 months beginning in May 2016, Care Coordination began outreaching to the 60 members. Members were outreached to at least 3 attempts, before being labelled as unable to reach. As shown below in the table, 28(46.7%) members of the 60 cohort group were successfully outreached to and of those 28, 24(40.0%) members had their HbA1C completed.

Metrics	Count	Rate
Total number of members reached	28	46.7%
Labs completed	24	40.0%
Labs under value >8	21	75.0%
Labs over value <8	3	10.7%
Barriers identified	11	39.3%

After 3 unsuccessful attempts, Care Coordination labeled 20 of the 60 members as unsuccessfully reached for education and reminders. Of those 20 members, 8(13.3%) members completed their labs.

Metrics	Count	Rate
Total #of members not reached	20	33.3%
Labs completed	8	13.3%
Labs under value >8	7	35.0%
Labs unavailable	5	25.0%
Labs over value of 8	0	0.0%
Barriers identified	0	0.0%

PROGRAM BARRIERS

The barriers encountered by outreaching to the identified members were not unexpected as this is a population group that requires intense resource allocation to providing the best care. There were takeaways encountered in the operational workflow that will help to improve the design of an outreach program in the future.

- Care Coordination noted that as a Health Plan, health education should focus on educating members, AORs or any representatives on what is an HbA1c. Many of the individuals encountered during outreach attempts had not come across the terminology as a patient with diabetes and/or representative.
- Retrieving lab data proved to be difficult from facilities that we did not receive supplemental data from. HPSM is only contracted to receive lab data from San Mateo Medical Center, Quest Diagnostics, Seton Medical Center and Lab Corp. If members had labs done from any other facility, obtaining the values proved to be extremely difficult and time consuming.
- Sending letters to members were unsuccessful as only one member could verify that they had read and/or understood the letter's content. The large non success rate is partly due to incorrect addresses from our databases and feeds from the state.
- Some members were resistant to outreach as they had not heard the same information from their primary care physician. If their primary care physician had not reached out to the members about completing an HbA1c, the members did not care to hear HPSM's suggestions. This suggests any clinical suggestion made on behalf of the health plan will either need provider feedback or follow similar clinical regimen of the members. This also entails that some members have strong relationships with their PCP.
- Care Coordination noted that follow up for this group is intense and requires intense resource allocation. Hunting for the correct contact information and who is the correct person to speak to was time intensive.

ACTION PLAN FOR 2017

In early 2017, a disease management program will be implemented targeting members to improve their diabetes management and reduce the progression of the disease. This program will target the Medi-cal population and include Care Advantage members referred by their provider or health plan case manager. The program will focus on educating members on opportunities to improve their health outcomes and provide comprehensive case management for those identified as having highest health needs, such as HbA1c > 9 or

multiple chronic conditions. This differs from 2016's outreach in that the members will be stratified by risk and receive support based on their health conditions and/or unmet needs. All members will receive educational material that will draw on the lessons learned from 2016's outreach. Providers will also receive notifications of their member's clinical gaps. This promotes a more coordinated outreach efforts from multiple fronts including the providers and health plan.

INITIAL HEALTH ASSESSMENT (IHA)

PROGRAM DESCRIPTION

The Initial Health Assessment (IHA) has become an increasingly higher priority in health plans across California. Focus has also increased in primary care and preventative services as the Medi-Cal population has a higher incidence of chronic and/or preventable illnesses, many of which could be modified through appropriate health behavior change and early detection to promote lifestyle changes. The purpose of the IHA enables a provider to comprehensively assess the member's chronic, acute and preventative needs and to identify patients whose needs require additional coordination with other resources. The All Plan Letter (APL 08-003) requires all primary care providers to administer an IHA to all Medi-Cal managed care patients as part of their initial and well care visits. The past two years, DHCS audit of November 2014 and November 2015 have found that the plan did not ensure that IHAs for new members were completed within 120 calendar days of enrollment. It is required that health plan's reach a 100% compliance rate ensuring every member enrolled is seen by their primary care physician. The program will continue to work on developing a text messaging campaign to further market awareness of seeking early primary care services is in its planning stages. The potential to reach more members through text messaging versus mail has evidence of success as studies have shown that more of the health plan's membership has access to a cell phone and messaging services. The Quality Improvement team is working with a vendor and various departments to begin implementation in 2017.

PROGRAM UPDATES

The audit of November 2015 found a deficiency in how HPSM confirmed an IHA completion. In an effort to resolve the deficiency, the QI Specialist conferred with Informatics and management to remove established patient codes from being counted as a completed IHA in our claims system. Once new specifications were implemented, a drop in compliance rate was seen in the first quarter of 2016. Marketing material was created for HPSM members to be sent out monthly in conjunction with their welcome packet, urging members to seek primary care services as soon as they are able to set an appointment with their provider. Training material for HPSM's provider network was created to continue driving the point to providers the need and benefit to outreach to their members to get them in to be seen. Continued effort to increase compliance is being explored through innovative methods such as a text messaging program for members.

The overall goals for increasing IHA compliance in 2016 include the following:

1) Increase plan providers awareness of panel assignment to initiate care and establish a medical home for HPSM members.
2) To provide member awareness of the importance of seeking care within first 120 days of enrollment.

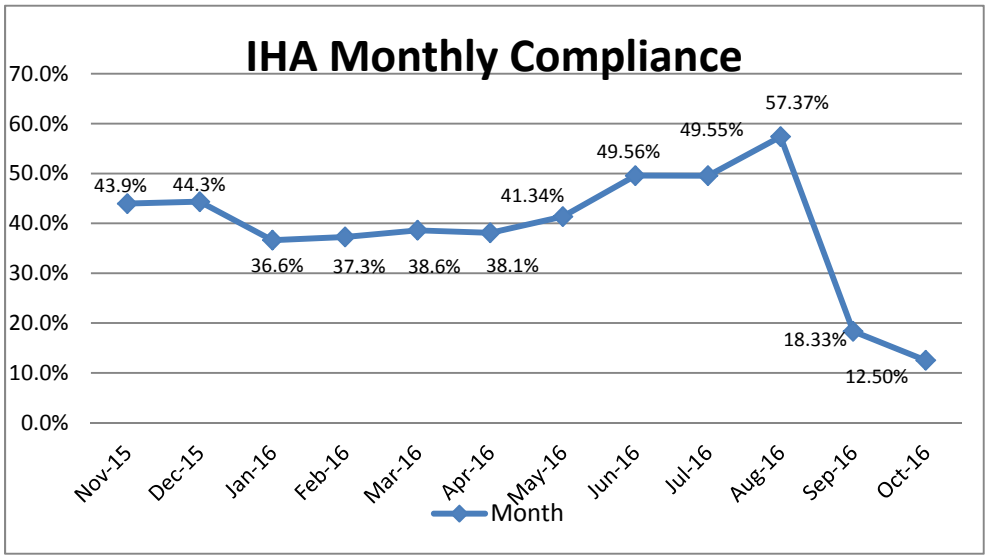
PROGRAM METRICS

2016 Program Objective: By December 31, 2016, HPSM seeks to increase compliance rate to 60% in Q4 2016 from Q1 2016 rate of 38%.

Trends show during the first quarter of the year over the past two years, monthly compliance decreases but continues upward through the first half of the year into the second half. The rates for November and December

are not accurate at this point of time as claims are not complete for the last quarter of the year. A more accurate portrayal of compliance will be provided in the first half of 2017.

A trend that continues to occur is incorrect physician assignment for members. The member may be assigned to one provider but has no encounters in clinical system when audited. This has proven difficult to decrease as a percentage of our population is transient and have revolving enrollment in the health plan.



PROGRAM MAJOR ACCOMPLISHMENTS & PROGRESS

There are six areas of focus that the QI Specialist worked on for 2016 to help increase awareness to members and train providers. They are listed below:

1. ***Reminder Letter:*** Targeted messages were developed by the Quality Improvement (QI) Department to HPSM patients identified in month as newly enrolled to promote healthy behaviors and encourage members to seek out primary care physician for their well visits upon joining HPSM managed care organization. These messages were to encourage the member to initiate discussion, establish relationships with their identified medical home.
2. ***Provider Training*:** A toolkit was developed in 2016 for providers and office staff to be dispersed and trained by QI staff in partnership with the Provider Services team. The Provider Toolkit includes a FAQ sheet on all the components necessary to train the provider network on all components of what constitutes an IHA. A fax blast reminder was sent out to all primary care providers by the Provider Services department detailing/refreshing billing requirements for the IHA and the requirements for Pay for Performance Incentive Program attached with the completion of the IHA. Additional messaging was included in the fall edition of Health Matters MD, to educate providers about the importance of outreaching to their members.
3. ***Provider Website Update:*** The complete Provider Toolkit was uploaded onto the provider resources section of the website. This is another avenue HPSM's uses to streamline information to our provider network on any changes or regulations that they need to be aware of.
4. ***IHA Policy Update:*** HPSM's policy was updated to reflect the changes in the IHA specifications. Specifications were revised to eliminate crediting established patient visits as a complete IHA.

5. ***Q1 Facility Site Review Initial Health Assessment Audit:*** Quality Department requested that all IHAs claims in Quarter 1 through Quarter 3 2016 be provided to randomly audit the county clinics. Four county clinics were audited in 2016. Results are show below in program barriers.
6. ***Member and Provider Newslette***r: Articles were written for both the member and provider newsletter to push the importance of early primary care service. The provider newsletter article encouraged providers to use the opportunity of outreaching to members as a method for establishing care, seeking resources from HPSM for establishing their e-reports and receiving their monthly case management lists

PROGRAM BARRIERS

The completion of the Staying Healthy Assessment (SHA) remains a barrier for the adult population in the county clinics. The Initial Health Assessment (IHA) has a higher rate of compliance by pediatrics versus adults per the audits completed by the Facility Site Nurses. The audit done at 39th Avenue Pediatrics shows that of the 20 records reviewed, 80% of members had a complete IHA and SHA on file. The three other county clinics (Fair Oaks, Daly City Adult and 39th Ave Adults) have rates ranging from around 30% compliance to over 70% compliance. Some of the audit findings include no encounter data, incomplete IHA or dates that differ from the claim dates. The Quality Improvement Department continues to review new avenues to increase IHA compliance.

39th Ave Pediatrics

Total # Records Audited	20
Total #of Members with IHA completed	16
Total # of Members without a IHA/SHA on file	4
Compliance Percentage	80%

39th Ave Adults

Total # Records Audited	19
Total #of Members with IHA completed	6
Total # of Members without a IHA/SHA on file	13
Compliance Percentage	32%

Daly City Adult

Total # Records Audited	15
Total #of Members with IHA completed	1
Total # of Members without a IHA/SHA on file	14

Compliance Percentage	7%

Fair Oaks Health Center

Total # Records Audited	24
Total #of Members with IHA completed	17
Total # of Members without a IHA/SHA on file	7
Compliance Percentage	71%

ACTION PLAN FOR 2017

The SHA proves to be a significant area for providers to comply with. Training has been developed to address this, but the additional component of a questionnaire in busy practices is a barrier to fully completing the IHA. Providers have relayed the want to modify the questionnaire along with the difficulty in adding the questionnaire into their electronic health records. California Department of Health Care Services (DHCS) is aware of the issues and is in the early stages of modifying the questionnaire. Until a modification from DHCS has been made aware to the health plan, training from all touch points to the providers and/or office staff will remain a focus. The Quality Improvement and Provider Services departments have teamed up to provide continual training to providers through 2017.

PCP assignment continues to play a significant factor in crediting the correct providers with completing the initial health assessment of members assigned to them. Processes need to be developed to actively update PCP assignments of members when they decide to switch providers. Providers are also not actively outreaching to new members through their case management lists.

SAFETY OF CARE AND QUALITY OF SERVICE ACTIVITIES

ANNUAL REVIEW OF CLINICAL GUIDELINES

HPSM's Quality department ensures that the clinical guidelines posted in the provider section of the HPSM website are current, and relevant, to health conditions common in the member population. Once a year, a Quality Improvement Specialist checks the source organization for each specific guideline, online, to see if the guideline has been updated and noted with a new edition year. A guideline that has not been updated by the source organization within the past 12 months, maintains its current status on the HPSM website if it was last updated within 3 to 5 years.

Specific evidence-based guidelines: HPSM's Quality department selects guidelines that are tied to the National Guidelines Clearinghouse or Centers for Disease Control, and recommended by the Agency for Healthcare Quality and Research (AHRQ).

Health Condition	Guidelines and Tools
Asthma and COPD	• Approaching Asthma Diagnosis and Treatment

	• Diagnosis and Management of Asthma Algorithm • Diagnosis and Management of Chronic Obstructive Disease
Cardiovascular	• Heart Failure in Adults Algorithm • Hypertension Diagnosis and Treatment Algorithm • Hypertension Treatment Algorithm • Lipid Management in Adults
Diabetes	•Diagnosis and Management of Type 2 Diabetes Mellitus in Adults Algorithm
Obesity in Adults	• Prevention and Diagnosis for Adults Algorithm • Adult BMI Calculator • Adult Body Mass Index Table
Obesity in Children & Teens	• Prevention and Management for Children and Adolescents
Immunization Schedules	•Birth to age 18 schedule •Catch-up schedule: 4 months to 18 years •Adult schedule •Combination Vaccines
Sexually Transmitted Infections	•CDC Sexually Transmitted Guidelines •San Mateo County Disease Reporting Form •HPV Vaccine for Child/Teen

Source websites for evidence-based guidelines posted on HPSM's website.

•Institute for Clinical Systems Improvement (algorithms)
•National Heart Lung and Blood Institute
•Joint National Committee Evidence-Based Guidelines
•Centers for Disease Control

PROJECT UPDATE

Annual review and approval process by Quality Improvement Committee (QIC)

In September 2016, the Quality Improvement department presented the clinical guidelines links posted on the HPSM website at the quarterly Quality Improvement Committee meeting. The condition-specific and preventive guidelines were listed in an outline that was distributed, and identified the 6 general categories under which the guidelines are posted: Diabetes, Respiratory, Cardiovascular, Immunization, Obesity, Sexually Transmitted Infections, in addition to a General Resources section. The outline indicates the source organization and most recent updated year, for each specific guideline. In addition to reviewing the outline, QIC members are able to view the links on the HPSM website displayed on a large monitor. QIC members were invited to make suggestions for adding new guideline links to supplement, or broaden, the range of guideline topics. After the QIC reviewed the outline and made comments and suggestions for two additional guidelines, the Chief Medical Officer asked the committee members to vote on approving the guidelines.

ACTION PLAN FOR 2017

The Quality Improvement department promotes the use of the clinical guidelines among network providers by raising awareness of their availability through the HPSM provider newsletter, and encouraging provider service representatives to inform providers of their availability on the HPSM website, during regular provider visits. HPSM Quality believes that a key factor in helping providers deliver the highest quality of care to our members is to inform them on how to access, evidence-based, clinical guidelines on the HPSM website.

Potential Quality Issue Monitoring

A Potential Quality Issue (PQI) is a suspected deviation from expected provider performance, clinical care, or outcome of care, which requires further investigation to determine whether an actual quality issue or opportunity for improvement exists. The purpose is to provide a systematic method for the identification, reporting, and processing of a potential quality issue (PQI) to determine opportunities for improvement in the provision of care and services to HPSM members, and to direct appropriate actions for improvement based on outcome, risk, frequency and severity.

Prior to 2015, HPSM did not have a comprehensive PQI process which was identified during the previous year's DHCS survey. Referrals for quality of care concerns originated solely from member grievances that were forwarded to the Associate Medical Director for review. On April 2015, a Grievance and Appeals (G&A) Nurse was hired to assist the Associate Medical Director to assist in processing quality of care reviews and member appeals. The G & A Nurse, Chief Medical Officer (CMO), and Associate Medical Directors started to collaborate to make amendments to the QAI-03 policy and procedure which was completed in June 2015. The aforementioned policy serves as a framework for the PQI process.

Starting May 2015, all Quality of care reviews were forwarded to the Quality Improvement Department for record keeping for secure and access limited record keeping. Soon afterwards, PQI case leveling started based on a standardized PQI Case Leveling Grid. PQI training then was conducted by the CMO and G&A Nurse to the Health Services Department on the PQI process. Collaboration followed with Project Specialist for Health Services, Senior Health Data Analyst and G&A Nurse to transition PQI information into the Everest database and to develop work flow. In September 2015, Everest training was done for QI admin and use of Everest to house PQI information was initiated.

We conducted additional PQI training to the Compliance Dept and MSSP team in November. Review of M14 (member/family does not want to pursue a grievance) daily reports by G&A Nurse was initiated. In January 2016, the Project Specialist for Health Services and G&A Nurse revised G&A QOC work flow due to MedHok implementation for G&A Dept. PQI overall work flow process also revised and uploaded to C360. In 2016, information regarding the PQI process was sent to HPSM providers via the newsletter and continued education regarding the PQI process to HPSM providers is currently being done through the QI Provider Toolkit.

We have completed 268 PQI/Quality of Care Reviews from 1/1/2016 to 12/13/2016.

Facility Site Review and Medical Record Review

Credentialing is part of the comprehensive quality improvement system included in all Medi-Cal managed care contracts as mandated by the California Code of Regulations (CCR) Title 22, sections 53100 and 53280 and Title 10 of the California Administrative Code, beginning with section 1300.43. As one element of the QI process, credentialing ensures that physician

and non-physician medical practitioners are licensed and certified in accordance with State and Federal requirements. Full scope site reviews are conducted initially during the pre-credentialing period and triennially thereafter for primary care providers, including pediatricians, and obstetricians. These reviews are done as a requirement of participation in the California State Medi-Cal Managed Care Program, regardless of the status of other accreditation and/or certifications to assure providers are in compliance with applicable local, state, federal and HPSM standards.

HPSM conducts full scope reviews utilizing the criteria and guidelines of California Department of Health Care Services Medi-Cal Managed Care (MMCD Policy Letter 02-002 Dated May16, 2002 or any superseding Policy Letter). HPSM may also address additional requirements as appropriate for quality studies. A passing Site Review Survey shall be considered "current" if it is dated within the last 3 years, and need not be repeated until the due date of the next scheduled site review survey or when determined necessary through monitoring activities by the plan.

The schedule for performing facility site review is determined by Quality Management staff and the prospective provider. It is based on the prospective credentialing date, as well as provider availability and preference. Site reviews for continuing providers are scheduled and performed within three years of the provider's last site review in compliance with criteria and guidelines of a full scope review is conducted utilizing the criteria and guidelines of California Department of Health Care Services Medi-Cal Managed Care (MMCD Policy Letter 02-002 Dated May 16, 2002, or superseding Policy Letter) Full Scope Site Review Survey 2012 and Medical Record Survey Tool 2012.

Providers who move to a new site must undergo a full scope site review unless the site has been reviewed with a passing score within the last three years (MMCD PL 02-002). The site review must be completed as soon as possible after the provider's move to the site or the provider's notice to HPSM (whichever is later), and not later than 30 calendar days after the date the new site was opened for business or HPSM's notification date. A minimum passing score of 80% on both the Site Review Survey and Medical Record Review Survey is required for a provider to continue as an HPSM provider in good standing. If critical elements of deficiencies are identified, a score in any section of the site or medical record review scores below 90%, or there is a deficiency in Pharmacy or Infection Control, or an overall score below 90%, then a Corrective Action Plan (CAP) is requested to be completed by the provider and must be completed as part of compliance with the provider's HPSM contract.

HPSM reviews sites more frequently when determined necessary based on monitoring, evaluation or Corrective Action Plan (CAP) follow-up needs. Additional site reviews may be performed at the discretion of the Medical Director, using input from the Quality Site Review nurses, if patient safety or compliance with applicable standards is in question. The same audit criteria applicable for Initial Full Scope Site Reviews are applicable for subsequent site reviews.

When providers are required to correct deficiencies identified during the survey. Corrective Action Plans (CAPs) are monitored by the QAI Nurses. Provider Review issues are reviewed by the Medical Director and may be referred to the PR for action or follow up.

Of the 16 Facility Site Reviews completed in 2016, the average score was 95.5%.

Of the 17 Medical Record Reviews completed in 2016, the average score was 91.84%.

In collaboration with San Francisco Health Plan, we received 7 review surveys.

CHALLENGES & BARRIERS PERTAINING TO FACILITY SITE REVIEWS:

We work with our providers in scheduling the Facility Site Reviews to meet compliance in timeliness. This is often an issue with the busy providers since it is important that Facility Site Reviews and Medical Record Reviews do not disrupt the flow of patient care. Providers will often cancel FSR/MRR dates to accommodate their changing staffing needs. Facilities require security clearance for the Medical Record Review portion. This can take time in getting the clearance. This makes scheduling sometimes difficult in both paper and electronic medical records. Being able to review the bigger facilities and all their locations can be difficult in accessing specific NPI numbers for the doctors at larger sites. Tracking the providers and staying within a specific compliance timelines is challenging. We have instituted a Master Site Audit List for compliance.

Common Deficiencies identified in Facility Site Review:

- Evacuation Routes are not posted in visible locations
- Illiterate Eye Charts are not readily available
- Stadiometers or Wall Mounted height measurement are not used
- Written policies of documenting medication expiration are not available
- Lab Supplies are accessible to unauthorized personnel
- Documentation of Employee Trainings are often incomplete
- Specialized Equipment such as Scales, EKG's are not always calibrated
- All stored and dispensed prescription drugs are not always labeled appropriately

Critical Elements in the Facility Site Review identified were the following:

- Emergency Equipment for certain practices are not always appropriate
- Personal Protective Equipment is not readily available to staff
- Medical Assistance were not verifying medications with a licensed person prior to administrations
- Spore testing was not completed for 6 months in an office
- Exit doors and aisles are obstructed and egress is not accessible
- Needle stick safety precautions are not practiced on site
- Biohazard waste container were not being used

Common Deficiencies identified in Adult Medical Record Review

- Staying Healthy Assessments as well as subsequent Staying Health Assessments are not completed.
- TB risk assessments are not always documented.
- Advance Care Directives
- Mammograms
- Cervical Cancer Screenings
- Colorectal Cancer Screenings
- Adult Immunizations
- VIS documentation
- Completion of IHA within 120 days of enrollment

Common Deficiencies identified in Pediatric Medical Record Review

- Staying Healthy Assessments as well as subsequent Staying Healthy Assessments are not completed.
- TB risk assessments are not always documented
- VIS documentations are not completed

Our providers are given educational materials with the results of the review on the specific deficiencies to aid them in completing the Corrective Action Plan.

GOALS FOR 2017:

- Continue with our processes with completing FSR/MRRs.
- Make educational materials, guidelines and tools available HPSM's website. Direct our providers towards obtaining information about FSR/MRRs and completing Corrective Action Plans from the resources on our HPSM Website. This will help reduce deficiencies in future FSRs and MRRs and help providers to maintain full compliance.
- We will continue to collaborate with other MC Health Plans to obtain results of site reviews as to not duplicate site reviews of the same provider.

PHYSICAL ACCESSIBILITY REVIEW (PAR)

Department of Health Care Services Policy Letter 12-006 and All Plan Letter 15-023 requires Medi-Cal managed care health plans to use FSR Attachment C, D and E appropriate to their provider type in line with the three year cycle requirement of FSR Attachment A and B. Attachment C is for provider sites that serves a high volume of Senior and Person with Disabilities (SPD).

Attachment D is for Ancillary Services. Ancillary Services refers to Diagnostic and Therapeutic services but not limited to Radiology, Imaging, Cardiac Testing, Kidney dialysis, Physical Therapy, Occupational Therapy, Speech therapy, Speech Therapy, Cardiac rehabilitation and Pulmonary Testing. Lastly, Attachment E is for Community Based Adult Services (CBAS) and includes all facilities that provide bundle CBAS services and do not include Licensed Only Adult Daly Health Care Center and Programs.

Attachment C, D and E has accessibility indicator symbols that determine the level of accessibility. If a provider's office or site meets all critical elements (CE), they will have "Basic Access". If they miss one or more CE then they will have "Limited Access". If they meet all medical equipment guidelines then they will have "Medical Equipment Access". Accessibility Indicator Symbols are the following:

Accessibility Indicator Symbols
P= Parking
EB= Exterior Building
IB= Interior Building
R= Restroom
E= Exam Table
T=Medical Equipment
PD=Patient Diagnostic and Treatment Use
PA= Participant Areas

A total of 45 Physical Accessibility Reviews (PAR) was done for 2016. PAR included 44 PCP Facilities and 1 Hospital. There were no CBAS or Ancillary facilities due for a PAR in 2016.

Below is the break down for 2016:

Level of Access:	**# of PCP/Hospital**
Basic Access	4
Basic Access/ Medical Equipment	2
Limited Access	37
Limited Access/Medical Equipment	0
None	2

Four PCP sites meet all CE receiving "Basic Access". Two PCP sites meet all CE in addition they also have "Medical Equipment". 36 PCP sites received" Limited Access" and one hospital received "Limited Access". Only two of the PCP has no accessible access.

The goal is to continue to provide the PAR results of Access Level and the Accessibility Indicators so that our SPD members can identify a facility to obtain healthcare services in the Provider Directory that will best fit their physical needs. The focus will be to continue to keep all providers' sites, ancillary and CBAS up to date with any physical changes to the Parking, Exterior

Building, Interior Building, Restroom, Exam Room, Medical Equipment, Participant Areas, Patient Diagnostic and Treatment Use.

NURSE ADVICE LINE (NAL)

PROGRAM DESCRIPTION

HPSM provides its entire membership (all LOBs) access to a free nurse advice line (NAL) 24 hours/7 days a week. Members can call the NAL for urgent health concerns and receive advice on what to do. The NAL uses a triage protocol to determine the appropriate advice for a member's concern. The categories of medical advice are 1) receive urgent care, 2) see your PCP within 1-2 weeks 3) use self-care at home or 4) go to the emergency room(ER). HPSM mails a postcard twice a year to current members in all LOBs to remind them to call the NAL if they cannot reach their PCP for urgent medical advice, or if they're unsure if they need to go to the ER. Newly enrolled Medi-Cal members initially receive information about the NAL in the Medi-Cal guide, which is provided in their new member packet.

PROGRAM UPDATES

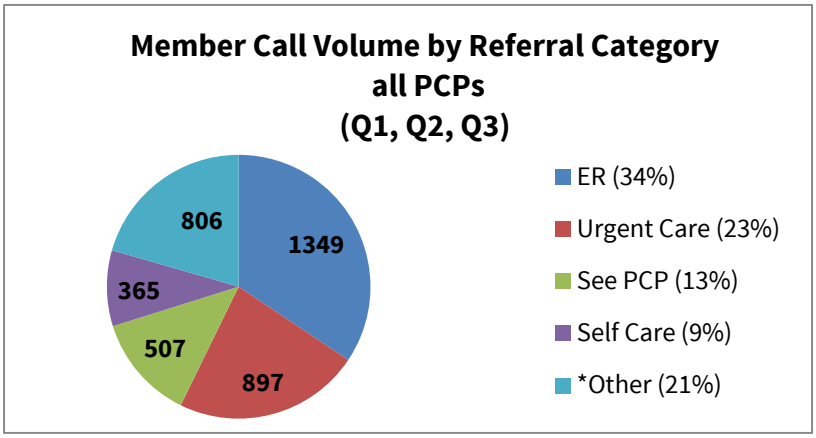
In 2016, the NAL reminder postcard was mailed to current members in July and December.

MEMBER CALLS TO NAL AND ACCESS TO PCP FOLLOWING NAL REFERRALS

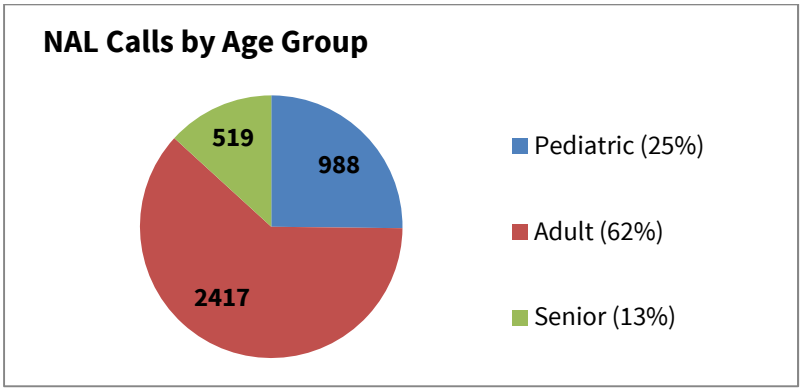
The following information summarizes member calls to the NAL from January through September 2016.
It shows call volume by LOB, triage referral category, age group, and language. A separate table below shows the number of calls HPSM has linked to a doctor's visit, for follow up care.

Member Calls by LOB (clinical calls only):

By LOB	Call Volume	# Unique Members that Called			# Members with 2 ≥ Calls		
	Q1, Q2, Q3	Q1	Q2	Q3	Q1	Q2	Q3
CareAdvantage	457	142	120	123	20	17	17
Medi-Cal	2,532	879	711	595	117	87	51
ACE	473	151	137	131	16	19	10
Healthy Kids	36	15	14	4	1	1	1
HealthWorx	48	11	11	15	1	2	1
Total	3,546	1,198	993	868	155	126	80



* "Other" refers to calls not related to symptoms (i.e. administrative calls)



NAL Calls by Language in each age group:

By Age group	English	Spanish	Chinese	Tagalog	Other	Total
Pediatric (parents)	453	484		9	42	988
Adult (age 19 – 64)	1,553	631	6	17	230	2417
Senior (65+)	305	126	10	22	56	519
	2291	1241	16	48	328	3924

Visits to PCP or other provider following calls to NAL:

This shows access to care following a NAL referral by linking provider claims for outpatient visits within 7 days after a call date. Claims for Dr. Visits following a NAL referral might indicate member's inability to access their assigned PCP for follow up care.

Number of PCPs with NAL linked claims (w/in 7 days after call date)	Q1	Q2	Q3
PCP visit claim linked to "See PCP" within 2 weeks	10	6	6
PCP visit claim linked to Urgent Care referral	16	12	15
Dr. Visit claim linked to Urgent Care and "See PCP" referral	39	35	45

RECOMMENDATIONS FOR 2017

- **Decrease triage to ER and increase to Urgent Care:** The analysis of the call volume by referral category shows that at 34%, referrals to the ER surpass the number of calls referred to Urgent Care (23%) and to other referral categories. This is concerning to HPSM because the purpose of providing members access to a nurse advice line, is to help direct members away from unnecessary and costly visits to the ER. HPSM's Nurse Advice Line Workgroup will discuss this issue at a workgroup meeting in December, and determine necessity to meet with NAL vendor to reduce the volume of non-emergency referrals to the ER.
- **Decrease volume of calls for "Other" (not related to health concern/symptoms):** Twenty-one percent of calls are for health plan administrative and benefit questions, and unrelated to a health concern. This represents 806 calls, which is unacceptably high because it suggests that members perceive the NAL to be a phone number they can use for calls related to their health benefits. The NAL workgroup should address this issue in a discussion with Member Services and Marketing to identify ways to reduce these types of calls to NAL.
- **Add claims data specific to members with "special member codes" to quarterly analysis:** Members with special member codes are not assigned to a PCP, and can receive care from any provider that accepts Medi-Cal. Tracking their access to a provider following a NAL call within 7 days will help assess their access to follow up care.

ACTION PLAN FOR 2017

- **Survey providers regarding office/clinic-based phone triage systems:** HPSM's NAL workgroup will discuss plans to survey contracted providers on their phone triage systems in place. Timely access regulations, from the Department of Managed Health Care, state that members should have access to a phone triage system, 24/7, for urgent health concerns.
- **Decrease triage referrals to ER and increase to Urgent Care:** HPSM's Nurse Advice Line Workgroup will continue to monitor the quarterly data for referrals to the ER. It will address the issue of non-emergency referrals to the ER during workgroup meetings, and determine the necessity to meet with NAL vendor to reduce the volume of these types of calls.
- **Decrease volume of calls for "Other" (not related to health concern/symptoms):** The NAL workgroup will continue to address the issue of members calling the NAL for benefit-related questions and matters. The workgroup will consider meeting with Member Services and Marketing to identify ways to reduce these types of member calls to the NAL.
- **Monitor linked claims data specific to members with "special member codes" to quarterly analysis.** Members with special member codes are not assigned to a PCP, and can receive care from any provider that accepts Medi-Cal. Tracking their access to a provider following a NAL call within 7 days will help assess their access to follow up care.

TIMELY ACCESS TO CARE

Health Plan of San Mateo contracted with DSS Research to assess members' experiences with their health plan. By examining the accessibility of health services, HPSM can proactively address issues to improve overall satisfaction.

This project is designed to achieve the following objectives:

1) Measure access to health care using questions from the Medicaid CAHPS survey and other questions
2) Identify differences in access between adult and child members and between members who speak English, Spanish or other languages.

SURVEY ADMINISTRATION

HPSM collaborated with DSS to develop a survey instrument designed for mail and telephone administration. The survey was offered in English, Spanish, Chinese and Tagalog. All data were collected by DSS Research using a combined approach with mail and CATI (computer-assisted telephone interviewing). The sample, selected randomly from our membership, included 5,000members (2,611adult and 2,389 child). 1,169 surveys were completed (508 adult and 661 child). The overall response rate was 23.4%.

KEY FINDINGS

- More than three-quarters (77.4%) gave their health plan an overall rating of 8, 9 or 10.
- Most members found it easy to get care but some difficulties exist.
  - 73.0% of those who sought care, tests or treatment through the plan indicated that it was always or usually easy to get what they needed. This is significantly lower than the 81.0% recorded in 2014.
  - Inconvenient appointment times and delays while waiting for approval for care are the most common obstacles.
- The Member Services Department continues to perform well.
  - Three-quarters of those who sought information or help from the Member Services Department indicated that the staff always or usually gave them what they needed.
  - Most callers got the help or information they wanted with just one call and few had any problems with the department.
- Most found it easy to get an appointment. However, a few other access measures are significantly different than in 2014.
  - Specialist appointments:

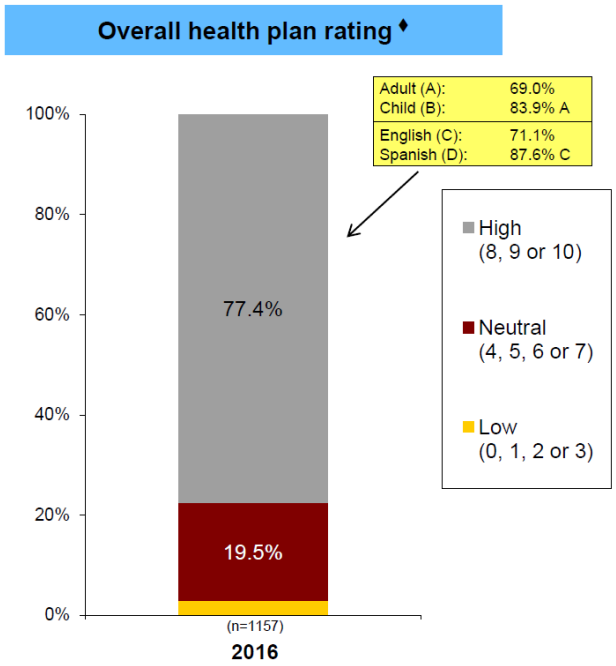
- A lower percentage tried to make an appointment to see a specialist, but the ease of getting those appointments is also lower than in 2014.
- While inconvenient appointment times is the most common problem, higher percentages than in 2014 had issues with the network or a language barrier.

o Urgent care appointments: a lower percentage said they always or usually got an appointment for urgent care as soon as they needed it and a higher percentage had to wait more than four days.

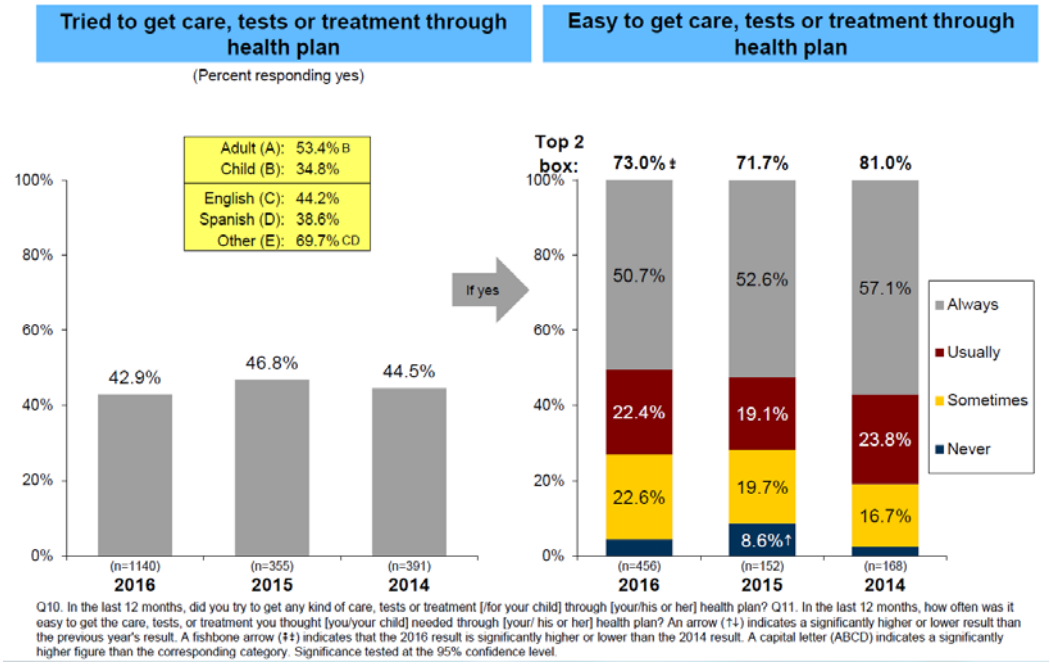
The overall rating of the plan is significantly higher among Spanish speakers and those representing a child member. These groups used their plan less, but had better experiences when doing so.

HEALTH PLAN

More than three-quarters rated their health plan highly.



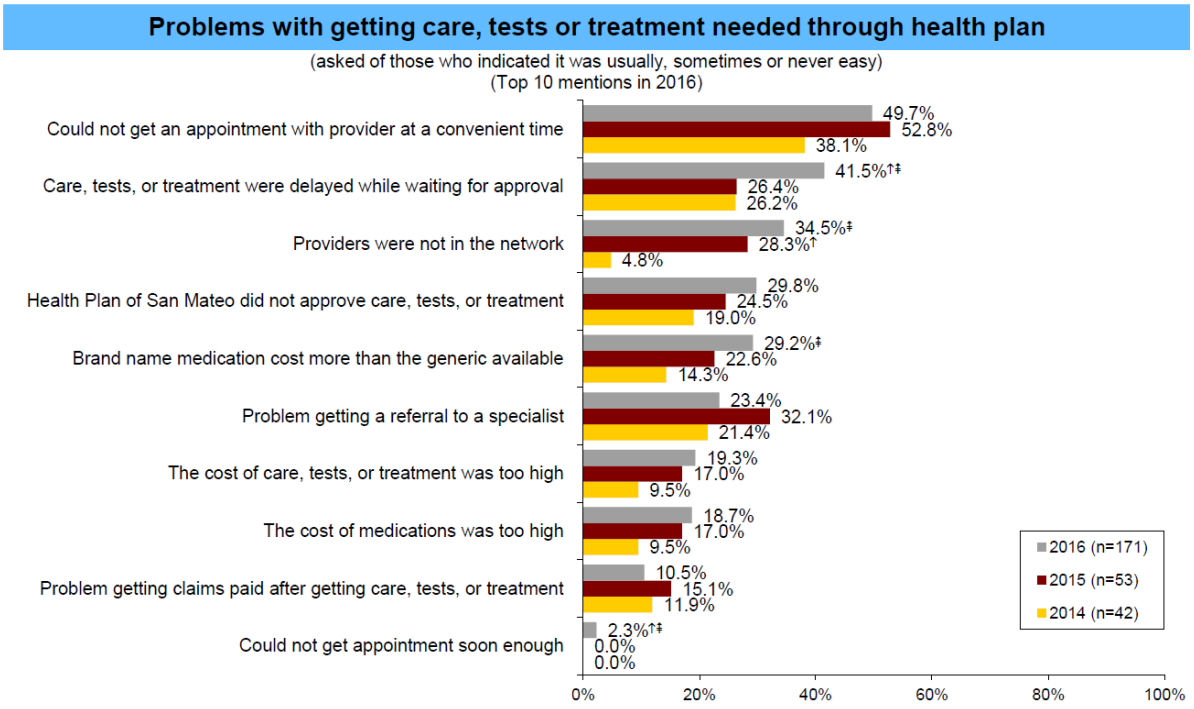
A slightly lower percentage than in 2015 tried to access care using their health plan and, among those who did, a significantly lower percentage than in 2014 indicated that it was always or usually easy to get the care they needed.



Q10. In the last 12 months, did you try to get any kind of care, tests or treatment [/for your child] through [your/his or her] health plan? Q11. In the last 12 months, how often was it easy to get the care, tests, or treatment you thought [you/your child] needed through [your/ his or her] health plan? An arrow (↑↓) indicates a significantly higher or lower result than the previous year's result. A fishbone arrow (‡‡) indicates that the 2016 result is significantly higher or lower than the 2014 result. A capital letter (ABCD) indicates a significantly higher figure than the corresponding category. Significance tested at the 95% confidence level.

BARRIERS/OBSTACLES

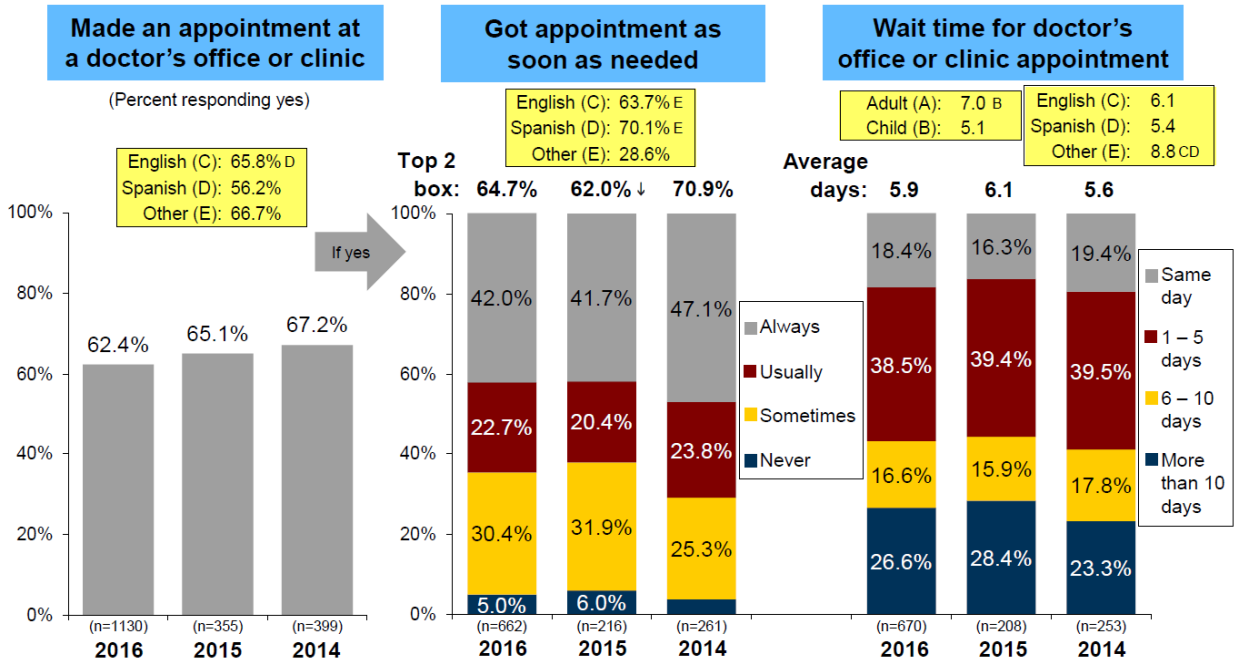
The most common obstacles are inconvenient appointment times and approval delays, with the latter being significantly more common than in 2015 and 2014. Mentions of network size, denials and the cost of brand name drugs are increasingly common, as well.



Q12. In the last 12 months, if [you/your child] had a problem getting the care, test or treatment you [/thought your child] needed through [your/his or her] health plan, what was the main problem [you/your child] had? An arrow (↑↓) indicates a significantly higher or lower result than the previous year's result. A fishbone arrow (‡‡) indicates that the 2016 result is significantly higher or lower than the 2014 result. Significance tested at the 95% confidence level.

NON-URGENT CARE (DOCTOR'S OFFICE OR CLINIC)

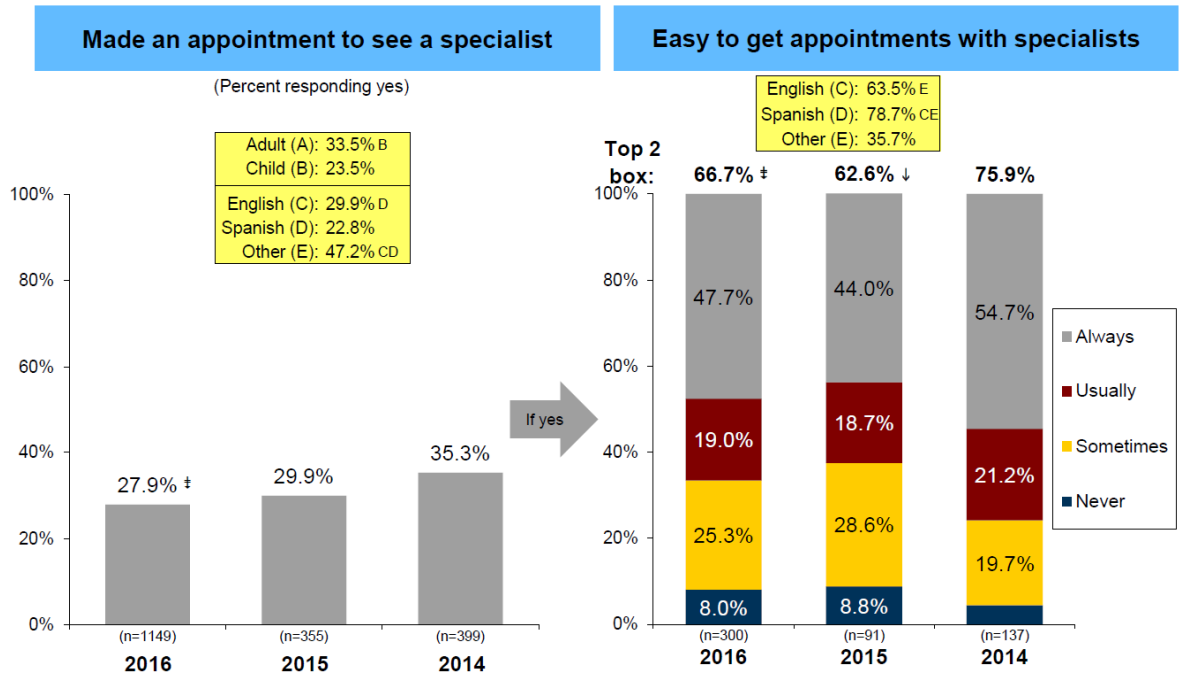
Appointment availability and wait times are stable.



Q4. In the last 12 months, not counting the times [you/your child] needed care right away, did you make any appointments for [your/your child's] health care at a doctor's office or clinic? Q5. In the last 12 months, not counting the times [you/your child] needed care right away, how often did you get an appointment for [your/your child's] health care at a doctor's office or clinic as soon as you thought [you/your child] needed? Q6. In the last 12 months, when you called to make an appointment for care [you/your child] did not need right away, how long did [you/your child] usually have to wait for the appointment? An arrow (↑↓) indicates a significantly higher or lower result than the previous year's result. A fishbone arrow (‡‡) indicates that the 2016 result is significantly higher or lower than the 2014 result. A capital letter (ABCD) indicates a significantly higher figure than the corresponding category. Significance tested at the 95% confidence level.

SPECIALITY CARE

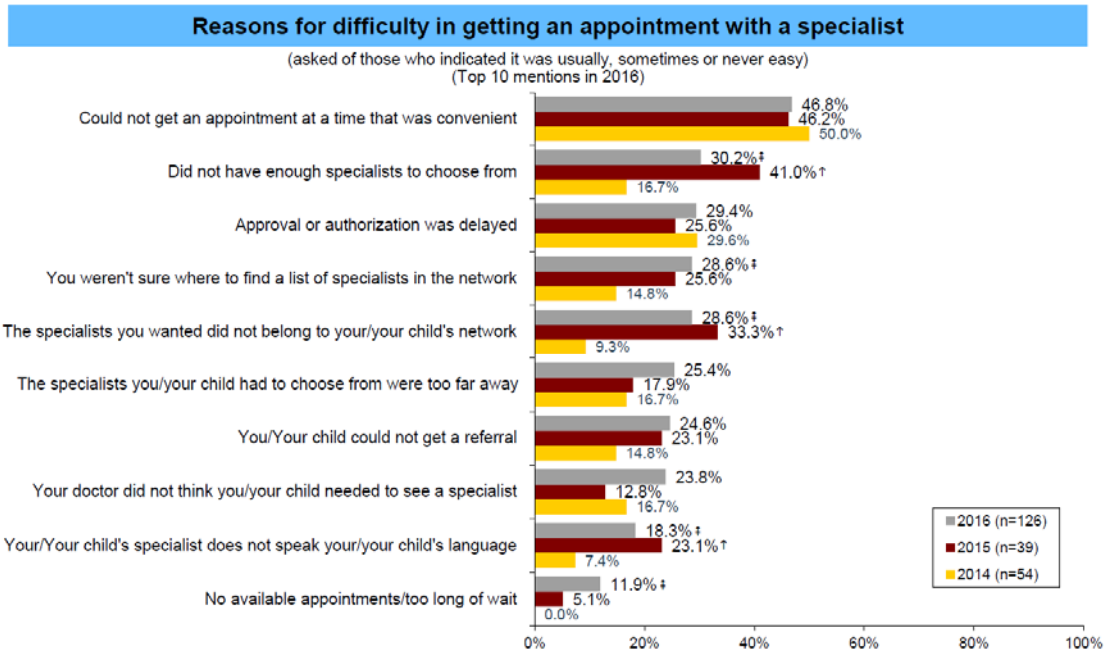
A significantly lower percentage than in 2014 tried to make an appointment to see a specialist, but the ease of getting those appointments is also significantly lower than in 2014.



Q7. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors and other doctors who specialize in one area of health care. In the last 12 months, did you try to make any appointments [/for your child] to see a specialist? Q8. In the last 12 months, how often was it easy to get appointments [/for your child] with specialists? An arrow (↑↓) indicates a significantly higher or lower result than the previous year's result. A fishbone arrow (‡‡) indicates that the 2016 result is significantly higher or lower than the 2014 result. A capital letter (ABCD) indicates a significantly higher figure than the corresponding category. Significance tested at the 95% confidence level.

BARRIERS/OBSTACLES

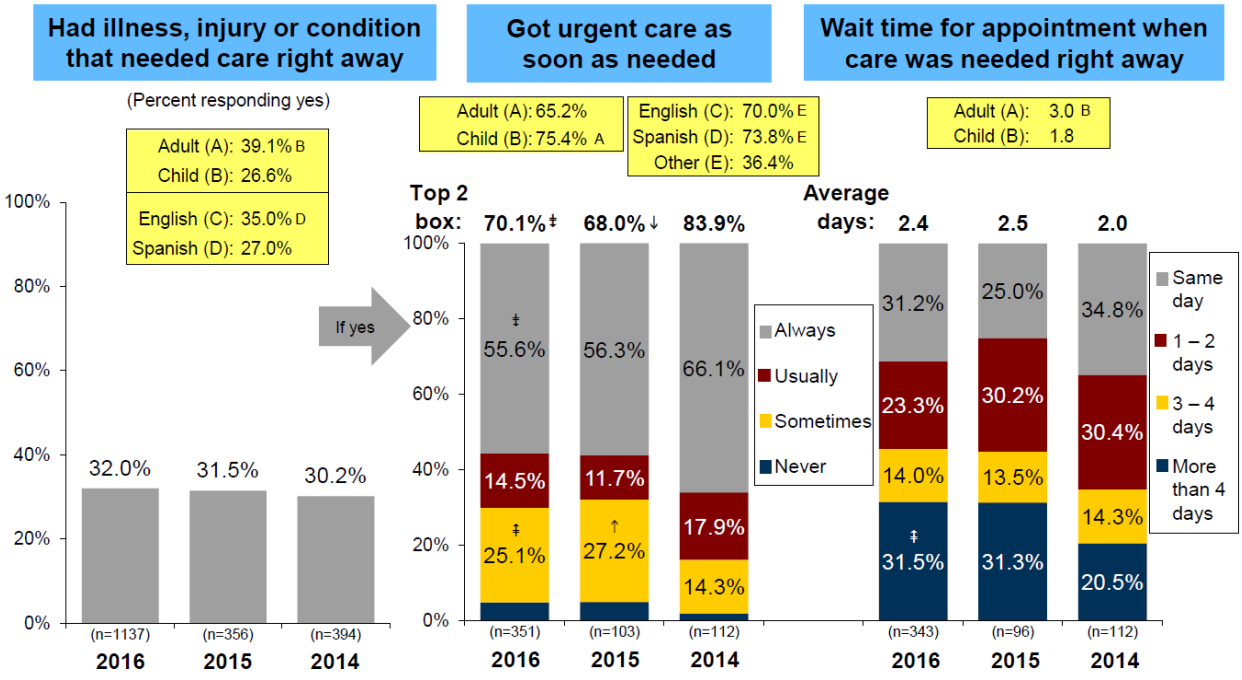
Inconvenient appointment times remain the most common obstacle to seeing a specialist. Additionally, significantly higher percentages than in 2014 had issues with the network or a language barrier.



Q9. Were any of the following a reason it was difficult to get an appointment [/for your child] with a specialist? An arrow (↑↓) indicates a significantly higher or lower result than the previous year's result. A fishbone arrow (↕↕) indicates that the 2016 result is significantly higher or lower than the 2014 result. Significance tested at the 95% confidence level.

URGENT CARE

Nearly one-third required urgent care and, with an average wait time of two to three days, a significantly lower percentage than in 2014 indicated that they always or usually received it as soon as needed. Children received care significantly faster than adults.



Q1. In the last 12 months, did [you/your child] have an illness, injury or condition that needed care right away in a clinic, emergency room or doctor's office? Q2. In the last 12 months, when [you/your child] needed care right away, how often did [you/your child] get care as soon as you thought [you/he or she] needed? Q3. In the last 12 months, when you called to make an appointment when [you/your child] needed care right away, how long did [you/your child] usually have to wait for the appointment? An arrow (↑↓) indicates a significantly higher or lower result than the previous year's result. A fishbone arrow (‡‡) indicates that the 2016 result is significantly higher or lower than the 2014 result. A capital letter (ABCD) indicates a significantly higher figure than the corresponding category. Significance tested at the 95% confidence level.

PATIENT EXPERIENCE - CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS) SURVEY RESULTS

2016 CAHPS SURVEY SUMMARY

2016 CAHPS Data	Medicare	Medi-Cal Adult	Medi-Cal Child
Sample Size (*includes oversampling*)	815	1,384	1,731
Patient Level Records Used: Complete & Valid	266	344	511
Total Response Rate: Complete/(Sample-Ineligible) *	**32.64%**	**26.58%**	**31.56%**

** "Completed" indicates that at least one question was answered. "Ineligible" indicates that member met at least one of the following criteria: they were deceased, were invalid (did not meet eligible population criteria, were mentally or physically incapacitated (adult population only), or had a language barrier.*

MEDICARE SURVEY RESTULTS

Health Plan Composite Measures	National MA	National MMP	HPSM 2015	HPSM 2016	↑↓
Getting Needed Care	3.51	3.39	3.50	3.47	

Getting Appointment and Care Quickly	3.28	3.19	3.26	3.12	↓
Doctors Who Communicate Well	3.73	3.69	N/A	3.74	
Customer Service	3.63	3.57	3.47	3.65	
Care Coordination	3.59	3.54	3.57	3.54	
Rating of Health Plan	8.5	8.4	8.8	8.8	↑
Rating of Health Care Quality	8.6	8.4	8.6	8.5	
Personal Doctor	9.1	8.9	9.2	9.3	
Specialist	8.9	8.8	N/A	N/A	

Note: An up arrow (↑) indicates that your contract scored significantly better than the national average, a down arrow (↓) that it scored significantly worse than the national average, and the absence of an arrow means that it was not significantly different from the national average.

For the Medicare population, the results for the Customer Service measure increased from 3.47 in 2015 to 3.65 in 2016. HPSM's score for Rating of Health plan is 8.8 and is the only measure that is higher than national average of 8.4 at a statistically significant rate.

Adult Medi-Cal Survey Results

Composite Questions	2010 HPSM Score	2013 HPSM Score	2016 HPSM Score	2013 National Comparison	2013 HPSM Rate*	2013 MCMC Avg.*
Getting Needed Care	2.18	2.27	**2.23**	★★	77.9	74.3
Getting Care Quickly	2.19	2.26	**2.14**	★	77.9	77.3
How Well Doctors Communicate	2.55	2.50	**2.58**	★★	88.3	85.4
Customer Service	2.31	2.43	**NA**	★★★	84.4	84.3
Rating Questions	**2010 HPSM Score**	**2013 HPSM Score**	**2016 HPSM Score**	**2013 National Comparison**	**2013 HPSM Rate***	**2013 MCMC Avg.***
Rating of All Health Care	2.31	2.40	**2.35**	★★★★	57.4 ↑	52.2
Rating of Personal Doctor	2.53	2.51	**2.60**	★★★★	67.5	64.7
Rating of Specialist Seen Most Often	2.46	2.60	**NA**	★★★★	71.2	66.9
Rating of Health Plan	2.39	2.43	**2.4**	★★★	62.1 ↑	59.8

** Combined rates for adult and child Medi-Cal Population. Results are case-mix adjusted and weighted to reflect the distribution of adults and children in each unit of analysis.*

★★★★★ indicates a score at or above the 90th percentile

★★★★ indicates a score at or above the 75th and below the 90th percentiles

★★★ indicates a score at or above the 50th and below the 75th percentiles

★★ indicates a score at or above the 25th and below the 50th percentiles

★ indicates a score below the 25th percentile

For the Adult Medi-Cal population, the Getting Needed Care and Getting Care Quickly composite measures have both declined slightly since 2013. How well doctors communicate has increased since 2013. When comparing HPSM results to the state average, no statistical significance was found for any of the composite measures. While there was a slight decrease for Rating of All Health Care in 2016, as of 2013, HPSM was higher than the state average at a statistically significant rate for both Rating of All Health Care and Rating of Health Plan. Rating of personal doctor increased from 2.51 in 2015 to 2.60 in 2016.

Child Medi-Cal Survey Results

Composite Questions	2010 HPSM Score	2013 HPSM Score	2016 HPSM Score	2013 National Comparison	2013 HPSM Rate*	2013 MCMC Avg.*
Getting Needed Care	2.13	2.28	**2.28**	★	77.9	74.3
Getting Care Quickly	2.27	2.47	**2.35**	★	77.9	77.3
How Well Doctors Communicate	2.59	2.62	**2.68**	★	88.3	85.4
Customer Service	2.23	2.46	**2.49**	★★★	84.4	84.3

Rating Questions	2010 HPSM Score	2013 HPSM Score	2016 HPSM Score	2013 National Comparison	2013 HPSM Rate*	2013 MCMC Avg.*
Rating of All Health Care	2.52	2.55	**2.60**	★★★	57.4 ⬆	52.2
Rating of Personal Doctor	2.68	2.71	**2.70**	★★★★	67.5	64.7
Rating of Specialist Seen Most Often	2.68	2.68	**NA**	★★★★	71.2	66.9
Rating of Health Plan	2.60	2.61	**2.60**	★★★	62.1 ⬆	59.8

**Combined rates for adult and child Medi-Cal Population. Results are case-mix adjusted and weighted to reflect the distribution of adults and children in each unit of analysis.*

★★★★★ indicates a score at or above the 90th percentile

★★★★ indicates a score at or above the 75th and below the 90th percentiles

★★★ indicates a score at or above the 50th and below the 75th percentiles

★★ indicates a score at or above the 25th and below the 50th percentiles

★ indicates a score below the 25th percentile

For the Child Medi-Cal population composite measures, Getting Needed Care stayed the same from 2015 to 2016. Getting Care Quickly decreased slightly in 2016. How Well Doctors Communicate and Customer Service both increased in 2016. Similar to the Adult Medi-Cal population, Getting Needed Care, Getting Care Quickly and How Well Doctors Communicate score very low when compared to national averages and are below the 25th percentile. For the rating measures, Rating of All Health Care increased slightly in 2016. Rating of Personal Doctor and Rating of Health Plan have stayed the same since 2013. Overall, HPSM does well when comparing to national and state rates on all of these measures.

2016 CAHPS Summary of Results

CAHPS Survey	Strengths	Opportunities for Improvement
MEDICARE	Customer Service Rating of Health Plan	Getting Appointment and Care Quickly
Medi-Cal Adult & Child	Rating of all Health Care (score went down in 2016, comparatively high) Rating of Health Plan	Getting Needed Care Getting Care Quickly How Well Doctors Communicate
Medi-Cal Child	Rating of All Health Care Rating of Health Plan	Getting Needed Care Getting Care Quickly How Well Doctors Communicate

Overall, there are opportunities for improvement on the access related measures across all three populations. HPSM does well on the Rating of All Health Care and Ratings of Health Plan measures indicating that despite access issues, once members get in for care they rate their experience highly.

CULTURAL AND LINGUISTICS

The Health Plan of San Mateo (HPSM) recognizes that its members represent a diverse mix of languages, ethnicities, cultures, and countries of origin, each of which may be accompanied by a variety of attitudes, beliefs and behaviors regarding their health and well-being. Having a better understanding of our members' cultures and their preferences are key principles driving our quality improvement activities. When making decisions about quality improvement interventions, HPSM examines yearly the demographic characteristic of its member population to ensure the inventions are culturally appropriate.

MEMBERSHIP:

The following summarizes HPSM's membership profile by age, gender, language, and ethnicity as of December 2016.

Membership By Age:

Age	Number of Members	% of Membership
Age 00-05	15,489	10.50%
Age 06-18	35,676	24.30%
Age 19-24	11,169	7.60%
Age 25-64	67,253	45.70%
Age 65+	17,455	11.90%
Total	147,042	

Membership By Gender:

Gender	Number of Members	% of Membership
Female	78,978	53.70%
Male	68,060	46.30%
Unsure	4	0

Membership By Language:

Language	Number of Members	% of Membership
Chinese	5,830	4.00%

English	73,740	50.10%
Not Reported	1,191	0.80%
Other	4,377	3%
Russian	734	0.50%
Spanish	57,903	39.40%
Tagalog	3,267	2.20%
Total	147,042	

Membership By Ethnicity:

Ethnicity	Number of Members	% of Membership
African American	4,513	3.10%
Asian	36,347	24.70%
Caucasian	20,150	13.70%
Hispanic	66,970	45.50%
Not Reported	5,468	3.70%
Other	13,594	9.20%
Total	**147,042**	

Based on our analysis of HPSM membership for 2016, the predominate languages spoken by HPSM members are English at 55.10%, followed by Spanish at 39.40%, Chinese at 4.00%, and Tagalog at 2.20%. These four languages are HPSM threshold languages. HPSM strives to make available easy-to-read, well translated health education material, and continuously increase the availability of material in other formats (audio, Braille, large formats).

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

Organizationally, Health Plan of San Mateo's (HPSM) CLAS activities are imbedded into the daily work of each department at the health plan. Structurally, the CLAS Program is integrated into the Quality Improvement Program. Weekly updates at the Quality Department's Team Meeting are provided as a standing agenda item by Culturally and Linguistically Appropriate Services (CLAS) Committee members.

HEALTH INEQUITIES/CLAS WORKGROUP

In 2016, HPSM's CLAS Committee, formally called the Health Inequities Committee, changed its name and purpose to better align with the National CLAS Standards. The CLAS Committee reports to the Service Quality Committee, Clinical Quality Committee, Consumer Advisory Committee and Quality Improvement Committee. The CLAS Committee is a multidisciplinary team that is comprised of Managers and Supervisors, as well as key staff throughout the organization that interact directly with members. The committee meets monthly to review and assess cultural and linguistic services efforts throughout departments within HPSM. The CLAS committee reviews the CLAS Program Description, work plan, and annual evaluations against contract requirements and revises to address any updates or quality/process improvements on an annual basis.

CLAS TRAINING FOR HPSM STAFF

HPSM provides on-going education on C&L rights, requirements, services, resources, and cultural competencies. The 2016 staff cultural awareness training was an online-line Cultural Awareness training module titled “ResCUE Effective Cross Cultural Interactions”. The training was designed to deliver cultural awareness education to all HPSM staff for the purpose of achieving the following:

- Build greater respect for cultural diversity
- Develop a broader skill set for communicating clearly in cross-cultural interactions
- Explore cultural differences to understand them more deeply
- Practice effectively engaging with individuals in cross-cultural interactions

Training Evaluation:
All staff who participated in the online training module also completed an evaluation to assess if there was an improved level of awareness of cultural differences and broadened skills for communicating clearly in cross cultural interactions.

Evaluation Results:
A total of 254 HPSM employees completed the training and survey evaluation. The recurring comment themes that staff found to be most valuable of the Quality Interaction course included:

1) Increase understanding and awareness
2) Reminder not to stereotype and make assumptions
3) Learn to be patient & listen to member
4) Good refresher
5) Two way stream in communication
6) Acceptance and respect of other cultures

Overall, the results of the evaluations were very positive. The case examples presented in the online training were identified as the staff's favorite part of the training. Since this was the first time HPSM offered an on-line training, the CLAS Committee facilitated an in-person discussion session inviting all HPSM to discuss how to apply what was learned in the training module. In this one hour session, a quick review of the training content followed by a discussion on how to apply the training concepts to the workplace setting through interacting and communicating with both colleagues and HPSM members. Feedback provided from this in-person discussion was very positive as well. Staff seemed to enjoy learning of their own cultural biases and learning how to work with individuals from different cultures. The feedback provided by HPSM Staff was reviewed by the CLAS Committee and is being used to plan for next year's online training module. Since the online training was well received by staff in 2016, we are looking to build on the ResCUE Effective Cross Cultural Interactions for the 2017 training.

PROVIDER EDUCATION

HPSM recognizes that the ability to provide services in a culturally and linguistically appropriate manner must be cultivated through training and experience. HPSM is committed to conducting regular trainings regarding various CLAS topics for HPSM's network providers through the following mechanisms:

- New provider orientation that covers HPSM's CLAS policies and procedures, specifically addressing provider's responsibility for providing CLAS and utilization of interpreter services.
- One-on-one training for providers and provider's office staff on CLAS issues when a need is identified that will improve provider effectiveness in meeting members' C&L needs.
- Senior and Persons with Disabilities (SPD) competency and sensitivity training is provided to providers, their staff and health plan staff utilizing the training developed by Medi-Cal Managed Care Division (MMCD).

In addition, the fall issue of the Provider newsletter had an article about interpreter services and introduced the new provider toolkit. The provider toolkit is available at any time and includes information on cultural and linguistic services requirements, tips for communicating across language barriers, and tips for working with interpreters. Additionally, in May 2016 HPSM sent a mass fax to all of HPSM contracted provides informing them of language assistance services free of charge.

MEMBER EDUCATION

Health Plan of San Mateo provides members with information on their right to language assistance services through several routes including:

- HPSM Member Handbook/Evidence of Coverage (EOC) mailed with New Member Packet.
- Disclosure Forms
- Notices in Provider Offices-Signs are provided in threshold languages during new provider visits and annually thereafter by Provider Services staff.
- HPSM website includes information about interpreter services that is provided in both the member and provider section of HPSM's website.
- Informative articles in HPSM's member newsletters

- Listings in the Health Education Class Schedules
- One-on-one interactions between members and Member Service Representatives CareAdvantage Navigators, Grievance Coordinator, Health Educators, and other staff in contact with members.
- Information is published in the provider directory.

Language Assistance

AVAILABILITY OF TRANSLATED MATERIAL

HPSM translated member materials are available in all threshold languages identified by the Department of Health Care Services and Title 28 Section 1300.67.04 for the following lines of business: Medi-Cal, Healthy Kids, CareAdvantage, and ACE. For Medi-Cal, Health Kids, and Ace materials are translated into Spanish, Chinese and Tagalog. For CareAdvantage members, materials are translated into Tagalog, Russian and Chinese. Translated materials are given to members on a regular basis.

ACCESS TO INTERPRETER SERVICES

HPSM provides its entire limited English Proficient (LEP) membership access to free interpreter services to reduce any language barriers. Telephonic interpreter services are available for all medical and non-medical points of contact 24 hours/7 days a week. In addition, face-to-face and sign language interpretation are available upon request. HPSM informs its Members and Providers of the availability and their right to interpreter services through the Member and Provider Newsletter, the Member Handbook/Evidence of Coverage, and the Provider Directory.

The following summarizes the member and provider the usage of interpreter Services for 2016. It shows interpreter services volume by telephonic, face-to-face, sign language, and is also broken out by HPSM and Provider Group.

Interpreter Service Usage

Interpreter Services	Total
Sign Language	47
In-Person	913
Telephonic	
HPSM	10,863
Provider Group	4,349

Telephonic Utilization by top 5 Language

Provider Network		HPSM	
By language	Call volume	By Language	Call volume
Spanish	3,085	Spanish	5,412
Chinese Cantonese	355	Tagalog	1,095
Chinese Mandarin	300	Chinese Cantonese	1,081
Burmese	135	Chinese Mandarin	1,044
Arabic	110	Chinese	678

LINGUISTIC CAPABILITY OF PLAN STAFF

HPSM goal is to maintain staff that is reflective of the cultural and linguistic diversity of HPSM membership, with bilingual or bilingual/bicultural staff. All employees that provide interpreting services to HPSM members must undergo evaluation of their language skills to demonstrate fluency orally and when reading. This includes conversational fluency in the target language

and English using adequate vocabulary. This also includes an oral interview conducted in the language in question with a manager or supervisor who has already demonstrated fluency.

LINGUISTIC CAPABILITY OF PROVIDER NETWORK

Providers who are new and re-credentialing providers to HPSM's network are required to document their language capabilities on their initial application to become contracted providers. At least annually, HPSM conducts a self-reporting survey of the language capabilities available at each provider location, using the ICE Language Assessment Tool. The tool provides a basic and subjective idea of the bilingual capabilities of the staff fluently other than English. If the staff passes the assessment, the staff would need to use a professional language testing vendor to evaluate their level of proficiency. The information collected from the tool and used as a first step to identify bilingual capabilities. The data collected from the survey is audited against the provider directory. The directories are updated to reflect new information. As office staff changes are communicated to HPSM, linguistic capabilities of the new staff are added to the directory. HPSM publishes provider language information both on-line through HPSM website and via a hard copy Provider Directory to help members select a provider by language capabilities.

PROVIDER NETWORK

The following summarizes language spoken by HPSM's Provider network.

Arabic	French	Italian	Spanish
Bengali	French	Japanese	Tagalog
Burmese	Galician	Kapampangan	Taiwan
Cantonese	German	Korean	Taiwanese
Cantonese (Yue Chinese)	Greek	Mandarin	Tamil
Chinese	Gujarati	Persian	Turkish
Croatian	Hebrew	Portuguese	Ukrainian
Czech	Hindi	Romanian	Urdu
English	Ilocano	Russian	Vietnamese
Farsi	Indian	Serbian	

The language capabilities provided by HPSM Provider network align with the top threshold languages spoken by HPSM membership. HPSM will continue to monitor the language capabilities of its provider network and make slight adjustment to ensure there are sufficient numbers of providers with different language capabilities.

PROVIDER COMPLIANCE WITH LANGUAGE ASSISTANCE PROGRAM

HPSM continuously monitors issues related to provider interpreter capabilities through member complaint and grievance logs. Corrective Action Plan is developed with provider sites if issues are identified. HPSM uses a variety of formats and tools to ensure providers are aware of interpreter service options and educational opportunities for their staff. Examples: Provider newsletter articles, HPSM Provider Cultural and Linguistic Toolkits, links to Industry Collaboration Efforts (ICE) on HPSM website, reminder at providers site in-services.

MONITORING AND ADHERENCE

HPSM recognizes that the provision of culturally and linguistically appropriate health care services is challenging and requires a great deal of coordination. To ensure that HPSM's employees, providers, pharmacies and subcontractors adhere to its cultural and linguistic services policies and procedures, HPSM conducts regular monitoring activities regarding staff, provider,

pharmacies, and subcontractors interpreter performance that include, but not limited to, consumer satisfaction surveys, review of member grievances, annual provider language assessments, and provider site-reviews. Corrective action plans are developed if deficiencies are identified.

CLAS RELATED GRIEVANCES & APPEALS

Member Complaints and Grievances related to Cultural and Linguistic issues are reviewed quarterly to identify opportunities to improve the languages assistance services.

In 2016, there were a total of 5 grievances related to cultural and linguistic services; due to the low number in grievances no trends were noted.

CONCLUSION AND NEXT STEPS

HPSM will continue exploring ways to improving services and measure performance for C&L services. Together, the CLAS Committee will discuss the work plan goals and actions plans for the upcoming year.

HPSM will continue working on improving the translation process workflow. HPSM is working with a letter generator consultant to standardize the process for ensuring translated letters are sent to member's threshold language. The system will track members needing a translated letter and will also keep the letter on file for review. HPSM will continue the discussion to create translation aids, such as a glossary of managed care terms in threshold languages, style guides and translation memory tools to assist with providing quality translation.

HPSM will continue to train all new hires on HPSM cultural and linguistic services. In addition, training with an increased focused for staff that daily direct contact with members will be provided. HPSM is committed to offering innovative training to meet the growing needs of HPSM Staff. Additional training on selected linguistic and cultural groups represented in HPSM membership will be developed.

HPSM will continue to monitor quarterly complaints and grievances related to cultural and linguistic issues.

HEALTH EDUCATION

GROUP NEEDS ASSESSMENT

The Health Plan of San Mateo (HPSM) conducted the GNA survey to identify: health education needs and gaps; accessibility and availability of cultural and linguistic services; improvements to existing services; and new approaches to address health disparities. The survey was sent to 4,000 MC beneficiaries in four different languages (English, Spanish, Chinese and Tagalog) and targeted to two groups (adults and children). A total of 555 beneficiaries completed the survey, with a response rate of 13.8% and representative of 0.45% of the total HPSM MC population. The GNA survey included six additional questions regarding access to care, relationship with PCP, emerging health education needs and overall satisfaction with HPSM.
Due to MC expansion in 2014, HPSM's MC population has more than doubled from 56,209 to 123,186 since the last GNA. Of these, 19% are SPDs and 1.9% are children with special needs. In 2015, the membership includes Hispanics (36.7%), Asian or Pacific Islanders (27.7%), Caucasians (16.6%) and African Americans (3.9%). In 2015, 59.5% of the beneficiaries prefer English; 29.1% prefer Spanish and 2.7% prefer Tagalog. Of the GNA respondents, 90.6% indicated that the PCPs or their office staff spoke their preferred language.

KEY FINDINGS

Children (note-surveys completed by parents or caregivers):

- Most respondents are aware that that HPSM has interpreters and are comfortable asking for interpreters.

- Most respondents think that not having enough safe places to walk or play was a health concern.
- Most respondents get information about shots/vaccines for their children, hearing and vision tests and regular medical and dental checkups.
- Most respondents are very satisfied or satisfied with HPSM, with Hispanics being the most satisfied, followed by Asians or Pacific Islanders and Caucasians.

Adults:

- Many adults are unaware that HPSM has interpreters, and are not comfortable asking for interpreter services and have used family or friend to interpret for them.
- Most adults think that not having enough appointment times was an important health concern, and many adults wanted help with getting an appointment with a specialist.
- Most adults get information about regular medical and dental checkups, but many indicated that they don't get preventative services information from HPSM.
- Most adults are very satisfied or satisfied with HPSM, with Asians or Pacific Islanders being the most satisfied, followed by Hispanics and Caucasians.

Seniors and Persons with Disabilities (SPD):

- Many SPDs are unaware that the HPSM has interpreters and are not comfortable asking for interpreter services and have used family or friend to interpret for them.
- Most SPDs think that not having enough appointment times was an important health concern and many wanted help with getting an appointment with a specialist and transportation.
- Many SPDs always and sometimes had a hard time filling out forms by themselves.
- Most SPDs get information about regular medical and dental checkups, but many indicated that they don't get preventative services information from HPSM.

General findings across all groups:

- All indicated that the PCP or office staff spoke the language they preferred and always explained things in a way they understood.
- All wanted information about who to call at night when their child is sick.
- All spoke to a health professional or searched the internet for health information, as opposed to very few went to health-related class or used HPSM's website.
- All preferred to get information sent to their home, followed by email.
- All indicated that they do not want or need an interpreter.
- All wanted information on exercise, weight loss, healthy eating, healthy teeth and healthy aging.
- Most respondents use the internet daily or weekly, except for the SPDs.

KEY RECOMMENDATIONS BASED ON GNA FINDINGS

Children:

- Continue to send out reminder post cards for immunizations, well baby and adolescent checkups.
- Develop more content on children's health to post on HPSM's website.

Adults:

- Update and improve the quality of HPSM's website.
- Consider mailing the diabetes education class schedule directly to people with diabetes.
- Mail out a New Year's Resolution to Quit Smoking flyers to all smokers and select providers.

- Identify partners to collaborate on interventions in the African Americans community to address the high utilization of emergency room as well as the high rates of diabetes, obesity, asthma and smoking.
- Continue to offer Weight Watchers vouchers.
- Continue to promote health education opportunities (classes, support groups, etc.).

Seniors and Persons with Disabilities:

- Identify new materials or approaches to assist the SPD population with filling out health forms.

General Recommendations across all groups:

- Collaborate with San Mateo County's Active Access to promote free outdoor activities.
- Publish articles in newsletter and on website on healthy eating, exercise, weight control, healthy teeth and healthy aging.
- Promote the Nurse Advice Hotline to help beneficiaries with health issues after hours.
- Continue to educate beneficiaries about the availability of free interpreter services.

CONCLUSIONS AND PLANNED ACTIONS

Many of the proposed planned actions will be a continuation of current activities including offering vouchers to a weight loss program, promoting health education classes and availability of interpreter services, publishing educational articles (i.e. dental health, nutrition) in our newsletter, mailing well visit reminder post cards, and creating more user friendly content for HPSM's website. We will continue to improve in these areas, as well as address other emerging issues with our beneficiaries like increasing health literacy and access to on-line and community resources.

WEIGHT WATCHERS

Weight Watchers is a weight loss program available to adult Medi-Cal members with a BMI over 25. The objective of this program were 1) By December 2016, 50 adult members with a BMI > 25 will participate in at least 10 Weight Watchers meetings; 2) by December 2016, 50 adult members with a BMI >25 participating in Weight Watchers will lose 5% of their body weight.

When a fax referral from a provider is received, the Health Educator is responsible for enrolling members into the program. The health educator completes the initial data entry, discusses the program requirements, assists the member in finding a convenient meeting location, completes the pre-program survey and requests that a set of 5 vouchers are sent to the member. A physician referral is not required, and the Health Educator may enroll the member into the program through the Health Education line. Members must send in their weigh in logs after each set of 5 visits and can receive up to 4 sets of vouchers (a total of 20).

A total of 76 members were referred by their PCP to the Weight Watcher program. Of those, 23.69% (18) attended at least one class; 15.79% (12) attended 1 class; 3.95% (3) attended 6-9 classes; and 3.95% (3) attended 16-18 classes. Only those who attended 6 or more classes demonstrated weight loss of 3.19%- 6.58% of their body weight.
One of the challenges of this program is that attending group support classes is not always a preferred intervention for our members. In addition, none of the classes were offered in Spanish. Although this program did not have significant outcomes, it is an appreciated benefit for our members who lack access to any other type of weight loss program. This program has filled an important gap to our membership where, according to the 2013 Community Needs Assessment Report for San Mateo County, 55% of adults are overweight and 22% are obese, many of these residents are our members. This program will continue to be offered to our members next year to assess other opportunities to build more interest in the program.

VEGGIERX

HPSM partnered with Fresh Approach to pilot the VeggieRx program with Spanish speaking members between the ages 13 and 18. VeggieRx is a program is a 16-week long program that can help teens and their parent/guardian eat healthier foods, be active, and lose weight. Program implementation was originally planned for 2015; however, the program was postponed to 2016 due to recruitment issues.

The objectives of this program 1) By June 2016, at least 50% of participants will report an increase in their fruit and vegetable consumption; 2) By June 2016, at least 50% of participants will lose or maintain their weight; 3) June 2016, at least 50% of participants will complete the entire 8 class series; and 4) By June 2015, at least 75% of participants will utilize their farmers market vouchers.

HPSM and Fresh Approach worked with providers at the San Mateo Medical Center Pediatric Clinic to recruit active Spanish speaking HPSM members and their parents/guardians. Providers at the clinic faxed patient referrals to HPSM. Classes began on January 20, 2016 and concluded on April 27, 2016.

- 22 families registered by January 2016 (1 youth and 1 adult from each household)
    - Of these 22 families, only 11 attended at least 1 class session
- Of the 11 families who enrolled by attending at least one class session, 5 families completed the VeggieRx program by attending at least 6 of the 8 class sessions. (45% of those enrolled completed the program.)
- 3 out of the 5 youth (60%) reduced their BMI percentile during VeggieRx
- 2 out of 5 youth (40%) maintained their BMI percentile from class 1 to class 8.

Considering that only half of those who registered attended one class (11 out of 22) and half of those completed 6 of the 8 classes (5 out of 11), this is not a cost or programmatically effective educational program to offer to our members. In addition, only half of the participants (3 out of 5) reduced their BMI. Even the youth who completed the program had mixed results as to whether they increased their awareness and uptake in fruits and vegetables at the end of the program:

- 4 out of 5 youth (80%) reported they believe they are eating more fruits at the end of VeggieRx than they did before the program.
- 3 out of 5 youth (60%) reported they believe they are eating more vegetables at the end of VeggieRx than they did before the program.
- 3 out of 5 youth (60%) reported they were very comfortable cooking with fruits and vegetables at the end of the program. Before the program, 2 out of 5 were somewhat comfortable, two were somewhat uncomfortable, and one was very uncomfortable cooking with fruits and vegetables.
- 5 out of 5 youth reported they believe that eating fresh fruits and vegetables is very important. Before the program, 2 out of 5 thought that eating fresh fruits and vegetables was very important, and the other 3 only thought it was somewhat important.
- 5 out of 5 youth reported they were very sure about where to get fresh fruits and vegetables in their neighborhood. Before the program, 2 out of 5 were very sure about where to get fresh fruits and vegetables in their neighborhood, one was somewhat sure, and the other 2 were somewhat unsure.
- 4 out of 5 youth reported being very likely to continue buying the same amount of fruits and vegetables after VeggieRx as they did during the program, and one youth reported being somewhat likely.

Anecdotal information collected by HPSM staff indicated that the 5:30 start time for the class was in competition with other youth and family activities that made it difficult for participation. Some parents were willing to attend without their child, but since that was not how the program was set up, it was not allowed.

Although the majority of those who participated could enumerate the benefits, there were not enough attendees in the classes to make Veggie Rx a sustainable cost effective and results-based program.

HEALTH EDUCATION MATERIALS

All health education materials should be in the sixth grade reading level that is culturally and linguistically appropriate for our members. A total of ten health education materials were due for their 3 year review this year. All materials were evaluated using the Health Literacy Advisor software and the Readability and Suitability checklist. Both a hard copy and electronic copy are available for review if requested.

HPSM published and distributed Health Education Classes & Resource Guide, a list of free and/or low-cost health education classes and resources available throughout San Mateo County in order to expand member access to affordable health

education. The guide is mailed out in new member packets, and referrals are provided to members through HPSM's Health Education Phone Line.

The primary challenge with this resource guide is the large amount of time it takes to compile up to date information and get it published in a timely manner. Once it is published, often times some of the resources are already out of date. This has been addressed by compiling a list of resources specific to a health issue and distributing current information to those who would most directly benefit from the resources. Thus far, a community resource binder for diabetes, asthma, physical activity, weight loss and smoking has been compiled and distributed internally.

HEALTH EDUCATION CLASSES

HPSM observed and evaluated selected health education classes and resources to ensure high quality and appropriate referrals are provided. In 2016, HPSM's Health Educator evaluated 3 classes which included Diabetes and Nutrition at Mills Peninsula Health Services, Diabetes Medications at Seton Hospital and at Diabetes Essentials (Spanish) at the San Mateo Medical Center. All classes were found to be high quality and appropriate for our members. Separate from the resource guide, a list of community diabetes classes was made available to members with diabetes and HPSM staff who work directly with our members.

SMOKING CESSATION

HPSM continues to conduct direct flyer mailings to promote the use of the California Smoker's Helpline. Smokers are identified by ICD-10 codes and prescriptions of tobacco cessation medication on a monthly basis. In 2016, HPSM mailed out 3,164 tobacco cessation promotional flyers in English, Spanish, Korean and Chinese. Currently, the California Smoker's Helpline does not include services in Tagalog or Russian. According to data provided from the California Smoker's Helpline, there were a total of 151 San Mateo County callers to the Helpline from January-December 2016 reporting period. A total of 43% were Caucasian, 12.5% were Asian or Pacific Islander, 16.5% were Latino and 9% were African American. Of these, 82% spoke English, 6.6% spoke Spanish, 5.2% spoke Mandarin and 3.3% spoke Cantonese and 2.2% spoke Korean.

However, to encourage the use of smoking cessation services throughout the year, a new flyer to promote the California Smoker's Helpline was developed to respond to the tradition of making it a New Year's resolution to quit smoking. The flyers were translated into English, Spanish and Chinese. Again, since the CA Smoker's Helpline does not have services in Tagalog, a Tagalog version was not created. A total of 3,701 flyers were mailed out based on their smoking status in the last six month period. Of these, 3148 were in English, 445 were in Spanish and 108 were in Chinese.

HPSM WEBSITE

In order to address a CAP, the HPSM website was updated to include information specific to HIV/AIDS in addition to the existing information on sexual health. Also to be in compliance with all of the mandated health education topics, a section on alternative care was added that includes stress management and positive thinking. Due to the lack of dedicated staff to keep the website up to date, the website updates have been minimal.

GRIEVANCES AND APPEALS

RATE OF COMPLAINTS PER 1,000 MEMBERS

The rate of complaints per 1,000 members accounts for the differences in the enrollment numbers across HPSM's lines of business.

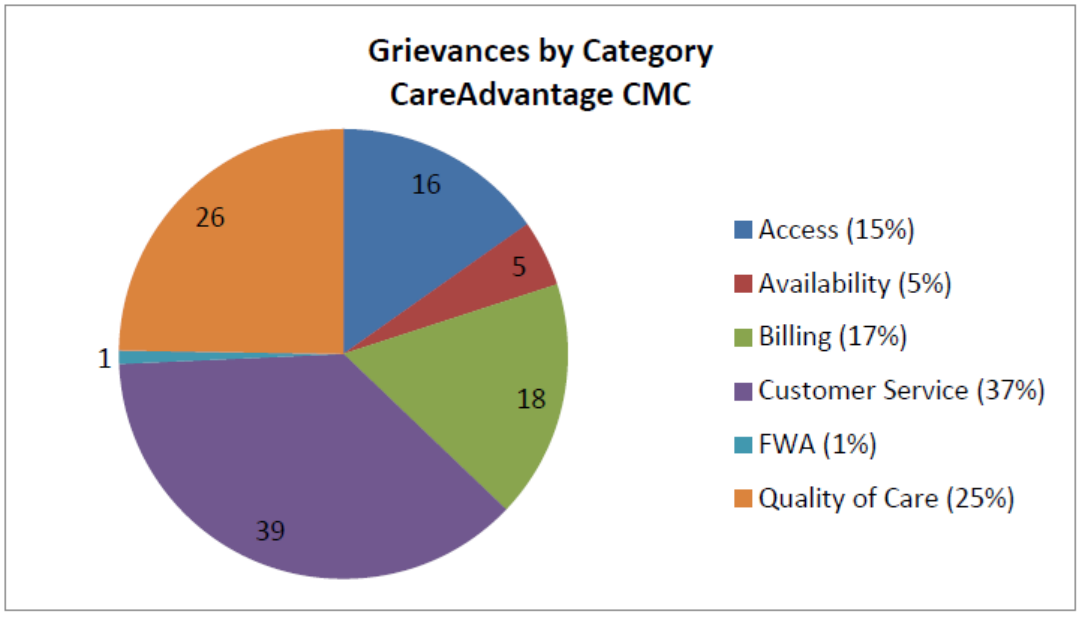
Line of Business	Q1	Q2	Q3	Q4
CareAdvantage CMC	11.4	11.4	14.8	15.2
CareAdvantage D-SNP	10.2	7.9	17.9	13.8
Medi-Cal Only (Excluding CCS)	3.3	2.3	2.3	2.5
Healthy Kids	1.3	0.7	3.2	9.3
HealthWorx	9.1	4.8	5.7	9.5
ACE	1.1	0.9	0.7	0.2
CCS	n/a	1.9	2.5	4.9
TOTAL	**3.6**	**2.7**	**3.0**	**3.1**

CAREADVANTAGE CAL MEDICONNECT (CAREADVANTAGE CMC)

NUMBER OF APPEALS AND GRIEVANCES (COMPLAINTS) RECEIVED

LINE OF BUSINESS			Q1	Q2	Q3	Q4	TOTAL
CAREADVANTAGE CMC							
Appeals	**Part C (Medical)**	**Expedited**	1	3	1	3	**8**
		Standard	8	10	12	31	**61**
	Part D (Drugs)	**Expedited**	1	0	1	1	**3**
		Standard	13	11	12	3	**39**
	Total Appeals		**23**	**24**	**26**	**37**	**110**
Grievances	**Part C (Medical)**	**Expedited**	1	0	0	0	**1**
		Standard	74	76	105	93	**348**
	Part D (Drugs)	**Expedited**	0	0	0	0	**0**
		Standard	11	7	8	12	**38**
	Total Grievances		**86**	**83**	**113**	**105**	**387**
	CareAdvantage CMC Subtotal		**109**	**107**	**139**	**142**	**497**

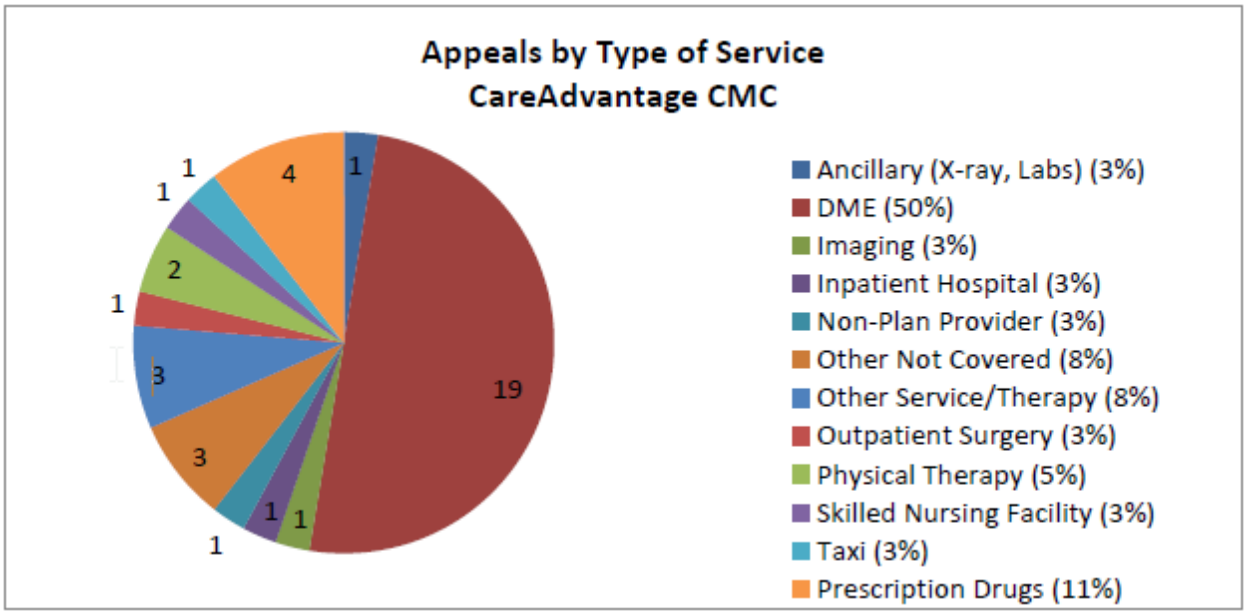
TYPES OF GRIEVANCES RECEIVED 2016 Q4



TYPE OF GRIEVANCES RECEIVED, BY SUB-CATEGORY CMC 2016 Q4

Category	Sub-Category	# Received
Access	No MRF or Rx on File	2
	No TAR or Prescription on File	4
	OHC	1
	Other	2
	Product Lost	1
	Provider Not Providing Drug	4
	Provider Not Providing Item	2
Access Total		16
Availability	Excessive Wait Time for Appointment	1
	Unable to Schedule Appointment	4
Availability Total		5
Billing	Balance Bill in Collections	10
	Full Bill Direct to Mbr	5
	Other	3
Billing Total		18
Customer Service	Communication - Disrespect/Rudeness/Discrimination	4
	Communication - Other Issue with Staff	17
	Taxi - Driver no-show	5
	Taxi - Driver rude/disrespectful	1
	Taxi - Driver Safety	1
	Taxi - Late pick-up/ drop off	2
	Taxi - Other	6
	Timeliness - No return call	2
	Timeliness - Other	1
Customer Service Total		39
FWA	Fraud - Identity Theft	1
FWA Total		1
Quality of Care	Other	11
	Relationship - Provider Not Listening to Concerns	1
	Treatment - Drug Not Prescribed	1
	Treatment - Incorrect Prescription	3
	Treatment - Poor Treatment	7
	Treatment - Services Not Rendered	3
Quality of Care Total		26
Total		**105**

TYPES OF APPEALS, BY TYPE OF SERVICE CMC 2016 Q4



CAREADVANTAGE D-SNP

NUMBER OF APPEALS AND GRIEVANCES (COMPLAINTS) RECEIVED

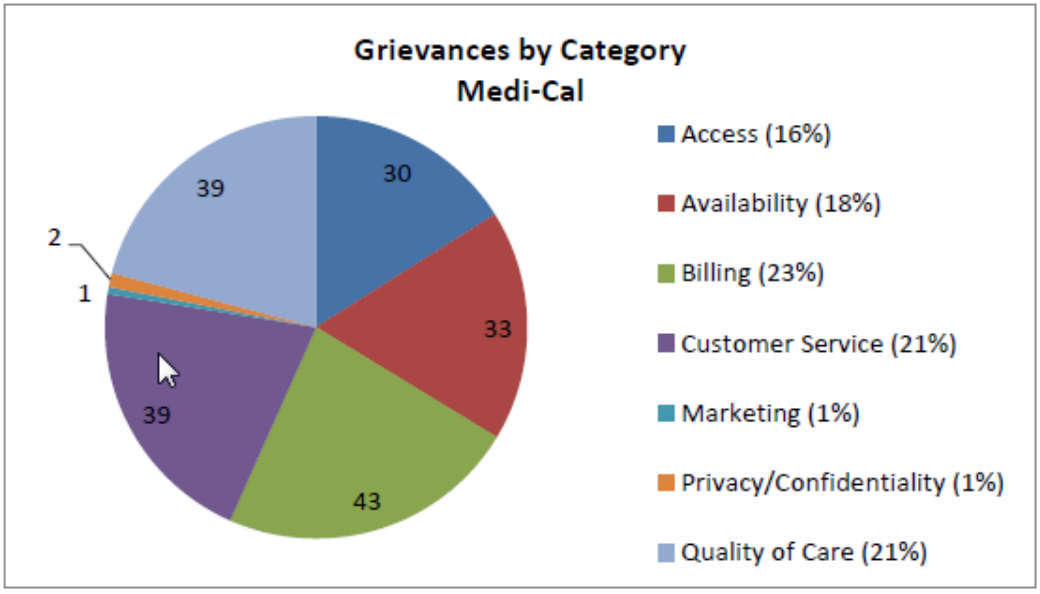
LINE OF BUSINESS			Q1	Q2	Q3	Q4	TOTAL
CAREADVANTAGE DSNP							
Appeals	**Part C (Medical)**	**Expedited**	1	0	0	0	**1**
		Standard	0	0	1	1	**2**
	Part D (Drugs)	**Expedited**	1	0	1	0	**2**
		Standard	1	1	0	0	**2**
	Total Appeals		**3**	**1**	**2**	**1**	**7**
Grievances	**Part C (Medical)**	**Expedited**	0	0	0	0	**0**
		Standard	5	5	10	6	**26**
	Part D (Drugs)	**Expedited**	0	0	0	0	**0**
		Standard	0	0	0	0	**0**
	Total Grievances		**5**	**5**	**10**	**6**	**26**
CareAdvantage D-SNP Subtotal			**8**	**6**	**12**	**7**	**33**

MEDI-CAL

NUMBER OF APPEALS and GRIEVANCES (COMPLAINTS) RECEIVED

LINE OF BUSINESS			Q1	Q2	Q3	Q4	TOTAL
Medi-Cal							
Appeals	**Medical/Services**	**Expedited**	2	4	2	3	**11**
		Standard	26	27	31	44	**128**
	Drugs	**Expedited**	4	5	5	4	**18**
		Standard	27	21	29	43	**120**
	Total Appeals		**59**	**57**	**67**	**94**	**277**
Grievances	**Medical/Services**	**Expedited**	4	3	5	4	**16**
		Standard	288	187	182	172	**829**
	Drugs	**Expedited**	2	2	0	3	**7**
		Standard	17	9	7	8	**41**
	Total Grievances		**311**	**201**	**194**	**187**	**893**
		Medi-Cal Subtotal	**370**	**258**	**261**	**281**	**1170**

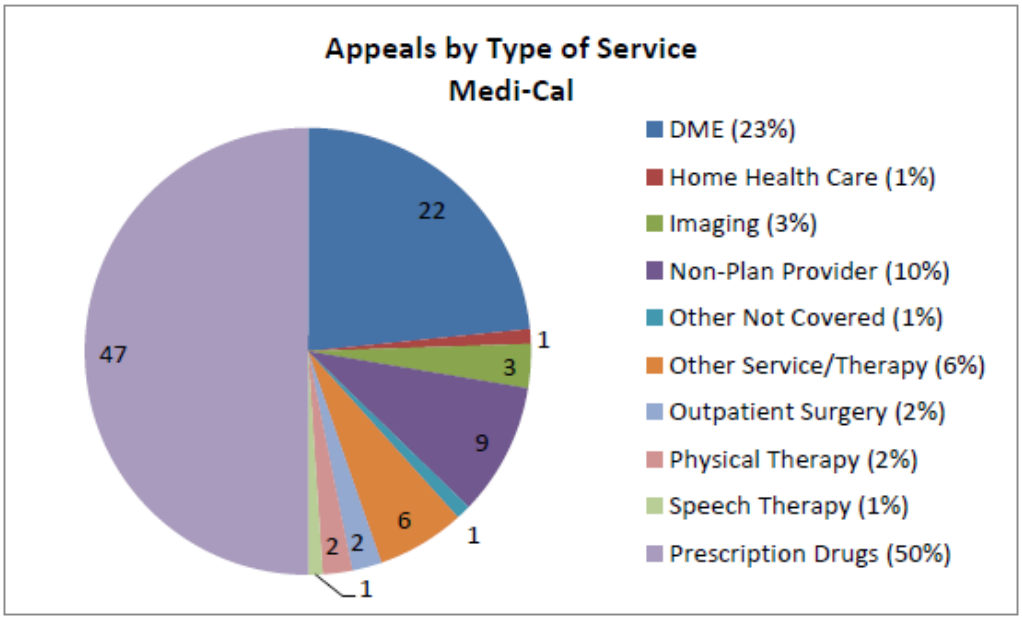
TYPES OF GRIEVANCES RECEIVED, BY CATEGORY 2016 Q4



GRIEVANCES BY SUB-CATEGORY 2016 Q4

Category	Sub-Category	# Received
Access	ADA Access	2
	Network - Specialist	3
	No MRF or Rx on File	3
	No TAR or Prescription on File	9
	Other	10
	Provider Not Providing Item	3
Access Total		30
Availability	Excessive Wait Time for Appointment	16
	Other	3
	Unable to Schedule Appointment	14
Availability Total		33
Billing	Balance Bill in Collections	9
	Balance Bill Not in Collections	2
	Full Bill Direct to Mbr	28
	Other	4
Billing Total		43
Customer Service	Communication - Disrespect/Rudeness/Discrimination	6
	Communication – Incorrect Info Given to Mbr	9
	Communication - Other Issue with Staff	17
	Communication – Staff Not Working/Distracted	1
	Taxi - Late pick-up/ drop off	1
	Taxi - Other	2
	Timeliness - No return call	1
	Timeliness - Office hours	1
	Timeliness - Other	1
Customer Service Total		39
Marketing	Incorrect Information Provided	1
Marketing Total		1
Privacy/Confidentiality	Mbr PHI Visible to Others	1
	Other	1
Privacy/Confidentiality Total		2
Quality of Care	Facility - Dirty/Disorganized Office	1
	Other	12
	Relationship - Provider is Rude/Mean/Etc	2
	Relationship – Provider Not Listening to Concerns	4
	Treatment - Poor Diagnosis	1
	Treatment - Poor Treatment	13
	Treatment - Services Not Rendered	6
Quality of Care Total		39
Total		**187**

TYPES OF APPEALS RECEIVED



OTHER LINES OF BUSINESS:

NUMBERS OF APPEALS AND GRIEVANCES (COMPLAINTS) RECEIVED FOR OTHER LINES OF BUSINESS

LINE OF BUSINESS		Q1	Q2	Q3	Q4	TOTAL
HEALTHY KIDS						
Appeals	**Expedited**	0	0	0	0	**0**
	Standard	0	0	0	0	**0**
Grievances	**Expedited**	0	0	0	0	**0**
	Standard	3	2	3	8	**16**
	Healthy Kids Subtotal	**3**	**2**	**3**	**8**	**16**
HEALTHWORX						
Appeals	**Expedited**	0	0	1	0	**1**
	Standard	1	0	2	3	**6**
Grievances	**Expedited**	0	0	0	0	**0**
	Standard	9	5	3	7	**24**
	HealthWorx Subtotal	**10**	**5**	**6**	**10**	**31**
ACE						
Appeals	**Expedited**	0	0	0	0	**0**
	Standard	2	3	4	0	**9**
Grievances	**Expedited**	0	0	0	0	**0**
	Standard	19	14	11	5	**49**
	ACE Subtotal	**21**	**17**	**15**	**5**	**58**
CCS						
Appeals	**Expedited**	0	0	0	2	**2**
	Standard	0	0	2	3	**5**
Grievances	**Expedited**	0	0	0	0	**0**
	Standard	0	3	2	3	**8**
	CCS Subtotal	**0**	**3**	**4**	**8**	**15**

TYPES OF GRIEVANCES FOR HEALTHY KIDS, HEALTHWORX, ACE, AND CALIFORNIA CHILDREN'S SERVICES

CATEGORY	HK	HW	ACE	CCS	TOTAL
Access	-	1	-	2	**3**
Availability (Appointments)	1	2	-	-	**3**
Benefit	-	-	-	-	**0**
Billing	-	3	3	-	**6**
Customer Service	5	-	2	1	**8**
Quality of Care	1	1	-	-	**2**
Confidentiality/Privacy	-	-	-	-	**0**
Marketing	1	-	-	-	**1**
Enrollment/Disenrollment	-	-	-	-	**0**
Fraud, Waste, & Abuse	-	-	-	-	**0**
Other	-	-	-	-	**0**
TOTAL	**8**	**7**	**5**	**3**	**23**

TIMELINESS OF COMPLAINT RESOLUTION

RESOLUTIONS WITHIN 24 HOURS OF RECEIPT

The following reflect complaints that were resolved by HPSM staff within 24 hours of the member informing HPSM of the complaint. These complaints are included in the count of grievances in the tables above, but do not enter the formal grievance process.

HPSM Call Centers		Q1	Q2	Q3	Q4	Total
CareAdvantage CMC	Medical Services/Supplies	36	16	15	10	77
	Prescription Drugs	107	94	74	54	329
CareAdvantage DSNP	Medical Services/Supplies	2	1	0	0	3
	Prescription Drugs	5	5	4	2	16
Medi-Cal	Medical Services/Supplies	53	22	18	25	118
	Prescription Drugs	112	109	80	82	383
Other LOBs (CCS, HW, HK, ACE)	Medical Services/Supplies	2	1	6	1	10
	Prescription Drugs	6	1	11	6	24
Total About Medical Services/ Supplies		**93**	**40**	**39**	**36**	**208**
Total About Prescription Drugs		**230**	**209**	**169**	**144**	**752**
TOTAL		**323**	**249**	**208**	**180**	**960**

The G&A Unit's goal, as mandated by CMS, is to resolve 95% of grievances and appeals within the required timeframe. Below are the timeliness rates for all lines of business 2016 Q4. This table excludes cases resolved within 24 hours of receipt.

Type of Complaint	Number Received (all LOBs)	# Resolved Timely	% Resolved Timely
Grievances	321	311	97%
Medical Appeals	86	81	94%
Pharmacy Appeals	55	48	87%

Reason for PCP Change	Number of Changes in Q3
Difficulty In Obtaining An Appt.	43
Poor Service	67
Provider And Patient Incompatible	7
Providers Attitude/Atmosphere	0
Total	**117**

A total of 117 members requested to change their assigned PCP during Quarter 4 due to dissatisfaction. Members switched away from a total of 36 different PCPs. Of those, 20 were clinics and 16 were individual providers. For 9 providers, 5 or more Members requested to switch away from their practice. Of these, 8 were group practices or clinics and 1 was an individual practitioner

HEDIS 2016 Results

		Medi-Cal			CareAdvantageCMC			2016	
HEDIS Abrv.	Name & Description	2015 rate	2016 rate	change ↕	2015 rate	2016 rate	change ↕	MPL	HPL
Pediatric Preventative Care									
CIS-3*	Childhood Immunization Status - Combo 3: Percentage of children 2 years of age who receive a series of vaccines (# of injections) by their second birthday: Dtap (4), Hep B (3), PCV (4), IPV (3), HiB (3), MMR (1), VZV (1)	81.60%	78.08%	-3.52%	NR	NR		66.19%	81.25%
IMA - Combo1*	Immunizations for Adolescents Percentage of adolescents 13 years of age who had:	77.08%	74.32%	-2.76%	NR	NR		63.79%	87.71%
	▪ 1 Meningococcal vaccine (MCV) injection between 11-13 years old	80.56%	82.43%	1.87%	NR	NR			
	▪ 1 Tetanus, diphtheria toxoids and acellular pertussis vaccine (tDap) or one TD between 10-13 years old	88.19%	82.09%	-6.10%	NR	NR			
W-34*	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life Percentage of members 3-6 years of age who had one or more well child visits with a PCP during the MY	73.16%	71.34%	-1.82%	NR	NR		65.54%	83.75%
CAP	Children & Adolescents' Access to Primary Care Practitioners: Percentage of members 12 months - 19 years of age who had a visit with a PCP								
CAP-1224	▪ 12-24 months	93.89%	92.20%	-1.69%	NR	NR		94.23%	98.17%
CAP-256	▪ 25 months - 6 years	89.21%	86.45%	-2.76%	NR	NR		85.41%	92.93%
CAP-711	▪ 7-11 years	91.49%	90.97%	-0.52%	NR	NR		88.89%	95.88%
CAP-1219	▪ 12-19 years	87.36%	87.89%	0.53%	NR	NR		87.25%	94.91%

		Medi-Cal			CareAdvantageCMC			2016	
HEDIS Abrv.	**Name & Description**	**2015 rate**	**2016 rate**	change ↕	**2015 rate**	**2016 rate**	change ↕	**MPL**	**HPL**
WCC*	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents Percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the MY								
WCC-BMI	▪ BMI percentile	73.96%	79.08%	▲ 5.12%	NR	NR		51.27%	85.61%
WCC-N	▪ Counseling for nutrition	75.00%	79.08%	▲ 4.08%	NR	NR		51.98%	79.56%
WCC-PA	▪ Counseling for physical activity	61.98%	68.62%	▲ 6.64%	NR	NR		44.16%	71.53%
Adult Preventative Care & Screening									
ABA*	Adult BMI Assessment Percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the MY or the year prior to the MY	NR	NR		70.49%	87.10%	▲ 16.61%		
BCS	Breast Cancer Screening Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer	NR	NR		69.11%	69.72%	▬ 0.61%		
COL*	Colorectal Cancer Screening Percentage of members 50-75 years of age who had appropriate screening for colorectal cancer	NR	NR		59.44%	61.80%	▲ 2.36%		
COA*	Care for Older Adults Percentage of adults 66 years and older who had each of the following during the MY	NR	NR						
	▪ Advance Care Planning				6.33%	26.28%	▲ 19.95%		
	▪ Medication Review				35.04%	75.18%	▲ 40.14%		
	▪ Functional Status Assessment				8.52%	44.04%	▲ 35.52%		
	▪ Pain Assessment				29.93%	71.78%	▲ 41.85%		

		Medi-Cal			CareAdvantageCMC			2016	
HEDIS Abrv.	**Name & Description**	**2015 rate**	**2016 rate**	change ↕	**2015 rate**	**2016 rate**	change ↕	**MPL**	**HPL**
CCS*	Cervical Cancer Screening: Percentage of women 21-64 years of age who were screened for cervical cancer ▪ 21-64 years: Cervical Cytology within the last 3 years ▪ 30-64 years: Cervical Cytology/HPV co-testing within the last 5 years ▪ Or evidence of a hysterectomy	55.10%	54.79%	-0.31%	NR	NR		54.33%	73.08%
PSA	Non-Recommend PSA-Based Screening: The percentage of men 70 years and older who were screened unnecessarily for prostate cancer using prostate-specific antigen (PSA)-based screening. Note: A lower rate indicates better performance.	NR	NR		39.31%	27.40%	-11.91%		
OMW	Osteoporosis Management in Women Who Had a Fracture Percentage of women 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.	NR	NR		23.19%	10.81%	-12.38%		
LBP	Use of Imaging Studies for Low Back Pain: Percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis	83.47%	84.38%	0.91%	NR	NR		71.82%	82.86%
AAP	Adults' Access to Preventive/Ambulatory Health Services	NR	NR						

		Medi-Cal			CareAdvantageCMC			2016	
HEDIS Abrv.	**Name & Description**	**2015 rate**	**2016 rate**	change ↕	**2015 rate**	**2016 rate**	change ↕	**MPL**	**HPL**
	Percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.								
	▪ Rate: 20 - 44				95.13%	89.72%	▼ -5.41%		
	▪ Rate: 45 - 64				96.64%	95.63%	▬ -1.01%		
	▪ Rate: 65+				96.57%	94.49%	▼ -2.08%		
	▪ Total Rate				96.49%	94.44%	▼ -2.05%		
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD Percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis	NR	NR		19.74%	25.59%	▲ 5.85%		
Prenatal & Post Partum Care									
PPC*	Prenatal & Postpartum Care (2 indicators): Percentage of deliveries of live births between November 6 of the year prior to the MY and November 5 of the measurement year. The measure assesses the following:								
PPC - Pre	▪ Timeliness of Prenatal Care	77.89%	79.95%	▲ 2.06%	NR	NR		77.44%	91.73%
PPC - Pst	▪ Postpartum Care	63.07%	64.84%	▬ 1.77%	NR	NR		55.47%	72.43%
Chronic Disease Management & Treatment									
CBP*	Controlling High Blood Pressure Percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled: ▪ 18-59 years (<140/90)	61.80%	68.88%	▲ 7.08%	60.34%	70.32%	▲ 9.98%	49.88%	70.32%

		Medi-Cal			CareAdvantageCMC			2016	
HEDIS Abrv.	**Name & Description**	**2015 rate**	**2016 rate**	change ↕	**2015 rate**	**2016 rate**	change ↕	**MPL**	**HPL**
	▪ 60 - 85 years with diabetes (<140/90) ▪ 60-85 years without diabetes (<150/90)								
CDC*	Comprehensive Diabetes Care **(6 indicators):** Percentage of members 18-75 years of age with diabetes (type 1 and 2) who had each of the indicators								
CDC-E	▪ Eye Exam (Retinal) Performed	63.75%	58.92%	-4.83%	70.56%	72.51%	1.95%	47.06%	67.74%
CDC-HT	▪ HbA1c Testing	89.29%	86.55%	-2.74%	89.54%	90.02%	0.48%	83.19%	91.94%
CDC-H9	▪ HbA1c Poor Control (>9.0%)- lower is better	38.20%	43.52%	5.32%	37.96%	48.91%	10.95%	49.89%	29.68%
CDC-H8	▪ HbA1c Control (<8.0%)	54.99%	48.90%	-6.09%	54.26%	46.23%	-8.03%	40.00%	58.58%
CDC-N	▪ Medical Attn. for Nephropathy	83.94%	87.29%	3.35%	86.13%	94.65%	8.52%	77.95%	87.70%
CDC-BP	▪ Blood pressure control (<140/90mmHg)	60.10%	61.12%	1.02%	55.47%	65.45%	9.98%	56.45%	76.64%
MMA	Medication Management for People with Asthma: Percentage of members 5-64 years of age who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period								
	▪ Total - Medication Compliance 50%	47.09%	55.45%	8.36%	NR	72.92%		47.41%	67.24%
	▪ Total - Medication Compliance 75%	26.38%	31.58%	5.20%	NR	58.33%		23.72%	43.38%
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	NR	NR		87.88%	100.00%	12.12%		

		Medi-Cal			CareAdvantageCMC			2016	
HEDIS Abrv.	Name & Description	2015 rate	2016 rate	change ↕	2015 rate	2016 rate	change ↕	MPL	HPL
	Percentage of members 18 years of age and older during the MY who were hospitalized and discharged from July 1 of the year prior to the MY to June 30 of the MY with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge								
ART	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis Percentage of members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug	NR	NR		67.61%	80.90%	▲ 13.29%		
PCE	Pharmacotherapy Management of COPD Exacerbation	NR	NR						
	▪ Dispensed a systemic corticosteroid				69.23%	41.48%	▼ -27.75%		
	▪ Dispensed a bronchodilator				87.69%	76.14%	▼ -11.55%		
Pharmacy									
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis: Percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription	35.50%	36.05%	▬ 0.55%	NR	NR		22.00%	40.38%
MPM	Annual Monitoring for Patients on Persistent Medications (without anticonvulsant, 3 indicators):								

		Medi-Cal			CareAdvantageCMC			2016	
HEDIS Abrv.	**Name & Description**	**2015 rate**	**2016 rate**	change ↕	**2015 rate**	**2016 rate**	change ↕	**MPL**	**HPL**
	Percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and at least one therapeutic monitoring event for the therapeutic agent								
MPM - ACE	▪ ACE inhibitors or ARBs	89.51%	89.92%	0.41%	92.12%	92.08%	-0.04%	84.87%	92.01%
MPM - Dig	▪ Diuretics	90.03%	89.69%	-0.34%	92.93%	93.07%	0.14%	84.66%	91.78%
MPM - Diu	▪ Digoxin	49.35%	50.70%	1.35%	44.09%	54.05%	9.96%	49.35%	61.04%
MRP	Medication Reconciliation Post-Discharge Percentage of discharges from January 1 - December 1 of the MY for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge	NR	NR		18.73%	25.79%	7.06%		
DDE	Potentially Harmful Drug-Disease Interactions in the Elderly Percentage of Medicare members 65 years of age and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis								
	▪ Falls + Tricyclic Antidepressants or Antipsychotics	NR	NR		50.68%	51.60%	0.92%		
	▪ Dementia + Tricyclic Antidepressants or Anticholinergic Agents	NR	NR		58.01%	55.08%	-2.93%		
	▪ Chronic Renal Failure + Non-aspirin NSAIDs or Cox - 2 Selective NSAIDs	NR	NR		10.37%	11.58%	1.21%		
	▪ Total rate	NR	NR		45.21%	43.05%	-2.16%		
DAE	Use of High Risk Medications in the Elderly								

		Medi-Cal			CareAdvantageCMC			2016	
HEDIS Abrv.	**Name & Description**	**2015 rate**	**2016 rate**	change ↕	**2015 rate**	**2016 rate**	change ↕	**MPL**	**HPL**
	▪ Percentage of Medicare members 66 years of age and older who received at least one high-risk medication	NR	NR		28.94%	26.34%	▼ -2.60%		
	▪ Percentage of Medicare members 66 years of age and older who received at least two different high-risk medications	NR	NR		6.56%	5.69%	▬ -0.87%		
AMM	Antidepressant Medication Management Percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported								
	▪ Effective Acute Phase Treatment	NR	NR		63.58%	70.15%	▲ 6.57%		
	▪ Effective Continuation Phase Treatment	NR	NR		42.59%	56.22%	▲ 13.63%		
Behavioral Health									
FUH	Follow-Up After Hospitalization for Mental Illness Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health provider. Two rates were reported:								
	▪ 30-Day Follow-Up	NR	NR		58.64%	39.16%	▼ -19.48%		
	▪ 7-Day Follow-Up	NR	NR		37.65%	19.58%	▼ -18.07%		
MPT	Mental health Utilization Percentage of members receiving the following mental health services during the measurement year:								

		Medi-Cal			CareAdvantageCMC			2016	
HEDIS Abrv.	Name & Description	2015 rate	2016 rate	change ↕	2015 rate	2016 rate	change ↕	MPL	HPL
	▪ Any Service	NR	NR		20.13%	16.94%	-3.19%		
	▪ Inpatient service	NR	NR		1.67%	1.28%	-0.39%		
	▪ Outpatient service	NR	NR		0.36%	0.18%	-0.18%		
	▪ Emergency Department	NR	NR		19.77%	16.32%	-3.45%		
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Percentage of adolescent and adult members with a new episode of alcohol and other drug (AOD) dependence who received the following treatment:								
	▪ Initiation of AOD Treatment	NR	NR		32.08%	34.74%	2.66%		
	▪ Engagement of AOD Treatment	NR	NR		2.83%	6.58%	3.75%		
IAD	Identification of Alcohol and Other Drug Services Summary of the number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the MY								
	▪ Any Service % for Male	NR	NR		9.37%	9.81%	0.44%		
	▪ Any Service % for Female	NR	NR		4.58%	4.06%	-0.52%		
	▪ Any Service % Total	NR	NR		6.39%	6.21%	-0.18%		
	▪ Inpatient Service % for Male	NR	NR		2.87%	2.64%	-0.23%		
	▪ Inpatient Service % for Female	NR	NR		1.31%	1.16%	-0.15%		
	▪ Inpatient Service % Total	NR	NR		1.90%	1.72%	-0.18%		
	▪ Outpatient Service % for Male	NR	NR		0.00%	0.03%	0.03%		
	▪ Outpatient Service % for Female	NR	NR		0.02%	0.00%	-0.02%		
	▪ Outpatient Service % Total	NR	NR		0.01%	0.01%	0.00%		
	▪ ED Service % for Male	NR	NR		8.10%	8.54%	0.44%		
	▪ ED Service % for Female	NR	NR		3.83%	3.54%	-0.29%		
	▪ ED Service % Total	NR	NR		5.45%	5.41%	-0.04%		

		Medi-Cal			CareAdvantageCMC			2016	
HEDIS Abrv.	Name & Description	2015 rate	2016 rate	change ↕	2015 rate	2016 rate	change ↕	MPL	HPL
Utilization									
PCR	Plan All-Cause Readmissions For members 18 years of age and older, the number of acute inpatient stays during the MY that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Lower rate is better.								
	▪ Age: 18 - 44	NR	10.32%		20.47%	16.96%	▲ -3.51%		
	▪ Age: 45 - 54	NR	18.47%		20.51%	17.80%	▲ -2.71%		
	▪ Age: 55 - 64	NR	17.02%		16.67%	8.53%	▲ -8.14%		
	▪ Age 65 - 74	NR	14.99%		13.24%	13.91%	▬ 0.67%		
	▪ Age: 75 - 84	NR	14.30%		15.40%	13.50%	▬ -1.90%		
	▪ Age: 85+	NR	16.89%		16.08%	16.53%	▬ 0.45%		
	Total	16.99%	15.19%	▬ -1.80%	16.11%	14.27%	▬ -1.84%		
	Ambulatory Care: Summarized utilization of ambulatory care								
AMB- OB	▪ Outpatient Total Visit/1000 member mbr year	NR	NR		11988.33	12108.78	▲ 120		
AMB-ER	▪ Emergency Department Visits	NR	NR		658.65	701.39	▲ 43		
IPU	Inpatient Utilization - General Hospital/Acute Care Summary of utilization of acute inpatient care and services in the following categories: total inpatient, maternity, surgery, medicine								
	▪ Total Inpatient Ds/1000 MM Total	NR	NR		240.13	254.94	15		
	▪ Medicine Total Ds/1000	NR	NR		186.45	205.45	19		
	▪ Surgery Total Ds/1000	NR	NR		52.74	49.29	-3		
	▪ Maternity Total Ds/1000	NR	NR		3.36	0.91	-2		

		Medi-Cal			CareAdvantageCMC			2016	
HEDIS Abrv.	**Name & Description**	**2015 rate**	**2016 rate**	change ↕	**2015 rate**	**2016 rate**	change ↕	**MPL**	**HPL**

*	Hybrid Measure (medical records can be used in data collection)
NR	Not reported
	Rate Under MPL
	Rate Above HPL
	DHCS does not hold plans to MPL

2017 QUALITY IMPROVEMENT PROGRAM DESCRIPTION

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2017 Quality Improvement (QI) Program Description Approval Form

X _____

Margaret Beed, MD

Chief Medical Officer

Health Plan of San Mateo

X _____

Barbara Erbacher

Quality Improvement Committee Chairperson

San Mateo Health Commission Chairperson

MISSION STATEMENT:

The Health Plan of San Mateo provides San Mateo County's vulnerable and underserved residents access to high quality care services and supports that help them live the healthiest lives possible.

We have a vision, that healthy is for everyone.

ORGANIZATION

BACKGROUND

The Health Plan of San Mateo (HPSM) was created in 1987 by a coalition of local elected officials, hospitals, physicians, and community advocates to serve the needs of Medi-Cal eligible beneficiaries. As a County Organized Health System (COHS), HPSM is authorized by state and federal law to administer Medi-Cal (Medicaid) benefits in San Mateo County. Based within the community it serves, HPSM is sensitive to, and its operation reflects, the unique health care environment and needs of San Mateo County's Medi-Cal beneficiaries. In 1998, HPSM began a Healthy Families (HF) program that served low income children that didn't qualify for Medi-Cal. In 2006, HPSM began a Dual Eligible Special Needs Plan (D-SNP), CareAdvantage, which allowed HPSM to offer the Medicare and Medi-Cal benefits under one umbrella to all dually eligible individuals with the goal of providing members with access to high quality services delivered in a cost-effective and compassionate manner. Beginning April 2014, HPSM began its Cal MediConnect (CCI) Medicare-Medicaid Plan to further serve dually eligible members.

Consistent with its mission, HPSM operates additional product lines in response to community needs. These include Healthy Kids and HealthWorx. Healthy Kids serves low income children who don't qualify for Medi-Cal, while the latter serves In-Home Supportive Services (IHSS) workers. By taking on these additional groups and a state-licensed Medicare program under a competitive, risk-based contract with the Centers for Medicare and Medicaid Services (CMS), HPSM has expanded and reaffirmed its commitment to providing health care to San Mateo County's most vulnerable residents.

Effective February 2010, HPSM expanded its service contract with the Department of Health Care Services (DHCS), to include Long Term Care (LTC). This expansion includes facility charges in LTC facilities, sub-acute and intermediate care facilities (ICFs). In July 2012, Community-Based Adult Services (CBAS) was added to HPSM's DHCS' contract. In 2013, beneficiaries in the Healthy Families Program have been transitioned to Medi-Cal, as part of phased transition throughout the State of California.

As of 2016, HPSM serves approximately 125,000 members under the following lines of business:

Medi-Cal, CareAdvantage Cal MediConnect (MMP), Healthy Kids and HealthWorx. All HPSM Dual eligible members of CA CMC and Medi-Cal Seniors and Persons with disabilities (SPDs) will be eligible for CCI Medi-Cal services.

HPSM'S DELIVERY SYSTEM

HPSM is able to fulfill its mission in San Mateo County because of its successful partnership with its outstanding healthcare delivery partners. Medical services are delivered to our members through our directly-contracted provider network. HPSM's network includes over 650 primary care physicians and over 2,400 specialists. In addition, HPSM's network includes 8 hospitals and medical centers located in San Mateo County and in neighboring San Francisco. While HPSM does not contract directly with its pharmacy network, HPSM's delegates this responsibility to its contracted pharmacy benefits manager, Argus. All pharmacy and medical service authorizations under HPSM's scope of service for each line of business are performed by HPSM licensed clinical staff.

SCOPE OF SERVICES

HPSM provides a comprehensive scope of acute and preventive care services for its members through its Medi-Cal, Healthy Kids, HealthWorx, Care Advantage (D SNP), and CareAdvantage Cal MediConnect (MMP) lines of business. Certain services are not covered by HPSM or may be provided by a different agency:

- Mental Health services (Mild to Moderate mental health services and Behavioral Health Treatment (BHT) for autism) are administered by the San Mateo County Behavioral Health and Recovery Services for all lines of business.
- Delta Dental contracts with HPSM to provide services for Healthy Kids and CareAdvantage members.
- California Children's Services (CCS) is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS authorizes care and in San Mateo County, HPSM pays for the specific medical services and equipment provided by CCS-approved specialists. The CCS program is funded with State, County, and Federal tax monies, along with some fees paid by parents or guardians.
- Health Plan of San Mateo works with community programs to ensure that members with special health care needs, high risk or complex medical and developmental conditions receive additional services that enhance their medical benefits. These partnerships are established through special programs and specific Memorandums of Understanding (MOUs) with certain community agencies including the San Mateo County Health Services Agency (HSA), California Children's Services (CCS), and the Golden Gate Regional Center (GGRC).

AUTHORITY AND RESPONSIBILITY

The San Mateo Health Commission (Commission) assumes ultimate responsibility for the Quality Improvement Program (QIP) and has established Quality Improvement Committee (QIC) to oversee this function. The Commission plays a key role in monitoring the quality of health care services provided to members and improving quality services delivered to our members. The Commission authorizes and designates the Chief Executive Officer (CEO) as the individual responsible for the implementation of the QIP. The CEO has delegated oversight of the day-to-day operations of the QIP to the Chief Medical Officer (CMO).

The Quality Improvement Committee (QIC) and the Chief Medical Officer have the responsibility for planning, designing, implementing, evaluating and coordinating the patient care and clinical quality improvement activities. The QIC reports on QIP activities to the Commission.

Performance accountability of the Commission includes:

- Annual review and approval of the Quality Improvement Program description, Quality Improvement Work Plan and the Quality Improvement Program Evaluation.
- Review status of QIP and annual work plan at least quarterly.
- Evaluate effectiveness of QI activities and provide feedback to the QIC as appropriate.
- Establish direction and strategy for the QIP.

PURPOSE

The Quality Improvement Program provides a formal process to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety, and effectiveness of care and service utilizing a

multidimensional approach. This approach enables HPSM to focus on opportunities for improving operational processes and health outcomes, ensuring cultural and linguistically appropriate services and high levels of member and practitioner/provider satisfaction. The QIP promotes the accountability of all employees and affiliated health personnel for the quality of care and services provided to our members.

GOALS

The goals of the QIP are to:

- Provide timely access to high-quality healthcare for all members, through a cost-effective, safe linguistically and culturally appropriate health care delivery system that objectively and systemically monitors and evaluates quality and appropriateness of health care and services.
- Pursue opportunities to improve health care, services and safety; and
- Resolve identified problems in a timely manner.

FUNCTIONS

The Quality Improvement Program functions include, but are not limited to:

- Implement a multidimensional and multi-disciplinary QIP that effectively and systematically monitors and evaluates the quality and safety of clinical care and service rendered to members.
- Improve health care delivery by monitoring and implementing corrective action, as necessary, for access and availability of provider services to members.
- Improve health outcomes for all members by incorporating health promotion programs and preventive medicine services into all the primary care delivery sites.
- Evaluate the standards of clinical care and promote the most effective use of medical resources while maintaining acceptable and high standards. This includes an annual evaluation of the Quality Improvement Program.
- Ensure effectiveness of continuous quality improvement activities across the organization.
- Conduct effective oversight of delegated providers.

OBJECTIVES

- Design and maintain the quality improvement structure and processes that support continuous quality improvement, including measurement, trending, analysis, intervention and re-measurement.
- Meet the cultural and linguistic needs of the membership.
- Comply and coordinate with all governmental agency requirements.
- Support practitioners with participation in quality improvement initiatives of HPSM and all governing regulatory agencies.

- Establish clinical and service indicators that reflect demographic and epidemiological characteristics of the membership, including benchmarks and performance goals for continuous and or periodic monitoring and evaluation.
- Maintain an on-going up-to-date credentialing and re-credentialing system that compiles with HPSM standards, including primary verification, the use of quality improvement, and other performance indicators in the re-credentialing process.
- Measure availability and accessibility to clinical care and service.
- Measure member satisfaction, identify and address areas of dissatisfaction in a timely manner through:
    - quarterly analysis of trended member complaint data;
    - member satisfaction surveys; and
    - solicitation of member suggestions to improve clinical care and service
- Continue to develop, adopt, and adapt practice guidelines (including preventive health) reflective of the membership. Measure compliance with a minimum of two guidelines annually.
- Measure the conformance of contracted practitioners' medical records against HPSM medical record standards at least once every three years. Take steps to improve performance and re-measure to determine organization-wide and practitioner specific performance.
- Develop studies or quality activities for member populations using demographic data. Studies and/or activities are designed to identify barriers to improved performance and/or validate a problem or measure conformance to standards.
- Oversee delegated activities by:
    - establishing performance standards,
    - monitoring performance through regular reporting, and
    - evaluating performance annually
- Evaluate under and over-utilization, continuity, and coordination of care through a variety of methods and frequencies based upon members' needs. These methods include but are not limited to an annual evaluation of:
    - medical record review
    - rates of referral to specialists
    - hospital discharge summaries in office charts
    - communication between referring and referred-to physicians
    - quarterly analysis of member complaints regarding difficulty obtaining referrals
    - identification and follow-up of non-utilizing members
    - profiles of physicians
    - rates of referrals per 1000 members and

- measurement of compliance with practice guidelines

- Coordinate QI activities with all other activities, including, but not limited to, the identification and reporting of risk situations, the identification and reporting of adverse occurrences from UM activities, and the identification and reporting of quality of care concerns through complaints and grievances collected through the Member Services Department.
- Implement and maintain health promotion activities and disease management programs linked to QI actions to improve performance. These activities include, at a minimum, identification of high-risk and/or chronically ill members, education of practitioners, and outreach programs to members.
- Create and maintain the infrastructure to achieve accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting body as appropriate.
- Evaluate the QI Program Description and Work Plan at least annually and modify as necessary.

  The evaluation addresses:

  - a description of completed and going QI activities that address the quality and safety of clinical care and quality of services;
  - trending of measures to assess performance in quality and safety of clinical and the quality of service indicator data;
  - analysis of the results of the QI initiatives, including barrier analysis that evaluates the effectiveness of QI interventions for the previous year (demonstrated improvements in the quality and safety of clinical care and in the quality service);
  - an evaluation of the overall effectiveness of the QI program, including progress toward influencing safe clinical practices throughout the network that determines the appropriateness of the program structure, processes, and objectives;
  - recommendations that are used to re-establish a Work Plan for the upcoming year which includes a schedule of activities for the year, measurable objectives, and monitoring of previously identified issues, explanation of barriers to completion of unmet goals and assessments of goals.

SCOPE of QUALITY IMPROVEMENT PROGRAM

The QIP provides for review and evaluation of all aspects of health care, encompassing both clinical care and services provided to external and internal customers. External and internal customers are defined as members, practitioners, governmental agencies, and Health Plan of San Mateo employees.

All departments participate in the quality improvement process. The Chief Medical Officer integrates the review and evaluation of components to demonstrate the process is effective in improving health care. Measuring clinical and service outcomes and member satisfaction is used to monitor the effectiveness of the process.

- The scope of quality review will be reflective of the health care delivery systems, including quality of clinical care and quality of service.
- All activities will reflect the member population in terms of age groups, disease categories and special risk status including those members with particularly complex needs.

- The scope of services include, but are not limited to services provided in institutional settings including acute inpatient, long term care, skilled nursing, ambulatory care, home care and behavioral health (as provided by product line); and services provided by primary care, specialty care and other practitioners.

ORGANIZATIONAL STRUCTURE

Oversight of the Quality Improvement Program is provided through a committee structure, which allows for the flow of information to and from the San Mateo Health Commission.

ROLE OF THE CHIEF MEDICAL OFFICER

The Chief Executive Officer (CEO) has appointed the Chief Medical Officer (CMO) as the designated physician to support the Quality Improvement Committees outlined in this program by providing day-to-day oversight and management of all quality improvement activities. The Chief Medical Officer is responsible for:

- All activities requiring day-to-day physician involvement. The Chief Medical Officer may delegate performance of any of these responsibilities to other physicians within the Health Plan.
- Directing the Health Care Services Department and the various functions under its umbrella, including Quality Improvement, Credentialing, Utilization Management, Complex Care Coordination, Behavioral Health Services (as covered by product line) and Pharmacy. The Chief Medical Officer consults with an employed contracted psychiatrist (designated behavioral health care practitioner), as necessary, for behavioral health issues.
- Communicating with the San Mateo Health Commission (Commission) information from the Quality Improvement Committee (QIC), the Clinical Quality Improvement Committee (CQC), the Credentialing Sub-Committee, the Utilization Management Committee (UMC), the Service Quality Improvement Committee (SQIC) and the Pharmacy and Therapeutics Committee (P&T).
- Communicating feedback from the Commission to the above listed committees.
- Serving as chair for the QIC, CQC, and the Credentialing Sub-Committee.
- Serving as the co-chair for the UMC and P&T.
- Overseeing meeting preparations for the above committees, educating committee members regarding the principals of quality improvement, keeping the committees and corporation current with the regulations and standards of the California Department of Health Care Services, Center for Medicare and Medicaid Services (CMS) and NCQA.
- Participating in the Service Quality Improvement Committee (SQIC) as a member and serving as an advisor to the committee.
- Ensuring that the goals, objectives and scope of the QIP are interrelated in the process of monitoring the quality of clinical care, clinical safety and services to members. The Chief Medical Officer will not be influenced by fiscal motives in making medical policy decisions and establishing medical policies.
- Ensuring that a review and evaluation of the components of the QIP are performed annually in order to demonstrate that the process is effective in improving member care, safety and services.
- Providing oversight to the implementation of the Quality Improvement Program (QIP).

- Guiding the formulation of quality indicators and clinical care guidelines in collaboration with network practitioners.
- Providing direct oversight of the credentialing and re-credentialing process.
- Developing or approving policies and procedures for quality improvement, credentialing, preventive health, utilization management, pharmacy management and behavioral health.
- Reviewing aggregated outcomes from member complaints and grievances, member satisfaction surveys and practitioners' satisfaction surveys.
- Overseeing the development of member and practitioner education relation to QIP issues.
- Ensuring that quality of care is a component in all policy development related to health care services.
- Communicating directly with practitioners on any issues of the QIP to include quality of care; peer review; credentialing; or clinical care guidelines.
- Assisting the senior management team in the analysis, design and implementation of interventions to improve health care service delivery.
- Serving as an advisor to the Member Appeals Committee.
- Communicating information and updates regarding the QIP to HPSM leadership and staff via General Staff, senior management team meeting, and other internal meetings.
- Delegating staff from other divisions to perform QI Program activities by agreement of appropriate division chief.

ROLE of PARTICIPATING PRACTITIONERS

Participating practitioners serve on the QIP Committees as necessary to support and provide clinical input. Through these committees' activities, network practitioners:

- Review, evaluate and make recommendations for credentialing and re-credentialing decisions;
- Review individual medical records reflecting adverse occurrences;
- Participate in peer review activities;
- Review and provide feedback on proposed medical guidelines, preventive health guidelines, clinical protocols, disease management programs, quality and HEDIS results, new technology and any other clinical issues regarding policies and procedures;
- Review proposed QI study designs; and
- Participate in the development of action plans and interventions to improve levels of care and service.

DESIGNATED BEHAVIORAL HEALTH PRACTITIONER

Health Plan of San Mateo has designated a behavioral health practitioner for the QIP. The designated behavioral health practitioner advises the Quality Improvement Committee (QIC) to ensure that the goals, objectives and scope of the QIP are interrelated in the process of monitoring the quality of behavioral health care, safety and services to members.

LINES OF COMMUNICATION AND INFORMATION FLOW

Methods of communication include, but are not limited to, quality improvement reports, oral presentations and discussions, memorandums, policies and procedures and meeting minutes. HPSM monitors providers through quality monitors and on-site inspections and audits. The Quality Improvement Manager is the focal point for convergence of quality improvement related activities and information.

The Quality Improvement Manager is responsible for the coordination and distribution of all quality improvement related data and information. The Quality Improvement Committee (QIC) reviews, analyzes, makes recommendations, initiates actions, and/or recommends follow-up based on the data collected and presented. The Chief Medical Officer communicates the QIC's activity to the Commission. The Commission reviews QI activities. Any concerns of the Commission are communicated back to the source for clarification or resolution.

QIP COMMITTEE MEMBERS

For staff participants, qualifications and term of service as a Committee member is determined by the duration of time a staff member holds the position, which initially qualified him/her for Committee membership (i.e., term of service continues as long as the Quality Improvement Manager holds his/her position which is also a designated position on the QIC).

Selected contracted practitioners and providers are invited to serve as members of a QIP Committee by the chairperson or co-chair. Selection is based on the following attributes:

- Availability/accessibility
- Board certification
- Communication skill/diplomacy
- Credentials/re-credentials verification
- Interest/enthusiasm
- Knowledge/expertise
- Managed care knowledge/experience
- Medical/surgical experience
- Peer/personal recommendation
- Previous quality committee experience
- QM audit results greater than average
- Reputation/ethical standards
- Specialty type

A practitioner representative selected to participate on any QIP Committee continues to serve as long as he/she continues to qualify as a contracted practitioner whose specialty is required on the Committee panel and meets acceptable standards of behavior, with the following exceptions:

- Practitioner requests voluntary removal or
- Involuntary request for removal may be made when a provider:
    - Is no longer qualified

- Is repeatedly unavailable (unexcused absences from three consecutive meetings)
- Develops a conflict of interest
- Behavior is disruptive and not conducive to effective, professional discussions and performance of business
- Fails to meet QIP expectations

CONFLICT of INTEREST

Health care providers serving on any QIP Committee who are/were involved in the care of a member under review by the committee, are not allowed to participate in discussions and determinations regarding the case. In addition, committee members cannot review cases involving family members, providers with whom they have a financial or contractual affiliation or other similar conflict of interest issues. Prior to participating in any QIP activities, committee members are required to sign a Conflict of Interest statement, which is maintained on file in the Quality Department.

CONFIDENTIALITY

Because of the goals and objectives of the QIP, sensitive and confidential information is often discussed during CQC and Credentialing Sub-Committee meetings. All participants understand that information and parties under investigation or discussion by the Committee members are considered confidential. Prior to participating in CQC and Credentialing activities, committee members are required to sign a Confidentiality Statement which is kept on file in the Quality Department.

QIP COMMITTEE MEETINGS

The Quality Improvement Committee (QIC) and subcommittees convene at regularly scheduled meetings, or more often is the chairperson deems it necessary; minimum frequency for QIC meetings will not extend beyond a quarterly basis. Meetings may be held in person or via teleconference.

A quorum consisting of either four members or 50% of the members, whichever is less, must be present for any QIP committee to conduct business, unless the chairperson has attempted to reschedule and notify participants of the meeting and a quorum still does not exist.

If a quorum cannot be assembled within thirty (30) minutes of the scheduled meeting, those in attendance will select an alternate date and time. If at the alternate meeting, a quorum is still not present and cannot be obtained within thirty (30) minutes, the committee may either elect to meet and conduct business or adjourn. If the committee elects to meet, action items may be voted upon via email following the meeting.

The chairperson, with the assistance of the co-chair, is ultimately responsible for notifying committee members about the meeting schedules. Reminder phone calls will be placed to the committee members a minimum of three (3) days prior to the scheduled meeting to encourage participation. An agenda and any necessary reading materials will be mailed to participants in advance to expedite the meeting time and prepare for discussion.

QIP COMMITTEE MINUTES

Comprehensive, accurate minutes are prepared and maintained for each QIP regular or ad hoc meetings. Minutes include at a minimum, the name of the committee, date, list of members present, and the names and titles of guests, if applicable. The minutes reflect all decisions and recommendations, including rationale for each, the status of any activities in progress, and a description of the discussions involving recommended studies, corrective action plans, responsible person, follow-up and due date. Minutes will be maintained in a confidential secure file. Each committee chairperson will sign and date all minutes at the time of approval.

Minutes of the QI Program committees meetings are provided for review to the:

- Committee members
- San Mateo Health Commission, and
- Regulatory bodies (as required and applicable).

COMMITTEE AGENDA

The QIP Committees agendas shall follow the basic outline:

- Review of Minutes
- Unfinished Business
- Ongoing Reports
- Review of Protocols/Policies
- New Business

Copies of all minutes, reports, data, medical records and other documents used for quality or utilization review purposes, are maintained in a manner that will ensure confidentially of the members and providers involved in each case. Access to these records is restricted to the QIP committees' members and selected administrative personnel as deemed necessary (i.e., CEO, legal staff/counsel, Commission). All sensitive information, medical records and QIC findings are maintained in locked files.

QIP reports, minutes, audit results and other Quality Improvement documentation are only distributed for review to the:

- Chief Medical Officer
- Chief Executive Officer
- San Mateo Health Commission
- QIP Committee members
- Regulatory bodies (as required and applicable)

All distributed copies are collected and destroyed after review; originals are maintained in secured files by committee chair and/or co-chair.

QUALITY IMPROVEMENT COMMITTEE

The Quality Improvement Committee (QIC) establishes strategic direction, recommends policy decisions, analyzes and evaluates the results of QI activities, and ensures practitioner participation in the QI program through planning, design, implementation, or review. The QIC ensures that appropriate actions and follow-up are implemented and evaluates improvement opportunities. The QIC meets and reports at least quarterly to the Commission. The QIC is a multi-disciplinary committee, the membership includes:

- At least one Commission member, co-chair
- Chief Medical Officer, co-chair
- Quality Improvement Manager
- Practicing network physicians
- Support staff and guests will be invited to attend the meetings as reporting requirements dictate.

RESPONSIBILITIES AND FUNCTIONS:

- Review the QI Program Description that establishes strategic direction for HPSM and forward to the Commission for approval.
- Evaluate the Quality Work Plans, which includes providing feedback and recommendations to the appropriate sub-committee department and forward to the Commission for approval.
- Evaluate the effectiveness of the QI Program with input from other communities and departments annually.
- Receive, review and analyze status reports on the implementation of Work Plans, including aggregate trend reports and analysis of clinical and service indicators.
- Appoint subcommittees and ad hoc committees as needed.
- Ensure that system-wide trends are identified and analyzed.
- Ensure that quality improvement efforts are prioritized, resources are appropriate, and resolutions occur.
- Prioritize quality improvement efforts and assure that resources are allotted.
- Approve Quality Improvement Program policies.
- Ensure appropriate oversight of delegated activities.

  Ensure integration, coordination, and communication among committees reporting to QIC.

CLINICAL QUALITY COMMITTEE (CQC)

The Clinical Quality Committee advises the QIC of the QIP program activities and procedures performed to monitor and evaluate the quality, safety, and appropriateness of health care. The CQC meets at least quarterly. The CQC reports to the QIC quarterly.

RESPONSIBILITIES:

- Analyzing demographic and epidemiological data.
- Identifying risk member populations.
- Selecting disease management clinical practice guidelines and quality activities.
- Developing, communicating and implementing clinical practice guidelines based on current medical standards of care. These guidelines include, but not limited to, standards instituted and approved by the
    - American Academy of Family Physicians
    - American Board of Internal Medicine
    - American Academy of Pediatrics
    - American Academy of Ophthalmology
    - American College of Obstetricians and Gynecologists
    - California's Child Health and Disability Prevention Program
    - Health Care Effectiveness Data and Information Set (HEDIS)
    - United States Preventive Services Task Force
- Identifying sub-optimal care through the analysis of data referred from all departments.
- Reviewing and approving identified trends and opportunities for improvement and recommendation for strategies to prevent adverse outcomes.
- Identifying practitioners/providers not complying with HPSM medical care standards, service standards, guidelines and/or policies and procedures

  Reviewing and approving action plans for practitioners/providers in collaboration with company-wide departments.

MEMBERS:

The Clinical Quality Committee consists of the representatives listed below. Additional participants and staff representatives provide useful information and/or serve as liaisons to their respective departments.

- Chief Medical Officer, co-chair
- Quality Improvement Manager, co-chair
- Medical Directors
- UM Manager
- Provider Relations representative
- Care Coordination Manager
- Pharmacy Services Manager

MAJOR RESPONSIBILITIES

Chief Medical Officer:

- Serves as the Committee co-chairperson
- Reports CQC activities to QIC and Commission

Quality Improvement Manager:

- Serves as the Committee co-chairperson
- Reports CQC activities to the QIC, in the absence of the Chief Medical Officer
- Conducts literature searches to help develop potential indicators based on accepted standards of care
- Develop mechanisms to collect, store and profile data
- Reports summaries of site inspections, quality indicator screens, medical records audits, member complaints and grievances, environmental health and safety/infection control issues, risk management issues and other issues as indicated to the Committee

CREDENTIALING COMMITTEE

The Credentialing Committee is a sub-committee of the QIC. The committee is responsible for the review of credentialing files and makes decisions regarding credentialing and re-credentialing of practitioners. The Credentialing Committee makes decisions regarding provider organizational credentialing/re-credentialing. The committee is responsible for the review of performance data at the time of re-credentialing and making on-going contract recommendations as a result of re-credentialing.

The Credentialing Committee serves as the practitioner Peer Review and Appeals Committee. Peer review issues are presented for review discussion and determination of appropriate improvement action plans. The committee makes a reasonable effort to obtain the facts and conduct – hearing procedures for health care practitioners.

The committee meets at least quarterly. The Chief Medical Officer is the chairperson. The functions of the Credentialing Committee are:

- Review, recommend, and approve procedures for practitioner/provider credentialing/re-credentialing.
- Review and approve practitioner/provider credentials.
- Review and approve a practitioner/provider profile with input from all departments that analyze performance in conjunction with the re-credentialing process.
- Review and approve credentialing/re-credentialing standards/policy and procedures.
- Review and approve quality of care and service indicators for re-credentialing.
- Review of delegated credentialing performance.

PHARMACY AND THERAPEUTIC (P&T) COMMITTEE

The P&T Committee meets and reports to the QIC at least quarterly. The Chief Medical Officer and Pharmacy Manager serve as co-chairs.

MEMBERSHIP:

- Chief Medical Officer
- HPSM Pharmacists
- Network primary and specialty care practitioners
- Pharmacy Services Manager

RESPONSIBILITIES AND FUNCTIONS:

- Formulating policies on the evaluation, selection, distribution, use and safety procedures relating to medication therapy.
- Developing and maintaining the Drug Formulary.
- Monitoring activities related to the Formulary Exception Policy.
- Monitoring prescribing practices and drug utilization for appropriateness.
- Submitting quarterly report to the QIC of the status of all activities.

UTILIZATION MANAGEMENT COMMITTEE (UMC)

The Utilization Management Committee provides direction to and oversight of the Utilization Management Program (UMC). The UMC meets at least quarterly and reports to the QIC quarterly. The Deputy Chief Medical Officer serves as the chair.

The UMC is a multi-disciplinary committee whose members include:

- Chief Medical Officer
- Medical Directors
- UM Manager
- Care Coordination Manager
- Quality Improvement staff representative
- Network practitioners as appropriate

RESPONSIBILITIES AND FUNCTIONS:

- Reviews and approves the UM Program Description that establishes direction for the organization
- Receives, reviews, and analyzes utilization reports on the progress of the UM Program
- Conducts new technology assessment
- Reviews recommendations for delegation of utilization management and makes recommendations to the QIC
- Formalizes UM policies and procedures

- Reviews, approves, and distributes medical criteria for review at least annually
- Monitors continuity and coordination of care
- Conducts under/over utilization monitoring on practitioner specific and organizational-wide dimensions
- Evaluates satisfaction with the UM Program using member and practitioner input.

SERVICE QUALITY IMPROVEMENT COMMITTEE (SQIC)

The Service Quality Improvement Committee (SQIC) monitors and evaluates the quality, safety, and appropriateness of non-clinical services to members, practitioners and providers and operations of the organization. The Service Quality Improvement Committee meets at least quarterly and reports to the QIC quarterly. The Chief Services Officer is the chairperson.

The Service Quality Improvement membership includes:

- Chief Medical Officer
- Chief Information Officer
- Claims Director
- Quality Improvement Manager
- UM Managers
- Chief Compliance Officer
- Supervisor Member Services
- Grievance and Appeals Manager
- Director of Customer Support

RESPONSIBILITIES AND FUNCTIONS:

Responsibilities of the Service QIC include reviewing and making recommendations for interventions to improve all service activities relative to:

- Complaints
- Grievances
- Member and Provider Appeal trends
- Member satisfaction survey data
- Telephone and turnaround time standard performance
- UM turnaround times
- Access and availability
- Claims services standards
- Enrollment service standards
- Plan operations

- Member and practitioner satisfaction/dissatisfaction as identified by surveys including monitoring of PCP change request and results of access and availability monitoring.

STAFF GRIEVANCE AND APPEALS COMMITTEE (SGAC)

The primary function of the committee is to provide oversight and support to all Culturally and Linguistically Appropriate Services (CLAS) Program activities. HPSM CLAS activities are imbedded into the daily work of each employee at the health plan. Structurally, the CLAS Program is integrated into the Quality Improvement Program. The CLAS Committee meets monthly and reports to the Service Quality Committee, Clinical Quality Committee, Consumer Advisory Committee and Quality Improvement Committee.

COMMIITTEE COMPOSITION & TERMS:

The CLAS Committee is intended to leverage the experience, expertise, and insight of key individuals at HPSM to ensure organizational compliance with regulatory CLAS program requirements. The CLAS Committee is a multidisciplinary team that is comprised of Managers and Supervisors, as well as key staff throughout the organization with direct member interaction.

All members will remain on the committee unless or until replaced by another department representative.

RESPONSIBILITY AND FUNCTION:

The CLAS Committee objectives are also aligned with the National CLAS Standards and are intended to advance healthy equity, improve quality and help eliminate health disparities for HPSM's member population. The CLAS Committee is responsible for reviewing, updating and implementing the Cultural Competency Plan. The CLAS Committee oversees policies, activities and procedures that meet requirements provided by State and Federal regulators. This ensures that all plan members-regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status, or disability have equal access to health care.

QUALITY IMPROVEMENT DEPARTMENT

The Quality Improvement Department reports to the Chief Medical Officer. Responsibilities of the department include:

- Provide staff support to the Quality Improvement Committee, Clinical Quality Committee; and Sub-Committees;
- Develop initial drafts of the QI Program documents for review and approval by the QIC;
- Develop a work plan identifying the responsibilities of the operations that support the program implementation;
- Review and evaluate the work plans and quarterly reports of the sub-committees reporting to the CQC;

- Review and evaluate delegates reports;
- Assist in data collection for selected components of contractual reporting requirements for external review agencies;
- Develop and implement systematic data collection methodologies;
- Assist in the development of research design and methodologies for disease management programs;
- Monitor the QI Program to assure compliance with regulatory and accrediting agency requirements; and
- Assist in the development of company-wide policies and procedures related to Quality Improvement.

CREDENTIALING DEPARTMENT

The Credentialing Department reports to the Chief Network Officer and is responsible for developing policies, procedures and forms used in the credentialing and re-credentialing of practitioners. The Credentialing Unit assist the Contracts Department in development of policies, procedures and forms used in the credentialing and re-credentialing of health care delivery organizations. The credentialing staff implements the policies and procedures, including gathering all applications, primary source verification, and presents a completed file for the Chief Medical Officer or designee for review and action by the Credentialing Committee.

BEHAVIORAL HEALTH SERVICES

HPSM behavioral health management philosophy is to provide behavioral health care services to members in order to achieve the best possible clinical outcomes with the most efficient use of resources. It is our philosophy that timely, high-quality care, delivered by the appropriate provider in the least restrictive treatment setting is the key to achieving that objective. The goal of our Behavioral Health Program is to return our members to healthy, productive lifestyles as quickly as possible and to maintain that level.

Behavioral health benefits are structured as follows:

- Members with Serious Mental Illness are served by San Mateo County Behavioral Health and Recovery Services (BHRS) under the carve out of Specialty Mental Health Services
- Medi-Cal members with mild to moderate behavioral health conditions or with Autism requiring behavioral health treatment are served by Behavioral Health and Recovery Services which functions as a delegated entity under HPSM
- Members covered under other lines of business are also served by Behavioral Health and Recovery Services which is a delegated entity under HPSM
- Addiction treatment services are largely carved out and are managed by Behavioral Health and Recovery Services.

HPSM staff work closely with San Mateo County Behavioral Health and Recovery Services to oversee and monitor the behavioral health benefit.

MEMBER SAFETY

Health Plan of San Mateo is committed to an ongoing collaboration with network practitioners, providers and vendors to build a safer health system. This is accomplished through established quality initiatives that promote best practices, tracking outcomes and educating patients, providers and members. The goals of the safety program include but are not limited to:

- Informing and educating members, practitioners and providers of issues affecting member safety
- Identifying and evaluating strategies for analyzing events, promoting reporting and improving patient safety

The QIC, with input from its reporting committees, develops and implements a process that addresses improving member safety. The goal of the process is to foster a supportive environment to aid practitioners and organizational providers in improving safety in their practice. Activities that may be included in this process are:

CARE COORDINATION PROGRAMS:

- Assists in the coordination of managed care efforts to reduce or prevent omission or duplication of orders when multiple providers are involved
- Monitors Emergency Room utilization beyond a threshold of two or more times in any quarter to identify the lack of primary care, the absence of coordinated care, potential drug interactions, unnecessary testing and treatments, omission or duplication of care, or patient non-adherence with a care plan.

DRUG SAFETY:

HPSM monitors for appropriate medication use to ensure the safety of members. These techniques include, but not limited to:

- Potential drug and drug disease interactions
- Analyzing pharmacy data to identify polypharmacy, potential adverse drug reactions, inappropriate medication usage, excessive controlled substance usage and voluntary drug recalls
- Assuring that affected members and practitioners are notified of FDA or voluntary drug alerts
- Notification and education of members and practitioners of other identified events
- Conducting pharmacy system edits to assist in avoiding medication errors

Working with contracted pharmacies to assure a system is in place for classifying drug-drug interactions and/or notifying dispensing providers of specific interactions when they meet HPSM's severity threshold

UTILIZATION MANAGEMENT:

The concurrent review process has established a medical management process which follows identified participants throughout the healthcare delivery system to ensure optimal delivery of care including transition from acute to subacute, long term care and home settings.

HEALTH MANAGEMENT PROGRAMS:

Work to assist, communicate, and educate patients and practitioners in standard of care in all aspect of specific disease processes. These programs are especially important to help identify over and under-utilization, patient non-compliance, and care that does not meet the standards, thus assisting to reduce adverse medical events.

Clinical practice guidelines go hand-in-hand with the disease management programs and addresses patient safety by communicating evidenced based standards of care to practitioners and members.

QUALITY IMPROVEMENT:

- Establishes standards for medical record documentation
- Conducts an on-going medical review process that evaluates key components of documentation to address patient safety
- Establishes a rigorous process for investigation and resolution of complaints, especially quality of service and care complaints against practitioners and providers
- Monitors quality of care indicators to identify patterns and/or trends
- Strives to contract only with hospitals and ancillary providers that are JCAHO accredited or other nationally recognized accreditation organization

ADMINISTRATIVE PATIENT SAFETY ACTIVITIES:

In addition to the activities listed above, HPSM participates in many other patient safety activities. These activities include, but not limited to:

- Conducts office site reviews as a part of the initial practitioners credentialing process, and triennially thereafter
- Conducts a rigorous credentialing and re-credentialing process to ensure only qualified practitioners and organizations provide care in the network
- Establishes a process that monitors the continuity and coordination of care between the medical delivery system and behavioral healthcare, and between the medical delivery system and health delivery organizations.

MECHANISMS FOR COMMUNICATION INCLUDE:

- HPSM website
- Newsletters
- Drug safety recalls, refill history and dosage alerts
- Safety specific letter to individual practitioners, providers or members

MONITORING AND EVALUATION:

Patient safety activities are monitored continuously and will be trended and reported quarterly. The Patient Safety Program will be evaluated annually.

QUALITY ISSUE IDENTIFICATION

To provide overall quality functioning, each division and/or department will continually monitor specific important aspects of care. These aspects or activities of care and/or service include, but are not limited to:

- Access/Availability
- Continuity/Coordination
- Health and Pharmacy Management Systems
- Under/Over Utilization
- Behavioral Healthcare
- Chronic/Acute Care
- High-Risk/High-Volume/Problem Prone Care
- Preventive Healthcare
- Member Satisfaction/Dissatisfaction (Customer Service)
- Member Appeals and Grievances
- Medical Record Documentation
- Clinical Practice Guidelines/Preventive Health Guideline Compliance
- HPSM Service Standards
- Individual Care Review
- Potential Quality Issue Tracking
- Credentialing
- Provider Relations
- Claims Analysis
- Marketing Feedback

SERVING MEMBERS with COMPLEX HEALTH NEEDS

Health Plan of San Mateo ensures that members with complex health needs receive medically necessary services in a timely manner. HPSM is committed to coordinating care for these members and ensuring access to appropriate specialty and primary care. This includes:

- Providing care coordination/case management services for
    - Members who have multiple comorbidities
    - Members with ESRD
    - Members with malignancies, HIV/AIDS, degenerative disorders
    - Members with significant co-existing medical and behavioral issues
- Identifying and addressing any barriers to care for members with complex needs
- Coordinating care across the continuum

QUALITY IMPROVEMENT PROGRAM ACTIVITIES

The QI Program's scope includes implementation of QI activities or initiatives. The QI Committee and the subcommittees select the activities that are designed to improve performance on selected high volume and/or high-risk aspects of clinical care and member service.

PRIORITIZATION:

Certain aspects of clinical and service may identify opportunities to maximize the use of quality improvement resources. Priority will be given for the following:

- The annual analysis of member demographic and epidemiological data.
- Those aspects of care which occur most frequently or affect large numbers of members.

- Those diagnoses in which members are at risk for serious consequences or deprivation of substantial benefit if care does not meet community standards or is not medically indicated.
- Those processes involved in the delivery of care or service that through process improvement interventions could achieve a high level of performance.

USE OF COMMITTEE FINDINGS:

To the degree possible, quality improvement systems are structured to recognize care for favorable outcomes as well as correcting instances of deficient or sub-optimal practice. The vast majority of practicing physicians provide care results in favorable outcomes. Quality improvement systems explore methods to identify and recognize those treatment methodologies or protocols that consistently contribute to improved health outcomes. Information of such results is communicated to the Commission and providers on a regular basis. Written communication to primary practitioners is the responsibility of the Committee chairperson. Submission of written corrective action plans, as necessary, is required for the Committee's approval. Significant findings of quality improvement activities are incorporated into practitioner educational programs, the re-credentialing process, and the re-contracting process and personnel annual performance evaluations. All quality improvement activities are documented and the result of actions taken recorded to demonstrate the program's overall impact on improving health care and the delivery system.

PREVENTIVE HEALTH/HEDIS MEASURES:

The Clinical Quality Committee will determine aspects of care to be evaluated based on member population and regulatory requirements. At a minimum, HEDIS performance indicators will be monitored annually. These include:

- Adult Body Mass Index (BMI) Assessment
- Adult's Access to Preventive/Ambulatory Health Services
- Annual Monitoring for Patients on Persistent Medications
- Antidepressant Medication Management
- Asthma Medication Ration
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Breast Cancer Screening
- Board Certification
- Care for Older Adults
- Cervical Cancer Screening
- Childhood Immunization Status – Combo 3
- Children and Adolescent's Access to Primary Care Providers
- Colorectal Cancer Screening
- Comprehensive Diabetes Care
- Controlling High Blood Pressure
- Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Frequency of Selected Procedures
- Follow-Up After Hospitalization for Mental Illness
- Hospitalization for Potentially Preventable Conditions
- Identification of Alcohol and Other Drug Services
- Immunizations for Adolescents
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Lead Screening in Children
- Medication Management for People with Asthma

- Medication Reconciliation Post-Discharge
- Mental Health Utilization
- Non-Recommended PSA-Based Screening in Older Men
- Osteoporosis Management in Women Who Had a Fracture
- Persistence of Beta Blocker Treatment After a Heart Attack
- Pharmacotherapy Management of COPD Exacerbation
- Plan All-Cause Readmissions
- Potentially Harmful Drug-Disease Interactions in the Elderly
- Prenatal and Postpartum Care
- Standardized Healthcare-Associated Infection Ratio
- Statin Therapy for Patients with Cardiovascular Disease
- Statin Therapy for Patients with Diabetes
- Use of High-Risk Medications in the Elderly
- Use of Imaging Studies for Low Back Pain
- Use of Services – Ambulatory Care
- Use of Services – Emergency Department Utilization
- Use of Services – Inpatient Utilization – General Hospital/Acute Care
- Use of Services – Mental Health Utilization
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Weight Assessment/Counseling for Nutrition & Physical Activity for Children/Adolescents
- Well Child Visit in the Third, Fourth, Fifth, and Sixth Years of Life

DISEASE MANAGEMENT PROGRAMS:

The Health Services Department staff, Clinical Quality Committee and network practitioners identify members with, or at risk for, chronic medical conditions. The Clinical Quality Committee is responsible for the development and implementation of disease management programs for identified conditions. Disease management programs are designed to support the practitioner- patient relationship and plan of care. The programs will emphasize the prevention of exacerbation and complications using evidence-based practice guidelines. The active disease management programs and their components will be identified in the annual QI work plan.

Complex case management and chronic care improvement are major components of the disease management program. Specific criteria are used to identify members appropriate for each component. Member self-referral and practitioner referral will be considered for entry into these programs. Following confidentiality standards, eligible members are notified that they are enrolled in these programs, how they qualified, and how to opt-out if they desire. Case managers and care coordinators are assigned to specific members or groups of members and defined by stratification of the complexity of their condition and care required. The care coordinators/case managers help members navigate the care system and obtain necessary services in the most optimal setting.

Components of complex case management and chronic care improvement programs shall include:

- Members' right to decline participation and dis-enroll from case management programs and services
- Initial assessment of members' health status including condition-specific issues
- Documentation of clinical history including medications
- Initial assessment of activities of daily living
- Initial assessment of mental health status including cognitive functioning
- Initial assessment of life planning activities

- Evaluation of cultural and linguistic needs, preferences or limitations
- Evaluation of caregiver resources
- Evaluation of available benefits
- Development of a case management plan including long and short term goals
- Identification of barriers to meeting goals or complying with the plan
- Development of a schedule for follow-up and communication with the member
- Development and communication of self-management plans for members
- Process to assess progress toward meeting the goals of member's case management plans

CONTINUITY AND COORDINATION OF CARE:

The continuity and coordination of care that members receive is monitored across all practice and provider sites. As meaningful clinical issues relevant to the membership are identified, they will be addressed in the quality improvement work plan. The following areas are reviewed for potential clinical continuity and coordination of care concerns.

- Primary care services
- OB/GYN services
- Behavioral health care services
- Inpatient hospitalization services
- Home health services
- Skilled nursing facility services
- Long Term Care

The continuity and coordination of care received by members include medical and behavioral health care. Health Plan of San Mateo collaborates with Behavioral Health and Recovery Services to ensure the following activities are accomplished:

- Information Exchange – information exchange between medical practitioners and behavioral health practitioners must be member-approved and be conducted in an effective, timely and confidential manner.
- Referral of Behavioral Health Disorders – Primary care practitioners are encouraged to make timely referral treatment of behavioral health disorders commonly seen in their practices, i.e., depression.
- Evaluation of Psychopharmacological Medication – Drug use evaluations are conducted to increase appropriate use, or decrease inappropriate use and to reduce the incidence of adverse drug reactions.
- Data Collection – Data is collected and analyzed to identify opportunities for improvement and collaborate with behavioral health practitioners for possible improvement actions.
- Implementations of Corrective Action – Collaborative interventions are implemented when opportunities for improvement are identified.

RISK MANAGEMENT:

The purpose of the Risk Management component of the QI Program is to prevent or reduce risk due to adverse member occurrences associated with care or service. The risk management function involves identifying potential areas of risk, analyzing the cause and designing interventions to prevent or reduce risk. The activities of Quality Improvement, Utilization Management, Member Services, Provider Relations and risk management are coordinated.

CLINICAL PRACTICE GUIDELINES:

HPSM utilizes evidence-based practice guidelines to establish requirements and measure performance on a minimum of three practice guidelines (acute, chronic and behavioral health) annually to strive to reduce variability in clinical processes. The links for these specific guidelines are tied directly to nationally recognized websites recommended by the Agency for Healthcare Quality and Research (AHRQ) including the National Guidelines Clearinghouse, the Centers for Disease Control, the Institute for Clinical Systems Improvement, and the Joint National Committee's Evidence-Based Guidelines. Practice guidelines are developed with representation from the network practitioners. The guidelines are implemented after input from participating practitioners of the Clinical Quality Improvement, Utilization Management and Pharmacy and Therapeutics Committees. Guidelines will be reviewed and revised, as applicable, at least every two years.

The Quality also department ensures that the clinical guidelines posted in the provider section of the HPSM website are current, and relevant, to health conditions common in the member population. Once a year, a Quality Improvement Specialist checks the source organization for each specific guideline, online, to see if the guideline has been updated and noted with a new edition year. A guideline that has not been updated by the source organization within the past 12 months, maintains its current status on the HPSM website if it was last updated within 3 to 5 years.

DATE SOURCES and STAFF RESOURCES

Quality Improvement is a data driven process. Health Plan of San Mateo maintains an information data system appropriate to provide tracking of multiple data sources for implementing the QIP. These sources include, but are not limited to, the following:

- Encounter data
- Claims data
- Pharmacy data
- Laboratory data
- Medical records
- Utilization data
- Utilization case review data
- Practitioner, provider and member complaint data
- Practitioner, provider and member survey results
- Appeals and grievance information
- Statistical, epidemiological and demographic member information
- Authorization data
- Enrollment data
- HEDIS data
- Behavioral Health data
- Risk Management data

In addition, Health Plan of San Mateo staff and analytical resources include, but are not limited to:

- Quality Improvement
- Health Education
- Utilization Management
- Member Services
- Case Management
- Provider Services
- Informatics
    - Quality Data Analyst
    - Information Systems Analysts
    - Biostatistician
    - Statistical Analysis System (SAS) software suite – a comprehensive system for analyzing data

The Quality Improvement Committee uses the above data and resources to fully evaluate the concern by objective or quantitative methods in order to define the specific problem. The Committee must proceed to implement a problem solving action based on its findings and the objective parameters measured. After adequate time has been permitted for problem resolution, a re-evaluation is performed using the same quantitative measures. The Committee bases the re-evaluation time frame (1 month, 3 months, 6 months, etc.) on the severity of the problem identified. The steps outlined below must be supported by adequate documentation of a problem-oriented approach to quality improvement:

- Define of specific indicators of performance through monitoring process
- Collect and analysis of appropriate data
- Identify opportunities to improve performance
- Implementation of interventions and/or guidelines to improve performance
- Measure effectiveness of interventions and/or conformance to guidelines
- Re-evaluate for further potential performance improvements with the same quantitative measures

MEMBER SATISFACTION, COMPLAINT, AND GRIEVANCE/APPEAL MONITORING

An NCQA certified vendor conducts a member satisfaction survey (Consumer Assessment of Healthcare Providers and Systems – CAHPS) annually for the Medicare Advantage Special Needs Plan (SNP) and Medicare-Medicaid Plan (MMP) members and triennially for Medi-Cal members. The results of the surveys are reported to the Service QIC, Consumer Advisory Committee, QIC and Commission.

Quarterly summaries of complaints and grievances/appeals are reported to the Service QIC and Consumer Advisory Committee. Reporting is trended by type of complaint, HPSM departments, sites, facilities and physicians as indicated. Cases reviewed by the Chief Medical Officer are included in the quarterly summaries.

Any complaint that has a potential quality of care issue receives medical review as follows:

- The QI Nurse screens it immediately upon receipt for potential quality issues.
- Supporting documentation is requested from primary care sites, hospitals, etc.
- The Chief Medical Officer/designee reviews the complaint and any supporting documentation, categorizes the quality of care concerns, communicates with the primary care provider as indicated

PRACTITIONER COMPLIANCE MONITORING

Health Plan of San Mateo monitors and evaluates practitioners' compliance with policies and procedures through on-site provider compliance surveys. The purpose of this monitoring is to ensure compliance with established protocols and policies and assist in the implementation of corrective action plans, as indicated.

During each compliance survey, a site facility inspection is conducted and a review of medical records per physician per age group (adults/pediatrics) for members being treated is performed. The medical record score is based on a survey standard of at least ten randomly selected records per provider. All records surveyed are from adult, obstetric, or pediatric preventative care areas. For sites with only adult, only obstetric, or only pediatric members, all records surveyed are only in that preventive care area.

The site's contact person is provided with an exit summary at the end of the inspection and copies of the completed survey tools.

A corrective action plan is required for deficiencies noted and a follow-up survey is conducted for compliance ratings of 'Conditional Pass' and 'Not Pass.' The follow-up visit is scheduled from the time the formal summary report is provided to the site.

MEMBER HEALTH EDUCATION

The Health Education program is reviewed annually to assess that there is an appropriate allocation of health education resources to address the health education needs and gaps of HPSM members. This assessment includes completing required readability and suitability checklists for health education materials; reviewing and presenting consumer survey results; soliciting health educational requests information from other HPSM department staff; conducting on-site evaluations of classes offered in the community; analyzing encounter data and other relevant data sources; and identifying other intervention activities to accomplish the objectives in the work plan.

Health education programs are offered to the member at no cost directly and/or through subcontractors or other formal agreement with providers that have expertise in delivering health education services.

HPSM conducts targeted outreach to members that his heavily based on mailings to educate them about resources available to them in the community. The Health Educator will monitor the availability and accessibility through self-referral or referral from of provider for these programs.

RESPONSIBILITY AND AUTHORITY

- The Chief Medical Officer is responsible for overseeing and monitoring overall compliance for the health education activities at HPSM.
- Under the direction of the Chief Medical Officer, the Health Educator is responsible for managing the health education system.

PROGRAM SCOPE

HPSM will provide health education interventions, materials and programs that address a wide variety of health topics, including, but not limited to, the following: effective use of managed health care services, risk-reduction and healthy lifestyles, and self-care and management of health conditions, like pregnancy, asthma, diabetes, hypertension, smoking cessation, nutrition, weight control, dental care and physical activity.

HPSM's Health Educator ensures the successful delivery of health education programs using educational strategies, methods, and materials that are appropriate for the member population and effective in achieving behavioral change for improved health outcomes.

Objective 1: All relevant health education materials will be updated and reviewed to ensure that an updated Readability and Suitability checklist has been completed as well as that they are available in the four threshold languages.

HEALTH EDUCATION CLASSES AND RESOURCES

The Health Educator will evaluate specific health education classes, submit articles to member and provider newsletters and compile a schedule of health education classes relevant to our members. The updated health education class schedule will be distributed to members and HPSM staff who work with members on a semi-annual basis. The top five topics that members identified that they want to know more about in the Group Needs Assessment (GNA) were healthy eating, exercise, weight loss, healthy teeth and healthy aging. Information and community resources related to these topics will be regularly updated and compiled in a resource binder for HPSM staff to provide to members. In addition, articles in the member and provider newsletters will address these topics more generally throughout the year. When necessary, the health information section of the HPSM website will be updated with current class schedules and/or new health education information.

HEALTH EDUCATION MATERIALS

As mentioned above, the top 5 topics identified from the GNA survey results will be updated and be available in the form of a community resource binder to HPSM departments that directly interact with members. All new health education materials will be evaluated for readability and suitability and translated accordingly in our four threshold languages. New content areas will be solicited from other HPSM departments to respond to additional needs of members. Newly purchased materials will be used for home visits and/or sent to members upon request. All new materials will be purchased from an approved vendor.

DISEASE MANAGEMENT (ASTHMA & DIABETES) HEALTH EDUCATION MATERIALS

The Disease Management program is designed to improve members' diabetes and asthma management and reduce disease progression and complications. The health education component will include the development of an informational series to be sent to targeted members on a semi-annual basis. Both the diabetes and asthma educational pieces will specifically address the measureable outcomes outlined in the Disease Management program. For members with asthma, the underlying message will be to make sure they get their medications refilled before they run out. And for the members with diabetes, the message will be to get their HbA1c. The initial rollout for the materials is scheduled for March 2017 with a second round possibly in June or July. All materials will be in the sixth grade reading level and translated in all four threshold languages.

Objective 2: Collaborate with external partners to offer, promote and evaluate health education programs, i.e. Weight Watchers, etc. that are tailored to our members.

WEIGHT WATCHERS

Weight Watchers is a weight loss program available to adult Medi-Cal members with a BMI over 25. The objectives of this program are 1) By December 2017, 25 adult members with a BMI > 25 will participate in at least 10 Weight Watchers meetings; 2) by December 2017, 15 adult members with a BMI >25 participating in Weight Watchers will lose 5% of their body weight.

When a fax referral from a provider is received, the member is enrolled into the program. The member completes the pre-program survey and is sent a set of 5 vouchers to attend 5 meetings. A physician referral is not required, and the Health Educator may enroll the member directly into the program through the Health

Education line. Members must send in their weigh in logs after each set of 5 visits in order to receive another set of vouchers, and can receive up to 4 sets of vouchers (a total of 20). However, requests for continuation may be granted depending on weigh in logs, attendance and availability of vouchers. Data from the member logs will be entered into the Weight Watchers data base and used to evaluate the effectiveness of the program.

Objective 3: Increase referrals to the California Smokers' Helpline that offers free services in three of our threshold languages.

SMOKING CESSATION

HPSM continues to mail out flyers to promote the use of the California Smoker's Helpline. Smokers are identified by ICD-10 codes and prescriptions of tobacco cessation medication on a monthly basis. Flyers are mailed out in English, Spanish, Korean and Chinese. Currently, the California Smoker's Helpline does not include language services in Tagalog or Russian. Smokers will also receive an additional flyer at the end of the year to urge them to make quitting smoking a new year's resolution.

Also during provider visits, providers will receive the Quality Improvement Provider Toolkit that includes information on the mandatory assessment of the members' smoking status. It also includes resources to encourage them to make referrals to the California Smokers' Helpline.

QUALITY IMPROVEMENT PROGRAMS

PRENATAL AND POSTPARTUM CARE PROGRAM

Health Plan of San Mateo's (HPSM) Prenatal and Postpartum Care Program is for pregnant women enrolled in its Medi-Cal line of business. The goal is to improve access to early prenatal and postpartum care. The program incentivizes members as they meet pregnancy milestones. The incentives include gift card rewards for timely entry into the Prenatal Care Program in their first trimester as well as postpartum. Members are identified by the following data sources: prenatal ultrasound visits, first prenatal visit, prenatal vitamins, pregnancy diagnosis codes, and a recent delivery. Members are also identified through P4P Provider Referral Incentive Forms, OB Providers, Family Health Services, and Self-Referral. Once the member is identified as pregnant through the different data sources, the Health Promotion Coordinator conducts outbound calls to this list of members. If the member chooses to participate, the Health Promotion Coordinator enrolls and follows-up with the member throughout her pregnancy. In addition, the Health Promotion Coordinator links the member to community programs related to their psycho-social wants or needs.

Program Goal: The objective of the program is to increase enrollment in the Prenatal and Postpartum Care Program. High enrollment into HPSM prenatal program reflects higher rates of women getting timely prenatal and postpartum care.

CERVICAL CANCER SCREENING OUTREACH PROJECT

The Quality department implements a targeted mailing to Medi-Cal members due for cervical cancer screening (CCS). The mailing consists of a letter written to inform these women of their need to receive a routine Pap test and encourage them to schedule an appointment with their primary care provider (PCP), or gynecology practice. The letter, signed by HPSM's Chief Medical Officer, includes the name and phone number of their PCP (or Gyn), in addition to educational messages on the importance of receiving routine CCS until age 64. Women

continuously enrolled in Medi-Cal, age 21 to 64 are identified for the targeted mailing, and separated into mailing cohorts based on assigned PCPs.

2017 PROJECT IMPROVEMENTS:

Based on what we learned in 2016, the following strategies will be implemented in 2017 to help increase the impact of a targeted CCS mailing:

- **Clean member mailing data file prior to mailing:** Use the member data file provided by Informatics to cross-check mailing address data with Member Services and/or Marketing. The purpose would be to identify addresses that have previously been "returned" as non-deliverable. Remove these from the CCS mailing list.

- **Inform assigned PCPs of HSPM outreach letter project:** Prior to mailing letter to target population, contact assigned PCPs via email and include copy of intervention letter. Request their cooperation in advising staff of member calls to schedule CCS, and in promoting the benefits of preventive CCS to their female patients in the target age range.

- **Use a text messages to supplement the outreach letter, including reminding women of scheduled appointments:** To reinforce the message in the intervention letter, schedule text messages to be sent to target population one week after mailing date of letter. Provide PCP phone number to call for CCS appointment. Send text reminders of scheduled CCS appointments.

CERVICAL CANCER SCREENING PERFORMANCE IMPROVEMENT PROJECT (PIP)

The CCS PIP focuses on supporting Ravenswood Family Health Center (RFHC) in identifying all assigned Medi-Cal members who are due for a Pap test, for timely preventive care. It is a collaborative effort to create and test a safety net system for reaching out to women that have been previously excluded, or have not responded to the clinic's existing CCS recall/reminder system. HPSM Quality Improvement Department provides RFHC a monthly file of new and currently assigned Medi-Cal female members, age 24 to 64, for whom HPSM does not have an administrative claim for cervical cancer screening within the past 3 to 5 years. The purpose in receiving this monthly file is twofold: 1) it enables RFHC Decision Support and Women's Health teams to identify both newly and currently assigned women that need to be contacted about scheduling an appointment and 2) allows RFHC's data staff to update the screening status of the women in file, based on clinic data that confirms completion of CCS. In the long term, use of this monthly file will help increase Ravenswood's CCS rate.

2017 ACTION PLAN:

Continue to work with RFHC on implementing the test cycles for this process improvement project through June 2017. The assigned Quality Improvement (QI) Specialist will continue to receive from HPSM Informatics team, the monthly file of Medi-Cal assigned women to RFHC with updated CCS status, and forward to RFHC staff at the beginning of each month. At the end of each month, when RFHC sends back the monthly file with the added clinic data, the QI specialist will review data before forwarding to HPSM Informatics to analyze and calculate the monthly CCS rate for RFHC.

The QI specialist will continually assess the need to make adjustments to expectations related to systems/processes changes at RFHC, with input from RFHC staff. This assessment will be based on the review of appointments scheduled and completed for the women identified for outreach in the monthly

files. The assessment will also include input from RFHC regarding staff resources to implement phone outreach on a regular basis, for women who don't respond to reminder letter, will be solicited to.

- Meet HSAG (Health Services Advisory Group) reporting requirements for process improvement project. The QI specialist will submit Mods 4 and 5 for final validation in August 2017.

REDUCING 30-DAY READMISSIONS PERFORMANCE IMPROVEMENT PLAN (PIP)

The performance improvement plan (PIP) targets reducing readmissions from St. Francis Pavilion and St. Francis Heights because these two particular SNFs have the highest volume of index discharges and readmissions back into acute care. The PIP is aimed at reducing the readmission rate in the target population of members who have been discharged from an acute care facility to two of the high volume SNFs, St. Francis Pavilion and St. Francis Heights. The goal for this PIP is to decrease the rate of 30 day readmissions from two skilled nursing facilities (St. Francis Pavilion and St. Francis Heights) back to hospitals among all of HPSM's MMP population, from 22.3% to 16% by June 30, 2017. Data shows that the average age of these members are 77.2 years old and that they are being readmitted with diagnoses related to initial admission diagnosis indicating these facilities are not adequately rehabilitating members to be discharged back to their homes.

2017 ACTION PLAN

Beginning in November 2016 and through June 2017, the PIP will work with St. Francis Pavilion and St. Francis Heights skilled nursing facilities by measuring how many SBAR forms are fully completed by nurses in a month's time. The second process measure evaluates if the SBAR form was addressed by the skilled nursing facilities MD or Director RN within the hour the form was filled out by the shift nurse. The SBAR tool (Situation, Background, Assessment and Recommendation) is a standardized communication tool used by clinical staff at both SNFs to record prompt and appropriate communication of changes in the member's health status. The Quality Improvement Specialist will continually evaluate and analyze the impact of the SNF focused intervention. The Care Transitions team will work with the Quality Improvement department to provide data for the analysis and evaluation of the Coleman Model intervention.

CONTROLLING HIGH BLOOD PRESSURE

The Health Plan of San Mateo (HPSM) has partnered with a county clinic, Fair Oaks (FOHC), to provide care to a large volume of HPSM's members. The HPSM entered into collaboration with FOHC clinic staff to provide hypertension classes/clinics to members identified by HPSM beginning in 2015 through 2017. The target population is about 200 members with the following criteria: Care Advantage or CalMediConnect member with a diagnosis of hypertension identified through claims beginning January 2014 and whose primary care physician is based at FOHC.

Blood pressure monitors are provided to members served at their primary care provider's office. Outreach is completed by the assigned clinical staff that leads the program. The members who enroll sign a contract verifying acceptance of blood pressure monitor and are taught how to take blood pressure in accordance to each individual's specific needs. The assigned clinician also educates members on signs and symptoms of hypertension, diet, proper medication adherence and use of the blood pressure monitor. The blood pressure monitors need to be connected to a gateway "cloud" device to upload the pressure readings via internet. Each blood pressure monitor has a connection with the county clinic's electronic medical record system as the primary care physician can view the patient's medical records along with readings to make treatment adjustments as necessary.

2017 ACTION PLAN

In 2017, implementation of the pilot at North East Medical Services in Daly City will begin. Outreach will begin in January 2017 to the 55 identified Care Advantage members first and then to the remaining 200 plus members that were identified as Medi-Cal.

The QI Specialist has worked with the lead physician and health educator to define how the pilot can best benefit the members and work into the workflows of the clinic. The adapted changes were a result of an evaluation on the barriers from the pilot at FOHC and the data measures that will provide an improved analysis of the pilot's progress.

The lead physician of the clinic and the clinic's health educator will train all front and back office staff on the procedures of notifying the health educator and physician that the member on the list is here for an appointment to coordinate care. The health educator will outreach to all identified members who with a hypertension diagnosis and who were seen in the clinic in the last year. When a member has an appointment to be seen by a physician, staff will notify the physician and the health educator to market the benefits of joining the pilot to the member. When the member agrees to participating in the pilot, the health educator will provide a BP (in the language of member's choice), record baseline BP, review medications and lifestyles with physician present and inform the member how to use and upload BP readings.

The QI Specialist will collect data on a quarterly basis from the clinic measuring the number of members in pilot that are participating, length of time (in weeks) for a member to achieve controlled blood pressure, if the member is seen at least once by the health educator quarterly , if member is on hypertensive medications and if member is compliant.

The QI Specialist will continue to seek out providers and/or clinics that would be candidates in partnering in the pilot program in 2017.

INITIAL HEALTH ASSESSMENT

The Initial Health Assessment (IHA) has become a high priority in health plans, primary care and preventative services across California as the Medi-Cal population has a higher prevalence of chronic and/or preventable illnesses. Many of which could be modified through appropriate health behavior change and early detection to promote lifestyle changes. The IHA enables a provider to comprehensively assess the member's chronic, acute and preventative needs and to identify patients whose needs require additional coordination with other resources. The All Plan Letter (APL 08-003) requires all primary care providers to administer an IHA to all Medi-Cal managed care patients as part of their IHA and well care visits. California Department of Health Care Services (DHCS) audits in both November 2014 and November 2015 found that the plan did not ensure that IHAs for new members were completed within 120 calendar days of enrollment. It is required that health plan's reach a 100% compliance rate ensuring every member enrolled is seen by their primary care physician. HPSM is exploring the potential use of a text messaging campaign to further market awareness of seeking early primary care services. Reaching members through text messaging versus mail has the potential to reach more members as studies have shown that populations similar to HPSM's membership has access to a cell phone and messaging services. The Quality Improvement team is working with vendor and various departments to begin implementation in 2017.

2017 ACTION PLAN

The Staying Healthy Assessment (SHA) also proves to be a difficult area for providers to comply with. Training has been developed to address this, but the additional questionnaire component in busy practices is hindering. Providers have relayed feedback that they want to modify the questionnaire along with the challenges they face when adding the questionnaire into their electronic health records. The state is aware of the issues and is in the early stages of modifying the questionnaire. Until a modification from DHCS has been made aware to the health plan, training from all touch points to the providers and/or office staff will remain a focus. The Quality Improvement and Provider Services team have teamed up to provide continual training to providers through 2017.

CULTURALLY & LINGUISTICALLY APPROPRIATE SERVICES (CLAS) PROGRAM

The Health Plan of San Mateo (HPSM) is committed to delivering cultural and linguistically appropriate services (CLAS) health care services to our diverse membership. HPSM's CLAS Program complies with Title VI of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, and 45 C.F.R. Part 80) and the Cultural and Linguistic Services requirements in accordance to the contractual agreement with the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and the Centers for Medicare and Medicaid Services (CMS).

The goal of CLAS is to ensure that all plan members-regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status, or disability have equal access to health care. Recognizing and having a better understanding of our members' culture and their preferences is key to the development of successful and effective programs. HPSM is committed to accommodating this diversity in a manner that accepts and respects differences while promoting optimal health outcomes.

VISION:

To plan, develop, implement, support and evaluate the cultural and linguistic services available to HPSM members including those mandated by our contractual obligations with regulatory agencies. The provision of culturally appropriate care and language services are an integral component of effective health care delivery.

CLAS PROGRAM OBJECTIVES:

The CLAS Committee objectives are aligned with the National CLAS Standards and are intended to advance healthy equity, improve quality and help eliminate health disparities for HPSM's member population.

The CLAS Program Objectives are as follows:

- Promote effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.
- Advance and sustain organizational governance and leadership that promote CLAS and health equity through policy, practice and other resources.

- Create culturally and linguistically appropriate goals, policies, and management accountability, and imbed them throughout HPSM's planning and operations.
- Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
- Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, members, and the provider network.

CLAS PROGRAM GOALS:

1. Report CLAS Program initiatives to the Service Quality Committee, Clinical Quality Committee and Quality Improvement Committee on an ongoing basis to identify areas for improvement and to provide guidance to improvement activities.

2. Ensure compliance with state and federal contract regulation to caring for Limited English Proficiency (LEP) and sensory impaired members.
3. Provide interpreter services to individuals who have limited English proficiency and/or other communication needs, free of charge to them, to facilitate timely access to all health care. This is measured through Language Utilization reports from Member Services and providers, annually.

4. Inform individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

5. Ensure the competences of individuals providing language assistance services, understanding that the use of a professional interpreter is recommended and that the use of a family member or minor should be avoided.

6. Regularly monitor ongoing assessments of the organization's CLAS related activities and integrate CLAS related measures into measurement and continuous quality improvement activities, annually, in the CLAS program evaluation.

7. Ensure quality interpretation and translation of written materials in members' preferred language and format are available and accessible.

8. Establish processes for review of member materials to assess various components of health literacy and cultural appropriateness.

9. Collect and maintain accurate and reliable race/ethnicity/language (REL) data to monitor and evaluate the impact of the CLAS Program on health equity and outcomes and to inform service delivery, annually.

10. Analyze Healthcare Effectiveness Data and Information Set (HEDIS) data and Consumer Assessment of Healthcare Providers and Systems (CAHPS) by REL data to identify disparities in quality of care and member experience, annually.

11. Implement interventions aimed at reducing (REL) based disparities related to quality of care or member experience, when they exist.

12. Assess member health assets, as well as barriers to care, and use the results to plan and implement services that respond to the cultural and linguistic diversity of the population in the service area.

13. Ensure that both limited English proficient (LEP) and non-LEP members receive the same quality of health care services by providing Cultural and Linguistic Services (oral and written).

14. Ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable to identify, prevent, and resolve cross cultural conflicts or complaints.

15. Ensure annual Staff and Provider Training on culturally and linguistically appropriateness to improve quality of care and workplace environment.

DELEGATION

Health Plan of San Mateo may delegate Utilization Management, Quality Improvement, Credentialing, Member Rights and Responsibilities, Medical Record and Facility Review, Claims payment and Preventive Health activities to Health Plans, County entities, and/or vendors who meet the requirements as defined in a written delegation agreement and delegation policies and according to NCQA accreditation and regulatory standards.

To ensure that delegates meet required performance standards, HPSM:

- Provides oversight to ensure compliance with federal and state regulatory standards, and NCQA standards for accreditation.
- Reviews and approves program documents, evaluations, and policies and procedures relevant to the delegated activities.
- Conducts required pre-delegation activities
- Conducts annual oversight audits
- Review reports from delegated entities
- Collaborates with delegated entities to continuously improve health service quality

The Delegation Oversight Committee oversees the delegate's compliance with delegation agreements/documents. HPSM monitors delegated compliance through an annual oversight review. Review includes appropriate policies and procedures, programs, reports and files may be reviewed at this time. Should an improvement action plan be required of the delegate, HPSM will review and approve the plan and perform follow-up tracking of compliance in accordance with stated time frames. If the delegated activities are not being carried out in accordance with the terms of the delegation agreement and/or improvement action plan, corrective action (up to and including revocation of delegated status) may be implemented.

Delegated oversight review results are reported to the QIP committees as appropriate and to the QIC.

ANNUAL REVIEW AND UPDATE of QUALITY IMPROVEMENT PROGRAM

The purpose of the annual QIP evaluation by the QIC is to determine if quality improvement processes and recommendations made throughout the year result in demonstrated quality improvements in health care, disease prevention and the delivery of health care services to members.

The annual evaluation assesses whether the QIP activities are systematically tracking improvement projects, resulting in improved clinical care and services, and providing appropriate follow-up of corrective actions to monitor their effectiveness. The QIC is responsible for assessing reports, analyzing study and survey findings, and identifying areas of care, which demonstrate improvement and other areas, which may still require interventions. Once a determination is made, the program plan is evaluated to see if certain processes require modification. A final report, including QIP program recommendations is submitted to the Commission for annual approval. The following aspects of the Quality Department activities are assessed during the annual plan evaluation:

- Ongoing surveillance of quality indicators for the year
- Quality improvement projects (goals and objectives) for the year
- Tracking of previously identified issues requiring continued surveillance
- Quality improvement review of the QIP and outcome results from the previous year
- Evaluation and modification, if necessary, of the QIP for the upcoming year
- Implementation of the quality improvement strategy
- Promotion of the development of an effective quality improvement program based on quality improvement strategies
- Completion of the work plan in a timely basis
- Determination if additional resources are necessary to accomplish the quality improvement strategy, and
- Recommendations for needed changes in the quality improvement program or administration

Practitioners and members are notified annually that a summary of the QIP is available upon request. This summary included information about the QIP's goals, processes, and outcomes are they relate to member care and service.

ANNUAL QUALITY IMPROVEMENT WORK PLAN

Annually the QI department develops a QI Work Plan for the calendar year. The Work Plan integrates QI reporting, studies from all areas of organization (clinical and service) and includes requirements for external reporting. The QI Work Plan is also based on the results of the annual program evaluation.

The Work Plan includes the following elements:

- Measurable objectives for each QI activity planned for the year, including patient safety
- Program scope
- Activities planned for the year, the quality, and safety of clinical care and service indicators, benchmarks, performance goals and previous year results
- Timeframe within which each activity is to be completed.
- The person responsible for initiation, implementation, and management of each activity
- Planned monitoring and follow-up activities from previously identified issues

- Time frame for evaluation of the effectiveness of the QI Program.

Planned Additions to the QI Work Plan include:

- Scheduled reports to the QIC and the Commission
- Scheduled reporting to external regulators (i.e. DHCS)
- The oversight of reporting delegated activities
- Schedules of all planned quality activities (i.e. member satisfaction surveys, practitioner compliance surveys)

APPROVAL OF THE QUALITY IMPROVEMENT PROGRAM

Annually, following each review and update, the Quality Improvement Program description and work plan is reviewed and approved by the Quality Improvement Committee, the Chief Medical Officer and the San Mateo Health Commission. The approval process includes the authorized signatures at each level of review.

2017 Quality Improvement Department Work Plan

LOB	Project	Objectives	Planned Activities	Final Deliverables	Responsible Party	Frequency	Start Date	Finish Date
Members' Experience								
Medi-Cal	Health Education Classes & Resources	All classes and resources provided to our members in a timely manner will be relevant to their identified health education needs and at no cost.	▪ Evaluate health education classes, submit articles to member and provider newsletters (healthy eating, weight loss, exercise, healthy teeth and healthy aging) and compile and distribute a schedule of health education classes relevant to our members. ▪ Update health information sections of HPSM website as needed.	▪ Updated health education class schedule ▪ Completed class observation forms ▪ Articles in member and provider newsletters ▪ Updated web pages.	Karen	Ongoing	Feb. 2017	Nov. 2017
Quality of Clinical Care								
Medi-Cal	Transition MCE Quality Reporting Pilot Project to the Quality Metric Reporting Payment Project for the Clinical Partnership Program.	By April 30, 2018, participating clinics will: 1) meet their improvement targets for their chosen quality metrics; 2) reduce the number of days for 3rd Next Available Appointment for New Patient and Return Visits, and 3) increase the percentage of members seen at their clinic who have been continuously assigned for past 12 months.	▪ Provide reporting template(s) to facilitate clinic documentation of quarterly progress on their chosen quality metrics and measurement of 3NA for new patient and return visit. ▪ Discuss barriers and facilitators to meeting objectives during Partnership Program quarterly meetings. ▪ Collaborate with Deputy CEO and Primary Care Program Coordinator to identify parameters for successful measurement and reporting.	▪ Clinic quarterly reports (Q2 2017 through Q2 2018) on measurement of chosen quality metrics. ▪ HPSM consolidated report on clinic data trend for Clinical Partnership Program Committee. ▪ Minutes from Partnership quarterly meetings	Vicky	Quarterly	April 2017	June 2018
All	Clinical Guidelines on HPSM website	1) Ensure clinical guidelines posted on HPSM website are	▪ Review source website for each posted guideline link, to	▪ Meeting minutes for QIC Q3 will	Vicky	Annually	Sept. 2017	Dec. 2017

LOB	Project	Objectives	Planned Activities	Final Deliverables	Responsible Party	Frequency	Start Date	Finish Date
		current per National Guidelines Clearinghouse, and address common conditions in HPSM membership. 2) Promote awareness and use of guidelines by provider network through provider newsletter article	check for updates and confirm current status. ▪ At Q3 QIC meeting, present list of guidelines by health condition posted on website for Committee review, confirmation of current status, suggested changes, and approval. ▪ Solicit input from QIC members and submit changes to Marketing for updates to website.	document presentation and review of clinical guidelines, Committee discussion, suggested additions, and formal approval of guidelines posted on HPSM website. ▪ Fall Provider Newsletter will include article on Clinical Guidelines				
Medi-Cal	Smoking Cessation	To increase smoking quit rates and utilization of the CA Smoker's Helpline.	▪ Send monthly mailings to smokers to promote CA Smoker's Helpline and annual mailing for quitting in the new year.	▪ 2017 Quality Improvement Evaluation will include number of monthly/end of the year mailings sent out to members.	Karen	Monthly/ Annually	Jan. 2017	Dec. 2017
All	HEDIS 2017 Project Plan	Ensure timely completion of all project deliverables by June 15, 2017.	▪ Create, implement and complete all project deliverables listed in the HEDIS 2017 Project Plan. ▪ Manage HEDIS vendor ▪ Completion of test, production and admin runs. ▪ Completion of 2017 roadmap. Completion of HEDIS production project. Completion & Submission of IDSS. Completion & Submission of PLD files. Completion of chart extraction.	▪ Final submission of HPSM HEDIS data to HSAG auditors and NCQA.	Cindy	Annually		June 2017

LOB	Project	Objectives	Planned Activities	Final Deliverables	Responsible Party	Frequency	Start Date	Finish Date
Medi-Cal	Prenatal and Postpartum	1) By 12/31/2017, improve timely (21-56 day post-delivery) postpartum care from to 64.84% (HEDIS 2016) to 67.53% (Medicaid 75th %tile). 2) By 12/31/2017, improve timely prenatal (within 42 days of enrollment or during the first trimester) care from 79.95% (HEDIS 2016) to 82.25% (Medicaid 50th%tile).	▪ Continue to outreach to identified members due for a postpartum appointment through reminder calls and text messages. ▪ Analyze postpartum outreach efforts and present to Prenatal & Postpartum workgroup. ▪ Work with Provider Services and Informatics to identify HPSM Medi-Cal members with a recent delivery through the weekly delivery report. ▪ Continue to outreach to potentially pregnant members for enrollment into HPSM incentive program. ▪ Work with Provider Services to address access issues in OB Provider network. ▪ Work with PCP offices that offer pregnancy test to send a referral list of members who are pregnant.	▪ PIP module 4 and 5 submission completed by August 30, 2017. ▪ 2017 Annual Quality Improvement Evaluation will include a section on the effectives and usefulness of program in increasing member enrollment into HPSM incentive program.	Leticia	Ongoing		Ongoing
Medi-Cal, D-SNP and CMC	Reducing 30 Day Readmissions	By Dec 31, 2017, improve the rate of 30 day readmissions in the CMC population from HEDIS 2015 13.15% (75th percentile rate) to 8.33% (90th percentile rate).	▪ Continue to evaluate Coleman Coaches effect on readmissions to Seton. ▪ Update dashboard quarterly with data trends. ▪ Continue to evaluate skilled nursing facility SBAR intervention effect on readmissions.	▪ Submit QIPs (2) to CMS - Jan 2018 ▪ Submit Module 4 and 5 to HSAG - August 2017	Ramla	Quarterly	Jan. 2017	July 2017
CMC	Controlling Blood Pressure	1) By Dec 31, 2017, increase the rate of controlled blood	▪ Expand pilot programs to other clinics.	▪ Dashboard evaluations.	Ramla	Quarterly	Jan. 2017	Dec. 2017

LOB	Project	Objectives	Planned Activities	Final Deliverables	Responsible Party	Frequency	Start Date	Finish Date
		pressure in Medi-Cal members diagnosed with hypertension from HEDIS 2015 68.88% (75th percentile rate) to 70.55% (90th percentile rate). 2) By Dec, 31, 2017, increase the rate of controlled blood pressure in Medicare members diagnosed with hypertension from HEDIS 2015 70.32% (50th percentile rate) to 79.32% (75th percentile rate).	▪ Measure impact of home blood monitoring kits with members who participate in program.	▪ Report results out to various committees throughout 2017.				
Medi-Cal	Improving Cervical Cancer Screening (CCS) rate at Ravenswood Family Health Center (RFHC)	By June 30, 2017, increase the cervical cancer screening compliance rate among women, ages 24 to 64, assigned to Ravenswood, from baseline rate of 69% to 77%.	▪ Implement PDSA cycles that test a new process (safety net intervention) for identifying and reaching out to assigned women that have been previously excluded, or included, in Ravenswood's current Pap recall system, who are overdue for CCS. ▪ Measure how many women are identified through this new process, and how many are either sent a reminder letter or receive a phone call, or are flagged on an upcoming PCP appointment to discuss CCS and relevant barriers. ▪ Collaborate with HPSM Informatics and RFHC data team to collect target population data using administrative and clinic data	▪ HPSM Quality will successfully complete and meet timelines for submitting required Modules 1 through 5 to HSAG.	Vicky	Quarterly	Oct. 2016	Aug. 2017

LOB	Project	Objectives	Planned Activities	Final Deliverables	Responsible Party	Frequency	Start Date	Finish Date
			sources. Data on clinic process measures will also be tracked and collected with support from RFHC data team. Vicky will prepare and submit Modules 1 through 5.					
Medi-Cal	Cervical Cancer Screening Outreach	Increase CCS rate among women, ages 24 to 64, who are continuously enrolled in Medi-Cal from 2016 rate of 54.79% to 63.7 % (75th percentile)	▪ Informatics identifies cohorts of women in target age group who are continuously enrolled and due for CCS. Quality prepares reminder letter. Informatics prepares member mailing lists. Marketing plans and implements Pap reminder letter mailing for cohorts identified quarterly	▪ Quarterly file that identifies the cohorts. ▪ Quarterly reports that show updated CCS status for women identified for the mailing cohorts. ▪ Reminder letter developed and translated into threshold languages.	Vicky	Quarterly	April 2017	Dec. 2017
All	Potential Quality Issue (PQI)	Educate providers about the PQI process.	▪ Continue providing PQI process education to HPSM providers via the Provider Toolkit. ▪ Continue to perform quarterly reports to trend potential quality issues of HPSM providers.	▪ Provide Everest reports to CMO and Quality Manager 10 business days after the end of the quarter.	Richard C.	Quarterly		Ongoing
Medi-Cal	Disease Management	To create and provide health education messages and materials that support the Disease Management program outcomes targeted to a specific group of members.	▪ Develop informational series on diabetes and asthma that include key health education messages that support the Disease Management program outcomes.	▪ Final copy of informational series distributed to members	Karen	Semi-annually	Jan. 2017 March 2017	March 2017 June 2017
Quality of Service								
Medi-Cal	Initial Health Assessment (IHA)	1) By Dec 31, 2017, increase IHA compliance rate from an	▪ Improve validation, audit, marketing and training of IHA.	▪ The 2017 Quality Improvement	Ramla	Quarterly	Jan. 2017	Dec. 2017

LOB	Project	Objectives	Planned Activities	Final Deliverables	Responsible Party	Frequency	Start Date	Finish Date
	Compliance	average of 39% in 2016 to 50% in 2017. 2) Train all providers on initial health assessment requirements and required compliance.	▪ Submit article to Provider and Member Newsletter for annual outreach. ▪ Work with FSR nurses, Provider Services and PCPs to increase rates. ▪ Continue to outreach to identified members. ▪ Evaluate IHA outreach efforts.	Evaluation will include a section about IHA efforts, IHA Dashboard, Curriculum, Sign-in sheets and evaluations from provider trainings.				
All	Nurse Advice Line	1) Convene NAL workgroup to meet in Spring and Fall to review quarterly reports. 2) Participate in RFP process for new NAL vendor selection; select new vendor by December 1, 2017	▪ Obtain quarterly reports on member call data from Informatics. ▪ Review member call volume and analyze trends by provider assignment. ▪ Present analysis to NAL Workgoup and Services Quality Improvement Committee. ▪ Collaborate with Informatics on development of quarterly reports, and with Project Management on RFP process for new vendor selection.	▪ Two NAL reports; one for Spring and one for Fall workgroup meeting. ▪ Meeting minutes for NAL workgroup will be prepared and delivered to meeting participants. ▪ Project Management will confirm selection of new vendor.	Vicky	Biannual for NAL workgroup Monthly for RFP process	Jan. 2017	Dec. 2017
All	HPSM Website Update	Develop more robust Quality Department and Health Information website sections to provide information to all interested parties.	▪ Notify providers of quality measures, upload HEDIS results, upload current improvement plans department is working on, update health information section.	▪ Updated QI sections for the HPSM website	All	Ongoing		Ongoing
All	QI Program Evaluation		▪ Annual QI Program Evaluation	▪ 2017 Annual Quality Improvement Evaluation submit to QIC, Commission and DHCS	Nicole	Annually	Jan 2017	Jan 2018

LOB	Project	Objectives	Planned Activities	Final Deliverables	Responsible Party	Frequency	Start Date	Finish Date
Medi-Cal	Weight Watchers	To reduce obesity in members over 18 years old with a BMI >25.	▪ Continue to collaborate with providers and HPSM departments to offer vouchers to cover the cost of Weight Watchers meetings to adults.	▪ Evaluation report of the effectiveness and usefulness of program in increasing weight loss among adults ages 18+ with a BMI >25	Karen	Annually	Jan. 2017	Dec. 2017
Safety of Clinical Care								
Medi-Cal	Facility Site Review Medical Record Review	To comply with DHCS mandated credentialing reviews for Facility Site Review and Medical Record Reviews required for HPSM Provider network credentialing.	▪ Facility Site Reviews are performed at PCP, Pediatric, and OB/GYNs that perform PCP services, upon initial credentialing before any new member assignments, & triennially thereafter for re-credentialing. ▪ Medical Record Reviews are performed approximately 6 months after the new provider has seen HPSM members to evaluate Coordination/Continuity of Care, Preventive Services and all other sections of the State mandated tool. ▪ Corrective Action Plans (CAPs) are instituted for deficiencies. Intermittent focused and monitoring reviews are performed between cycles to confirm CAP closures and to evaluate potential quality issues of concern.	▪ Facility Site Review and Medical Record Review results are reported biannually; January 31st & July 31st to DHCS. On October 1st of each year, DHCS is notified if there are any changes to HPSM's methodology and/or benchmarks to identify high producing SPD Specialists and Ancillary Service Providers, for the purpose of performing Physical Accessibility Reviews.	Beth	Ongoing with biannual reporting	Jan. 2017	Ongoing
Medi-Cal	Physical	To comply with DHCS mandated	▪ Physical Accessibility Reviews	▪ Results of completed	Gladys	Ongoing		Ongoi

LOB	Project	Objectives	Planned Activities	Final Deliverables	Responsible Party	Frequency	Start Date	Finish Date
CMC	Accessibility Reviews	Physical Accessibility Reviews required for HPSM Provider network credentialing.	(PAR) are performed utilizing State mandated tools Attachments "C", "D", & "E", on all PCPs, Pediatricians, OB/GYN, and SPD benchmarked high producing Specialists and Ancillary Service Providers. This methodology is benchmarked with monthly reports to identify high producing SPD Specialists and Ancillary Service Providers which provide services to Seniors and Persons with Disabilities (SPDs) with 5 visits or more per day per annum.	PAR reviews are provided to Provider Services which post the results in HPSM's Provider Directory, with the identified Access Level and Accessibility Indicators.				ng
Serving a Diverse Membership/Culturally & Linguistically Appropriate Services (CLAS)								
Medi-Cal	Reducing Health Disparities	To evaluate and identify member health needs and risks by reviewing GNA findings and addressing any health education issues identified.	▪ Review and update GNA survey results	▪ GNA Report	Karen	Annually	April 2017	May 2017
All	Health Education Materials	To ensure that all key health education materials meet the criteria in the readability and suitability checklist and are in the four threshold languages.	▪ Review all key health education materials to ensure that they meet the criteria on the readability and suitability checklist and that they are in the four threshold languages.	▪ List of Health education materials in threshold languages and completed Readability and Suitability checklists.	Karen	Annually	June 2017	July/ Aug. 2017
All	CLAS Committee	Operationalize culturally and linguistically appropriate services and promote cultural awareness.	▪ CLAS Committee will meet monthly to plan and implement effective programs and trainings and	▪ CLAS meeting minutes.	Leticia	Monthly	Jan. 2017	Dec. 2017

LOB	Project	Objectives	Planned Activities	Final Deliverables	Responsible Party	Frequency	Start Date	Finish Date
			to review and implement new regulations.					
All	CLAS Work Plan	Document annual plan for internal and external accountability.	▪ Review work plan with CLAS committee and revise if necessary.	▪ 2017 CLAS work plan	Leticia	Review semi-annually	Jan. 2017	Dec. 2017
All	Provider Education	1) Ensure that providers document patient's language in chart. 2) Offer qualified interpreter services to LEP patients, document refusal of interpreter services. 3) Offer vital documents in threshold languages,	▪ FSR Nurse will verify during FSR and report non-compliance to QI Specialist and Provider Services. ▪ QI Specialist will provide training and education as needed.	▪ FSR Reports	Leticia	Monthly	Jan. 2017	Dec. 2017
All	Bilingual Skills Assessment of HPSM Employees	Standardize language proficiency test for written and verbal testing of employees.	▪ Review pre-employment oral and/or written skills exam to bi-lingual staff. ▪ Review bilingual skills testing process.	▪ Assessment test results	Leticia	Ongoing	Feb. 2017	May 2017
All	All staff Cultural Competence Training	Increase staff knowledge and improve individual awareness and communication skills.	▪ Develop goals & objectives for training. ▪ Conduct training and review evaluation of training.	▪ Attendance training sheet and evaluations	Leticia	Monthly	Jan. 2017	Dec. 2017
All	New Employee Orientation for C&L	1. Improve cultural awareness of staff. 2. Educate staff regarding policy and procedures, and services related to improving access and quality of care for members.	▪ Provide CLAS training as part of the orientation of all new hire.	▪ Training outline ▪ Attendance sheets	Leticia	Ongoing	Jan. 2017	Dec. 2017
All	Inform Limited English Proficient (LEP) Members of Free Language Assistance (LA)	Promote LEP member utilization of language assistance services in order to improve member access and quality of care.	▪ Educate members about interpreter services through member newsletter and HPSMs member internet	▪ Interpreter Services Usage Reports	Leticia	Semi-annually	April 15 Oct. 15	April 15 Oct. 15

LOB	Project	Objectives	Planned Activities	Final Deliverables	Responsible Party	Frequency	Start Date	Finish Date
	Services		page.					
All	Analyze Utilization of Interpreter Services	Promote utilization of interpreter services and guide future provider training & education activities in order to improve LEP member access and quality of care.	▪ Review and analyze language utilization and provider language reports. ▪ Educate providers regarding CLAS topics through use of the provider toolkit, orientations, trainings, one-one visits and as needed. ▪ Annual notification to network providers on use of the Health Plan of San Mateo interpreter services.	▪ Language Utilization Reports	Leticia	Monthly	Jan. 2017	Dec. 2017
All	Monitor Grievances	Regularly monitor grievances related to cultural and linguistic services.	▪ Analyze quarterly grievances related to language barriers or service delays related to language. ▪ Quality to provide training & education as needed to providers with a grievance.	▪ Quarterly reports of grievances	Leticia	Quarterly	Jan. 2017	Ongoing
All	Provider Education	Educate providers about high priority QI topics including IHA and the CLAS Program.	▪ Disseminate QI Provider toolkit through provider orientations, trainings, one-one visits and as needed.	▪ Evaluation report of number of providers trained and efficacy of training.	Ramla	Monthly	Jan. 2017	Dec. 2017

AGENDA ITEM: 5.4

DATE: April 12, 2017

No Meeting materials are included for Item 5.4 California Children's Service Demonstration Project

AGENDA ITEM: 5.5

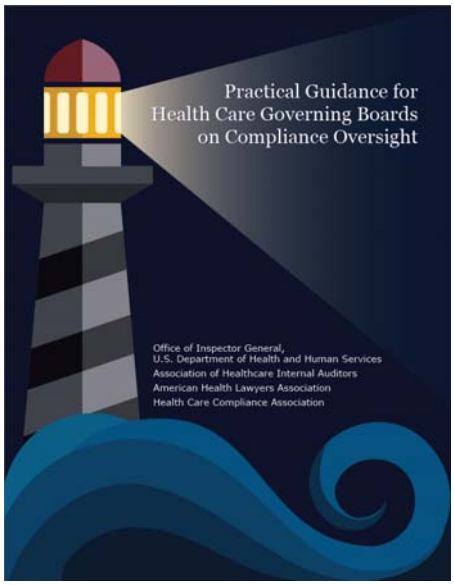
DATE: April 12, 2017

Commission Education Session:

Practical Guidance for Health Care Governing Boards on Compliance Oversight

Prepared by:
Ian Johansson, Chief Compliance Officer
April 12, 2017

Background



- Released in 2015
- Commission training in 2016
  - Focus on:
    - OIG recommendations, guidance and examples
    - HPSM practices, actions and responses
    - Starting a discussion

What was required?

- Act in good faith
- Use benchmarks
- Stay informed
- Receive educational sessions
- Set expectations
- Understand size, scope and adequacy
- Encourage accountability

Approach

- Ramp up (2016)
  - More information, more frequently
  - Providing meaningful updates and data
  - Establish a base of knowledge and understanding
- Continue and improve (2017)
  - Less generic, more real world experience and results

Commission Oversight

- Prior year program performance
- Survey responses from staff
- Compliance and FWA training
- Independent audit results
- External & internal audit performance
- Significant compliance issues
- Risks and outcomes

Commission Oversight

- 2016
  - 9 presentations to Commission & Finance/Executive Committee
- 2017
  - 4 presentations to date
  - Still to come: Annual training, external and internal audit results, and ad hoc reports

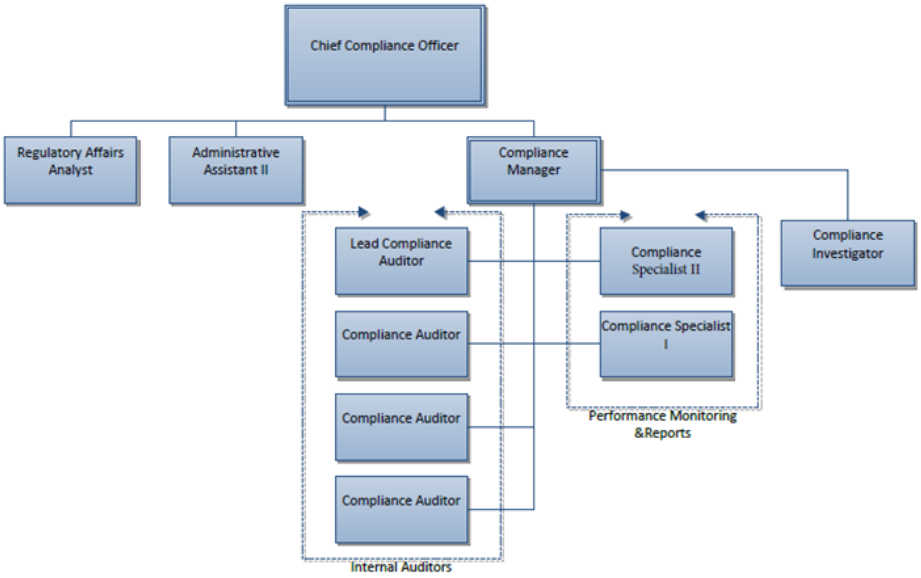
Benchmarks and Resources

- Use established tools to determine performance
  - e.g. audit specifications from the Centers for Medicare and Medicaid Services (CMS)
- Maintain data integrity
  - Obtain data from sources and systems, not people
- Consult subject matter experts (“SMEs”)
  - Consultants available to staff

Size and Scope

- Risk assessment guides the process
  - Evaluates:
    - Audit performance
    - Survey results
    - Reported issues
    - New requirements, laws, and regulations
    - Risk factors from the government
    - Input from stakeholders
- Risks in turn determine resource needs
- Benchmark: ability to respond to and mitigate risks

Size and Scope



Staying Informed

- Do you feel comfortable with what you know?
  - Ask questions
  - Ask for data, examples
  - Ask for regular reports on risks and outcomes
  - Ask about infrastructure
- Make informed decisions that benefit HPSM members and fulfill our mission

Read the document

- Distributed by email ahead of presentation
- Contact the Chief Compliance Officer or CEO with questions or concerns

Commission Information Session:

2016 Compliance Program Effectiveness Survey Results

2016 Survey Process

- Measures staff view of compliance program
- CMS requirement
- 2016 calendar year
- Factored into risk assessment and compliance/audit work plans
- Conducted February 10, 2017 – March 3, 2017
- Results shared March 6th and March 8th

Goals from 2015

- Improve participation
  - 25% increase (50% → 75%)
- Get more information
  - Follow up questions added
- Educate staff on non-intimidation and non-retaliation
  - Working with HR on conducing joint training in 2017

2016 Survey Results

Calendar Year:	2016	2015	2014
Participation Rate:	75%	50%	62%

Questions	Score		
Familiar with the Compliance Program	99%	95%	99%
Know where to view the Code of Conduct	98%	92%	96%
Know where to locate P&Ps	97%	95%	99%
Know P&P related to job function	98%	97%	98%
Know the Compliance Officer	100%	100%	95%
Know where the CO office is	95%	93%	89%
Feel comfortable reporting to the CO	95%	92%	96%
Feel comfortable reporting to Supervisor	97%	96%	98%
Observed non-compliant behavior	14%	17%	12%
Observed behavior and didn't report	5%	4%	4%
Knows about non-retaliation policy	92%	--	--
Fear of retaliation would prevent reporting	21%	34%	29%
Confident issues will be handled timely	97%	93%	93%
Confident issues will be handled confidentially	98%	94%	93%

Next Steps

- Create action plan based on results
  - Share results with all HPSM staff
  - Increase participation in 2018
  - Conduct plan-wide training on non-intimidation and non-retaliation

Questions?

- Email: ian.johansson@hpsm.org
- Call: 650-616-2151
- Office: 3rd floor, west side

MEMORANDUM

AGENDA ITEM: 7.0

DATE: April 12, 2017

DATE: April 4, 2017

TO: San Mateo Health Commission

FROM: Maya Altman, Chief Executive Officer

RE: CEO Update

Affordable Care Act

As everyone is aware, the *American Health Care Act*, which – if enacted – would have dramatically changed both Medicaid and the health insurance marketplaces, never reached a vote in the House of Representatives. So, for now, the Affordable Care Act still stands as the law of the land.

This was a huge win for patients and the health plans they rely on for health coverage; however, this is hardly the end of the road. The Administration is sure to use its executive authority to continue to reshape publicly-supported health coverage programs. And Congress could very well revisit health care in the future. We are hearing of revived discussions this week between the White House and members of the Freedom Caucus as well as with more moderate Republicans. It is too early to tell if these talks will lead anywhere. In the meantime, I do not expect to see significant changes to the Medi-Cal program in the Governor's May Revise beyond what he has already proposed for the IHSS program and the Coordinated Care Initiative. That is a big relief.

State Budget

I'm afraid I do not have any additional information to report regarding progress toward mitigating the Governor's $626 million shift to counties for IHSS costs and the removal of IHSS from the Coordinated Care Initiative (CCI). Counties continue to advocate hard against this move; threatened legal action brought the Governor and the Department of Finance to the negotiating table but there have been no reports yet of significant progress. The State Assembly has proposed a loan to counties to soften the financial impact. However, this proposal has not yet gained support from the State Senate or the Administration, at least as of this writing.
I've attached an article that appeared recently in the San Mateo Daily Journal and that featured Ligia Andrade-Zuniga, a member of the Commission. She eloquently describes the potential impact of IHSS cutbacks and the loss of CCI's close coordination with IHSS on people in her situation.

Autism Benefit Update

Earlier this year, HPSM began transitioning administration of the Plan's autism benefit from Behavioral Health and Recovery Services to Magellan Health Services. The Commission approved an agreement with Magellan late last year. I'm pleased to report that the transition has gone smoothly.

All members currently receiving services have now been transitioned, without any disruption in services. For Behavioral Health Therapy (BHT) providers, there is still some adaptation to changes in referral and authorization processes; however, Magellan has been responsive and clear, and providers are adapting.

Magellan has created a dashboard for metrics specified in the contract with HPSM, as well as for the Plan's regulatory reporting to the Department of Health Care Services and the Department of Managed Health Care. With the end of the first quarter last week, Magellan has begun populating the dashboard with first quarter data. Also starting this quarter, we will hold Consumer Engagement Committee and Provider Engagement Committee meetings, to solicit feedback on the autism program from members and providers.

A big thank you and kudos to Hanh Pham, who directs our California Children's Services (CCS) Demonstration, and David Ries, HPSM's Provider Network Relations Manager, for leading this successful transition.

THE DAILY JOURNAL
The Peninsula's homepage

Health concerns over state budget: Governor's proposal includes cuts to Health System's Coordinated Care Initiative

March 21, 2017, 05:00 AM By Samantha Weigel Daily Journal

Samantha Weigel/Daily Journal
Ligia Andrade-Zuniga, who became a quadriplegic after a car accident when she was 28, receives support from the county Health System's Coordinated Care Initiative at her San Mateo home.

For 36-year-old Ligia Andrade-Zuniga, California's upcoming budget could have life and death consequence.

While all eyes are on Washington, D.C., as lawmakers debate federal health care reform, local San Mateo County providers and beneficiaries are pointing to potential consequences of Gov. Jerry Brown's spending proposal for the coming fiscal year.

Andrade-Zuniga, a San Mateo woman who in 2009 became a quadriplegic following a car accident, said the county Health System's Coordinated Care Initiative has changed her life. But now, the state is considering canceling the pilot program through which seven counties have expanded in-home support services for high-risk patients who might otherwise end up in a nursing home.

"It could be a matter of life and death; really, if I don't have enough care and if there's nobody there to help advocate for me," she said.

A mother of two, Andrade-Zuniga said the benefits of being enrolled in the program have been immense. She more quickly received a new motorized wheelchair, what she calls her "legs;" and twice daily she receives in-home visits. Along with the additional emotional support, Andrade-Zuniga said participating in the pilot has unquestionably changed her life for the better.

"I can do more for myself than I could before; that program is great. Now, with it being in jeopardy, it's devastating," she said.

Earlier this year, the governor proposed eliminating funding for the pilot program, which San Mateo County initiated almost three years ago as a way to provide quicker and more coordinated care for disabled adults. Brown's proposal is an effort to help balance projected state deficits, but it could have life-changing effects on clients who receive enhanced services through the health care program.

Although San Mateo County stands to lose $6.9 million from the state due to the cut, because the pilot is matched with federal and local funds, the county's entire $28 million program is at risk, said Louise Rogers, chief of San Mateo County's Health System. Rogers said the state budget reductions along with threats to the Affordable Care Act are one-two punch against efforts to support those in need.

Direct impact

More will be fleshed out in the governor's budget during the May revise but, in the meantime, Rogers predicted the loss of the coordinated care initiative could have direct impacts on local residents.

The program "links the in-home care with the medical planning that has to go on and we're really concerned that the governor's proposal will eliminate that collaboration and have it take longer for people to get the care they need," she said.

Although the entire $101 million in-home support services program isn't going away, losing coordinated care would result in cutbacks to services for clients who might be on the brink of being unable to remain in their homes. And there's evidence of the initiative's success. Since the county began the pilot three years ago, 140 people have been able to remain at home, Rogers said, noting that opens up resources for others.

"There's a shortage of skilled nursing beds in the Bay Area and it's really critical the beds that are available be used for people that really need that care, and that people who can remain in their homes can do that," Rogers explained.

Additionally, when faced with the pressures of the real estate market, seniors and the disabled are acutely at risk of being priced out after a temporary stay at a nursing home, she said.

"Housing is a huge crisis in the Bay Area and, once someone loses their home, whether they own it or whether they rent it, it's very hard to get it back again, certainly very hard at the same price," Rogers said.

Reducing nursing home stays

The coordinated care initiative has also helped reduce the number of days people were in skilled nursing facilities by 33 percent, allowing them to spend more time in their own homes, said Lisa Mancini, director of the Health System's Aging and Adult Services.

Through in-home support services, "we keep people in their homes on average eight years longer than if they hadn't received our services," Mancini said.

With about 5,000 county residents receiving in-home support services, the initiative focuses in on about 300 clients at a time whose needs are complex, but who are able to remain at home with the right care, Mancini said.

With California's senior population expected to double to 12 million by 2060, Rogers said it's critical "to think about what are the systems of care that allow people to remain in their homes. Because there's no way there will ever be enough [skilled nursing] beds."

Andrade-Zuniga, who was raised in Redwood City before her spinal cord was severed in a car accident when she was 28, couldn't have imagined needing the level of care on which she's now dependent.

Reliant on disability insurance, she said trying to get back into the rental market after being in a nursing home would likely dry up her financial resources. Then there's the emotional toll that goes along with being bed-ridden — which she was for three months — or in a nursing facility.

“I’ve been in a nursing home and maybe even though I’d have my physical needs met, emotionally you deteriorate and your spirit dies,” she said.

Eight years after her accident, Andrade-Zuniga hasn’t been able to return to her old job working for the county’s juvenile probation department. Instead, she’s thrown herself into an array of community-oriented positions serving on multiple advisory committees including for the county’s Commission on Disability, and as treasurer for the Center for Independence of Individuals with Disabilities.

Not only living a life in which she relies on in-home support services, but working with others in need, she hopes recognition of the overarching benefits behind the coordinated care initiative will curb cuts to state funding.

“It’s just more involved care for people that need more care. I’m pretty good at navigating the system, but I can’t imagine for people that can’t advocate for themselves,” she said. “If we don’t advocate, people will die, people won’t get what they need, and it’s not right.”