THIRD AMENDMENT TO MEMORANDUM OF AGREEMENT

BETWEEN THE COUNTY OF SAN MATEO AND THE HEALTH PLAN OF SAN MATEO

THIS THIRD AMENDMENT TO THE AGREEMENT between the COUNTY OF SAN MATEO, hereinafter called "County," and **SAN MATEO HEALTH COMMISSION** dba **HEALTH PLAN OF SAN MATEO," hereinafter called "HPSM";**

W I T N E S S E T H:

WHEREAS, pursuant to Government Code, Section 31000, County may contract with independent contractors for the furnishing of such services to or for County or any Department thereof;

WHEREAS, the parties entered into a Memorandum of Agreement (MOA) for Whole Person Care (WPC) services on June 6, 2017 (Resolution 075225, CMS Contract ID3521);

WHEREAS, the parties amended the MOA on March 6, 2018 (CMS Contract ID 3765) to add the scope of work inadvertently labeled as Section One, to add the WPC Care Coordination Policy and Approach inadvertently labeled as Section Two, and to add WPC and Measure K Payment Plan inadvertently labeled as Section Three;

WHEREAS, the parties amended the MOA on December 10, 2019 (Resolution #077133) to amend the scope of work inadvertently labeled as Section One, to add required reports inadvertently labeled as Section Two, and to amend the payment plan inadvertently labeled as Section Three; and

WHEREAS, the parties now wish to amend the MOA to extend the term through June 30, 2022, clarify the deadlines for required reports in section 3(b), add Section 2(f) to increase the fiscal obligation by $5,992,990 from $24,340,463 to $30,333,453, amend the scope of work now properly labeling it as Exhibit A, amend the payment plan to include recuperative care services properly labeling it as Exhibit B, include WPC and Measure K Payment Plan in Exhibit B, and properly label the WPC Care Coordination policy and approach as Exhibit C.

NOW, THEREFORE, IT IS HEREBY AGREED BY THE PARTIES HERETO AS FOLLOWS:

1. Section One (1) of the MOA is amended to read as follows:

   Term of Agreement: The term of this Agreement shall begin on January 1, 2017 and shall end on June 30, 2022, unless sooner terminated pursuant to the terms of this Agreement.

2. Section 2(f) is incorporated into the MOA to read as follows:

Funding for calendar year 2021 (Program Year 6) shall not exceed five million, nine hundred and ninety-two thousand, nine hundred and ninety dollars ($5,992,990) and is subject to the availability of funding.

3. Section 3 (b) is incorporated into the MOA to read as follows:

The HPSM will provide to the WPC Administrative Hub a semi-annual narrative report of achievements, challenges, lessons learned from program activities and process improvement projects using the Plan Study Do Act (PSDAs) methodology in a format provided.

	Mid-Year Report	**Annual Report**
Due to WPC Hub	07/15	02/15
Due to DHCS	60 calendar days after June 30 of each year	90 calendar days after end of program year
	08/31/2019 and ongoing	04/1/2020 and ongoing

Pay for outcome and pay for reporting data will be submitted in the required format on a quarterly basis by the 20th of the month following the previous quarter.

4. A revised scope of work is attached to the MOA as Exhibit A.

5. A revised WPC/Measure K Payment Plan is attached to the MOA as Exhibit B

6. The WPC Care Coordination Policy and Approach is attached as Exhibit C.

7. **All other terms and conditions of the agreement dated June 6, 2017 (Resolution 075225, CMS Contract ID3521) as amended on March 6, 2018 (CMS Contract ID 3765), and December 10, 2019 (Resolution #077133) between the County and HPSM shall remain in full force and effect.**

In witness of and in agreement with this Agreement's terms, the parties, by their duly authorized representatives, affix their respective signatures:

For SAN MATEO HEALTH COMMISSION DBA HEALTH OF SAN MATEO:

Contractor Signature	February 9, 2021 Date	MAYA ALTMAN

COUNTY OF SAN MATEO

By:

President, Board of Supervisors, San Mateo County

Date:

ATTEST:

By:

Clerk of Said Board

EXHIBIT A

1. Revised Scope of Work – Whole Person Care, November 24, 2020

This scope of work covers services provided from January 1 to December 31, 2021

Categories of Responsibilities	County of San Mateo Health System (County)	Medi-Cal Managed Care Plan (HPSM)
A. Administrative	1. Collaborate on data sharing, collection and analysis to support program goals, including: a. Accurate and timely submission to State of project enrollment and outcome data files 2. Reporting to HPSM a. State communications b. Project requirements c. Outcome data results d. Project level financial projections and actuals	1. Collaborate on data sharing, collection and analysis to support program goals 2. Reporting to County a. Claims and financial reporting as necessary b. Measure K housing and financial reports 3. Participate in appropriate WPC administrative meetings a. Planning meetings and workgroups b. Housing related coordination meetings c. Care coordination planning and operations
B. Care Coordination	1. Coordination of Care a. Provide points of contact at administrative and operational levels for all WPC programs b. Communicate referrals in a timely fashion	1. Coordination of Care a. Provide points of contact at administrative and operational levels for matters related to WPC clients b. Communicate information about WPC client

Categories of Responsibilities	County of San Mateo Health System (County)	Medi-Cal Managed Care Plan (HPSM)
	c. with all necessary supporting documentation d. Participate in interdisciplinary meetings, as needed 2. Access to Care a. Inform HPSM of any deficiencies in care access across provider systems, including BHRS and medical services b. Coordinate with HPSM on alternative methods for accessing care if availability is limited for urgent cases	c. cases in a timely and complete fashion d. Participate in interdisciplinary meetings, as necessary 2. Access to Care a. Ensure WPC client access to HPSM network provider services b. Coordinate with County on identifying gaps in services or care that funding or incremental services could alleviate

Categories of Responsibilities	County of San Mateo Health System (County)	Medi-Cal Managed Care Plan (HPSM)
C. Community Care Settings Pilot	1. Ensure timely payment of WPC match funding to HPSM a. Including at least $3,000,000 in annual funds through CY 2021 b. Additional pay-for-outcomes and pay-for-reporting funding as available 2. Support the CCSP collaborative care planning and case review process a. Participation in twice monthly Core Group meetings by agency or case management entities, e.g. IMAT, Public Guardian, BHRS, IHSS, CCT, when connected to CCSP cases 3. Collaborate on WPC-specific criteria for referrals by WPC program teams into CCSP for connection to services	1. Maintain CCSP funding support and programming at least at the level necessary to draw down entirety of WPC match funding, e.g. the following activities: a. Intensive transitional care management and service coordination b. Non Medi-Cal billable services and supports necessary to safely enable community living c. Housing services and supports d. Multidisciplinary Core Group case review e. Management and oversight of program contractors 2. Expand CCSP program consistent with the goals of WPC a. Collaborate on criteria and processes for referrals by WPC program teams into CCSP for connection to services b. Introduce new referral pipelines, e.g. supporting hospital discharges, that are well suited to the WPC eligible population

Categories of Responsibilities	County of San Mateo Health System (County)	Medi-Cal Managed Care Plan (HPSM)
		3. Regularly monitor WPC Pay for Outcome and Pay for Reporting metrics relating to CCSP and ensure timely submission of reports to the WPC Administrative Hub. (a) Institute of Aging (IOA) will submit a quarterly report on the WPC pay for outcome metrics relating to CCSP to the WPC Administrative Hub including but not limited to: • Number and percentage of clients transitioning to community living; • The average number of days to transition a client; • The proportion of clients still in the community at six months within the measurement year; • The proportion of clients still in the community at 12 months. (b) IOA will provide a quarterly enrollment and care plan report (CLP) in the required format to the WPC Administrative Hub for running the Pay for reporting metrics.

D. Housing Services – Measure K Funding	1. Ensure timely and complete payment of $2,000,000 in annual Measure K funds to HPSM through at least CY2021 2. Ensure that all referrals for Measure K housing services are connected to a case management program that can perform primary oversight of individual care needs to deliver stability in a community setting 3. If, for any reason, Measure K funding is discontinued for these purposes, develop and implement a contingency strategy to continue housing supports or transition placed individuals to alternative settings	1. Develop and execute contract with primary housing services provider 2. Perform oversight of housing contractor 3. Execute contractual agreements with contractor(s) to ensure delivery of services featured in this agreement 4. Convey necessary payments to contractors on a timely basis 5. Ensure quality of services performed by contractors connected to WPC Pilot 6. Perform financial oversight of contracts and report on expenditures to County 7. Provide regulatory oversight 8. Ensure contractors are appropriately coordinating with WPC Pilot programs and staff 9. Engage contractor to deliver housing services and supports for up to 35 cases at a time, including: a. Participant housing assessments b. Housing search and acquisition c. Subsidy payments to support participant housing needs, as appropriate d. Landlord relationship management e. Habitability checks and modifications, as

		appropriate f. On-call support for participant incidents and other urgent matters g. Regular housing related check-ins with participants to support longevity of residency h. Support transitions into and out of placements i. Project support staffing and overhead 10. Develop incremental housing programs and resources to meet WPC client needs a. Leverage resources, e.g. waiver programs, where possible, to support WPC client's residential needs b. Administer Measure K savings for housing location services (including 1 follow-up retention visit) for a select number of individuals who have been awarded Mainstream Vouchers through both the WPC Housing Committee and through BHRS/Housing authority c. Continue to engage and oversee a Contractor to provide Recuperative Care Services to Whole Person Care (WPC) clients who are homeless and in need of recuperation following a hospital stay. d. Ensure quality of services performed by recuperative care contractors connected to WPC Pilot. e. Develop sustainability plan for recuperative care services

Exhibit B: Revised Whole Person Care CCSP/Measure K Payment Plan, November 24, 2020

Program Year	Payment No.	Description	WPC	Measure K	Total Planned Payment	DHCS payment date if applicable	HPSM Payment due date
2016 (PY1)	**1**	FY16-17		**$1,000,000.00**	$1,000,000.00		6/30/2017
	2	Jan-Dec 2016	**$3,000,000.00**		$3,000,000.00		6/30/2017
		CY Total			**$4,000,000.00**		
2017 (PY 2)	**3**	Jan-June 2017	$1,000,000.00		$1,000,000.00		6/30/2017
	4	FY17-18		**$2,000,000.00**	$2,000,000.00		6/30/2018
	5	July-Dec 2017	$2,000,000.00		$2,000,000.00	Scheduled Payment by DHCS 05/18	6/30/2018
		CY Total	**$3,000,000.00**		**$5,000,000.00**		
	6	FY 18-19		**$2,000,000.00**	$2,000,000.00		6/30/2019
	7	Jan-Dec 2018	**$3,000,000.00**		$3,000,000.00	Scheduled Payment by DHCS 05/19	6/30/2019
		CY Total			**$5,000,000.00**		
	8	FY19-20		**$2,000,000.00**	$2,000,000.00		6/30/2020
	9	Jan2019-June 2020	**$3,340,463.00**		$3,340,463.00	Scheduled Payment by DHCS 05/20	6/30/2020
		CY Total			**$5,340,463.00**		

Program Year	Payment No.	Description	WPC	Measure K	Total Planned Payment	DHCS payment date if applicable	HPSM Payment due date
2020 (PY5)	**10**	FY 20-21		**$2,000,000.00**	$2,000,000.00		6/30/2021
	11	Jan-Dec 2020	**$3,000,000.00**		$3,000,000.00	Scheduled Payment by DHCS 05/21	6/30/2021
2021 (PY6)	**12**	FY 20-21		**$2,000,000.00**	$2,000,000.00		6/30/2022
	13	Jan-Dec 2021	**$3,992,989.80**		$3,992,989.00	Scheduled Payment by DHCS 05/22	6/30/2022
		CY Total			**$5,992,989.80**		
TOTAL			**$19,333,452.80**	**$11,000,000.00**	**$30,333,452.80.**		

EXHIBIT C

San Mateo County Health System, Whole Person Care, Care Coordination Policy and Approach

As part of our commitment to fulfill the goals of the Whole Person Care Pilot, this Memorandum of Understanding seeks to clarify our understanding of Care Coordination both within and outside of the Health System. For purposes of the Whole Person Care Pilot, Care Coordination has been defined to meet the needs of our target populations and is related to non-Medi-Cal billable services. This policy is in no way meant to restrict other Care Coordination activities appropriate for Medi-Cal billing or otherwise. We acknowledge that Coordinated Care assists us to ensure that we are maximizing our ability to improve health outcomes for the individuals utilizing our services. We also recognize that Care Coordination occurs at both the individual client level as well as at the cohort or population level. The following examples provide a guideline for how we will provide Care Coordination and report client utilization of this service.

1. Individual Level Care Coordination
Occurs when a practitioner acts with or on behalf of a Whole Person Care client to:
   a. Assist the individual to access care or service within and/or outside of the Health System
   b. Assist the client to receive the appropriate service/care within and/or outside of the Health system
   c. Facilitate access to the comprehensive care plan by all care team members consistent with HIPAA, 42 CFR and other federal and state privacy regulations.
   d. Promote the value of providing service consistent with the care plan and client wishes
   e. Provide appropriate referrals and follow-up to referrals
   f. Assist the client to receive and access eligible benefits

2. Cohort/Population based Care Coordination
Occurs when two or more practitioners, analysts, supervisors and/or managers act on behalf of a cohort and/or the entire population of Whole Person Care clients to:
   a. Analyze data that identifies specific characteristics of the population that then informs practice and allows for policy decisions
   b. Discuss the implications of data for both the population and the individual clients within the cohort to inform practice and policy
   c. Evaluate existing system structures that may support coordination needs of the cohort
   d. Identify gaps within the system that must be addressed to support care coordination

e. Problem-solve solutions to ensure effective care coordination
f. Establish access, referral and service pathways
g. Determine resource allocation based upon service needs
h. Establish pathways for ensuring benefits eligibility and on-going coverage
i. Provide quality improvement analysis