Health Plan of San Mateo
Cal MediConnect Advisory Committee
Meeting Minutes
Friday, April 20, 2018 – 11:30 a.m.
Health Plan of San Mateo
801 Gateway Blvd., Boardroom
South San Francisco, CA 94080

Committee Members Present: Gay Kaplan, Teresa Guingona Ferrer, Sharolyn Kriger, Susy Castoria, Lisa Mancini, Angie Pratt, and Nancy Keegan.

Committee Members Absent: Ligia Andrade Zuniga, Janet Hogan, Danilyn Nguyen, Sasha Martinez, Pete Williams, Christina Kahn, and Diane Prosser.

Staff Present: Pat Curran, Gabrielle Ault-Riche, and Melora Simon.

Guests Present: Beverly Karnatz

1. Call to Order

The meeting was called to order at 11:37 a.m. by Gay Kaplan.

2. Public Comment

Angie Pratt announced that on Sunday, April 22nd at 7:00pm, 60 Minutes will air a special feature with Dr. Jon LaPook about a couple he has followed for the past 10 years and the effects Alzheimer's has had on their lives. The wife has Alzheimer's and the husband has been providing her care. This feature shows interviews with the couple over the past ten years, the progression of her illness, and the affect this disease has had on the patient and her family.

Ms. Pratt also announced there will be an Updates on Dementia Conference on May 10th, from 8am – 4:15pm, at the South San Francisco Conference Center with about 800 attendees expected.

There was no additional public comment at this time.

3. Approval of Minutes

The minutes for the January 19, 2018 meeting were approved as presented. **M/S/P.**

4. Ombuds Report

Due to the absence of Legal Aid participants, no Ombuds report was given at this meeting.

5. Grievances and Appeals Report

Gabrielle Ault-Riche reported on the 4th quarter of 2017 which is attached:

- Appeals have remained steady between Q3 and Q4
- Grievances started the year high which is typical for the first quarter and leveled out throughout the year.

- Grievances by category have also remained consistent. Customer Service is the category with the highest number of grievances; Quality of Care is up a little and is an area being watched.
- Taxi grievances continue to be category with the highest number of grievances by sub-category. Ms. Ault-Riche explained the "Communication – Other Issues with Staff" category is mostly due to grievances against provider office staff not HPSM staff.
- The breakdown of the types of appeals received continues to be consistent with previous quarters. DME was up slightly in the 4th quarter but not a concern. The number of appeals for Other Service/Therapy is mostly due to denials of non-contracted provider claims for services which could be offered in network.
- Overturned appeals has consistently been going down which is a good indication that initial information needed for approvals are being provided or staff is doing a better job of getting information needed.
- Pat Curran talked about balanced billing issues noting most are due to non-contracted providers billing members or sending notices that look like bills. Provider Services consistently works to address these issues with providers.
- The number of grievances resolved Within 24 Hours of Receipt remained flat for the year.
- Rate of Complaints per 1,000 members is higher in the CMC line of business is generally expected since these members have more needs and interact with the health care system more frequently compared to Medi-Cal. The rate of complaints has gone done throughout the year. Ms. Simon added that compared to other CMC plans HPSM has a low rate of complaints.
- The target of 95% for Timeliness of Complaint of Resolution had been met through Q1 through Q3 but fell slightly below in Q4 on grievances and medical appeals. Pharmacy appeals exceeded the target.
- PCP changes are tracked quarterly (report reflects all lines of business). Only two providers had five or more members request a change: one clinic; and, one individual physician (which is more of a concern and being reviewed by Provider Services).

A question was asked if Home Health Agency grievances are tracked. Ms. Ault-Riche answered they are but there have been no trends around Home Health or specific providers. Mr. Curran added that while we continue to add providers, the complaints are usually related to access.

6. Updates and Discussion

a. CMC Dashboard

Ms. Simon reviewed the attached presentation covering the recent data related to the CMC program:

- IHSS is showing a slight decrease in Q4 but is not being seen in the overall numbers.
- CBAS continues to be flat probably due to the wait list at Senior Focus.
- MSSP was down in all of 2017 due to staffing issues that are starting to turn around.
- Use of Long Term Care Nursing Facilities shows a rise in the first quarter of 2017 due to the addition of people with developmental disabilities but declined throughout the year due to the Community Care Settings Program moving people back into the community.

- Transitions of Care data continues to show strong performance well above the California state benchmark.
- 81% of CMC members have had a follow up visit with a clinician within 30 days of hospital discharge.
- Call volume was up in Q4 and over 90% of calls were answered within 30 seconds. It was noted that in June there was high call volume but a decrease in the percentage of calls answered in 30 seconds, which was due to staffing issues and possibly the number of working days in the month.
- Timely HRA Completion has improved mainly due to Independent Living Systems, who is now conducting the initial HRA and care planning and resulting in a higher completion rate and a lower "unwilling to participate" and "unable to be locate" rate. In Q4, the proportion of members completing care plans fell and is continuing to fall in Q1 of 2018. Staff is working on turning this around.
- Ms. Simon reviewed the quality withhold measures noting the data shows strong performance.
    - Plan all-cause readmissions – CMS has changed the way this is calculated. We met the benchmark in 2016.
    - Annual flu vaccine continues to do well
    - Data for follow-up visits after a mental health admission is only available for 2016, but CMC did well
    - Reducing the Risk of Falling has been suspended as a quality measure.
    - Controlling Blood Pressure data is only available for 2016 but CMC is doing well.
    - Encounter data showing how frequently and timely we are submitting claims data to CMS and DHCS. We have exceeded this measure, as it is a strength for HPSM.
    - The remainder of the measures CAW6 – CAW9 are California specific measures and data indicate there is room for improvement:
        1. ER Use for serious mental illness and substance use disorder data is based on 2015 performance. 2016 and 2017 show a decline in performance but in 2018 we are moving in the right direction.
        2. Percentage of Members with a Care Coordinator and Care Team contact improved in 2017 but is falling in 2018 and being watched by staff.
        3. Performance has been very low in the Members with at least one documented discussion of care goals in the ICP category. Staff is working on doing a better job of capturing those conversations.
        4. Joint care planning between the health plan, mental health provider and PCP for those with mental illness was only a measure for 2017 and relied on staff getting data on specialty mental health. This service is carved out of CMC. HPSM and BHRS are now meeting monthly to work on this issue with care planning sessions.

      Ms. Simon stated that based on internal analysis HPSM will have passed six of the measures earning about 75% of the 2016 withhold.

- 2018 Medical Loss Ratio Dashboard indicates positive results. This year the overall budget is broken out into quarters:
    - Enrollment is still below target. We are seeing more new enrollments and continued success in the deeming process.
    - Risk Adjustment process is in line in terms of budget.
    - Acute Inpatient Utilization is below budget.
    - SNF costs are also on budget and below budgeted utilization.
    - Other Medical Costs is below budget. Landmark is above budget but they are having success in engaging new members.
    - Pharmacy costs are below budget.

  Overall the financial picture is positive but the report is an early picture of the year due to claims lag, which is projected using IBNR (Incurred by not reported) analysis.

  Ms. Simon said the state publicly reported some inaccuracies on measures for all the plans a few months ago. Advocates are communicating to the state they should measure the success in nursing home transitions or hospitalization instead of process measures. HPSM staff is using this to have conversation with the state about how we can bring out more outcome measures and the success of the program.

  Ms. Simon reviewed the Other Program updates:
    - HomeAdvantage has 1,273 members engaged in care
    - Community Care Settings Program transitioned over 200 members
    - Wider Circle Program is expanding
    - Post-Acute Care Pilot will soon begin. Landmark will provide higher level touch care in certain facilities beyond the CMC members to help avoid readmissions and provide transition services
    - Staff is looking into more ways of working with the resident services coordinators to be extenders of the health plan.

b. IHSS Update:

Ms. Mancini reported the IHSS referral count has stayed flat, averaging about 180 referrals a month. The case load count of 4,878 on the report only accounts for the IHSS cases handled by IHSS social workers. Adding MSSP, CCI group and linkages program brings the total case load to 5,097 and this has been the case for a few months. AAS staff compares how many years clients are able to remain in their home with the help of IHSS vs. without and results indicate people are getting to stay in their homes 6.4 years longer. She feels this is reflective of the average case load count increasing at a higher rate than the referrals.

IHSS social workers have a very high case load of about 250 cases per social worker, which makes it very challenging to do case management. The state requires an annual visit to no less than 90% of clients. AAS staff has exceeded that over the last six years. They may not reach that this year due to staff turnover. Staff is focusing on how to structure their workload to find clients for whom an annual visit may be sufficient and see if they can focus on more intensive case management needed to help people remain in their home.

Some discussion ensued around the difficulties case workers have and how difficult their jobs are. Ms. Mancini stated that an initial visit includes 29 forms to be completed by the client. Ms. Kaplan noted that the referral form to justify the need for IHSS in San Francisco is eight pages. Other challenges discussed were the difficulty finding home care workers to match the clients and geographic challenges. Another issue discussed was housing costs and the difficulty for workers to find affordable housing. An idea discussed was having integrated IHSS for IHSS recipients within a facility. However, this approach does not work based on the state regulations that assess hours per client.

c. Other State/CMS Updates

Mr. Curran reported that the health plan is working in collaboration with the California Dental Association on legislation to include permissive language to allow a pilot in San Mateo County for integrating medical and dental care (Medi-Cal and Denti-Cal) through the health plan. Once legislation is passed, staff and the community can determine if it makes sense operationally and financially. The hope is this legislation will pass in the next few months.

Mr. Curran thanked the group participating in the strategic planning conversation. The consultant has worked with committees, commissioners, providers and other stakeholders, and produced a summary of the feedback received. Next, the work begins with HPSM management to get additional staff input. He said we are still in the information gathering stage and invited members of the committee to let him know if they had anything to add.

Ms. Krieger stated that she would like to see the transition of people out of nursing homes into lower levels of care go faster. Ms. Simon stated that the numbers of people transitioning out has slowed down in the past few months due to the capacity of lower level of care. Much of the capacity has been used in the county and there aren't any new RCFE beds at the Assisted Living Waiver rates. There is private capacity but at a very high rate. Another challenge is finding care givers.

7. Adjournment

The meeting adjourned at 12:45 p.m.

Next meeting: July 20, 2018

Respectfully submitted:

C. Burgess

C. Burgess
Clerk of the Commission

Cal MediConnect Advisory Committee – Grievance & Appeals Report

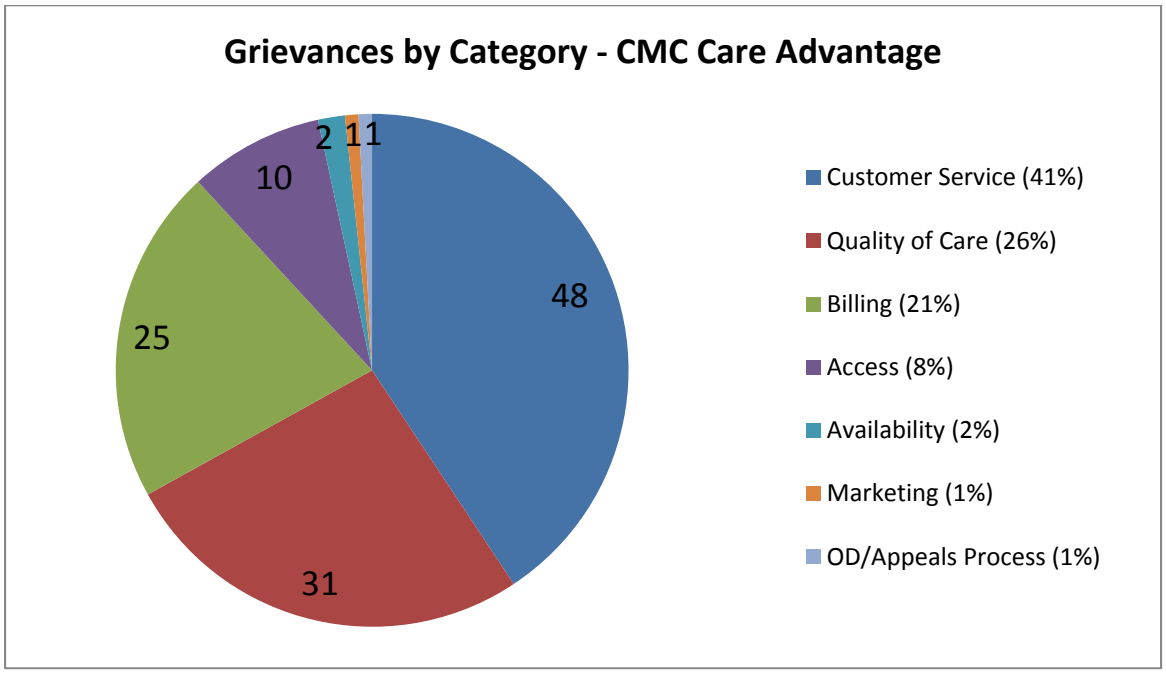
Reporting Period: Q4 2017 (October – December 2017)

I. CareAdvantage Cal MediConnect (CMC)

1. Number of Appeals and Grievances (Complaints) Received

LINE OF BUSINESS			Q1	Q2	Q3	Q4	TOTAL
CareAdvantage CMC							
Appeals	**Part C (Medical)**	**Expedited**	5	4	3	3	15
		Standard	43	56	64	53	216
	Part D (Drugs)	**Expedited**	2	7	6	4	19
		Standard	16	12	10	4	42
	Total Appeals		**66**	**79**	**83**	**64**	**292**
Grievances	**Part C**	**Expedited Grievance**	1	0	0	0	1
		Standard Grievance	152	93	107	112	464
	Part D (Drugs)	**Expedited Grievance**	0	0	0	0	0
		Standard Grievance	5	6	6	6	23
	Total Grievances		**158**	**99**	**113**	**118**	**488**
		CareAdvantage CMC Subtotal	**224**	**178**	**196**	**182**	**780**

2. Types of Grievances Received, by Category

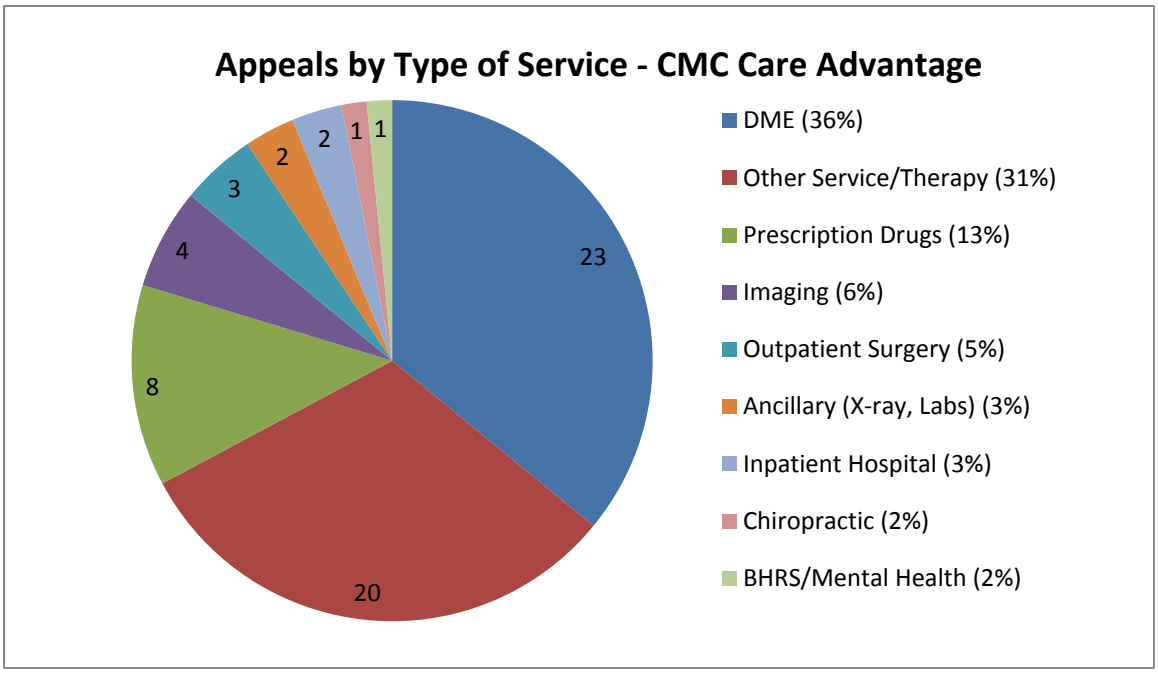


3. Type of Grievances Received, by Sub-Category

Category	Sub-Category	# Received
Access	Location too far	1
	Network - Ancillary (Lab, Radiology, PT/OT)	1
	No TAR or Prescription on File	4
	Provider Not Dispensing Drug	1
	Provider Not Dispensing Item	2
	Other	1
Access Total		**10**
Availability	Excessive Wait Time for Appointment	1
	Other	1
Availability Total		**2**
Billing	Balance Bill Not in Collections	3
	Balance Bill in Collections	15
	Full Bill Direct to Member	5
	Other	2
Billing Total		**25**
Customer Service	Communication - Disrespect/Rudeness/Discrimination	1
	Communication - Incorrect Info Given to Member	2
	Communication - Other Issue with Staff	17
	Taxi - Driver no-show	6
	Taxi - Driver rude/disrespectful	1
	Taxi - Incorrect Info Given	2
	Taxi - Late pick-up/ drop off	9
	Taxi – Other	8
	Time - Long wait time during appt.	1
	Time - Other	1
Customer Service Total		**48**
Marketing	Other	1
Marketing Total		**1**
OD/Appeals Process	Appeals Process Incorrect	1
OD/Appeals Process Total		**1**
Quality of Care	Facility – Dirty/Disorganized Office	1
	Referral – Provider did not refer	1
	Relationship - Provider Not Listening to Concerns	2
	Relationship - Provider is Rude/Mean/Etc.	5
	Treatment - Drug not Prescribed	2
	Treatment - Incorrect Prescription	1
	Treatment - Poor Diagnosis	1
	Treatment - Poor Treatment	13
	Treatment – Services not Rendered	3
	Other	2
Quality of Care Total		**31**

Total		**118**

4. Types of Appeals Received



5. Rate of Overturned Appeals

The table below includes appeal resolutions and the percentage of appeals that result in an overturned denial decision (i.e. an approved medical service/item or prescription drug).

Type of Denial	Total Appeals	Upheld in Full	Upheld in Part	Overturned	Withdrawn or Dismissed	% Overturned on Appeal
Part C- Medical Services/Supplies	56	33	1	12	10	21%
Part D - Prescription Drugs	8	2	0	4	2	50%

II. 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	8	17	18	15	58
	Prescription Drugs	75	51	36	39	201
CareAdvantage DSNP	Medical Services/Supplies	0	0	0	0	0
	Prescription Drugs	0	0	0	0	0
Medi-Cal	Medical Services/Supplies	16	16	18	24	74
	Prescription Drugs	145	161	63	83	452
Other LOBs (CCS, HW, HK, ACE)	Medical Services/Supplies	3	1	1	6	11
	Prescription Drugs	4	23	12	8	47
Total About Medical Services/ Supplies		**27**	**34**	**37**	**45**	**143**
Total About Prescription Drugs		**224**	**235**	**111**	**130**	**700**
TOTAL		**251**	**269**	**148**	**175**	**843**

24 – Hour Resolutions, by Category and Subcategory:

Category	Subcategory	# Received
Access	Code 1 Override	3
	Location too far	1
	Network - PCP	1
	Network - Specialist	2
	No MRF or Rx on File	5
	No TAR or Prescription on File	10
	OHC	20
	Provider Not Dispensing Drug	66
	Provider Not Dispensing Item	5
	Other	37
Access Total		150
Availability	Excessive Wait Time for Apt	2
	Other	3
	Unable to Schedule Appointment	2
Availability Total		7
Billing	Full Bill Direct to Member	3
	Other	4
Billing Total		7
Customer Service	Communication - Incorrect Info Given to Mbr	2
	Communication - Other Issue with Staff	2
	Taxi - Incorrect Info Given	1
	Taxi – Other	2
Customer Service Total		7
Enrollment/Disenrollment	Delay in Enrollment Process	1
	Issue with Eligibility	3
Enrollment/Disenrollment Total		4
Total 24-Hour Grievances		**175**

III. 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	23.6	19.0	21.1	19.7
CareAdvantage D-SNP	-	-	-	-
Medi-Cal Only (Excluding CCS)	2.6	3.0	2.7	2.9
Healthy Kids	3.7	3.3	6.6	5.5
HealthWorx	5.7	10.4	7.6	11.4
ACE	0.4	0.6	1.2	0.8
CCS	6.1	4.3	6.2	6.9
TOTAL	**3.7**	**3.7**	**3.7**	**3.8**

The rate of complaints per 1,000 members is based on the average enrollment numbers for Q4, 2017.

Line of Business	Average Enrollment for Q4
CareAdvantage CMC	9,221
CareAdvantage DSNP	--
Medi-Cal Only (excluding CCS)	110,636
Healthy Kids	1,450
HealthWorx	1,056
ACE	21,655
CCS	1,587
Total	**145,605**

IV. Timeliness of Complaint Resolution

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. This table excludes cases resolved within 24 hours of receipt.

Type of Complaint	Number Received (all LOBs)	# Resolved Timely	% Resolved Timely
Grievances	351	326	93%
Medical Appeals	149	137	92%
Pharmacy Appeals	50	48	96%

V. Primary Care Provider (PCP) Changes by Provider

Reason for PCP Change	Number of Changes in Q4 2017
Difficulty In Obtaining An Appt.	24
Poor Service	27
Provider And Patient Incompatible	9
Provider's Attitude/Atmosphere	3
Total	**63**

Across all lines of business, a total of 63 members requested to change their assigned PCP during Quarter 4 due to dissatisfaction. Members switched away from a total of 29 different PCPs. Of those, 14 were clinics and 15 were individual providers. For 2 providers, 5 or more Members requested to switch away from their practice. One was a clinic and the other one was an individual physician.

CMC Key Performance Indicators

CMC Advisory Committee

April 20, 2018

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Today's discussion

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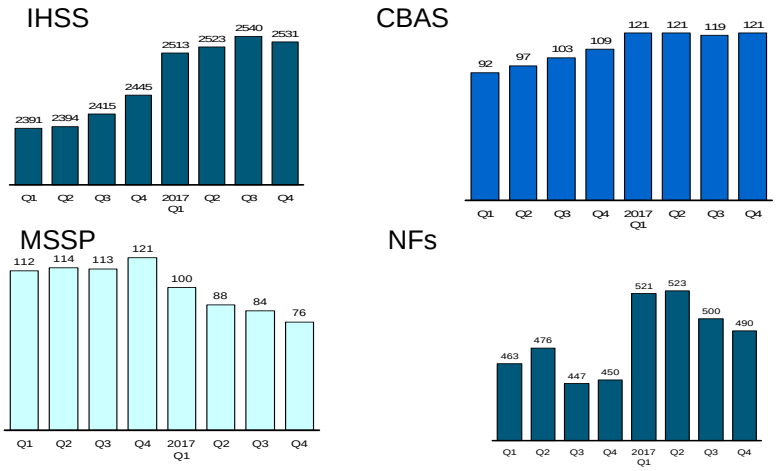
Contents

- Quarterly performance review
- Other Updates

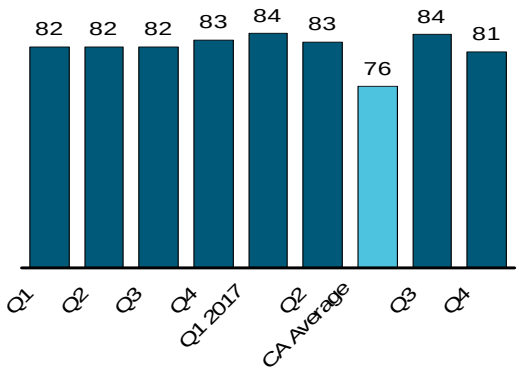
Utilization of LTSS among CMC enrollees

Number of unique members using services



- IHSS down slightly in Q4
- CBAS flat
- MSSP was down in 2017 due to short-staffing
- Rise in LTC in Q1 2017 due to transition of the developmentally disabled into CMC, but numbers declined over the year

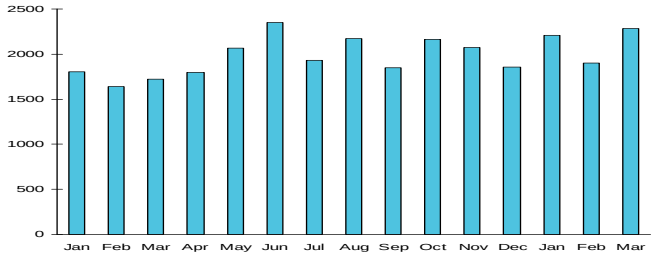
Transitions of Care: 81% of our members have an ambulatory care follow-up visit within 30 days of discharge



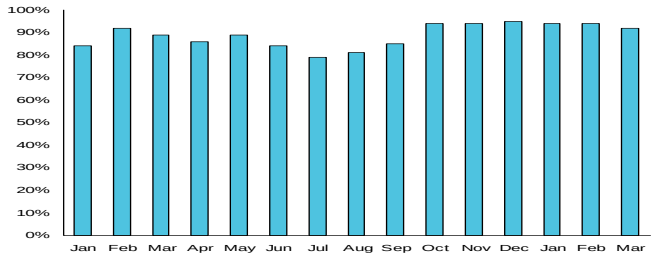
Source: CA 1.11 – Ambulatory f/u after discharge; CA Average from Q2 2017.

Call Center: Performance was strong in Q1 despite high call volume

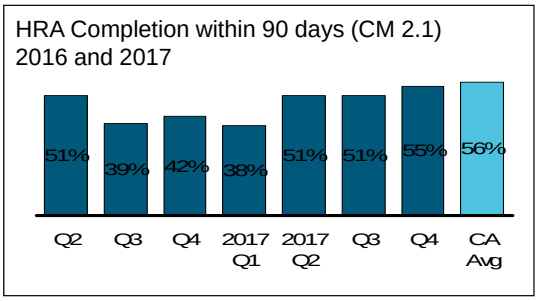
Call volume

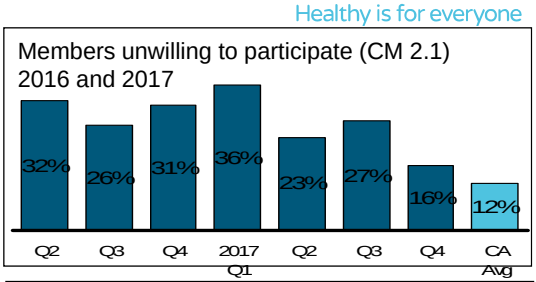


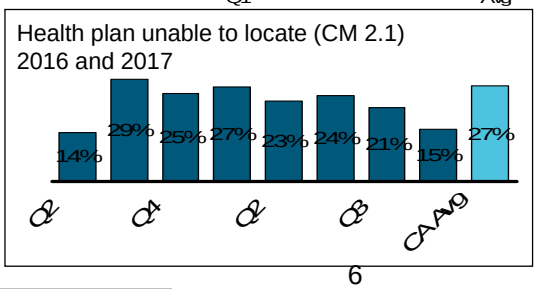
% answered within 30 seconds



Timely HRA Completion: Our new vendor for HRAs has improved our completion rate and reduced both our unwilling to participate and our unable to locate rates

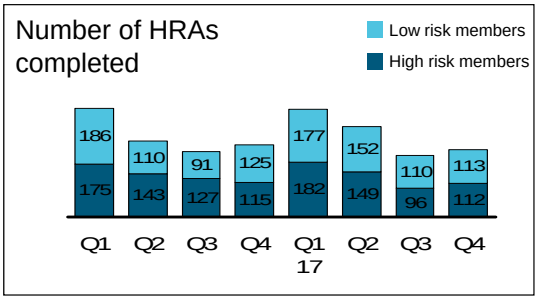


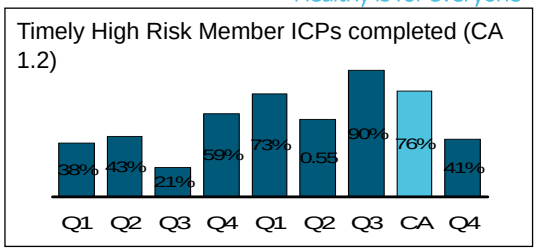


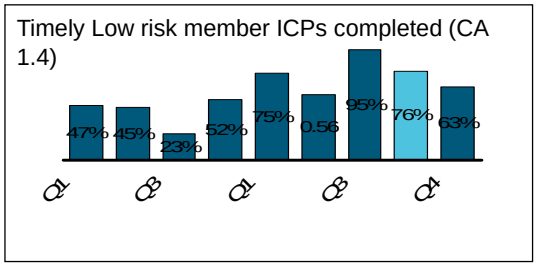


Source:Core Measure 2.1; CA Average from NORC using Q4 2017 data.

Timely ICP Completion fell in Q4 due to implementation challenges with the new vendor, which have persisted through Q1







Source: CA 1.2 and CA 1.4; CA Average from NORC

Performance on Quality Withhold Measures is strong

Updated 4/18/2018

Indicator	Threshold	2016 Performance	2017 Performance	2018 Performance
CW6 – Plan all-cause readmissions	1.00	0.8127	Pending HEDIS	Too early to calculate
CW7 – Annual flu vaccine	69%	73% (2016)	77% (2017)	Part of CAHPS (September)
CW8 – Follow-up after hospitalization for mental illness – 30 day	56%	64.84% (2016)	Pending HEDIS	Too early to calculate
CW10 – Reducing the risk of falling (will be excluded from 2016 onward)	55%	77% (2016)	Suspended	
CW11 – Controlling blood pressure	56%	64.37% (2016)	Pending HEDIS	Medical record based, no interim reporting
CW12 – Medication adherence for diabetes medications	73%	84% (2016)	85% (2017)	Too soon to tell
CW13 – Encounter Data – monthly	80%	92% submitted within 180 days for Medicare (2016)	91% submitted within 180 days for Medicare 2017	91.42% submitted as of March 2018
CAW 7 - Reduction in emergency room use for seriously mentally ill and substance use disorder enrollees	83.6 per 1000 member months (10% less than 2015 baseline)	89.6 per 1000 member months (2016)	90.68 per 1000 overall for 2017	86.3 rolling 12 months as of April 2018
CAW 9 - Percentage of members who have a care coordinator and at least one care team contact (CA 1.12)	2016/2017: 78% 2018: 83% 2019: 88%	76.9% (2016)	86% for 2017	73.7% as of 4/1
CAW 8 - Number of members with at least one documented discussion of care goals in the individualized care plan (CA 1.6)	2016/2017: 55% 2018: 60% 2019: 65%	16% (2016) (May be opportunity to restate the denominator)	32%	
CAW6 – Mental Health ICP with Primary Mental Health Provider (CA 1.7)	Highest scoring state plan minus 10 points	Measure suspended for 2014, 2015, and 2016	33%	N/A: Only applies to 2017
Overall Performance		**Passed 6 of 9 measures = 67% which translates to earning back 75% of Quality Withhold**		

2018 MLR dashboard: Early data shows positive performance across all metrics

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UPDATED 4/18/2018

Category	Proposed Indicator	Budget	Q1 Budget	Most Recent Performance	Notes
Revenue	Enrollment	9,233	9,233	9,099 as of 4/1/2018 YTD Average 9,116	Membership losses flattening out. • 73 new enrollments from March report • 42/72 regained from deeming as of 4/1
Revenue	Initial RAF based on RAPS (2018 Payment Year)	1.35	1.35 (Initial rather than Q1)	1.352 as of 3/9 1.361 as of 2/21	Based on estimate of initial. Only includes RAPS. 1.342 last year February. Blend projected at 1.342 based on -4.6% difference from Milliman report.
Medical cost	Acute Inpatient PMPM	$397	$408	$402 as of 3/31 $425 as of 2/28	Admits per 1000 at 280 (down from 309 in March, Q1 target of 290). Average paid per admission at $17,271 (up from $15,451 in March, target of $16,861)
Medical cost	SNF PMPM	$78	$90	$90 as of 3/31 $81 as of 2/28	Days per 1000 at 1,751 (up from 1,639 last month, target of 1800) and paid per day at $618 (up from $596 last month, target of $602 per day)
Medical cost	Physician, OP, and Other PMPM Landmark Home Advantage	$579	$508 $47	$474 $62	HomeAdvantage Enrollment is higher than planned (1200 members)
Medical cost	Pharmacy PMPM	$492	$492	$480 as of 3/31 $487 as of 2/28	Cost per scrip at $117 and utilization at 4.09 Rx PMPM Generic Dispensing rate = 83%
Offsets	Pharmacy rebates PMPM	$62	$62	$53.10 for Q3 2017 as of March wire. $60.40 for 2Q 2017 as of March wire; $59.84 for 1Q 2017 as of March wire	Lagging indicator

Other program updates

HealthPlan OF SAN MATEO
Healthy is for everyone

- HomeAdvantage engagement at 1,273 (last year 329)
- Community Care Settings Program has transitioned more than 200 members since inception (last year at 146)
- Expanding Wider Circle from a 50 member pilot to a broader program
- Rolling out a Post-Acute Care Pilot, providing higher touch care in 6 high-volume skilled nursing and LTC facilities

- Burlingame Long-Term Care
- Millbrae Skilled Care
- Peninsula Post-Acute
- Providence San Bruno
- St. Francis Convalescent Pavilion
- St. Francis Heights Convalescent Hospital

Thank You