Health Plan of San Mateo
Cal MediConnect Advisory Committee
Meeting Minutes
Friday, January 19, 2018 – 11:30 a.m.
Health Plan of San Mateo
801 Gateway Blvd., Boardroom
South San Francisco, CA 94080

Committee Members Present: Gay Kaplan, Sharolyn Kriger, Ligia Andrade Zuniga, Lisa Mancini, Janet Hogan, Angie Pratt, Nancy Keegan, Sasha Martinez, and Christina Kahn.

Committee Members Absent: Susy Castoria, Teresa Guingona Ferrer, Danilyn Nguyen, Pete Williams and Diane Prosser.

Staff Present: Leilani Llorente-San Gabriel, Maya Altman, Pat Curran, Gabrielle Ault-Riche, Luarnie Bermudo, Carolina Gutierrez, Mike Smigielski, and Melora Simon.

Guests Present: Mr. Kunal Sethy, Landmark Health.

1. Call to Order
The meeting was called to order at 11:30 a.m. by Gay Kaplan.

2. Public Comment
There was no public comment at this time.

3. Approval of Minutes
The minutes for the November 17, 2017 meeting were approved as presented. **M/S/P.**

4. Ombuds Report
Sasha Martinez from Legal Aid reported:

- When people are being discharged from acute nursing facilities, they are having trouble getting their coordinated care they need to help transition them to assisting living facilities or getting IHSS set up. These people have difficulty managing this themselves and are experiencing difficulty getting a social worker or someone involved in helping get set up.
- County workers are not aware of spousal impoverishment rules, especially updates to spousal impoverishment that happen when the ACA came into effect (the ability to apply for spousal impoverishment and IHO waiver).
- Delays in people getting Aid pending which creates a problem when in enrolled in HPSM or Kaiser. Kaiser has been disenrolling them and then when the Aid pending is turned back on they are then enrolled in HPSM instead of being re-enrolled into Kaiser.
- Share of Cost issues – if they have SOC and apply for IHSS they are told they cannot be evaluated for IHSS unless they eliminate the SOC first. They should be able to be evaluated even if they have the SOC.

A question came up about the "Aid pending". Ms. Martinez explained that when people are being terminated from Medi-Cal and they file a hearing request before the end of the

month, the member should be able to have their aid continue pending the date of the hearing. This is supposed to be put in effect as soon as possible but when there are low staffing times they are delays that causes a lag and possibly the trigger to disenroll. Ms. Altman asked who makes that change in the system. Ms. Martinez explained the process that includes the state who contacts the county to turn this on. Ms. Altman asked Ms. Martinez to check with the health plan to look into this issue for this client.

Ms. Mancini asked about which county department was unaware of the spousal impoverishment rules. Ms. Martinez stated it was with HSA.

Ms. Kriger asked about the nursing home transition issue if the people are back in the community and not feeling they have the support they need? Ms. Martinez answered they are being transitioned back into the community but still need further care such as IHSS and they don't know how to go about that. Ms. Altman asked if they are HPSM members and Ms. Martinez said she would look into it and follow up on that.

5. Grievances and Appeals Report

Gabrielle Ault-Riche reported on the 4rd quarter of 2017:

- Part C Appeals are up steadily throughout the year which is consistent with other lines of business.
- Part D Appeals have remained stable.
- Grievances started out the year with a lot of grievances which is normal. The Q3 numbers are higher than typical.
- Types of grievances are consistent with past quarters with the majority in Customer Service which tend to be taxi.
- She pointed out the data in the report that breaks down of numbers within the types of grievances and appeals received both being typical.
- She noted that the chart showing 29% of the types of appeals being Other Service/Therapy are actually non-contracted providers which makes sense that these services get denied and then appealed.
- The rate of overturned appeals is down which a good indication that staff is doing a good job of getting the information needed to make the right decision upon submission.
- The resolutions with 24 hours are usually up at the begging of the year. The total number has gone down with a small increase in Medical Services and a significant decrease in the Prescription Drug category.
- Rate of complaints per 1,000 member is consistent for the CMC program.
- Timeliness of complaint resolution is still within goal of 95%. This means members are getting resolution to complaints timely.
- PCP changes (4) requested by members were all within group practices or clinics which is not meaningful as opposed to individual PCP practices.

6. Updates and Discussion

a. HomeAdvantage Update

Mr. Sethey reported:

- Described Landmark's history of its operation noting its first home visit was in 2014; launched in our area in 2016; and, now covers over 61,000 members across 17 markets in 7 states.
- In the Bay Area the cohort is about 2500 eligible members with five or more chronic conditions; approximately 1100 members engaged; intensive care coordination with multiple agencies. Also seeing non-medical needs such as housing and care giving shortage resulting in intensive care coordination with community based partners.
- Described the clinical approach and the interdisciplinary team as an at risk medical provider group with a large array of staff members who support the physicians in the field making house calls; social workers; pharmacist; behavioral health specialists; dieticians; nurse care managers; care coordinators who are medical assistants all utilizing through a centralized call center.
- 24/7 triage capability which is a key benefit for the community partners and members.
- Dedicated behavioral health teams focusing on social determinates of health
- Operate as a company with an approach of improving the member experience.
- Focus on end of life planning, advanced directives and having those appropriate conversations in a culturally appropriate way.
- Work closely with HPSM Member Services, Case Managers, etc. and participate in weekly case conferences and have begun to pull in some of the community based partners
- Conducting co-visits with IHSS and Landmark social workers, which has proven to effective.
- Key milestones: 1070 engaged members, 43% engagement rate; 55% of high-risk referrals from the plan have been engaged; surpassed targets for the quality of care for all six contractual HEDIS measures likely translating into 5-star levels; recaptured 90% of outstanding HCC diagnosis codes; near fully staffed and ready for future growth in 2018; established collaborative relationships with key community partners.
- Goals for 2018: launch post-acute and long-term care program in six SNFs by mid-March to reduce readmissions and average length of stay; projecting a $11.9 million savings over three years; launch a palliative care program in line with SB1004; and, continue to take on more non-risk referrals (very high acuity that are approved by the plan) and create a more formalized work flow around that; more focus on reducing unnecessary inpatient utilization; more localized outreach; more warm transitions to and from community based partners; greater operational excellence through operational standardization.

Leilani Llorente-San Gabriel, HPSM Care Coordination Unit Manager, works with the team of nurse case managers and care coordination technicians at the health plan. Related to Landmark, Ms. Llorente-San Gabriel reported the following:

- Landmark performs home-visits and have been the eyes and ears to the plan's care coordination team and nurses because they are able to provide information that we otherwise would not get over the phone and through documents from providers.

- HPSM and Landmark have ad hoc calls and meetings to review and discuss cases. In addition we hold weekly meetings to review complex cases and make decisions on how to best help the members with Landmark's support. The HPSM Program Manager, Carolina Gutierrez, also is in constant contact Landmark regarding operational issues.
- Care Transition teams are assigned to key hospitals. These are non-clinical staff stationed in San Mateo Medical Center, Stanford, Seton and Mills-Peninsula, advocating for our members that are admitted and actively engage Landmark for members once they identify them as eligible.
- The Landmark and HPSM leadership meet bi-monthly reviewing operational issues.
- Ms. Llorente-San Gabriel shared two member stories that highlight some the benefits to HPSM members, positive outcomes and quality of life improvements that are taking place through this program.

The question was asked about which SNF facilities in San Mateo County are working with Landmark. Mr. Sethy answered, the two St. Francis facilities, Millbrae, Peninsula Post-Acute, San Bruno Skilled Nursing Facility and Burlingame LTC.

Ms. Kriger asked if the 105 IDT contacts in one of the shared member stories is typical. Mr. Sethy stated they are working against certain benchmarks and guidelines, they do have their own clinical reference and protocols that the clinical leadership trains staff but it is what is most appropriate on a case by case basis so often times they exceed those targets for certain members and they have an acuity stratification system that allows them to operationalize and scale this so their A Acuity level patients are most intense and have the most needs medically but more and more they are learning more medically as well. So they are thinking about having a separate acuity stratification system for behavioral health needs and then it is A-B-C-D, D being the lowest acuity members. Often what they see with the higher acuity members it is a small percentage of the market then they try to optimize elsewhere. There are other members who may not need as frequent touches. They are constantly focusing on how to do high value visits and make the most of the 45 minutes in the visit that they can. They are working on operational ways to work that such as breaking out the visit into two segments so that they aren't rushed through the process. They have broken this out into an initial 45-60 minute visit and two weeks later have a follow up visit for 45 minutes. They are trying to take as thoughtful as possible approach. The goal is to avoid institutionalization if reasonable or possible.

b. CMC Dashboard:

Ms. Simon reviewed the MLR Dashboard:

- Utilization of LTSS among CMC for Q3: IHSS is up a little; CBAS relatively flat; MSSP was down due to short staffing; LTC in nursing facilities it jumped up in Q1 due to the transition of the developmentally disabled who were in the D-SNP and has gone down in Q3 due to the work in deinstitutionalization and transitions.
- Regarding transitions of care: HPSM is at 83% in getting its members back into ambulatory care within 30 days of discharge from an inpatient admission. This is

better than the California average. This is attributed to the work of the Care Coordination team getting our members connected back to care.

- The Call Center performance shows an improvement in performance in the last quarter of the year.
- The Timely HRA Completion that happens when members come on the program continues to be about half which is a little below the California average but has remained consistent. We have experienced a higher than average number of members unwilling to participate. This may be due to the DD members that came from the D-SNP and are challenging to engage. Since then a new vendor has begun in October in the HRAs and will have an update soon hoping for improvement.
- The Individualized Care Plan (ICPs) saw some improvement from the previous year.
- The quality withhold measures are the equivalent to the Medicare Stars measures for the CMC line of business. There is a delay in getting the performance data but we anticipate 75% withhold revenue coming back. It is still too early to tell for 2017 but know that we have surpassed the measure in a number of areas.
- The MLR dashboard indicates that the November performance is similar to what has been seen all year where enrollment revenue is down and inpatient and SNF cost continue to be higher than budget. However, we are seeing improvement in the risk adjustment coding documentation work, our medical costs and non-acute and inpatient facilities as well as in pharmacy.

c. IHSS Update

Ms. Janet Hogan reported for IHSS:

- Just around 5,000 members in IHSS
- Slow but steady increase in the number people receiving IHSS services
- Taking in approximately 160 referrals a month
- Greatest challenge is the staffing issues, down 5 social workers at this time. they are actively interviewing and hiring as quickly as possible.
- With that, the case loads are at about 240 per social worker.

The Public Authority has just completed the transition for the HomeBridge clients coming over to the registry. At the end of this three month process, there are 88% of the clients being served by registry providers. There only 15 left not being served by the registry, many of those have mental health issues and they continue to work with the community partners in stabilizing those cases.

Ms. Simon thanked Ms. Hogan and her team for the smooth transition work. Ms. Hogan added that the work that the agencies performed worked well together and it all benefited the clients.

d. Proposal to move to quarterly meetings

Ms. Kaplan stated that originally the group decided to meet every other month but now that the program has been up and running for some time that the need to meet could be better served moving to a quarterly frequency to be in line with the reporting.

The group decided this was a good approach and the meeting months will be January, April, July and October. Corinne will work on the dates and logistics for the future meeting dates.

e. Other State/CMS Updates

Ms. Altman reported that the health plan held a 30th anniversary celebration on December 4th which was well attended by commissioners, former commissioners and staff as well as community partners. Ms. Kaplan congratulated the plan for 30 years and was glad to attend.

At the last meeting, Ms. Simon talked about a proposal from all the plans that are in the Coordinated Care Initiative and Duals Demonstration Program in California. This proposal to the state would attempt to align the incentives better for helping us continue this work to move people out of institutions and prevent them from going into long term care. One stumbling block our supportive placements where we have to provide ongoing support have been in the assisted living because there are not enough affordable housing units. Assisted living has been one of our better alternatives and is a lower level of care than nursing home care. The plan pays out for this ongoing stay and this is not sustainable. Other plans are now contracting with Institute on Aging and Brilliant Corners to do the same kind of program while other plans have not embarked on this approach and will not do it because large plans will lose a lot of money if it does work out. In January, in a meeting with the state, Ms. Altman felt they were not very receptive but more work looking at other states and what they are doing will be ongoing. She noted a concern is that quality among plans is uneven. Justice on Aging is supporting our proposal for our long term care collaborative made up of a number of agencies around the state.

7. Adjournment

The meeting adjourned at 12:35 p.m.

Next meeting: To be Announced

Respectfully submitted:

C. Burgess

C. Burgess
Clerk of the Commission