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

Committee Members Present: Sasha Martinez, Ligia Andrade Zuniga, Janet Hogan, Gay Kaplan, Teresa Guingona Ferrer, Beverly Karnatz, Angie Pratt, and Kirsten Irgens-Moller.

Committee Members Absent: Lisa Mancini, Nancy Keegan, Sharolyn Kriger, Danilyn Nguyen, Pete Williams, Christina Kahn, and Diane Prosser.

Staff Present: Pat Curran, Gabrielle Ault-Riche, and Maya Altman, Dr. Susan Huang, Katie-Elyse Turner, and Luarnie Bermudo.

1. Call to Order

The meeting was called to order at 11:35 a.m. by Gay Kaplan. Ms. Altman introduced Dr. Susan Huang the new Chief Medical Officer for HPSM.

2. Public Comment

There was no additional public comment at this time.

3. Approval of Minutes

The minutes for the April 20, 2018 meeting were approved as presented. **M/S/P.**

4. Ombuds Report

Sasha Martinez reported that Legal Aid has been receiving calls from referrals for issues they are unable to help with. She talked about some of the issues they can and cannot help with:

- Legal Aid cannot assist with estate planning including wills, trusts, power of attorney; advance health care directives; or any issues that are tied to employment law issues, such as worker's compensation, and they cannot assist with appeals regarding quality and placement in long term care facilities.
- Legal Aid will help with evaluating share of cost for possible elimination or reduction for a member; service denials and terminations from Medi-Cal or Covered California; and, some assistance with medical billings.

Ms. Zuniga asked what happens to calls where Legal Aid is not able to help. Ms. Martinez indicated that they are referred out to the appropriate agency. Ms. Ault-Riche noted Legal Aid can also help to some degree with conservatorship issues. Ms. Martinez confirmed that if the person is eligible, there are attorneys who do help with some of those issues. Ms. Altman added that Legal Aid does a lot of work with the elderly. HPSM also has contracts with Legal Aid to assist in specific areas. She added that the conservatorship program was started to

assist CCS families whose children were reaching adult age. Ms. Altman suggested that Legal Aid present information about the services they provide to HPSM members at a future meeting.

5. Grievances and Appeals Report

Gabrielle Ault-Riche reported on the first quarter of 2018:

- Grievances were up in the first quarter which is typical for the beginning of the year. Appeals remain stable from the previous quarter.
- The pie chart related to grievances by category is consistent with previous quarters. The Quality of Care category was up a little in the last quarter of 2017 but is now down to its previous level.
- Appeals by type of service remains consistent with past quarters with 1/3 of appeals related to prescription drugs, and another approximate 1/3 related to DME.
- The rate of Overturned Appeals is up a little with Medical Services and Supplies at 30% (up from 21%); and, prescription drugs up to 63% (up from 50%) which is being watched by staff. The Grievance and Appeals staff have been collaborating with the Medical Directors and Health Services staff, to review monthly the overturned appeals for trends.
- Resolution within 24 hours is up to 362 for the quarter (up from 250 the same time last year). This indicates that the call center is resolving issues quickly.
- The rate of complaints per 1,000 members has remained consistent.
- Timeliness of Complaint Resolution dipped slightly below the requirement of 95% in the first quarter for grievances and medical appeals. She forecasts that the second quarter will be lower yet noting staffing challenges recently.

Beverly Karnatz commented that she receives fast resolution to issues whenever she calls HPSM and that she is impressed that the HPSM navigators are empowered to resolve issues; Ms. Karnatz asked if the grievances were not a reflection of HPSM staff. Ms. Ault-Riche stated that very little actually is a complaint against HPSM staff, however, the health plan is still responsible for the performance of its vendors and providers.

Ms. Ferrer said from the reports it is not evident that these issues are not with HPSM and was glad to hear that very few complaints are against HPSM staff. Ms. Ault-Riche noted that there has been discussion about tracking data in a slightly different way in order to have information to report on complaints related HPSM staff and at exactly what percentage. The system is not set to capture this and the data gets merged with all the other customer service complaints.

Ms. Altman said the "rates of complaints per 1,000 members" is low when you consider the amount of health care resources that are used for this population.

6. Updates and Discussion

a. Update on WiderCircle Pilot

Ms. Luarnie Bermudo gave an update on the "Connect for Life" program administered by Wider Circle. Ms. Bermudo explained that the program was a pilot that began in May of 2017 with three pilot sites and 50 members for Medicare eligible older adults living in

assisted living settings.

She gave some background information that led to this program. In comparison to the many good healthy lifestyles habits we may have such as good nutrition and exercise, close relationships and social integration actually topped the list of ways to live a long life. The Connect for Life program provides opportunities for the members / residents to connect and the program goal is for the members to make at least one friend at these group events. Weekly small group meetings are held for 6 to 12 weeks and focus on movement, health promotion, and socialization. She talked about a social event called the Wellness Ring which opens the group up to talk about health.

The pilot that began in May was first done in English and later they added a Spanish speaking group in North County. The goals were to improve physical and emotional health among our members; social cohesion reducing loneliness and making sure our members were satisfied with our service. She shared some pictures of the members engaged in various events and activities.

Ms. Bermudo shared some information on scores that related to physical and mental components noting an improvement of about 12% for physical and 13% for mental components. The end result is that the members really love this program. Ms. Karnatz talked about how at Rotary Plaza, the members who participated graduated and have continued to get together with other groups for activities like bocce ball in the park. She said the Spanish speaking group started just the other day and she could hear the laughter and singing coming from the room next to her office.

There was a question about how people are chosen to participate in the pilot. Ms. Bermudo said there is an algorithm to help set up the groups. Members are referred from Member Services or Care Coordination; and, outreach is done to members who fit the eligibility.

It was asked how they are measuring these improvements. Ms. Bermudo answered that they are currently using HOS, the longitudinal evaluation of the physical and mental health outcomes of beneficiaries enrolled in MMC plans nationwide. She mentioned they will also be incorporating an evaluation component and client satisfaction surveys to understand how the clients feel about the program. Later, there will be a return on investment evaluation done.

Because of the positive results of the pilot, the program is being expanded to 500 members including CareAdvantage members, and those who are eligible for CareAdvantage. The program will focus on English and Spanish groups at this time. They did receive a referral for a Mandarin speaking member so staff is working on ways of being inclusive. Ms. Altman said that through the Community Care Setting Pilot it was found that members were lonely when moved back into the community or back to their homes. Wider Circle approached the health plan at that time. Some of the participants come from that program as well.

b. CMC Dashboard

Ms. Turner reviewed the attached presentation covering the recent data related to the CMC program. She focused on 2016:

Quality Withhold Measures:

- Ms. Turner explained that the quality withhold for CMC is arrangement where the state withholds a certain amount of our premium which we need to earn back based on performance and different quality measures. These measures change yearly so there is a bit of a retrospective look at the data and then the quality withhold is determined.
- At the last meeting it was reported that about 75% of the withhold would be returned for 2016, however, a couple of the measures changed in terms of how they are calculated resulting in a 100% return of our withhold for those measures.
- There have been some changes in the 2017 measures which are resulting in HSPM staying above the benchmark for the CAHPS and HEDIS reporting.
- It is too early to calculate for 2018.

MLR Dashboard:

- Ms. Turner explained that the Medical Loss Ratio (MLR) is the premium vs. cost which is tracked by using enrollment and the risk adjustment premium that we get from Medicare and medical costs, inpatient spend and anything related to primary care.
- The data is coming from the first month or two of the second quarter and compared to the first quarter.
- The budget assumed approximately 9,230 enrollments. The actual number of enrollments as of the beginning of July is 9,036 meaning enrollment is flattening out. A question about the cause of the decline in membership was asked. Ms. Turner answered that involuntary disenrollment is the largest driver to the loss of members (death, losing their Medicaid or moving out of the county). Very few members leave HPSM to go to a different plan. Approximately 150 members will go through the deeming process and lose their Medi-Cal eligibility. The enrollment/ disenrollment team work with the members and external partners to help them regain their Medi-Cal eligibility (59% of members who lost their eligibility were able to get it back in the first quarter of 2016).
- HomeAdvantage is the program administered by Landmark for CMC members with five or more chronic conditions. Last year about this time the enrollment for HomeAdvantage was about 570 members. Current enrollment is about 1,360 members as of July. Landmark is at just about operating capacity though they do continue to grow.

- Other data previously reported as part of this dash board will be reported on at the next meeting in October: Utilization of LTSS; Transitions of Care; Call Center Performance; Timely HRA Completion; Timely Individual Care Plans.

c. IHSS Update:

Ms. Hogan gave an up on IHSS:

- At the end of the fiscal year, there were a total of 5,124 people utilizing the IHSS program which is up 150 from last year at the same time.
- Referral Count is averaging about 180 per month, with an average 13 day wait time for clients to be connected with a registry caregiver from the time of referral.
- Some staffing challenges over the past few months resulted in an increase in the amount of time that it takes from the day of the first phone call to the screener contacting the applicant to take their application. They have brought this delay down to 2 weeks now and the goal is to get to clients within a day or so.
- Three social workers have been hired and have about 770 contacts with clients since they were hired in January.

Ms. Kaplan asked what the staffing issues were. Ms. Hogan explained how they were trying to get a couple of positions approved which took some time and caused a slowdown in the referral process. Now that the positions are approved and filled, they are catching up. It was asked if clients coming from skill nursing facility referrals are connected with caregivers faster. Ms. Hogan stated the 13 day lag is for referrals to the registry. Referrals coming into IHSS with an urgent need are expedited.

Ms. Altman asked how recruitment was going. Ms. Hogan said the effort for recruitment is moving into social media (e.g., Twitter, Next Door and Facebook) in the next month. There is a full-time staff member committed to recruitment, holding orientations in English and Spanish monthly. Some months they may have two orientations in both English and Spanish in order to increase the number of incoming providers. On July 1st, the pay increase to $13.90 an hour went into effect and providers will also be paid time and a half for anything over 40 hours.

Ms. Zuniga added that the rate of pay has been the biggest challenge. It is hard to find people to do this work for the amount of money per hour. As well, it doesn't matter what kind of help the person needs, the rate is the same. Clients have different needs and levels of care that need to be provided. The rate is the same whether the client needs just housecleaning help or more intense personal care.

Ms. Zuniga reported that the Commission on Disabilities is working on the creation of a forum to compile information about disconnects to present to program decision makers. While they do want to highlight the many positives of the program they want to share this important information with the people who make the decisions about the program. The information is going to be recorded and presented to the Board of Supervisors as well as legislators. She said the problems are not just in San Mateo County, it is everywhere. She expressed concern over the growing aged population and the impact this will have on the resources to care for the disabled of all ages. She hopes there will be some creative solutions developed to help everyone. Another group she is involved with is exploring the idea of using grants to ask for financial help from different health systems. The forum is still in its planning stages and will be dividing up the county based on the number of recipients. She will bring more information back to this committee as this grows.

d. Other State/CMS Updates

Ms. Altman asked Mr. Curran to talk about the Dental Integration Program. Mr. Curran reported that the legislation for the program has been passed which allows the state to work with San Mateo County to integrate medical and dental services in San Mateo County only. This would mean that HPSM members medical and dental services would be coordinated through the health plan.

The next step is to hold stakeholder meetings to involve the community in designing the program and identify the challenges in successfully helping people gain access to dental care. That invitation will be sent to this group and interested parties are encouraged to participate. At the same time, HPSM staff will be working on operational and financial analyses. We know more access will cost more so the financial analysis will be important. All this will work toward a proposal to the commission early next year. The pilot would be a six year project through the state, and with investment by the community and HPSM.

Some questions about how members would access care and the number of providers ensued. Mr. Curran explained how the goal would be to engage as many of the community practitioners as possible and the health plan would help members find a dental provider. Ms. Kaplan asked if the health plan will be contacting the dental schools. Mr. Curran said the San Mateo Oral Health Coalition will be invited and this does include the dental schools. This coalition may also meet with the dental schools separately as well. Ms. Zuniga said COD may be interested in being involved since people with disabilities tend not to see the dentist and then end up in the emergency room with dental issues. Ms. Karnatz added that she has noticed that residents have trouble finding a provider who will do bridge work.

Ms. Altman continued with updates:

- Ms. Altman explained when people are placed in assisted living through the Community Care Settings Program (CCSP), the health plan covers this cost because it is not a Medicaid benefit. This can become quite costly since some people who enter assisted living may be there for the rest of their lives. The state develops our rates using the plan's cost experience and because housing is not a covered benefit these costs are not captured. Ms. Altman has been trying to engage the state on considering different rate settings and the Director is now willing to have discussions on the subject. A meeting with the rates staff has been scheduled and they hope to develop alternatives to the nursing home rates.
- HEDIS had a successful season overall, including CMC. The health plan had seven high performance level measures in Medi-Cal compared to two last year, which is a great improvement. Ms. Altman will have staff come to a future meeting to present HEDIS information specific to CMC.
- There has been news about Seton that may include the sale of all or some of their hospitals. She will keep the committee updated on news as it becomes available.
- On October 20th the health plan will hold a member appreciation event for CareAdvantage that will offer flu shots, health screenings, and benefit information. This will be focused on the members of CareAdvantage or those we know are eligible for CareAdvantage.

7. Adjournment

The meeting adjourned at 12:50 p.m.

Next meeting: October 19, 2018 at 11:30am at the Health Plan of San Mateo Boardroom.

Respectfully submitted:

C. Burgess

C. Burgess
Clerk of the Commission

Cal MediConnect Advisory Committee – Grievance & Appeals Report

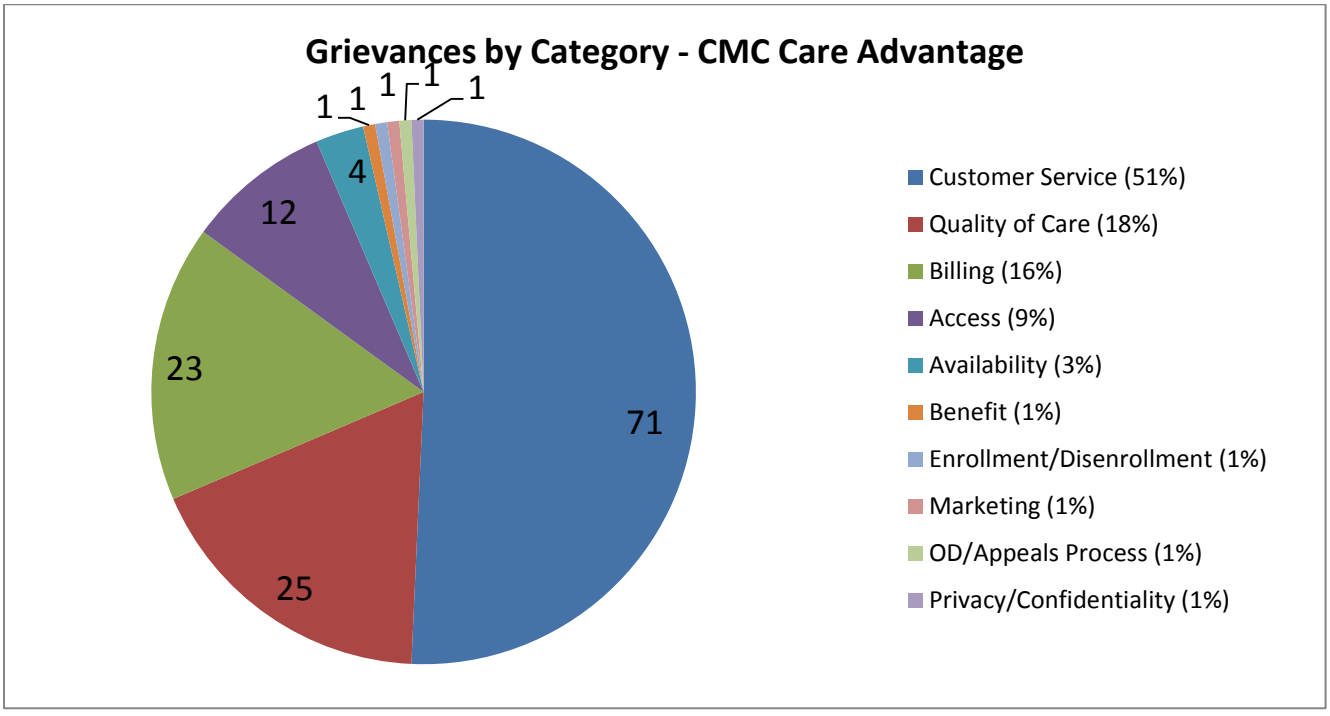
Reporting Period: Q1 2018 (January – March 2018)

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**	3				
		Standard	37				
	Part D (Drugs)	**Expedited**	1				
		Standard	15				
	Total Appeals		**56**				
Grievances	**Part C (Medical)**	**Expedited**	1				
		Standard	125				
	Part D (Drugs)	**Expedited**	0				
		Standard	14				
	Total Grievances		**140**				
CareAdvantage CMC Subtotal			**196**				

2. Types of Grievances Received, by Category

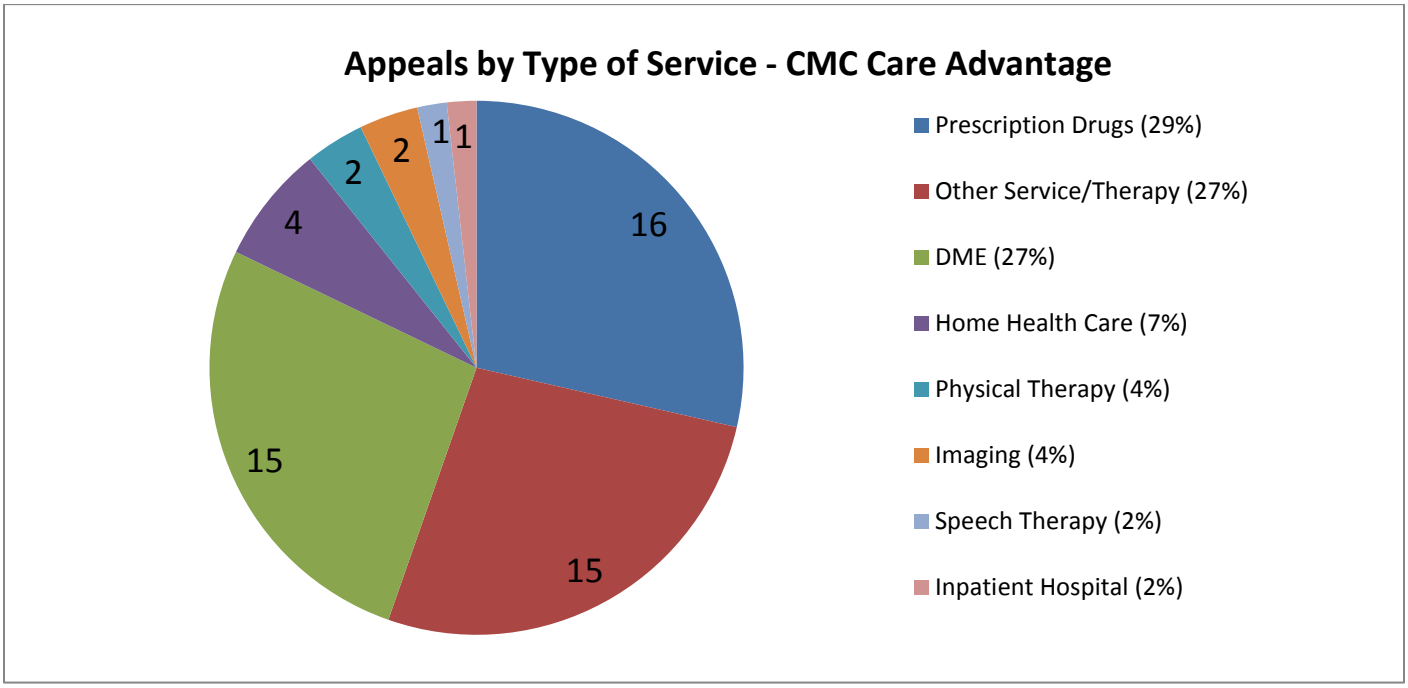


3. Type of Grievances Received, by Sub-Category

Category	Sub-Category	# Received
Access	Interpretation Srvc Not Used	1
	No TAR or Prescription on File	4
	Provider Not Dispensing Drug	5
	Provider Not Dispensing Item	1
	Interpretation Srvc Not Used	1
	Other	1
Access Total		**12**
Availability	Excessive Wait Time for Appointment	1
	Other	3
Availability Total		**4**
Benefit	Other	1
Benefit Total		**1**
Billing	Balance Bill Not in Collections	4
	Balance Bill in Collections	10
	Full Bill Direct to Member	7
	Other	2
Billing Total		**23**
Customer Service	Communication - Disrespect/Rudeness/Discrimination	5
	Communication - Incorrect Info Given to Member	6
	Communication - Other Issue with Staff	22
	Comm - Staff Not Working/Distracted	1
	Taxi - Driver Safety	1
	Taxi - Driver no-show	14
	Taxi - Incorrect Info Given	2
	Taxi - Late pick-up/ drop off	6
	Taxi – Other	8
	Time - Long hold time on phone	2
	Time - No return call	3
	Time - Other	1
Customer Service Total		**71**
Enrollment/Disenrollment	Other	1
Enrollment/Disenrollment Total		**1**
Marketing	Unclear Materials	1
Marketing Total		**1**
OD/Appeals Process	Appeals Process Incorrect	1
OD/Appeals Process Total		**1**
Privacy/Confidentiality	Inappropriate Sharing Member PHI	1
Privacy/Confidentiality Total		**1**

Category	Sub-Category	# Received
Quality of Care	Referral - Delay in referral	1
	Referral – Provider did not refer	2
	Relationship - Provider Not Listening to Concerns	3
	Relationship - Provider is Rude/Mean/Etc.	1
	Treatment - Poor Diagnosis	2
	Treatment - Poor Treatment	8
	Other	8
Quality of Care Total		**25**
Total		**140**

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	40	19	0	12	9	30%
Part D - Prescription Drugs	16	6	0	10	0	63%

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**	**75**				
	Prescription Drugs	**69**				
Medi-Cal	Medical Services/Supplies	67				
	Prescription Drugs	129				
Other LOBs (CCS, HW, HK, ACE)	Medical Services/Supplies	7				
	Prescription Drugs	15				
Total About Medical Services/ Supplies		**149**				
Total About Prescription Drugs		**213**				
TOTAL		**362**				

24 – Hour Resolutions, by Category and Subcategory:

Category	Subcategory	# Received
Access	Code 1 Override	5
	Interpretation Service Not Used	3
	Network - PCP	2
	No MRF or Rx on File	32
	No TAR or Prescription on File	25
	OHC	34
	Provider Not Dispensing Drug	81
	Provider Not Dispensing Item	2
	Other	33
Access Total		**217**
Availability	Excessive Wait Time for Apt	2
	Unable to Schedule Appointment	15
	Other	3
Availability Total		**20**
Benefit	Other	3
Benefit Total		**3**
Billing	Balance Bill Not in Collections	1
	Full Bill Direct to Member	8
	Other	13
Billing Total		**22**
Customer Service	Comm - Incorrect Info Given to Mbr	6
	Comm - Other Issue with Staff	1
	Taxi - Driver no-show	2
	Taxi - Incorrect Info Given	6
	Taxi - Late pick-up/ drop off	1
	Taxi - Other	66
	Time - Other	1
Customer Service Total		**83**
Enrollment/Disenrollment	Issue with Eligibility	14
	Other	2

Category	Subcategory	# Received
Enrollment/Disenrollment Total		**16**
Pharmacy Unit/Appeals Process	Pharmacy Unit Process	1
Pharmacy Unit/Appeals Process Total		**1**
Total 24-Hour Grievances		**362**

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	**21.5**			
Medi-Cal Only (Excluding CCS)	2.9			
Healthy Kids	4.0			
HealthWorx	1.9			
ACE	0.6			
CCS	7.0			
TOTAL	**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	9,116
Medi-Cal Only (excluding CCS)	110,144
Healthy Kids	1,513
HealthWorx	1,057
ACE	21,664
CCS	1,573
Total	**145,067**

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	343	323	94.2%
Medical Appeals	129	118	91.47%
Pharmacy Appeals	76	75	98.7%

V. Primary Care Provider (PCP) Changes by Provider

Reason for PCP Change	Number of Changes in Q1 2018
Difficulty In Obtaining An Appt.	40
Poor Service	35
Provider And Patient Incompatible	12
Provider's Attitude/Atmosphere	1
Total	**88**

A total of 88 members requested to change their assigned PCP during Quarter 1 due to dissatisfaction. Members switched away from a total of 34 different PCPs. Of those, 19 were clinics and 15 were individual providers. For 5 providers, 5 or more Members requested to switch away from their practice. Three were clinics and the other two were individual physicians.