HEALTH PLAN OF SAN MATEO
CONSUMER ADVISORY COMMITTEE MEETING
Meeting Minutes
Thursday, September 6, 2018
801 Gateway Blvd. 1st Floor-Boardroom
South San Francisco, CA 94080

Committee Members Present: Mary Pappas, Danilyn Nguyen, Ricky Kot, Robert Fucilla, Angela Valdez
Staff Present: Maya Altman, Pat Curran, Carolyn Thon, Gabrielle Ault-Riche, Dr. Richard Moore, Kati Phillips, Charlene Barairo, Michelle Heryford.

1.0 Call to Order/Introductions: The meeting was called to order at 12:02 pm by Danilyn Nguyen.

2.0 Public Comment: There were no public comments.

3.0 Approval of Agenda: Ms. Ault-Riche reported that Dr. Richard Moore would be doing the CMO report on behalf of Dr. Susan Huang and Kati Phillips would be giving the Provider Services report on behalf of Colleen Murphey. The agenda was approved as amended. **M/S/P**

4.0 Approval of Meeting Minutes for June 7, 2018: Ms. Pappas moved to approve the meeting summary from June 7, 2018. Mr. Kot seconded the motion. **M/S/P**

5.1 HPSM Operational Reports and Updates

5.2 CEO Update: Ms. Altman updated the group on the recent Seton Medical Center bankruptcy. HPSM is very concerned about how this will affect our members and is making every effort to divert our members to other facilities. In particular there is concern about the SNF beds at Coastside and the population who utilizes the sub-acute unit at Seton. These beds are difficult to find in our area. Many of these units can only be found in the city. There was a question about the percentage of HPSM members that had been seen at Seton. While concrete numbers were not available, it is estimated that approximately 20% of our Medicaid patients and about 40% of Medicare admissions were at Seton. She also noted they provide a significant amount of outpatient services

as well. Ms. Altman also mentioned the impact it will have on the community as Seton is the largest employer in Daly City.

5.2 CMO Report: Dr. Moore reported on several new developments.

- **Dignity Health Contract** – Dr. Moore spoke about the Dignity contract. This contract also includes Saint Francis Memorial Hospital and St. Mary's Medical Center. Dr. Moore spoke glowingly about the state-of-the-art Bothin Burn Center at St. Francis, the largest in Northern California. The Dignity contract also includes the Dignity Health Medical Group and the Dignity Health-GoHealth Urgent Care Centers. Each location is a full-service urgent care clinic. There are three locations on the Peninsula in Redwood City, San Bruno and Daly City. This should help alleviate improper use of Emergency Departments and low acuity follow-ups that should be completed in a lower acuity setting, such as; suture/staple removal, IV therapy, wound care and abscess drainage. This is a joint venture between Dignity Health and GoHealth Urgent Care. Dr. Moore also mentioned that Provider Services will soon implement an Emergency Department Education Initiative. This initiative will educate Providers about when it is prudent to send members to the Emergency Department and when they should see a PCP or Urgent Care facility instead.
- **DaVita Dialysis** – Dr. Moore also reviewed the contract with DaVita Dialysis. There are 5 locations and our members will benefit from DaVita's close relationship with our network nephrologists. DaVita has been recognized by CMS with top marks in its Five-Star Quality Rating Program. All of the DaVita and Satellite Dialysis centers have 4-5 star ratings and 93% of all DaVita Centers are rated with 3, 4 or 5 stars for 2018 compared to 86% for the rest of the industry. DaVita participates in CMS's end stage renal disease quality incentive program which encourages dialysis centers to meet or exceed certain performance standards.

- **NCQA** – Dr. Moore updated the group on the NCQA accreditation. The National Committee for Quality Assurance is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda. Organizations incorporating the seal into advertising and marketing

materials must first pass a rigorous, comprehensive review and must annually report on their performance. For consumers, the seal is a reliable indicator that an organization is well-managed and delivers high quality care and service. Last year HPSM was successful in receiving interim accreditation, the Plan scored 49 out of a possible 50 points. There are seven different categories of measurement, including population health management, network management, utilization management, quality improvement, credentialing, member rights/responsibilities, and member connections. The goal this year is to receive full accreditation with a perfect 50 out of 50. HPSM believes at some point the State will move toward requiring NCQA Accreditation for all health plans.

- **Provider Credentialing –** Dr. Moore went on to explain that per HPSM policy, all providers are required to be board certified. The only exceptions are sub-specialties, or for geographical or language issues. Using these determinants, if a provider is not board-certified, that provider will not be credentialed/re-credentialed.

5.3 Grievance and Appeals: Ms. Ault-Riche started by noting that the NCQA has required changes to the reports filed for Grievance and Appeals and Member Services . She went over the purpose and the methodology of the reports and the goal attached to each metric.

- Ms. Ault Riche reviewed the enrollment averages for each line of business for Q2 2018, noting that complaint rates differ significantly by line of business in large part because each line of business serves a different population. In Q1 2018, the rate of complaints filed by HealthWorx members and ACE participants was within the stated goal, but all other lines of business were above the goal. However, no line of business had a rate of complaint that was more than 1 complaint per 1,000 members beyond the goal. In Q2 2018, Medi-Cal, Health Kids, and ACE all fell within the goal rate, while CA CMC, HealthWorx and CCS did not. It should be noted that the volume of complaints from HealthWorx and CCS members is very small, as a few grievances can skew the rates significantly. The type and root cause of complaints vary by line of business. It is difficult to propose one solution to address the high volume of complaints across multiple lines of business. She asked the group to reference the subsequent sections for an analysis of the barriers and proposed corrective actions to address issues specific to

each program. She also went over the timeliness for complaint resolution numbers for all lines of business; these numbers exclude cases resolved within 24 hours of receipt. The G&A Unit failed to meet its goal of 95% timeliness for both Q1 and Q2 2018 in processing grievances and appeals. In contrast, the Pharmacy Unit, which processes pharmacy appeals, met their goal of 95% timeliness. The G&A Unit attributes their failure of that goal to staffing shortages. The department lost both a G&A Coordinator and a G&A Manager. The loss of the CMO and the Quality Review Nurse has contributed to this as well. HPSM has since hired a new CMO and a Quality Review Nurse.

CareAdvantage/ CMC: The volume of grievances remained relatively constant between Q1 and Q2 2018, as did the type of grievances received. While the percentage of grievances related to Customer Service decreased, the percentage of grievances related to Quality of Care, billing and Access all rose slightly, but remained within 5 percentage points for their Q1 rate. Therefore there are not areas of concern in the type of grievances received.

- **Appeals**: The percentage of appeals related to prescription drugs increased significantly from 29% in Q1 2018 to 55% in Q2 2018. This is due to a doubling of the volume of pharmacy appeals (16 appeals in Q1 vs. 33 appeals in Q2). HPSM attributes this increase to two primary factors. The first is **Process Standardization**. In March 2018, the Pharmacy Unit changed its policy regarding members requesting exceptions to the formulary. The new policy requires members to have tried and failed two formulary alternatives prior to approval of the non-formulary drug. This change likely resulted in an increase in denials and therefore in appeals for these non-formulary medications. **Proposed Action**: The process change was necessary to ensure standardization across clinical reviews and bring HPSM in line with industry standards. Therefore, while this change resulted in a short-term increase in denials, there are no proposed actions to address this issue, as it is not a long term deficiency. The second factor is the **Annual Transition Period**. Every year during the first 3 months of the year, a transition period begins, in which Medicare members are provided with up to a 31 day supply of prescription that may not otherwise have been provided without a prior authorization or formulary exception. For members at a long-term facility who have been with CMC for 180 days or less, the transition benefit extends up to

a 98-day supply during the first 180 days. The transition period which typically occurs between January and March ensures a smooth transition to accommodate changes from the previous year's formulary drugs and changes in formulary for members that are new to CMC. The transition period ends for most members in Q2 and the rate of denials increases, leading to an increased volume of pharmacy appeals. **Proposed Action**: CMS defines the requirements surrounding this transition process, which is built into the annual process for Medicare members. As such, there are no proposed actions needed to address this issue, as it is part of the yearly process for CareAdvantage CMC members. **Rate of Overturned Appeals:** The rate of overturned appeals for medical services increased from 30% in Q1 to 41% in Q2. However, the overturn rate for pharmacy appeals decreased from 63% in Q1 to 45% in Q2. The reasons for the increase in overturned appeals for medical services are currently under review. **Proposed Action**: In an effort to identify trends among the reason that requests are overturned on appeal, HPSM runs a monthly report of all overturned appeal decisions. This report if jointly reviewed during a monthly meeting with the Director of Health Services, Associate Medical Director, Senior Medical Director, Clinical Review Nurse, Utilization Management Manager and Supervisor, director of Customer Support, Lead Grievance and Appeals Coordinator, and Compliance Manager. This group compares the original denial rationale against the overturned decision on appeal to identify the reason for the discrepancy and whether the denial could have been avoided during the initial review. Data from these reviews is still being collected and analyzed in order to identify trends and possible areas for improvement.

Medi-Cal: The volume of grievances decreased from 184 received in Q1 to 159 in Q2. This decrease is consistent with past years, in which HPSM has historically seen a rise in phone calls and grievances in the first quarter of the year. The type of grievances remained constant throughout both quarters. Customer Service grievances decreased slightly from 26% (47 grievances) to 19% (31 grievances). Although the percentage of grievances related to Quality of Care increased slightly from 26% in Q1 to 30% in Q2, this did not indicate an increase in case volume, since there were no significant changes in the volume

or type of grievances received, there is no need for any proposed corrective actions related to Medi-Cal grievances.

- **Appeals**: The volume of pharmacy appeals remained constant, but the volume of appeals for medical services decreased significantly from 83 appeals in Q1 to 52 in Q2. HPSM has not identified a particular cause for this decrease. The decrease does not indicate a problematic trend and therefore no proposed corrective action is recommended. **Rate of Overturned Appeals:** The rate of overturned appeals related to medical services increased from 43% in Q1 to 52% in Q2, and the rate for pharmacy appeals also increased, from 50% in Q1 to 61% in Q2. As stated in the section regarding the overturned appeal rate for CareAdvantage CMC, HPSM meets monthly to conduct an interdisciplinary retrospective review of each case in order to identify trends and areas for improvement. The results from these reviews are currently being complied and the data is being analyzed to determine root causes and next steps.

NCQA Data Collection & Grouping: For all Medi-Cal members, including those covered under CCS, the National Committee of Quality Assurance (NCQA) requires specific data collection and grouping standards which we are including for Medi-Cal and CCS members only. In the tables in the reports, grievances and appeals are separated based on whether they are related to Behavioral Health services, and further broken down in the categories NCQA requires. The rate of 1,000 members is calculated using the number of members enrolled in Medi-Cal or CCS, not all of whom receive behavioral health or other healthcare services.

Goal Rates: The numbers in the table below reflect the goal rates per 1,000 members. These goal rates include all services, not only those related to behavioral or non-behavioral health services, and include both grievances and appeals. Therefore, the G&A Unit has established separate goal rates for the data presented below, in order to account for the more limited denominators.

Type	Goal Rate per 1,000 members
Behavioral Health: Grievances	1
Behavioral Health: Appeals	1
Non-Behavioral Health: Grievances	4
Non-Behavioral Health: Appeals	2

- **Medi-Cal and CCS Behavioral Health Grievances: Analysis, Barriers and Proposed Action**: Across all categories, the rate of grievances and the rate of appeals fall within the established goal rates. With the exception of BHRS-related appeals, no other category is expected to increase in the following quarters. Therefore, no corrective action is needed at this time.
- **Resolutions Within 24 Hours of Receipt:** Resolutions within 24 hours were up for Q2 from Q1. These complains are not included in the count of grievances in the tables above, and do not enter the formal grievance process.
- **Primary Care Provider (PCP) changes by Provider**: A total of 106 members requested to change their assigned PCP during Q2 due to dissatisfaction. Members switched away from a total of 37 different PCP's. Of those, 19 were clinics and 18 were individual providers. For 6 providers, 5 or more members requested to switch away from their practice. Five were clinics and one was an individual physician.

5.4 **Provider Services:** Kati Phillips reported for Provider Services. She informed the committee that HPSM has initiated a number of process improvement projects focused on member assignment management. The department had their first round of Medi-Cal PCP re-assignments back in July and had 831 members re-assigned to the PCP they've been going to over the last 15 months. It was noted that the current mechanism for re-assignment is driven by member or provider outreach but the data showed that this was not consistently happening and the department feels it is important to correct assignment based on where members are choosing to receive primary care services. This is not only important for care continuity but also has implications for documentation and can be useful with the retrieval of medical records as needed. There are provider payment implications for where members are assigned and seen as well. This relates to the new primary care payment model that was reviewed at the last CAC meeting. Their next round is underway and just last week 356 member letters were sent out to members who meet the re-assignment criteria for providers willing to accept them on their panel. Members are given approximately a month to reach out to HPSM with any questions or to opt out. October 1st is the next date for re-assignment to be effective as it is a quarterly process. Criteria for re-assignment is 0 visits at their assigned PCP and at least 2 visits at only one other non-assigned PCP

over a 15 month period. There were some cases where members went to the non-assigned PCP more than 10 times during this look back period. The department is also looking at their process for member assignment for members with identified primary other health coverage and looking at refreshing certain aspects of their Medi-Cal auto-assignment process, which assigns members to a MC PCP if they do not self-select an in-network PCP within 30 days of enrolling with HPSM.

5.5 Member Services: Ms. Ault-Riche reviewed the new reports for Member Services and the Care Advantage Unit which provide an overview of the performance trends in HPSM enrollment and HPSM's two call centers, as well as updates related to program changes affecting HPSM members.

Methodology: Enrollment Data: Member enrollment and disenrollment data is stored in HEALTHsuite, HPSM's system for authorizations, claims and eligibility.

- HPSM receives enrollment information for Medi-Cal members from the California Department of Health Care Services (DHCS) via the monthly 834 Eligibility File.
- The San Mateo County Health System (i.e. Health Coverage Unit) provides enrollment information for Healthy Kids and ACE.
- Enrollment information for HealthWorx is provided by the Public Authority and the City of San Mateo.

All files from these sources are entered into HEALTHsuite through automated file transfers. Enrollment data for CareAdvantage Cal MediConnect (CA CMC) members is entered directly into HEALTHsuite by HPSM's Enrollment/Disenrollment Unit and is confirmed via information received from the Centers for Medicare and Medicaid Services (CMS) transaction reports.

Call Center Data: The data regarding call response times in HPSM's two call centers, Member Services and the CareAdvantage Unit is pulled from HPSM's ACD (automatic call distributor) system, Avaya. Avaya records all in-coming and outbound calls and holds all data regarding call volume and call response times. Avaya also records and calculates call volume, hold time, speed to answer and abandonment rate. **CTM Complaint Data**: This data is provided by CMS and is pulled from Medicare's Complaint Tracking Module (CTM). This data represents complaints filed with 1-800-Medicare (i.e. CMS) against HPSM or its providers.

Enrollment Data: HPSM currently serves 144,550 members. **Medi-Cal**: Enrollment in Medi-Cal decreased slightly from 112,553 members in January 2018 to 108,232 members in June 2018. **CareAdvantage CMC (CA CMC):** Enrollment in CA CMC has also decreased slightly, from 9,583 members in January 2018 to 9,031 members in June 2018, CA CMC enrolled a total of 446 members (371 new members and 75 re-enrolled members). However, a total of 595 members disenrolled during that time. The most common reason for disenrollments from CA CMC is death (189 members) and loss of Medi-Cal (140 members). **ACE**: Beginning September 1, 2018, the ACE Fee Waiver program will be expanding by an estimated 2,300 members, individuals with Restricted Medi-Cal (i.e. emergency and pregnancy-related coverage) will now be auto-enrolled in the ACE Fee Waiver program. Participants will no longer need to enroll separately for the program. This has been a much-anticipated implementation, which is designed to simplify the application process and ensure seamless coverage for all eligible participants. **Enrollment Analysis & Proposed Action Plan**: **Medi-Cal, Health Kids, HealthWorx, and ACE**: HPSM does not process enrollments for these lines of business and therefore does not set enrollments foals or performance improvement plans related to enrollment for these programs. **Care Advantage CMC: Analysis:** For 2018, the HPSM Marketing team set a performance improvement goal of 120 enrollments a month. It was intentionally set high in order to incentivize creati ve thinking among the team around ways in which HPSM has enrolled 70- 80 members in CA CMC each month. Enrollment in 2018 ranges from a low of 69 in March 2018 to a high of 75 enrollments in June and therefore did not meet the stretch goal. **Barriers**: The Marketing Team reported that the primary barrier to increasing enrollments is the difficulty HPSM encounters in reaching potential members. **Action Plan**: The Marketing team has implemented several new strategies to increase outreach to potential CA CMC members. The team has created and mailed new flyers to potential members' homes and has increased phone outreach attempts. Additionally, HPSM will be hosting a member appreciation event for current and potential CMC members in October which will include information about member benefits; member and potential members can also receive free flu shots and referrals to community resources and refreshments.

Member Services Call Center Data: The Member Services Call Center answers calls from Medi-Cal, Healthy Kids, and HealthWorx members as well as ACE participants. **Average Speed to Answer** has improved significantly from

January 2018 and has remained steady throughout Q2 2018. The overall average speed to answer for Q1 was 1 minute and 3 seconds, which decreased to an average of 24 seconds in Q2. **Call volume** has continued to decrease throughout the year. **Average Hold Time** decreased from January 2018 and has remained steady at around 1 minute 18 seconds since March 2018. This hold time is well within the goal of having an average hold time below 2 minutes. **Calls Answered Within 30 Seconds**: The percentage of calls answered within 30 seconds of the caller entering the call queue has improved from a baseline of only 47% in January of this year to 82% in June. Regulatory standards require HPSM to answer at least 80% of calls within 30 seconds, and the Member Services Call Center achieved that goal throughout Q2.
Abandonment Rate: Although the abandonment rate started high at 10% in January 2018, it has remained within the regulatory standard of no more than 5% for all other months.
Member Services Call Center Analysis & proposed Action Plan: Analysis and Barriers: Regulatory Metrics: In Q2 2018, the Member Services Call Center met its goals for the following regulatory metrics: average hold time, percentage of calls answered within 30 seconds, and abandonment rate. However, in January 2018 the abandonment rate surpassed the goal by 5 percentage points. This was due to a significant increase in call volume, which is a historical and repeating phenomenon each year. There is an increase in call volume the first quarter of each year largely due to the following factors: ***Renewals for Covered California*** – When San Mateo County residents are required to renew their insurance coverage through Covered California at the end of the year, they often learn that they are eligible for Medi-Cal instead. This leads to an increase in Medi-Cal applications and Medi-Cal eligibility, which in turn results in more calls to the Member Services Call Center regarding Medi-Cal eligibility and benefits. ***Proof of Insurance for Income Taxes***: Although the Human Services Agency (HSA) provides Medi-Cal members with the proof of health insurance to include with their annual income taxes, many members call HPSM instead to request this form. This is a common call in January of each year. ***Requests for New ID Cards***: HPSM does not distribute new ID cards each year, but members often expect a new ID card with each new year. When they do not receive a new ID card in January, they often call the Member Services Call Center to inquire about receiving one. In addition to the increase in call volume, HPSM experiences staffing shortages each December and January due to staff taking vacation time during the

holidays. **Average Speed to Answer:** There is no regulatory goal for the average speed to answer. However, the call center set a self-imposed goal of answering calls with an average speed to answer no greater than 30 seconds. This was a stretch goal, which was achieved in April and May, but was not met during the other months of Q1 and Q2 2018. The call centers did not meet this goal in large part due to a staffing shortage. **Call Volume**: The Call Center does not set goals for call volume, since there is no regulatory standard set for these metrics. Additionally, call volume is highly dependent on the incidence of new programs or other developments within HPSM, and fluctuations in call volume do not necessarily indicate an increase in member dissatisfaction. **Action Plan**: There are no proposed actions to improve the call centers regulatory metrics, since it is currently meeting all required goals. For January 2019, the Member Services Department may develop additional outreach materials to members to avoid confusion about tax forms and new ID cards and therefore minimize the anticipated increase in call volume. The department will also continue its ongoing recruitment efforts to ensure adequate staffing and phone coverage.

Care Advantage Call Center Data: The Care Advantage Call Center answers calls from CareAdvantage CMC members. **Average Speed to Answer**: This has increased slightly in March, April and May, but has begun to decrease to its original average of around 11 seconds. The overall average speed to answer for Q1 was 14 seconds, which increased to an average of 19 seconds in Q2. It should be noted that the increase is not significant and the call centers speed to answer is well within expected standards. **Call volume** has remained relatively constant throughout the year. CareAdvantage received a total of 6,393 calls in Q1 and 6,503 calls in Q2. **Average Hold Time**: has remained steady at around 1 minute and 20-30 seconds throughout the year. This hold time is well within the goal of having an average hold time below 2 minutes. **Calls Answered Within 30 Seconds**: The percentage of calls answered within 30 seconds of the caller entering the call queue has ranged from a low of 87% in May to a high of 95% in June. Regulatory standards require HPSM to answer at least 80% of calls within 30 seconds, but the CareAdvantage Unit has set an internal goal of 90%. The CA Unit consistently met the regulatory goal of 80% throughout the year and has met the internal goal of 90% for all but two months, April and May of 2018. **Abandonment rate**: The abandonment rate has remained within the regulatory standard of no more than 5% throughout all of Q1 and Q2. **Analysis**: in Q2 2018, the CareAdvantage Call Center met its

goals for the following regulatory metrics, average hold time, percentage of calls answered within 30 seconds, and abandonment rate. The call center does not set goals for the average speed to answer or call volume, since regulatory standards are not set for these metrics. As with the Member Services Call center, call volume is highly dependent on the incidence of new programs or other developments within HPSM, and fluctuations in call volume do not necessarily indicate an increase in member dissatisfaction. There are no applicable barriers or action plan as the call center is currently meeting all required goals. **CTM Complaint Data**: The CMS Complaint Tracking Module (CTM) tracks complaints filed by CareAdvantage CMC members directly with CMS through its toll-free phone line, 1-800-MEDICARE. Since its inception, HPSM has received very few complaints. HPSM has received zero CTM complaints to date in 2018. **Complaint Analysis & Proposed Action Plan**: There are no proposed actions given that HPSM has received zero CTM complaints this year.

6.0 Committee Feedback on Authorization Process: Ms. Ault-Riche asked for the committees' suggestions or feedback about the authorization process. There were no suggestions, comments or feedback.

7.0 New Business: There was no new business.

8.0 Adjournment: The meeting was adjourned at 12:56 pm.

Respectfully submitted:

M. Heryford

M. Heryford
Assistant Clerk to the Commission