DRAFT

HEALTH PLAN OF SAN MATEO
CONSUMER ADVISORY COMMITTEE MEETING
Meeting Minutes - Thursday, December 13, 2018
801 Gateway Blvd. 1st Floor-Boardroom
South San Francisco, CA 94080

Agenda Item: 4.0
Date: March 7, 2019

Committee Members Present: Tricia Vinson, Robert Fucilla
Committee Members Absent: Judy Garcia, Hazel Carrillo, Cynthia Pascual, Ricky Kot, Mary Pappas, Angela Valdez
Staff Present: Gabrielle Ault-Riche, Dr. Susan Huang, Carolyn Thon, Pat Curran, Charlene Barairo, Rustica Escandor, Karla Rosado-Torres, Colleen Murphey, Michelle Heryford

1.0 Call to Order/Introductions: The meeting was called to order at 12:05 pm by Ms. Vinson.

2.0 Public Comment: There was no public comment.

3.0 Approval of Agenda: Ms. Ault-Riche noted that Pat Curran, Deputy CEO would provide the CEO report on behalf of Maya Altman. The agenda was approved as amended. **M/S/P**

4.0 Approval of Meeting Minutes for September 6, 2018: Ms. Vinson asked for approval of the September 6, 2018 CAC Meeting Summary. The minutes were approved as presented. **M/S/P**

5.0 HPSM Operational Reports and Updates

5.1 CEO Update: Mr. Curran reported on behalf of Ms. Altman. He asked Ms. Vinson to update the group on the recent proposed changes to public charge. Ms. Vinson advised the group that some of the proposed changes will include looking at whether one used Federal Health Care benefits in the past. She advised the group that they are specifically looking at individuals who are applying for a Green Card or those who have used Federal Health Care benefits in the past, including Part D. She also emphasized that they are focusing on individuals and not families. DACA recipients will be most impacted by this change. She reminded the group that this is only prospective, and will not impact those with benefits now. In fact, if implemented, it should only impact a

small group of people. Those with LPR status will not be affected by public charge changes. She notified the group about the education efforts being made by the Health Consumer Center at the Legal Aid Society to inform those who may be affected to use their benefits now while they can. She reminded the group that the Department of Homeland Security must reply to all comments submitted; at present there are more than 240,000 comments.

Mr. Curran advised the group about the completion of the Strategic Framework and provided copies to all CAC members. He also reported on HPSM's recent implementation of a recuperative program for recently discharged homeless members. He noted the difficulty this group has with fully recovering from their illnesses while not having a home or a safe place to go. There was an inquiry on the number of homeless HPSM members; that number was not available as it was noted that this population is ever changing and very difficult to monitor.

5.2 CMO Update: Dr. Huang reported on the following:

- Health Homes program launch for 2019. The program will target those with a high number of chronic conditions and those that have a high utilization of acute care. ¼ of the first cohort will be children, mostly those who have asthma and have frequent ED visits because of it. The second cohort will be for those with developmental disabilities and/or the homeless.
- She also spoke about the CAHP survey coming up in 2019 for HPSM members in the Duals programs and Medi-Cal.
- She updated the group about the status of the NCQA accreditation. HPSM has submitted all materials on December 5th and are presently awaiting word.
- Dr. Huang advised the group of the launch of PreManage, the new software system that alerts HPSM of all ED admissions within the county on an on-time basis.

Ms. Vinson inquired on the asthma cohort for Health Homes, specifically noting how housing code violations can impact children's health. Her organization found that helping doctors craft letters to landlords about unhealthy conditions, such as mold and mildew in the home, can result in major changes that benefit overall health.

5.3 Grievance and Appeals - Ms. Ault-Riche reported on the Grievance and Appeals report. She opened by noting the decrease in Medi-Cal members. This decrease is being felt by other plans in the Bay Area as well. She then outlined the methodology, enrollment averages for Q3 2018, as well as the Goal Ranges and Rate of Complaints per line of business.

Analysis – In Q3 all lines of business except Healthy Kids and CCS were within the goal rate of complains per 1,000 members. Given the small number of members enrolled in Health Kids and CCS these programs are susceptible to large changes in calculated rates, which often do not indicate a significant change in member experience. CMC, Medi-Cal and ACE which all have larger member populations, were within their established goals indicating that no corrective action is needed.

Barriers and Proposed Actions:

- **Finding**: The rate of complaints per 1,000 members was only higher than the goal rate for two smaller lines of business (Health Kids and CCS). All other lines of business were within the goal.
- **Barriers and Proposed Action**: There is no identified need for action at this time.

Timeliness of Complaint Resolution – Ms. Ault-Riche mentioned that the Grievance & Appeals team is struggling with timeliness; they have been short staffed but the addition of the new G&A Manager should help with that. They expect to be fully staffed by January 2019. The G&A Unit's goal, as mandated, is to resolve at least 95% of grievances and appeals within the required regulatory timeframe. The G&A Unit failed to meet its goals of 95% timeliness for Q1-Q3 2018 in processing grievances and appeals. In contrast, the Pharmacy Unit, which processes pharmacy appeals, met their goal of 95% timeliness.

Barriers and Root Causes:

- **Staffing shortage and Case Review Timeliness**
  - **Q2 2018**
    - Untimely case resolution in Q2 2018 was largely due to staffing shortages among the G&A Coordinators, G&A Manager and clinical reviewers, as described in last quarters report. In addition insufficient resources dedicated to the case review process resulted in delays.
  - **Q3 2018**

- While the G&A Unit continued to struggle with case timeliness in Q3, additions to G&A staffing and changes to the case review process are expected to have a positive effect in 2019.

Proposed Actions/Solutions – Many delays in case timeliness are the result of untimely case reviews. In response, the Unit has begun a restructuring process to expand responsibility and training for case reviews. The unit is also increasing its staff in January 2019. They anticipate that with more trained staff on case review, delays will be minimized.

CareAdvantage CMC– Ms. Ault-Riche updated the group on the CareAdvantage Unit. She went over the number of appeals and grievances received; the types of grievances received by category and sub-category as well as the resolutions within 24 hours, the types of appeals received and the rate of overturned appeals.

Analysis, Barriers and Proposed Actions/Solutions:

Grievances – The volume of grievances decreased significantly from 140 grievances in Q1 to 109 grievances in Q3 2018. The percentage of grievances related to Customer Service had decreased slightly from 51% in Q1 2018 to 44% in Q2 2018, but rose again to 49% in Q3. The percentage of grievances related to Quality of Care, Billing, and Access all remained within 5 percentage points of their rate in Q1 and Q2 2018. Therefore, there are no areas of concern in the type of grievances received.

Appeals - The percentage of appeals related to prescription drugs had increased from 29% (16 appeals) in Q1 2018 to 55% (33 appeals) in Q2 2018. In Q3, the volume of pharmacy-related appeals decreased back down to 35% (15 appeals), a volume similar to Q1 2018. This confirms that the increase in Q2 was due to the process standardization and annual transition period described in last quarter's report. Note: The percentage of appeals related to Durable Medical Equipment (DME) increased from 18% in Q2 to 26% in Q3. However, this percentage increase is only a reflection of the decrease in Part D appeals; the Unit received 11 DME-related appeals in both quarters. The volume in all non-pharmacy areas remained constant.

Proposed Action: Since Part D appeals have returned to their expected volume, no corrective action is needed.

Rate of Overturned Appeals: The rate of overturned appeals for medical services steadily increased from 30% in Q1 and 41% in Q2 to 43% in Q3. The overturn rate for pharmacy appeals had decreased from 63% in Q1 to 45% in Q2, but rose again to 67% in Q3.

Proposed Action: The Overturned Appeals Workgroup (a collaboration between the G&A Unit, Utilization Management Department, HPSM Medical Directors, and the Compliance Department) continues its monthly review of the reason for overturned medical appeals. Thus far, this review has indicated that the majority of overturned appeals are approved after receipt of medical records that provide clinical information previously missing from the original decision. This clinical information is usually requested by the UM Department during the initial clinical review process but is not always submitted by the provider's office until the request is undergoing an appeal. HPSM will continue to review these cases monthly.

Medi-Cal – Ms. Ault-Riche went over the Medi-Cal numbers. She reviewed the number of appeals and grievances received; the types of grievances received by category and sub-category, resolutions within 24 hours of receipt, as well as the types of appeals received and the rate of overturned appeals.

Analysis, Barriers, and Proposed Action - Across all categories, the rate of grievances and the rate of appeals fall within the established goal rates. Therefore, no corrective action is needed at this time.

Primary Care Provider (PCP) Changes by Provider - A total of 76 members requested to change their assigned PCP during Quarter 3 due to dissatisfaction. Members switched away from a total of 31 different PCPs. Of those, 16 were clinics and 15 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.

BHRS: In 2017 HPSM received 1.97 behavioral health grievances for every 1,000 members using behavioral health services. Based on this baseline, we have increased the goal rate to 1.5 grievances.

Note: BHRS has initiated changes to their utilization management process, intended to bring BHRS further into compliance with state regulation. These changes are expected to result in an increase in denials for behavioral health services, which will result in an increase in appeals, at least in the short term. In 2017, BHRS and Magellan only received 0.09 appeals per 1,000 members utilizing behavioral health services. This is expected to increase in 2018 and 2019. The rate of appeals is not expected to change for non-behavioral health services.

5.4 Provider Services: Ms. Murphey provided an update on Provider Services, some of the items they have been working on:

- Efforts to engage and improve provider relations from a provider network perspective. They recently had their first meeting with SNF facilities to introduce them to HPSM trainers who are working with front-line staff in nursing homes. They received good initial feedback from the facilities and will be working with them to co-design a new payment model. They will work on the payment model redesign in March.
- They are also working with Primary Care Physicians on collaborations with the Health Homes initiative.
- The department recently re-designed the PCP base contract.
- PS will be introducing Provider education and training in early 2019 as well as the Provider Portal; this will allow HPSM Providers to log in and check in on the status of claims and authorizations. She asked for feedback from the group on topics for Provider education.
- They are also working on the Provider Directory; this was created to help members search for a new physician or for physicians looking for a referral. They are still working on some back end changes to ensure accuracy and usability for members.
- Ms. Murphey announced the completion of the Timely Access and Provider Satisfaction surveys. Results from the Provider Satisfaction survey should be received in early January. The Timely Access Survey was just completed, it is an annual survey done for PCP's and select specialists to determine their appointment availability.
- She spoke about the Dignity contract with St. Mary's, St. Francis and Sequoia as well as their medical group. The recent addition of 3 Urgent Care facilities; will bring them up to 5 for the county. They have been

working with Provider's to help them educate members on when to use an urgent care facility versus the emergency room.

Ms. Vinson asked if they are seeing an overall decrease in physicians willing to accept Medi-Cal. Ms. Murphey replied that they haven't seen a major downturn this year in that respect.

5.5 Member Services: Ms. Ault-Riche provided the Member Services report. She reviewed the enrollment data for both Medi-Cal and CA CMC members. She reminded the group again about the decrease in Medi-Cal members, which is being felt by all Plans in the area. She also noted the efforts of Charlene Barairo and the enrollment/disenrollment team as well as the Marketing & Communications department for their success in enrolling new CareAdvantage members as well as their efforts in reaching out to members in the deeming period. For 2018, the HPSM Marketing Team set a stretch goal of 120 enrollments per month, although historically HPSM has enrolled 70-80 members monthly in CMC. In every month of Q3, HPSM enrolled a record number of members with a high of 111 members in September 2018.

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 increased slightly in Q3 2018 to an average of 52 seconds compared to an average of 24 seconds in Q2 2018.
- Call volume increased significantly in July and August, but in September returned to levels similar to Q2.
- Average hold time has remained steady at around 1 minute 22 seconds since March 2018, though it increased slightly to 1 minute 28 seconds in September. This hold time is well within the goal of two minutes.
- The percentage of calls answered within 30 seconds has decreased each month in Q3 from a baseline of 82% in June to a low of 63% in September. The unit did not meet the regulatory standard of answering at least 80% of calls within 30 seconds for Q3.

Ms. Vinson asked about the content of the calls, Ms. Ault-Riche replied that the majority of calls are inquiries about benefits, eligibility and authorizations. Ms. Vinson inquired about the percentage of calls that are specifically about Medi-Cal. Ms. Ault-Riche noted that that is sometimes

hard to monitor specific calls. Currently they have broad categories that do not provide enough detail about the content of the calls. They are currently working on a project to better code incoming calls.

Member Services Call Center Analysis & Proposed Action Plan –

Analysis: In Q3 2018, the Member Services Call Center did not meet its goals for the following regulatory metrics: 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.

Barriers: The Member Services Call Center was short staffed for part of Q2 2018 and all of Q3 2018. The Call Center was missing two Representatives – one Spanish-speaking and one Chinese-speaking.

Action Plan: The Customer Support Division hired a "floater" Representative in September 2018. This Representative is cross-trained in several Customer Support areas. As of November, he has completed his onboarding training and is currently assisting the Member Services Call Center full-time. Additionally, the Call Center hired two new Representatives in October 2018 who are currently in training.

6.0 CAC 2019 Meeting Calendar: Ms. Ault-Riche went over the proposed dates for the 2019 calendar year. There was no objection, the group agreed to adopt the dates as submitted.

7.0 New Business: There was no new business.

8.0 Adjournment: The meeting was adjourned at 1:00 pm by Ms. Vinson. **M/S/P**

Respectfully submitted:

Michelle Heryford

Michelle Heryford
Assistant Clerk to the Commission