Health Plan of San Mateo
Cal MediConnect Advisory Committee
Meeting Minutes
Friday, April 26, 2019 – 10:00 a.m.
Health Plan of San Mateo
801 Gateway Blvd., Boardroom
South San Francisco, CA 94080

Committee Members Present: Gay Kaplan, Lisa Mancini, Teresa Guingona Ferrer, Ligia Andrade Zuniga, Pete Williams, Claire Day, Janet Hogan, and Kirsten Irgens-Moller.

Committee Members Absent: Christina Kahn, Nancy Keegan, Evelina Chang, Tricia Berke Vincent, Beverly Karnatz, Sharolyn Kriger, and Diane Prosser.

Staff Present: Maya Altman, Pat Curran, Adrienne Lebsack, Gabrielle Ault-Riche, Katie-Elyse Turner, and Susan Huang, M.D.

Guests Present: Michael Grimes, Nina Rhee, Jill Dawson.

1. Call to Order
The meeting was called to order at 10:00 a.m. by Gay Kaplan.

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

3. Approval of Minutes
The minutes for the January 18, 2019 meeting were approved as presented. **M/S/P.**

4. Ombudsman Services (LTC) Report
Ms. Irgens-Moller, Regional Coordinator for Ombudsman Services of San Mateo County, advocating for the rights of residents in long-term care facilities, reported they have been seeing out of county people due to SNFs in San Francisco declining to accept Medi-Cal. People are struggling to transfer from San Francisco Health Plan to HSPM. Ms. Altman stated that this is not under HPSM control and likely under the responsibility of Human Services at the County. Ms. Ault-Riche asked that information on these cases be sent to her to review but that Human Services is responsible for inter-county transfers. Ms. Mancini was concerned by this because she stated there is a lack of Medi-Cal beds in San Mateo County and wondered what is happening in San Francisco. Ms. Irgens-Moller stated it is her understanding that all the Kindred facilities are transitioning into Medicare/rehab, short-term only and not accepting new Medi-Cal patients. She will look into this further.

The other concern Ms. Irgens-Moeller raised was related to Seton and if the new buyer will be committed to continuing to serve the Medi-Cal population. Ms. Altman stated that the status on Verity is that the court recently approved the new buyer. Next, the Attorney General will need to

approve the sale and public hearings will be scheduled. There were commitments made in 2015 that would need to be kept and she does not expect much to change at this point. She did note, however, they have said they would reduce the cancer service of which they do not have much. Mr. Curran added that the status of the sub-acute unit and Coastside long term care have been topics of discussion. There is no indication of any change but is really important to us.

Ms. Irgens-Moller commented that Seton staff are being told they need to start "correcting the payment mix." Ms. Altman said there have been discussions about them serving more Medicare with a goal to increase services provided at Coastside but expressed concern about preserving the mix. Ms. Altman said HPSM provided funding to reopen the Skilled Nursing Facility Unit on the 9th floor of Seton and part of the agreement was Seton taking on HPSM patients. They are full and have a lot of HPSM patients.

Ms. Irgens-Moller stated that the ongoing difficulty in discharges is another concern. It is hard to figure out what to do with people who don't have resources who are leaving nursing homes. Ms. Altman stated that HPSM is in the process of implementing a recuperative care program and is doing as much as possible through the Community Care Settings Program (CCSP). San Mateo County is having the same problem of losing Board and Care facilities having lost three last week in San Bruno and South San Francisco. Ms. Altman reported that IOA has been contracting with some new ones but overall the picture is grim.

Ms. Mancini suggested presenting recent data on the CCSP to get a better overall picture. She reported that they learned recently that one of their low income motels, Bel-Mateo Hotel will be closing. For years, this has been a place where they could house folks for a short period of time and get them stabilized at a lower rate and is another lost housing resource.

Ms. Irgens-Moller concluded that the Ombudsman groups at the state level will be meeting soon to lobby for much needed support.

5. Legal Aid Report

Representatives from Legal Aid were unable to attend this meeting. They will give a report at the next meeting.

6. Grievances and Appeals Report

Ms. Ault-Riche reported on Q4 of 2018:

- Rate of Complaints per 1,000 members for CMC has been well within the goal range of 21.3 per thousand for CMC members.
- Timeliness of Complaint Resolution shows that Grievances and Appeals are up due again to staffing issues. The goal is 95% but the last quarter resulted in 75% of grievances and 87% of Medical appeals resolved on time. In the last month, staff has cleared up a significant backlog. Currently, they have two nurse positions open.
- Volume and Types of Complaints: Appeals have remained steady and grievances have gone down throughout the year.

- Types of Grievances are consistent with past quarters; they are not seeing any unusual trends or problems for members.
- **Resolutions Within 24 Hours of Receipt**: Prescription Drug issues have remained steady (being resolved while the member is generally still at the pharmacy); resolution of issues related to Medical Supplies has gone down significantly from a total of 75 in the first quarter of the year to 9 at the last quarter of the year.
- **Types of Appeals** has remained consistent as well as the Rate of Overturned Appeals
    i. **Part C (Medical Services)**: the overturned appeals rate is 25%
    ii. **Part D (Prescription Drugs):** still high at 67% - this is primarily due to incomplete information. The Pharmacy Unit has less time to chase information. Staff continues to keep watch on this though due to the tight timeframes, the expectation is that this is normal.
- **Overturned Appeals by Provider Type** – the types of services that tend to be overturned are pharmacy, ancillary and home health. The initial decisions on Physical Therapy and Specialist appeals are generally upheld which means we are receiving the information needed to make the correct decision the first time.
- **PCP Changes** indicate that of the 75 members across all lines of business who requested to change their PCP during the quarter were for a total of 30 different providers and half of those were clinics. Also, providers with five or more members requesting a switch were from clinics. There is generally more concern when multiple members move from an individual provider rather than a clinic. This activity is consistent with previous quarters.

Ms. Kaplan asked if there is a trend in the type of drugs that are involved with the appeals. Ms. Ault-Riche said she would research this. Ms. Kaplan asked if there is a trend in reasons related to PCP changes. Ms. Ault-Riche responded that of the 75 changes, 26 switched because they could not get an appointment with their current PCP; 43 switched because of what they felt was poor service.

7. Updates and Discussion

- **Education Topics (taken out of sequence)**

Ms. Katie-Elyse Turner explained that, as a CMC plan, staff have a monthly call with CMS and DHCS to report on the CMC program regarding grievances and appeals, enrollment, marketing issues; this usually includes a monthly discussion topic identified by CMS. CMS sends questions for their selected topic to staff in advance which relate to various CMC benefits, plan processes or overall reporting across the Plans. Through this process, Plans receive information on what CMS identifies as best practices or trends. Ms. Turner presented an overview of the topics discussed at these meetings over the past quarter. She plans to give a similar report as educational topics at these CMC meetings going forward. In Q1 2019, the topics discussed were MSSP, Quality of Care in nursing facilities, and CAHPS scores. Her presentation with the outline of this information is attached:

MSSP

In January, CMS and DHCS were interested in MSSP particularly around participation, referrals and how integrated MSSP works. She noted that HPSM is the only CMC Plan that has integrated its program with the County systems.

Multipurpose Senior Services Program (MSSP) is an intensive home-based case management program with the goal of helping members stay in the community. Members eligible for MSSP are those who have a nursing facility level need of care, are already living in the community, and need some case management support to stay in their home. San Mateo County Health's Partners for Independence (PFI) is the newly re-branded agency which administers this program (previously called CCI-IHSS Unit). Ricky Kot is the manager of this unit and will join this meeting in the future. Key to this program is the Interdisciplinary Care Team (ICT) that works with members to develop individualized care plans (ICP). CMS and DHCS were interested in the process for intake and referrals.

Ms. Altman added that the MSSP Site Association sent a letter to DHCS to suggest that ongoing MSSP integration efforts not move forward and that MSSP be carved out of CMC. HPSM and LHPC plans have drafted letters to make a case to keep MSSP integration within the Plans moving forward. Ms. Turner noted that MSSP has been an integrated program at HPSM since 2014 and it would take a lot of work to unravel. Ms. Kaplan asked why they would want to fragment programs again. Ms. Altman was unsure how this would be beneficial. The message HPSM and the LHPC plans would like to send is that this program is worth working on and it is possible for integration to be successful.

There was a question about where the referrals come from. Ms. Turner stated the biggest referral source right now is the Health Risk Assessment process and the Care Planning process that staff administers. The assessment is a 50 question telephonic assessment and the care plan generates follow up items that go to the Care Coordination Team. They work with the PFI team to make the referral.

Quality of Care in Nursing Facilities

In February, CMS and DHCS asked about how the Plan was improving quality of care in nursing facilities and the overall quality of our facility network. Ms. Turner listed Post-Acute Care Pilot; Long Term Care Collaborative; and, Integration of LTSS into the Model of Care as initiatives for improving quality. Dr. Huang touched on these programs:

- Post-Acute Care (PAC) Pilot is a program through Landmark Health which provides care in the skilled nursing facilities for patients transitioning out of the hospital and also for long term care.

- Long Term Care Collaborative is an initiative that Pat Curran has been working on with 11 network facility administrators and staff to consider process improvements and quality improvement within nursing facilities. Reporting around some of the quality

measures and discussion about best practices is being shared, as well as performance. Within this is a payment sub group to discuss how to better support these network facilities. Staff shortages and effectively managing the members to get them back into the community continue to be a challenge. Staff is working more closely with providers on integrated discharge planning.

- Integration of LTSS into the model of care is in line with MSSP integration and the availability of CBAS centers. These programs promote the deinstitutionalization of members and support placement in the community. More supports around them are needed, not only housing but also intensive case management and social aspects.

- Related to quality of network, Dr. Huang noted that a pilot was started this year for staff to visit the facilities to review the active census of our members, sample a number of charts looking at the MDS and Acute sections to see how we can support the facilities in their discharge planning process.

  Ms. Kaplan asked about the lack of places for people to go upon discharge. Dr. Huang said staff are working on multiple mechanisms to place members into the community such as with housing subsidy vouchers, some set-aside units and possibly subsidizing the cost for assisted living facilities as well as Board and Care. Ms. Altman stated that the problem with assisted living in San Francisco and San Mateo County areas is that Board and Cares are shutting down and it's hard to stay in front of that, however, given the market forces, we are doing all that we can. Subsidized housing seems to be the best option for people who can live independently but the timing is always an issue.

  Ms. Irgens-Moller asked if the Plan is working with shelters. Dr. Huang stated we are not but Ms. Altman stated that the Plan has just been approved by the commission to work with a vendor on recuperative care for homeless members who are coming out of the hospital and still need some medical care. The biggest challenge is the permanent housing of course.

- In March, CMS and DHCS were interested in our 2018 CAHPS survey results and interventions. This survey was discussed in detail at our October meeting. Ms. Turner reviewed some of the results from Q2 2018 noting that overall, respondents were very satisfied with their health plan and drug plan. Improvements focused on "getting needed care" and "overall health care quality". Our Care Coordination Composite score was 5% above other CA MMP plans. Interventions were member-focused events and outreach communications; launching a member experience workgroup; hiring a Quality Improvement Specialist; and, building staff awareness of member-facing surveys and all the communications. The CAHP survey is currently out and we anticipate getting this year's results for member experience in the last six months of 2018 sometime in September or October.

- **CMC Updates and Dashboards (taken out of sequence)**
  Ms. Turner reviewed a few charts related to CMC (attached):
  - Charts related to LTSS Utilization were presented for IHSS, MSSP, NFs, and CBAS. These charts showed that overall utilization has been going up. This is good news for IHSS and MSSP. Nursing Facility utilization going up is not desirable. CBAS utilization has been stable in terms of the number of CMC members engaged.
  - Health Risk Assessment (HRA) chart shows the activities related to these assessments with detail indicating the percentage of HRAs complete within 90 days, the percentage of members who were unwilling to participate or those who were unable to be located broken down by quarter from 2016 through 2018. The number of HRAs completed in the 3rd and 4th quarter of 2018 dipped and the percentage of members unwilling to participate and who were unable to be located went up. Compared to the average CMC plan in California, we are a little bit below the 62% benchmark for HRAs completed in 90 days of enrollment. HRAs are a bit challenging for us due to the length of the HRA form itself.
  - Individualized Care Plan Completion chart indicates that high risk members percentage is at 82% compared to the State average of 69%; and, the low risk members is also at 82% compared to the State average of 71%. This is a good indication that we are doing a good job of completing the individualized care plans. Our numbers have been going up and we are well above the State average.

- **IHSS Update**
  Ms. Mancini introduced Nina Rhee who manages the IHSS program and Jill Dawson, Supervisor for the IHSS unit. In January, the group discussed having open discussions about IHSS at this CMC Advisory Committee. One of the areas we talked about was Protected Supervision and fair hearings.

  Ms. Rhee stated that there are 5,200 IHSS recipients, which is a wide population that includes seniors and people with disabilities. Protected supervision is available to safeguard against accidents or hazards by observing or monitoring the behaviors of non-self-directing, confused, mentally impaired or mentally ill persons (as defined by the State). Ms. Rhee continued to describe some of the process the social workers go through in determining and recommending protective services for a person. The assessment can take up to two hours to determine if a person is able to be directed. The goal is to keep people in their homes as safely as possible. Unfortunately when people hear the term protective supervision they think this is 24/7 care but it is not and they informed exactly what IHSS can provide. If they feel they have not been assessed accurately, they are encouraged to go through the State Fair Hearing process. Information on how to file a Fair Hearing is included on the notices that go to recipients. She noted that while there has been as slight increase in the number of State Fair Hearings, the percentage of people who are served with authorized hours for protective supervision is not really changing and remains constant at about 9%.

When reassessments take place, the same questions are asked but at this point they are looking to see if anything has changed since the last assessment. Is this a good time to consider protective services or, if they already have authorized protective service hours, are they still needed.

To give an idea of the type of IHSS recipient who might need protected supervision, Ms. Dawson gave an example of an individual who had a massive stroke and was able to recover well physically however, the cognitive functions changed dramatically. This left the person unable to work or deal with safety awareness. This person began wandering away from the home; started smoking and not managing this safely in the home; and, the spouse was unable to stay home to provide the needed care. Since applying for IHSS and having the specifics of protective services explained they have been able to stabilize the right kind of support to help the person stay safely in the home. A question about the requirement to receive protected services related to other programs was asked. Ms. Dawson explained it is not a requirement to be connected to some other program (like CBAS) but the social worker would help to determine if this was desired they could include that in the care plan.

A question was asked how an individual using the registry is matched with a person who would be able to provide the appropriate type of care. Ms. Hogan explained that the registry is restricted to specific criteria: gender, regular IHSS approved tasks, location, and language. Protected Services is for a maximum of nine hours a day so the provider would also have to be available for that within their schedule. It is the client's choice and they are responsible for training and scheduling the providers. Ms. Zuniga asked if there could be another leg to this process where there could be assistance for the clients in interviewing or how to approach these issues. She is concerned that people do not know how to handle it from the employer side. Ms. Rhee stated this is one of the more challenging areas is managing the provider portion. On the social work side they try to provide education with printed material, etc. For some consumers, managing providers is just too much and they get a lot of phone calls about this. Ms. Hogan stated that the registry is solely a referral service and are restricted to that, however, they have hired three social workers to hopefully help in these areas and whether or not the client needs the social worker to support them in the hiring process. They will also go out and meet with new providers and the clients when they hire a new provider to cover the logistics, the paperwork, timesheets, review the tasks that have been approved so there is a clear understanding of the relationship from the beginning. Ms. Day from the Alzheimer's Association stated they do help clients with some of this process as well and some of the questions they should be asking.

Ms. Rhee added that, as they get requests, they have been doing more outreach presenting at a variety of events recently in the community. These have been well received.

8. Other State/CMS Updates

Ms. Altman reported:

- Cal MediConnect has been extended to 2022 by CMS. There are a few changes: the quality withhold will increase to 4% as of 2020; there will be a disenrollment penalty for Plans that have a large number of voluntary CMC disenrollments; and they will increase the savings between the Plans and the State and Federal Government for profitable CMC plans.

- We are making progress with the State in building understanding of the programs that offer "In lieu of" services which give us the flexibility to design a care plan that is suited to the consumer and helps them to live safely and independently. The State is showing interest and we hope there will be more movement in this direction coming.

- The Governor's proposal in his executive order includes pulling pharmacy services out of the Medicaid Managed Care Plans and we would no longer manage the benefit. Part of the proposal is to do bulk purchasing for pharmaceuticals and pull this responsibility from the Plans. Most of our pharmacy benefit is for Medicaid so approximately 50% of our appeals are related to pharmacy which would result in all of those issues being handled at the State level. The governor will need a legislative appropriation to implement to hire staff, a PBM, etc., though the Order is set to go into effect in 2021. HPSM is working with internally and with our CA plan peers to develop alternatives that will meet the Governor's goals while letting us continue to manage the benefit.

9. Adjournment

The meeting adjourned at 11:28 p.m.

Respectfully submitted:

C. Burgess

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Clerk of the Commission

CMC Discussion & Updates

CMC Advisory Committee

26 April 2019

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Updates & Discussion

HealthPlan OF SAN MATEO
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- Q1 CMS-DHCS Discussion Topics
  - MSSP
  - Quality of Care in NFs
  - CAHPS
- CMC Dashboards
  - LTSS Utilization
  - HRAs & ICPs

Q1 CMS-DHCS Discussion Topics

Multipurpose Senior Support Program (MSSP)

- CMS-DHCS interested in MSSP referrals, participation, and plan-provider partnership
- Intensive case management and purchase of services with goal of supporting members to reside in the community
  - Home-based and provided by county CCI team (SW and/or PHN)
  - Member follows an ICP, which is developed in partnership with ICT
- HPSM has one of the highest rates of MSSP participation among CMC plan peers
  - Q1 2018: 7.1 members/k (tied for 2nd of 9 plans)
  - Q2 2018: 7.4 members/k (4th of 9 plans)
- Referrals: HPSM Care Coordination or County CCI
  - All 18+ CMC & MC members eligible
  - Must meet nursing facility level of care need

Quality of Care in Nursing Facilities

- CMS-DHCS interested in how HPSM is improving QOC for in NFs and the overall quality of the facility network
- Quality of Care
  - Post Acute Care (PAC) Pilot – Landmark Health
  - Long Term Care (LTC) Collaborative w/ 11 network facilities
  - Integrating LTSS into the model of care (MSSP, CBAS, CCSP, WPC)
- Quality of Network
  - SNF Payment Model Re-design (through LTC Collaborative)
  - SNF Chart Review – pilot to identify members for referral to CCSP

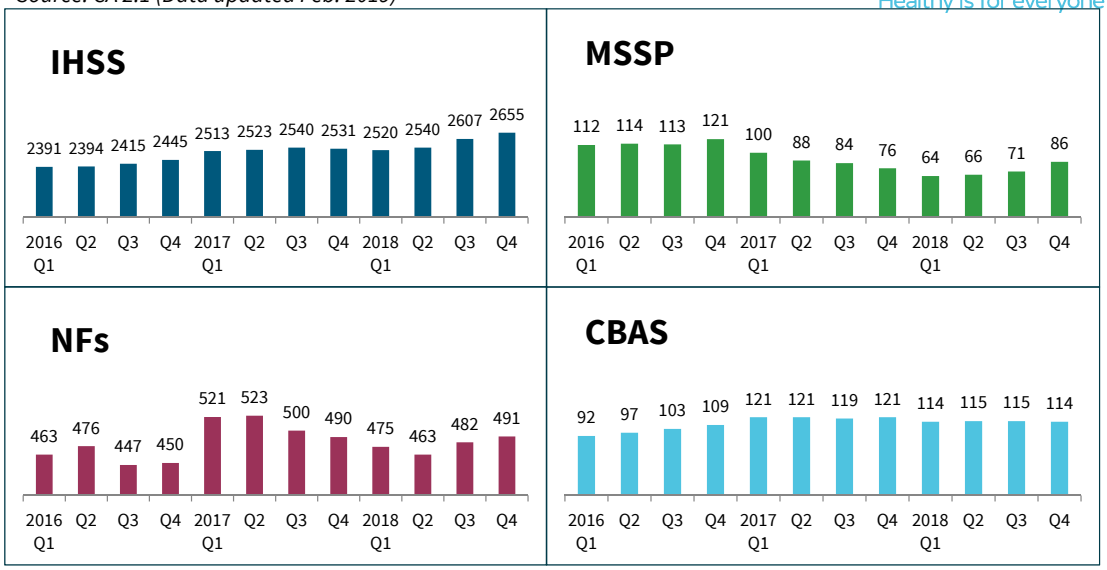
Consumer Assessment of Healthcare Providers and Systems (CAHPS)

- CMS-DHCS interested in 2018 CAHPS results interpretation & interventions
  - CMC Advisory Committee discussed 2018 CAHPS results in Oct. 2018
  - 2018 survey administered in English and Spanish in Q2 2018 with a 33.1% response rate (~265 respondents)
- Results
  - Overall, respondents are very satisfied with their health plan and drug plan; both aligned with CA MMPs
  - Opportunity for improvement in “getting needed care” and “overall health care quality”
  - “Care Coordination Composite” score is 5% above CA MMP average
- Interventions
  - Member-focused events & refreshing outreach communications
  - Launched Member Experience Workgroup & hired QI specialist w/ member focus
  - Building staff awareness of member-facing surveys (in-service training)

CMC Dashboards

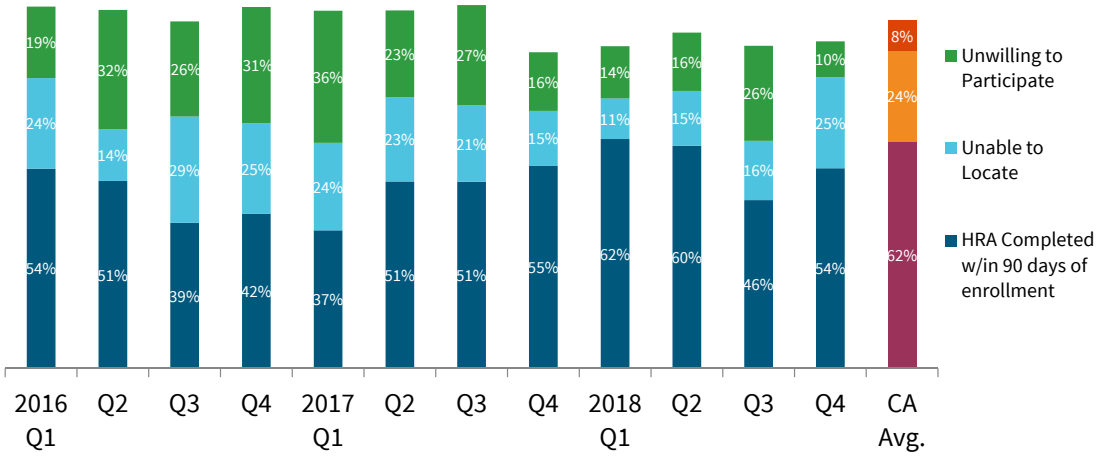
LTSS Utilization Among CMC Enrollees

Source: CA 2.1 (Data updated Feb. 2019)



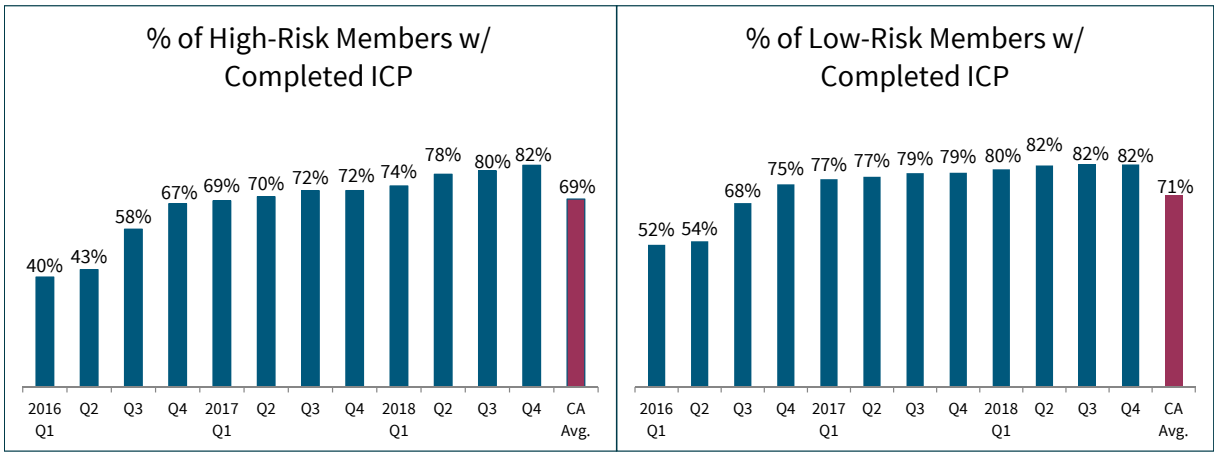
Health Risk Assessment (HRA) Completion

Source: Core 2.1 (Data updated Feb. 2019) & CA Average from Q4 2018 NORC



Individualized Care Plan (ICP) Completion

Source: Core 3.2 (Data updated Feb. 2019) & CA Avg. from Q4 2018 NORC



Thank You