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

Committee Members Present: Gay Kaplan, Sharolyn Kriger, Lisa Mancini, Janet Hogan, Christina Kahn, Teresa Guingona Ferrer, Ligia Andrade Zuniga, Pete Williams, Tricia Berke Vincent, and Kirsten Irgens-Moller.

Committee Members Absent: Angie Pratt, Nancy Keegan, Beverly Karnatz, and Diane Prosser.

Staff Present: Maya Altman, Gabrielle Ault-Riche, Pat Curran, Katie-Elyse Turner, Megan Noe, Nicole Ford, and Dr. Susan Huang.

1. Call to Order
The meeting was called to order at 11:34 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 July 20, 2018 meeting were approved as presented. **M/S/P.**

4. Ombudsperson Report
Ms. Tricia Berke Vinson reported:

- Legal Aid continues to provide the Ombudsman service to the CMC population and will be participating in a health fair taking place the next day.
- There has been a bit of staff turnover so there may be a slight delay in response to some things temporarily. She invited anyone who is having trouble to contact her at Legal Aid (650) 517-8961.

Ms. Irgens-Moller suggested adding a standing agenda item for "Ombudsman Services" to report trends related to Cal MediConnect as her office is the Ombudsman for the county. Ms. Altman explained that when the program started, it had its own Ombudsperson program headed by Legal Aid in San Diego and our local Legal Aid is the official ombudsman for that program. This reporting is a good way to hear what is going on in the Long Term Care facilities.

5. Grievances and Appeals Report
Ms. Katie-Elyse Turner postponed this report until Ms. Gabrielle Ault-Riche arrived at the meeting.

6. Updates and Discussion

a. 2018 CAHPS Survey Results

Ms. Katie-Elyse Turner reviewed the results of the CAHPS survey which is a member experience survey conducted annually:

- The survey is mailed to CMC members in English and Spanish and there is a telephonic follow up done after that
- Response rate was 33% which equals about 265 respondents with questions that are answered on scale, some are 0-10 with zero being is the worst and 10 being the best; or a never, sometimes, usually or always scale.
- Highlighted questions presented show that the health plan continues to perform well compared to other MMPs within California and nationally. She explained that the responses show that 30% of respondents rated HSPM in the 7 or 8 scale; and 62% rated HPSM in the 9 to 10 scale. Comparatively HPSM scored higher than other California or national MMPs. She noted that these figures were also an improvement from the previous year.
    - There were questions about how people who receive the survey are selected. It was noted that an outside vendor administers the survey and is primarily a random selection of members.
    - How accessible are the surveys, is only by hard copy? It was stated that it is a paper survey with a telephonic option to complete it. There is also the option to have a proxy complete it.
    - Do we know how many of the people sent the survey would be persons with disabilities? We do not have this information because of the random sample of the membership that receives the survey. Ms. Zuniga commented it would be helpful to have a demographical measurement to identify the numbers of people who have disabilities and would really help to see how satisfied they are with services. Ms. Turner explained that this is a national survey and have a set of questions that must be asked in the same way every year. We do have the opportunity to create or choose supplemental questions but not sure it would be able to impact the demographic area. Ms. Ford added that we can ask the vendor if there is a possibility of using our supplemental questions to get this information. Ms. Altman stated that the survey has always been a challenge for example they only translate the survey to Spanish and not the other HPSM threshold languages.
    - Ms. Vinson suggested that we consider doing our own survey. While CAHPS does give a comparison with other MMPs it is not able to show us local trends and what areas we might address or population segment.
- In general our members are satisfied with the quality of care they received at a score of 85 based on a case-mix adjustment which is above average.
- Access to appointments and care was rated as average and slightly below the national average.
- We are seeing some downward shifts in the area of members feeling they can get the care, tests, or treatment they need but still ranking strongly performing at 85%.
- Courteous Customer Services was ranked at 90%

    - A comment about the comparison in some of the measures being lower than the California or national results was surprising and a bit concerning. It was noted that this survey has its challenges in its comparisons for example the fact that it is only printed in English and Spanish, the selection bias in terms the types of members that tend to respond to two surveys, and this set of questions regarding customer service is not specific to customer services from the health plan and is open for interpretation for members to respond thinking about pharmacy, provider's office or anywhere that you are interacting with the health care system.
- Regarding Care Coordination, members are reporting they are getting more consistent support resulting in an improved ranking at about 89%.
- Members are reporting they have few problems getting their needed prescription drugs, ranking us at 96% and overall rating our drug plan at 90%.

b. CMC Dashboard

Ms. Turner reviewed:

Quality Withhold Measures:

- Ms. Turner explained that the Quality Withhold Measures are a set of measures that HPSM needs to meet in order to earn back a certain percentage of our premium that is withheld by CMS and our regulators for the CMC program. We have done well with this in the past earning 100% of the withhold and we are now tracking to figure out how 2017 and 2018 will fair.

MLR Dashboard:

- Ms. Turner reported that LTSS Utilization for CMC shows growth overtime in IHSS; Nursing Facilities is showing a downward trend over the last year and half with 463 members as of Q2 2018; MSSP and CBAS showing overtime that MSSP enrollment has declined to 66% and growth in utilization of CBAS which may indicate that those who are leaving MSSP are engaging more with the CBAS centers.
- Health Risk Assessments and Care Plans: the new vendor who began in 2017 has reduced the percentages on the number of people who are unwilling to participate and unable to be located, likewise they are performing more timely completion of the HRAs.
- Interdisciplinary Care Plan (ICP) Completion: More ICPs are being completed through the new vendor with 78% of high-risk members and 82% of low-risk members having completed ICPs.
- Timeliness is no longer reported to the state however but is tracked internally. Tracking as of the end of 2017 shows that there were some timeliness issues in the past but we have seen a shift in completion in the past few months with the new vendor.
- Call Center data shows: Average 2,100 inbound calls a month with an average talk time of 4.33 minutes. 65% of calls are about explanation of benefits, 20% are related to the provider network, 10% balance billing, and 5% are a mix of other issues. Data related to performance shows that the call center outperforms the CMS benchmarks

related to hold times, answer times, percent of calls answered in 30 seconds, and call abandonment rate.

Ms. Altman added that CAHP did a comparison of other plans for the quality withhold measures and there were only a few that received 100% of the quality withhold. HPSM was one of them. Some of these are related to process and some are related outcomes so we are doing well in these areas. Ms. Turner stated that while 2017 and 2018 are not yet complete our tracking seems to indicate that we are doing well in most areas.

c. IHSS Update:

Ms. Hogan gave an up on IHSS:

- Referral Count continues to fluctuate monthly but consistently continues.
- Caseload count is at about 5,253 for the IHSS program
- Staffing challenges have occurred in the last few months with Social Workers but they have filled most of those positions.
- A new Medi-Cal Benefits Analyst Specialist is now located in the IHSS program to help with clients who are about to lose Medi-Cal, or are in need of Medi-Cal, in order to qualify for IHSS.
- An evaluation of the intake process has just been completed and they will soon implement a few changes to increase efficiencies in the time frame between the screening process and assignment.

Ms. Mancini added that the county is expecting a larger gap from revenue to expenses especially in health. The County Manager has asked that all departments prepare for a 2.5% reduction in the net county cost. We are being asked to add another 2.5% bringing it to a 5% reduction in our net county cost in health, due to an estimated from $27-$50 million gap. They are seeing constant increases in the IHSS case load and expect this to continue. This will impact the work done with clients so they are looking at efficiencies such as in the intake process and other areas. Ms. Mancini hopes to bring more of an update on the budgeting issues in January. Ms. Altman noted that this will not happen immediately so there is time to plan for it but part of the way the IHSS is funded may be impacted with the current and upcoming administrations and will be affecting all counties.

Ms. Kaplan asked about the work force issue. Ms. Mancini answered there is an issue and a wage increase was just implemented for the providers to $13.90 an hour. They are seeing more providers coming into the county. Ms. Hogan added that they are embarking on a new social media program beginning November 1st using Facebook, Twitter, and Next Door to bring in more providers and are seeing about 12 new providers a month. They are filling their schedules almost immediately.

Ms. Zuniga stated that San Mateo County is the most generous in terms of benefits and incentives for providers compared to other counties. The Commission on Disabilities is trying to support the IHSS program us much as possible. In 2019, they hope to do a forum to explore what is working and what is not, and to advocate for increased funding for public authority workers like case managers and social workers. The information will be gathered and shared with legislators to advocate to the state.

Ms. Kaplan asked if there is an influx of disabled veterans and if so do they use the county services. Ms. Mancini stated that there are some but was unsure how many. Ms. Hogan stated that if they are aware they are veterans, they ask them to use those services as much as possible since they do have a robust program for home care providers. She was not sure of the percentage but will find out for the next meeting.

Ms. Vinson commented that a 5% cut to these type of services would be devastating and asked if there is a way to have consumers present or share what the program means to them and what a cut would look like for them. Ms. Mancini replied that a report had just been presented to the Board of Supervisors regarding the health budget and their process for planning for the next two year budget cycle. Staff is reaching out to stakeholder groups to hear concerns to bring those to the board. Ms. Kreiger commented that there is a desperate need to find workers for the skilled nursing facilities. People cannot afford to live in the county anymore, the unemployment rate is under 2%, everyone who wants a job, has a job and this is a problem. Many facilities are filing for work force shortage waivers and have to tell the families, etc. that they are short staffed.

Grievances and Appeals Report (taken out of order)

Ms. Ault-Riche reviewed her written report:

- The new layout of the report is a result of the plan's efforts to be NCQA accredited.
- Enrollment and complaints per thousand members are broken down by line of business. NCQA requires the plan to set benchmarks. She expressed a bit of concern around setting goals around volume of complaints because it can incentivize under-reporting if staff is trying to get below a certain target. In the past, the plan's philosophy was that we want to hear from our members and get their feedback regardless of the number of complaints.
- In 2017 and 2018, there were a minimum of 19 complaints per thousand members for CareAdvantage which includes both grievances and appeals and a maximum of 23.6 per thousand members. Based on this information the goal of 21.3 per thousand members was set. Q1 the number of complaints was 21.5 and Q2 was 21.6 which is in the ballpark of the goal.
- Timeliness of Complaint Resolution: pharmacy has solved appeals on time; and, grievances and appeals struggled a bit at the beginning of the year due to staffing issues but they are now fully staffed.
- Appeals and Grievances for the Q1 and Q2 have remained consistent in the number received and in the distribution of the types of grievances.
- The types of appeals received shows an increase in the number of prescription drug appeals received between Q1 and Q2 due to two issues: members have an annual transition period where they are given a certain amount of time to stay on a drug that may no longer be on the formulary in order to give them time to transition so a drug that had previously been approved for them is now getting denied; and, a change in process in the pharmacy department in the progression of taking one

medication before going to another which leads to more denials initially and results in more appeals. This is actually an improvement from a process perspective but results in an increase in appeals.

- The rate of overturned appeals for medical services increased a bit from 30% in Q1 to 40% in Q2; pharmacy went down with 63% in Q1 to 45% in Q2. A workgroup made up of Medical Directors and other departments was formed to do a case by case review looking at overturned appeals and the reasons. The good news is that the UM staff has strengthened their process with their outreach on the front end. Usually, overturned appeals are a result of records being received outside of the regulatory timeframe not because of a lack of effort by the UM staff.
- PCP changes by provider were consistent and there was nothing of concern showing there.

Questions:

- Ms. Vinson asked regarding the Medical overturns if there was a particular type or consistent pattern or trend. Ms. Ault-Riche stated that they have not looked at this however, many appeals are related to durable medical equipment but she does not have the percentage of those being overturned vs. other issues but this is something she can look into in the future.
- Ms. Kaplan asked about the prescription drugs and if we are being affected by the opioid issue. Dr. Huang stated that they are taking a closer look into this issue because she feels that it is an issue that is impacting across age. She added that health plans should not take a blunt approach to this by just imposing dose restrictions because this will inadvertently have consequences. She noted that pharmacies are now required to look at the records for these meds. The health plan is limited in its claims data since the health plan does not capture those that are paid for in cash. They are now looking for patterns in the pharmacy data within prescriber pools to help identify problems and sharing provider level reporting, along with other approaches and solutions.

7. Other State/CMS Updates

Ms. Altman reported:

- CMC is scheduled to end at the end of 2019 and the state has put in a request for an extension through 2020. CMS is asking for a longer extension from the state. We don't know where this discussion is at this point. Her main concern is by November 12, 2018, we would have to put in a letter of intent to apply for a special needs plan which is a long and costly process. We hope to learn more soon to avoid this.
- Verity bankruptcy process continues. Seton is the highest volume hospital for HPSM Medicare members. They also have a large SNF volume on the Coastside and the new inpatient unit that HPSM helped pay for, as well as a sub-acute population, all of which we are concerned about. Contingency plans are in the works and staff is watching this issue closely.
- Ms. Altman asked what topics the group would be interested in hearing about in future meetings.
- The health plan has reached an agreement with Dignity Health effective October 1st which includes their San Francisco hospitals.

Questions:

- Ms. Kahn asked about the contingency plans. Ms. Altman stated they are not ready to share this yet but wanted to assure that nothing will happen very soon. It is very difficult to close a hospital with all the state and federal regulations. They cannot abandon patients, they have to find placements for them all and HSPM would be interested in trying to encourage any operator that will continue to operate SNF beds. The greatest concern is the sub-acute patients since there is a shortage of these services. For regular inpatient there is plenty of capacity and people should not worry. It was asked if there were a way to publicly reassure the community or patients. Ms. Altman thought this was a good point but difficult to do because the issue is under the direction of the bankruptcy judge. She will think about how this might be done.
- There was some discussion about the status of Three Bells on the Coastside and their ability to provide service. It was noted that this is something to look into.
- More discussion began around Sutter's non-profit status and the idea of assisting Seton Coastside or relicensing empty beds as SNF beds.

CareAdvantage All Aboard event will take place on October 20 in the health plan offices. Care Advantage members and potential members have been invited. There will be booths, vendors, flu shots among other activities for these people will be able to participate. Staff will be available to answer questions and talk to people. Ms. Kaplan asked how they will get to the health plan. Ms. Ault-Riche stated that if they do not have a means of transportation they can use their transportation benefit if necessary.

Meeting dates for 2019:
Ms. Kaplan pointed out the list of meeting dates for next year. All were in agreement.

Ms. Zuniga added that also on October 20th is an event from 11-3pm for people with disabilities that are transitioning from adolescents to adulthood – at Mills High School. At the end of the month is a disabilities expo at the Expo Center on 11/24-11/26.

8. Adjournment

The meeting adjourned at 1:00 p.m.

Next meeting: January 18, 2019 at 11:30am at the Health Plan of San Mateo Boardroom.

Respectfully submitted:

C. Burgess

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Clerk of the Commission