Health Plan of San Mateo
Cal MediConnect Advisory Committee
Meeting Minutes
Friday, July 21, 2017 – 11:30 a.m.
Health Plan of San Mateo
801 Gateway Blvd., Boardroom
South San Francisco, CA 94080

Committee Members Present: Susy Castoria, Gay Kaplan, Christina Kahn, Sharolyn Kriger, Lisa Mancini, Janet Hogan, Angie Pratt.

Committee Members Absent: Ligia Andrade Zuniga, Nancy Keegan, Teresa Guingona Ferrer, Danilyn Nguyen, Stephen Kaplan, Diane Prosser, Pete Williams

Staff Present: Maya Altman, Gabrielle Ault-Riche, Melora Simon, and Katie-Elyse Turner.

1. Call to Order
The meeting was called to order at 11:32 a.m. by Gay Kaplan.

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

3. Approval of Minutes
The minutes for the May 19, 2017 meeting were approved as presented. **M/S/P.**

4. Ombuds Report
Representatives from Legal Aid were unavailable to attend. No Ombuds report was given.

Grievance & Appeals Report – Q1 2017 (not numbered on the agenda)
Ms. Gabrielle Ault-Riche reported on the first quarter of 2017 (January – March 2017):

- Grievances and Appeals increased for CMC members: 66 appeals in Q1 (compared to 37 last quarter); 158 Grievances (compared to 105 the previous quarter). Changes in utilization management processes may be a reason for an increase in appeals.
- Breakdown of grievances shows an increase in the Access and Billing categories. Access grievances was 27 (compared to 16 in previous quarter); Billing grievances doubled from the previous quarter. Ms. Ault-Riche will investigate the reasons for these increases.
- Availability (timely appointments) stayed consistent; Quality of Care had an increase of five which is insignificant.
- By type: Appeals were mostly generated by DME issues consistent with previous quarters; next was prescription drugs with a slight increase from the previous quarter.
- Overturned Appeals were up: Medical Services was 39.6%; Prescription Drugs was 66.7%. Dr. Beed is looking into correcting this by using more proactive outreach by staff to avoid overturned decisions.

- Resolutions within 24 Hours of Receipt have gone up. This is not necessarily bad since it means more issues are being resolved quickly. For CareAdvantage, 75 of these calls were Prescription Drug issues compared to 54 in the previous quarter, but compared to the same quarter the previous year, this is down from 107.
- Rate of Complaints per 1,000 members is relative to the number of Grievances and Appeals for the quarter but timeliness of complaint resolution has gone up. This indicates that staff has kept up with the volume.
- PCP changes were consistent with previous quarters.

5. Updates and Discussion

a. Review of CMC Key Performance Indicators

Ms. Melora Simon distributed a copy of a presentation about the CMC program. A copy of the handout is attached. Ms. Simon covered the following points:

- Enrollment in CA CMC – numbers are declining slowly over time due to increase in disenrollments, 92% of which are involuntary (losing Medi-Cal, etc.) The reduced deeming period of 2-months compared to 6-months is affecting reinstatement of benefits. Another factor is a recent issue around the sharing of information with HSA that has caused a delay in helping people retain their benefits. Ms. Altman said they have reached out to the state for a determination about this with the case being made that this information is necessary for Medi-Cal administration. Ms. Hogan noted that this same issue has affected IHSS and Adult Protective Services.

  Ms. Simon pointed out the number of people who are CMC eligible that are not currently enrolled and some of the steps being taken to reach out to them. Ms. Altman added that an agreement with Sutter Health has been reached which will avoid members disenrolling due to network considerations and staff will continue negotiations with Dignity Health to encourage their participation.

- Demographics – Ms. Simon reported that demographics have remained stable with 75% of the membership being over 65 and half is over 75. Overall the membership is aging a little bit. Geographically, about half the members are from North County and the rest is roughly split between Central and South County with a small group on the Coastside and outside of the county.

- Functional Status of Membership – Ms. Simon explained that the state uses categories: Members living in institutions; (HCBS) Home and Community Based Services/High; Home and Community Based Services/Low; and, Community Well. Our institutional population is decreasing slightly probably driven by the Community Care Settings Pilot. The Community Well category is also reducing as people age and functional impairment increases.

- Utilization of Long Term Supports and Services – across the board utilization has gone up except in long term care.

- Assessments – the duals demonstration is performing health risk assessments (HRAs) for new members joining the program which are being used to develop care plans. About 40% of new members are having assessments done in a timely manner which is a little below the California average. This is mostly due to members not wanting to participate. A new vendor is about to go live on October 1 and the hope is this will increase the numbers of assessments performed.

- Care Plans – Because care plans had been difficult complete in a timely manner, the health plan recruited a vendor to help in 2016 and now 75% of new members are getting these care plans completed timely which is above the average. The new HRA vendor will also begin developing the care plans.

- Primary Care Engagement – 87% of our members see a PCP each year. For members that have an assigned PCP, about 77% are seeing their assigned physician. Staff has been focusing on connecting the members who do not have an assigned PCP to a physician in our network. This number is going down but those without an in-network PCP are much less likely to see a physician. Susy Castoria asked if people are just seeing their specialist and having their primary care handled that way. Ms. Simon stated they have not looked at the specialists but could take a look at this. Ms. Altman stated that we know there are members who are not being seen by a doctor at all.

- Landmark (HomeAdvantage Program) – the program launched in November 2016 and has engaged 500 members which amount to about 20% of the target population. Ms. Mancini asked if we know how many of these 500 members have IHSS. Ms. Simon said she would furnish a list monthly to Aging and Adult Services Department.

- Transitions of Care – about 84% of members who have a hospitalization and are moving back into some sort of ambulatory care are seeing a PCP or specialist after discharge. She will have the California average to compare at the next meeting.

- Call Center Performance – the performance of the call center has been very strong with low abandoned call rates and high speed to answer. There was a small dip in January because staffing was low and call volume was high.

- Grievances – Ms. Simon stated that grievances are lower than the California average.

- Quality Withhold – staff have focused on demonstration year two and three because the measures have changed since the program began in 2014-15. While results were good in 2014, we were about half way there in 2015. In terms of demonstration year two and three, results were good. Some are HEDIS measures that are across the lines of business and some are related specifically to the demonstration but, in general, 2016 performance is at or above the benchmark in the majority of the measures.

- Financials – Ms. Altman stated that this slide does not indicate a good picture. While the health plan is doing everything it can to move people out of institutions and are way ahead of any other health plan, the financials show a loss. Ms. Simon reviewed the slide showing the financials covering the past three years. The chart indicates losses on both the Medicare and Medi-Cal side. Based on budgets, we expect those losses to continue.

- Planned Initiatives –Staff has a goal to get to 90% Medical Loss Ratio (MLR) over time and make the program sustainable. Initiatives include working on: Quality withhold; Risk Adjustment; Inpatient Cost; Pharmacy; and, Enrollment.

Ms. Altman asked for input on information the group would like to see reported at this meeting. Some discussion ensued around the financials and how other health plans are doing in comparison with HPSM. Ms. Altman stated that since final rates have not been received, it is uncertain if HPSM is really losing money. Without rates it is not clear where we stand and other plans are in the same situation. Risk Adjustment is the key to the process but Medicare does not pay for all the challenges that these members face (such as dementia).

b. IHSS Update

Janet Hogan shared information regarding the IHSS program:

- Public Authority has just completed their first year of Essential Care Giving Skills Training series. They were pleased to have increased training from 8 to 65 trainings with a total of 1,045 enrollees for all workshop classes (some enrollees enrolled in multiple classes). There were a total of 69 people who finished the series and received their certification.

- Registry Database – conversion will begin in a week to the new system. This system will provide the ability to maintain provider availability through the use of a web based program. Being able to know the availability of registered providers has been a big challenge. Providers will be able to go in and adjust their availability as they gain or lose clients. This system will also increase reporting capabilities and streamline the process related to training, the registry, and the health benefits which are all currently managed manually.

- Electronic Timesheets – will begin on October 9, 2017. IHSS recipients and providers will start to receive notification about this change two weeks prior to implementation. Both parties will need an email address provided to the county and will be able to register online to participate. This new system is a result of an audit the state did the timeliness of payment to IHSS providers and is the first step in correcting that problem. Within the three pilot counties, about 12% are signing up. Additionally, there is a telephonic option for those who are not able to do this online. They have to register online but will receive phone calls to approve the timesheets. Another push is to get people set up with direct deposit to get providers paid as quickly as possible.

- Ms. Hogan reviewed charts related to caseloads and referrals in IHSS:
    - Referrals have dropped a little with 159 referrals in June. Referrals are unpredictable. Overall, about 40 less referrals were received last year compared to the year prior.
    - There are currently 4,565 IHSS caseload/patients authorized for services that are being managed.

- Ms. Simon talked about HomeBridge which provides the contract mode. Half of the people in this group have dementia or mental health illness which is a challenge for providers. It has been difficult finding IHSS providers for this population and is the reason why referrals here are way down.
- The number of unserved hours is up which relates to the same issue of provider availability.
- Ms. Hogan reported they are offering monthly orientations as opposed to quarterly and getting 15-20 each time with most completing the process and getting to work almost immediately. They receive about 100 referrals a month from IHSS.

c. Other State/CMS Updates

Ms. Altman mentioned that the last time this group met the funding for the IHSS program was very uncertain. Ms. Mancini reported that the May revise came out and the program funding has been extended for the next two years. There will be no reductions in the IHSS program or MSSP Program. Before any decisions are made related to CCI, staff is waiting to see what the program will look like going forward. However, there will not be any additions. Caseloads are growing yet unpredictable. Caseloads for social workers have increased because of a pause on hiring until a decision is made about hiring to backfill some of those positions. She added that numbers related to the maintenance of effort on an annual basis have not been received.

Ms. Altman had nothing definitive to report related to actions by the federal government. She did say if the current Better Care Reconciliation Act (BCRA) fails that would be good news. She spoke about the senate bill and impacts on Medicaid. Advocacy to voice objection to these actions through the "Medicaid Is Us" multi-media campaign is being pushed. On July 15th, Congresswoman Jackie Speier held a town hall meeting with about 500 people participating. People gave moving speeches about the positive impacts of the ACA and why it is important to them and their families.

Ms. Altman reported on the health plan completing a CMS audit that began 18 months prior. She explained there were 28 deficiencies found that had to be corrected, and then there was a validation process to prove the corrections were actually made. This was a tremendous amount of work and she was very pleased with the work done by staff.

6. Adjournment

The meeting adjourned at 12:55 p.m.

Next meeting: September 15, 2017 at 11:30 a.m.
Health Plan of San Mateo
801 Gateway Blvd., Suite 100, South San Francisco

Respectfully submitted:

C. Burgess
C. Burgess
Clerk of the Commission

ATTACHMENT 1

Cal MediConnect Advisory Committee – Grievance & Appeals Report

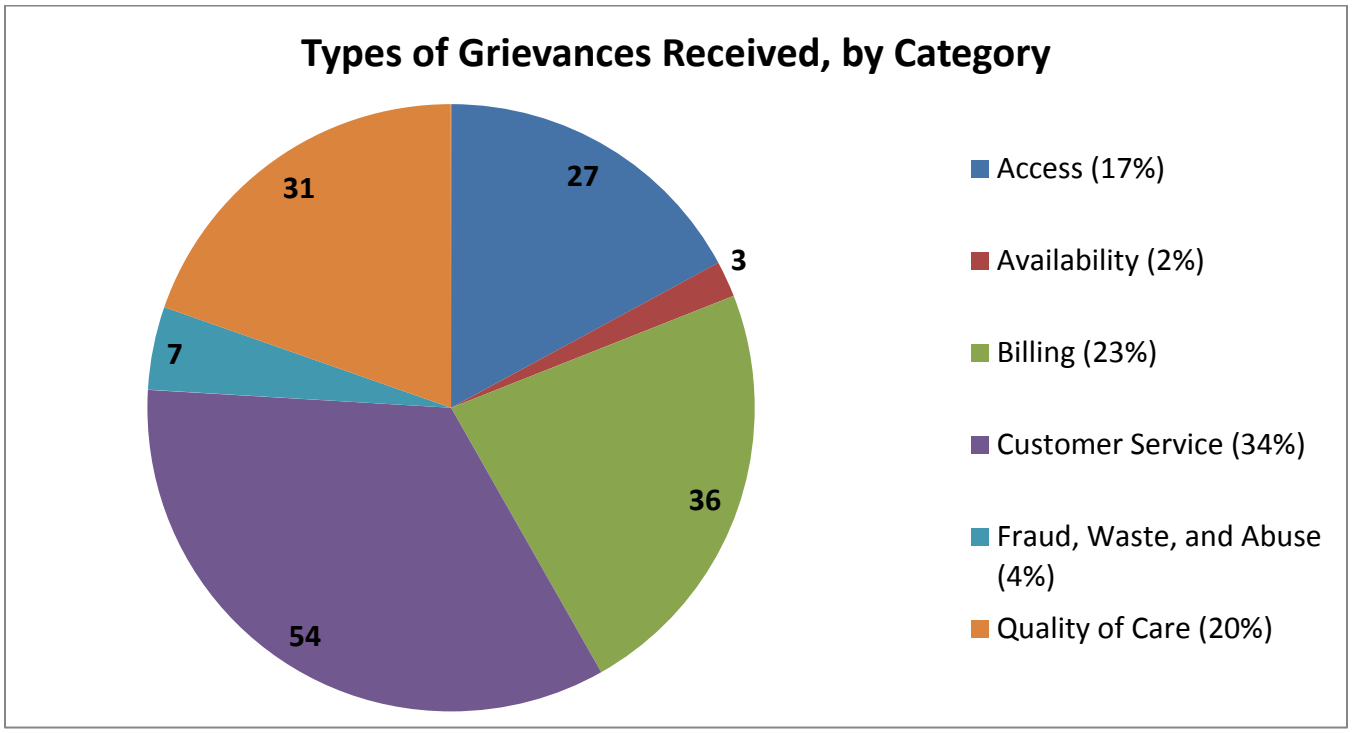
Reporting Period: Q1 2017 (January – March 2017)

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**	5				
		Standard	43				
	Part D (Drugs)	**Expedited**	2				
		Standard	16				
	Total Appeals		**66**				
Grievances	**Part C**	**Expedited Grievance**	1				
		Standard Grievance	152				
	Part D (Drugs)	**Expedited Grievance**	0				
		Standard Grievance	5				
	Total Grievances		**158**				
	CareAdvantage CMC Subtotal		**224**				

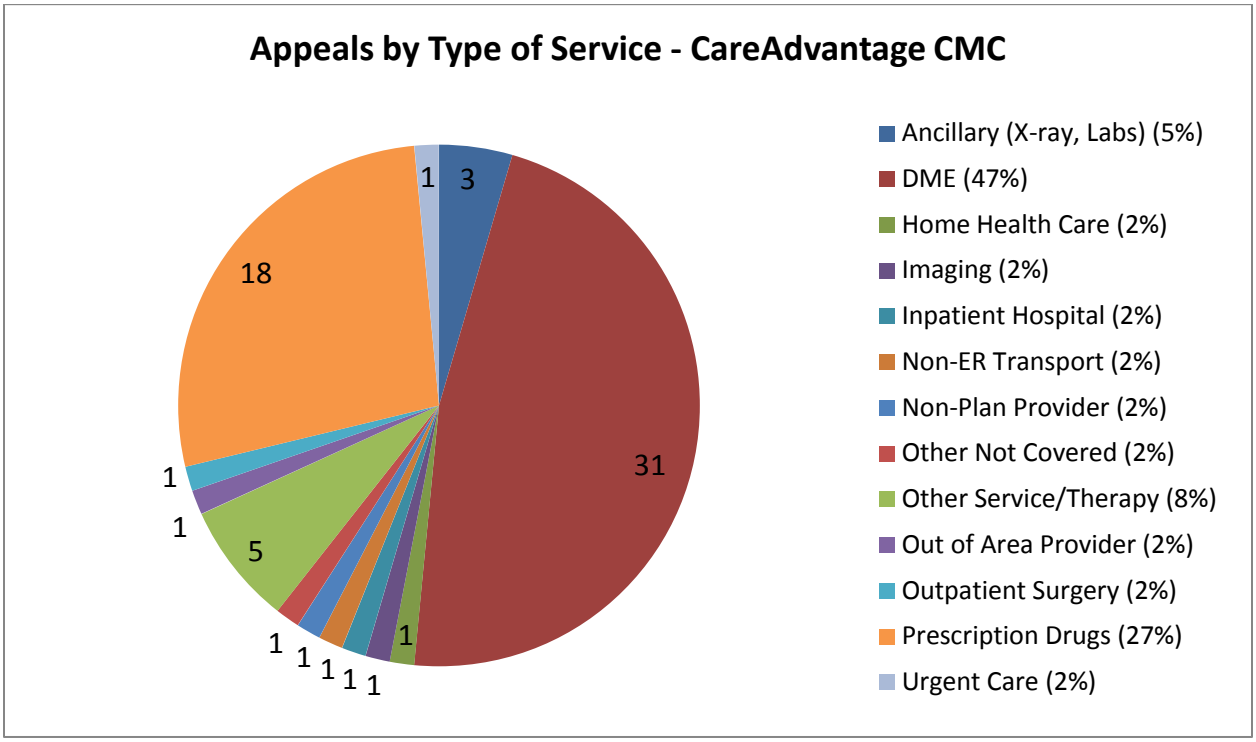
2. Types of Grievances Received, by Category



3. Type of Grievances Received, by Sub-Category

Category	Sub-Category	# Received
Access	Network - Facility (Hospital, Skilled Nursing Facility)	1
	Network - PCP	2
	Network - Specialist	2
	No Treatment Authorization Request or Prescription on File	7
	Other	6
	Provider Not Dispensing Drug	2
	Provider Not Dispensing Item	7
Access Total		27
Availability	Other	1
	Unable to Schedule Appointment	2
Availability Total		3
Billing	Balance Bill Not in Collections	2
	Balance Bill in Collections	20
	Full Bill Direct to Member	12
	Other	2
Billing Total		36
Customer Service	Communication - Disrespect/Rudeness/Discrimination	7
	Communication - Incorrect Info Given to Member	3
	Communication - Other Issue with Staff	21
	Taxi - Driver no-show	2
	Taxi - Late pick-up/ drop off	5
	Taxi - Other	7
	Timeliness - No return call	7
	Timeliness - Other	2
Customer Service Total		54
Fraud, Waste & Abuse	Fraud - Identity Theft	1
	Fraud - Other	1
	Fraud – Provider Billed without Rendering Service	3
	Waste	1
Fraud, Waste & Abuse Total		6
Privacy/Confidentiality	Other	1
Privacy/Confidentiality Total		1
Quality of Care	Other	12
	Relationship - Provider Not Listening to Concerns	3
	Relationship - Provider is Rude/Mean/Etc.	2
	Treatment - Drug Not Prescribed	1
	Treatment - Poor Diagnosis	1
	Treatment - Poor Treatment	10
	Treatment - Services Not Rendered	2
Quality of Care Total		31
Total		**158**

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	48	18	2	19	9	39.6%
Part D - Prescription Drugs	18	6	0	12	0	66.7%

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	8				
	Prescription Drugs	75				
CareAdvantage DSNP	Medical Services/Supplies	0				
	Prescription Drugs	0				
Medi-Cal	Medical Services/Supplies	16				
	Prescription Drugs	145				
Other LOBs (CCS, HW, HK, ACE)	Medical Services/Supplies	3				
	Prescription Drugs	4				
Total About Medical Services/ Supplies		**27**				
Total About Prescription Drugs		**224**				
TOTAL		**251**				

24 – Hour Resolutions, by Category and Subcategory:

Category	Subcategory	# Received
Access	Code 1 Override	3
	Network – Ancillary (Lab, Radiology, PT/OT)	1
	Network – DME/Other	1
	Network – Specialist	1
	No Prior Authorization or Prescription on File	8
	Other Health Coverage	66
	Other	55
	Provider Not Dispensing Drug	64
	Provider Not Dispensing Item	2
Access Total		201
Availability	Excessive Wait Time for Appointment	1
	Other	5
	Unable to Schedule Appointment	8
Availability Total		14
Billing	Full Bill Direct to Member	23
	Other	1
Billing Total		24
Customer Service	Communication – Incorrect Info Given to Member	2
	Communication – Other Issue with Staff	2
	Taxi – Driver no-show	1
Customer Service Total		5
Enrollment/Disenrollment	Issue with Eligibility	6
Enrollment/Disenrollment Total		6
Privacy / Confidentiality	Other	1
Privacy / Confidentiality Total		1
Total 24-Hour Grievances		**251**

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	23.6			
CareAdvantage D-SNP	-			
Medi-Cal Only (Excluding CCS)	2.6			
Healthy Kids	3.7			
HealthWorx	5.7			
ACE	0.4			
CCS	6.1			
TOTAL	**3.7**			

The rate of complaints per 1,000 members is based on the average enrollment numbers for Q1, 2017.

Line of Business	Average Enrollment for Q1
CareAdvantage CMC	9,497
CareAdvantage DSNP	--
Medi-Cal Only (excluding CCS)	112,327
Healthy Kids	1,076
HealthWorx	1,050
ACE	21,605
CCS	1,642
Total	**147,196**

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	370	367	99%
Medical Appeals	108	104	96%
Pharmacy Appeals	67	67	100%

V. Primary Care Provider (PCP) Changes by Provider

Reason for PCP Change	Number of Changes in Q1
Difficulty In Obtaining An Appt.	45
Poor Service	47
Provider And Patient Incompatible	10
Total	**102**

A total of 102 members requested to change their assigned PCP during Quarter 1 due to dissatisfaction. Members switched away from a total of 41 different PCPs. Of those, 21 were clinics and 20 were individual providers. For 5 providers, 5 or more Members requested to switch away from their practice. Of these, 4 were group practices or clinics and 1 was an individual practitioner.

ATTACHMENT 2

Duals Demonstration Update

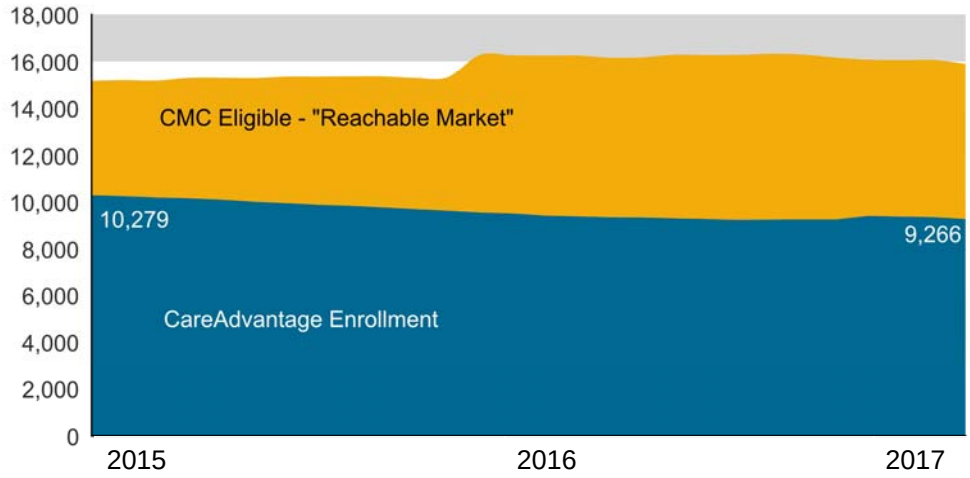
CMC Advisory Committee
July 21, 2017

Today's discussion

CA CMC Overview

- Enrollment
- Demographics
- Key Performance Indicators
- Quality Withhold Performance
- Financials

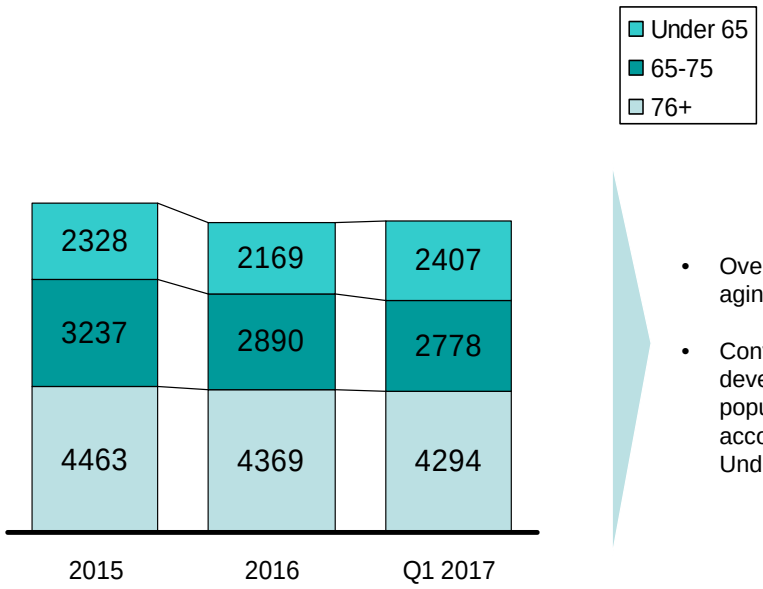
10% Decline in CareAdvantage CMC Enrollment Since 2015



- Major driver relative to pre-2014 is a 30% increase in disenrollments, likely due to shorter deeming period (2 mos. vs 6 mos.) and loss of MEDS access
- New enrollments are also down, though higher in 2016 due to DD conversion
- Other plans are also experiencing declining enrollment (7%) overall though IEHP and LA Care have recently seen growth

~75% of our membership is over 65

Average monthly membership

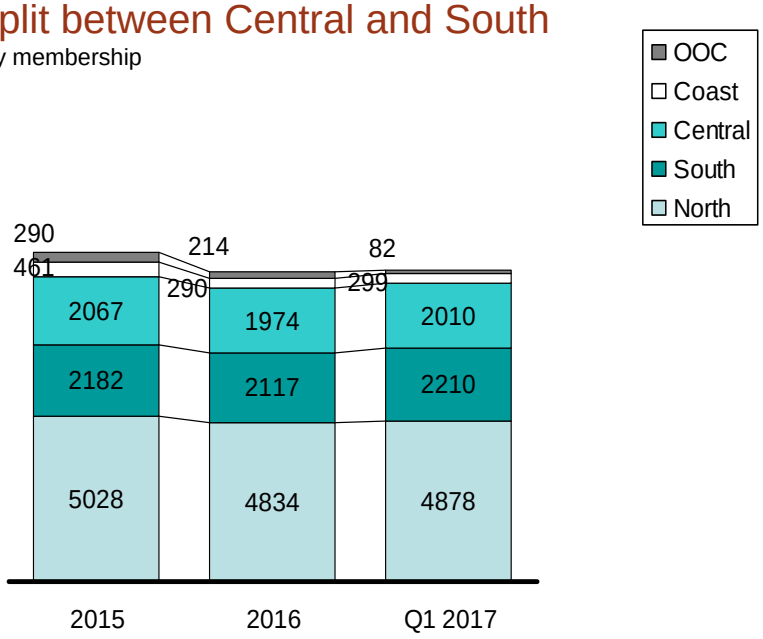


	2015	2016	Q1 2017
Average age	71.9	72.4	71.9

- Overall, membership is aging
- Conversion of the developmentally disabled population to CA CMC accounts for the rise in Under 65s in 2017

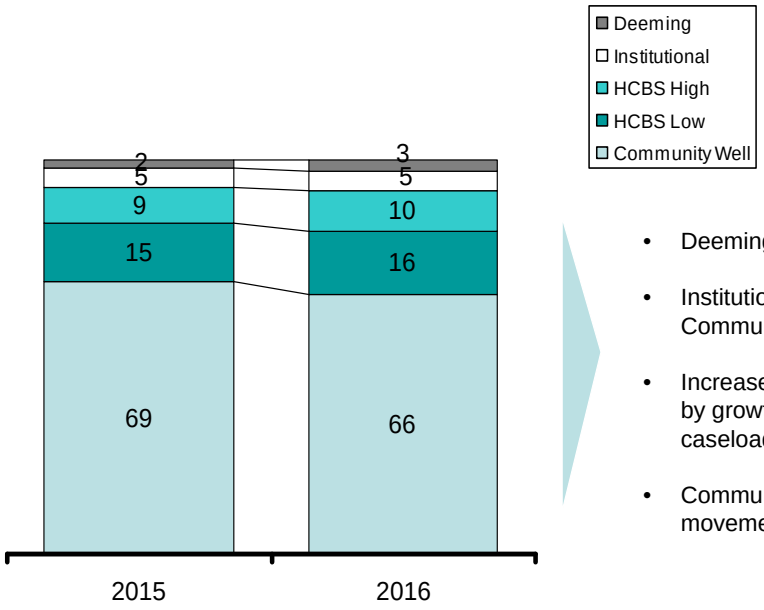
Half of membership is in North County with the rest roughly split between Central and South

Average monthly membership



Membership has shifted away from Institutional and Community Well over time

%, Average of monthly membership based on COA as of 12/1

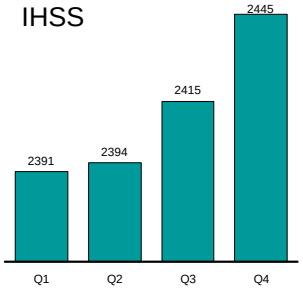


- Deeming slightly higher
- Institutional down slightly, driven by the Community Care Settings Pilot
- Increases in HCBS High and Low driven by growth in IHSS, CBAS, and MSSP caseloads
- Community Well down due to movement into the other categories

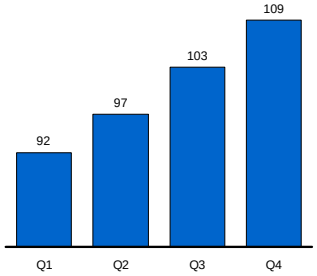
Utilization of LTSS up for all services in 2016 except Long Term Care

Number of unique members using services, 2016

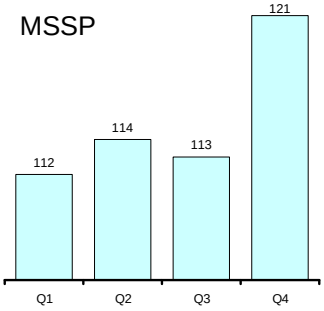
IHSS



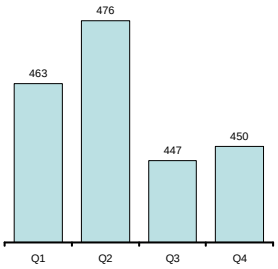
CBAS



MSSP



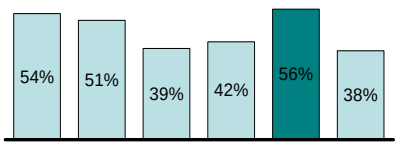
NFs



Assessments: We are able to conduct timely assessments on about 40% of new members, with about a third not willing to participate

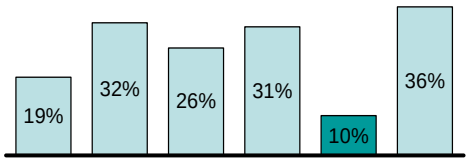
DY1: Quality Withhold Measure

HRA Completion within 90 days (CM 2.1)
2016 and 2017

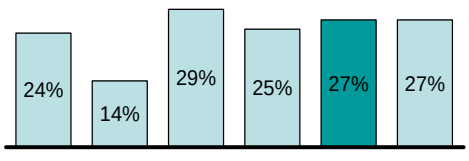


53	69	78	97		213	HRAs completed

Members unwilling to participate (CM 2.1)
2016 and 2017



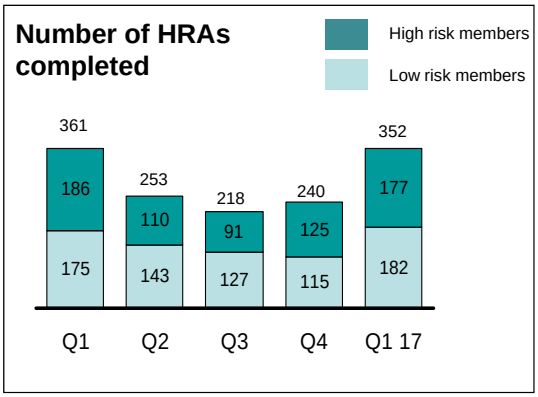
Health plan unable to locate (CM 2.1)
2016 and 2017

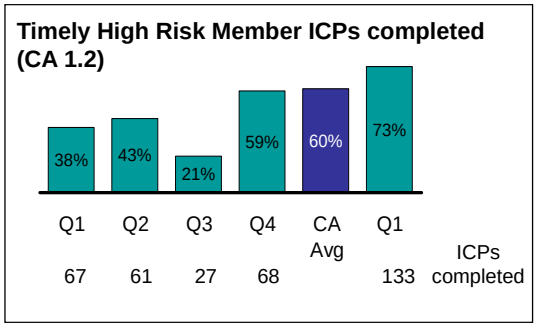


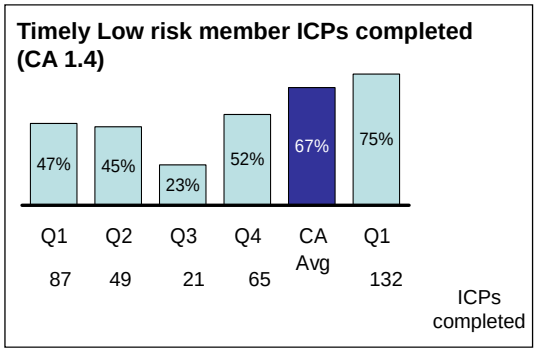
Selected a new vendor for HRAs who will start on October 1

Source:Core Measure 2.1; CA Average from NORC using Q3 2016 data.

Care plans: Our recent efforts have paid off and we completed care plans for 75% of new members in Q1

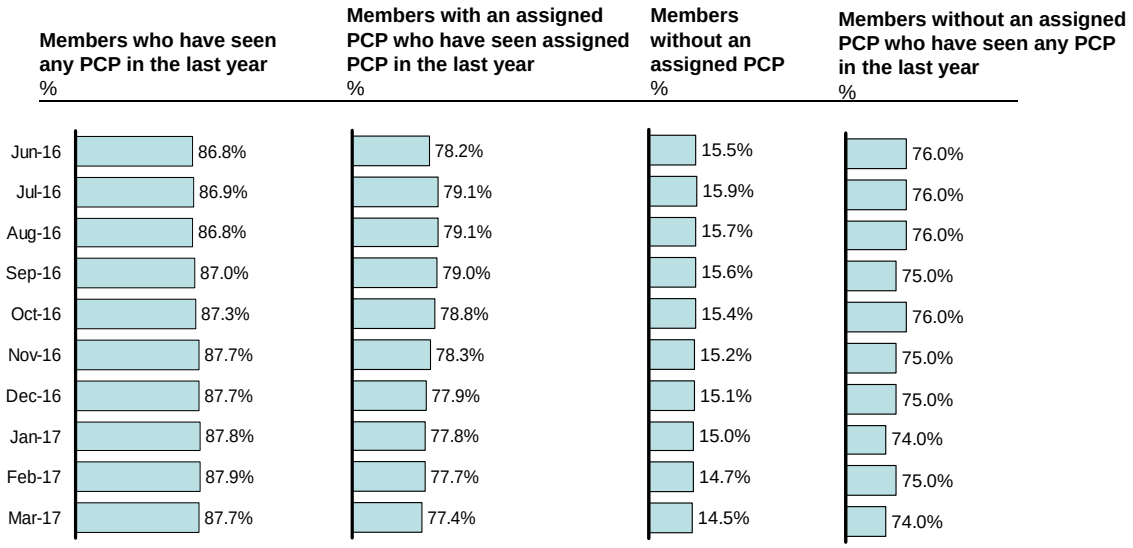






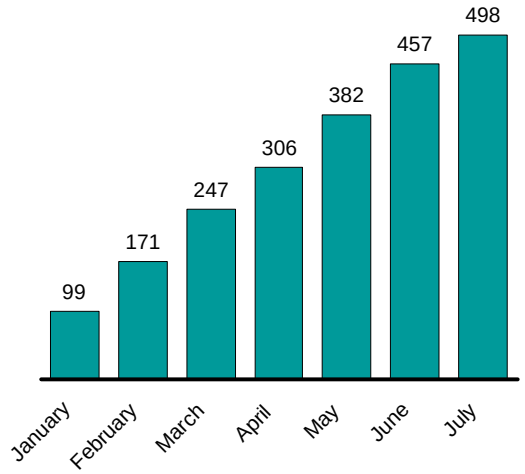
Source: CA 1.2 and CA 1.4; CA Average from NORC using Q3 2016 data.

Primary care engagement: 87% of members see a PCP in a given year

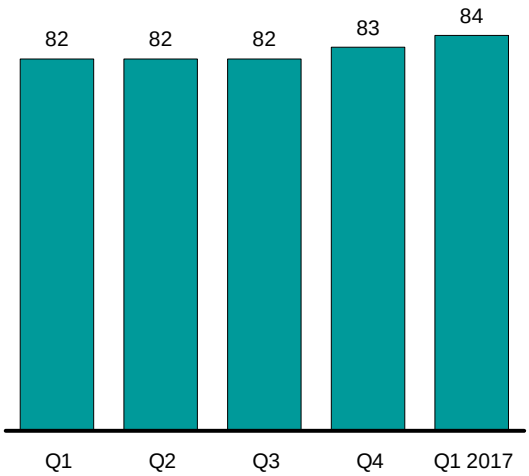


Landmark engagement continues to grow – about to hit 500th member

# of engaged members



Transitions of Care: 84% of our members have an ambulatory care follow-up visit within 30 days of discharge



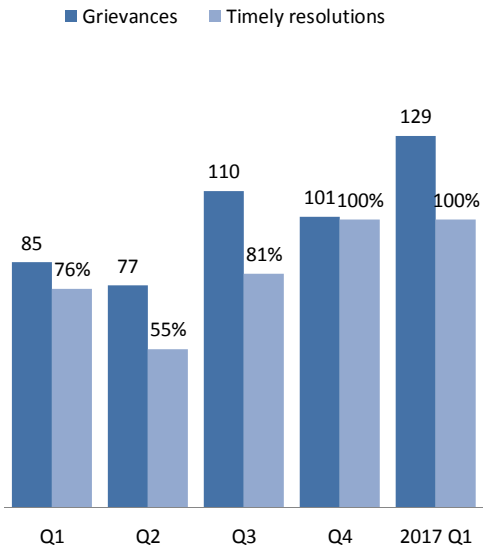
Source: CA 1.11 – Ambulatory f/u after discharge

Call Center Performance remains strong after a dip in January

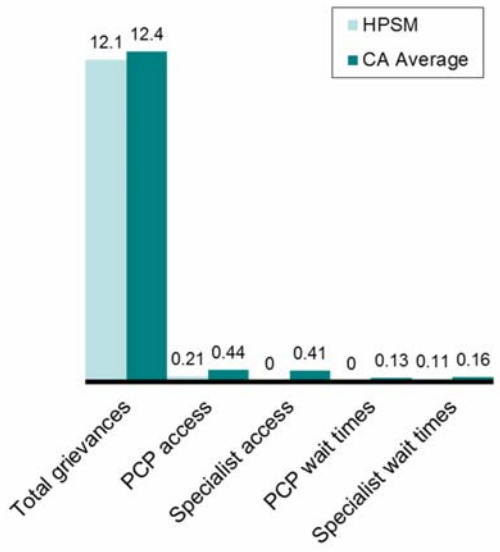
2017 CareAdvantage ACD	1	2	3	4		5
Month	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Number of Calls Received	2,395	2,074	2,212	1,798	2,067	2,349
# Answered Calls	2,090	1,907	2,029	1,704	1,975	2,224
% of Answered Calls	87%	92%	92%	95%	96%	95%
# Answered within 30 seconds	1,678	1,671	1,763	1,459	1,753	1,869
% Answered within 30 seconds	80%	88%	87%	86%	89%	84%
# Answered over 30 seconds	412	236	266	245	222	355
% Answered over 30 seconds	20%	12%	13%	14%	11%	16%
# Abandoned after 10 secs	178	86	102	54	51	79
% Abandoned after 10 secs	7.4%	4.1%	4.6%	3.0%	2.5%	3.4%
# Answered calls within 2 mins.	1905	1790	1916	1596	1882	2070
% Answered calls within 2 mins.	91.1%	93.9%	94.4%	93.7%	95.3%	93.1%
# Flow Out Calls (to vm)	127	81	81	40	41	46
Outbound Calls	2,270	2,026	2,031	2,039	2,437	2,512
Transferred Out Calls	556	601	640	558	701	740
Average Speed to Answer	:35	0:26	0:25	0:25	0:20	0:27
Average Talk Time	4:44	4:23	4:16	4:10	4:19	4:09
Maximum Delay	9:25	9:25	9:24	9:15	9:15	9:24
Enrollment	9,583	9,475	9,433			

Grievance Volume is up, but lower than CA Average

Grievance volumes 2016



Grievances per 1000 members Q3 2016



Source: 2016 Submissions for CA 2.1 and Core Measure 4.2; CA Average from NORC using Q3 2016 data.

Performance on DY 1 Quality Withhold measures

Measure	Source	Benchmark	2015	Passed?
CW1 – Assessments	CMS defined process measure 2.1	90% (Highest scoring state plan minus 10 points)	77%	N
CW2 – Consumer Governance Board	CMS defined process measure 5.3	100%	100%	Y
CW3 – Customer service	CAHPS	86%	82%	N
CW4 – Encounter Data	MMP Encounter Data	80% within 180 days of date of service	95%	Measure excluded
CW5 – Getting Appointments and Care Quickly	CAHPS	74%	75%	Y
CAW1 – Documentation of Care Goals	State defined process measure CA 1.6	90% (Highest scoring state plan minus 10 points)	3.7%	N
CAW2 – BH Shared Accountability MOU and P&Ps	State defined process measure CA 2.2	100%	100%	Y
CAW3 – Mental Health Shared Accountability ICP with Primary Mental Health Provider	State defined process measure CA 1.7	Highest scoring state plan minus 10 points	Measure suspended	n/a
CAW4 – Interaction with Care Team	State defined process measure CA 1.12	90% (Highest scoring state plan minus 10 points)	75%	N
CAW5 – Ensuring Physical Access to Buildings, Services and Equipment	State defined process measure CA 3.1	100%	100%	Y

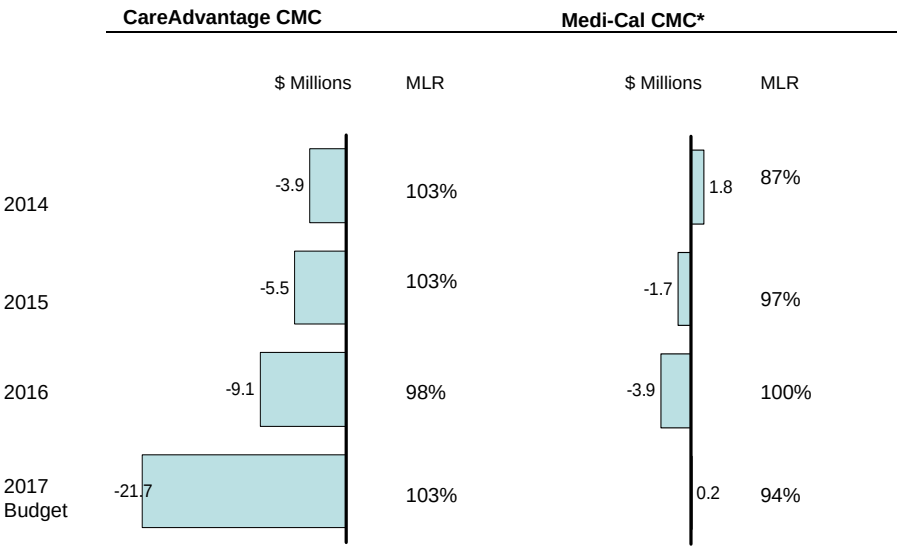
2014: Earned 100%, worth $519k
2015: Internal estimate is that we passed 5, earning back 50% ($1.2 million)

DY 2 (2016) and 3 (2017) Quality Withhold Measures

Updated as of 7/20

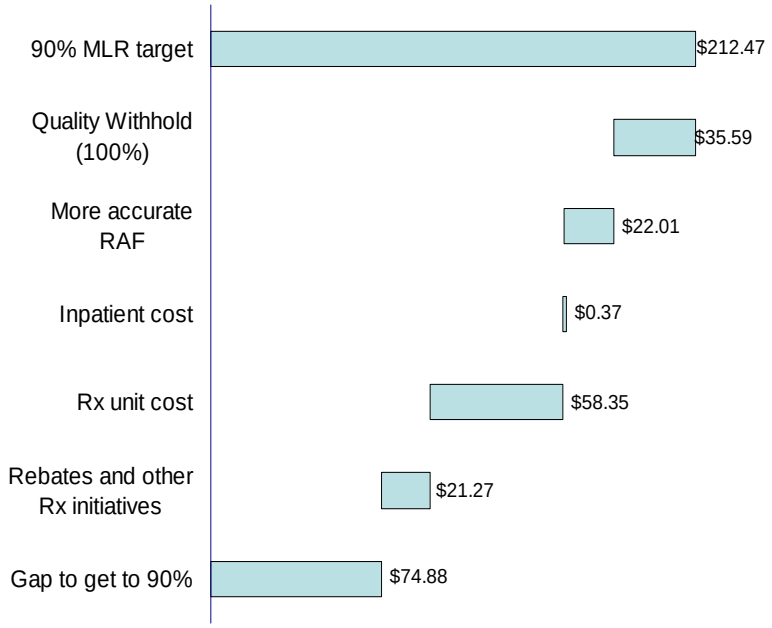
Category	Proposed Indicator	Target	2016 Performance	Recent Performance/Notes
Quality Withhold	CW6 – Plan all-cause readmissions	11%	15.19% overall 10.48% STAR Metric (2016)	14.85% overall for rolling 12 months through 1Q 2017
Quality Withhold	CW7 – Annual flu vaccine	69%	73% (2016)	2017 Available in October
Quality Withhold	CW8 – Follow-up after hospitalization for mental illness – 30 day	56% Improvement = 40.8%	64.84% (2016)	
Quality Withhold	CW10 – Reducing the risk of falling	55%	N/A until 2018 when initial cohort (2016) is resurveyed	
Quality Withhold	CW11 – Controlling blood pressure	53%	64.37% (2016)	Medical record based, no interim reporting
Quality Withhold	CW12 – Medication adherence for diabetes medications	73%	84% (2016)	94% for 2017 to date up to July
Quality Withhold	CW13 – Encounter Data – monthly	80%	92% submitted within 180 days (2016)	94% for 2017
Quality Withhold	Reduction in emergency room use for seriously mentally ill and substance use disorder enrollees	TBD	89.59 per 1000 member months (2016)	1Q 2017 data available in July
Quality Withhold	CAW4 - Percentage of members who have a care coordinator and at least one care team contact	TBD - Probably 88.4%; Improvement might be 78.2%	76.9% (2016)	88.3% - Rolling 12 months as of 5/31/2017
Quality Withhold	CAW1 - Number of members with at least one documented discussion of care goals in the individualized care plan	TBD - Probably 90%; Improvement might be 29.4%	22.7% (2016)	Monthly report in process

Financials – CMC was loss generating on both Medi-Cal and Medicare sides in 2015 and 2016 with losses budgeted for 2017



Note: Using most recently updated Medi-Cal rates, restated using the actual dates of service.

Planned initiatives get us to 95% MLR for CA CMC



Source: 2017 Budget; Cost of Healthcare Savings Goals; PopHealthCare May report; Internal analysis.

Overview of planned initiatives

FOR DISCUSSION

	Description of initiatives
Quality withhold	• Sustain high performance on existing measures • Continue to refine processes to improve performance on Care Team Contacts (CA 1.12) and Documented Discussion of Care Goals (CA 1.6)
Risk Adjustment	• Continued optimization of our risk adjustment program • Integration of Landmark's efforts for their engaged members
Inpatient cost	Acute Inpatient • Increase time spent on concurrent review and early discharge planning • Strengthen program support (Landmark) • Enhance handoff between IP and Care Coordination teams • DRG Outlier payment work Skilled Nursing/LTC • Introduce SNFist program for short and long term stays • SNF Value-Based Payment • Continued expansion of Community Care Settings Pilot
Pharmacy	• Vendor management to ensure unit cost and rebate targets met • PCP outreach to improve Generic Dispensing Rate and Generic switching • Continued focus on Prescription Drug Event Reconciliation • Strengthening of Drug Utilization Review efforts
Enrollment	• Birthday campaign (goal of 125 new enrollments per month) • Continued efforts to keep deeming success rate at 50% with potential focus on institutional members • Continued efforts to keep voluntary disenrollment low

CA-CMC MLR Dashboard

UPDATED 7/20/2017

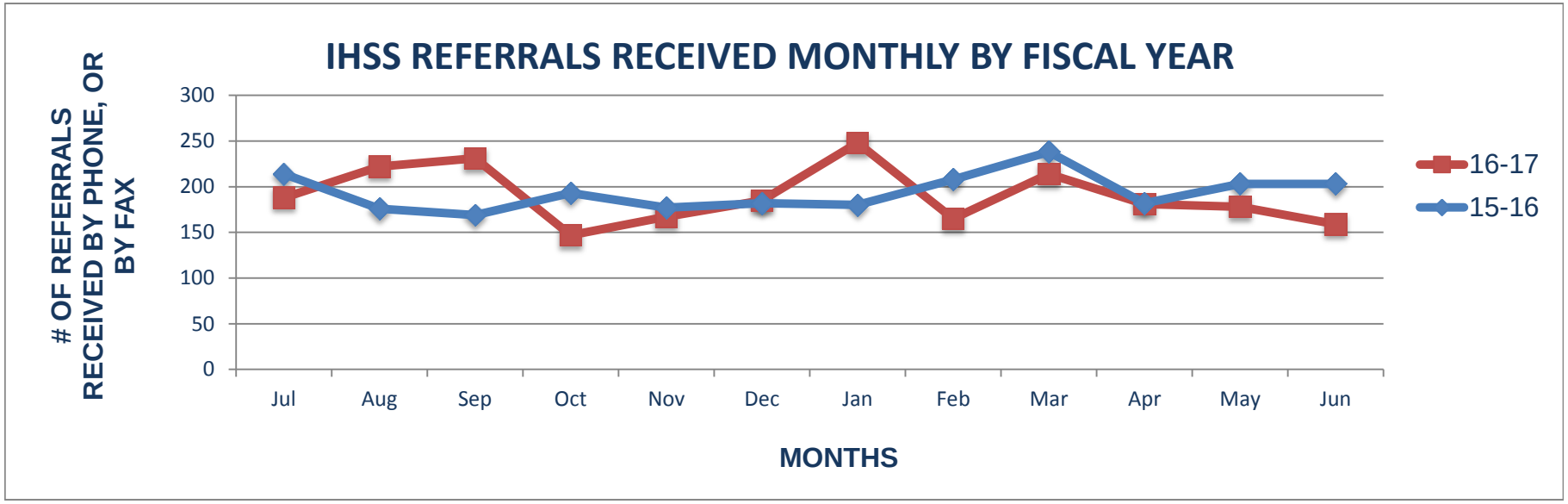
Category	Proposed Indicator	Budget	Target	Most Recent Performance	Notes
Revenue	Enrollment	9,628	9,628	9,309 as of 7/13	Continue to lose more members than new enrollments • 55 new enrollments from June report • 71/122 regained from deeming as of 7/1
Revenue	Expiring RAF	N/A	TBD	TBD	Working on developing a reportable measure around this
Medical cost	Acute Inpatient PMPM	$383	*$384*	$464 as of 6/30 ($475 as of 5/31)	Admits per 1000 at 321 (target of 275). Average paid per admission at $17,328 (target of $16,921)
Medical cost	SNF PMPM	$79	*$78*	$96 as pf 6/30 ($96 as of 5/31)	Days per 1000 at 1,884 (target of 1500) and paid per day at $612 (target of $558 per day)
Medical cost	Physician, OP, and Other PMPM	$530	$530	$501 as of 6/30 ($492 as of 5/31)	Often lower in first quarter as MediCal picks up deductible
Medical cost	Pharmacy PMPM	$505	*$446*	$476 as of 6/30 ($456 as of 5/31)	Cost per scrip at $115 and utilization at 4.16 Rx PMPM Generic Dispensing rate = 84%
Offsets	Pharmacy rebates PMPM	$22	*$43*	$48 PMPM for 2016	Lagging indicator – Q4 2016 not yet complete and no data yet for 2017. Q3 2016 was $63.59 PMPM

ATTACHMENT 3

IHSS REFERRAL COUNT

Displays the number of IHSS Referrals received through TIES phone calls each month within the fiscal year

IHSS REFERRALS RECEIVED MONTHLY BY FISCAL YEAR												
FY	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
14-15	191	175	195	201	144	152	168	183	206	200	173	198
15-16	214	176	169	193	177	182	180	208	238	182	203	203
16-17	188	222	231	147	167	185	248	165	214	181	178	159



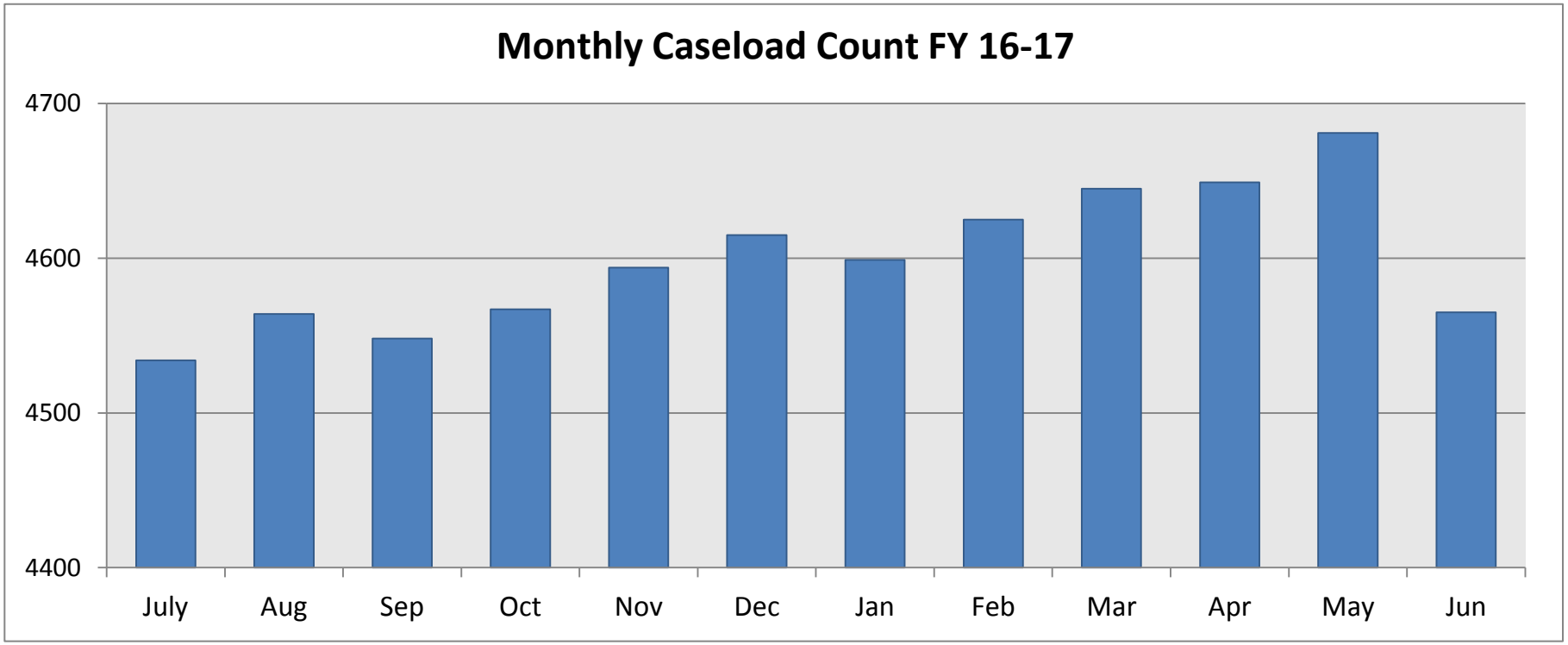
Location: M:\General\IHSS\IHSS Metrics\IHSS Referrals Received\FY 16-17\1_IHSS Referrals Received.xlsx
Data Source: Q Case Management System
JSajise/July 3, 2017

COUNTY OF SAN MATEO
HEALTH SYSTEM

IHSS CASELOAD COUNT

Displays the number of Active and Cases on Leave each month within the FY 2016-2017

ACTIVE AND LEAVE CASES PER MONTH												
FY	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
16-17	4534	4564	4548	4567	4594	4615	4599	4625	4645	4649	4681	4565



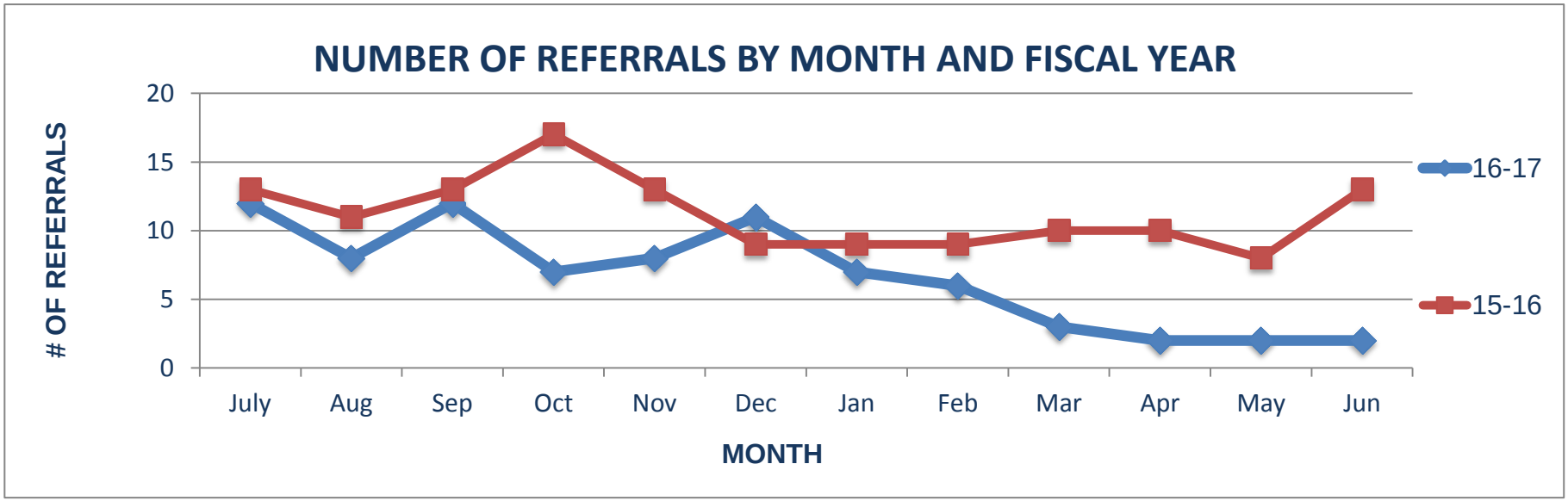
Location: M:\General\IHSS\IHSS Metrics\Email Reports\2017\June\Excel\IHSS Active and Leave Case Count FY 16-17.xlsx
Data Source: CMIPS II Data Download July 2017
JSajise/July 3, 2017

COUNTY OF SAN MATEO
HEALTH SYSTEM

CONTRACT MODE REFERRAL COUNT

Displays the number of referrals to the contract mode each month within the fiscal year

MONTHLY REFERRALS SENT TO HOMEBRIDGE BY MONTH PER FISCAL YEAR												
FY	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
14-15	N/A	N/A	N/A	9	12	4	0	17	17	9	3	12
15-16	13	11	13	17	13	9	9	9	10	10	8	13
16-17	12	8	12	7	8	11	7	6	3	2	2	2



Location: M:\General\IHSS\Homebridge\Service Summary Reports\Referrals Analysis.FY.16-17.xlsx
Data Source: IHSS Contract Monitoring Report
JSajise/July 3, 2017

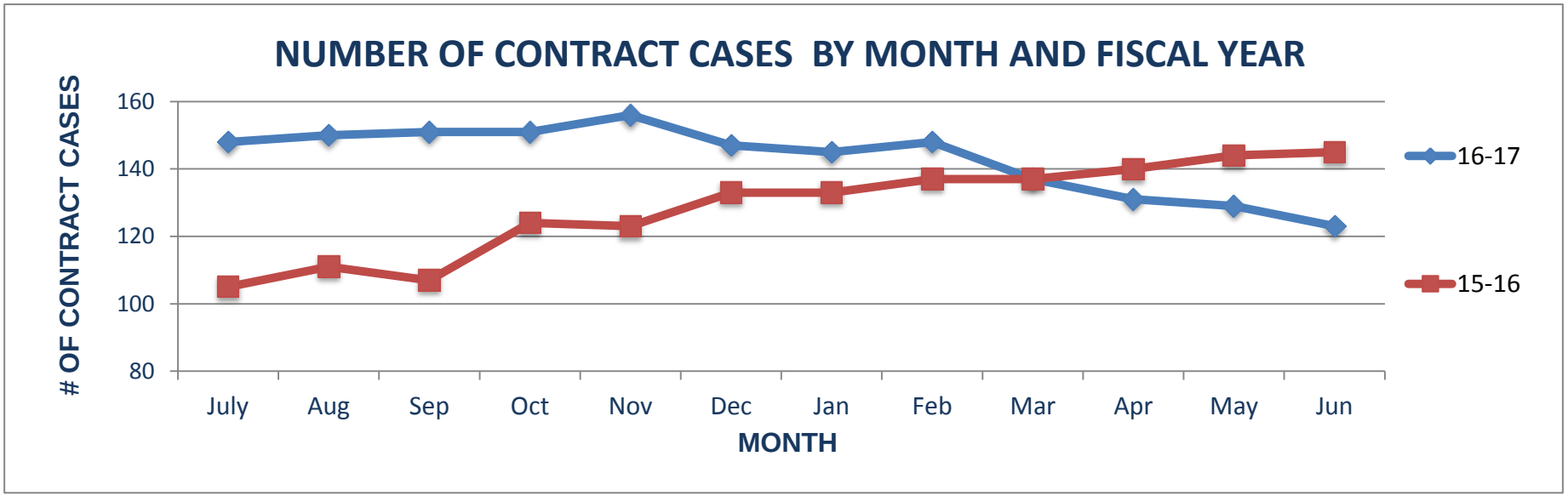
HOMEBRIDGE

COUNTY OF SAN MATEO
HEALTH SYSTEM

CONTRACT MODE CASELOAD COUNT

Displays the number of IHSS cases receiving contract mode services each month within the fiscal year

CONTRACT CASES BY MONTH AND FISCAL YEAR												
FY	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
14-15	N/A	N/A	N/A	65	76	75	68	83	92	95	93	103
15-16	105	111	107	124	123	133	133	137	137	140	144	145
16-17	148	150	151	151	156	147	145	148	137	131	129	123



Location: M:\General\IHSS\Homebridge\Service Summary Reports\Referrals Analysis.FY.16-17.xlsx
Data Source: IHSS Contract Monitoring Report
JSajise/July 3, 2017

HOMEBRIDGE

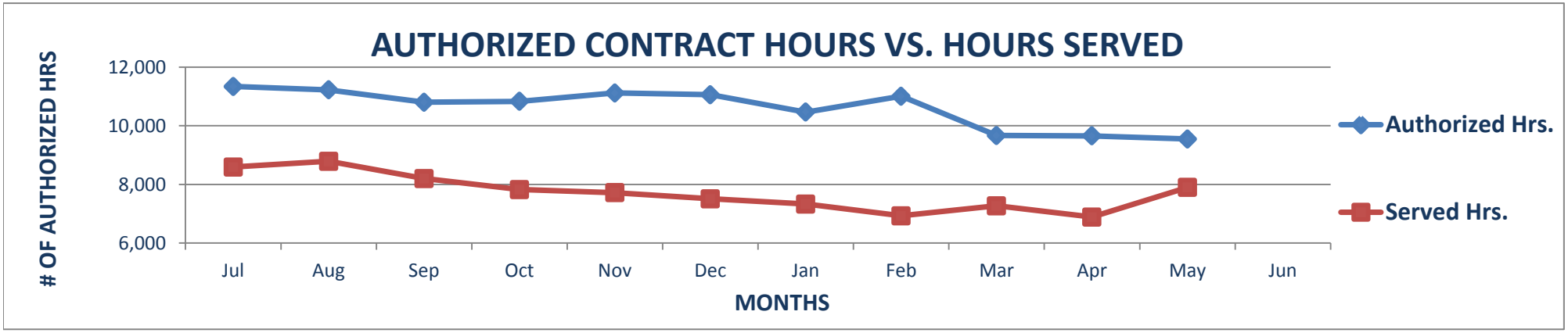
COUNTY OF SAN MATEO
HEALTH SYSTEM

HOMEBRIDGE SERVICE PROVISION REPORT

Displays the number of IHSS hours authorized under the contract mode versus how much is served per month for Fiscal Year 16-17

CONTRACT SERVICE SUMMARY REPORT FY 2016-2017

Fiscal Year 16-17	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Authorized Hrs.	11,342	11,227	10,802	10,834	11,120	11,060	10,465	11,009	9,670	9,658	9,548	
Served Hrs.	8,595	8,789	8,203	7,824	7,718	7,511	7,332	6,928	7,270	6,886	7,899	
Unserved Hrs.*	2,747	2,438	2,599	3,010	3,402	3,549	3,133	4,081	2,399	2,772	1,649	
% Unserved	24%	22%	24%	28%	31%	32%	30%	37%	25%	29%	17%	



* No provider available for assignment, client hospitalization, vacation, canceled scheduled service and not scheduled per client requests, factors in to the unserved hours.

Source: Data based from Homebridge's Monthly Service Summary Report (SOC2277). Numbers are rounded off to the nearest hour.

HOMEBRIDGE