Health Plan of San Mateo
Cal MediConnect Advisory Committee
Meeting Minutes
Friday, July 19, 2019 – 10:00 a.m.
Health Plan of San Mateo
801 Gateway Blvd., Boardroom
South San Francisco, CA 94080

Committee Members Present: Gay Kaplan, Beverly Karnatz, Christina Kahn, Sharolyn Kriger, Ligia Andrade Zuniga, Claire Day, Tricia Berke Vincent, Nicole Ford, and Kirsten Irgens-Moller.

Committee Members Absent: Pete Williams, Lisa Mancini, Nancy Keegan, Janet Hogan, Evelina Chang, Teresa Guingona Ferrer, and Diane Prosser.

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

1. Call to Order

The meeting was called to order at 11:30 a.m. by Gay Kaplan.

2. Public Comment

Beverly Karnatz from Human Good talked about the facilities they run in San Mateo County. Within their almost 400 apartments there are about 125 residents that belong to the health plan. At the meeting last month there was discussion about the lack of Medi-Cal beds and she is seeing more of this with residents having to go to Vallejo, Modesto and Oakland. She feels our partnerships are making a positive impact and she is looking forward to quarterly CMC meetings.

There was no further public comment at this time.

3. Approval of Minutes

The minutes for the April 26, 2019 meeting were approved as presented. **M/S/P.**

4. CCI Ombudsman Services Report (Legal Aid)

Ms. Berke Vinson gave some background about the role of the Ombudsperson program related to Cal MediConnect (CMC). When the CMC program began, the state wanted to ensure that dual eligible members had assistance understanding the new program. Legal Aid was available to help people understand the program to make an informed decision of whether or not they wanted to enroll in the CMC program. Referrals to Legal Aid from the CareAdvantage case manager were given to people who were having problems with their health care coverage, who might be facing disenrollment or having issues getting specific treatment, or other issues that members were facing. Ms. Altman added that at the beginning the state set up a consumer center with Legal Aid of San Diego taking the lead to help members through the implementation of the program. She stated that San Mateo County was not experiencing the same issues that were being seen around the state. Ms. Berke Vinson added that majority of the cases had to do with unaffordable shares of cost. This year there was a change in the federal poverty level that

has caused an issue for people who suddenly found themselves over the level for pre Medi-Cal by a very small amount.

Legal Aid also deals with systemic issues for example, issues around income requirements. They have been working with the state to make clarity between the seniors program and the rest of Medi-Cal. They have had some success but there are still problems. She talked about bills that were part of a senior package which included changes to the asset increase but did not pass. There was discussion about a number of legislative bills currently pending that could have an affect on members. Ms. Vinson said she would send the group information on these bills with updates after the meeting.

Local advocacy work they do includes working with Human Services Agency to explore possible steps to improve renewals for seniors, and disabled people to help them maintain their Medi-Cal status. They are also working on improving education about the working disabled program under share of cost Medi-Cal.

Lastly, she reported there was a study done by UCSF about satisfaction with the CMC plans. It was specifically recorded that CMC members in San Mateo County have high levels of satisfaction.

5. LTC Ombudsperson Services Report

Ms. Kirsten Irgens-Moller had nothing additional to report.

6. Grievances and Appeals Report

Ms. Ault-Riche reported on Q1 of 2019 (attached):

- Rate of Complaints per 1,000 members for CMC was well below the goal of no more than 21 complaints per 1,000 members. Historically, the first quarter of the year has the highest number of complaints. For the first quarter 2019 there were 16 per thousand.

- Timeliness of Complaint Resolution shows that both grievances and pharmacy appeals met the threshold for resolving the cases timely. 100% of Pharmacy appeals were resolved timely, and 96% of grievances. Medi-Cal appeals were at 93% just below the 95% goal but a systems issue was identified causing a delay in responding timely so this was an easy fix.

- Volume and Types of Complaints: compared to the first quarter of 2018 we saw a decrease in grievances going from 140 last year to 106 this year.

- Types of Grievances: there was a decrease in durable medical equipment appeals.

- Overturned Appeals by Provider Type: A workgroup of staff is watching these to see how often original decisions are overturned and why. A high rate could indicate more research could be done upfront prior to the denial. Our internal goal was set at 30% which is consistent with sister plans. For the Q1 of 2019 overturned appeals for Part C - Medical was 26%. Pharmacy is more of a challenge due to very short turnaround time.

- **PCP Changes**
  All of the providers who had five or more people move away from them were all clinics. Our provider services team has been working with our reporting analysts in Grievances and Appeals to revamp the quarterly report that shows the PCP changes and grievances against providers. The new report results are more actionable focusing on the rate of grievances by provider then honing in on potential issues. These results will be included in our next report.

  A question was asked about Specialists. Ms. Ault-Riche stated that staff is looking into this but the system is not a perfect measurement. They are trying to get a sense of if the changes are with higher volume specialists or lower volume specialists and how this fits in with number of grievances being received.

  Another question was asked about access and availability. Ms. Ault-Riche explained the percentages in the report, the types of situations captured in this section of the report and how staff addresses specific issues. This conversation led to the question of member / provider education in the use of interpreter services. Ms. Ault-Riche said she would go back and look at newsletters for the last time information on these issues was published. Nicole Ford stated that in the Member newsletter, information regarding interpreter services and how to use them is included. There was discussion about the reading level for printed materials. Ms. Ford informed the group that the requirement by state guidelines is 6th grade.

  There was a question about the availability and access to the member and provider newsletters. Ms. Ford pointed out that these can be found on our HPSM website.

  Ms. Kahn asked if the grievances related to "balance bill not in collections" is for claims that members have not submitted. Ms. Ault-Riche explained these grievances about providers billing the member instead of the health plan. This sometimes happens because they don't realize that the member is CMC and are billing the member the balance after the health plan has pays its portion. This is not supposed to happen. Staff is able to redirect these and make it clear the member is not responsible. Sometimes members receive mailings that are not a bill but the members think it is. The majority are from out of network providers.

7. Updates and Discussion

- **Dashboard** (Katie-Elyse Turner)

  Quality Withhold:
  These are a set of dollars that is withheld from our plan premium each year by CMS and DHCS. The plan needs to earn these funds back by performance on set quality measures. These measures are brought in by our HEDIS quality reporting, CAHPS consumer experience survey, encounter data as well as pharmacy data and supplemental data that the plan submits to the state and CMS.

The tracking results show that the plan is heading towards doing well in 2018. It is a little too soon for results on 2019. Of the nine measures, eight are meeting the reporting benchmark and are slated to surpass the measure for the quality withhold. The one area that is a concern and of which staff are actively working to improve is the measure of members with at least one documented discussion of care goals in the ICP. We think it is a reporting issue rather than a performance issue. Based on this dashboard, we feel we are on track for earning back 100% of the quality withholds. For 2017, the plan received 100% of the withholds for that year's measures.

LTSS Utilization among CMC Enrollees:

There are four different categories for LTSS: IHSS, MSSP, Nursing Facilities (NFs), and CBAS. We continue to see some of the same trends that we have seen over the last couple of quarters.

- Growth in IHSS enrollment
- Growth in MSSP
- CBAS has been stable for the past two years
- A small increase of CMC members in Nursing Facilities

Health Risk Assessment and Individual Care Plan Completion:

The Health Risk Assessments (HRAs) and Individual Care Plans (ICPs) are the two contract requirements for CMC.

HRAs are broken down into three categories:

a) new enrollees within 90 days of enrollment;
b) unable to locate; and,
c) those who are unwilling to participate.

For 2019 Q1 – 58% of HRAs were completed within 90 days of enrollment; 26% we were unable to locate; and, 11% were unwilling to participate. The plan was close to par to the California average in these categories. Ms. Turner stated that staff has been working to put in place mechanisms to locate folks and get more HRAs completed.

ICPs are broken down into high and low risk member categories and take a look at over time, what percentage of our overall membership has had a completed care plan. The difference between the high and low risk are the results of the HRA. Over time, the percentage of our enrolled membership that has a completed care plan has increased and is well above the California average.

There was a question about performing the HRAs at the doctor's office. Ms. Turner explained that this had been piloted, but did not work well given the process complexity. Dr. Huang stated that there has been some discussion about working with Wider Circle to see if there is an opportunity of completing an HRA with the "unwilling to participate" category. She explained that Wider Circle is a socialization program for seniors that the

health plan has been working with. Ms. Turner added that they have talked about the idea of turning the visits with Wider Circle into a one on one home visit between a community health worker who is a Wider Circle facilitator and the member to introduce them to the health plan, complete the HRA and dial them into to their PCP and health plan operations. It is a very new idea and staff is still looking for an opportunity to pilot something like this. There has even been some talk about performing the HRA at the time of enrollment into the CareAdvantage program.

The group talked more about the Wider Circle program. Ms. Turner said she would add this to the next meeting agenda.

- **Education Topics** (Susan Huang, M.D., and Nicole Ford)
  Topics that were discussed are those that have been selected for focus by the contract management team at CMS and DHCS:

  Care Plan Options:
  Dr. Huang explained that Care Plan Options is a set of services that the health plan can choose to provide but are not part of the benefits package. This program gives the plan some flexibility to meet community needs and fill gaps. This could include home or respite care, nutrition, or anything to do with home maintenance. Right now these services are basically being facilitated through Institute on Aging. The case workers assess the needs and make the referrals. These services are not reimbursed at this point. Ms. Altman has been advocating with the state to capture some of these costs.

  There was a question about who makes the decision with respects to these services through the CCSP. Dr. Huang said it is complicated but that IOA is the key partner who is trying to decide how to place some of these folks into the CCSP. The biggest bucket of the program is the housing component. We do rely on their social workers and case managers to assess the needs. The health plan staff does oversee this but IOA is making the recommendations as they deem appropriate.

  HEDIS 2019
  Nicole Ford stated that the plan is required to report HEDIS metrics for our CareAdvantage CMC members as do other Medicare plans. This is a way that we can be compared across other Medicare plans in terms of quality metrics. HPSM has recently received HEDIS performance metrics from all CMC plans as well as comparative benchmarks, both of which will help us better understand our performance. CMS is looking at, based on our recent calls, some areas where other plans like ours also struggle and what is being done to address and improve these challenging areas.

  Focus HEDIS Measure: Follow-Up After Hospitalization for Mental Illness (7 days):
  In the hospital upon a mental illness diagnosis, the measure is for the patient to be seen by a behaviorist within seven days of discharge from the hospital. This is extremely challenging because the plan does not know about the hospitalization until the claim is

received. Once we know, there is a short time to reach out and get them set up with a behaviorist. Staff has been working with the Care Coordination team regarding hospitalizations to be informed when a patient will be discharged. This process was just implemented in April so we hope to see improvement next year.

Focus HEDIS Measure: Medication Reconciliation Post-Discharge:
This is a follow up measure for the patient. The challenge is getting the member in to see the provider but also getting the provider to document that and hope they have performed their medication reconciliations so it can be counted. Staff has been pulling the resources such as Landmark and the Care Transitions team who contacts the member while still in the hospital to make sure they are getting into care.

- ***IHSS Updates***
  The reports were passed out to the group but were not reviewed at the meeting (copy attached).

8. Other State/CMS Updates

Ms. Altman asked the group to please refer any CMC members who would be interested in serving on this committee to her. Ms. Ault-Riche added that if anyone knows of other HPSM Medi-Cal members we also want to recruit more members to the Consumer Advisory Committee. Ms. Ault-Riche is also working on a welcome packet for new committee members to introduce them to their role on a consumer committee. She asked if anyone has input on the content she would like to hear from them.

9. Adjournment

The meeting adjourned at 1:10 p.m.

Respectfully submitted:

C. Burgess

C. Burgess
Clerk of the Commission

CMC Discussion & Updates

CMC Advisory Committee

19 July 2019

HealthPlan OF SAN MATEO
Healthy is for everyone

Updates & Discussion

HealthPlan OF SAN MATEO
Healthy is for everyone

- CMC Dashboards
  - Quality Withhold
  - LTSS Utilization
  - HRAs & ICPs
- Q2 CMS-DHCS Educational Topics
  - Care Plan Options (CPO)
  - HEDIS Reporting

CMC Dashboards

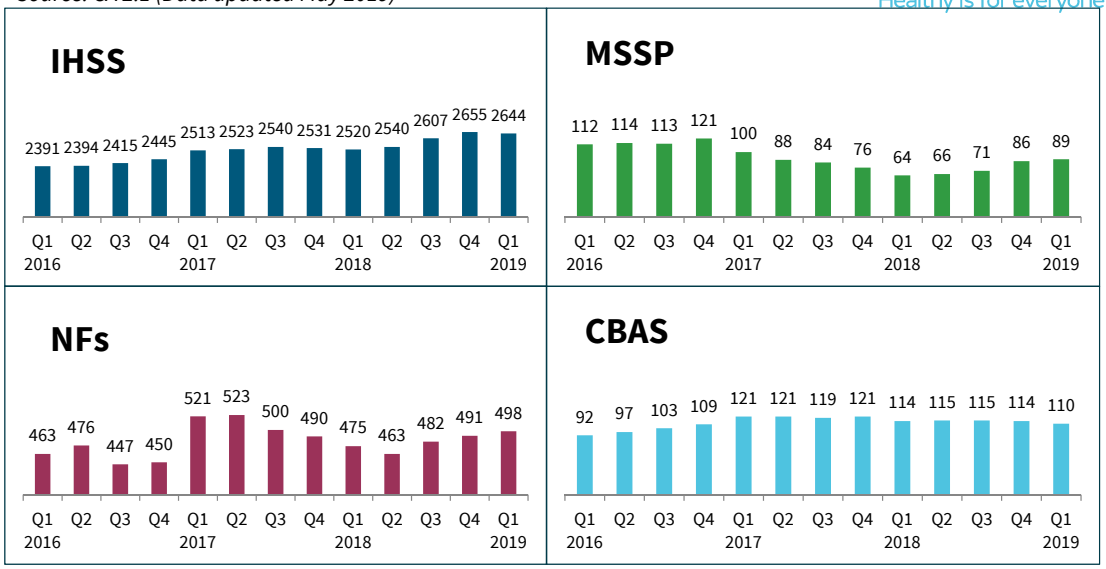
Quality Withhold Tracking: Dys 4 & 5

Last update: 7/10/2019

Measure	Source	Benchmark (DY2-5)	2018 (DY4) Tracking	2019 (DY5) Tracking
CW6 – Plan all-cause readmissions	HEDIS	<1.00	0.65	0.57 (through Apr. 2019)
CW7 – Annual flu vaccine	CAHPS	>69%	78%	Pending CAHPS (Sept. 2019)
CW8 – F/u after hospitalization for mental illness – 30 day	HEDIS	>56%	60.81%	56.6% (through Apr. 2019)
CW11 – Controlling BP	HEDIS	>56%	71.53%	Pending HEDIS 2020
CW12 – Medication adherence for diabetes medications	PDE Data	>73%	85.74%	96.63% at end of Q1 2019
CW13 – Encounter Data	EDS	>80%	83.8%	91.5%
CAW7 - Reduction in ER use for SMI and SUD enrollees	CA 4.1	<83.6/1000 mem.mos.	83.5/1000 mem. mos.	81.4/1000 mem.mos. (rolling 12 months through May 2019)
CAW8 - # of members with at least one documented discussion of care goals in the ICP	CA 1.6	2018: 60% 2019: 65%	29.3%	Not yet available
CAW9 - Percentage of members who have a care coordinator and at least one care team contact	CA 1.12	2018: 83% 2019: 88%	99.3% as of 12/3/18	97.4%
Overall Performance			TBD	TBD

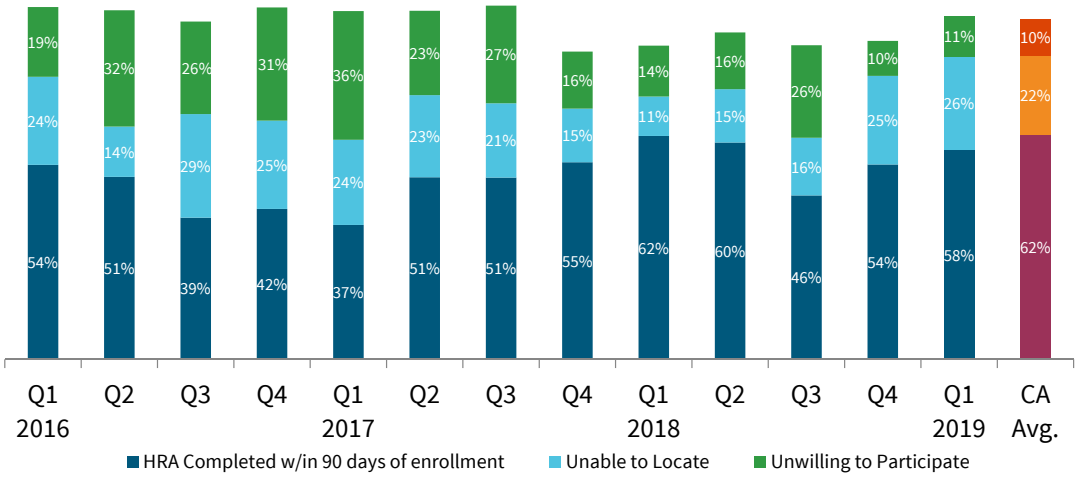
LTSS Utilization Among CMC Enrollees

Source: CA 2.1 (Data updated May 2019)



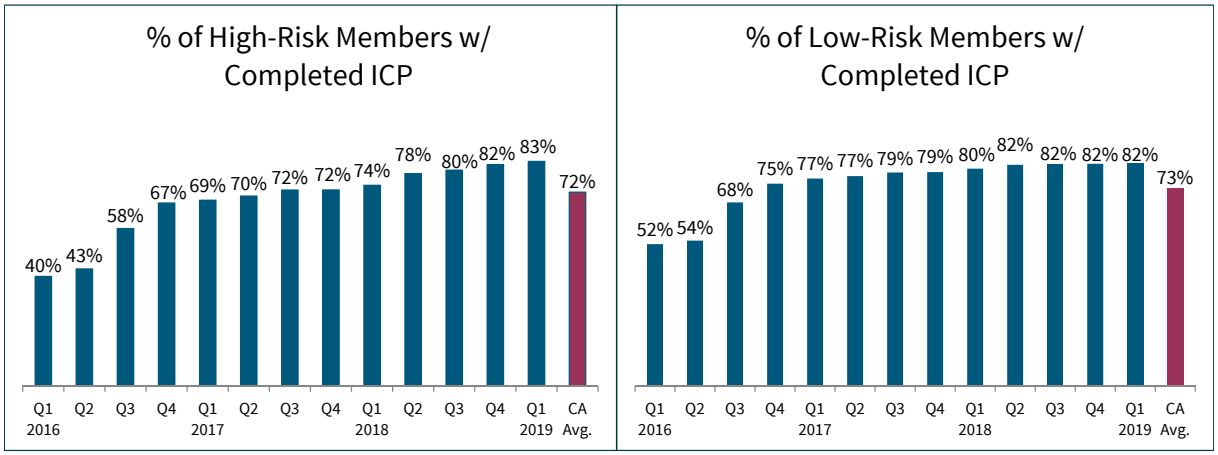
Health Risk Assessment (HRA) Completion

Source: Core 2.1 (Data updated May 2019) & CA Average from Q1 2019 NORC



Individualized Care Plan (ICP) Completion

Source: CA1.5 (Data updated May 2019) & CA Avg. from Q1 2019 NORC



Q2 CMS-DHCS Educational Topics

Care Plan Option (CPO) Services

- CMS-DHCS interested in how HPSM leverages CPO Services and in what contexts
- Care Plan Option (CPO) services provide flexibility to HPSM to provide a wider range of services to support independent living
  - Examples include: home/respite care, nutrition/meal services, home maintenance or adaptation
  - CPO services is a type of LTSS and does not replace participation/enrollment in other programs
- HPSM's Community Care Settings Program (CCSP) is the primary mechanism through which members access CPO services
  - Care Coordination is also able to make referrals for CPO services

HEDIS 2019

- CMS-DHCS interested in HPSM's recent HEDIS results as compared to previous years, improvements, and challenges
- **H**ealth **E**ffectiveness **D**ata **I**nformation **S**et (HEDIS)
  - Annually reported performance metrics that assess the effectiveness and access/availability of care; HPSM compared to all health plans nationally
- Focus Measures
  - Follow-up after hospitalization for mental illness (7 days): challenging as follow-up requires discharge notification; HPSM & BHRS have put several improvements in place (e.g., timely billing, concurrent review for MH stays, etc.)
  - Medication Reconciliation Post-Discharge: challenging as medical record documentation and follow-up practices among providers are inconsistent; HPSM leverages the HomeAdvantage program and the Care Transitions team in this area

Thank You

ATTACHMENT 2 TO
JULY 19, 2019 MINUTES

CareAdvantage Cal MediConnect

Advisory Committee

Grievance & Appeals Report

Reporting Period: Q1 2019 (January– March 2019)

Presented 07/19/2019

Table of Contents

1.Overview

1.1 Purpose

This report provides Health Plan of San Mateo's (HPSM) CareAdvantage Cal MediConnect (CMC) Advisory Committee with an overview of the volume and type of complaints received from CareAdvantage CMC members, as well as whether the Grievance and Appeals (G&A) Unit is addressing these complaints in a timely manner. Throughout this report, the term "complaints" refers to both grievances and appeals.

1.2 Methodology

The data for this report comes from two databases:

1. MedHOK: system of record for appeals and grievances
2. HEALTHsuite: system of record for authorizations, claims, and member eligibility

All complaints received during the reporting period were analyzed by line of business and type of complaint.

Case data is pulled from MedHOK based on the date HPSM received the case. If it is filed by a member's representative (e.g. family member, friend, attorney), the receive date is based on the date the member authorized that person to represent them. Complaint timeliness is calculated using this receive date as the start date of the complaint.

By tracking and trending complaints filed with HPSM, the Grievance and Appeals (G&A) Unit hopes to identify and address the root causes leading to member dissatisfaction.

2. Rate of Complaints per 1,000 Members

2.1 Enrollment Averages for Q1 2019

The rate of complaints per 1,000 members allows the G&A Unit to compare complaint rates while accounting for the differences in enrollment numbers across different lines of business. The rate of complaints per 1,000 members is based on the average enrollment numbers for Q1 2019.

Line of Business	Average Enrollment for Q1
CareAdvantage CMC	**8,925**
Medi-Cal Only (Excluding CCS)	101,594
Healthy Kids	1,632
HealthWorx	1,155
ACE	23,374
CCS	1,782
TOTAL	**138,462**

2.2 Rate of Complaints per 1,000 members for Q1 2019

Line of Business	Q1	Q2	Q3	Q4	Goal
CareAdvantage CMC	**16.8**				**21.3**
Medi-Cal Only (Excluding CCS)	2.77				2.75
Healthy Kids	3.68				3.95
HealthWorx	4.33				6.65
ACE	0.47				0.75
CCS	9.54				5.6
TOTAL	**3.4**				**3.6**

CMC's rate of complaints was within the established goal during Q1 2019, indicating that no corrective action is needed.

3. Timeliness of Complaint Resolution

3.1 Timeliness Rates for Complaint Resolution

The G&A Unit's goal, as mandated by the Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS), and the Department of Managed Health Care (DMHC), is to resolve at least 95% of grievances and appeals within the required regulatory timeframe. Below are the timeliness rates across all lines of business. This table excludes cases resolved within 24 hours of receipt.

The G&A Unit met its goal of 95% timeliness during Q1 of 2019 in processing grievances, but not appeals. The Pharmacy Unit, which processes pharmacy appeals, met their goal of 95%

Type of Complaint	# Received (all LOBs)	# Resolved Timely	% Resolved Timely (Q4 2018)	% Resolved Timely (Q1 2019)
Grievances	353	342	75.5%	96.9%
Medical Appeals	45	42	87.1%	93.3%
Pharmacy Appeals	72	72	98.7%	100%

3.2 Barriers and Root Causes

The G&A Unit significantly improved its case timeliness during Q1 2019. As a result of resolving its staffing shortage, the Unit was able to complete all case investigation and case review in a timely manner. The three medical appeals cases that were not resolved timely were the result of a system's issue that delayed the mailing of the member's written resolution letters. Importantly, these delays were not due to process or staffing failures.

3.3 Proposed Actions/ Solutions

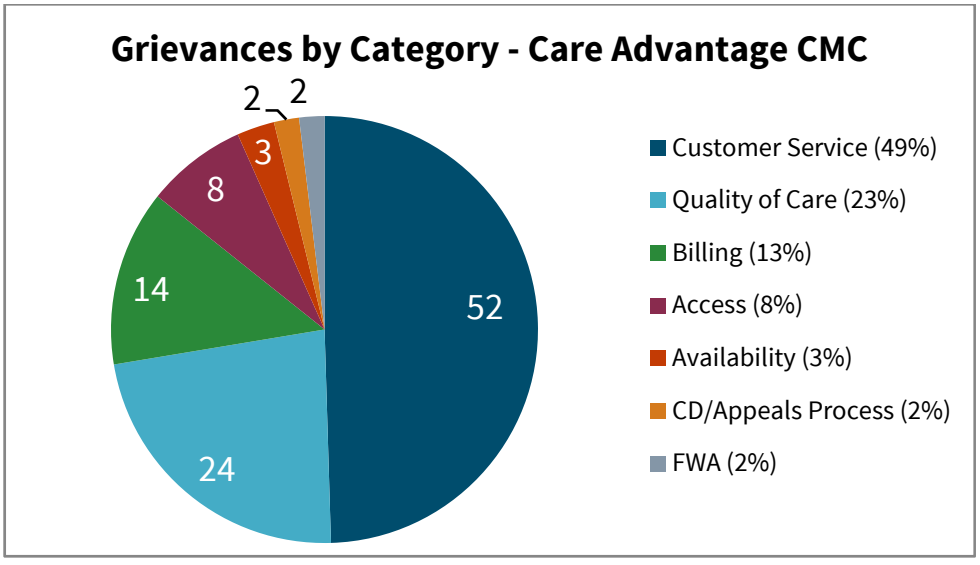
The G&A Unit has been informed of a new cutoff time for triggering letters to prevent future occurrences of system delays. HPSM's Business Systems Integration Unit has also been informed of the incident to determine the root cause and extend timeframe of letter submission. We are expecting this measure to be in compliance for Q2 2019.

4.CareAdvantage Cal-MediConnect (CA CMC)

4.1 Number of Appeals and Grievances (Complaints) Received

LINE OF BUSINESS			Q1	Q2	Q3	Q4	TOTAL
CareAdvantage CMC							
Appeals	**Part C**	**Expedited**	2				2
		Standard	17				17
	Part D	**Expedited**	7				7
		Standard	18				18
	Total Appeals		**44**				**44**
Grievances	**Part C**	**Expedited**	0				0
		Standard	99				99
	Part D	**Expedited**	0				0
		Standard	7				7
	Total Grievances		**106**				**106**
CareAdvantage CMC Total			**150**				**150**

4.2 Types of Grievances Received, by Category



4.3 Type of Grievances Received, by Sub-Category

Category	Sub-Category	# Received

Category	Sub-Category	# Received
Access	No MRF or Rx on File	1
	No TAR or Prescription on File	1
	Provider Not Dispensing Drug	1
	Provider Not Dispensing Item	4
	Other	1
Access total		8
Availability	Excessive Wait Time for Appointment	2
	Unable to Schedule Appt	1
Availability total		3
Benefit	Drug not a Benefit	1
Benefit total		1
Billing	Balance Bill Not in Collections	11
	Balance Bill in Collections	1
	Full Bill Direct to Mbr	2
Billing Total		14
CD/Appeals Process	Appeals Process Incorrect	1
	CD Process Incorrect	1
CD/Appeals Process Total		2
Customer Service	Comm - Disrespect/Rudeness/Discrimination	6
	Comm - Incorrect Info Given to Mbr	4
	Comm - Other Issue with Staff	8
	Taxi - Driver no-show	11
	Taxi - Driver rude/disrespectful	2
	Taxi - Incorrect Info Given	1
	Taxi - Late pick-up/ drop off	11
	Taxi – Other	4
	Time - No return call	3
	Time - Other	2
Customer Service Total		52
FWA	Fraud - Prov Billed w/o Rendering Srvc	2
Quality of Care	Relationship - Provider Not Listening to Concerns	1
	Relationship - Provider is Rude/Mean/Etc	3
	Treatment - Incorrect Prescription	1
	Treatment - Poor Treatment	10
	Treatment - Services Not Rendered	4
	Facility - Inadequate/Unsafe Equipment	2
	Other	3
Quality of Care Total		24
Total		**106**

4.4 Resolutions Within 24 Hours of Receipt

The following reflects complaints that were resolved by HPSM's staff within 24 hours of the member informing HPSM of the complaint. These complaints are not included in the count of grievances in the tables above and do not enter the formal grievance process.

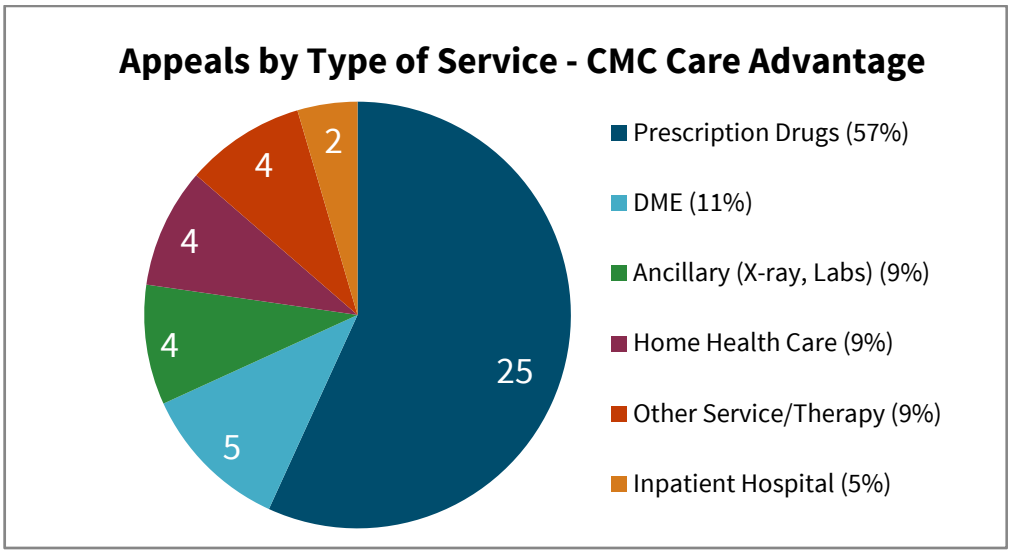
- **24 - Hour Resolutions, by Type of Service**

Types of Service	Q1	Q2	Q3	Q4	Total
Medical Services/Supplies	8				8
Prescription Drugs	51				51
Total	**59**				**59**

- **24 - Hour Resolutions, by Category**

Category	Part C Grievance	Part D Grievance
Access	2	48
Benefit	0	1
Customer Service	6	2
Grand Total	**8**	**51**

4.5 Types of Appeals Received



4.6 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).

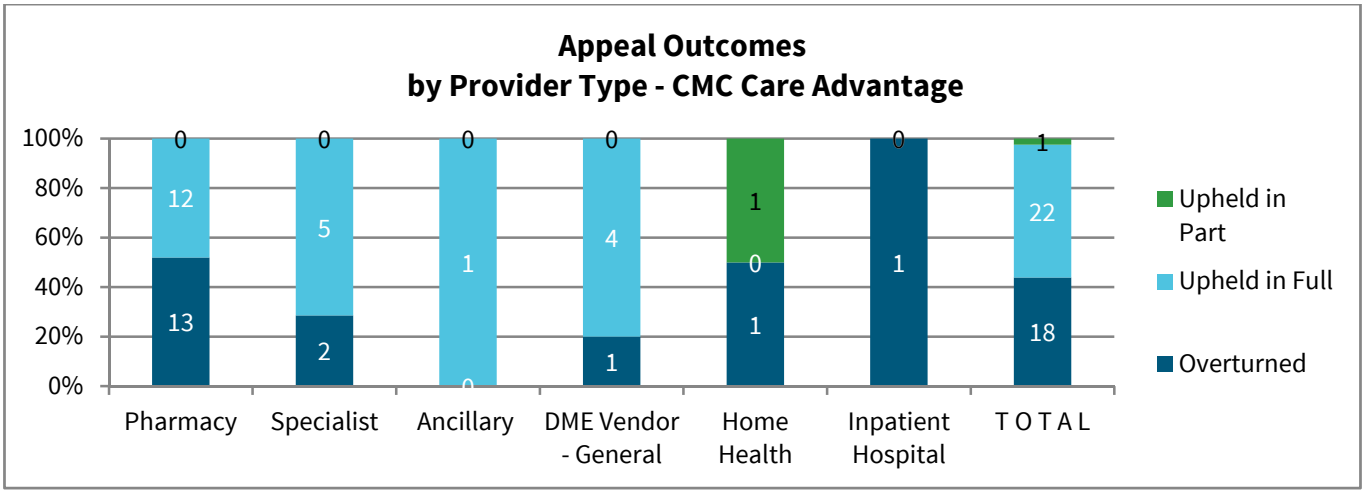
Type of Denial	Total Appeals	Upheld in Full	Upheld in Part	Overturned	Withdrawn or Dismissed	% Overturned on Appeal
Part C- Medical	19	10	1	5	3	26%
Part D - Prescription	25	12	0	13	0	52%

4.7 Appeal Outcome by Provider Type

For the 41 appeals that were neither withdrawn nor dismissed, the outcome is further broken down by Provider Type in the table below:

Provider Type	Overturned	Upheld in Full	Upheld in Part
Pharmacy	13	12	0
Specialist	2	5	0
Ancillary	0	1	0
DME Vendor - General	1	4	0
Home Health	1	0	1
Inpatient Hospital	1	0	0
Total	**18**	**22**	**1**

The frequency of each outcome is charted below as a percentage within each provider type:



4.8 Analysis, Barriers, and Proposed Actions/Solutions (CA CMC)

- **Grievances:**
  - The volume of grievances increased slightly during Q1 2019, from 90 grievances in Q4 2018 to 106 grievances in Q1 2019. However, in comparison to Q1 2018 (140 grievances) the volume of grievances is lower and continues to show the decrease in volume identified during 2018. The percentage of grievances related to Customer Service increased from 41% in Q4 2018 to 49% in Q1 2019. The percentage of grievances related to Billing decreased by 10 percentage points from Q4 2018.

- **Appeals:**
  - The percentage of appeals related to prescription drugs increased to 57% for Q1 2019 in comparison to 44% for Q4 2018; however, the same number of cases (25 appeals) was received during both quarters.
  - Appeals related to Durable Medical Equipment (DME) decreased from 25% in Q4 2018 (14 appeals) to 11% on Q1 2019 (5 appeals).

- **Rate of Overturned Appeals:** The rate of overturned appeals for medical services in Q1 2019 is 26%, which represents five appeals. The rate shows one percent higher than Q4 2018; however, this is due to a higher number of appeals (32 appeals) received during Q4 2018 in comparison to 19 appeals for Q1 2019.

  - **Proposed Action:** The Overturned Appeals Workgroup (a collaboration between the G&A Unit, Utilization Management Department, HPSM Medical Directors, and the Compliance Department) has completed its trends report and has determined a threshold for overturned appeals. This will be monitored on a quarterly basis to identify outliers and any corrective actions needed.

5.Primary Care Provider (PCP) Changes by Provider

Reason for PCP Change	Number of Changes in Q1 2019
Difficulty In Obtaining An Appointment.	44
Poor Service	46
Provider And Patient Incompatible	3
Provider's Attitude/Atmosphere	1
Total	**94**

A total of 94 members *across all lines of business* requested to change their assigned PCP effective on Quarter 1 2019 due to dissatisfaction. Members switched away from a total of 37 different PCPs. Of those, 25 were clinics and 12 were individual providers. For 6 providers, 5 or more members requested to switch away from their practice. All of them were clinics, as opposed to individual physicians.

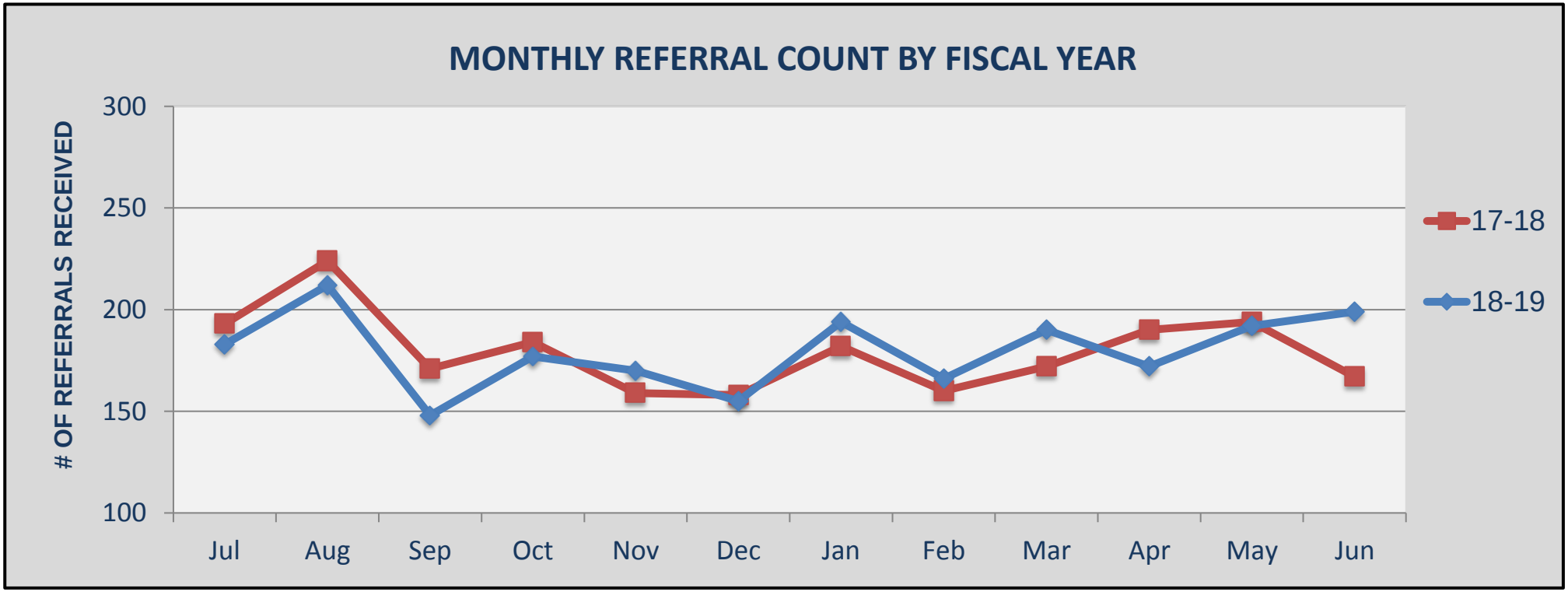
ATTACHMENT 3 TO
JULY 19, 2019 MINUTES

IHSS REFERRAL COUNT

Displays the number of IHSS Referrals received 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	AVE
15-16	214	176	169	193	177	182	180	208	238	182	203	203	*194*
16-17	188	222	231	147	167	185	248	165	214	181	178	159	*190*
17-18	193	224	171	184	159	158	182	160	172	190	194	167	*180*
18-19	183	212	148	177	170	155	194	166	190	172	192	199	*180*



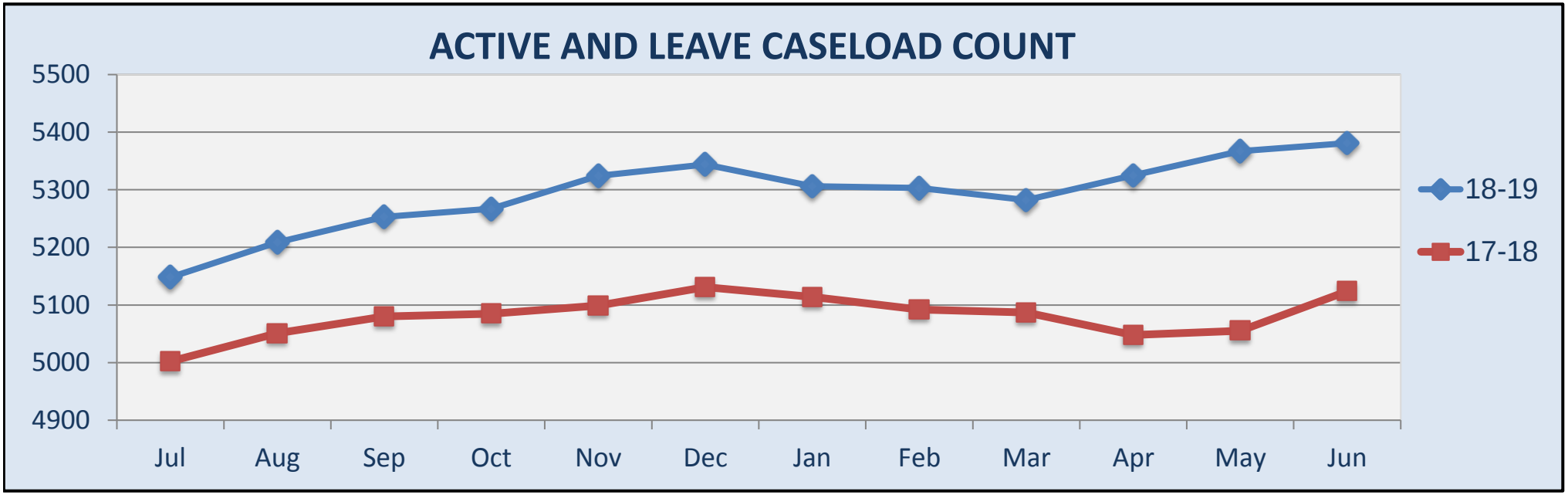
Location: M:\General\IHSS\IHSS Metrics\IHSS Referrals Received\FY 18-19\1_IHSS Referrals Received.xlsx
Data Source: Q Case Management System
JSajise/July 1, 2019

ALL PROGRAMS CASELOAD COUNT

Displays the number of IHSS, PI and MSSP cases each month within the fiscal year

IHSS, PI and MSSP ACTIVE AND LEAVE CASES PER MONTH

FY	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	*AVG*
16-17	4899	4881	4871	4886	4917	4929	4914	4941	4951	4945	4958	4977	*4,922*
17-18	5002	5051	5080	5085	5099	5131	5114	5092	5087	5048	5055	5124	*5,081*
18-19	5148	5209	5253	5267	5324	5344	5306	5303	5282	5325	5367	5381	*5,292*



Location:M:\General\IHSS\IHSS Metrics\FY 18-19\1_All Programs Active and Leave.xlsx
Data Source: IHSS Data Download 6/30/19
JSajise/July 2, 2019