Cal MediConnect/D-SNP Dashboard

Released June 2023

Program Background:

The Cal MediConnect (CMC) program was a voluntary demonstration operated by the Department of Health Care Services (DHCS) in collaboration with the Centers for Medicare and Medicaid Services (CMS) to provide better coordinated care for beneficiaries eligible for both Medicare and Medicaid (also known as "duals"). Cal MediConnect Plans (Plans), combine and coordinate Medicare and Medi-Cal benefits for eligible members, including medical, behavioral health, long-term institutional, and home-and-community based services. The Cal MediConnect Plans were available in the following counties – Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

Program Update:

The Cal MediConnect program transitioned on December 31, 2022. Starting on January 1, 2023, Cal MediConnect members were transitioned to Medicare Medi-Cal Plans or Medi-Medi Plans. Medi-Medi Plans is the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs). Under exclusively aligned enrollment, beneficiaries enroll in a D-SNP for Medicare benefits and in a Medi-Cal Managed Care Plan (MCP) for Medi-Cal benefits, which are both operated by the same parent organization for better care coordination and integration. Medi-Medi Plans offer an integrated approach to care and care coordination that is similar to Cal MediConnect. The D-SNP and Medi-Cal MCP work together to deliver all covered benefits to their members, and members will receive integrated member materials, such as one integrated member ID card. In 2024, Medi-Medi Plans will be expanded to five additional counties: Fresno, Kings, Madera, Sacramento, and Tulare. For a list of Medi-Medi Plans available in California in 2023, visit the 2023 Medicare Medi-Cal Plan List webpage. For more information, visit The Future of Cal MediConnect webpage.

DASHBOARD OVERVIEW AND KEY TRENDS

This dashboard provides select data and measures on key aspects of the CMC Program:

- **Enrollment and Demographics:** *Figures 1-6*

Figure 1a is an updated measure that was added to the June 2023 release of this Dashboard to report beneficiary enrollment in Medi-Medi Plans. The advantage of this data is that it captures CMC enrollment in up to December 2022 and Medi-Medi Plan enrollment beginning January 1, 2023, which illustrates beneficiary enrollment transition from CMC to Medi-Medi Plans. From January 2023 to April 2023, enrollment has increased from approximately 218,000 in Medi-Medi Plans as of January 2023 to about 231,000 as of April 2023. Enrollment in the Medi-Medi Plans as of April 2023 is more than twice the enrollment in CMC Plans before the transition to the new Medi-Medi Plan model. Figure 1b shows Medi-Medi Plan enrollment as of April 2023 amongst the 16 Medi-Medi

Plans which includes those enrolled ages 0-64 and ages 65 and older. The data regarding Medi-Medi Plans is preliminary.

Figures 2-6 reflects CMC beneficiary enrollment for the reporting periods of January through December 2022 and includes demographic stratification by race and/or ethnicity, sex and age. Statewide enrollment in CMC decreased from 115,696 members in December 2021 to 111,255 in December 2022. In Q4 2022, 51% of enrollees spoke English and 33% spoke Spanish as their primary language, with 40% of enrollees identifying as Hispanic. Males and females aged 65 and older represent 31% and 46% of the total CMC population, respectively.

Quality Withhold Summary: *Figure 7*

- Three plans received 100% of the quality withhold repayment, and the remaining plans all received 75% of the quality withhold repayment, for calendar year 2021.

- **Care Coordination:** *Figures 8-19*
  Figure 8 shows that the percentage of members with a health risk assessment (HRA) completed within 90 days of enrollment decreased from 97% in Q3 2022 to 95% in Q4 2022. Figure 12 shows that the percentage of members with an Individualized Care Plan (ICP) completed within 90 days of enrollment decreased from 89% in Q3 2022 to 85% in Q4 2022.
- **Grievances and Appeals:** *Figures 20-23*
  Per 10,000 member months Plans reported 18.7% more grievances in 2022 compared to 2021. In 2022 Plans reported more appeals than in 2021 per 10,000 member months. Of the total appeals, Figure 22 shows that 46% of Plan decisions were either fully or partially favorable to the member.
- **Behavioral Health Services:** *Figures 24-25*
  Figure 24 shows the rate of CMC members seeking care in the emergency room for behavioral health services. Utilization was higher in 2021 when compared to 2022. However, utilization increased from 13.0 visits per 10,000 member months in Q4 2021 to 13.8 visits per 10,000 member months in Q4 2022.
- **Long-term Services and Supports (LTSS):** *Figures 26-45*
  Figure 26 shows that LTSS utilization per 1,000 members decreased compared to the previous reporting period: from an average of 292.6 members per 1,000 receiving LTSS in Q4 2021, to an average of 272.3 members per 1,000 in Q4 2022. Figures 28-45 display LTSS member referrals and utilization in five categories: In-Home Support Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), Nursing Facility (NF) and Care Plan Options (CPO). IHSS member referral data are not included in this dashboard due to ongoing data availability issues from the CMC Plans.

Data and Analysis Notes:

The dashboard is a tool that displays a combination of quarterly and annual measures. Dashboard data are

reported by Plans, except for the enrollment and demographic data which are calculated on a county-basis by DHCS (more information below). The dashboard presents the most current data available. Therefore, the reporting time periods for each metric reported may vary for each release.

- **Quarterly Rolling Statewide Average:** Figures 8, 10, 12, 14, 24, 26, 28, 30, 32, 34, 36, 38, 40, 42 and 44.
  Metrics represent the entire CMC program, by calendar quarters.
- **Current Quarter data by plan:** Figures 9, 11, 13, 15, 27, 29, 31, 33, 35, 37, 39, 41, 43 and 45.
  Metrics represent the data for the most recent quarter, by plan.
- **Annual data:** Figures 7, 16-23 and 25**.**
  Annual data are updated once a year and are compared to previous years that are only collected in aggregate.
- **Updated data:** Figures 1-18, 20-33, 36-45 have been updated for the June 2023 release.

CMC Plan Key:

Ian Name	Plan Abbreviation on Dashboard
Anthem Blue Cross Partnership of California	Anthem
Blue Shield of California Promise Health*	Blue Shield
CalOptima	CalOptima
Community Health Group	CHG
Health Net	Health Net
Health Plan of San Mateo	HPSM
Inland Empire Health Plan	IEHP
L.A. Care	L.A. Care
Molina Healthcare	Molina
Santa Clara Family Health Plan	SCFHP

***Formerly Care1st Health Plan**

Appendix: Detailed Dashboard Metrics and Trends

Cal MediConnect Enrollment and Demographics:

Enrollment and demographic data are a point-in-time view of the CMC population. The data comes from the DHCS data warehouse and the Medi-Cal Management Information System/Decision Support System (MIS/DSS). Enrollment data for the Medi-Medi Plans for 2023 are also from the MIS/DSS.

In addition to the quarterly enrollment and demographic data reported in this dashboard, monthly enrollment data will now be available through the Medi-Cal Managed Care Enrollment Reports available at https://data.ca.gov/dataset/medi-cal-managed-care-enrollment-report

Quality Withhold Measures

CMS and DHCS monitored Plans using quality measures relating to beneficiaries' overall experience, care coordination, fostering and support of community living, and more. These measures, which were required to be reported under the Cal MediConnect demonstration build on other required data: Healthcare Effectiveness Data and Information Set (HEDIS), Medicare Health Outcomes Survey, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey data.[1]

CMS and DHCS utilized reported metrics from the combined set of core and California-specific quality measures. Core measures are common across all states participating in duals demonstrations and were primarily developed by CMS. California-specific measures were created through a collaborative partnership between DHCS, CMS, and public stakeholders.

Based on their performance on a designated set of core and California-specific measures, called “quality withhold measures,” Plans received all or a portion of an amount withheld from their capitation payment (with the exception of Part D components).[2]

All quality withhold measures have benchmarks that the Plans were required to meet in order to receive some or all of the quality withhold amount.

[1] Core and State-Specific Reporting Requirements: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html

[2] Core and State-Specific Quality Withhold Methodology and Technical Notes: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes

DHCS recognized the tremendous impact of the COVID-19 pandemic on older adults and people with disabilities, including those enrolled in CMC. Due to the pandemic, which began to impact California on a large scale in 2020, DHCS, CMS, CMC Plans, and providers undertook a number of efforts and delivery system changes to prioritize infection prevention and treatment, which in turn impacted the ability of CMC Plans to collect and submit quality data in 2020 and 2021. Due to the COVID-19 Public Health Emergency, all CMC Plans were eligible to qualify for a quality withhold adjustment for an extreme and uncontrollable circumstance. Consequently, all CMC Plans received 100% of the withheld amount for CY 2020 based solely on full reporting of all applicable quality withhold measures.

Figure 7 shows the Quality Withhold Summary for CY 2021. Definitions of the measures included are below:

CW stands for "core withhold", and in most cases, a core withhold measure corresponds with a core quality measure. CAW stands for "California withhold" and usually corresponds with a state-specific quality measure. Quality withhold measures may be stand-alone, or based on HEDIS, CAHPS, or other national data sources.

- **Plan All-Cause Readmission:** The ratio of the plan's observed readmission rate to the plans' expected readmission rate. The readmission rate is based on the percent of plan members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason. (CW6)
- **Annual Flu Vaccine:** Percent of plan members who got a vaccine (flu shot) in the past six months. (CW7)
- **Follow-Up After Hospitalization for Mental Illness:** Percentage of discharges for plan members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge. (CW8)
- **Controlling Blood Pressure:** Percentage of plan members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year. (CW11)
- **Medication Adherence for Diabetes Medications:** Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. (CW12)
- **Encounter Data:** Encounter data for all services covered under the demonstration, with the exception of prescription drug event data, submitted timely in compliance with demonstration requirements. (CW13)
- **Behavioral Health Shared Accountability Outcome Measure:** Reduction in emergency department (ED) use for seriously mentally ill and substance use disorder members. (CAW7)

- **Documentation of Care Goals:** Members with documented discussions of care goals. (CAW8)
- **Interaction with Care Team:** Percent of members who have a care coordinator and have at least one care team contact during the reporting period. (CAW9)
- **Care Plan Completion:** Percentage of members with a care plan completed within 90 days of enrollment. (CAW 10)

Care Coordination Measures:

Enhanced, person-centered care coordination was a key benefit of CMC. The dashboard tracks different measures and aspects of that benefit, from the initial HRA to begin the care coordination process, to the development of an individualized care plan, to the assignment of care coordinators, and post-hospital discharge follow-up care.

- **Health Risk Assessments (HRAs):** An HRA is a survey tool conducted by the Plans to assess a member's current health risk(s) and identifies further assessment needs such as behavioral health, substance use, chronic conditions, disabilities, functional impairments, assistance in key activities of daily living, dementia, cognitive and mental status, and the capacity to make informed decisions.

    o Plans must complete HRAs for high-risk members within 45 days of enrollment, and for low-risk members within 90 days of enrollment. Plans report their 90 days HRA completion rates via Core measure 2.1. Figures 8 and 9 provide Plan HRA completion rates within 90 days of enrollment for members who did not refuse an HRA, and for members who the Plan was able to reach. Figures 10 and 11 include the rates of members the Plans were unable to reach to conduct an HRA within 90 days of enrollment-both low and high risk. These unable to reach rates represent the percentage of members who the plan was unable to reach, following three documented outreach attempts to participate in the HRA, and who never had an HRA completed within 90 days of enrollment.

- **Individualized Care Plans (ICPs):** The ICP is developed by members with their interdisciplinary care team. Engaging members in developing their own care goals and care plans is a central tenant of person-centered care. ICPs must include the member's goals, preferences, choices, and abilities. Documenting discussions of care goals with members is one way to assess how Plans are engaging members in their care planning and are monitored through multiple California-specific measures.

- Plans must complete a care plan for each member within 90 days of enrollment. Information tracking 90- day

ICP completion rates comes from Core measure 3.2. Figures 12 and 13 do not include unwilling and unable to reach populations in calculations however, figures 14 and 15 do report ICP unable to reach rates. These unable to reach rates represent the percentage of members who the plan was unable to reach following three documented outreach attempts to complete a care plan, and who never had a care plan completed within 90 days of enrollment.

- **Follow-up Visits within 30 Days of Hospital Discharge:** Supporting members through care transitions, particularly out of an acute hospital stay, is another measure of care coordination activities.
- **Care Coordination and Interdisciplinary Care teams (ICT):** An ICT works with a member to develop, implement, and maintain an ICP. The ICT is comprised of the primary care provider and care coordinator, and other providers at the discretion of the member.

Care Coordination Trends:

Figure 8 shows that the quarterly statewide percentage of members willing to participate in a HRA, and who the Plan was able to locate, with an assessment completed within 90 days of enrollment decreased from 97% in Q3 2022 to 95% in Q4 2022. Figure 9 shows that 5 of 10 Plans (Anthem, Blue Shield, CHG, IEHP, and LA Care) were above the statewide average of 95% for Q4 2022. The other 5 plans were within 4 percentage points of the average.

Figure 10 shows that the quarterly statewide percentage of members who the plan was unable to locate within 90 days to complete an HRA decreased from 25% in Q3 2022 to 24% in Q4 2022. Figure 11 shows that 6 of 10 Plans were at or below the statewide average of 24% for Q4 2022, while the 4 remaining Plans (Anthem, Blue Shield, Molina, and SCFHP) were above the statewide average. Blue Shield was unable to locate 47% of members within 90 days to complete an HRA in Q4 2022, which represents an increase of 4 percentage points from 43% in Q3 2022. Note, the goal for this measure is for the Plans to have a low unable to reach rate, so lower rates indicate better performance.

The percentage of members with an ICP completed within 90 days of enrollment has decreased slightly from 89% from Q3 2022 to 85% in Q4 2022 (Figure 12). Figure 13 shows that for 7 Plans (Anthem, CHG, IEHP, LA Care, Cal Optima, HPSM, and SCFHP), the percentage of members with an ICP completed within 90 days of enrollment is at or above the statewide average of 85% for Q4 2022. Blue Shield experienced a sharp decrease in the percentage of members with a completed ICP, from 61% in Q3 2022 to 46% in Q4 2022. Similarly, Molina had a nearly 9 percentage point decreased in the ICP completion rate between Q3 and Q4 2022, from 82% to 73%.

Figure 14 shows that the quarterly statewide percentage of members who the plan was unable to locate for the purpose of completing an ICP within 90 days of enrollment has stayed the same from 35% in Q3 2022 to 35% in Q4 2022. Figure 15 shows that 6 of 10 Plans are below the statewide average of 35% for Q4 2022 and the remaining 4 (Blue Shield, Health Net, LA Care, and SCFHP) are at or above the statewide average. Unable to reach rates for Blue Shield increased between Q3 2022 and Q4 2022, from 75% to 77%. Note, the goal for this measure is for the Plans to have a low unable to reach rate, so lower rates indicate better performance. Plans should continue efforts to ensure member contact information is up-to-date, especially in consideration of the impending unwinding of COVID-19 Public Health Emergency flexibilities.

Grievances and Appeals:

This dashboard includes data on the two ways CMC beneficiaries can attempt to resolve issues with their Plans:

- **Grievances:** Grievances are complaints or disputes members file with the Plans that are evaluated at the Plan- levelexpressingdissatisfactionwithanyaspectofthePlan's operations,activities,orbehavior.This includes, but is not limited to, the quality of care or services provided (such as wait times or inability to schedule appointments), aspects of interpersonal relationships such as rudeness of a provider or employee, or failure torespectamember's rights.Thisdoesnotincludebenefit determinations.
- **Appeals:** If a Plan denies, reduces, or terminates benefits or services for a member, the member can appeal either through internal processes or an external process through Medi-Cal or Medicare. Appeals can bedeterminedas "adverse" (denyingthemember's appeal)or partially or fully favorable to the member's appeal. This dashboard only includes data regarding appeals determined at the Plan's level.

Grievances and Appeals Trends[3]*:

In an effort to refine the reporting and analysis process on grievances and appeals, the following new grievances categories were introduced in 2018: access to care, transportation, billing, and home health/personal care. Figures 20 and 21 show a breakdown of a total of 26,982 grievances, by category and by Plan, filed by members in 2022. From 2021 to 2022, L.A. Care reported an approximate 51% increase in member grievances per 10,000 member months, having total of 9,184 grievances in 2022.[4] IEHP is the largest plan so it is expected they will have the highest total number and highest rate of grievances when not compared per 10,000 member months. DHCS and CMS are actively working with IEHP to monitor the high number of grievances filed. L.A. Care had a higher rate of grievances than IEHP in 2022.

The number of appeals varies greatly by Plan, as well as the percentage of decisions that are adverse versus partially or fully favorable. Figure 22 indicates 1,425 appeals were filed by members in 2022, an increase of around 18% per 10,000 member months of total reported appeals compared to 2021.[5]

Figure 22 indicates that 46% of Plan decisions were either fully or partially favorable to the member appeals filed in 2022.

DHCS and CMS continue to work with the Plans to better understand the trends in grievances and appeals to ensure optimal beneficiary access to services.

[3] The change in Grievances and Appeals from 2021 to 2022 does not necessarily indicate a change in actual instances; but may reflect changes in the administrative processing, reconciliation and/or reporting by individual Plans.
[4] Cal MediConnect Performance Dashboard September 2020: https://www.dhcs.ca.gov/services/Documents/MCQMD/CMCDashboard9-20.pdf
[5] For more historical detail, refer to Cal MediConnect Performance Dashboard June 2020, September 2020, and June 2021: https://www.dhcs.ca.gov/Pages/Cal_MediConnectDashboard.aspx

Behavioral Health Emergency Room Utilization:

This metric measures behavioral health-related emergency visits. A visit is comprised of a revenue code for an emergency department visit and a principal diagnosis related to behavioral health. This metric is a Core measure.

Behavioral Health Emergency Room Utilization Trends:

One goal for Plans is to improve the coordination of behavioral health services for their members, including between the mental health and substance use disorder (SUD) treatments covered by the Plans and the specialty mental health services provided by county behavioral health departments. Figure 24 shows the overall trend of CMC members seeking care in the emergency room for behavioral health services has decreased from 17.8 visits per 10,000 member months in Q3 2022 to 13.8 visits per 10,000 member months in Q4 2022.

Long-term Services and Supports (LTSS) Utilziation:

A central goal of CMC was to improve access to and coordination of long-term services and supports for members to help more members live in the community. DHCS has worked closely with Plans to increase referrals to LTSS programs, particularly home and community-based services, as well as to encourage Plans to help their members transition out of nursing facilities and into the community where appropriate.

- **LTLTSS Utilization and Referrals:** LTSS Utilization and Referrals are reported by each Plan for LTSS which includes (IHSS) (carved out beginning in 2018), (CBAS) (carved in), (MSSP) (carved out beginning January 1, 2022), (NF) (carved in) and (CPO) (carved in).

LTSS Trends:

DHCS has worked with the Plans to enhance LTSS referrals and encourages Plans to support members in transitioning out of nursing facilities and into the community with home- and community-based LTSS, as appropriate. In 2019 in particular, the CMS-DHCS contract management teams worked closely with the plans to review their MSSP and CPO referral rates, and to identify best practices to ensure members are being connected with needed services.

Figure 26 shows that LTSS utilization has decreased from an average of 274.1 per 1,000 members in Q3 2022 to 272.3 per 1,000 members receiving LTSS in Q4 2022.

As shown in Figure 28, IHSS utilization has increased from an average of 224.8 per 1,000 members in Q3 2022 to 225.6 per 1,000 members receiving IHSS in Q4 2022.

Figure 30 shows that CBAS referral rates have decreased from 2.0 per 1,000 members in Q3 2022 to 1.4 per 1,000 members in Q4 2022. SCFHP reported a decreased in CBAS referrals of 3.9 per 1,000 members in Q4 2022 when compared to Q3 2022, as shown in Figure 31. Figure 32 shows that CBAS utilization per 1,000 members has decreased from 9.4 members per 1,000 receiving CBAS in Q3 2022 to 7.7 members per 1,000 receiving CBAS in Q4 2022.

Figure 34 shows that MSSP referrals per 1,000 members has increased from an average of 0.5 per 1,000 members in Q3 2021 to an average of 0.6 per 1,000 members in Q4 2021. Anthem reported the highest number of MSSP referrals of 2.2 per 1,000 members in Q4 2021, as seen in Figure 35. Figure 36 shows that MSSP utilization per 1,000 members has stayed the same from 13.5 per 1,000 members in Q3 2022 to 13.5 per 1,000 members in Q4 2022.

Figure 38 shows that NF referrals per 1,000 members has decreased from an average of 4.5 member referrals per 1,000 in Q3 2022 to an average 4.0 member referrals per 1,000 in Q4 2022. HPSM reported the same number of NF referrals of 10.2 per 1,000 members in Q4 2022 (Figure 39) when compared to Q3 2022. Figure 40 shows that NF utilization has decreased from an average of 26.4 members per 1,000 in Q3 2022 to an average of 25.6 members per 1,000 in Q4 2022.

Figure 42 shows that CPO referrals per 1,000 members has decreased from 2.2 referrals per 1,000 members from Q3 2022 to 0.9 per 1,000 members in Q4 2022. HPSM reported a large decrease in number of CPO referrals per 1,000 members in Q4 2022 when compared to Q3 2022, as seen in Figure 43. Figure 44 shows that CPO utilization per 1,000 members has decreased from an average of 1.9 per 1,000 members from Q3 2022 to 0.6 per members in Q4 2022.

CPO referral and utilization data shown in Figures 42-45 between Q4 2021 and Q4 2022 are based on the revised CPO template and instructions.

Cal MediConnect to Medi-Medi Plan Transition

Fig. 1a: Monthly Enrollment

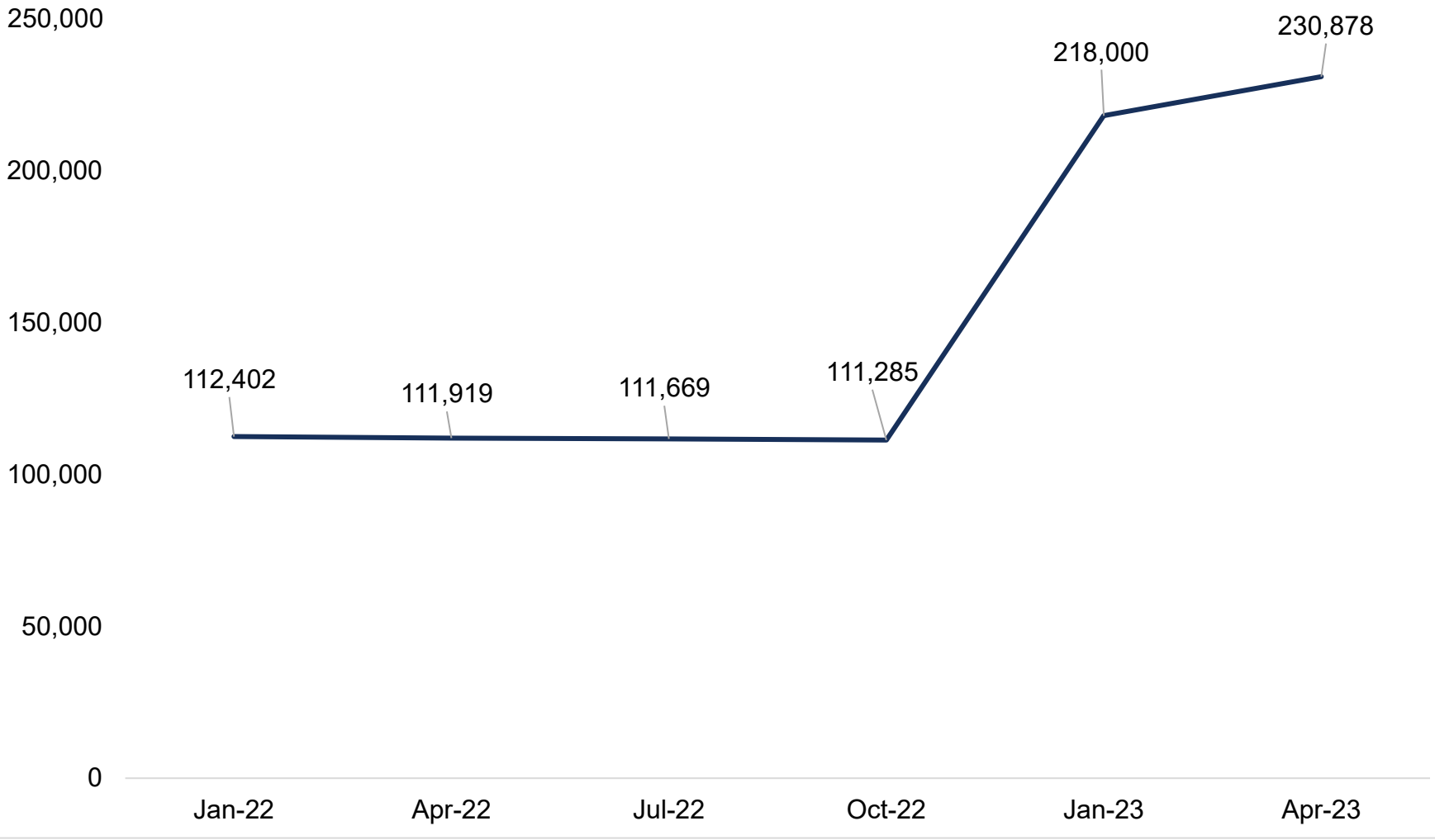
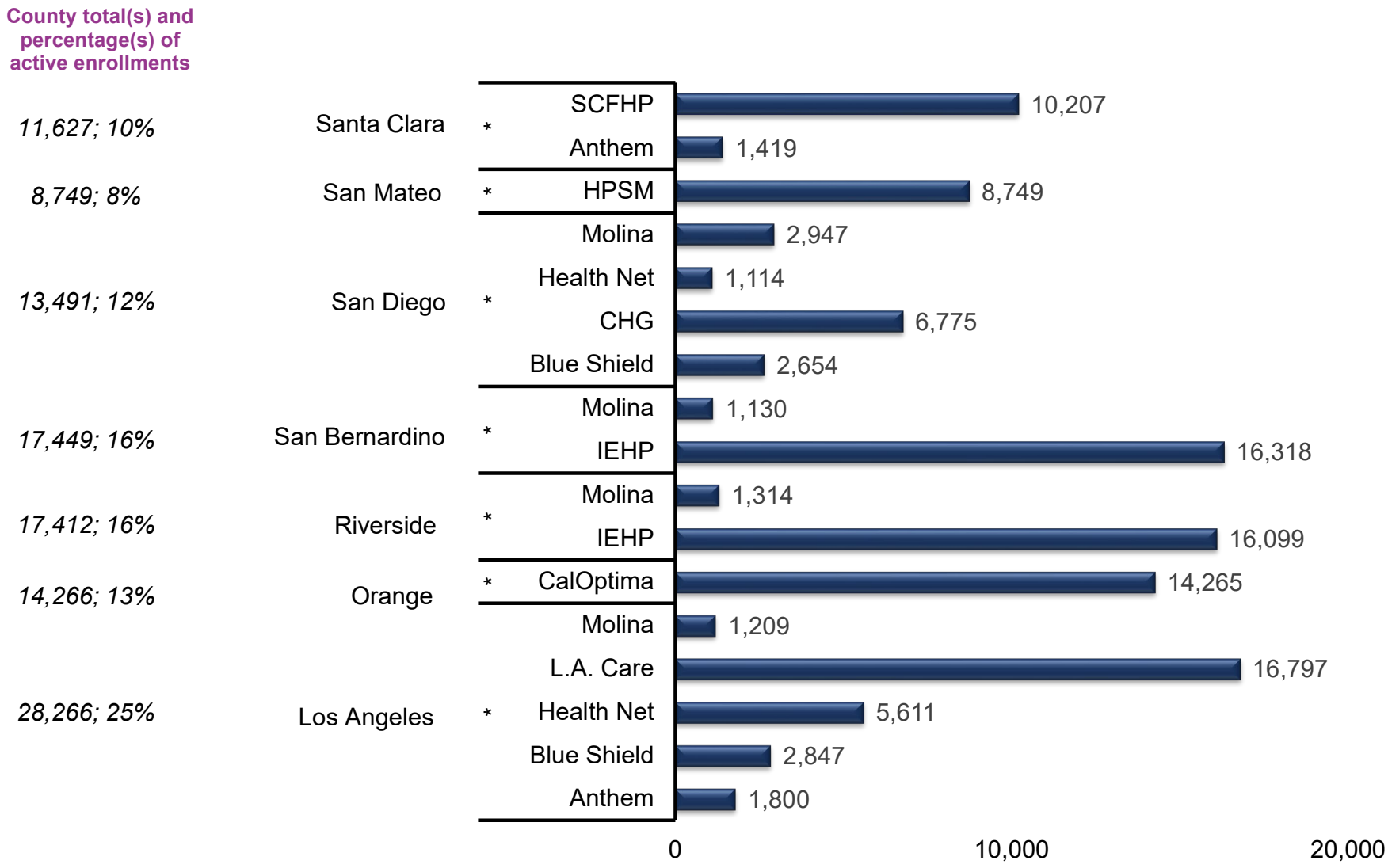


Figure 1b: April 2023 Enrollment by Medi-Medi Plan

Medi-Medi Plan Marketing Name	0-64	65+	Total
Aetna Medicare Preferred Plan (HMO D-SNP)	189	679	868
Anthem MediBlue Full Dual Advantage (HMO D-SNP)	3,911	25,170	29,081
Blue Shield TotalDual Plan (HMO D-SNP)	3,204	15,165	18,369
CareAdvantage (HMO D-SNP)	1,682	7,012	8,694
CommuniCare Advantage (HMO D-SNP)	1,211	5,360	6,571
IEHP DualChoice (HMO D-SNP)	9,741	23,252	32,993
L.A. Care Medicare Plus (HMO D-SNP)	3,666	14,172	17,838
Molina Medicare Complete Care Plus (HMO D-SNP)	2,313	7,930	10,243
OneCare (HMO D-SNP)	3,650	13,896	17,546
SCFHP DualConnect (HMO D-SNP)	1,609	8,982	10,591
Senior Advantage Medicare Medi-Cal Los Angeles (HMO D-SNP)	4,375	19,437	23,812
Senior Advantage Medicare Medi-Cal San Diego (HMO D-SNP)	1,085	3,082	4,167
Senior Advantage Medicare Medi-Cal San Mateo (HMO D-SNP)	226	1,094	1,320
Senior Advantage Medicare Medi-Cal Santa Clara (HMO D-SNP)	716	2,803	3,519
Wellcare Dual Align 001 (HMO D-SNP)	2,113	12,186	14,299
Wellcare Dual Align 129 (HMO D-SNP)	6,097	24,870	30,967
Total	45,788	185,090	230,878

Cal MediConnect Enrollment and Demographics Figure 2: Breakdowns of Dual Populations (As of 12/31/2022)
See metric summary for additional information

Fig. 2: Count and Percentage of Total Active Enrollments, by County and Plan as of December 2022



Cal MediConnect Enrollment and Demographics Figure 3 - 6: Breakdowns of Dual Populations (As of 12/31/2022) See metric summary for additional information

Fig. 3: Quarter 4 Enrollment by Race/Ethnicity

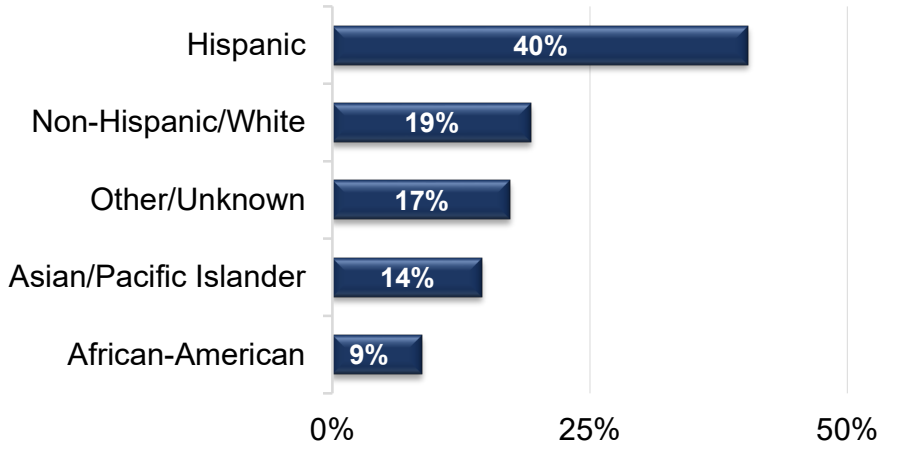


Fig. 4: Quarter 4 Enrollment by Age

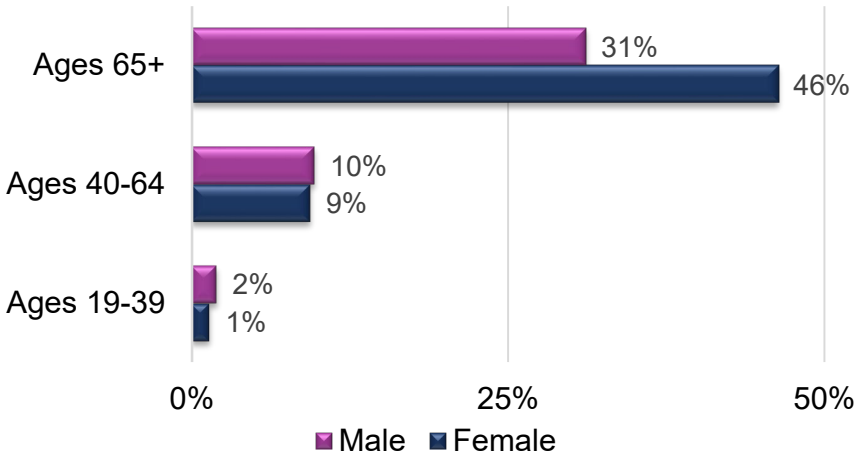


Fig. 5: Quarter 4 Enrollment by Threshold Language Spoken

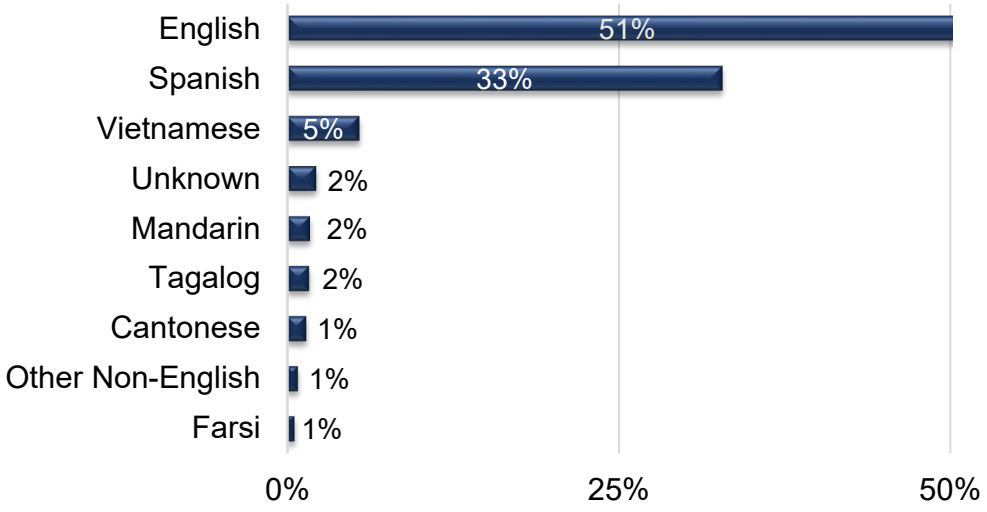
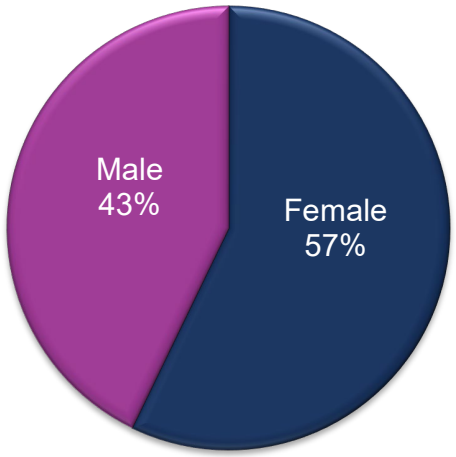


Fig. 6: Quarter 4 Enrollment by Gender



Cal MediConnect Figure 7: Quality Withhold Summary Table (CY 2021); Demonstration Year 6
See metric summary for additional information

Medicare-Medicaid Plan	CW6 - Plan All - Cause Readmissions	CW7 – Annual Flu Vaccine*	CW8 – FollowUp After Hospitalization for Mental Illness*	CW11 – Controlling Blood Pressure*	CW12 – Medication Adherence for Diabetes Medications*
	Benchmark: 1.00	Benchmark: 69%	Benchmark: 56%	Benchmark: 71%	Benchmark: 80%
Anthem	Met	Met	Met	Met	Met
Blue Shield	Not Met	Met	Met	Met	Met
CHG	Not Met	Met	Not Met	Met	Met
Health Net	Not Met	Not Met	Met	Met	Met
IEHP	Not Met	Met	Met	Met	Met
L.A. Care	Not Met	Met	Met	Met	Met
Molina	Met	Not Met	Not Met	Met	Met
CalOptima	Met	Met	Not Met	Not Met	Met
HPSM	Met	Met	Met	Met	Met
SCFHP	Not Met	Met	Met	Not Met	Met

Medicare-Medicaid Plan	CW13 – Encounter Data	CAW7 – Behavioral Health Shared Accountability Outcome Measure*	CAW8 – Documentation of Care Goals*	CAW9 – Interaction with Care Team*	CAW10 – Care Plan Completion*
	Benchmark: 80%	Benchmark: 10% Decrease	Benchmark: 95%	Benchmark: 95%	Benchmark: 85%
Anthem	Met	Met	Met	Not Met	Not Met
Blue Shield	Met	Not Met	Met	Not Met	Met
CHG	Met	Met	Met	Met	Met
Health Net	Met	Met	Met	Met	Not Met
IEHP	Met	Met	Not Met	Not Met	Met
L.A. Care	Met	Met	Met	Met	Met
Molina	Met	Met	Not Met	Met	Not Met
CalOptima	Met	Met	Met	Not Met	Met
HPSM	Met	Not Met	Not Met	Met	Not Met
SCFHP	Met	Not Met	Met	Met	Met

Care Coordination Figure 8 & 9: Percent of Members Willing to Participate and who the Plan was able to Locate with an Assessment Completed Within 90 Days of Enrollment (1/2022-12/2022) See metric summary for additional information

Fig. 8: Quarterly Rolling Statewide Percentage of Members Willing to Participate and who the Plan was able to Locate with an Assessment Completed Within 90 Days of Enrollment

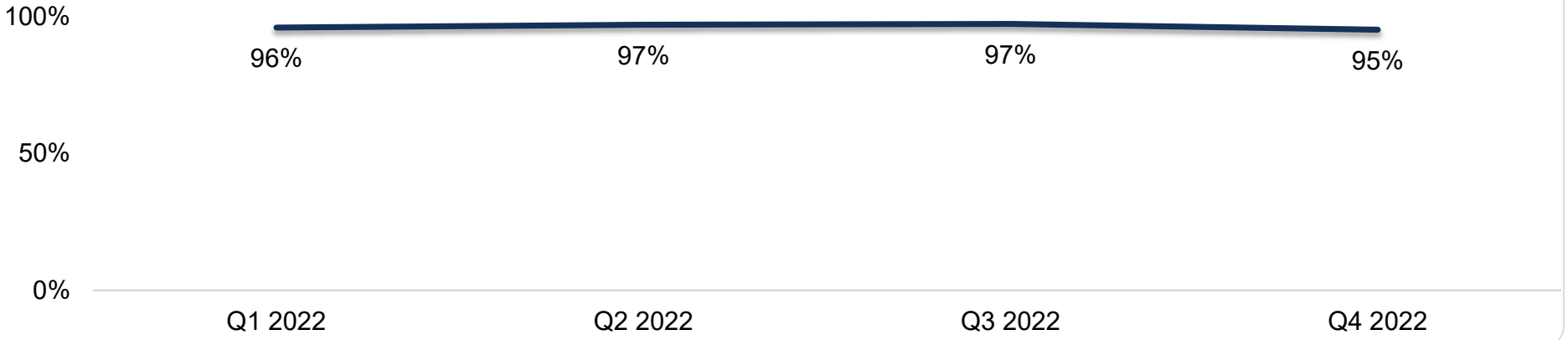
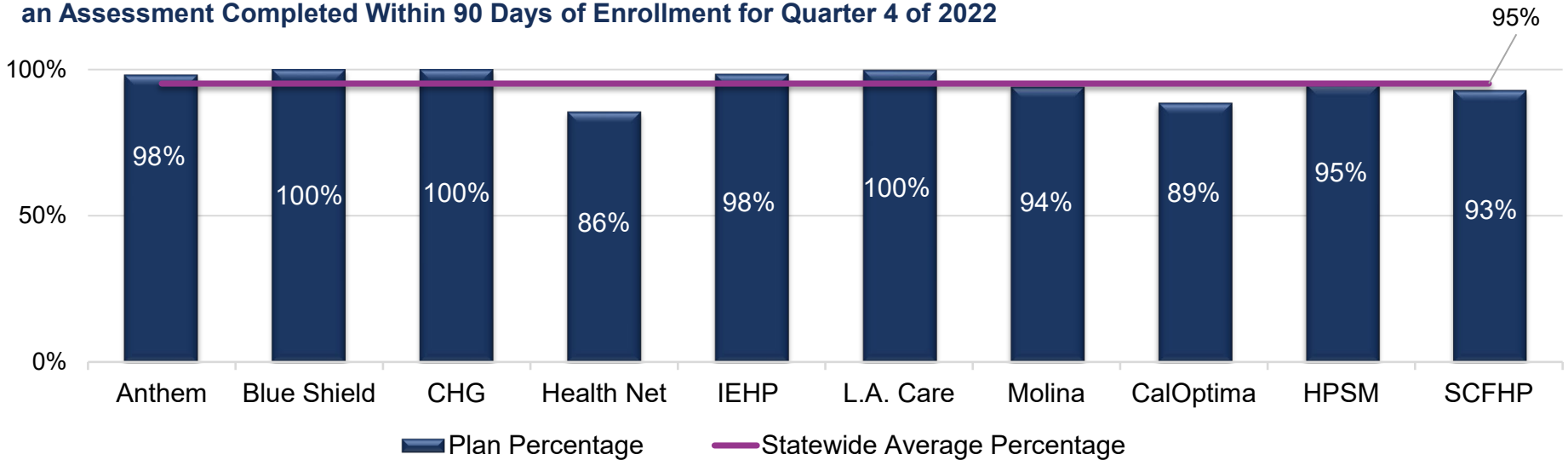


Fig. 9: The Percentage of Members Willing to Participate and who the Plan was able to Locate with an Assessment Completed Within 90 Days of Enrollment for Quarter 4 of 2022



Care Coordination Figure 10 & 11: Percentage of Members Who the Plan Was Unable to Locate within 90 Days to Complete an Assessment (HRA) (01/2022-12/2022) See metric summary for additional information

Fig. 10: Quarterly Rolling Statewide Percentage of Members Who the Plan Was Unable to Locate within 90 Days to Complete an Assessment (HRA)

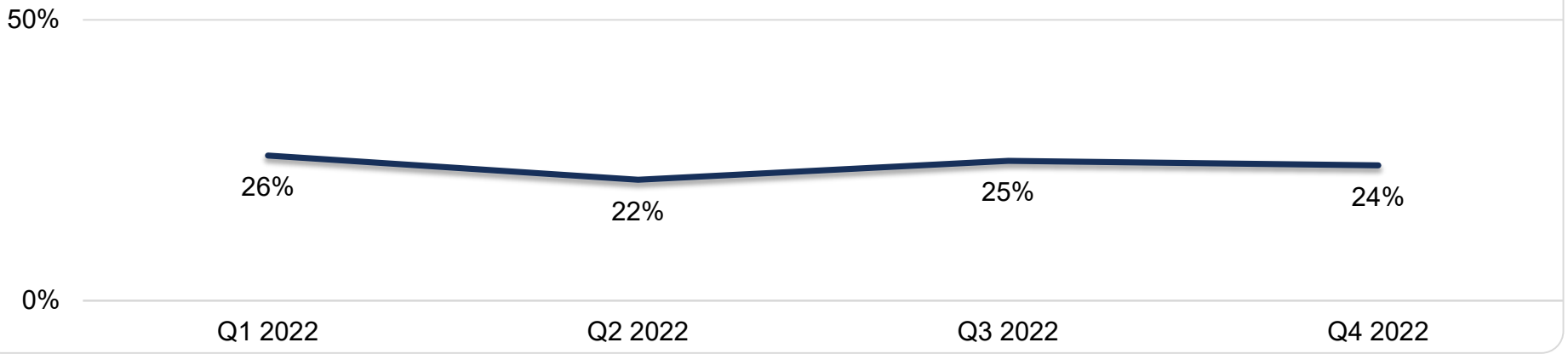
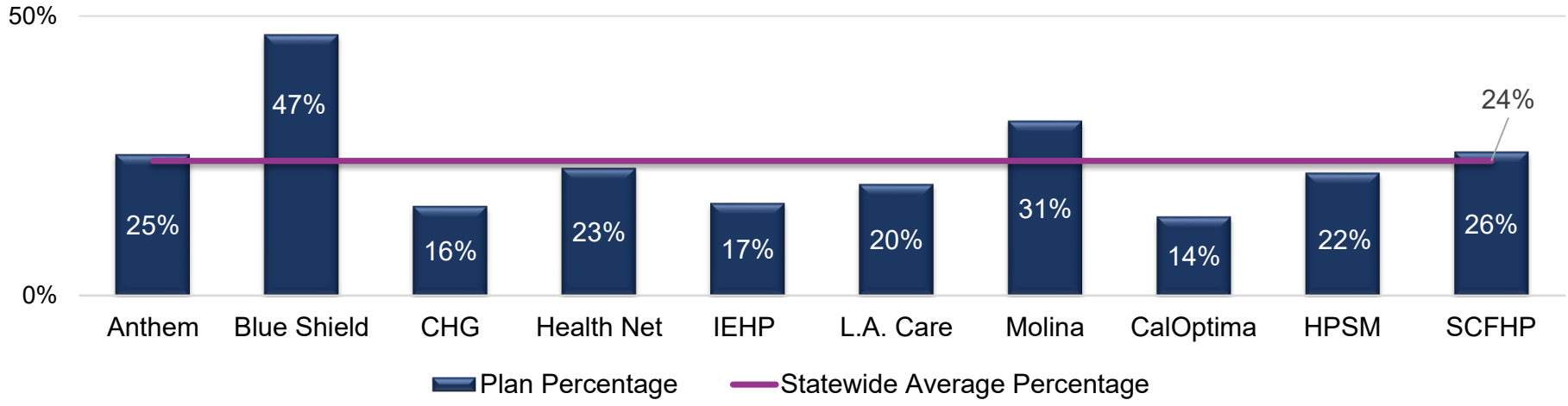


Fig. 11: Percentage of Members Who the Plan Was Unable to Locate within 90 Days to Complete an Assessment (HRA) for Quarter 4 of 2022



Care Coordination Figure 12 & 13: Percentage of Members with an Individualized Care Plan (ICP) Completed Within 90 Days of Enrollment (01/2022-12/2022) See metric summary for additional information

Fig. 12: Quarterly Rolling Statewide Percentage of Members with an ICP Completed Within 90 Days of Enrollment

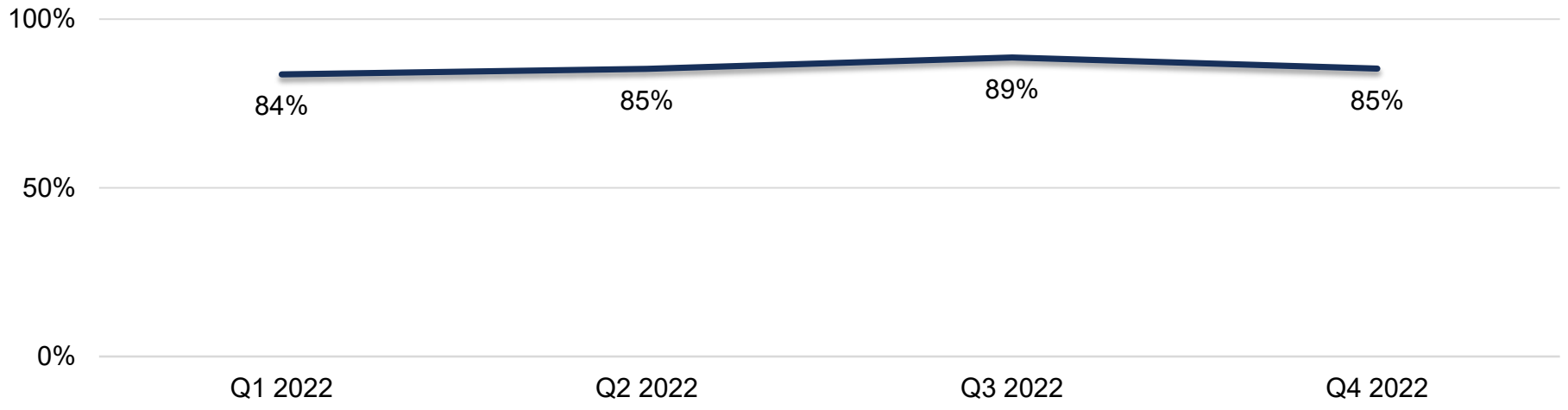
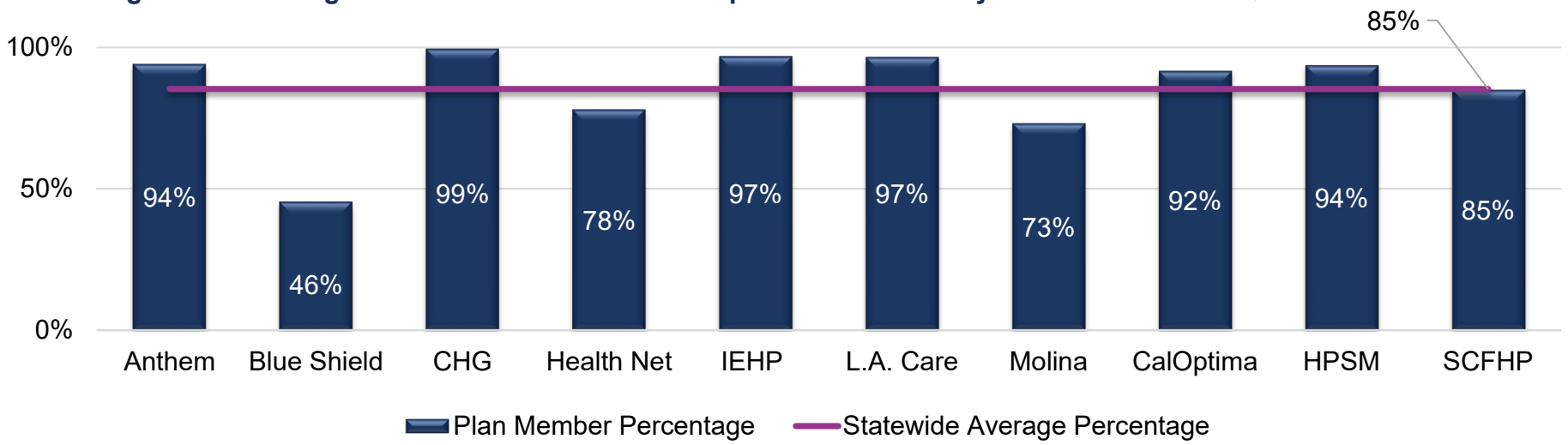


Fig. 13: Percentage of Members with an ICP Completed Within 90 Days of Enrollment for Quarter 4 of 2022



Care Coordination Figure 14 & 15: Percentage of Members Who the Plan Was Unable to Locate to Complete an ICP Within 90 Days of Enrollment (01/2022-12/2022) See metric summary for additional information

Fig. 14: Quarterly Rolling Statewide Percentage of Members Who the Plan Was Unable to Locate to Complete an ICP Within 90 Days of Enrollment

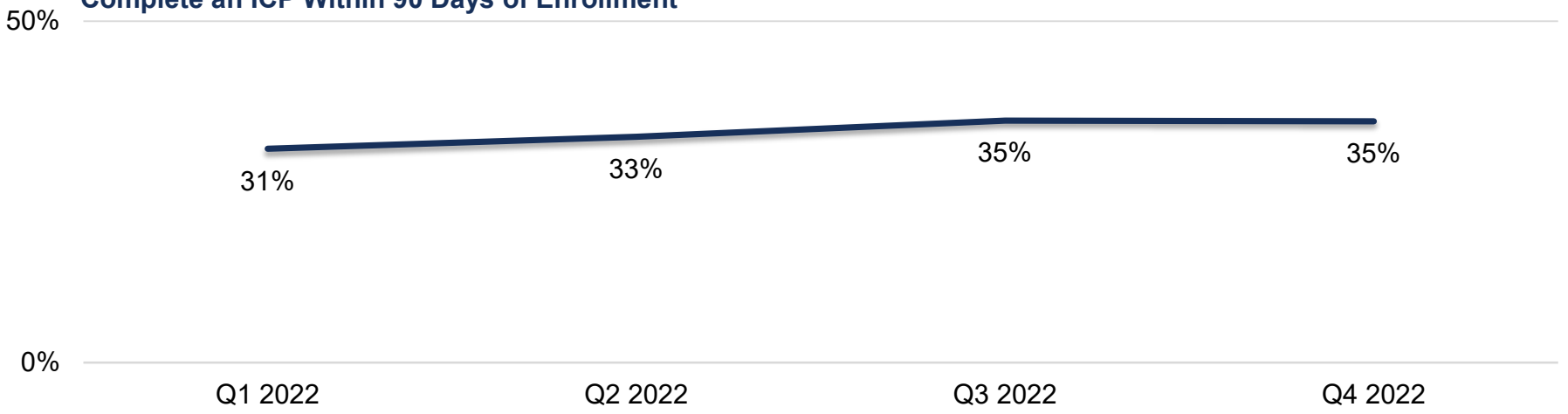
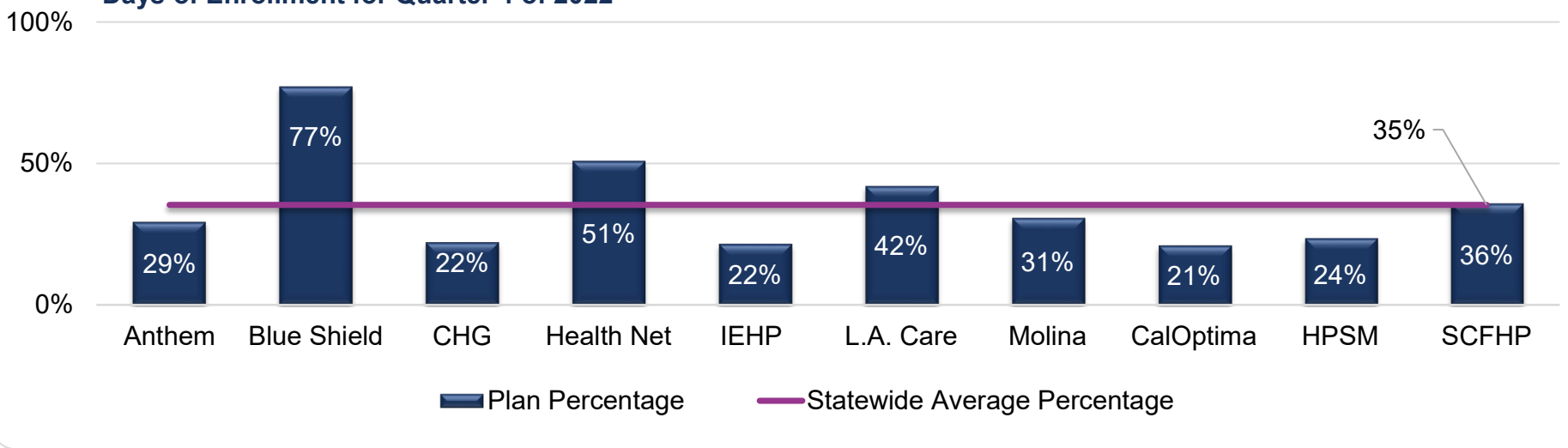
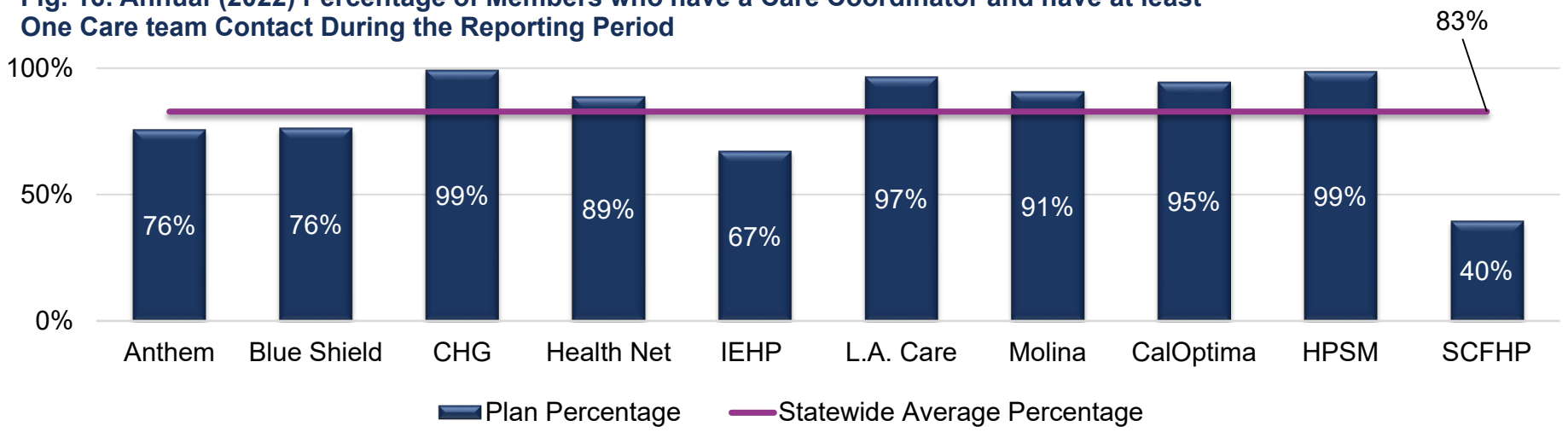


Fig. 15: Percentage of Members Who the Plan Was Unable to Locate to Complete an ICP Within 90 Days of Enrollment for Quarter 4 of 2022



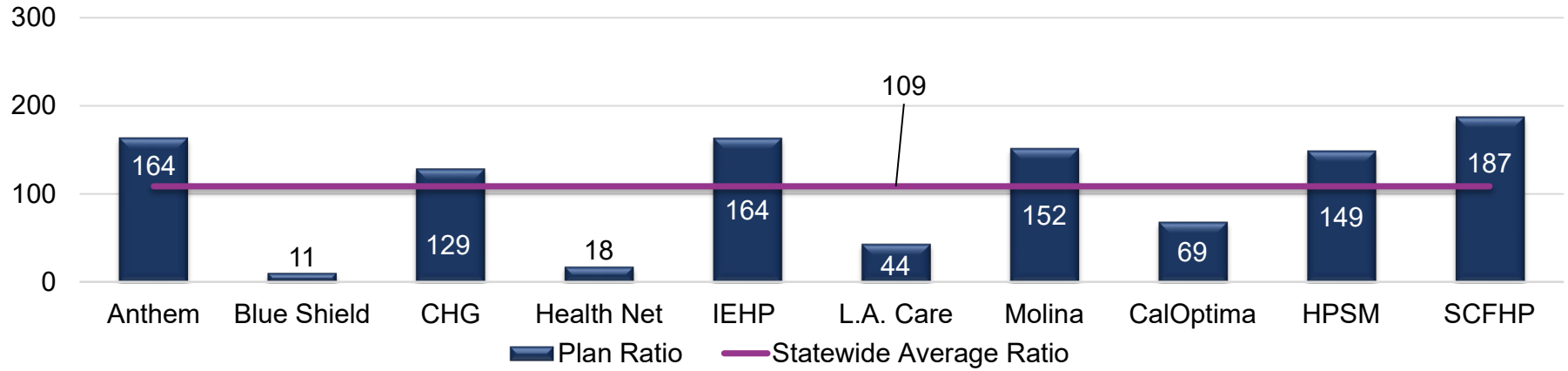
Care Coordination Figure 16: Percentage of Members Who Have a Care Coordinator and Have at Least One Care Team Contact During the Reporting Period (01/2022-12/2022) See metric summary for additional information

Fig. 16: Annual (2022) Percentage of Members who have a Care Coordinator and have at least One Care team Contact During the Reporting Period



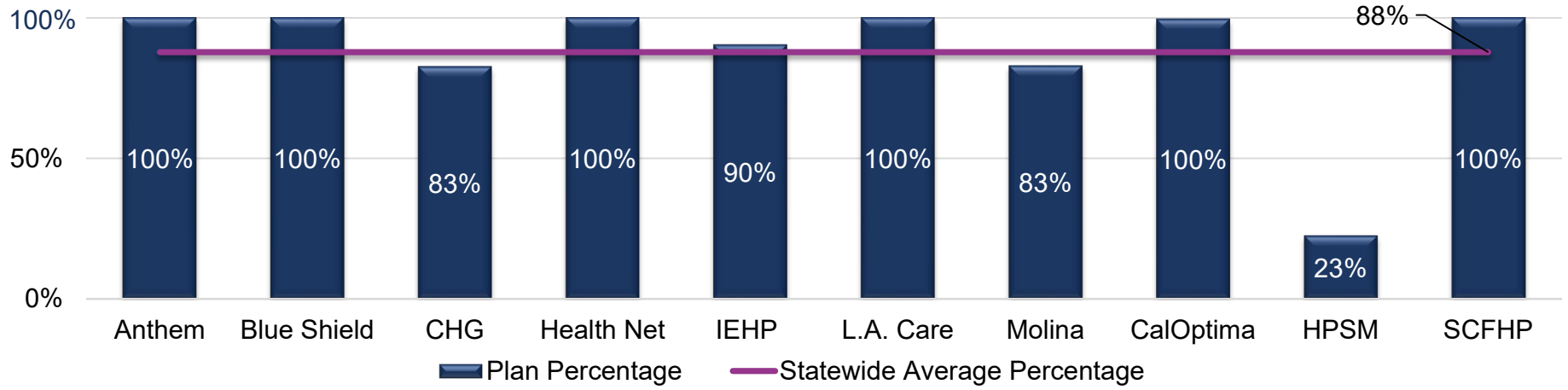
Care Coordination Figure 17: Member to Care Coordinator Ratio (01/2022-12/2022) See metric summary for additional information

Fig. 17: Annual (2022) Number of Members to Care Coordinator Ratio



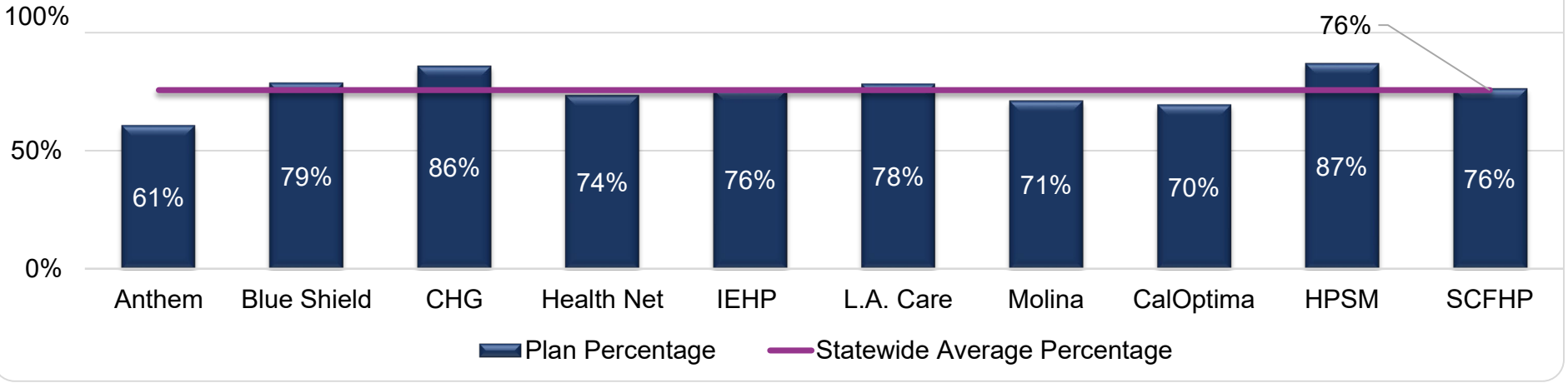
Care Coordination Figure 18: Percentage of Members with Documented Discussions of Care Goals (01/2022-12/2022) See metric summary for additional information

Fig. 18: Annual (2022) Percentage of Members with Documented Discussions of Care Goals



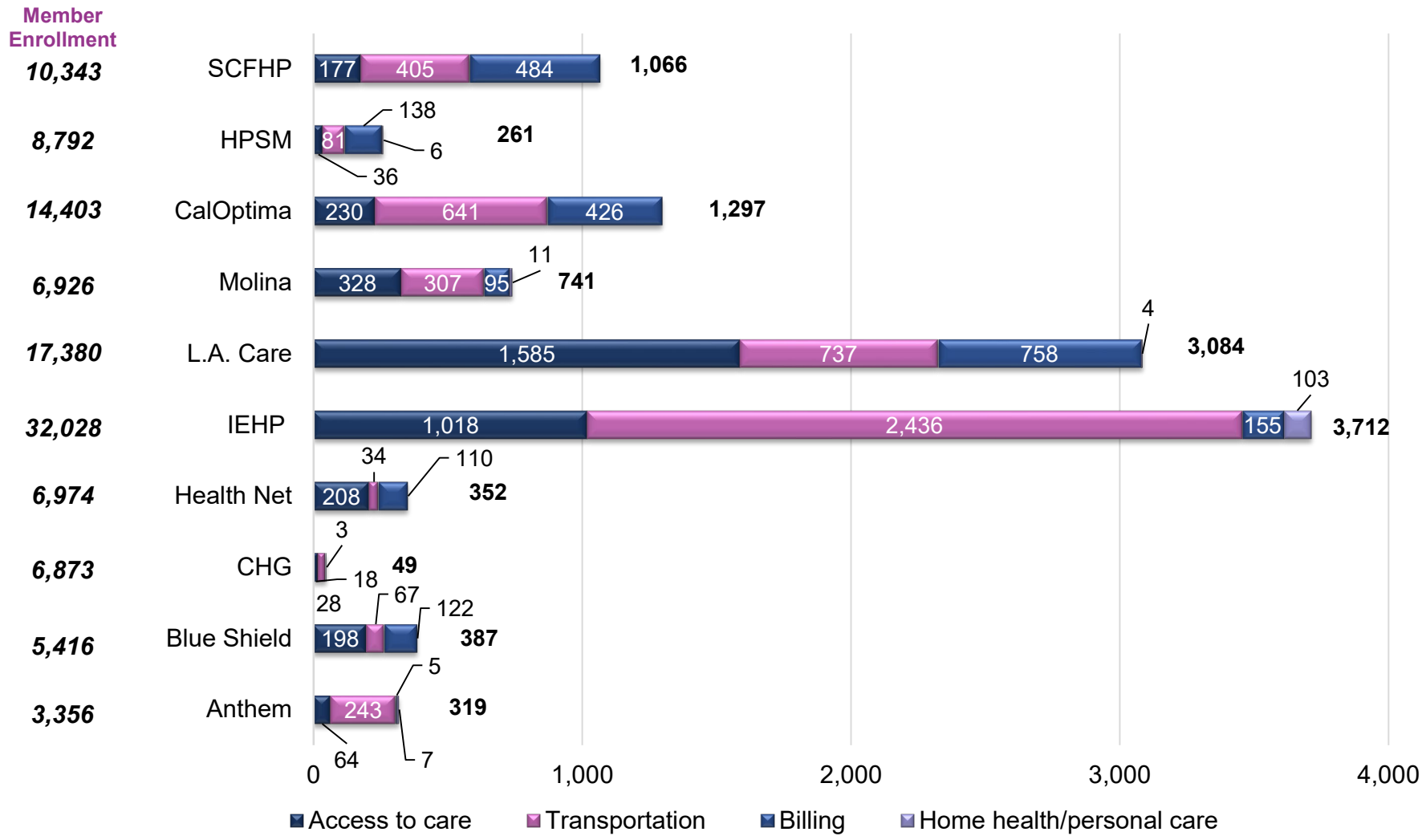
Care Coordination Figure 19: Percentage of Members with First Follow-up Visit within 30 Days after Hospital Discharge (01/2021-12/2021) See metric summary for additional information

Fig. 19: Annual (2021) Percentage of Members with First Follow-Up Visit within 30 Days after Hospital Discharge



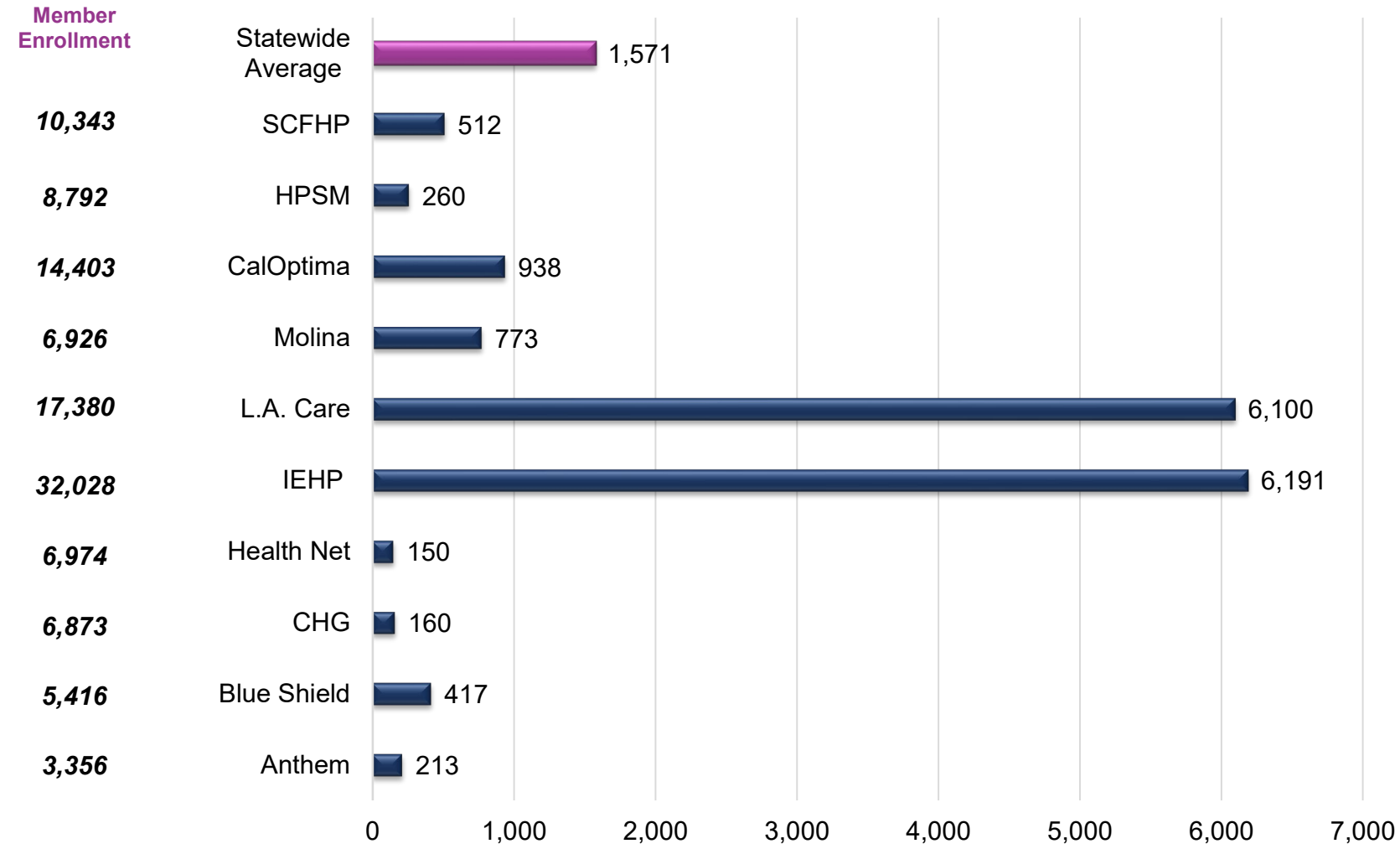
Grievance Figure 20: Count Grievances by type, Except "Other" (01/2022-12/2022)
See metric summary for additional information

Fig. 20: Annual Count of Grievances Broken Down by Type, besides "Other"



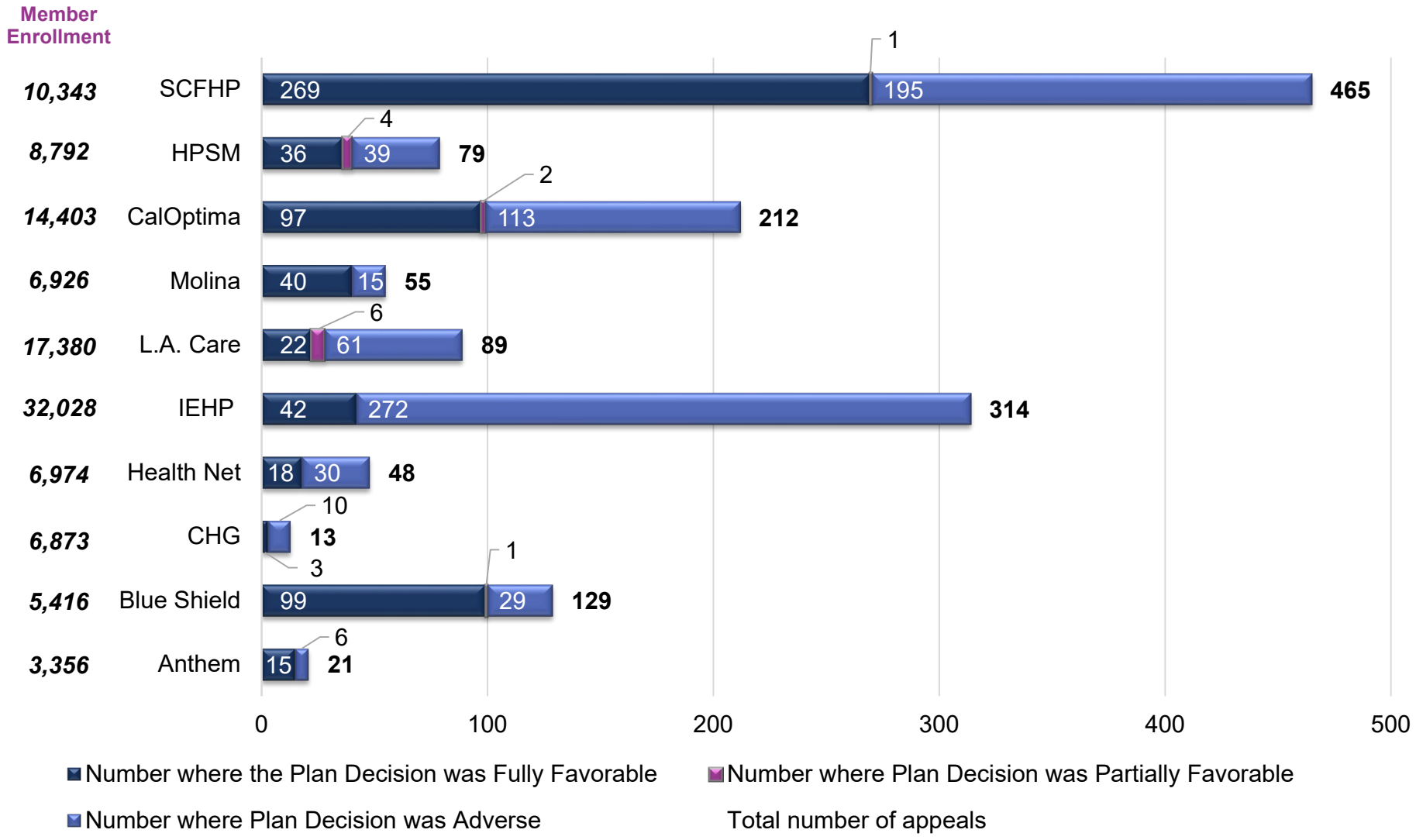
Grievance Figure 21: Count of "Other" Grievances (01/2022-12/2022) See metric summary for additional information

Fig. 21: Annual Count of "Other" Grievances



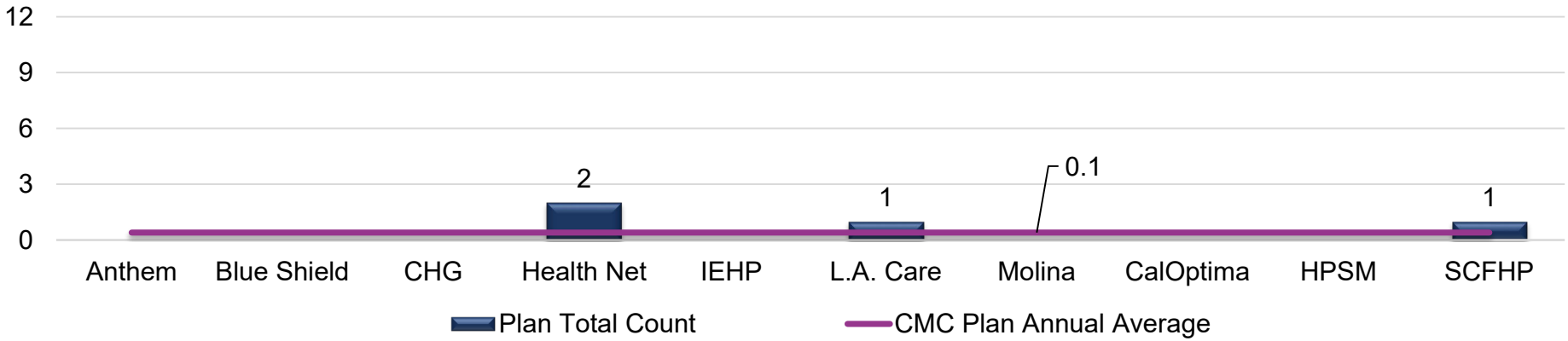
Appeal Figure 22: Count of Appeals (01/2022-12/2022). See metric summary for additional information

Fig. 22: Annual Count of Appeals Broken Down by Outcome



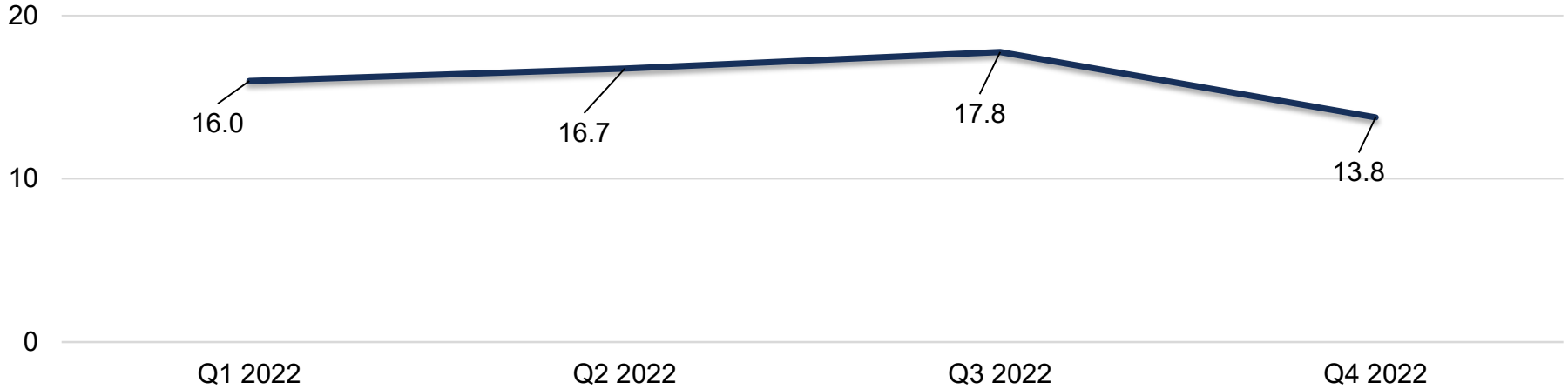
Appeals Figure 23: Total of all Appeals Related to the Denial or Limited Authorization of Mental Health Services (01/2022-12/2022)
See metric summary for additional information

Fig. 23: 2022 Appeals Related to the Denial or Limited Authorization of Mental Health Services; Plan Total Count and CMC Plan Annual Average



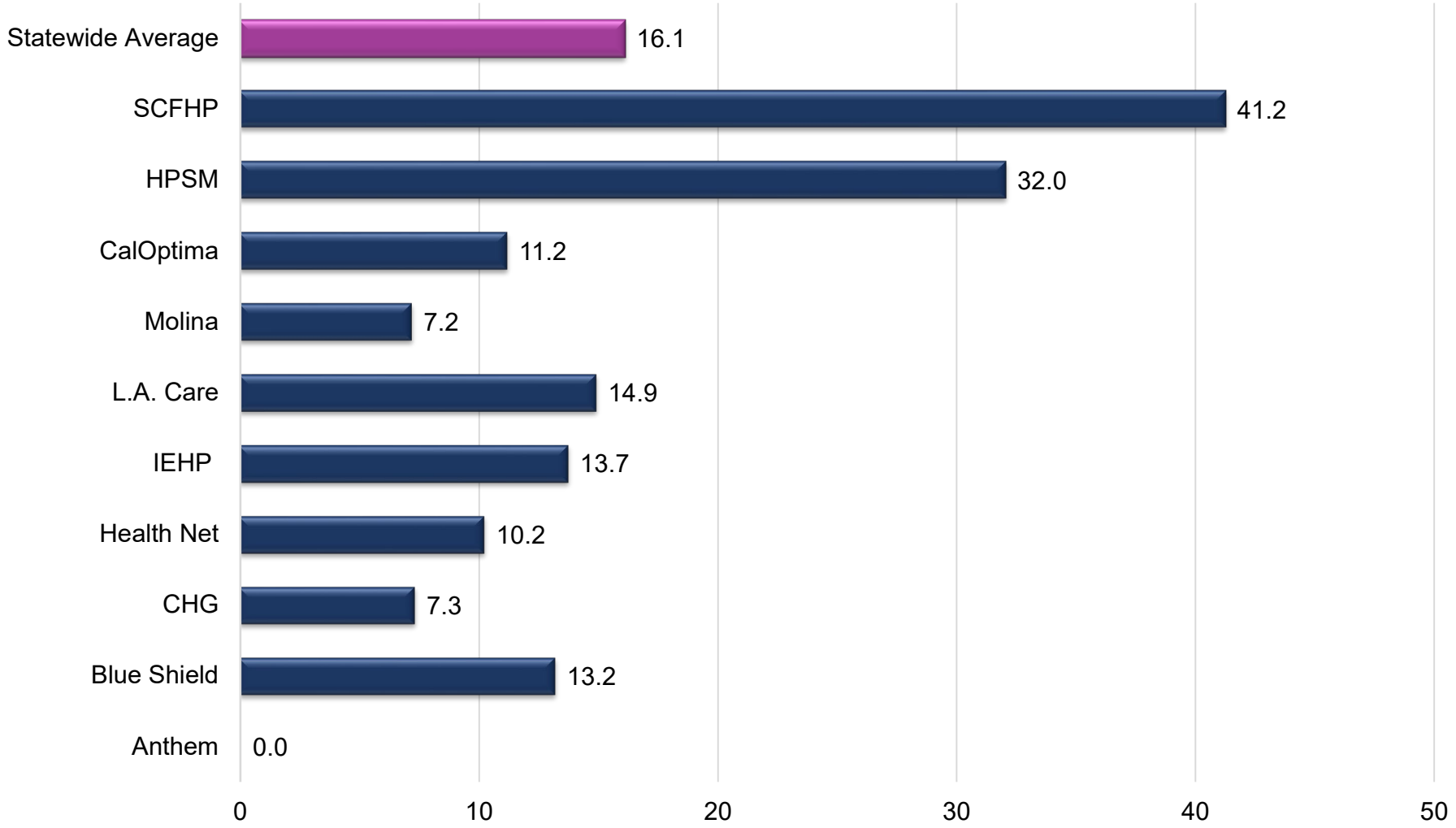
Behavioral Health Figure 24: Emergency Room Behavioral Health Services Utilization per 10,000 Member Months (01/2022-12/2022)
See metric summary for additional information

Fig. 24: Quarterly Rolling Statewide Average Count of Emergency Room Behavioral Health Services Utilization per 10,000 Member Months



Behavioral Health Figure 25: Emergency Room Behavioral Health Services Utilization per 10,000 Member Months (01/2022-12/2022)
See metric summary for additional information

Fig. 25: Annual Count of Emergency Room Behavioral Health Services Utilization per 10,000 Member Months



Long Term Services & Supports (LTSS) Figure 26 & 27: Utilization of Members Receiving LTSS per 1,000 Members (01/2022-12/2022) See metric summary for additional information

Fig. 26: Quarterly Rolling Statewide Average of Members Receiving LTSS per 1,000 Members

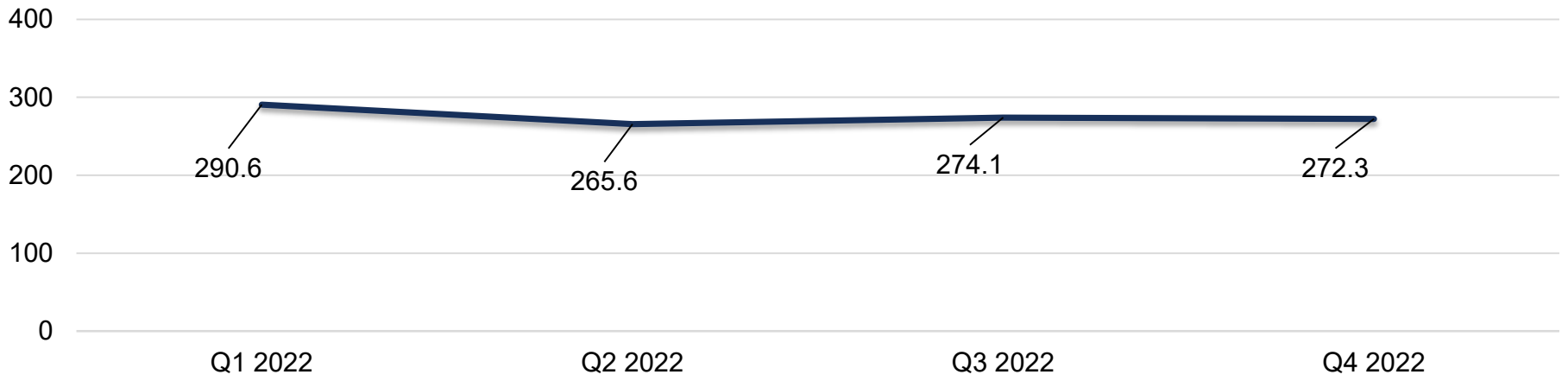
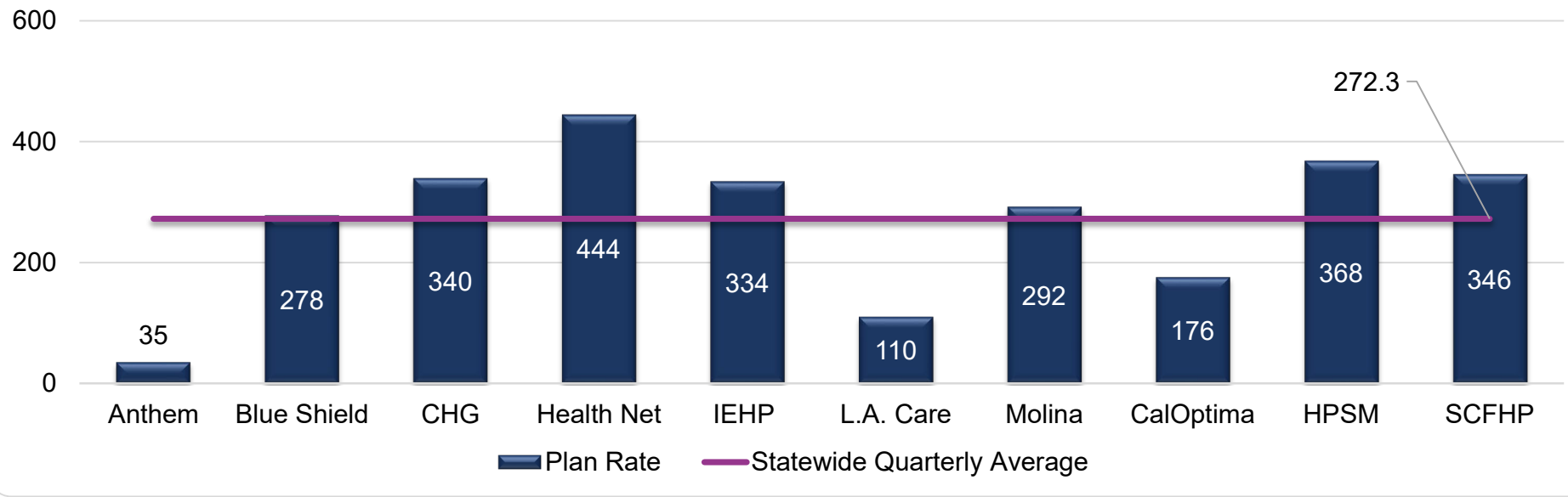


Fig. 27: Count of Members Receiving LTSS per 1,000 members for Quarter 4 of 2022



Long Term Services & Supports (LTSS) Figure 28 & 29: Count of IHSS per 1,000 Members (01/2022-12/2022) See metric summary for additional information

Fig. 28: Quarterly Rolling Statewide Average of Members Receiving IHSS per 1,000 Members

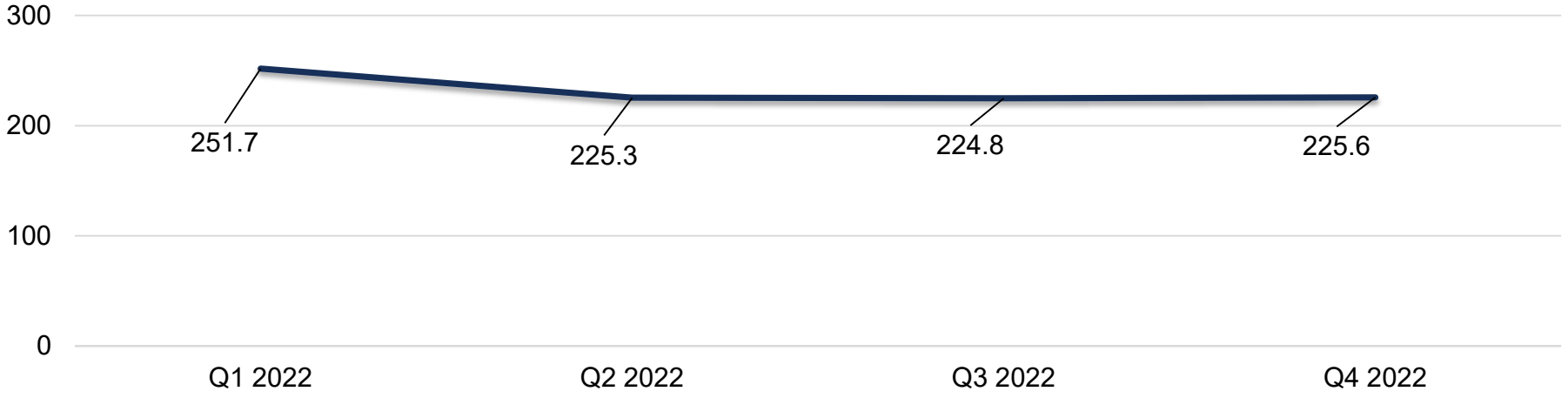
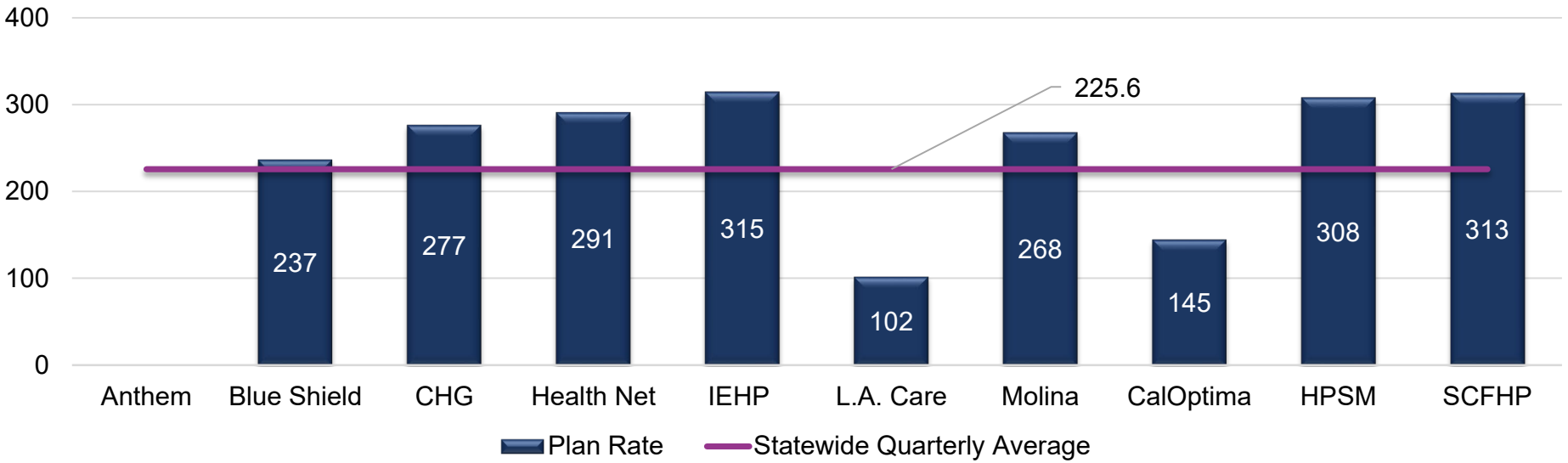


Fig. 29: Count of Members Receiving IHSS per 1,000 members for Quarter 4 of 2022



Long Term Services & Supports (LTSS) Figure 30 & 31: Count of CBAS per 1,000 Members (01/2022-12/2022) See metric summary for additional information

Fig. 30: Quarterly Rolling Statewide Average of CBAS Member Referrals per 1,000 Members

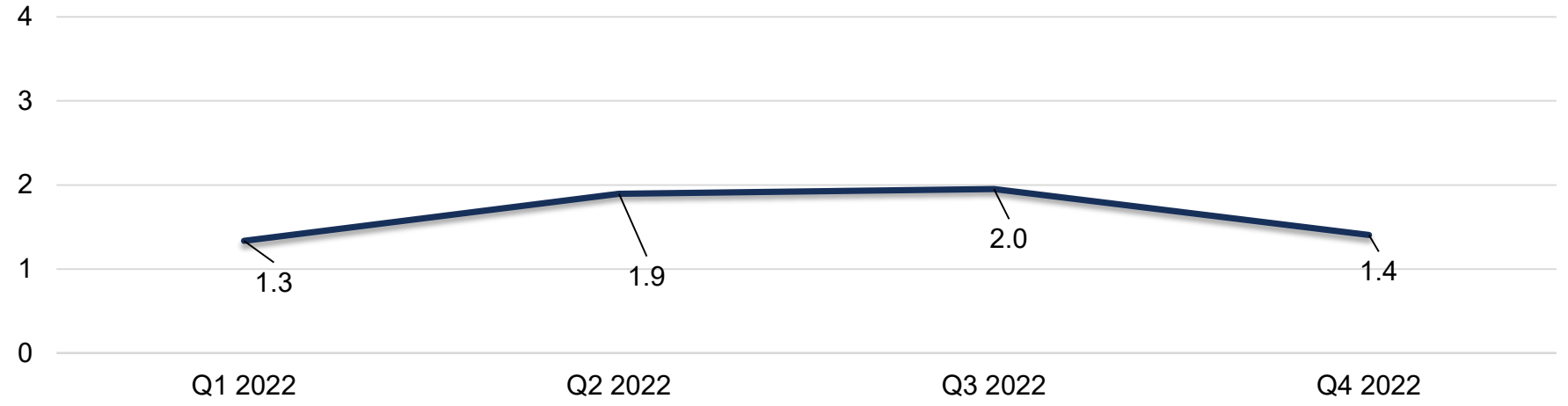
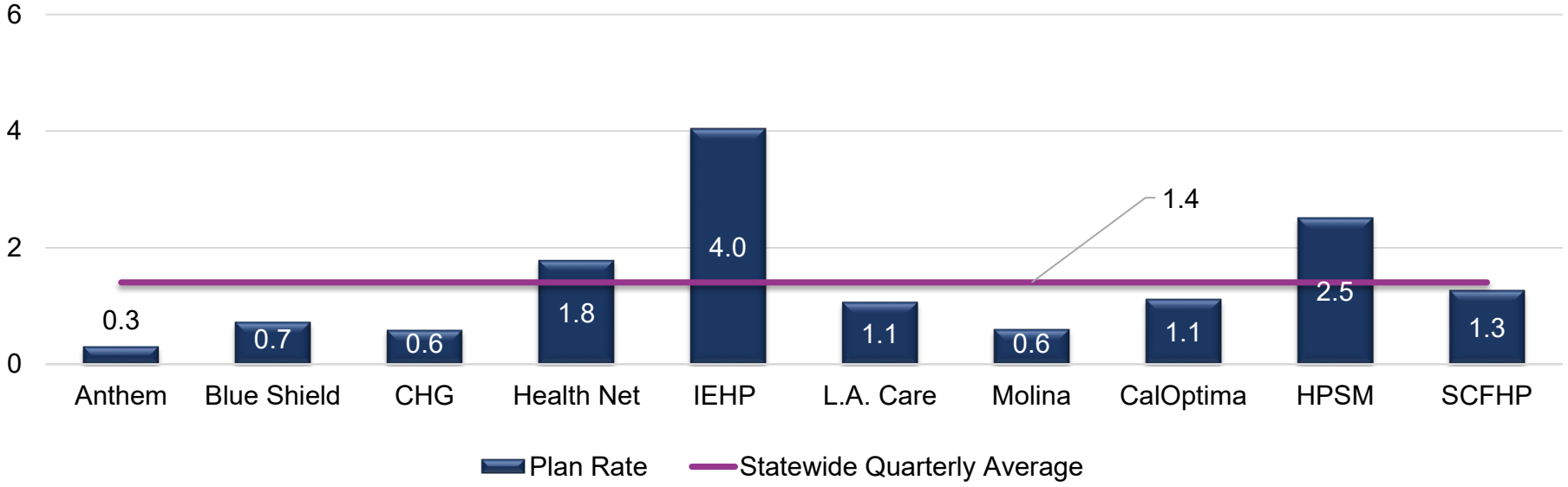


Fig. 31: Count of CBAS Member Referrals per 1,000 members for Quarter 4 of 2022



Long Term Services & Supports (LTSS) Figure 32 & 33: Count of CBAS per 1,000 Members (01/2022-12/2022)
See metric summary for additional information

Fig. 32: Quarterly Rolling Statewide Average of Members Receiving CBAS per 1,000 Members

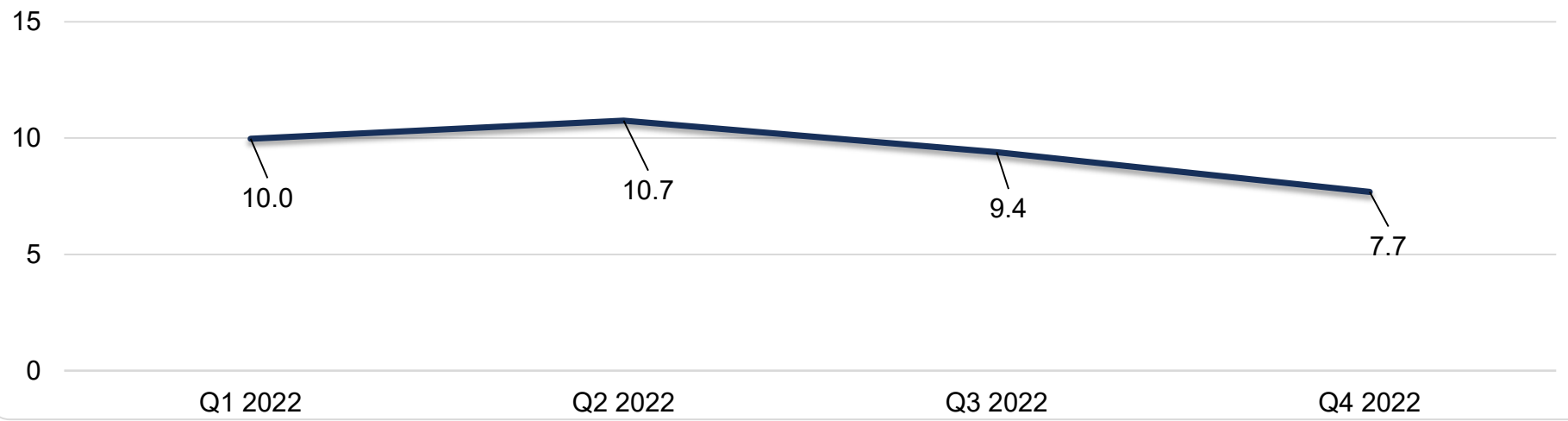
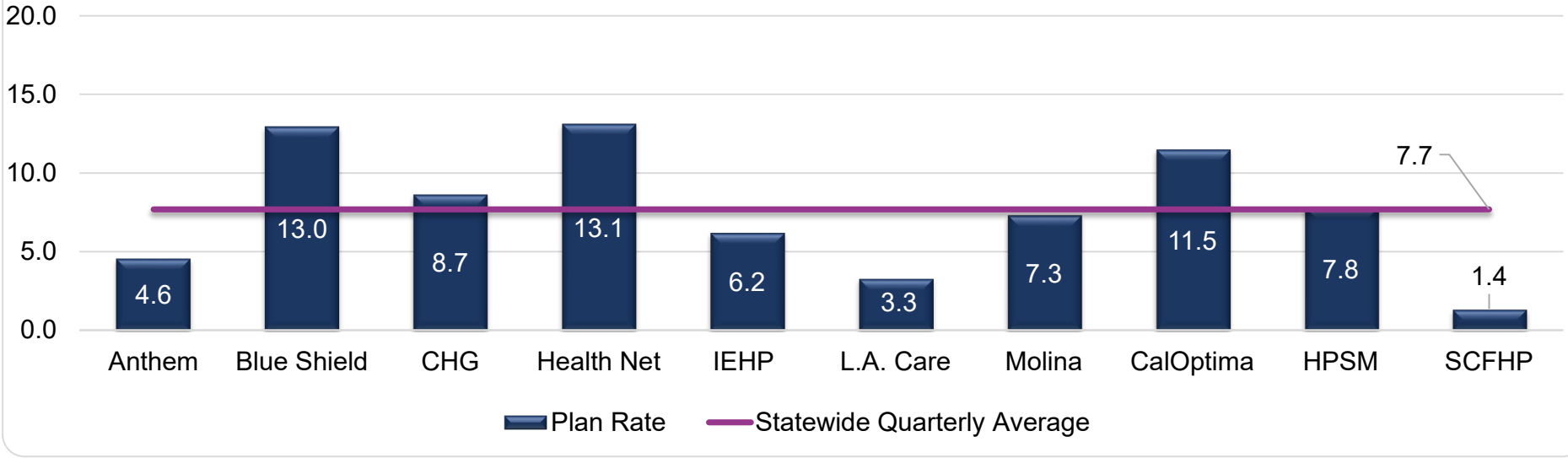


Fig. 33: Count of Members Receiving CBAS per 1,000 members for Quarter 4 of 2022



Long Term Services & Supports (LTSS) Figure 34 & 35: Count of MSSP per 1,000 Members (01/2021-12/2021)
See metric summary for additional information

Fig. 34: Quarterly Rolling Statewide Average of MSSP Member Referrals per 1,000 Members

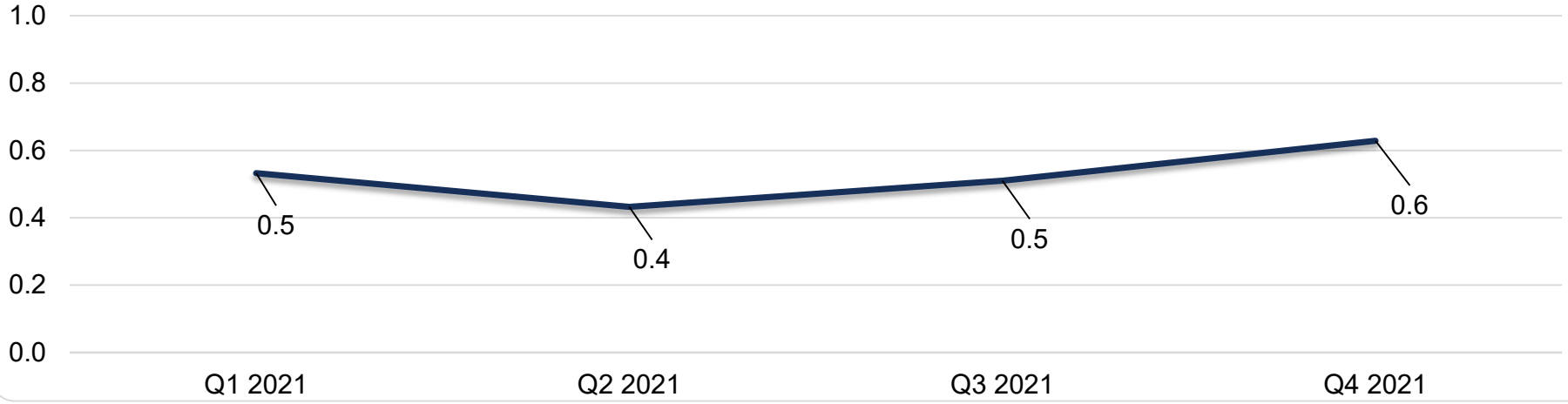
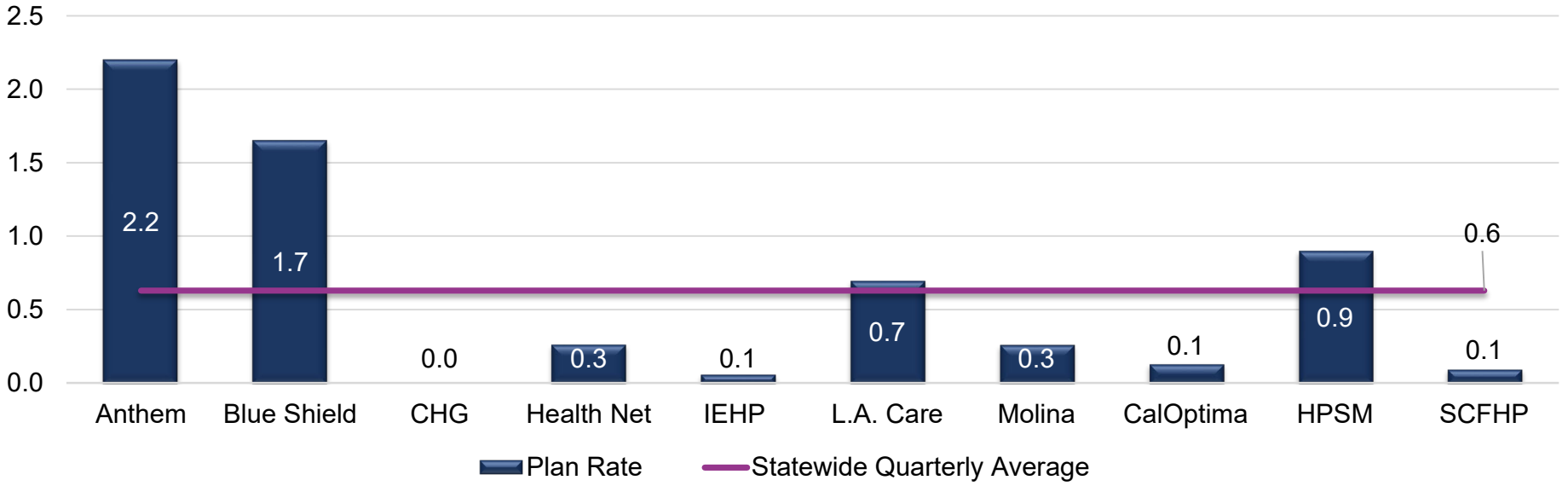


Fig. 35: Count of MSSP Member Referrals per 1,000 members for Quarter 4 of 2021



Long Term Services & Supports (LTSS) Figure 36 & 37: Count of MSSP per 1,000 Members (01/2022-12/2022)
See metric summary for additional information

Fig. 36: Quarterly Rolling Statewide Average of Member Receiving MSSP per 1,000 Members

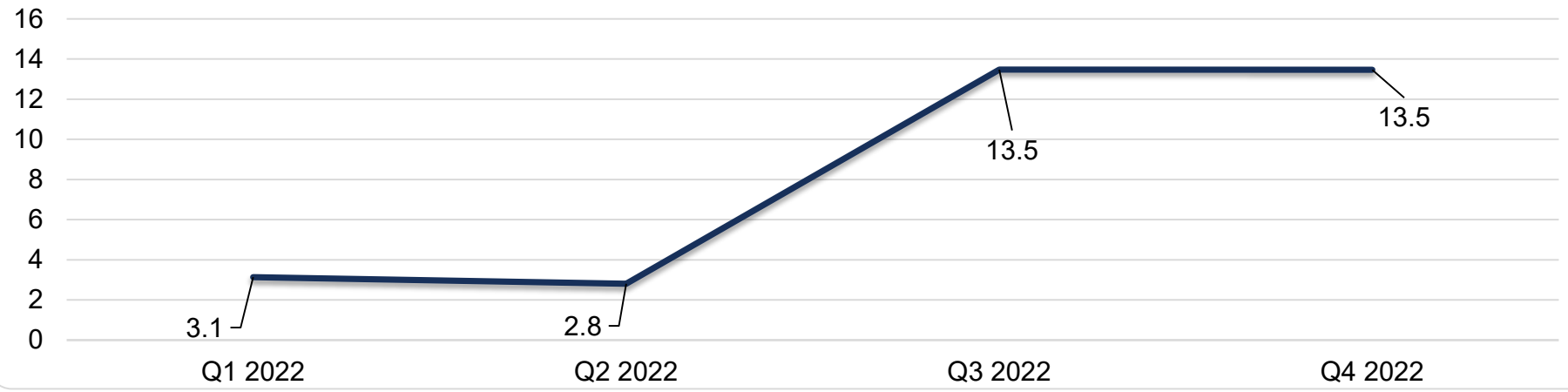
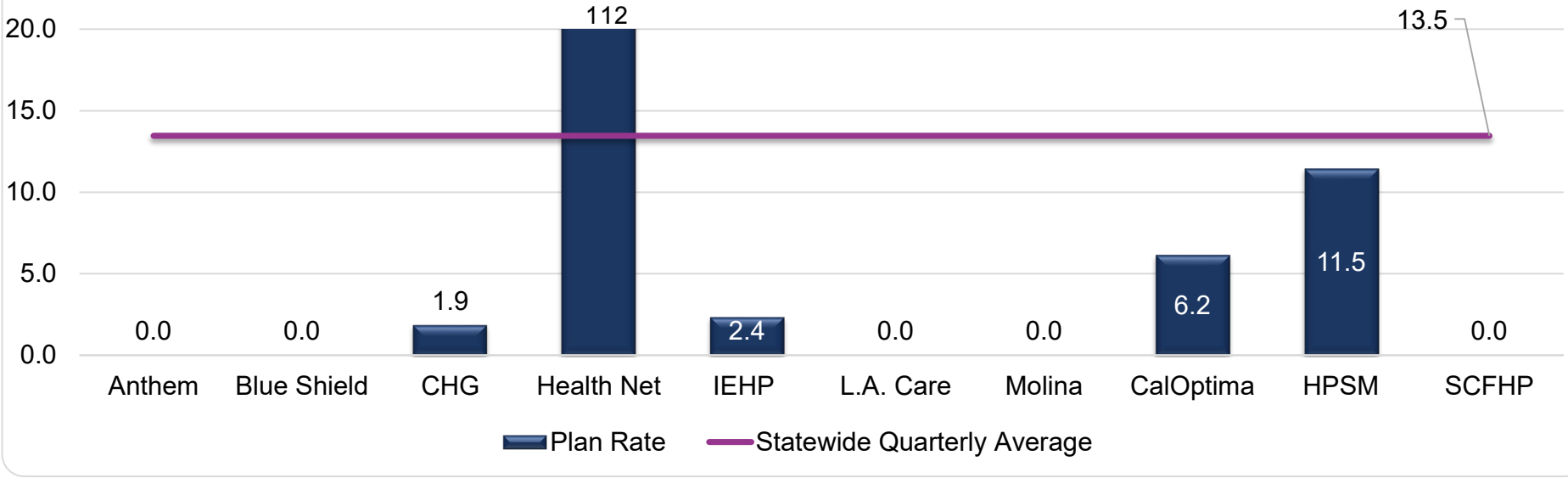


Fig. 37: Count of Members Receiving MSSP per 1,000 members for Quarter 4 of 2022



Long Term Services & Supports (LTSS) Figure 38 & 39: Count of NF per 1,000 Members (01/2022-12/2022)
See metric summary for additional information

Fig. 38: Quarterly Rolling Statewide Average of NF Member Referrals per 1,000 Members

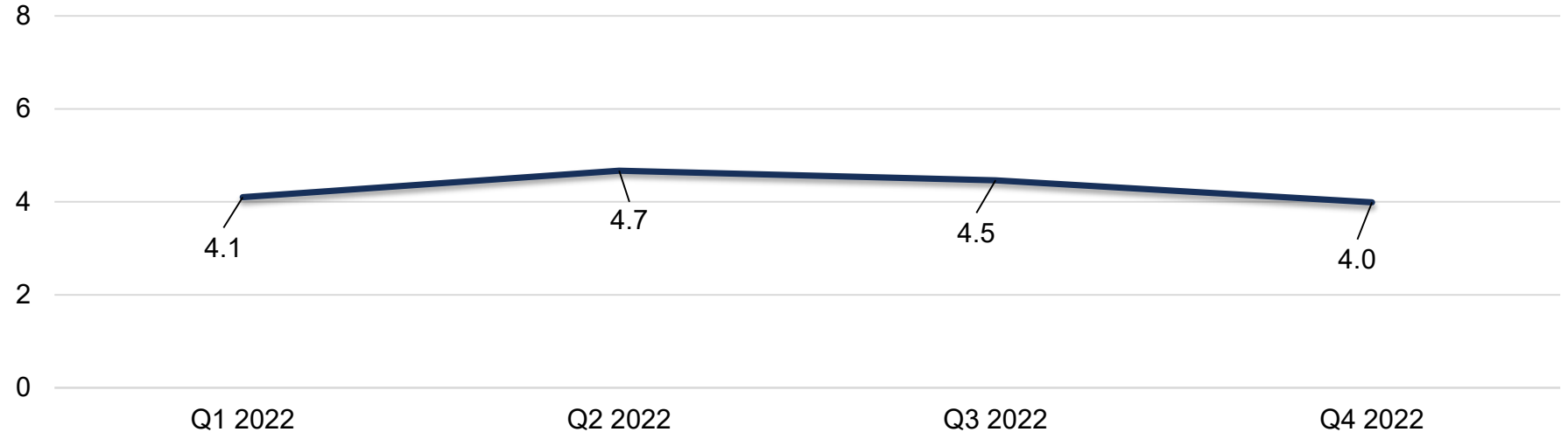
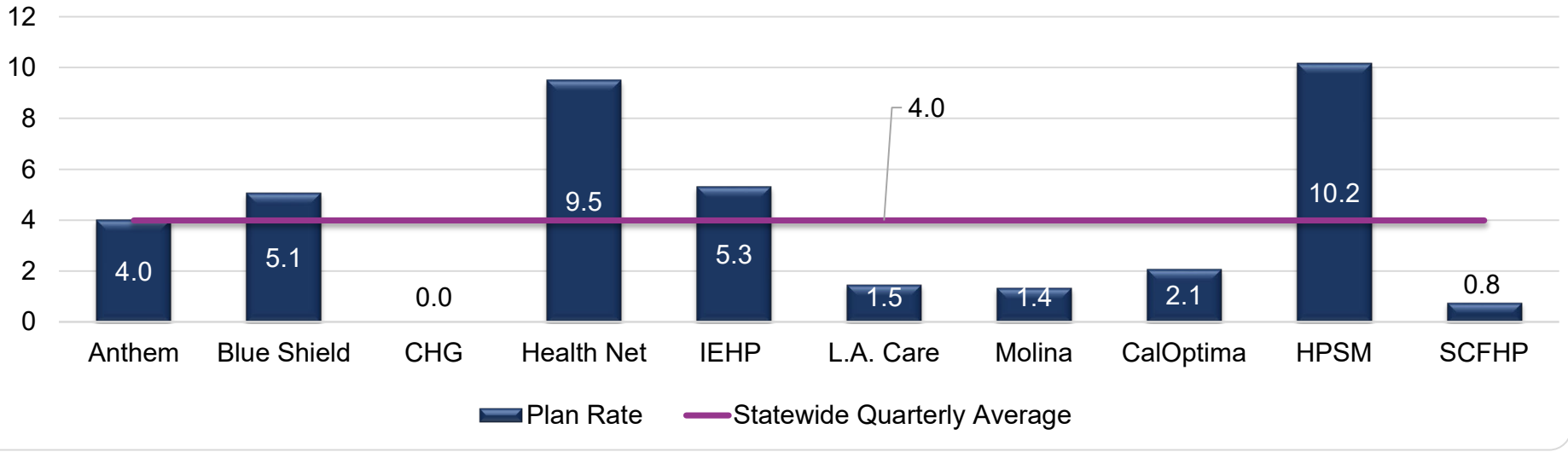


Fig. 39: Count of NF Member Referrals per 1,000 members for Quarter 4 of 2022



Long Term Services & Supports (LTSS) Figure 40 & 41: Count of NF per 1,000 Members (01/2022-12/2022) See metric summary for additional information

Fig. 40: Quarterly Rolling Statewide Average of Members Receiving NF per 1,000 Members

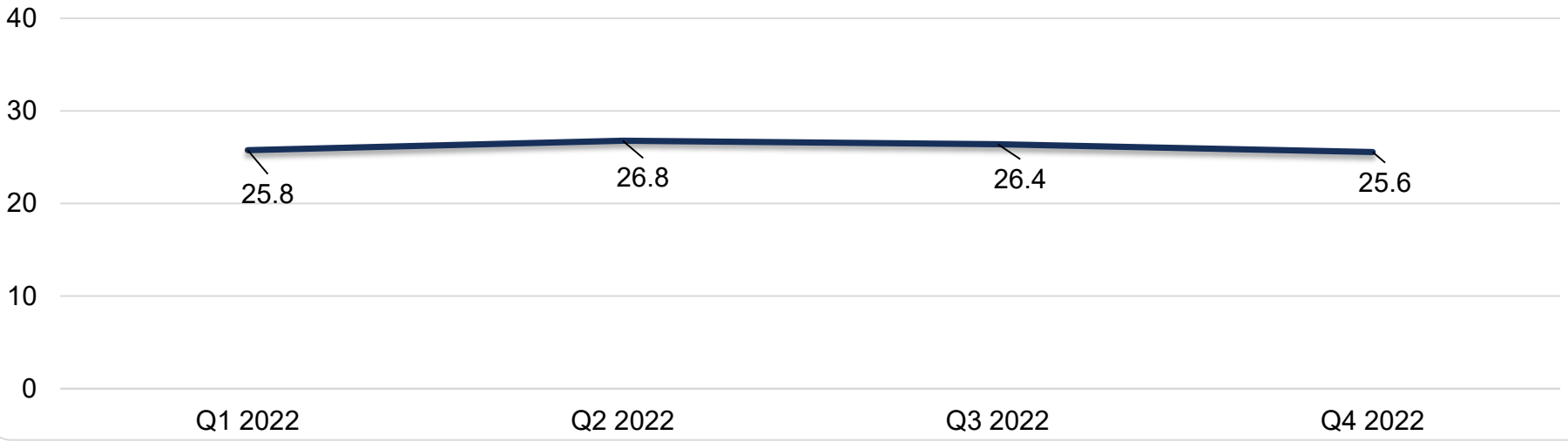
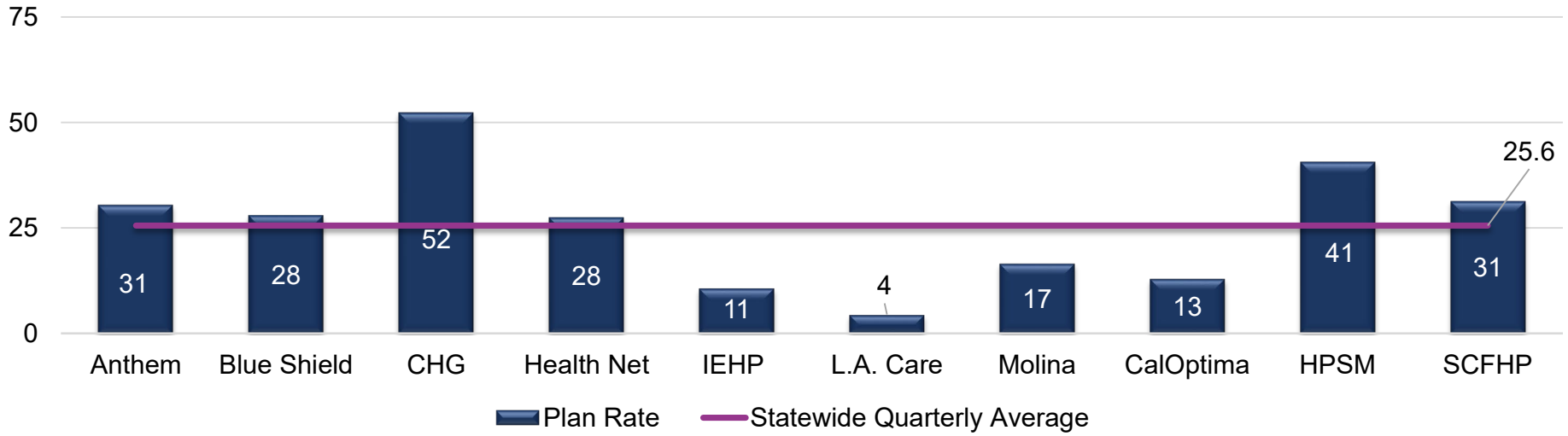


Fig. 41: Count of Members Receiving NF per 1,000 Members for Quarter 4 of 2022



Long Term Services & Supports (LTSS) Figure 42 & 43: Count of CPO per 1,000 Members (1/2022-12/2022)
See metric summary for additional information

Fig. 42: Quarterly Rolling Statewide Average of CPO Member Referrals per 1,000 Members

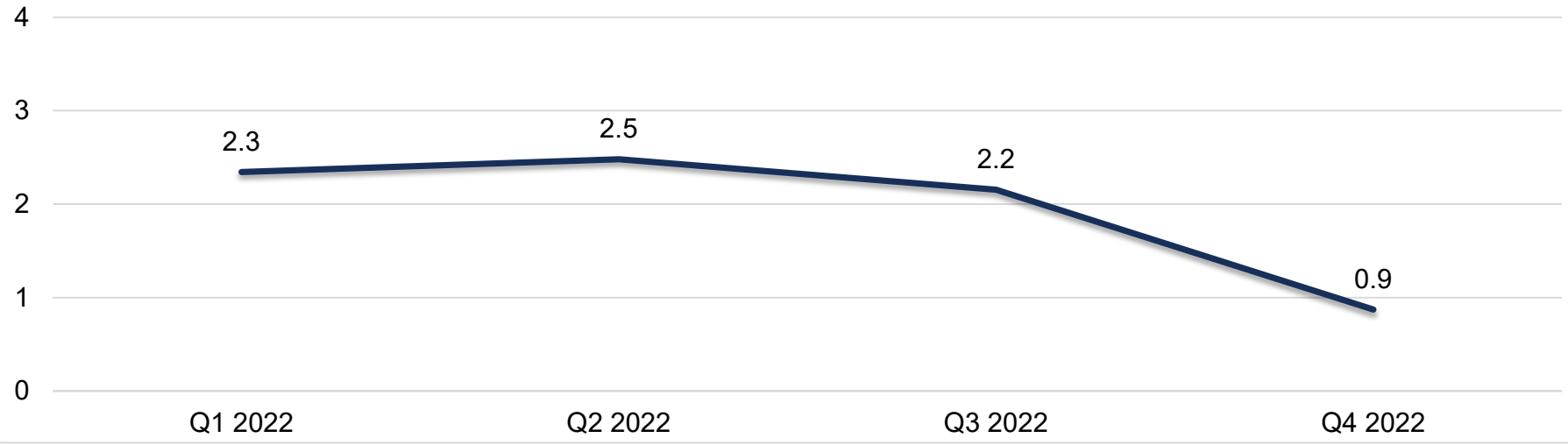
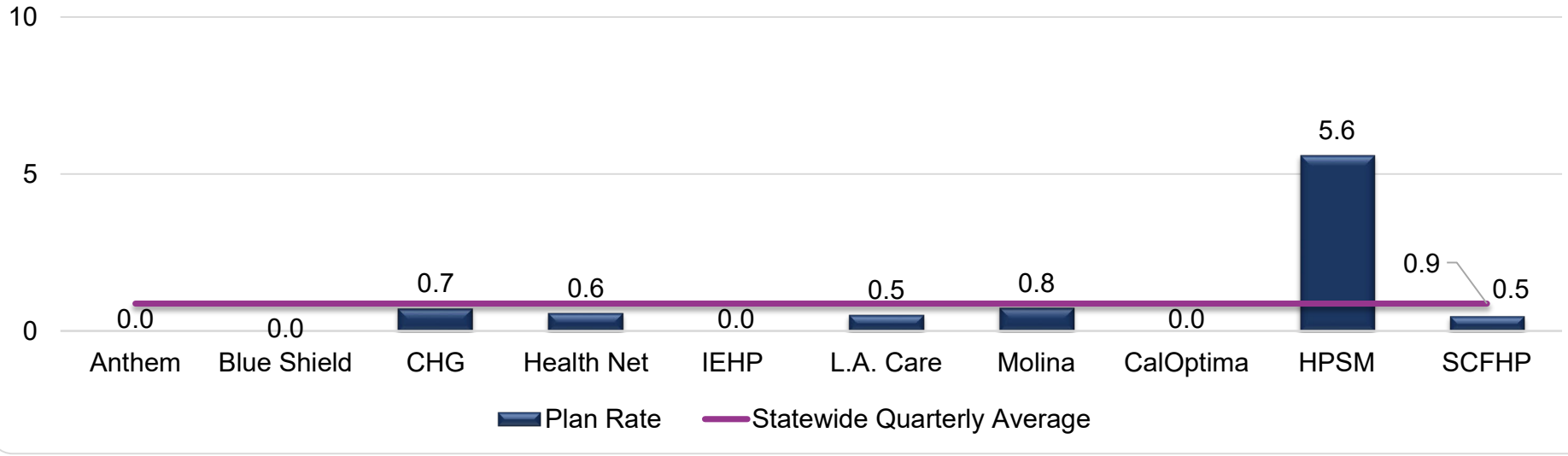


Fig. 43: Count of CPO Member Referrals per 1,000 members for Quarter 4 of 2022



Long Term Services & Supports (LTSS) Figure 44 & 45: Count of CPO per 1,000 Members (01/2022-12/2022)
See metric summary for additional information

Fig. 44: Quarterly Rolling Statewide Average of Members Receiving CPO per 1,000 Members

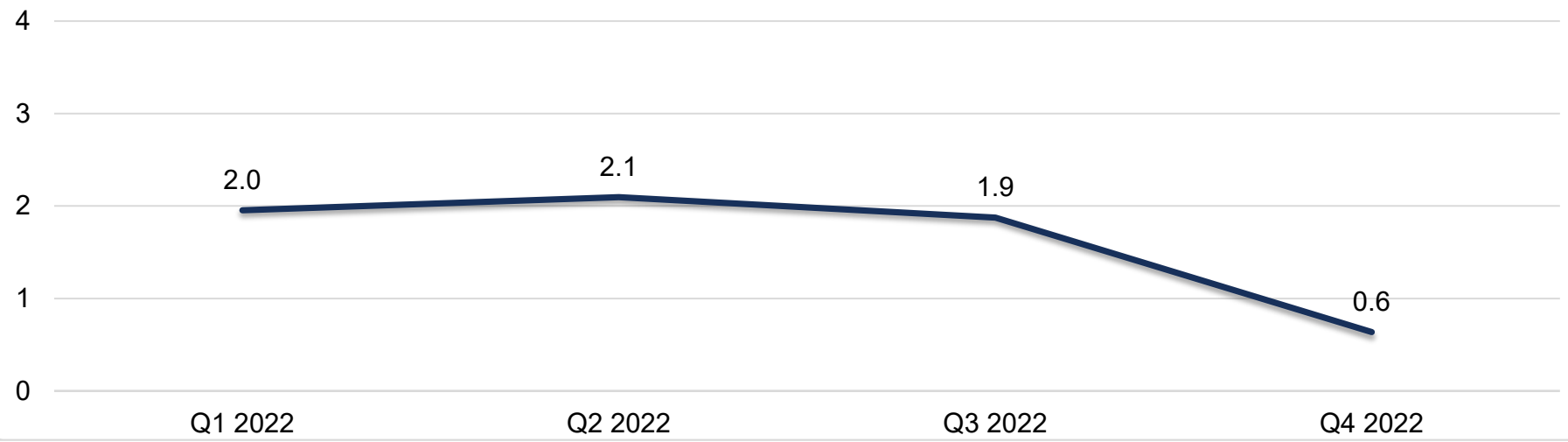


Fig. 45: Count of Members Receiving CPO per 1,000 Members for Quarter 4 of 2022