Cal MediConnect Performance Dashboard Metrics Summary
Released September 2020

The Cal MediConnect (CMC) program is 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. Seven counties are participating in the program: Los Angeles, Orange, San Diego, San Mateo, Riverside, San Bernardino and Santa Clara.

DASHBOARD OVERVIEW AND KEY TRENDS
This dashboard provides select data and measures on key aspects of the Cal MediConnect Program:

- **Enrollment and Demographics:** *Figures 1-6*
  Statewide enrollment in Cal MediConnect increased steadily from 106,875 members in April 2019 to 108,412 in December 2019. The enrollment then decreased to 106,188 in January 2020 before reaching 106,749 members in March 2020. In Q1 2020, 50% of enrollees spoke English and 32% spoke Spanish as their primary language, with 38% of enrollees identifying as Hispanic. Males and females aged 65 and older represent 29% and 45% of the total CMC population, respectively.

- **Quality Withhold Summary:** *Figure 7*
  All Plans met at least four quality withhold measures for Calendar Year 2018. Eight of the ten Plans received 100% of their withhold: Anthem, Blue Shield, Health Net, L.A. Care, Molina, CalOptima, HPSM and SCFHP.

- **Care Coordination:** *Figures 8-15*
  Figure 8 shows that the percentage of members with a health risk assessment (HRA) completed within 90 days of enrollment slightly decreased from 89% in Q4 2019 to 88% in Q1 2020. Figure 10 shows that the percentage of members with an ICP completed within 90 days of enrollment has increased from 63% in Q4 2019 to 72% in Q1 2020.

- **Grievances and Appeals:** *Figures 16-19*
  Plans reported 20% more grievances in 2019 compared to 2018. In 2019, Plans reported 183% more appeals than in 2018. Of the total appeals, Figure 16 shows that 79% of Plan decisions were either fully or partially favorable to the member.

- **Behavioral Health Services:** *Figures 20-21*
  Figure 20 shows the rate of Cal MediConnect members seeking care in the emergency room for behavioral health services. Utilization has decreased from 20.8 visits per 10,000 member months in Q1 2019 to 18.4 visits in Q4 2019.

- **Long-term Services and Supports:** *Figures 22-41*
  Figure 22 shows that LTSS utilization per 1,000 members has increased throughout the reporting period; from an average of 298.5 members per 1,000 receiving LTSS in Q2 2019, to an average of 302 members in Q1 2020. DHCS is continuing to work with Plans to enhance LTSS referrals. Figures 24-41 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 quality assessment.

Data and Analysis Notes:

The dashboard is a tool that displays a combination of quarterly and annual measures. Dashboard data are reported by plan, 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, 20, 22, 24, 26, 28, 30, 32, 34, 36, 38 and 40. Metrics represent the entire CMC program, by calendar quarters.
- **Current Quarter data by plan:** Figures 9, 11, 23, 25, 27, 29, 31, 33, 35, 37, 39 and 41.
  Metrics represent the data for the most recent quarter, by plan.
- **Annual data:** Figures 7, 12, 13, 14, 15, 16, 17, 18, 19 and 21.
  Annual data are updated once a year and are compared to previous years that are only collected in aggregate.
- **Updated data:** Figures 1-11, Figure 15, and Figures 22-41 have been updated for the September 2020 release.

DETAILED DASHBOARD METRICS AND TRENDS

This section of the Dashboard Metrics Summary provides a detailed explanation of the performance metrics as well as a summary of key trends.

Cal MediConnect Enrollment and Demographics:

Enrollment and demographic data are a point-in-time view of the Cal MediConnect population. The data come from the DHCS data warehouse and the Medi-Cal Management Information System/Decision Support System (MIS/DSS).

In addition to the quarterly enrollment and demographic data reported in this dashboard, monthly Cal MediConnect 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 monitor Plans using quality measures relating to beneficiaries' overall experience, care coordination, fostering and support of community living, and more.[1] These measures, which are required to be reported under Medicare and Medicaid, build on other required data: Healthcare Effectiveness Data and Information Set (HEDIS), Medicare Health Outcome Survey, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data.

CMS and DHCS utilize 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,"[2] Plans may receive all or a portion of an amount withheld from their capitation payment (with the exception of Part D components), at the end of each calendar year.

All quality withhold measures have benchmarks that the Plans are required to meet in order to receive some or all of the quality withhold payment. The Quality Withhold Summary is for Calendar Year 2018.

Figure 7 shows the quality withhold measures for the calendar year 2018. Definitions of the measures included for Figure 7 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.

[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.html

Quality withhold measure results indicated with "*" represent measures that also utilize the gap closure target methodology.[1] For Plans that are affected by an extreme and uncontrollable circumstance, such as a major natural disaster, CMS and the State remit the full quality withhold payment for the year in which the extreme and uncontrollable circumstance occurred, provided that the Plan fully reports all applicable quality withhold measures. Affected Plans are identified according to the methodology utilized for Medicare Part C and D Star Ratings for the applicable measurement year. These Plans are denoted with "^" on Figure 7.

- **Plan All-Cause Readmission:** The ratio of the plan's observed readmission rate to the plan's 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) prior to flu season. (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)
- **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 PDE 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. (California-specific measure 4.1, CAW7)
- **Documentation of Care Goals:** Members with documented discussions of care goals. (California-specific measure 1.6, 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. (California-specific measure 1.12, CAW9)

[1]California Medicare-Medicaid Plan Quality Withhold Analysis Results Demonstration Year 4:

https://www.cms.gov/files/document/qualitywithholdresultsreportcady4.pdf

Quality Withhold Trends:

The latest data available show that all 10 Plans met at least five quality withhold measures for Calendar Year 2018. Eight of the ten Plans received 100% of their withhold: Anthem, Blue Shield, Health Net, L.A. Care, Molina, CalOptima, HPSM and SCFHP.

Care Coordination Measures:

Enhanced, person-centered care coordination is a key benefit of Cal MediConnect. The dashboard tracks different measures and aspects of that benefit, from the initial health risk assessment to start the care coordination process, to the development of an individualized care plan, to 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 assessments for high risk members within 45 days of enrollment, and for low-risk members within 90 days of enrollment. Information tracking 90-day HRA completion rates comes from a Core measure. Figures 8 & 9 do not include unwilling and unable to reach populations in calculations.
- **Individualized Care Plans (ICPs):** The care plan is developed by members with their interdisciplinary care team or Plans. 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.
    - o Plans must complete a care plan for each member within 90 days of enrollment. Information tracking 90-day ICP completion rates comes from a Core measure. Figures 10 & 11 do not include unwilling and unable to reach populations in calculations. CMS-DHCS continues to work with Plans to ensure improved ICP completion rates 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. In 2016, DHCS released a Dual Plan Letter on discharge planning in Cal MediConnect, and this continues to be an area of focus for program improvements. Information comes from a California-specific measure.

- **Care Coordinators 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. Information comes from a California-specific measure.

Care Coordination Trends:

Figure 8 shows that the quarterly statewide percentage of members willing to participate in care coordination, and who the Plan was able to locate, with an assessment completed within 90 days of enrollment has slightly decreased from 89% in Q4 2019 to 88% in Q1 2020. Figure 9 shows that three out of ten Plans (Blue Shield, HealthNet and HPSM) are below the statewide average of 88% for Q1 2020.

Figure 10 indicates that the percentage of members with an ICP completed within 90 days of enrollment has increased from 55% in Q2 2019 to 72% in Q1 2020. Figure 11 indicates that in four of the ten Plans (Blue Shield, HealthNet, CalOptima and HPSM), the percentage of members with an ICP completed within 90 days of enrollment is below the statewide average of 72% for Q1 2020. ICP performance will continue to be a focus of DHCS program improvements in the coming year, including potentially enhancing or modifying the quality measures and improving the performance improvement plans that Plans must perform each year.

DHCS is working with Plans to better understand the wide variation in the percentage of members with documented discussions of care goals, as well as variation in member to care coordinator ratios.

Grievances and Appeals:

This dashboard includes data on the two ways Cal MediConnect 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-level expressing dissatisfaction with any aspect of the Plan's operations, activities, or behavior. 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 to respect a member's rights. This does not include benefit 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 be determined as "adverse" (denying the member'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:

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 16 and 17 show a breakdown of a total of 18,376 grievances, by category and by Plan, filed by members in 2019. This is an increase of 3,073 member grievances reported as compared to 2018.[1] The Plans that contributed the most to the increased grievances in 2019 compared to 2018 are L.A. Care, [2] Anthem, CHG, and SCFHP. The most common complaints were reported under the "other" category (grievances other than access to care, transportation, billing and home health/personal care). In addition to the reporting that Plans provide to CMS and DHCS, each Plan may internally categorize their grievances and appeals differently, which may account for some of the higher number of "other" grievances when reported through the CMS and DHCS.

The number of appeals varies greatly by Plans, as well as the percentage of decisions that are adverse versus partially or fully favorable. Figure 18 shows that a total of 9,847 appeals were filed by members in 2019, an increase of 6,363 appeals when compared to 2018[1]. The Plans that contributed the most to the increase in appeals in 2019 compared to 2018 are Molina[3] and Blue Shield.[4] Figure 18 also shows that 79% of Plan decisions were either fully or partially favorable to the member's appeal filed in 2019. Figure 19 shows that few Plans had appeals related to mental health services.

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

[1]Cal MediConnect Performance Dashboard June 2019: https://www.dhcs.ca.gov/Documents/CMCDashboard6.19.pdf

[2]L.A. Care has continued to take every opportunity to report grievances as accurately as possible. An increase in grievances as compared to other plans reflects improvements in the accuracy of reporting

[3]The volume of appeals that Molina reported for 2019 was unusually high due to two issues. The primary issue was a large volume of provider appeals related to a change in reimbursement rate for Non-Emergency Medical Transportation (NEMT) and the second issue was that Molina included provider appeals in addition to beneficiary appeals in the 2019 reporting.

[4] Blue Shield's Increased appeals was due to post-service payment appeals.

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 20 shows the overall trend of Cal MediConnect members seeking care in the emergency room for behavioral health services has decreased from 20.8 visits per 10,000 member months in Q1 2019 to 18.4 visits per 10,000 member months in Q4 2019. In mid-2017, Plans began to receive additional and more accurate behavioral health data that may have affected how Plans report. DHCS and CMS are monitoring the effects of this change.

Long-term Services and Supports (LTSS) Utilization:

A central goal of Cal MediConnect is to improve access to and coordination of long-term services and supports for members in order to help more members live in the community. DHCS has worked closely with Plans to improve 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.

- **LTSS Utilization and Referrals:** LTSS Utilization and Referrals are reported by each Plan for LTSS which includes In-Home Support Services (IHSS) (carved out beginning in 2018), Community-based Adult Services (CBAS), Multi-purpose Senior Services Program (MSSP) (will be carved out starting January 1, 2021), Nursing Facility Services (NF) (will be carved in to all Medi-Cal managed care health plan models types starting January 1, 2021) and Care Plan Options (CPO).
  - **New CPO Template:** In an effort to improve data quality, a new CPO template and instructions were shared with the Plans. Plans started reporting on this new template as of Q3 2019.

LTSS Trends:

DHCS is working with the Plans to enhance LTSS referrals, and encouraging 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 have been working 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 22 shows that LTSS utilization per 1,000 members has increased throughout reporting period, from an average of 298.5 members per 1,000 receiving LTSS in Q2 2019, to an average of 302 members in Q1 2020.

Figure 24 shows that IHSS utilization per 1,000 members has similarly increased throughout reporting period from an average of 250.6 members per 1,000 receiving IHSS in Q2 2019, to an average of 254.7 members in Q1 2020.

Figure 26 shows that CBAS referrals per 1,000 members has remained steady throughout the reporting period at 1.9 member referrals per 1,000 members. SCFHP reported the highest number of CBAS referrals of 5.8 per 1,000 members in Q1 2020, as shown in Figure 27. Figure 28 shows that CBAS utilization per 1,000 members has increased slightly from 10.8 members per 1,000 receiving CBAS in Q2 2019 to 11.1 members per 1,000 receiving CBAS in Q1 2020.

Figure 30 shows that MSSP referrals per 1,000 members has changed slightly from an average of 0.8 per 1,000 in Q2 and Q3 2019 to an average of 0.6 per 1,000 in Q4 2019 and then increased to 0.8 per 1,000 in Q1 2020. Figure 31 shows that Anthem reported the highest number of MSSP referrals of 2.8 per 1,000 members in Q1 2020. Figure 32 shows that MSSP utilization per 1,000 members has increased from 5.9 in Q1 2019 to 6.6 members per 1,000 in Q1 2020. DHCS worked closely with the Plans in 2019 to better understand MSSP referral policy and procedures, as well as how plans are providing enhanced care coordination and other supports to members on MSSP wait lists. A best practices summary of those efforts was provided to the plans to encourage increased referrals to MSSP.

Figure 34 shows that NF referrals per 1,000 members has decreased slightly from an average of 3.6 member referrals per 1,000 in Q2 2019 to an average 3.5 member referrals per 1,000 in Q1 2020. Figure 35 shows that HPSM reported the highest number of NF referrals of 12.3 per 1,000 members respectively in Q1 2020. Figure 36 shows that NF utilization per 1,000 members has decreased from 31.2 members per 1,000 in Q2 2019 to 29.5 members per 1,000 in Q1 2020.

Figure 38 shows that CPO referrals per 1,000 members has increased from an average of 0.8 member referrals per 1,000 in Q2 2019 to an average of 2.3 member referrals per 1,000 in Q1 2020. Figure 39 shows that HPSM reported the highest number of CPO referrals of 11.3 per 1,000 members in Q1 2020. Figure 40 shows that CPO utilization per 1,000 members has increased slightly from 1.9 members per 1,000 in Q2 2019 to 2.1 members per 1,000 in Q1 2020.

CPO referral and utilization data shown in Figures 38-41 for Q3 2019, Q4 2019 and Q1 2020 are based on the new revised CPO template and instructions. DHCS will continue to work with the Plans to ensure better understanding of the definition of CPO services, the benefits of providing those services, and best practices on referring and supporting members who could benefit from CPO services.

Plan Key:

Plan 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.

Cal MediConnect Enrollment and Demographics Figure 1: Breakdowns of Dual Populations (As of 03/01/2020)
See metric summary for additional information

Fig. 1: Monthly Enrollment
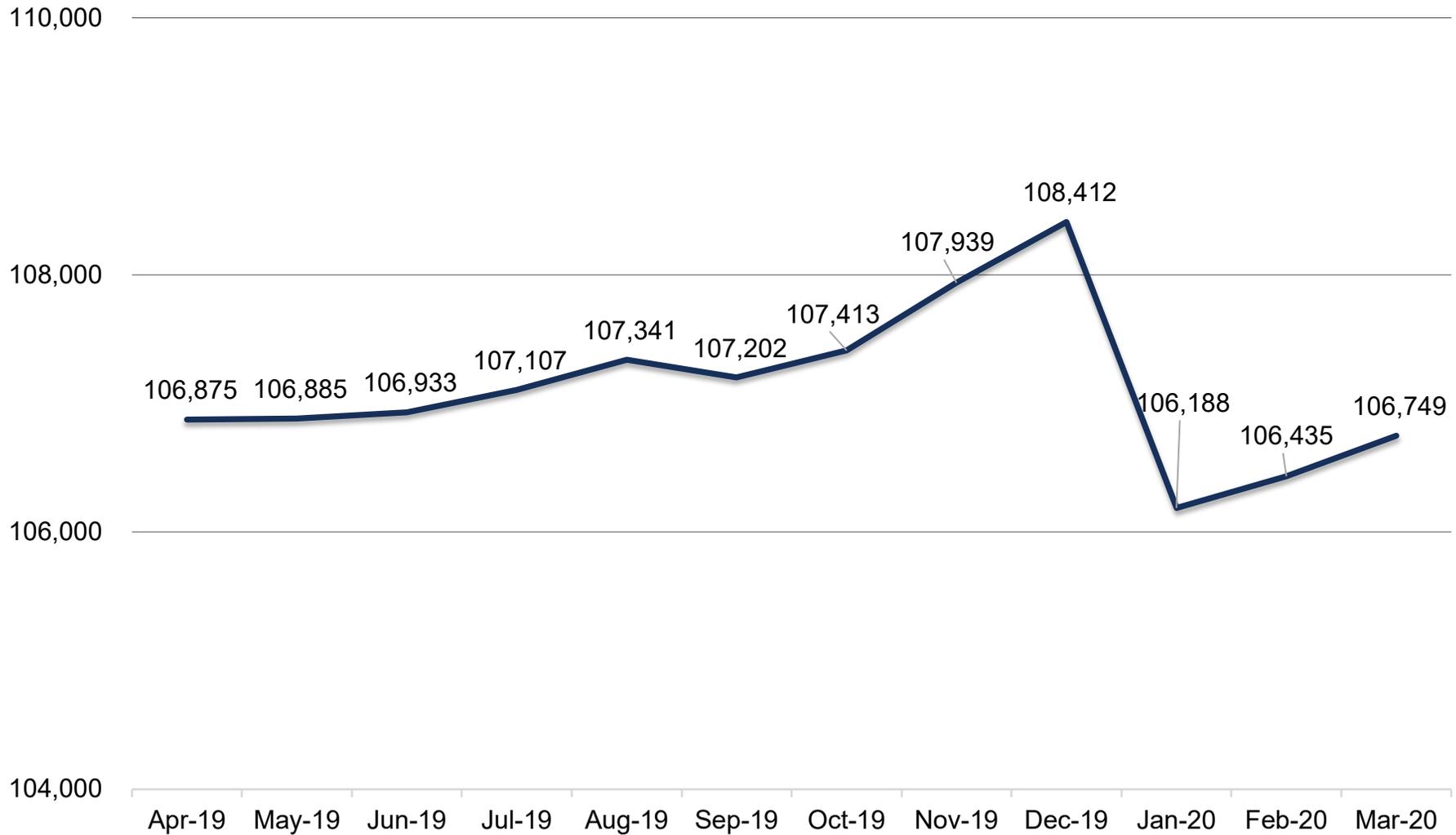
Cal MediConnect Enrollment and Demographics Figure 2: Breakdowns of Dual Populations (As of 03/01/2020)
See metric summary for additional information

Fig. 2: Count and Percentage of Total Active Enrollments, by County and Plan as of March 2020

County total(s) and percentage(s) of active enrollments

County total / %	County	Plan	Enrollment
10,304; 10%	Santa Clara	SCFHP	8,283
		Anthem	2,021
8,469; 8%	San Mateo	HPSM	8,469
	San Diego	Molina	3,933
		Health Net	1,309
13,641; 13%		CHG	6,242
		Blue Shield	2,157
15,111; 14%	San Bernardino	Molina	1,488
		IEHP	13,623
15,652; 15%	Riverside	Molina	1,606
		IEHP	14,046
13,838; 13%	Orange	CalOptima	13,838
	Los Angeles	Molina	1,715
		L.A. Care	15,700
29,734; 28%		Health Net	7,409
		Blue Shield	2,677
		Anthem	2,233

Axis: - , 10,000 , 20,000

Cal MediConnect Enrollment and Demographics Figure 3 - 6: Breakdowns of Dual Populations (As of 03/01/2020)
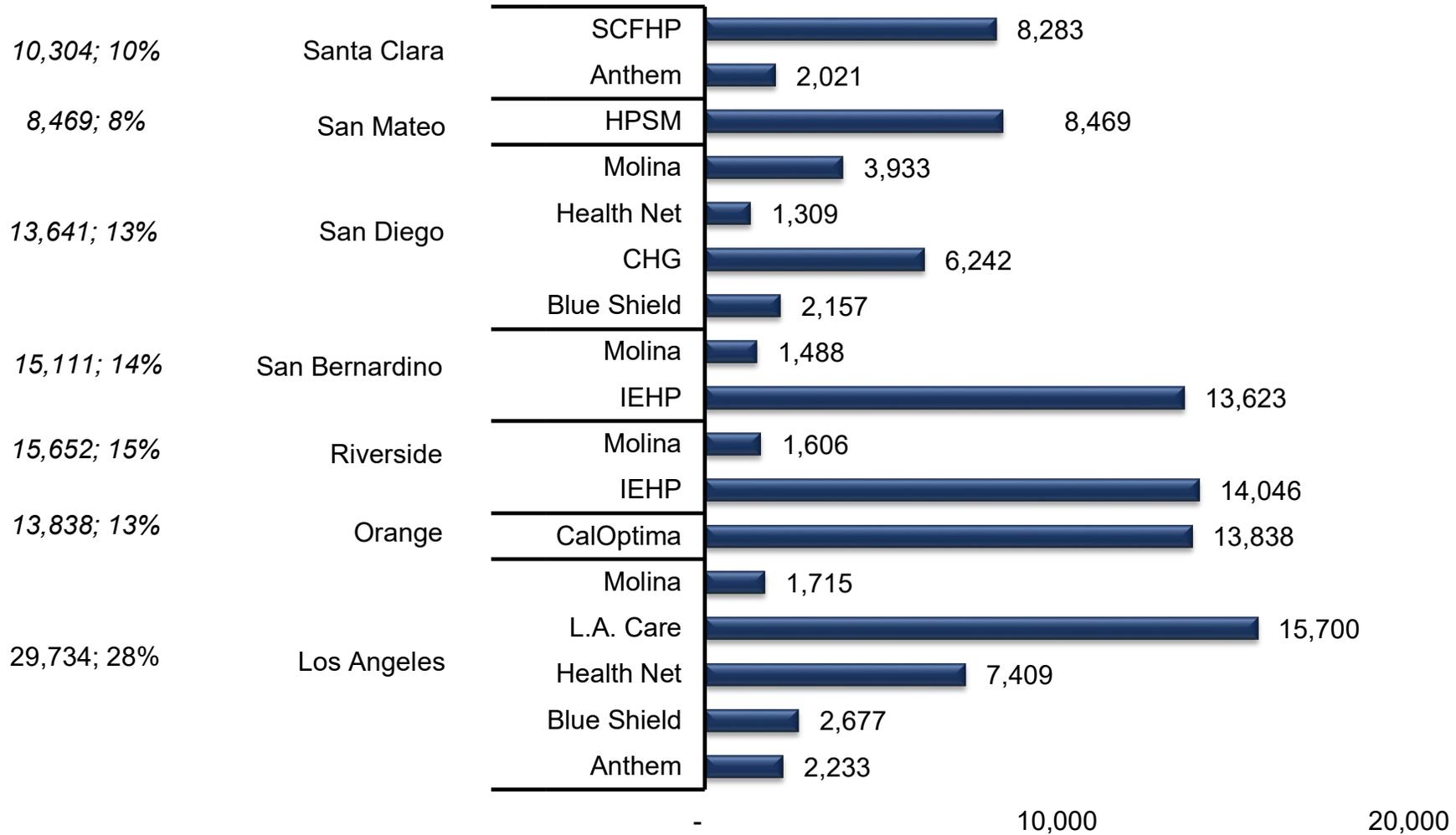**See metric summary for additional information**

Fig. 3: Quarter 1 Enrollment by Race/Ethnicity

- Hispanic: **38%**
- Non-Hispanic/White: **19%**
- Other/Unknown: **18%**
- Asian/Pacific Islander: **16%**
- African-American: **9%**
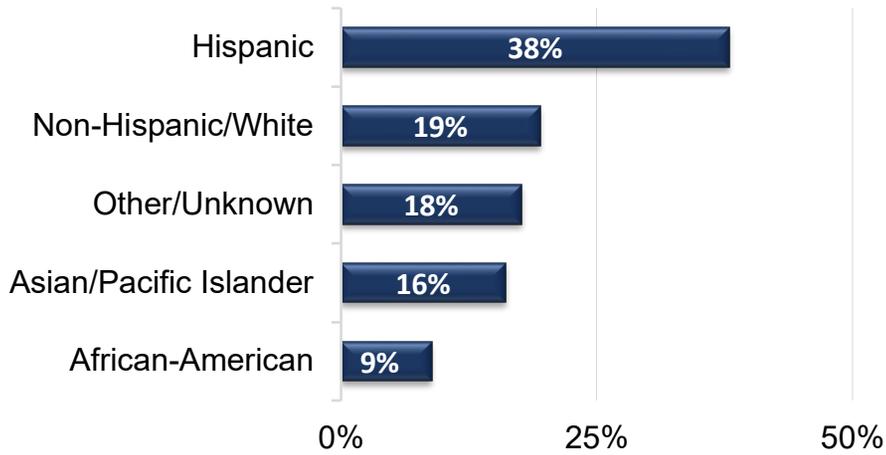
Fig. 4: Quarter 1 Enrollment by Age

- Ages 65+: Male 29%, Female 45%
- Ages 40-64: Male 11%, Female 11%
- Ages 19-39: Male 2%, Female 2%

■ Male ■ Female
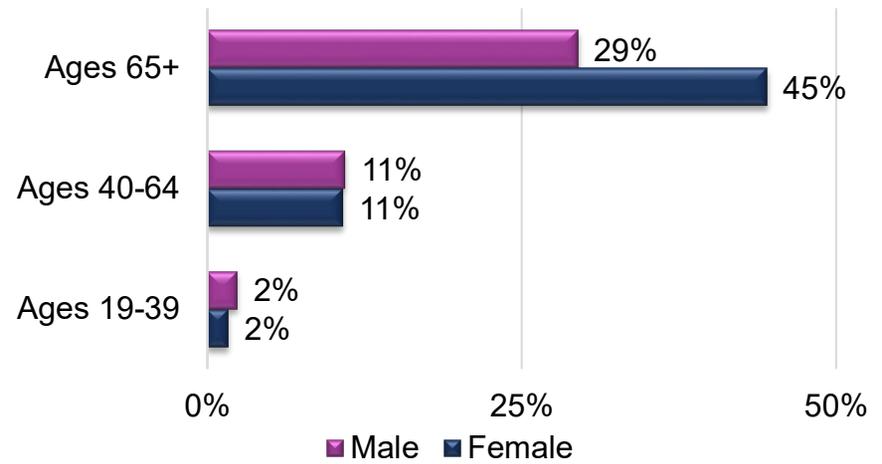
Fig. 5: Quarter 1 Enrollment by Threshold Language Spoken

- English: **50%**
- Spanish: 32%
- Unknown: 4%
- Vietnamese: 5%
- Tagalog: 2%
- Mandarin: 2%
- Cantonese: 1%
- Other Non-English: 1%
- Farsi: 1%

Fig. 6: Quarter 1 Enrollment by Gender

- Male 43%
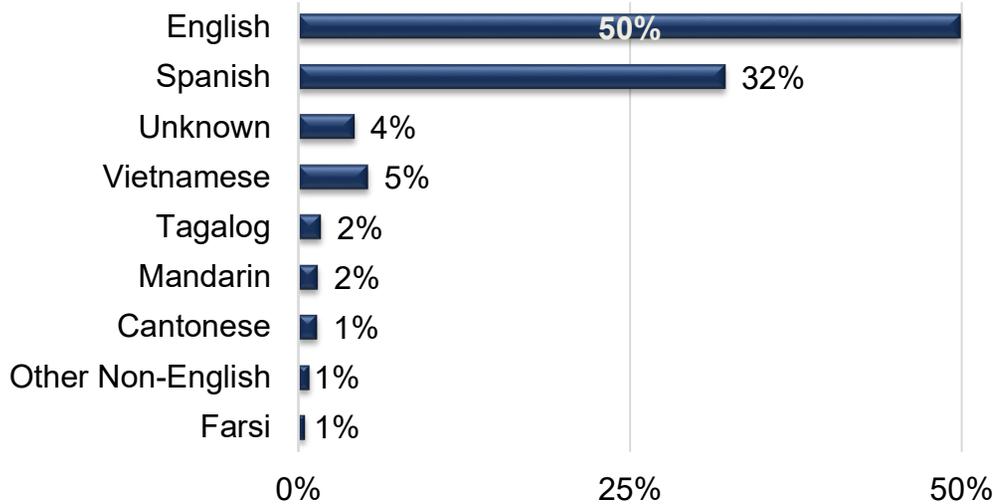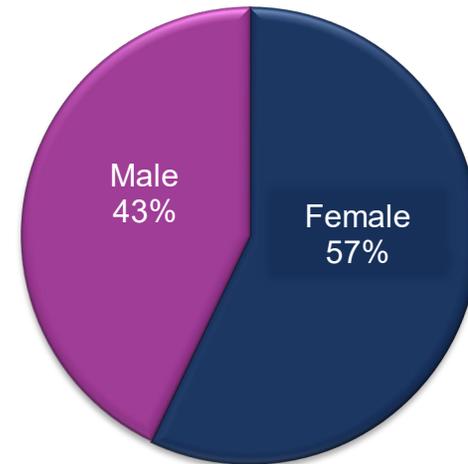- Female 57%

Cal MediConnect Figure 7: Quality Withhold Summary Table (CY 2018)
See metric summary for additional information

Medicare-Medicaid Plan	CW6 Benchmark: 1.00	CW7* Benchmark: 69%	CW8* Benchmark: 56%	CW12* Benchmark: 73%	CW13 Benchmark: 80%
Anthem	Met	Met	N/A	Met	Met
Blue Shield	Met	Met	Not Met	Met	Not Met
CHG	Met	Met	Not Met	Met	Not Met
Health Net	Met	Not Met	Not Met	Met	Not Met
IEHP	Met	Met	Met	Met	Not Met
L.A. Care	Met	Not Met	Met	Met	L.Met
Molina	Met	Not Met	Met	Met	Met
CalOptima	Met	Met	Not Met	Met	CalMet
HPSM	Met	Met	Met	Met	HMet
SCFHP	Met	Met	Met	Met	Met

Medicare-Medicaid Plan	CAW7* Benchmark: 10% Decrease	CAW8* Benchmark: 60%	CAW9* Benchmark: 83%	Total # of Measures	Total # Met	% Met	% of Withhold Received
Anthem	Not Met	Met	Not Met	7	5	71%	100%^
Blue Shield	Not Met	Met	Met	8	5	63%	100%^
CHG	Met	Met	Met	8	6	75%	75%
Health Net	Met	Met	Met	8	5	63%	100%^
IEHP	Not Met	Met	Not Met	8	5	63%	75%
L.A. Care	Met	Met	Not Met	8	6	75%	100%^
Molina	Met	Met	Met	8	7	88%	100%
CalOptima	Met	Met	Met	8	7	88%	100%
HPSM	Met	Not Met	Met	8	7	88%	100%
SCFHP	Met	Met	Met	8	8	100%	100%
California Averages				**8**	**6**	**77%**	**95%**

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 (04/2019-03/2020) 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
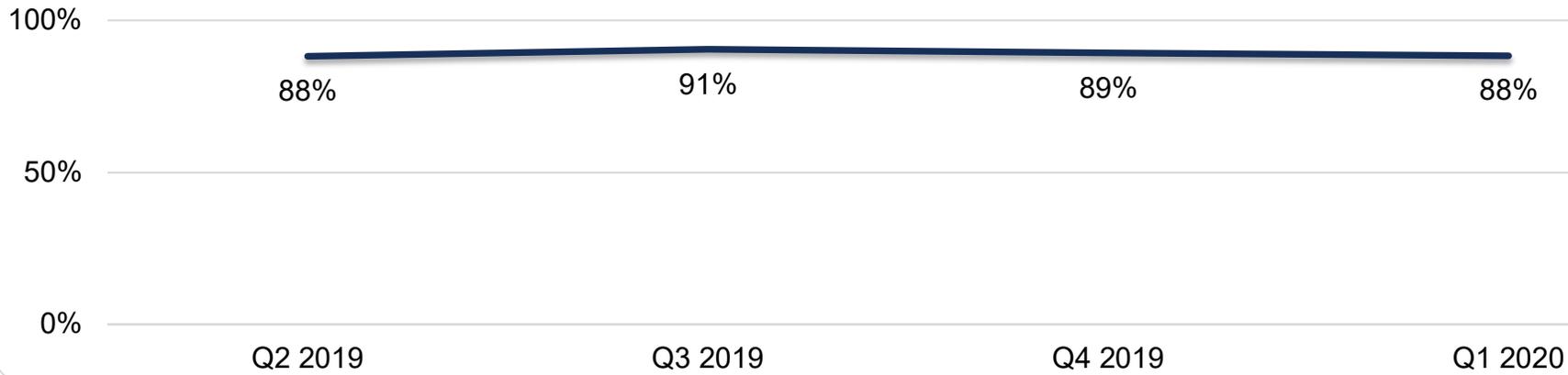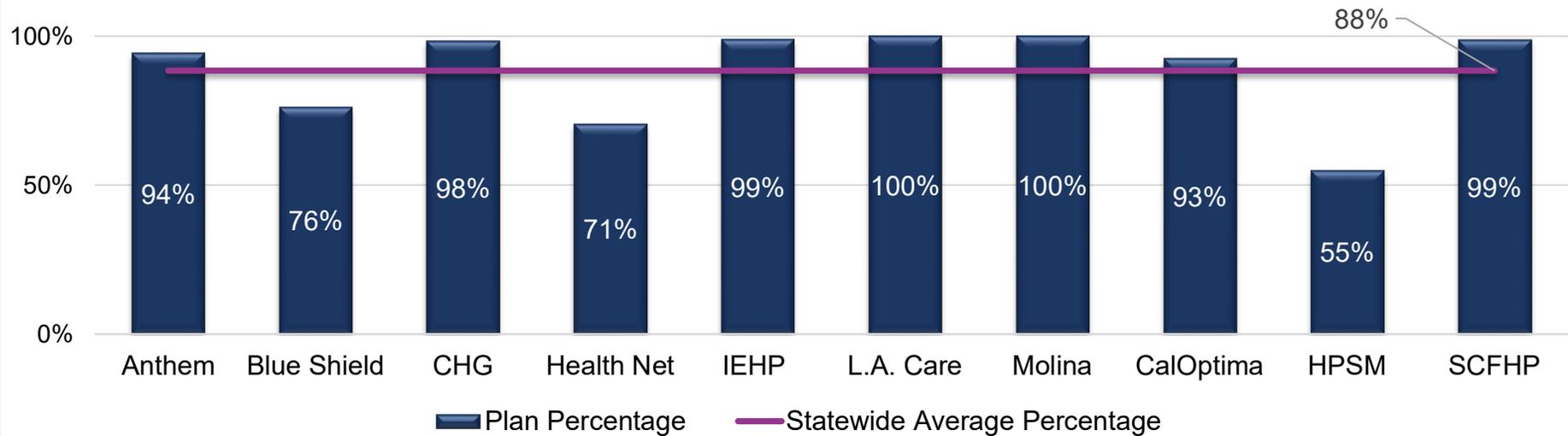

Fig. 9: The Percentage of Members Willing to Participate and who the Plan was able to Locate with an Assessment Completed Within 90 Days of Enrollment for Quarter 1 of 2020

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Care Coordination Figure 10 & 11: Percentage of Members with an Individualized Care Plan (ICP) Completed Within 90 Days of Enrollment (04/2019-03/2020) See metric summary for additional information

Fig. 10: Quarterly Rolling Statewide Percentage of Members with an ICP Completed Within 90 Days of Enrollment
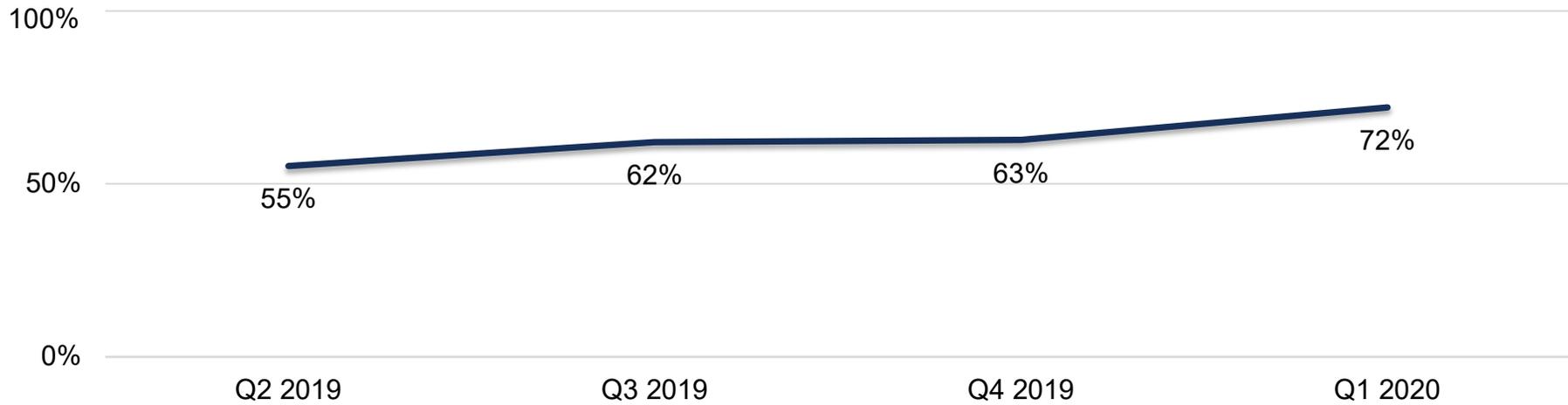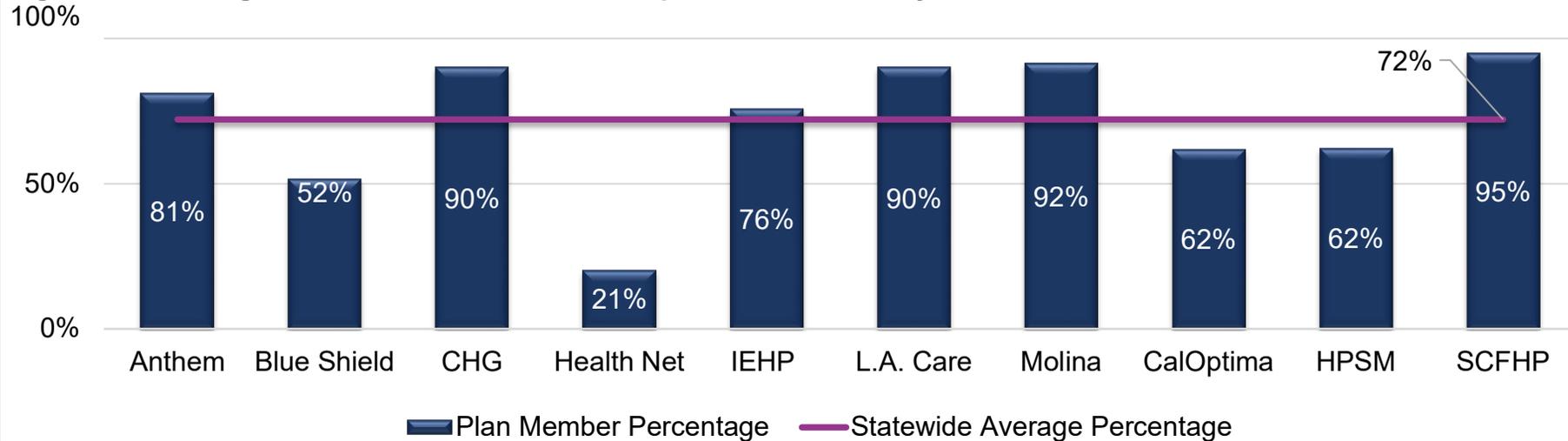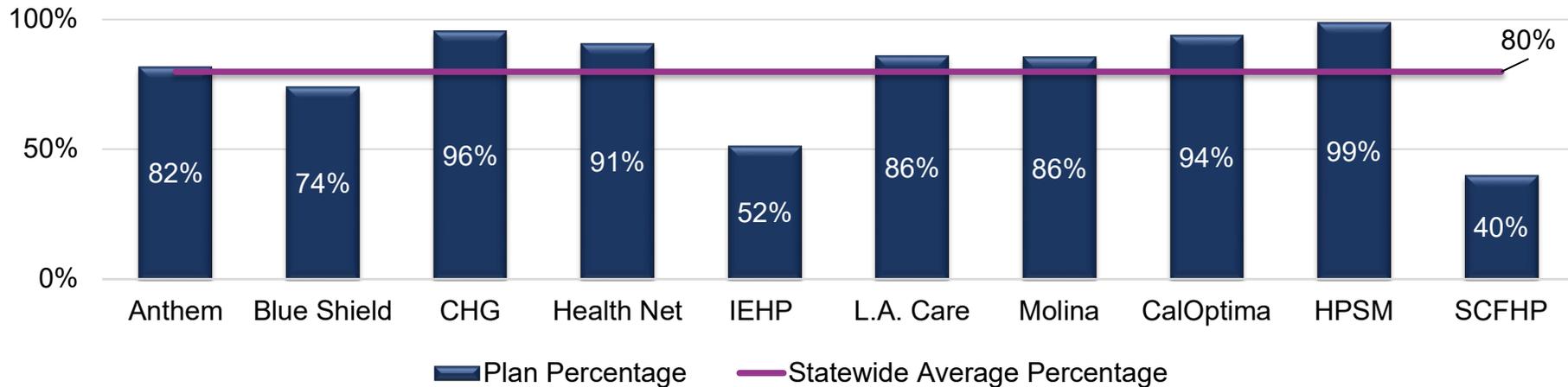

Fig. 11: Percentage of Members with an ICP Completed Within 90 Days of Enrollment for Quarter 1 of 2020

Care Coordination Figure 12: Percentage of Members Who Have a Care Coordinator and Have at Least One Care Team Contact During the Reporting Period (01/2019-12/2019). See metric summary for additional information

Fig. 12: Annual (2019) Percentage of Members who have a Care Coordinator and have at least One Care team Contact During the Reporting Period

Plan	Plan Percentage
Anthem	82%
Blue Shield	74%
CHG	96%
Health Net	91%
IEHP	52%
L.A. Care	86%
Molina	86%
CalOptima	94%
HPSM	99%
SCFHP	40%

Statewide Average Percentage: 80%

■ Plan Percentage —— Statewide Average Percentage

**Care Coordination Figure 13: Member to Care Coordinator Ratio (01/2019-12/2019)
See metric summary for additional information**

Fig. 13: Annual (2019) Number of Members to Care Coordinator Ratio

Plan	Plan Ratio
Anthem	63
Blue Shield	8
CHG	246
Health Net	33
IEHP	112
L.A. Care	42
Molina	150
CalOptima	61
HPSM	113
SCFHP	326

Statewide Average Ratio: 115

■ Plan Ratio —— Statewide Average Ratio
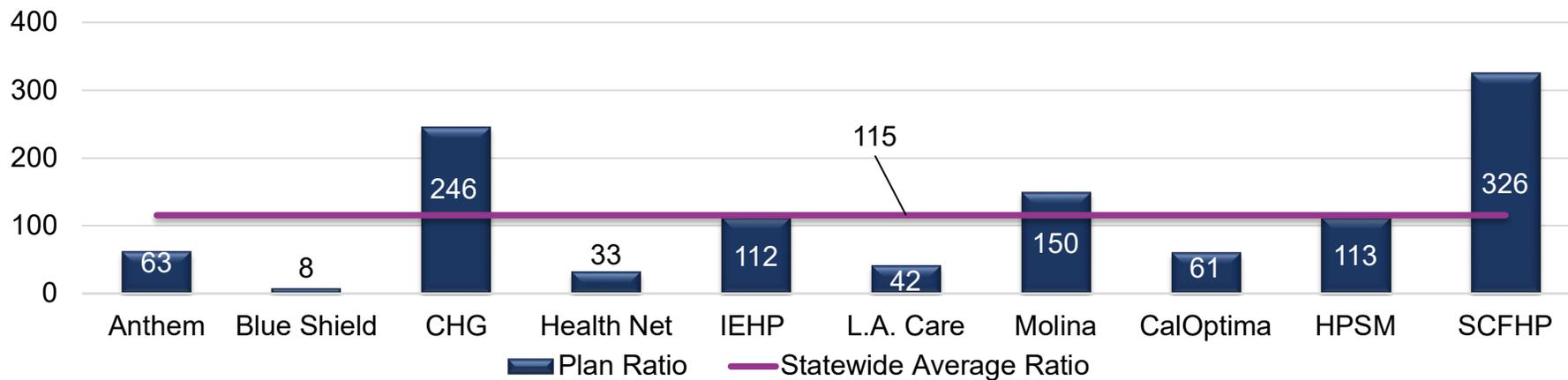
Care Coordination Figure 14: Percentage of Members with Documented Discussions of Care Goals (01/2019-12/2019) See metric summary for additional information

Fig. 14: Annual (2019) Percentage of Members with Documented Discussions of Care Goals

Plan	Plan Percentage
Anthem	100%
Blue Shield	46%
CHG	72%
Health Net	100%
IEHP	100%
L.A. Care	100%
Molina	62%
CalOptima	92%
HPSM	42%
SCFHP	100%

Statewide Average Percentage: 81%

Legend: Plan Percentage — Statewide Average Percentage
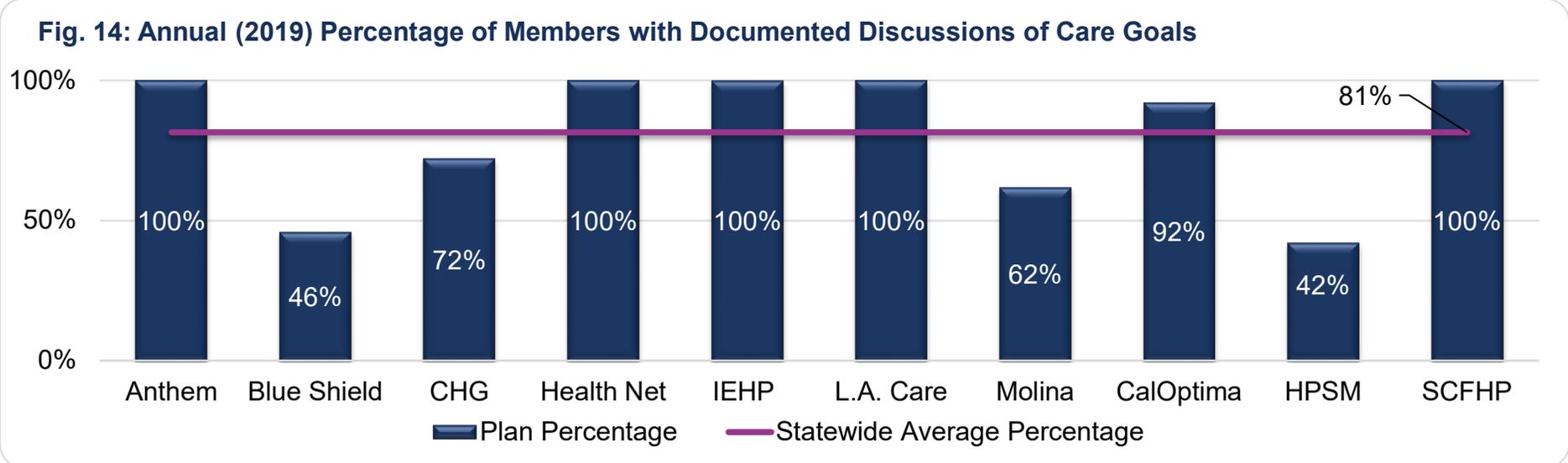
Care Coordination Figure 15: Percentage of Members with First Follow-up Visit within 30 Days after Hospital Discharge (01/2019-12/2019) See metric summary for additional information

Fig. 15: Annual (2019) Percentage of Members with First Follow-Up Visit within 30 Days after Hospital Discharge

Plan	Plan Percentage
Anthem	63%
Blue Shield	80%
CHG	85%
Health Net	69%
IEHP	72%
L.A. Care	73%
Molina	73%
CalOptima	79%
HPSM	88%
SCFHP	84%

Statewide Average Percentage: 76%

Legend: Plan Percentage — Statewide Average Percentage
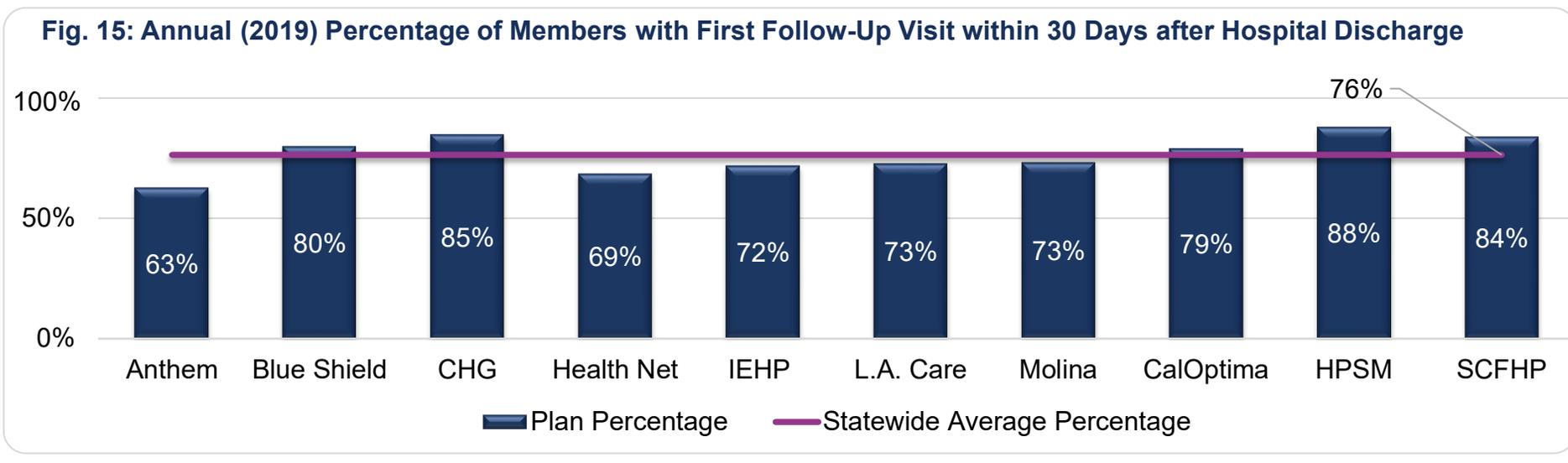
Grievance Figure 16: Count Grievances by type, Except "Other" (01/2019-12/2019)
See metric summary for additional information

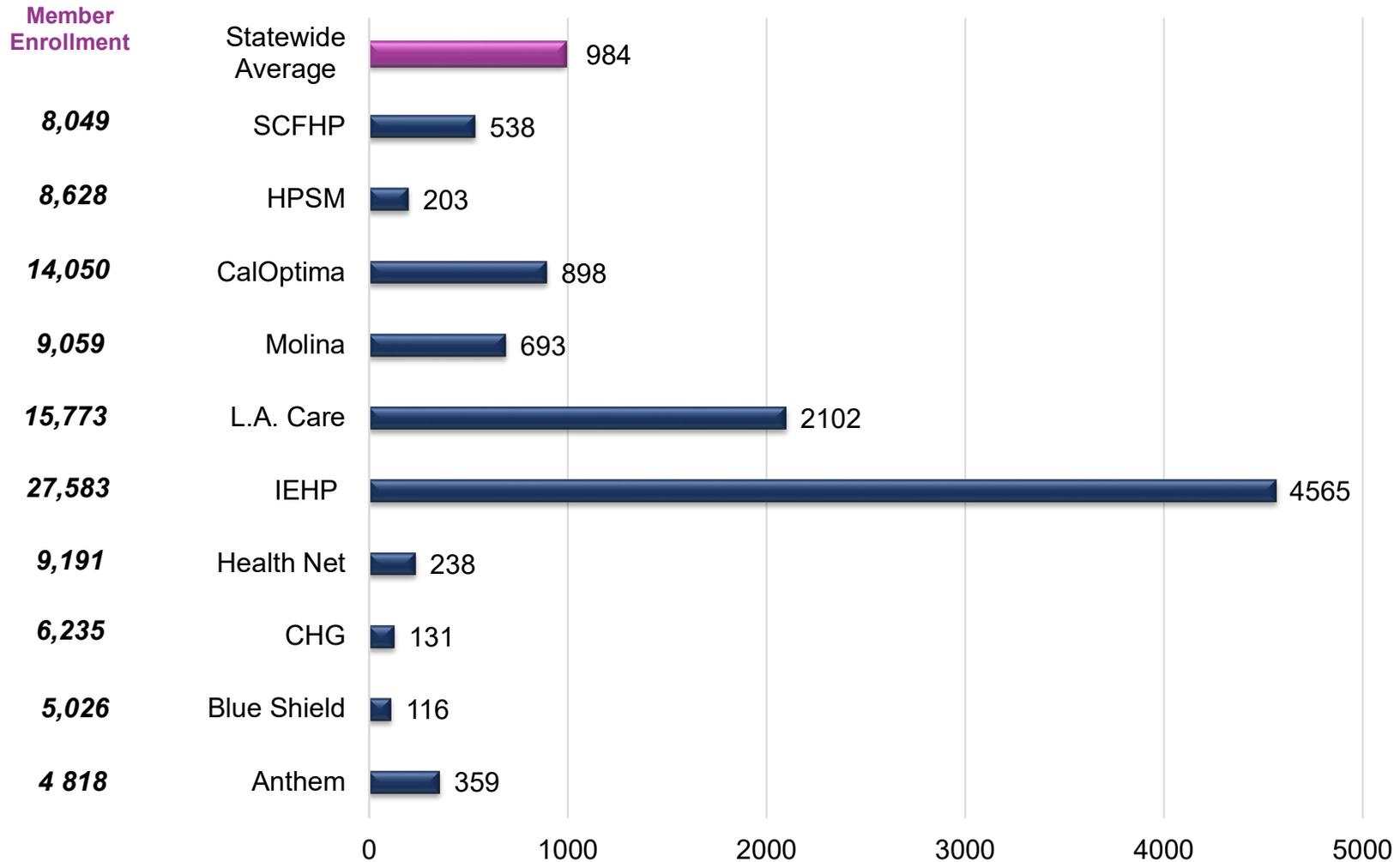## Fig. 16: Annual Count of Grievances Broken Down by Type, besides "Other"

Member Enrollment

Member Enrollment	Plan	Access to care	Transportation	Billing	Home health/personal care	Total
8,049	SCFHP	210	192	558		960
8,628	HPSM	39	165	53	9	266
14,050	CalOptima	161	987	544	4	1696
9,059	Molina	272	316	160		750
15,773	L.A. Care	856	791	482		2129
27,583	IEHP	612	832	172	37	1653
9,191	Health Net	262	100	32		395
6,235	CHG	26	26			56
5,026	Blue Shield	23	14	177		214
4,818	Anthem	49	356	4		414

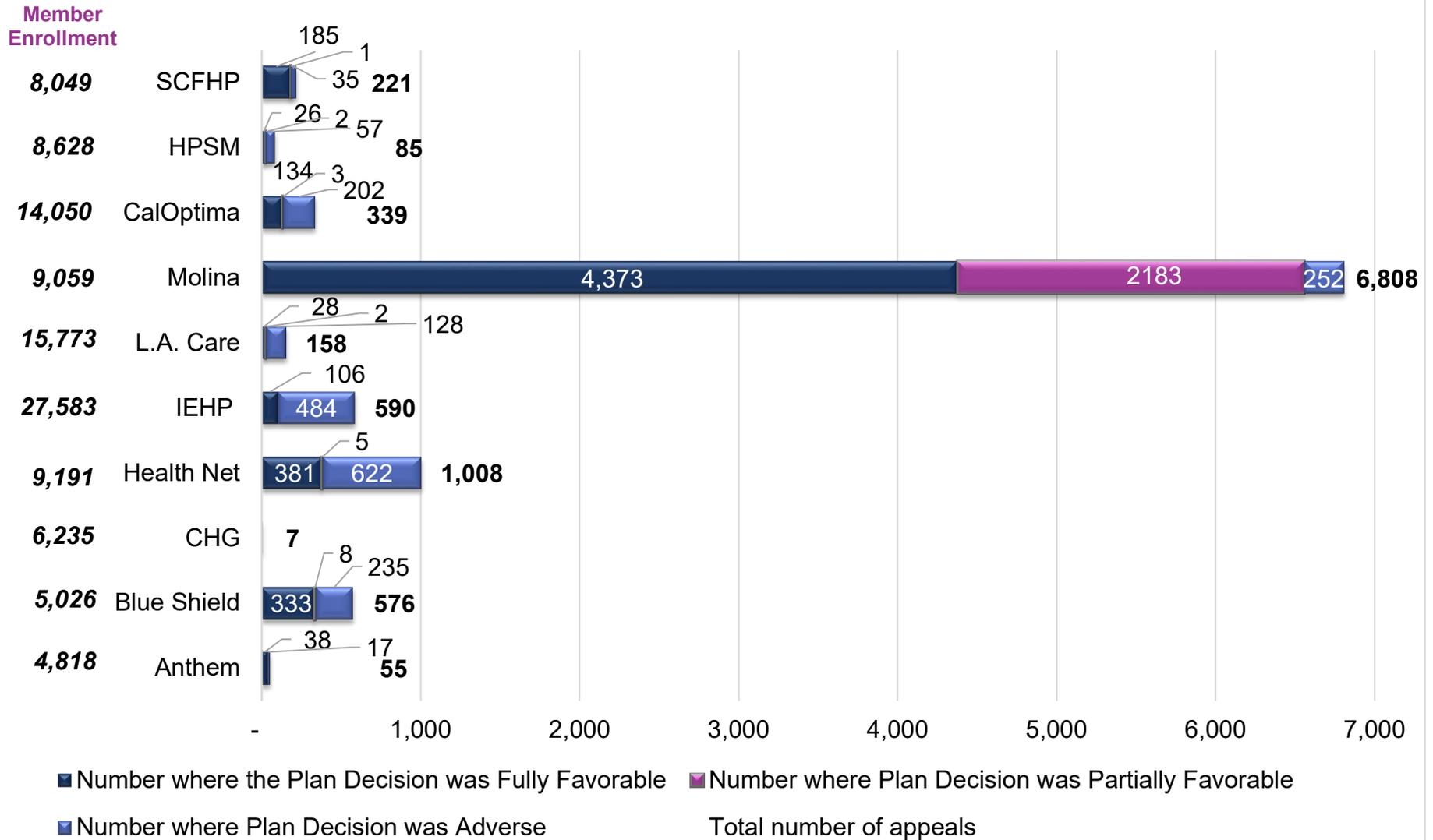■ Access to care ■ Transportation ■ Billing ■ Home health/personal care

Grievance Figure 17: Count of "Other" Grievances (01/2019-12/2019) See metric summary for additional information

Fig. 17: Annual Count of "Other" Grievances

| Member Enrollment	Plan	Count
	Statewide Average	984
8,049	SCFHP	538
8,628	HPSM	203
14,050	CalOptima	898
9,059	Molina	693
15,773	L.A. Care	2102
27,583	IEHP	4565
9,191	Health Net	238
6,235	CHG	131
5,026	Blue Shield	116
4 818	Anthem	359

Appeal Figure 18: Count of Appeals (01/2019-12/2019). See metric summary for additional information

Fig. 18: Annual Count of Appeals Broken Down by Outcome

Member Enrollment		
8,049	SCFHP	185 / 1 / 35 **221**
8,628	HPSM	26 / 2 / 57 **85**
14,050	CalOptima	134 / 3 / 202 **339**
9,059	Molina	4,373 / 2183 / 252 **6,808**
15,773	L.A. Care	28 / 2 / 128 **158**
27,583	IEHP	106 / 484 **590**
9,191	Health Net	381 / 5 / 622 **1,008**
6,235	CHG	**7**
5,026	Blue Shield	333 / 8 / 235 **576**
4,818	Anthem	38 / 17 **55**

- 1,000 2,000 3,000 4,000 5,000 6,000 7,000

■ Number where the Plan Decision was Fully Favorable ■ Number where Plan Decision was Partially Favorable

■ Number where Plan Decision was Adverse   Total number of appeals

Appeals Figure 19: Total Number of Appeals Related to the Denial or Limited Authorization of Mental Health Services (01/2019-12/2019) See metric summary for additional information

Fig. 19: Annual (2019) Total of all Appeals Related to the Denial or Limited Authorization of Mental Health Services
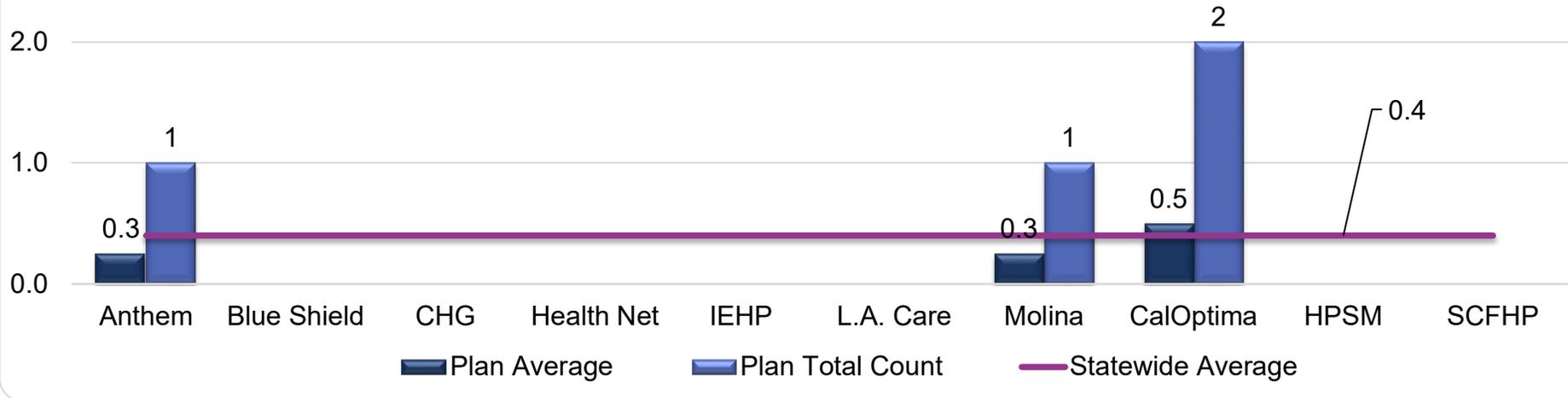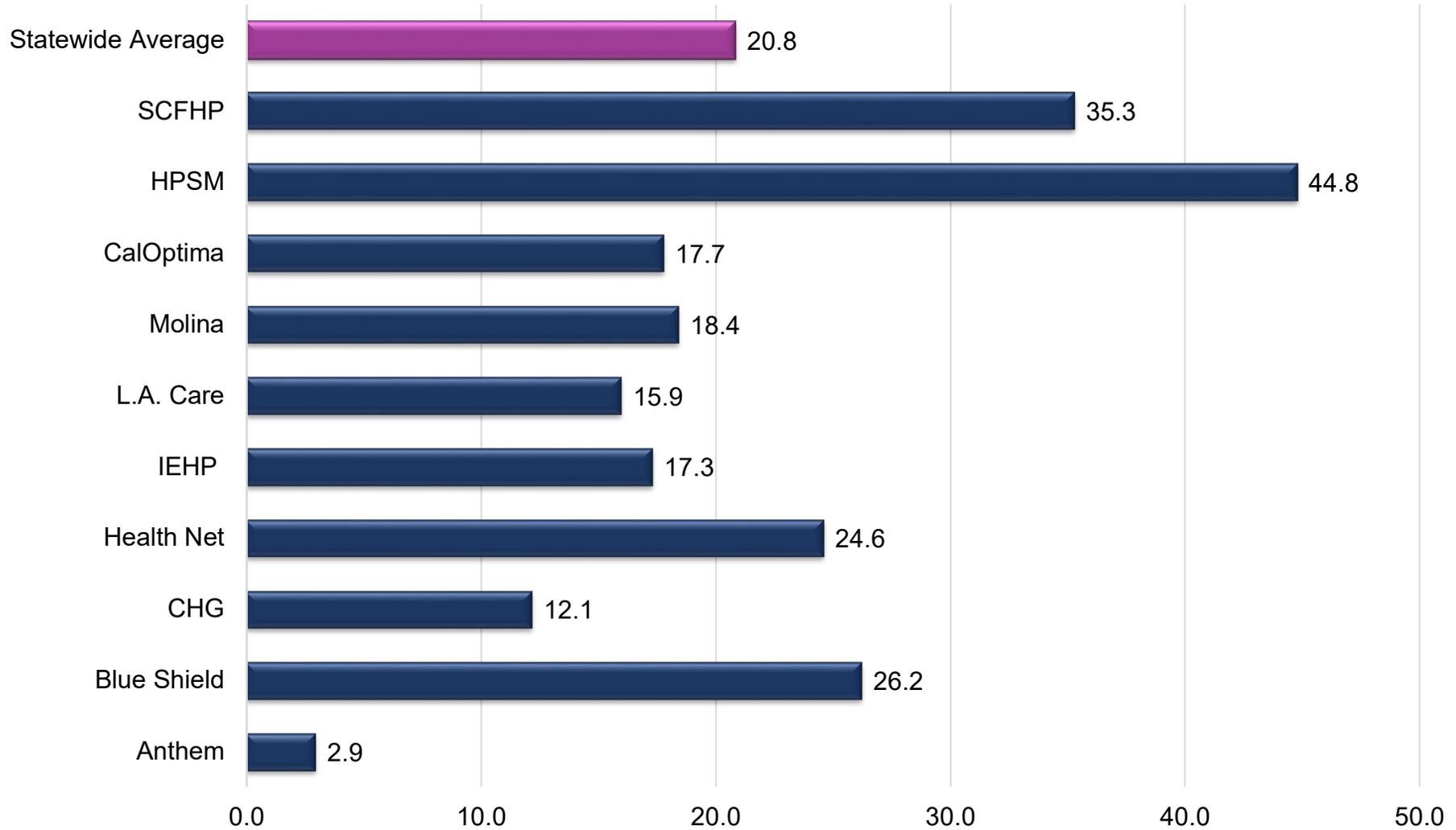

Behavioral Health Figure 20: Emergency Room Behavioral Health Services Utilization per 10,000 Member Months (01/2019-12/2019) See metric summary for additional information

Fig. 20: Quarterly Rolling Statewide Average Count of Emergency Room Behavioral Health Services Utilization per 10,000 Member Months
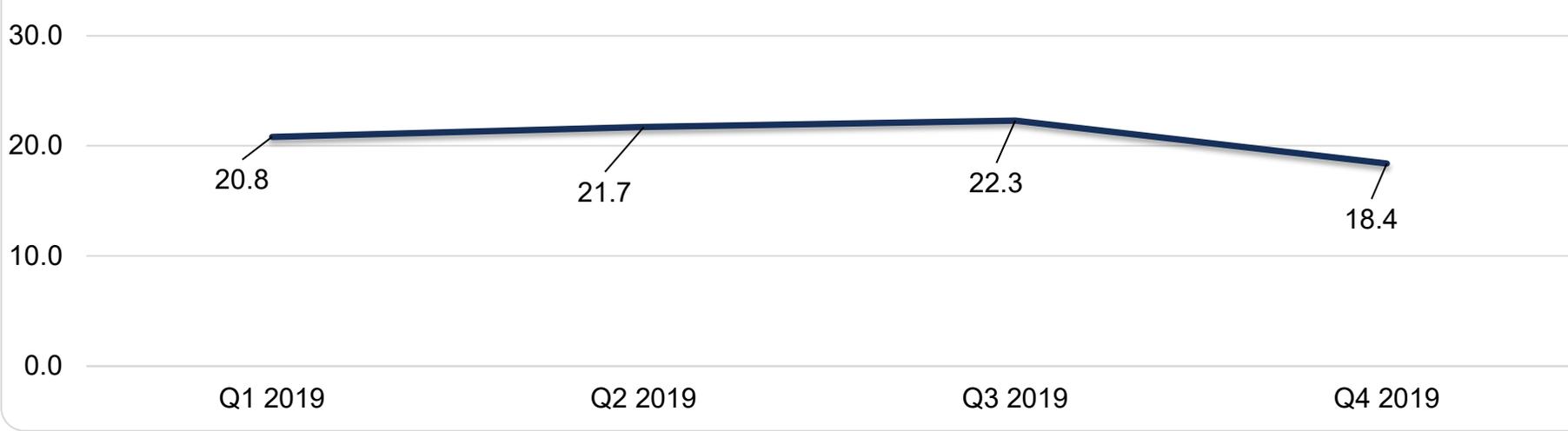
Behavioral Health Figure 21: Emergency Room Behavioral Health Services Utilization per 10,000 Member Months (01/2019-12/2019) See metric summary for additional information

Fig. 21: Annual Count of Emergency Room Behavioral Health Services Utilization per 10,000 Member Months

Plan	Value
Statewide Average	20.8
SCFHP	35.3
HPSM	44.8
CalOptima	17.7
Molina	18.4
L.A. Care	15.9
IEHP	17.3
Health Net	24.6
CHG	12.1
Blue Shield	26.2
Anthem	2.9

Long Term Services & Supports (LTSS) Figure 22 & 23: Utilization of Members Receiving LTSS per 1,000 Members (04/2019-03/2020) See metric summary for additional information

Fig. 22: Quarterly Rolling Statewide Average of Members Receiving LTSS per 1,000 Members
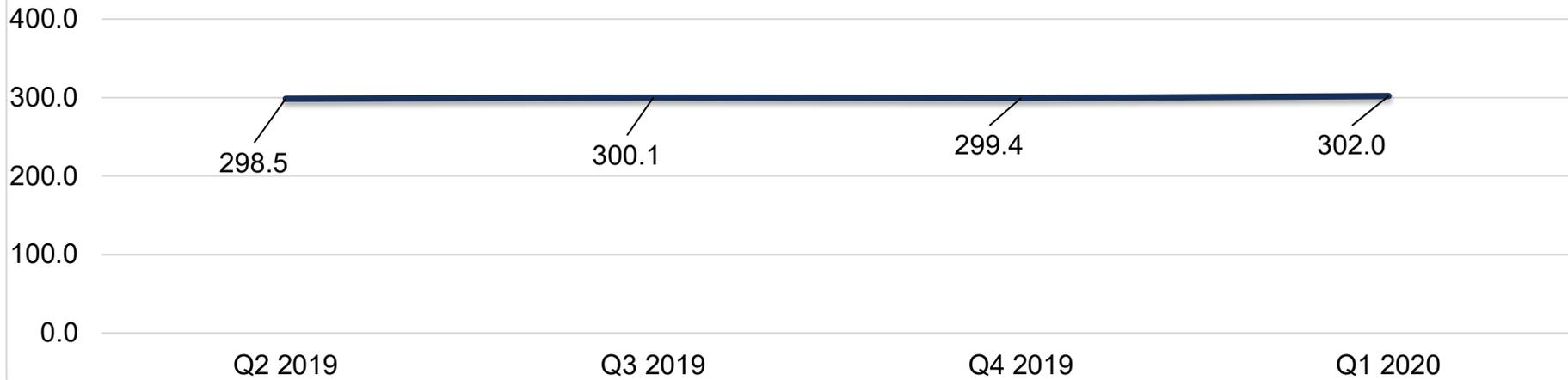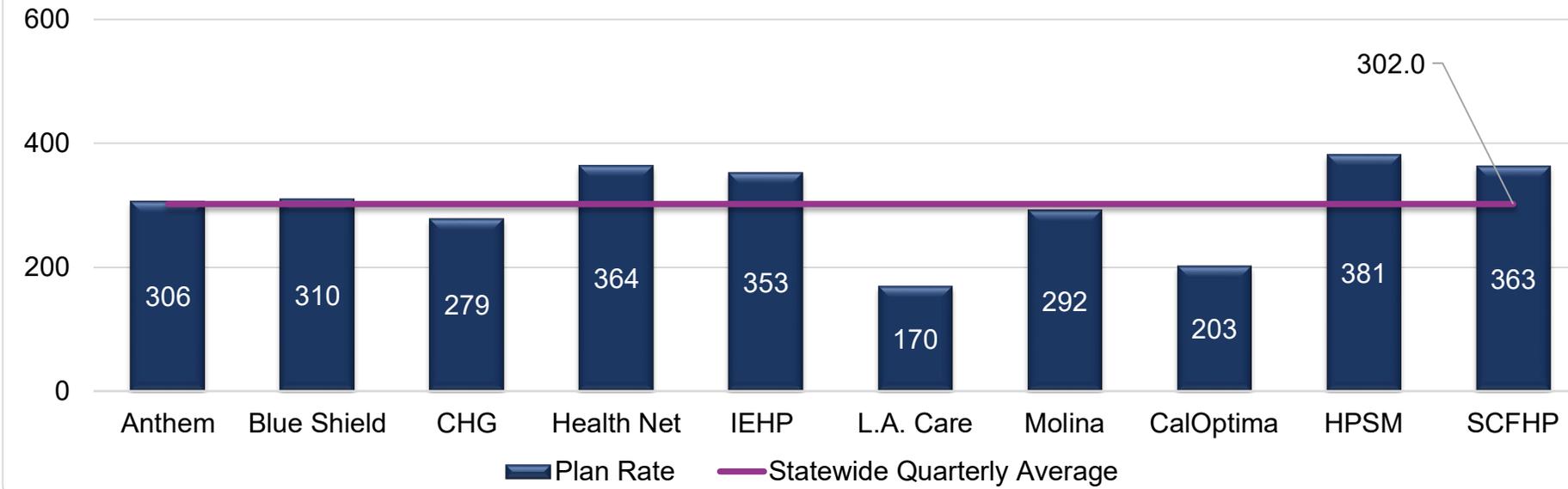

Fig. 23: Count of Members Receiving LTSS per 1,000 members for Quarter 1 of 2020

Long Term Services & Supports (LTSS) Figure 24 & 25: Count of IHSS per 1,000 Members (04/2019-03/2020)
See metric summary for additional information

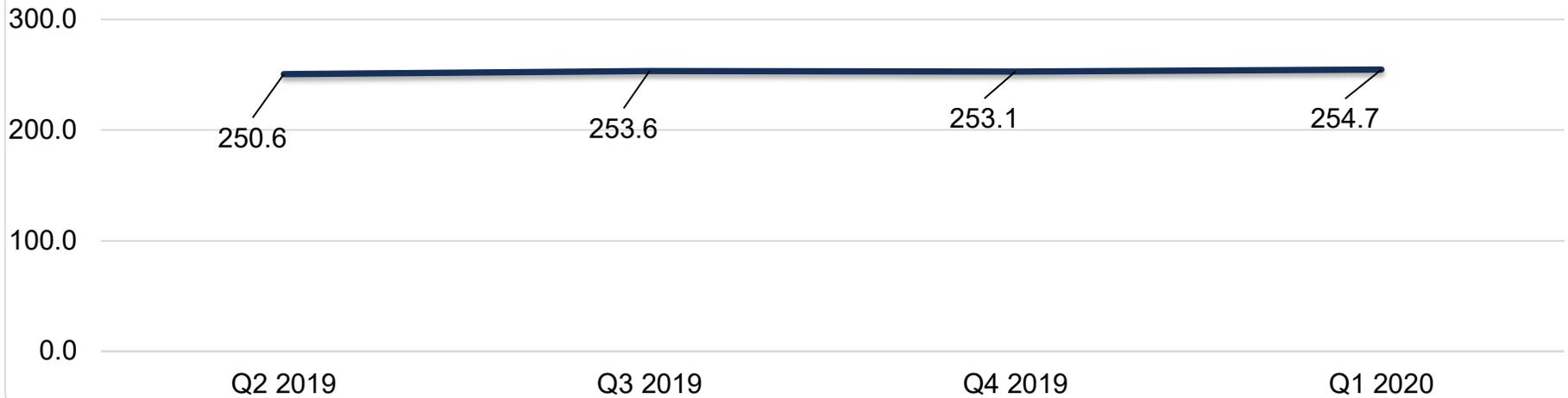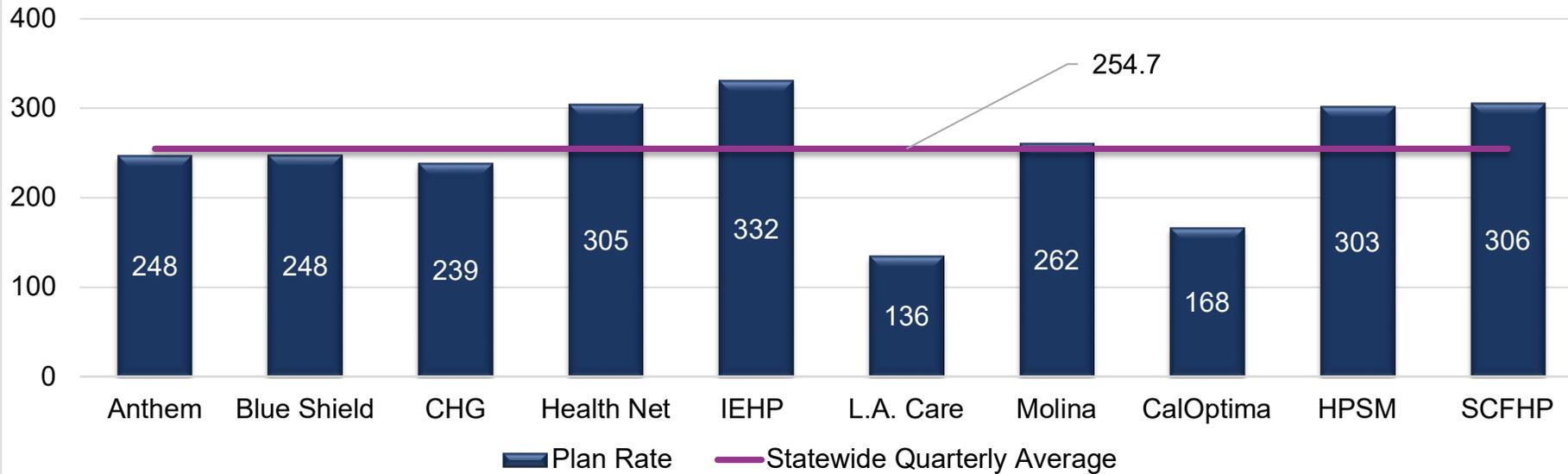### Fig. 24: Quarterly Rolling Statewide Average of Members Receiving IHSS per 1,000 Members

	Q2 2019	Q3 2019	Q4 2019	Q1 2020
	250.6	253.6	253.1	254.7

Fig. 25: Count of Members Receiving IHSS per 1,000 members for Quarter 1 of 2020

254.7

Anthem	Blue Shield	CHG	Health Net	IEHP	L.A. Care	Molina	CalOptima	HPSM	SCFHP
248	248	239	305	332	136	262	168	303	306

Plan Rate — Statewide Quarterly Average

DHCS
California Department of
HealthCareServices

CalMediConnect
Your choice for complete care

Long Term Services & Supports (LTSS) Figure 26 & 27: Count of CBAS per 1,000 Members (04/2019-03/2020)
See metric summary for additional information

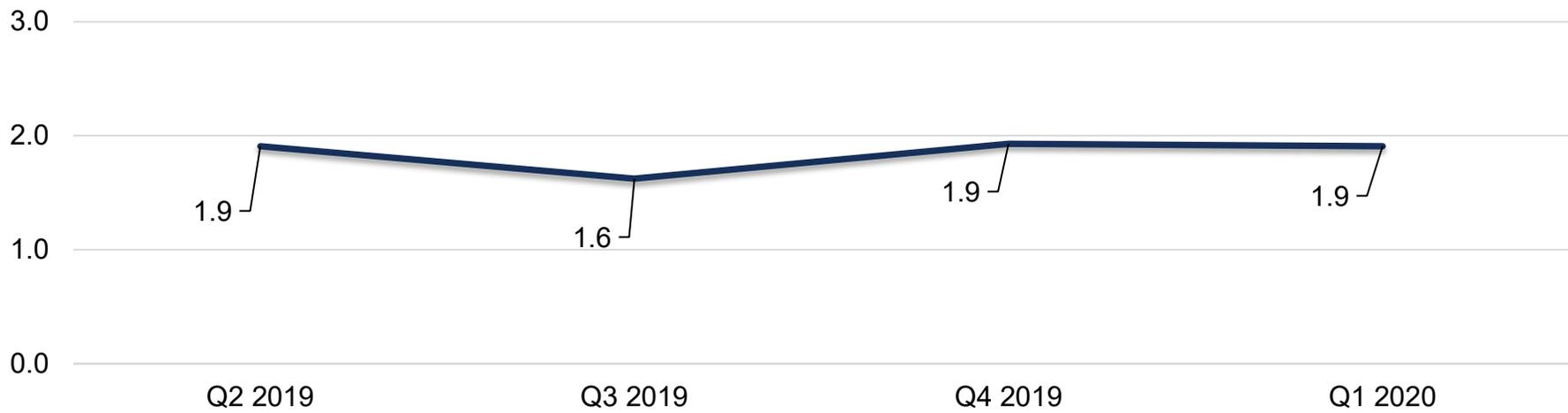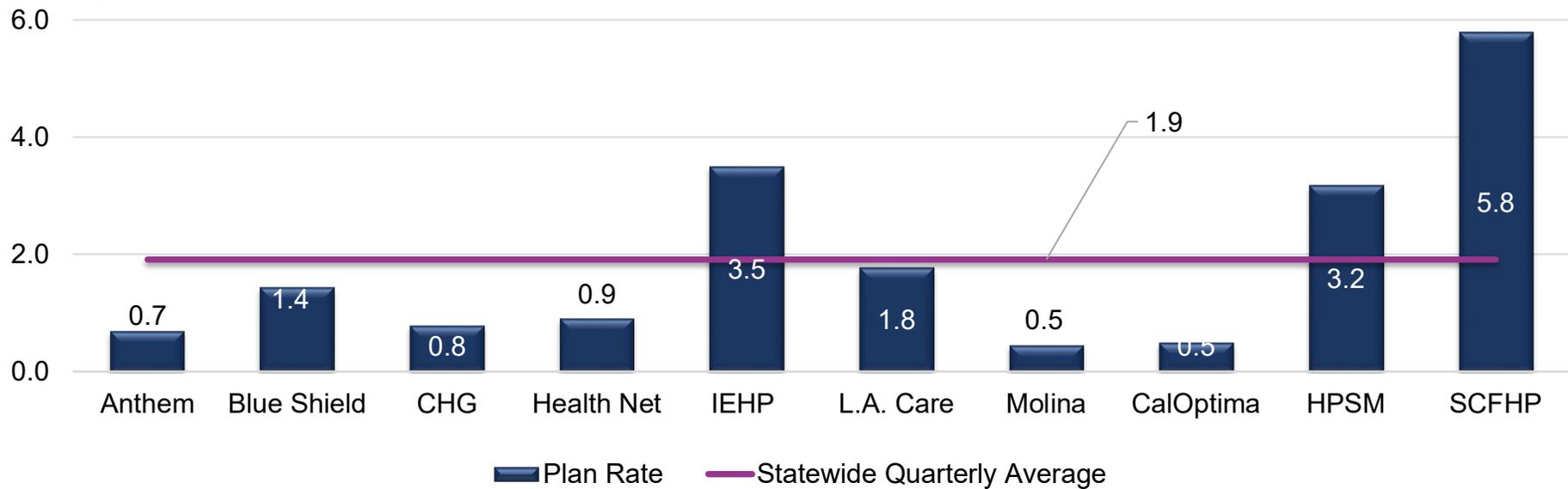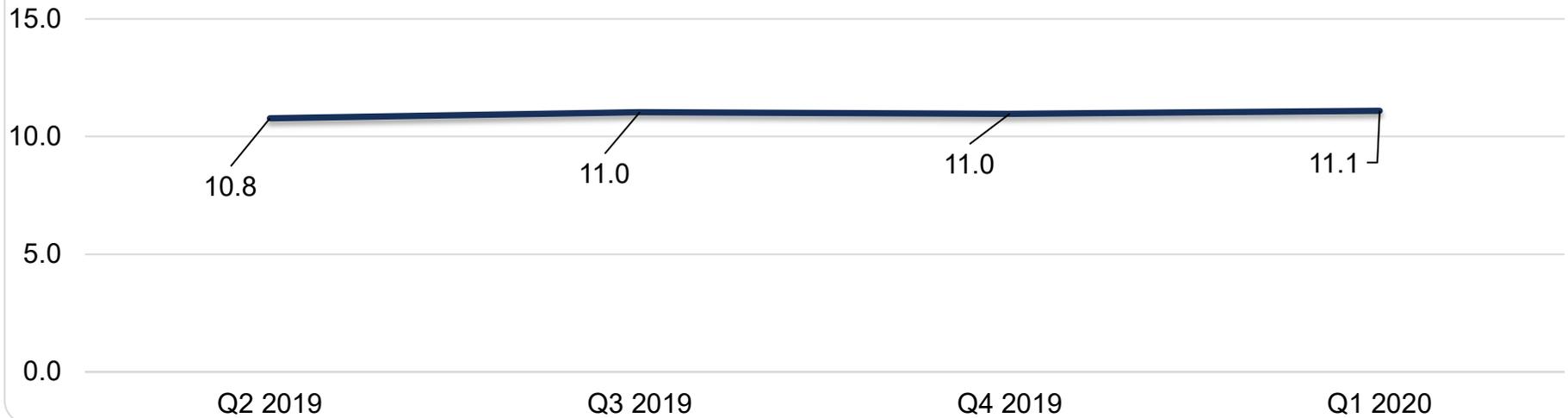**Fig. 26: Quarterly Rolling Statewide Average of CBAS Member Referrals per 1,000 Members**

	Q2 2019	Q3 2019	Q4 2019	Q1 2020
	1.9	1.6	1.9	1.9

Fig. 27: Count of CBAS Member Referrals per 1,000 members for Quarter 1 of 2020

Anthem	Blue Shield	CHG	Health Net	IEHP	L.A. Care	Molina	CalOptima	HPSM	SCFHP
0.7	1.4	0.8	0.9	3.5	1.8	0.5	0.5	3.2	5.8

Statewide Quarterly Average: 1.9

▬ Plan Rate ▬ Statewide Quarterly Average

DHCS — California Department of HealthCare Services

CalMediConnect — Your choice for complete care

Long Term Services & Supports (LTSS) Figure 28 & 29: Count of CBAS per 1,000 Members (04/2019-03/2020)
See metric summary for additional information

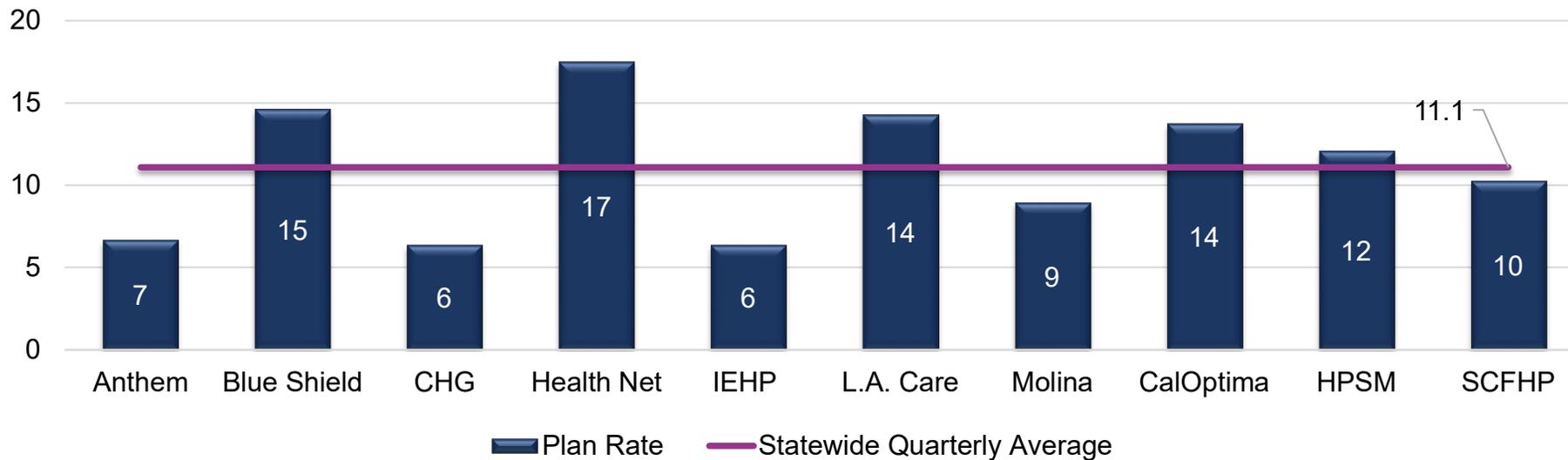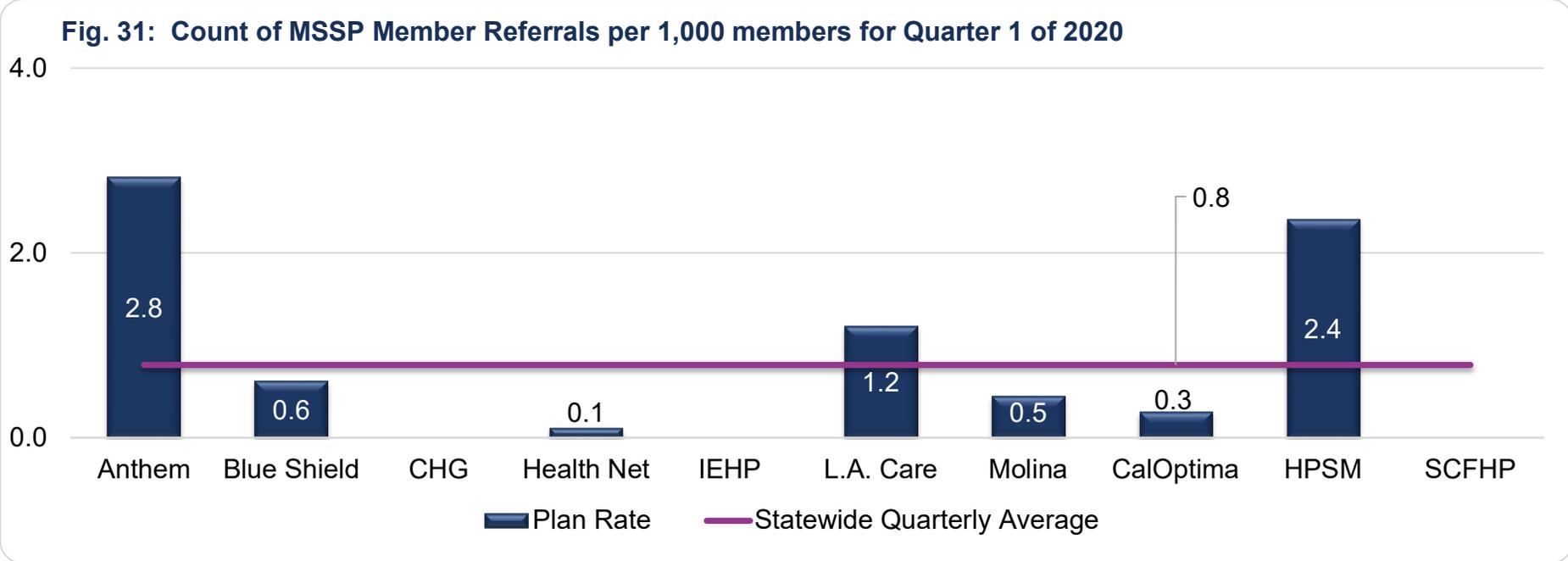**Fig. 28: Quarterly Rolling Statewide Average of Members Receiving CBAS per 1,000 Members**


	Q2 2019	Q3 2019	Q4 2019	Q1 2020
	10.8	11.0	11.0	11.1

Fig. 29: Count of Members Receiving CBAS per 1,000 members for Quarter 1 of 2020

Anthem	Blue Shield	CHG	Health Net	IEHP	L.A. Care	Molina	CalOptima	HPSM	SCFHP
7	15	6	17	6	14	9	14	12	10

Statewide Quarterly Average: 11.1

Plan Rate ▬ Statewide Quarterly Average ▬

Long Term Services & Supports (LTSS) Figure 30 & 31: Count of MSSP per 1,000 Members (04/2019-03/2020)
See metric summary for additional information

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

Fig. 31: Count of MSSP Member Referrals per 1,000 members for Quarter 1 of 2020

Legend: Plan Rate — Statewide Quarterly Average
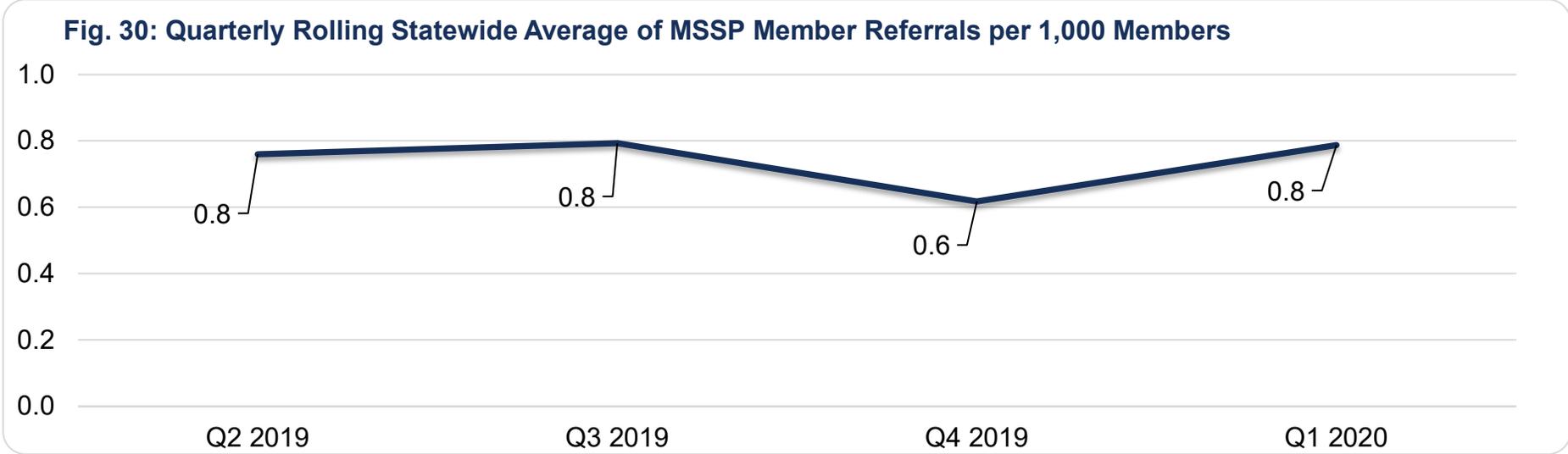
Long Term Services & Supports (LTSS) Figure 32 & 33: Count of MSSP per 1,000 Members (04/2019-03/2020)
See metric summary for additional information

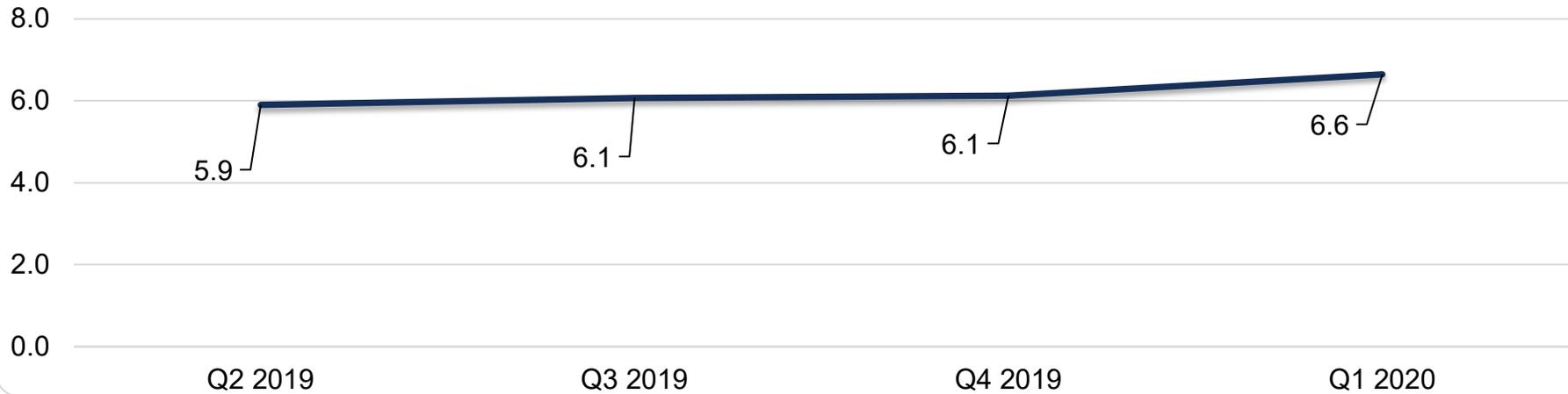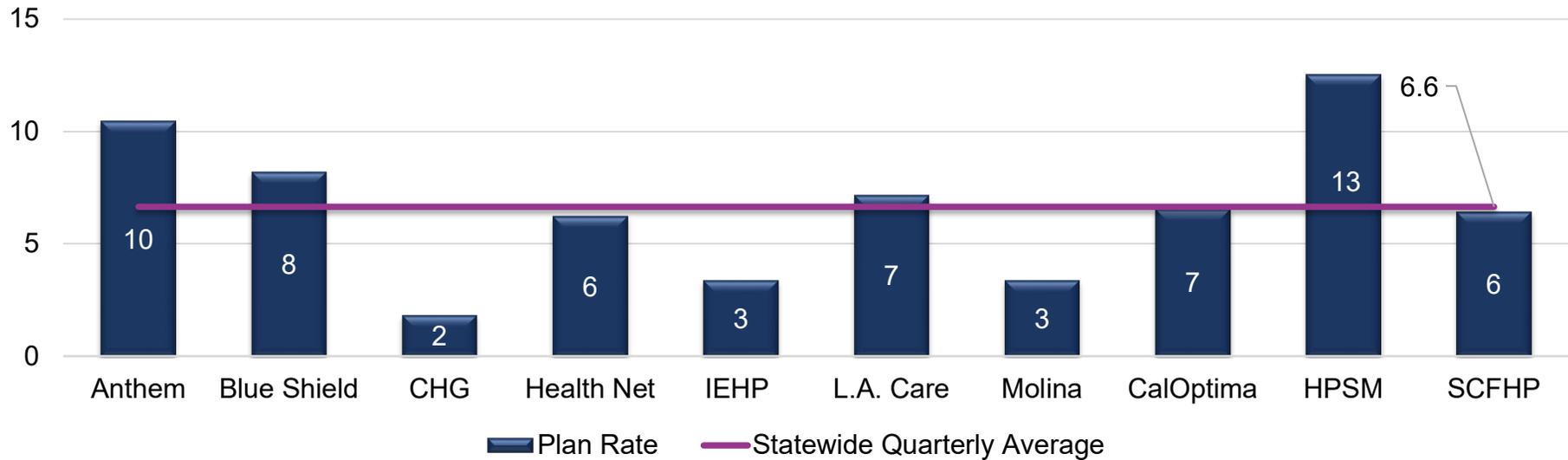**Fig. 32: Quarterly Rolling Statewide Average of Member Receiving MSSP per 1,000 Members**

Fig. 33: Count of Members Receiving MSSP per 1,000 members for Quarter 1 of 2020

Long Term Services & Supports (LTSS) Figure 34 & 35: Count of NF per 1,000 Members (04/2019-03/2020)
See metric summary for additional information

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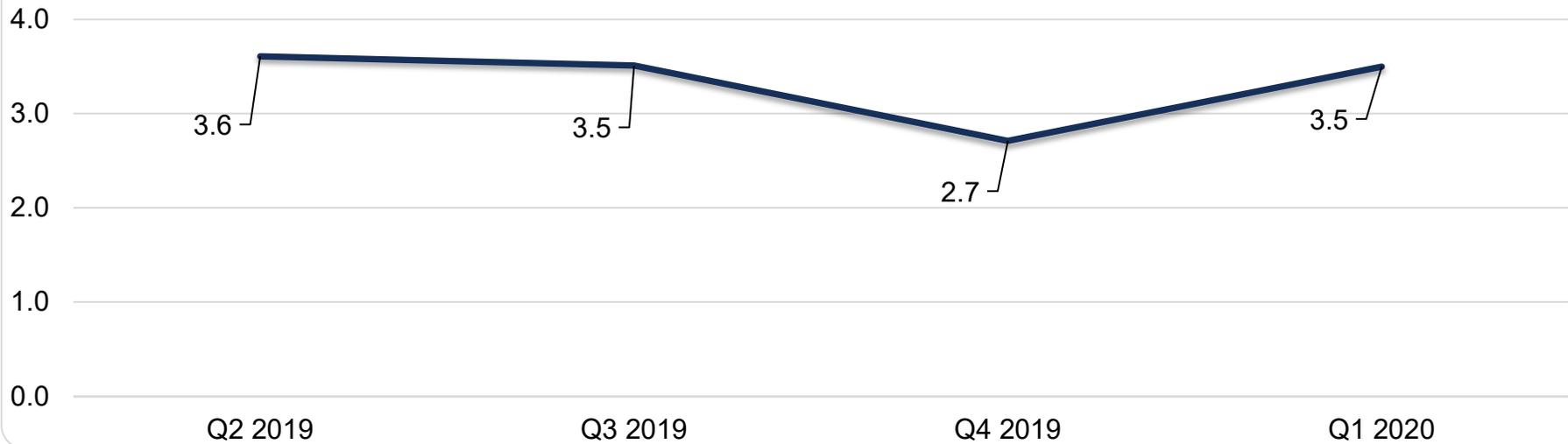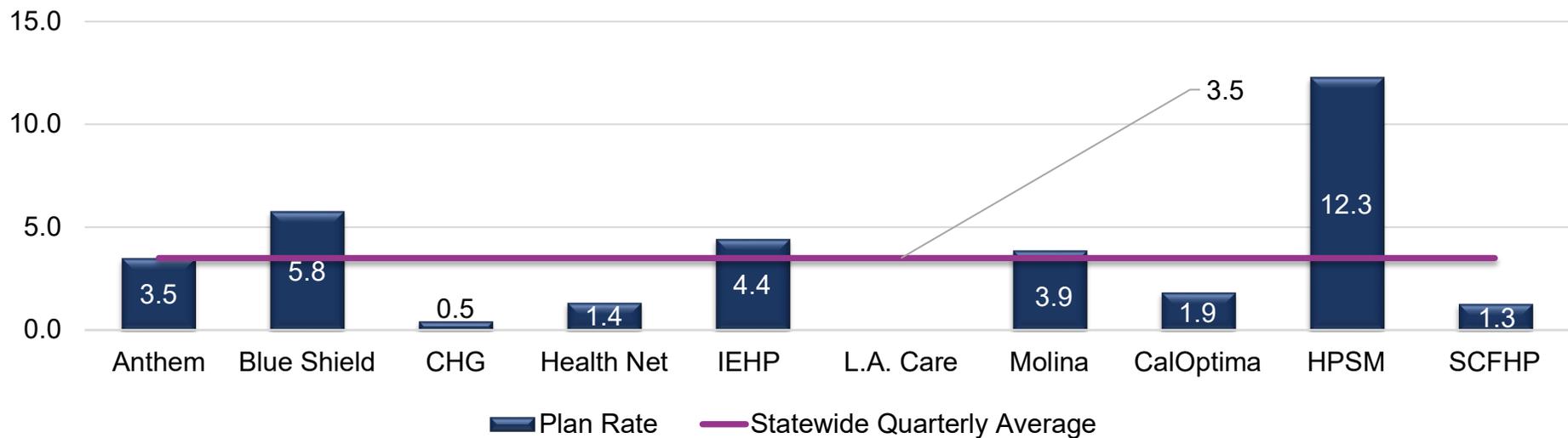

Q2 2019: 3.6
Q3 2019: 3.5
Q4 2019: 2.7
Q1 2020: 3.5

Fig. 35: Count of NF Member Referrals per 1,000 members for Quarter 1 of 2020

Plan	Rate
Anthem	3.5
Blue Shield	5.8
CHG	0.5
Health Net	1.4
IEHP	4.4
L.A. Care	3.5
Molina	3.9
CalOptima	1.9
HPSM	12.3
SCFHP	1.3

■ Plan Rate —— Statewide Quarterly Average

Long Term Services & Supports (LTSS) Figure 36 & 37: Count of NF per 1,000 Members (04/2019-03/2020)
See metric summary for additional information

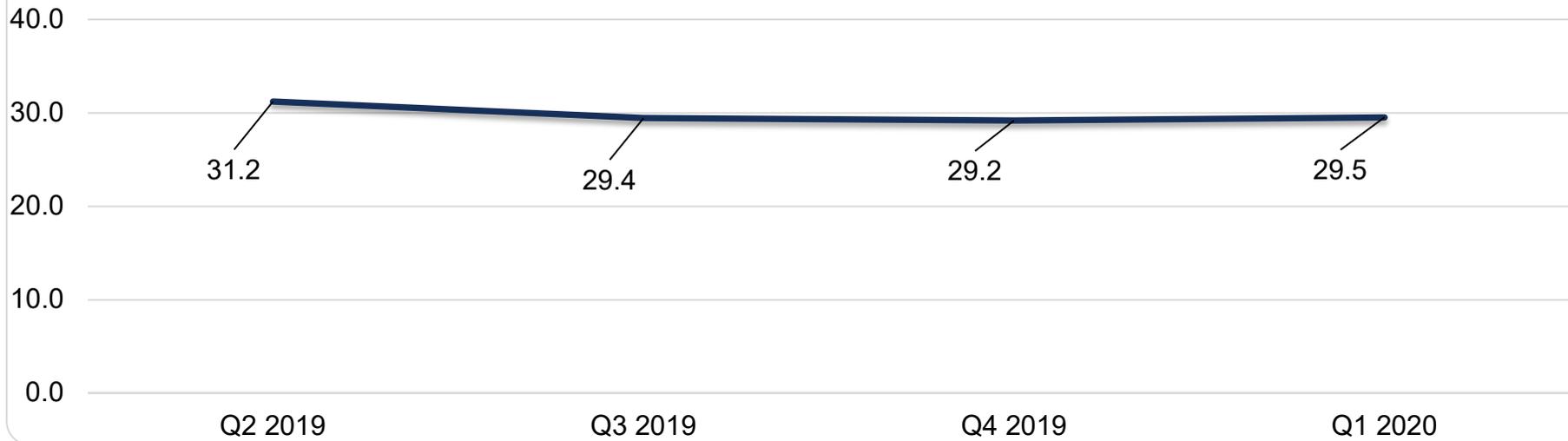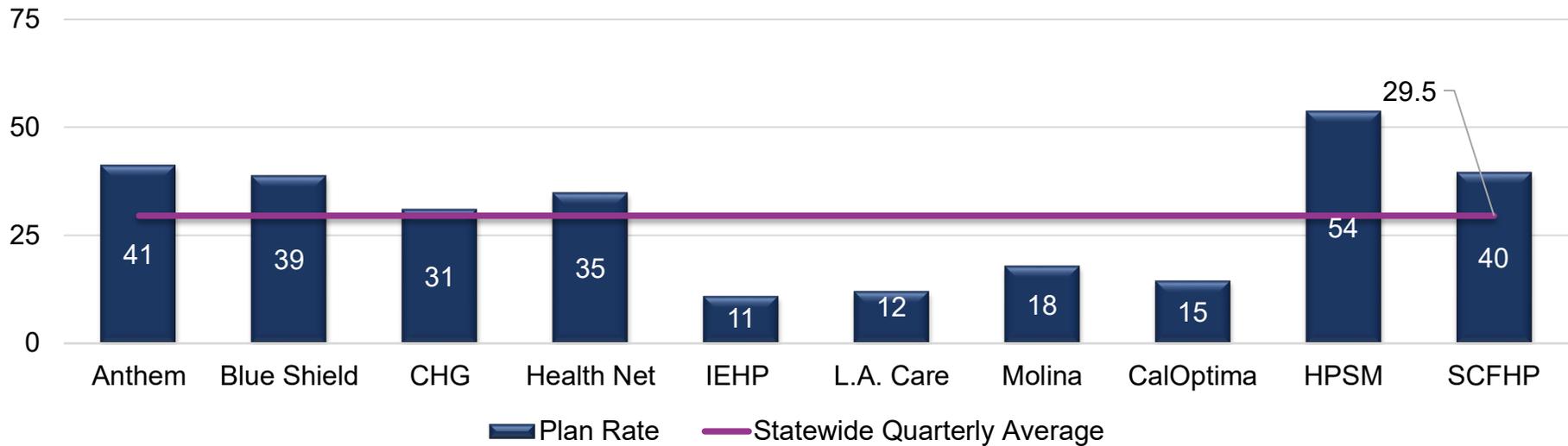**Fig. 36: Quarterly Rolling Statewide Average of Members Receiving NF per 1,000 Members**

	Q2 2019	Q3 2019	Q4 2019	Q1 2020
	31.2	29.4	29.2	29.5

Fig. 37: Count of Members Receiving NF per 1,000 Members for Quarter 1 of 2020

Anthem	Blue Shield	CHG	Health Net	IEHP	L.A. Care	Molina	CalOptima	HPSM	SCFHP
41	39	31	35	11	12	18	15	54	40

29.5

Plan Rate —— Statewide Quarterly Average

Long Term Services & Supports (LTSS) Figure 38 & 39: Count of CPO per 1,000 Members (04/2019-03/2020)
See metric summary for additional information

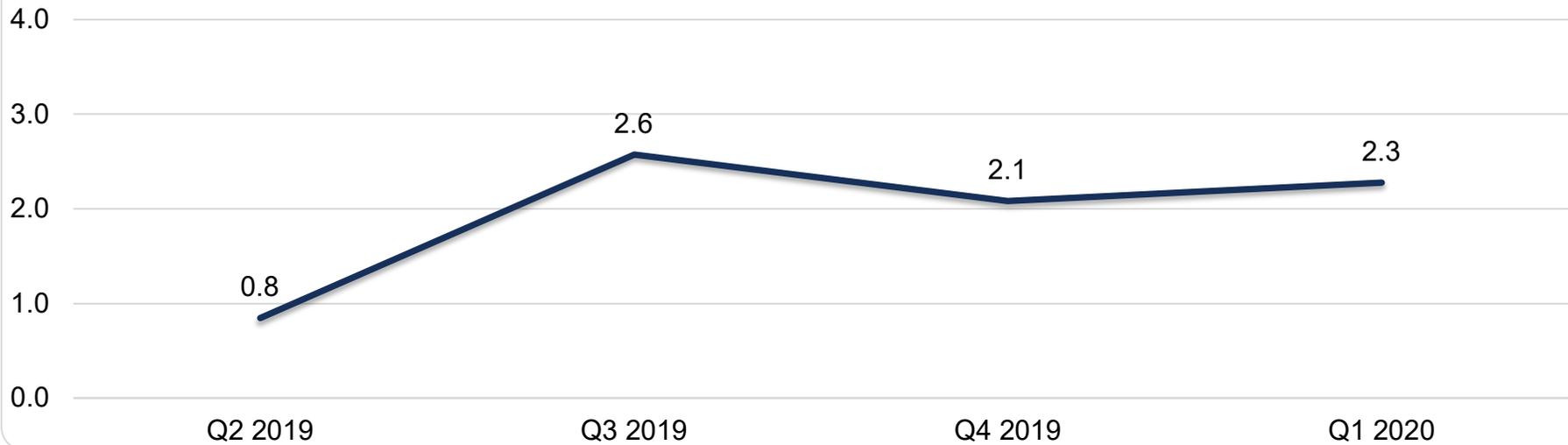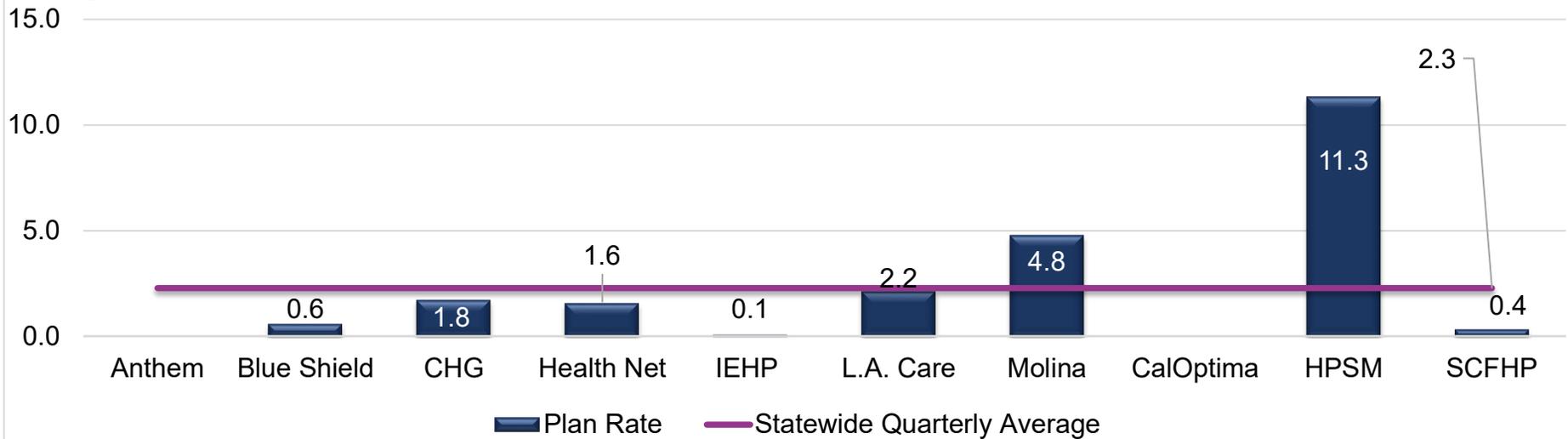**Fig. 38: Quarterly Rolling Statewide Average of CPO Member Referrals per 1,000 Members**

Fig. 39: Count of CPO Member Referrals per 1,000 members for Quarter 1 of 2020

■ Plan Rate　——Statewide Quarterly Average

Long Term Services & Supports (LTSS) Figure 40 & 41: Count of CPO per 1,000 Members (04/2019-03/2020)
See metric summary for additional information

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

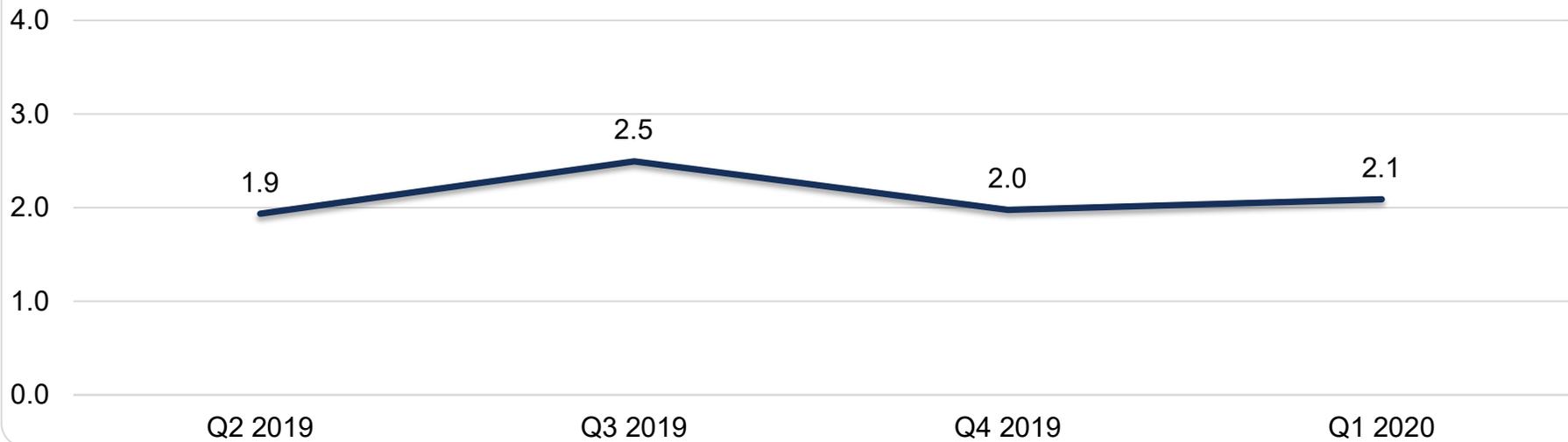|	Q2 2019	Q3 2019	Q4 2019	Q1 2020
	1.9	2.5	2.0	2.1

Fig. 41: Count of Members Receiving CPO per 1,000 Members for Quarter 1 of 2020

Anthem	Blue Shield	CHG	Health Net	IEHP	L.A. Care	Molina	CalOptima	HPSM	SCFHP
	0.6	1.8	0.9	0.1	1.1	4.8		11.3	0.2

Statewide Quarterly Average: 2.1

■ Plan Rate ▬ Statewide Quarterly Average