Cal MediConnect Performance Dashboard Metrics Summary

Released December 2019

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 has decreased consistently from 111,631 in September 2018 to 106,933 in June 2019. In Q2 2019, 50% of enrollees spoke English and 32% spoke Spanish as their primary language, with 37% of enrollees identifying as Hispanic. Males and females aged 65 and older represent 29% and 44% of the total CMC population, respectively.
- **Quality Withhold Summary:** *Figure 7*
  All Plans met at least four quality withhold measures for Calendar Year 2017. Nine of the ten Plans received 100% of their withhold: Anthem, Blue Shield, CHG, 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 91% in Q1 2019 to 88% in Q2 2019.
- **Grievances and Appeals:** *Figures 16-19*
  Plans reported 69% more grievances in 2018 compared to 2017. In 2018, Plans reported 133% more appeals than in 2017. Of the total appeals, Figure 16 shows that 30% of Plan decisions were either fully or partially favorable to the member. Please note that the Grievance and Appeals measure specifications changed in 2018 which may have contributed to the increased reporting for grievances and appeals. See "Grievances and Appeals Trends" section for more details.
- **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 24.9 visits per 10,000 member months in Q1 2018 to 19.1 visits in Q4 2018.
- **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 279.9 members per 1,000 receiving LTSS in Q3 2018, to an average of 297.0 members in Q2 2019. 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 1-6, Figures 8-11, and Figures 22-41 have been updated for the December 2019 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) reporting system.

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 2017.

Figure 7 shows the quality withhold measures for the calendar year 2017. 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 "N/A" represent measures that were not applicable for a plan due to low enrollment or the inability to meet other reporting criteria. Quality withhold measure results indicated with "*" represent measures that also utilize the gap closure target methodology.[1] For MMPs 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 MMP fully reports all applicable quality withhold measures. Affected MMPs are identified according to the methodology utilized for Medicare Part C and D Star Ratings for the applicable measurement year. These MMPs 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)
- **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 (<140/90) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes 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 PDE data, submitted timely in compliance with demonstration requirements. (CW13)

[1]California Medicare-Medicaid Plan Quality Withhold Analysis Results Demonstration Year 3:
https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/QualityWithholdResultsReportCADY3.pdf

- **Behavioral Health Shared Accountability Process Measure:** Percent of members receiving Medi-Cal specialty mental health services that received care coordination with the primary mental health provider. (California specific measure CA1.7, CAW6)
- **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)

Quality Withhold Trends:

The latest data available show that all 10 Plans met at least four quality withhold measures for Calendar Year 2017. Nine of the ten Plans received 100% of their withhold: Anthem, Blue Shield, CHG, 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.
    - Plans must complete assessments for high risk members within 45 days of enrollment, and for low-risk members within 90 days. 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.

- **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 Q3 2018 to 88% in Q2 2019. Figure 9 shows that four out of ten Plans (Anthem, Blue Shield, Health Net, and HPSM) are below the statewide average of 88% for Q2 2019.

Figure 10 indicates that the percentage of members with an ICP has slightly decreased from 69% in Q3 2018 to 68% in Q2 2019. Figure 11 indicates that in five of the ten Plans (Blue Shield, IEHP, L.A. Care, CalOptima and SCFHP), the percentage of members with an ICP is below the statewide average of 68% for Q2 2019. 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 will also be 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 17 and 18 show a breakdown of a total of 15,303 grievances, by category and by Plan, filed by members in 2018. This is an increase of 6,231 member grievances reported as compared to 2017[1]. The Plans that contributed the most to the increased grievance in 2018 are IEHP, CalOptima, L.A. Care, SCFHP, and Molina. 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. Figures 16 shows that a total of 3,484 appeals were filed by members in 2018, an increase of 1,987 appeals when compared to 2017[1]. The Plans that contributed the most to the increase in appeals are HealthNet, Molina and IEHP. Figure 16 also shows that 30% of Plan decisions were either fully or partially favorable to the member's appeal filed in 2018. 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 March 2019: https://www.dhcs.ca.gov/Documents/CMCDashboard3.19.pdf

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 24.9 visits per 10,000 member months in Q1 2018 to 19.1 visits in Q4 2018. In mid-2017, Plans began to receive additional and more accurate behavioral health data that may begin to affect 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 Services 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).

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 services, 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 279.9 members per 1,000 receiving LTSS in Q3 2018, to an average of 297.0 members in Q2 2019.

Figure 24 shows that IHSS utilization per 1,000 members has similarly increased slightly throughout reporting period from an average of 236.1 members per 1,000 receiving IHSS in Q3 2018, to an average of 250.9 members in Q2 2019.

Figure 26 shows that CBAS referrals per 1,000 members have increased from an average of 1.6 member referrals per 1,000 in Q3 2018 to an average 2.3 member referrals per 1,000 in Q2 2019. IEHP reported the highest number of CBAS referrals of 4.7 per 1,000 members in Q2 2019, as shown in Figure 27. Figure 28 shows that CBAS utilization per 1,000 members has increased slightly from 10.0 members per 1,000 receiving CBAS in Q3 2018 to 10.8 members per 1,000 receiving CBAS in Q2 2019.

Figure 30 shows that MSSP referrals per 1,000 members have increased slightly from an average of 0.7 per 1,000 in Q3 2018 to an average of 0.8 per 1,000 in Q2 2019. Figure 31 shows that HPSM reported the highest number of MSSP referrals of 2.1 per 1,000 members in Q2 2019. Figure 32 shows that MSSP utilization per 1,000 members has shifted slightly over time from 5.7 in Q3 and Q4 2018 to 5.5 in Q1 2019 and up again to 5.9 members in Q2 2019. 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 increased from an average of 3.8 member referrals per 1,000 in Q3 2018 to an average 5.6 member referrals per 1,000 in Q2 2019. Figure 35 shows that Blue Shield reported the highest number of NF referrals of 24.5 per 1,000 members respectively in Q2 2019. Figure 36 shows that NF utilization per 1,000 members has increased from 28.2 members per 1,000 in Q3 2018 to 29.4 members per 1,000 in Q2 2019.

Figure 38 shows that CPO referrals per 1,000 members has decreased from an average of 9.2 member referrals per 1,000 in Q3 2018 to an average of 0.8 member referrals per 1,000 in Q2 2019. Figure 39 shows that CHG reported the highest number of CPO referrals of 4.4 per 1,000 members in Q2 2019. Figure 40 shows that CPO utilization per 1,000 members has decreased from 18.6 members per 1,000 in Q3 2018 to 1.8 members per 1,000 in Q2 2019. The decline in CPO utilization data is due to the impact of DHCS efforts to clarify CPO service definitions and interpretation of qualified services with the Plans. 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:

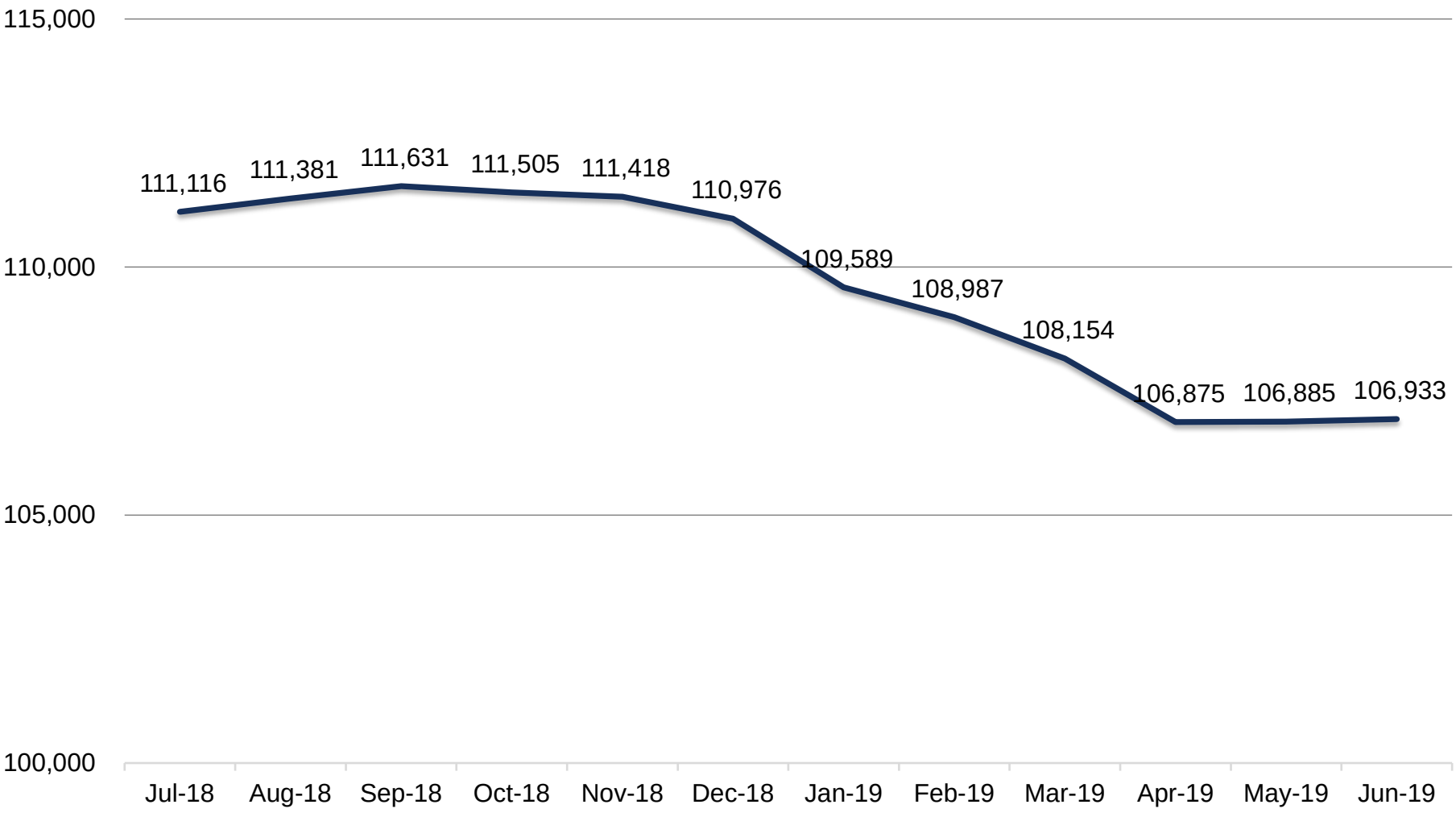
Plan Name	Plan Abbreviation on Dashboard
Anthem Blue Cross Partnership of California	Anthem
Blue Shield of California Promise Health	Blue Shield
CalOptima	CalOptima
Community Health Group	CHG
Health Net	Health Net
Health Plan of San Mateo	HPSM
Inland Empire Health Plan	IEHP
L.A. Care	L.A. Care
Molina 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 06/1/2019)

See metric summary for additional information

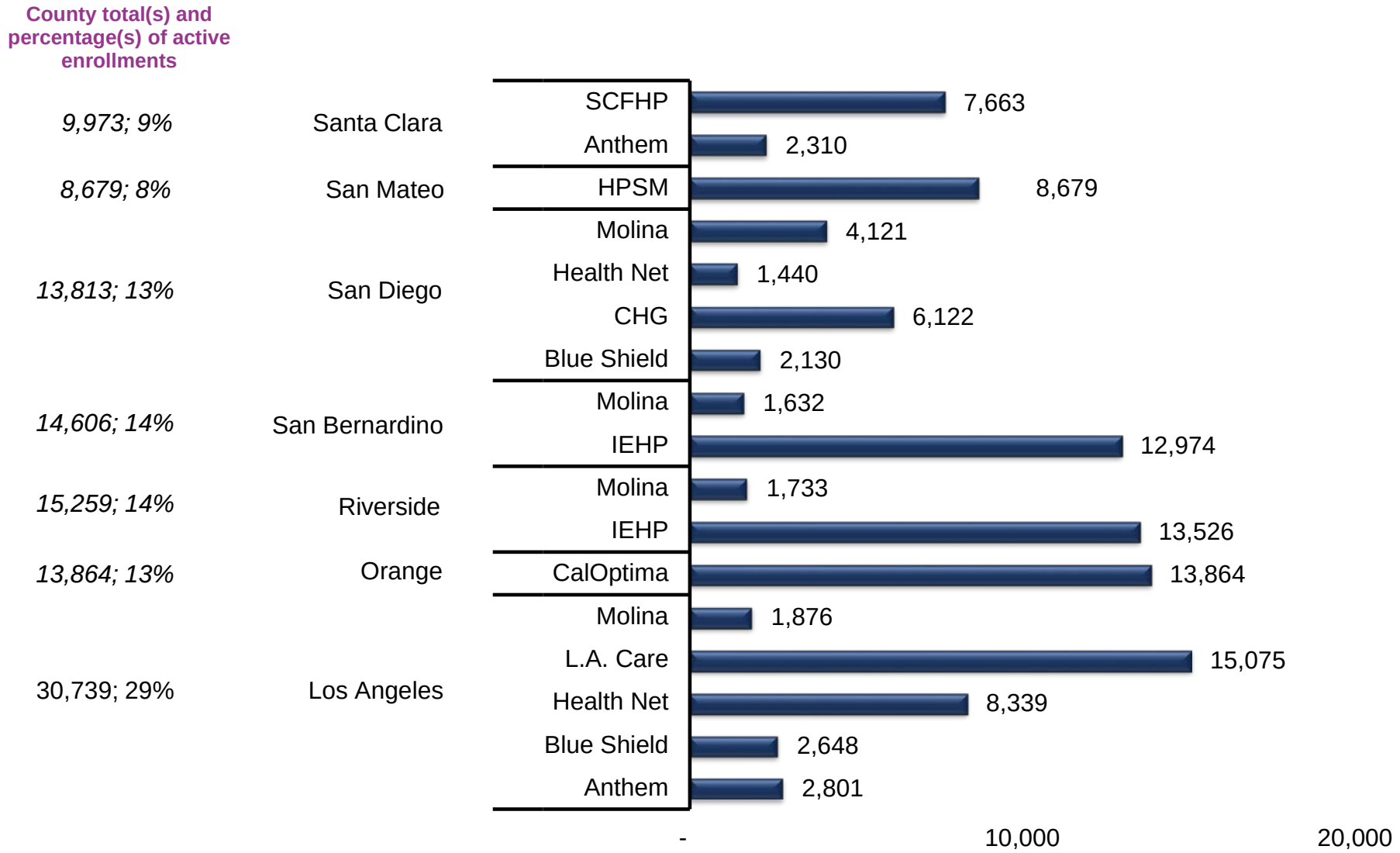
Fig. 1: Monthly Enrollment



Cal MediConnect Enrollment and Demographics Figure 2: Breakdowns of Dual Populations (As of 06/1/2019)

See metric summary for additional information

Fig. 2: Count and Percentage of Total Active Enrollments, by County and Plan as of June 2019



Cal MediConnect Enrollment and Demographics Figure 3 - 6: Breakdowns of Dual Populations (As of 06/1/2019)

See metric summary for additional information

Fig. 3: Quarter 2 Enrollment by Race/Ethnicity

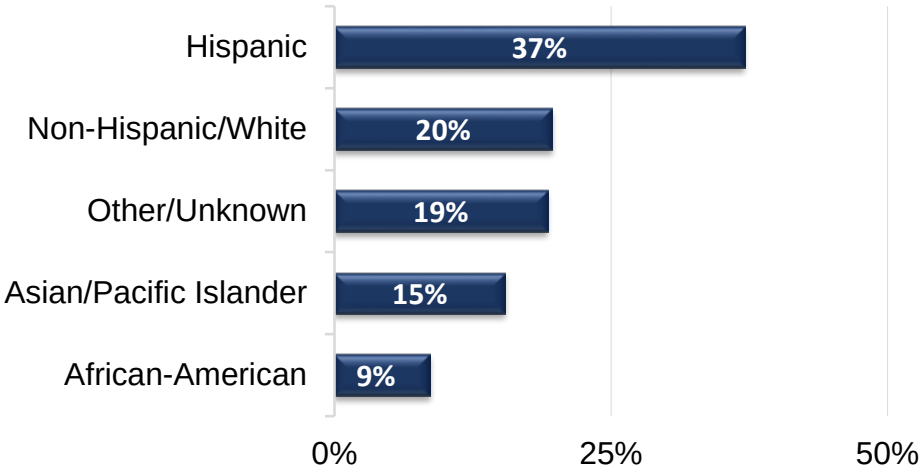


Fig. 4: Quarter 2 Enrollment by Age

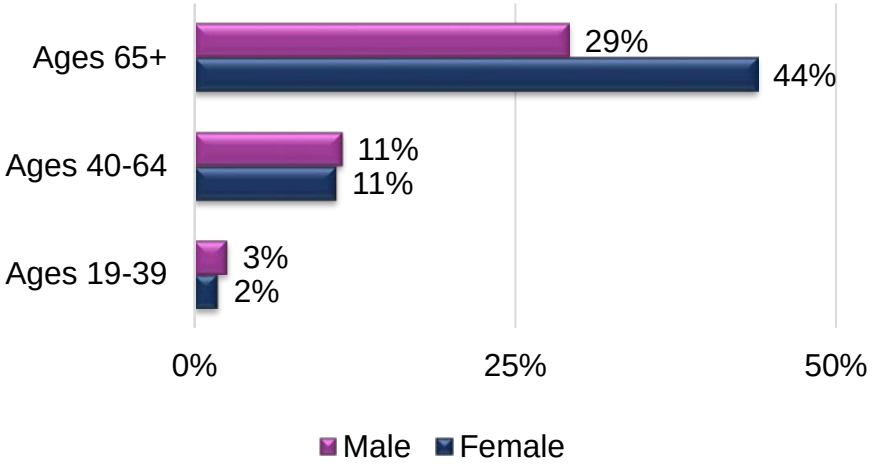


Fig. 5: Quarter 2 Enrollment by Threshold Language Spoken

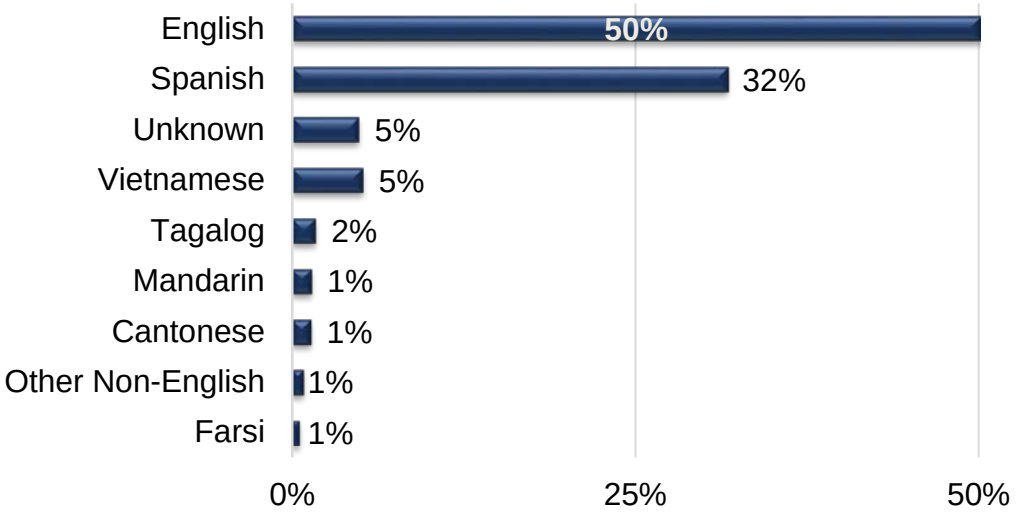
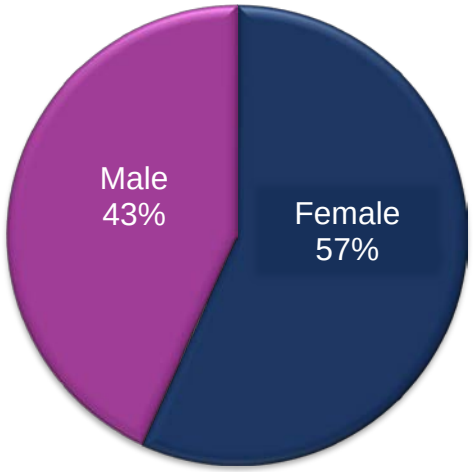


Fig. 6: Quarter 2 Enrollment by Gender



Cal MediConnect Figure 7: Quality Withhold Summary Table (CY 2017)
See metric summary for additional information

Medicare-Medicaid Plan	CW6 Benchmark: 1.00	CW7* Benchmark: 69%	CW8* Benchmark: 56%	CW11* Benchmark: 56%	CW12* Benchmark: 73%	CW13 Benchmark: 80%
Anthem	Met	Met	Met	Met	Met	Met
Blue Shield	Met	Not Met	Not Met	Met	Met	Not Met
CHG	Met	Met	Met	Met	Met	Met
Health Net	Met	Not Met	Met	Met	Met	Not Met
IEHP	Met	Not Met	Not Met	Met	Met	Not Met
L.A. Care	Met	Met	Met	Met	Met	Met
Molina	Met	Met	Not Met	Met	Met	Met
CalOptima	Met	Met	Not Met	Met	Met	Met
HPSM	Met	Met	Met	Met	Met	Met
SCFHP	Met	Met	Met	Met	Met	Met

Medicare-Medicaid Plan	CAW6 Benchmark: 90%	CAW7 Benchmark: 10% Decrease	CAW8* Benchmark: 55%	CAW9* Benchmark: 78%	Total # of Measures	Total # Met	% Met	% of Withhold Received
Anthem+	Not Met	Met	Met	Met	10	9	90%	100%
Blue Shield^	Met	Not Met	Not Met	Not Met	10	4	40%	100%
CHG+	Not Met	Met	Met	Met	10	9	90%	100%
Health Net^	Met	Met	Not Met	Met	10	7	70%	100%
IEHP	Met	Met	Met	Not Met	10	6	60%	75%
L.A. Care+	Met	Not Met	Met	Met	10	9	90%	100%
Molina^	Not Met	Met	Met	Not Met	10	7	70%	100%
CalOptima^	Not Met	Met	Met	Not Met	10	7	70%	100%
HPSM	Not Met	Met	Met	Met	10	9	90%	100%
SCFHP	Not Met	Met	Not Met	Met	10	8	80%	100%
California Averages					**10**	**8**	**75%**	**98%**

"*" Indicate measures that utilize the gap closure target methodology.
"^" Represent MMPs that are eligible and received quality withhold adjustment due to the wildfires in California during 2017.
"+" Represent MMPs that are eligible, but earned 100% withhold without requiring the quality withhold adjustment.

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 (07/2018-06/2019). 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

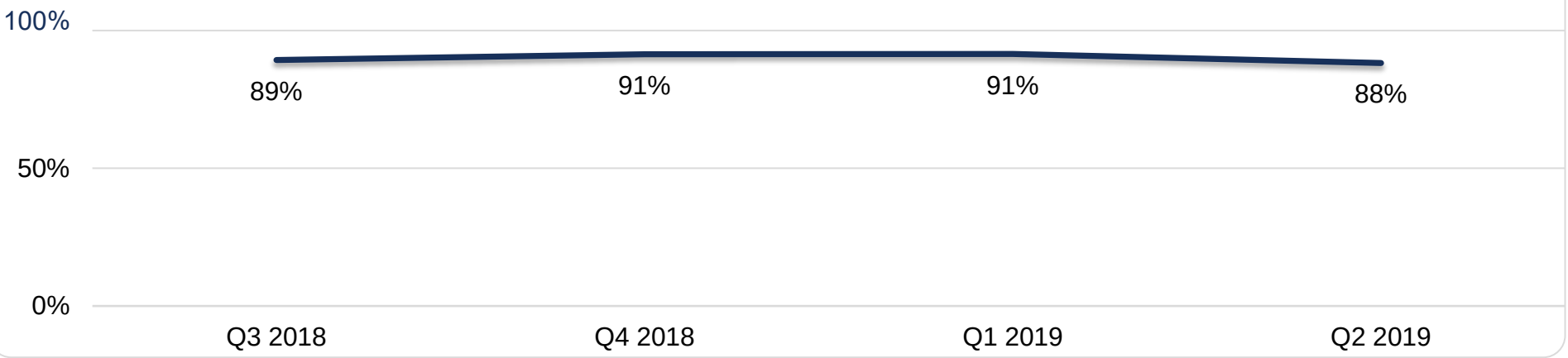
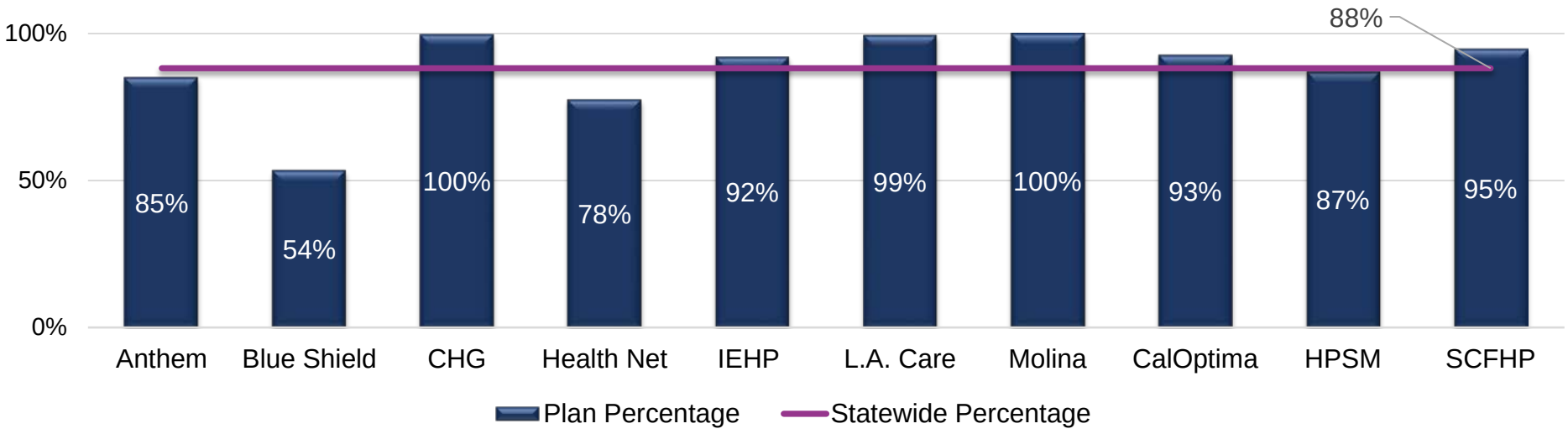


Fig. 9: The Percentage of Members Willing to Participate and who the Plan was able to Locate with an Assessment Completed Within 90 Days of Enrollment for Quarter 2 of 2019



Care Coordination Figure 10 & 11: Percentage of Members with an Individualized Care Plan (ICP) (07/2018-06/2019)

See metric summary for additional information

Fig. 10: Quarterly Rolling Statewide Percentage of Members with an ICP

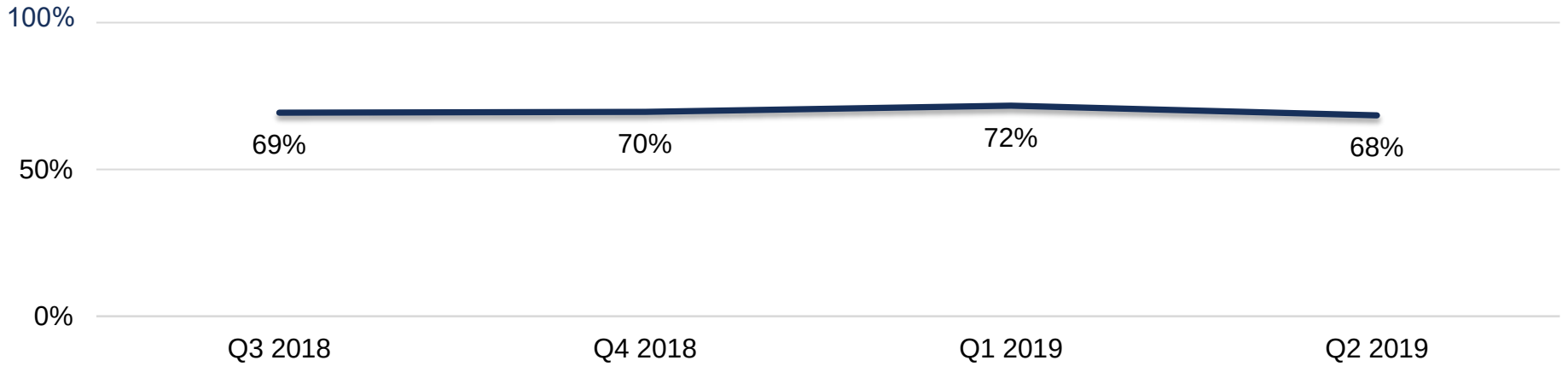
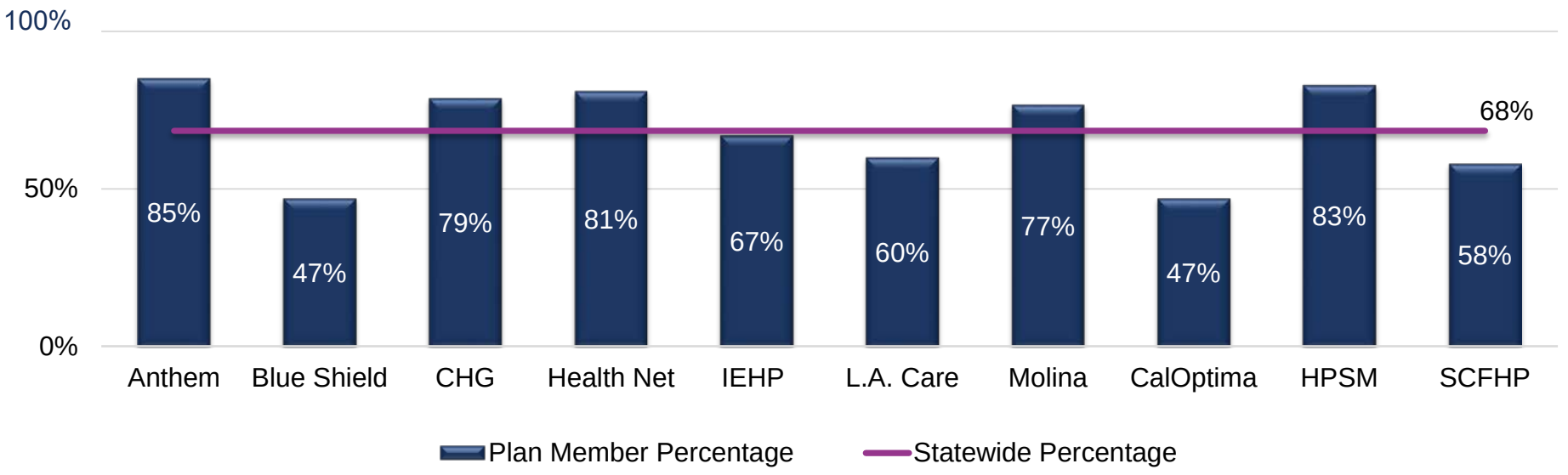
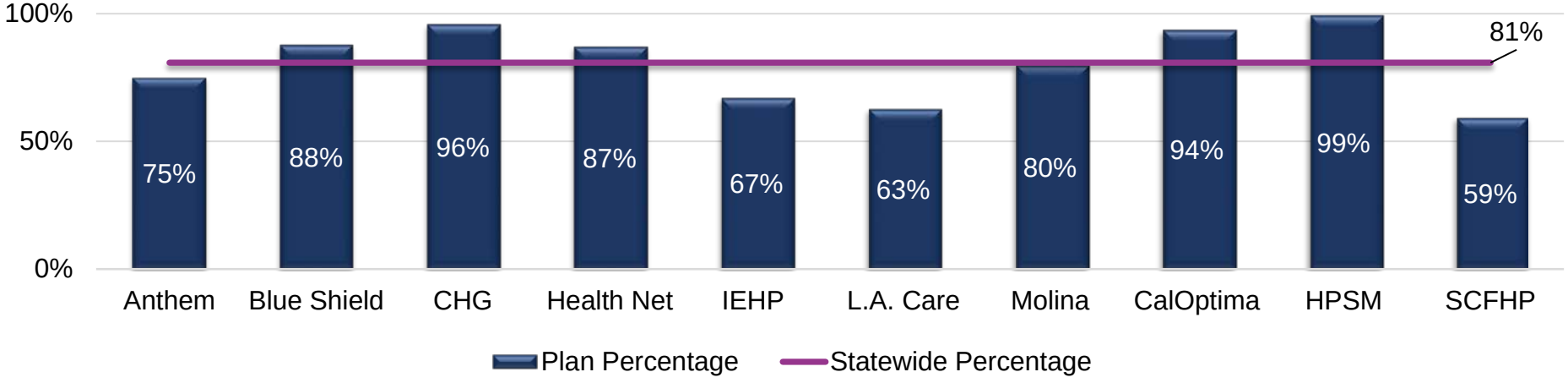


Fig. 11: Percentage of Members with an ICP for Quarter 2 of 2019



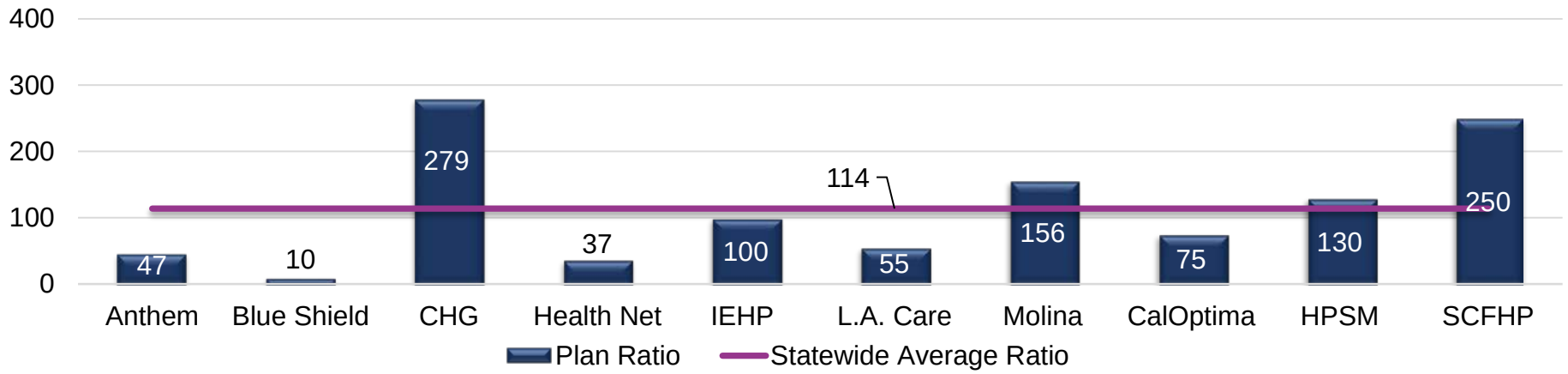
Care Coordination Figure 12: Percentage of Members Who Have a Care Coordinator and Have at Least One Care Team Contact During the Reporting Period (01/2018-12/2018). See metric summary for additional information

Fig. 12: Annual (2018) Percentage of Members who have a Care Coordinator and have at least One Care team Contact During the Reporting Period



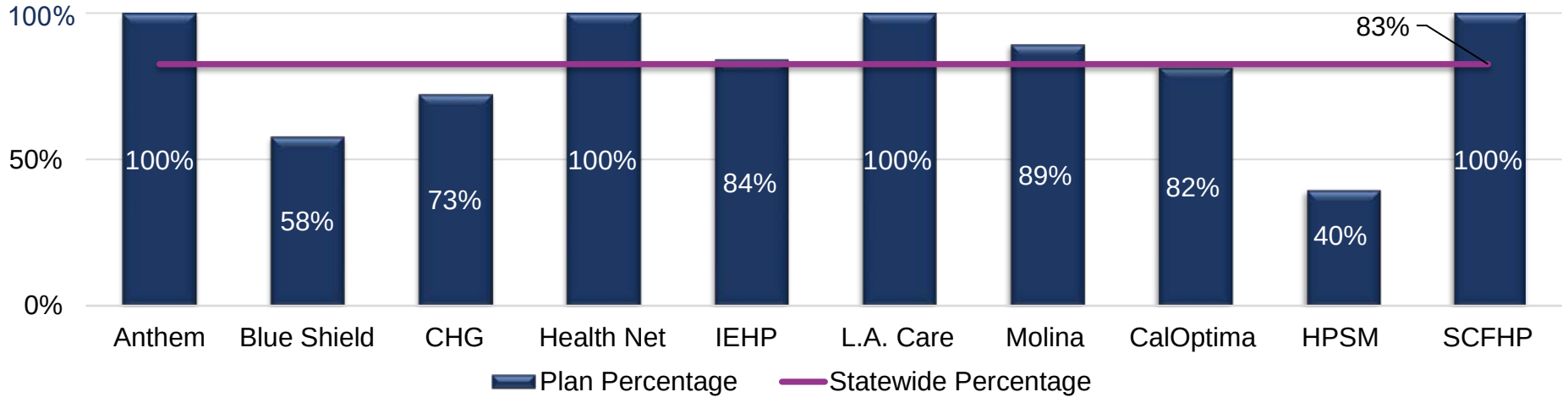
Care Coordination Figure 13: Member to Care Coordinator Ratio (01/2018-12/2018) See metric summary for additional information

Fig. 13: Annual (2018) Number of Members to Care Coordinator Ratio



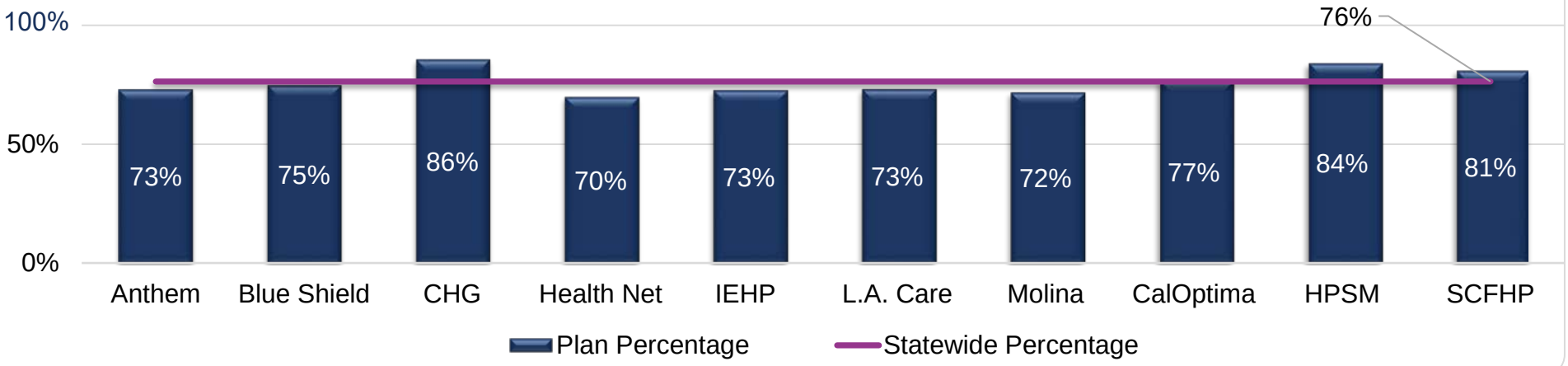
Care Coordination Figure 14: Percentage of Members with Documented Discussions of Care Goals (01/2018-12/2018) See metric summary for additional information

Fig. 14: Annual (2018) Percentage of Members with Documented Discussions of Care Goals



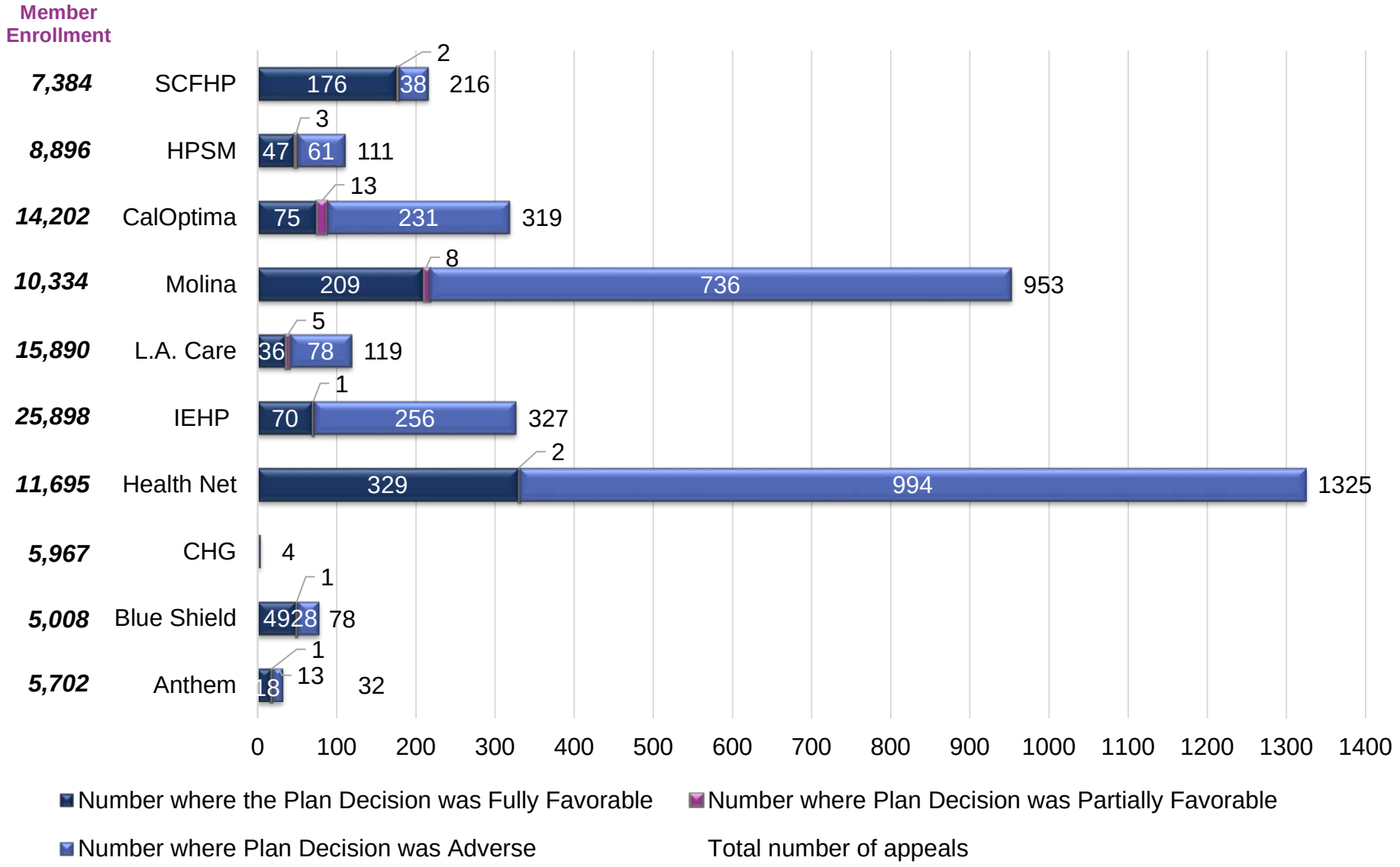
Care Coordination Figure 15: Percentage of Members with First Follow-up Visit within 30 Days after Hospital Discharge (01/2018-12/2018). See metric summary for additional information

Fig. 15: Annual (2018) Percentage of Members with First Follow-Up Visit within 30 Days after Hospital Discharge



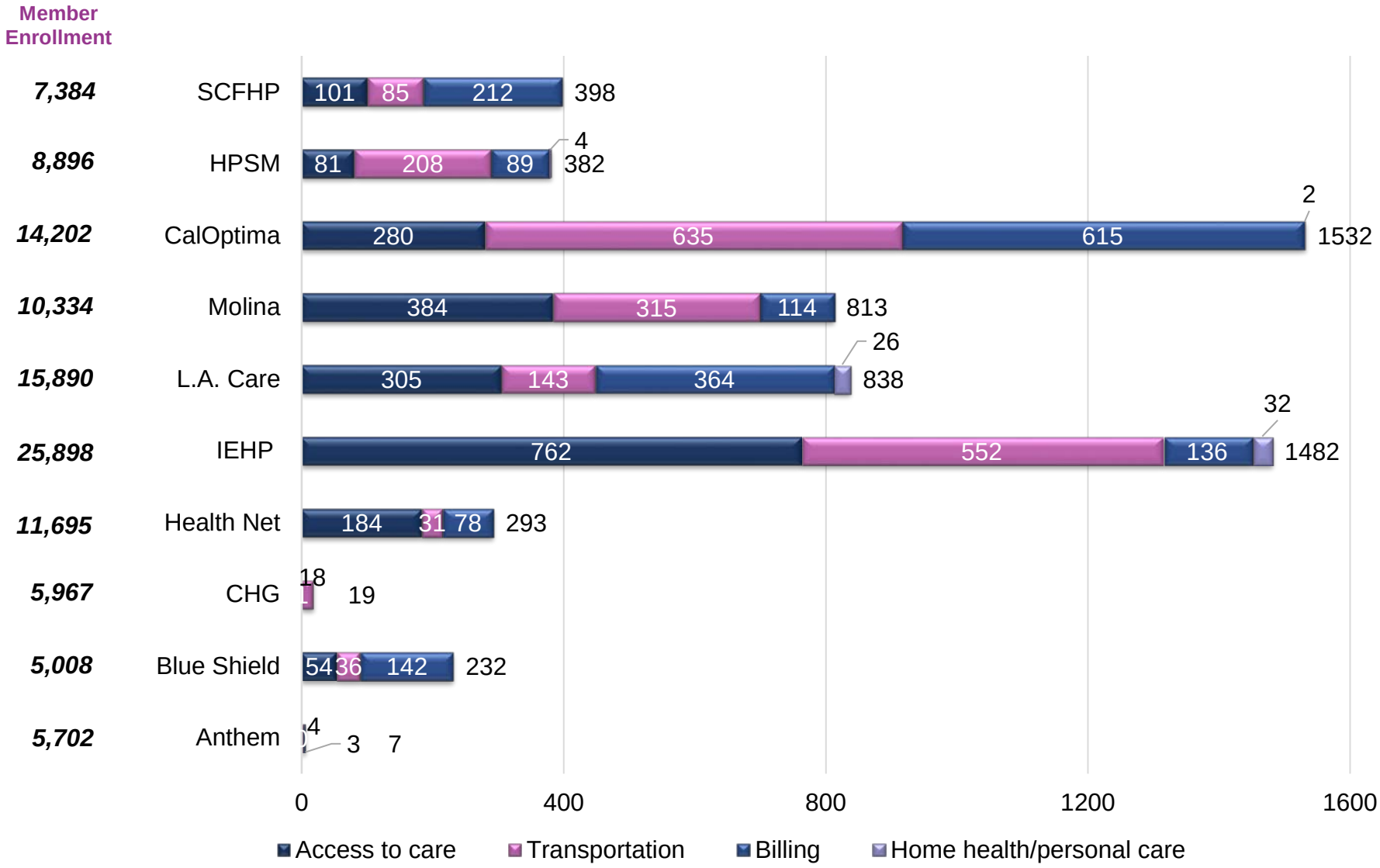
Appeal Figure 16: Count of Appeals (01/2018-12/2018). See metric summary for additional information

Fig. 16: Annual Count of Appeals Broken Down by Outcome



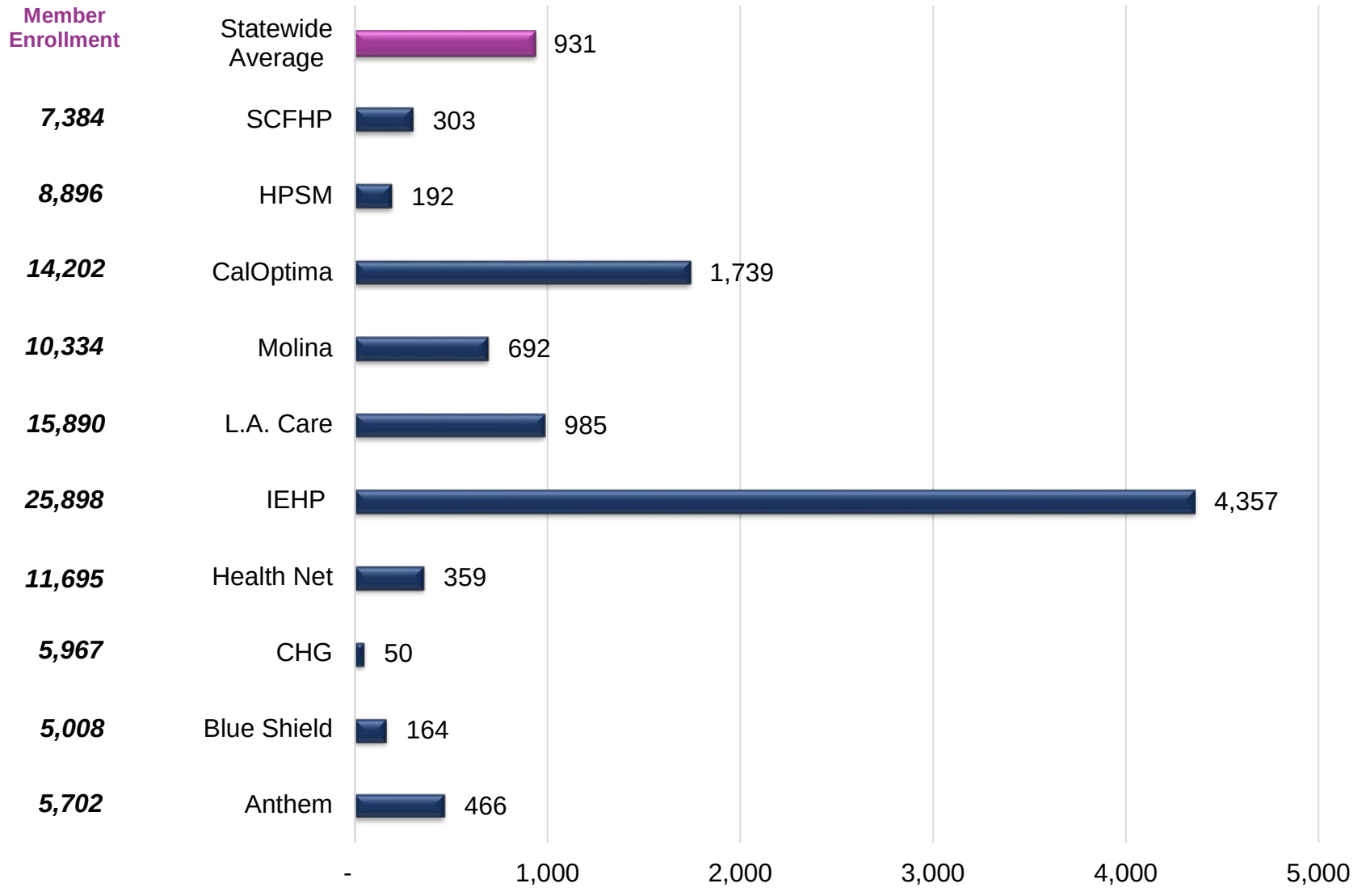
Grievance Figure 17: Count Grievances by type, Except "Other" (01/2018-12/2018)
See metric summary for additional information

Fig. 17: Annual Count of Grievances Broken Down by Type, besides "Other"



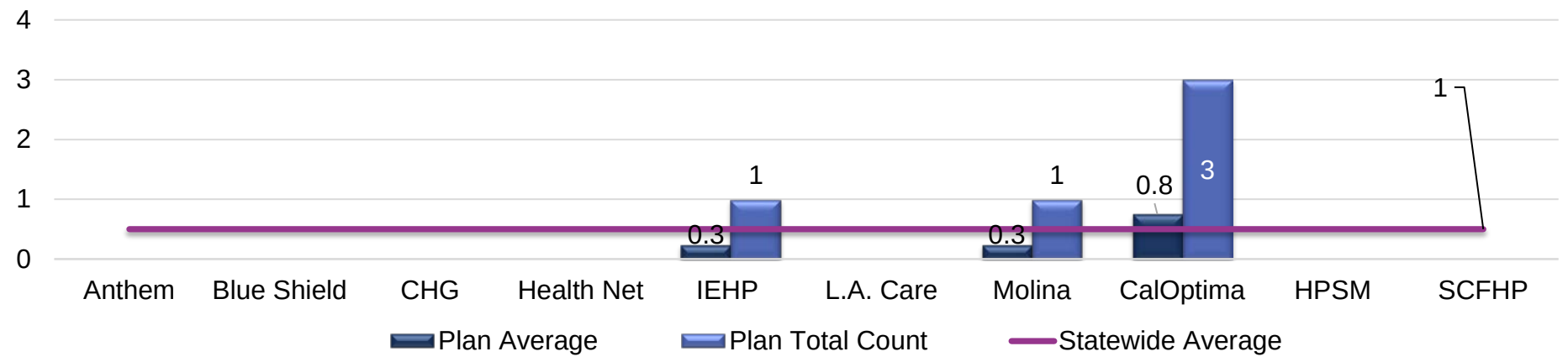
Grievance Figure 18: Count of "Other" Grievances (01/2018-12/2018). See metric summary for additional information

Fig. 18: Annual Count of "Other" Grievances



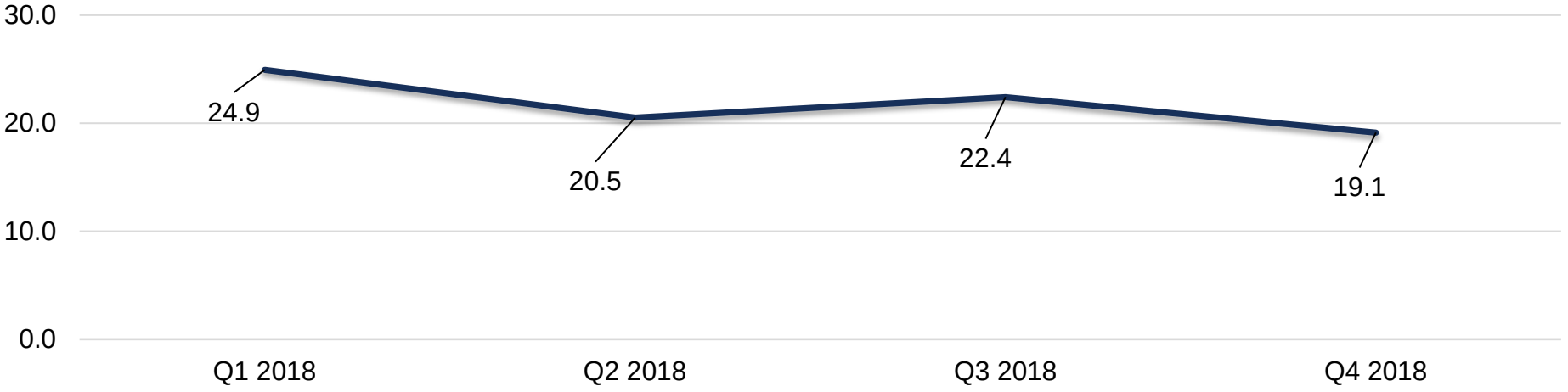
Appeals Figure 19: Total Number of Appeals Related to the Denial or Limited Authorization of Mental Health Services (01/2018-12/2018). See metric summary for additional information

Fig. 19: Annual (2018) Total of all Appeals Related to the Denial or Limited Authorization of Mental Health Services



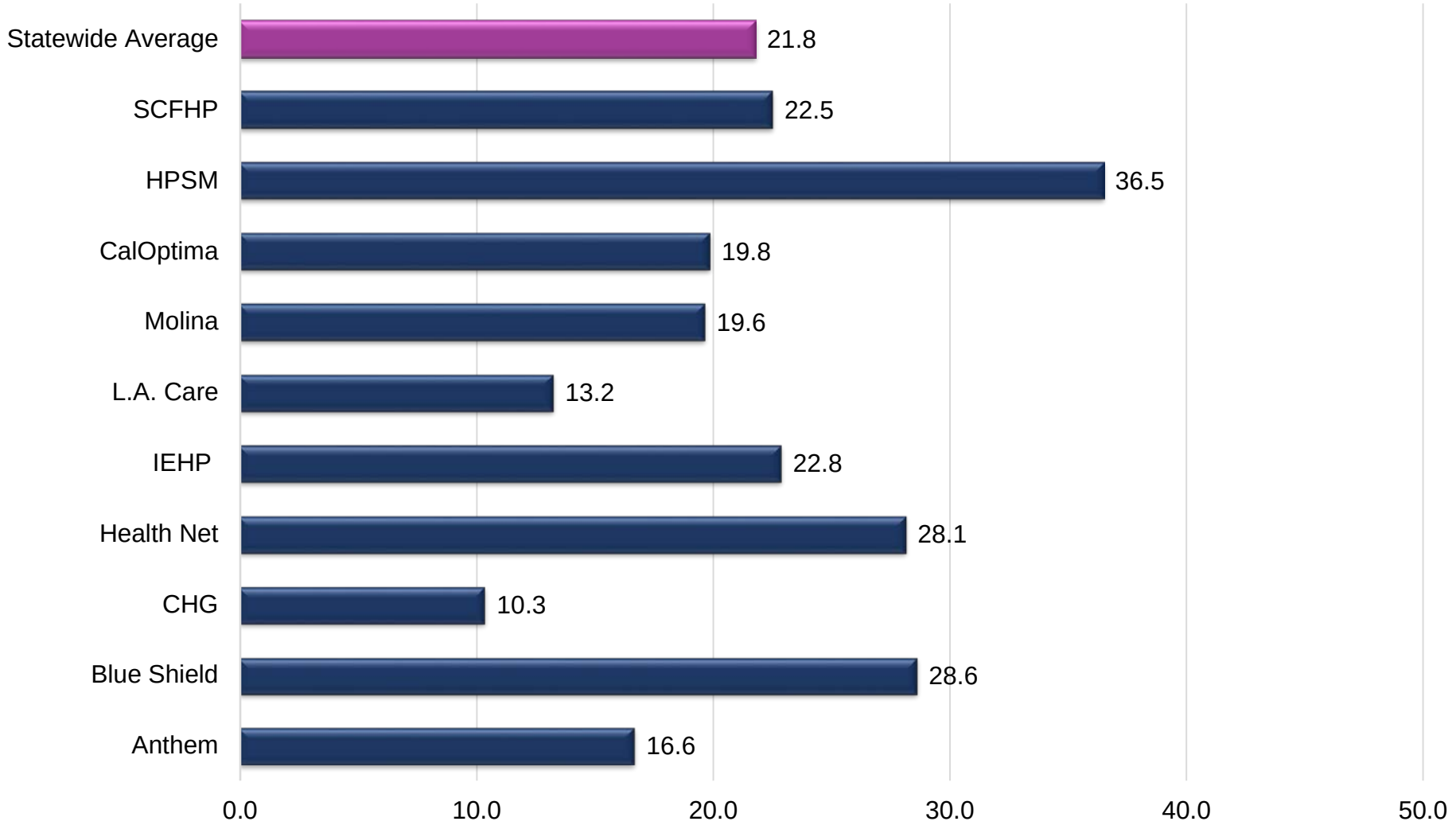
Behavioral Health Figure 20: Emergency Room Behavioral Health Services Utilization per 10,000 Member Months (01/2018-12/2018). See metric summary for additional information

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 (01/2018-12/2018). See metric summary for additional information

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



Long Term Services & Supports (LTSS) Figure 22 & 23: Utilization of Members Receiving LTSS per 1,000 Members (07/2018-06/2019). See metric summary for additional information

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

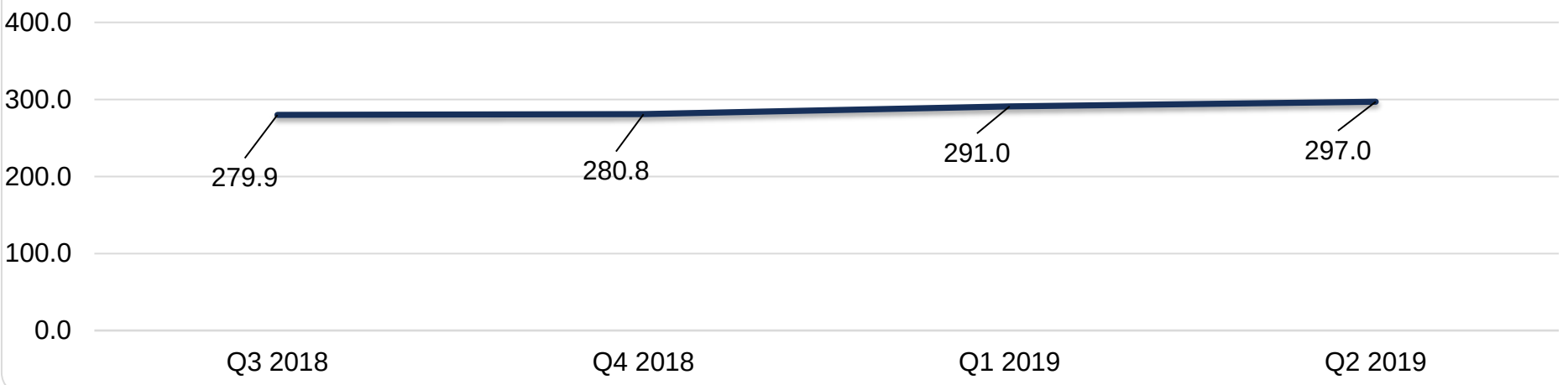
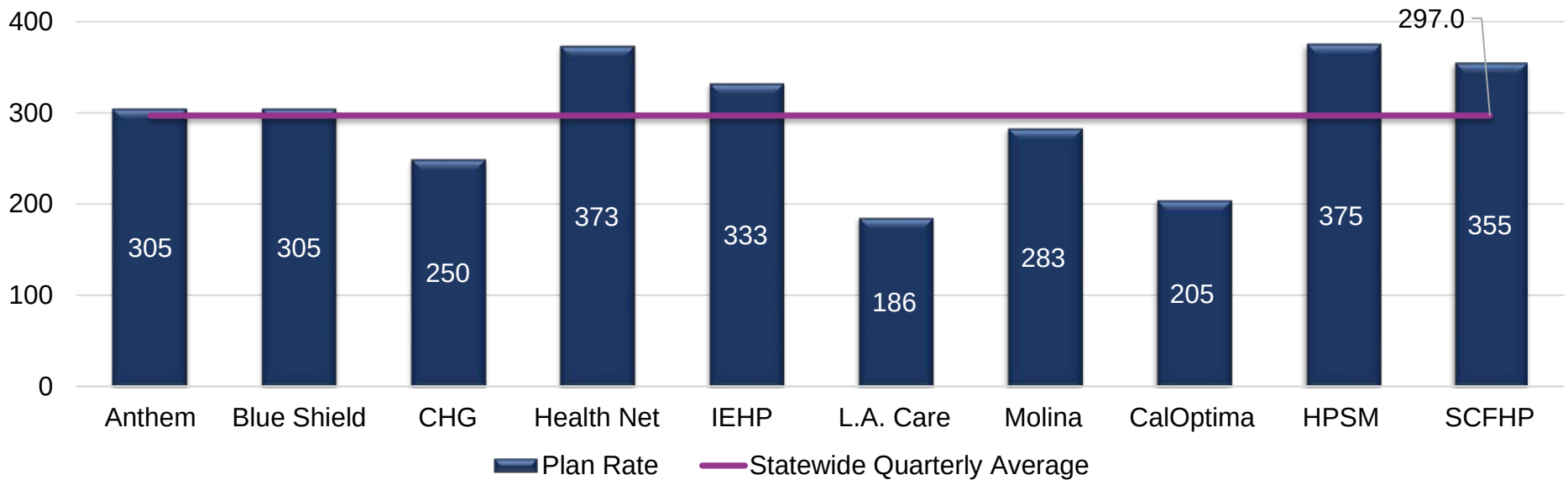


Fig. 23: Count of Members Receiving LTSS per 1,000 members for Quarter 2 of 2019



Long Term Services & Supports (LTSS) Figure 24 & 25: Count of IHSS per 1,000 Members (07/2018-06/2019)

See metric summary for additional information

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

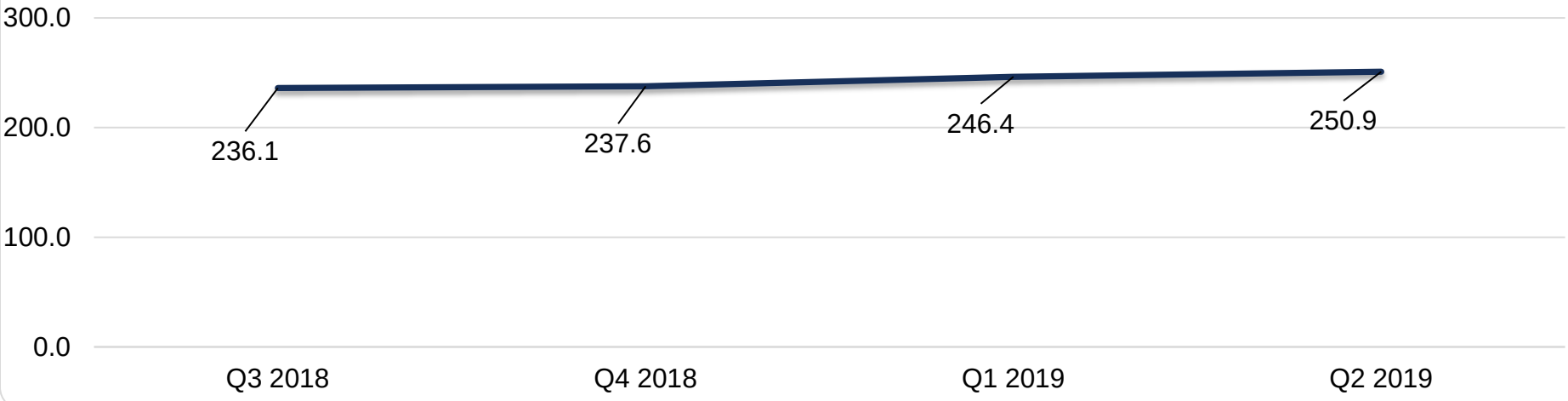
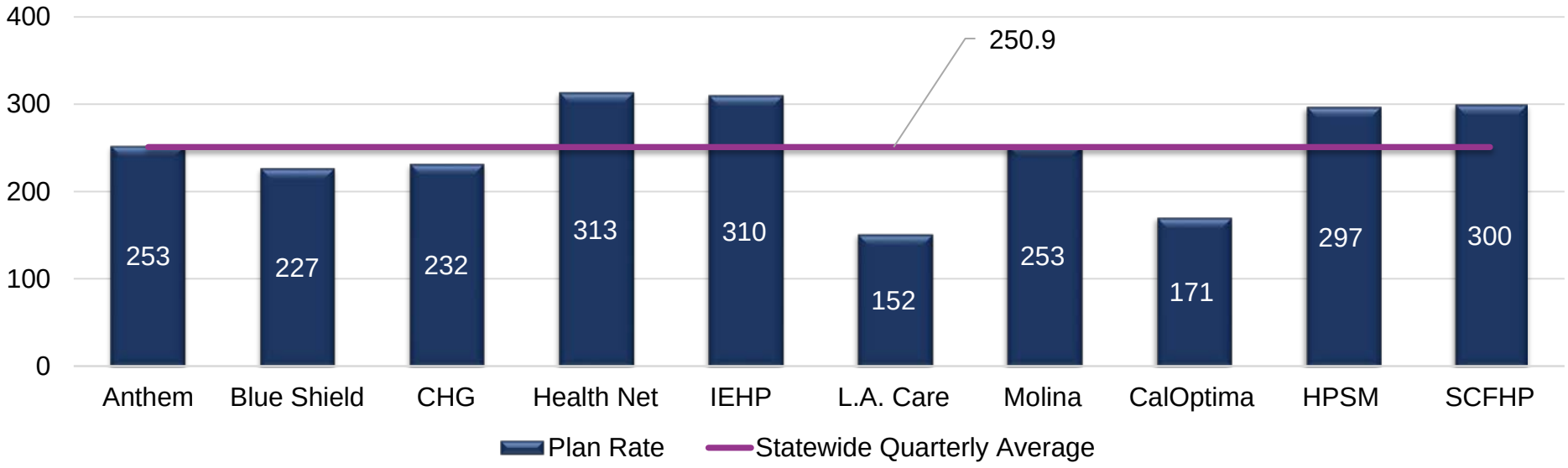


Fig. 25: Count of Members Receiving IHSS per 1,000 members for Quarter 2 of 2019



Long Term Services & Supports (LTSS) Figure 26 & 27: Count of CBAS per 1,000 Members (07/2018-06/2019)

See metric summary for additional information

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

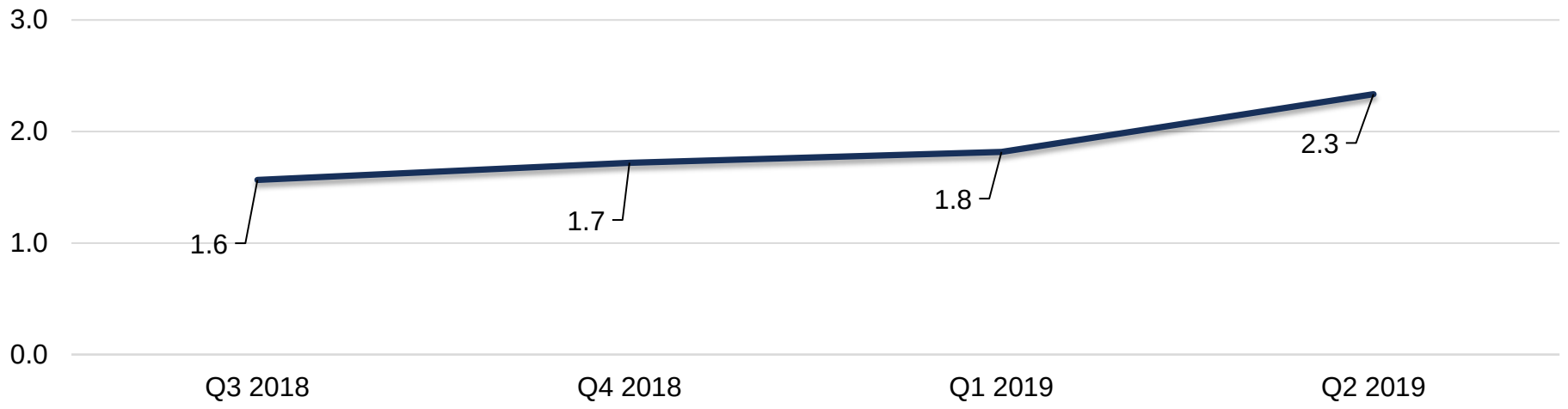
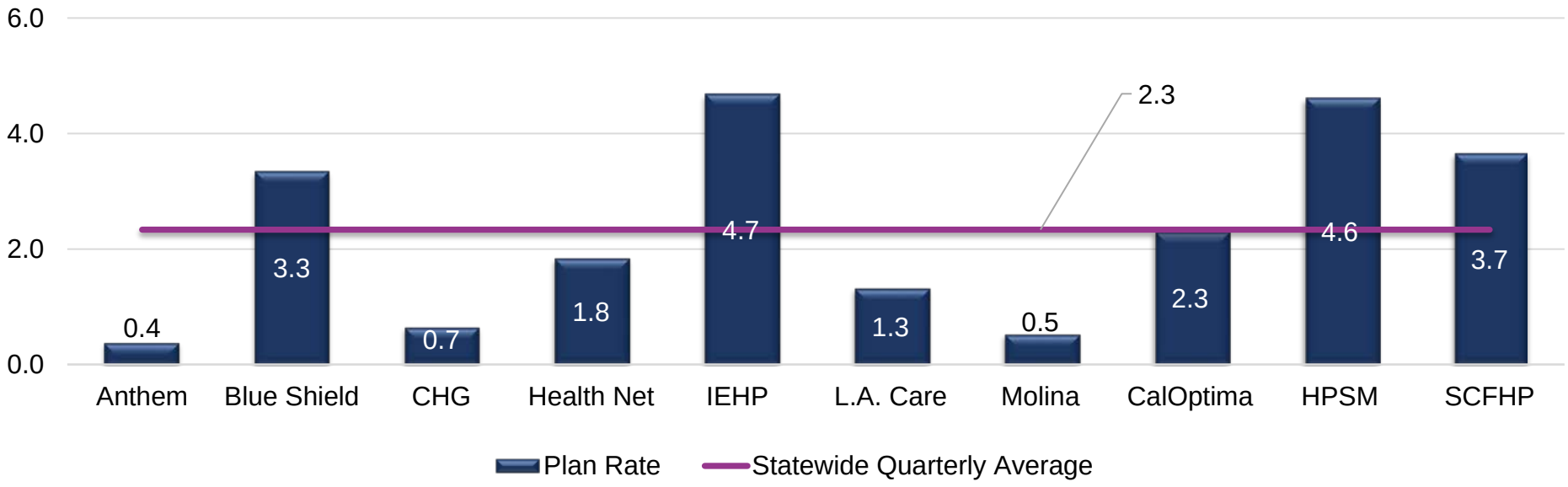


Fig. 27: Count of CBAS Member Referrals per 1,000 members for Quarter 2 of 2019



Long Term Services & Supports (LTSS) Figure 28 & 29: Count of CBAS per 1,000 Members (07/2018-06/2019)

See metric summary for additional information

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

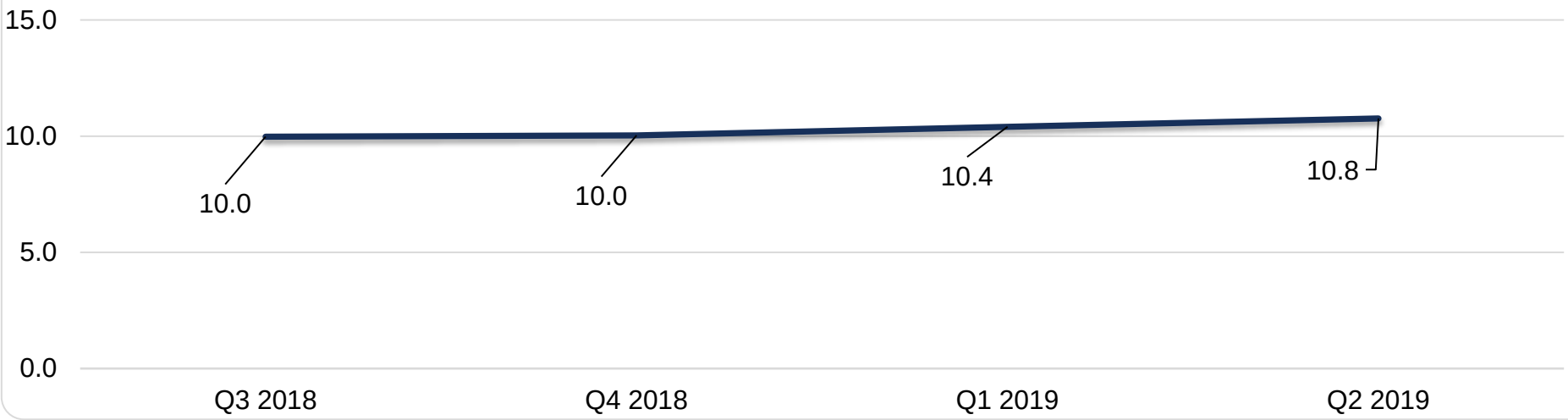
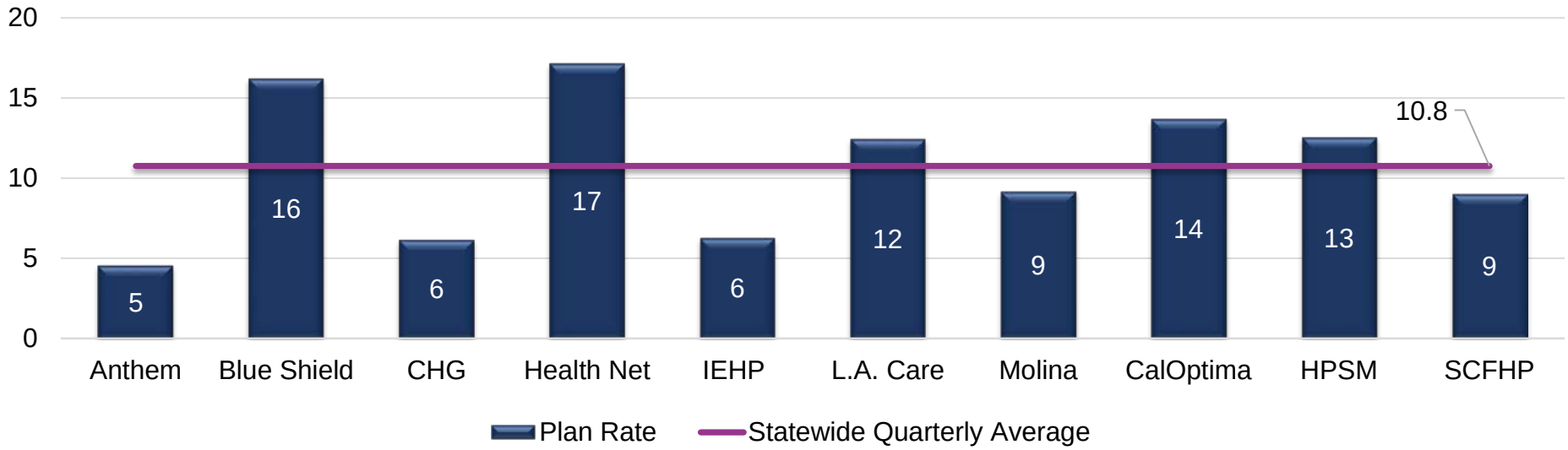


Fig. 29: Count of Members Receiving CBAS per 1,000 members for Quarter 2 of 2019



Long Term Services & Supports (LTSS) Figure 30 & 31: Count of MSSP per 1,000 Members (07/2018-06/2019)

See metric summary for additional information

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

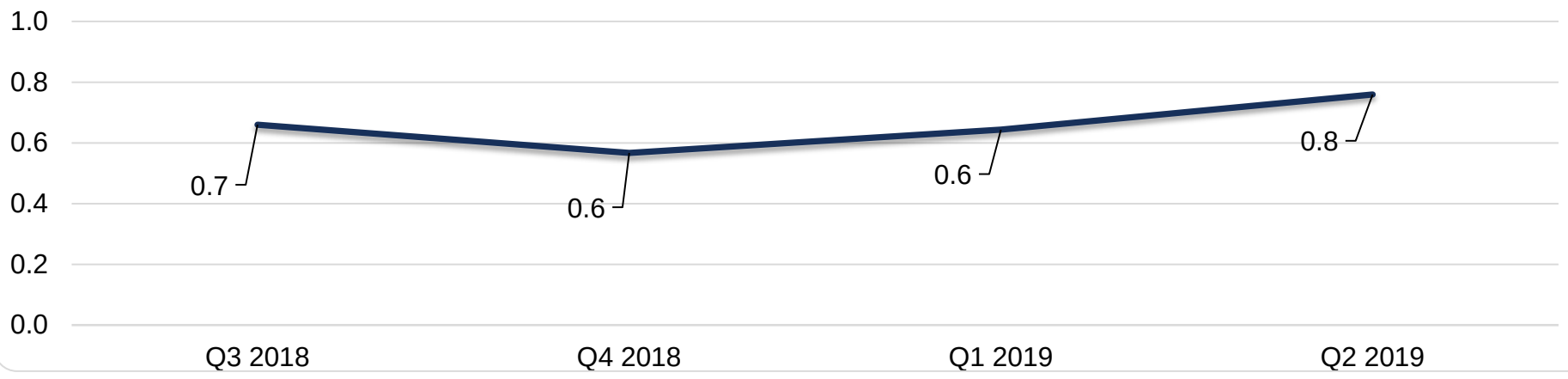
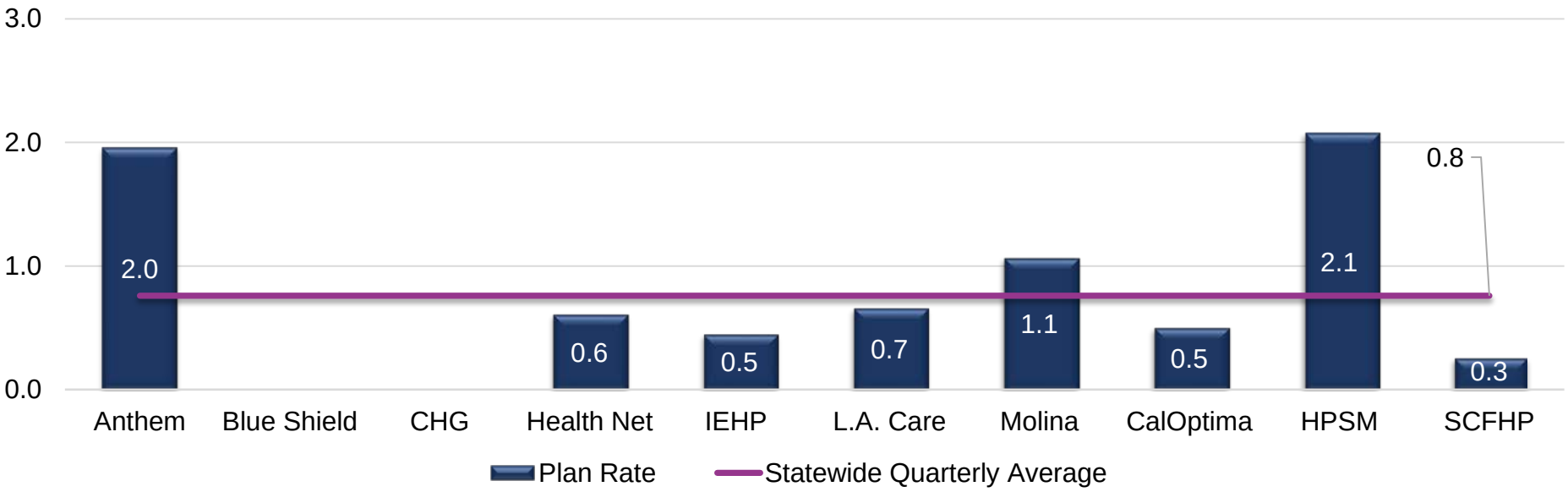


Fig. 31: Count of MSSP Member Referrals per 1,000 members for Quarter 2 of 2019



Long Term Services & Supports (LTSS) Figure 32 & 33: Count of MSSP per 1,000 Members (07/2018-06/2019)

See metric summary for additional information

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

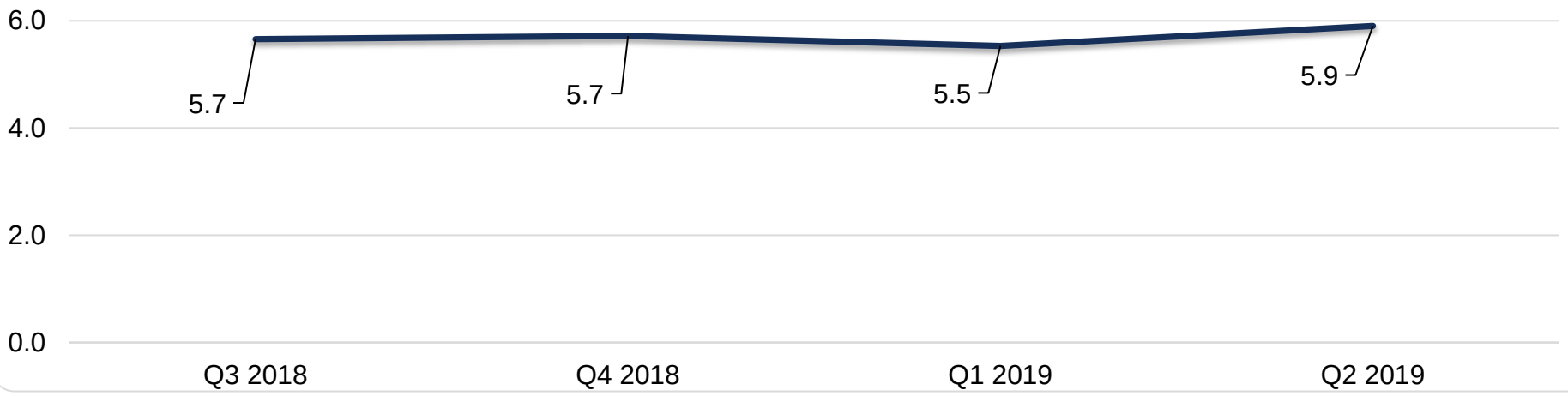
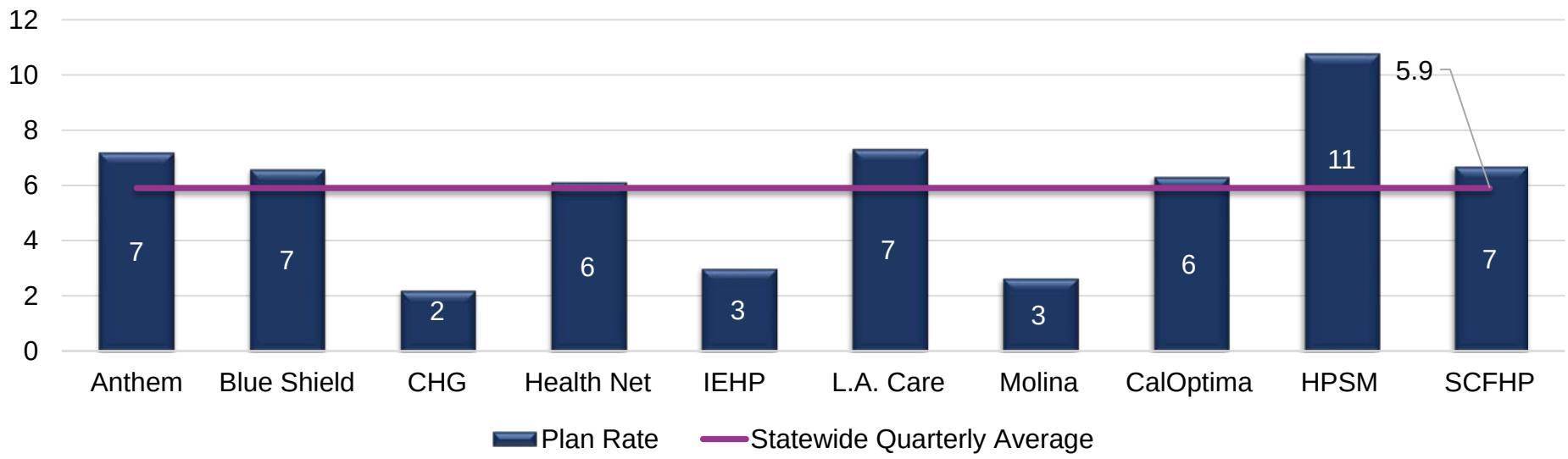


Fig. 33: Count of Members Receiving MSSP per 1,000 members for Quarter 2 of 2019



Long Term Services & Supports (LTSS) Figure 34 & 35: Count of NF per 1,000 Members (07/2018-06/2019)

See metric summary for additional information

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

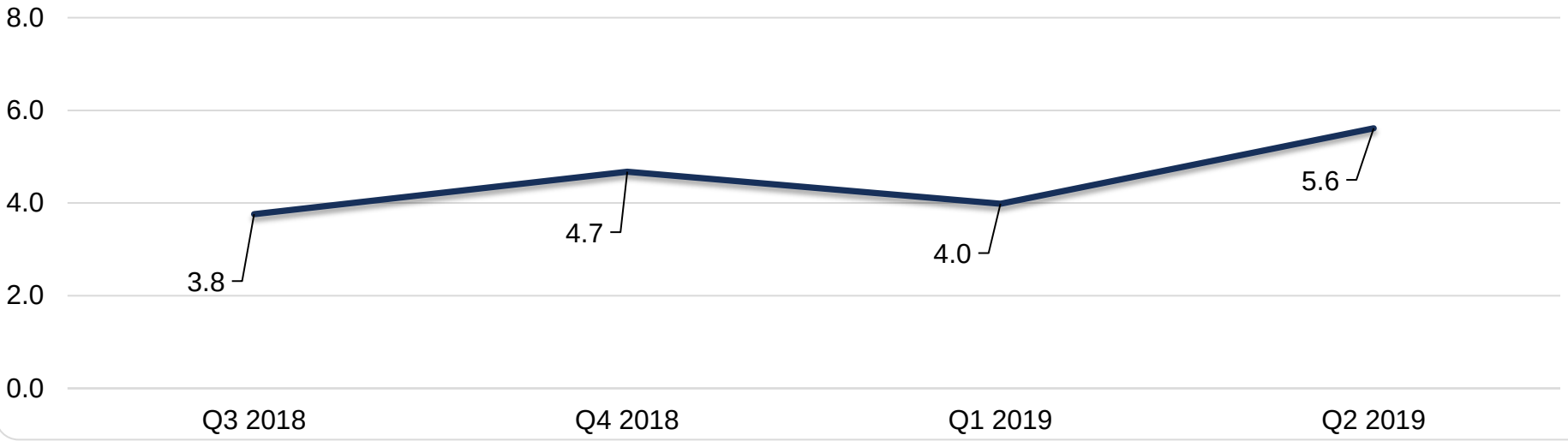
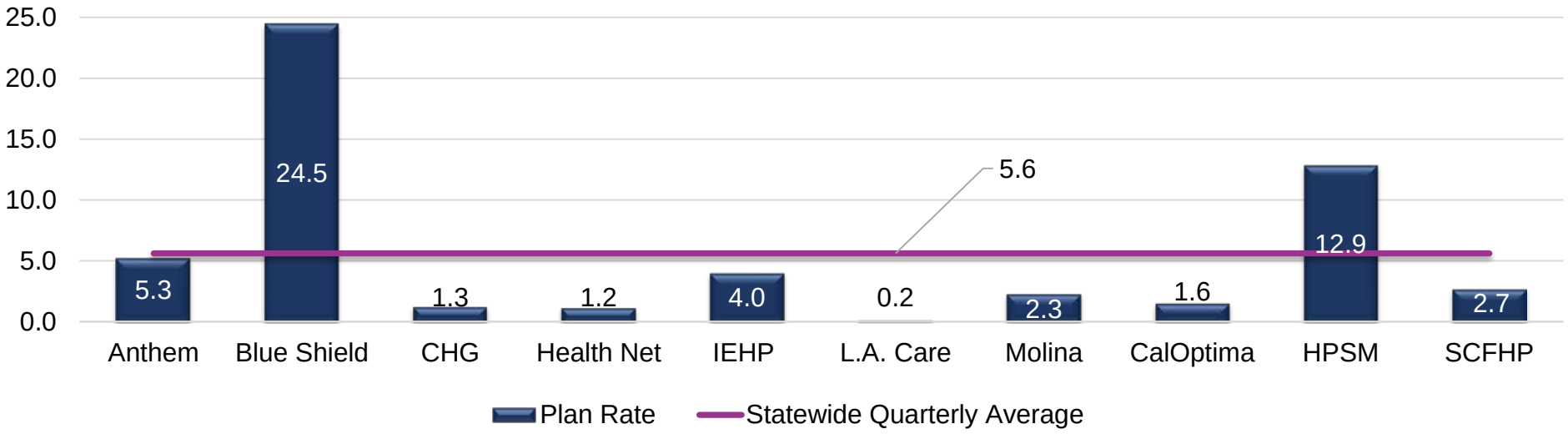


Fig. 35: Count of NF Member Referrals per 1,000 members for Quarter 2 of 2019



Long Term Services & Supports (LTSS) Figure 36 & 37: Count of NF per 1,000 Members (07/2018-06/2019)

See metric summary for additional information

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

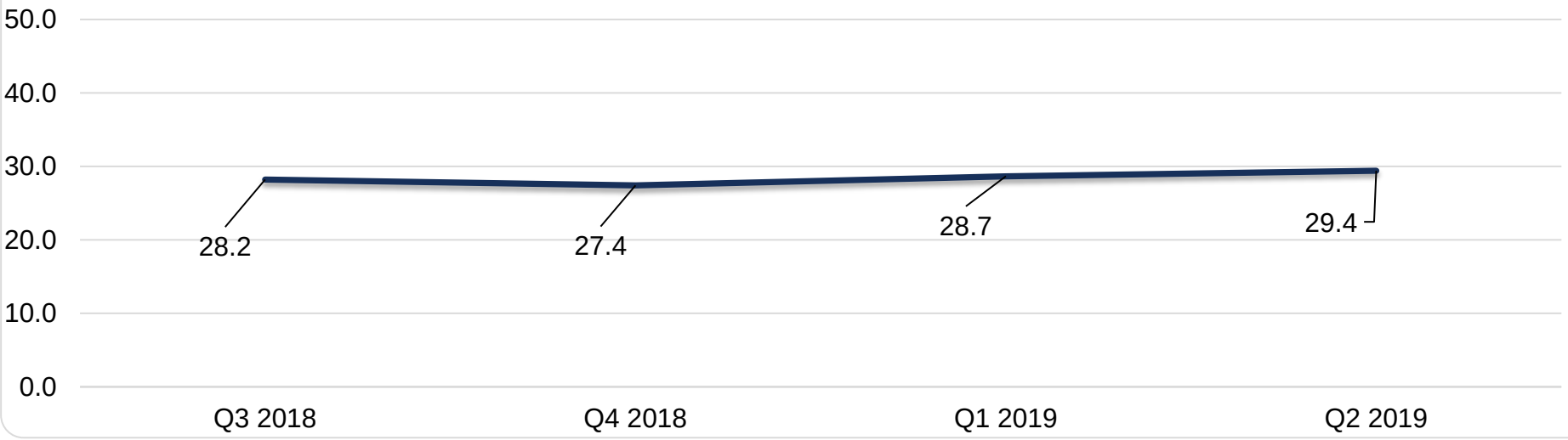
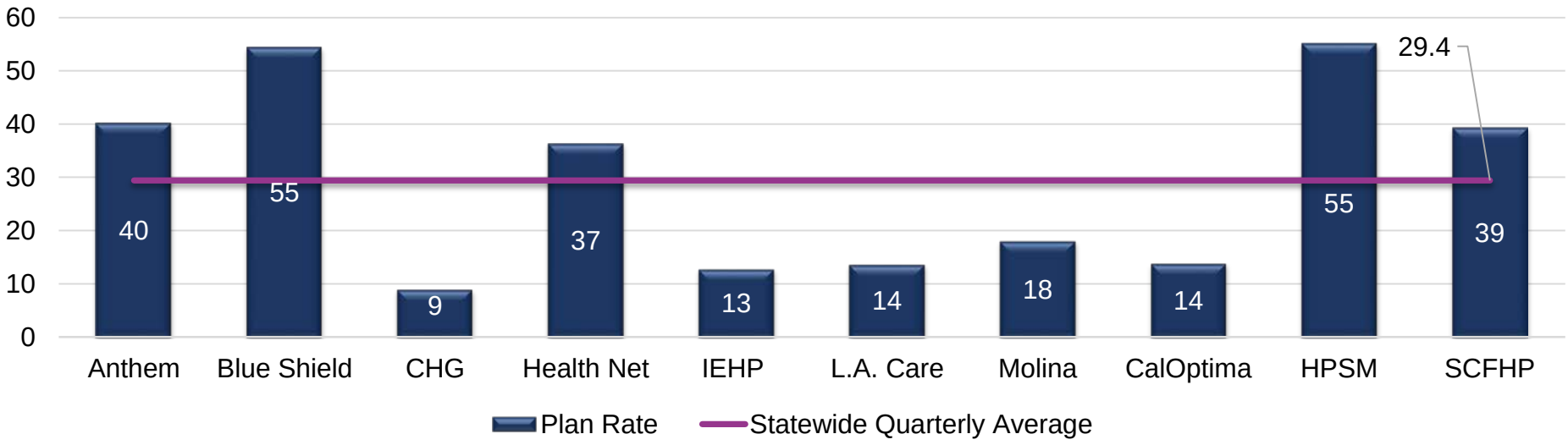


Fig. 37: Count of Members Receiving NF per 1,000 Members for Quarter 2 of 2019



Long Term Services & Supports (LTSS) Figure 38 & 39: Count of CPO per 1,000 Members (07/2018-06/2019)

See metric summary for additional information

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

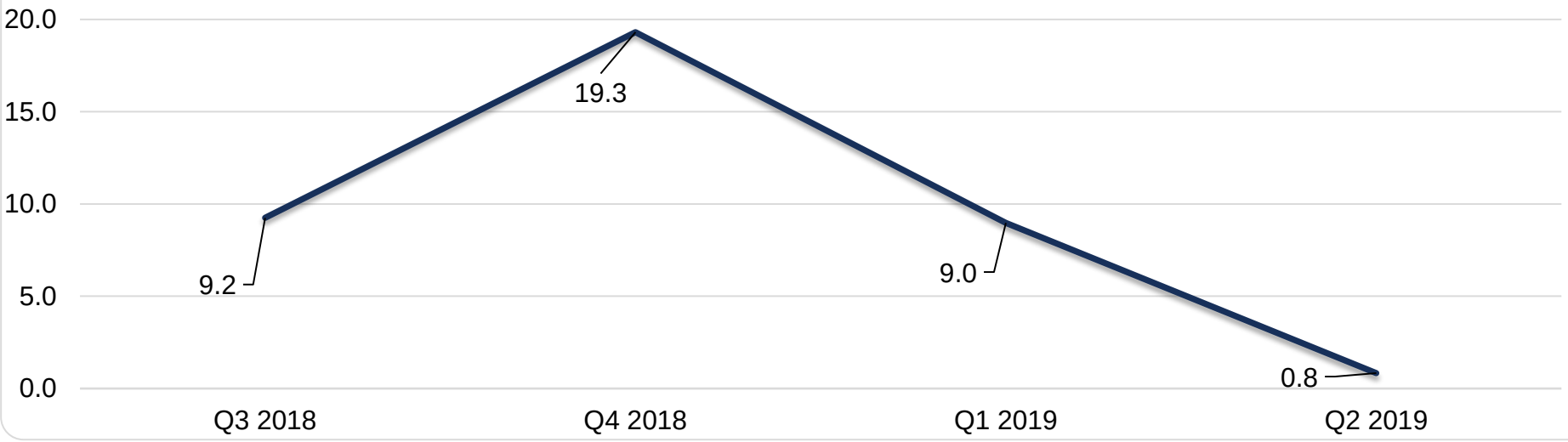
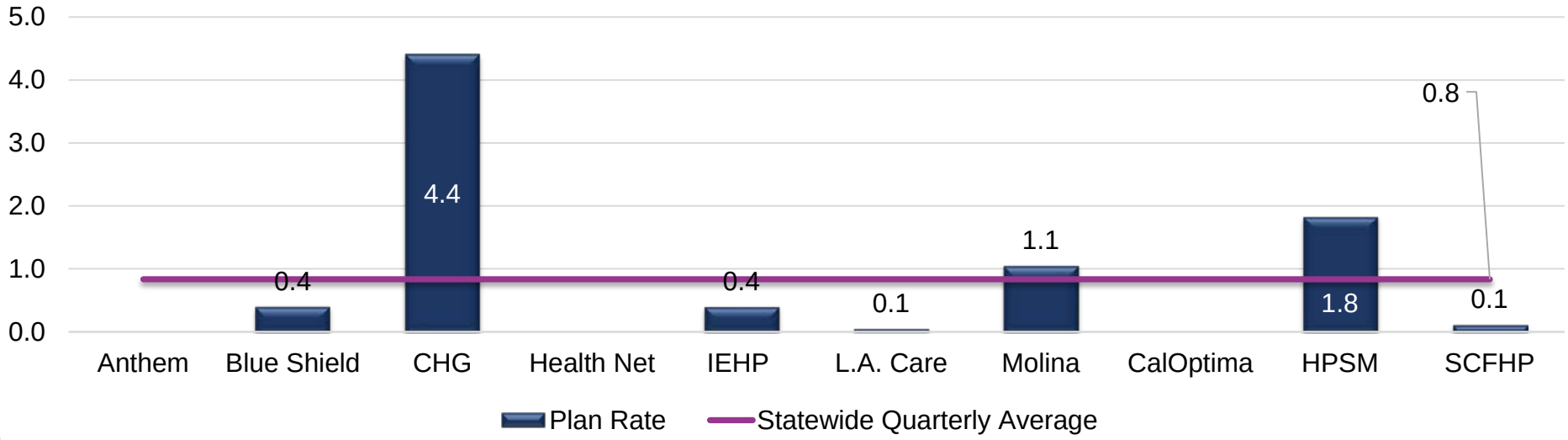


Fig. 39: Count of CPO Member Referrals per 1,000 members for Quarter 2 of 2019



Long Term Services & Supports (LTSS) Figure 40 & 41: Count of CPO per 1,000 Members (07/2018-06/2019)

See metric summary for additional information

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

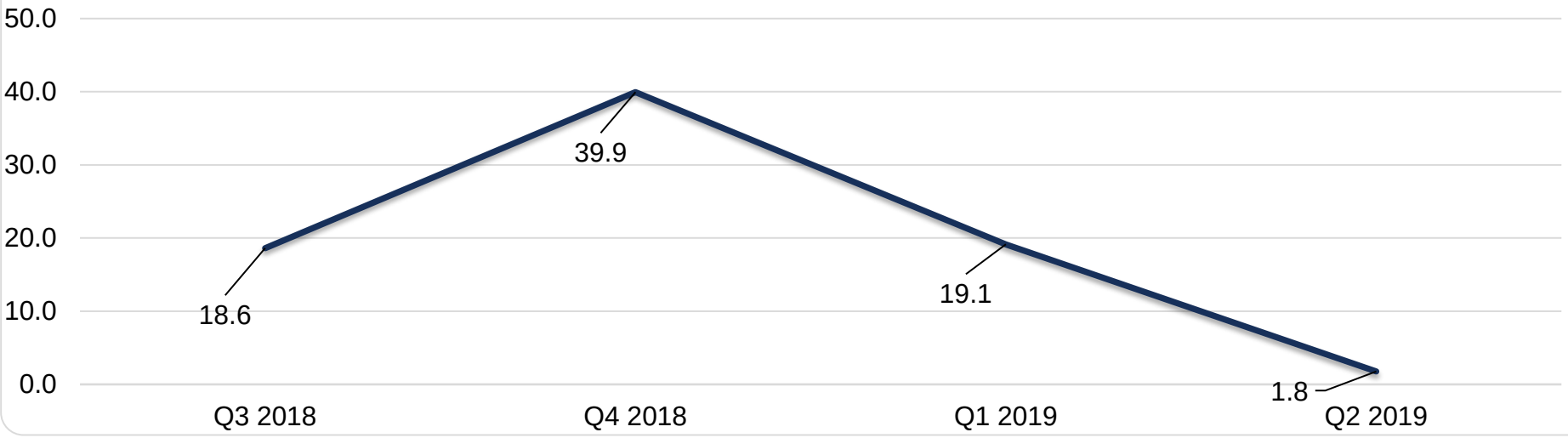
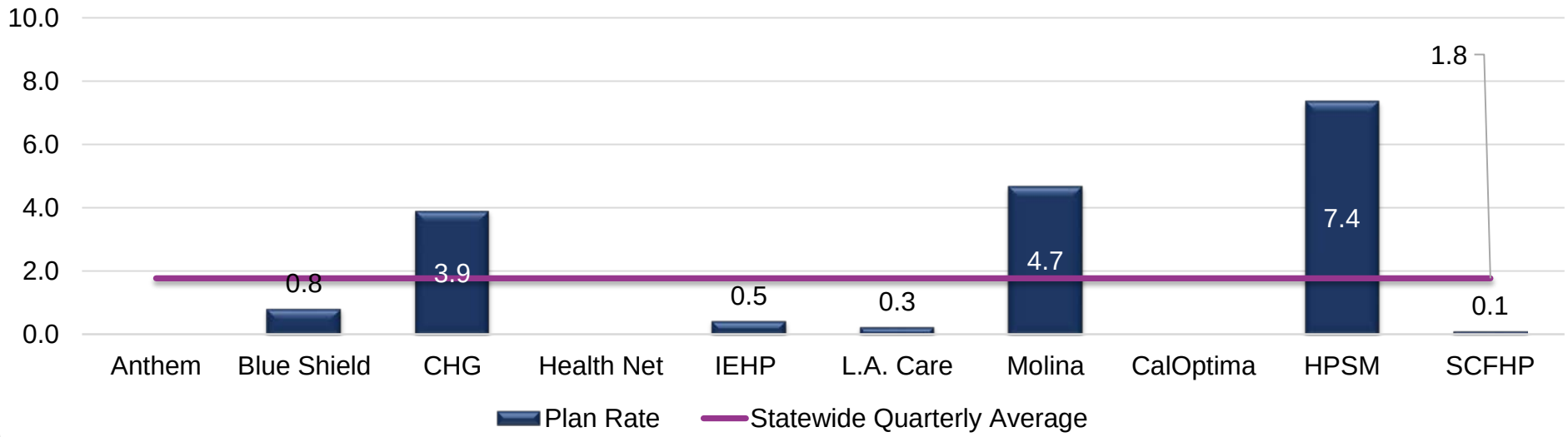



Fig. 41: Count of Members Receiving CPO per 1,000 Members for Quarter 2 of 2019