Cal MediConnect Performance Dashboard Metrics Summary
Released April 2018

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 1-5*
  Statewide enrollment in Cal MediConnect has stabilized with a slight upward trend over the past six months. Nearly half of enrollees speak English and 30.2% speak Spanish as their primary language, with 36% of enrollees identifying as Hispanic.
- **Quality Withhold Summary:** *Figure 6*
  All Plans received 75% or more of the quality withhold amount for Calendar Year 2014, which is the latest data available. Three of the eight Plans with data to report performed at 100%. Santa Clara and Orange counties entered the program in 2015 and early 2016.
- **Care Coordination:** *Figures 7-17*
  The rolling 12-month state average shows that a higher percentage of low-risk members have completed HRAs and ICPs compared to high-risk members, but the most recent quarter shows that Plan efforts to reach high-risk members may have started to reverse this trend. The percentage of members who had a follow-up visit within 30 days of discharge increased by about seven percentage points between Q2 2016 and Q1 2017.
- **Grievances and Appeals:** *Figures 18-21*
  Plan-level counts of grievances and appeals vary by total and topic. Many grievances are categorized as "other;" DHCS and CMS are considering researching the nature of these complaints. The majority of Plan decisions were either fully or partially favorable to the member's appeal for two-thirds of the Plans in which members filed appeals in 2016.

- **Behavioral Health Services:** *Figures 22-23*
  The overall downward trend of Cal MediConnect members seeking care in the emergency room for behavioral health services from Q3 2016 to Q2 2017 indicates that more members may be receiving care in more appropriate settings, and may be benefiting from enhanced behavioral health services coordination.
- **Long-term Services and Supports:** *Figures 24-27*
  LTSS utilization remained fairly flat over the reporting period, with a statewide average of three members receiving LTSS per 1,000 members and some variation by Plans. DHCS is continuing to work with Plans to enhance LTSS referrals.

Data Notes

Dashboard data are reported by Plans, except enrollment and demographic data. The dashboard is a measurement tool that captures metrics for each unique metric at intervals that display the most current data collected. Thus, the reporting time periods for each metric reported in this dashboard may vary.

- **12-month rolling data:** Figures 7, 9, 12, 22, 24, and 26
  Metrics represent each Plan in aggregate for the time period indicated.
- **Quarterly rolling statewide data:** Figures 8, 10, 11, 16, 23, 25, and 27
  Metrics represent all Plans as a whole state broken down by calendar quarters.
- **Annual data:** Figures 6, 13, 14, 15, 17, 18, 19, 20, and 21
  Annual data are updated once a year and are compared to previous years that are only collected in aggregate.

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 is a point-in-time view of the Cal MediConnect population. The data comes from the DHCS data warehouse and reporting system named the Medi-Cal Management Information System/Decision Support System (MIS/DSS). This data source is different for enrollment and demographics than previously used in the discontinued monthly Cal MediConnect enrollment dashboard and may not match those previous enrollment reports.

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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 http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.

Quality Withhold Measure Notes:
CalOptima entered the program in mid-2015 and early 2016. Santa Clara entered the program in January 2015. CW4 - Encounter Data was removed due to delays in clarifying encounter submission requirements for California MMPs CAW3 - Mental health accountability was suspended while updated technical specifications were under development'

Quality Withhold Measures
DHCS monitors Plans by using approximately 75 quality measures relating to beneficiaries' overall experience, care coordination, the fostering of and support of community living, and more.[1] These measures build on the required Healthcare Effectiveness Data and Information Set (HEDIS), Medicare Health Outcome Survey, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, which are required to be reported under Medicare and Medicaid. These measures also include measures related to LTSS. CMS also collects a set of Medicare Parts C and D metrics that apply to the CMC Plans.

CMS and DHCS utilize the reported measures in the combined set of Core and California-specific quality measures for various purposes, including implementation and ongoing monitoring, assessing Plan performance and outcomes, and allowing quality to be evaluated and compared between Plans. Core measures are common across all other states'

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[1] Core Reporting Requirements:
https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CoreReportingRequirements_CY2018_10252017.pdf

California-specific reporting requirements: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAReportingRequirements041317.pdf

demonstrations, and were primarily developed by CMS. California-specific measures were created through a collaborative partnership between DHCS, CMS, and stakeholders at the beginning of the demonstration. Based on their performance on a subset of core and state-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 demonstration year.

All quality withhold measures have benchmarks that the Plans are required to meet in order to receive the quality withhold payment. The Quality Withhold Summary is for Calendar Year 2014. As of the publication of the CMC dashboard, these are the latest data available.

Figure 6 contains the quality withhold measures for the first calendar year of Demonstration Year 1. DY 1 ran from April 1, 2014 to December 31, 2015. Definitions of the measures included for Figure 6 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, as mentioned above, based on HEDIS, CAHPS or other national data sources.

- **Assessments:** Members with initial Health Risk Assessments (HRAs) completed within 90 days of enrollment. (CMS Core Measure 2.1, CW1)
- **Consumer Governance Board Core:** Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements. (CMS Core Measure 5.3, CW2)
- **Documentation of Care Goals:** Percent of members with documented discussion of care goals. (California State-Specific Measure 1.6, CAW1)
- **Behavioral Health Shared Accountability Policies and Procedures:** Policies and procedures attached to the MOU with county behavioral health agency(ies) around assessments, referrals, coordinated care planning, and

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[2] California-specific quality withhold methodology and measures for DY 1: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidanceCA.pdf

Core quality withhold methodology and measures for DY 1: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidance060614.pdf

Core quality withhold methodology and measures for DY 2-3: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY2and3QualityWithholdGuidance042916.pdf

information sharing. (California-specific Measure 2.2, CAW2)

- **Interaction with Care Team:** Members who have a care coordinator and have at least one care team contact during the reporting period. (California State-Specific Measure 1.12, CAW4)
- **Ensuring Physical Access to Buildings, Services and Equipment:** Establishment of a physical access compliance policy and identification of an individual who is responsible for physical access compliance. (California State-Specific Measure 3.1, CAW5)

Quality Withhold Trends

All Plans received 75% or more of the quality withhold amount for Calendar Year 2014, which is the latest data available. Three of the eight Plans with data to report performed at 100%. Orange and Santa Clara counties entered the program in 2015 and early 2016. (*Figure 6)*

Care Coordination Measures

Enhanced, person-centered care coordination is a key benefit provided by 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 that assesses 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. Information tracking 90-day HRA completion rates comes from a Core measure. Figures 7 & 8 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. Figures 9 and 10 only measure stratified members from each Plan.
  - o **High-risk and Low-risk Members with ICPs 30 Working Days after Initial HRA Completion:** This data is helpful in assessing how efficiently Plans are connecting members to care coordination services. Information comes from a California-specific measure. Figures 11 & 12 do not include

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- **HRA Reassessment:** A reassessment should occur at least annually, within 12 months of the last health risk assessment, or as often as the health and/or functional status of the member requires. Information comes from a Core measure.
    - Reassessment Completed After Assessment: A percentage of currently enrolled members who had an assessment completed during the previous reporting period who had a reassessment completed during the current reporting period.
    - Reassessment Completed in the 365 Days from Assessment: A percentage of currently enrolled members that had a reassessment completed during the current reporting period that was within 365 days of the most recent assessment completed during the previous reporting period.
    - Reassessment Completed, No Assessment: A percentage of currently enrolled members who were enrolled for at least 90 days during the previous reporting period, did not have an assessment completed during the previous reporting period but had an assessment during the current reporting period.
- **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
The rolling 12-month state average shows that a higher percentage of low-risk members have completed HRAs and ICPs compared to high-risk members, but the most recent quarter shows that Plan efforts to reach high-risk members may have started to reverse this trend. The percentage of high-risk members with both an HRA and ICP has increased from 60.4% in Q3 2016 to 64.8% in Q2 2017, and is now higher than the percentage of low-risk members with both an HRA and ICP (62.9% in Q2 2017). *Figures 11, 12*

HRA and 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.

The percentage of members who had a follow-up visit within 30 days of discharge increased by nearly eight percentage

points between Q2 2016 and Q1 2017. *Figure 16*

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 resolve issues with their Plans:

- **Grievances:** Grievances are complaints or disputes members file with the Plans that are evaluated at the Plan's level expressing dissatisfaction with any aspect of the Plan' 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 includes 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

Between January and December 2016, members filed 6,193 grievances with Plans. The most common complaints were reported under the "other" category (grievances other than inability to get appointments or excessive wait times for an appointment). 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 categories that relate to ability and wait times to get an appointment, at least for 2015 and 2016 data.

The number of appeals varies greatly by Plans, as well as the percentage of decisions that are adverse versus partially or fully favorable. However, the majority (two-thirds) of Plan decisions were either fully or partially favorable to the member's appeal when filed in 2016. Few Plans had appeals related to mental health services.

Grievance and appeals reporting shown in this dashboard currently comes from a Core reporting measure upon which CMS and DHCS worked with plans to re-establish a more uniform requirement interpretation in 2017. To further refine the reporting and analysis process on grievances and appeals, CMS and DHCS collaborated to update or include new reporting categories for new or additional understanding on grievances and appeals. Relevant updates may be reflected in later

publications of the dashboard.

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 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. The overall trend of Cal MediConnect members seeking care in the emergency room for behavioral health services from Q3 2016 to Q2 2017 remained fairly steady. 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. The dashboard may reflect new collaborative analysis in the next publication as a result.

Long Term Care 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. DHCS now collects more detailed data on LTSS utilization and referrals, which will be added to the performance dashboard as it becomes available.

- **LTSS Utilization:** LTSS Utilization is reported by each Plan. LTSS services include In-Home Supportive Services (IHSS) (carved out beginning in 2018), Nursing Facility Services, Community Based Adult Services (CBAS), and Multi-Purpose Senior Services Program (MSSP). This metric is a California-specific measure.
- **Critical Incident and Abuse Reports for Members Receiving LTSS:** The measure encompasses reports of critical incidents and abuse for members receiving, including IHSS, CBAS, MSSP and nursing facility services.

LTSS Trends

LTSS utilization remained fairly flat over the reporting period, with a statewide average of three members receiving LTSS per 1,000 members, but varies by Plans. DHCS worked with the Plans to enhance LTSS referrals, and encouraged Plans to support members in transitioning out of nursing facilities and into the community with home-and-community based LTSS services, as appropriate. As more detailed data on LTSS referrals are available, they will be reported through this dashboard.

Most Plans primarily reported low numbers of critical incident and abuse reports for the LTSS population. Health Plan of San Mateo (HPSM), which reported the highest numbers, has focused on training staff on the identification and reporting of these incidents and abuses; HPSM may not be experiencing more critical incidents and abuses than other plans, the higher reporting is likely due to the difference in training and reporting. DHCS and CMS continue to work closely with the Plans to better understand their policies and procedures in this area, and identify any necessary modifications. Over time, this additional guidance and technical assistance may lead to more precise reporting and resolution.

Plan Key

Plan Name	Plan Abbreviation on Dashboard
Anthem Blue Cross Partnership of California	Anthem/CareMore
Care1st	Care 1st
CalOptima	CalOptima
Community Health Group	CHG
Health Net	Health Net
Health Plan of San Mateo	HPSM
Inland Empire Health Plan	IEHP
LA Care	L.A. Care
Molina Healthcare	Molina
Santa Clara Family Health Plan	SCFHP

Cal MediConnect Enrollment and Demographics Figure 1: Breakdowns of Dual Populations (As of 6/1/2017)
See metric summary for additional information

***Fig. 1:* Monthly Enrollment**

Date	Enrollment
1-Jun-17	115,071
1-May-17	114,631
1-Apr-17	114,816
1-Mar-17	114,597
1-Feb-17	114,316
1-Jan-17	113,413
1-Dec-16	111,513
1-Nov-16	112,201
1-Oct-16	113,226
1-Sep-16	114,176
1-Aug-16	115,838
1-Jul-16	117,481
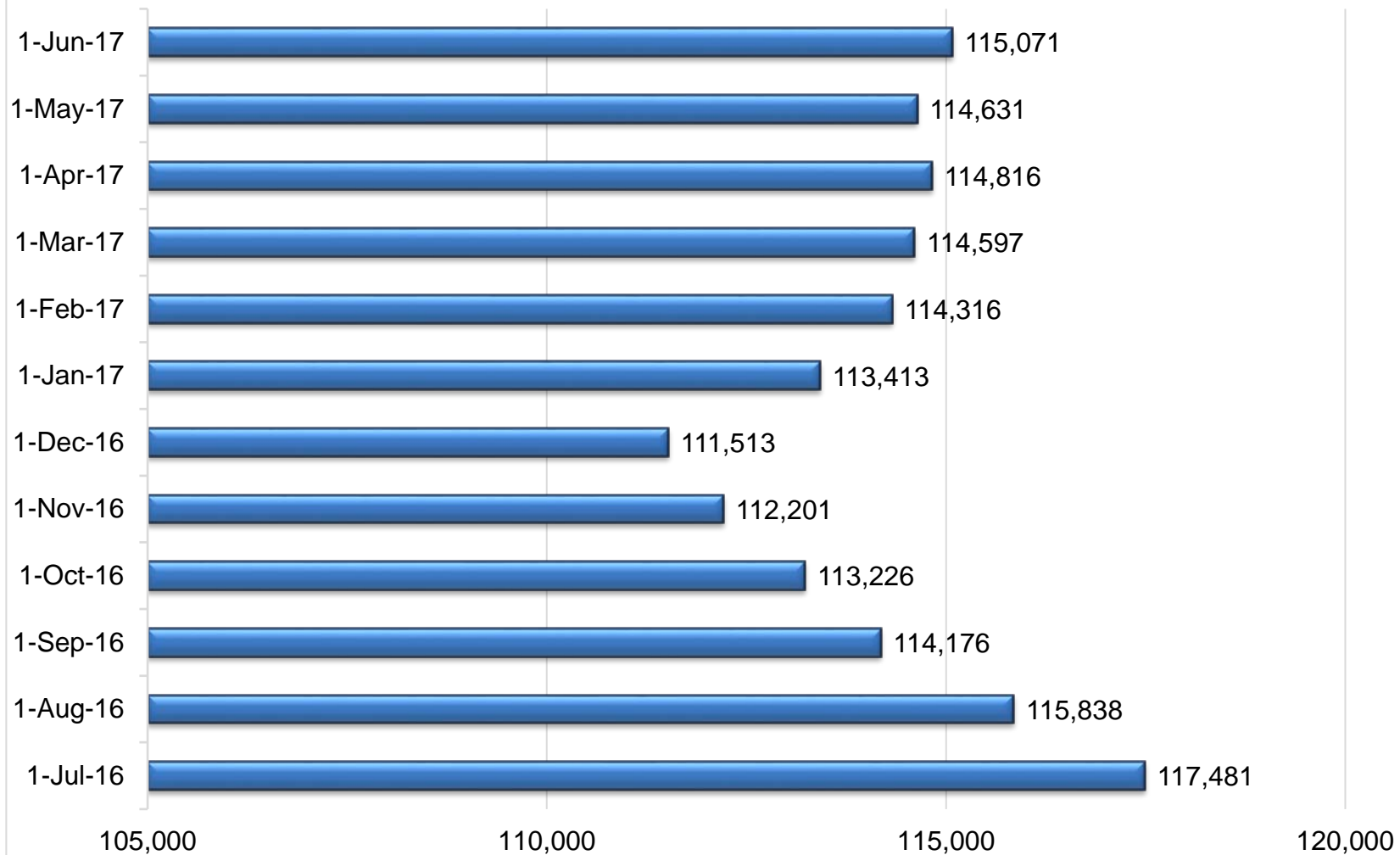
Cal MediConnect Enrollment and Demographics Figure 2: Breakdowns of Dual Populations (As of 6/1/2017)
See metric summary for additional information

Fig. 2: **Count and Percentage of Total Active Enrollments, by County and Plan as of June 2017**

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

County total & %	County	Plan	Count
10,248; 9%	Santa Clara	SCFHP	7,241
		Anthem	3,007
9,233; 8%	San Mateo	HPSM	9,232
14,427; 13%	San Diego	Molina	4,596
		Health Net	2,203
		CHG	5,185
		Care 1st	2,443
13,936; 12%	San Bernardino	Molina	2,381
		IEHP	11,555
14,196; 12%	Riverside	Molina	2,353
		IEHP	11,843
15,259; 13%	Orange	CalOptima	15,259
37,752; 33%	Los Angeles	Molina	2,596
		L.A. Care	14,598
		Health Net	13,127
		Care 1st	3,728
		CareMore	3,703
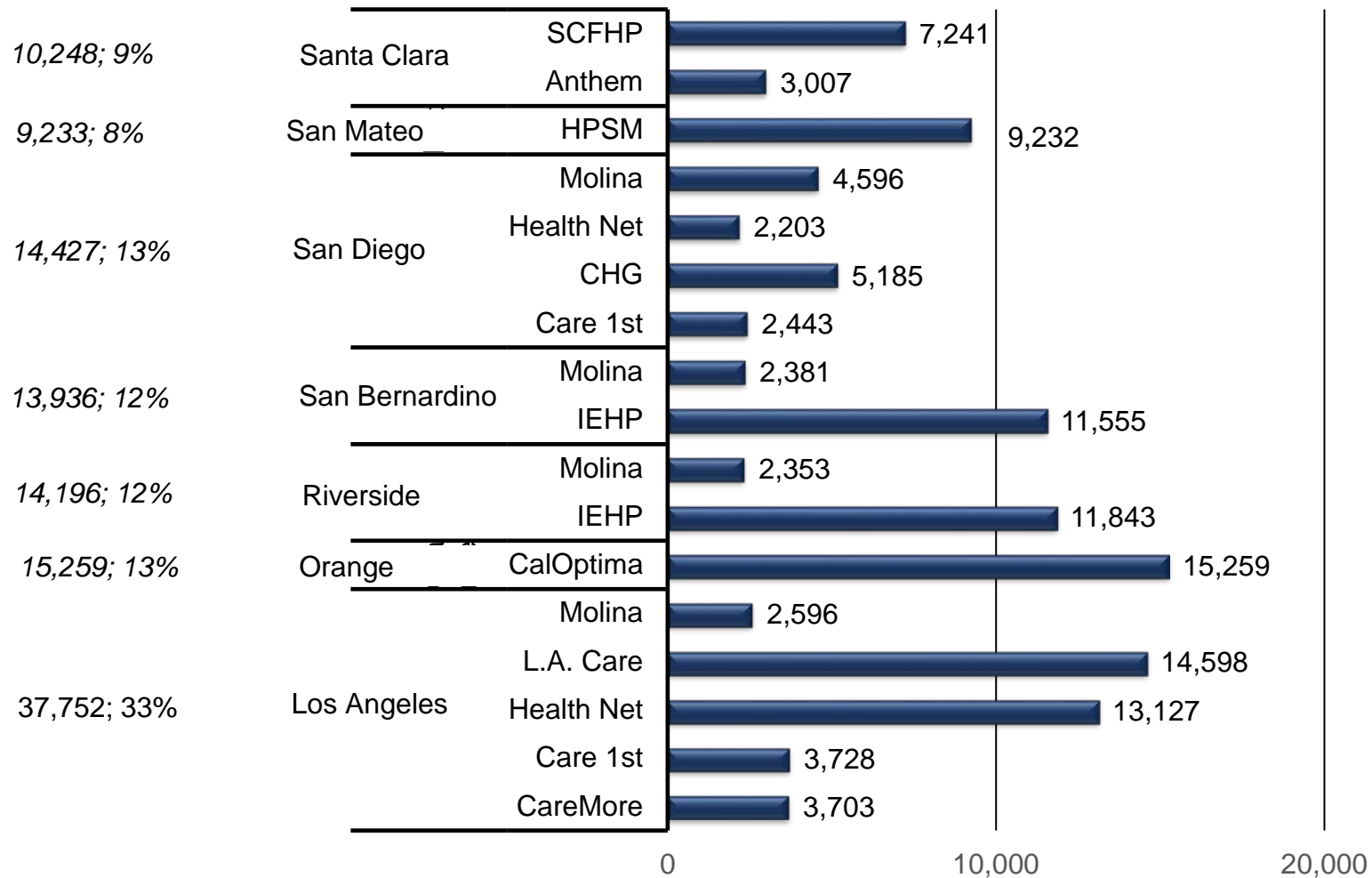
Cal MediConnect Enrollment and Demographics Figure 3 - 5: Breakdowns of Dual Populations (As of 6/1/2017)
See metric summary for additional information

Fig. 3: **Quarter 2 Enrollment by Threshold Language Spoken**

Language	Percentage
English	49%
Spanish	30%
Other/Not Reported	8%
Vietnamese	5%
Tagalog	2%
Mandarin	1%
Cantonese	1%
Farsi	1%
Arabic	0%
Russian	0%
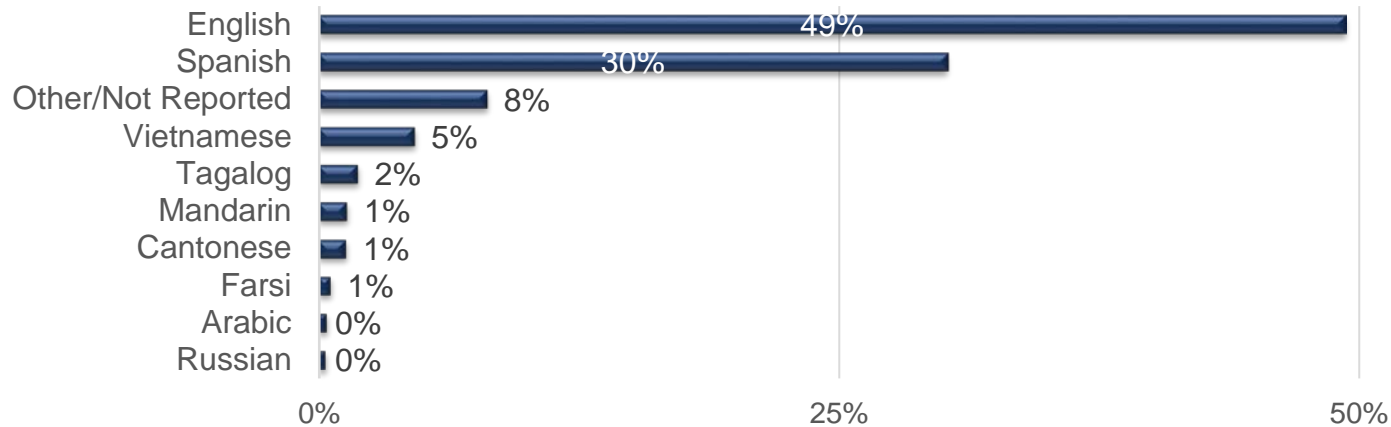
Fig. 4: **Quarter 2 Enrollment by Race/Ethnicity**

Race/Ethnicity	Percentage
Hispanic	36%
White	21%
Other/Unknown	19%
Asian/Pacific Islander	15%
African-American	9%
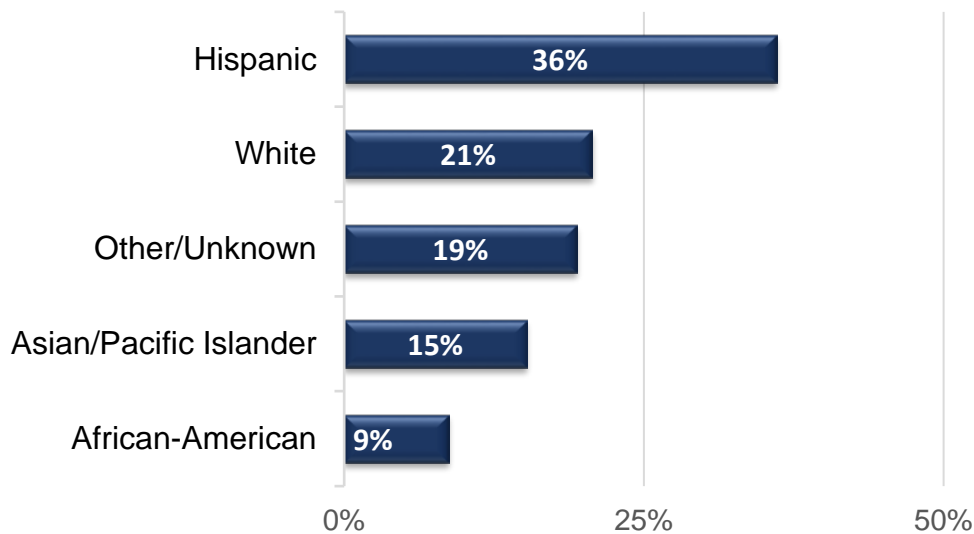
Fig. 5: **Quarter 2 Enrollment by Gender**

Gender	Percentage
Male	44%
Female	56%
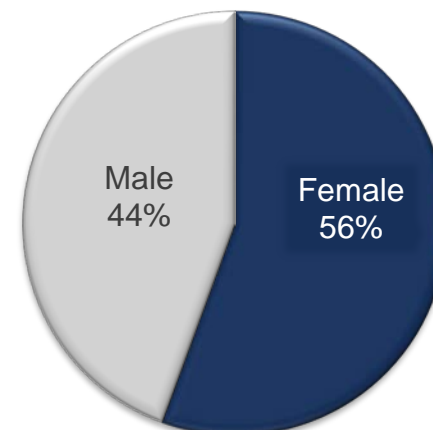
Cal MediConnect Figure 6: Quality Withhold Summary Table (CY 2014)
See metric summary for additional information

Plan Name	CW2 Assessments Core 5.3 Benchmark: 100% Met/Not Met	CAW1 Assessments CA 1.6 Benchmark: 90% Met/Not Met	CAW2 Assessments CA 2.2 Benchmark: 100% Met/Not Met	CAW4 – Interaction with Care Team CA 1.12 Benchmark: 90% Met/Not Met	CAW5 – Ensuring Physical Access to Building, Services and Equipment CA 3.1 Benchmark: 100% Met/Not Met
Anthem	Not Met	Met	Not Met	Met	Met
Molina	Not Met	Met	Not Met	Met	Met
Care1st	Not Met	Met	Met	Met	Met
CHG	Not Met	Met	Met	Met	Met
Health Net	Met	Met	Not Met	Met	Not Met
HPSM	Not Met	Met	Met	Met	Met
L.A. Care	Met	Not Met	Met	Not Met	Met
IEHP	Met	Met	Met	Not Met	Not Met

Plan Name	CW1 Assessments Core 2.1 Benchmark: 90% Met/Not Met	Total Number of Measures Met	Total Number of Measures Not Met	Percentage of Measures Met	Percentage of Withhold Received
Anthem	Met	4	2	67%	75%
Molina	Met	4	2	67%	75%
Care1st	Met	5	1	83%	100%
CHG	Met	5	1	83%	100%
Health Net	Met	4	2	67%	75%
HPSM	Met	5	1	83%	100%
L.A. Care	Met	4	2	67%	75%
IEHP	Met	4	2	67%	75%
California Averages		**4.4**	**1.63**	**73%**	**84%**

DHCS
California Department of
HealthCareServices

Cal MediConnect Performance Dashboard - Released April 2018

CalMediConnect
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Care Coordination Figure 7 & 8: Percent of Members Willing to Participate and who the MMP was able to Locate with an Assessment Completed Within 90 Days of Enrollment (07/2016-06/2017)
See metric summary for additional information

Fig. 7: **12-Month Rolling Percentage of Members Willing to Participate and who the MMP was able to Locate with an Assessment Completed Within 90 Days of Enrollment**

Legend: Plan Percentage ▬ Statewide Percentage

- Anthem: 98%
- Care 1st: 92%
- CHG: 96%
- Health Net: 94%
- IEHP: 70%
- L.A. Care: 95%
- Molina: 98%
- CalOptima: 93%
- HPSM: 92%
- SCFHP: 52%

Statewide: 88%

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

- Q3 2016: 87%
- Q4 2016: 90%
- Q1 2017: 86%
- Q2 2017: 90%
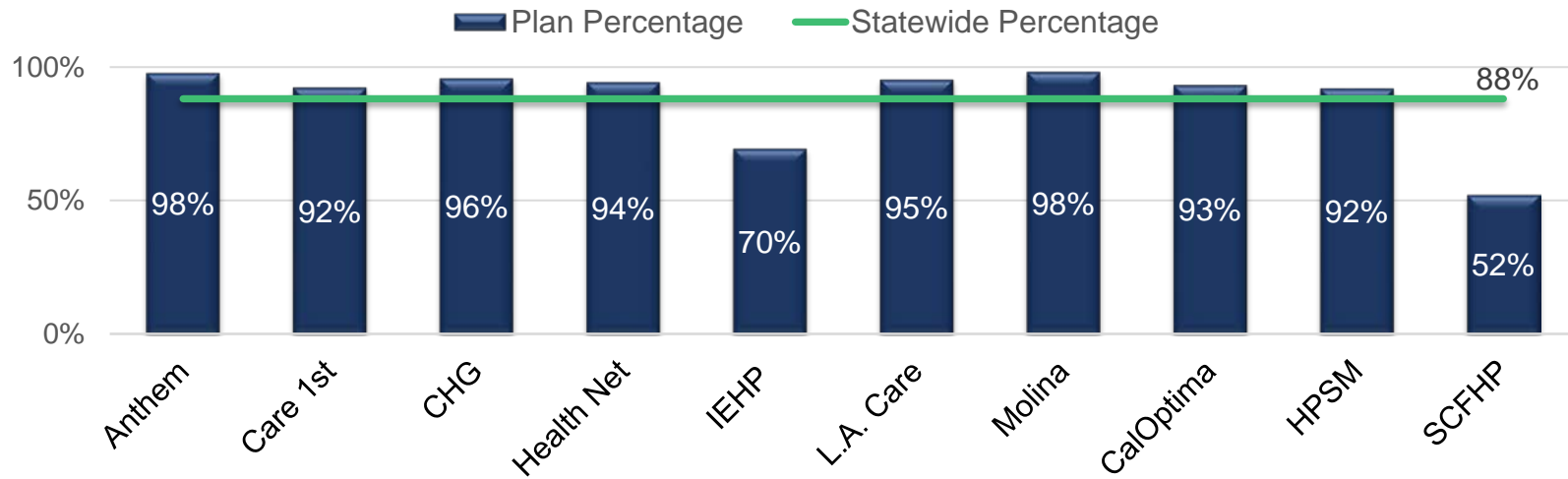
Care Coordination Figure 9 & 10: Percentage of Members with an Individualized Care Plan (ICP) (07/2016-06/2017) See metric summary for additional information

Fig. 9: **12-Month Rolling Percentage of Members with an ICP**

Legend: ■ Plan Member Percentage — Statewide Percentage

Plan	Percentage
Anthem	63%
Care 1st	48%
CHG	100%
Health Net	70%
IEHP	100%
L.A. Care	83%
Molina	67%
CalOptima	63%
HPSM	70%
SCFHP	51%

Statewide Percentage: 71%

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

Quarter	Percentage
Q3 2016	67%
Q4 2016	71%
Q1 2017	73%
Q2 2017	75%
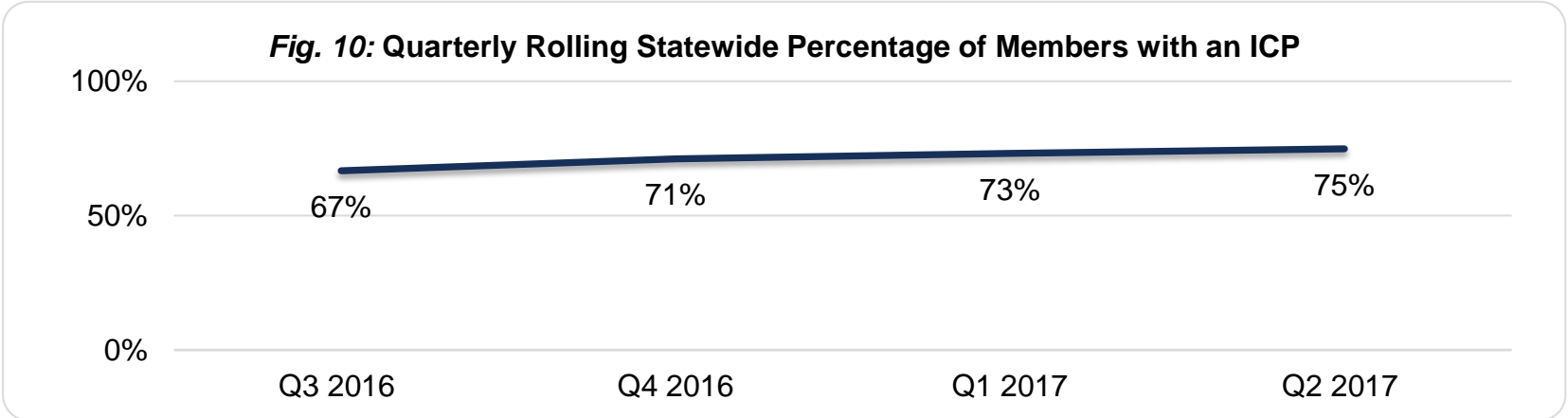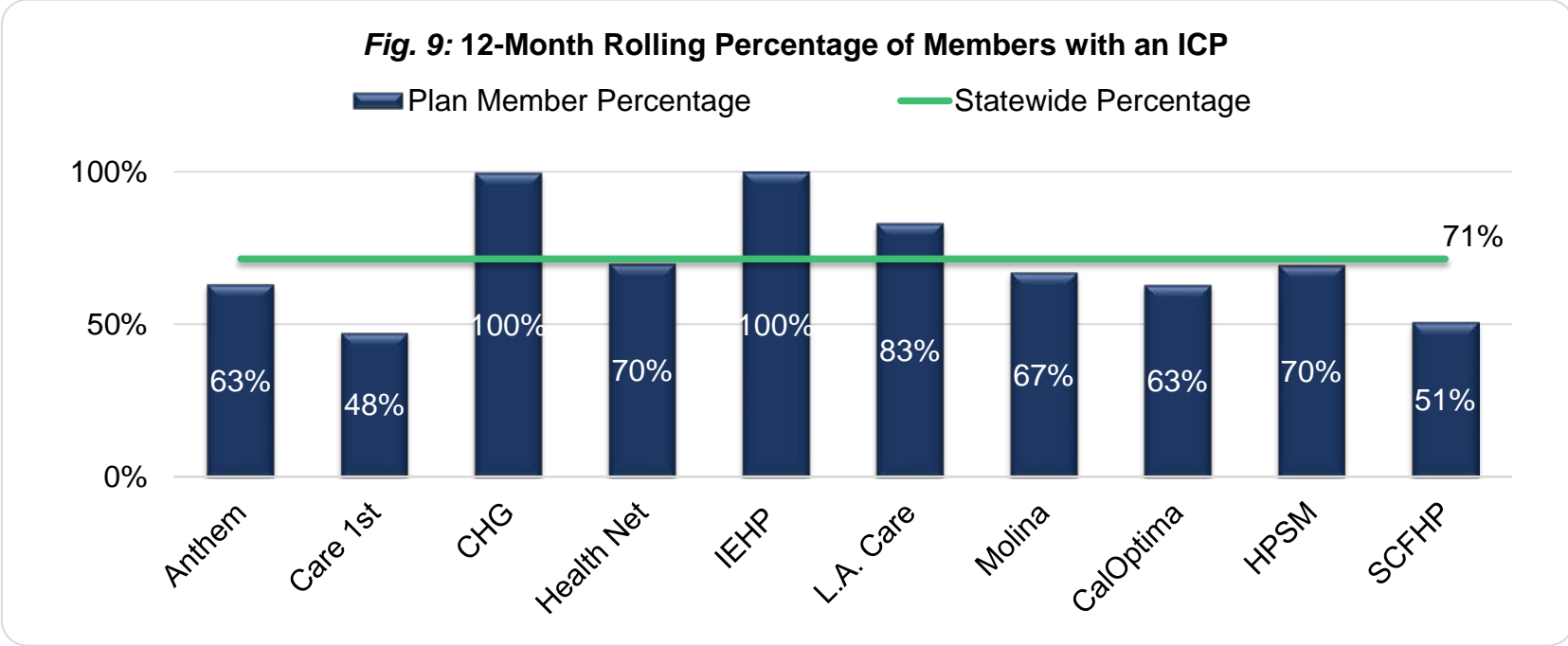
Care Coordination Figure 11: High-risk & Low-risk Members with an Individualized Care Plan (ICP) within 30 Working Days after the Completion of the Initial Health Risk Assessment (HRA) (07/2016-06/2017)
See metric summary for additional information

Fig. 11: **Quarterly Rolling Statewide Percentage of High-risk & Low-risk Members with an Individualized Care Plan (ICP) within 30 Working Days after the Completion of the Initial Health Risk Assessment (HRA)**
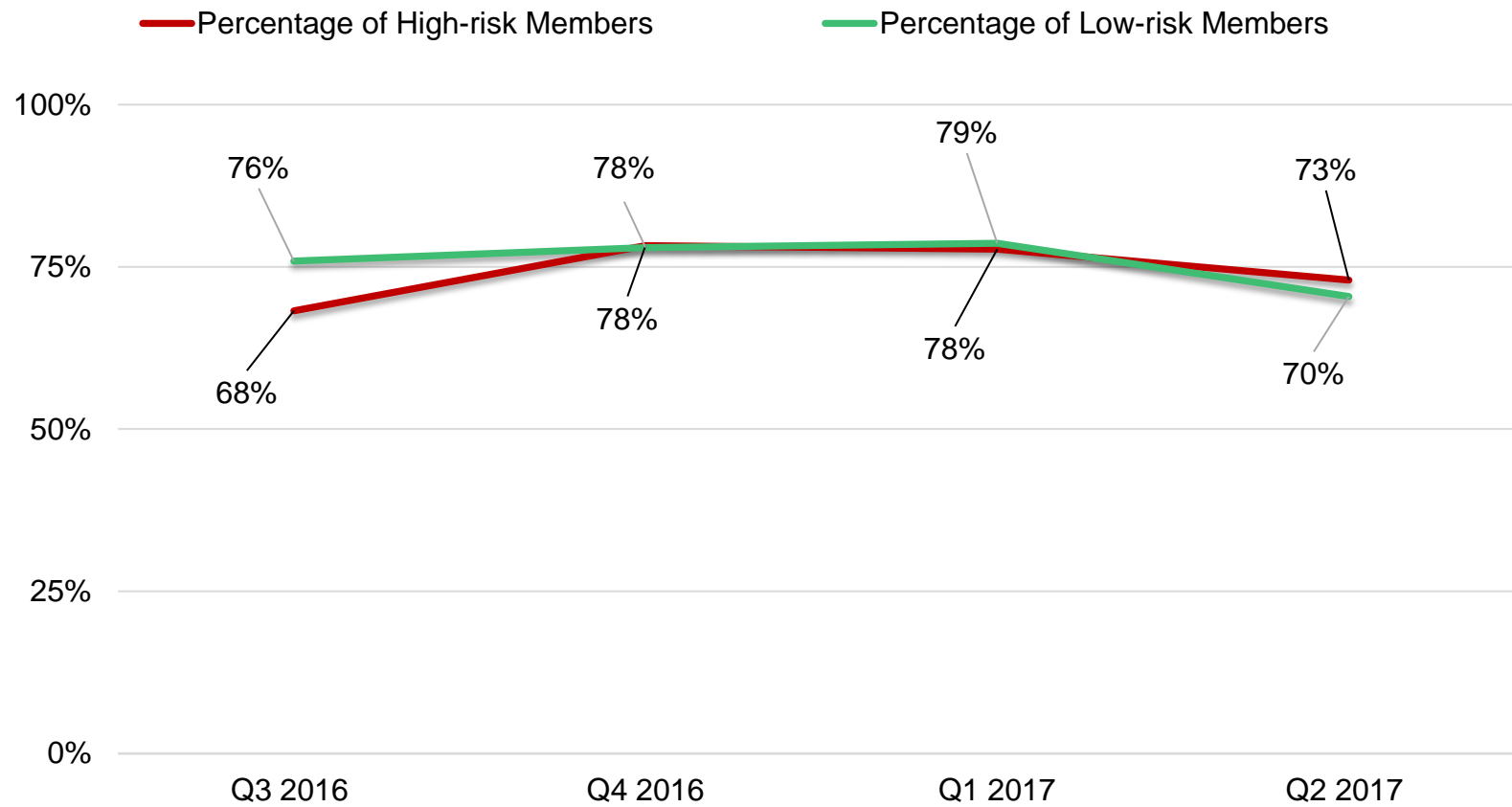
Care Coordination Figure 12: High-risk & Low-risk Members with an Individualized Care Plan (ICP) within 30 Working Days after the Completion of the Initial Health Risk Assessment (HRA) (07/2016-06/2017)
See metric summary for additional information

Fig. 12: **12-Month Rolling Percentage of High-risk & Low-risk Members with an Individualized Care Plan (ICP) within 30 Working Days after the Completion of the Initial Health Risk Assessment (HRA)**
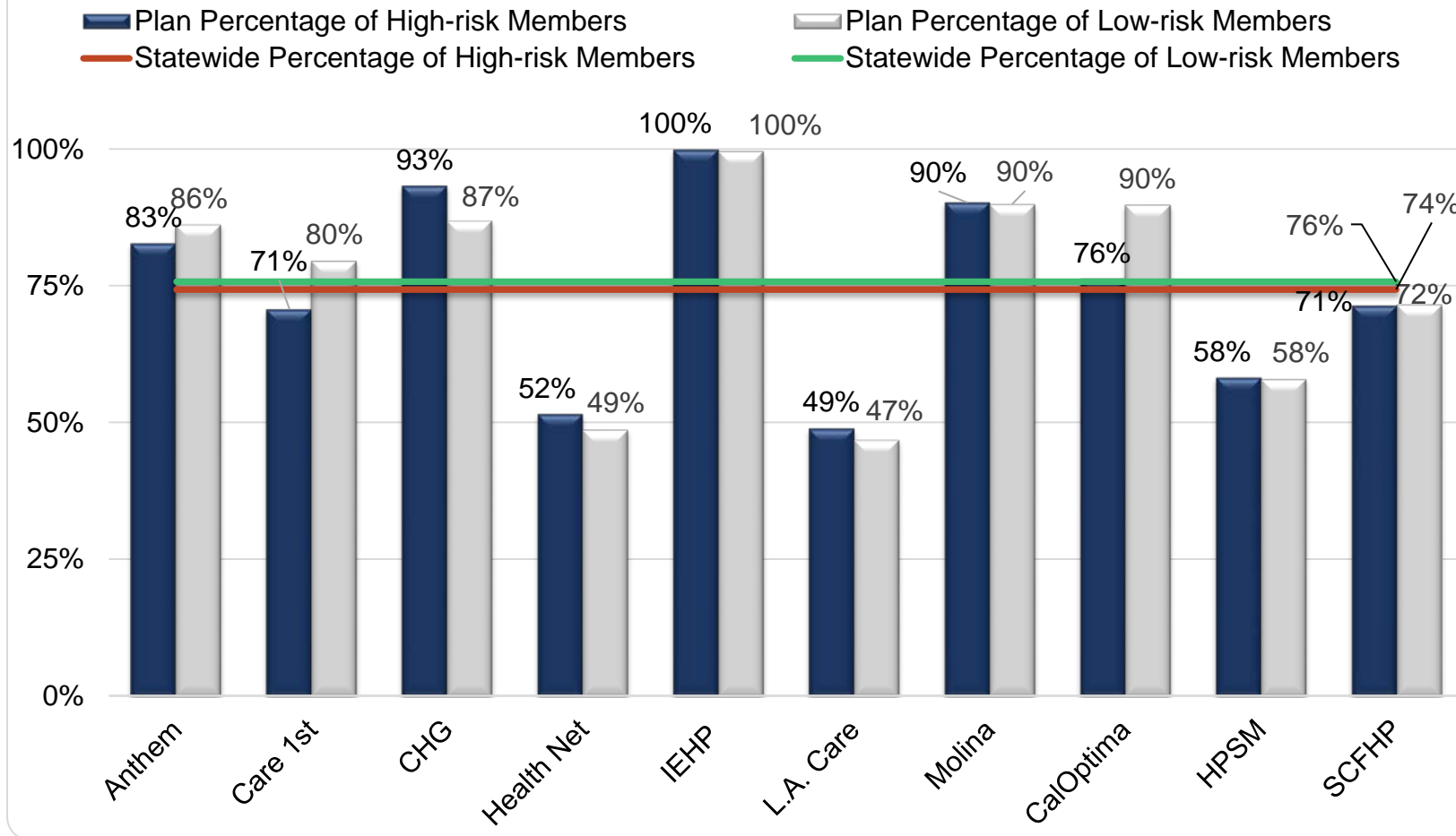
Care Coordination Figure 13: Percentage of Members Who Have a Care Coordinator and Have at Least One Care Team Contact During the Reporting Period (01/2016-12/2016) See metric summary for additional information

Fig. 13: **Annual (2016) Percentage of Members who have a Care Coordinator and have at least One Care team Contact During the Reporting Period**

Plan Percentage — Statewide Percentage

Anthem	Care 1st	CHG	Health Net	IEHP	L.A. Care	Molina	CalOptima	HPSM	SCFHP
95%	98%	98%	91%	75%	68%	98%	70%	77%	34%

Statewide: 80%
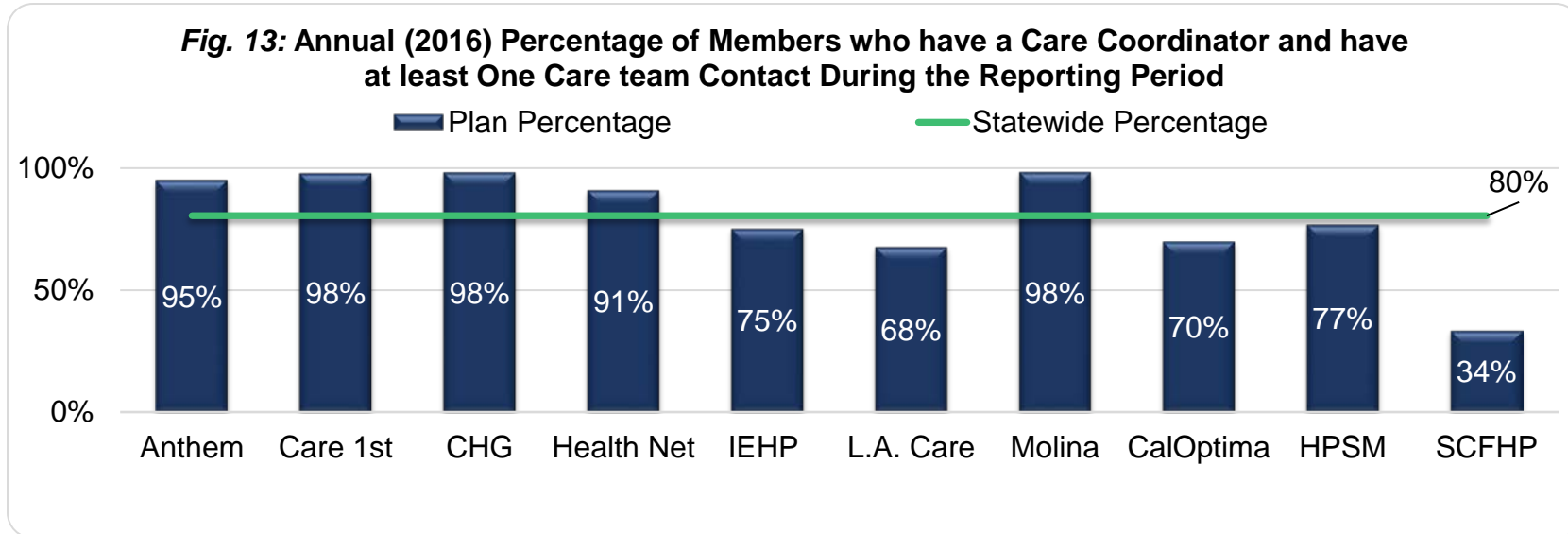
Care Coordination Figure 14: Member to Care Coordinator Ratio (01/2016-12/2016)
See metric summary for additional information

Fig. 14: **Annual (2016) Number of Members per Care Coordinator Ratio**

Plan Ratio — Statewide Average Ratio

| Anthem	Care 1st	CHG	Health Net	IEHP	L.A. Care	Molina	CalOptima	HPSM	SCFHP
103	21	177	53	97	51	98	102	204	171

Statewide: 108
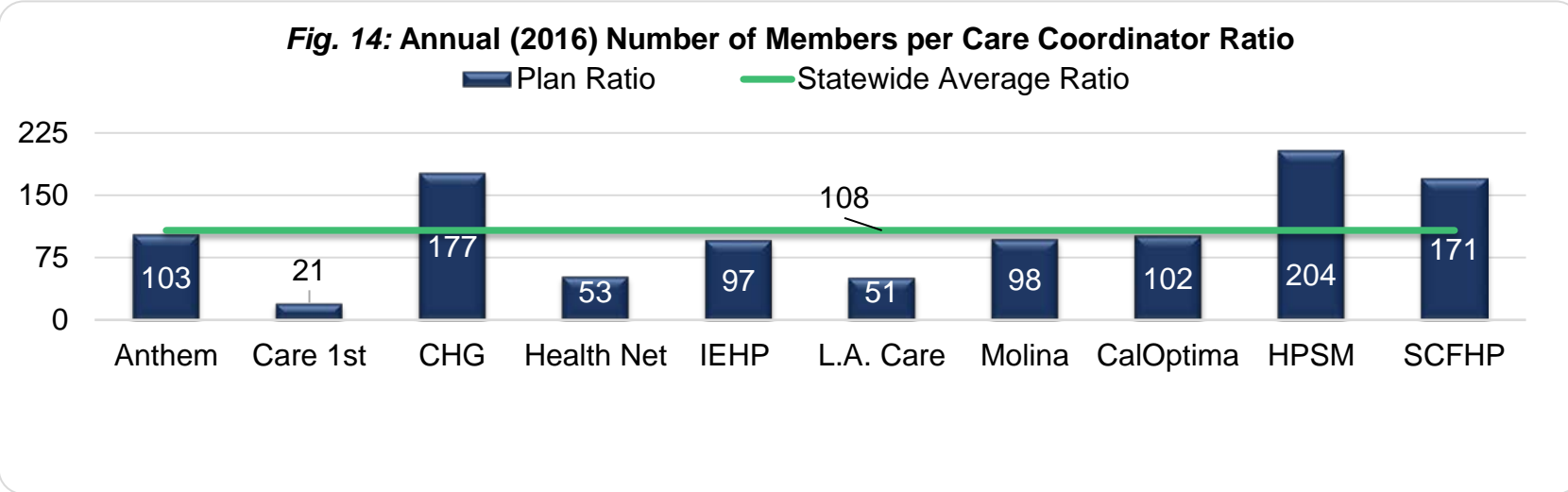
Care Coordination Figure 15: Percentage of Members with Documented Discussions of Care Goals (01/2016-12/2016)
See metric summary for additional information

Fig. 15: Annual (2016) Percentage of Members with Documented Discussions of Care Goals

- Plan Percentage
- Statewide Percentage

Plan	Percentage
Anthem	100%
Care 1st	63%
CHG	29%
Health Net	90%
IEHP	72%
L.A. Care	90%
Molina	86%
CalOptima	52%
HPSM	7%
SCFHP	58%

Statewide: 65%
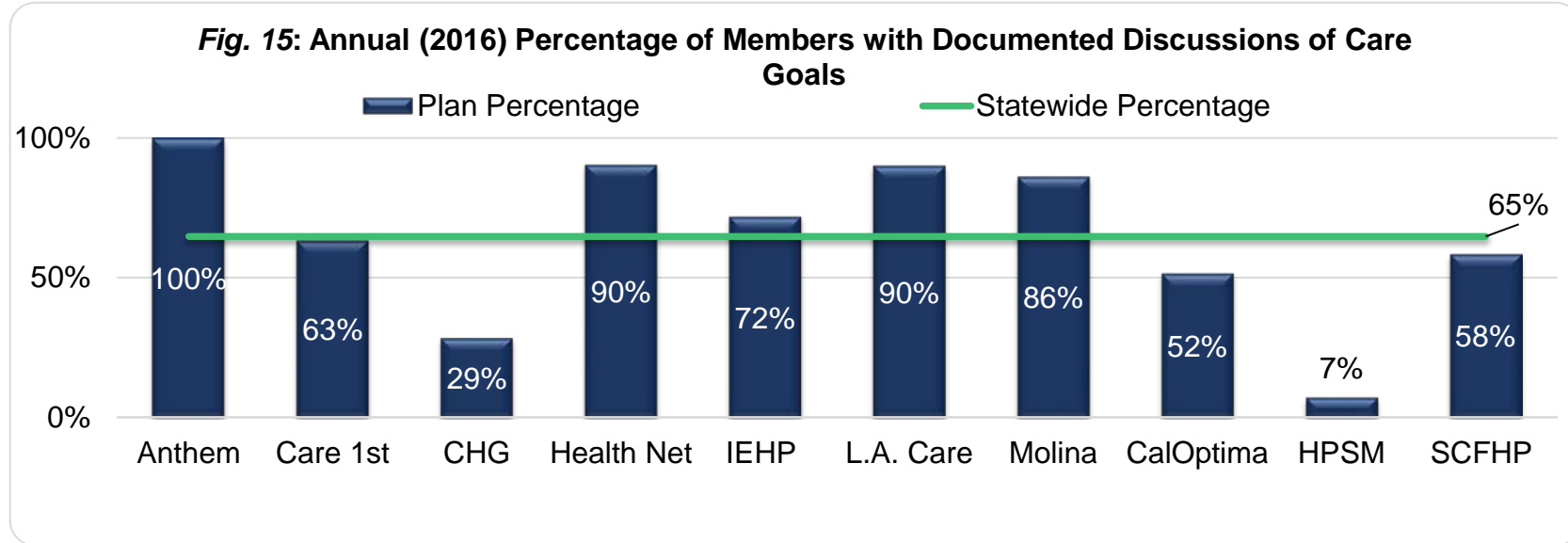
Care Coordination Figure 16: Percentage of Members with First Follow-up Visit within 30 Days after Hospital Discharge (6/2016-03/2017) See metric summary for additional information

Fig. 16: Quarterly Rolling Statewide Percentage of Members with First Follow-Up Visit within 30 Days after Hospital Discharge

Quarter	Percentage
Q2 2016	70%
Q3 2016	72%
Q4 2016	71%
Q1 2017	77%
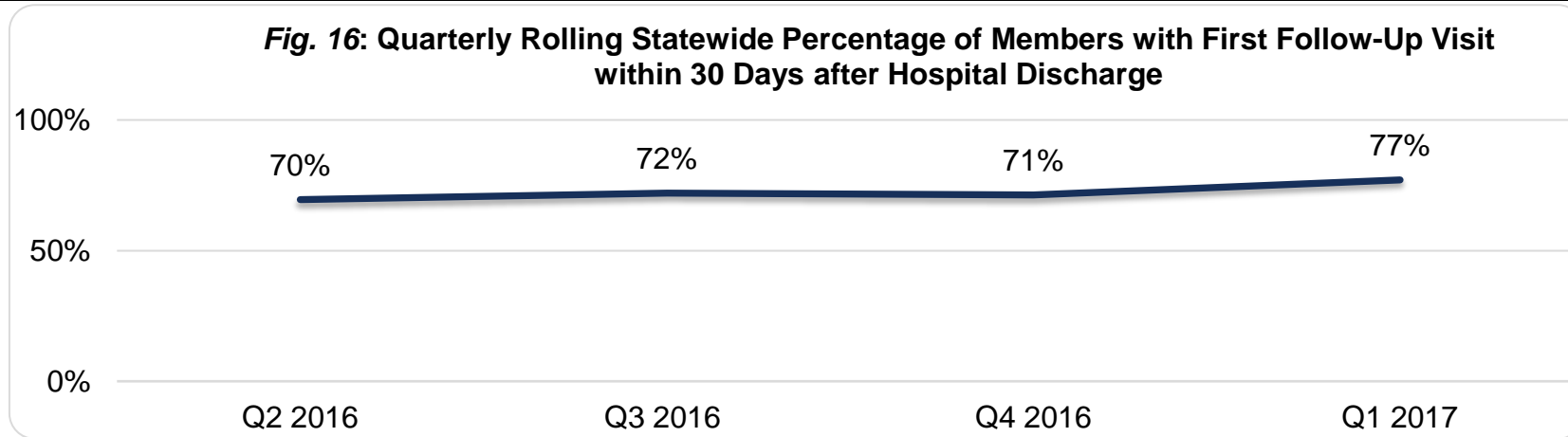
Care Coordination Figure 17: HRA Reassessments of Those Who Had an Assessment in the Previous Year (01/2015-12/2016) See metric summary for additional information

Fig. 17: Annual Average Percentage of HRA Reassessments

■ Percent of Currently Enrolled Members Who Had an Assessment Completed During the Previous Reporting Period Who Had a Reassessment Completed During the Current Reporting Period

▨ Percent of Currently Enrolled Members that Had a Reassessment Completed During the Current Reporting Period That Was Within 365 Days of the Most Recent Assessment Completed During the Previous Reporting Period

■ Percent of Currently Enrolled Members Who Were Enrolled For at Least 90 Days During the Previous Reporting Period Who Did Not Have an Assessment Completed in the Previous Reporting Period But Had an Assessment Completed During the Current Reporting Period

Appeal Figure 18: Count of Appeals (1/2016-12/2016) See metric summary for additional information

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

- Number where the Plan Decision was Fully Favorable
- Number where Plan Decision was Partially Favorable
- Number where Plan Decision was Adverse

Member Enrollment

Enrollment	Plan	Fully Favorable	Partially	Adverse	Total
7,520	SCFHP	22	4	5	31
9,405	HPSM	25	4	28	57
16,842	CalOptima	96	4	217	317
12,317	Molina	87	5	49	141
12,710	L.A. Care	13		36	49
22,220	IEHP	89	30	91	210
16,083	Health Net	52	2	56	110
4,969	CHG	0			
6,312	Care 1st	13	4	16	33
6,856	Anthem	17		6	23
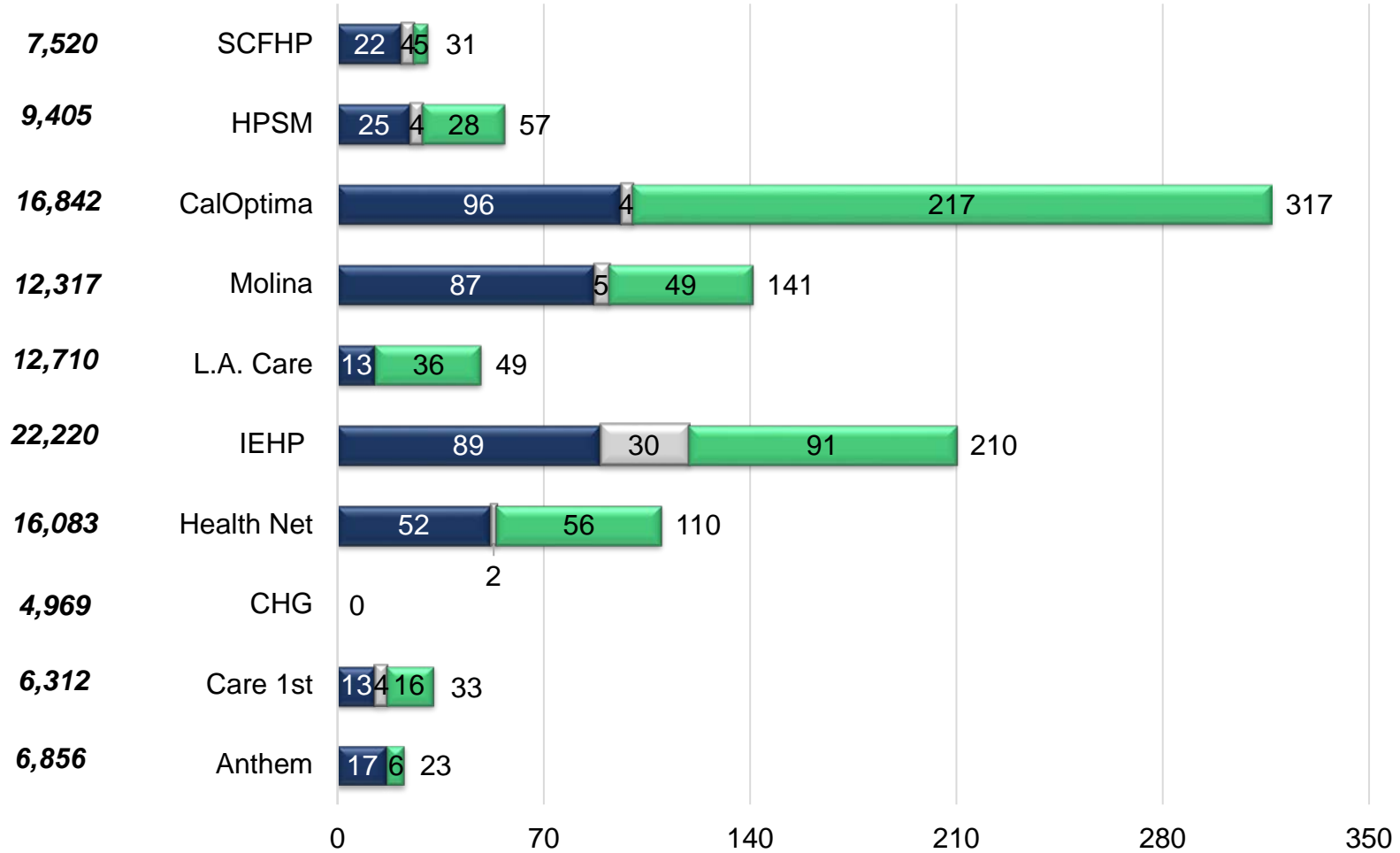
Grievance Figure 19: Count Grievances by type, Except "Other" (1/2016-12/2016)
See metric summary for additional information

Fig. 19: **Annual Count of Grievances Broken Down by Type, besides "Other"**
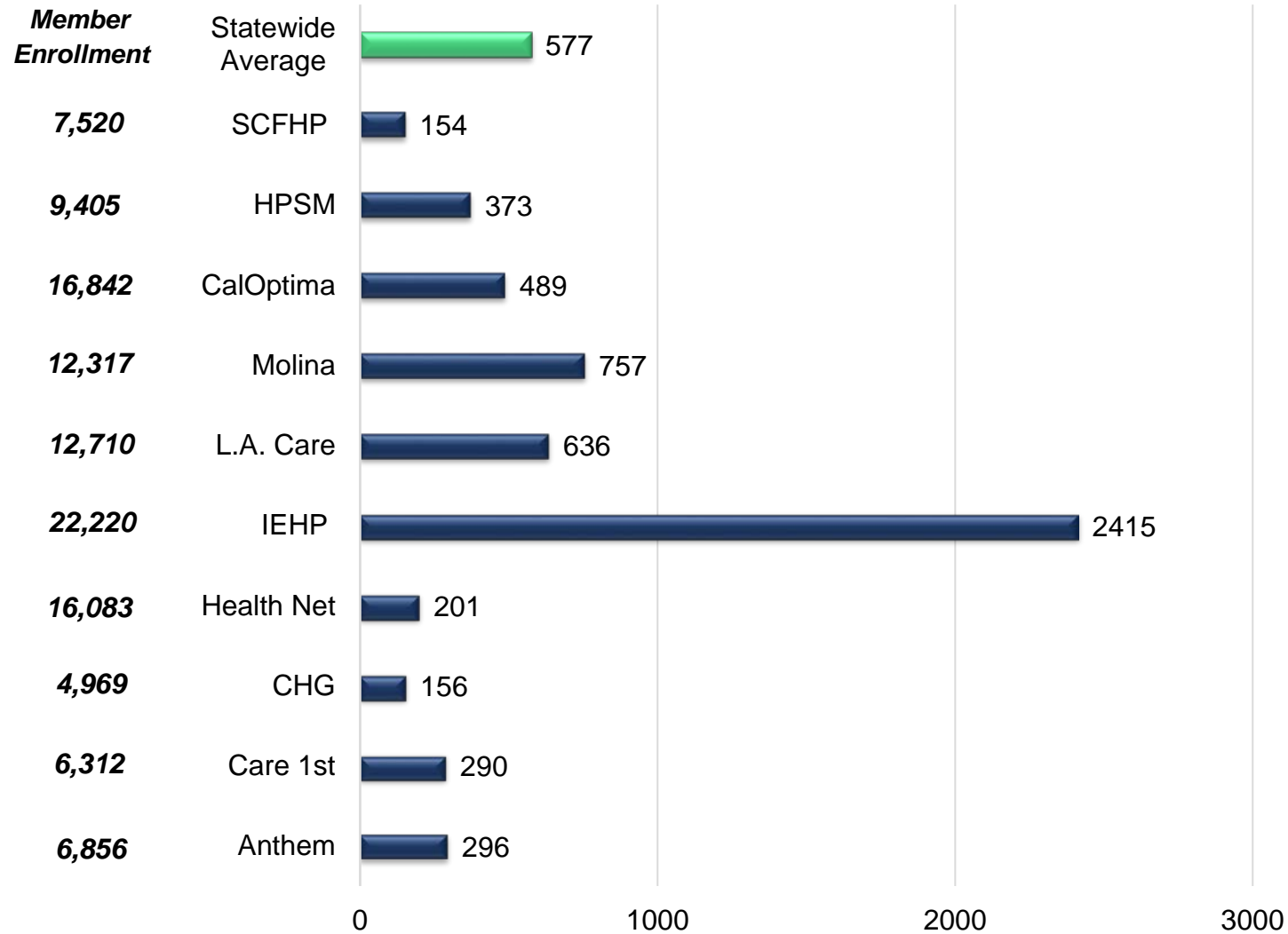
- ■ Inability to get an Appointment with a Primary Care Provider (PCP)
- □ Inability to get an Appointment with a Specialist
- ■ Excessive Wait Time to get an Appointment with a Primary Care Provider (PCP)
- ■ Excessive Wait Time to get an Appointment with a Specialist

Member Enrollment	Plan	Data
7,520	SCFHP	25, 69, 12, 3 — 109
9,405	HPSM	2, 2, 1, 3 — 8
16,842	CalOptima	6, 7, 4, 16 — 33
12,317	Molina	18, 83, 14, 10 — 125
12,710	L.A. Care	11, 4, 16, 10 — 41
22,220	IEHP	34, 40, 4 — 78
16,083	Health Net	1, 7 — 8
4,969	CHG	4, 5, 3, 2 — 14
6,312	Care 1st	5 — 5
6,856	Anthem	4, 1 — 5

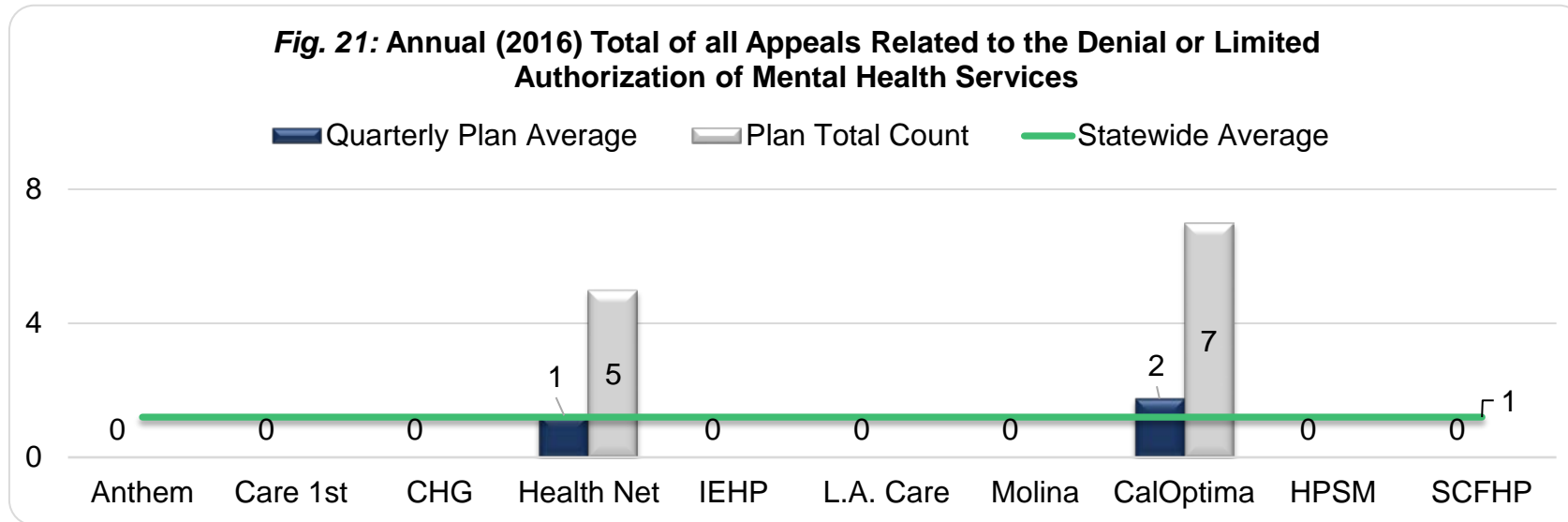(x-axis: 0, 25, 50, 75, 100, 125, 150)

Grievance Figure 20: Count of "Other" Grievances (1/2016-12/2016) See metric summary for additional information

Fig. 20: Annual Count of "Other" Grievances

Member Enrollment		Count
	Statewide Average	577
7,520	SCFHP	154
9,405	HPSM	373
16,842	CalOptima	489
12,317	Molina	757
12,710	L.A. Care	636
22,220	IEHP	2415
16,083	Health Net	201
4,969	CHG	156
6,312	Care 1st	290
6,856	Anthem	296

Appeals Figure 21: Total Number of Appeals Related to the Denial or Limited Authorization of Mental Health Services (1/2016-12/2016) See metric summary for additional information
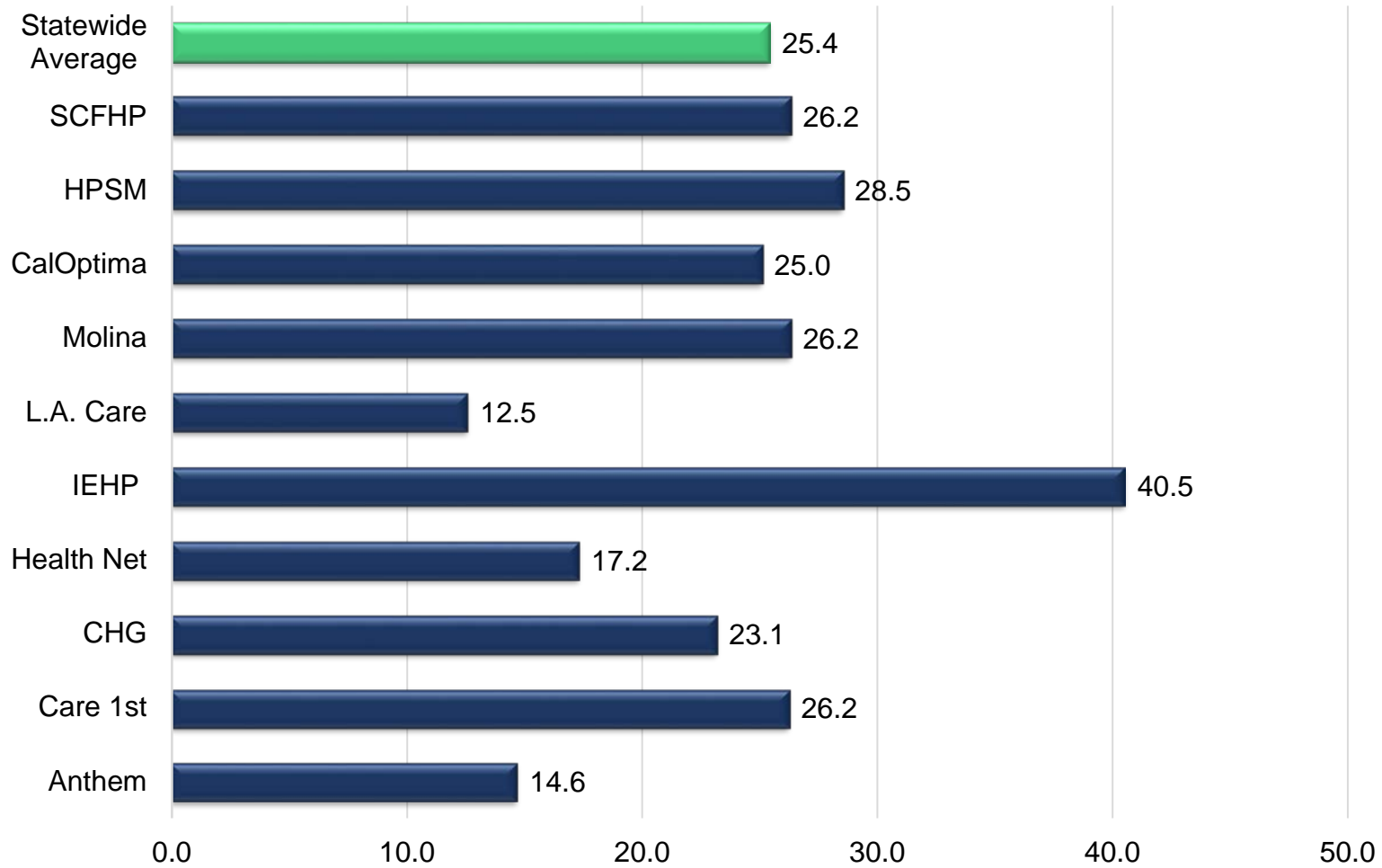

Fig. 21: Annual (2016) Total of all Appeals Related to the Denial or Limited Authorization of Mental Health Services

Quarterly Plan Average | Plan Total Count | Statewide Average

Behavioral Health Figure 22: Emergency Room Behavioral Health Services Utilization per 10,000 Member Months (07/2016-06/2017) See metric summary for additional information

Fig. 22: Quarterly Rolling Statewide Average Count of Emergency Room Behavioral Health Services Utilization
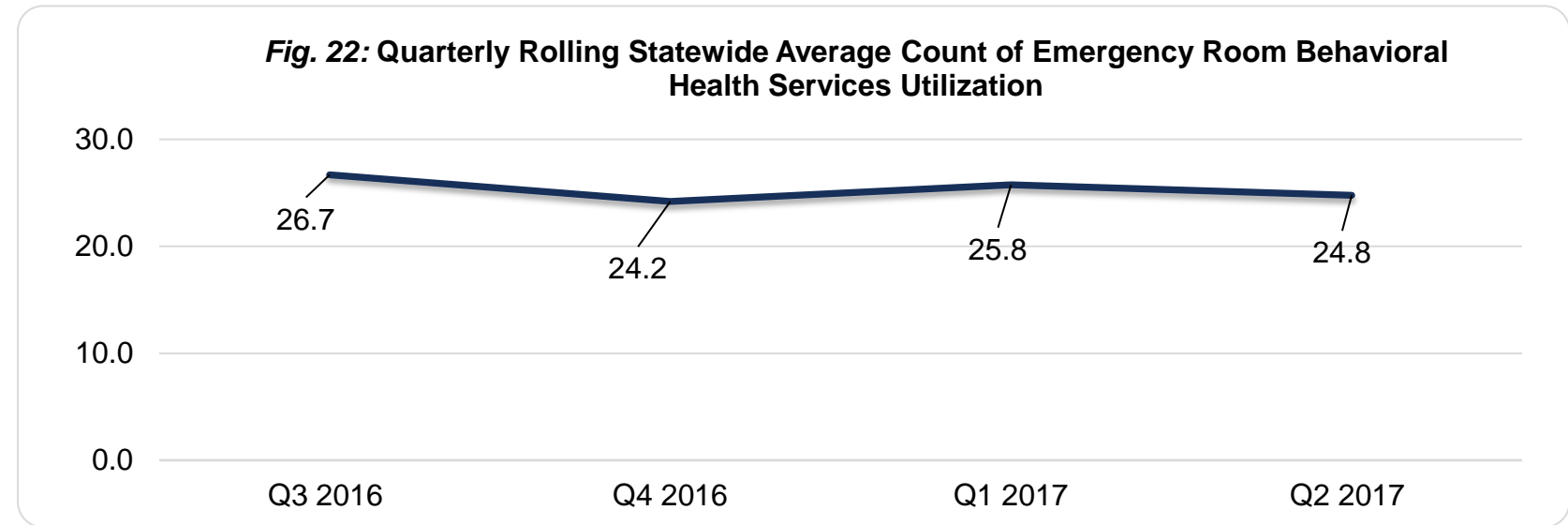
Behavioral Health Figure 23: Emergency Room Behavioral Health Services Utilization per 10,000 Member Months (07/2016-06/2017) See metric summary for additional information

Fig. 23: 12-Month Rolling Average Count of Emergency Room Behavioral Health Services Utilization

Plan	Value
Statewide Average	25.4
SCFHP	26.2
HPSM	28.5
CalOptima	25.0
Molina	26.2
L.A. Care	12.5
IEHP	40.5
Health Net	17.2
CHG	23.1
Care 1st	26.2
Anthem	14.6

Long Term Services & Supports (LTSS) Figure 24 & 25: Utilization of Members Receiving LTSS per 1,000 Members (10/2016-09/2017) See metric summary for additional information

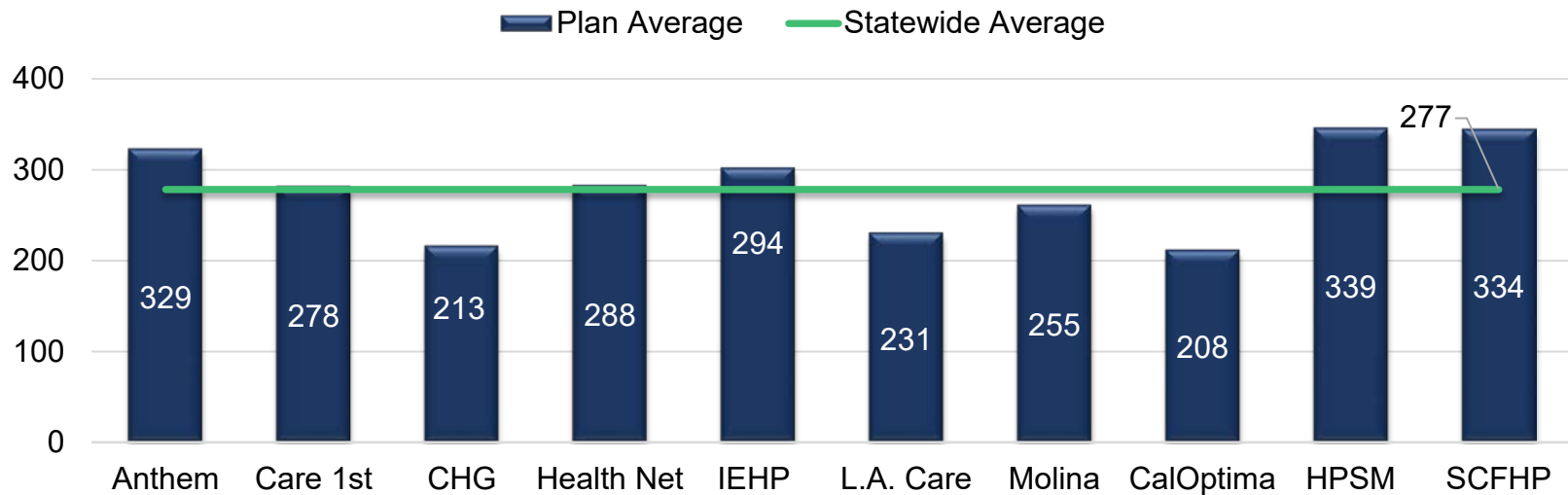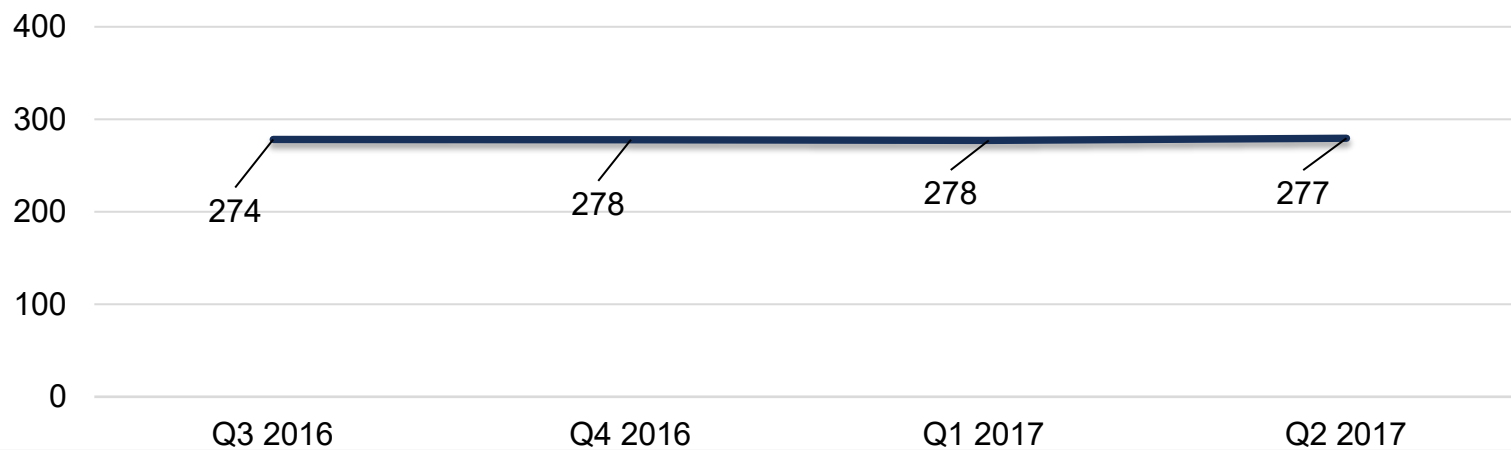### Fig. 24: 12-Month Rolling Average of Members Receiving LTSS per 1,000 Members

Legend: Plan Average ■ Statewide Average —

Plan	Value
Anthem	329
Care 1st	278
CHG	213
Health Net	288
IEHP	294
L.A. Care	231
Molina	255
CalOptima	208
HPSM	339
SCFHP	334

Statewide Average: 277

Fig. 25: Quarterly Rolling Statewide Average of Members Receiving LTSS per 1,000 Members

Quarter	Value
Q3 2016	274
Q4 2016	278
Q1 2017	278
Q2 2017	277

Long Term Services & Supports (LTSS) Figure 26 & 27: The Number of Critical Incident and Abuse Reports for Members Receiving LTSS (07/2016-06/2017) See metric summary for additional information

Fig. 26: 12-Month Rolling Count of Critical Incident and Abuse Reports for Members Receiving LTSS per 100 Members

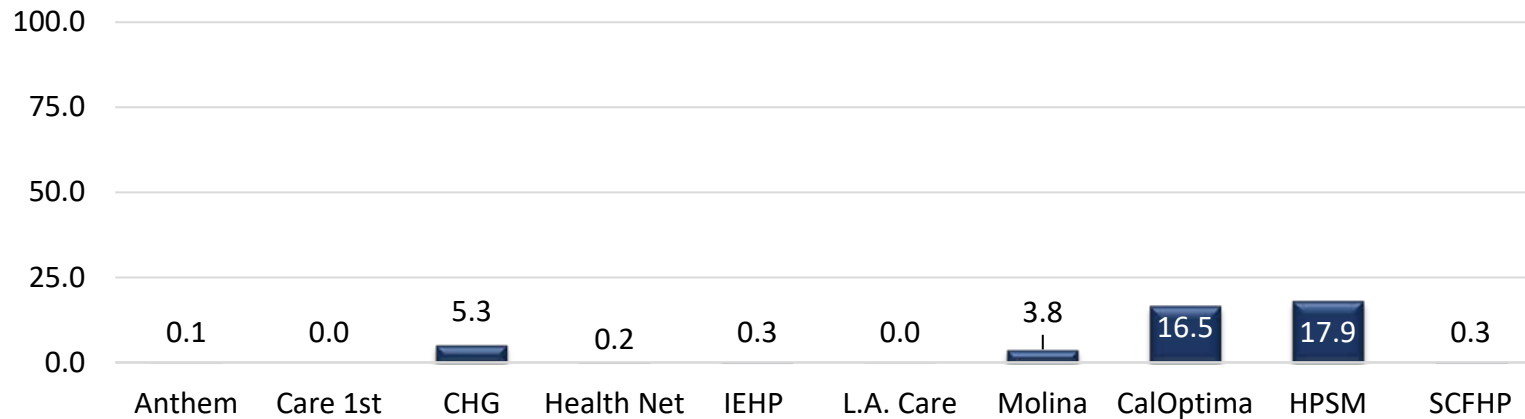| Anthem	Care 1st	CHG	Health Net	IEHP	L.A. Care	Molina	CalOptima	HPSM	SCFHP
0.1	0.0	5.3	0.2	0.3	0.0	3.8	16.5	17.9	0.3

Fig 27: Quarterly Rolling Statewide Count of Critical Incident and Abuse Reports for Members Receiving LTSS per 100 Members

Q3 2016	Q4 2016	Q1 2017	Q2 2017
12.9	11.6	14.1	5.7