Cal MediConnect Performance Dashboard Metrics Summary

Released March 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 from 114,796 members in October 2017 to 111,616 in September 2018, but has been trending slightly higher since April 2018. In Q3 2018, 50% of enrollees spoke English and 31% spoke Spanish as their primary language, with 36% of enrollees identifying as Hispanic. Males and females aged 65 and older represent 29% and 43% of the total CMC population, respectively.
- **Quality Withhold Summary:** *Figure 7*
  All Plans met at least four quality withhold measures and all ten Plans received 50% or more of the quality withhold amount for Calendar Year 2016. Four of the ten Plans received 100% of their withhold.
- **Care Coordination:** *Figures 8-15*
  Figure 8 shows the percentage of members with a health risk assessment (HRA) completed within 90 days of enrollment decreased from 92% in Q4 2017 to 89% in Q3 2018.
- **Grievances and Appeals:** *Figures 16-19*
  Plans reported 46% more grievances in 2017 compared to 2016. In 2017, Plans reported 54%more appeals than in 2016. Of the total appeals, Figure 16 shows that 51% of Plan decisions were either fully or partially favorable to the members appeal.
- **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 25.9 visits per 10,000 member months in Q4 2017 to 22.4 visits in Q3 2018.

- **Long-term Services and Supports:** *Figures 22-37*
  Figure 22 shows that LTSS utilization per 1,000 members has seen little change throughout the reporting period; from an average of 281 members per 1,000 receiving LTSS in Q4 2017, to an average of 280 members in Q3 2018. DHCS is continuing to work with Plans to enhance LTSS referrals. Figures 24-37 display LTSS member referrals and utilization in four categories: In-Home Support Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and Nursing Facility (NF).

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 shows 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, 15, 20, 22, 24, 26, 28, 30, 32, 34 and 36. Metrics represent the entire CMC program broken down by calendar quarters.
- **Current Quarter data by plan:** Figures 9, 11, 23, 25, 27, 29, 31, 33, 35 and 37.
  Metrics represent the data for the most recent quarter broken down by plan.
- **Annual data:** Figures 7, 12, 13, 14, 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, Figure 20 and Figures 22-37 have been updated for the March 2019 release.
- **New Data:** Figures 26, 27, 30, 31, 34 and 35 were added to display member referrals for LTSS services - CBAS, MSSP and NF. [1] The addition of these new figures has altered some figure numbers compared to the previous release.
- **Note 1:** Figure 1 has been changed to a line graph to effectively display the enrollment trend.
- **Note 2:** Care 1st's name has been changed to "Blue Shield of California Promise Health Plan".

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.

[1] IHSS member referral data are not included in this dashboard due to ongoing data quality assessment.

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

Quality Withhold Measures:

CMS and DHCS monitors Plans using quality measures relating to beneficiaries' overall experience, care coordination, fostering of 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 2016.

[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

Figure 7 shows the quality withhold measures for the calendar year 2016. 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, as mentioned above, or based on HEDIS, CAHPS, or other national data sources. Quality withhold measure results indicated with "N/A" represent measures that were not applicable for a plan due to low enrollment or inability to meet other reporting criteria. Quality withhold measure results indicated with "*" represents measures that also utilize the gap closure target methodology[1].

- **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 2: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/QualityWithholdResultsReport_CA_DY2_06192018.pdf

- **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)
- I**nteraction 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 shows that all 10 Plans met at least four quality withhold measures and nine of the ten Plans received at least 75% or more of their quality withhold amount for Calendar Year 2016. Anthem, IEHP, Molina and HPSM received 100% of their withhold.

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 decreased from 92% in Q4 2017 to 89% in Q3 2018. Figure 9 shows that four out of ten plans (Blue Shield, CHG, HealthNet, and HPSM) are below the statewide average of 89% for Q3 2018.

Figure 10 indicate that the percent of members with an ICP for Q3 2018 has increased to 69% from 65% in Q2 2018. Figure 11 indicates four out of ten plans have a percentage of members with an ICP below the statewide average of 69% for Q3 2018. 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 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:

Figures 17 and 18 show that in 2017, members filed 9,072 grievances with Plans. This is an increase of 2,879 member grievances reported as compared to 2016.[1] 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.

The number of appeals varies greatly by Plans, as well as the percentage of decisions that are adverse versus partially or fully favorable. However, Figure 16 shows that 51% of Plan decisions were either fully or partially favorable to the member's appeal when filed in 2017. Figure 19 shows that 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 and clarify 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.

[1]Cal MediConnect Performance Dashboard June 2018: https://www.dhcs.ca.gov/Documents/CMCDashboard6.18.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 slightly from 25.9 visits per 10,000 member months in Q4 2017 to 22.4 visits in Q3 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. 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 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) and Nursing Facility Services (NF).

LTSS Trends:

Figure 22 shows that LTSS utilization per 1,000 members has seen little change throughout reporting period, from an average of 281.1 members per 1,000 receiving LTSS in Q4 2017, to an average of 279.9 members in Q3 2018.

Figure 24 shows that IHSS utilization per 1,000 members has seen little change throughout reporting period from an average of 235.4 members per 1,000 receiving IHSS in Q4 2017, to an average of 236.1 members in Q3 2018.

Figure 26 shows that CBAS referrals per 1,000 members has decreased from an average of 1.9 members per 1,000 in Q2 2018 to an average 1.5 members per 1,000 in Q3 2018. Figure 27 shows IEHP and HPSM reported the highest number of CBAS referrals of roughly 4 per 1,000 members in Q3 2018. Figure 28 shows that CBAS utilization per 1,000 members has remained steady at an average of 10 members per 1,000 receiving CBAS between Q4 2017 – Q3 2018.

Figure 30 shows that MSSP referrals per 1,000 members has increased from an average of 0.6 members per 1,000 in Q2 2018 to an average 0.7 members per 1,000 in Q3 2018. Figure 32 shows that MSSP utilization per 1,000 members has increased slightly from 5.4 members per 1,000 in Q4 2017 to 5.7 members per 1,000 in Q3 2018.

Figure 34 shows that NF referrals per 1,000 members has increased from an average of 3.4 members per 1,000 in Q4 2017 to an average 4 members per 1,000 in Q3 2018. Figure 35 shows HPSM and SCFHP reported the highest number of NF referrals of 9 per 1,000 members in Q3 2018. Figure 36 shows that NF utilization per 1,000 members has decreased from 30.1 members per 1,000 in Q4 2017 to 28.2 members per 1,000 in Q3 2018.

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 are working closely with the plans to review their MSSP referral rates, and to identify best practices to ensure members are being connected with needed services.

Plan Key:

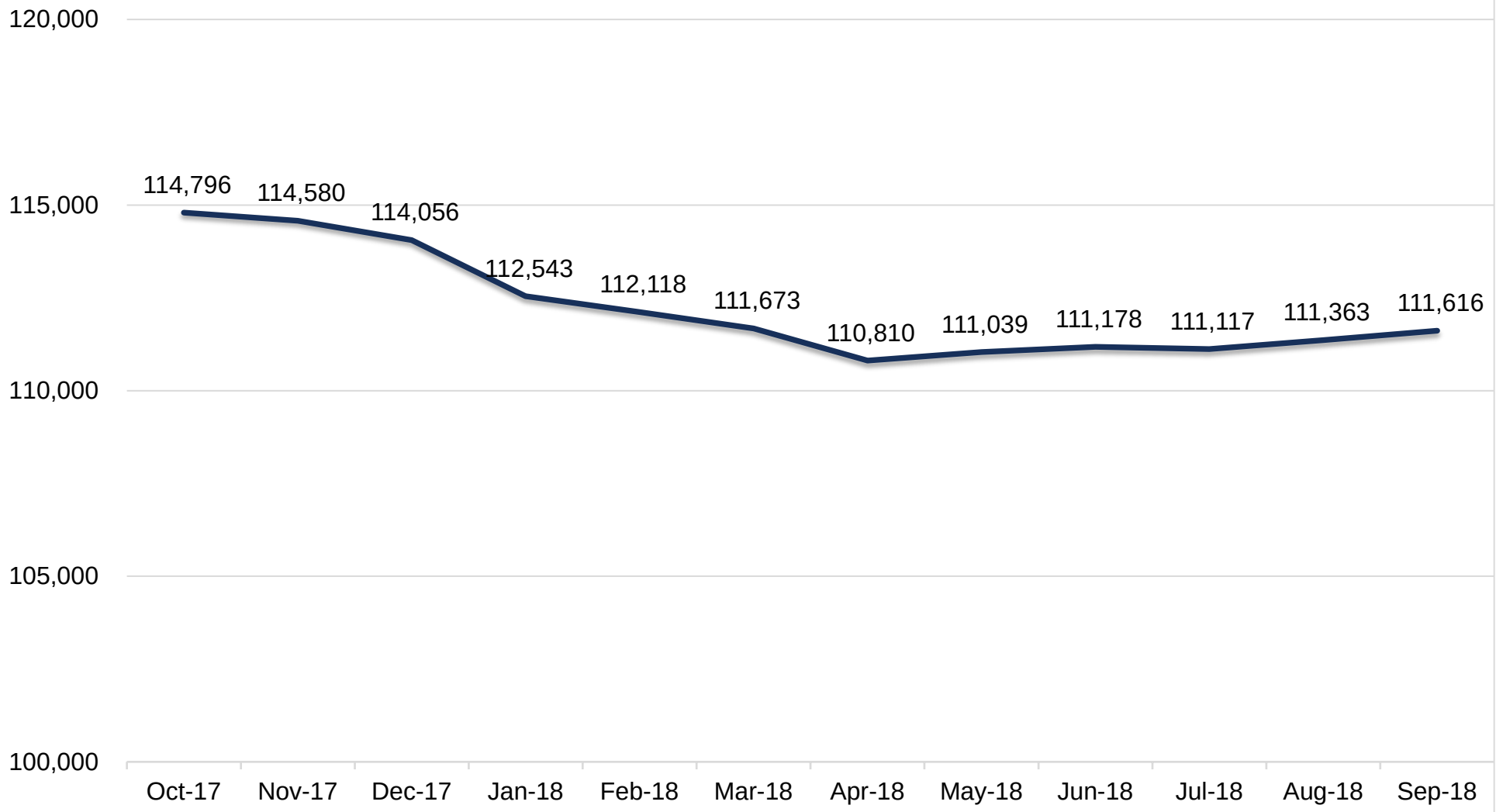
Plan Name	Plan Abbreviation on Dashboard
Anthem Blue Cross Partnership of California	Anthem/CareMore
Blue Shield of California Promise Health Plan*	Blue Shield
CalOptima	CalOptima
Community Health Group	CHG
Health Net	Health Net
Health Plan of San Mateo	HPSM
Inland Empire Health Plan	IEHP
L.A. Care	L.A. 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 09/1/2018)

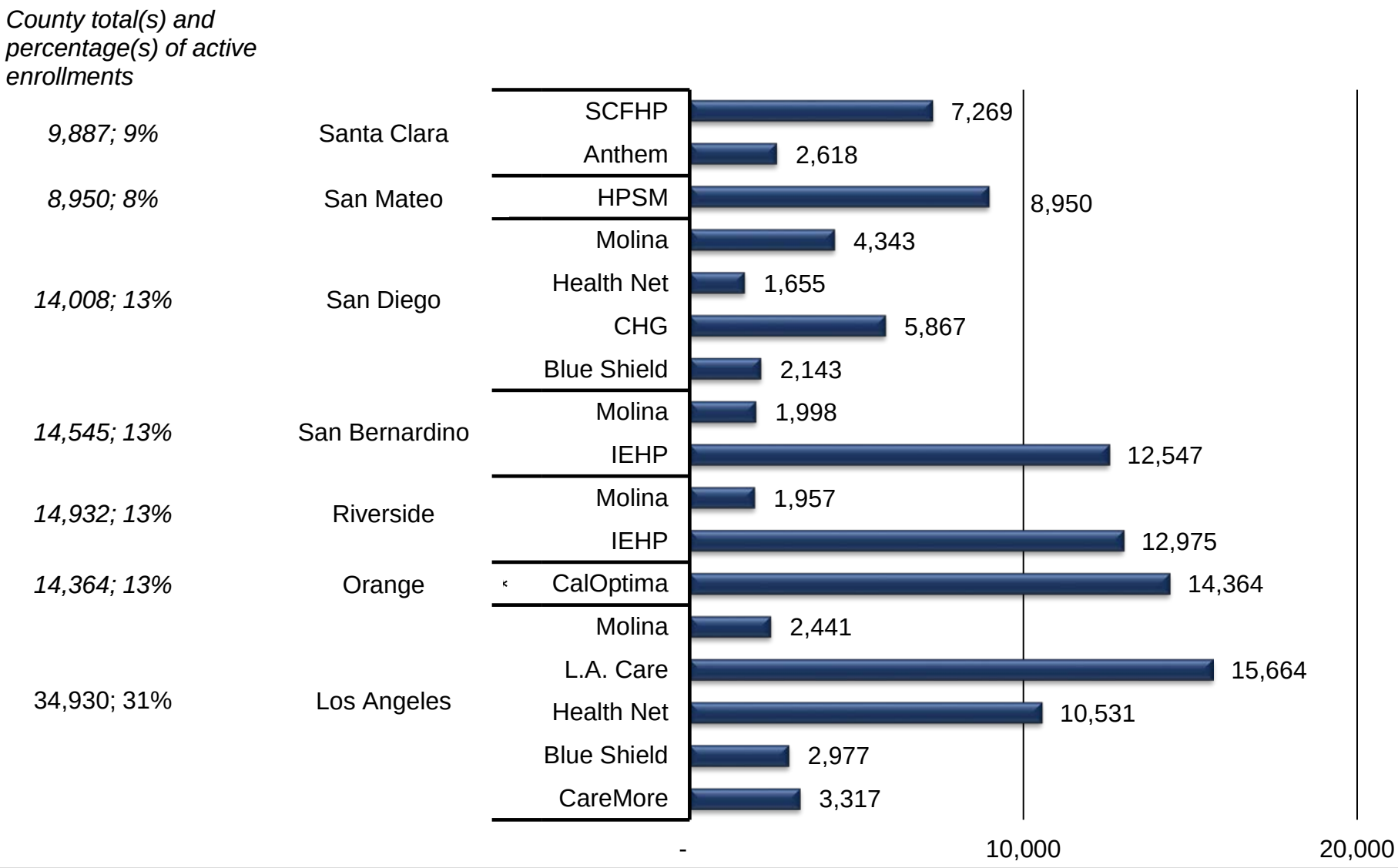
See metric summary for additional information

Fig. 1: **Monthly Enrollment**



Cal MediConnect Enrollment and Demographics Figure 2: Breakdowns of Dual Populations (As of 09/1/2018)
See metric summary for additional information

Fig. 2: **Count and Percentage of Total Active Enrollments, by County and Plan as of September 2018**



Cal MediConnect Enrollment and Demographics Figure 3 - 6: Breakdowns of Dual Populations (As of 09/1/2018)

See metric summary for additional information

***Fig. 3:* Quarter 3 Enrollment by Race/Ethnicity**

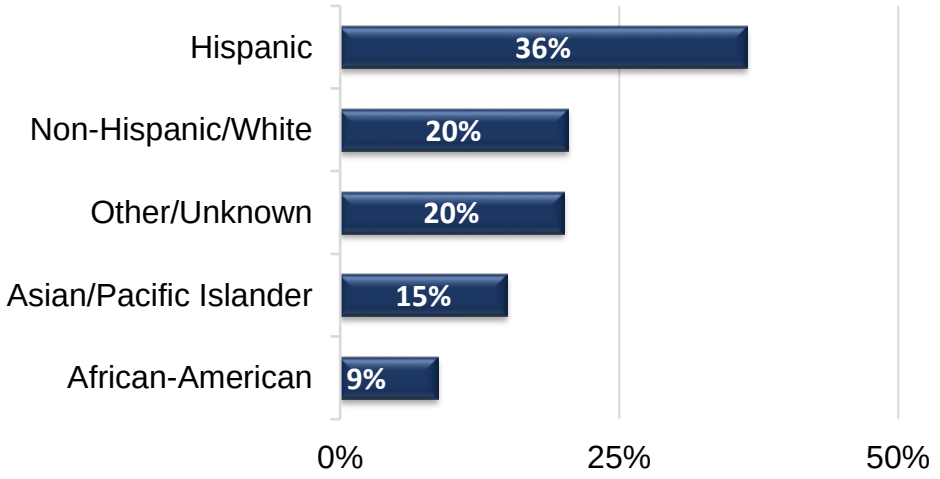


***Fig. 4:* Quarter 3 Enrollment by Age**

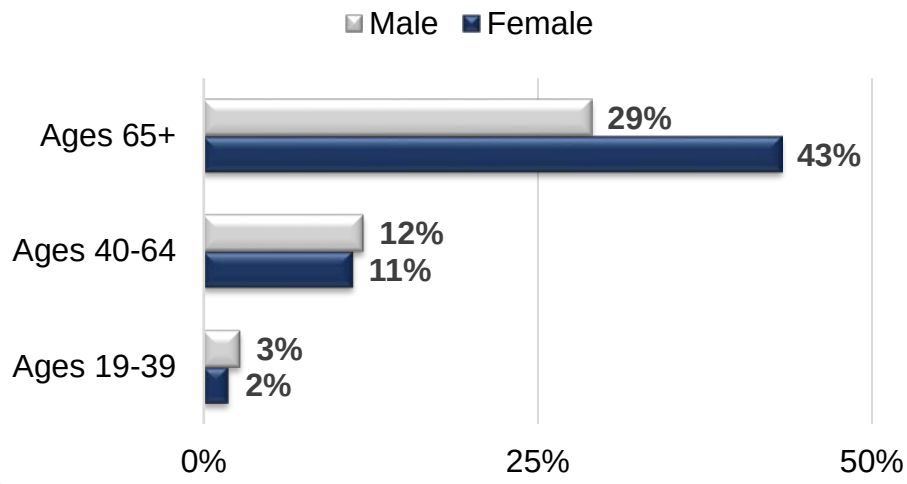


***Fig. 5*: Quarter 3 Enrollment by Threshold Language Spoken**

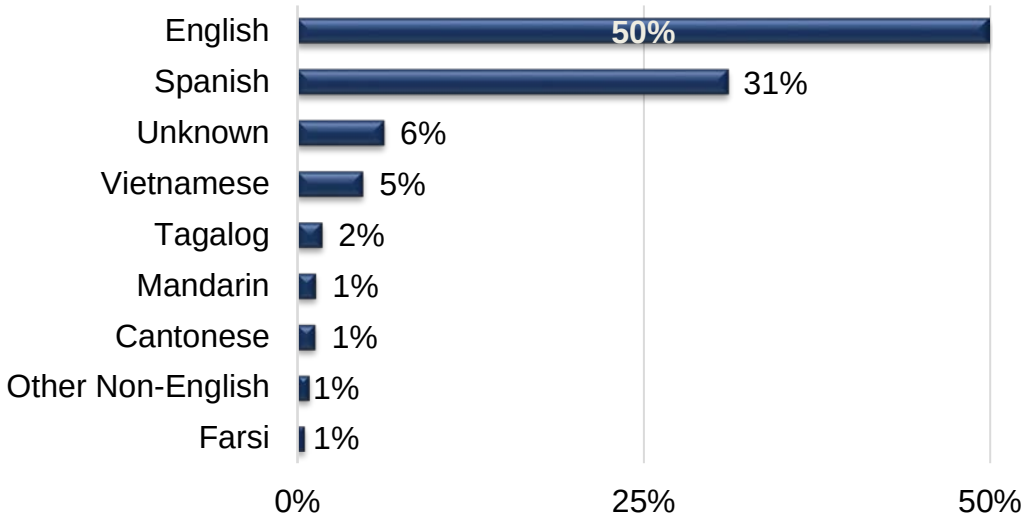
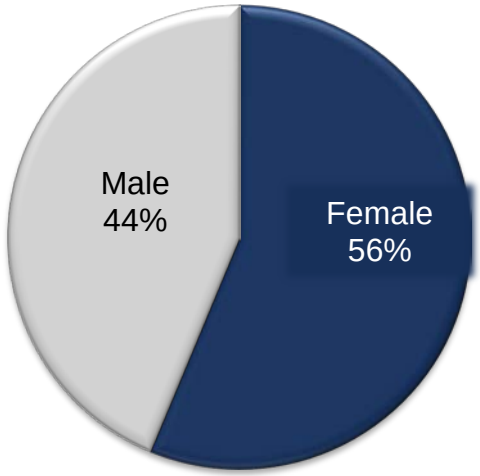


***Fig. 6:* Quarter 3 Enrollment by Gender**



Cal MediConnect Figure 7: Quality Withhold Summary Table (CY 2016)
See metric summary for additional information

Medicare-Medicaid Plan	CW6 – Plan All-Cause Readmissions Benchmark: 1.00	CW7 – Annual Flu Vaccine* Benchmark: 69%	CW8 – Follow-Up After Hospitalization for Mental Illness* Benchmark: 56%	CW11 – Controlling Blood Pressure* Benchmark: 56%	CW12 Medication Adherence for Diabetes Medications* Benchmark: 73%	CW13 Encounter Data Benchmark: 80%
Anthem	Met	Met	Not Met	Met	Met	Met
Blue Shield	Not Met	Met	Met	Met	Met	Met
CHG	Met	Met	Not Met	Met	Met	Met
Health Net	Met	Not Met	Not Met	Met	Met	Met
IEHP	Met	Met	Met	Met	Met	Not Met
L.A. Care	Met	Not Met	Met	Met	Met	Met
Molina	Met	Met	Met	Met	Met	Met
CalOptima	Met	N/A	Met	Met	Met	Not Met
HPSM	Met	Met	Met	Met	Met	Met
SCFHP	Met	Met	Met	Met	Met	Not Met

Medicare-Medicaid Plan	CAW7 Behavioral Health Shared Accountability Outcome Measure* Benchmark: 10% Decrease	CAW8 Documentation of Care Goals* Benchmark: 55%	CAW9 Interaction with Care Team* Benchmark: 78%	Total # of Measures in Analysis	Total # of Measures Met	% of Measures Met	% of Withhold Received
Anthem	N/A	Met	Met	8	7	88%	100%
Blue Shield	Not Met	Met	Met	9	7	78%	75%
CHG	Met	Not Met	Met	9	7	78%	75%
Health Net	Met	Met	Met	9	7	78%	75%
IEHP	Met	Met	Met	9	8	89%	100%
L.A. Care	Met	Met	Not Met	9	7	78%	75%
Molina	Met	Met	Met	9	9	100%	100%
CalOptima	N/A	Not Met	Not Met	7	4	57%	50%
HPSM	Met	Met	Met	9	9	100%	100%
SCFHP	N/A	Met	Not Met	8	6	75%	75%
California Averages				**9**	**7**	**82%**	**83%**

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 (10/2017-09/2018)

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**

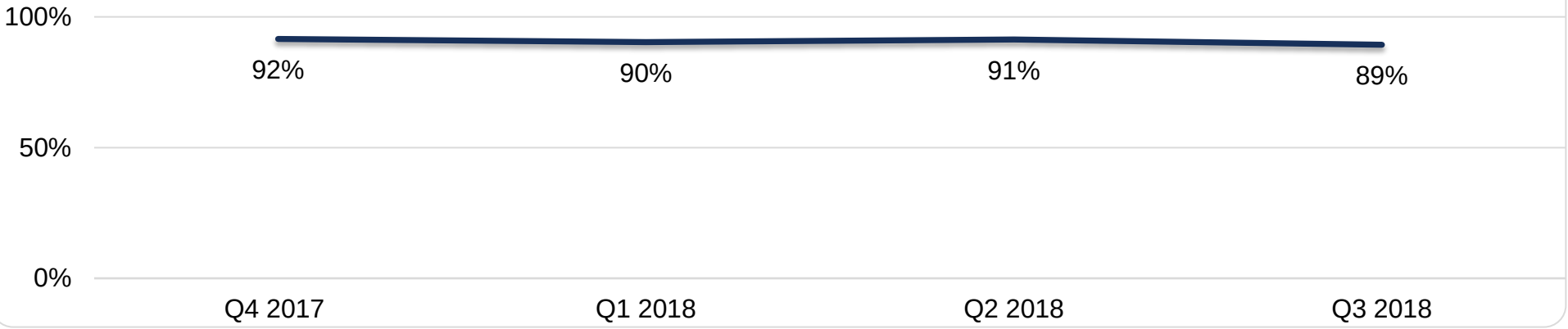
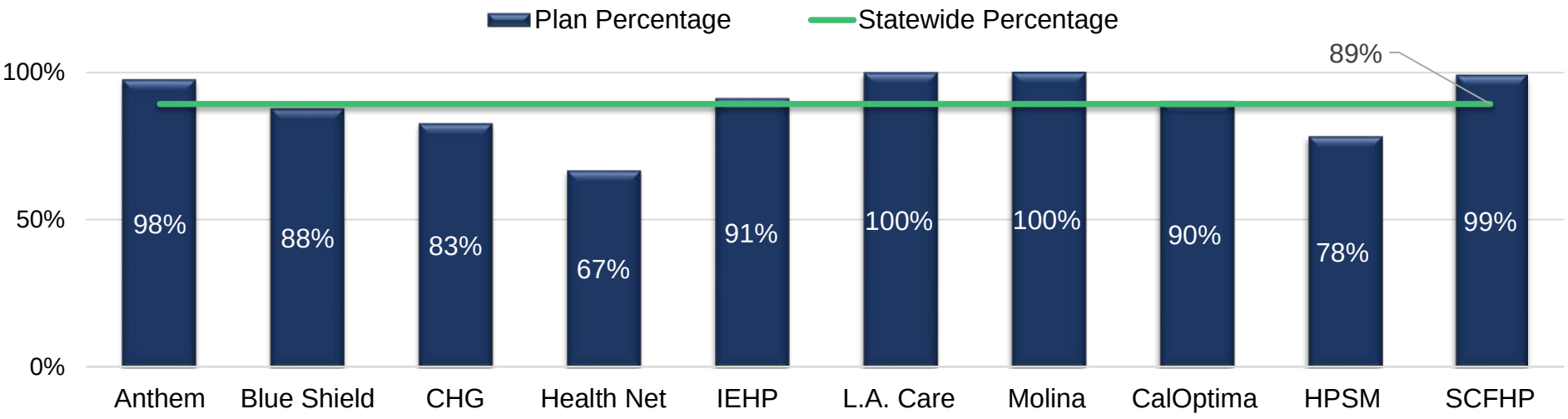


Fig. 9: **The Percentage of Members Willing to Participate and who the Plan was able to Locate with an Assessment Completed Within 90 Days of Enrollment for Quarter 3 of 2018**



Care Coordination Figure 10 & 11: Percentage of Members with an Individualized Care Plan (ICP)
(10/2017-09/2018) See metric summary for additional information

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

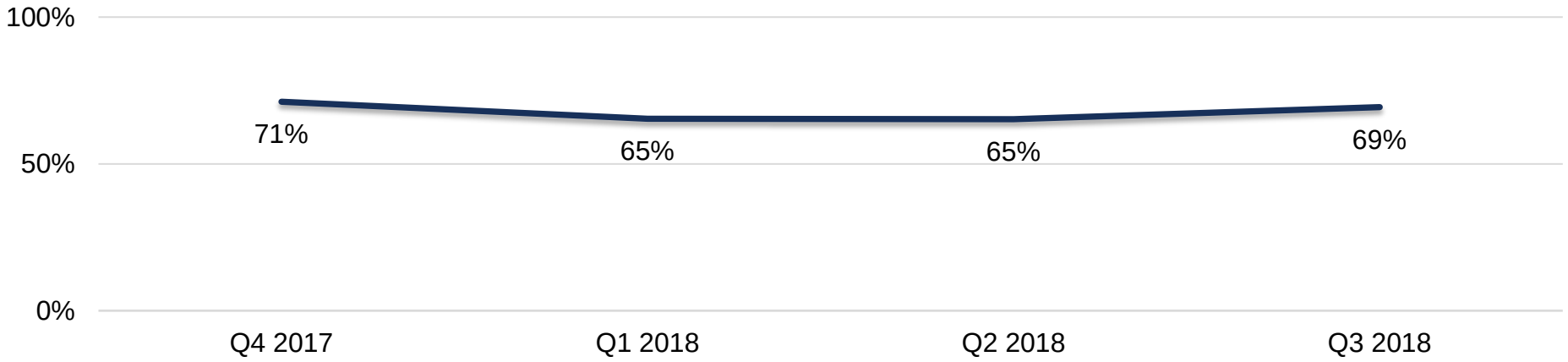
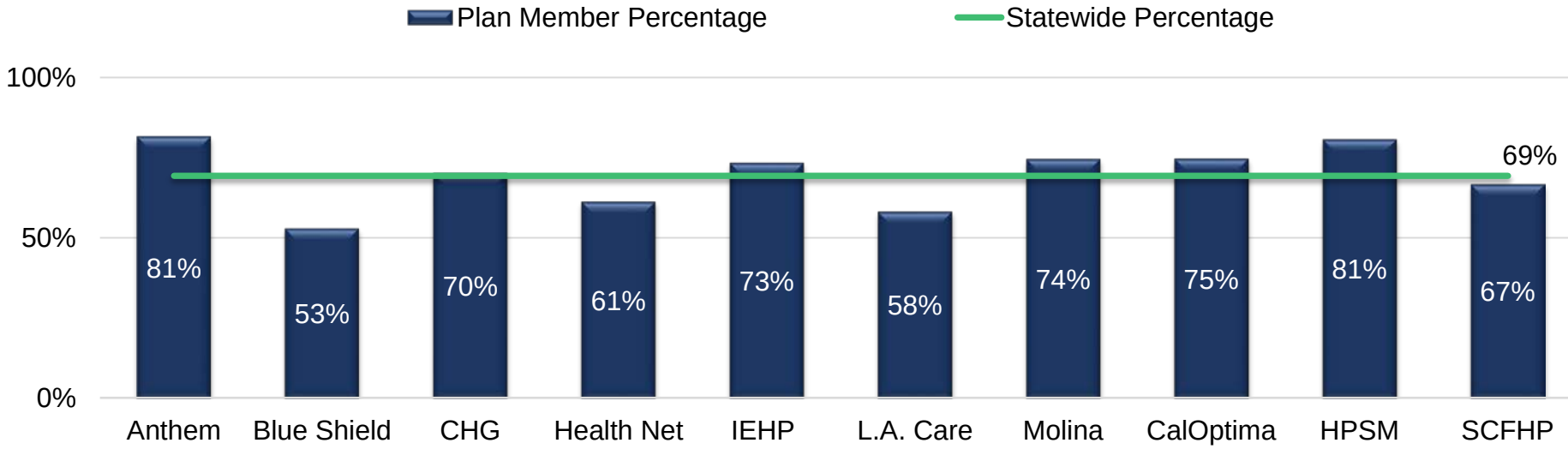
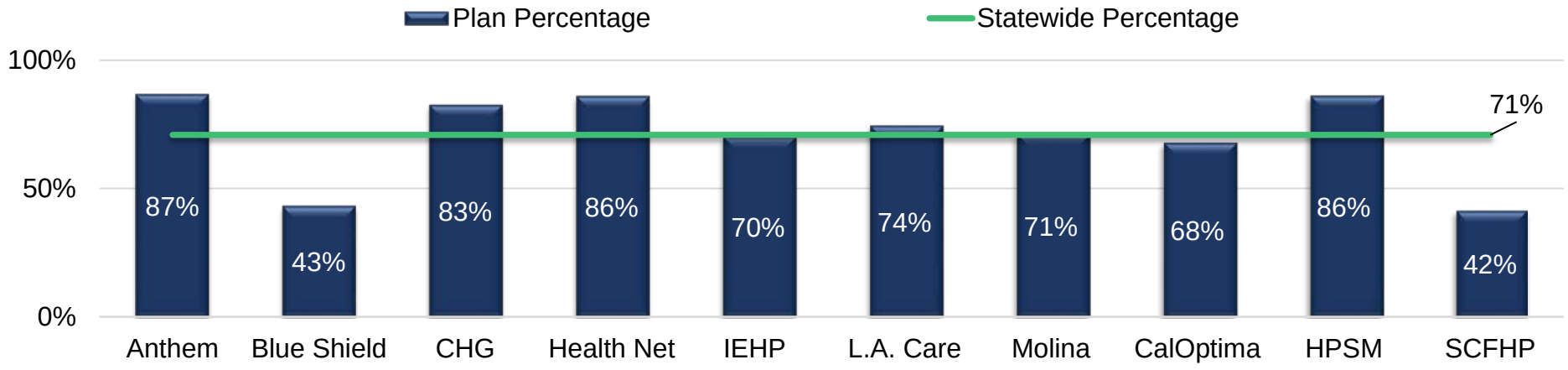


Fig. 11: **Percentage of Members with an ICP for Quarter 3 of 2018**



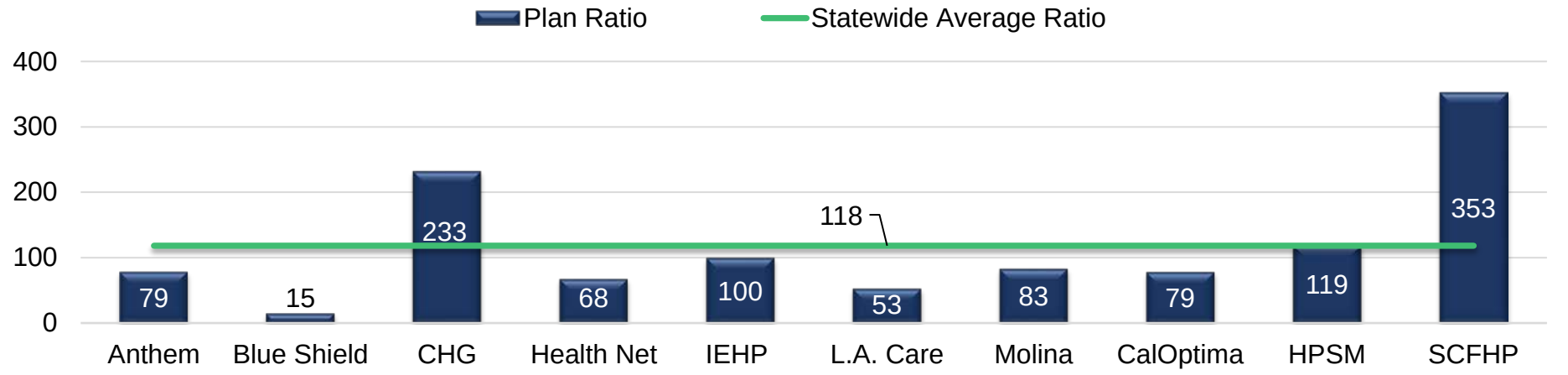
Care Coordination Figure 12: Percentage of Members Who Have a Care Coordinator and Have at Least One Care Team Contact During the Reporting Period (01/2017-12/2017) See metric summary for additional information

Fig. 12: **Annual (2017) Percentage of Members who have a Care Coordinator and have at least One Care team Contact During the Reporting Period**



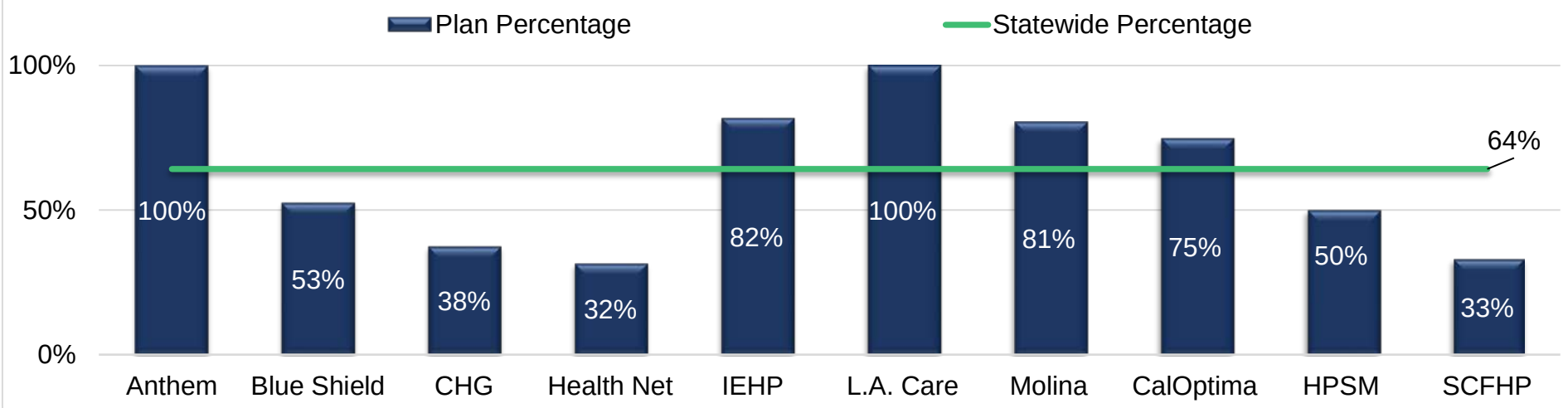
Care Coordination Figure 13: Member to Care Coordinator Ratio (01/2017-12/2017)
See metric summary for additional information

Fig. 13: **Annual (2017) Number of Members to Care Coordinator Ratio**



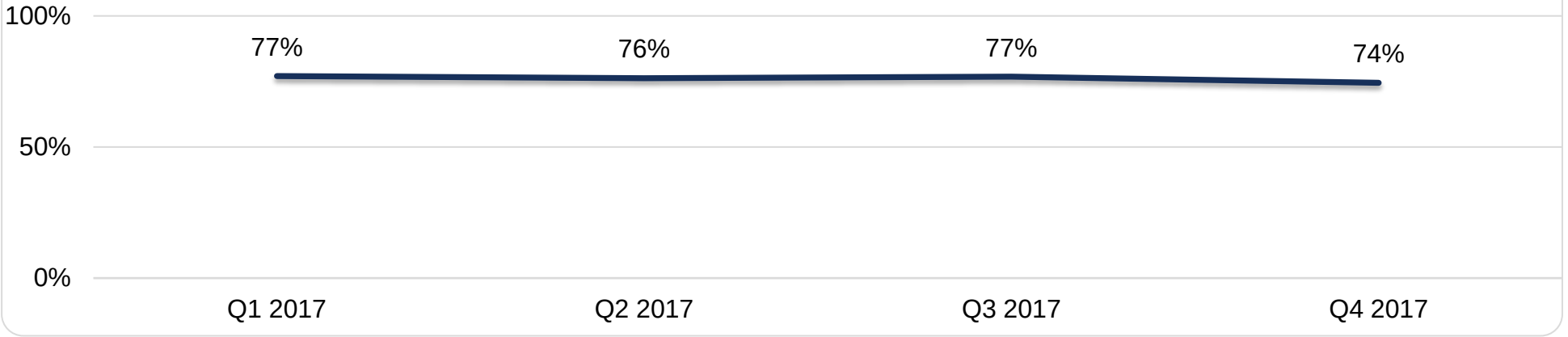
Care Coordination Figure 14: Percentage of Members with Documented Discussions of Care Goals (01/2017-12/2017)
See metric summary for additional information

***Fig. 14*: Annual (2017) Percentage of Members with Documented Discussions of Care Goals**



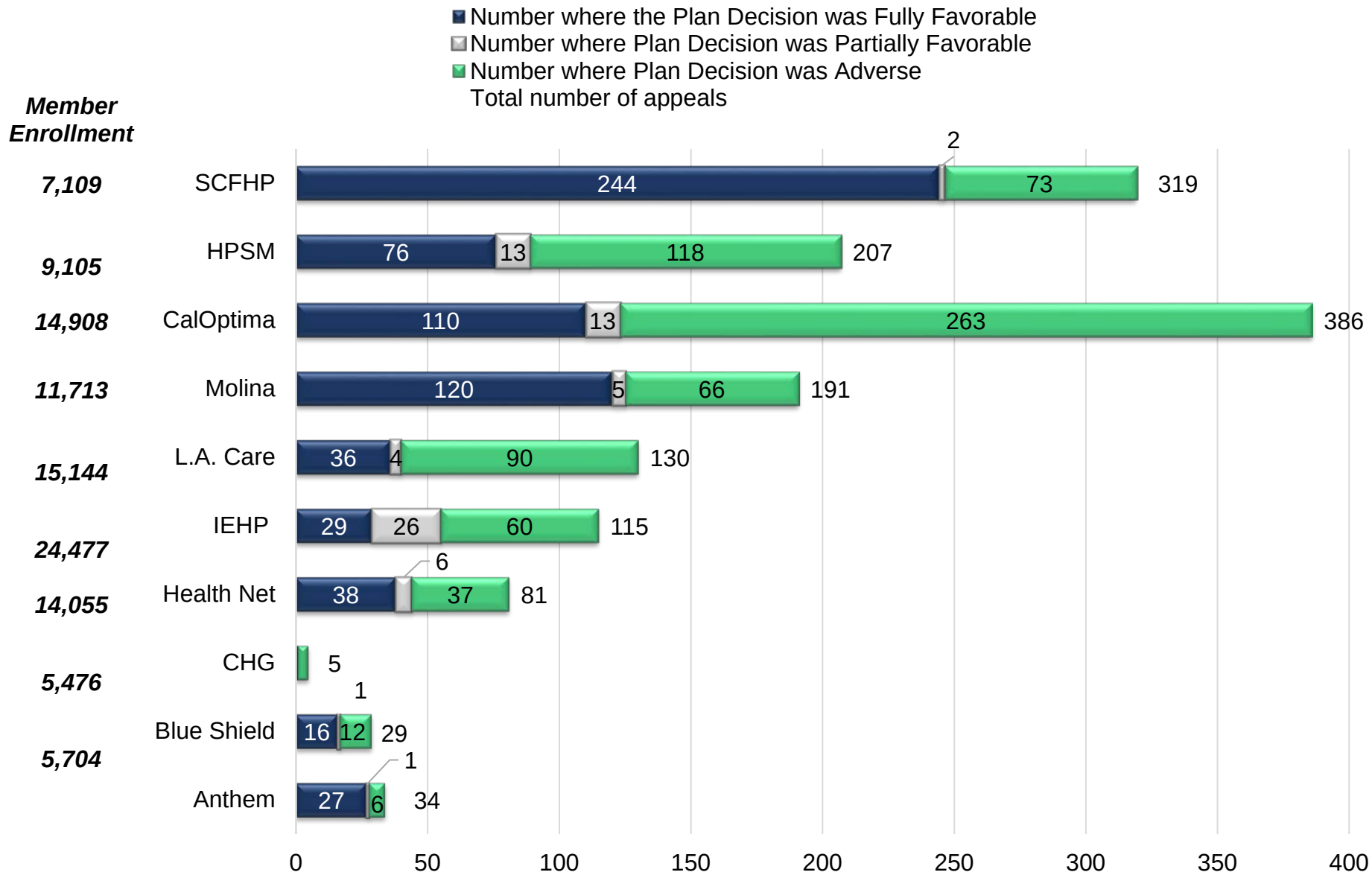
Care Coordination Figure 15: Percentage of Members with First Follow-up Visit within 30 Days after Hospital Discharge (01/2017-12/2017) See metric summary for additional information

***Fig. 15*: Quarterly Rolling Statewide Percentage of Members with First Follow-Up Visit within 30 Days after Hospital Discharge**



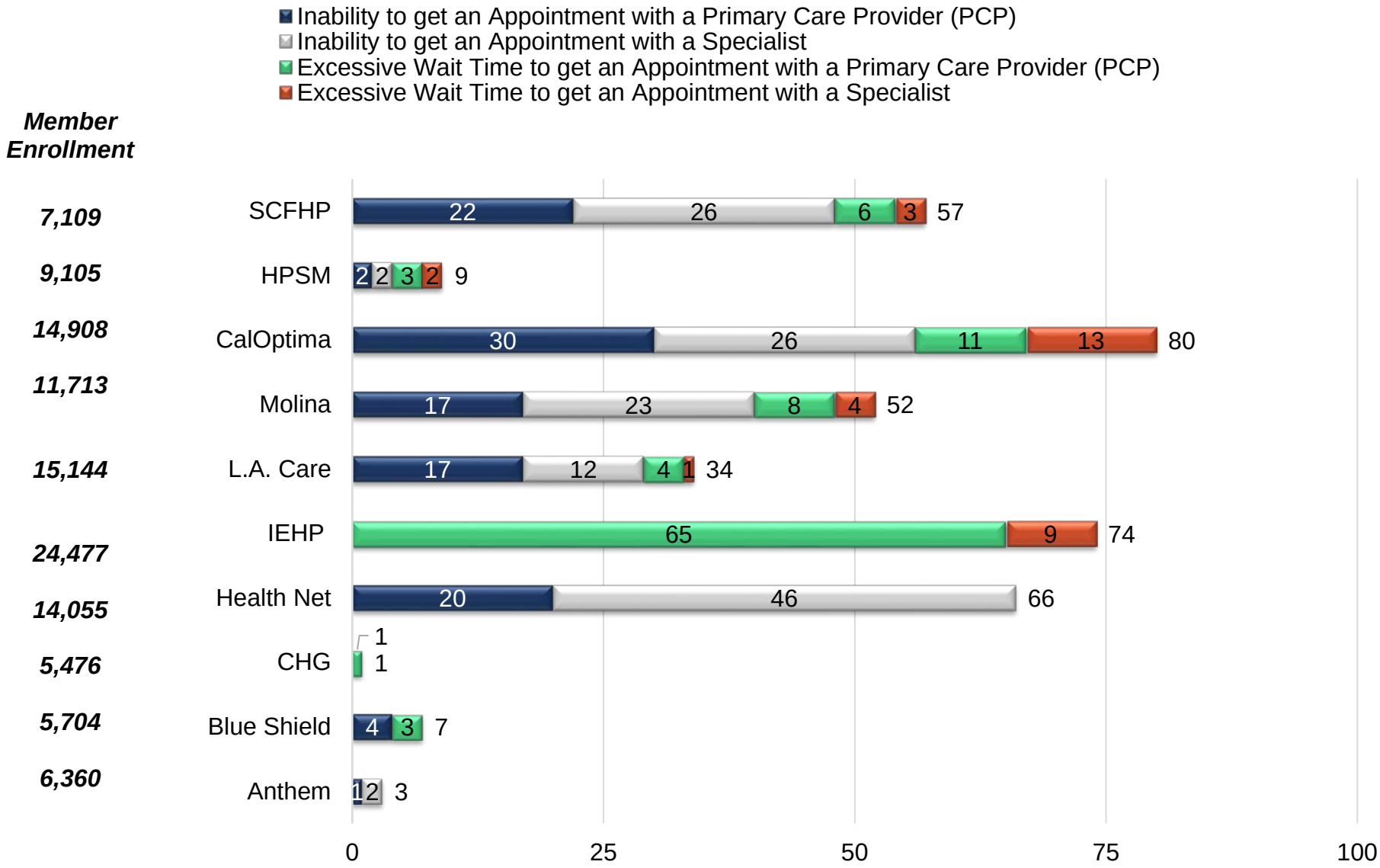
Appeal Figure 16: Count of Appeals (01/2017-12/2017) See metric summary for additional information

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



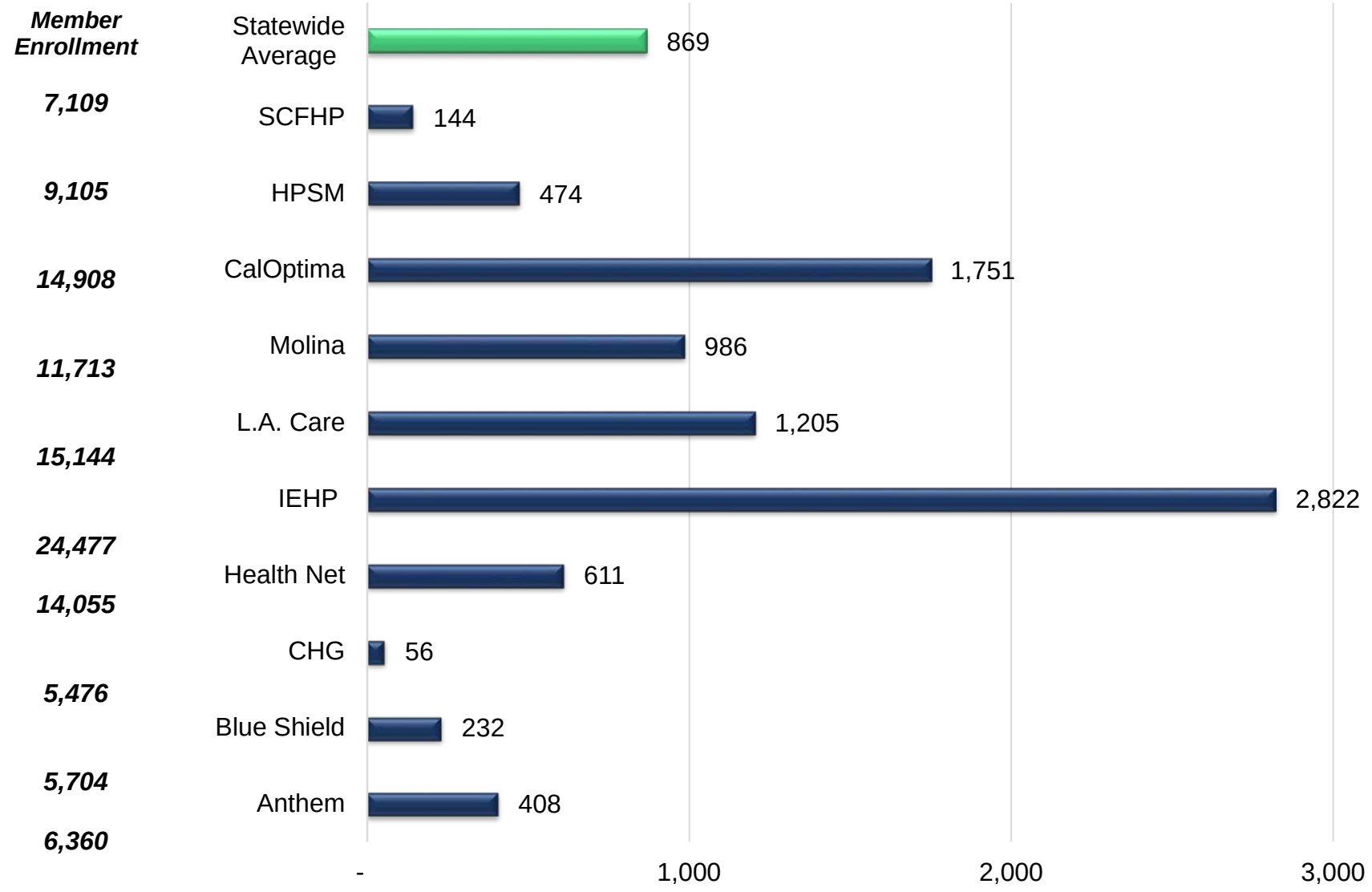
Grievance Figure 17: Count Grievances by type, Except "Other" (01/2017-12/2017)
See metric summary for additional information

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



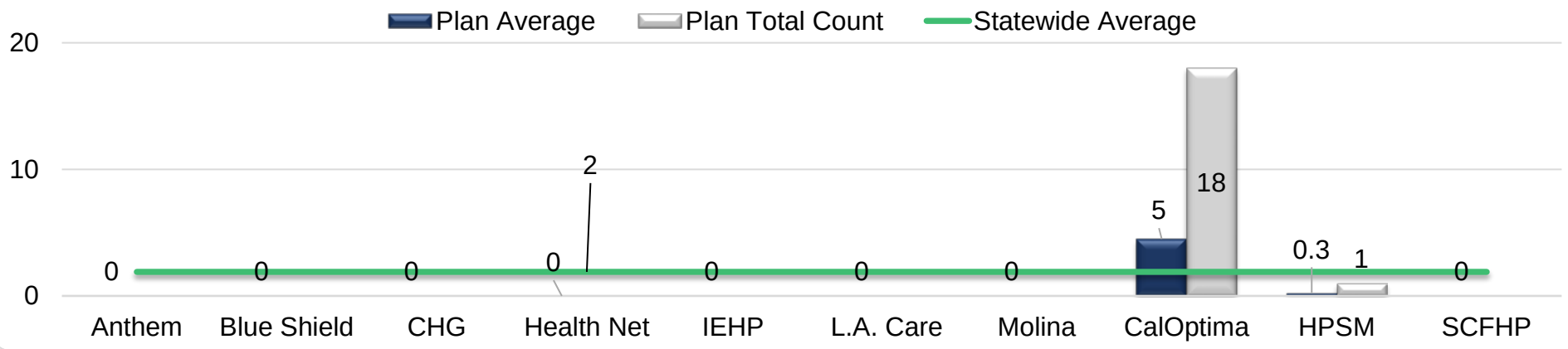
Grievance Figure 18: Count of "Other" Grievances (01/2017-12/2017) See metric summary for additional information

***Fig. 18*: Annual Count of "Other" Grievances**



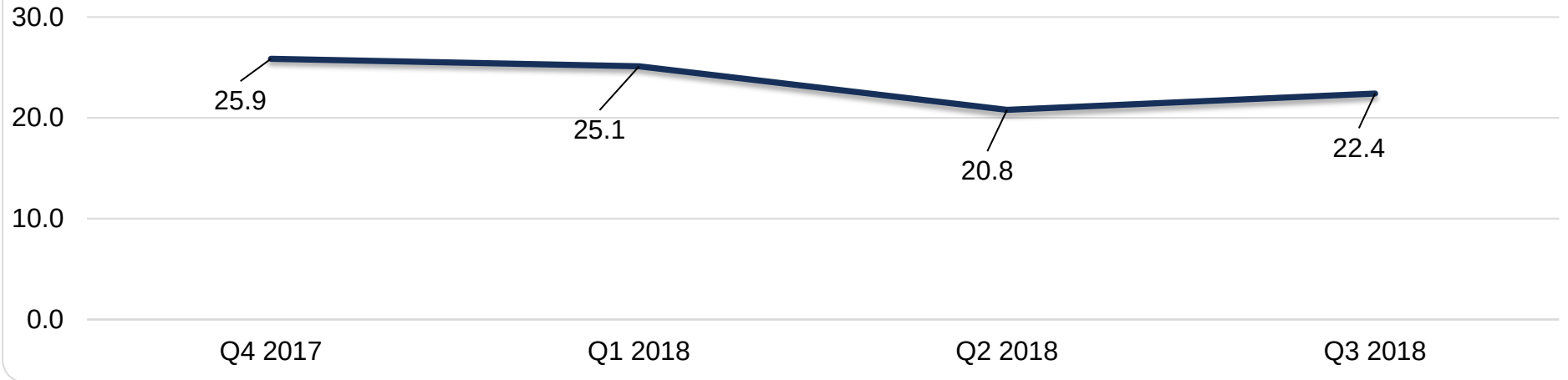
Appeals Figure 19: Total Number of Appeals Related to the Denial or Limited Authorization of Mental Health Services (01/2017-12/2017) See metric summary for additional information

Fig. 19: **Annual (2017) Total of all Appeals Related to the Denial or Limited Authorization of Mental Health Services**



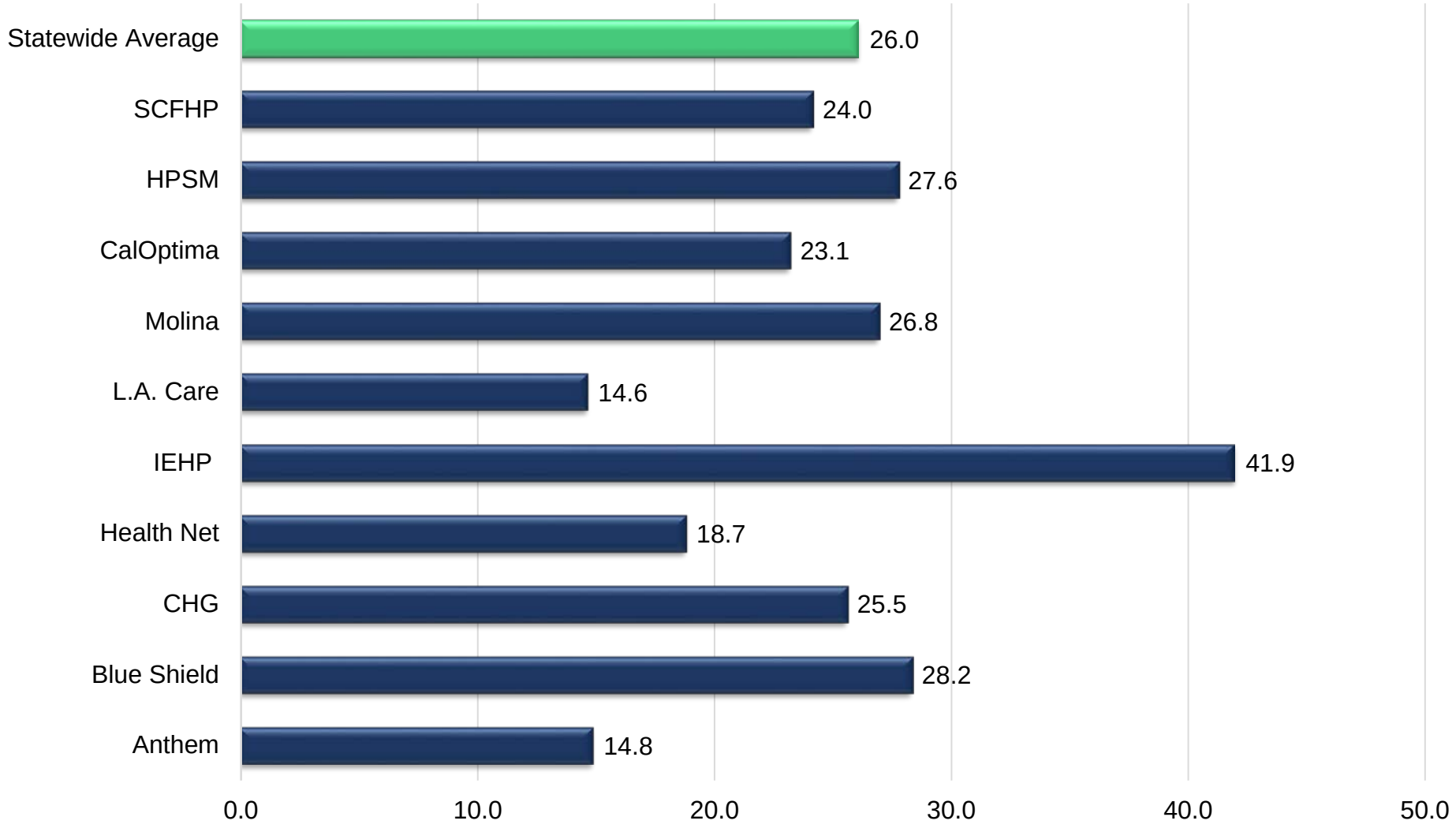
Behavioral Health Figure 20: Emergency Room Behavioral Health Services Utilization per 10,000 Member Months (10/2017-09/2018) See metric summary for additional information

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 (01/2017-12/2017) 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 (10/2017-09/2018) See metric summary for additional information

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

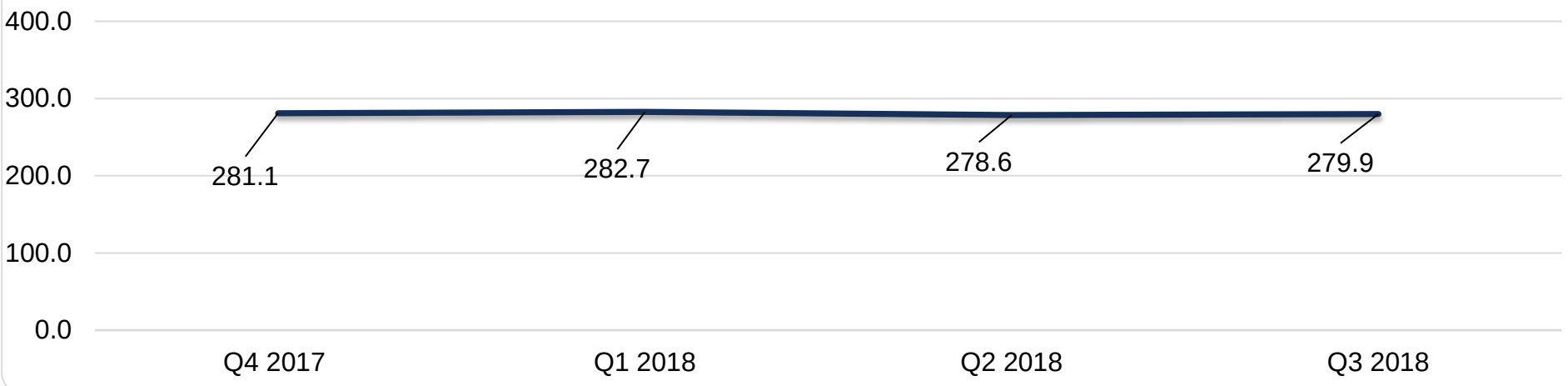
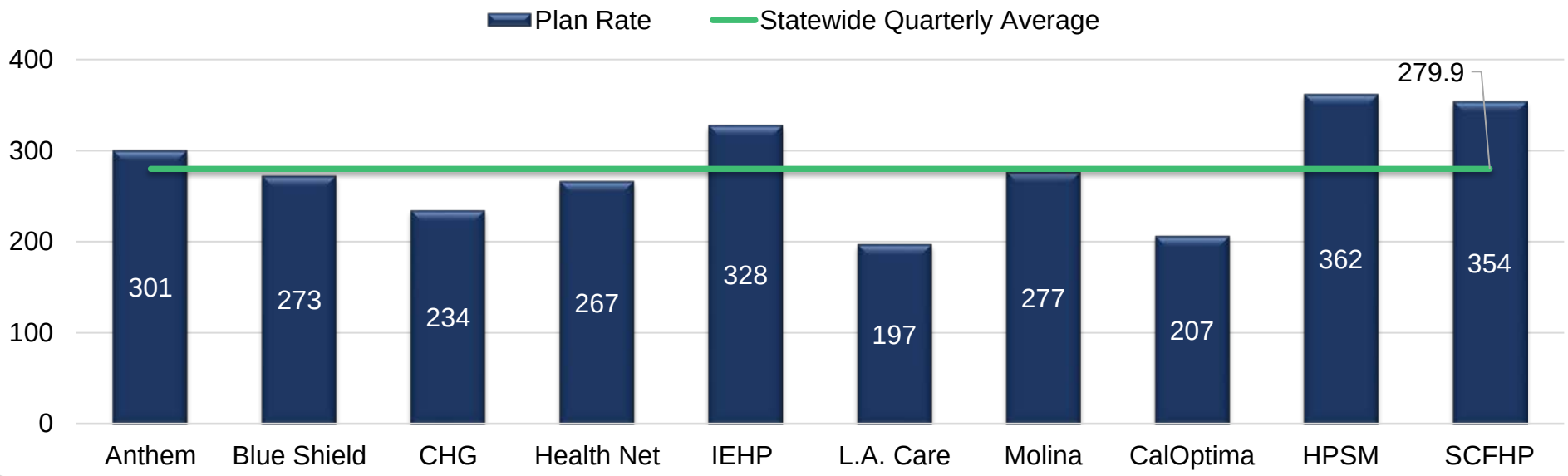


Fig. 23: Count of Members Receiving LTSS per 1,000 members for Quarter 3 of 2018



Long Term Services & Supports (LTSS) Figure 24 & 25: Count of IHSS per 1,000 Members
(10/2017-09/2018) See metric summary for additional information

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

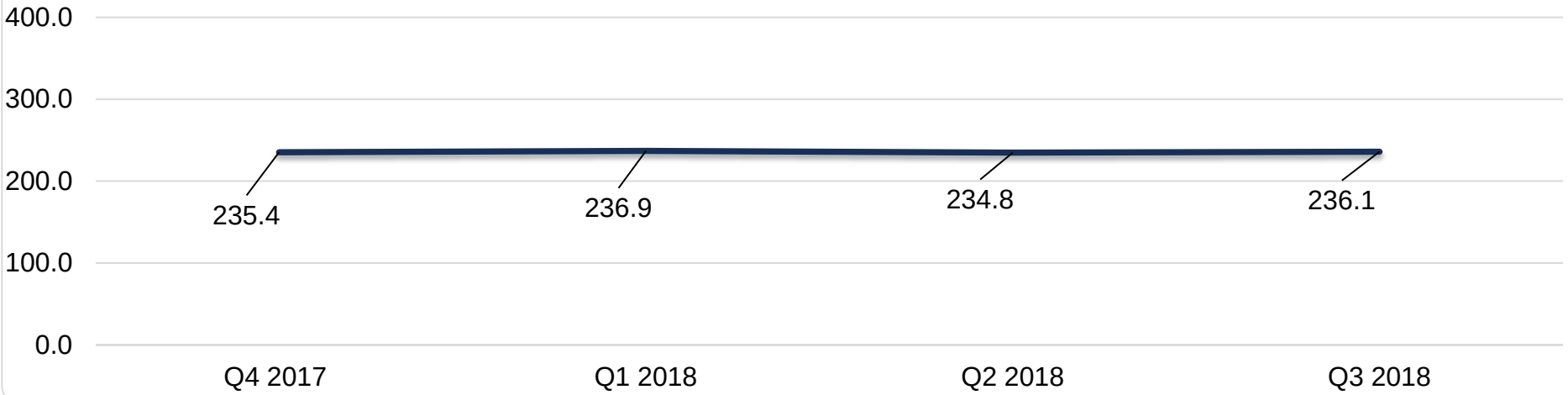
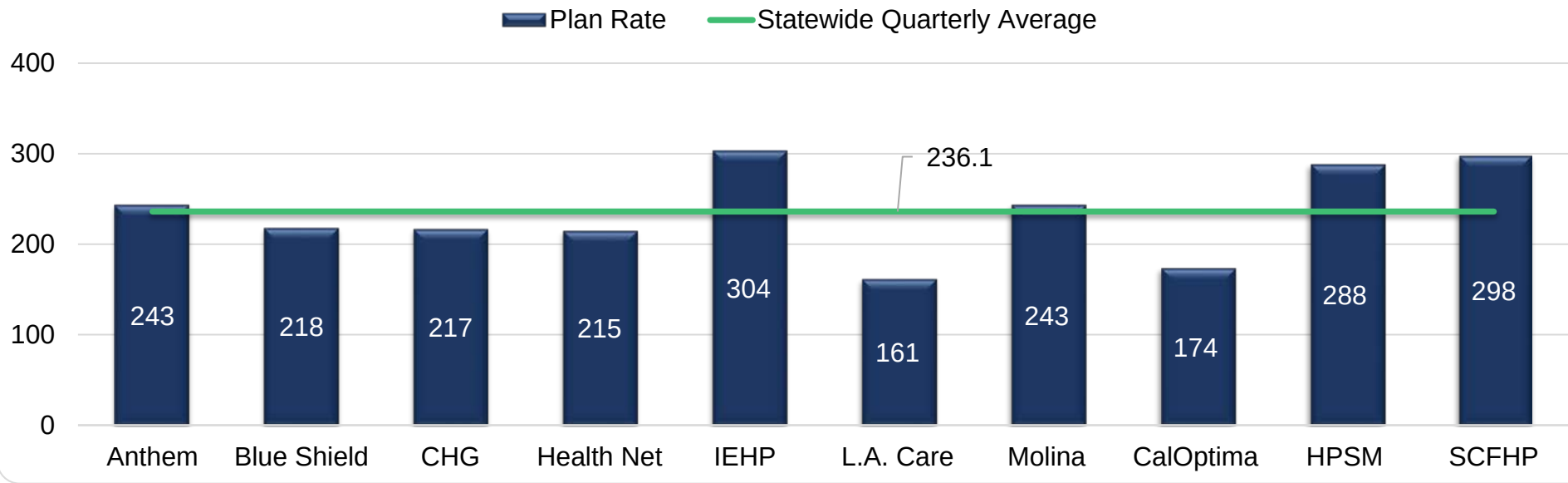


Fig. 25: Count of Members Receiving IHSS per 1,000 members for Quarter 3 of 2018



Long Term Services & Supports (LTSS) Figure 26 & 27: Count of CBAS per 1,000 Members
(10/2017-09/2018) See metric summary for additional information

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

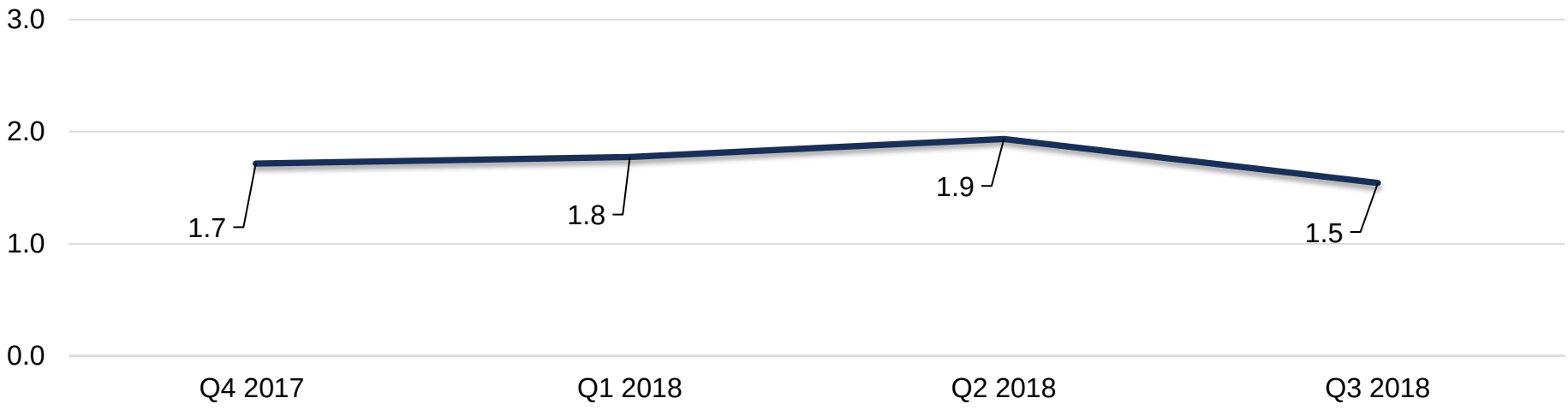
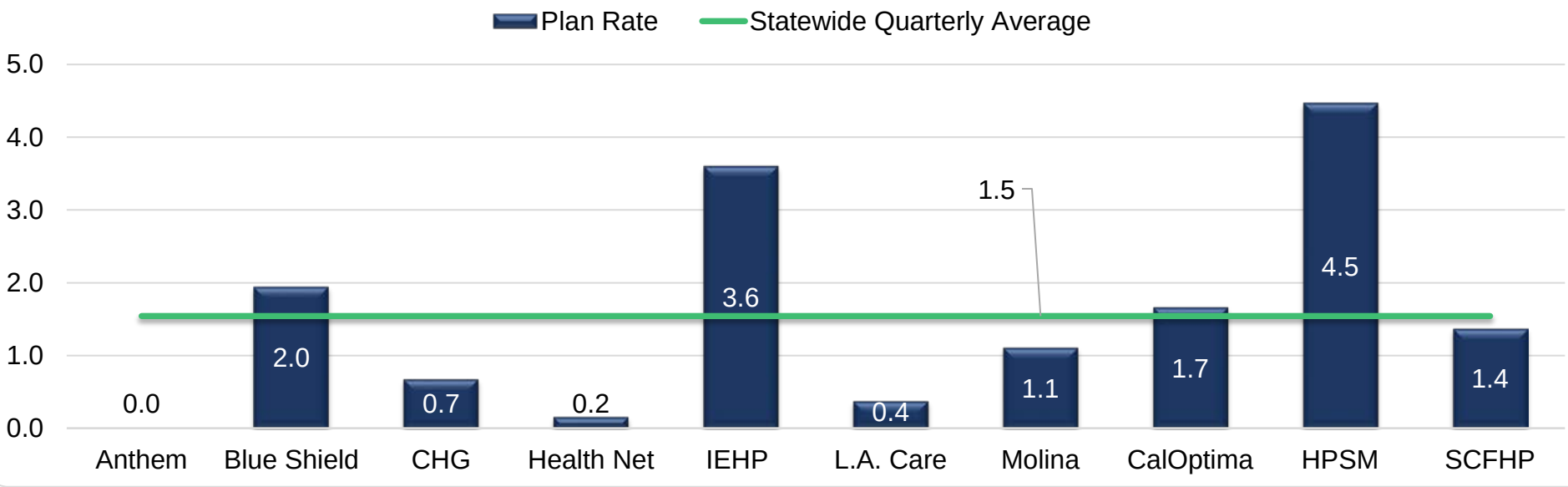


Fig. 27: Count of CBAS Member Referrals per 1,000 members for Quarter 3 of 2018



Long Term Services & Supports (LTSS) Figure 28 & 29: Count of CBAS per 1,000 Members
(10/2017-09/2018) See metric summary for additional information

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

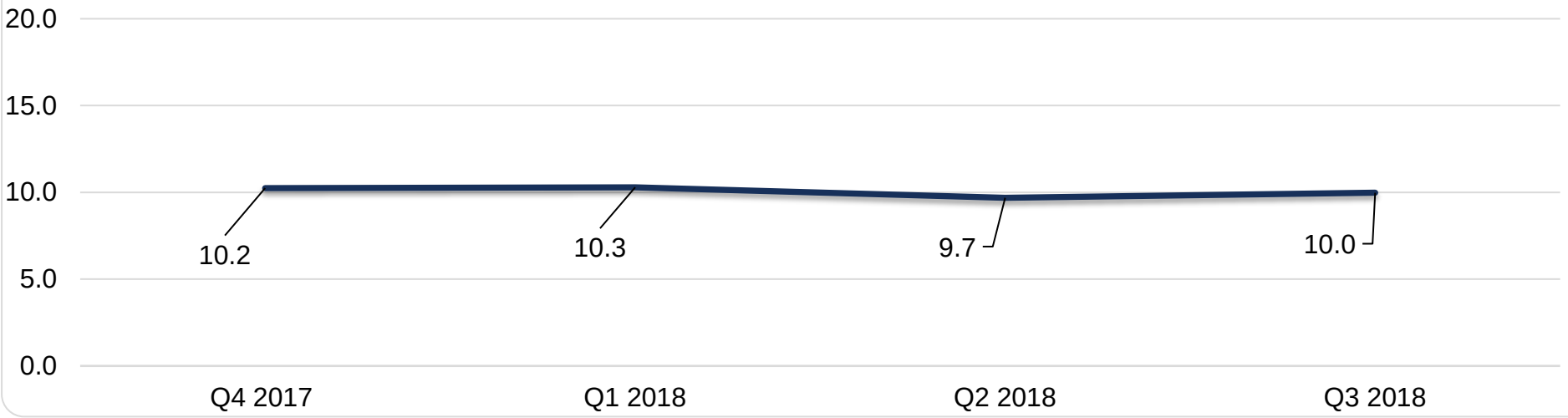
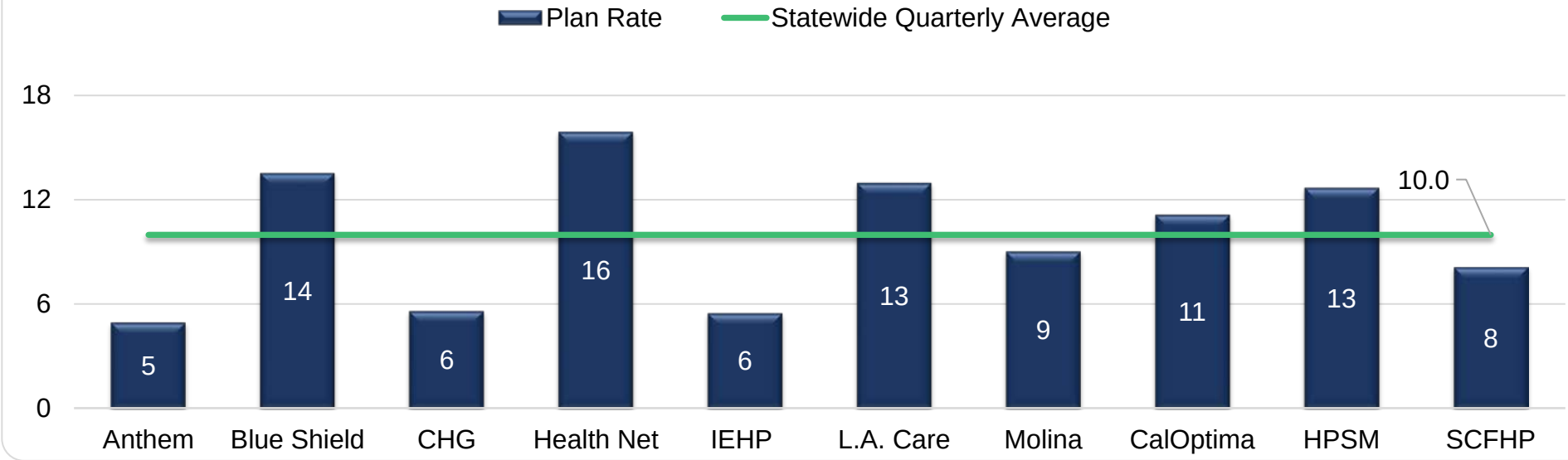


Fig. 29: Count of Members Receiving CBAS per 1,000 members for Quarter 3 of 2018



Long Term Services & Supports (LTSS) Figure 30 & 31: Count of MSSP per 1,000 Members
(10/2017-09/2018) See metric summary for additional information

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

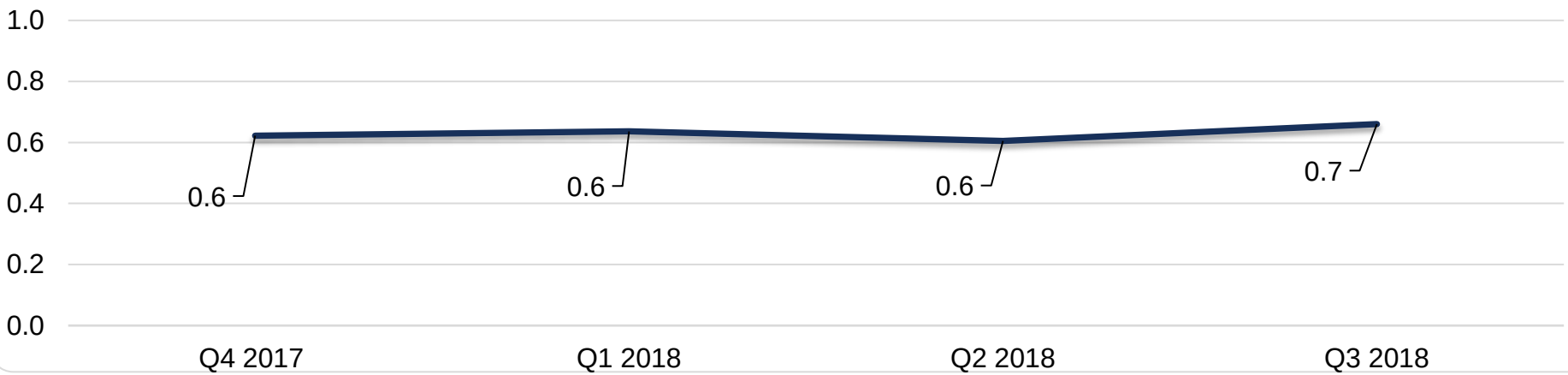
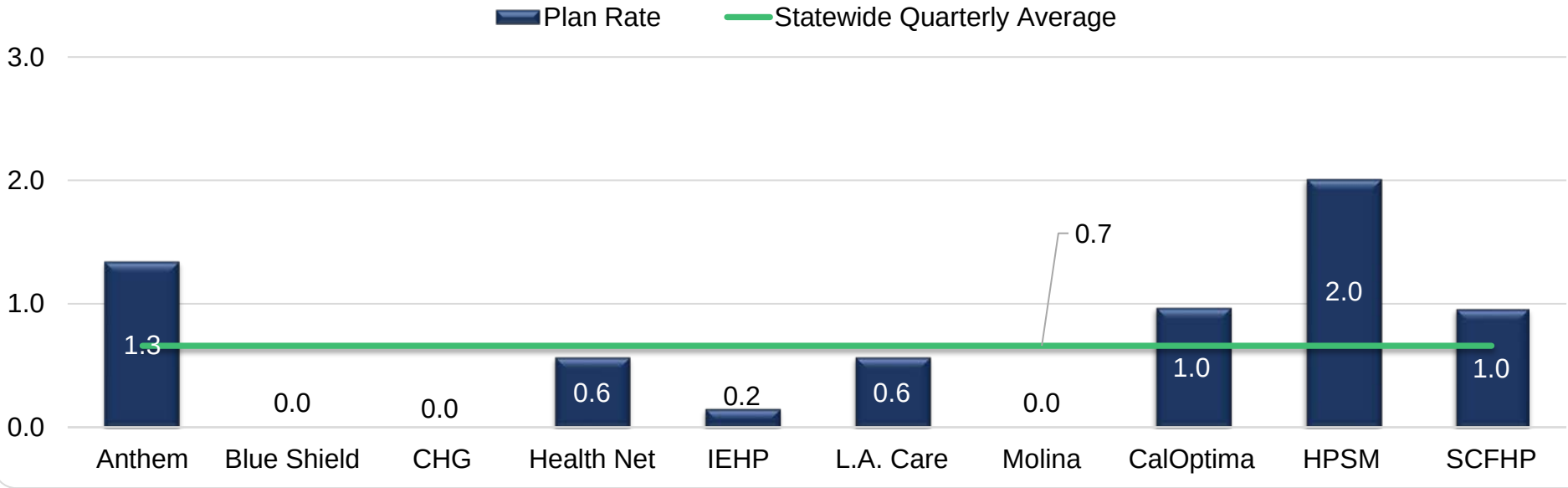


Fig. 31: Count of MSSP Member Referrals per 1,000 members for Quarter 3 of 2018



Long Term Services & Supports (LTSS) Figure 32 & 33: Count of MSSP per 1,000 Members
(10/2017-09/2018) See metric summary for additional information

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

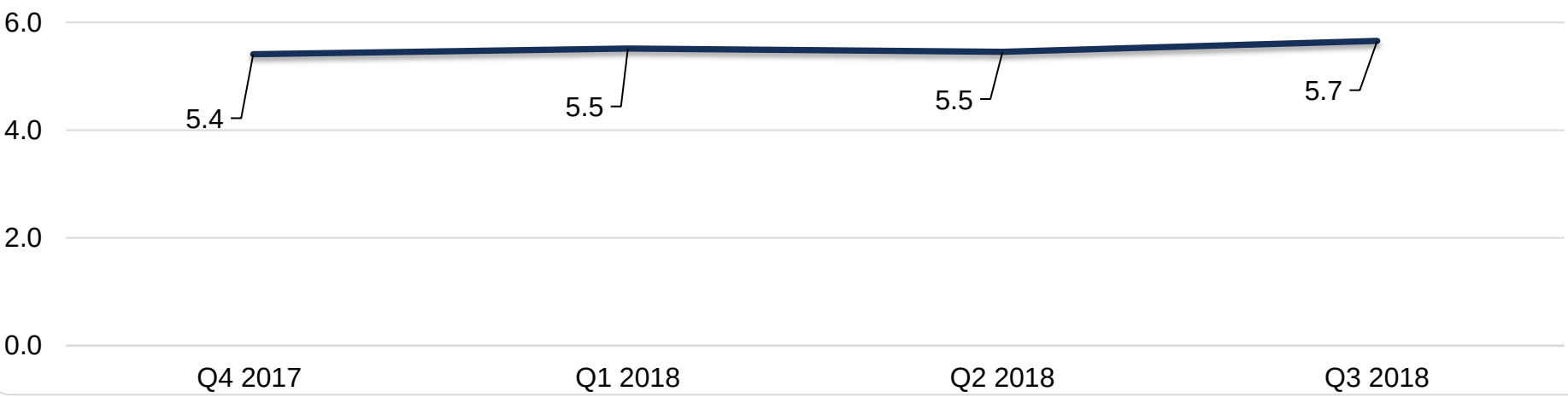
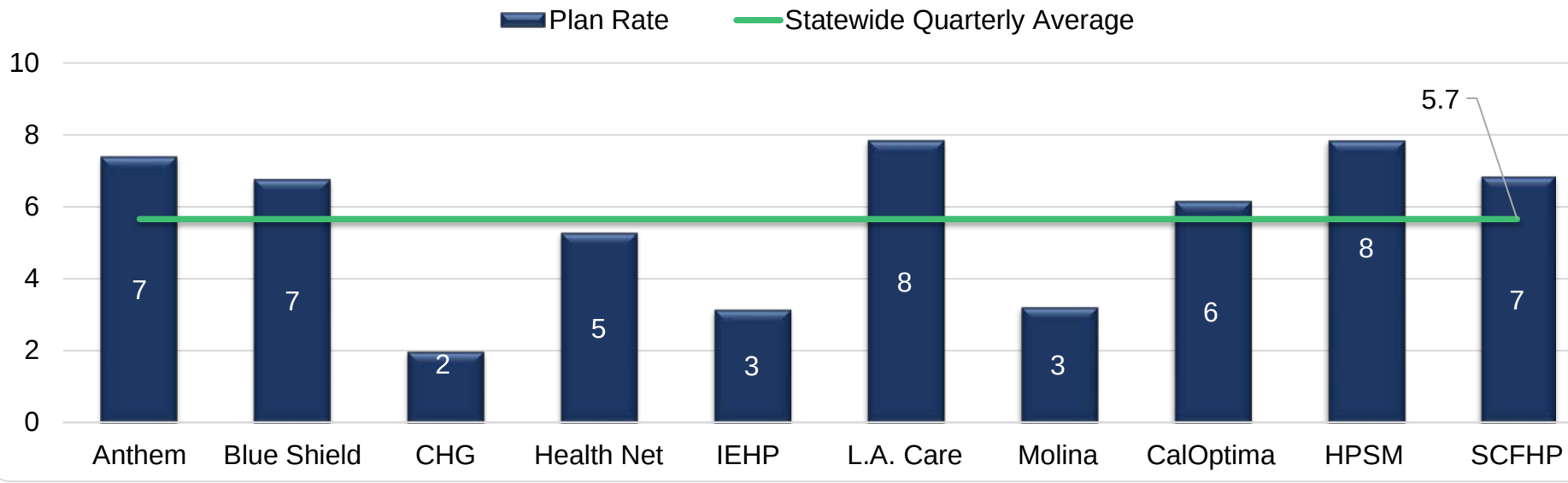


Fig. 33: Count of Members Receiving MSSP per 1,000 members for Quarter 3 of 2018



Long Term Services & Supports (LTSS) Figure 34 & 35: Count of NF per 1,000 Members
(10/2017-09/2018) See metric summary for additional information

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

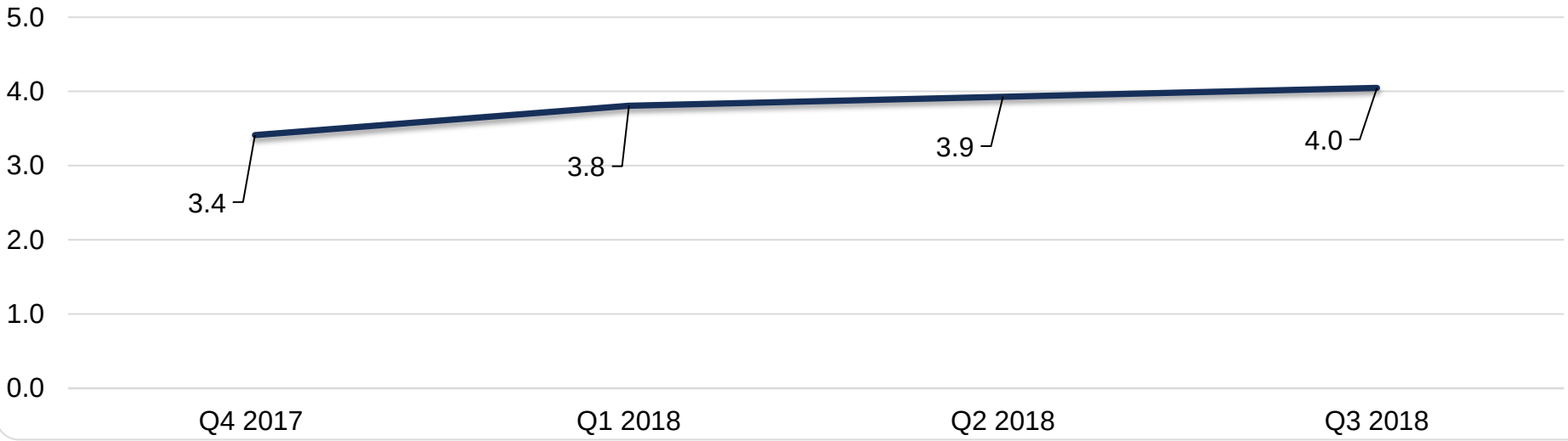
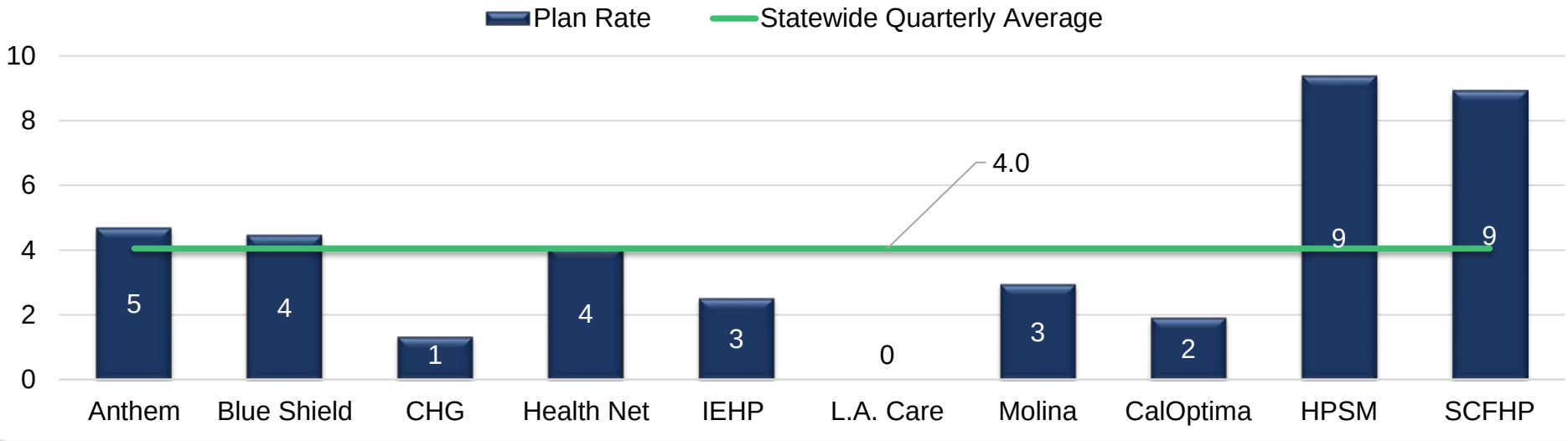


Fig. 35: Count of NF Member Referrals per 1,000 members for Quarter 3 of 2018



Long Term Services & Supports (LTSS) Figure 36 & 37: Count of NF per 1,000 Members
(10/2017-09/2018) See metric summary for additional information

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

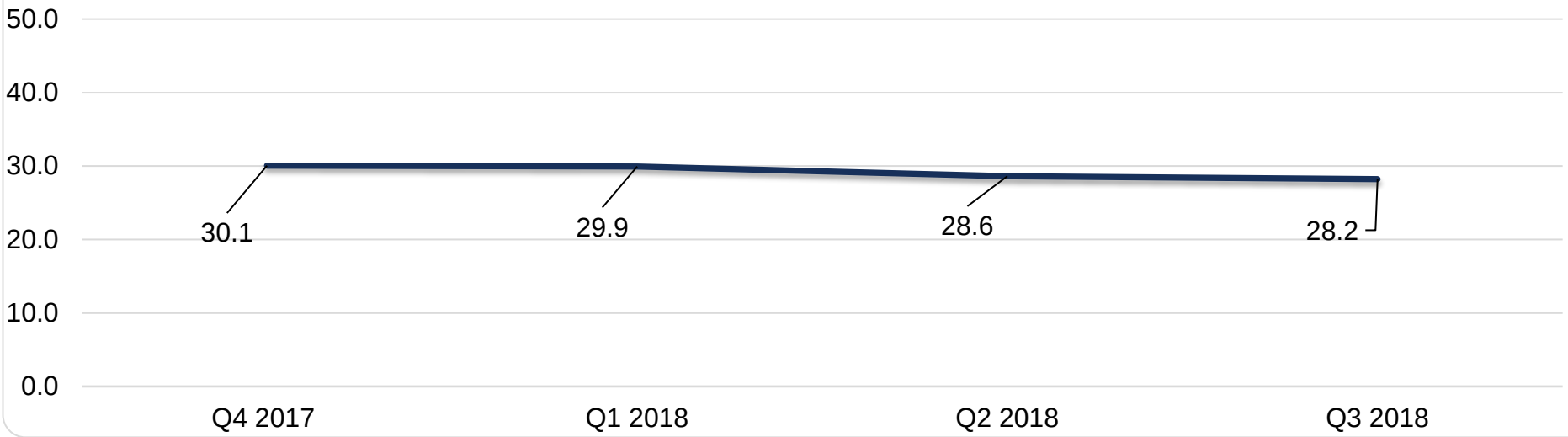


Fig. 37: Count of Members Receiving NF per 1,000 Members for Quarter 3 of 2018