# Cal MediConnect Performance Dashboard Metrics Summary

Released June 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 was stable between February and September 2017, enrollment only varied by 755 people (114,316 to 115,071, respectively) . In Q3 2017, 49% of enrollees spoke English and 30% spoke Spanish as their primary language, with 35% of enrollees identifying as Hispanic.
- **Quality Withhold Summary:** *Figure 6*
  All Plans met at least four of six quality withhold measures and 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%, meeting all six measures. Santa Clara and Orange counties entered the program in 2015, and are therefore not included in the data.
- **Care Coordination:** *Figures 7-17*
  The rolling 12-month state average shows that a slightly higher percentage of high-risk members (76%) have completed individual care plans (ICPs) compared to low-risk members (75%). The most recent quarter shows that Plan efforts to reach high- and low-risk members was equal (76%). The percentage of members who had a follow-up visit within 30 days of hospital discharge increased by six percentage points between Q4 2016 and Q3 2017, from 71% to 77%.
- **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*
  Data from Q3 2017 indicates a slight upward trend of Cal MediConnect members seeking care in the emergency room for behavioral health services from Q4 2016 to Q3 2017.
- **Long-term Services and Supports:** *Figures 24-25*
  Figure 25 shows LTSS utilization has seen little change through the reporting period, the population only changed from 278 average members receiving LTSS in 2016 Q4, to, 280 members in 2017 Q3. DHCS is continuing to work with Plans to enhance LTSS referrals.

### Data and Figure Notes:

Dashboard data are reported primarily statewide by Plans. Enrollment and demographic data are reported by county and plan. The dashboard is a tool that displays a combination of quarterly, 12-month rolling, and annual measures. The dashboard shows the most current data available, therefore, the reporting time periods for each metric reported may vary for each release.

- **12-month rolling data:** Figures 7, 9, 12, 23, and 24
  Metrics represent each Plan in aggregate for the time period indicated.
- **Quarterly rolling statewide data:** Figures 8, 10, 11, 16, 22, and 25
  Metrics represent the entire CMC program 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.
- **Updated data:**
  Figures 1-5, 7, 8,11,12,16, 22-25 were all brought up to date for June 2018 release. Figures 24 & 25 were corrected to appropriately display Utilization of Members Receiving LTSS per 1,000 members. Figures 26 & 27 have been removed for reassessment.

## 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).

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:

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', 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 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 some to all of 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.

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

[2] Core quality withhold methodology and measures for DY 2-5:
https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/QualityWithholdGuidanceDY2-503142018.pdf

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 6 contains the quality withhold measures for the first calendar year of Demonstration Year (DY)[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 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)

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

## 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. *Figure 6*

## Quality Withhold Measure Notes:

CalOptima and Santa Clara entered the program in 2015. CW4 - Encounter Data was removed due to delays in clarifying encounter submission requirements for Plans. CAW3 - Mental health accountability was suspended while updated technical specifications were under development.

## 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.
    - 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.
    - **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 unwilling and unable to reach populations in calculations.

- **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.
    - 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 who 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 slightly higher percentage of high-risk members (76%) have completed ICPs within 30 day compared to low-risk members (75%). The percentage of high-risk members and low-risk members with an ICP has decreased from 78% in Q4 2016 to 76% in Q3 2017, but is still higher than the percentage of low-risk and high-risk members with an ICP from the previous quarter (70% and 73%, respectively, in Q2 2017). *Figures 11, 12*

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 six percentage points between Q4 2016 (71%) and Q3 2017 (77%). *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. *Figure 13-15*

## 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'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:

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 Q4 2016 (24.2) to Q3 2017 (27.7) has increased slightly. 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.

## LTSS Measure Notes:

For the April 2018 Dashboard, DHCS identified a calculation error for Figures 24 & 25 which resulted in unusually low counts for these measures. In this release, Figure 24 & 25 were corrected to appropriately display Utilization of Members Receiving LTSS per 1,000 members. In addition, DHCS has removed Figure 26 and 27 for reassessment since the data displayed appear to be misleading in showing the Count of Critical Incidents for Member Receiving LTSS per 100 members.

## LTSS Trends:

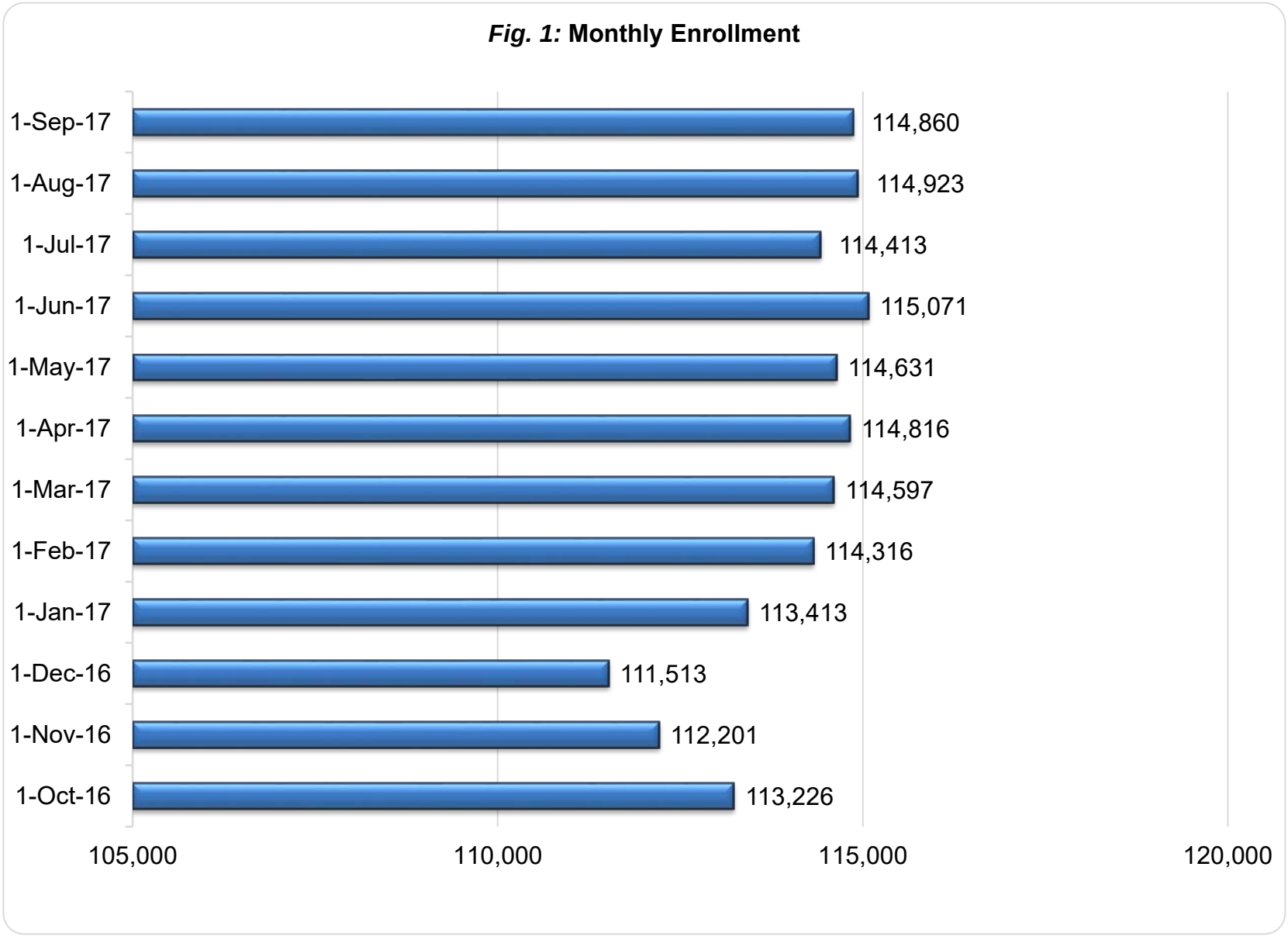
Figure 25 shows LTSS utilization has seen little change through the reporting period, the population only changed from 278 average members receiving LTSS in 2016 Q4, to, 280 members in 2017 Q3. DHCS worked with the Plans to enhance LTSS referrals, and encouraged Plans to support members in transitioning 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.

## 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 |

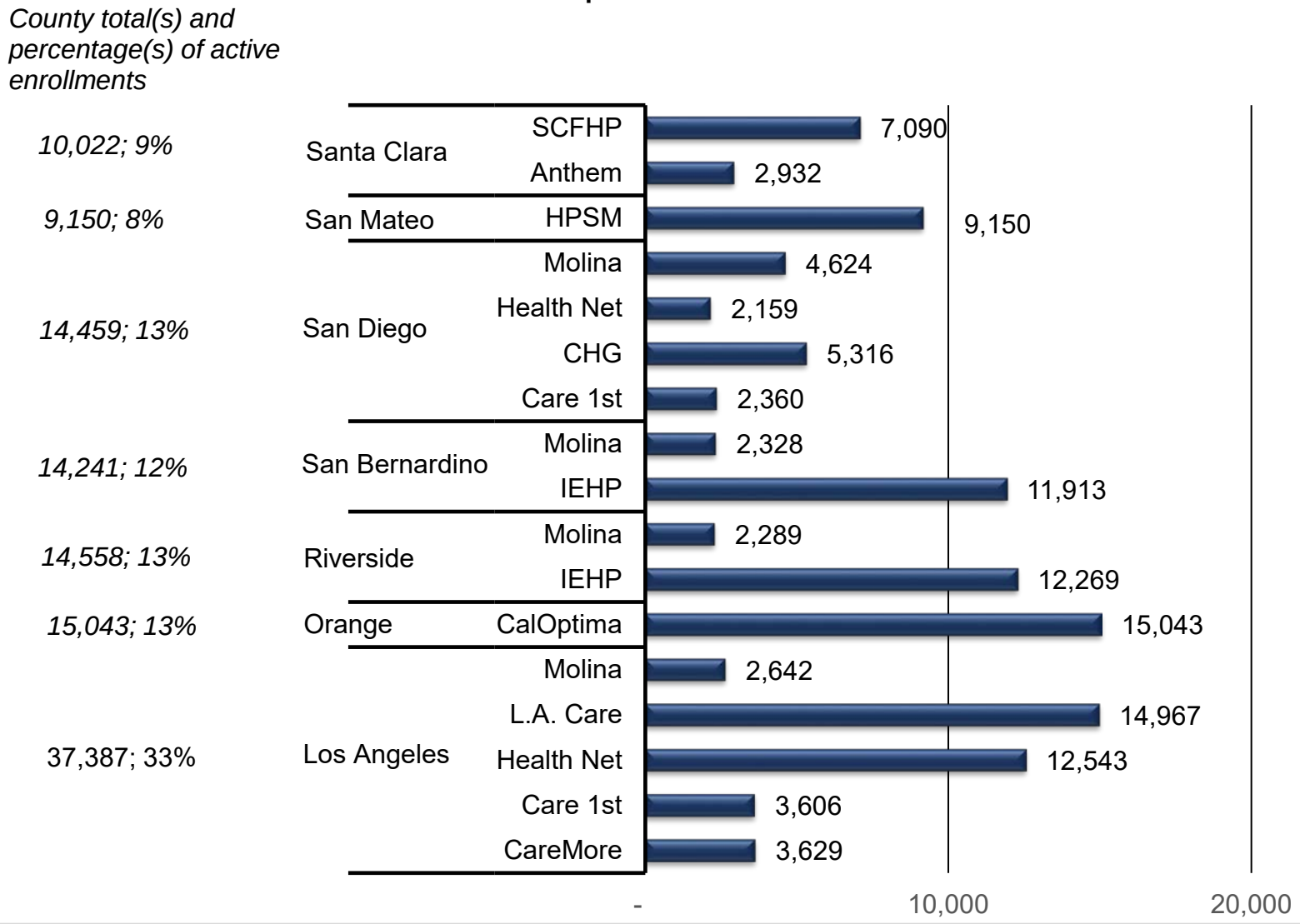
**Cal MediConnect Enrollment and Demographics Figure 1: Breakdowns of Dual Populations (As of 9/1/2017)** See metric summary for additional information

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



**Cal MediConnect Enrollment and Demographics Figure 2: Breakdowns of Dual Populations (As of 9/1/2017)**
See metric summary for additional information

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



**Cal MediConnect Enrollment and Demographics Figure 3 - 5: Breakdowns of Dual Populations (As of 9/1/2017)** See metric summary for additional information

***Fig. 3*: Quarter 3 2017 Enrollment by Threshold Language Spoken**

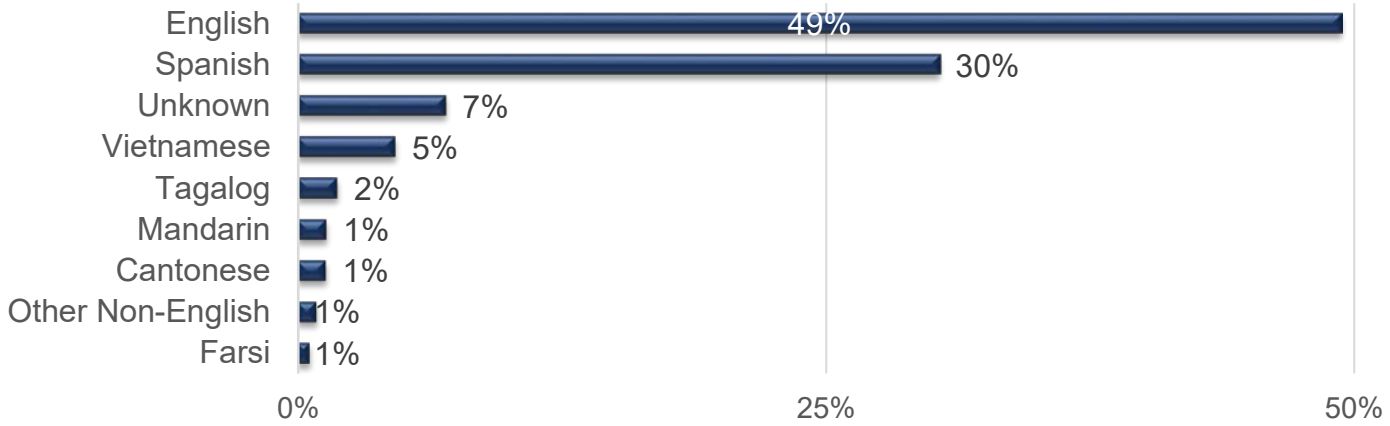



***Fig. 4:* Quarter 3 2017 Enrollment by Race/Ethnicity**

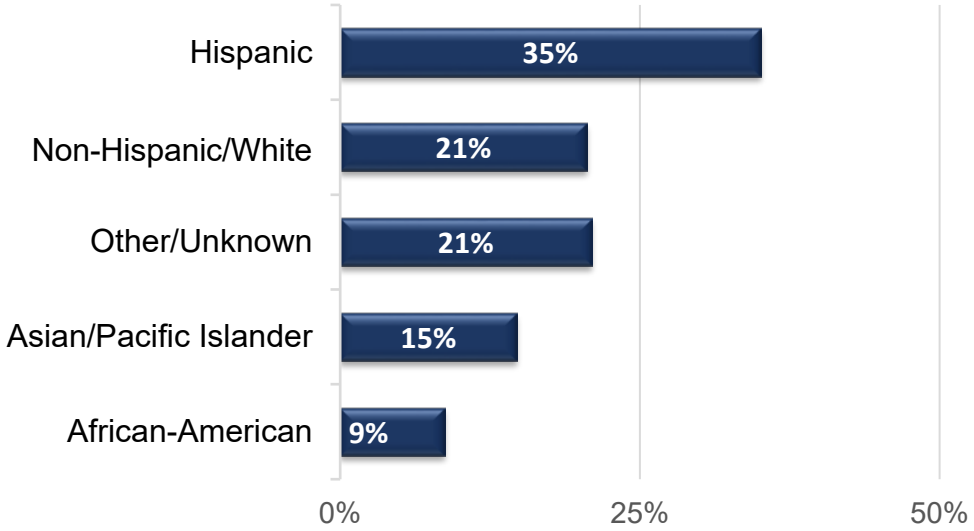
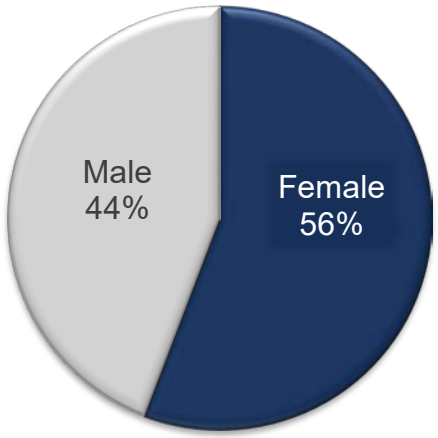



**Fig. 5: Quarter 3 2017 Enrollment by Gender**



**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%** |

**Care Coordination Figure 7 & 8: Percent of Members Willing to Participate and who the Plan was able to Locate with an Assessment Completed Within 90 Days of Enrollment (10/2016-09/2017)**
See metric summary for additional information

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

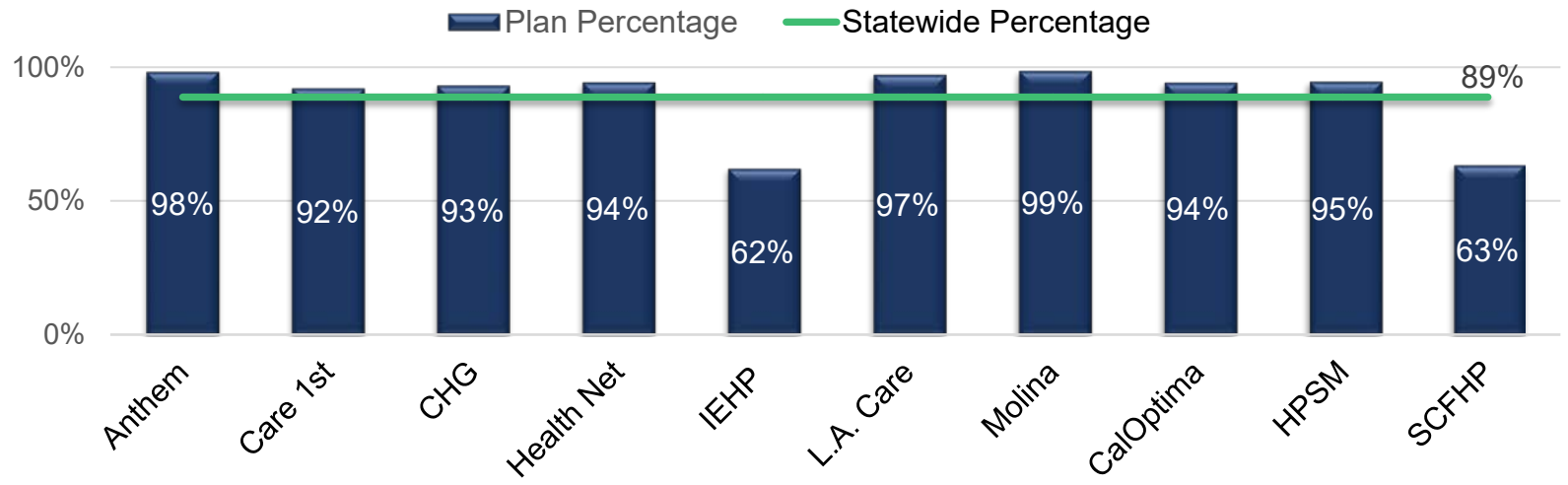
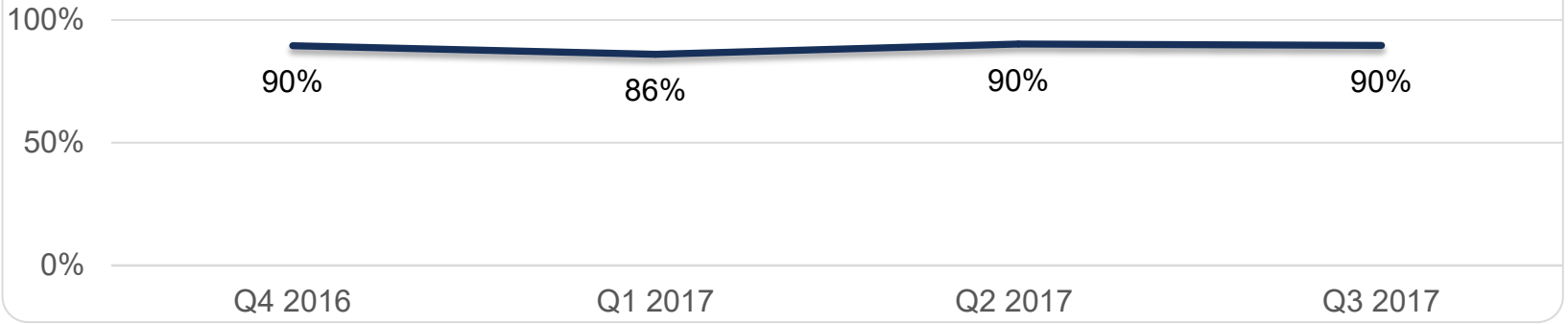



***Fig. 8:*** **Quarterly Rolling Statewide Percentage of Members Willing to Participate and who the Plan was able to Locate with an Assessment Completed Within 90 Days of Enrollment**



**Care Coordination Figure 9 & 10: Percentage of Members with an Individualized Care Plan (ICP) (10/2016-09/2017)** See metric summary for additional information

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

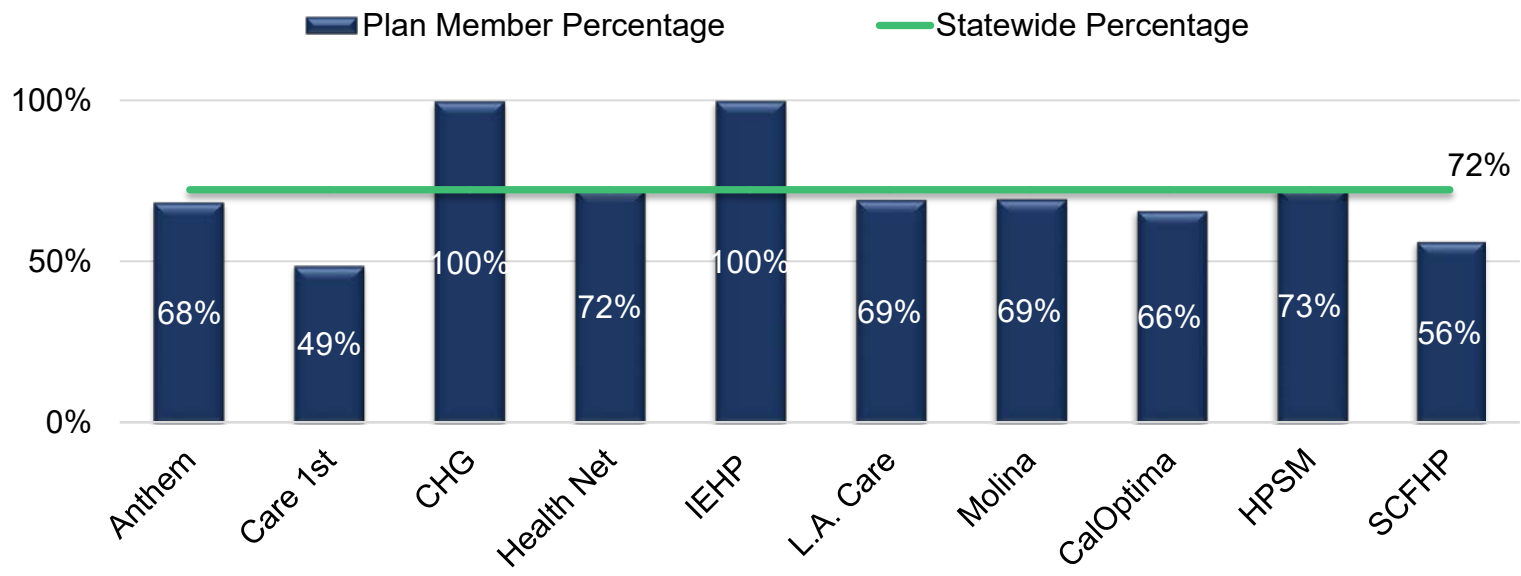
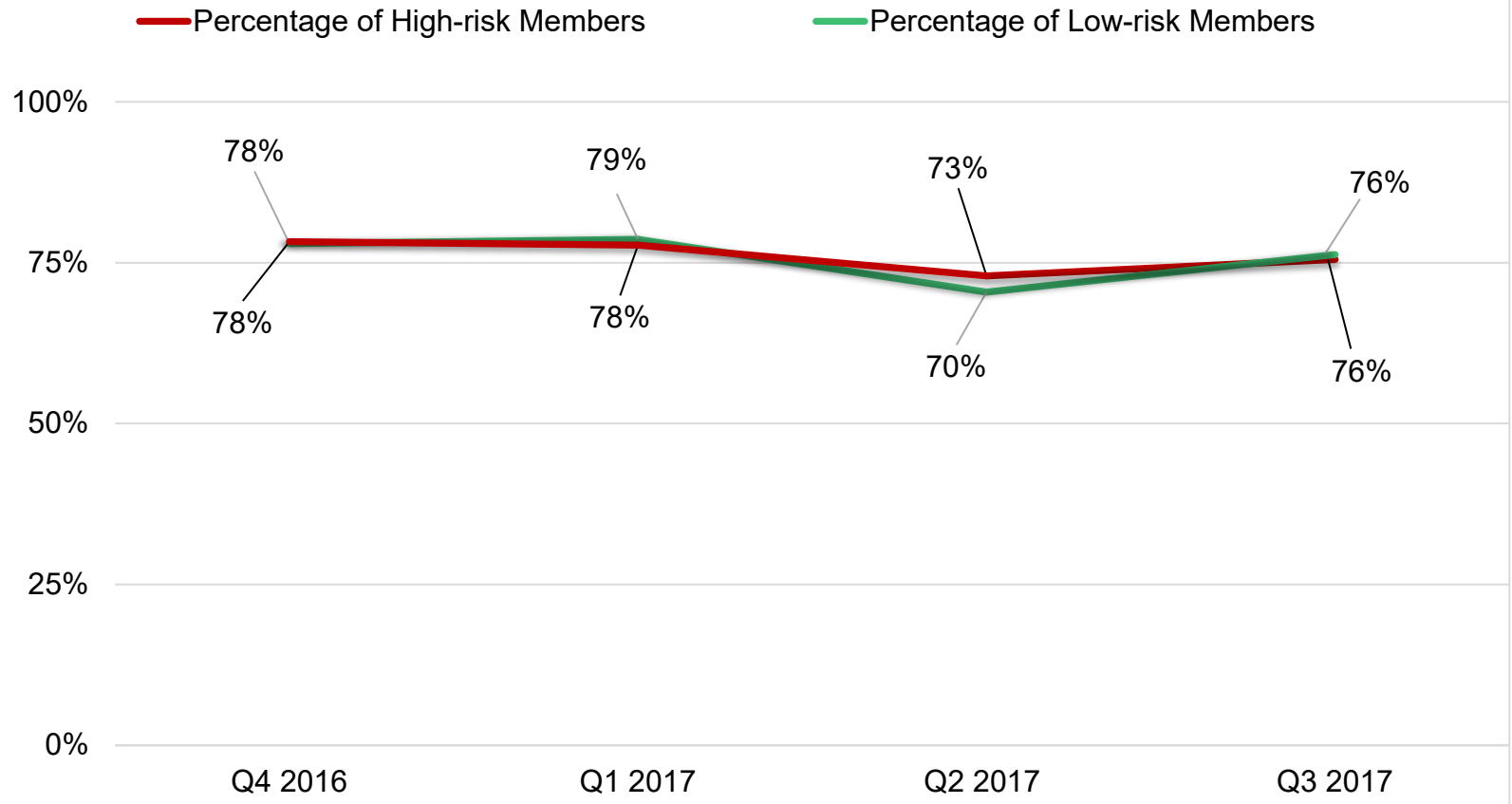



***Fig. 10:*** **Quarterly Rolling Statewide Percentage of Members with an ICP**

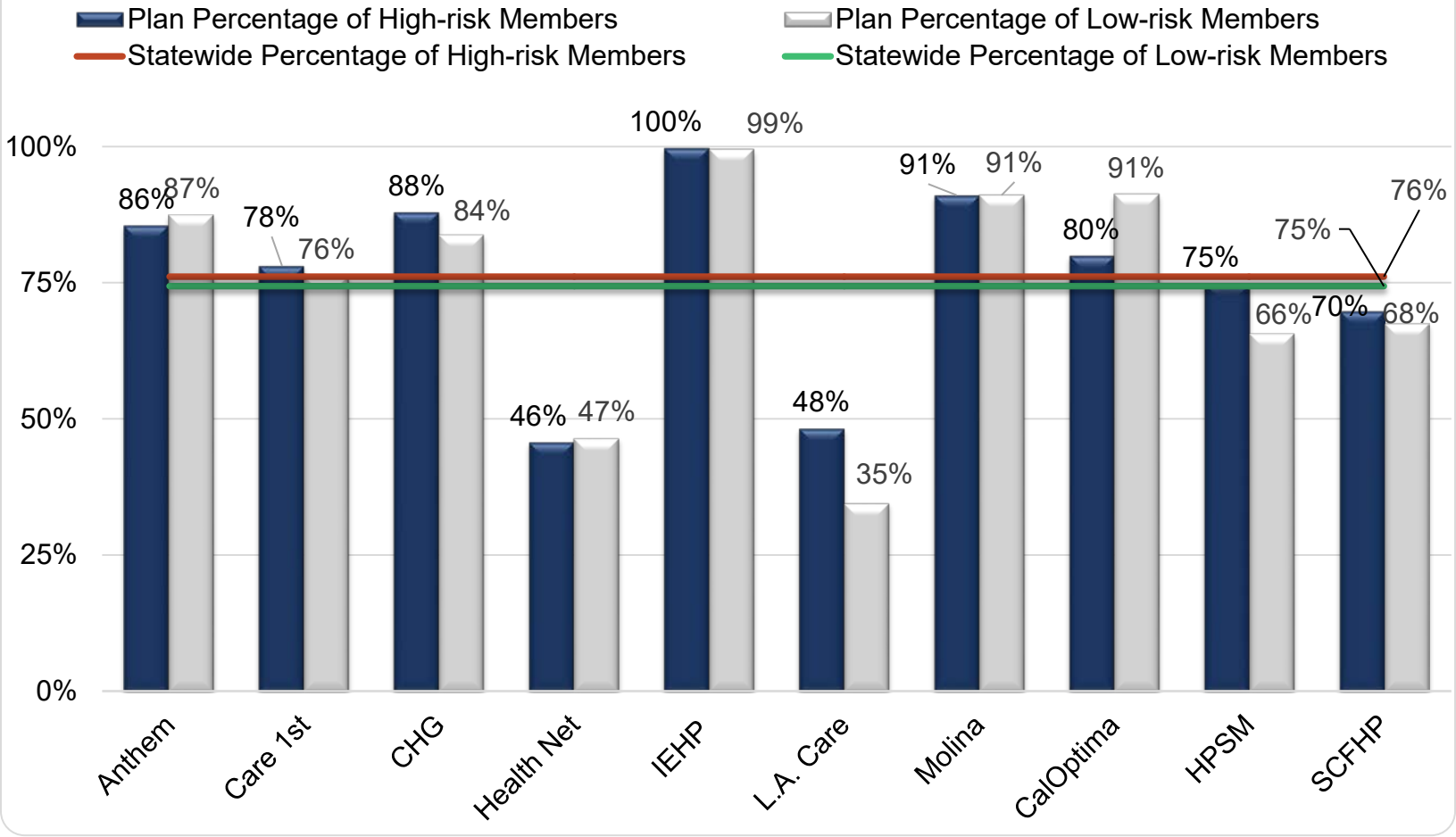
**Care Coordination Figure 11: High-risk & Low-risk Members with an Individualized Care Plan (ICP) within 30 Working Days after the Completion of the Initial Health Risk Assessment (HRA) (10/2016-09/2017)** See metric summary for additional information

***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)**



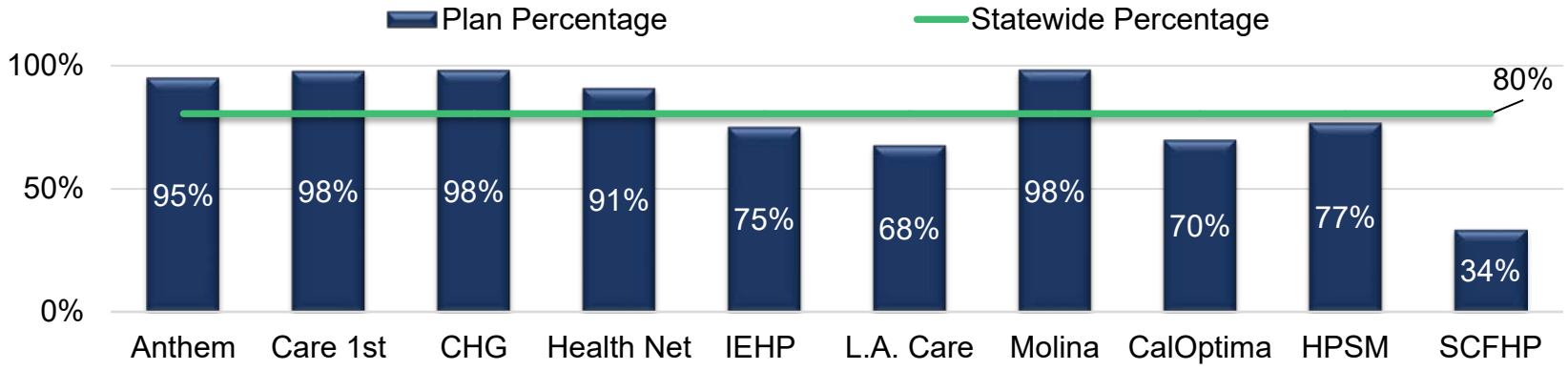
**Care Coordination Figure 12: High-risk & Low-risk Members with an Individualized Care Plan (ICP) within 30 Working Days after the Completion of the Initial Health Risk Assessment (HRA) (10/2016-09/2017)** See metric summary for additional information

***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)**



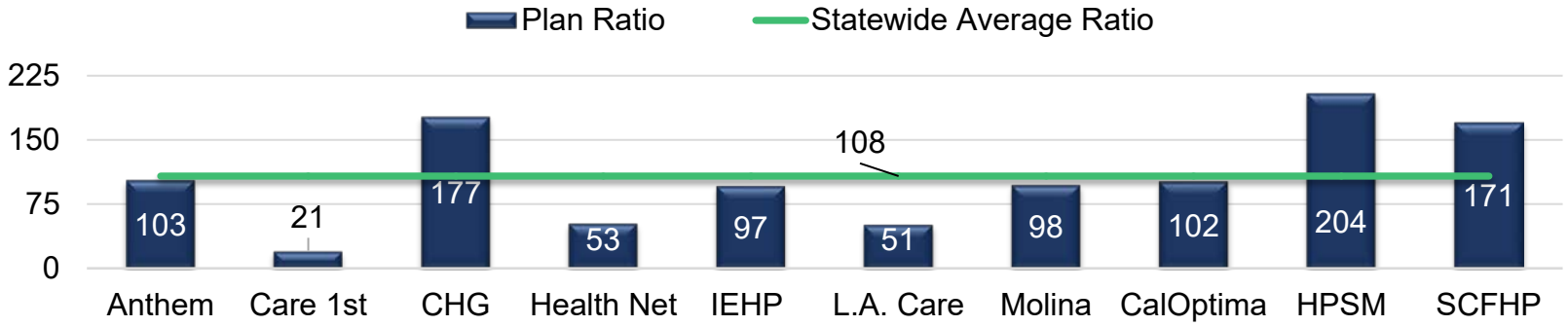
**Care Coordination Figure 13: Percentage of Members Who Have a Care Coordinator and Have at Least One Care Team Contact During the Reporting Period (01/2016-12/2016)** See metric summary for additional information

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



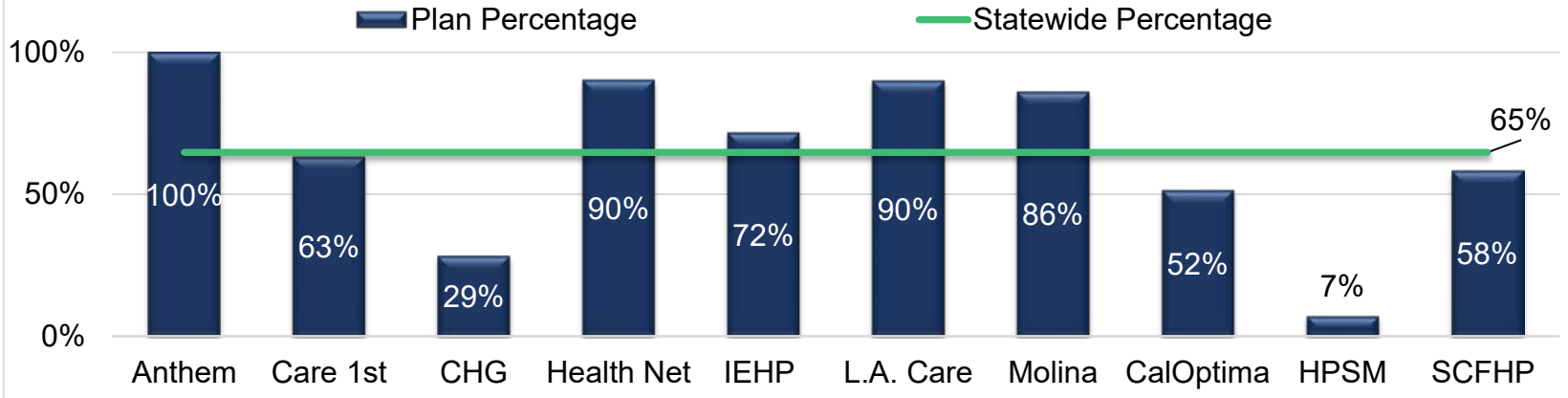

**Care Coordination Figure 14: Member to Care Coordinator Ratio (01/2016-12/2016)**
See metric summary for additional information

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



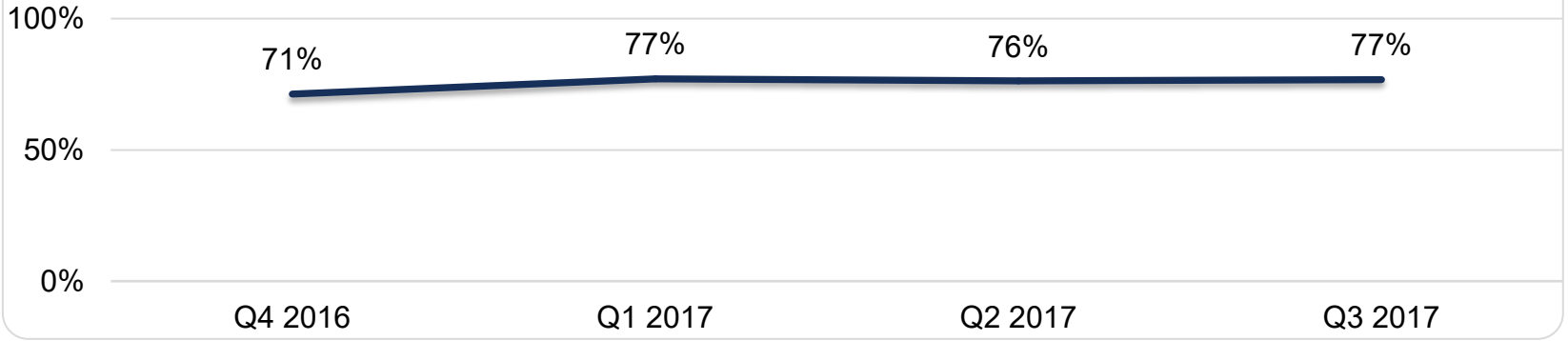
**Care Coordination Figure 15: Percentage of Members with Documented Discussions of Care Goals (01/2016-12/2016)** See metric summary for additional information

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



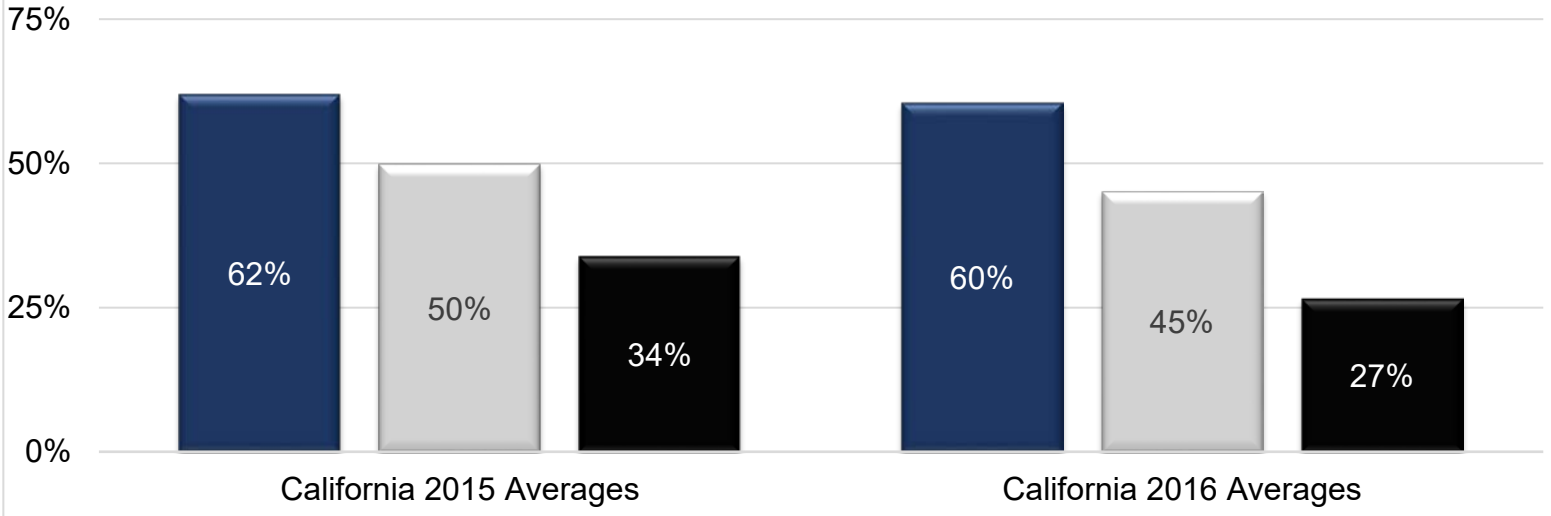

**Care Coordination Figure 16: Percentage of Members with First Follow-up Visit within 30 Days after Hospital Discharge (10/2016-09/2017)** See metric summary for additional information

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



**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

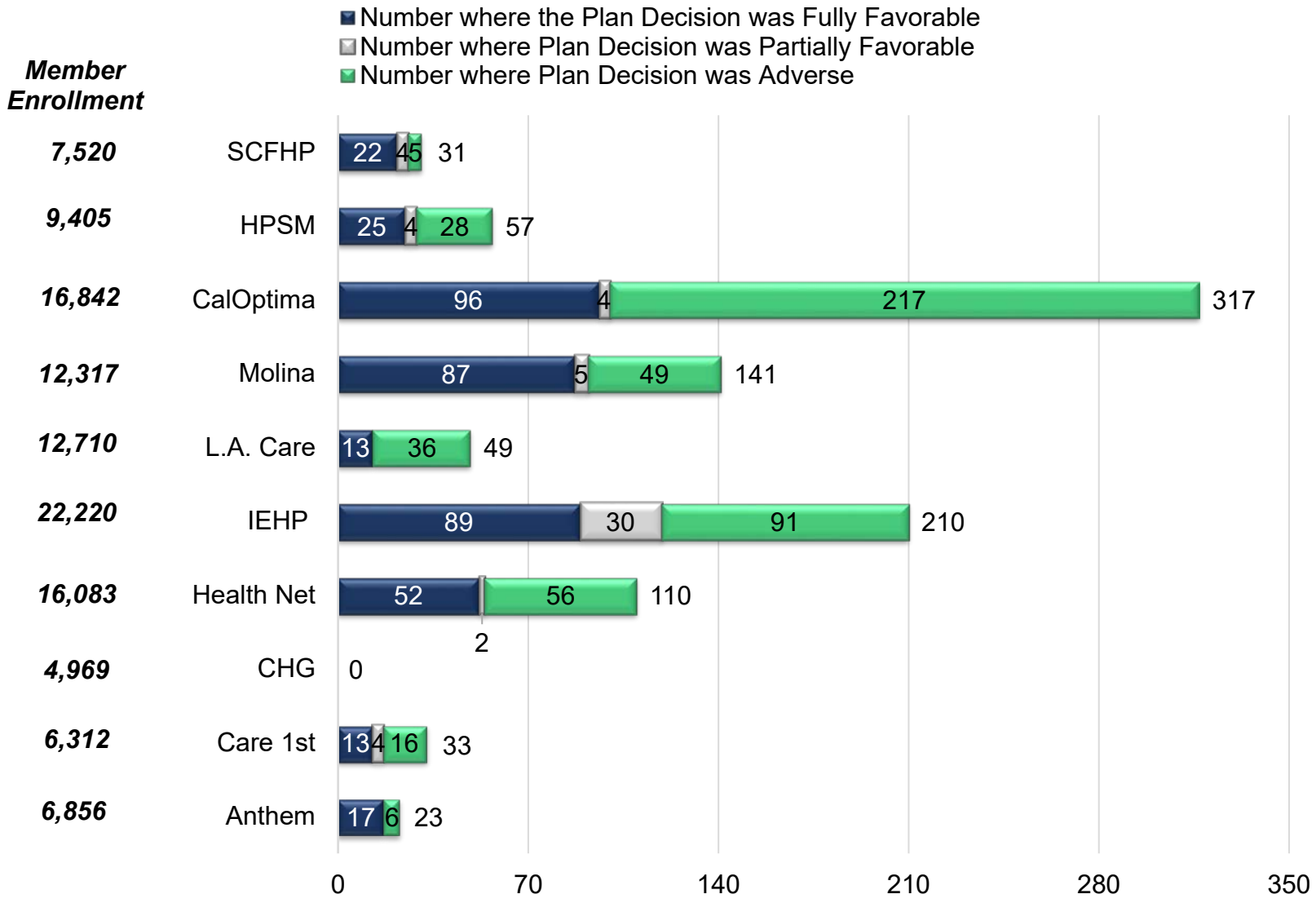
**Fig. 17: Annual Average Percentage of HRA Reassessments**




- 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

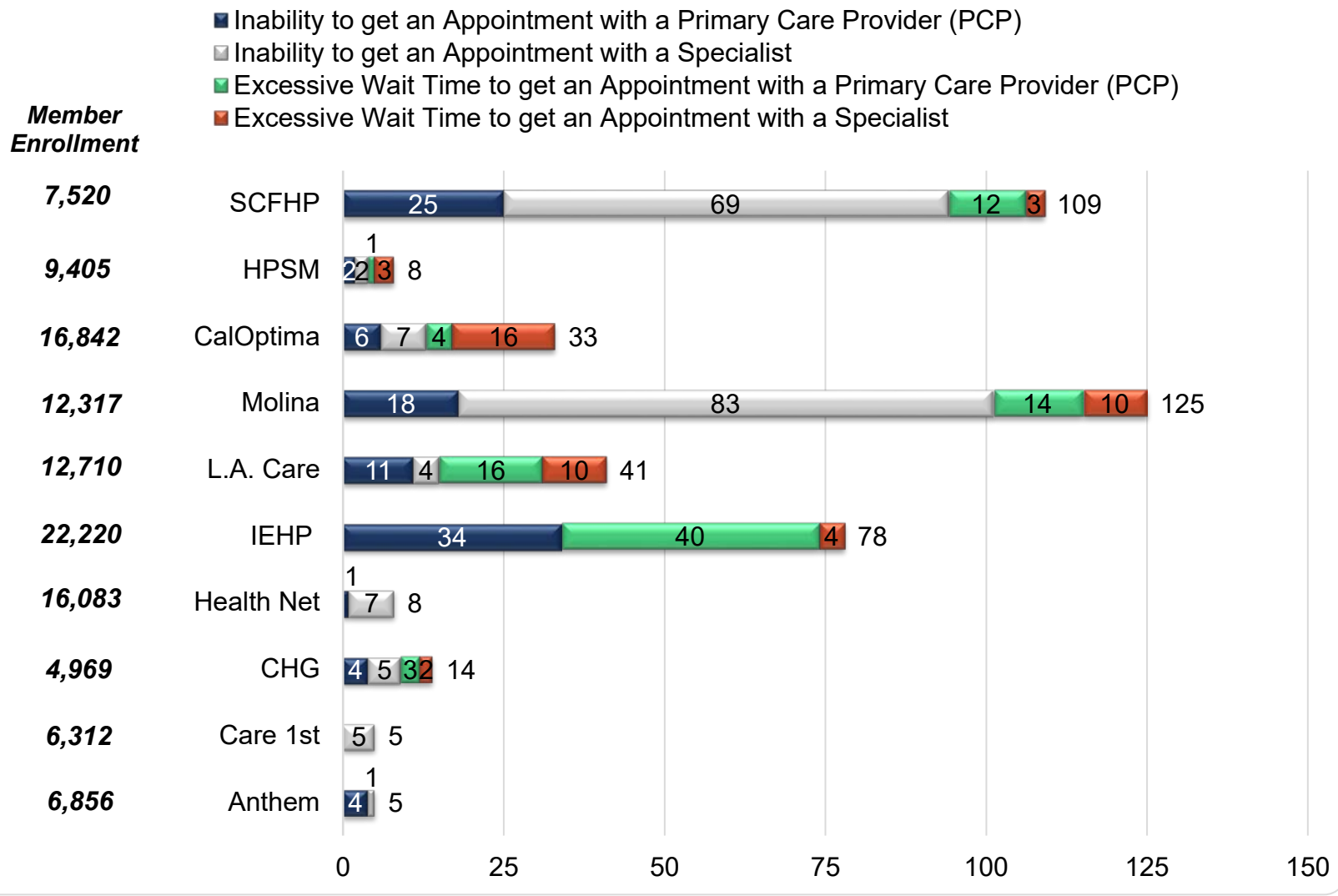
**Appeal Figure 18: Count of Appeals (1/2016-12/2016)** See metric summary for additional information

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



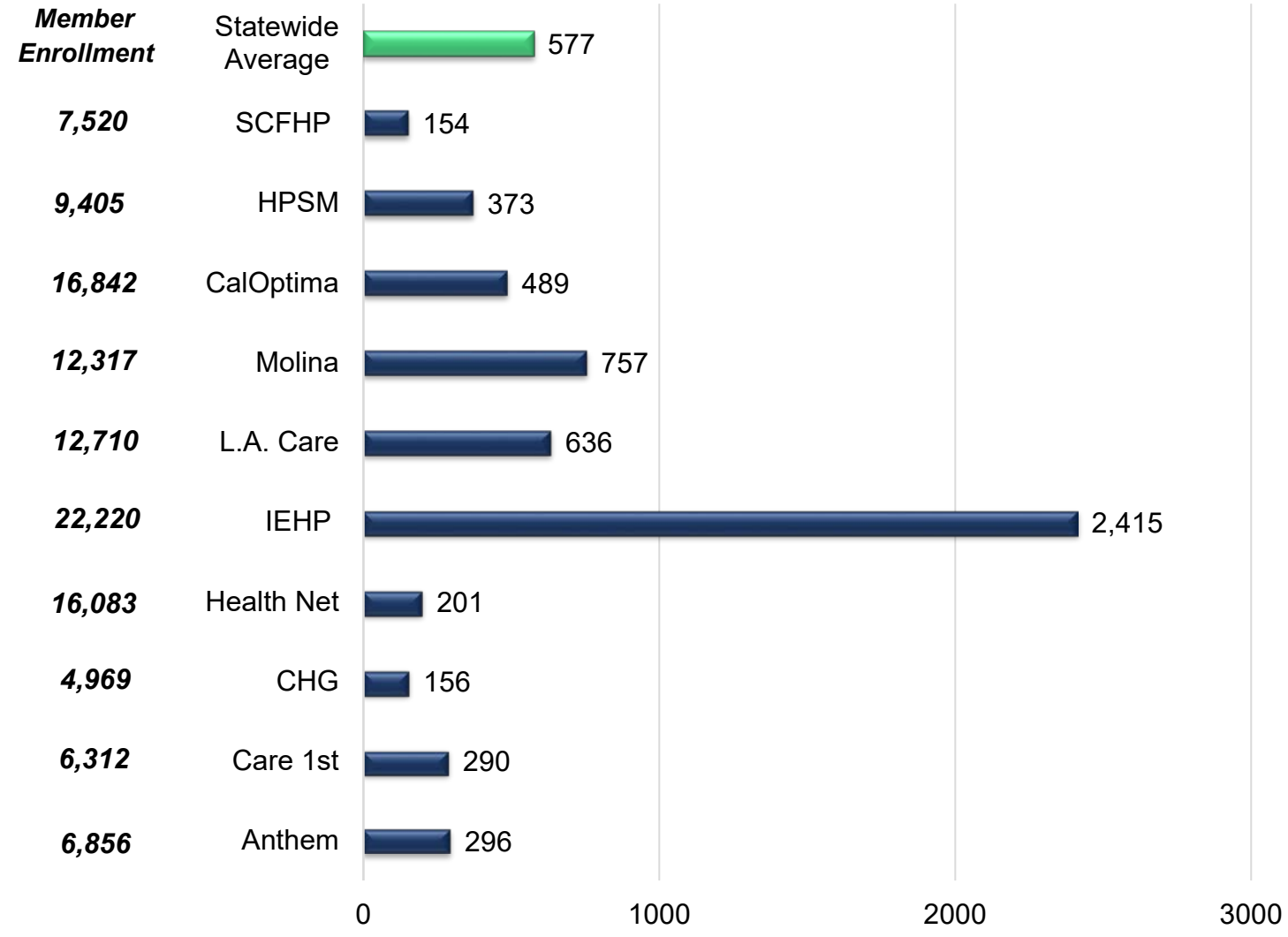
**Grievance Figure 19: Count Grievances by type, Except "Other" (1/2016-12/2016)**
See metric summary for additional information

***Fig. 19:* Annual Count of Grievances Broken Down by Type, besides "Other"**



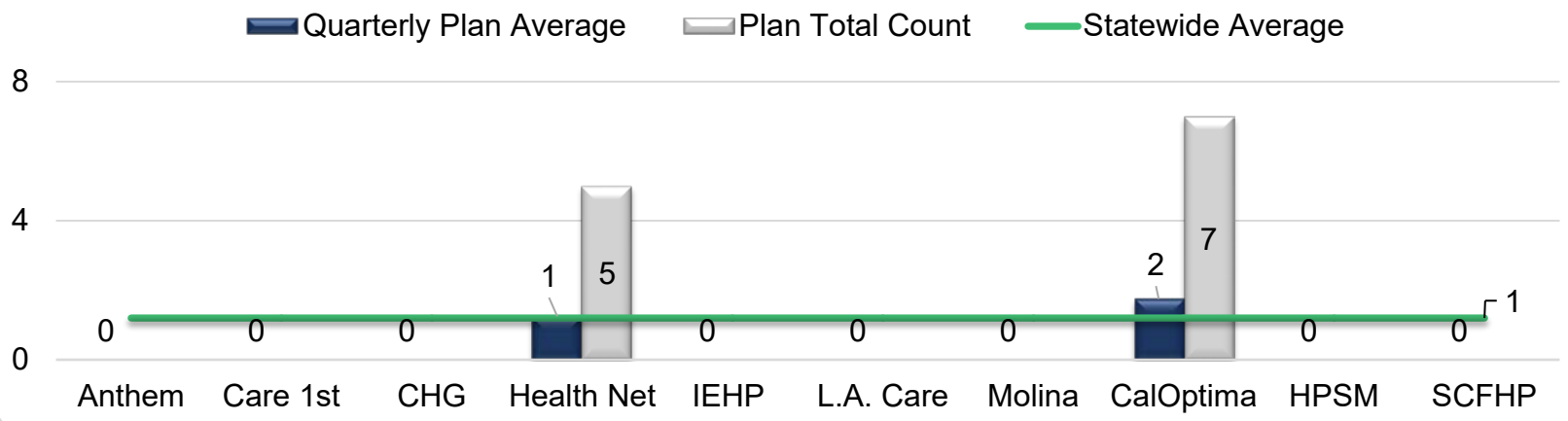
**Grievance Figure 20: Count of "Other" Grievances (1/2016-12/2016)** See metric summary for additional information

***Fig. 20*: Annual Count of "Other" Grievances**



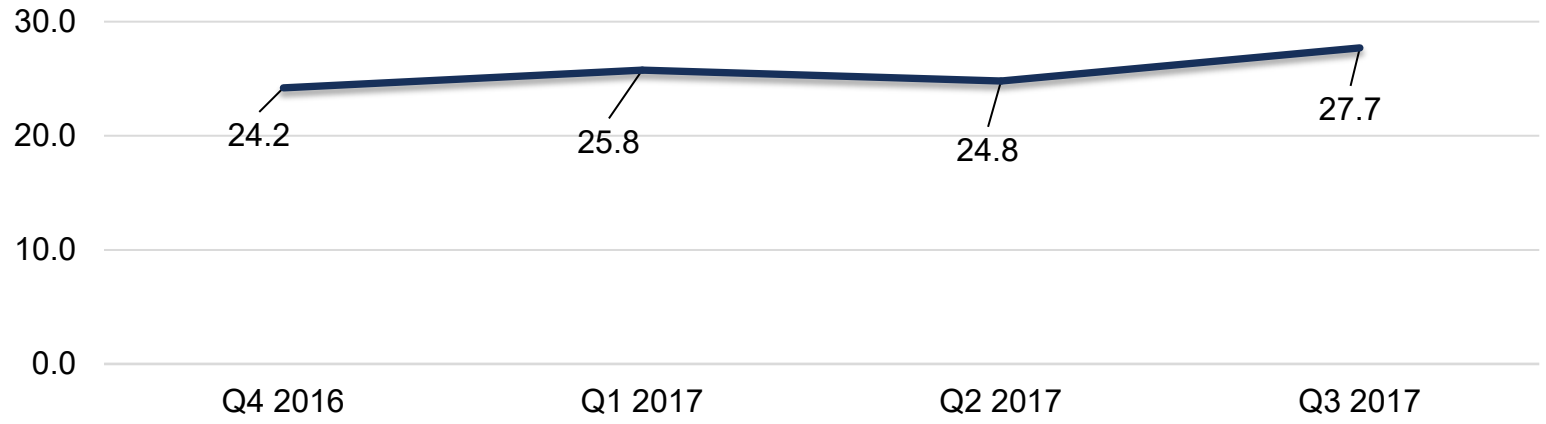
**Appeals Figure 21: Total Number of Appeals Related to the Denial or Limited Authorization of Mental Health Services (1/2016-12/2016)** See metric summary for additional information

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



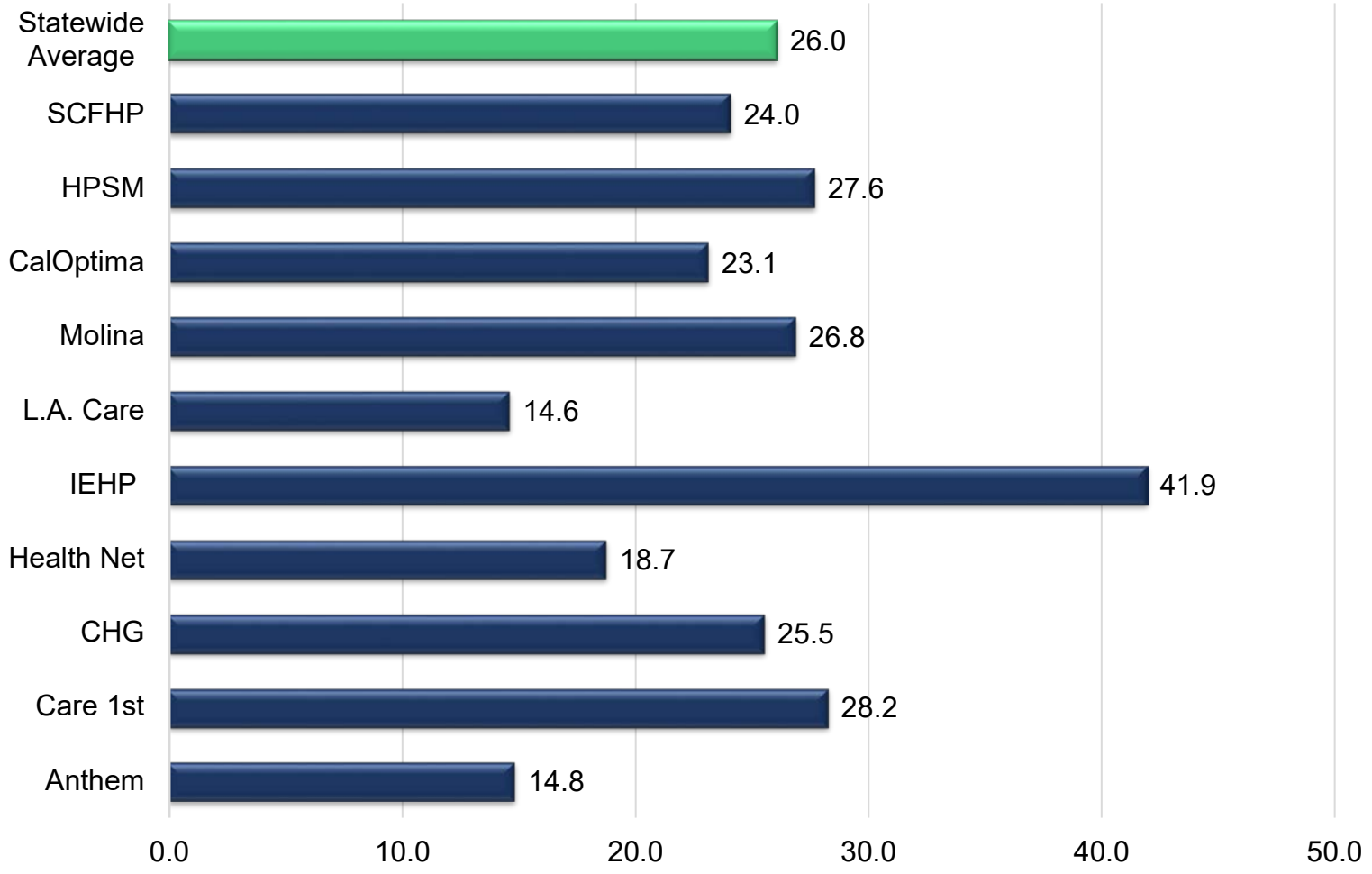

**Behavioral Health Figure 22: Emergency Room Behavioral Health Services Utilization per 10,000 Member Months (10/2016-09/2017)** See metric summary for additional information

***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 (01/2017-12/2017)** See metric summary for additional information

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



**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**

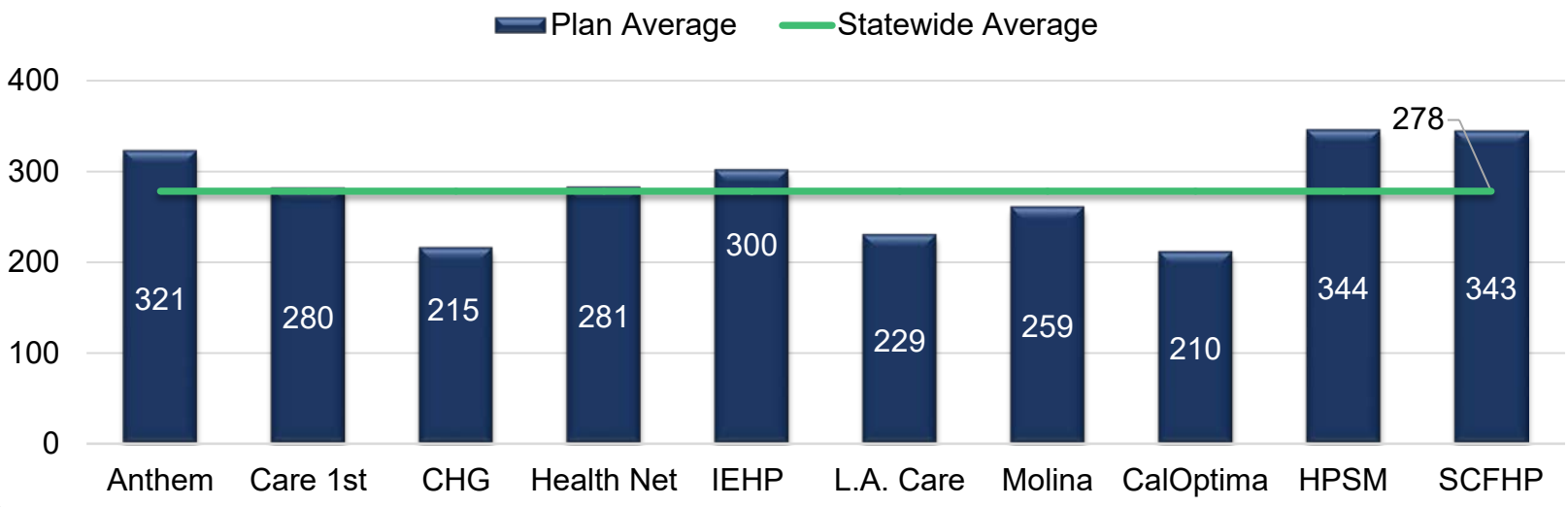



**Fig. 25: Quarterly Rolling Statewide Average of Members Receiving LTSS per 1,000 Members**