# Cal MediConnect Performance Dashboard Metrics Summary

Released September 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 1-6*
  Statewide enrollment in Cal MediConnect has been steady over the past year (2017). In Q4 2017, 50% of enrollees spoke English and 30%spoke Spanish as their primary language, with 35% 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 three quality withhold measures and nine out of ten Plans received 50% or more of the quality withhold amount for Calendar Year 2015. Two of the ten Plans received 100% of their withhold. CalOptima and SCFHP entered the program in 2015, and are included in the data.
- **Care Coordination:** *Figures 8-17*
  Figure 8 highlights an increase in percentage of members willing to participate, and who the Plan was able to locate, with an assessment completed within 90 days of enrollment from 90% in Q3 2017 to 92% in Q4 2017. The quarterly state average for Q4 2017, Figure 12, shows that a slightly higher percentage of low-risk members (72%) have completed individual care plans (ICPs) compared to high risk members (70%). This indicates a slight downward trend for both low-risk and high-risk members from Q3 2017.
- **Grievances and Appeals:** *Figures 18-21*
  In 2017, Plans reported 46% more grievances than in 2016. Of the total reported grievances, 96% are categorized as "other". DHCS and CMS are researching the nature of these complaints. In 2017, Plans reported 54% more appeals than in 2016. Of the total appeals, 51% of Plan decisions were either fully or partially favorable to the members appeal.
- **Behavioral Health Services:** *Figures 22-23*
  Figure 22 indicates a slight downward trend of Cal MediConnect members seeking care in the emergency room for behavioral health services. The utilization has gone from 27.7 visits per 10,000 member months in Q3 2017 to 25.9 visits in Q4 2017.

- **Long-term Services and Supports:** *Figures 24-33*
  Figure 24 shows LTSS utilization per 1,000 members has seen little change throughout the reporting period; from an average of 278 members per 1,000 receiving LTSS in Q1 2017, to an average of 281 members in Q4 2017. DHCS is continuing to work with Plans to enhance LTSS referrals. Figure 26-33 are new figures displaying LTSS services broken down by four categories; In-Home Support Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), Nursing Facility (NF).

### Data and Analysis Notes:

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 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.

- **Quarterly Rolling Statewide Average:** Figures 8, 10, 12, 17, 22, 24, 26, 28, 30 and 32.
  Metrics represent the entire CMC program broken down by calendar quarters.
- **Current Quarter data by plan:** Figures 9, 11, 13, 25, 27, 29, 31 and 33.
  Metrics represent the data for the most recent quarter broken down by plan. These figures have been changed from 12 month rolling percentage to current quarter data by plan.
- **Annual data:** Figures 7, 14, 15, 16, 18, 19, 20, 21 and 23.
  Annual data are updated once a year and are compared to previous years that are only collected in aggregate.
- **Updated data:** All figures except Figure 23 are updated for the September 2018 release. The Annual Average Percentage of HRA Reassessments display (Figure 17 in the June 2018 dashboard) has been removed for reevaluation.
- **New Data:** Figure 4 was added to display the age distribution of CMC beneficiaries. Figures 26-33 were added to show LTSS services by categories. The addition of these new figures has altered some figure numbers compared to the previous release.

## DETAILED DASHBOARD METRICS AND TRENDS

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

### Cal MediConnect Enrollment and Demographics:

Enrollment and demographic data 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 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 subset 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 demonstration 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 2015.

[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 7 contains the quality withhold measures for the calendar year 2015. 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.

- **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)
- **Customer Service:** Percent of the best possible score the plan earned on how easy it is for members to get information and help from the plan when needed (CW3)
- **Getting Appointments and Care Quickly:** Percent of best possible score the plan earned on how quickly members get appointments and care (CW5)
- **Documentation of Care Goals:** Percent of members with documented discussion of care goals. (California-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-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-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:

The latest data available shows that all 10 Plans met at least three quality withhold measures and five of the ten Plans received at least 75% or more of their quality withhold amount for Calendar Year 2015. CalOptima and SCFHP entered the program in 2015. *Figure 7*

## Quality Withhold Measure Notes:

CalOptima and SCFHP 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 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.
    - **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 12 & 13 do not include unwilling and unable to reach populations in calculations.

- **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 quarterly statewide percentage of members willing to participate, and who the Plan was able to locate, with an assessment completed within 90 days of enrollment has increased from 90% in Q3 2017 to 92% in Q4 2017. *Figure 8.*

The quarterly state average shows that a slightly higher percentage of low-risk members (72%) have completed ICPs within 30 days compared to high-risk members (70%). The percentage of high-risk members with an ICP has decreased from 78% in Q1 2017 to 70% in Q4 2017, and has decreased from 79% in Q1 2017 to 72% in Q4 2017 for low-risk members. *Figures 12, 13*

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. *Figure 14-16*

## 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:

In 2017, members filed 9,072 grievances with Plans. This is an increase of 2,879 member grievances reported in 2017 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, 51% of Plan decisions were either fully or partially favorable to the member's appeal when filed in 2017. 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: http://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 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 22 shows the overall trend of Cal MediConnect members seeking care in the emergency room for behavioral health services has decreased slightly from 27.7 visits per 10,000 member months in Q3 2017 to 25.9 visits in Q4 2017. 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:** LTSS Utilization is reported by each Plan. LTSS services include In-Home Supportive Services (IHSS) (carved out beginning in 2018), Nursing Facility Services (NF), Community-based Adult Services (CBAS), and Multi-Purpose Senior Services Program (MSSP). This metric is a California-specific measure.

## LTSS Measure Notes:

For the September 2018 Dashboard, DHCS has split apart LTSS into its respective services. This has resulted in an increase in displays (Figures 26-33) for IHSS, CBAS, MSSP, and NF.

## LTSS Trends:

Figure 24 shows LTSS utilization per 1,000 members has seen little change throughout reporting period from an average of 278 members per 1,000 receiving LTSS in Q1 2017, to an average of 281 members in Q4 2017. Figure 26 shows that an average 235 members per 1,000 received IHSS in Q4 2017. Figure 28 shows that an average 10 members per 1,000 received CBAS in Q4 2017. Figure 30 shows that an average 5 members per 1,000 received MSSP for Q4 2017. Figure 32 shows that an average 30 members per 1,000 resided in a NF in Q4 2017. 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.

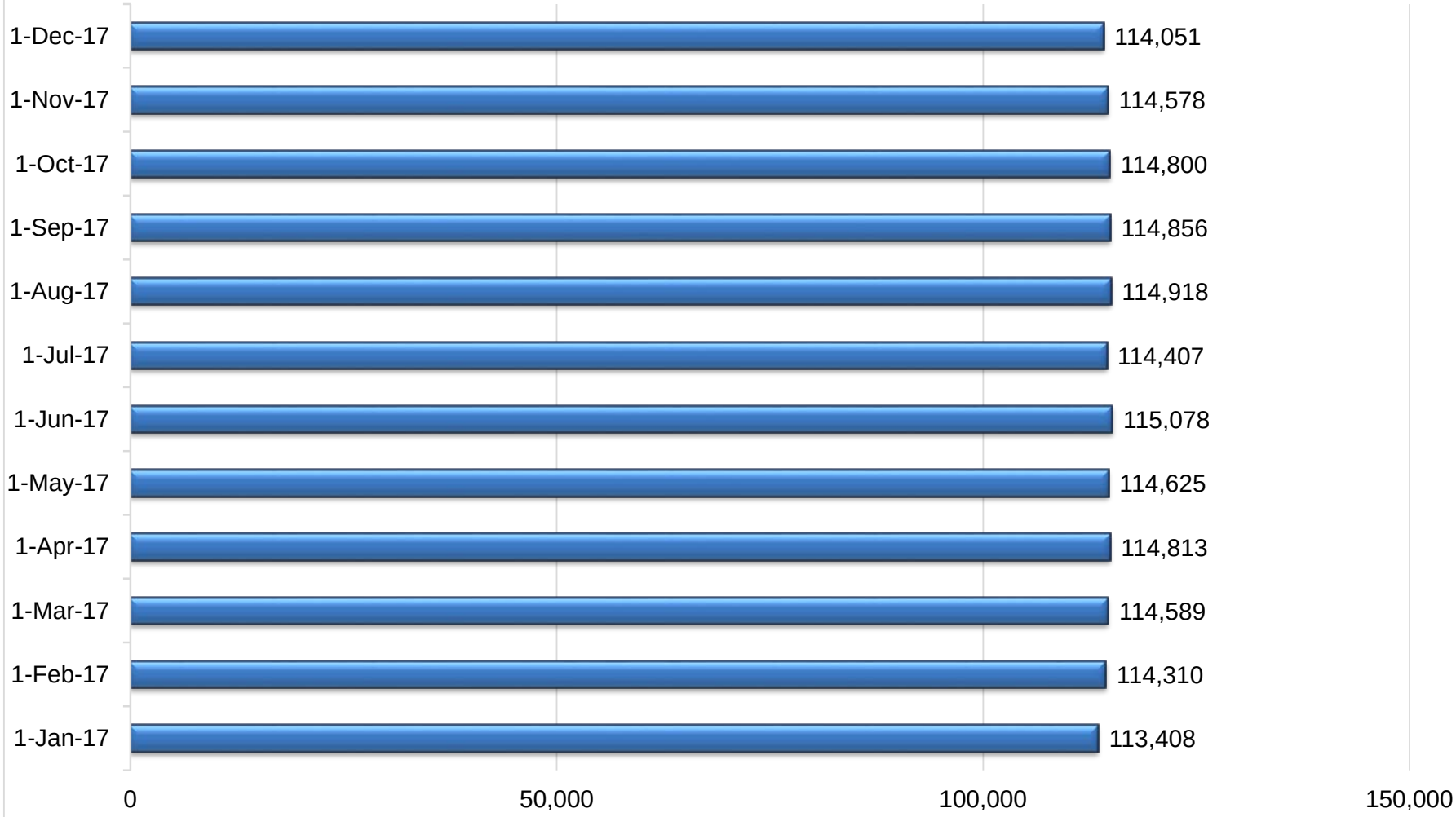
## Plan Key:

| 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 |
| L.A. 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 12/1/2017)**

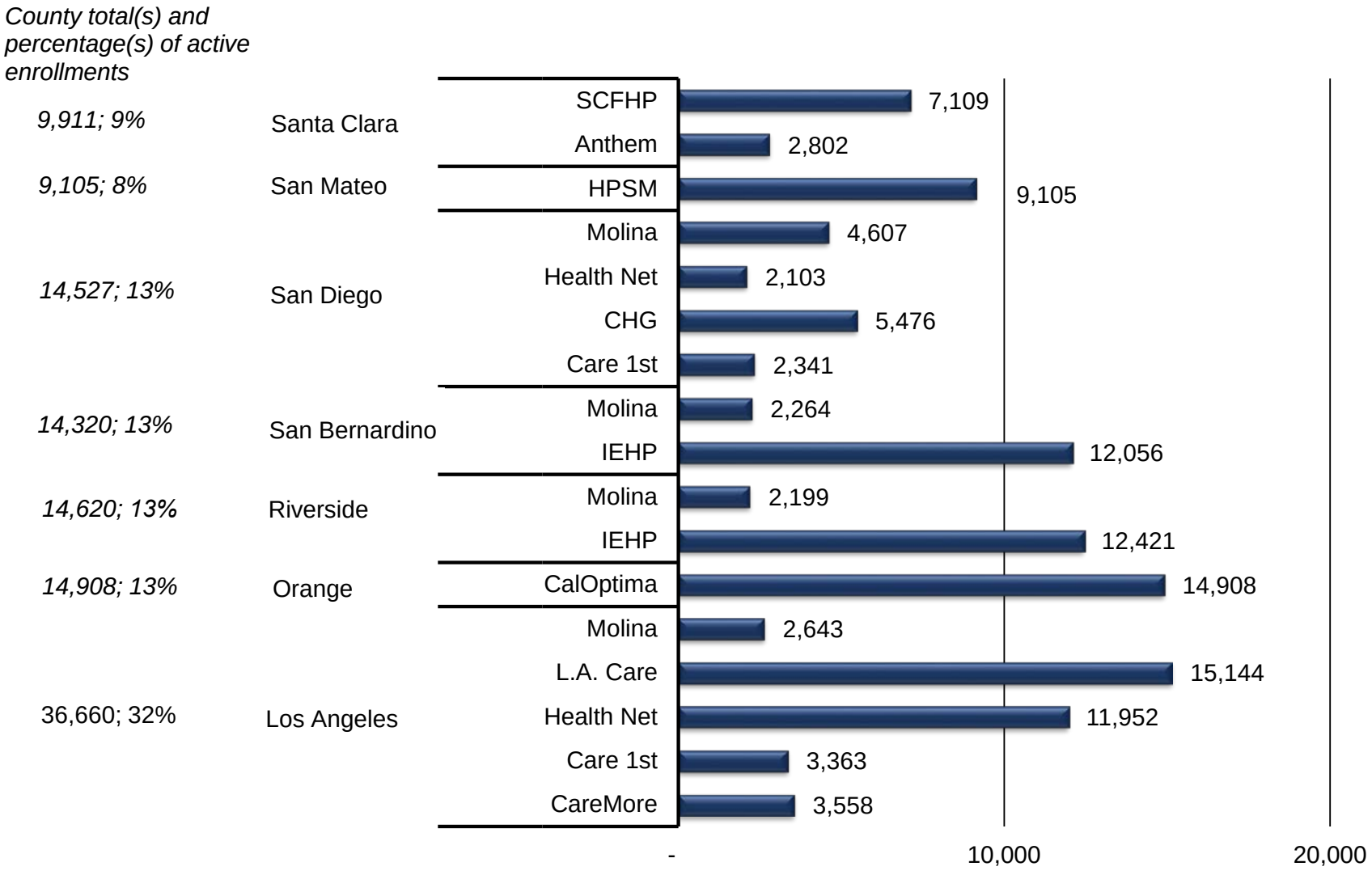
See metric summary for additional information

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



**Cal MediConnect Enrollment and Demographics Figure 2: Breakdowns of Dual Populations (As of 12/1/2017)**
See metric summary for additional information

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



**Cal MediConnect Enrollment and Demographics Figure 3 - 6: Breakdowns of Dual Populations (As of 12/1/2017)**
See metric summary for additional information

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

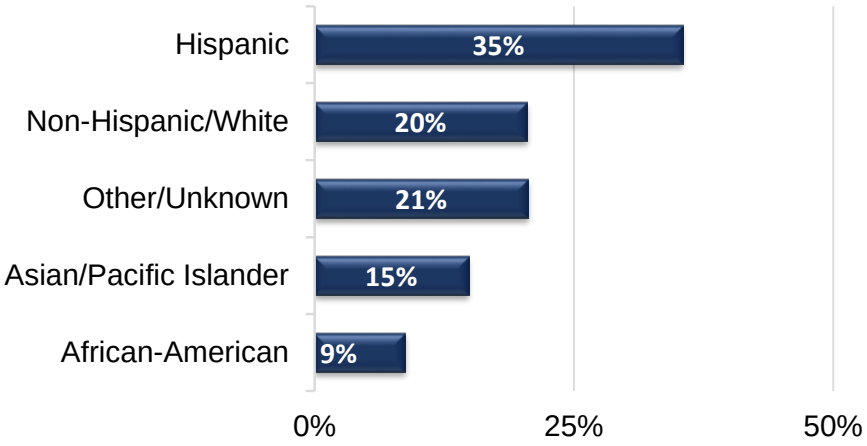



***Fig. 4:* Quarter 4 Enrollment by Age**

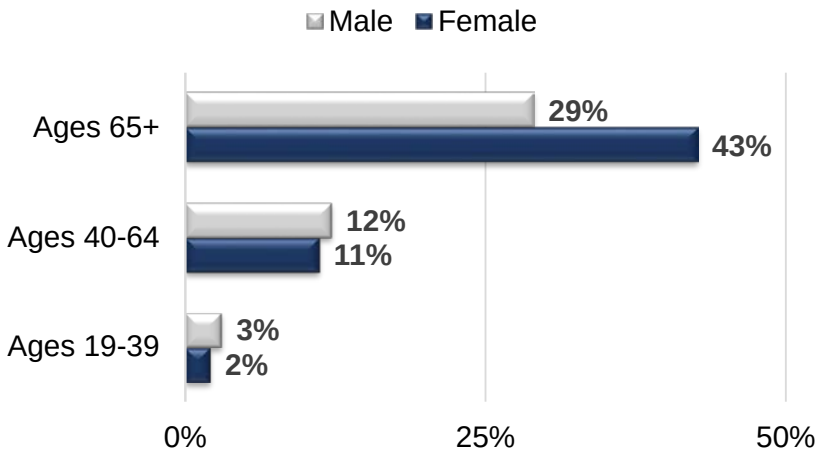



***Fig. 5*: Quarter 4 Enrollment by Threshold Language Spoken**

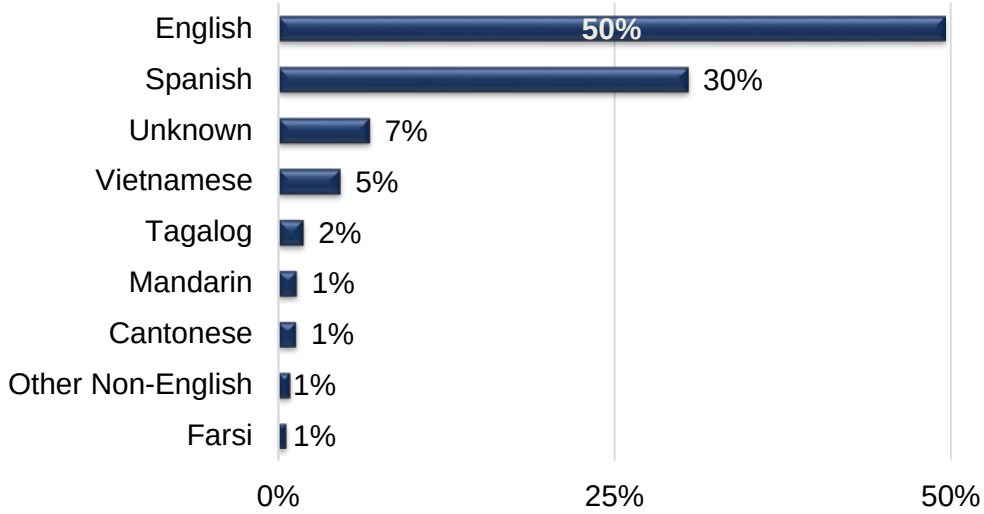
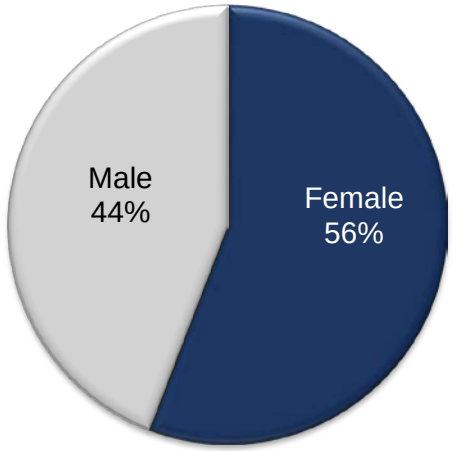



***Fig. 6:* Quarter 4 Enrollment by Gender**



**Cal MediConnect Figure 7: Quality Withhold Summary Table (CY 2015)**
See metric summary for additional information

| Medicare-Medicaid Plan | CW1 Assessments Benchmark: 88% | CW2 Consumer Governance Board Benchmark: 100% | CW3 Customer Service Benchmark: 86% | CW5 Getting Appointments and Care Quickly Benchmark: 74% | CAW1 Documentation of Care Goals Benchmark: 90% | CAW2 Behavioral Health Shared Accountability Benchmark: 100% |
|---|---|---|---|---|---|---|
| Anthem | Not Met | Met | N/A | N/A | Met | Met |
| Care 1st | Met | Met | N/A | Not Met | Not Met | Met |
| CHG | Not Met | Met | Not Met | Not Met | Met | Met |
| Health Net | Not Met | Met | N/A | Not Met | Not Met | Met |
| IEHP | Met | Met | Not Met | Not Met | Not Met | Not Met |
| L.A. Care | Met | Met | Not Met | Not Met | Not Met | Met |
| Molina | Met | Met | N/A | Not Met | Met | Met |
| CalOptima | Met | Not Met | N/A | N/A | Not Met | Met |
| HPSM | Not Met | Met | Not Met | Met | Not Met | Met |
| SCFHP | Not Met | Met | N/A | N/A | Not Met | Met |

| Medicare-Medicaid Plan | CAW4 Interaction with Care Team Benchmark: 90% | CAW5 Ensuring Physical Access to Buildings, Services and Equipment Benchmark: 100% | Total # of Measures in Analysis | Total # of Measures Met | % of Measures Met | % of Withhold Received |
|---|---|---|---|---|---|---|
| Anthem | Met | Met | 6 | 5 | 83% | 100% |
| Care 1st | Met | Met | 7 | 5 | 71% | 75% |
| CHG | Met | Met | 8 | 5 | 63% | 75% |
| Health Net | Not Met | Met | 7 | 3 | 43% | 50% |
| IEHP | Not Met | Met | 8 | 3 | 38% | 25% |
| L.A. Care | Not Met | Met | 8 | 4 | 50% | 50% |
| Molina | Met | Met | 7 | 6 | 86% | 100% |
| CalOptima | Met | Met | 6 | 4 | 67% | 75% |
| HPSM | Not Met | Met | 8 | 4 | 50% | 50% |
| SCFHP | Not Met | Met | 6 | 3 | 50% | 50% |
| **California Averages** | | | **7** | **4** | **60%** | **65%** |

**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 (01/2017-12/2017)**

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**

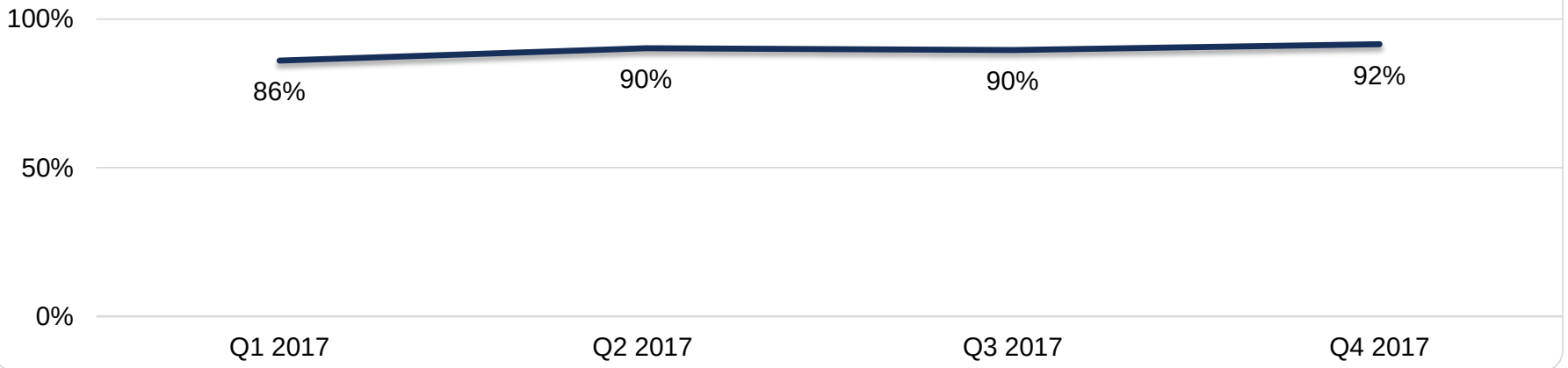
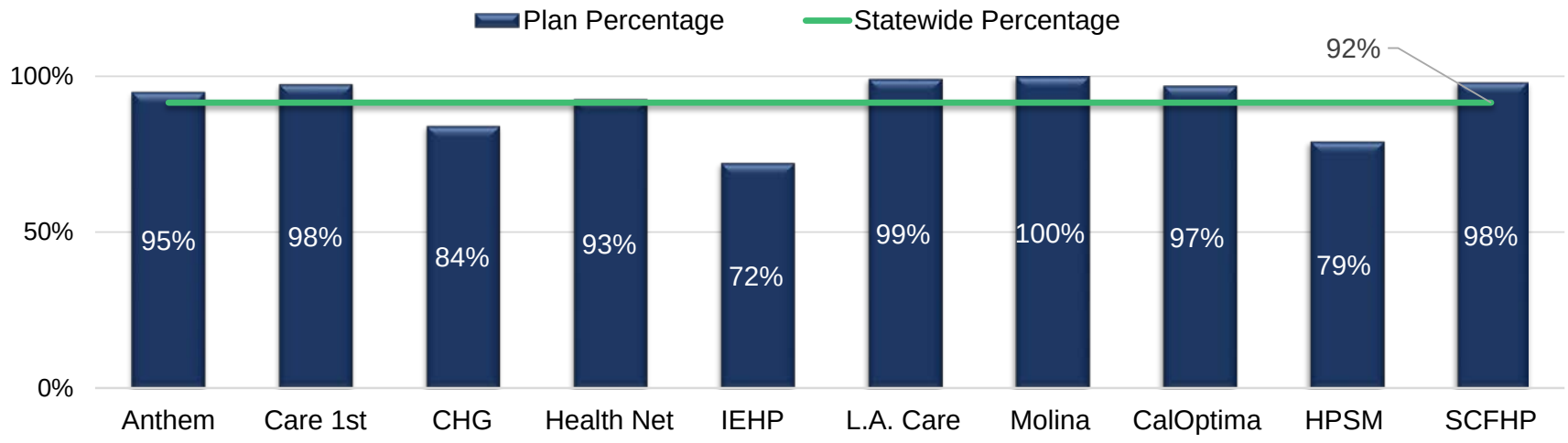



***Fig. 9:*** **The Percentage of Members Willing to Participate and who the Plan was able to Locate with an Assessment Completed Within 90 Days of Enrollment for Quarter 4 of 2017**



**Care Coordination Figure 10 & 11: Percentage of Members with an Individualized Care Plan (ICP)**
**(01/2017-12/2017)** See metric summary for additional information

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

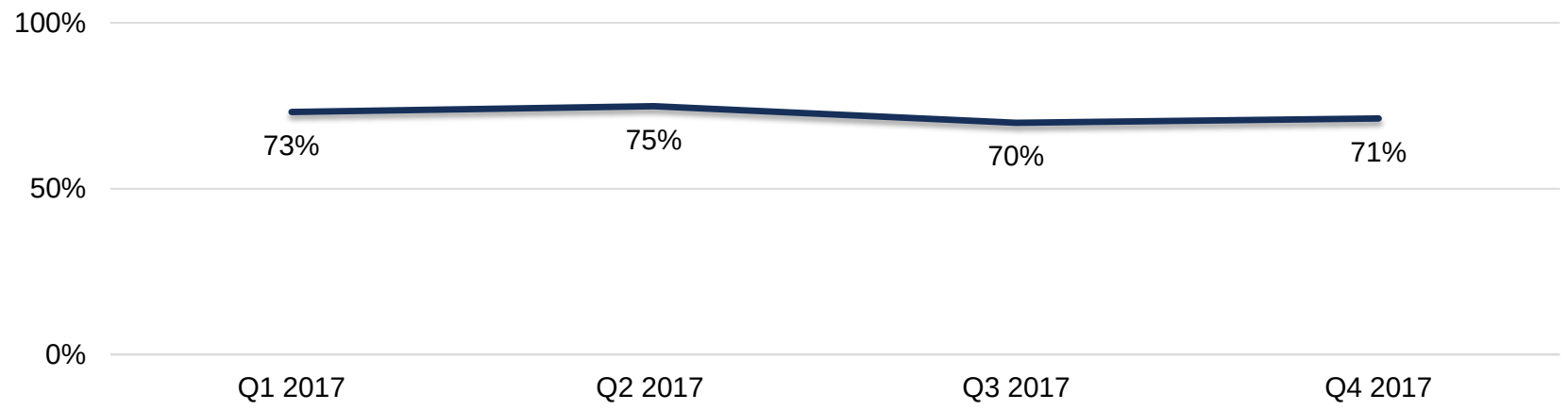
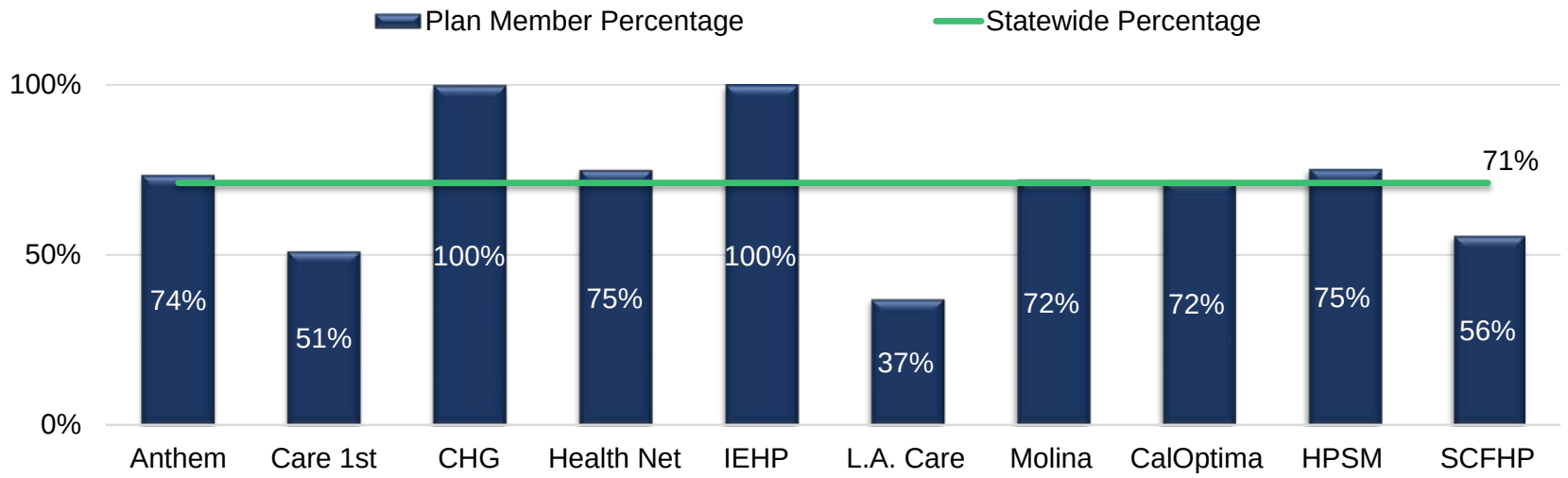


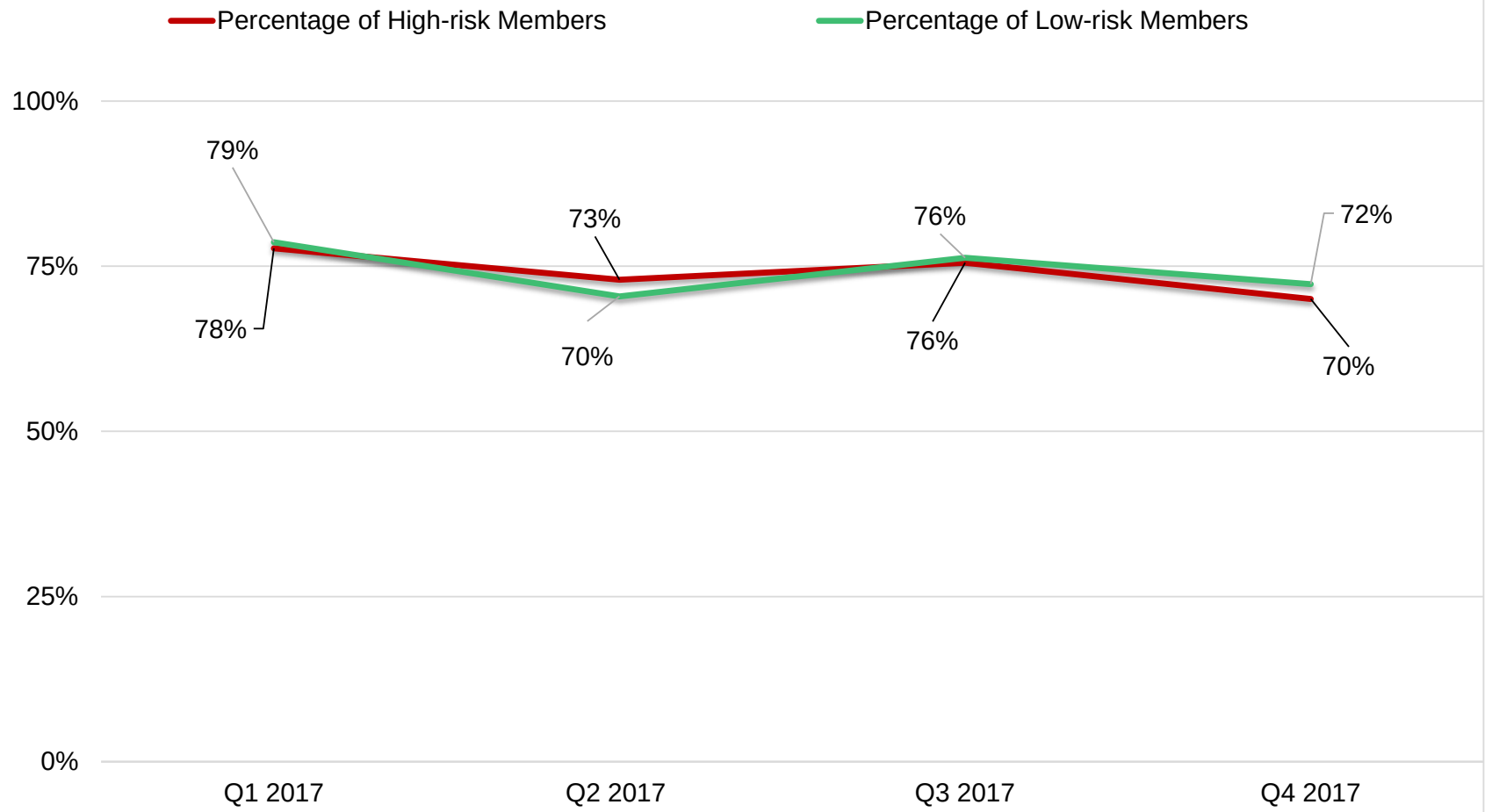

***Fig. 11:*** **Percentage of Members with an ICP for Quarter 4 of 2017**



**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) (01/2017-12/2017)**

See metric summary for additional information

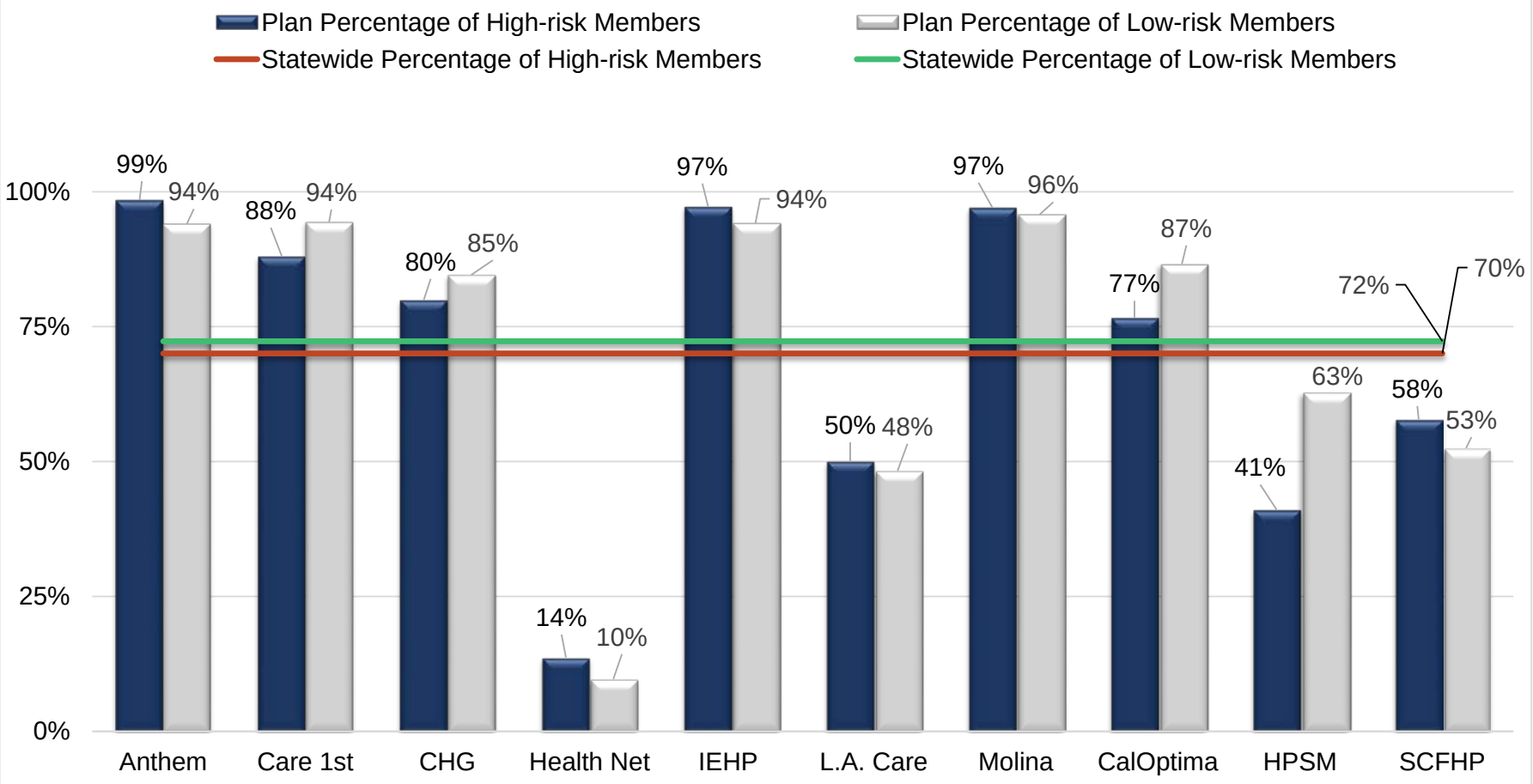
***Fig. 12:*** **Quarterly Rolling Statewide Percentage of High-risk & Low-risk Members with an Individualized Care Plan (ICP) within 30 Working Days after the Completion of the Initial Health Risk Assessment (HRA)**



**Care Coordination Figure 13: 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) Quarter 4 of 2017**

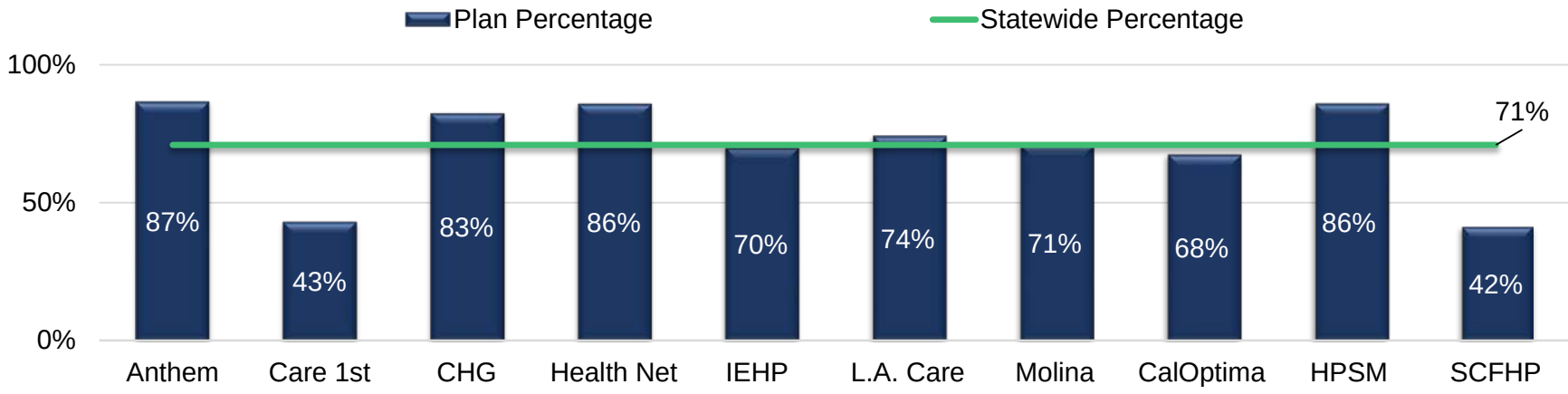
See metric summary for additional information

***Fig. 13:*** **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) in Quarter 4 of 2017**



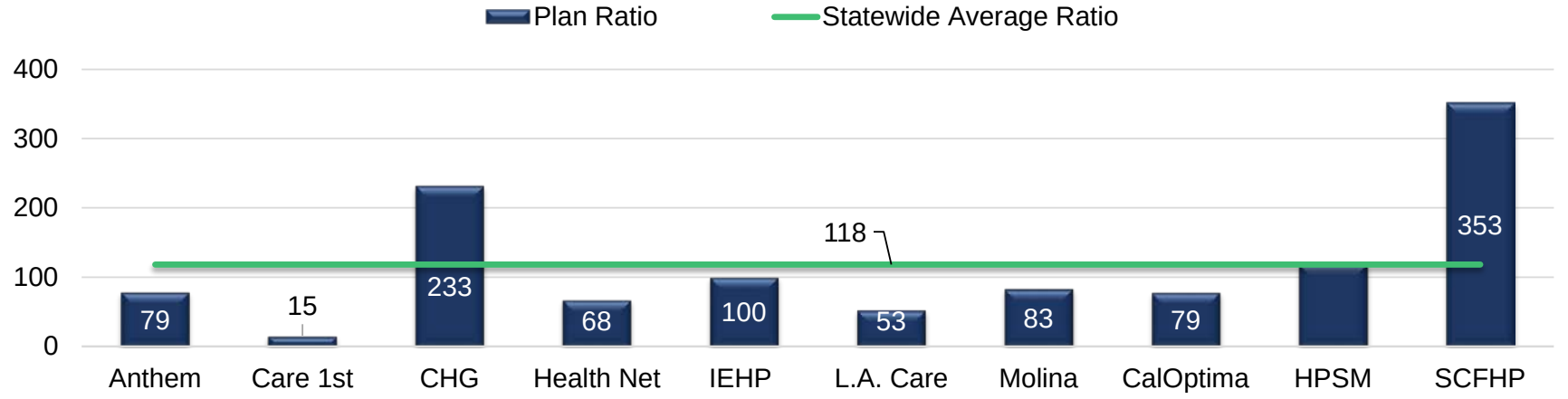
**Care Coordination Figure 14: Percentage of Members Who Have a Care Coordinator and Have at Least One Care Team Contact During the Reporting Period (01/2017-12/2017)** See metric summary for additional information

***Fig. 14:*** **Annual (2017) Percentage of Members who have a Care Coordinator and have at least One Care team Contact During the Reporting Period**



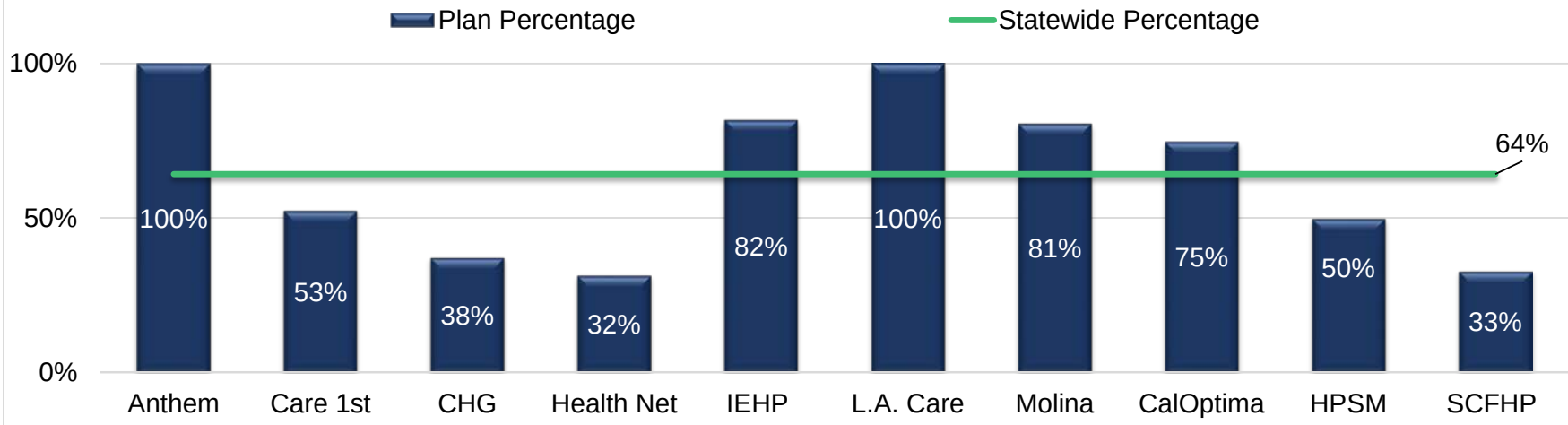

**Care Coordination Figure 15: Member to Care Coordinator Ratio (01/2017-12/2017)**
See metric summary for additional information

***Fig. 15:*** **Annual (2017) Number of Members to Care Coordinator Ratio**



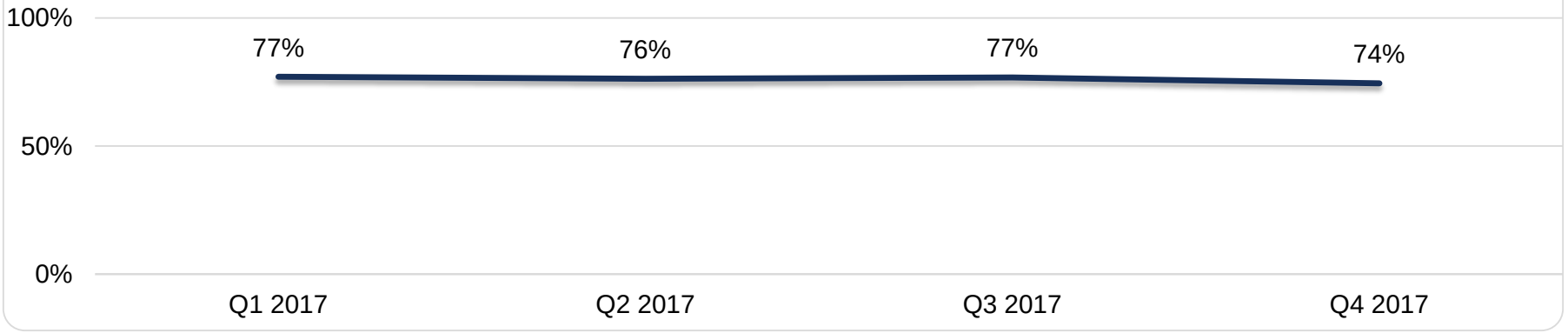
**Care Coordination Figure 16: Percentage of Members with Documented Discussions of Care Goals (01/2017-12/2017)**
See metric summary for additional information

***Fig. 16*: Annual (2017) Percentage of Members with Documented Discussions of Care Goals**



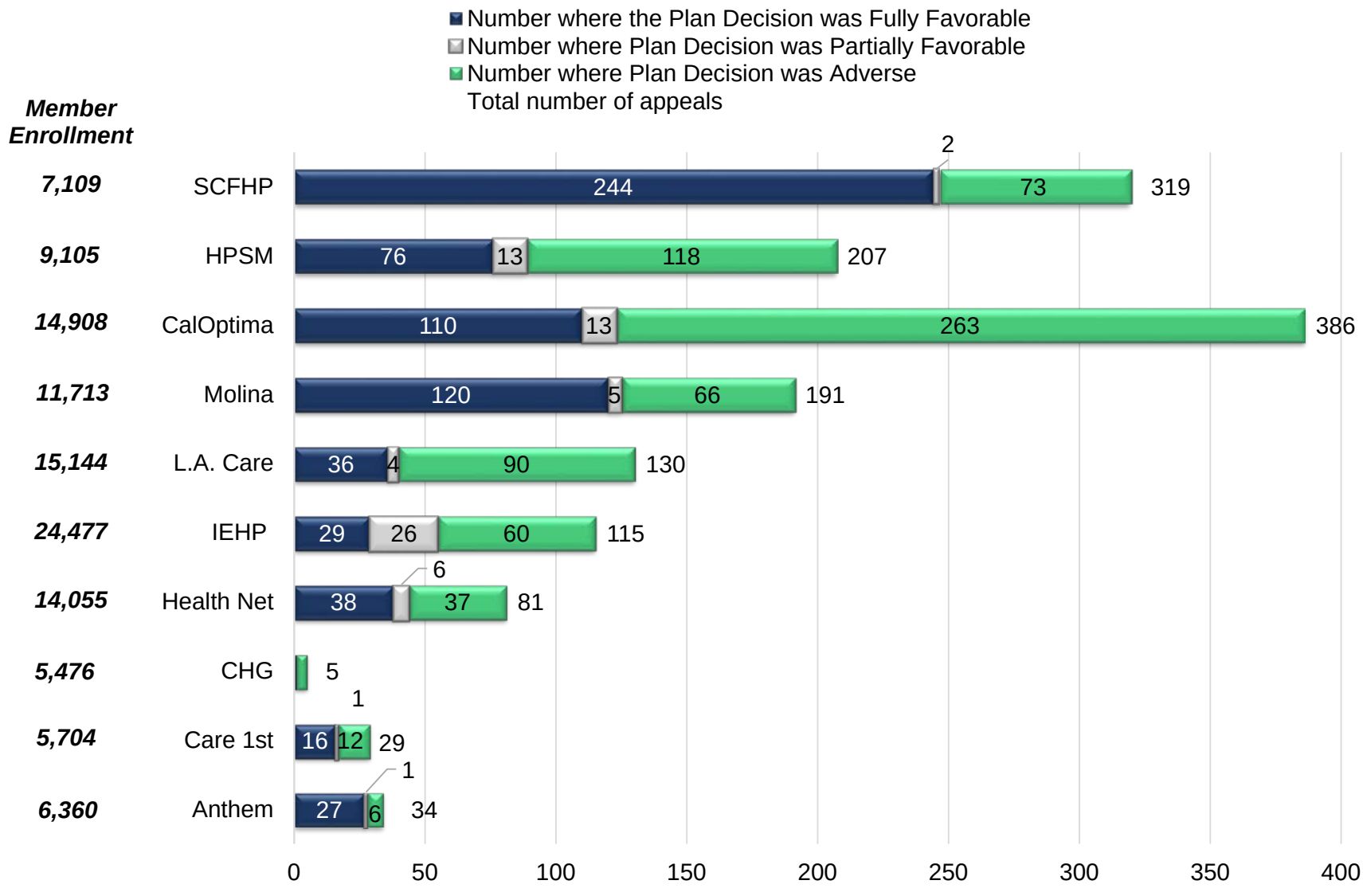

**Care Coordination Figure 17: Percentage of Members with First Follow-up Visit within 30 Days after Hospital Discharge (01/2017-12/2017)** See metric summary for additional information

***Fig. 17*: Quarterly Rolling Statewide Percentage of Members with First Follow-Up Visit within 30 Days after Hospital Discharge**



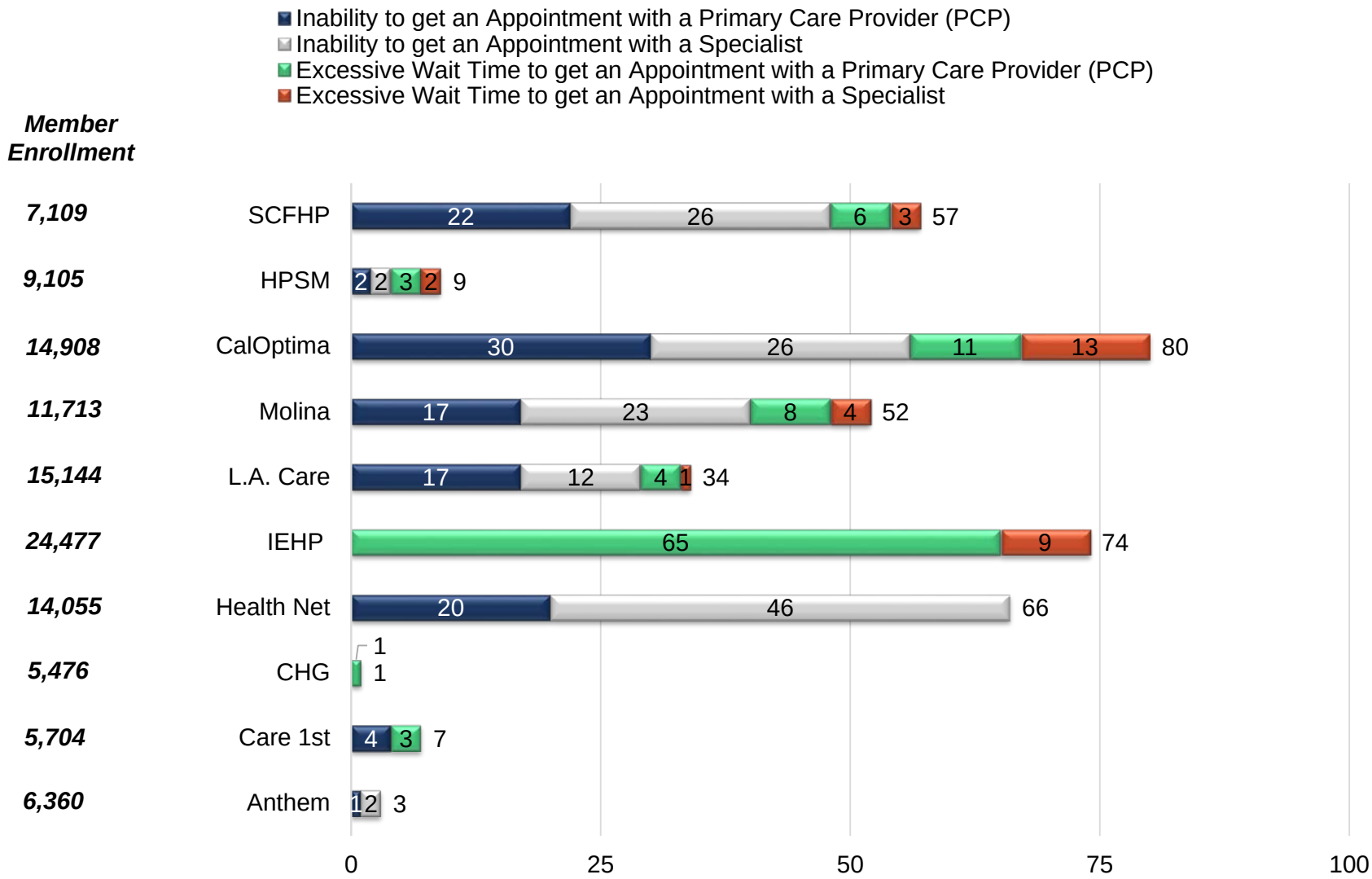
**Appeal Figure 18: Count of Appeals (01/2017-12/2017)** See metric summary for additional information

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



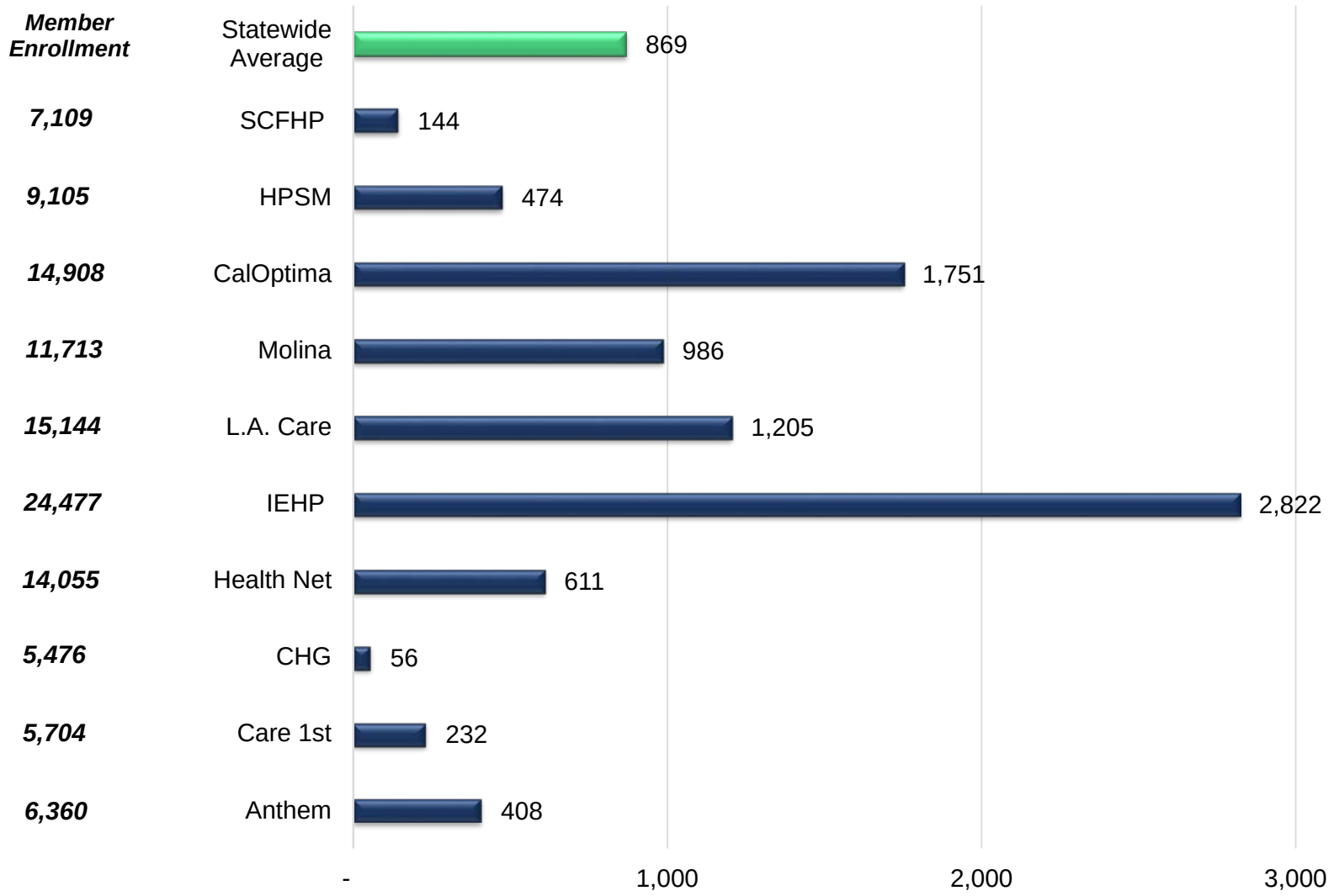
**Grievance Figure 19: Count Grievances by type, Except "Other" (01/2017-12/2017)**
See metric summary for additional information

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



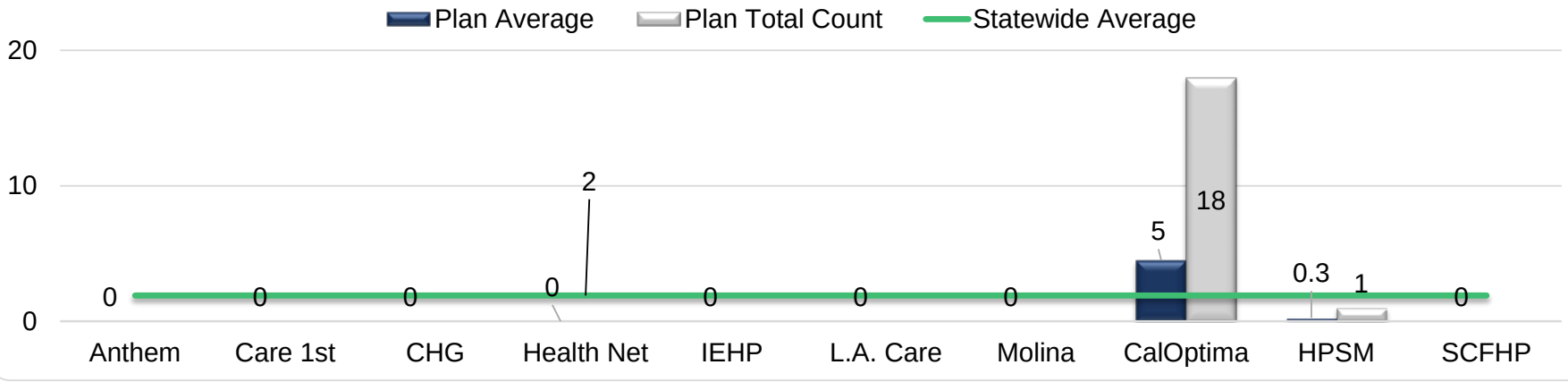
**Grievance Figure 20: Count of "Other" Grievances (01/2017-12/2017)** See metric summary for additional information

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



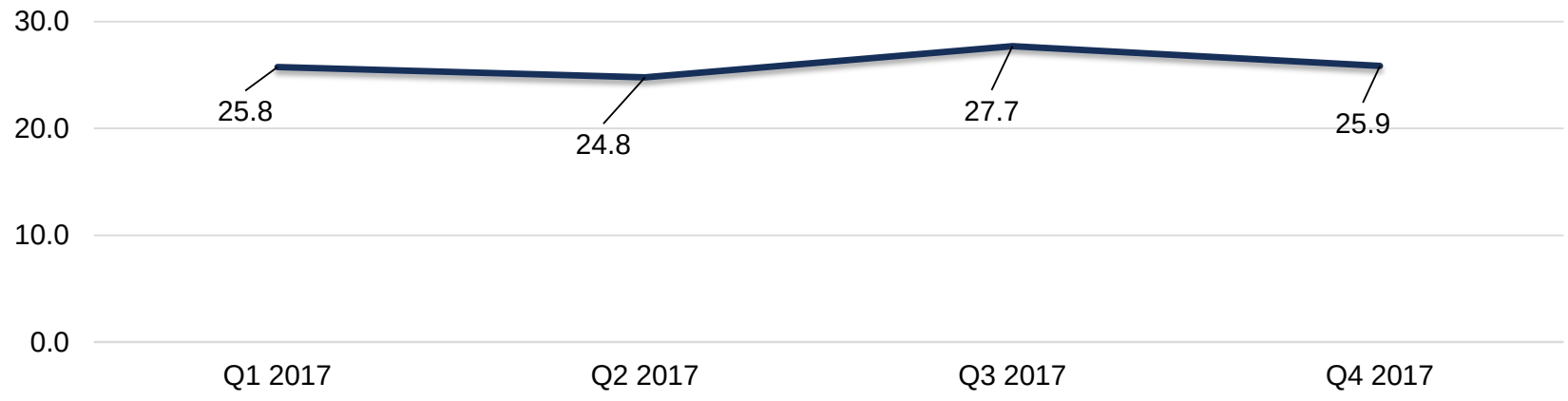
**Appeals Figure 21: Total Number of Appeals Related to the Denial or Limited Authorization of Mental Health Services (01/2017-12/2017)** See metric summary for additional information

***Fig. 21:*** **Annual (2017) Total of all Appeals Related to the Denial or Limited Authorization of Mental Health Services**



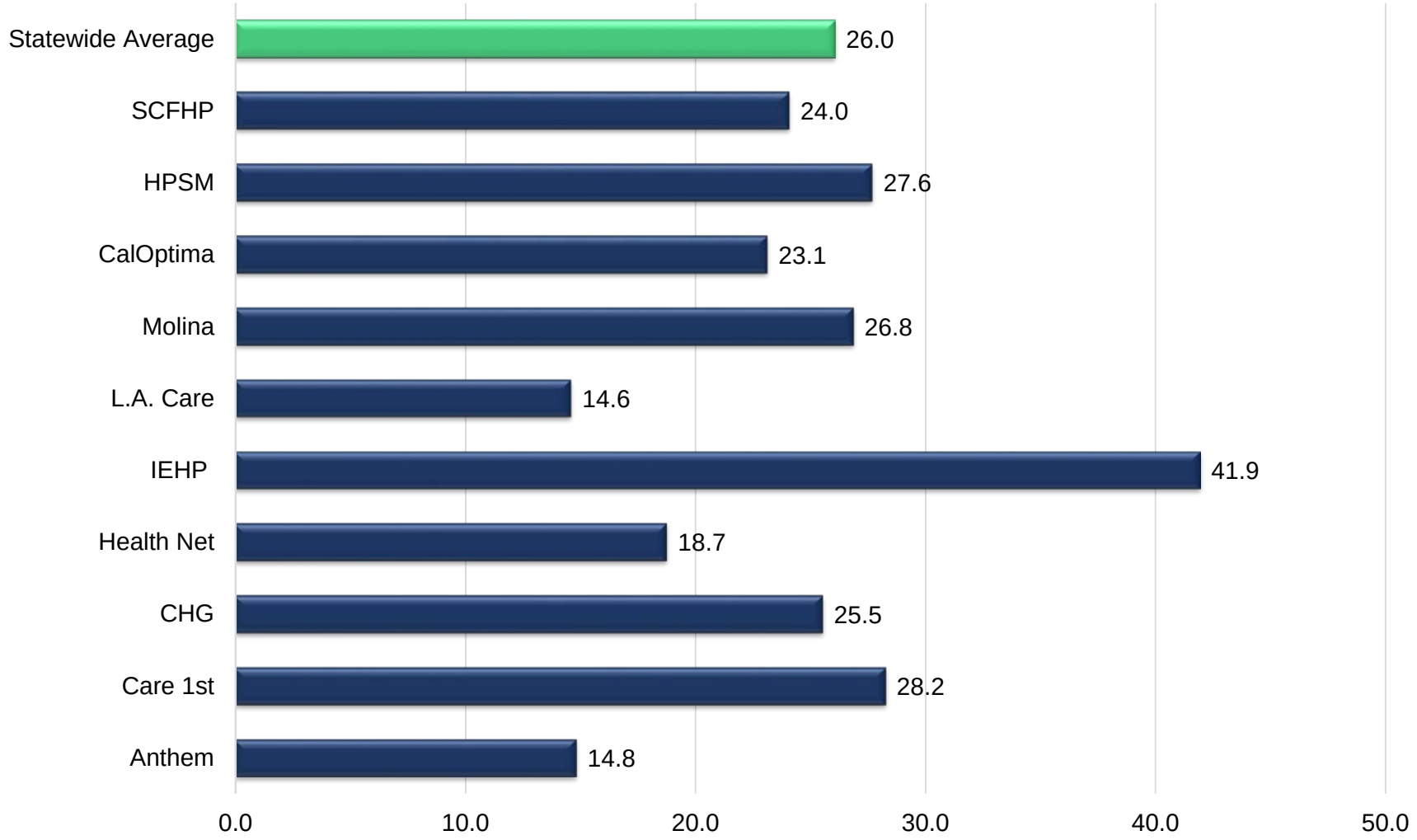

**Behavioral Health Figure 22: Emergency Room Behavioral Health Services Utilization per 10,000 Member Months (01/2017-12/2017)** See metric summary for additional information

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

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

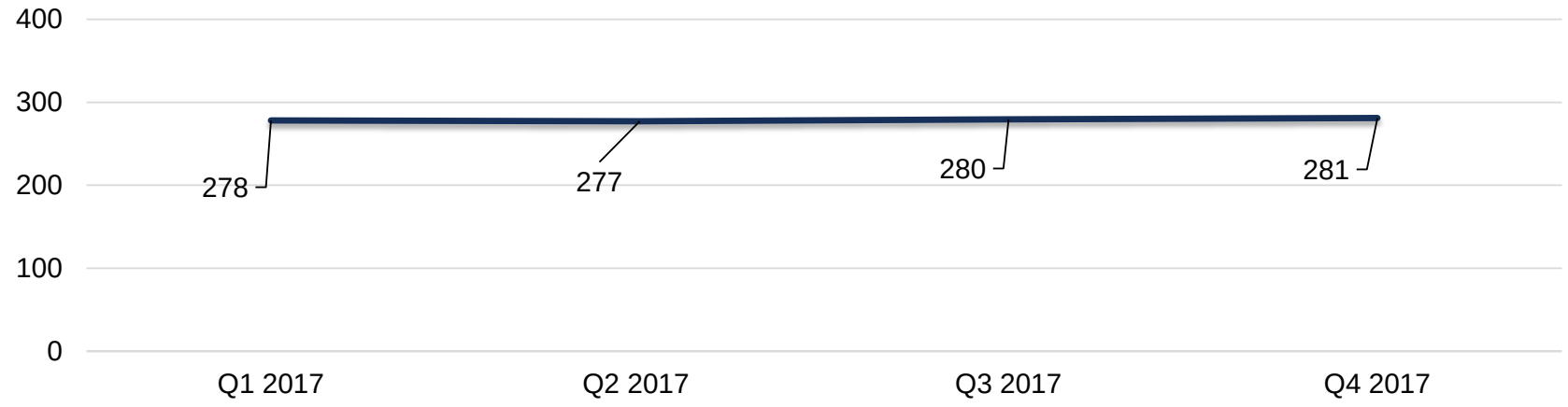
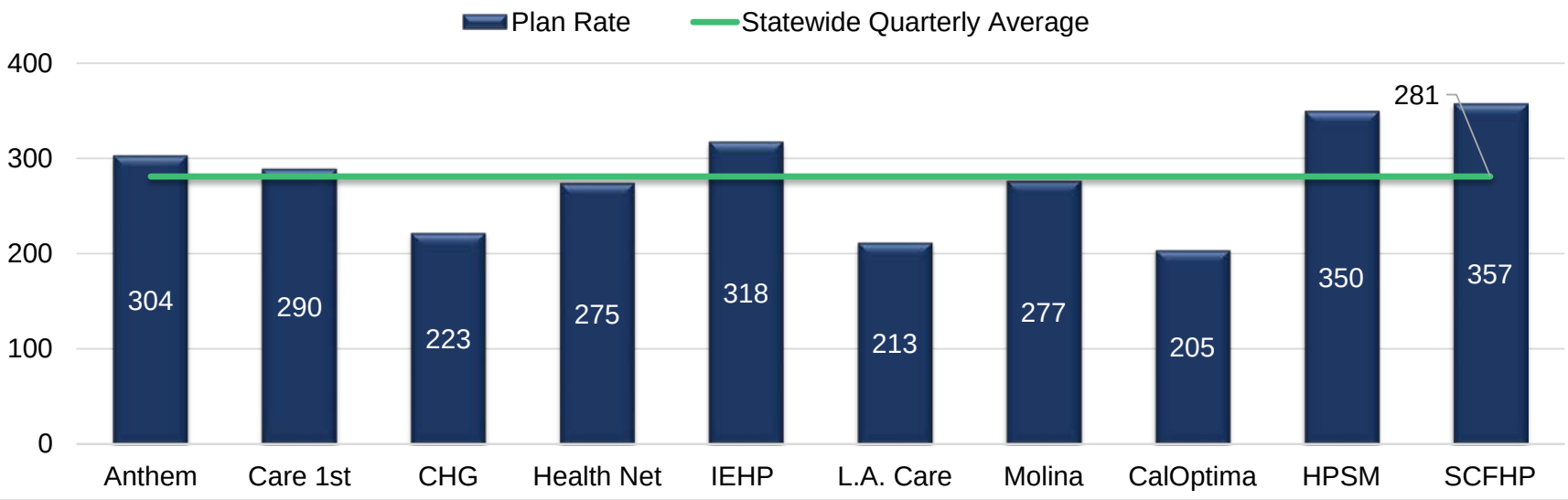



**Fig. 25: Count of Members Receiving LTSS per 1,000 members for Quarter 4 of 2017**



**Long Term Services & Supports (LTSS) Figure 26 & 27: Count of IHSS per 1,000 Members**
**(01/2017-12/2017)** See metric summary for additional information

**Fig. 26: Quarterly Rolling Statewide Average of Members Receiving IHSS per 1,000 Members**

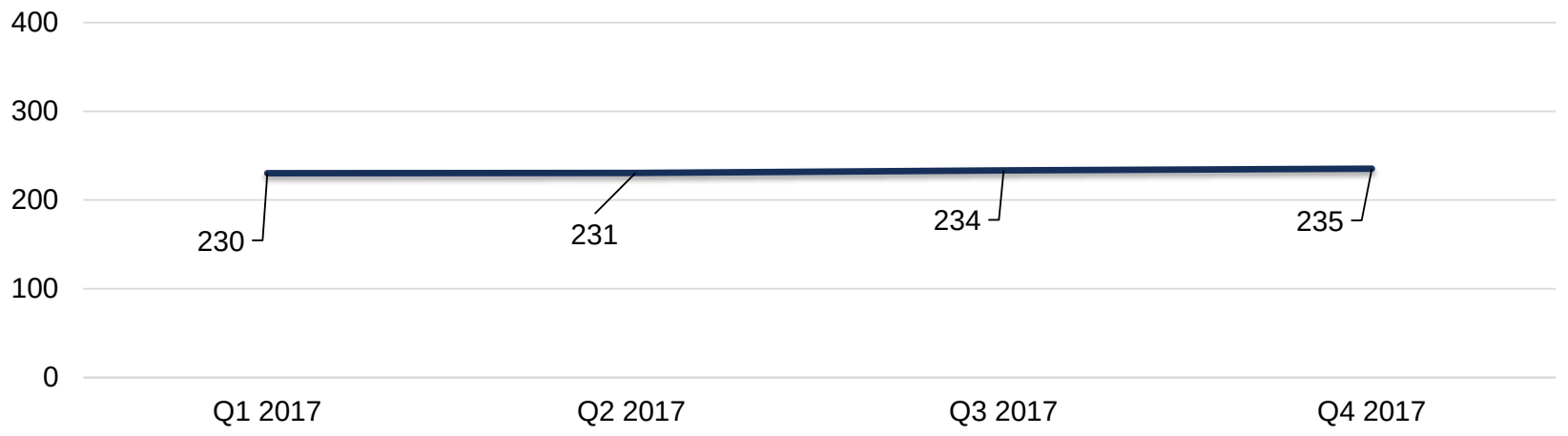
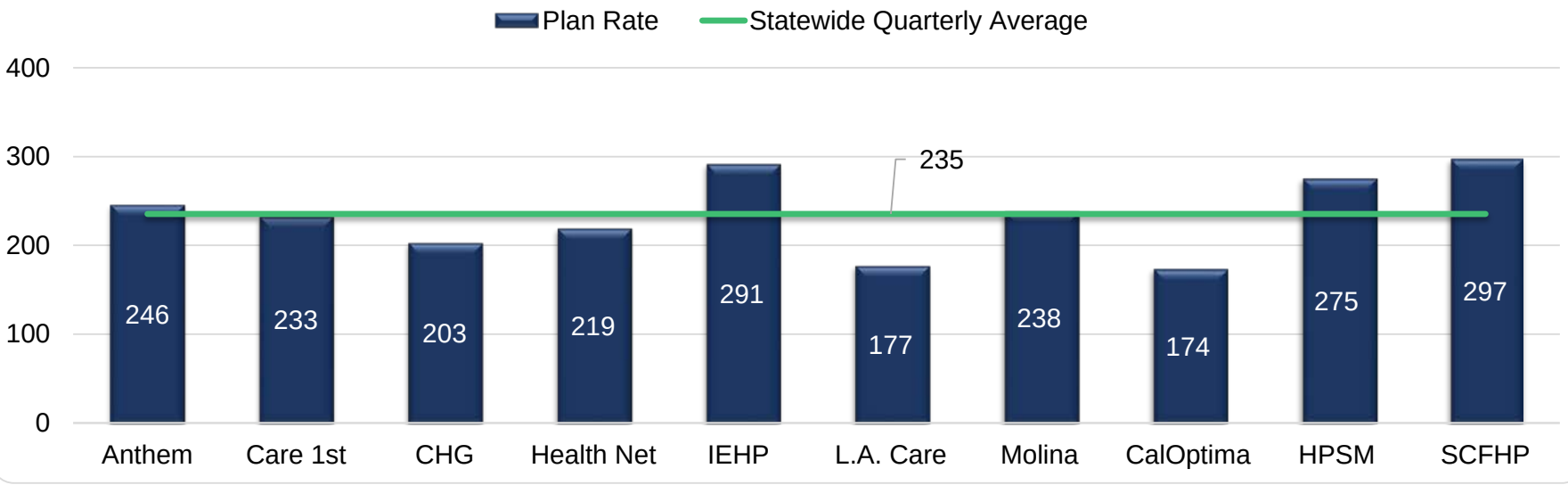



**Fig. 27: Count of Members receiving IHSS per 1,000 members for Quarter 4 of 2017**



**Long Term Services & Supports (LTSS) Figure 28 & 29: Count of CBAS per 1,000 Members**
**(01/2017-12/2017)** See metric summary for additional information

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

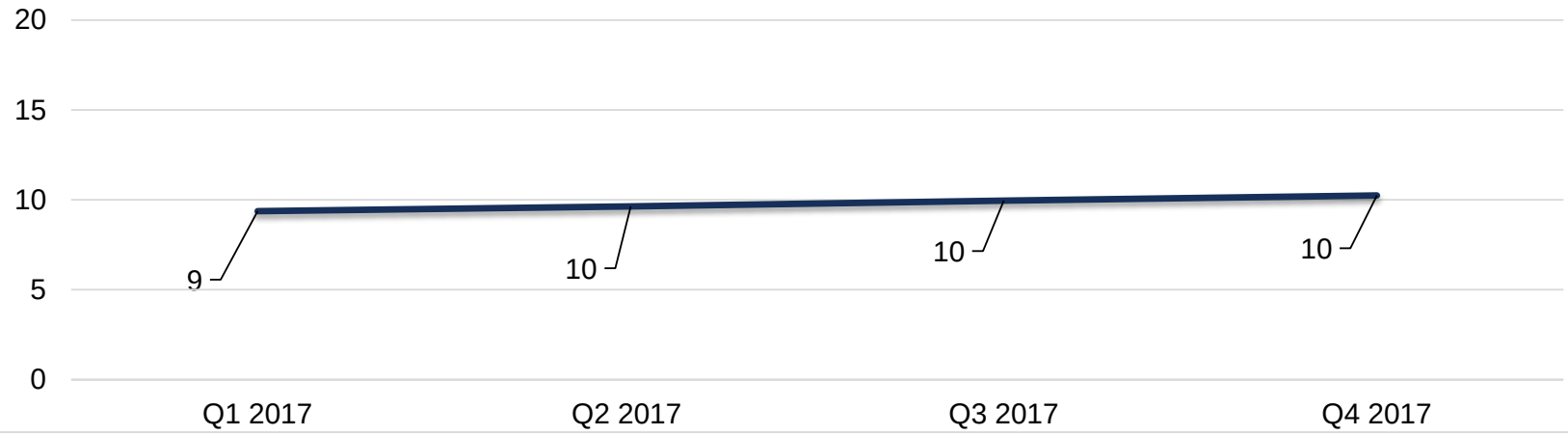
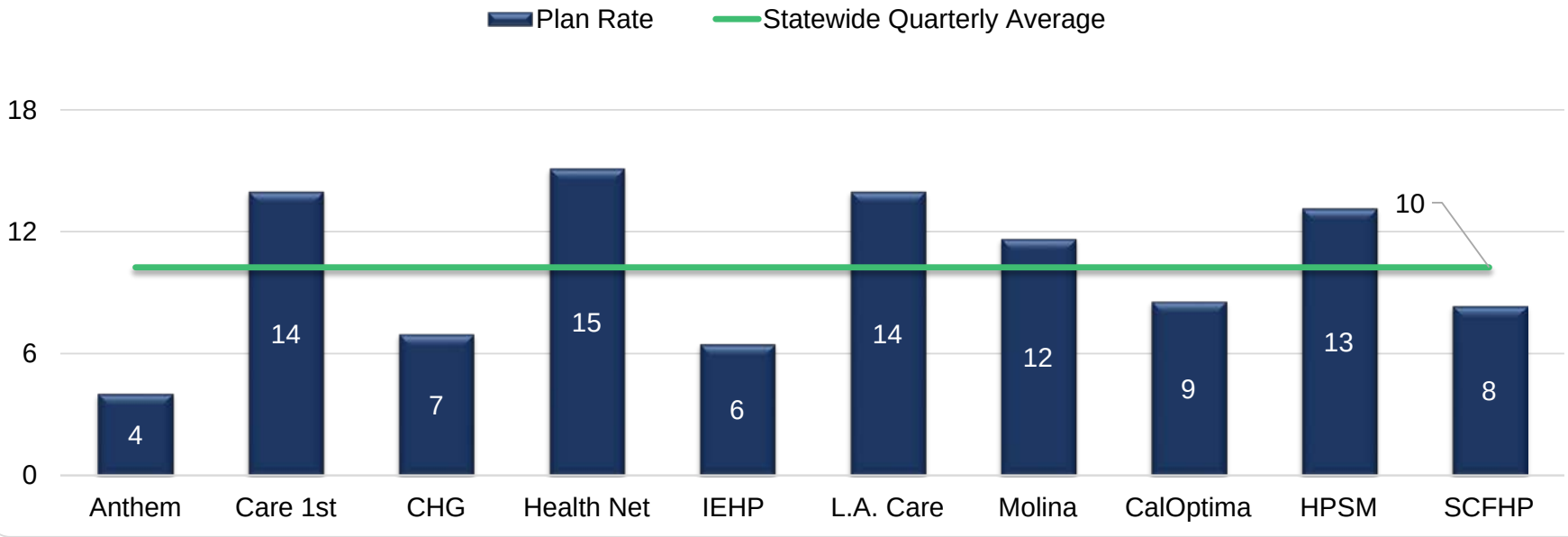



**Fig. 29: Count of Members receiving CBAS per 1,000 members for Quarter 4 of 2017**



**Long Term Services & Supports (LTSS) Figure 30 & 31: Count of MSSP per 1,000 Members**
**(01/2017-12/2017)** See metric summary for additional information

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

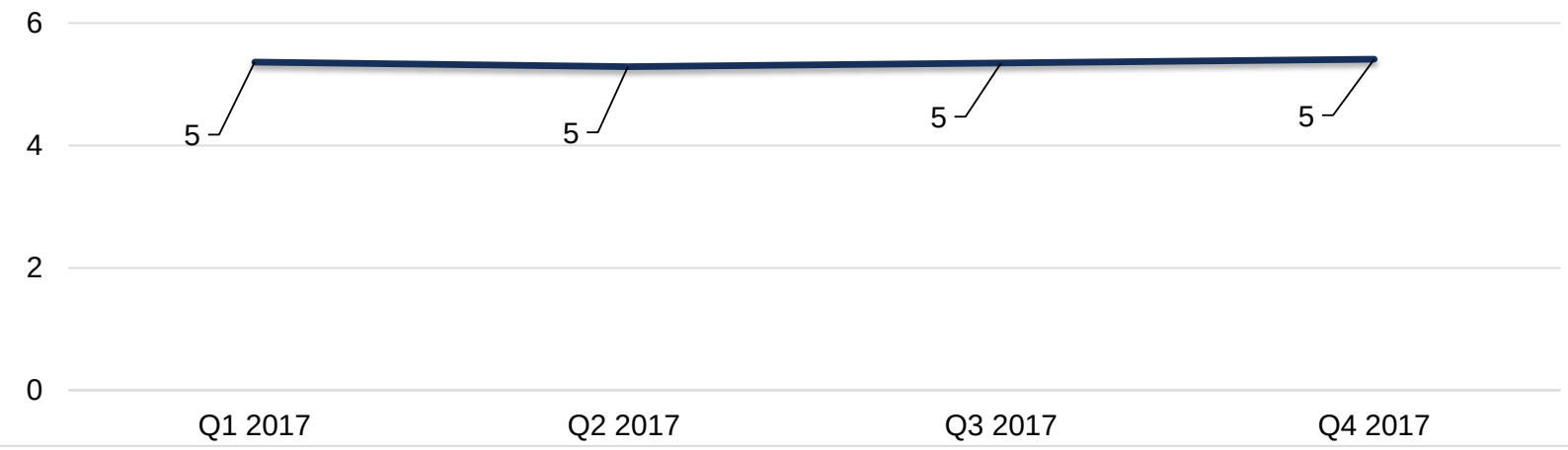
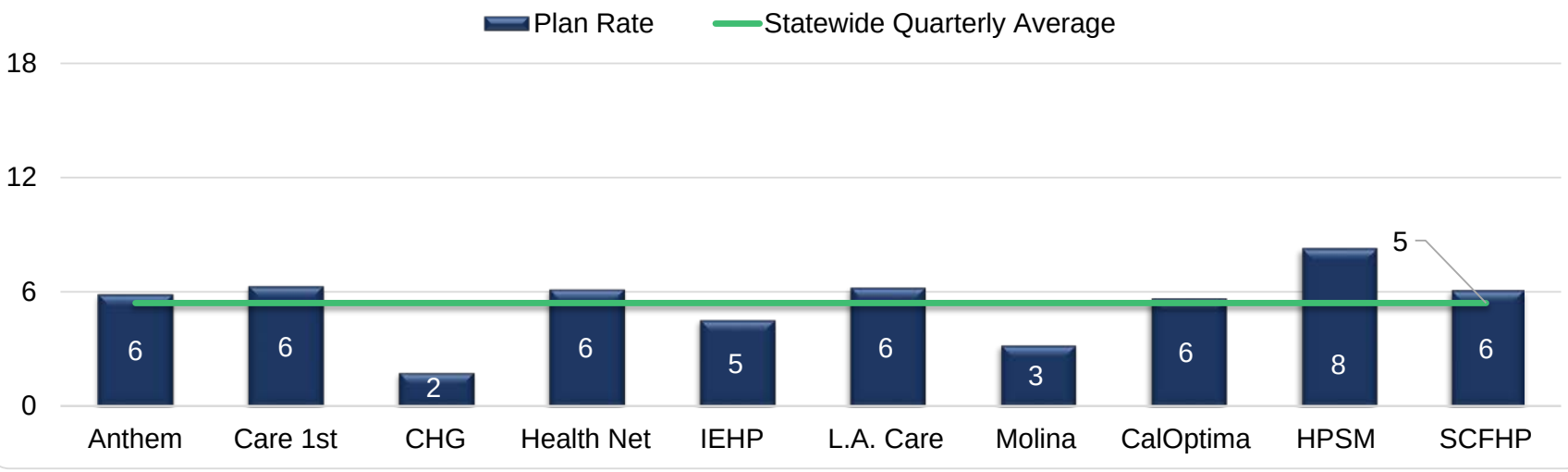



**Fig. 31: Count of Members receiving MSSP per 1,000 members for Quarter 4 of 2017**



**Long Term Services & Supports (LTSS) Figure 32 & 33: Count of NF per 1,000 Members**
**(01/2017-12/2017)** See metric summary for additional information

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

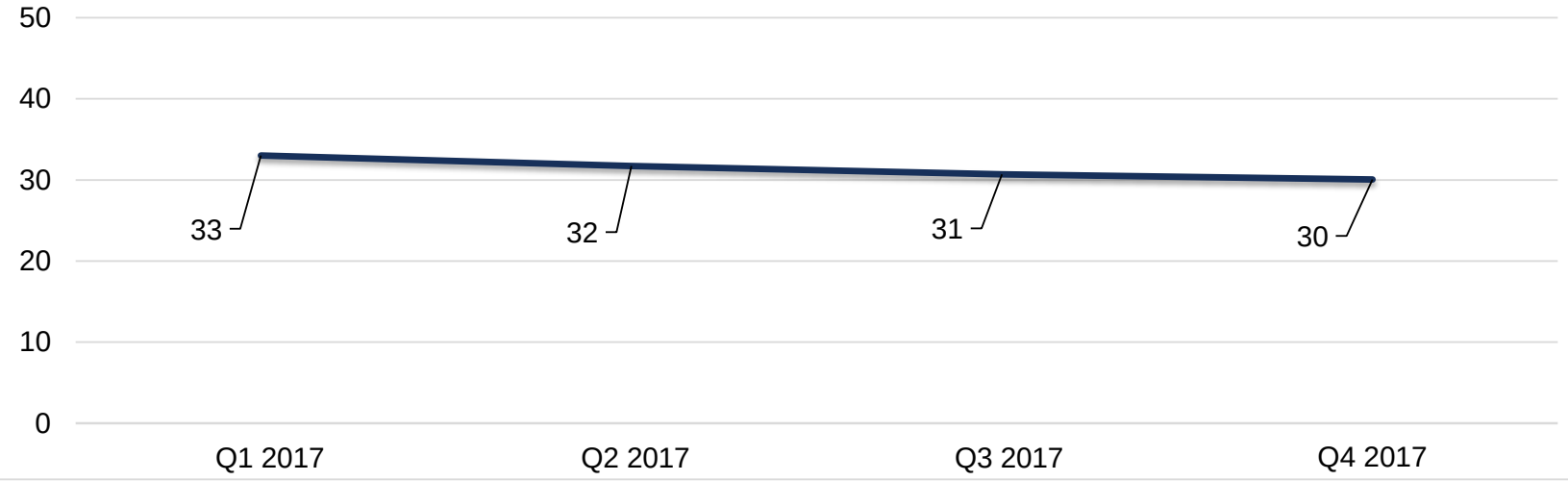



**Fig. 33: Count of Members receiving NF per 1,000 Members for Quarter 4 of 2017**