



Cal MediConnect Performance Dashboard Metrics Summary

Released September 2021



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 increased from 107,477 members in April 2020 to 112,945 in March 2021. In Q1 2021, 51% of enrollees spoke English and 33% spoke Spanish as their primary language, with 38% of enrollees identifying as Hispanic. Males and females aged 65 and older represent 30% and 45% of the total CMC population, respectively.
- **Quality Withhold Summary:** *Figure 7*
All Plans met at least five of eight quality withhold measures for Calendar Year 2018. Eight of the ten Plans received 100% of their withhold: Anthem, Blue Shield, Health Net, L.A. Care, Molina, CalOptima, HPSM and SCFHP.
- **Care Coordination:** *Figures 8-15*
Figure 8 shows that the percentage of members with a health risk assessment (HRA) completed within 90 days of enrollment increased from 94% in Q4 2020 to 95% in Q1 2021. Figure 10 shows that the percentage of members with an ICP completed within 90 days of enrollment has decreased from 86% in Q4 2020 to 85% in Q1 2021.
- **Grievances and Appeals:** *Figures 16-19*
Plans reported 12% more grievances in 2020 compared to 2019. In 2020, Plans reported 80% fewer appeals than in 2019. Of the total appeals, Figure 16 shows that 45% of Plan decisions were either fully or partially favorable to the member.
- **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 18.1 visits per 10,000 member months in Q1 2020 to 14.1 visits in Q4 2020.
- **Long-term Services and Supports:** *Figures 22-41*
Figure 22 shows that LTSS utilization per 1,000 members has increased during the reporting period; from an average of 292.8 members per 1,000 receiving LTSS in Q2 2020, to an average of 295.1 members per 1,000 in Q1 2021. DHCS is continuing to work with Plans to enhance LTSS referrals. Figures 24-41 display LTSS member referrals



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and utilization in five categories: In-Home Support Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), Nursing Facility (NF) and Care Plan Options (CPO). IHSS member referral data are not included in this dashboard due to ongoing data quality assessment.

Data and Analysis Notes:

The dashboard is a tool that displays a combination of quarterly and annual measures. Dashboard data are reported by plan, except for the enrollment and demographic data which are calculated on a county-basis by DHCS (more information below). The dashboard presents the most current data available. Therefore, the reporting time periods for each metric reported may vary for each release.

- **Quarterly Rolling Statewide Average:** Figures 8, 10, 20, 22, 24, 26, 28, 30, 32, 34, 36, 38 and 40. Metrics represent the entire CMC program, by calendar quarters.
- **Current Quarter data by plan:** Figures 9, 11, 23, 25, 27, 29, 31, 33, 35, 37, 39 and 41. Metrics represent the data for the most recent quarter, by plan.
- **Annual data:** Figures 7, 12, 13, 14, 15, 16, 17, 18, 19 and 21. Annual data are updated once a year and are compared to previous years that are only collected in aggregate.
- **Updated data:** Figures 1-6, Figures 8-11, Figure 15, and Figures 22-41 have been updated for the September 2021 release.

DETAILED DASHBOARD METRICS AND TRENDS

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

Cal MediConnect Enrollment and Demographics:

Enrollment and demographic data are a point-in-time view of the Cal MediConnect population. The data come from the DHCS data warehouse and the Medi-Cal Management Information System/Decision Support System (MIS/DSS).

In addition to the quarterly enrollment and demographic data reported in this dashboard, monthly Cal MediConnect enrollment data will now be available through the Medi-Cal Managed Care Enrollment Reports available at <https://data.ca.gov/dataset/medi-cal-managed-care-enrollment-report>



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Quality Withhold Measures

CMS and DHCS monitor Plans using quality measures relating to beneficiaries' overall experience, care coordination, fostering and support of community living, and more.¹ These measures, which are required to be reported under Medicare and Medicaid, build on other required data: Healthcare Effectiveness Data and Information Set (HEDIS), Medicare Health Outcomes Survey, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey 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 2018.

Figure 7 shows the quality withhold measures for the calendar year 2018. Definitions of the measures included for Figure 7 are below:

CW stands for “core withhold”, and in most cases, a core withhold measure corresponds with a core quality measure. CAW stands for “California withhold” and usually corresponds with a state-specific quality measure. Quality withhold measures may be stand-alone, or based on HEDIS, CAHPS, or other national data sources.

¹Core and State-Specific Reporting Requirements:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>

²Core 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>



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Quality withhold measure results indicated with "*" represent measures that also utilize the gap closure target methodology.¹ For Plans that are affected by an extreme and uncontrollable circumstance, such as a major natural disaster, CMS and the State remit the full quality withhold payment for the year in which the extreme and uncontrollable circumstance occurred, provided that the Plan fully reports all applicable quality withhold measures. Affected Plans are identified according to the methodology utilized for Medicare Part C and D Star Ratings for the applicable measurement year. These Plans are denoted with "^" on Figure 7.

- **Plan All-Cause Readmission:** The ratio of the plan's observed readmission rate to the plan's expected readmission rate. The readmission rate is based on the percent of plan members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason. (CW6)
- **Annual Flu Vaccine:** Percent of plan members who got a vaccine (flu shot) prior to flu season. (CW7)
- **Follow-Up After Hospitalization for Mental Illness:** Percentage of discharges for plan members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge. (CW8)
- **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)
- **Behavioral Health Shared Accountability Outcome Measure:** Reduction in emergency department (ED) use for seriously mentally ill and substance use disorder members. (California-specific measure 4.1, CAW7)
- **Documentation of Care Goals:** Members with documented discussions of care goals. (California-specific measure 1.6, CAW8)
- **Interaction with Care Team:** Percent of members who have a care coordinator and have at least one care team contact during the reporting period. (California-specific measure 1.12, CAW9)

¹California Medicare-Medicaid Plan Quality Withhold Analysis Results Demonstration Year 4:

<https://www.cms.gov/files/document/qualitywithholdresultsreportcady4.pdf>



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Quality Withhold Trends:

The latest data available show that all 10 Plans met at least five quality withhold measures for Calendar Year 2018. Eight of the ten Plans received 100% of their withhold: Anthem, Blue Shield, Health Net, L.A. Care, Molina, CalOptima, HPSM and SCFHP, four of which had their quality withhold adjusted to 100% due to an extreme and uncontrollable circumstance.

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.
 - o Plans must complete assessments for high-risk members within 45 days of enrollment, and for low-risk members within 90 days of enrollment. 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.
 - o Plans must complete a care plan for each member within 90 days of enrollment. Information tracking 90-day ICP completion rates comes from a Core measure. Figures 10 & 11 do not include unwilling and unable to reach populations in calculations. CMS-DHCS continues to work with Plans to ensure improved ICP completion rates within 90 days of enrollment.
- **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.



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Care Coordination Trends:

Figure 8 shows that the quarterly statewide percentage of members willing to participate in a health risk assessment, and who the Plan was able to locate, with an assessment completed within 90 days of enrollment has increased from 94% in Q4 2020 to 95% in Q1 2021. Figure 9 shows that 6 of 10 Plans are at or above the statewide average of 95% for Q1 2021 and the other four (Anthem, HealthNet, CalOptima and HPSM) are below the statewide average.

Figure 10 indicates that the percentage of members with an ICP completed within 90 days of enrollment has decreased from 86% in Q4 2020 to 85% in Q1 2021. Figure 11 indicates that in 6 of the ten Plans (CHG, IEHP, LA Care, Molina, CalOptima and SCFHP), the percentage of members with an ICP completed within 90 days of enrollment is above the statewide average of 85% for Q1 2021. 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 addressing low performance through Plan-specific performance improvement plans.

Grievances and Appeals:

This dashboard includes data on the two ways Cal MediConnect beneficiaries can attempt to resolve issues with their Plans:

- **Grievances:** Grievances are complaints or disputes members file with the Plans that are evaluated at the Plan-level expressing dissatisfaction with any aspect of the Plan's operations, activities, or behavior. This includes, but is not limited to, the quality of care or services provided (such as wait times or inability to schedule appointments), aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect a member's rights. This does not include benefit determinations.
- **Appeals:** If a Plan denies, reduces, or terminates benefits or services for a member, the member can appeal either through internal processes or an external process through Medi-Cal or Medicare. Appeals can be determined as "adverse" (denying the member's appeal) or partially or fully favorable to the member's appeal. This dashboard only includes data regarding appeals determined at the Plan's level.



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Grievances and Appeals Trends*:

In an effort to refine the reporting and analysis process on grievances and appeals, the following new grievances categories were introduced in 2018: access to care, transportation, billing, and home health/personal care. Figures 16 and 17 show a breakdown of a total of 20,501 grievances, by category and by Plan, filed by members in 2020. This is an increase of 2,125 member grievances reported as compared to 2019.¹ The Plan that contributed the most to the increased grievances in 2020 compared to 2019 is L.A. Care. The most common complaints were reported under the “other” category (grievances other than access to care, transportation, billing and home health/personal care). In addition to the reporting that Plans provide to CMS and DHCS, each Plan may internally categorize their grievances and appeals differently, which may account for some of the higher number of “other” grievances when reported through the CMS and DHCS.

The number of appeals varies greatly by Plan, as well as the percentage of decisions that are adverse versus partially or fully favorable. Figure 18 shows that a total of 1,972 appeals were filed by members in 2020, a decrease of 7,875 appeals when compared to 2019¹. The Plan that contributed the most to the decrease in appeals in 2020 compared to 2019 is Molina. Figure 18 also shows that 45% of Plan decisions were either fully or partially favorable to the member’s appeal filed in 2020. Figure 19 shows that few Plans had appeals related to mental health services.

DHCS and CMS will continue to work with the Plans to better understand the trends in grievances and appeals to ensure beneficiary access to services.

¹Cal MediConnect Performance Dashboard September 2020: <https://www.dhcs.ca.gov/services/Documents/MCQMD/CMCDashboard9-20.pdf>

*Plans can show increases and decreases in grievances and appeals. Plans work to ensure accurate reporting, This display can show their positive efforts in this respect. Totals can reflect changes in reporting, and can not only be understood as a change in count.



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Behavioral Health Emergency Room Utilization:

This metric measures behavioral health-related emergency visits. A visit is comprised of a revenue code for an emergency department visit and a principal diagnosis related to behavioral health. This metric is a Core measure.

Behavioral Health Emergency Room Utilization Trends:

One goal for Plans is to improve the coordination of behavioral health services for their members, including between the mental health and substance use disorder (SUD) treatments covered by the Plans and the specialty mental health services provided by county behavioral health departments. Figure 20 shows the overall trend of Cal MediConnect members seeking care in the emergency room for behavioral health services has decreased from 18.1 visits per 10,000 member months in Q1 2020 to 14.1 visits per 10,000 member months in Q4 2020. In mid-2017, Plans began to receive additional and more accurate behavioral health data that may have affected 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 increase referrals to LTSS programs, particularly home and community-based services, as well as to encourage Plans to help their members transition out of nursing facilities and into the community where appropriate.

- **LTSS Utilization and Referrals:** LTSS Utilization and Referrals are reported by each Plan for LTSS which includes In-Home Support Services (IHSS) (carved out beginning in 2018), Community-based Adult Services (CBAS), Multi-purpose Senior Services Program (MSSP) (will be carved out beginning January 1, 2022), Nursing Facility Services (NF) (will be carved in beginning January 1, 2023) and Care Plan Options (CPO).
 - **New CPO Template:** In an effort to improve data quality, a new CPO template and instructions were shared with the Plans. Plans started reporting on this new template as of Q3 2019.



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LTSS Trends:

DHCS is working with the Plans to enhance LTSS referrals, and encourages Plans to support members in transitioning out of nursing facilities and into the community with home- and community-based LTSS, as appropriate. In 2019 in particular, the CMS-DHCS contract management teams have been working closely with the plans to review their MSSP and CPO referral rates, and to identify best practices to ensure members are being connected with needed services.

Figure 22 shows that LTSS utilization has increased from an average of 292.6 per 1,000 members in Q4 2020 to 295.1 per 1,000 members receiving LTSS in Q1 2021.

Figure 24 shows that IHSS utilization has increased from an average of 251.2 per 1,000 members in Q4 2020 to 253.3 per 1,000 members receiving IHSS in Q1 2021.

Figure 26 shows that CBAS referral rates have increased from 1.4 per 1,000 members in Q2 2020 to 1.7 per 1,000 members in Q1 2021. IEHP reported the highest number of CBAS referrals of 4.6 per 1,000 members in Q1 2021, as shown in Figure 27. Figure 28 shows that CBAS utilization per 1,000 members has increased from 9.7 members per 1,000 receiving CBAS in Q4 2020 to 9.9 members per 1,000 receiving CBAS in Q1 2021.

Figure 30 shows that MSSP referrals per 1,000 members has remained steady at an average of 0.5 per 1,000 members in Q4 2020 and Q1 2021. Figure 31 shows that HPSM reported the highest number of MSSP referrals of 1.72 per 1,000 members in Q1 2021. Figure 32 shows that MSSP utilization per 1,000 members has increased from 6.6 per 1,000 members in Q4 2020 to 6.8 per 1,000 members in Q1 2021. DHCS worked closely with the Plans in 2019 to better understand MSSP referral policy and procedures, as well as how plans are providing enhanced care coordination and other supports to members on MSSP wait lists. A best practices summary of those efforts was provided to the plans to encourage increased referrals to MSSP.

Figure 34 shows that NF referrals per 1,000 members has increased from an average of 3.9 member referrals per 1,000 in Q4 2020 to an average 4.6 member referrals per 1,000 in Q1 2021. HPSM reported the highest number of NF referrals of 12.1 per 1,000 members respectively in Q1 2021 (Figure 35). As shown in Figure 36, NF utilization has remained steady at 25.1 members per 1,000 in Q4 2020 and Q1 2021.



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Figure 38 shows that CPO referrals per 1,000 members has decreased from 1.9 referrals per 1,000 members in Q4 2020 to 1.8 referrals per 1,000 members in Q1 2021. Figure 39 shows that HPSM reported the highest number of CPO referrals of 12.2 per 1,000 members in Q1 2021. Figure 40 shows that CPO utilization per 1,000 members has remained at an average of 1.8 per 1,000 members from Q2 2020 through Q1 2021.

CPO referral and utilization data shown in Figures 38-41 for Q2 2020, Q3 2020, Q4 2020 and Q1 2021, are based on the new revised CPO template and instructions. DHCS will continue to work with the Plans to ensure better understanding of the definition of CPO services, the benefits of providing those services, and best practices on referring and supporting members who could benefit from CPO services.

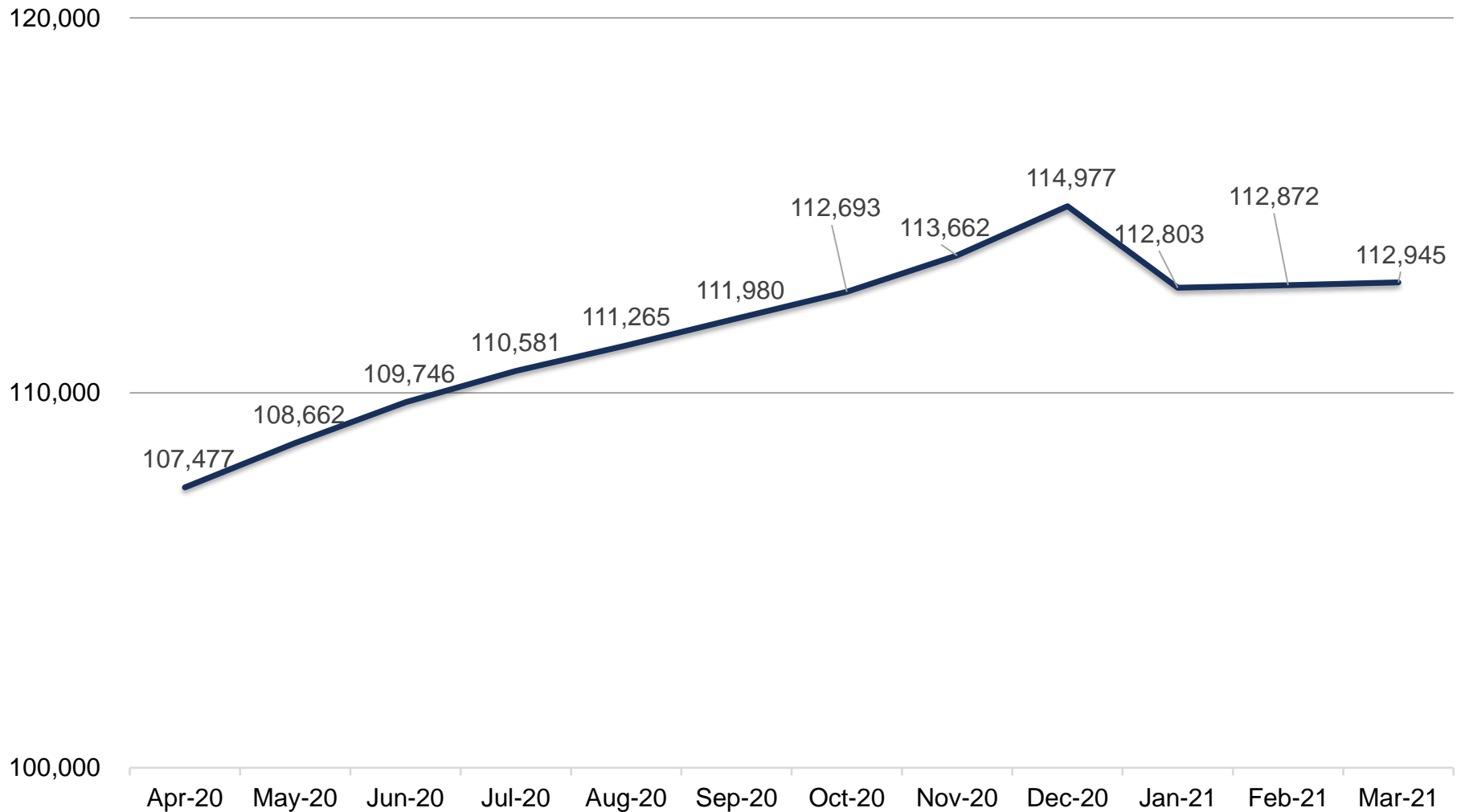
Plan Key:

Plan Name	Plan Abbreviation on Dashboard
Anthem Blue Cross Partnership of California	Anthem
Blue Shield of California Promise Health*	Blue Shield
CalOptima	CalOptima
Community Health Group	CHG
Health Net	Health Net
Health Plan of San Mateo	HPSM
Inland Empire Health Plan	IEHP
L.A. Care	L.A. Care
Molina Healthcare	Molina
Santa Clara Family Health Plan	SCFHP

*Formerly Care1st Health Plan.

Cal MediConnect Enrollment and Demographics Figure 1: Breakdowns of Dual Populations (As of 03/01/2021)
 See metric summary for additional information

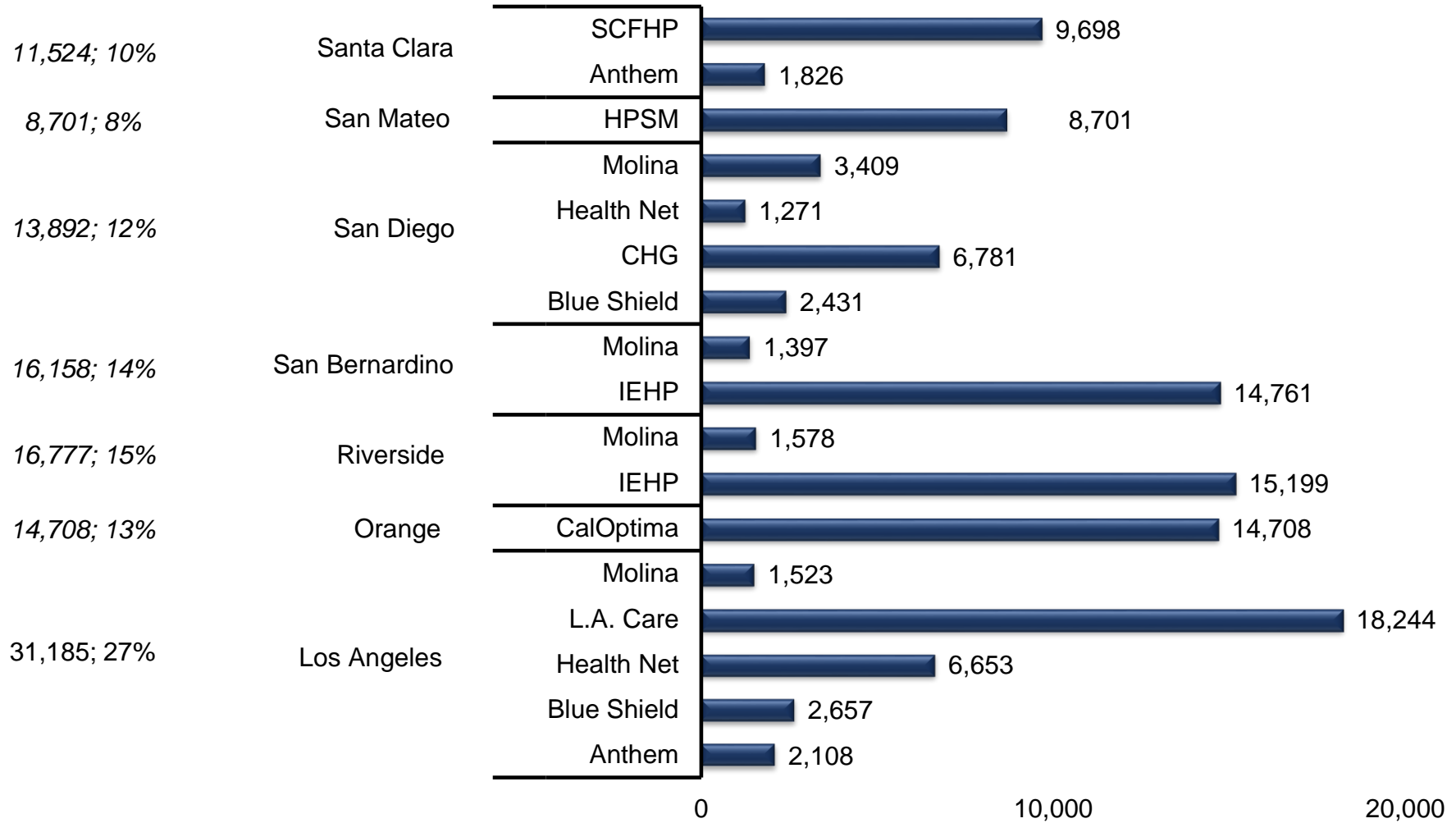
Fig. 1: Monthly Enrollment



Cal MediConnect Enrollment and Demographics Figure 2: Breakdowns of Dual Populations (As of 03/01/2021)
 See metric summary for additional information

Fig. 2: Count and Percentage of Total Active Enrollments, by County and Plan as of March 2021

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



Cal MediConnect Enrollment and Demographics Figure 3 - 6: Breakdowns of Dual Populations (As of 03/01/2021)
[See metric summary for additional information](#)

Fig. 3: Quarter 1 Enrollment by Race/Ethnicity

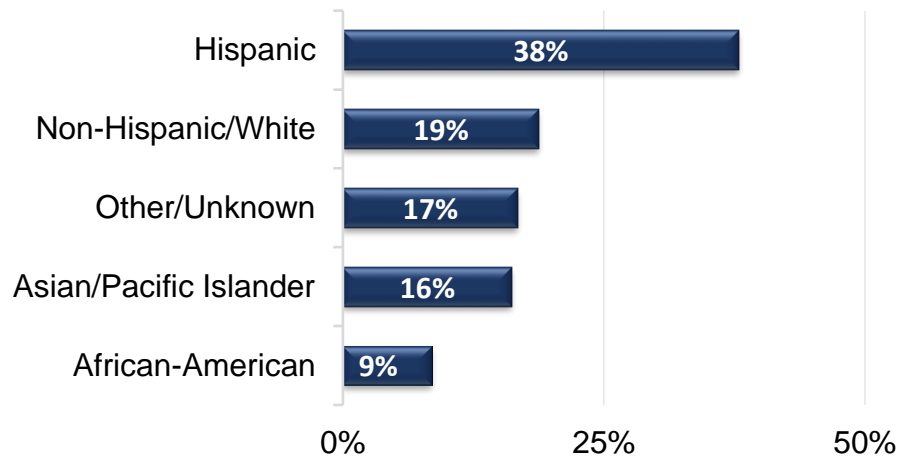


Fig. 4: Quarter 1 Enrollment by Age

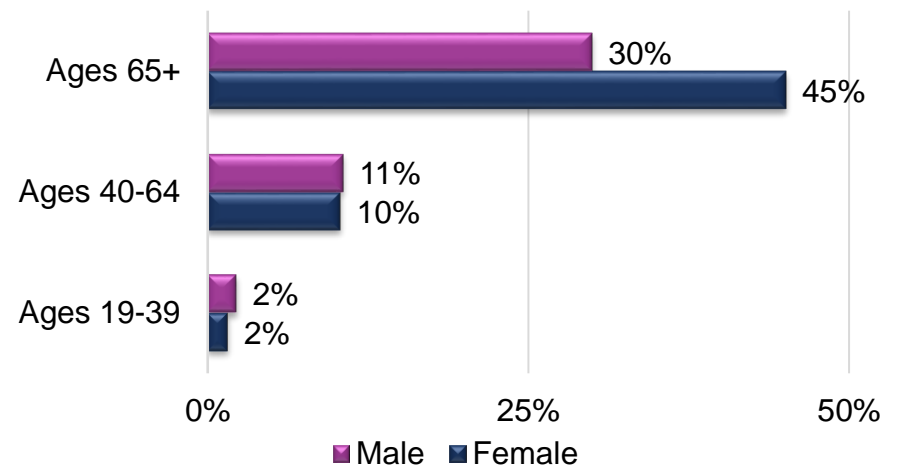


Fig. 5: Quarter 1 Enrollment by Threshold Language Spoken

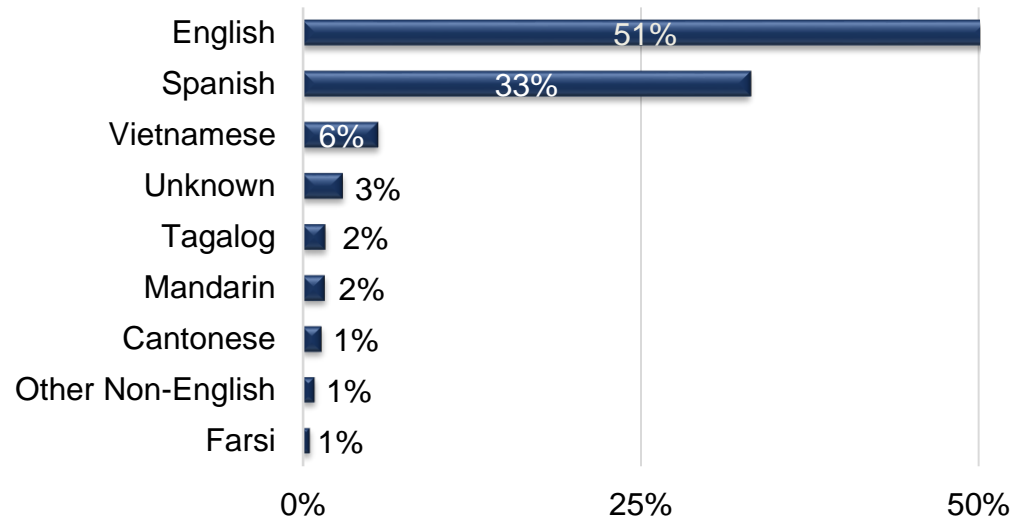
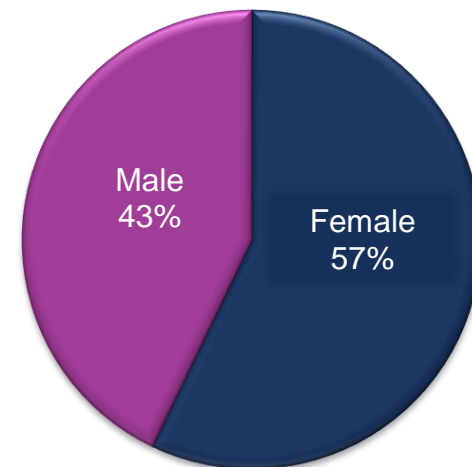


Fig. 6: Quarter 1 Enrollment by Gender



Cal MediConnect Figure 7: Quality Withhold Summary Table (CY 2018)
 See metric summary for additional information

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

Medicare-Medicaid Plan	CAW7* Benchmark: 10% Decrease	CAW8* Benchmark: 60%	CAW9* Benchmark: 83%	Total # of Measures	Total # Met	% Met	% of Withhold Received
Anthem	Not Met	Met	Not Met	7	5	71%	100%^
Blue Shield	Not Met	Met	Met	8	5	63%	100%^
CHG	Met	Met	Met	8	6	75%	75%
Health Net	Met	Met	Met	8	5	63%	100%^
IEHP	Not Met	Met	Not Met	8	5	63%	75%
L.A. Care	Met	Met	Not Met	8	6	75%	100%^
Molina	Met	Met	Met	8	7	88%	100%
CalOptima	Met	Met	Met	8	7	88%	100%
HPSM	Met	Not Met	Met	8	7	88%	100%
SCFHP	Met	Met	Met	8	8	100%	100%
California Averages				8	6	77%	95%

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 (04/2020-03/2021) 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

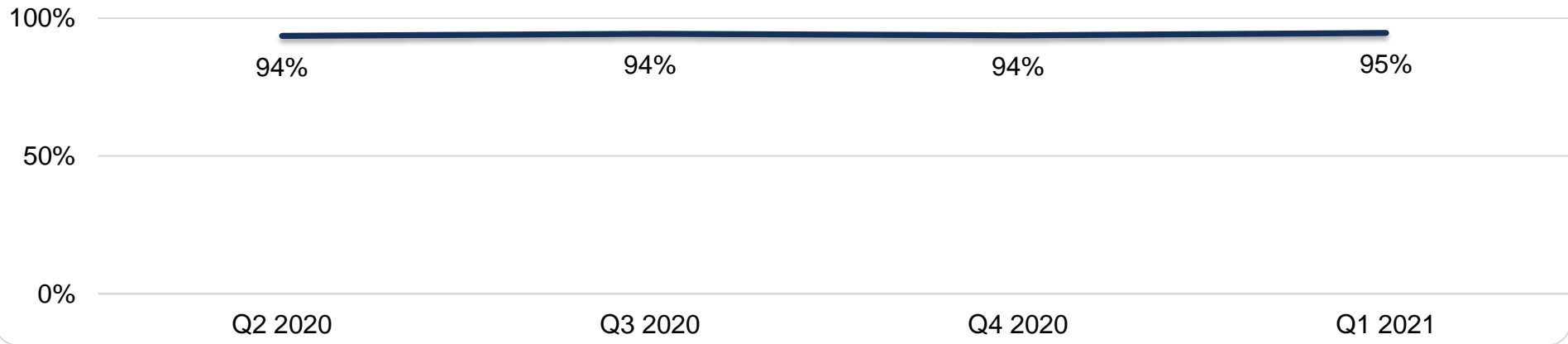
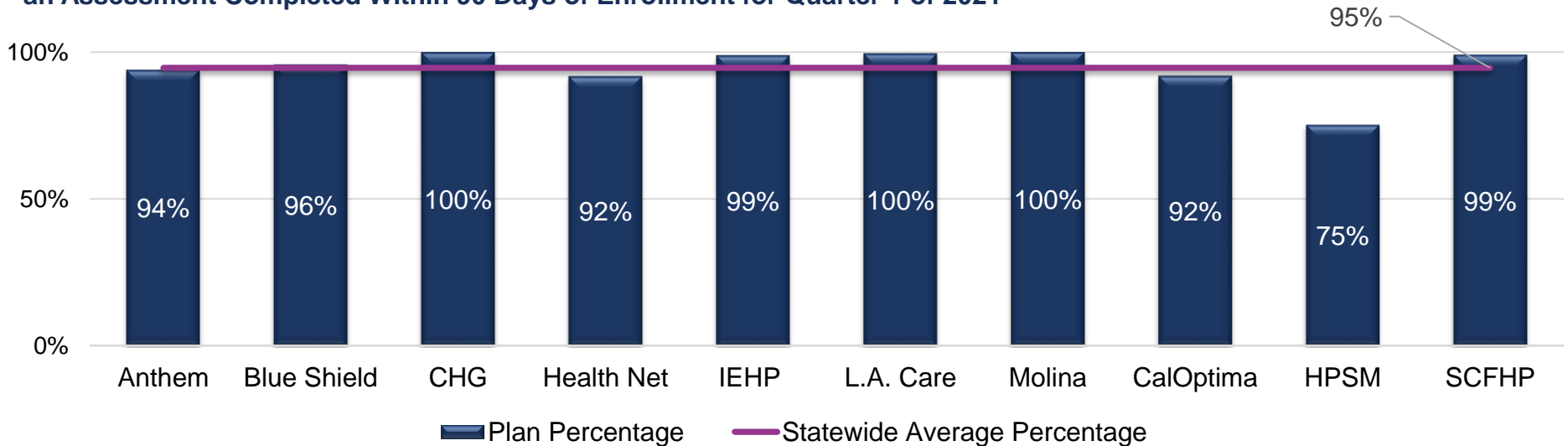


Fig. 9: The Percentage of Members Willing to Participate and who the Plan was able to Locate with an Assessment Completed Within 90 Days of Enrollment for Quarter 1 of 2021



Care Coordination Figure 10 & 11: Percentage of Members with an Individualized Care Plan (ICP) Completed Within 90 Days of Enrollment (04/2020-03/2021) See metric summary for additional information

Fig. 10: Quarterly Rolling Statewide Percentage of Members with an ICP Completed Within 90 Days of Enrollment

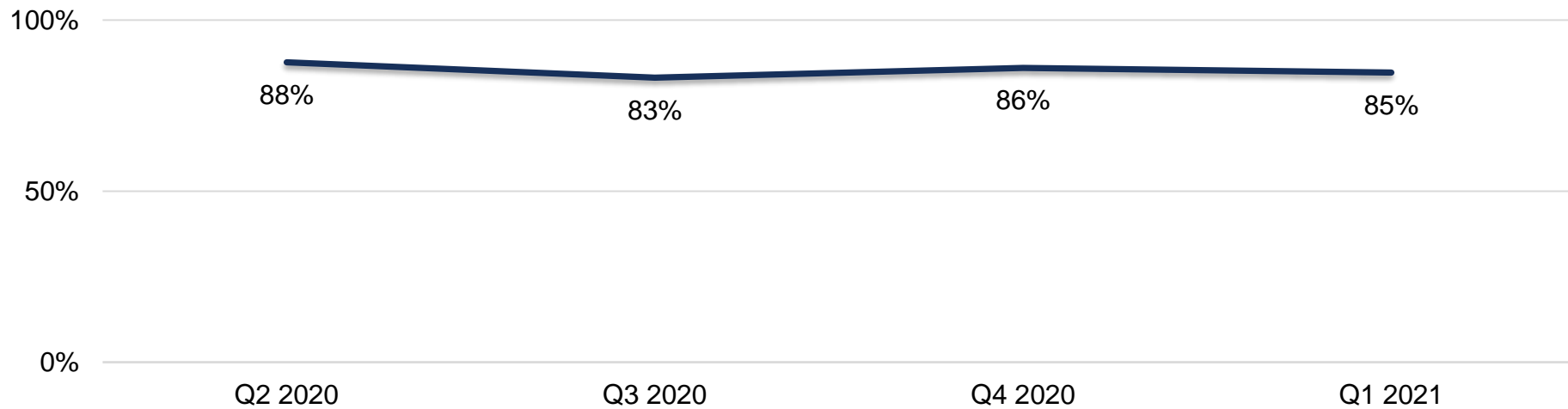
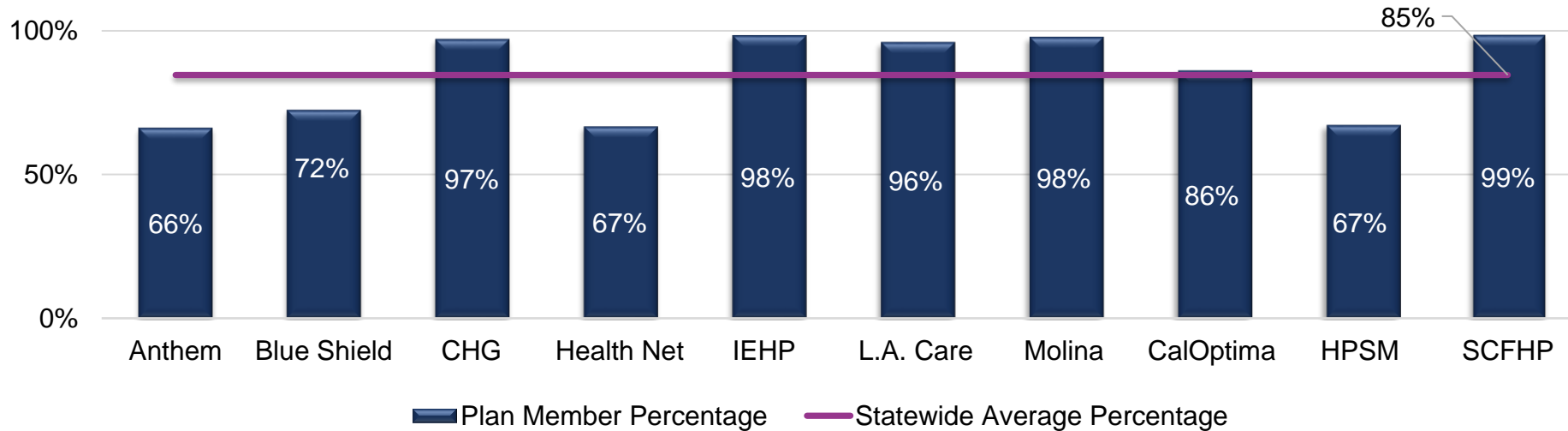
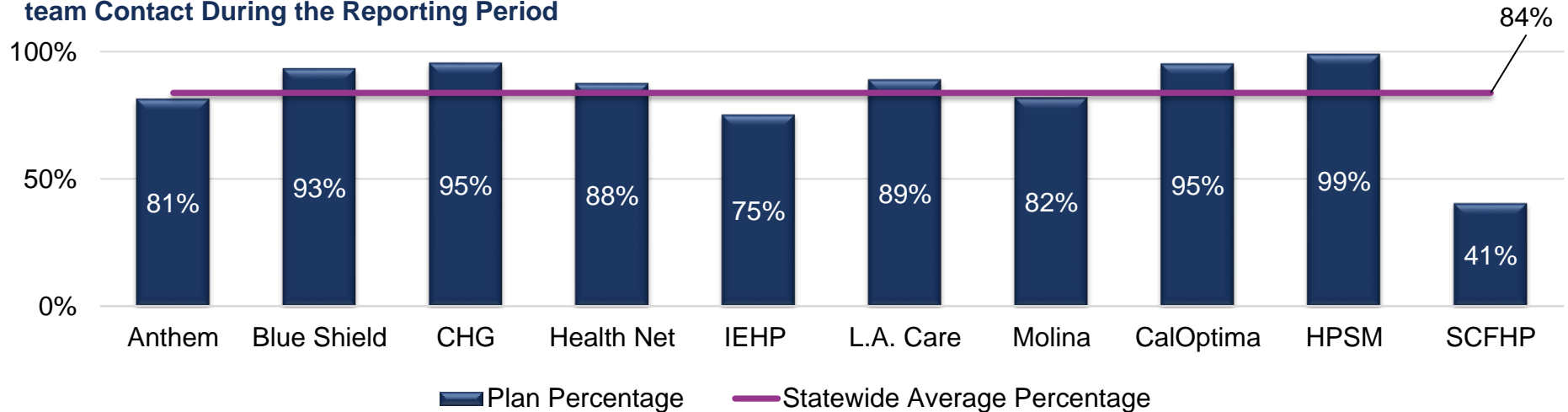


Fig. 11: Percentage of Members with an ICP Completed Within 90 Days of Enrollment for Quarter 1 of 2021



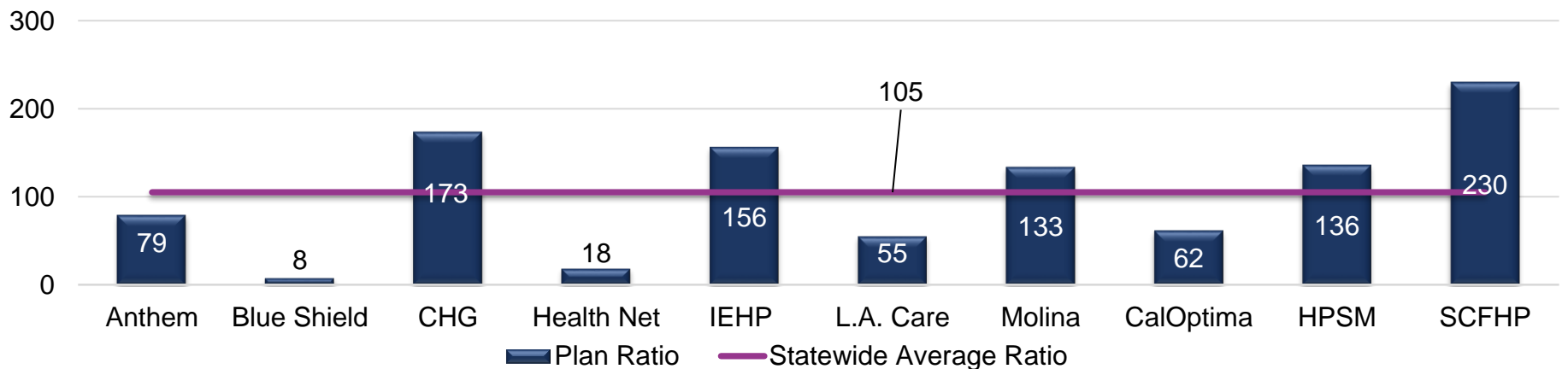
Care Coordination Figure 12: Percentage of Members Who Have a Care Coordinator and Have at Least One Care Team Contact During the Reporting Period (01/2020-12/2020) See metric summary for additional information

Fig. 12: Annual (2020) Percentage of Members who have a Care Coordinator and have at least One Care team Contact During the Reporting Period



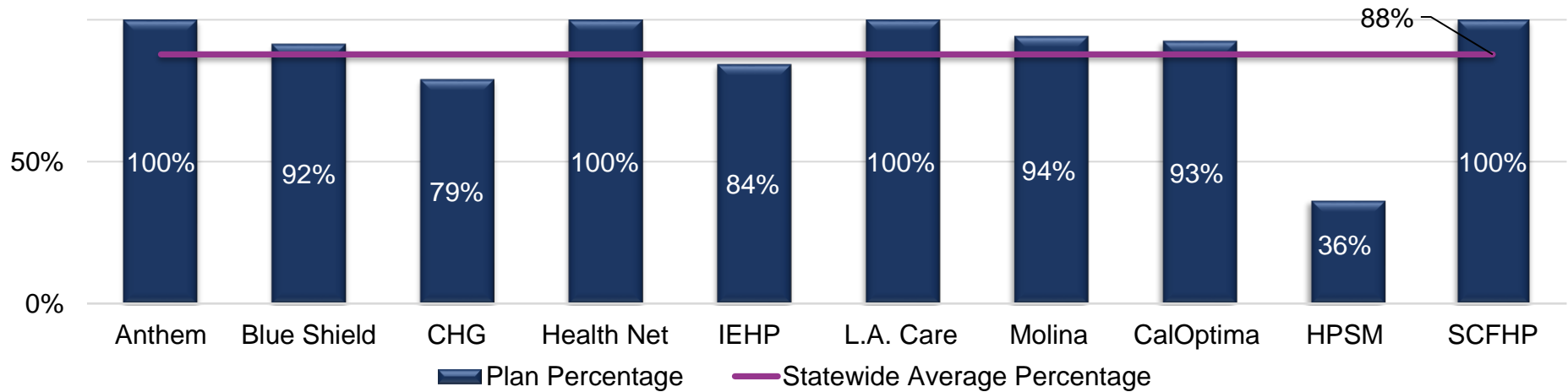
Care Coordination Figure 13: Member to Care Coordinator Ratio (01/2020-12/2020) See metric summary for additional information

Fig. 13: Annual (2020) Number of Members to Care Coordinator Ratio



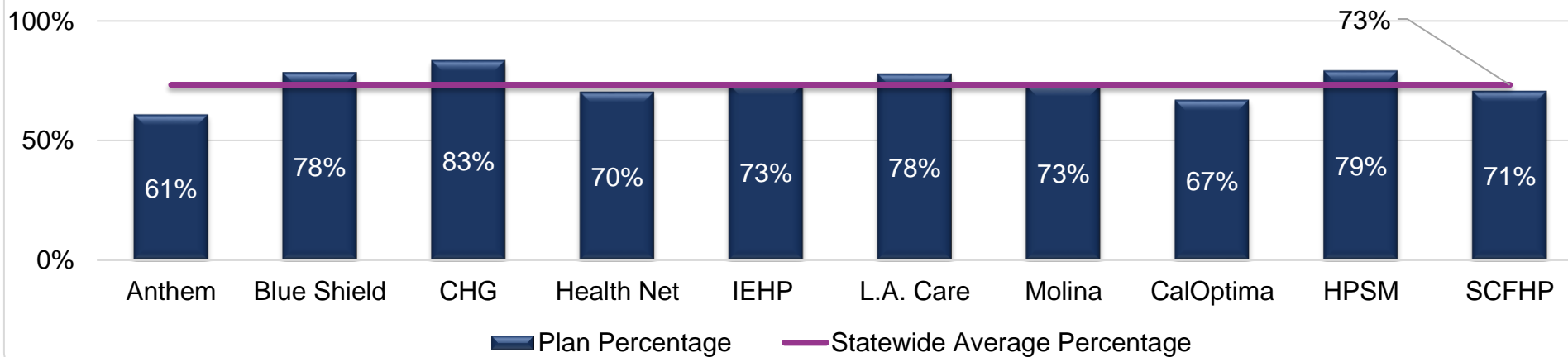
Care Coordination Figure 14: Percentage of Members with Documented Discussions of Care Goals (01/2020-12/2020)
 See metric summary for additional information

Fig. 14: Annual (2020) Percentage of members with at least one Care Goal Documented in the initial ICP Completed 100%



Care Coordination Figure 15: Percentage of Members with First Follow-up Visit within 30 Days after Hospital Discharge (01/2020-12/2020)
 See metric summary for additional information

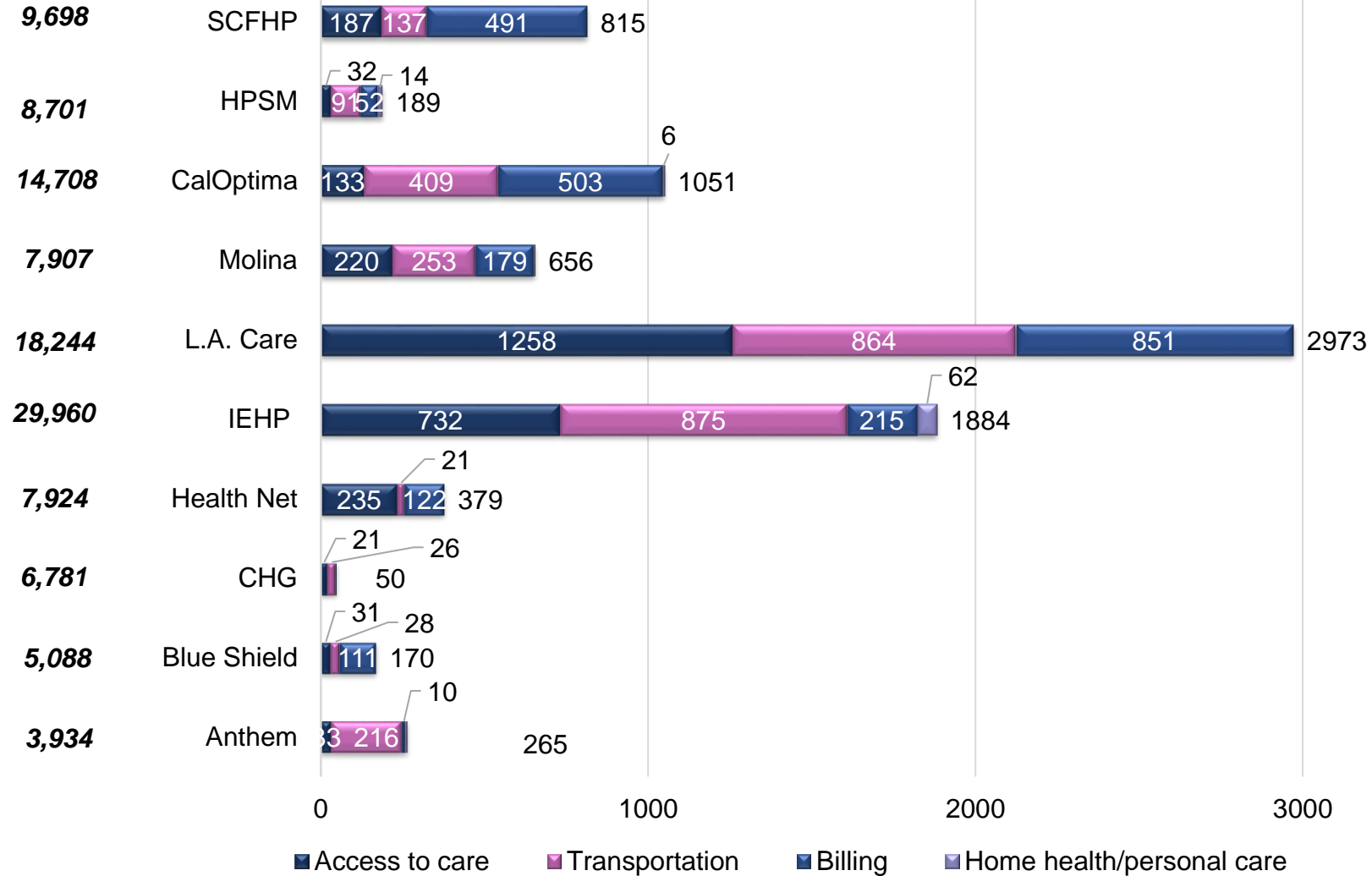
Fig. 15: Annual (2020) Percentage of Members with First Follow-Up Visit within 30 Days after Hospital Discharge



Grievance Figure 16: Count Grievances by type, Except "Other" (01/2020-12/2020) See metric summary for additional information

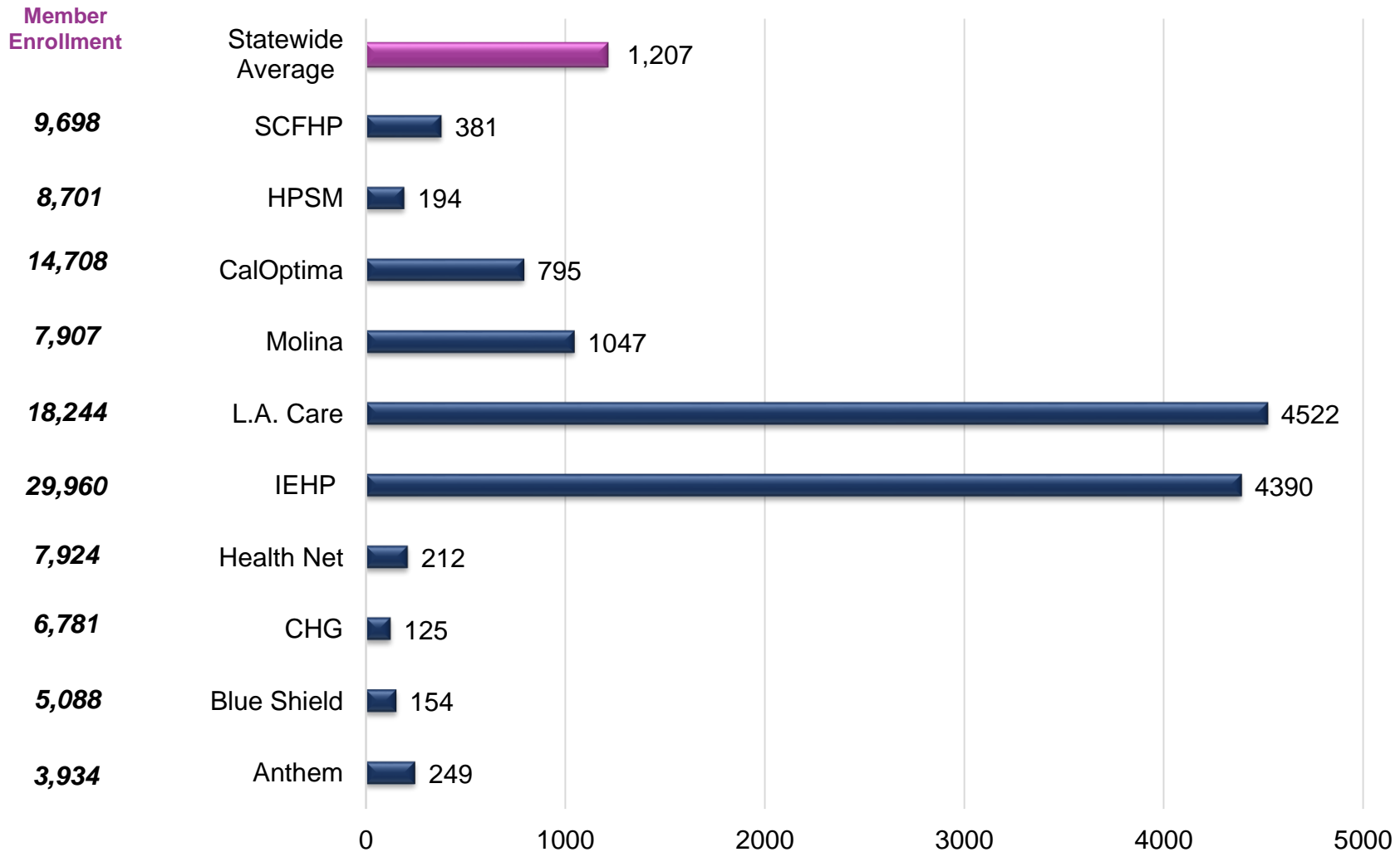
Fig. 16: Annual Count of Grievances Broken Down by Type, besides "Other"

Member Enrollment



Grievance Figure 17: Count of "Other" Grievances (01/2020-12/2020) See metric summary for additional information

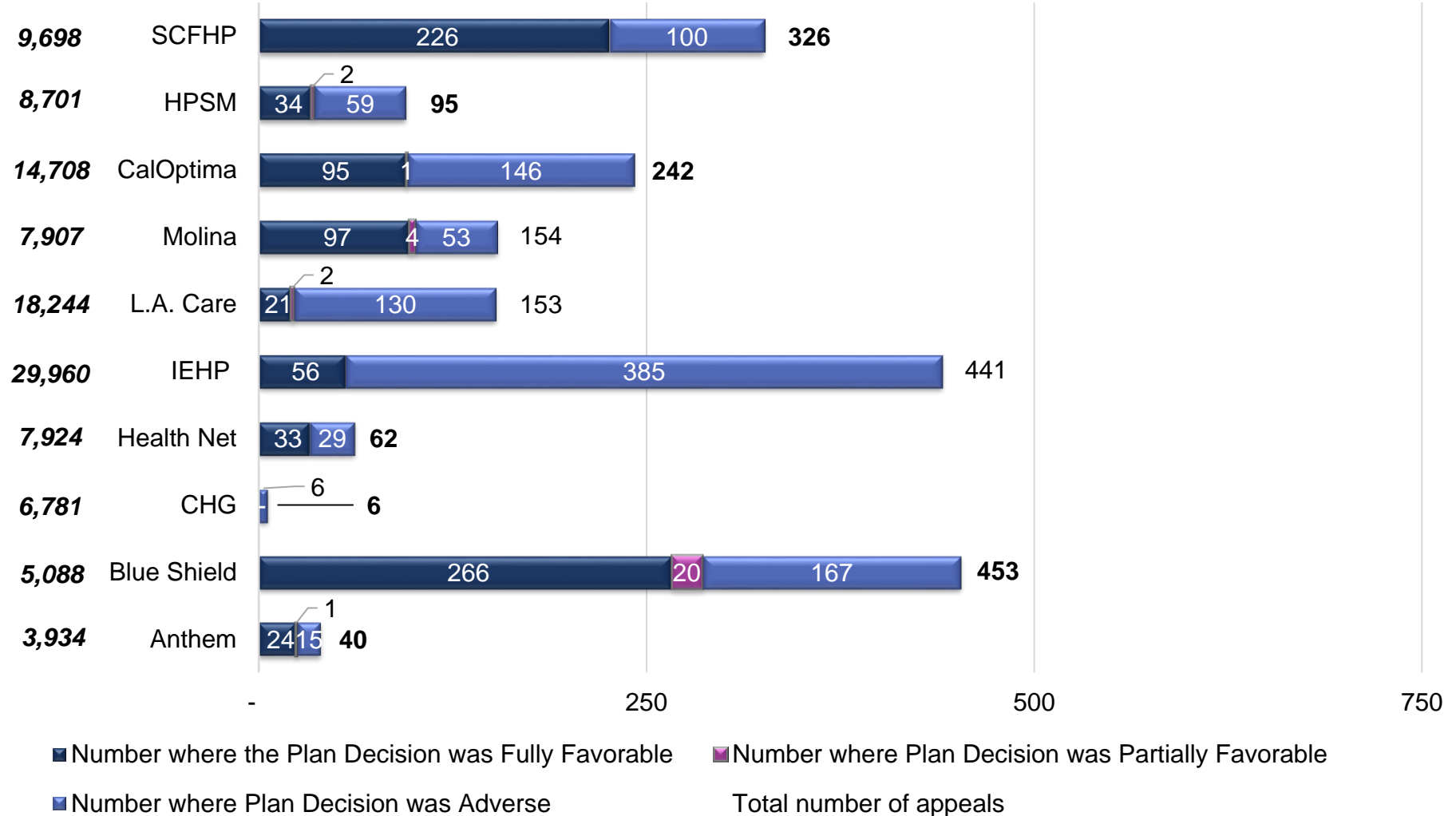
Fig. 17: Annual Count of "Other" Grievances



Appeal Figure 18: Count of Appeals (01/2020-12/2020). See metric summary for additional information

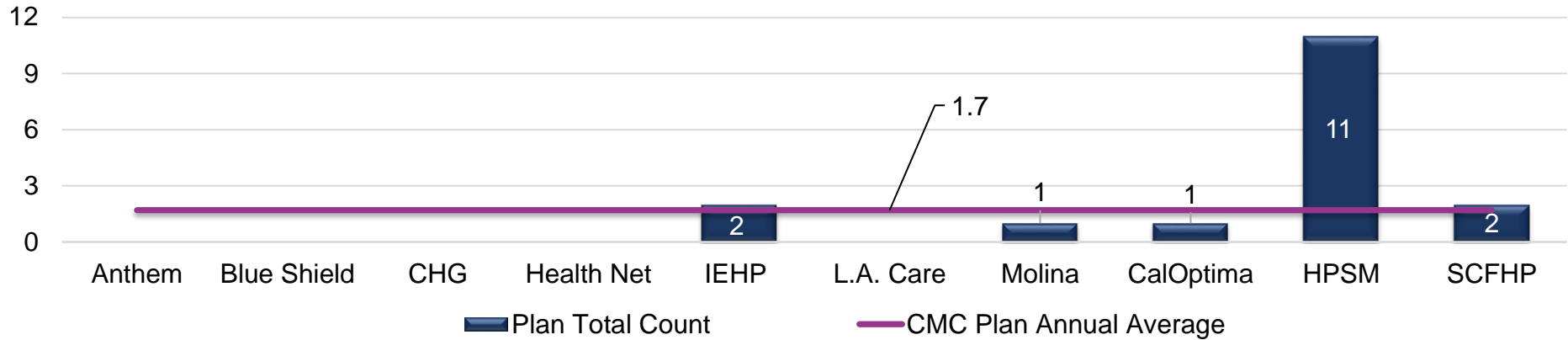
Fig. 18: Annual Count of Appeals Broken Down by Outcome

Member Enrollment



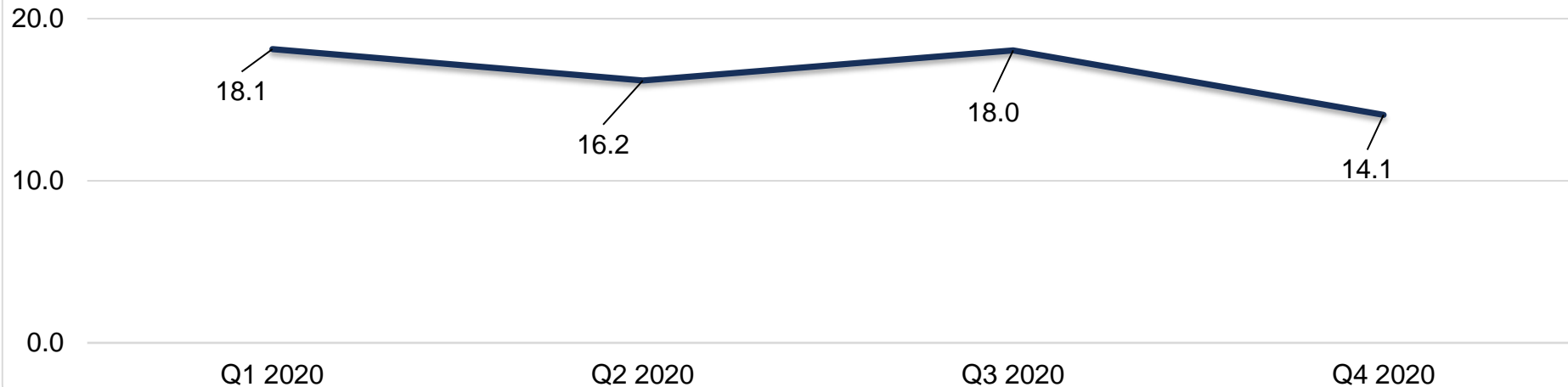
Appeals Figure 19: Total of all Appeals Related to the Denial or Limited Authorization of Mental Health Services (01/2020-12/2020)
 See metric summary for additional information

Fig. 19: 2020 Appeals Related to the Denial or Limited Authorization of Mental Health Services; Plan Total Count and CMC Plan Annual Average



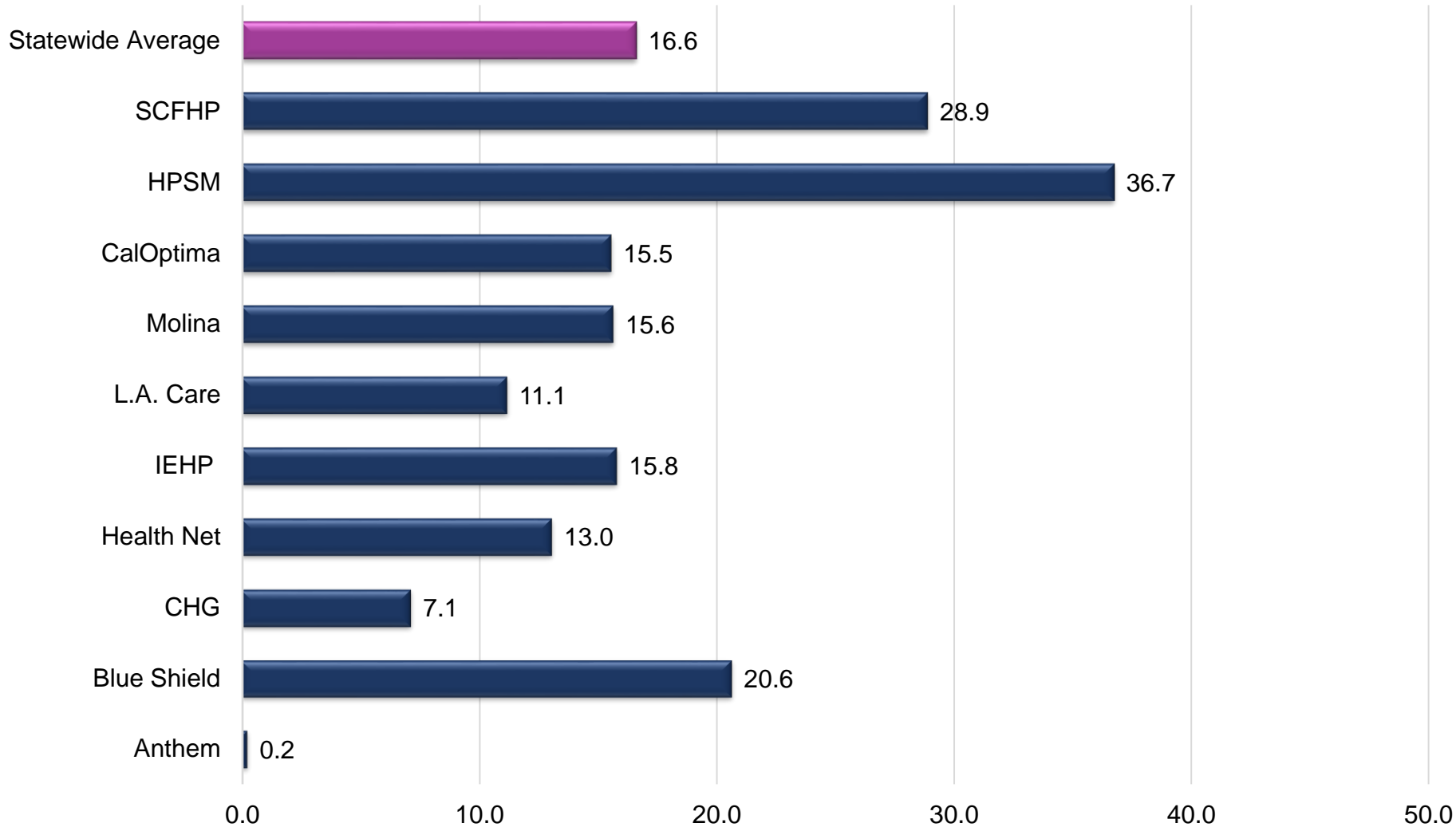
Behavioral Health Figure 20: Emergency Room Behavioral Health Services Utilization per 10,000 Member Months (01/2020-12/2020)
 See metric summary for additional information

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 (01/2020-12/2020) 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 (04/2020-03/2021) See metric summary for additional information

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

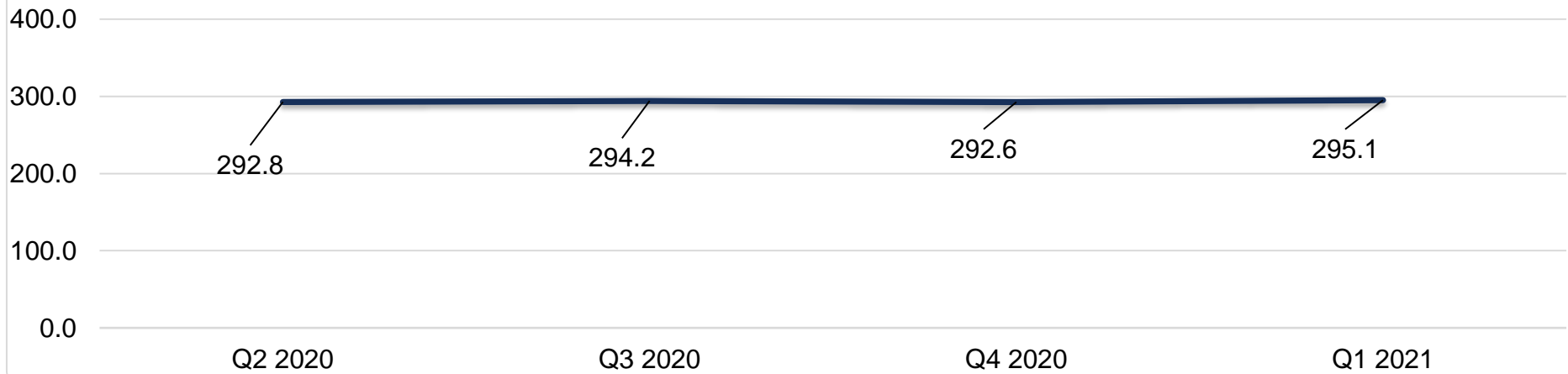
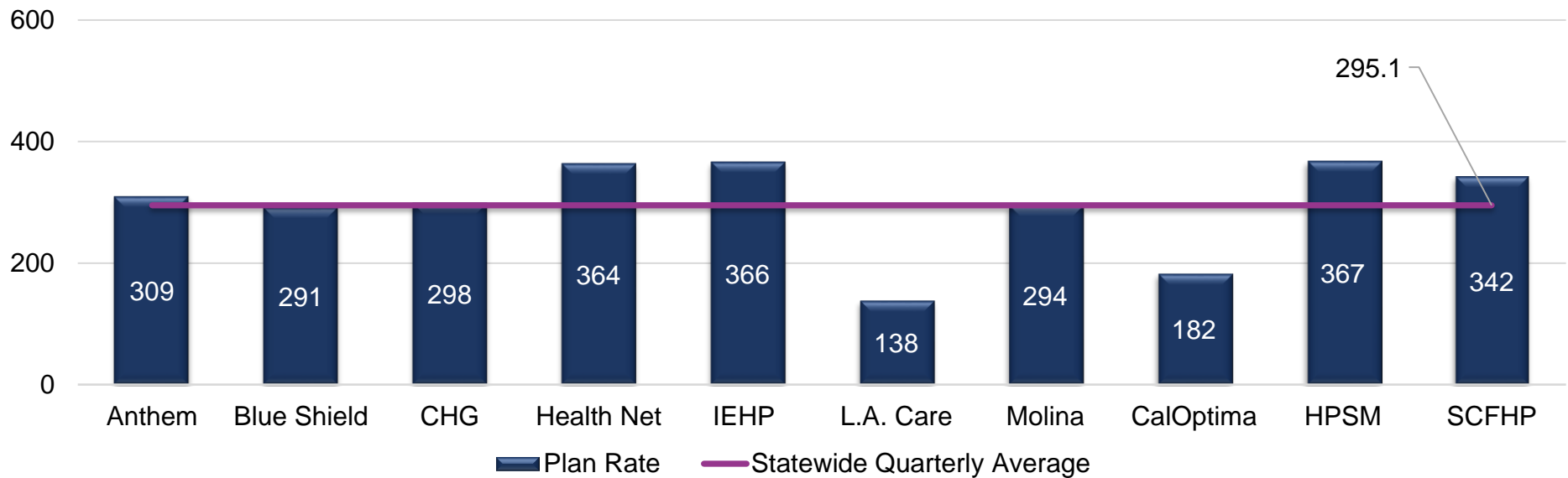


Fig. 23: Count of Members Receiving LTSS per 1,000 members for Quarter 1 of 2021



Long Term Services & Supports (LTSS) Figure 24 & 25: Count of IHSS per 1,000 Members (04/2020-03/2021)
 See metric summary for additional information

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

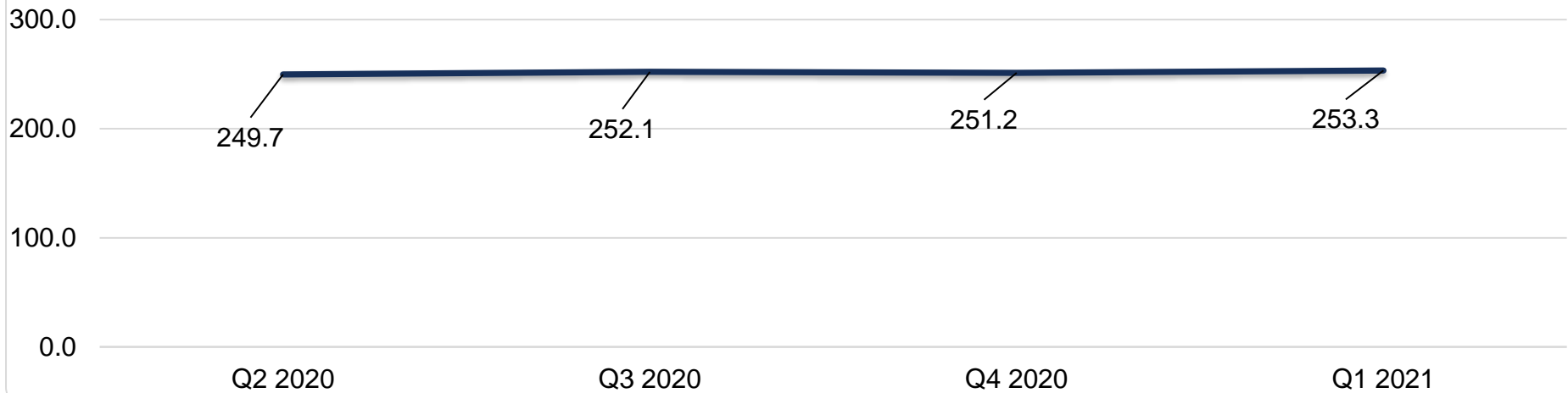
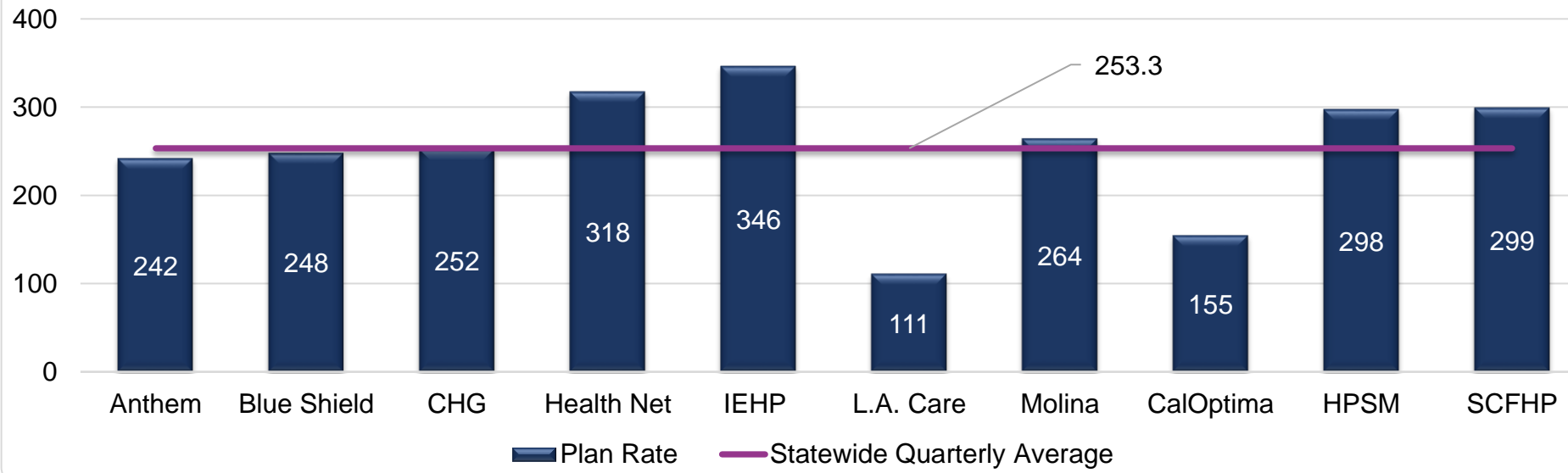


Fig. 25: Count of Members Receiving IHSS per 1,000 members for Quarter 1 of 2021



Long Term Services & Supports (LTSS) Figure 26 & 27: Count of CBAS per 1,000 Members (04/2020-03/2021)
 See metric summary for additional information

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

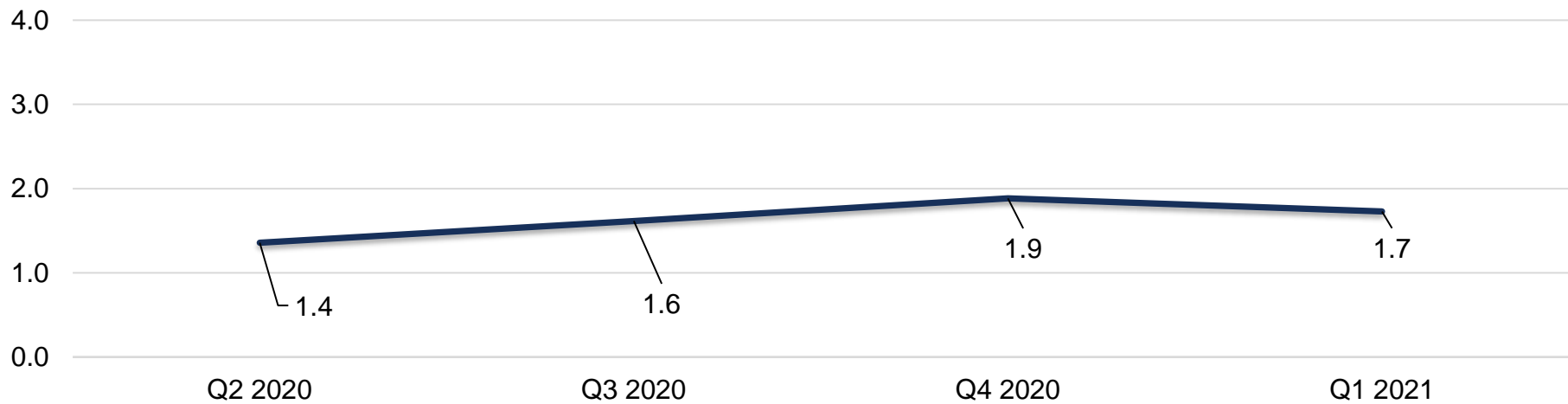
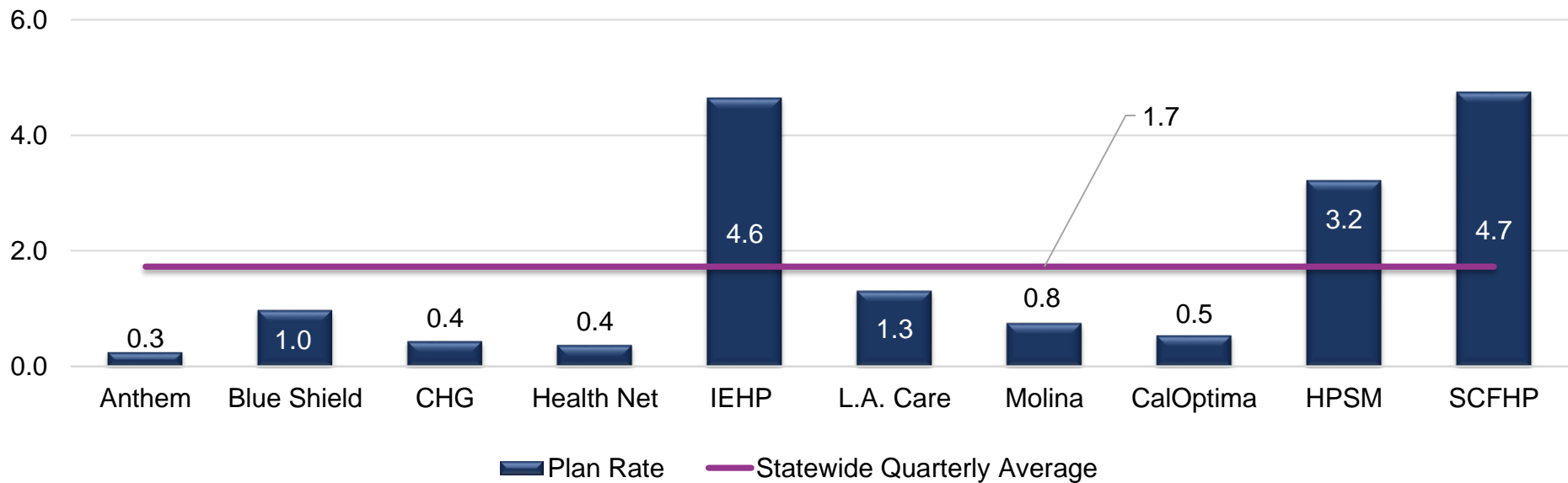


Fig. 27: Count of CBAS Member Referrals per 1,000 members for Quarter 1 of 2021



Long Term Services & Supports (LTSS) Figure 28 & 29: Count of CBAS per 1,000 Members (04/2020-03/2021)
 See metric summary for additional information

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

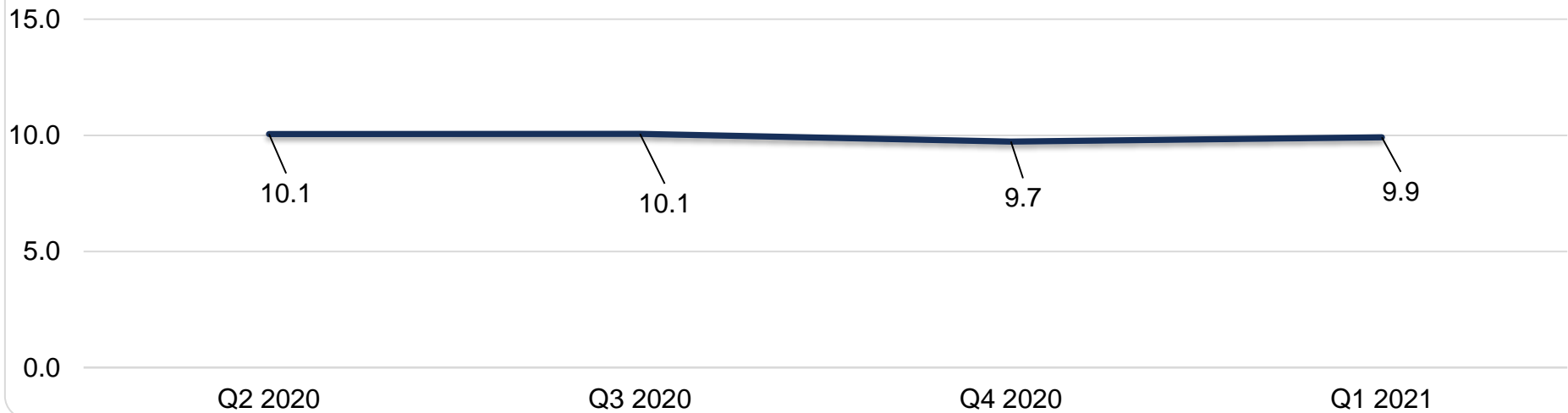
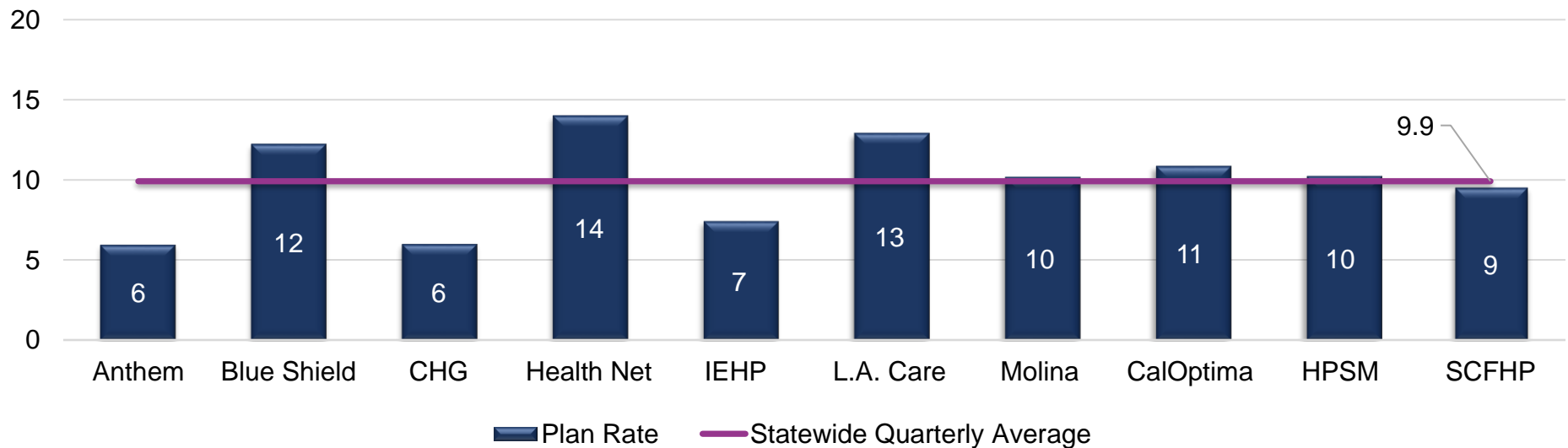
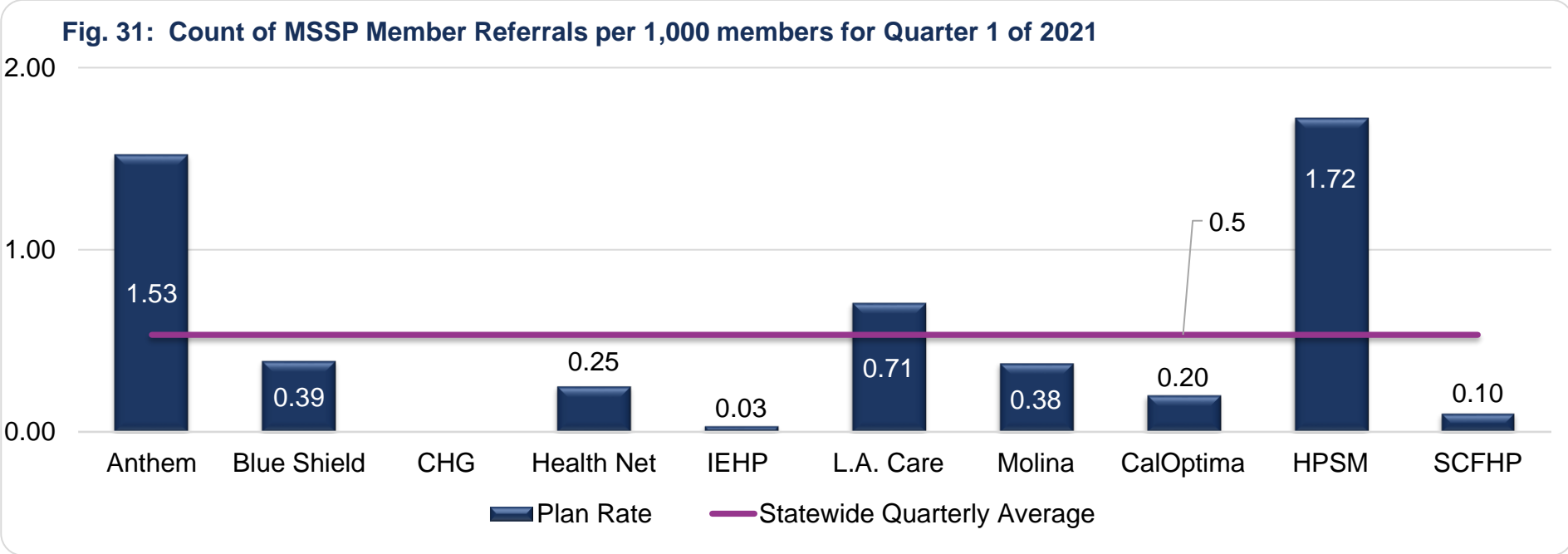
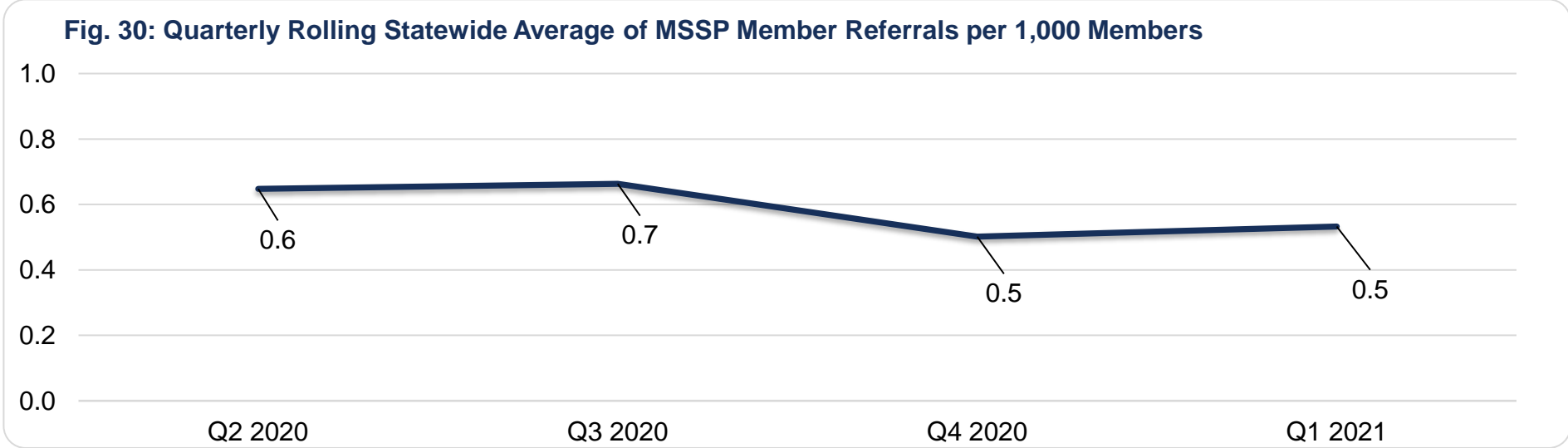


Fig. 29: Count of Members Receiving CBAS per 1,000 members for Quarter 1 of 2021



Long Term Services & Supports (LTSS) Figure 30 & 31: Count of MSSP per 1,000 Members (04/2020-03/2021)
 See metric summary for additional information



Long Term Services & Supports (LTSS) Figure 32 & 33: Count of MSSP per 1,000 Members (04/2020-03/2021)
 See metric summary for additional information

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

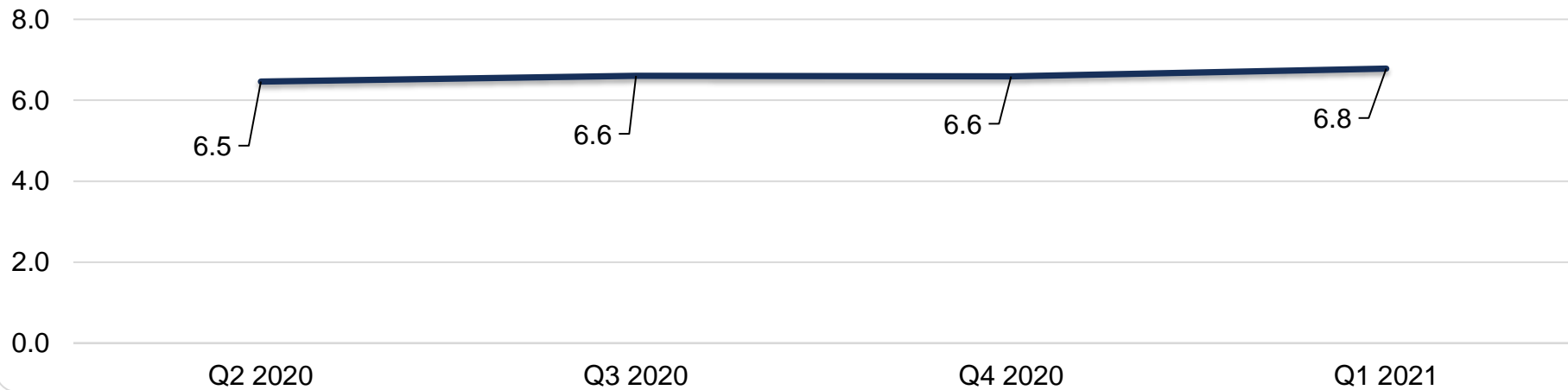
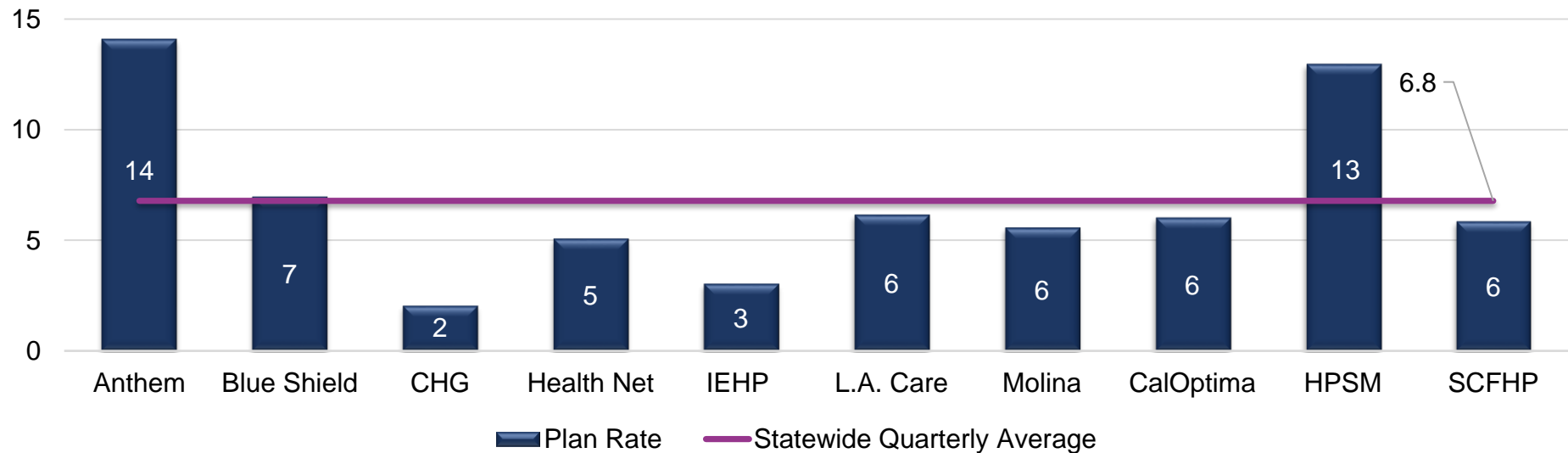


Fig. 33: Count of Members Receiving MSSP per 1,000 members for Quarter 1 of 2021



Long Term Services & Supports (LTSS) Figure 34 & 35: Count of NF per 1,000 Members (04/2020-03/2021)
 See metric summary for additional information

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

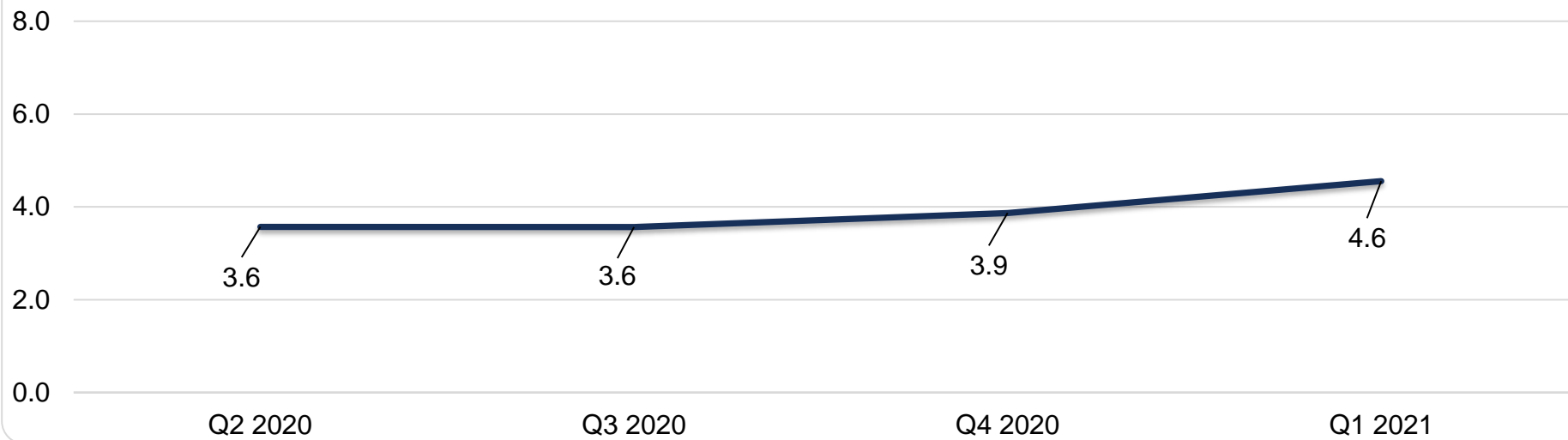
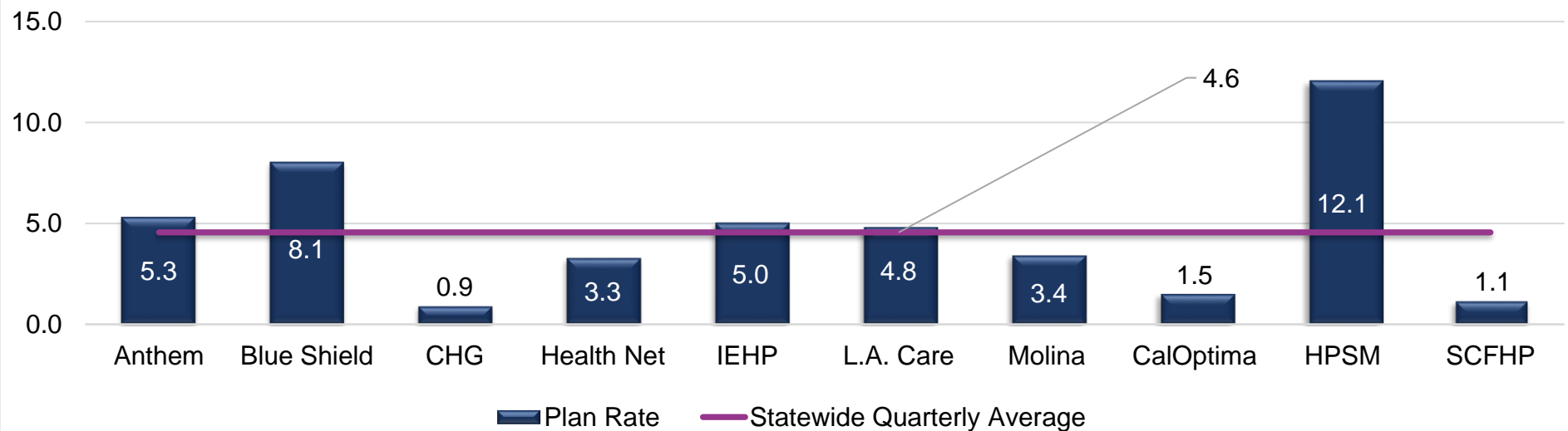


Fig. 35: Count of NF Member Referrals per 1,000 members for Quarter 1 of 2021



Long Term Services & Supports (LTSS) Figure 36 & 37: Count of NF per 1,000 Members (04/2020-03/2021)
 See metric summary for additional information

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

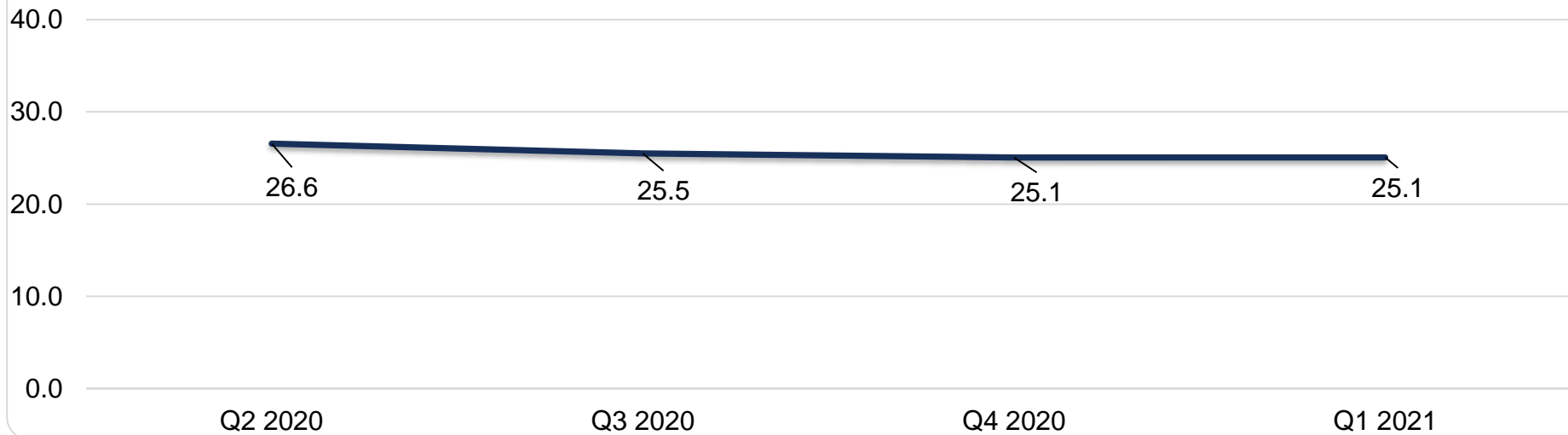
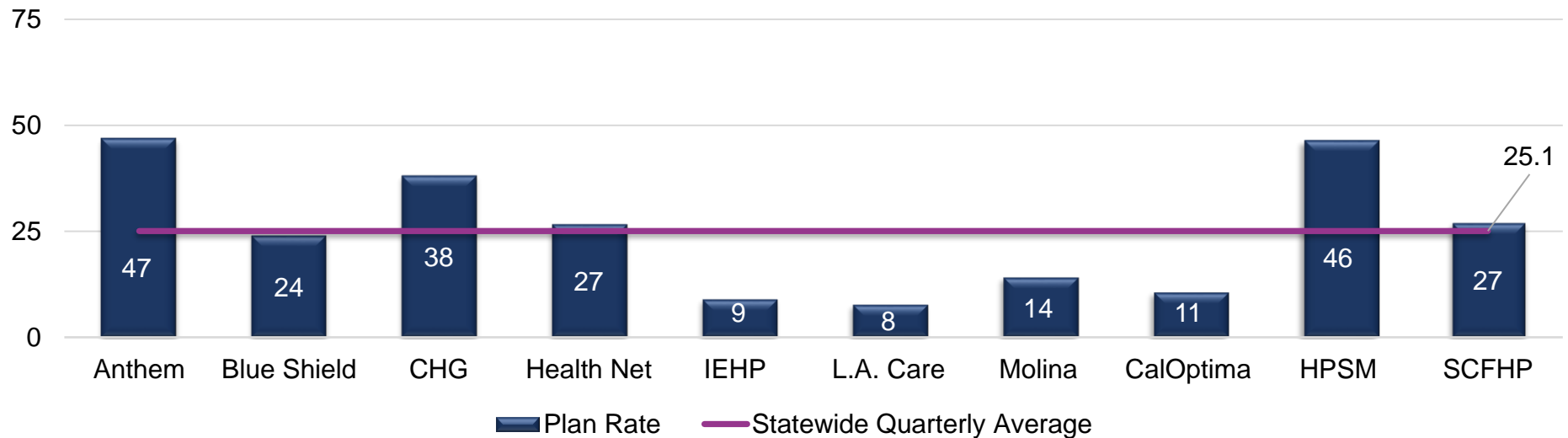


Fig. 37: Count of Members Receiving NF per 1,000 Members for Quarter 1 of 2021



Long Term Services & Supports (LTSS) Figure 38 & 39: Count of CPO per 1,000 Members (04/2020-03/2021)
 See metric summary for additional information

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

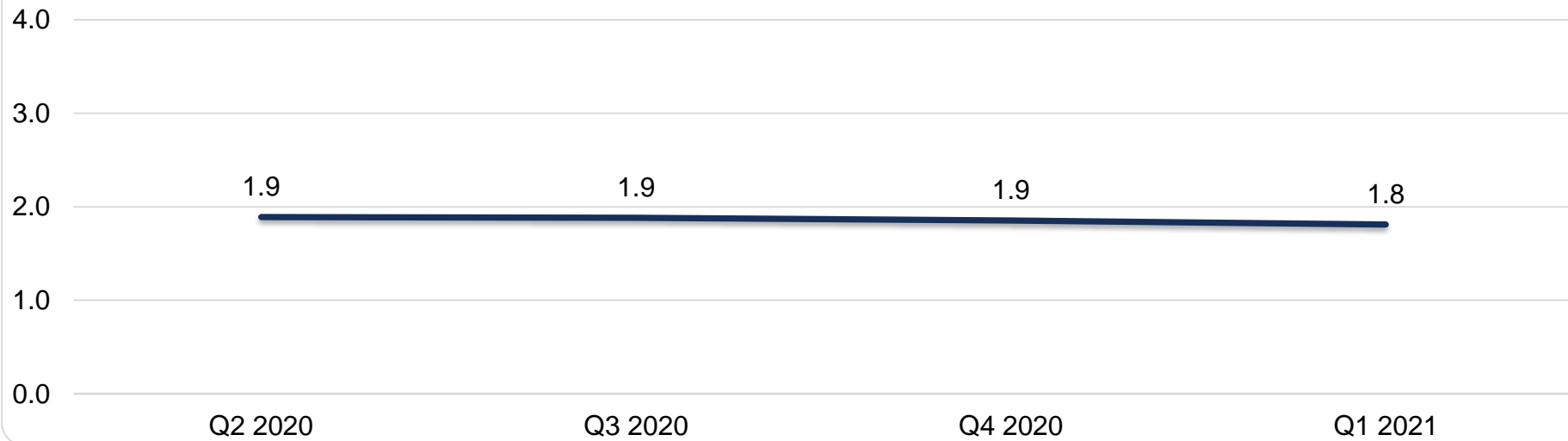
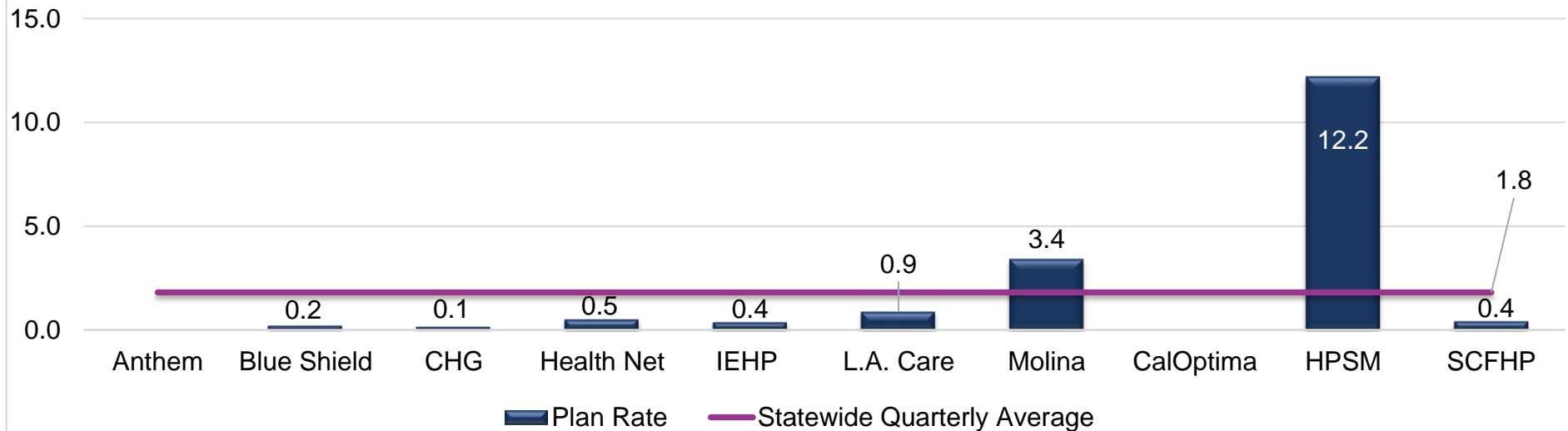


Fig. 39: Count of CPO Member Referrals per 1,000 members for Quarter 1 of 2021



Long Term Services & Supports (LTSS) Figure 40 & 41: Count of CPO per 1,000 Members (04/2020-03/2021)
 See metric summary for additional information

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

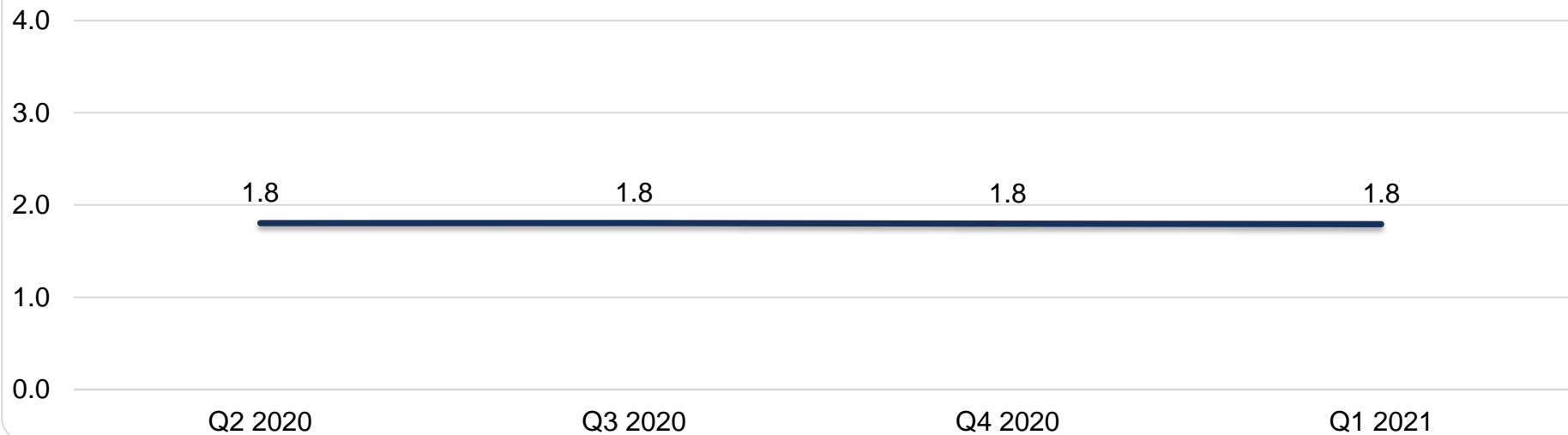


Fig. 41: Count of Members Receiving CPO per 1,000 Members for Quarter 1 of 2021

