Cal MediConnect Performance Dashboard Metrics Summary

Released June 2022

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 CMC Program:

- **Enrollment and Demographics:** *Figures 1-6*
  Statewide enrollment in CMC increased from 112,803 members in January 2021 to 115,700 in December 2021. In Q4 2021, 51% of enrollees spoke English and 33% spoke Spanish as their primary language, with 39% of enrollees identifying as Hispanic. Males and females aged 65 and older represent 31% and 46% of the total CMC population, respectively.
- **Quality Withhold Summary:** *Figure 7*
  All Plans in CY 2020 qualified for the disaster adjustment due to the COVID-19 public health emergency, and therefore all Plans received 100% of the withheld amount.
- **Care Coordination:** *Figures 8-19*
  Figure 8 shows that the percentage of members with a health risk assessment (HRA) completed within 90 days of enrollment increased from 97% in Q3 2021 to 98% in Q4 2021. Figure 12 shows that the percentage of members with an ICP completed within 90 days of enrollment has increased from 82% in Q3 2021 to 85% in Q4 2021.
- **Grievances and Appeals:** *Figures 20-23*
  Plans reported 10% more grievances in 2021 compared to 2020. In 2021, Plans reported 25% fewer appeals than in 2020. Of the total appeals, Figure 22 shows that 54% of Plan decisions were either fully or partially favorable to the member.
- **Behavioral Health Services:** *Figures 24-25*
  Figure 24 shows the rate of CMC members seeking care in the emergency room for behavioral health services. Utilization was higher in 2021 when compared to 2020. However, utilization has decreased from 14.1 visits per 10,000 member months in Q4 2020 to 13.0 visits in Q4 2021.
- **Long-term Services and Supports:** *Figures 26-45*
  Figure 26 shows that LTSS utilization per 1,000 members has decreased during the reporting period: from an average of 295.1 members per 1,000 receiving LTSS in Q1 2021, to an average of 292.6 members per 1,000 in Q4 2021. DHCS is continuing to work with Plans to enhance LTSS referrals. Figures 28-45 display LTSS member referrals -

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, 12, 14, 24, 26, 28, 30, 32, 34, 36, 38, 40, 42 and 44.
  Metrics represent the entire CMC program, by calendar quarters.
- **Current Quarter data by plan:** Figures 9, 11, 13, 15, 27, 29, 31, 33, 35, 37, 39, 41, 43 and 45.
  Metrics represent the data for the most recent quarter, by plan.
- **Annual data:** Figures 7, 16-23 and 25.
  Annual data are updated once a year and are compared to previous years that are only collected in aggregate.
- **Updated data:** Figures 1-18, Figures 20-45 have been updated for the June 2022 release.

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.

Appendix: Detailed Dashboard Metrics and Trends

Cal MediConnect Enrollment and Demographics:

Enrollment and demographic data are a point-in-time view of the CMC 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 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

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. 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.[1]

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," 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.[2]

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

[2] Core and State-Specific Quality Withhold Methodology and Technical Notes:
https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes

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.

DHCS recognizes the tremendous impact of the COVID-19 pandemic on older adults and people with disabilities, including those enrolled in CMC. Due to the pandemic, which began to impact California on a large scale in 2020, DHCS, CMS, MMPs, and providers undertook a number of efforts and delivery system changes to prioritize infection prevention and treatment, which in turn impacted the ability of MMPs to collect and submit quality data in 2020 and 2021. Due to the COVID-19 PHE, all MMPs were eligible for the qualify withhold adjustment for an extreme and controllable circumstance. Consequently, all MMPs received 100% of the withheld amount for Calendar Year (CY) 2020 based solely on full reporting of all applicable quality withhold measures.

Figure 7 shows the Quality Withhold Summary for CY 2020. Definitions of the measures included for 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.

- **Plan All-Cause Readmission:** The ratio of the plan's observed readmission rate to the plans' expected readmission rate. The readmission rate is based on the percent of plan members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.(CW6)
- **Annual Flu Vaccine:** Percent of plan members who got a vaccine (flu shot) prior to flu season. (CW7)
- **Follow-Up After Hospitalization for Mental Illness:** Percentage of discharges for plan members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge. (CW8)
- **Controlling Blood Pressure:** Percentage of plan members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year. (CW11)
- **Medication Adherence for Diabetes Medications:** Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. (CW12)
- **Encounter Data:** Encounter data for all services covered under the demonstration, with the exception of PDE data, submitted timely in compliance with demonstration requirements. (CW13)
- **Behavioral Health Shared Accountability Outcome Measure:** Reduction in emergency department (ED) -

use for seriously mentally ill and substance use disorder members. (CAW7)

- **Documentation of Care Goals:** Members with documented discussions of care goals. (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. (CAW9)
- **Care Plan Completion:** Percentage of members with a care plan completed within 90 days of enrollment. (CAW 10)

Care Coordination Measures:

Enhanced, person-centered care coordination is a key benefit of CMC. The dashboard tracks different measures and aspects of that benefit, from the initial HRA to begin the care coordination process, to the development of an individualized care plan, to the assignment of care coordinators, and post-hospital discharge follow-up care.

- **Health Risk Assessments (HRAs):** An HRA is a survey tool conducted by the Plans to assess a member's current health risk(s) and identifies further assessment needs such as behavioral health, substance use, chronic conditions, disabilities, functional impairments, assistance in key activities of daily living, dementia, cognitive and mental status, and the capacity to make informed decisions.
    - Plans must complete assessments for high-risk members within 45 days of enrollment, and for low-risk members within 90 days of enrollment. Plans report their 90 days HRA completion rates via Core measure. 2.1. Figures 8 and 9 provide Plan HRA completion rates within 90 days of enrollment for members who did not refuse an HRA, and for members who the Plan was able to reach. Figures 10 and 11 include the rates of members the Plans were unable to reach to conduct an HRA within 90 days of enrollment-both low and high risk. These unable to reach rates represent the percentage of members who the plan was unable to reach, following three documented outreach attempts to participate in the HRA, and who never had an HRA completed within 90 days of enrollment. CMS and DHCS continue to work with Plans to improve both unable to reach rates and HRA completion rates within 90 days of enrollment.
- **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.
    - Plans must complete a care plan for each member within 90 days of enrollment. Information tracking 90- day ICP completion rates comes from Core measure 3.2. Figures 12 and 13 do not include unwilling and unable to reach populations in calculations however, figures 14 and 15 do report ICP unable to reach rates. These unable to reach rates represent the percentage of members who the plan was unable to reach following three documented outreach attempts to complete a care plan, and who -

never had a care plan completed within 90 days of enrollment. CMS and DHCS continue to work with Plans to improve both unable to reach rates and ICP completion rates within 90days 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 CMC, and this continues to be an area of focus for program improvements.
- **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.

Care Coordination Trends:

Figure 8 shows that the quarterly statewide percentage of members willing to participate in a HRA, and who the Plan was able to locate, with an assessment completed within 90 days of enrollment has increased from 97% in Q3 2021 to 98% in Q4 2021. Figure 9 shows that 8 of 10 Plans (Anthem, Blue Shield, CHG, Health Net, IEHP, LA Care, Molina, and HPSM) are at or above the statewide average of 98% for Q4 2021 and the other 2 Plans are below the statewide average.

Figure 10 shows that the quarterly statewide percentage of members who the plan was unable to locate within 90 days for the purpose of completing an HRA decreased from 22% in Q3 2021 to 21% in Q4 2021. Figure 11 shows that 6 of 10 Plans (Anthem, CHG, IEHP, LA Care, CalOptima, and SCFHP) are at or below the statewide average of 21% for Q4 2021, while the remaining plans exceed the statewide average. However, Blue Shield is at 40%, decreasing from 43% in Q3 2021.

Figure 12 indicates that the percentage of members with an ICP completed within 90 days of enrollment has increased from 82% from Q3 2021 to 85% in Q4 2021. Figure 13 indicates that for 6 of the Plans (Blue Shield, CHG, IEHP, LA Care, CalOptima and SCFHP), the percentage of members with an ICP completed within 90 days of enrollment is at or above the statewide average of 85% for Q4 2021.

Figure 14 shows that the quarterly statewide percentage of members who the plan was unable to locate for the purpose of completing an ICP within 90 days of enrollment has remained the same at 25% from Q3 2021 to Q4 2021. Figure 15 shows that 5 of 10 Plans are at or below the statewide average of 25% for Q4 2021 and the remaining 5 (Blue Shield, Health Net, LA Care, Molina and SCFHP) exceed the statewide average. Though, Health Net worsened by experiencing 40% during Q3 2021 and 50% at Q4 2021. The goal for this measure is for the Plans to have a low unable to reach rate, so the lower the rate, the better.
ICP and HRA 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 CMC 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.

Grievances and Appeals Trends[3]*:

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 20 and 21 show a breakdown of a total of 22,476 grievances, by category and by Plan, filed by members in 2021. This is an increase of approximately 10% (1,975) of reported member grievances compared to 2020.[4] The Plan that contributed the most to the increased grievances in 2021 compared to 2020 is IEHP. IEHP is the largest plan so they will have the most and highest rate of grievances. DHCS and CMS are actively working with IEHP to monitor the high level of grievances. LA Care had a higher rate of grievances than IEHP in 2021, even though their grievance rate decreased significantly in Q3 and Q4 of 2021.

The number of appeals varies greatly by Plan, as well as the percentage of decisions that are adverse versus partially or fully favorable. Figure 22 indicates 1,474 appeals were filed by members in 2021, a decrease of around 25% (498) of total reported appeals compared to 2020[5].

Figure 22 indicates that 54% of Plan decisions were either fully or partially favorable to the member appeals filed in 2020.

DHCS and CMS continues to work with the Plans to better understand the trends in grievances and appeals to ensure -

[3] The change in Grievances and Appeals from 2020 to 2021 does not necessarily indicate a change in actual instances; but may reflect changes in the administrative processing, reconciliation and/or reporting by individual Plans.
[4] Cal MediConnect Performance Dashboard September 2020: https://www.dhcs.ca.gov/services/Documents/MCQMD/CMCDashboard9-20.pdf
[5] For more historical detail, refer to Cal MediConnect Performance Dashboard June 2020, September 2020, and June 2021: https://www.dhcs.ca.gov/Pages/Cal_MediConnectDashboard.aspx

optimal beneficiary access to services.

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 24 shows the overall trend of CMC members seeking care in the emergency room for behavioral health services has decreased from 17.2 visits per 10,000 member months in Q1 2021 to 13.0 visits per 10,000 member months in Q4 2021. This measure has been an improvement by quarter as this measure decreases.

Long-term Services and Supports (LTSS) Utilization:

A central goal of CMC 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).
    - **CPO Template:** In an effort to improve data quality, a CPO template and instructions were shared with the Plans in Q3 2019.

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 26 shows that LTSS utilization has decreased from an average of 296.9 per 1,000 members in Q3 2021 to -

292.6 per 1,000 members receiving LTSS in Q4 2021.

Figure 28 shows that IHSS utilization has increased from an average of 253.3 per 1,000 members in Q1 2021 to 253.5 per 1,000 members receiving IHSS in Q4 2021.

Figure 30 shows that CBAS referral rates have increased from 1.7 per 1,000 members in Q1 2021 to 1.9 per 1,000 members in Q4 2021. SCFHP reported the highest number of CBAS referrals of 5.3 per 1,000 members in Q4 2021, as shown in Figure 31. Figure 32 shows that CBAS utilization per 1,000 members has decreased from 8.5 members per 1,000 receiving CBAS in Q3 2021 to 7.9 members per 1,000 receiving CBAS in Q4 2021.

Figure 34 shows that MSSP referrals per 1,000 members has increased from an average of 0.5 per 1,000 members in Q3 2021 to an average of 0.6 per 1,000 members in Q4 2021. Figure 35 shows that Anthem reported the highest number of MSSP referrals of 2.2 per 1,000 members in Q4 2021. Figure 36 shows that MSSP utilization per 1,000 members has increased from 6.8 per 1,000 members in Q1 2021 to 7.0 per 1,000 members in Q4 2021.

Figure 38 shows that NF referrals per 1,000 members has increased from an average of 3.6 member referrals per 1,000 in Q3 2021 to an average 3.7 member referrals per 1,000 in Q4 2021. HPSM reported the highest number of NF referrals of 10.3 per 1,000 members in Q4 2021 (Figure 39). Figure 40 shows that NF utilization has increased from an average of 23.7 members per 1,000 in Q3 2021 to an average of 24.2 members per 1,000 in Q4 2021.

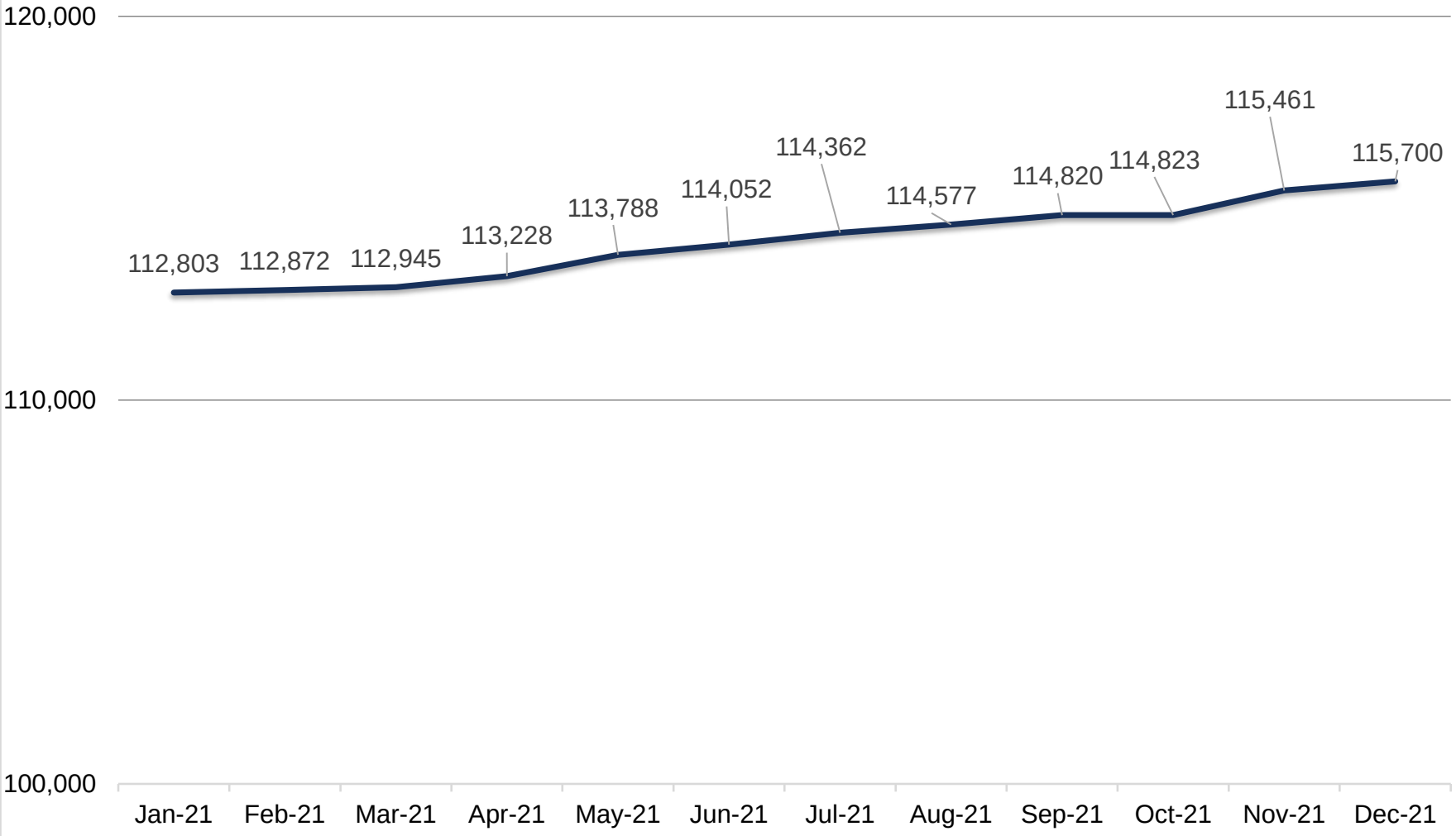
Figure 42 shows that CPO referrals per 1,000 members has remained the same at 1.8 referrals per 1,000 members from Q1 2021 to Q4 2021. Figure 43 shows that HPSM reported the highest number of CPO referrals of 12.8 per 1,000 members in Q4 2021. Figure 44 shows that CPO utilization per 1,000 members has remained the same at an average of 1.7 per 1,000 members from Q3 2021 to Q4 2021.

CPO referral and utilization data shown in Figures 42-45 for Q1 2021, Q2 2021, Q3 2021, and Q4 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.

Cal MediConnect Enrollment and Demographics Figure 1: Breakdowns of Dual Populations (As of 12/01/2021)

See metric summary for additional information

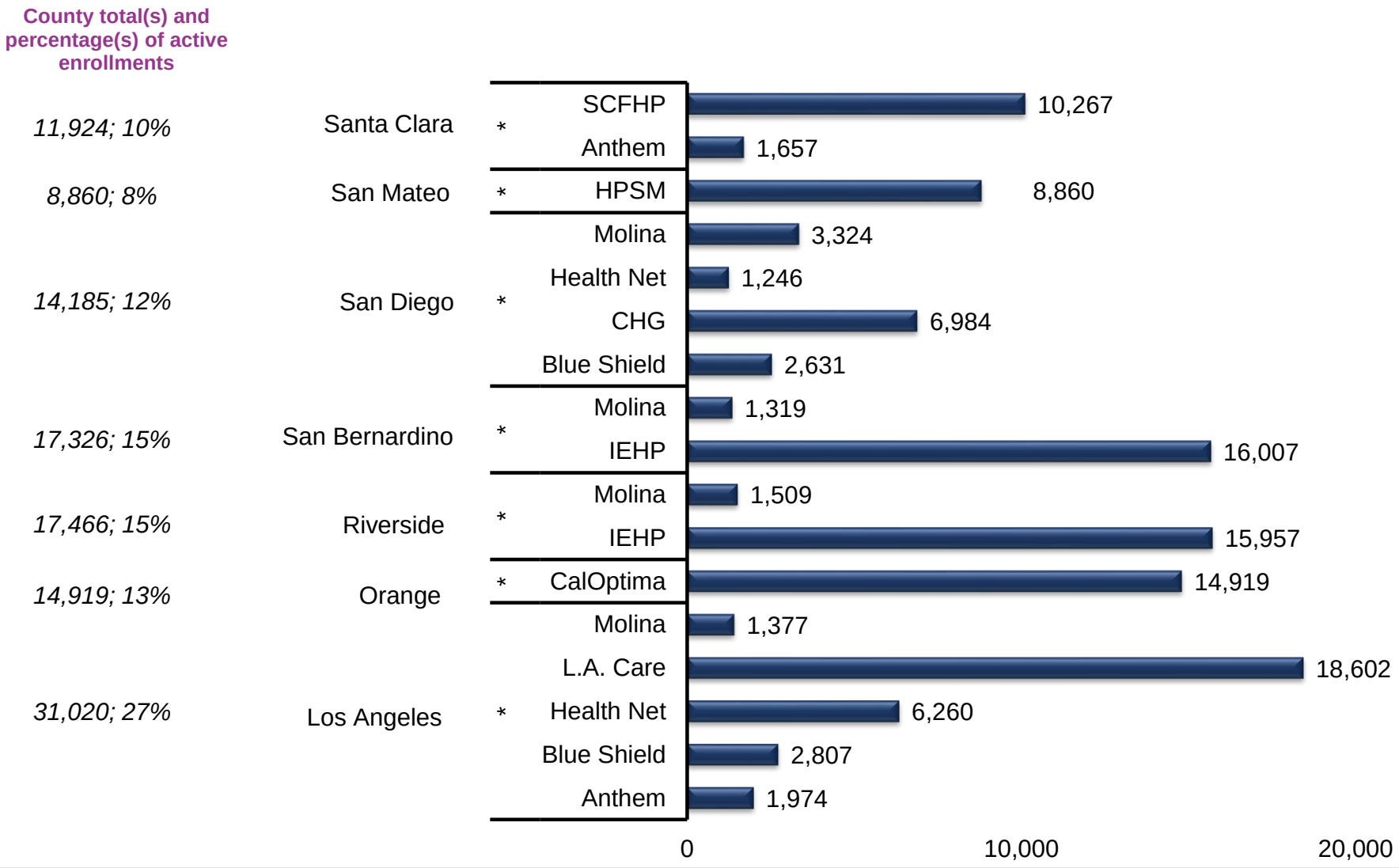
Fig. 1: Monthly Enrollment



Cal MediConnect Enrollment and Demographics Figure 2: Breakdowns of Dual Populations (As of 12/01/2021)

See metric summary for additional information

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



Cal MediConnect Enrollment and Demographics Figure 3 - 6: Breakdowns of Dual Populations (As of 12/01/2021)

See metric summary for additional information

Fig. 3: Quarter 4 Enrollment by Race/Ethnicity

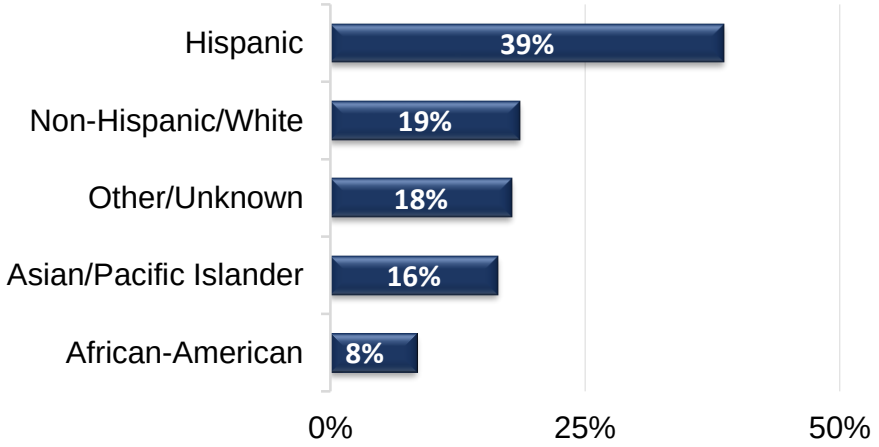


Fig. 4: Quarter 4 Enrollment by Age

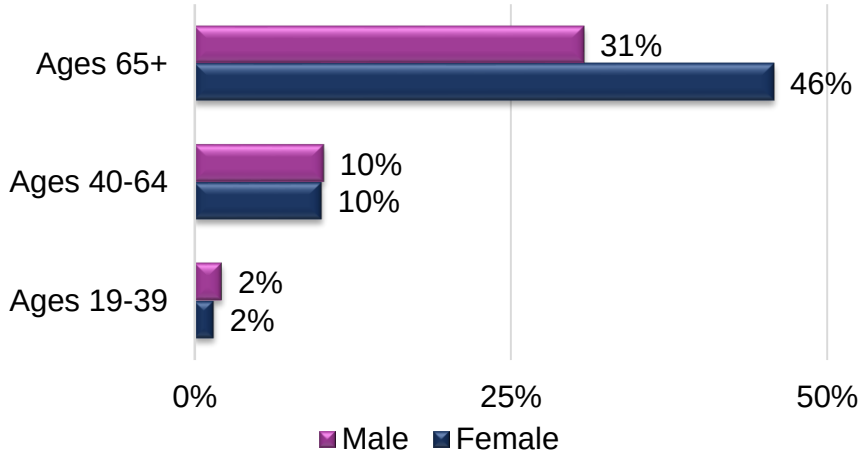


Fig. 5: Quarter 4 Enrollment by Threshold Language Spoken

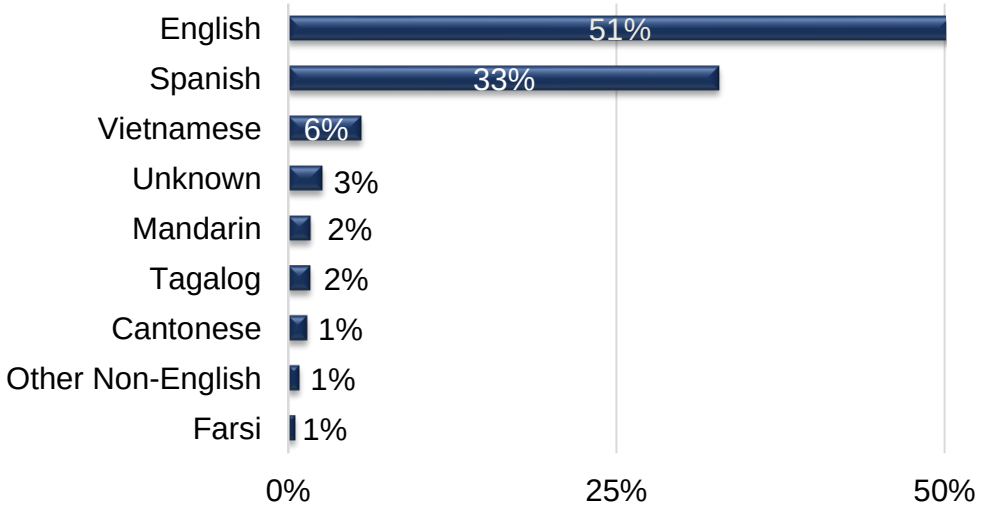
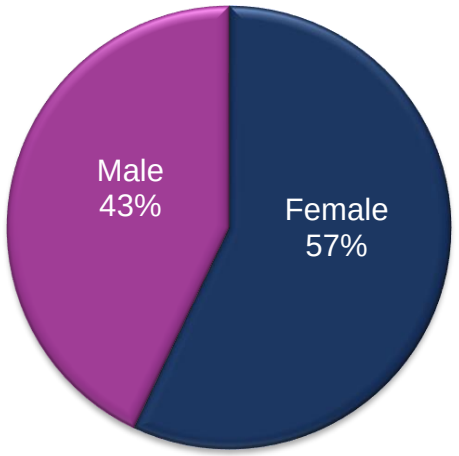


Fig. 6: Quarter 4 Enrollment by Gender



Cal MediConnect Figure 7: Quality Withhold Summary Table (CY 2020); Demonstration Year 6
See metric summary for additional information

Medicare-Medicaid Plan	CW6	CW7*	CW8	CW11	CW12
Anthem	Complete	N/A	Complete	Complete	Complete
Blue Shield	Complete	N/A	Complete	Complete	Complete
CHG	Complete	N/A	Complete	Complete	Complete
Health Net	Complete	N/A	Complete	Complete	Complete
IEHP	Complete	N/A	Complete	Complete	Complete
L.A. Care	Complete	N/A	Complete	Complete	Complete
Molina	Complete	N/A	Complete	Complete	Complete
CalOptima	Complete	N/A	Complete	Complete	Complete
HPSM	Complete	N/A	Complete	Complete	Complete
SCFHP	Complete	N/A	Complete	Complete	Complete

Medicare-Medicaid Plan	CW13	CAW7	CAW8	CAW9	CAW10
Anthem	Complete	Complete	Complete	Complete	Complete
Blue Shield	Complete	Complete	Complete	Complete	Complete
CHG	Complete	Complete	Complete	Complete	Complete
Health Net	Complete	Complete	Complete	Complete	Complete
IEHP	Complete	Complete	Complete	Complete	Complete
L.A. Care	Complete	Complete	Complete	Complete	Complete
Molina	Complete	Complete	Complete	Complete	Complete
CalOptima	Complete	Complete	Complete	Complete	Complete
HPSM	Complete	Complete	Complete	Complete	Complete
SCFHP	Complete	Complete	Complete	Complete	Complete

*Due to the COVID-19 PHE, MMPs were not required to report 2020 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures.

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 (01/2021-12/2021) 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

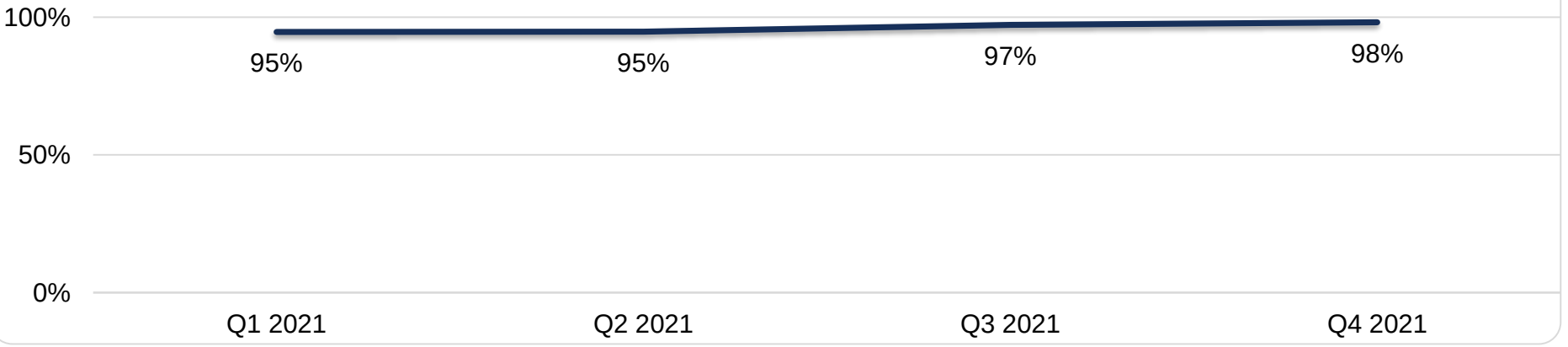
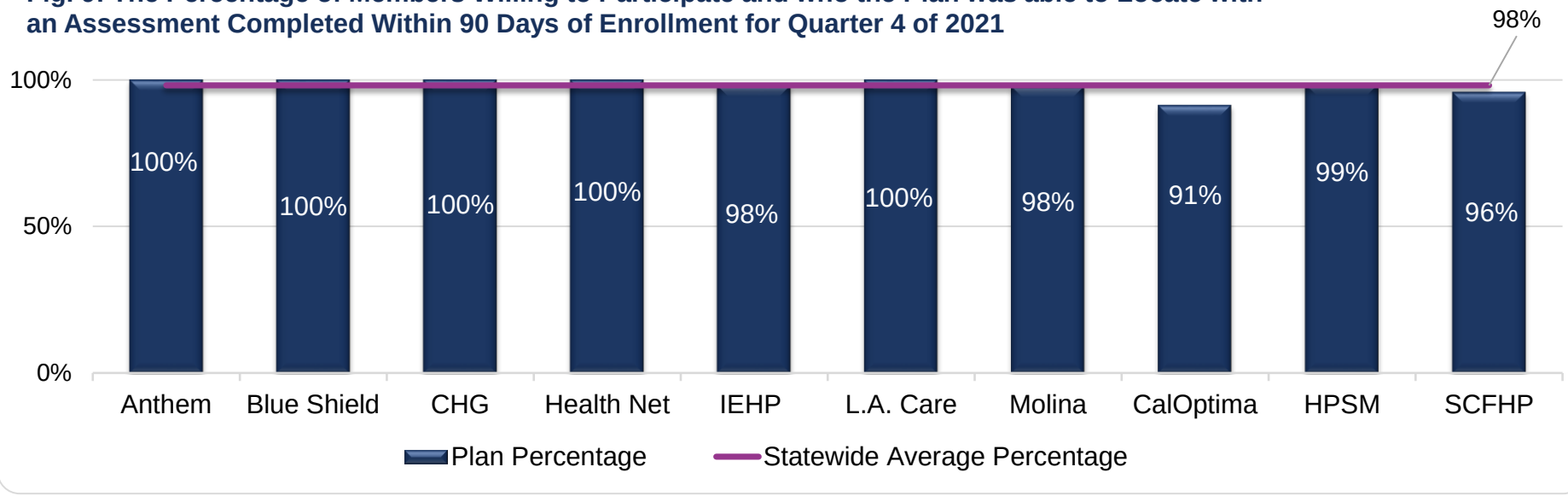


Fig. 9: The Percentage of Members Willing to Participate and who the Plan was able to Locate with an Assessment Completed Within 90 Days of Enrollment for Quarter 4 of 2021



Care Coordination Figure 10 & 11: Percentage of Members Who the Plan Was Unable to Locate within 90 Days to Complete an Assessment (HRA) (01/2021-12/2021) See metric summary for additional information

Fig. 10: Quarterly Rolling Statewide Percentage of Members Who the Plan Was Unable to Locate within 90 Days to Complete an Assessment (HRA)

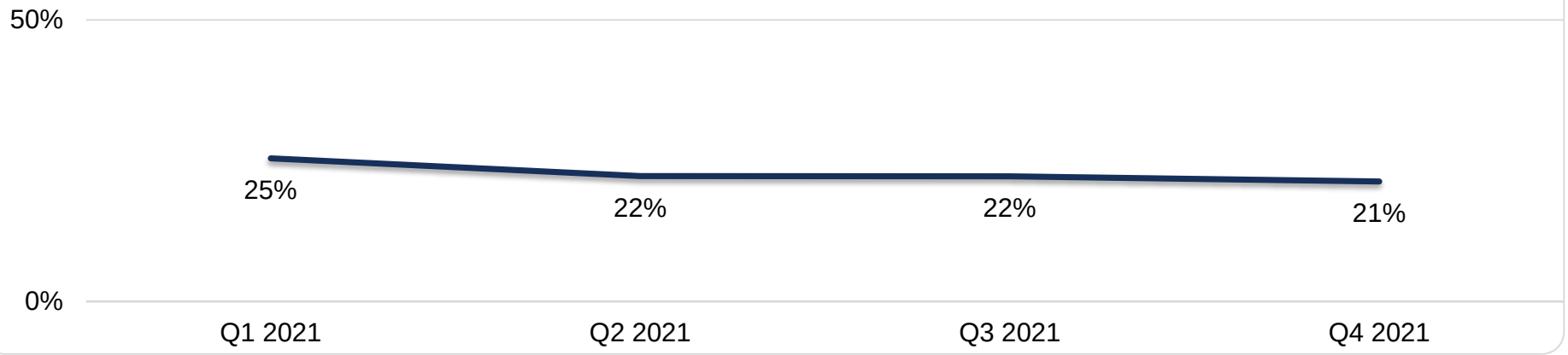
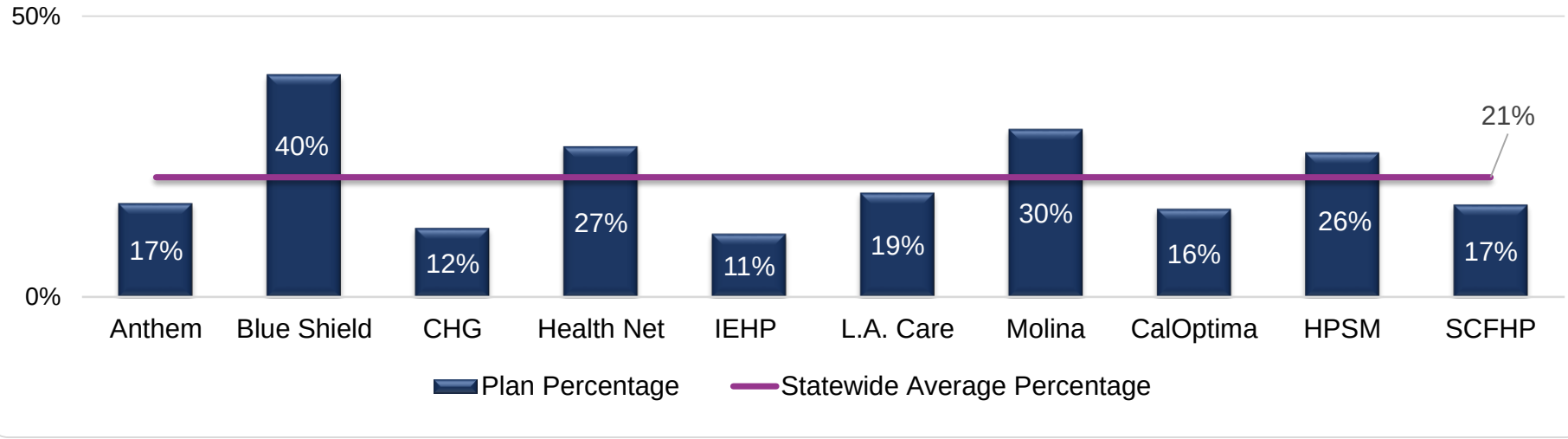


Fig. 11: Percentage of Members Who the Plan Was Unable to Locate within 90 Days to Complete an Assessment (HRA) for Quarter 4 of 2021



Care Coordination Figure 12 & 13: Percentage of Members with an Individualized Care Plan (ICP) Completed Within 90 Days of Enrollment (01/2021-12/2021) See metric summary for additional information

Fig. 12: Quarterly Rolling Statewide Percentage of Members with an ICP Completed Within 90 Days of Enrollment

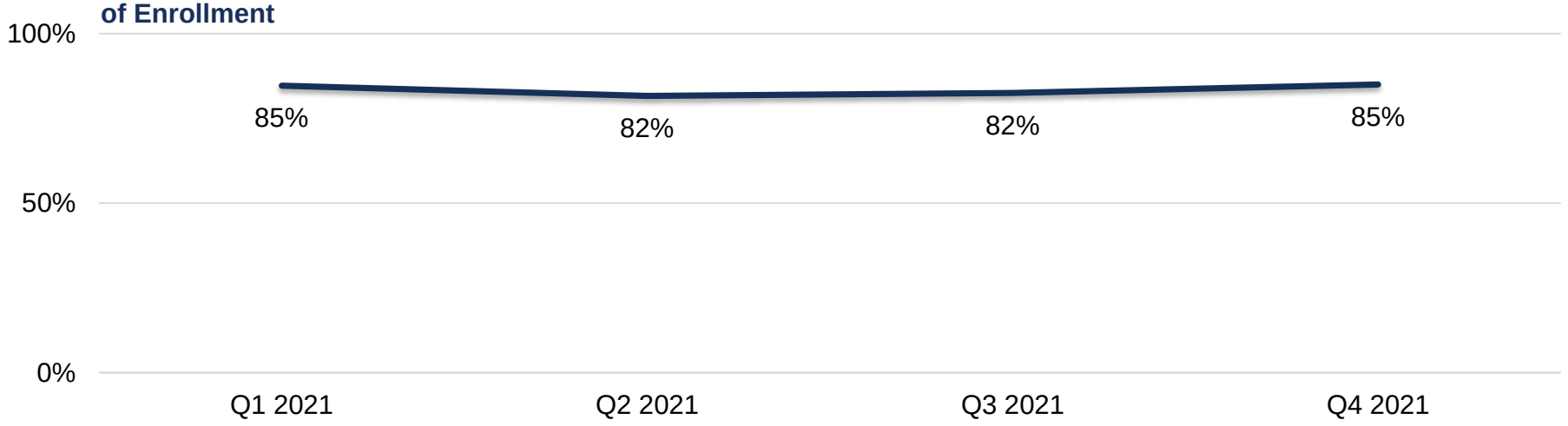
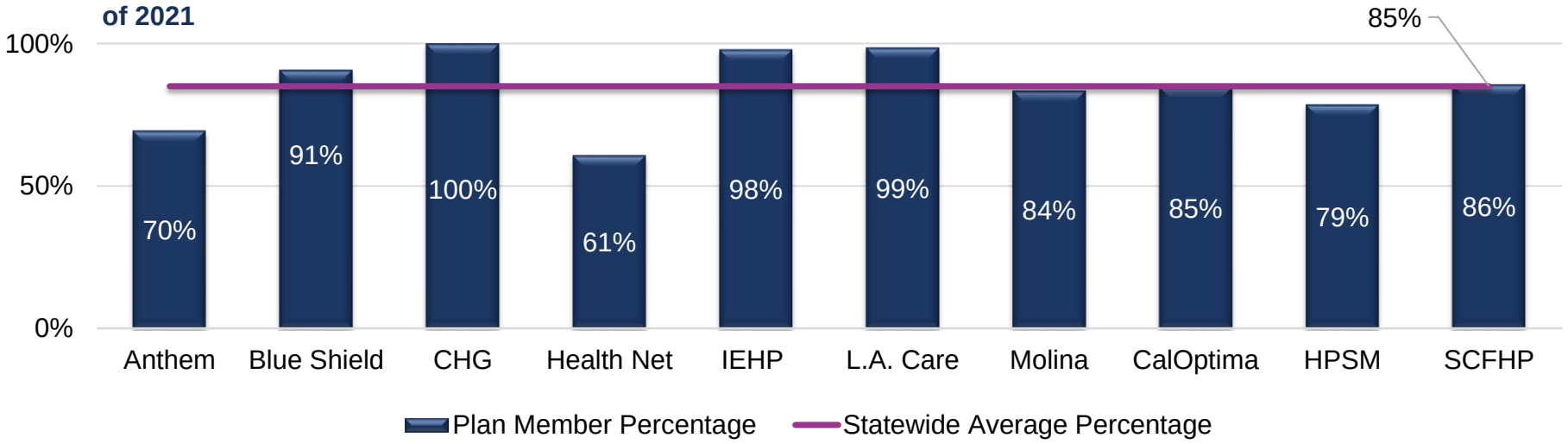


Fig. 13: Percentage of Members with an ICP Completed Within 90 Days of Enrollment for Quarter 4 of 2021



Care Coordination Figure 14 & 15: Percentage of Members Who the Plan Was Unable to Locate to Complete an ICP Within 90 Days of Enrollment (01/2021-12/2021) See metric summary for additional information

Fig. 14: Quarterly Rolling Statewide Percentage of Members Who the Plan Was Unable to Locate to Complete an ICP Within 90 Days of Enrollment

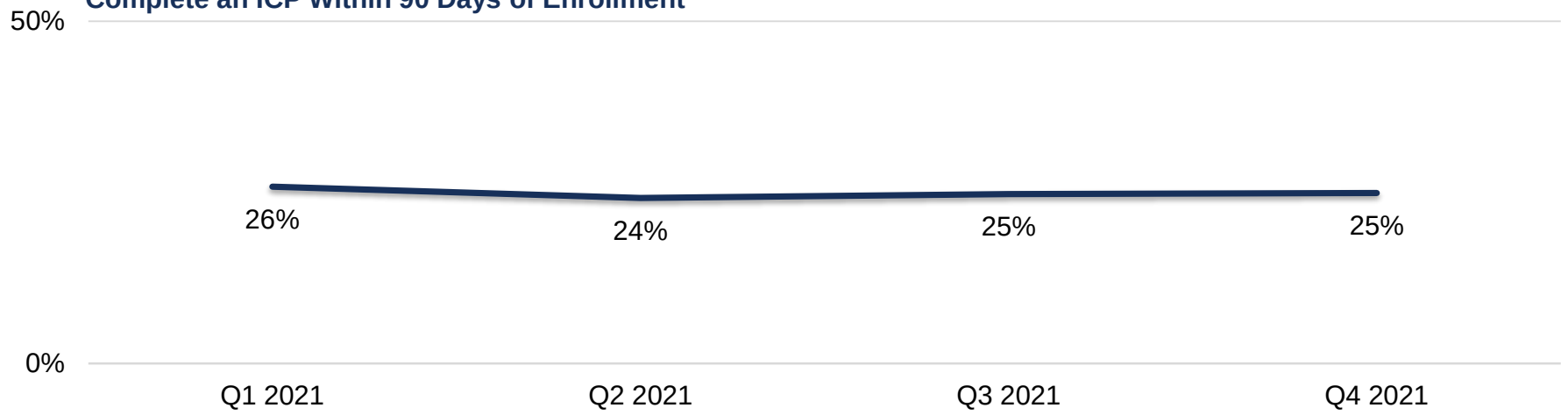
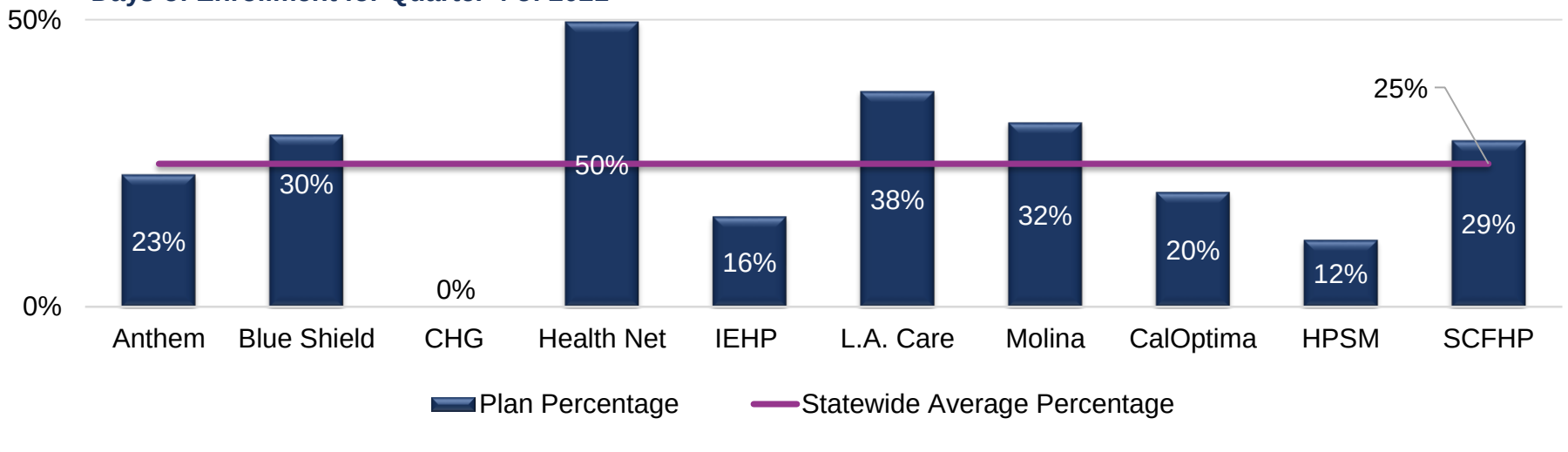
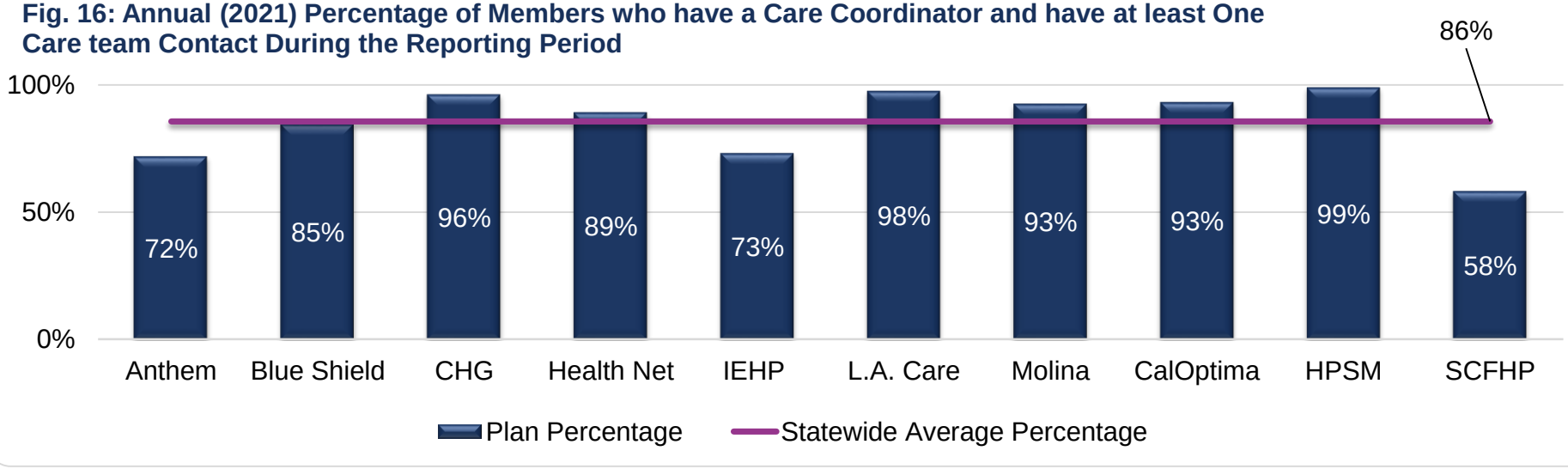


Fig. 15: Percentage of Members Who the Plan Was Unable to Locate to Complete an ICP Within 90 Days of Enrollment for Quarter 4 of 2021



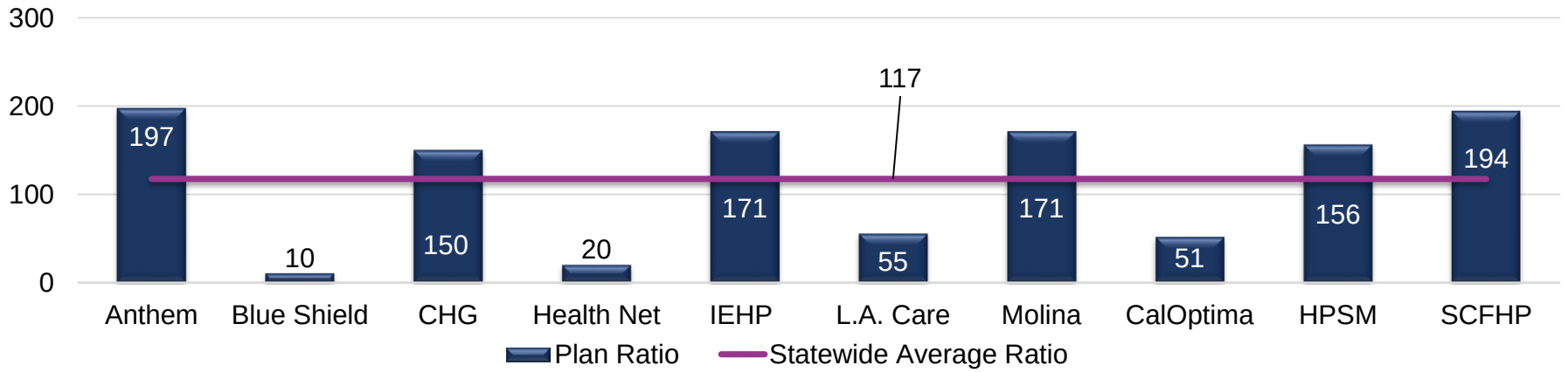
Care Coordination Figure 16: Percentage of Members Who Have a Care Coordinator and Have at Least One Care Team Contact During the Reporting Period (01/2021-12/2021) See metric summary for additional information

Fig. 16: Annual (2021) Percentage of Members who have a Care Coordinator and have at least One Care team Contact During the Reporting Period



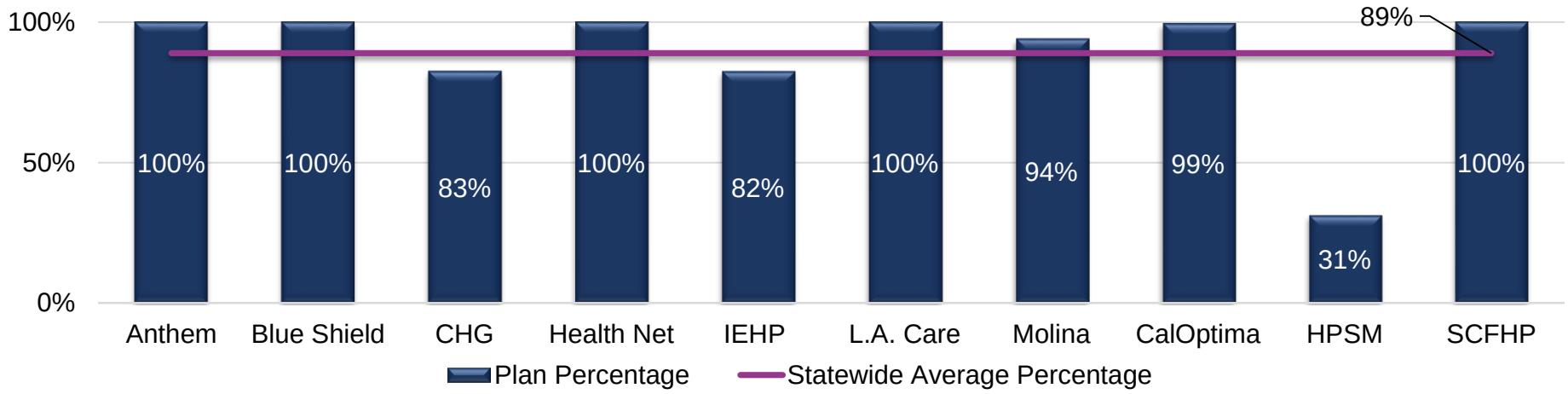
Care Coordination Figure 17: Member to Care Coordinator Ratio (01/2021-12/2021) See metric summary for additional information

Fig. 17: Annual (2021) Number of Members to Care Coordinator Ratio



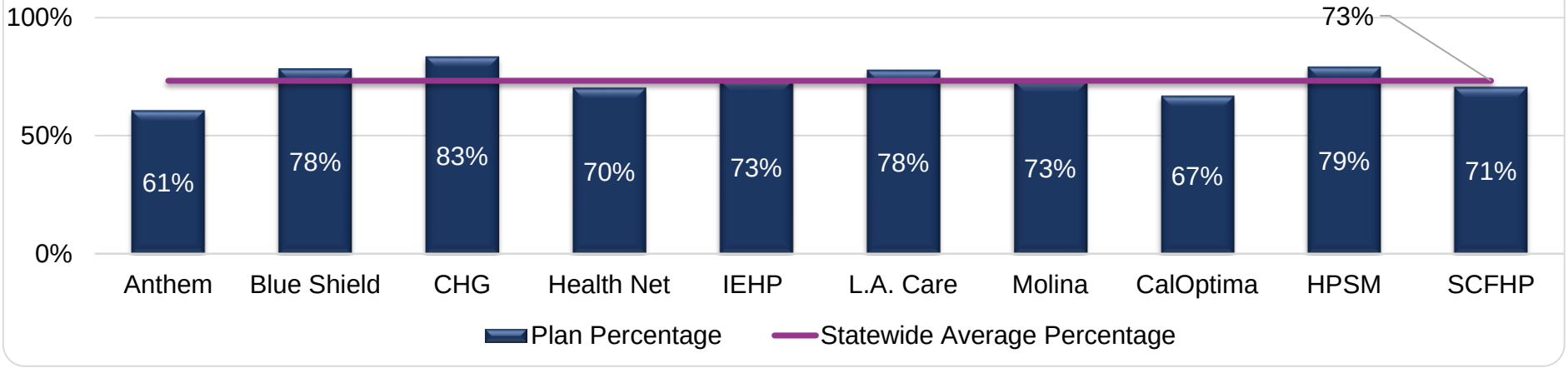
Care Coordination Figure 18: Percentage of Members with Documented Discussions of Care Goals (01/2021-12/2021) See metric summary for additional information

Fig. 18: Annual (2021) Percentage of Members with Documented Discussions of Care Goals



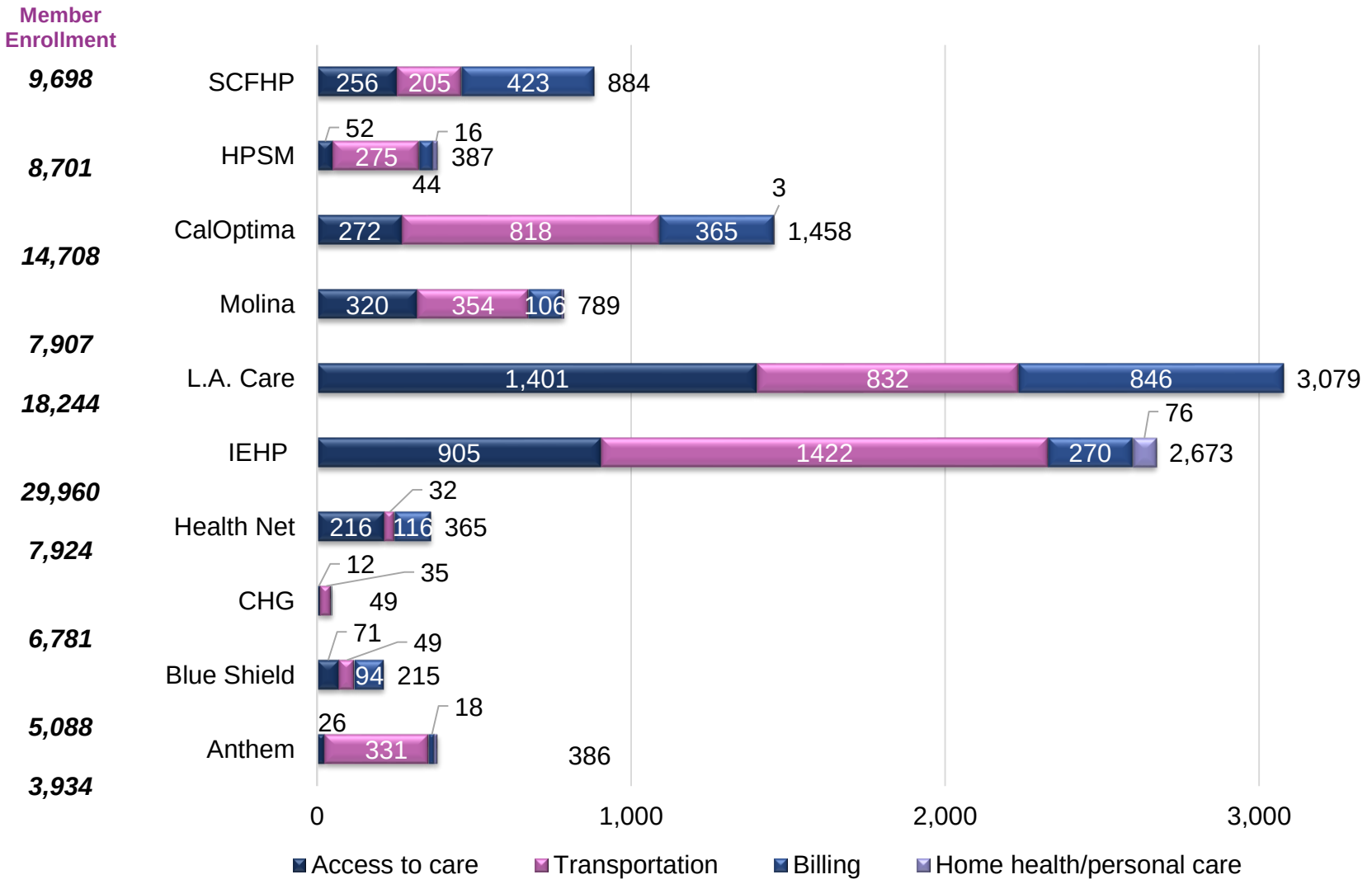
Care Coordination Figure 19: Percentage of Members with First Follow-up Visit within 30 Days after Hospital Discharge (01/2020-12/2020) See metric summary for additional information

Fig. 19: Annual (2020) Percentage of Members with First Follow-Up Visit within 30 Days after Hospital Discharge



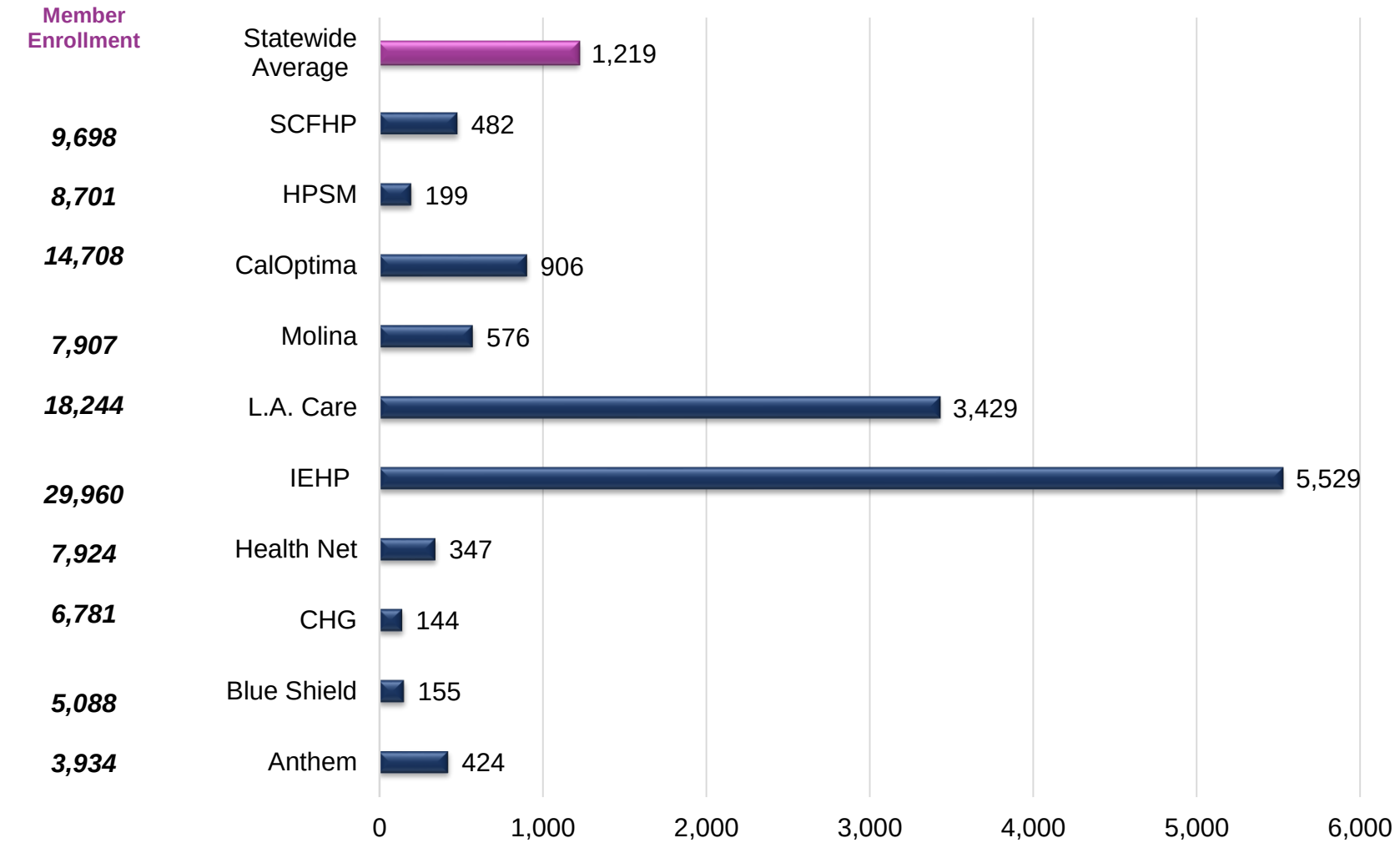
Grievance Figure 20: Count Grievances by type, Except "Other" (01/2021-12/2021)
See metric summary for additional information

Fig. 20: Annual Count of Grievances Broken Down by Type, besides "Other"



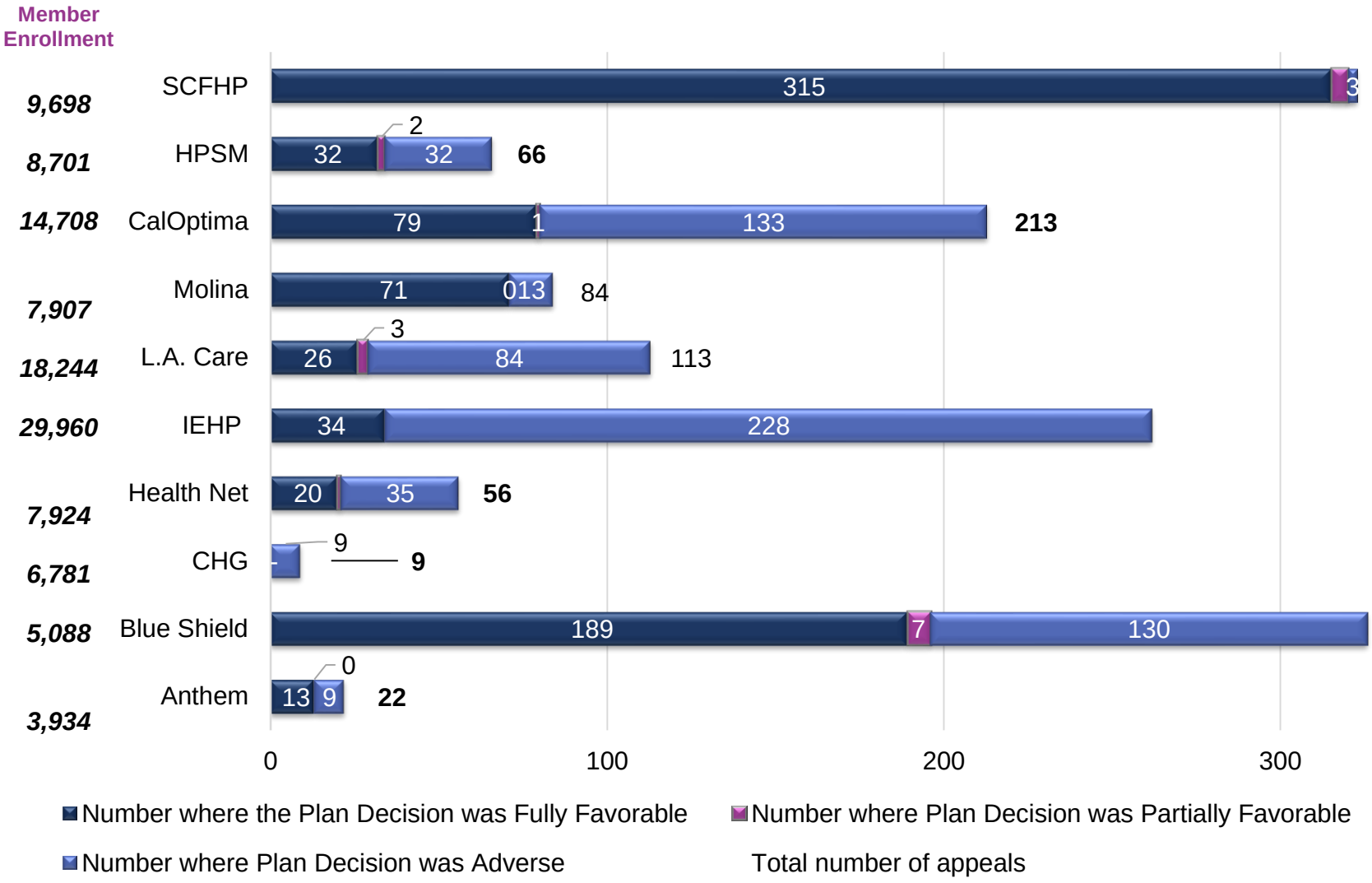
Grievance Figure 21: Count of "Other" Grievances (01/2021-12/2021) See metric summary for additional information

Fig. 21: Annual Count of "Other" Grievances



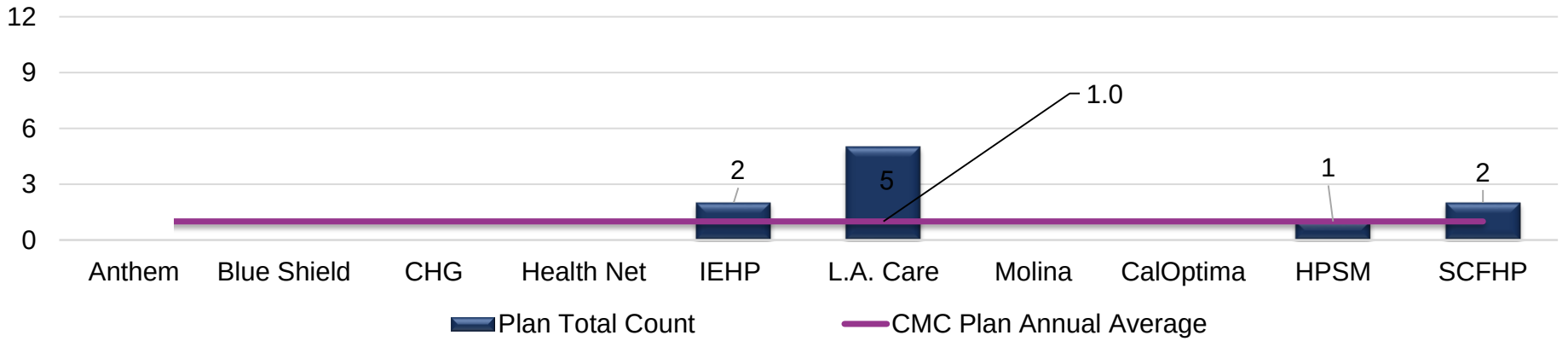
Appeal Figure 22: Count of Appeals (01/2021-12/2021). See metric summary for additional information

Fig. 22: Annual Count of Appeals Broken Down by Outcome



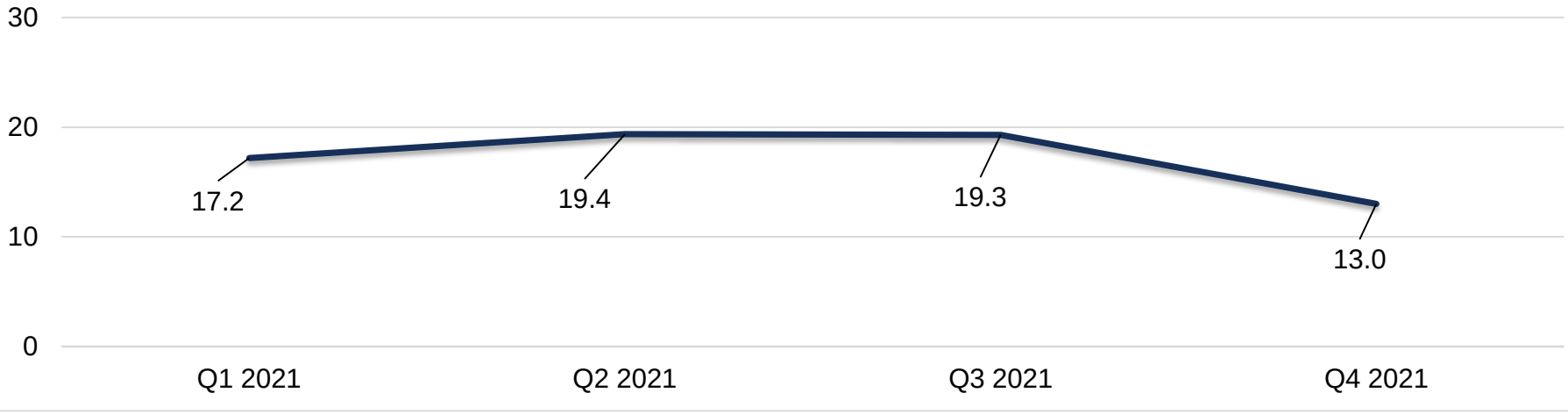
Appeals Figure 23: Total of all Appeals Related to the Denial or Limited Authorization of Mental Health Services (01/2021-12/2021) See metric summary for additional information

Fig. 23: 2021 Appeals Related to the Denial or Limited Authorization of Mental Health Services; Plan Total Count and CMC Plan Annual Average



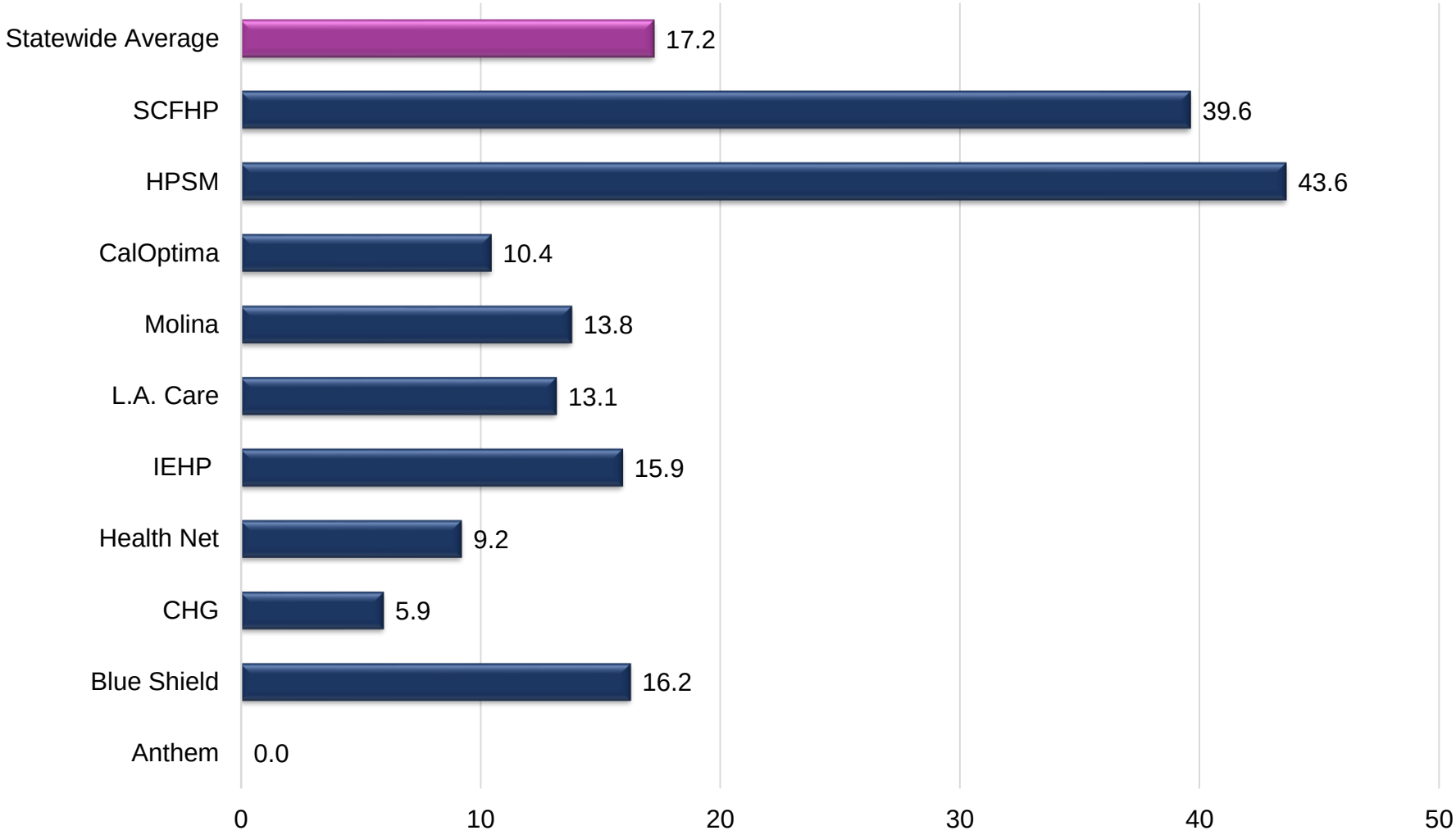
Behavioral Health Figure 24: Emergency Room Behavioral Health Services Utilization per 10,000 Member Months (01/2021-12/2021) See metric summary for additional information

Fig. 24: Quarterly Rolling Statewide Average Count of Emergency Room Behavioral Health Services Utilization per 10,000 Member Months



Behavioral Health Figure 25: Emergency Room Behavioral Health Services Utilization per 10,000 Member Months (01/2021-12/2021) See metric summary for additional information

Fig. 25: Annual Count of Emergency Room Behavioral Health Services Utilization per 10,000 Member Months



Long Term Services & Supports (LTSS) Figure 26 & 27: Utilization of Members Receiving LTSS per 1,000 Members (01/2021-12/2021) See metric summary for additional information

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

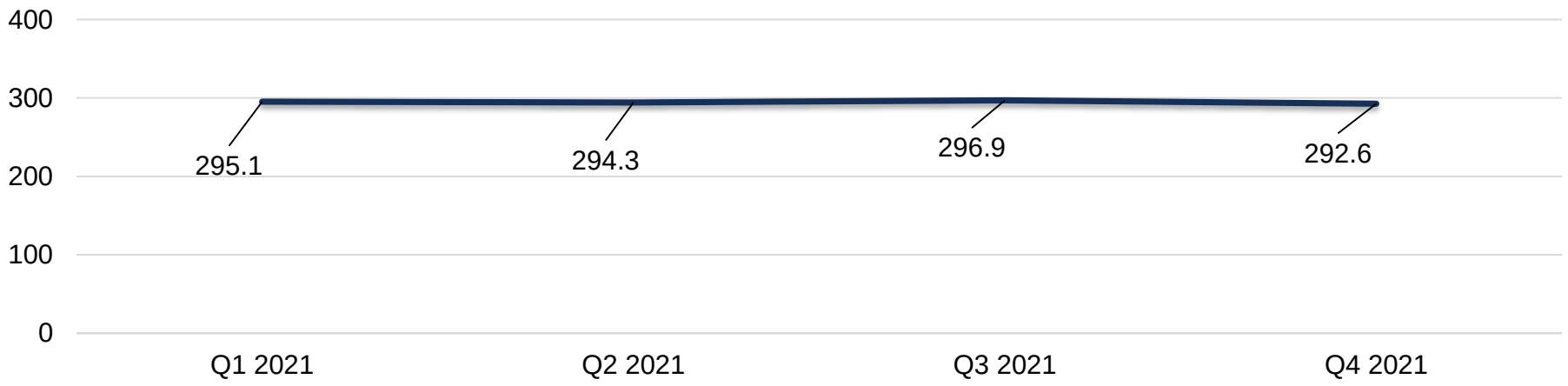
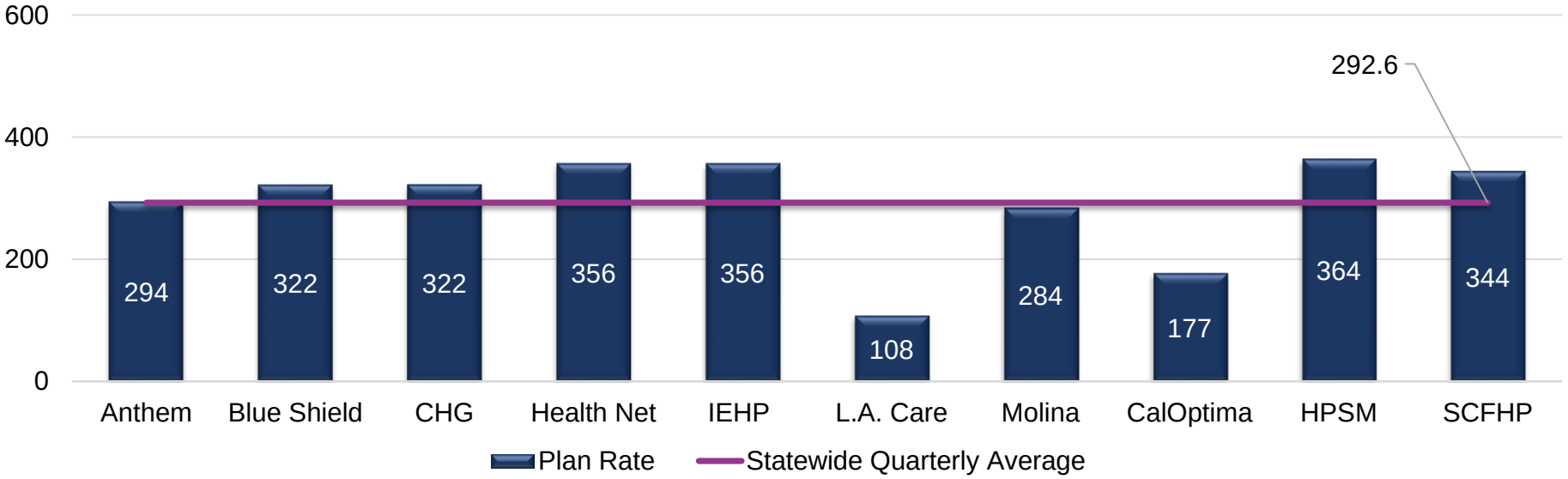


Fig. 27: Count of Members Receiving LTSS per 1,000 members for Quarter 4 of 2021



Long Term Services & Supports (LTSS) Figure 28 & 29: Count of IHSS per 1,000 Members (01/2021-12/2021) See metric summary for additional information

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

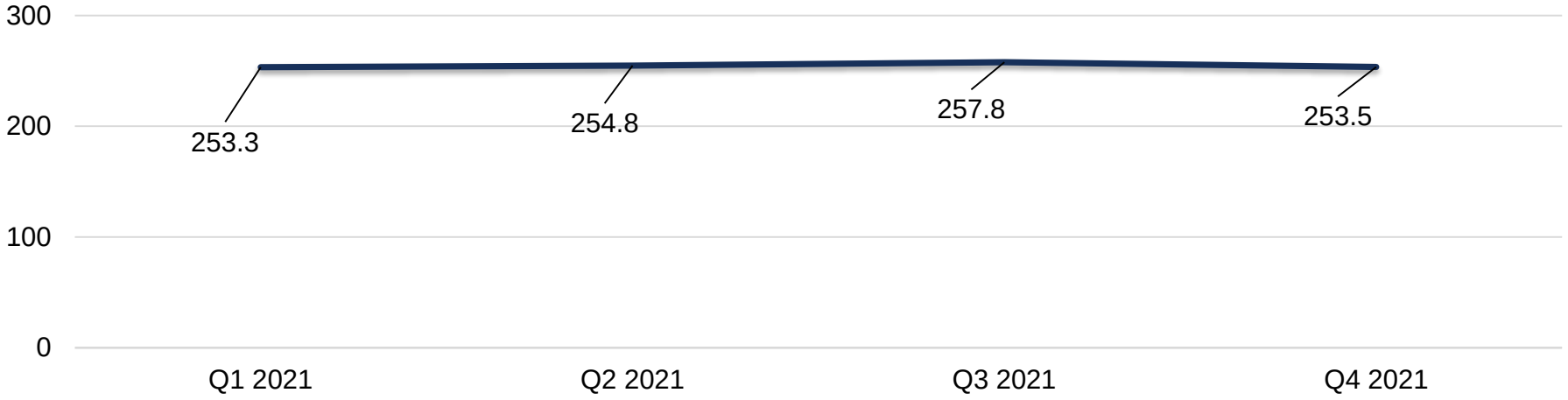
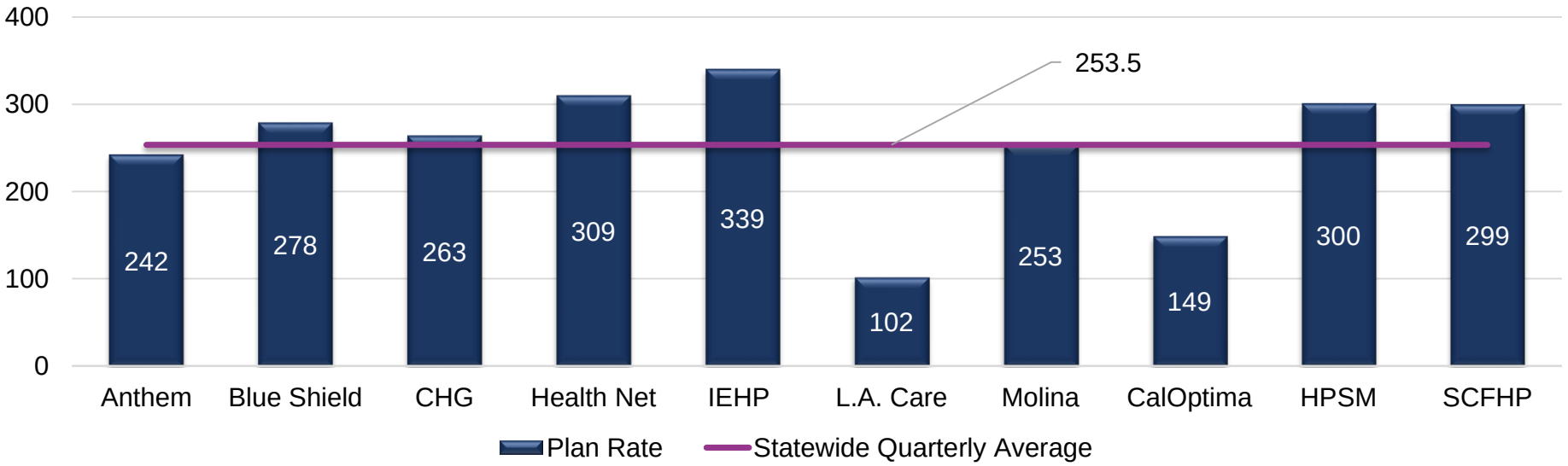


Fig. 29: Count of Members Receiving IHSS per 1,000 members for Quarter 4 of 2021



Long Term Services & Supports (LTSS) Figure 30 & 31: Count of CBAS per 1,000 Members (01/2021-12/2021) See metric summary for additional information

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

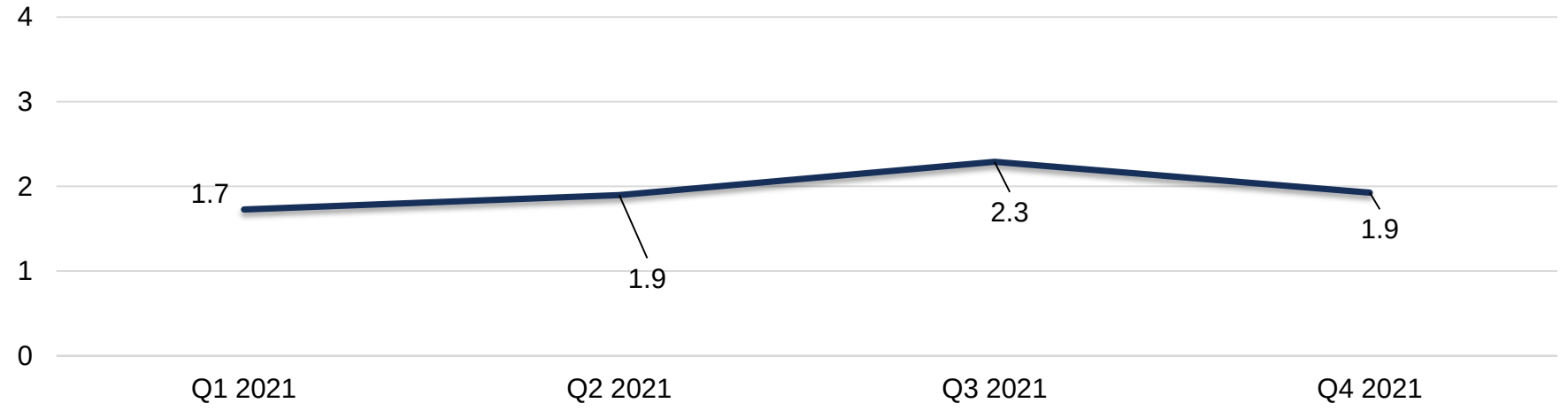
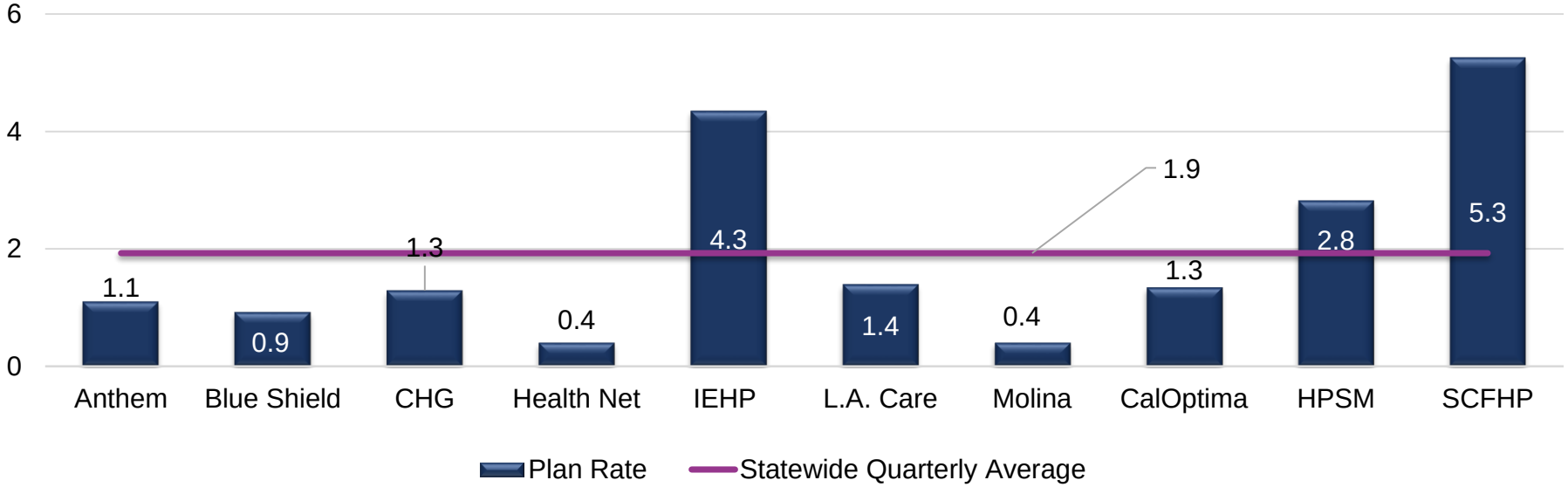


Fig. 31: Count of CBAS Member Referrals per 1,000 members for Quarter 4 of 2021



Long Term Services & Supports (LTSS) Figure 32 & 33: Count of CBAS per 1,000 Members (01/2021-12/2021)
See metric summary for additional information

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

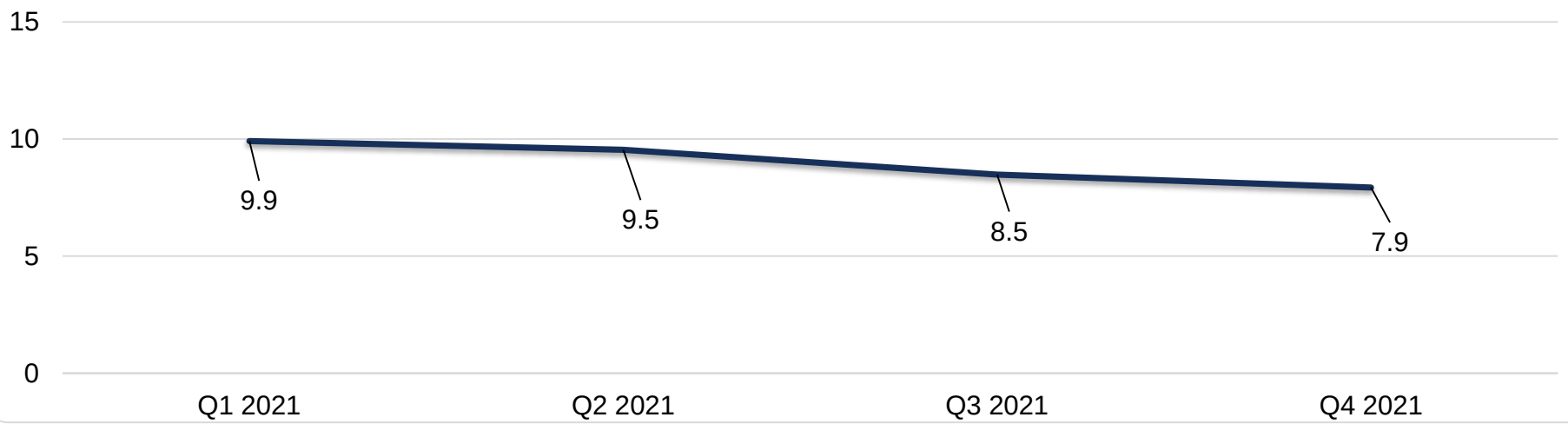
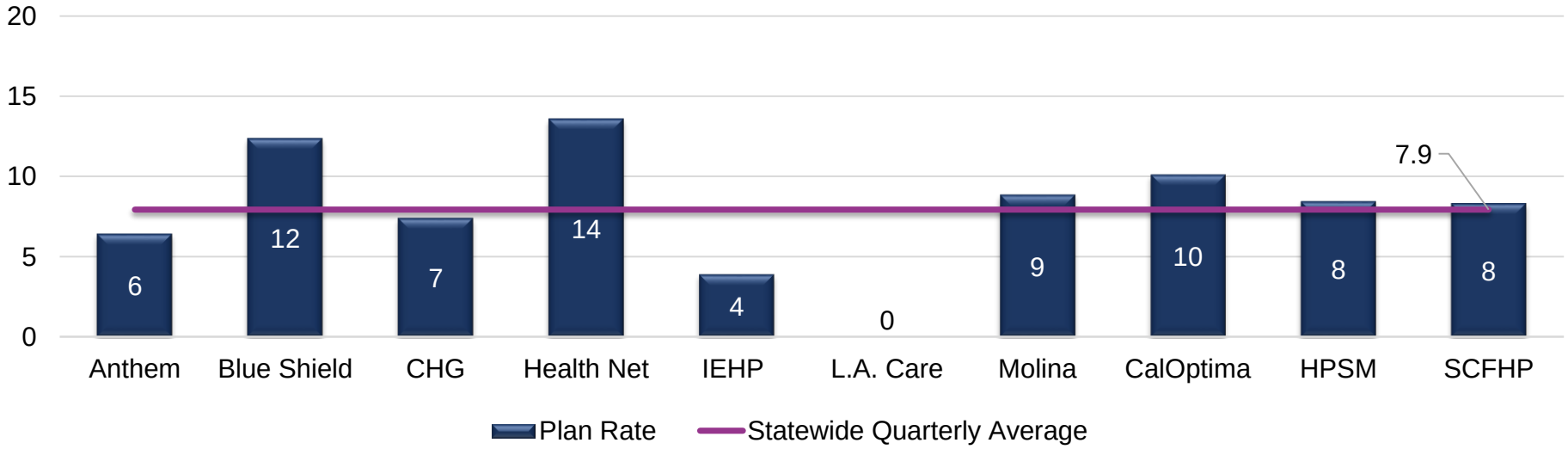


Fig. 33: Count of Members Receiving CBAS per 1,000 members for Quarter 4 of 2021



Long Term Services & Supports (LTSS) Figure 34 & 35: Count of MSSP per 1,000 Members (01/2021-12/2021)
See metric summary for additional information

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

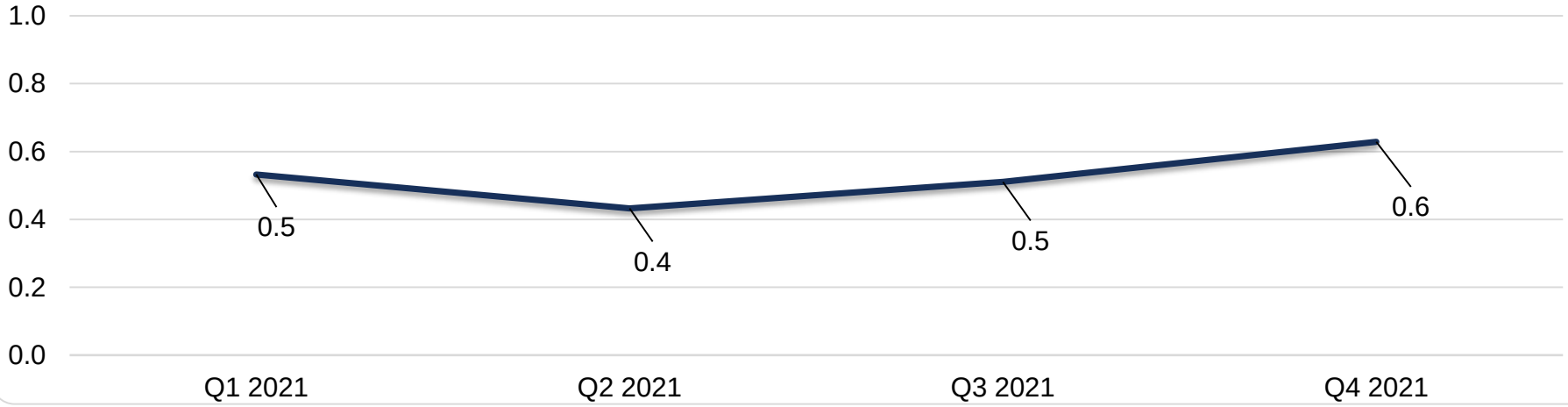
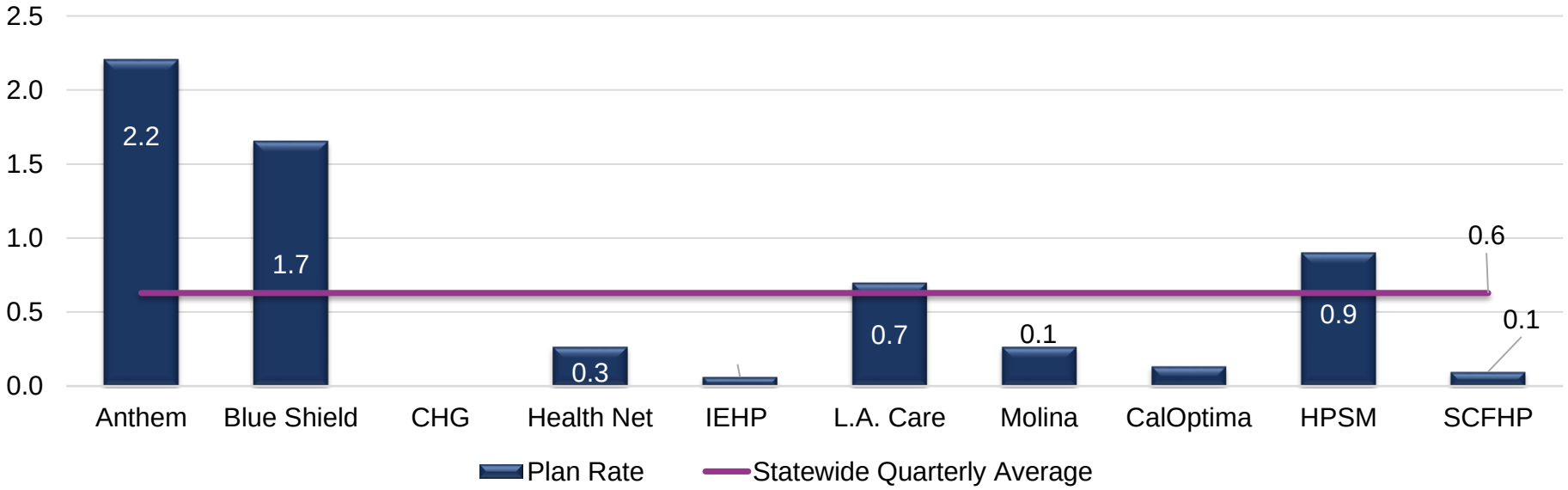


Fig. 35: Count of MSSP Member Referrals per 1,000 members for Quarter 4 of 2021



Long Term Services & Supports (LTSS) Figure 36 & 37: Count of MSSP per 1,000 Members (01/2021-12/2021)
See metric summary for additional information

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

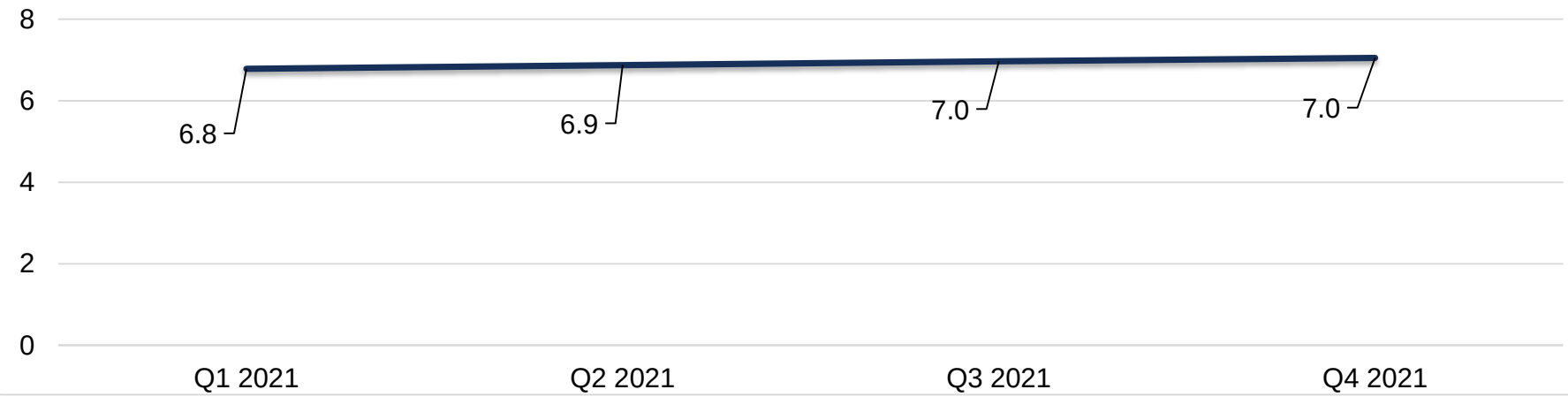
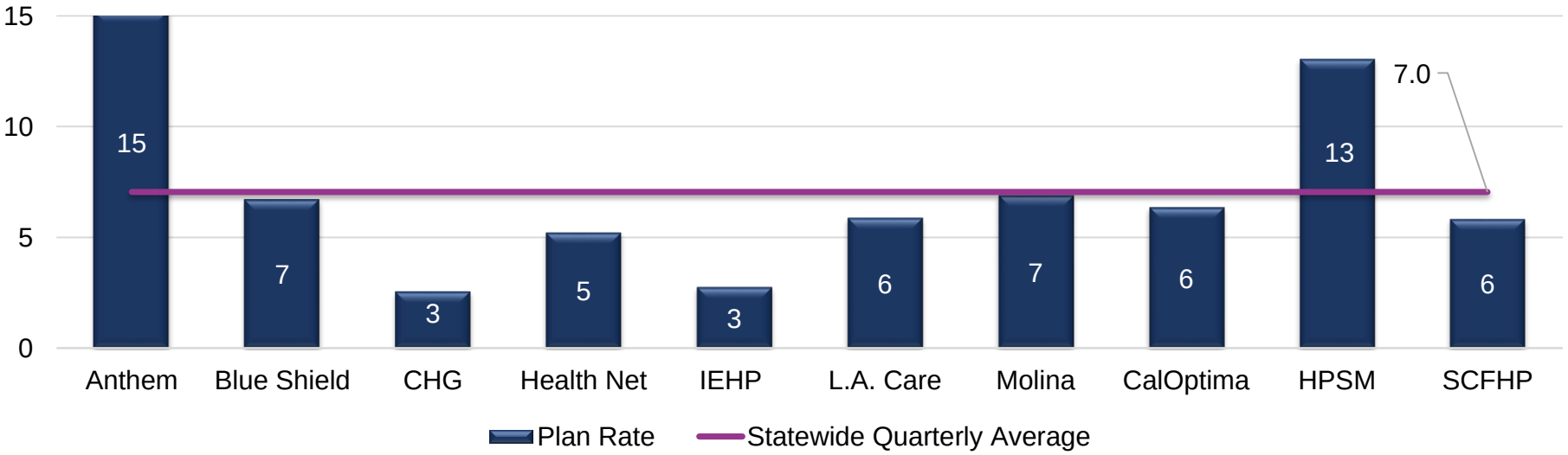


Fig. 37: Count of Members Receiving MSSP per 1,000 members for Quarter 4 of 2021



Long Term Services & Supports (LTSS) Figure 38 & 39: Count of NF per 1,000 Members (01/2021-12/2021)
See metric summary for additional information

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

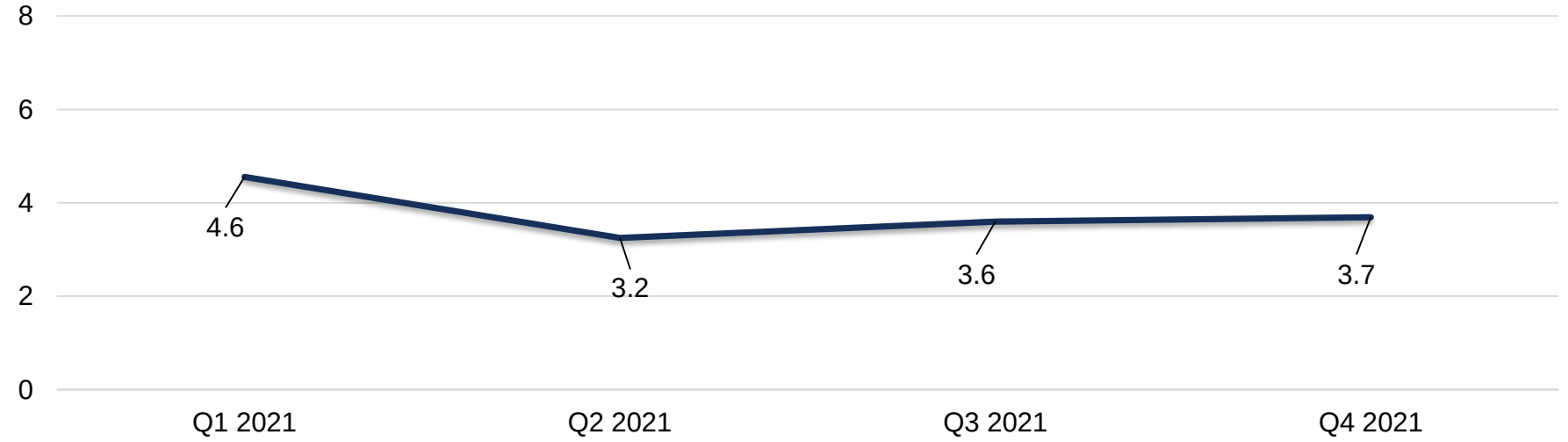
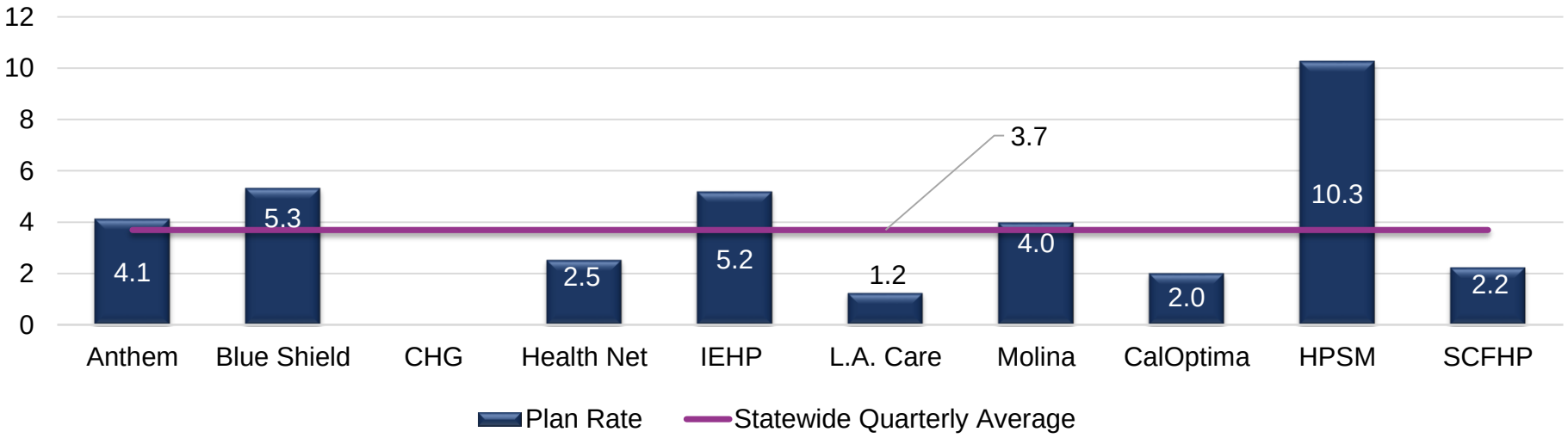


Fig. 39: Count of NF Member Referrals per 1,000 members for Quarter 4 of 2021



Long Term Services & Supports (LTSS) Figure 40 & 41: Count of NF per 1,000 Members (01/2021-12/2021) See metric summary for additional information

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

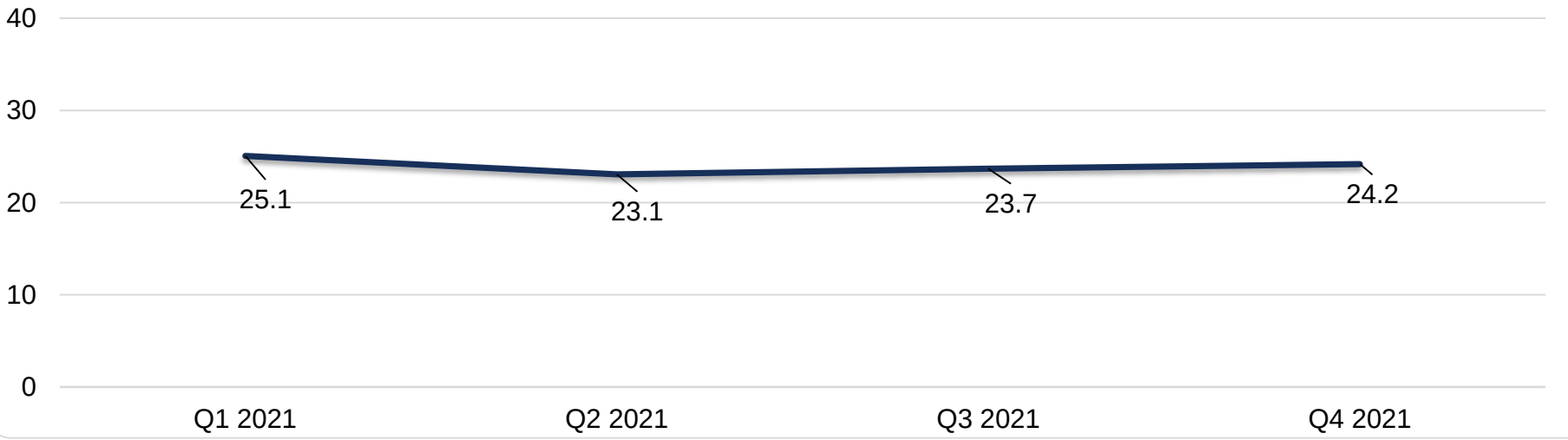
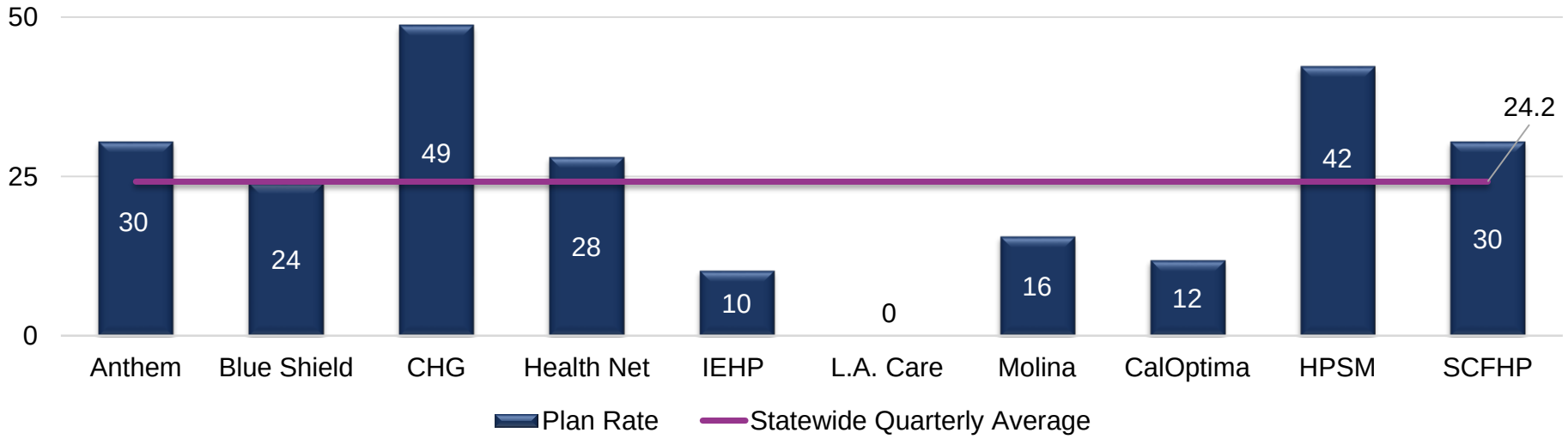


Fig. 41: Count of Members Receiving NF per 1,000 Members for Quarter 4 of 2021



Long Term Services & Supports (LTSS) Figure 42 & 43: Count of CPO per 1,000 Members (01/2021-12/2021)
See metric summary for additional information

Fig. 42: Quarterly Rolling Statewide Average of CPO Member Referrals per 1,000 Members

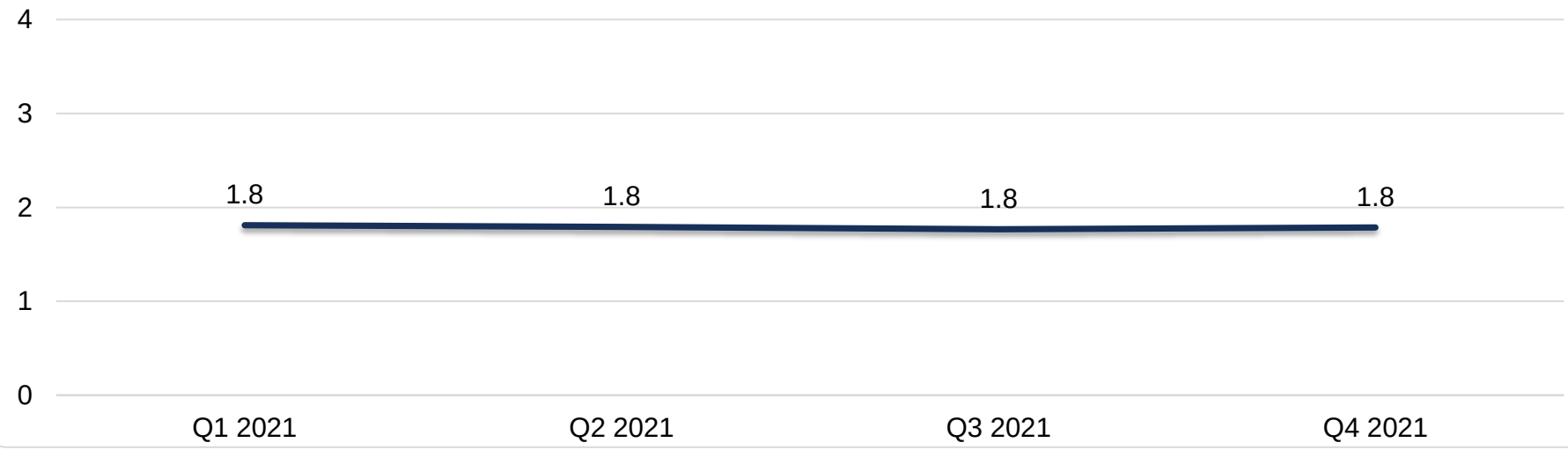
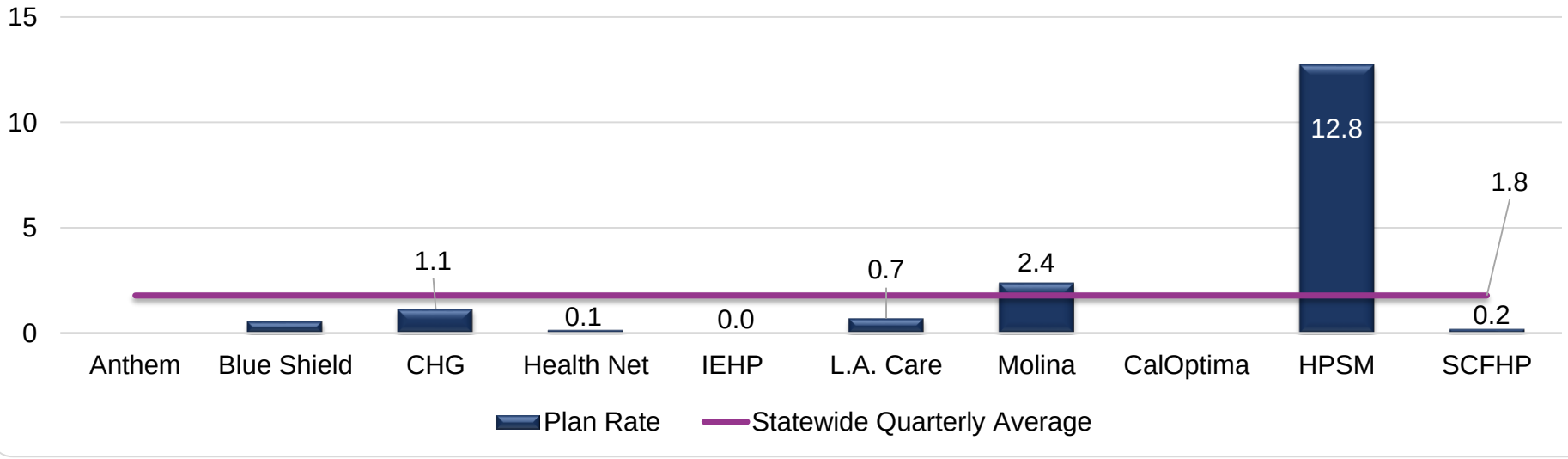


Fig. 43: Count of CPO Member Referrals per 1,000 members for Quarter 4 of 2021



Long Term Services & Supports (LTSS) Figure 44 & 45: Count of CPO per 1,000 Members (01/2021-12/2021)
See metric summary for additional information

Fig. 44: Quarterly Rolling Statewide Average of Members Receiving CPO per 1,000 Members

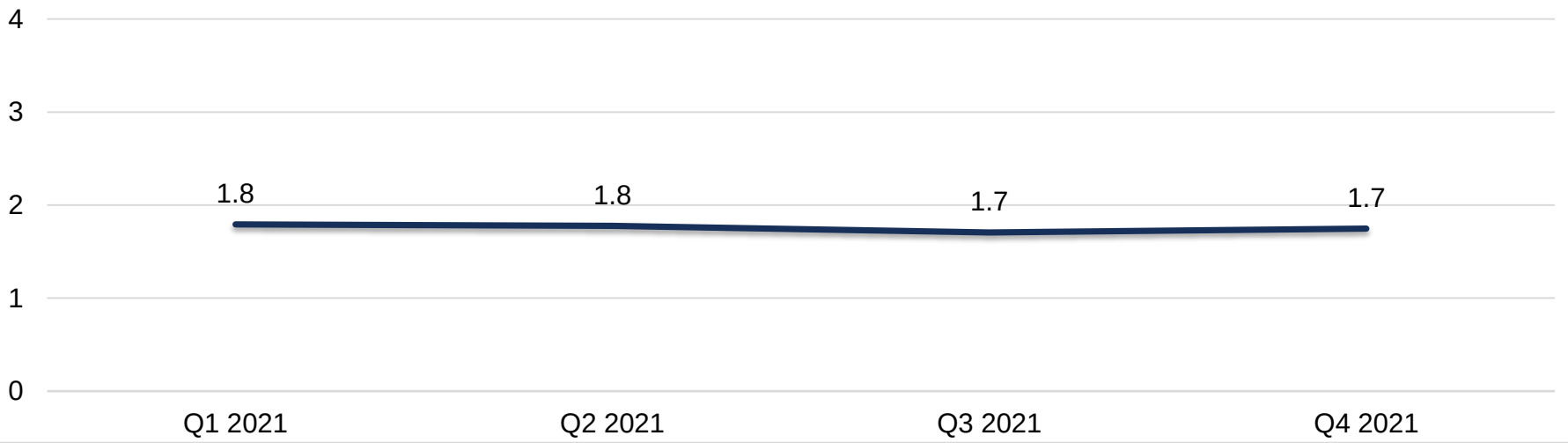


Fig. 45: Count of Members Receiving CPO per 1,000 Members for Quarter 4 of 2021