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# Integrated California Children's Services and Whole Child Model Dashboard

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## Introduction

The Integrated California Children's Services (CCS) and Whole Child Model (WCM) Dashboard contains data for January 2022 through December 2022. The data is broken down at the State, MCP and County levels for various services. The Dashboard is used to show the effectiveness of the WCM Program and to ensure that services are provided as in the CCS Program.

## Background

The CCS Program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-Eligible Conditions.

- The CCS Program is administered as a partnership between County Health Departments and the California Department of Health Care Services (DHCS).
- The intent of the CCS Program is to provide necessary medical services for children with CCS-Eligible Conditions whose parents or caregivers are unable to pay for these services, wholly or in part.
- The statute also requires DHCS and the County CCS program to seek eligible children by cooperating with local public or private agencies and providers of medical care to bring potentially eligible children to sources of expert diagnosis and treatment.

The WCM Program<sup>1</sup> is for children and youth under 21 years of age who meet the eligibility requirements of CCS and are enrolled in a Medi-Cal Managed Care Plan (MCP) under a County Organized Health System (COHS) or Regional Health Authority (RHA). From January 2022 to December 2024, WCM operated across 21 counties and collaborated with 5 participating MCPs, including Kaiser Permanente, which was added to the existing WCM counties as of January 1, 2024. Additional county and plan-specific information can be found here: [CCS Whole Child Model \(ca.gov\)](https://ca.gov/ccs-whole-child-model).

The goals of the WCM Program are to:

- Improve the coordination of primary and preventive services with specialty care services, medical therapy units, Early and Periodic Screening, Diagnostics, and Treatment benefits (EPSDT), long-term services and supports (LTSS), Regional Center services, and home-and community-based services using a child and youth and family-centered

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<sup>1</sup> Note: This dashboard only reflects data for the **Jan 2022 through Dec 2022** reporting period. WCM has since expanded to include Kaiser as of January 1, 2024, with expansion into additional counties starting January 1, 2025. Furthermore, the CCS/WCM policies and requirements mentioned are still under APL-21-005.

approach.

- Maintain or exceed CCS Program standards and specialty care access, including access to appropriate subspecialties.
- Provide for the continuity of child and youth access to expert, dedicated, CCS case management and care coordination, provider referrals, and service authorizations.
- Improve the transition of youth from CCS to adult Medi-Cal managed systems of care through better coordination of medical and nonmedical services and supports and improved access to appropriate adult providers for youth who age out of CCS.
- Identify, track, and evaluate the transition of children and youth from CCS to the WCM Program to inform future CCS Program improvements.

## Data and Analysis Notes

This Dashboard displays a combination of point-in-time, trend, and cumulative measures. WCM data is reported by MCP or Counties. CCS data refers to Counties operating outside WCM.

- **Point-in-time charts:** Figures 2 - 8, 46 and 47.  
Charts display data for the last month in the reporting period.
- **Trend charts:** Figures 1, 11, 12, 15, 16, 19, 22, 25, 28, 37, 38, 40, 41, 43 and 45.  
Charts display each month's or quarter's data for the reporting period of January 2022 through December 2022.
- **Cumulative charts:** Figures 9, 10, 13, 14, 17, 18, 20, 21, 23, 24, 26, 27, 29, 32 - 36, 39, 42, 44 and 48 - 50.  
Charts display the sum of the last 12 months' data (Jan 2022 to Dec 2022) in the reporting period as one figure.
- **Tables:** Figures 30 and 31.  
Tables display each month's data in the last 12 months (Jan 2022 to Dec 2022) of the reporting period.

## CCS and WCM Enrollment and Demographics: Figures 1-28

The data in this section comes from the DHCS Medi-Cal Management Information System/Decision Support system (MIS/DSS). The Enterprise Performance Monitoring (EPM) is utilized to extract and aggregate all WCM data for *Figures 1-28*. The Children's Medical Services Network (CMS Net) database is utilized to extract all CCS data for *Figures 1-7, 9-11, 13-15, 36 and 39*. *Figures 1-8* display enrollment and demographics and *Figures 9-28* display utilization data for CCS and WCM Programs. *Figures 1, 11, 12, 15, 16, 19, 22, 25 and 28* are trend charts displaying monthly data over the last 12 months. *Figures 2-8* show data for the last month in the reporting period as a point of time view of the CCS and WCM programs. *Figures 9, 10, 13, 14, 17, 18, 20, 21, 23, 24, 26 and 27* are cumulative charts, showing the sum of the 12 months' data as one figure.

## CCS and WCM Enrollment and Demographics: Figures 1-8

The data in this section examines the trend of enrollment over time as well as the breakdown of the CCS and WCM Member demographics. Evaluation of Medi-Cal members enrolled in CCS and in the MCPs participating in the WCM Program occurs monthly. Demographic data studies the structure of the CCS and WCM populations in terms of ethnicity, gender, primary languages, and age.

*Figure 1* displays the trend of total CCS and WCM enrollment over time. In January 2022, 145,572 members were enrolled in CCS. CCS enrollment increased 2% to 149,058 members by December 2022. In January 2022, 31,423 Members were enrolled in WCM. WCM enrollment increased 1% to 31,705 Members enrolled by December 2022.

*Figure 2* displays that 47% of CCS members identified themselves as Hispanic. This was calculated by using member reported ethnicity for the month of December 2022 as the numerator, divided by total enrollment for December 2022 as the denominator. *Figure 2* also displays that 58% of WCM Members identified themselves as Hispanic. This was calculated by using Member reported ethnicity for the month of December 2022 as the numerator, divided by total enrollment for December 2022 as the denominator.

*Figure 3* displays that the CCS members consist of 46.1% female and 53.9% male. This was calculated by using enrollment by gender in December 2022 as the numerator, divided by the total enrollment in December 2022 as the denominator. *Figure 3* also displays the WCM population consists of 53.1% male and 46.9% female. This was calculated by using enrollment by gender in December 2022 as the numerator, divided by the total enrollment in December 2022 as the denominator.

*Figure 4* displays enrollment by primary languages. In December 2022, 68.4% of CCS members spoke English and 27.1% spoke Spanish as their primary spoken language. This was calculated by using CCS enrollment for each language in December 2022 as the numerator, divided by the total CCS enrollment in December 2022 as the denominator. In December 2022, 62.0% of WCM Members spoke English and 35.6% spoke Spanish as their primary spoken language. This was calculated by using WCM Member enrollment for each language in December 2022 as the numerator, divided by the total WCM Member enrollment in December 2022 as the denominator.

*Figure 5* displays enrollment by age. In December 2022, 33% of CCS members were between the ages 12 and 17 and 16% of CCS members were between the ages of 18 and 20. This was calculated by using CCS enrollment for each age range for the month of December 2022 as the numerator, divided by total CCS enrollment for December 2022 as the denominator. In December 2022, 33% of WCM Members were between the ages 12 and 17, and 16% of WCM Members were between the ages of 18 and 20. This was calculated by using WCM Member enrollment for each age range for the month of December 2022 as the numerator, divided by total WCM Member enrollment for December 2022 as the denominator.

*Figures 6 and 7* display total CCS enrollment by County, in alphabetical order. The largest enrollment is Los Angeles County with 36,406



members. The smallest enrollment displayed is Mono County with 43 members. A letter “S” represents numbers have been suppressed for Counties that have low number of observations as they are seen as statistically unreliable.

*Figure 8* displays total WCM Member enrollment by County, in alphabetical order. Orange County had the most Member enrollments with 11,661 Members and Trinity County had the least with 53 Members.

### **CCS and WCM Outpatient Visits: Figures 9-12**

An outpatient visit is defined as a patient who visits a hospital, clinic, or associated facility for diagnosis or treatment. The data in this section is broken down by gender, ethnicity, and MCP.

*Figure 9* displays that for CCS, female members made 1,591 outpatient visits per 1,000 Members per month while males made 1,617 outpatient visits per 1,000 Members per month. This was calculated by using the number of CCS outpatient visits for each gender for January 2022 through December 2022 as the numerator, divided by the CCS enrollment for each gender for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000. *Figure 9* also displays that for WCM, female Members made 2,738 outpatient visits per 1,000 Members per month while males made 2,843 outpatient visits per 1,000 Members per month. This was calculated by using the number of WCM outpatient visits for each gender for January 2022 through December 2022 as the numerator, divided by the WCM Member enrollment for each gender for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000.

*Figure 10* displays CCS members that identified as African American made the most outpatient visits at 2,421 per 1,000 Members per month. This was calculated by using the number of CCS outpatient visits for each ethnicity for January 2022 through December 2022 as the numerator, divided by the CCS enrollment for each ethnicity for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000. *Figure 10* also displays WCM Members that identified as Asian/Pacific Islander made the most outpatient visits at 3,213 per 1,000 Members per month. This was calculated by using the number of WCM outpatient visits for each ethnicity for January 2022 through December 2022 as the numerator, divided by the WCM Member enrollment for each ethnicity for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000.

*Figure 11* displays the trend in the number of statewide CCS and WCM Member outpatient visits from January 2022 through December 2022. This was calculated by using the number of outpatient visits for each program per month for January 2022 through December 2022 as the numerator, divided by the enrollment for each program per month for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000. From January 2022 to December 2022, the CCS Program had an average of 42% fewer outpatient visits per 1,000, with a 9% decrease in utilization for CCS and a 7% decrease in utilization for WCM both the CCS and WCM Programs over the year.

*Figure 12* displays the trend in the number of WCM Member outpatient visits for each participating MCP from January 2022 through December 2022. This was calculated by using the number of outpatient visits for each MCP per month for January 2022 through December 2022 as the numerator, divided by the enrollment for each MCP per month for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000. Outpatient visits decreased by 4% for CalOptima, 9% for CenCal, 4% for CCAH, 11% for HPSM, and 12% for PHC. CalOptima had the most outpatient visits and CCAH had the fewest.

### **CCS and WCM Inpatient Admissions: Figures 13-16**

An inpatient admission is defined as a hospital patient who receives lodging and food as well as treatment. The data in this section is broken down by gender, ethnicity, and MCP.

*Figure 13* displays that for CCS, male members had 27 inpatient admissions per 1,000 Members per month and female members had 26 inpatient admissions per 1,000 Members per month. This was calculated by using the number of CCS inpatient visits for each gender for January 2022 through December 2022 as the numerator, divided by the CCS enrollment for each gender for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000. *Figure 13* also displays that for WCM, male Members had 25 inpatient admissions per 1,000 Members per month and female Members had 26 inpatient admissions per 1,000 Members per month. This was calculated by using the number of WCM Member inpatient visits for each gender for January 2022 through December 2022 as the numerator, divided by the WCM Member enrollment for each gender for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000.

*Figure 14* displays that in the CCS program, African American members had the most inpatient admissions at 48 per 1,000 Members per month. This was calculated by using the number of CCS inpatient visits for each ethnicity for January 2022 through December 2022 as the numerator, divided by the CCS member enrollment for each ethnicity for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000. In the WCM program, African American Members had the most inpatient admissions at 41 per 1,000 Members per month. This was calculated by using the number of WCM inpatient visits for each ethnicity for January 2022 through December 2022 as the numerator, divided by the WCM Member enrollment for each ethnicity for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000.

*Figure 15* displays the trend in the number of statewide CCS and WCM Member inpatient admissions from January 2022 through December 2022. This was calculated by using the number of inpatient admissions for each program per month for January 2022 through December 2022 as the numerator, divided by the enrollment for each program per month for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000. From January 2022 to December 2022, WCM MCPs averaged 4% fewer inpatient admissions per 1,000, with steady utilization for both programs over the year.

*Figure 16* displays the trend in the number of WCM Member inpatient admissions for each participating MCP from January 2022 through December 2022. This was calculated by using the number of inpatient admissions for each MCP per month for January 2022 through December 2022 as the numerator, divided by the enrollment for each MCP per month for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000. Between January 2022 and December 2022, Inpatient admissions remained steady for CalOptima, increased 19% for CenCal, increased 12% for CCAH, decreased 23% for HPSM, and decreased 6% for PHC.

### **WCM Emergency Department (ED) Visits: Figures 17-19**

This data is not reported by CCS County Programs at this time. The data below is reported for WCM. An ED visit is defined as a health care encounter where a patient presents at a hospital's emergency department, responsible for the administration and provision of immediate medical care to the patient. The data in this section is broken down by gender, ethnicity, and MCP.

*Figure 17* displays male Members made 75 ED visits per 1,000 Members per month and female Members made 75 ED visits per 1,000 Members per month. This was calculated by using the number of ED visits for each gender for January 2022 through December 2022 as the numerator, divided by the enrollment for each gender for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000.

*Figure 18* displays that African-American Members made the most ED visits at 112 per 1,000 Members per month. This was calculated by using the number of ED visits for each ethnicity for January 2022 through December 2022 as the numerator, divided by the enrollment for each ethnicity for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000.

*Figure 19* displays the trend in the number of ED visits for each participating MCP from January 2022 through December 2022. This was calculated by using the number of ED visits for each MCP per month for January 2022 through December 2022 as the numerator, divided by the enrollment for each MCP per month for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000. ED utilization increased 3% for CalOptima, 17% for CenCal, 37% for CCAH, 31% for HPSM, and 20% for PHC.

### **WCM Prescriptions Medications: Figures 20-22**

This data is not reported by CCS County Programs at this time. The data below is reported for WCM. Prescription medications is defined as medicines ordered by physicians for the treatment of patients. The data in this section is broken down by gender, ethnicity,

and MCP.

*Figure 20* displays that female Members had utilized 1,267 prescription medications per 1,000 Members per month while males had utilized 1,250 prescription medications per 1,000 Member per month. This was calculated by using the number of prescriptions for each gender for January 2022 through December 2022 as the numerator, divided by the enrollment for each gender for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000.

*Figure 21* displays that African-American Members utilized the most prescription medications at 1,534 per 1,000 Members per month. This was calculated by using the number of prescriptions for each ethnicity for January 2022 through December 2022 as the numerator, divided by the enrollment for each ethnicity for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000.

*Figure 22* displays the trend in the number of prescription medications for each participating MCP from January 2022 through December 2022. This was calculated by using the number of prescriptions reported by each MCP per month for January 2022 through December 2022 as the numerator, divided by the enrollment for each MCP per month for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000. Prescriptions increased 5% for CalOptima, 5% for CenCal, 12% for CCAH, 4% for HPSM, and 2% for PHC.

### **WCM Non-Specialty Mental Health (NSMH): Figures 23-25**

This data is not reported by CCS County Programs at this time. The data below is reported for WCM. NSMH is defined as services for the treatment of members' mental health that are covered by the plans' contracts, including, but not limited to, individual and group mental health evaluation and treatment; psychological testing; medication management; outpatient laboratory; medications; supplies and supplements. The data in this section is broken down by gender, ethnicity, and MCP.

*Figure 23* displays that female Members made 60 NSMH visits per 1,000 Members per month while males made 36 NSMH visits per 1,000 Members per month. This was calculated by using the number of NSMH visits for each gender for January 2022 through December 2022 as the numerator, divided by the enrollment for each gender for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000.

*Figure 24* displays that Non-Hispanic/White Members made the most NSMH visits at 85 per 1,000 Members per month. This was calculated by using the number of NSMH visits for each ethnicity for January 2022 through December 2022 as the numerator, divided by the enrollment for each ethnicity for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000.

*Figure 25* displays the trend in the number of NSMH visits for each participating MCP from January 2022 through December 2022. This was calculated by using the number of NSMH visits for each MCP per month for January 2022 through December 2022 as the numerator, divided by the enrollment for each MCP per month for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000. Between January 2022 and December 2022, NSMH visits increased 3% for CalOptima and 84% for CenCal. NSMH visits decreased 8% for CCAH, 18% for HPSM, and 10% for PHC.

### **WCM Emergency Department (ED) Visits with an Inpatient Admission: Figures 26-28**

This data is not reported by CCS County Programs at this time. The data below is reported for WCM. This data focuses on those patients who visited the ED and then were admitted to the hospital for treatment and care. The data in this section is broken down by gender, ethnicity, and MCP.

*Figure 26* displays male Members made 11 ED visits with an inpatient admission per 1,000 Members per month and female Members made 10 ED visits with an inpatient admission per 1,000 Members per month. This was calculated by using the number of ED visits with an inpatient admission for each gender for January 2022 through December 2022 as the numerator, divided by the enrollment for each gender for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000.

*Figure 27* displays that African American Members made the most ED visits with an inpatient admission at 19 per 1,000 Members per month. This was calculated by using the number of ED visits with an inpatient admission for each ethnicity for January 2022 through December 2022 as the numerator, divided by the enrollment for each ethnicity for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000.

*Figure 28* displays the trend in the number of ED visits with an inpatient admission for each participating MCP from January 2022 through December 2022. This was calculated by using the number of ED visits with an inpatient admission for each MCP per month for January 2022 through December 2022 as the numerator, divided by the denominator is enrollment for each MCP per month for January 2022 through December 2022 as the denominator. The dividend was then multiplied by 1,000. A letter "S" represents numbers have been suppressed for MCPs that have a low number of observations as they are seen as statistically unreliable. Considering suppressed numbers, ED visits with an inpatient admission decreased 1% for CalOptima, 3% for HPSM, and 1% for PHC and increased 70% for CenCal and 38% for CCAH.

### **WCM Continuity of Care (CoC): Figures 29-35**

This data is not reported by CCS County Programs at this time. The data below is reported for WCM. MCPs must establish and maintain a

process to allow Members to request and receive CoC with existing CCS provider(s) for up to 12 months. All existing rules and regulations apply with the following additions that are specific to WCM: specialized or customized durable medical equipment (DME), CoC case management, authorized prescription drugs, and extension of CoC period. CoC data is submitted by MCPs. *Figures 30-31* are tables displaying monthly data for 12 months. *Figures 29* and *32-35* are cumulative charts, showing the sum of the 12 months' data as one figure.

*Figure 29* displays requests for CoC per 1,000 Members ranged from less than 11 for CalOptima, CCAH, and PHC to 75 for CenCal. This was calculated by using the number of CoC requests for each MCP for January 2022 through December 2022 as the numerator, divided by the enrollment for each MCP in December 2022 as the denominator. The dividend was then multiplied by 1,000. *Figure 29* also displays percentage of CoC requests approved, by MCP and by County. The approval percentage ranged from 93% for CenCal to 97% for HPSM. This was calculated by using the number of approved CoC requests for each MCP and each County for January 2022 through December 2022 as the numerator, divided by the total number of CoC requests for each MCP and each County for January 2022 through December 2022 as the denominator.

*Figure 30* displays a total number of CoC requests for each MCP for the months 43 through 54 after joining the WCM program.. In the 43<sup>rd</sup> month of operation, CalOptima, CCAH, and HPSM reported fewer than 11 CoC requests, PHC reported 0 CoC requests, and CenCal reported 33 CoC requests. In the 54<sup>th</sup> month of operation, HPSM and PHC reported fewer than 11 CoC requests, CalOptima and CCAH reported 0 CoC requests, and CenCal reported 32 CoC requests. A letter "S" represents numbers have been suppressed for MCPs that have low number of observations as they are seen as statistically unreliable.

*Figure 31* displays Months 55 through 66 upon joining the program for CoC requests. In the 55<sup>th</sup> month of operation, CalOptima, HPSM, and PHC reported fewer than 11 CoC requests, CenCal reported 35 CoC requests, and CCAH reported 0 CoC requests. Figures were not available for the 66<sup>th</sup> month of operation.

*Figure 32* displays the average number of CoC requests for each MCP for months 43 through 54 compared to months 55 through 66. CenCal had an average of 25 requests for months 43 through 54. The remaining MCPs reported an average of fewer than 11 CoC requests for months 43 through 54 and 55 through 65 CoC data is not presently available for month 66. A letter "S" represents numbers that have been suppressed for MCPs that have low number of observations as they are seen as statistically unreliable.

*Figure 33* displays major categories for the CoC requests. Prescription drugs were requested fewer than 11 times, or 2.2% of the time, while 116, or 35.7%, of requests were made for major specialty types. This was calculated by using the number of CoC requests for each category for January 2022 through December 2022 as the numerator, divided by the total number of CoC requests for January 2022 through December 2022 as the denominator. A letter "S" represents numbers that have been suppressed for MCPs that have low number of observations as they are seen as statistically unreliable.

*Figure 34* displays reasons for CoC denials not required by APL 21-005. Criteria Not Met accounted for fewer than 11, or 21% of CoC denial reasons while Insufficient Documentation accounted for fewer than 11, or 14%. This was calculated by using the number of CoC denials for each reason for January 2022 through December 2022 as the numerator, divided by the total number of CoC denials for January 2022 through December 2022 as the denominator. A letter "S" represents numbers that have been suppressed for MCPs that have low number of observations as they are seen as statistically unreliable.

*Figure 35* displays reasons for CoC denials required by APL 21-005. No pre-existing relationship between WCM Member and Provider accounted for fewer than 11, or 21% of CoC denial reasons while fewer than 11, or 43% were due to quality-of-care issues. This was calculated by using the number of CoC denials for each reason for January 2022 through December 2022 as the numerator, divided by the total number of CoC denials for January 2022 through December 2022 as the denominator. A letter "S" represents numbers that have been suppressed for MCPs that have low number of observations as they are seen as statistically unreliable.

Please note that for *Figure 34*, only the top five denial reasons are displayed. *Figure 35* displays all denial categories as required by APL 21-005 besides "Others". Neither *Figure 34* nor *Figure 35* adds up to 100%.

## **CCS and WCM Case Management: Figures 36-45**

MCPs must provide case management and care coordination for CCS-eligible Members and their families. MCPs must ensure that information, education, and support is continuously provided to CCS-eligible Members and their families to assist in their understanding of the CCS-eligible Member's health, other available services, and overall collaboration on the CCS-eligible Member's Individual Care Plan (ICP). This dashboard focuses on Neonatal Intensive Care Unit (NICU), Pediatric Intensive Care Unit (PICU), Inpatient Facilities and Special Care Center (SCC), and Specialized or Customized DME authorization requests. Case management data is submitted by MCPs. *Figures 37 and 40* are trend charts displaying monthly data over the 12 months. *Figures 38, 41, 43 and 45* are trend charts displaying quarterly data over 12 months. *Figures 36, 39, 42, and 44* are cumulative charts, showing the sum of the 12 months' data as one figure.

## **CCS and WCM NICU Authorizations: Figures 36-38**

*Figure 36* displays total requests for NICU authorizations and percent approval rate by MCP and by County.

Total MCP enrollment and percent distribution of program enrollment in each plan is displayed on the far-left column for reference. The approval percentage ranged from 99% for CalOptima to 100% for CenCal, CCAH, and PHC. This was calculated by using the number of approved NICU authorizations for each MCP and each County for January 2022 through December 2022 the numerator, divided by the number of NICU requests for authorizations for each MCP and each County for January 2022 through December 2022



as the denominator. A letter “S” represents numbers have been suppressed for MCPs or Counties that have low number of observations as they are seen as statistically unreliable.

*Figure 37* displays the total NICU authorization requests per 1,000 Members, by month. The figure displays that there were 5.0 CCS NICU authorization requests per 1,000 Members for January 2022. There were 4.4 CCS NICU authorization requests per 1,000 Members for December 2022. The figure also displays that there were 3.0 WCM NICU authorization requests per 1,000 Members for January 2022. There were 3.4 WCM NICU authorization requests per 1,000 Members for December 2022.

*Figure 38* displays the trend of total requests seeking authorization for NICU services for each MCP each quarter. For example, CCAH reported 70 requests in Q1 2022, 81 requests in Q2 2022 62 requests in Q3 2022, and 60 requests in Q4 2022. HPSM reported fewer than 11 requests for all four quarters. A letter “S” represents numbers have been suppressed for MCPs that have low number of observations as they are seen as statistically unreliable.

### **CCS and WCM PICU Authorizations: Figures 39-41**

*Figure 39* displays total requests for PICU authorizations and approval rate, by MCP and by County. The figure displays total requests for PICU authorizations ranged from 41 for HPSM to 666 for CCAH. Total MCP enrollment and percent distribution of program enrollment in each MCP is displayed on the far-left column for reference. The approval percentage for PICU requests ranged from 99% for PHC and CalOptima to 100% for CenCal, CCAH, and HPSM. This was calculated by using the number of approved PICU requests for authorizations for each MCP and each County for January 2022 through December 2022 as the numerator, divided by the number of PICU authorizations for each MCP and each County for January 2022 through December 2022 as the denominator. A letter “S” represents numbers have been suppressed for Counties that have low number of observations as they are seen as statistically unreliable.

*Figure 40* displays total PICU authorization requests per 1,000 Members, by month. The figure displays there were 1.8 CCS PICU authorization requests per 1,000 Members in January 2022 and 2.3 CCS PICU authorization requests per 1,000 Members in December 2022. The figure also displays that there were 4.6 WCM PICU authorization requests per 1,000 Members in January 2022 and 3.9 WCM PICU authorization requests per 1,000 Members for December 2022.

*Figure 41* displays the trend of total requests seeking authorization for PICU services for each MCP each quarter. For example, CalOptima reported 115 requests in Q1 2022, 128 requests in Q2 2022, 140 requests in Q3 2022, and 79 requests in Q4 2022.

### **WCM Inpatient Facilities and SCC Authorizations: Figures 42-43**

This data is not reported by CCS counties at this time. The data below is reported for WCM.

*Figure 42* displays total requests for SCC authorizations and approval rate, by MCP and by County. The figure displays that Inpatient Facilities and SCC authorization requests ranged from 441 for CenCal to 4,078 for CalOptima. Total MCP enrollment and percent distribution of program enrollment in each MCP is displayed on the far-left column for reference. The approval percentage for Inpatient Facilities and SCC Authorizations ranged from 96% for PHC to 100% for CenCal and CCAH. This was calculated by using the number of approved Inpatient Facilities and SCC authorizations for each MCP and each County for January 2022 through December 2022 as the numerator, divided by the number of Inpatient Facilities and SCC requests for authorizations for each MCP and each County for January 2022 through December 2022 as the denominator.

*Figure 43* displays the total requests seeking authorization for SCC services for each MCP each quarter. For example, CenCal reported 117 requests in Q1 2022, 120 requests in Q2 2022, 98 requests in Q3 2022, and 106 requests in Q4 2022.

### **WCM Specialized or Customized DME Authorizations: Figures 44-45**

This data is not reported by CCS County Programs at this time. The data below is reported for WCM.

*Figure 44* displays total requests for DME authorizations and approval rate, by MCP and by County. The figure displays that specialized or customized DME requests for authorizations ranged from 94 for CenCal to 1,104 for PHC. Total MCP enrollment and percent distribution of program enrollment in each MCP is displayed on the far-left column for reference. The approval percentage ranged from 95% for PHC to 100% for CenCal and CCAH. This was calculated by using the number of approved specialized or customized DME authorizations for each MCP and each County for January 2022 through December 2022 as the numerator, divided by the number of specialized or customized DME requests for authorizations for each MCP and each County for January 2022 through December 2022 as the denominator.

*Figure 45* displays the total requests seeking authorization for DME services for each MCP each quarter. For example, PHC reported 235 requests in Q1 2022 415 requests in Q2 2022, 264 requests in Q3 2022, and 190 requests in Q4 2022. A letter “S” represents numbers have been suppressed for MCPs that have low number of observations as they are seen as statistically unreliable.

### **WCM Care Coordination: Figures 46-47**

This data is not reported by CCS County Programs at this time. The data below is reported for WCM. MCPs must assess each CCS child’s or youth’s risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data, or by other means. MCPs are required to develop and complete the risk assessment process for WCM transition Members, newly CCS-eligible Members, or new CCS Members enrolling in the MCP. The risk assessment

process must include the development of a pediatric risk stratification process (PRSP) that will be used to classify Members into high and low risk categories, allowing the plan to identify Members who have more complex health care needs. Members who do not have any information available will automatically be categorized as high risk until further assessment data is gathered to make an additional risk determination. An ICP must be created for high-risk Members. Care coordination data is submitted by MCPs and the dashboard charts show the last month in the reporting period as a point of time view.

*Figure 46* displays the percentage of high-risk Members who received an assessment ranged from 3% to 540%, which is fewer than 11 assessments for CalOptima and 27 assessments for HPSM<sup>2</sup>, respectively. This was calculated by using the number of high-risk assessments for each MCP as of December 2022 as the numerator, divided by the number of high-risk members in each MCP in December 2022 as the denominator. Each denominator is different because each MCP has a different number of high-risk Members.

*Figure 47* displays the percentage of low-risk Members who received an assessment ranged from 17% to 100%, which is 23 assessments for CalOptima and 33 assessments for CenCal, respectively. This was calculated by using the number of low-risk assessments for each MCP as of December 2022 as the numerator, divided by the number of low-risk Members in each MCP in December 2022 as the denominator. Each denominator is different because each MCP has a different number of low-risk Members.

## **WCM Grievances and Appeals: Figure 48-50**

This data is not reported by CCS County Programs at this time. The data below is reported for WCM. CCS-eligible Members enrolled in MCPs are provided the same grievance and appeal rights as other MCP Members. MCPs must have timely processes for accepting and acting upon Member grievances and appeals. Grievances and appeals data are submitted by MCPs.

*Figure 48* displays WCM appeals and grievances per 1,000 Members are trended over 12 months (January 2022 - December 2022).

*Figure 48* is a trend chart displaying monthly data over 12 months. *Figures 49* and *50* are cumulative charts, showing the sum of the 12 months' data as one figure. In January 2022, MCPs reported to have received 0.35 appeals per 1,000 Members and 1.24 grievances per 1,000 Members. In December 2022, MCPs received 0.35 appeals per 1,000 Members and 0.82 grievances per 1,000 Members.

*Figure 49* displays WCM appeals per 1,000 Members per month. HPSM reported to have received 1 appeal per 1,000 Members per month while PHC reported 8 appeals per 1,000 Members per month.

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<sup>2</sup> Data displayed in this section may show some discrepancies due to MCPs reporting the information differently on the reporting template. Per WCM Reporting Instructions, Care Coordination data is reported "to date" by the MCPs, however some MCPs provided "all time" data. Please note, per APL 21-005, risk assessments are conducted on an annual basis for all WCM eligible Members to ensure their risk classification remains an accurate reflection of their true risk level.

Figure 50 displays percent distribution of major categories of total grievances reported by MCPs. Total grievances for each MCP are displayed on the far-right end of the bar.<sup>2</sup> This was calculated by using the number of each grievance type for each MCP for January 2022 through December 2022 as the numerator, divided by the total number of grievances for each MCP from January 2022 through December 2022 as the denominator.

WCM Family Advisory Committee Meetings: Figure 51

This data is not reported by CCS County Programs at this time. The data below is reported for WCM. MCPs must establish a quarterly Family Advisory Committee (FAC) for WCM families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local Providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers.

Figure 51 summarizes the number of committee members, meetings held, recruitment efforts and seats to be filled for each MCP over 12 months (January 2022 - December 2022).

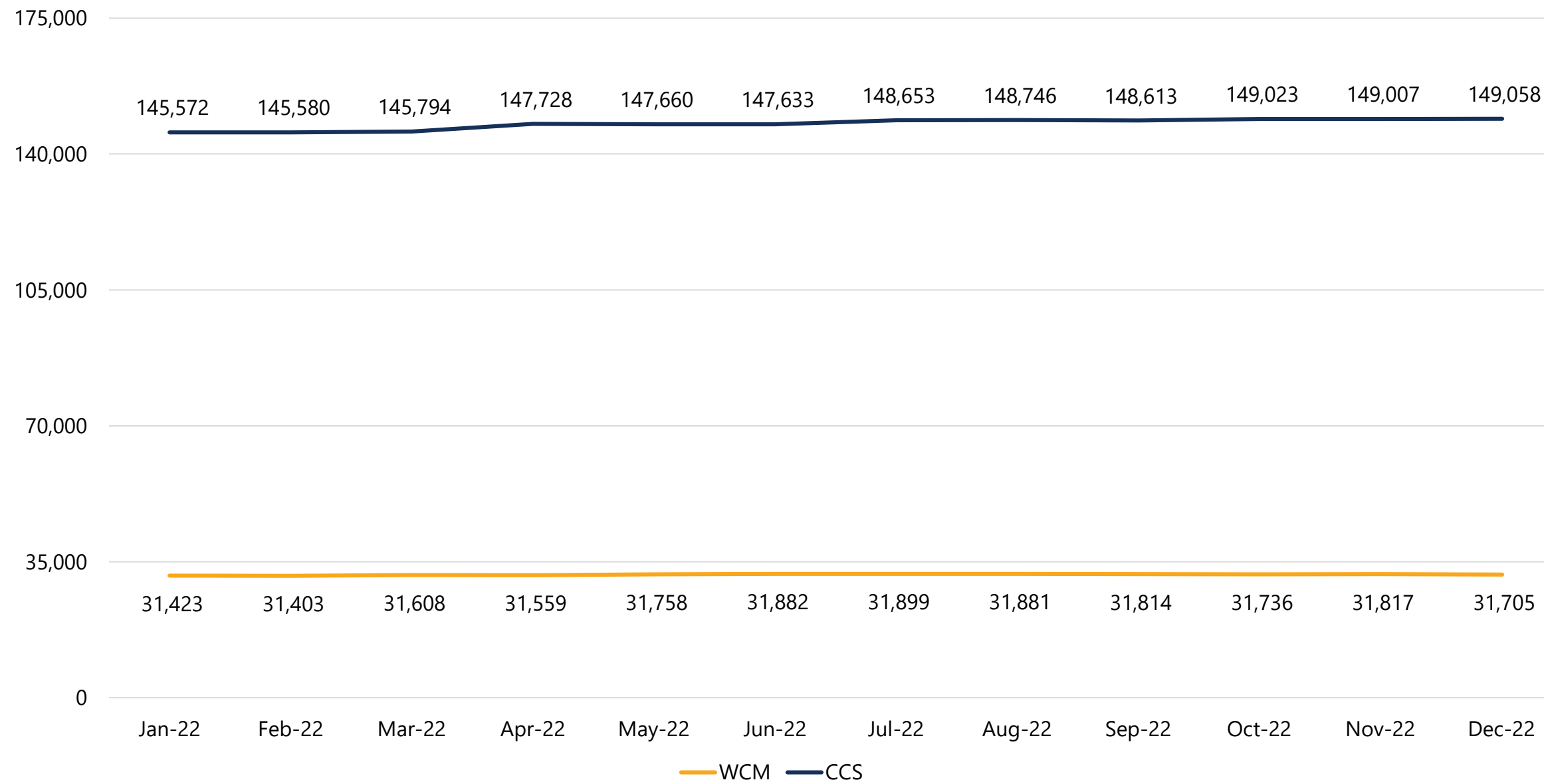
Plan Key:

| Plan Name                              | Plan Abbreviation on Dashboard | WCM Implementation Date |
|--|--------------------------------|-------------------------|
| CalOptima                              | CalOptima                      | July 1, 2019            |
| CenCal Health                          | CenCal                         | July 1, 2018            |
| Central California Alliance for Health | CCAH                           | July 1, 2018            |
| Health Plan of San Mateo               | HPSM                           | July 1, 2018            |
| Partnership Health Plan of California  | PHC                            | January 1, 2019         |

<sup>2</sup> Plans must give details on the "Others" grievance category. "Others" grievances included but were not limited to billing issues, staff dissatisfaction, other insurance/inadequate insurance coverage.

**CCS and WCM Enrollment and Demographics Figure 1: Breakdown of Enrollment (Jan'22 - Dec'22)**

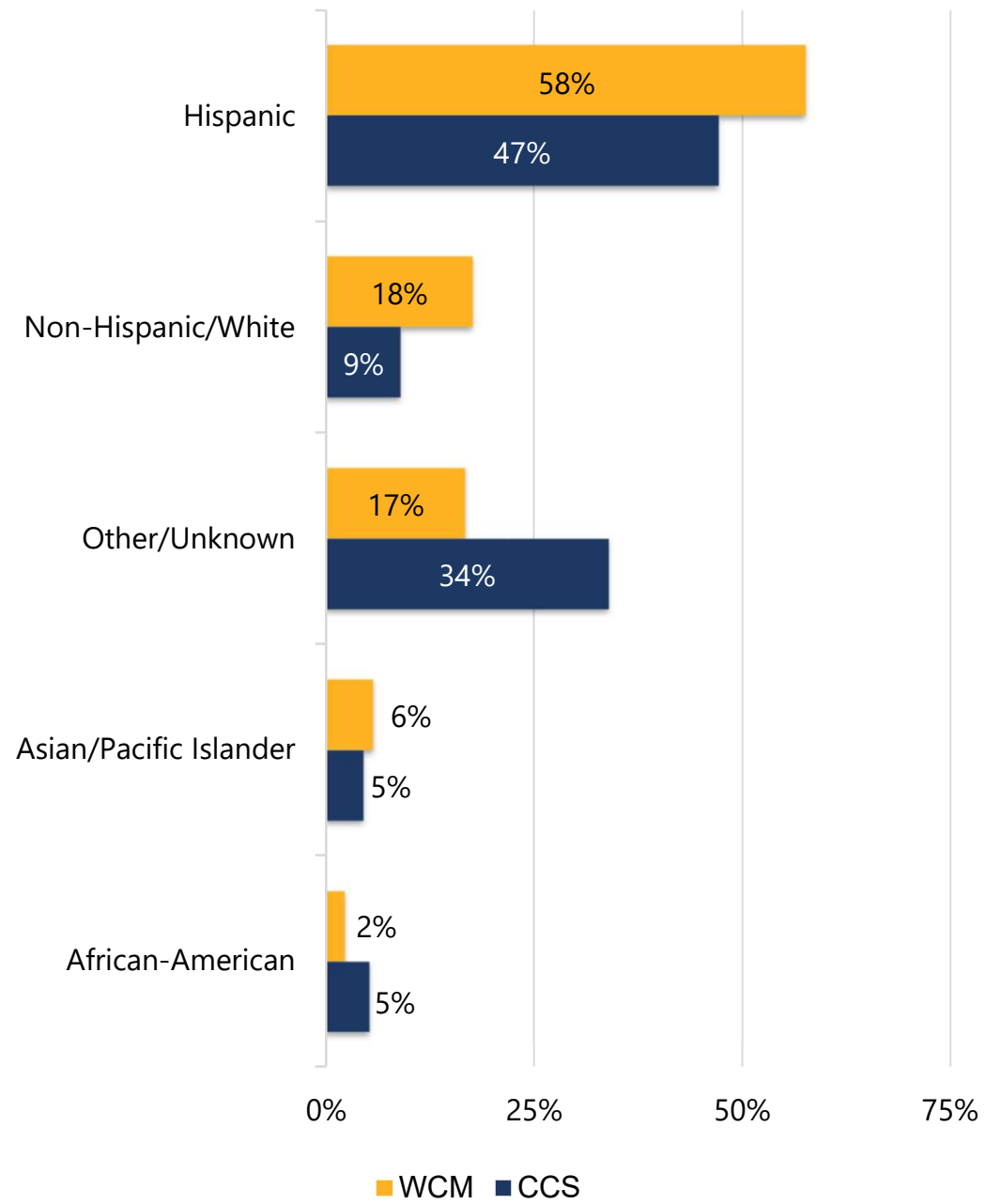
**Fig 1: Monthly Statewide Enrollment**



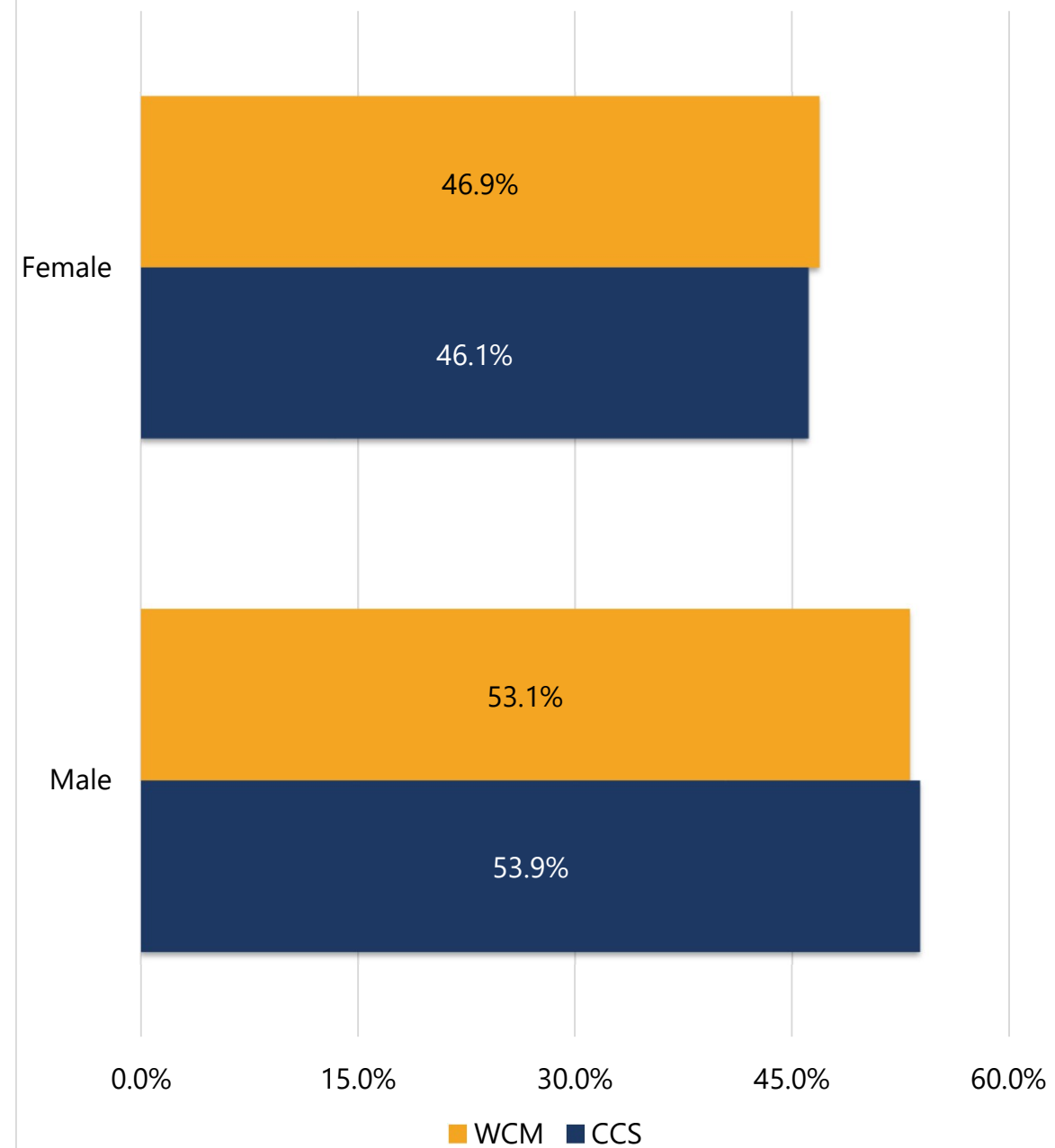
*Note: This report contains data from January 2022 to December 2022. CenCal, CCAH, and HPSM began offering WCM services in July 2018.*

**CCS and WCM Enrollment and Demographics Figures 2 & 3: Breakdowns of Population as of December 2022**

**Fig 2: Enrollment by Race/Ethnicity**



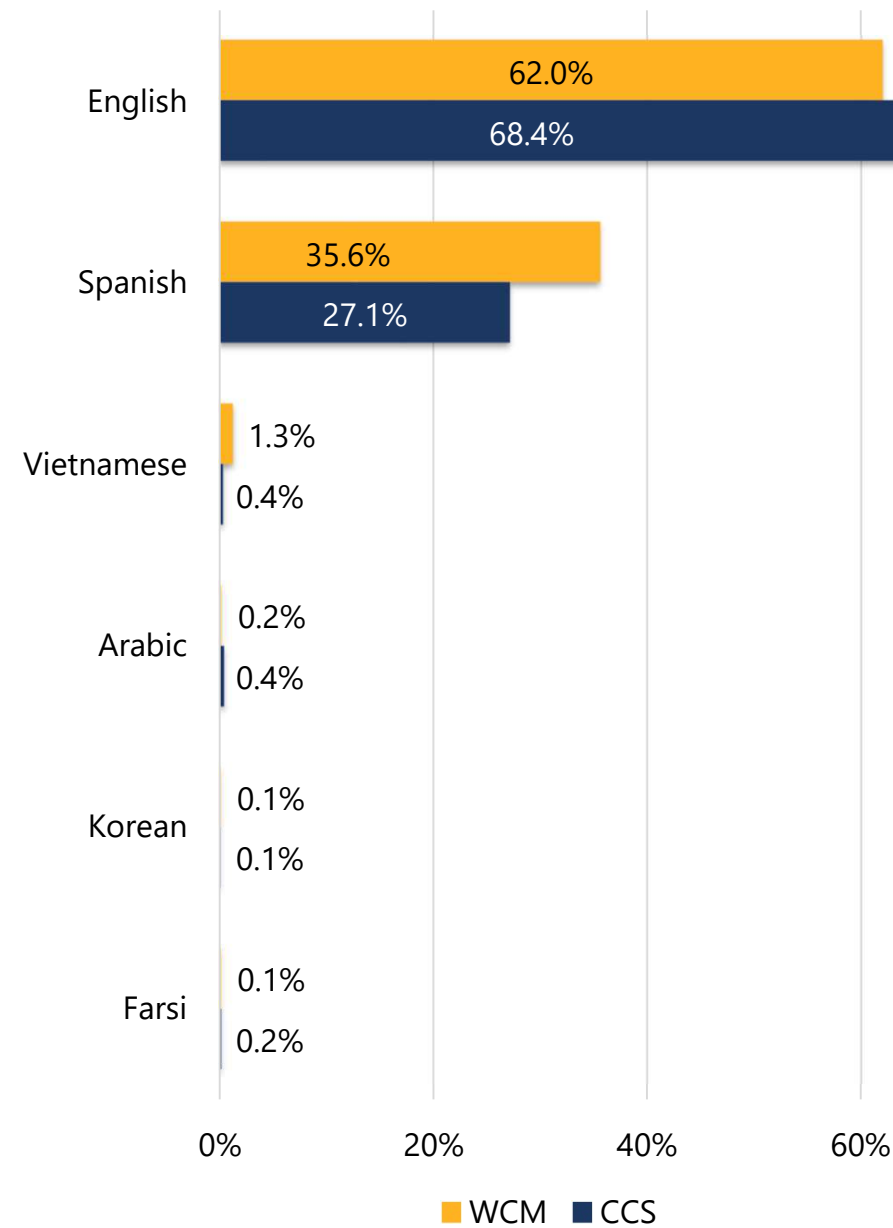
**Fig 3: Enrollment by Gender**



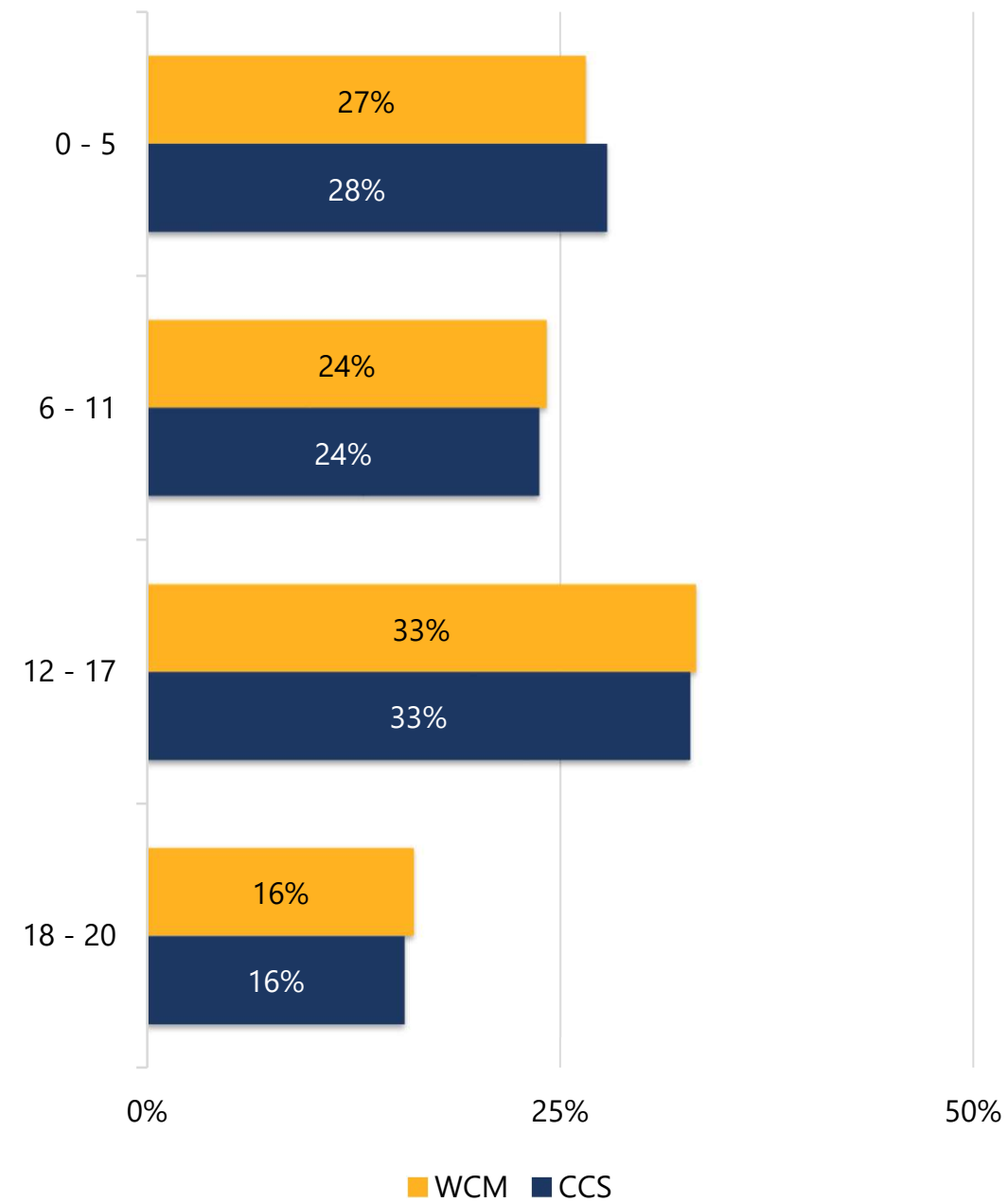
*Note: CCS refers to counties operating outside of the Whole Child Model Program*

**CCS and WCM Enrollment and Demographics Figures 4 & 5: Breakdowns of Population as of December 2022**

**Fig 4: Enrollment by Language Spoken (Top 6 for WCM)**



**Fig 5: Enrollment by Age**

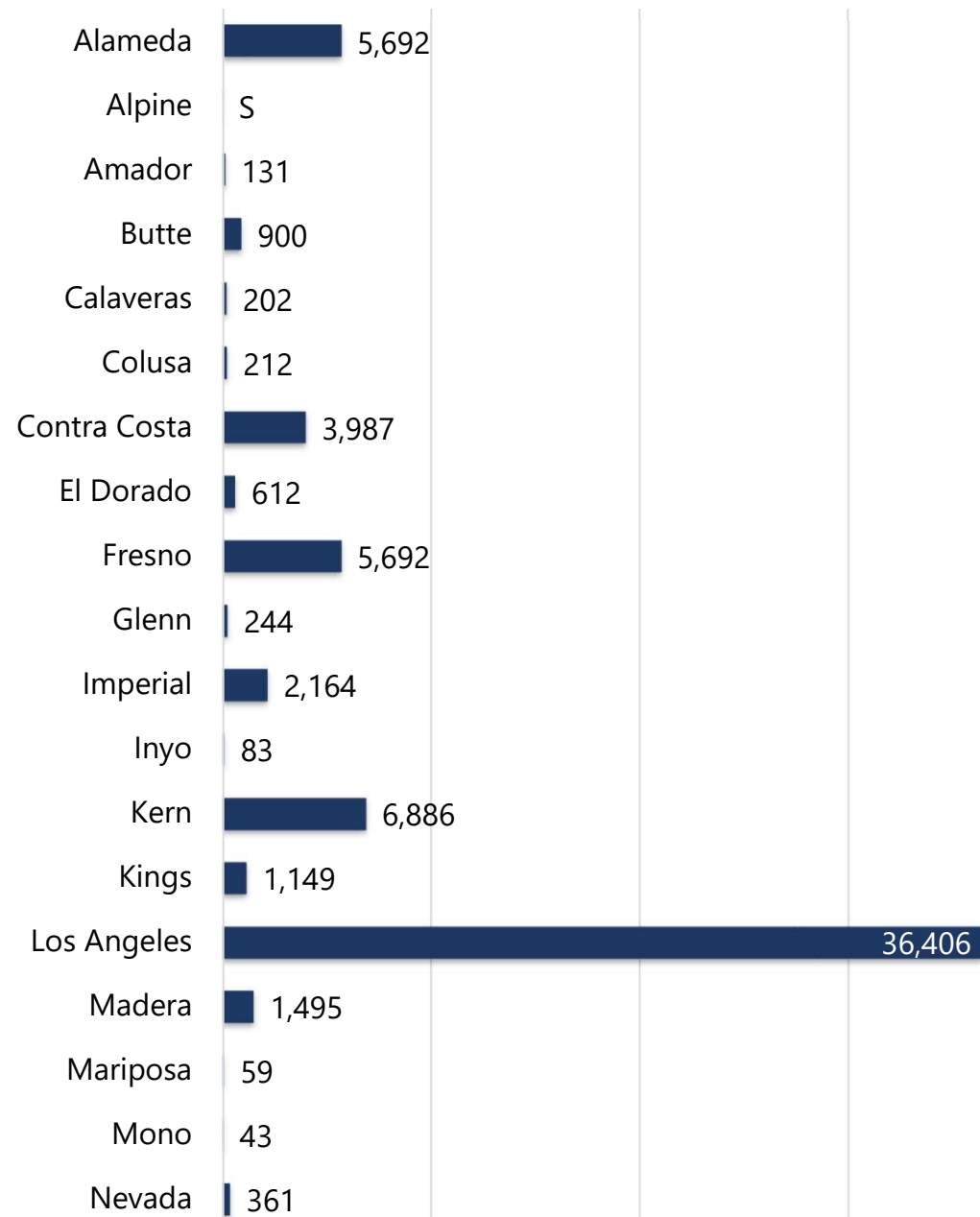


*Note: CCS refers to counties operating outside of the Whole Child Model Program*

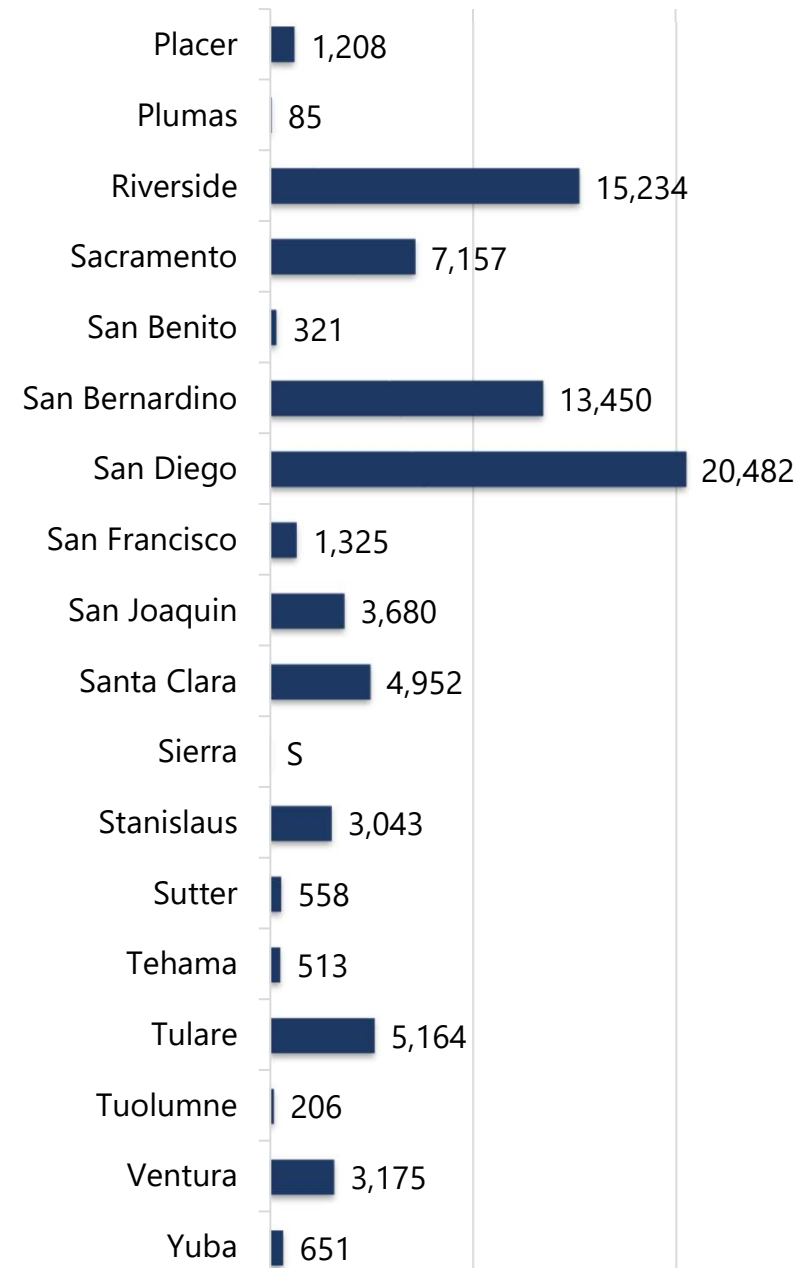


**CCS Enrollment and Demographics Figures 6 & 7: Breakdowns of Population as of December 2022**

**Fig 6: Total Classic CCS Enrollment by County**



**Fig 7: Total Classic CCS Enrollment by County**

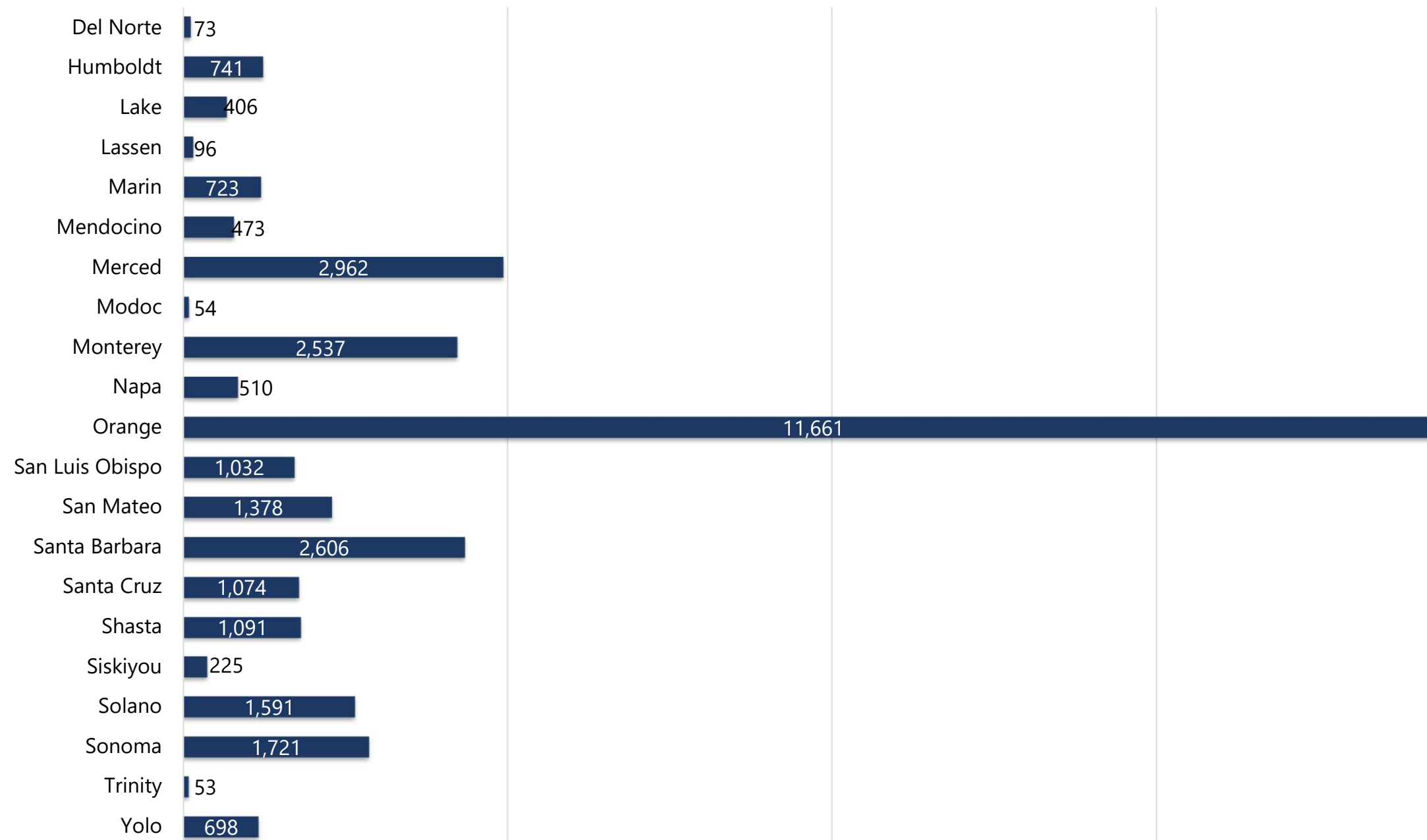


*Note: CCS refers to counties operating outside of the Whole Child Model Program.*

*Items marked with a letter "S" indicate counts of items that are < 11 and are suppressed per the DHCS De-identification guidelines v. 2.0, November 2016.*

**WCM Enrollment and Demographics Figure 8: Breakdowns of Population as of December 2022**

**Fig 8: WCM Enrollment by County**

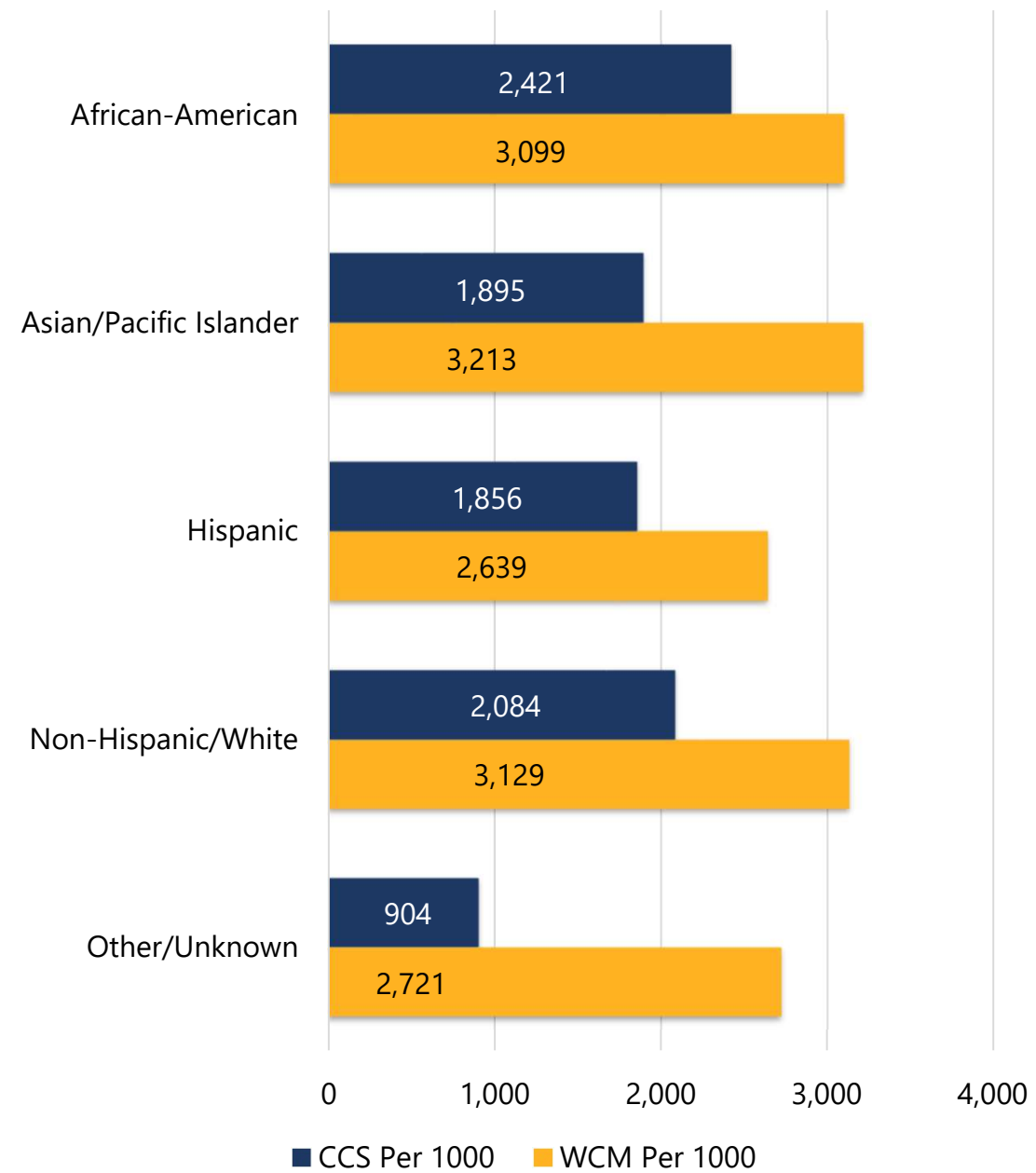


**CCS and WCM Utilization Figures 9 & 10: Breakdowns of Outpatient Admissions Utilization (Jan'22 - Dec'22)**

**Fig 9: Outpatient Visits per 1,000 Member Months by Gender**



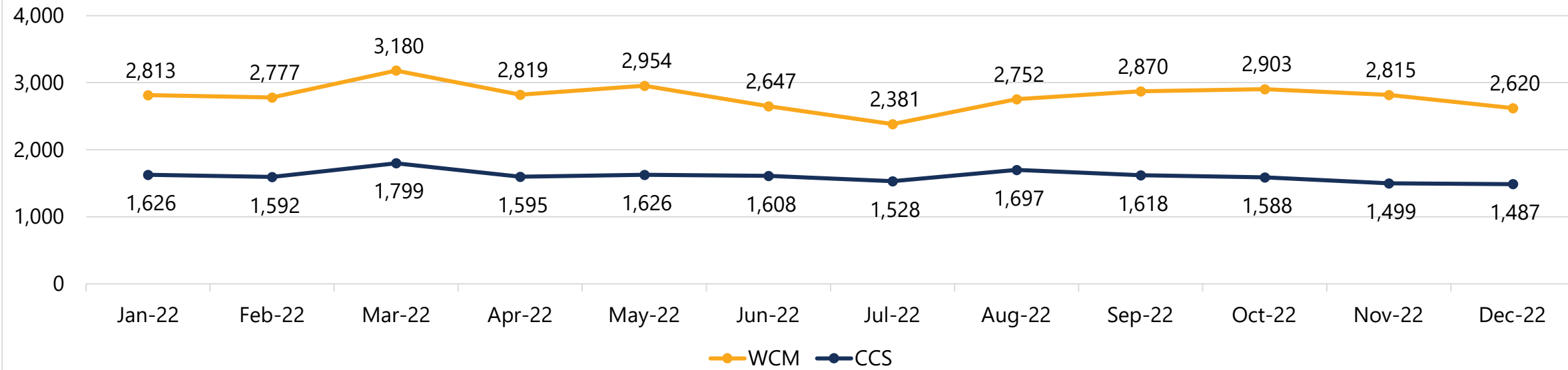
**Fig 10: Outpatient Visits per 1,000 Member Months by Ethnicity**



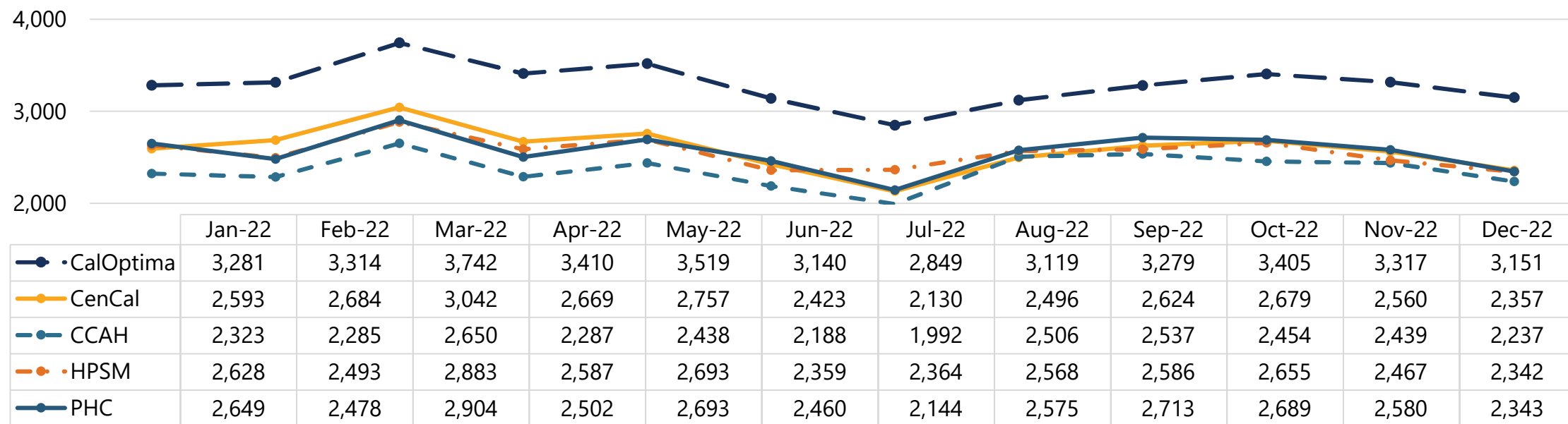
*Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from January 2022 to December 2022.*

**CCS and WCM Utilization Figures 11 & 12: Breakdowns of Outpatient Admissions Utilization (Jan'22 - Dec'22)**

**Fig 11: Outpatient Visits Statewide per 1,000 Members, by Month**



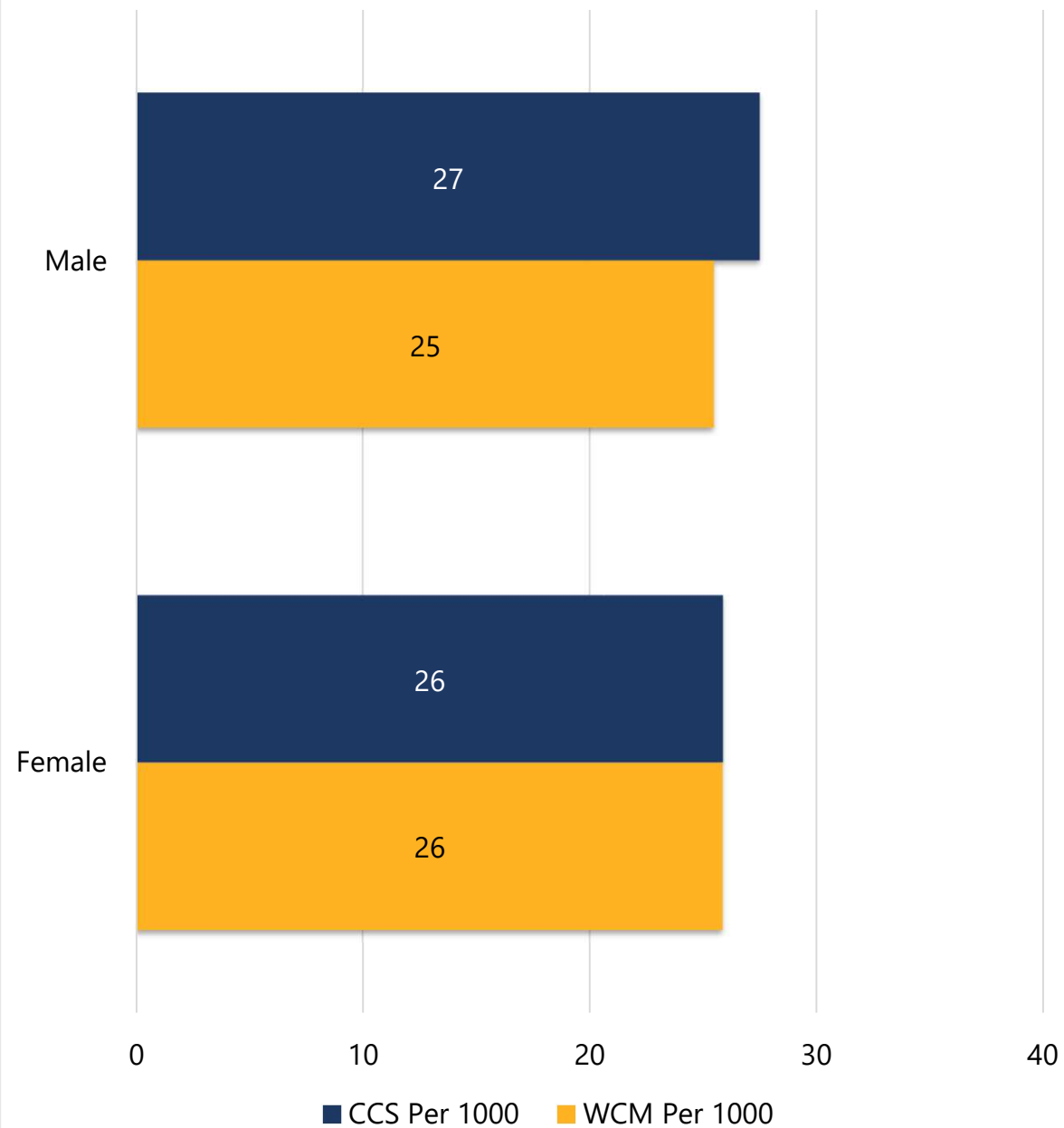
**Fig 12: WCM Outpatient Visits per 1,000 Members by Plan, by Month**



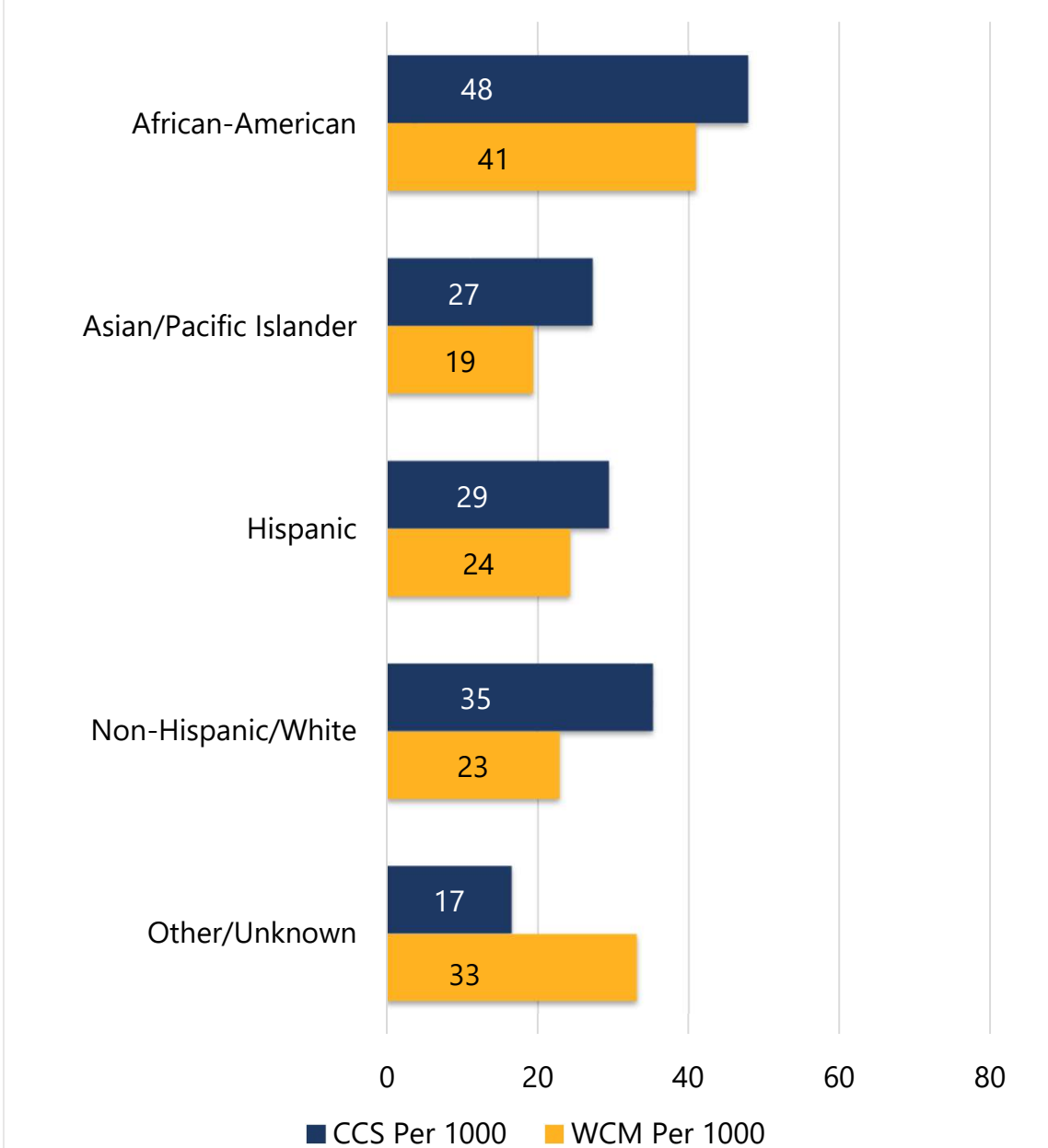
Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from January 2022 to December 2022.

**CCS and WCM Utilization Figures 13 & 14: Breakdowns of Inpatient Visits Utilization (Jan'22 - Dec'22)**

**Fig 13: Inpatient Admissions per 1,000 Member Months by Gender**



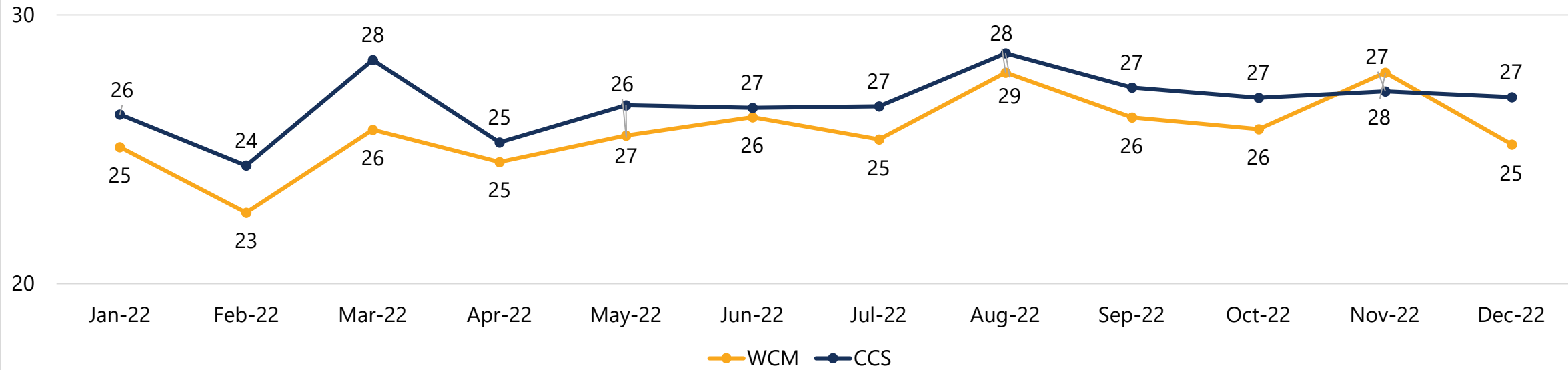
**Fig 14: Inpatient Admissions per 1,000 Member Months by Ethnicity**



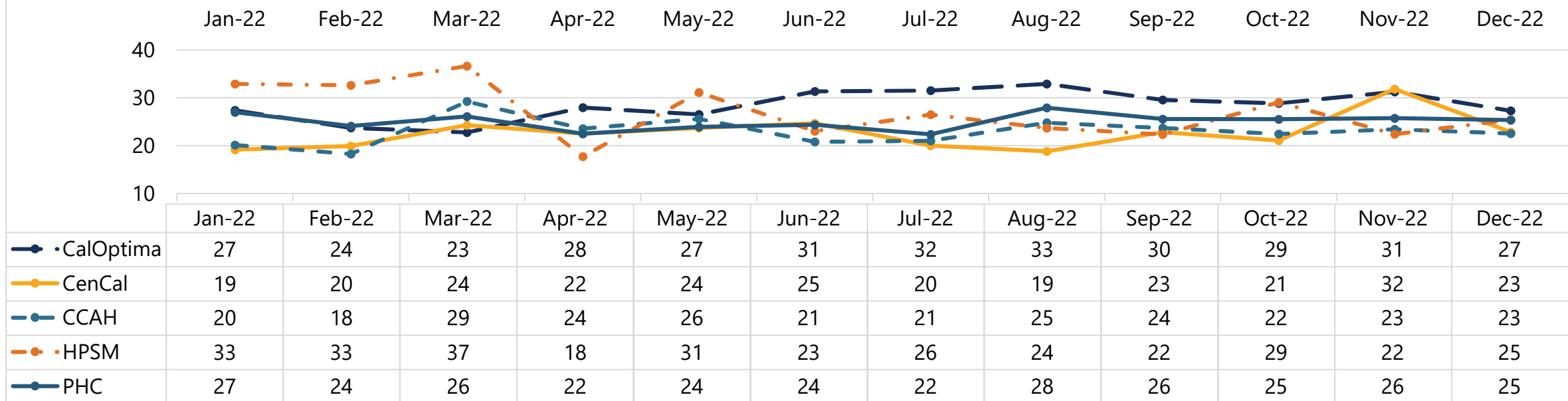
*Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from January 2022 to December 2022.*

**CCS and WCM Utilization Figures 15 & 16: Breakdowns of Inpatient Visits Utilization (Jan'22 - Dec'22)**

**Fig 15: Inpatient Admissions Statewide per 1,000 Members, by Month**



**Fig 16: WCM Inpatient Admissions per 1,000 Members by Plan, by Month**



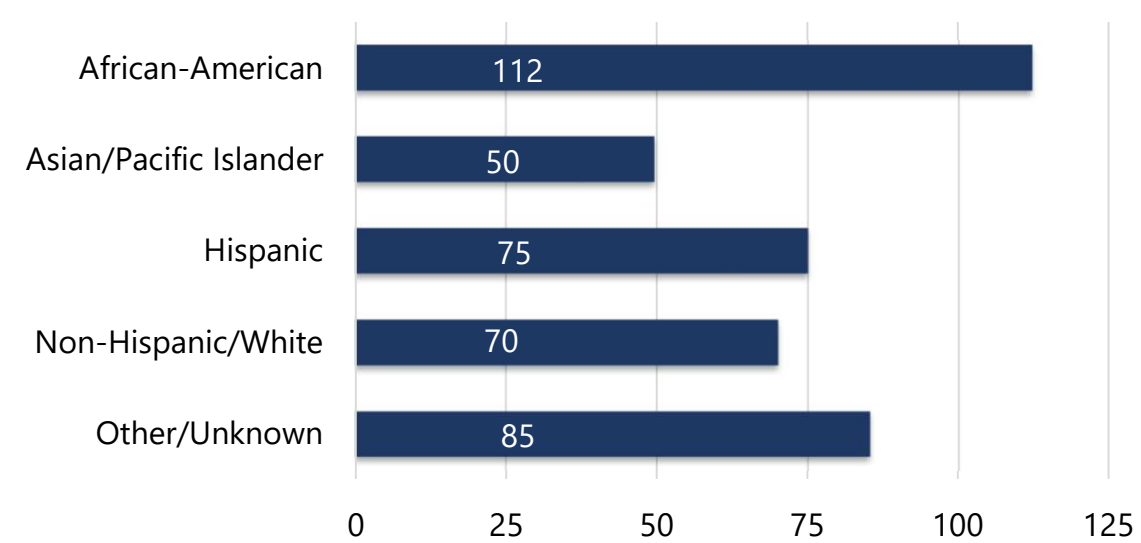
Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from January 2022 to December 2022.

**WCM Utilization Figure 17 - 19: Breakdowns of Emergency Department (ED) Utilization (Jan'22 - Dec'22)**

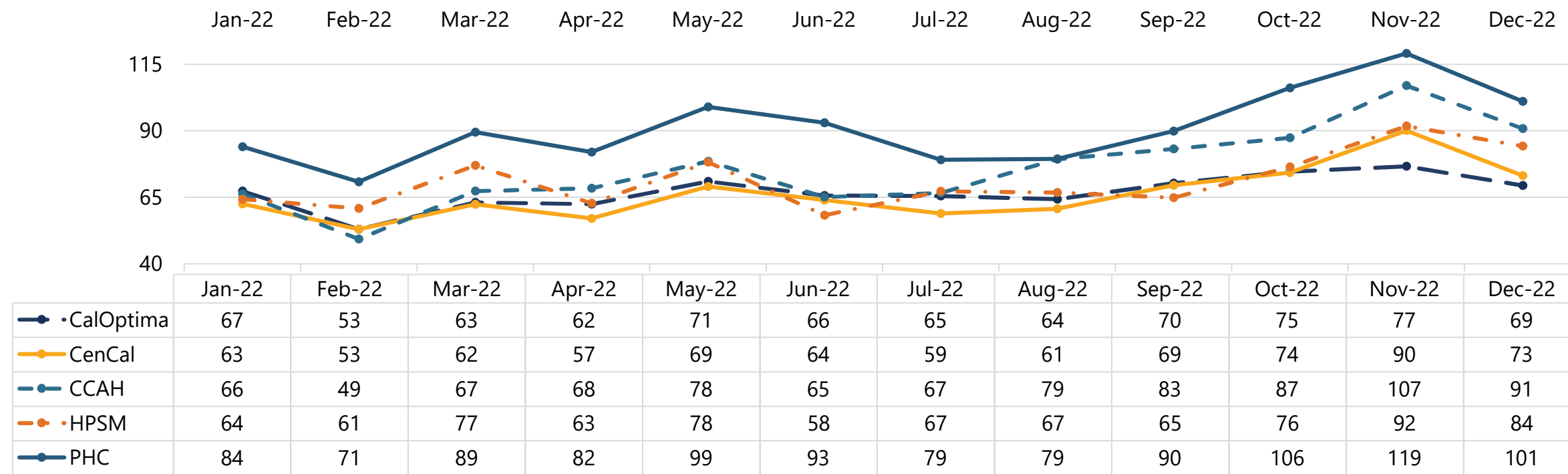
**Fig 17: ED Visits per 1,000 Member Months by Gender**



**Fig 18: ED Visits per 1,000 Member Months by Ethnicity**



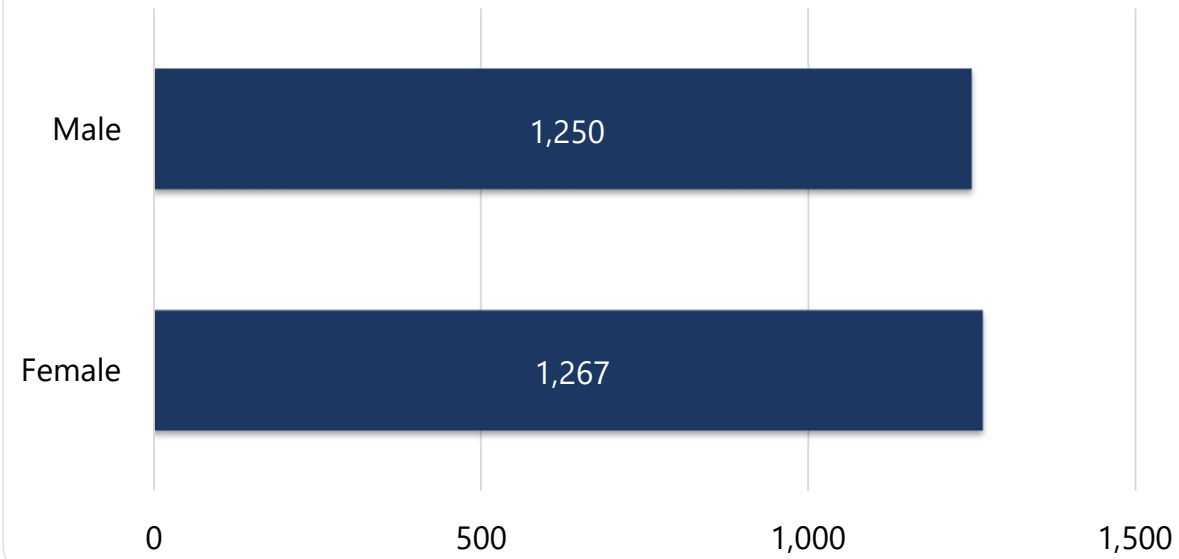
**Fig 19: ED Visits per 1,000 Members by Plan, by Month**



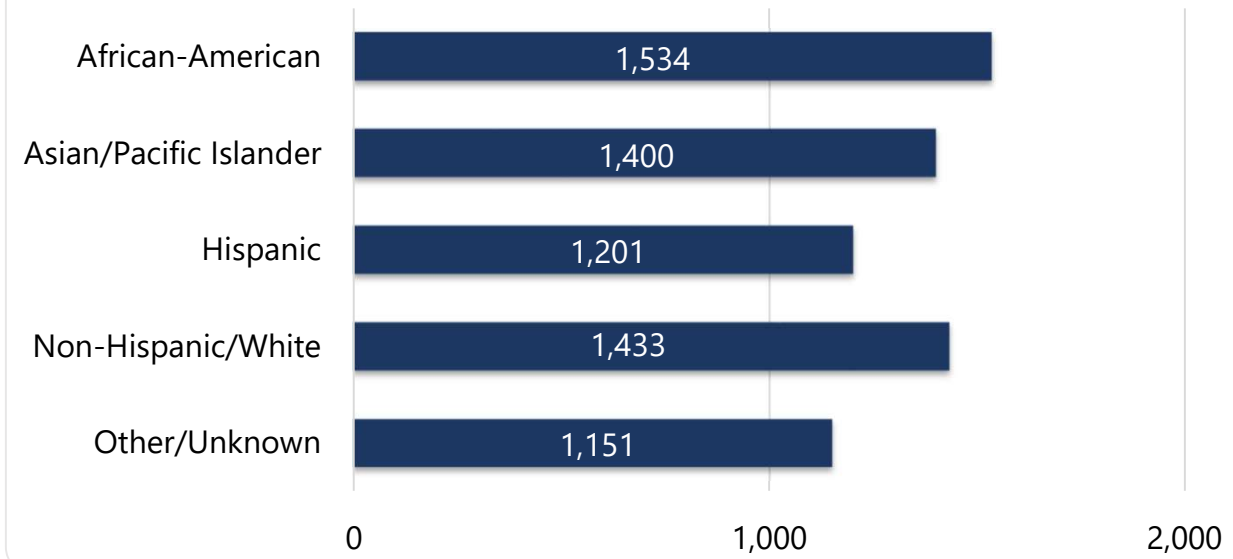


**WCM Utilization Figure 20 - 22: Breakdowns of Prescriptions Utilization (Jan'22 - Dec'22)**

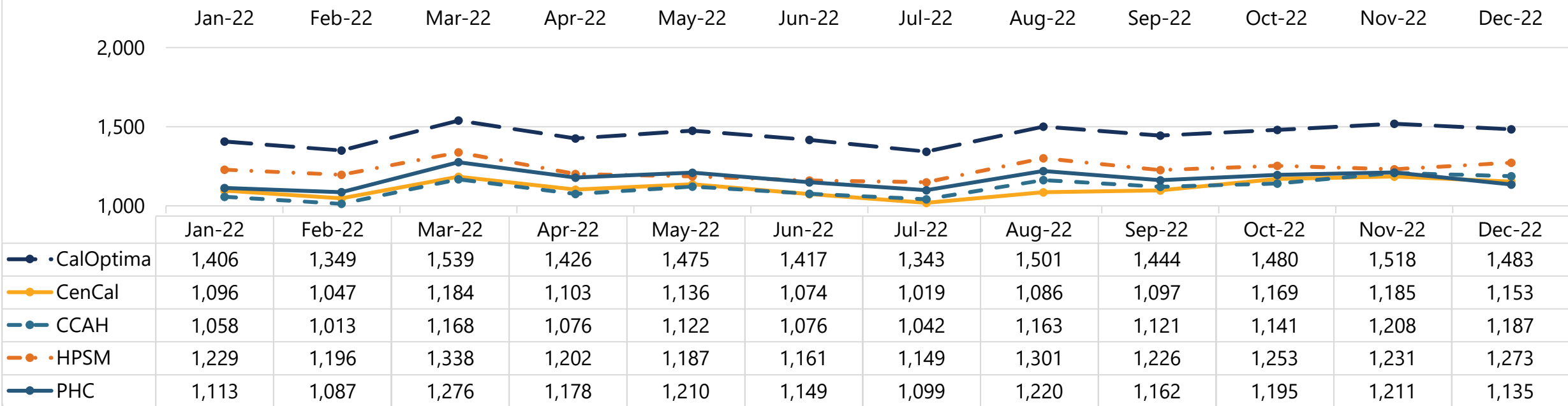
**Fig 20: Prescriptions per 1,000 Member Months by Gender**



**Fig 21: Prescriptions per 1,000 Member Months by Ethnicity**

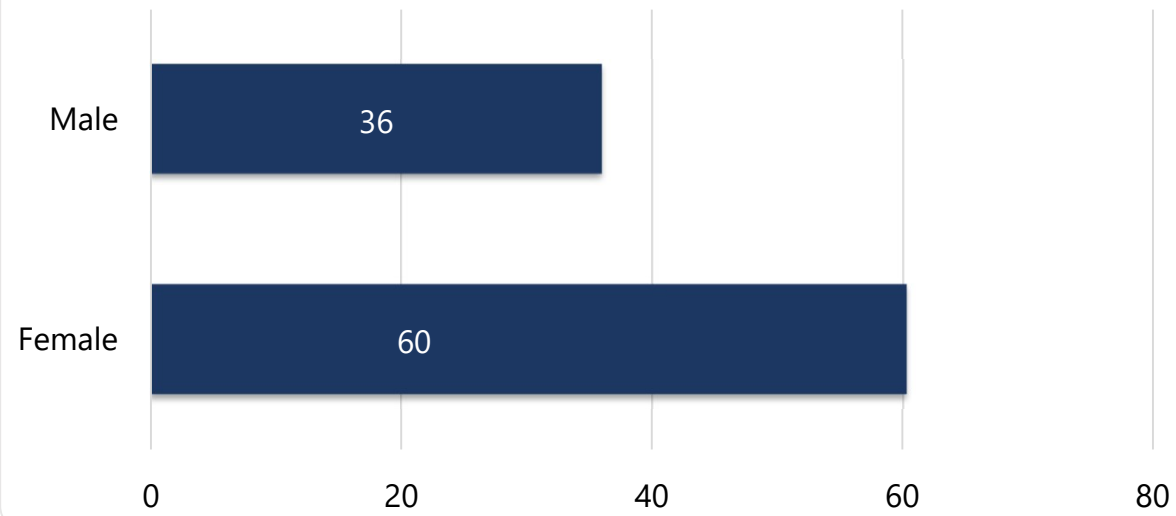


**Fig 22: Prescription per 1,000 Members by Plan, by Month**

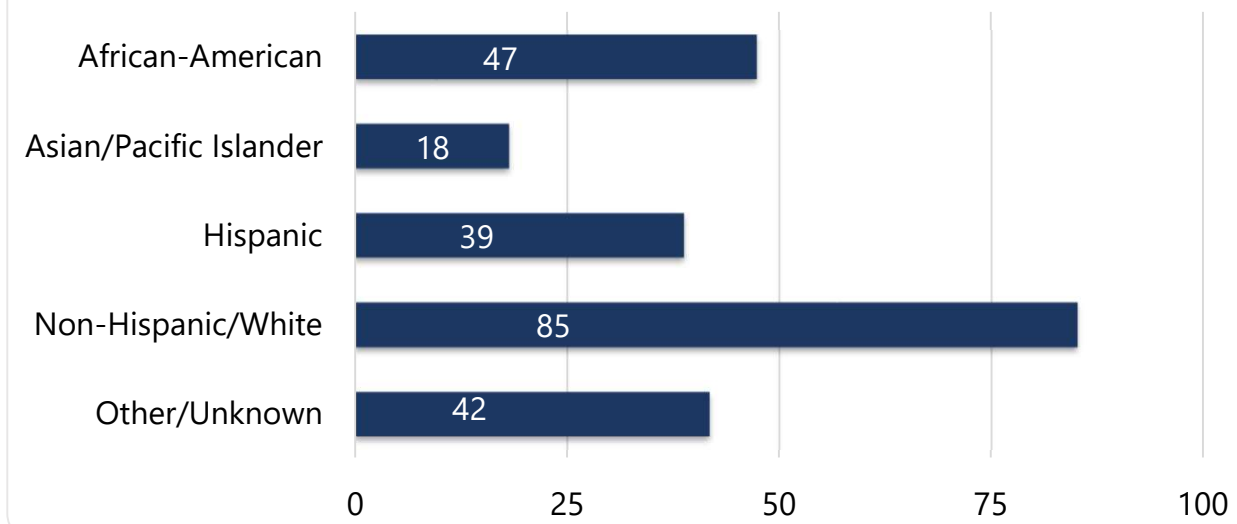


## WCM Utilization Figure 23 - 25: Breakdowns of Non-specialty Mental Health Visits Utilization (Jan'22 - Dec'22)

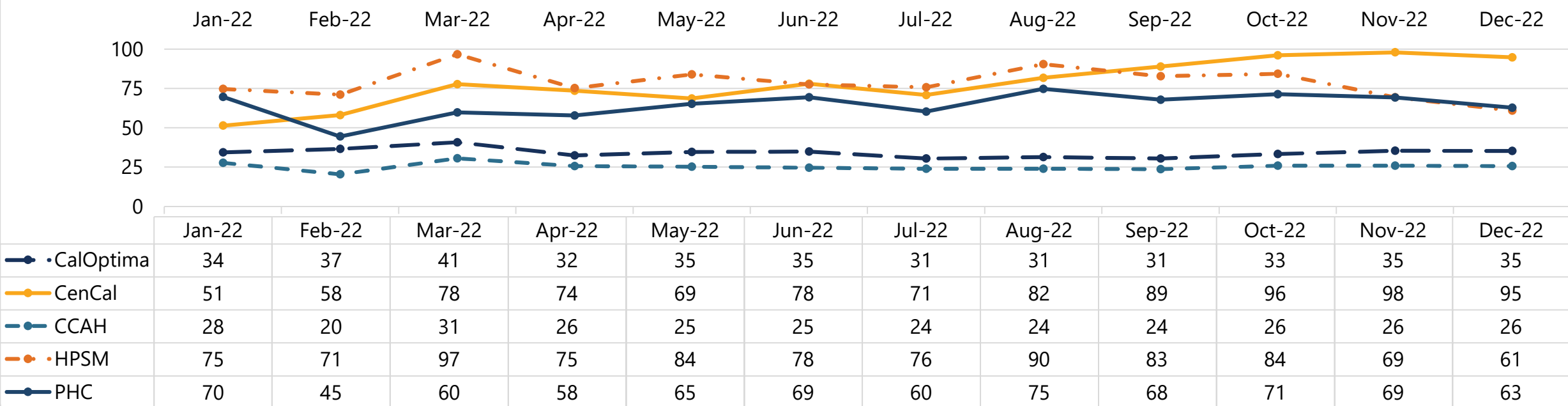
**Fig 23: Non-specialty Mental Health Visits per 1,000 Member Months by Gender**



**Fig 24: Non-specialty Mental Health Visits per 1,000 Member Months by Ethnicity**

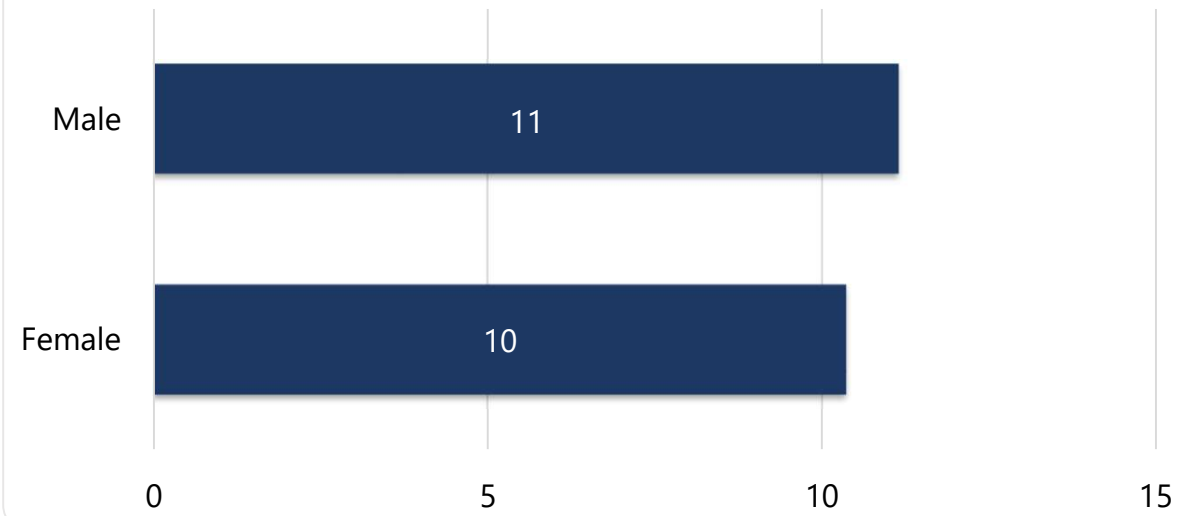


**Fig 25: Non-specialty Mental Health Visits per 1,000 Members by Plan, by Month**

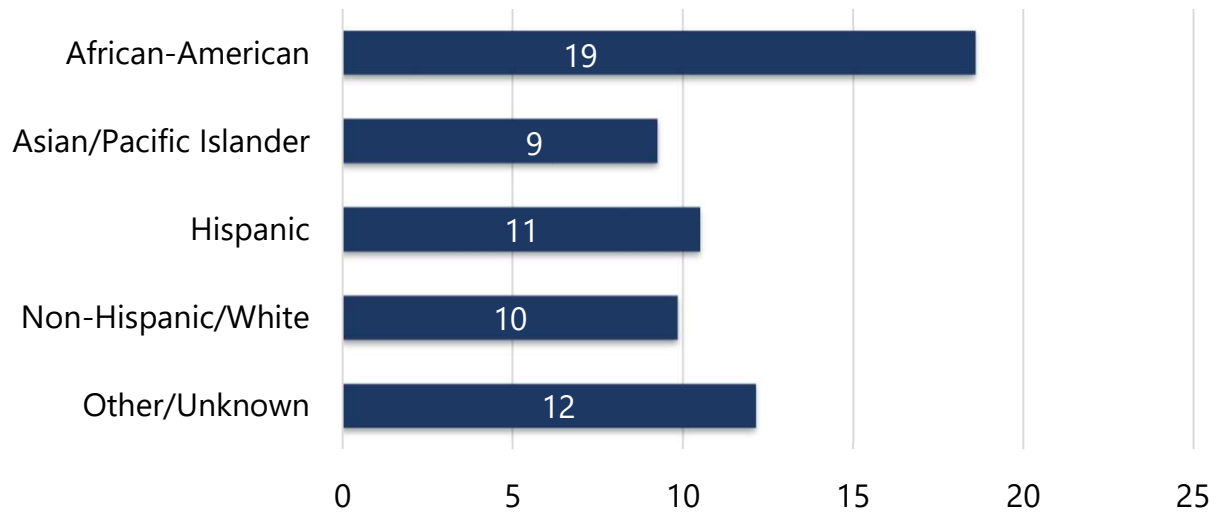


**WCM Utilization Figure 26 - 28: Breakdowns of Emergency Department Visits with an Inpatient Admission Utilization (Jan'22 - Dec'22)**

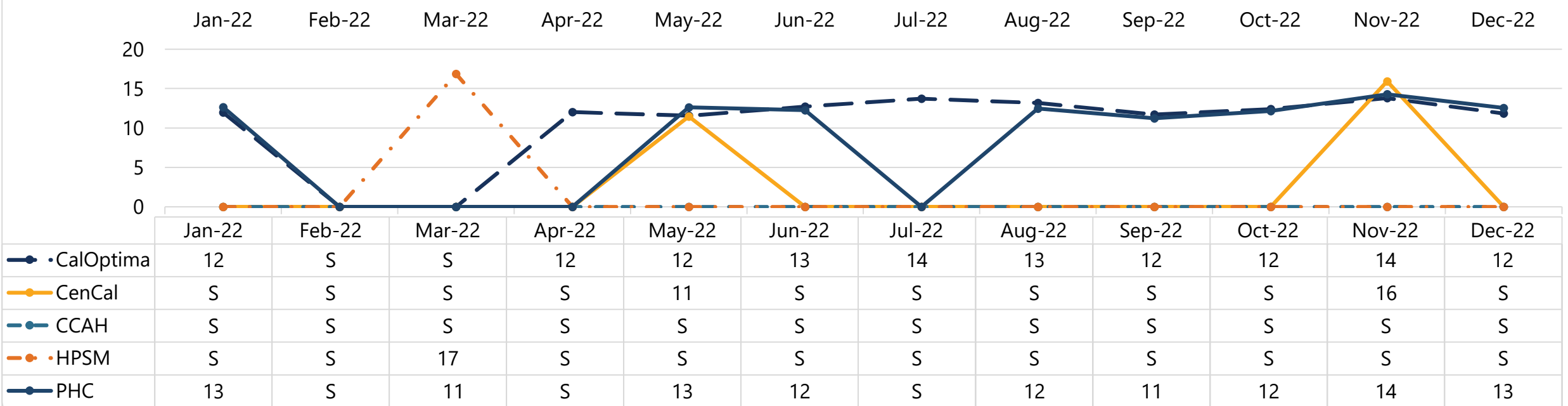
**Fig 26: Emergency Department Visits with an Inpatient Admission per 1,000 Member Months by Gender**



**Fig 27: Emergency Department Visits with an Inpatient Admission per 1,000 Member Months by Ethnicity**



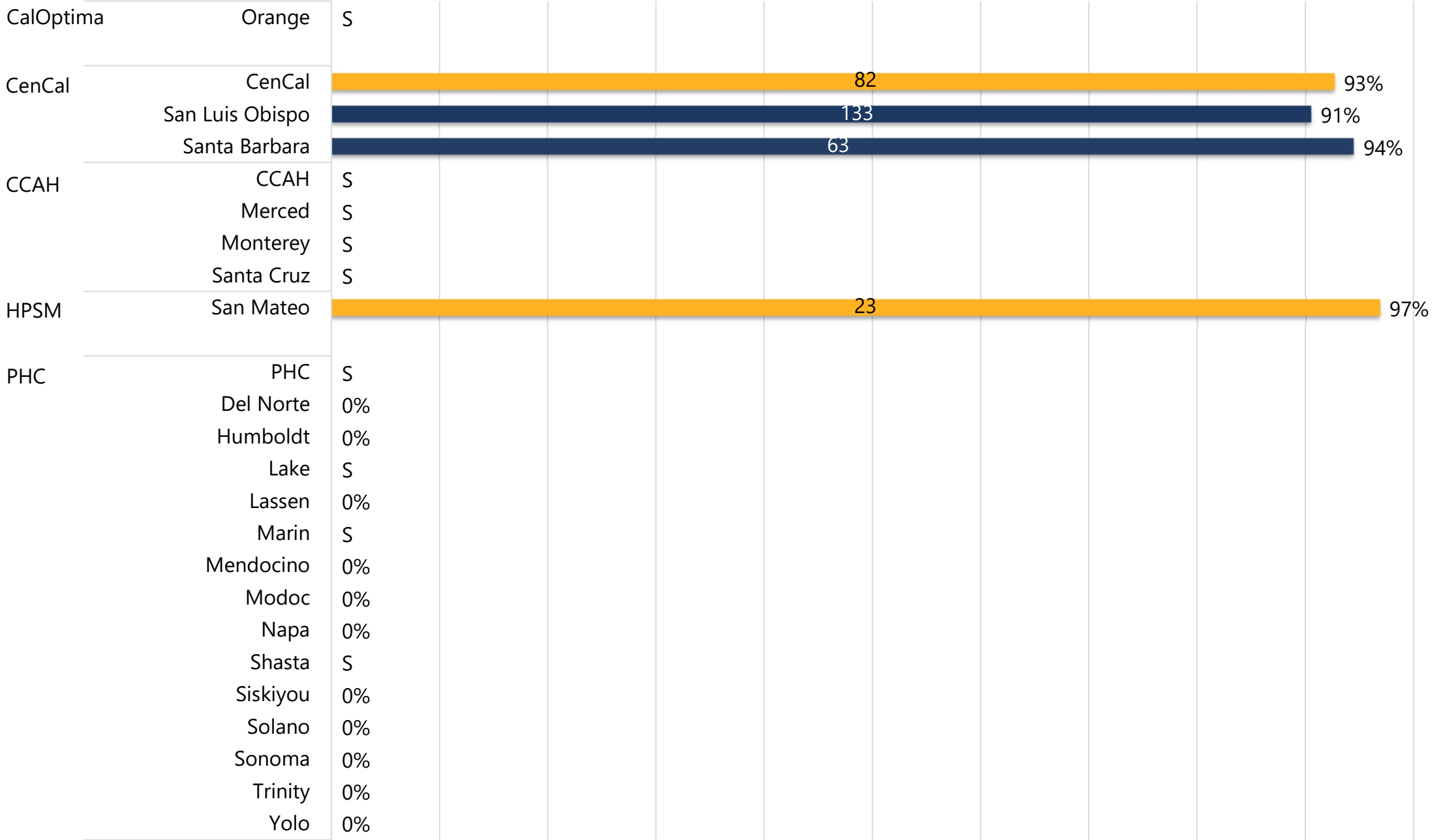
**Fig 28: Emergency Department Visits with an Inpatient Admission per 1,000 Members by Plan, by Month**



A letter "S" indicates counts of items that are < 11 and are suppressed per CDO guidelines.

WCM Figure 29: Continuity of Care (COC) Requests & Approvals per 1,000 Members (Jan'22 - Dec'22)

Fig 29: COC Request per 1,000 Members & Percentage Approval by Plan, by County



Note: This report contains data from January 2022 to December 2022. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019 and CalOptima joined in July 2019. A letter "S" indicates counts of items that are < 11 and are suppressed per CDO guidelines.

**WCM Figure 30: Continuity of Care (COC) Requests Upon Joining the Program, by Plan, by Month - Month 43 through Month 54**

|           | Month 43 | Month 44 | Month 45 | Month 46 | Month 47 | Month 48 | Month 49 | Month 50 | Month 51 | Month 52 | Month 53 | Month 54 |
|-----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| CalOptima | S        | S        | 0        | S        | S        | 0        | 0        | S        | S        | S        | S        | 0        |
| CenCal    | 33       | 17       | 37       | 23       | 28       | 29       | 20       | 25       | S        | 24       | 24       | 32       |
| CCAH      | S        | S        | S        | S        | S        | 0        | 0        | 0        | 0        | 0        | 0        | 0        |
| HPSM      | S        | S        | S        | S        | S        | S        | S        | S        | S        | S        | S        | S        |
| PHC       | 0        | 0        | 0        | S        | S        | 0        | S        | S        | 0        | 0        | 0        | S        |

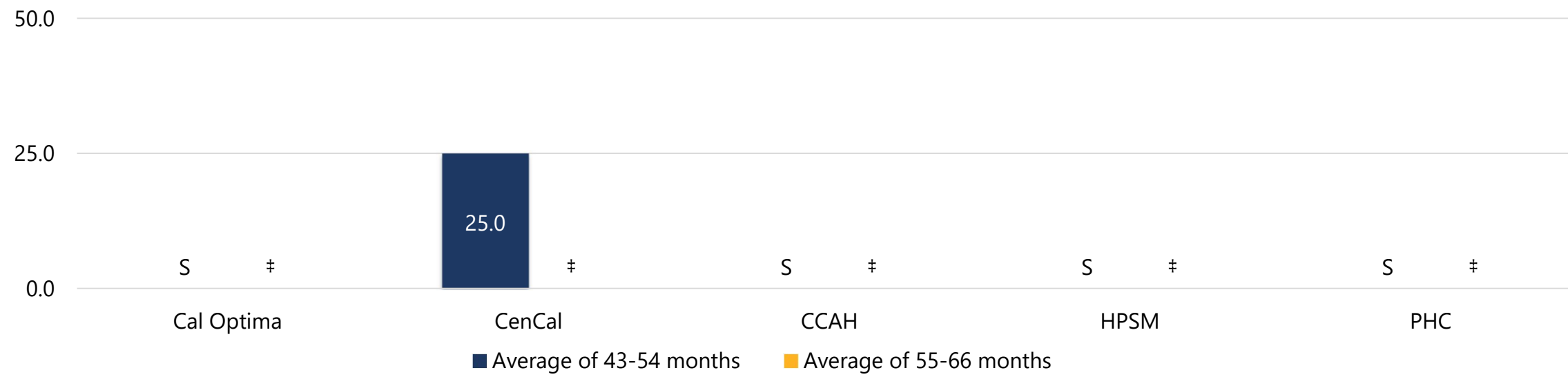
**WCM Figure 31: Continuity of Care (COC) Requests Upon Joining the Program, by Plan, by Month - Month 55 through Month 66**

|           | Month 55 | Month 56 | Month 57 | Month 58 | Month 59 | Month 60 | Month 61 | Month 62 | Month 63 | Month 64 | Month 65 | Month 66 |
|-----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| CalOptima | S        | 0        | 0        | 0        | 0        | 0        | 0        | 0        | 0        | 0        | 0        | #        |
| CenCal    | 35       | 14       | 24       | 24       | S        | 24       | S        | S        | 0        | 0        | 0        | #        |
| CCAH      | 0        | S        | S        | S        | S        | S        | 0        | 0        | 0        | S        | 0        | #        |
| HPSM      | S        | S        | 0        | S        | S        | S        | 0        | S        | S        | 0        | S        | #        |
| PHC       | S        | 0        | 0        | 0        | 0        | S        | S        | S        | 0        | 0        | 0        | #        |

*Note: CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019 and CalOptima joined in July 2019. A letter "S" indicates counts of items that are < 11 and are suppressed per CDO guidelines.  
#Plans have not reached this month in their observation yet.*

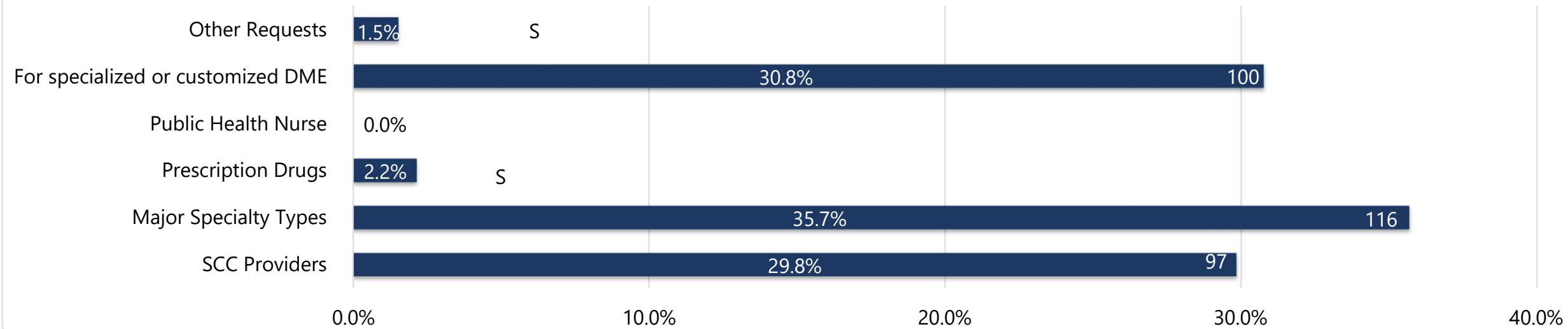
**WCM Figure 32: Continuity of Care (COC) - Requests, by Plan (Jan'22 - Dec'22)**

**Fig 32: Plan Average COC Request Upon Joining the Program, Month 43 - Month 54 vs Month 55 - Month 66**



**WCM Figure 33: Continuity of Care (COC) - Requests Categories (Jan'22 - Dec'22)**

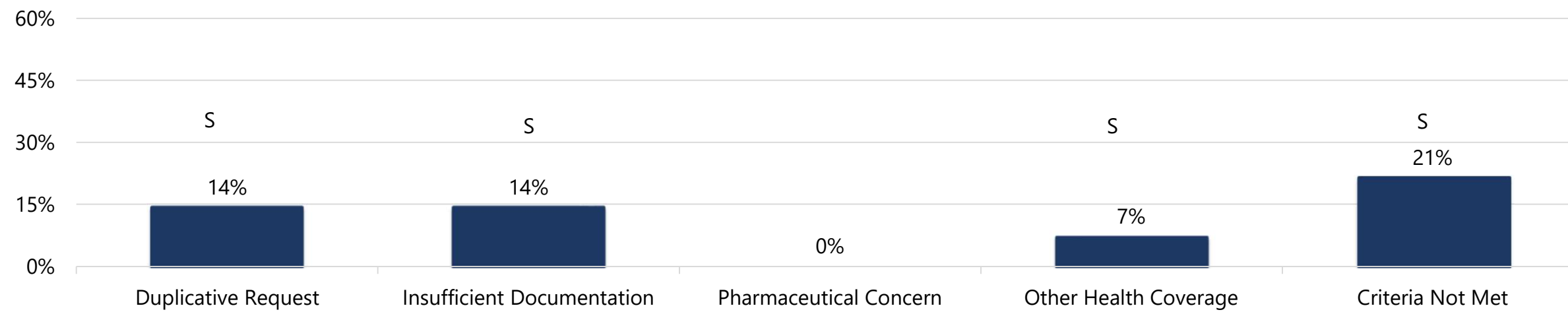
**Fig 33: COC Requests - Categories**



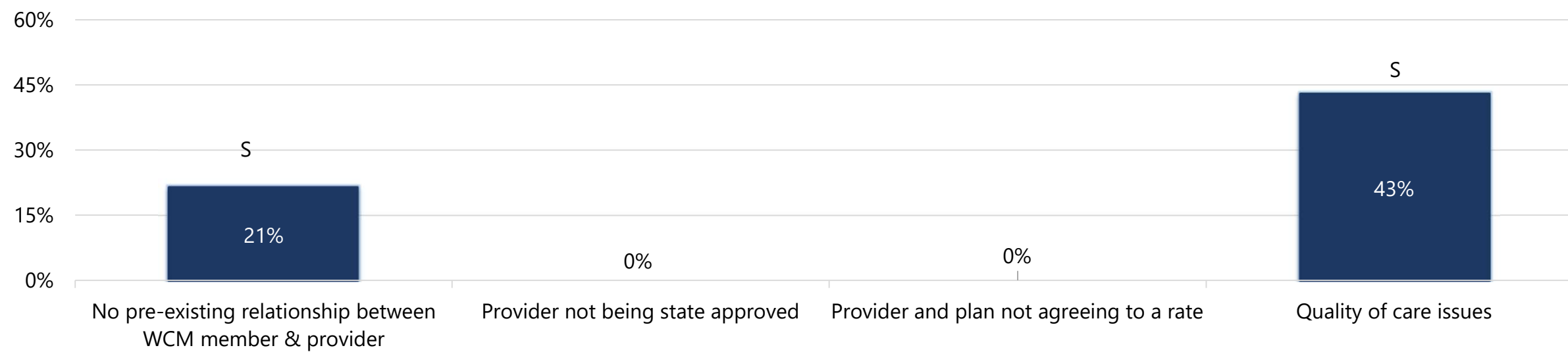
A letter "S" indicates counts of items that are < 11 and are suppressed per CDO guidelines. # Plans have not reached this month in their observation yet.

**WCM Figures 34 & 35: Continuity of Care (COC) - Denials Reasons (Jan'22 - Dec'22)**

**Fig 34: Top 5 COC Denial Reasons (Not Required by APL)**



**Fig 35: COC Denial Reasons (Required by APL)**

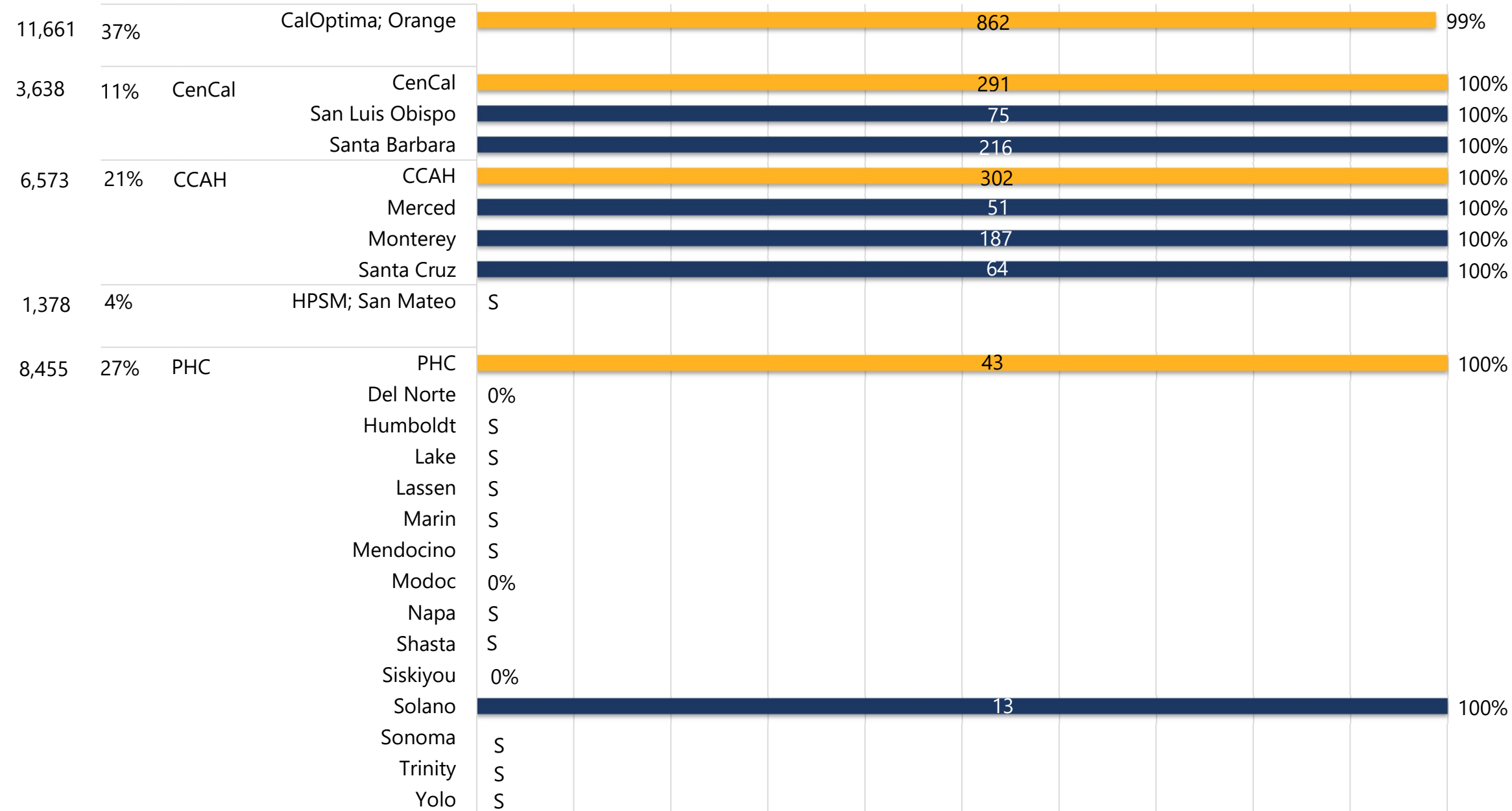


*Note: Please see page 8 for detailed information on why Figures 28 & 29 do not add up to 100%.*



**WCM Figure 36: Case Management NICU Authorization Requests & Approvals (Jan'22 - Dec'22)**

**Fig 36: WCM Total NICU Authorization Requests & Percentage Approved by Plan, by County**



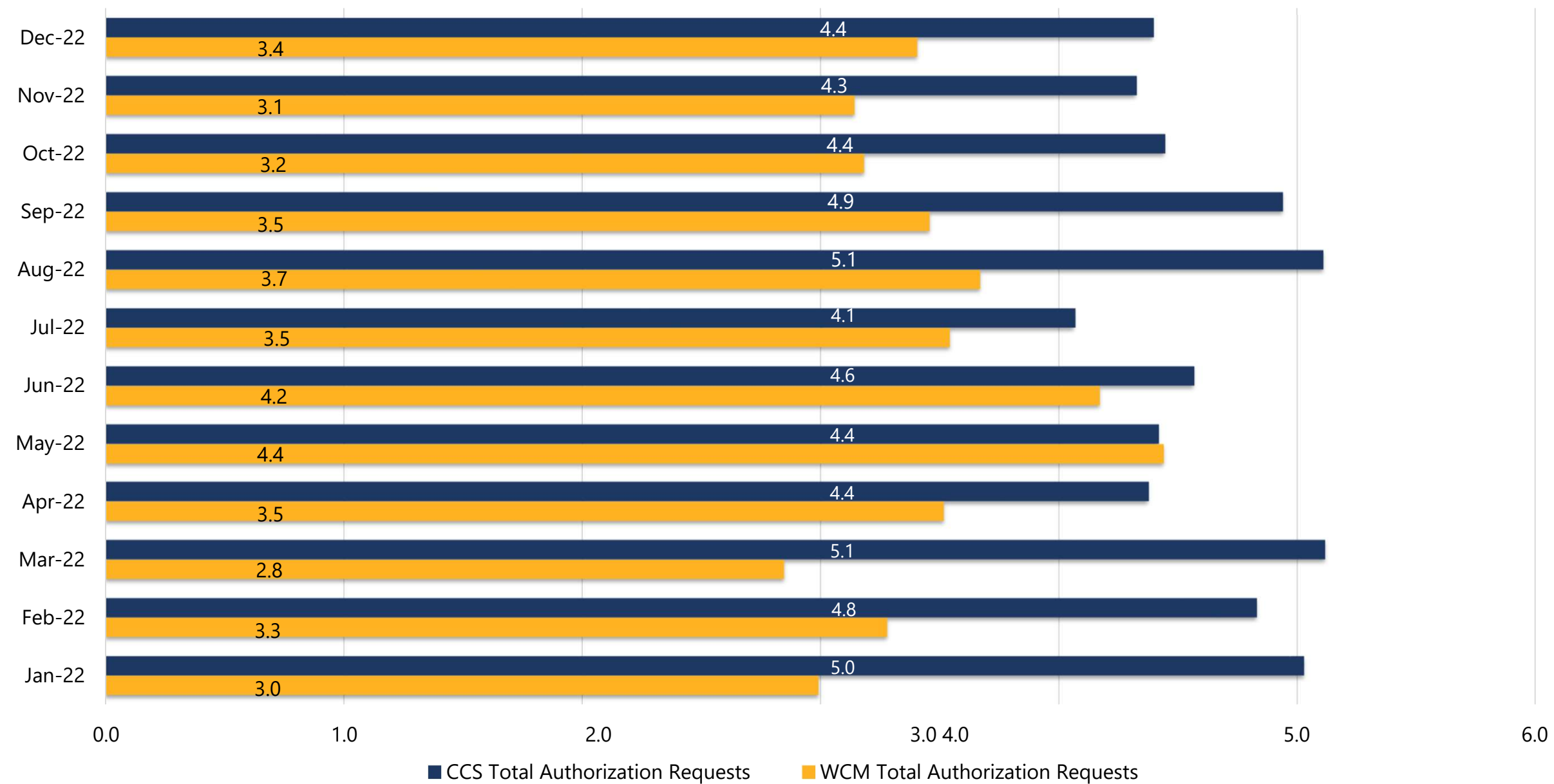
Note: This report contains data from January 2022 to December 2022.

CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019 and CalOptima joined in July 2019.

A letter "S" indicates counts of items that are < 11 and are suppressed per CDO guidelines.

**CCS and WCM Figure 37: Case Management NICU Authorization Requests (Jan'22 - Dec'22)**

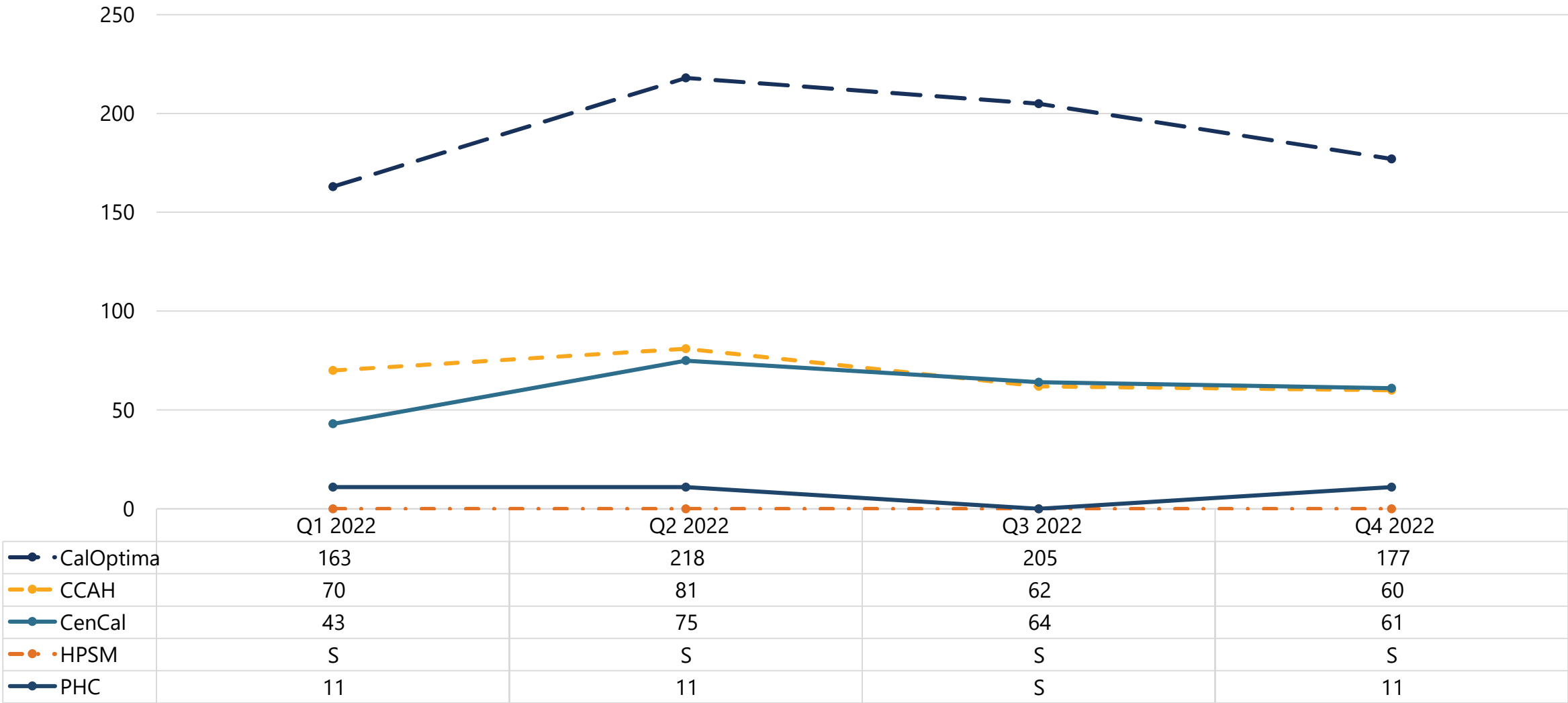
**Fig 37: Statewide Total NICU Authorization Requests per 1,000 Members, by Month**



*Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from January 2022 to December 2022. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019 and CalOptima joined in July 2019.*

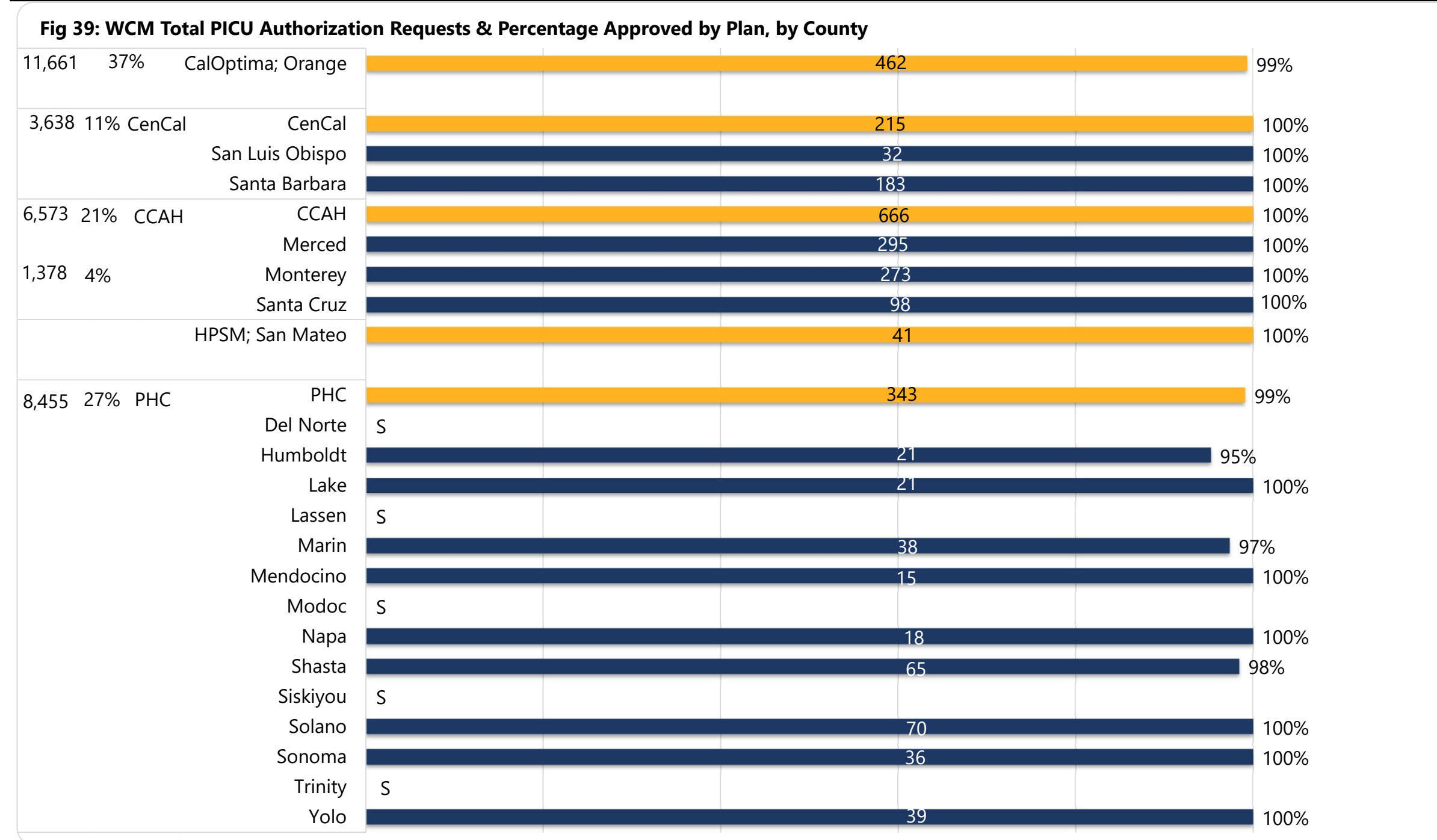
WCM Figure 38: Case Management NICU Authorization Requests (Jan'22 - Dec'22)

Fig 38: WCM Total NICU Authorization Requests by Plan, by Quarter



Note: This report contains data from January 2022 to December 2022. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019. Caution should be exercised when evaluating the results. Counties that have low number of observations are seen as statistically unreliable. A letter "S" indicates counts of items that are <11 and are suppressed per CDO guidelines.

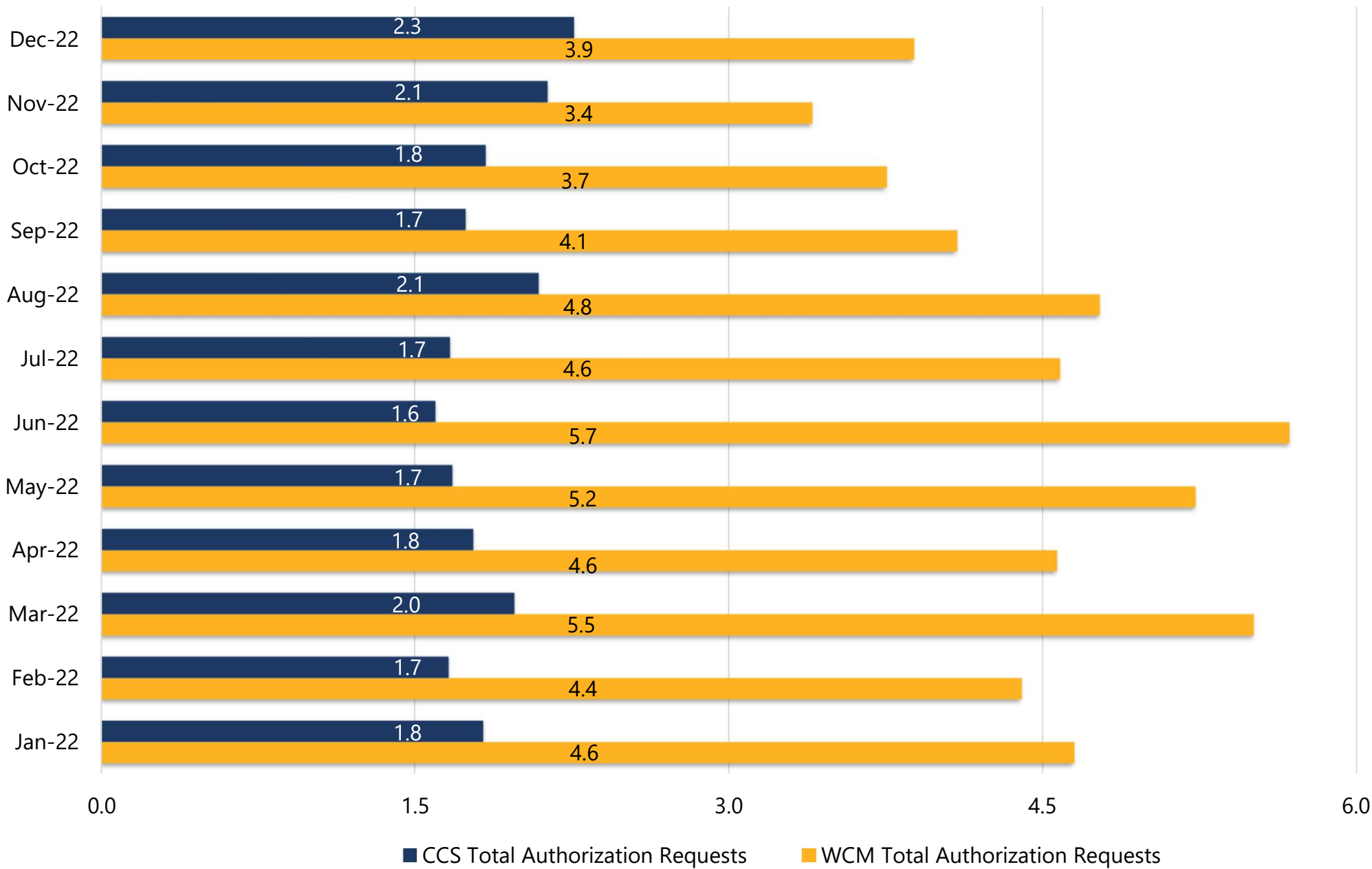
**WCM Figure 39: Case Management PICU Authorization Requests & Approvals (Jan'22 - Dec'22)**



Note: This report contains data from January 2022 to December 2022. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019 and CalOptima joined in July 2019. A letter "S" indicates counts of items that are < 11 and are suppressed per CDO guidelines.

CCS and WCM Figure 40: Case Management PICU Authorization Requests (Jan'22 - Dec'22)

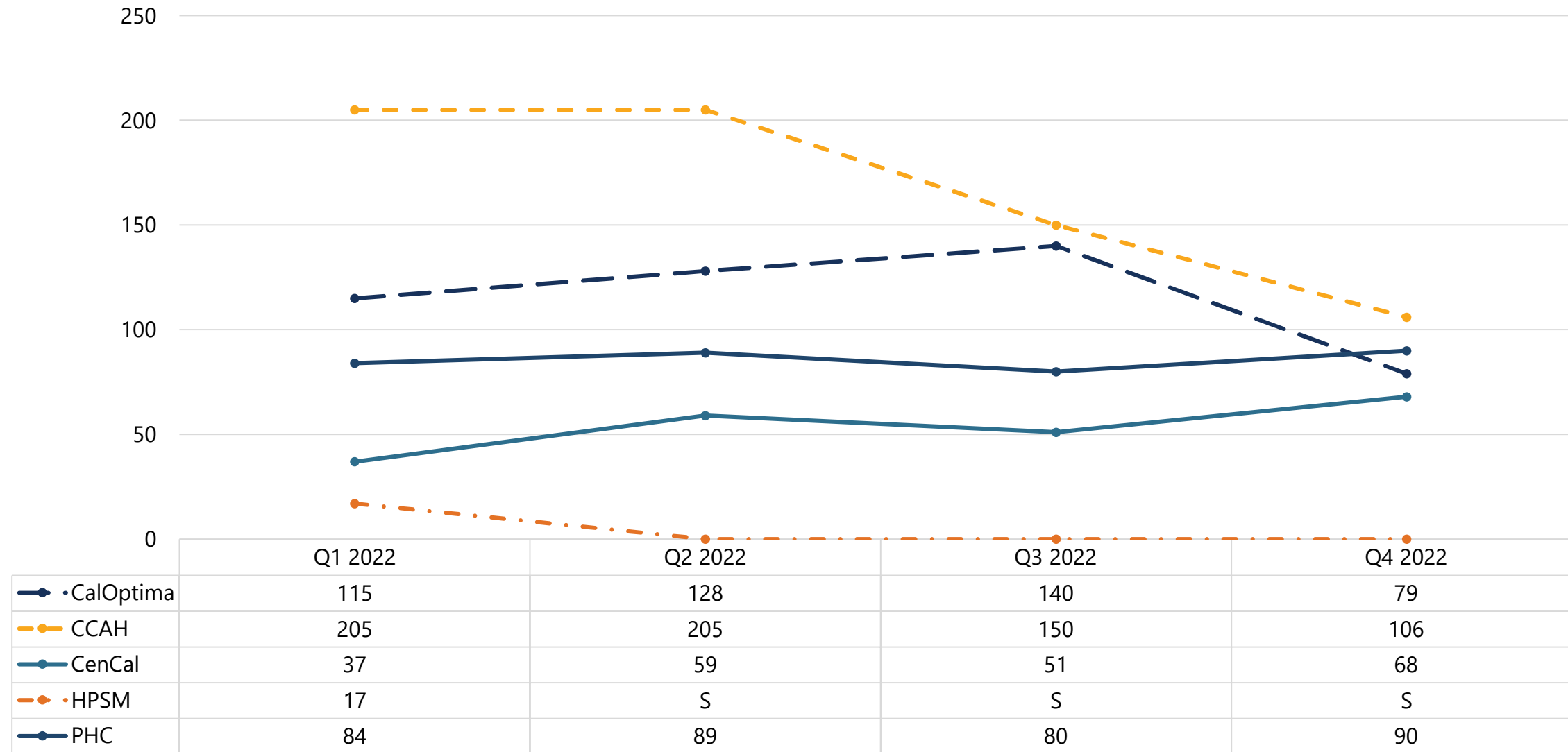
Fig 40: Statewide Total PICU Authorization Requests per 1,000 Members, by Month



Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from January 2022 to December 2022. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019 and CalOptima joined in July 2019.

**WCM Figure 41: Case Management PICU Authorization Requests (Jan'22 - Dec'22)**

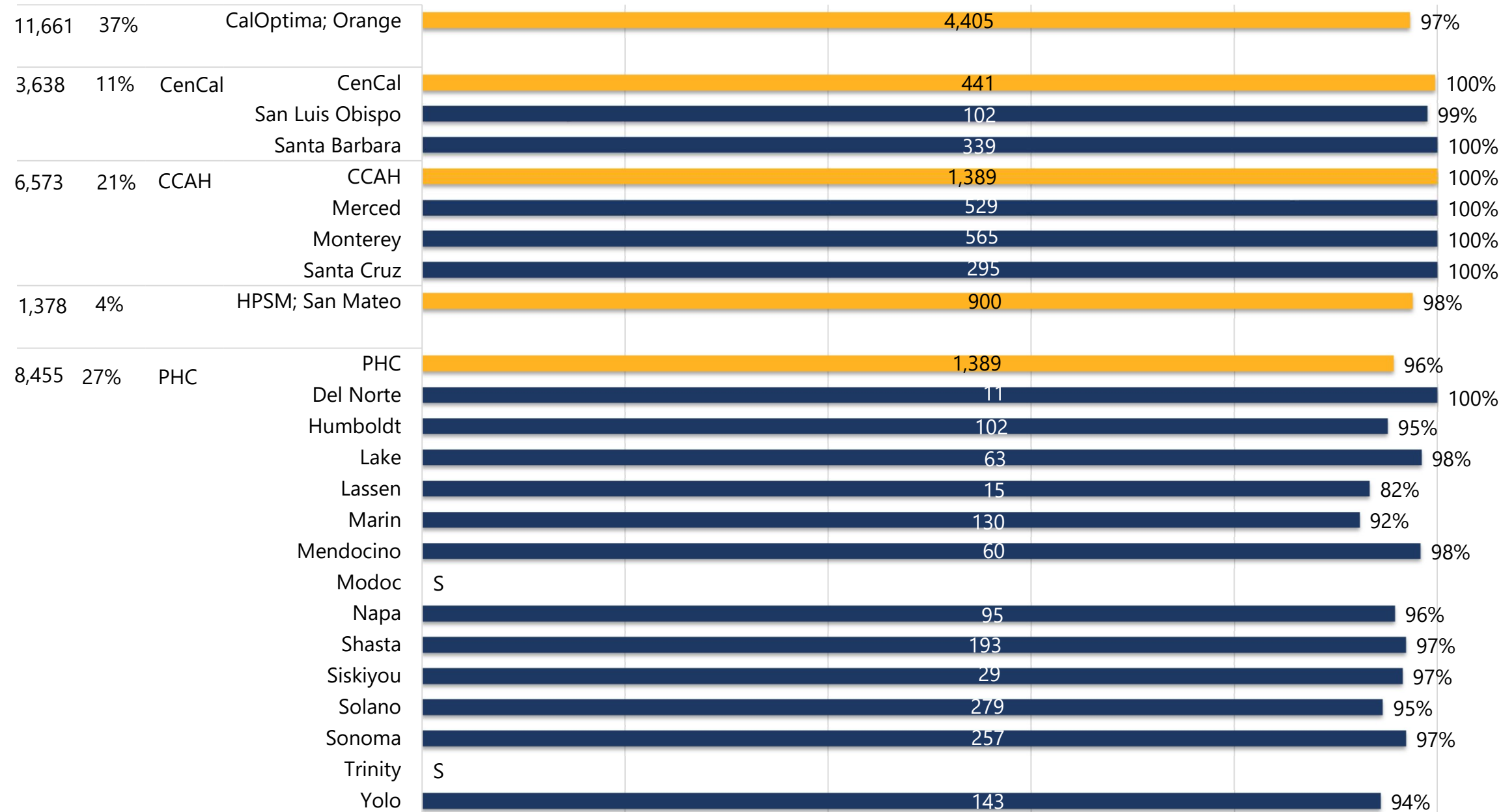
**Fig 41: WCM Total PICU Authorization Requests by Plan, by Quarter**



*Note: This report contains data from January 2022 to December 2022. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019. Caution should be exercised when evaluating the results. Counties that have low number of observations are seen as statistically unreliable.*

**WCM Figure 42: Case Management Inpatient Facilities and Special Care Centers (SCC) Authorization Requests & Approvals (Jan'22 - Dec'22)**

**Fig 42: WCM Total Inpatient Facilities and SCC Authorization Requests & Percentage Approved by Plan, by County**

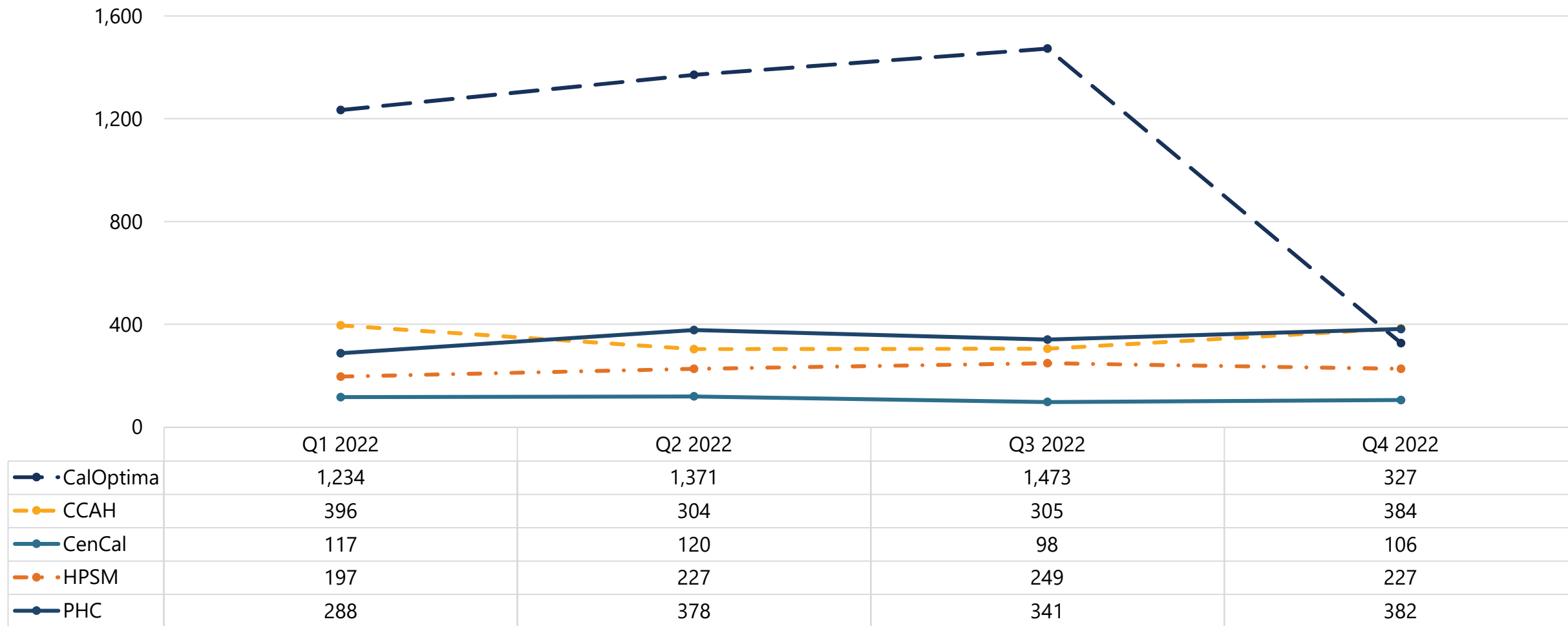


*Note: This report contains data from January 2022 to December 2022. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019 and CalOptima joined in July 2019. A letter "S" indicates counts of items that are <11 and are suppressed per CDO guidelines.*



**WCM Figure 43: Case Management Inpatient Facilities and Special Care Centers (SCC) Authorization Requests (Jan'22 - Dec'22)**

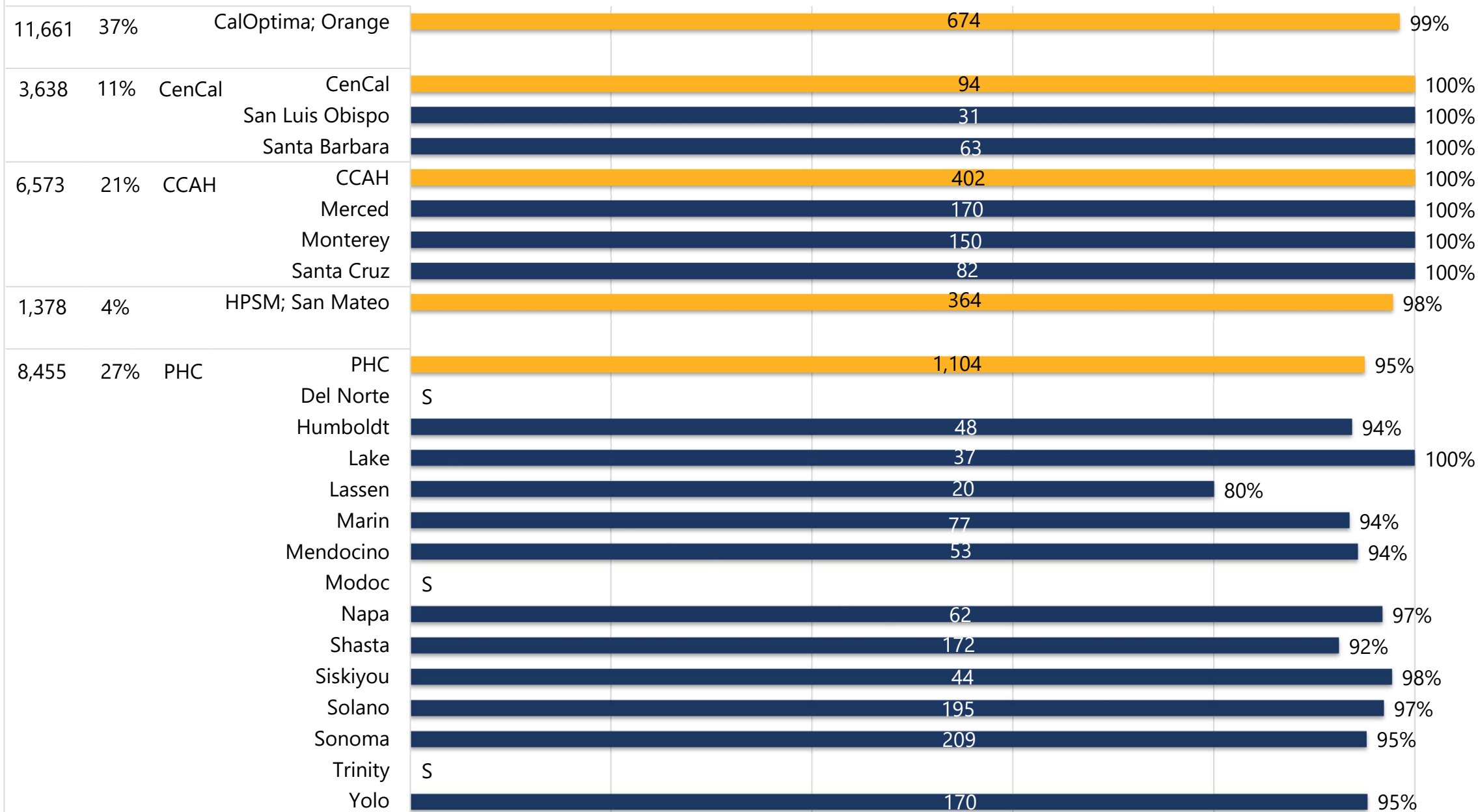
**Fig 43: WCM Total Inpatient Facilities and Special Care Centers (SCC) Authorization Requests by Plan, by Quarter**



*Note: This report contains data from January 2022 to December 2022. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019.*

**WCM Figure 44: Case Management Specialized or Customized DME Authorization Requests & Approvals (Jan'22 - Dec'22)**

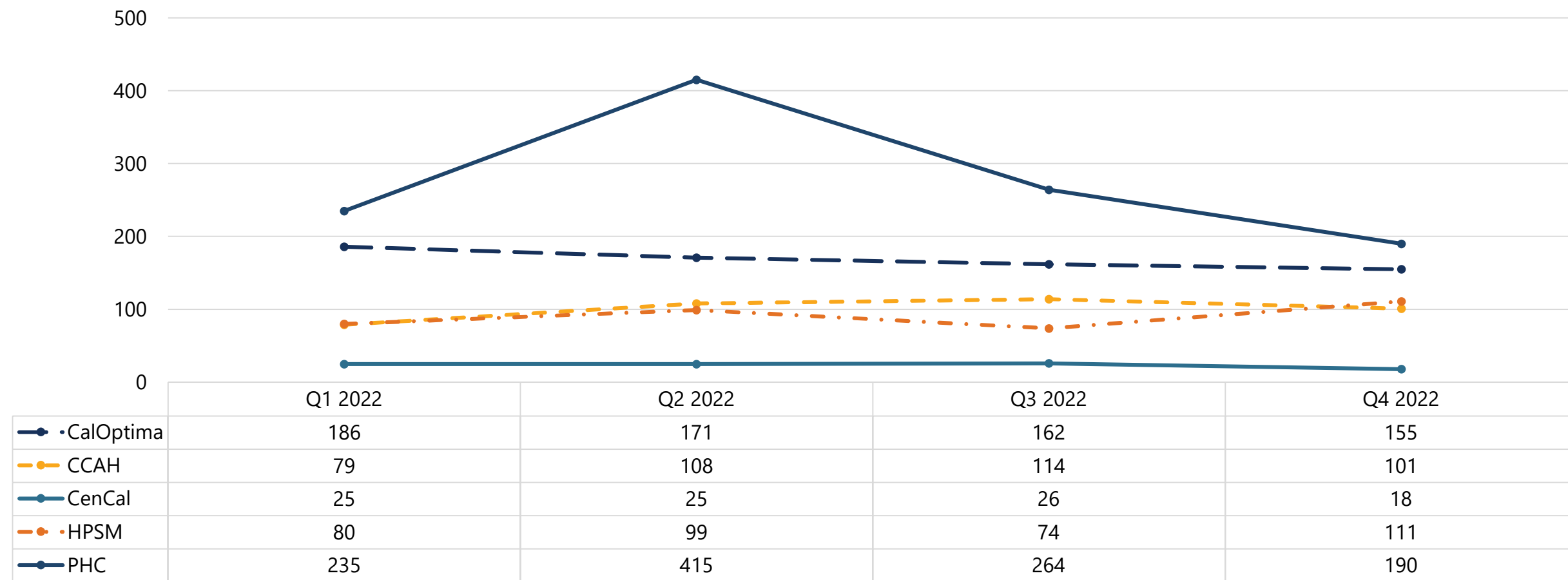
**Fig 44: WCM Total Specialized or Customized DME Authorization Requests & Percentage Approved by Plan, by County**



*Note: This report contains data from January 2022 to December 2022. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019 and CalOptima joined in July 2019. A letter "S" indicates counts of items that are < 11 and are suppressed per CDO guidelines.*

**WCM Figure 45: Case Management Specialized or Customized DME Authorization Requests (Jan'22 - Dec'22)**

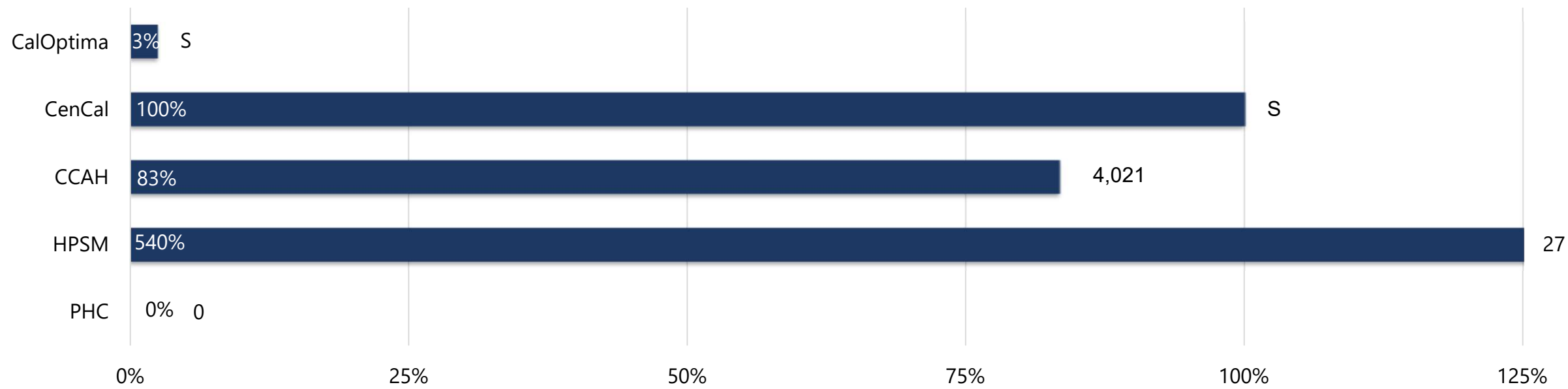
**Fig 45: WCM Total Specialized or Customized DME Authorization Requests by Plan, by Quarter**



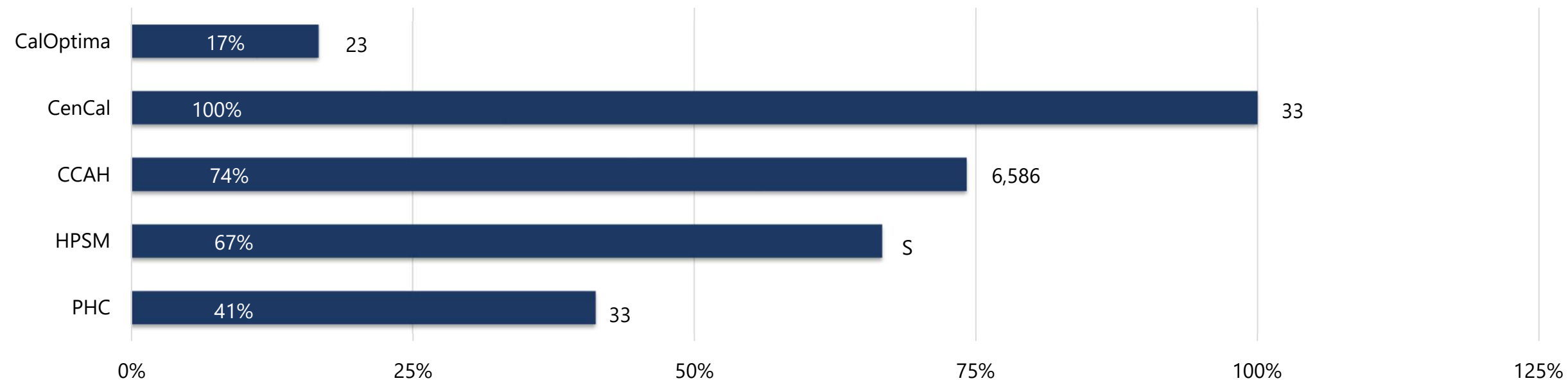
*Note: This report contains data from January 2022 to December 2022. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019. Caution should be exercised when evaluating the results. Counties that have low number of observations are seen as statistically unreliable. A letter "S" indicates counts of items that are < 11 and are suppressed per CDO guidelines.*

**WCM Figures 46 & 47: Care Coordination High-Risk and Low-Risk Assessments - December 2022**

**Fig 46: Percentage of High Risk Members who Received an Assessment, by Plan**



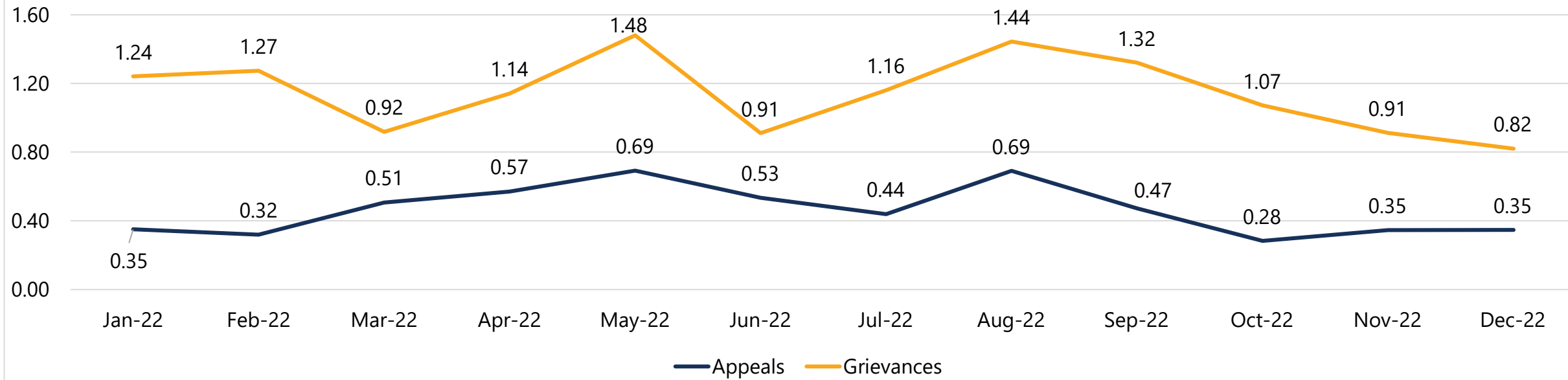
**Fig 47: Percentage of Low Risk Members who Received an Assessment, by Plan**



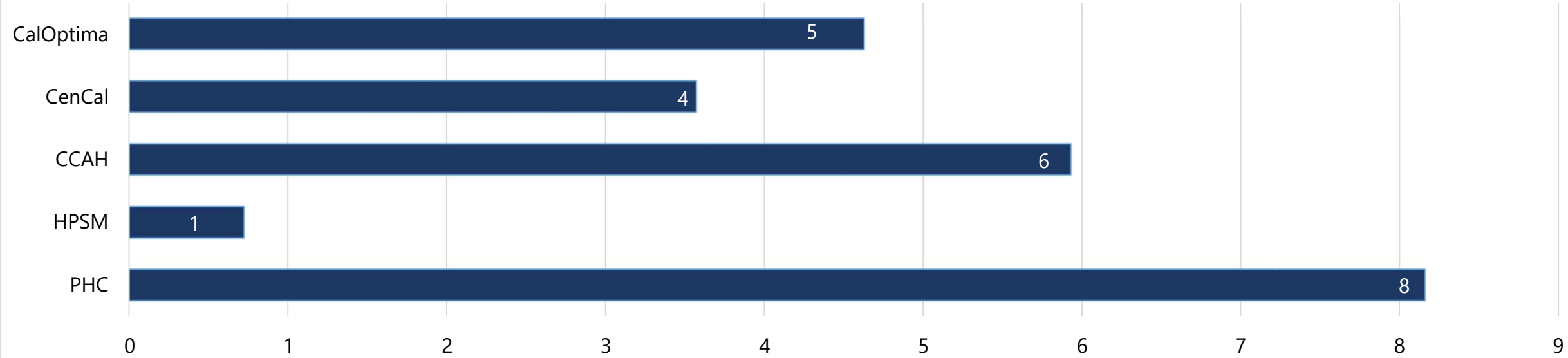
*Note: DHCS is following up with WCM MCPs on assessments to clarify expectations and provide technical assistance.*

**WCM Figures 48 & 49: Grievances & Appeals per 1,000 Member Months (Jan'22 - Dec'22)**

**Fig 48: WCM Grievances and Appeals per 1,000 Members**

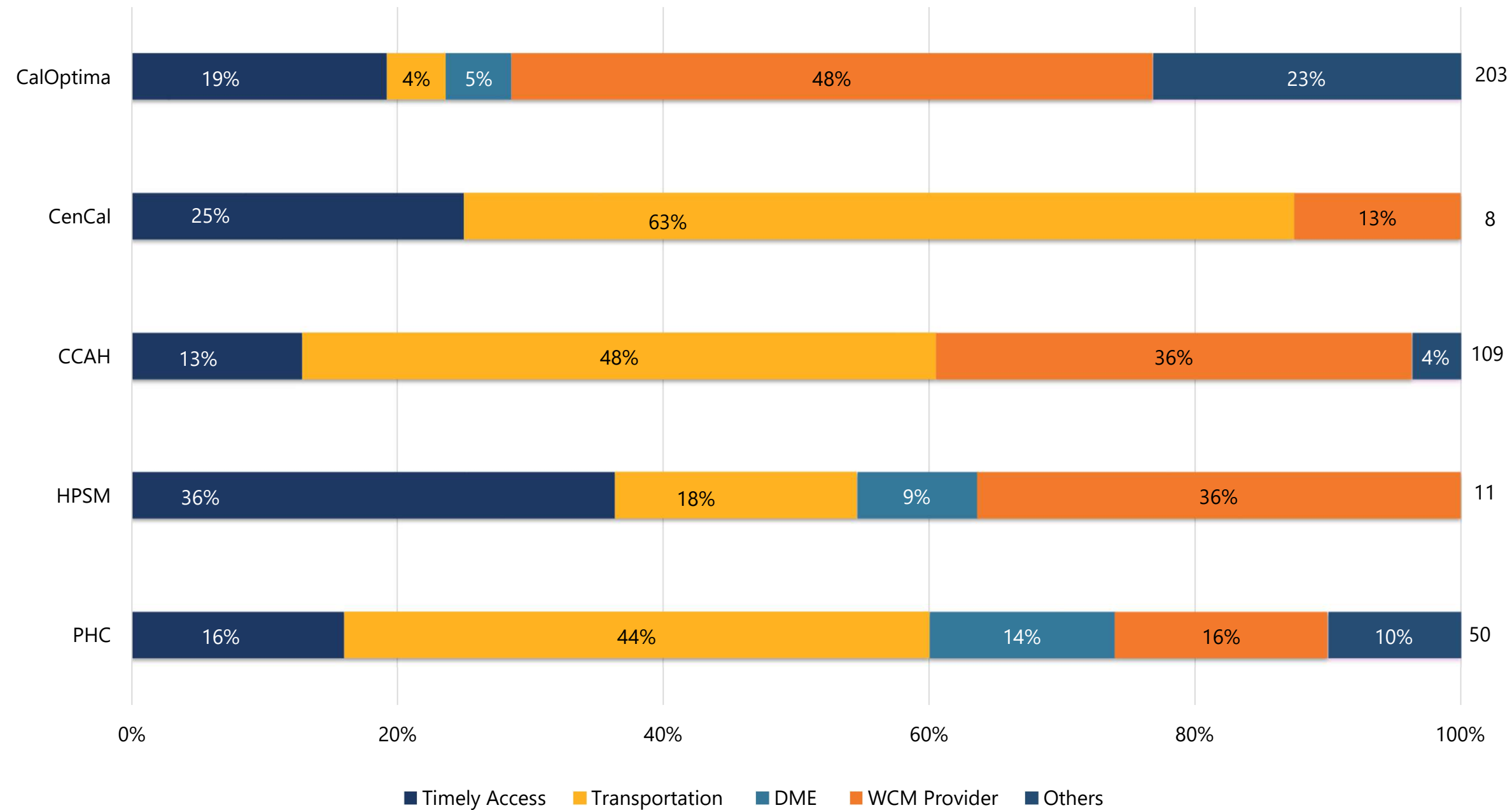


**Fig 49: WCM Appeals per 1,000 Member Months, by Plan**



**WCM Figure 50: Grievances - Breakdown by Categories, by Plan (Jan'22 - Dec'22)**

**Fig 50: Grievances Categories, by Plan**



**WCM Figure 51: Family Advisory Committee Meetings Table (Jan'22 - Dec'22)**

| Plan Name | Number of Committee Members | Number of Meetings Held Jan'22 - Dec'22 | Recruitment Efforts   | Seats to be Filled                      |
|-----------|-----------------------------|---|---|---|
| CalOptima | 8                           | 6                                       | Staff continued to recruit through existing members and publicizing the openings on CalOptima's website as well as regular updates in newsletters to community members.   | 3 of 11                                 |
| CCAH      | 12                          | 6                                       | Based on guidance from the California Department of Public Health and the California Governor's Office, In order to minimize the spread of the COVID-19 virus, Alliance offices were closed and these meetings were held virtually. Recruiting efforts were placed on hold until the resumption of in-person meetings.  | 6 of 19                                 |
| CenCal    | 17                          | 4                                       | Currently recruiting for 1 position - seeking help from family advocacy groups.   | 1 of 18                                 |
| HPSM      | 22                          | 3                                       | Efforts are ad hoc as HPSM's Social Workers make contact with families.   | N/A. No target number of seats to fill. |
| PHC       | 14                          | 5                                       | <ul style="list-style-type: none"> <li>• We have one additional member in process of joining, which will bring our current membership up to 14</li> <li>• Flyers have been distributed to CCS offices and several providers to post.</li> <li>• Single phone line is still in process, hoping for completion this month.</li> <li>• Our Care Coordination team has made several visits to the county MTCs to engage with families and also promote the FAC.</li> <li>• An incentive has been approved for any PHC staff member who successfully recruits a new family for the FAC.</li> </ul> | 14 of 28                                |

## Appendix

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