Integrated California Children's Services and Whole Child Model Dashboard

Released March 2024

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Introduction

The Integrated California Children's Services (CCS) and Whole Child Model (WCM) Dashboard contains data for October 2021 through September 2022. The data is broken down at the State, Plan 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.[1]

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 the 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 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). WCM currently operates in 21 Counties with 5 participating MCPs. The Counties are listed here: CCS Whole Child Model (ca.gov).

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 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.

[1] Capitalized terms have the meaning ascribed by MCP's Medi-Cal Managed Care Contract with DHCS, unless otherwise defined. The MCP Contract is available on DHCS's website.

- Improve the transition of youth from CCS to adult Medi-Cal managed systems of care through better coordinationof 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 in the last 12 months of the reporting period.
- **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 in the reporting period as one figure.
- **Tables:** Figures 30 and 31.
  Tables display each month's data in the last 12 months 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. 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.[2] 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 October 2021, 141,810 members were enrolled in CCS.

[2] For the purposes of this Dashboard, "WCM Member" means any Medi-Cal member who is enrolled in an MCP. "Medi-Cal member" means any individual enrolled in Medi-Cal.

Enrollment increased 4.8% to 148,613 members in September 2022. In October 2021, 31,222 Members were enrolled in WCM. Enrollment increased 1.9% to 31,814 Members enrolled in September 2022.

Figure 2 displays that 48% of CCS members identified themselves as Hispanic. This was calculated by using member reported ethnicity for the month of September 2022 as the numerator, divided by total enrollment for September 2022 as the denominator. *Figure 2* also displays that 57% of WCM Members identified themselves as Hispanic. This was calculated by using Member reported ethnicity for the month of September 2022 as the numerator, divided by total enrollment for September 2022 as the denominator.

Figure 3 displays the CCS members consists of 46.2% female and 53.8% male . This was calculated by using enrollment by gender in September 2022 as the numerator, divided by the total enrollment in September 2022 as the denominator. WCM Member's population consists of 53.2% male and 46.8% female as displayed in *Figure 3*. This was calculated by using enrollment by gender in September 2022 as the numerator, divided by the total enrollment in September 2022 as the denominator.

Figure 4 displays enrollment by primary languages. In September 2022, 68.1% of CCS members spoke English and 27.4% spoke Spanish as their primary spoken language. This was calculated by using CCS enrollment for each language in September 2022 as the numerator, divided by the total CCS enrollment in September 2022 as the denominator. In September 2022, 61.3% of WCM Members spoke English and 36.2% spoke Spanish as their primary spoken language. This was calculated by using WCM Member enrollment for each language in September 2022 as the numerator, divided by the total WCM Member enrollment in September 2022 as the denominator.

Figure 5 displays enrollment by age. In September 2022, 33% of CCS members were between the ages 12 and 17 and 15% 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 September 2022 as the numerator, divided by total CCS enrollment for September 2022 as the denominator. In September 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 September 2022 as the numerator, divided by total WCM Member enrollment for September 2022 as the denominator.

Figures 6 and *7* display total CCS enrollment by County, in alphabetical order. The largest enrollment is in Los Angeles County with 37,960 members. The smallest enrollment displayed is in Mono County with 45 members. An asterisk (*) 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 enrollment with 11,779 Members and Trinity County had the least with 52 Members.

CCS and WCM Outpatient Visits

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 1,687 outpatient visits per 1,000 member months while males made 1,733 outpatient visits per 1,000 member months. This was calculated by using the number of CCS outpatient visits for each gender for October 2021 through September 2022 as the numerator, divided by the CCS enrollment for each gender for October 2021 through September 2022 as the denominator. The dividend was then multiplied by 1,000. *Figure 9* also displays that for WCM, female Members made 2,744 outpatient visits per 1,000 Member months while male Members made 2,842 outpatient visits per 1,000 Member months. This was calculated by using the number of WCM outpatient visits for each gender for October 2021 through September 2022 as the numerator, divided by the WCM Member enrollment for each gender for October 2021 through September 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 2,522 per 1,000 member months. This was calculated by using the number of CCS outpatient visits for each ethnicity for October 2021 through September 2022 as the numerator, divided by the CCS enrollment for each ethnicity for October 2021 through September 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 3,288 per 1,000 Member months. This was calculated by using the number of WCM Member outpatient visits for each ethnicity for October 2021 through September 2022 as the numerator, divided by the WCM Member enrollment for each ethnicity for October 2021 through September 2022 as the denominator. The dividend was then multiplied by 1,000.

Figure 11 displays the trend in the number of statewide CCS member and WCM Member outpatient visits from October 2021 through September 2022. This was calculated by using the number of outpatient visits for each program per month for October 2021 through September 2022 as the numerator, divided by the enrollment for each program per month for October 2021 through September 2022 as the denominator. The dividend was then multiplied by 1,000. From October 2021 to September 2022, the CCS program has fewer outpatient visits per 1,000 on average, with a slight decrease in utilization for 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 plan from October 2021 through September 2022. This was calculated by using the number of outpatient visits for each plan per month for October 2021 through September 2022 as the numerator, divided by the enrollment for each plan per month for October 2021 through September 2022 as the denominator. The dividend was then multiplied by 1,000. Health Plan of San Mateo (HPSM), CalOptima, CenCal, and PHC had slight decreases. CCAH had a slight increase. CalOptima had the most outpatient visits and CCAH had the fewest.

CCS and WCM Inpatient Admissions

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 plan.

Figure 13 displays that for CCS, male members had 28 inpatient admissions per 1,000 member months and female members had 26 inpatient admissions per 1,000 member months. This was calculated by using the number of CCS inpatient visits for each gender for October 2021 through September 2022 as the numerator, divided by the CCS enrollment for each gender for October 2021 through September 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 member months and female members had 25 inpatient admissions per 1,000 member months. This was calculated by using the number of WCM Member inpatient visits for each gender for October 2021 through September 2022 as the numerator, divided by the WCM Member enrollment for each gender for October 2021 through September 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 47 per 1,000 member months. This was calculated by using the number of CCS inpatient visits for each ethnicity for October 2021 through September 2022 as the numerator, divided by the CCS enrollment for each ethnicity for October 2021 through September 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 37 per 1,000 Member months. This was calculated by using the number of WCM Member inpatient visits for each ethnicity for October 2021 through September 2022 as the numerator, divided by the WCM Member enrollment for each ethnicity for October 2021 through September 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 programs inpatient admissions from October 2021 through September 2022. This was calculated by using the number of inpatient admissions for each program per month for October 2021 through September 2022 as the numerator, divided by the enrollment for each program per month for October 2021 through September 2022 as the denominator. The dividend was then multiplied by 1,000. From October 2021 to September 2022, WCM MCPs have fewer inpatient admissions per 1,000 on average, 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 October 2021 through September 2022. This was calculated by using the number of inpatient admissions for each MCP per month for October 2021 through September 2022 as the numerator, divided by the enrollment for each MCP per month for October 2021 through September 2022 as the denominator. The dividend was then multiplied by 1,000. CalOptima and HPSM had slight decreases in inpatient admissions. Inpatient admissions remained steady for all other MCPs.

WCM Emergency Department (ED) Visits

This data is not currently reported by CCS counties. 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 that male Members made 69 ED visits per 1,000 Member months and female Members made 70 ED visits per 1,000 Member months. This was calculated by using the number of ED visits for each gender for October 2021 through September 2022 as the numerator, divided by the enrollment for each gender for October 2021 through September 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 103 per 1,000 Member months. This was calculated by using the number of ED visits for each ethnicity for October 2021 through September 2022 as the numerator, divided by the enrollment for each ethnicity for October 2021 through September 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 October 2021 through September 2022. This was calculated by using the number of ED visits for each MCP per month for October 2021 through September 2022 as the numerator, divided by the enrollment for each MCP per month for October 2021 through September 2022 as the denominator. The dividend was then multiplied by 1,000. ED utilization increased significantly for all MCPs.

WCM Prescriptions Medications

This data is not currently reported by CCS counties. 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 1,251 prescription medications per 1,000 Member months while male Members had utilized 1,231 prescription medications per 1,000 Member months. This was calculated by using the number of prescriptions for each gender for October 2021 through September 2022 as the numerator, divided by the enrollment for each gender for October 2021 through September 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 1,520 per 1,000 Member months. This was calculated by using the number of prescriptions for each ethnicity for October 2021 through September 2022 as the numerator, divided by the enrollment for each ethnicity for October 2021 through September 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 October 2021 through September 2022. This was calculated by using the number of prescriptions reported by each MCP per month for October 2021 through September 2022 as the numerator, divided by the enrollment for each MCP per month for October 2021 through September 2022 as the denominator. The dividend was then multiplied by 1,000. Prescriptions increased for CalOptima and CCAH and decreased for all other plans.

WCM Non-Specialty Mental Health (NSMH)

This data is not currently reported by CCS counties. 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 59 NSMH visits per 1,000 Member months while male Members made 34 NSMH visits per 1,000 Member months. This was calculated by using the number of NSMH visits for each gender for October 2021 through September 2022 as the numerator, divided by the enrollment for each gender for October 2021 through September 2022 as the denominator. The dividend was then multiplied by 1,000.

Figure 24 displays that Non-Hispanic/White Members made the most visits at 80 per 1,000 Member months. This was calculated by using the number of NSMH visits for each ethnicity for October 2021 through September 2022 as the numerator, divided by the enrollment for each ethnicity for October 2021 through September 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 October 2021 through September 2022. This was calculated by using the number of NSMH visits for each MCP per month for October 2021 through September 2022 as the numerator, divided by the enrollment for each MCP per month for October 2021 through September 2022 as the denominator. The dividend was then multiplied by 1,000. NSMH visits decreased for CalOptima, CCAH, and PHC. NSMH visits increased for CenCal and HPSM.

WCM ED Visits with an Inpatient Admission

This data is not reported by CCS counties at this time. This data focuses on those WCM Members 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 that male Members made 11 ED visits with an inpatient admission per 1,000 Member months and female Members made 10 ED visits with an inpatient admission per 1,000 Member months. This was calculated by using the number of ED visits with an inpatient admission for each gender for October 2021 through September 2022 as the numerator, divided by the enrollment for each gender for October 2021 through September 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 18 per 1,000 Member months. This was calculated by using the number of ED visits with an inpatient admission for each ethnicity for October 2021 through September 2022 the numerator, divided by the enrollment for each ethnicity for October 2021 through September 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 October 2021 through September 2022. This was calculated by using the number of ED visits with an inpatient admission for each MCP per month for October 2021 through September 2022 as the numerator, divided by the denominator is enrollment for each MCP per month for October 2021 through September 2022 as the denominator. The dividend was then multiplied by 1,000. An asterisk (*) represents numbers have been suppressed for MCPs that have a low number of observations as they are seen as statistically unreliable. Taking

into account suppressed numbers, ED visits with an inpatient admission decreased for CalOptima and CCAH. ED visits with an inpatient admission increased for CenCal and HPSM. ED visits with an inpatient admission remained steady for PHC.

WCM Continuity of Care (COC): Figures 29-35

This data is not currently reported by CCS counties. 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 MCP. 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 October 2021 through September 2022 as the numerator, divided by the enrollment for each plan in September 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 92% for CenCal to 97% for HPSM. This was calculated by using the number of approved CoC requests for each MCP and each County for October 2021 through September 2022 as the numerator, divided by the total number of CoC requests for each MCP and each County for October 2021 through September 2022 as the denominator.

Figure 30 displays the total number of CoC requests for each MCP for the months 40 through 51 after joining the program. In the 40th month of operation, CalOptima, CCAH, and HPSM reported fewer than 11 COC requests, PHC reported 0 COC requests, and CenCal reported 22 COC requests. In the 51st month of operation, CalOptima, CenCal, and HPSM reported fewer than 11 COC requests, and CCAH and PHC reported 0 COC requests. An asterisk (*) represents numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable.

Figure 31 displays Months 52 through 63 upon joining the program for CoC requests. In the 52nd month of operation, CalOptima and HPSM reported fewer than 11 COC requests, CenCal reported 24 COC requests, and CCAH and PHC reported 0 COC requests. In the 63rd month of operation, CalOptima, CenCal, CCAH, and PHC reported 0 CoC requests, and HPSM reported fewer than 11 COC requests. An asterisk (*) represents numbers that have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable.

Figure 32 displays the average number of CoC requests for each MCP for months 40 through 51 compared to months 52 through 63. CenCal had an average of 22.7 requests for months 40 through 51 and 17.8 requests for months 52 through 63. The remaining MCPs reported an average of less than 11 CoC requests for months 40 through 51 and 52 through 63. An asterisk (*) 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 9 times, or 2.8% of the time, while 117, or 35.8%, of requests were made for major specialty types. This was calculated by using the number of CoC requests for each category for October 2021 through September 2022 as the numerator, divided by the total number of CoC requests for October 2021 through September 2022 as the denominator.

Figure 34 displays reasons for CoC denials not required by APL. Criteria Not Met accounted for 3, or 16% of CoC denial reasons while Insufficient Documentation accounted for 2, or 11%. This was calculated by using the number of CoC denials for each reason for October 2021 through September 2022 as the numerator, divided by the total number of CoC denials for October 2021 through September 2022 as the denominator.

Figure 35 displays the reasons for CoC denials required by APL. No pre-existing relationship between WCM Member and Provider accounted for 7, or 37% of COC denial reasons while 6, or 32% were due to quality-of-care issues.[3] This was calculated by using the number of CoC denials for each reason for October 2021 through September 2022 as the numerator, divided by the total number of CoC denials for October 2021 through September 2022 as the denominator.

Please note that for *Figure 34*, only the top five denial reasons are displayed. *Figure 35* displays all denial categories as required by the All Plan Letter, 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) authorization requests, Pediatric Intensive Care Unit (PICU) authorization requests, Inpatient Facilities and Special CareCenter (SCC) authorization requests, 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[4]

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 MCP is displayed on the far-left column for reference. The approval percentage ranged from 98% for PHC to 100% for CenCal and CCAH. This was calculated by using the number of approved NICU authorizations for each MCP and each County for October 2021 through September 2022 the numerator, divided by the number of NICU requests for authorizations for each Plan and each County for October 2021 through September 2022 as the denominator. An asterisk (*) 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 4.9 CCS

[3] Follow up sent to MCPs reporting quality of care issues to remind MCPs of process for reporting quality of care issues related to Providers to DHCS for further investigation.
[4] MCPs must conduct NICU eligibility assessments of medical eligibility for care in a CCS-approved NICU in accordance with CCS Program guidelines found in CCS N.L. 05-0502, or any superseding N.L.

NICU authorization requests per 1,000 members for October 2021. There were 4.9 CCS NICU authorization requests per 1,000 members for September 2022. The figure also displays that there were 2.9 WCM NICU authorization requests per 1,000 Members for October 2021. There were 3.5 WCM NICU authorization requests per 1,000 Members for September 2022.

Figure 38 displays the trend of total requests seeking authorization for NICU services for each MCP each quarter. For example, CCAH reported 75 requests in Q4 2021, 70 requests in Q1 2022, 81 requests in Q2 2022, and 62 requests in Q3 2022. HPSM reported fewer than 11 requests for all four quarters.[5] An asterisk (*) 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

Figure 39 displays total requests for PICU authorizations and approval rate, by MCP and by County. The figure displays that total requests for PICU authorizations ranged from 37 for HPSM to 629 for CCAH. Total MCP enrollment and percent distribution of WCM 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 to 100% for CalOptima, CenCal, CCAH, and HPSM. This was calculated by using the number of approved PICU requests for authorizations for each MCP and each County for October 2021 through September 2022 as the numerator, divided by the number of PICU authorizations for each MCP and each County for October 2021 through September 2022 as the denominator. An asterisk (*) 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 that there were1.5 CCS PICU authorization requests per 1,000 members in October 2021 and 1.7 CCS PICU authorization requests per 1,000 members in September 2022. The figure also displays that there were 2.5 WCM PICU authorization requests per 1,000 Members in October 2021 and 4.1 WCM PICU authorization requests per 1,000 Members for September 2022.

Figure 41 displays the trend of total requests seeking authorization for PICU services for each MCP each quarter. For example, CalOptima reported 101 requests in Q4 2021, 115 requests in Q1 2022, 128 requests in Q2 2022, and 140 requests in Q3 2022.

WCM Inpatient Facilities and SCC Authorizations

This data is not currently reported by CCS counties. *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 464 for CenCal to 5,175 for CalOptima. Total MCP enrollment and percent distribution of WCM 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 94% 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 October 2021 through September 2022 as the numerator, divided by the number of Inpatient Facilities and

[5] Follow up was sent to HPSM to inquire why no NICU authorizations occurred during the reporting period. HPSM responded "One of the reasons this may occur is because of eligibility. It typically takes 30-45 days for a baby to be eligible in our system so any NICU authorizations prior to the 45 days are logged under the mother with a B1 distinction (not the baby since they are not in our system). Once the baby becomes an eligible HPSM member, then the NICU authorization can get loaded. During the reporting period, none of the WCM enrolled babies had a NICU authorization within their record."

SCC requests for authorizations for each Plan and each County for October 2021 through September 2022 as the denominator.

Figure 43 displays the total requests seeking authorization for SCC services for each plan each quarter. For example, CenCal reported 129 requests in Q4 2021, 116 requests in Q1 2022, 120 requests in Q2 2022, and 98 requests in Q3 2022.

WCM Specialized or Customized DME Authorizations

This data is not currently reported by CCS counties. *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 100 for CenCal to 1,232 for PHC. Total MCP enrollment and percent distribution of WCM program enrollment in each MCP is displayed on the far-left column for reference. The approval percentage ranged from 94% 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 October 2021 through September 2022 as the numerator, divided by the number of specialized or customized DME requests for authorizations for each MCP and each County for October 2021 through September 2022 as the denominator.

Figure 45 displays the total requests seeking authorization for DME services for each MCP each quarter. For example, PHC reported 318 requests in Q4 2021, 235 requests in Q1 2022 415 requests in Q2 2022, and 264 requests in Q3 2022. An asterisk (*) 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 currently reported by CCS counties. 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 transitioning 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 13% to 152%, which is 378 assessments for PHC and 1,511 assessments for HPSM, respectively[6]. This was calculated by using the number of high-risk assessments for each MCP as of September 2022 as the numerator, divided by the number of high-risk Members in each MCP in September 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 42% to 100%, which is 6,906

[6] 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 23-034, 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.

assessments for CalOptima and 5,133 assessments for CenCal, respectively. This was calculated by using the number of low-risk assessments for each MCP as of September 2022 as the numerator, divided by the number of low-risk Members in each MCP in September 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 currently reported by CCS counties. 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 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.

Figure 48 displays WCM appeals and grievances per 1,000 Members are trended over 12 months (October 2021 – September 2022). In October 2021, plans reported to have received 0.58 appeals per 1,000 Members and 0.83 grievances per 1,000 Members. In September 2022, plans received 0.47 appeals per 1,000 members and 1.32 grievances per 1,000 Members.

Figure 49 displays WCM appeals per 1,000 Member months. CenCal reported to have received 3 appeals per 1,000 Member months while CCAH and PHC reported 7 appeals per 1,000 Member months.

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.[7] This was calculated by using the number of each grievance type for each MCP for October 2021 through September 2022 as the numerator, divided by the total number of grievances for each MCP from October 2021 through September 2022 as the denominator.

WCM Family Advisory Committee Meetings: Figure 51

This data is not currently reported by CCS counties. 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 plan over 12 months (October 2021 - September 2022).

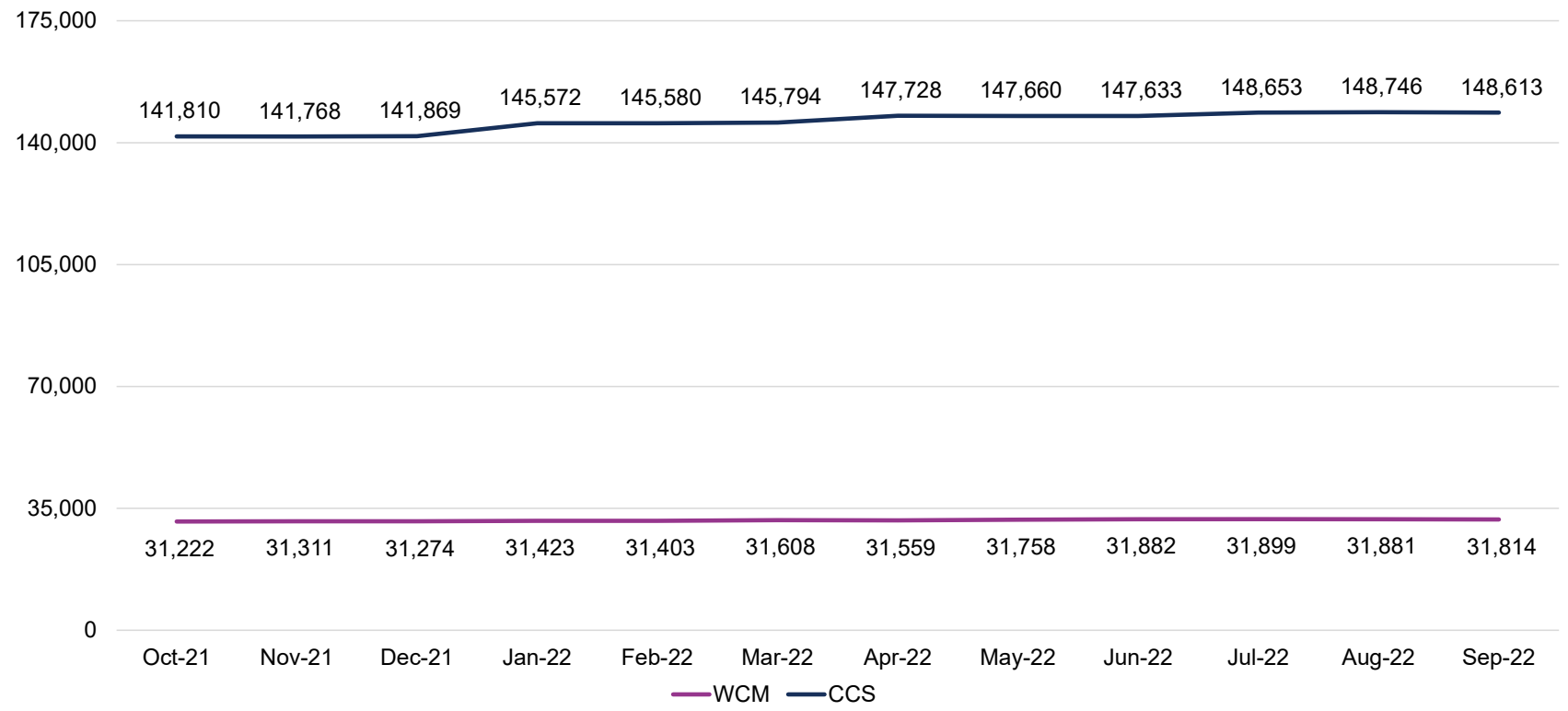
[7] Plans must give details on the "Others" grievance category. "Others" grievances included but were not limited to billing issues, staff dissatisfaction, other insurance/inadequate insurance coverage.

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

CCS and WCM Enrollment and Demographics Figure 1: Breakdown of Enrollment (Oct'21 - Sept'22)

Fig 1: Monthly Statewide Enrollment



Note: This report contains data from October 2021 to September 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.

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

Fig 2: Enrollment by Race/Ethnicity

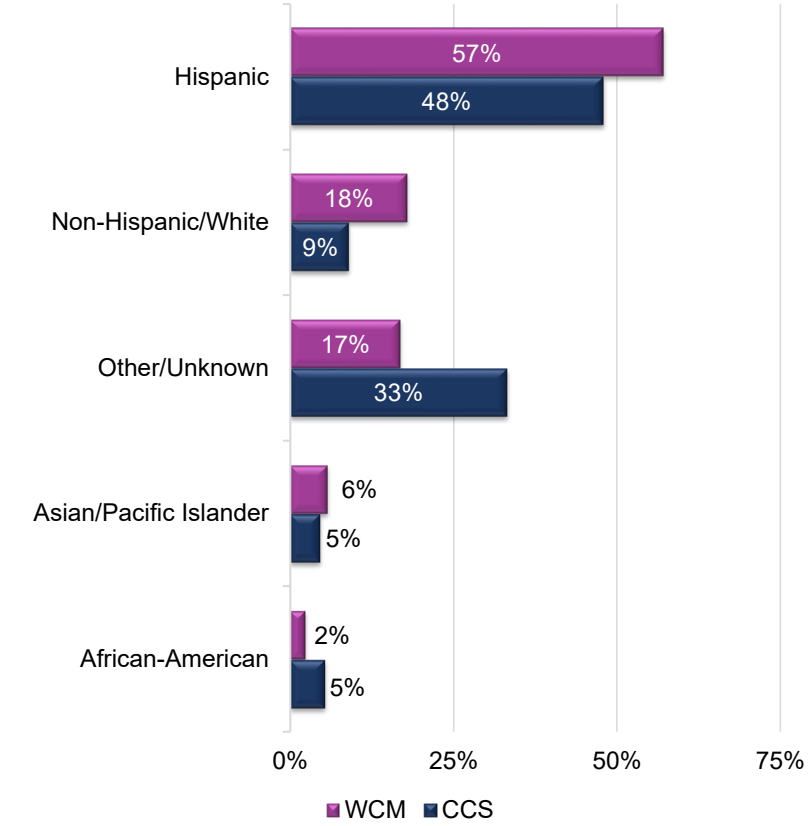
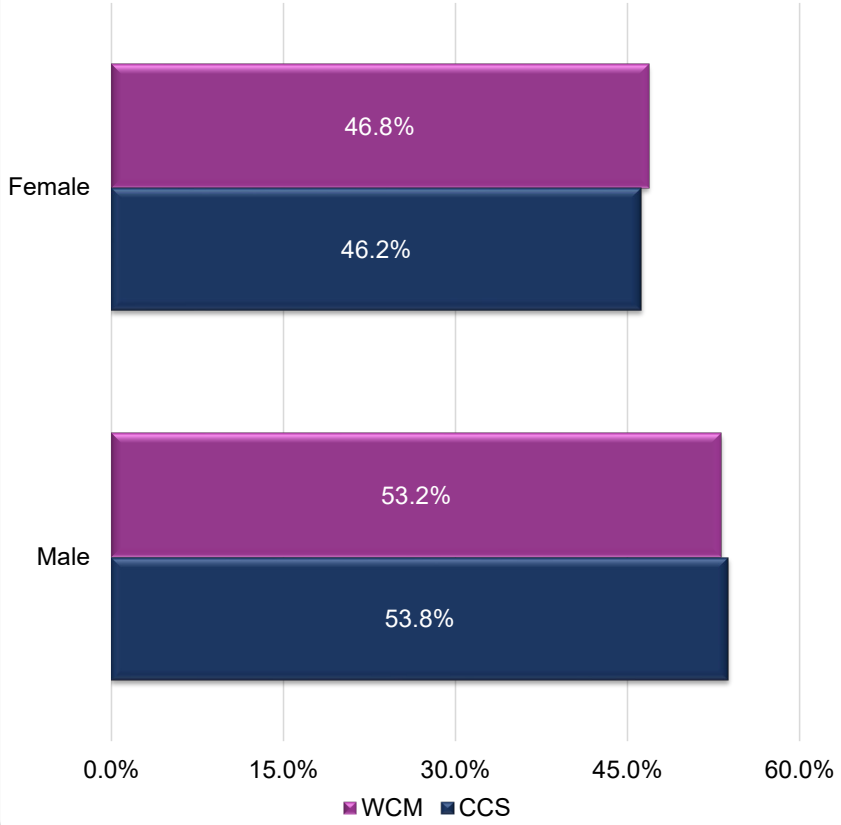


Fig 3: Enrollment by Gender



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 September 2022

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

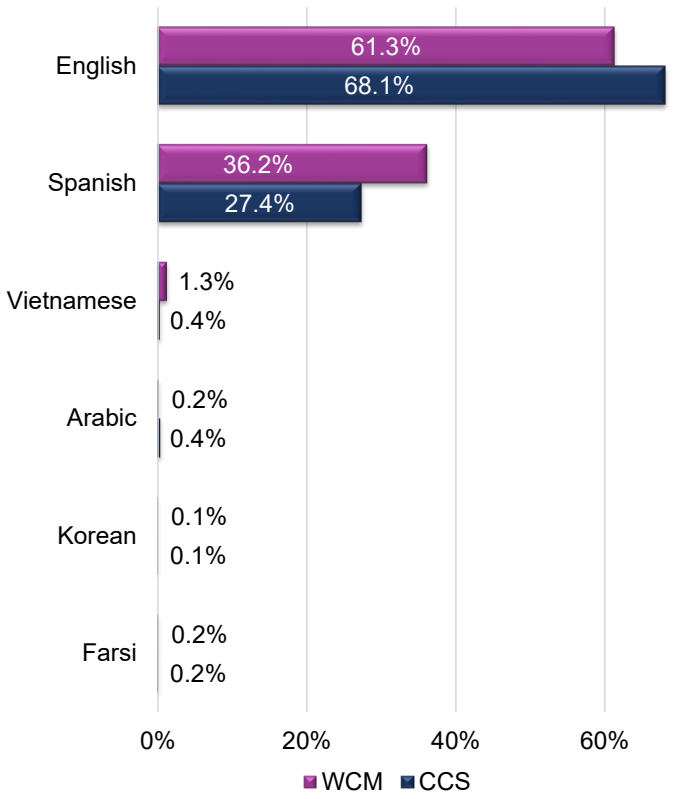
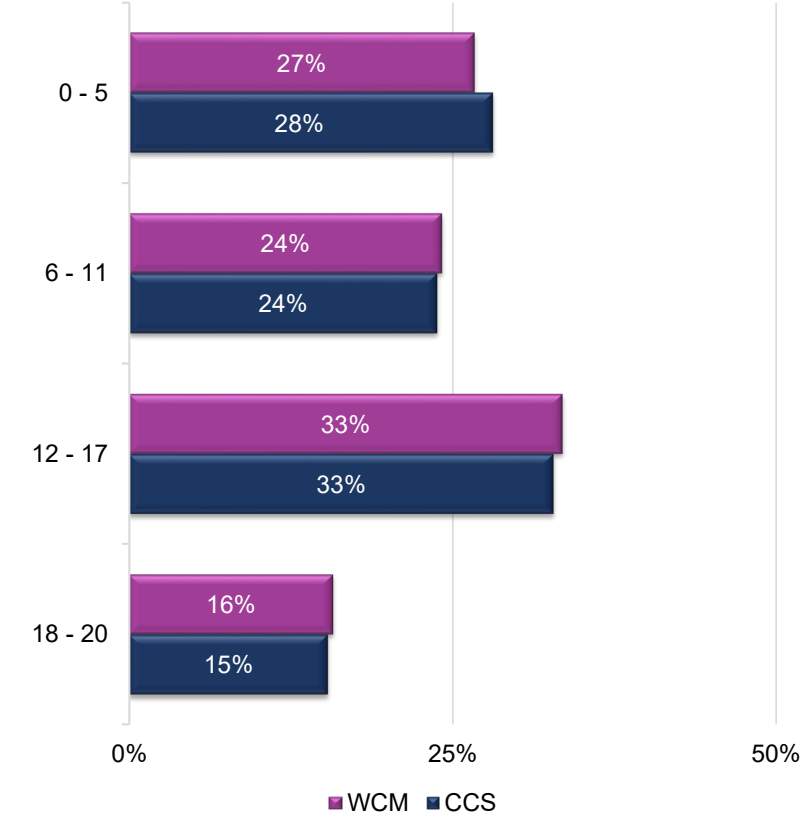


Fig 5: Enrollment by Age



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 September 2022

Fig 6: Total Classic CCS Enrollment by County

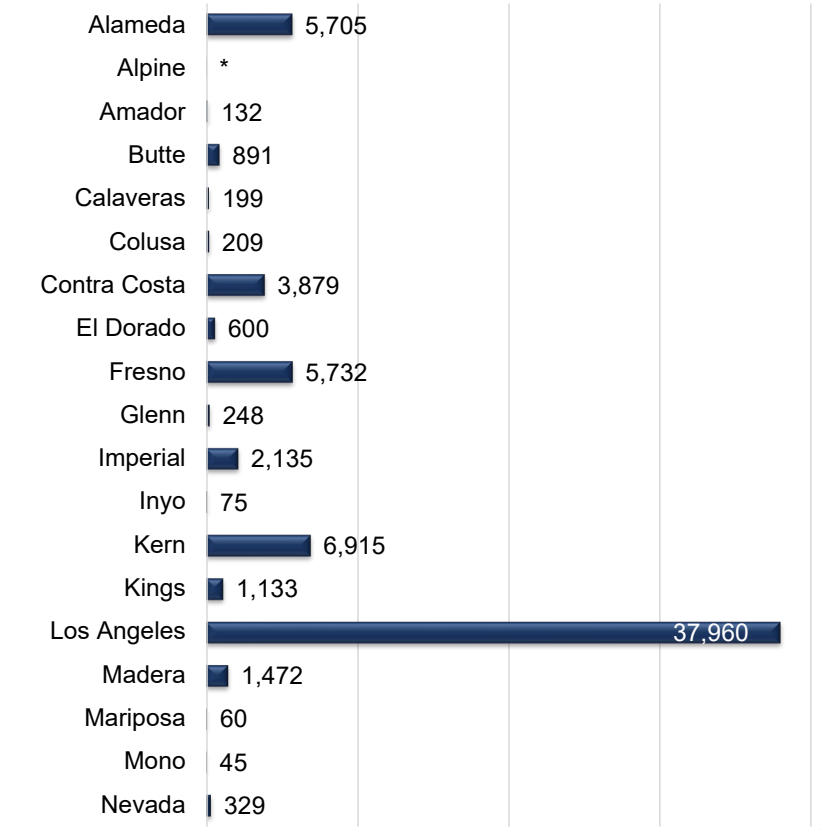
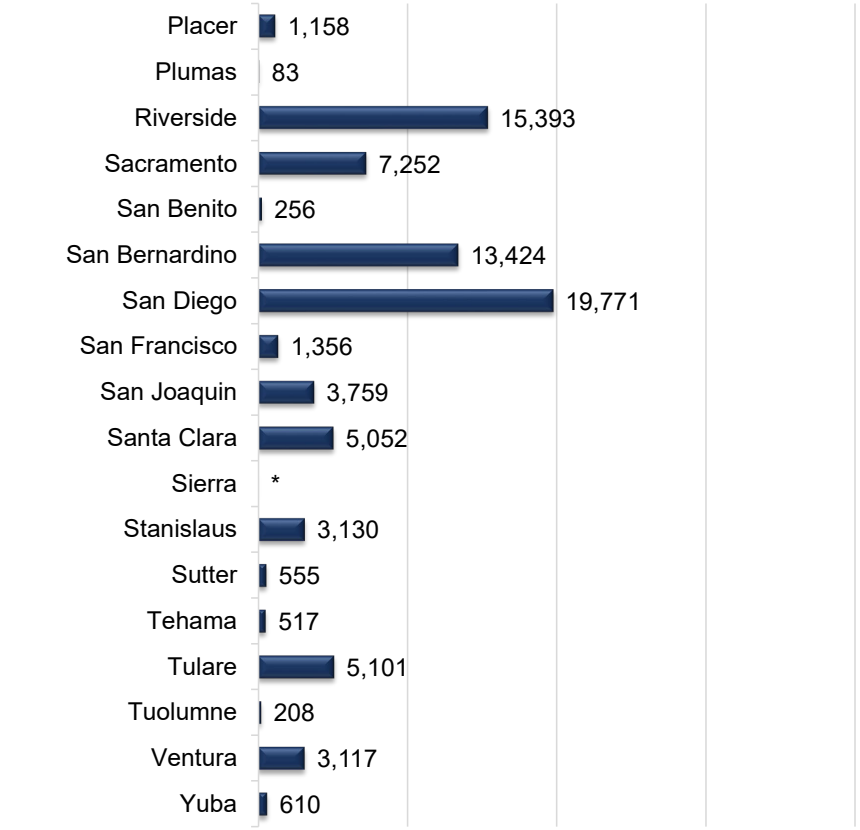


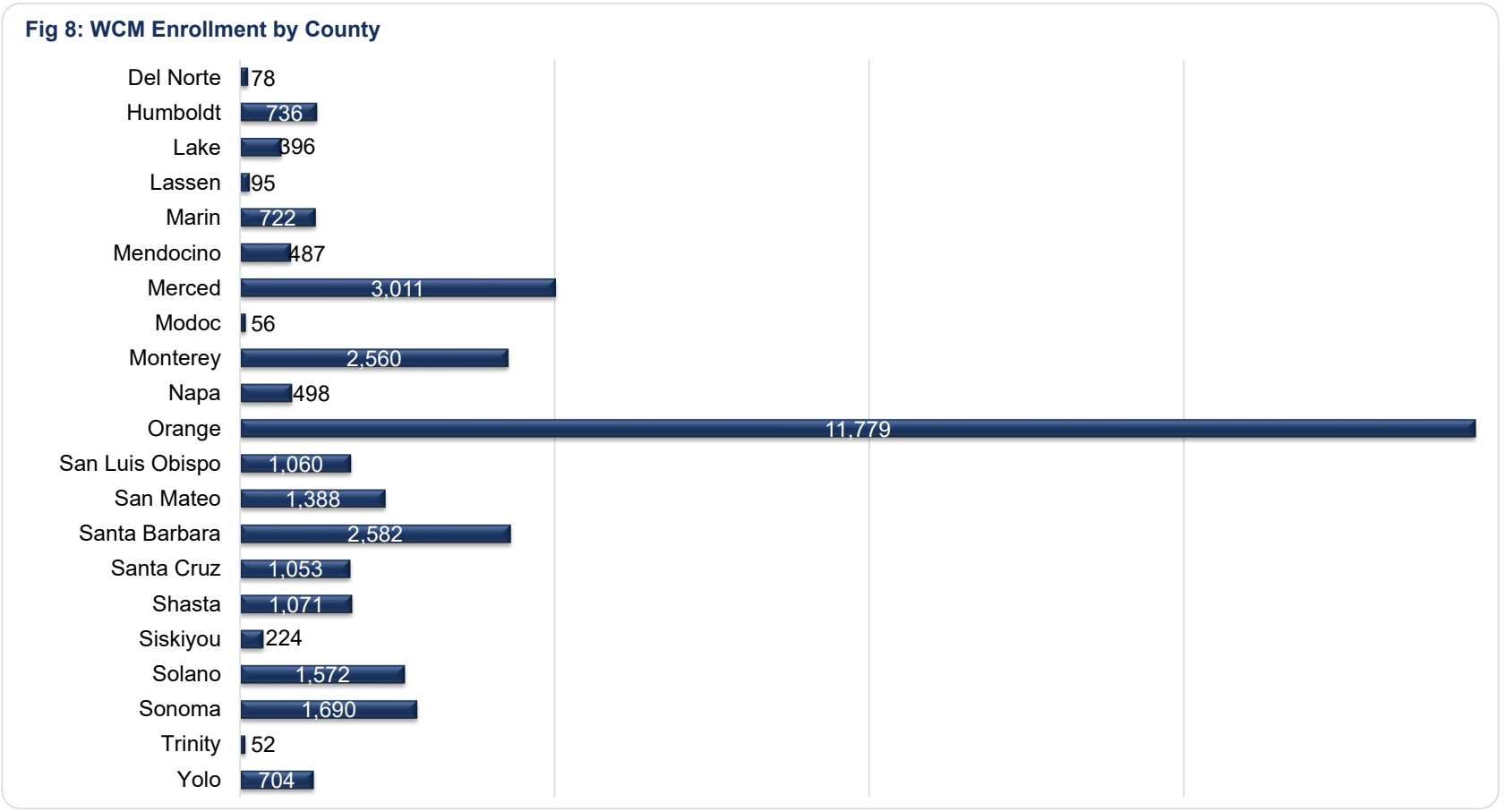
Fig 7: Total Classic CCS Enrollment by County



Note: CCS refers to counties operating outside of the Whole Child Model Program.
**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

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

Fig 8: WCM Enrollment by County



Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from October 2021 to September 2022.

CCS and WCM Utilization Figures 9 & 10: Breakdowns of Outpatient Admissions Utilization (Oct'21 - Sept'22)

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

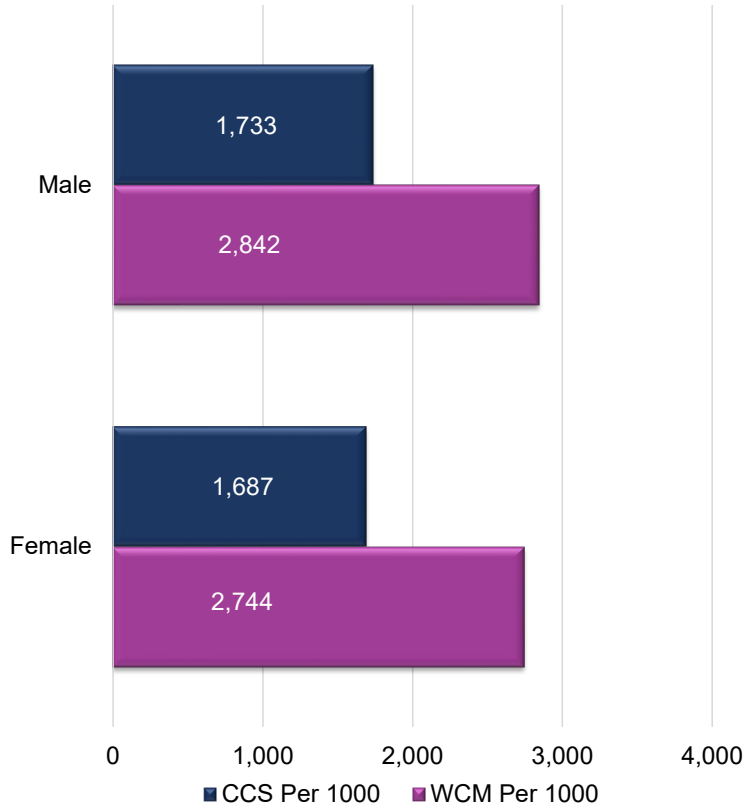
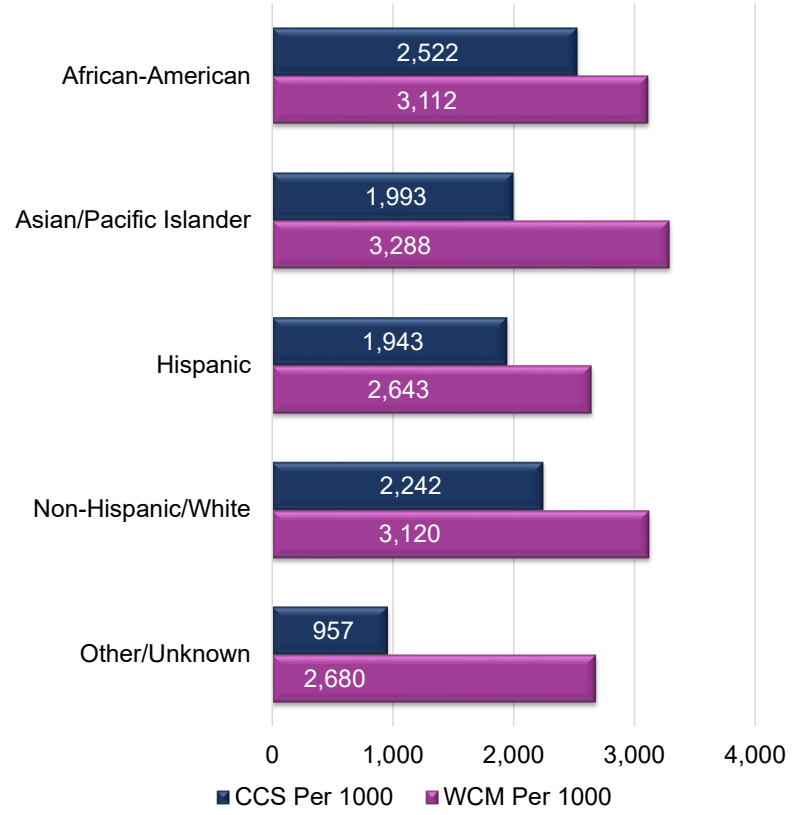


Fig 10: Outpatient Visits per 1,000 Member Months by Ethnicity



Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from October 2021 to September 2022.

CCS and WCM Utilization Figures 11 & 12: Breakdowns of Outpatient Admissions Utilization (Oct'21 - Sept'22)

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

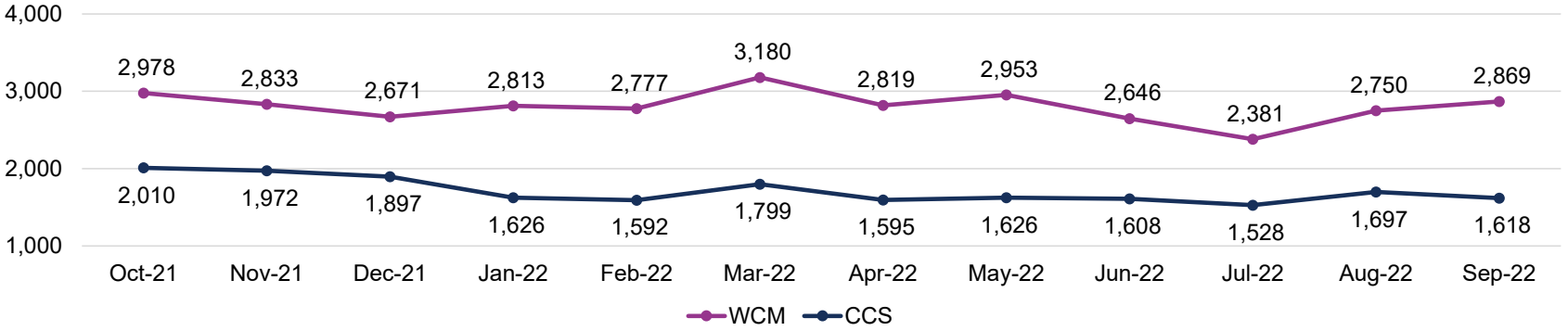
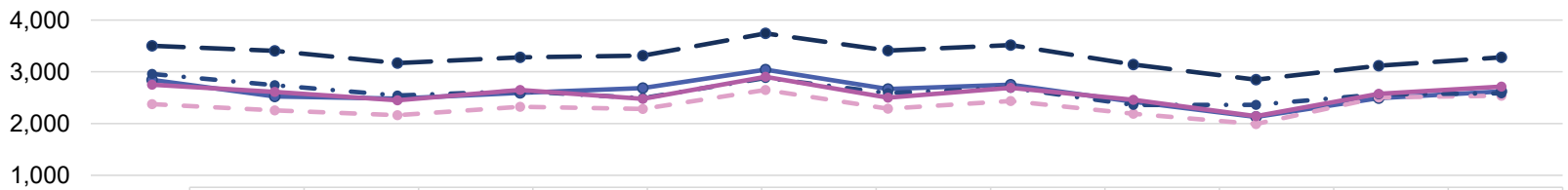


Fig 12: WCM Outpatient Visits per 1,000 Members by Plan, by Month



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
CalOptima	3,503	3,405	3,171	3,280	3,314	3,742	3,409	3,518	3,139	2,848	3,118	3,278
CenCal	2,845	2,525	2,483	2,593	2,684	3,042	2,668	2,751	2,421	2,129	2,489	2,621
CCAH	2,373	2,256	2,164	2,324	2,284	2,650	2,287	2,438	2,188	1,992	2,506	2,537
HPSM	2,958	2,742	2,543	2,628	2,494	2,883	2,587	2,693	2,359	2,363	2,566	2,585
PHC	2,751	2,612	2,451	2,649	2,478	2,903	2,502	2,693	2,460	2,143	2,574	2,713

Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from October 2021 to September 2022.

CCS and WCM Utilization Figures 13 & 14: Breakdowns of Inpatient Visits Utilization (Oct'21 - Sept'22)

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

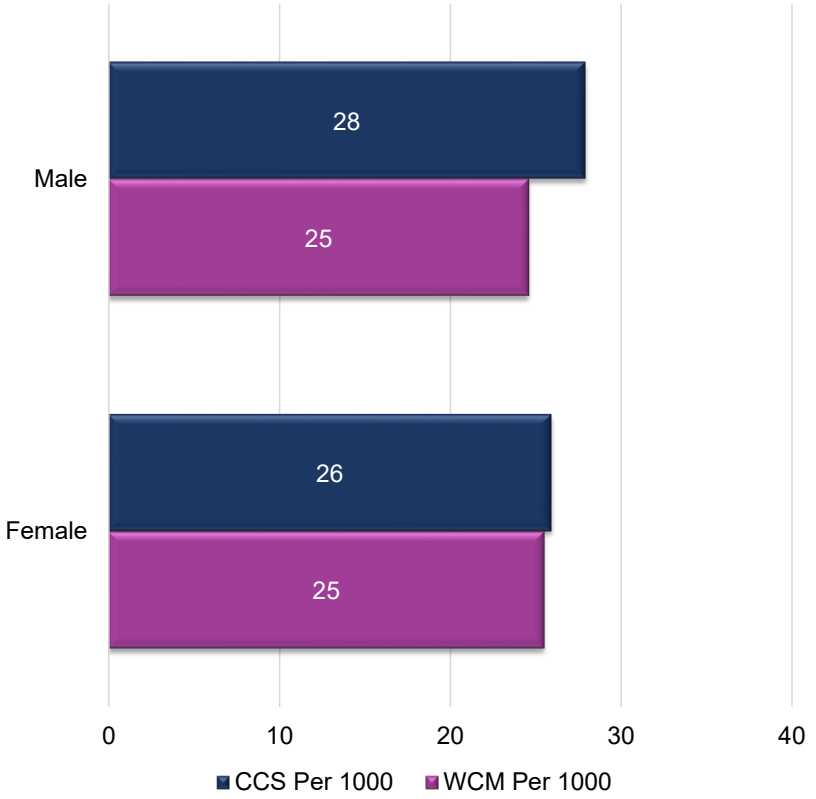
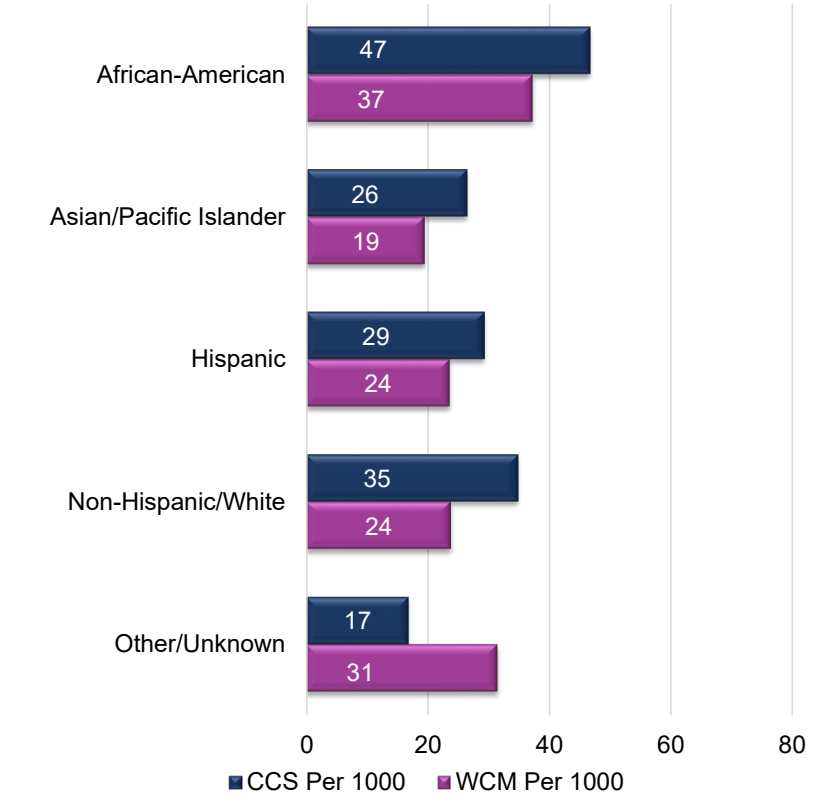


Fig 14: Inpatient Admissions per 1,000 Member Months by Ethnicity



Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from October 2021 to September 2022.

CCS and WCM Utilization Figures 15 & 16: Breakdowns of Inpatient Visits Utilization (Oct'21 - Sept'22)

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

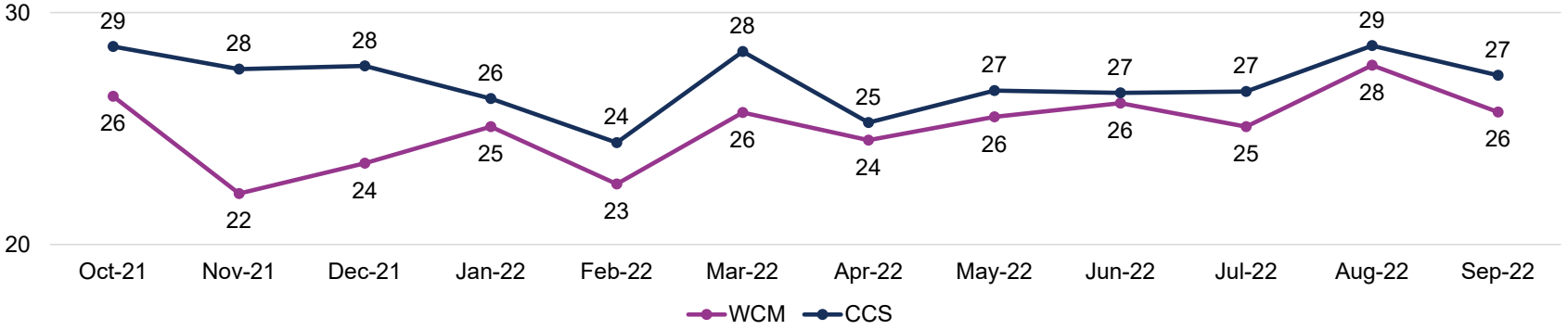
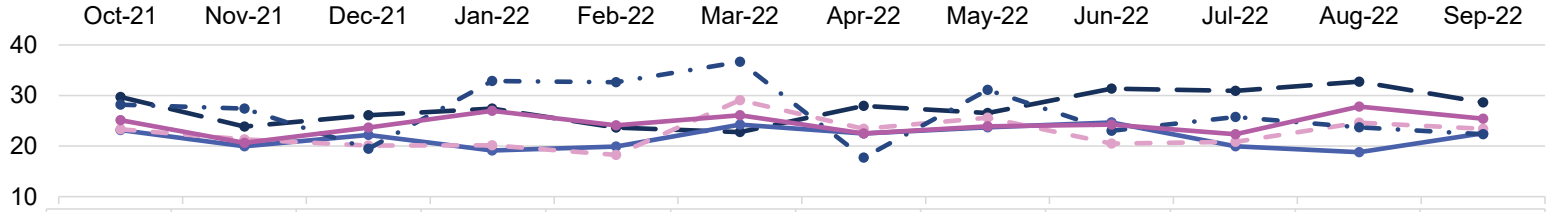


Fig 16: WCM Inpatient Admissions per 1,000 Members by Plan, by Month



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
CalOptima	30	24	26	27	24	23	28	27	31	31	33	29
CenCal	23	20	22	19	20	24	22	24	25	20	19	23
CCAH	23	21	20	20	18	29	23	26	20	21	25	23
HPSM	28	27	19	33	33	37	18	31	23	26	24	22
PHC	25	21	24	27	24	26	22	24	24	22	28	25

Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from October 2021 to September 2022.

WCM Utilization Figure 17 - 19: Breakdowns of Emergency Department (ED) Utilization (Oct'21 - Sept'22)

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

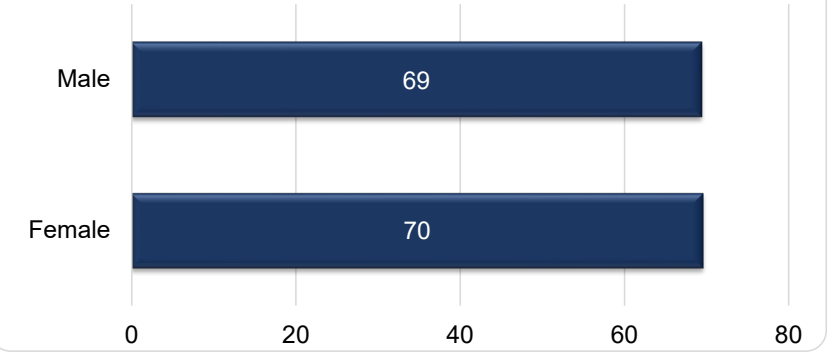


Fig 18: ED Visits per 1,000 Member Months by Ethnicity

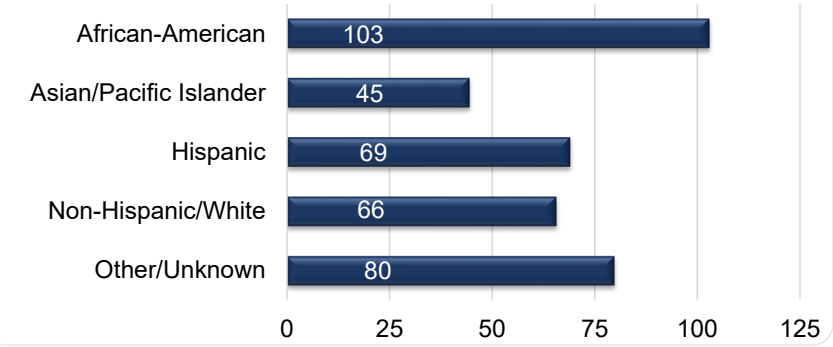
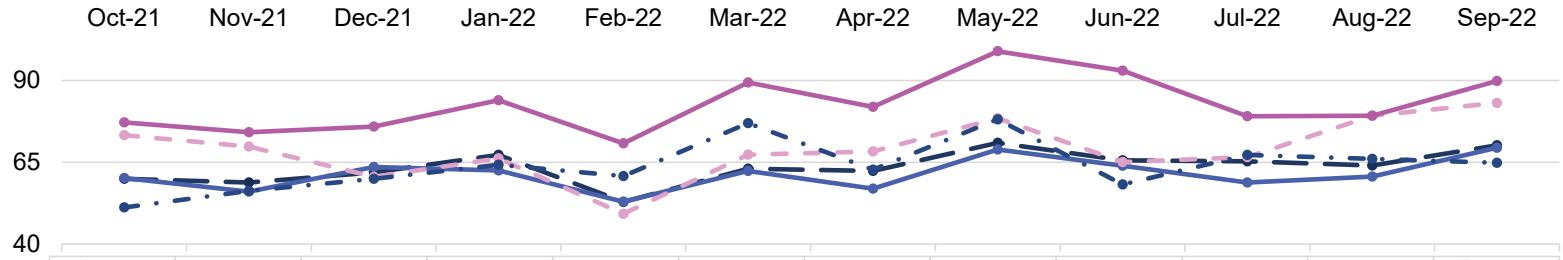


Fig 19: ED Visits per 1,000 Members by Plan, by Month



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
CalOptima	60	59	62	67	53	63	62	71	66	65	64	70
CenCal	60	56	64	63	53	62	57	69	64	59	61	69
CCAH	73	70	61	66	49	67	68	78	65	67	79	83
HPSM	51	56	60	64	61	77	63	78	58	67	66	65
PHC	77	74	76	84	71	89	82	99	93	79	79	90

WCM Utilization Figure 20 - 22: Breakdowns of Prescriptions Utilization (Oct'21 - Sept'22)

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

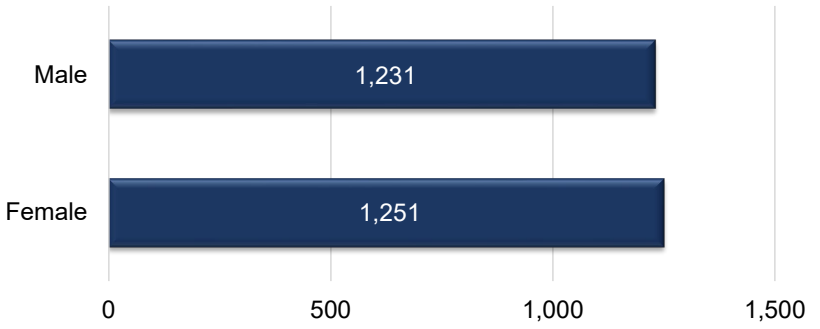


Fig 21: Prescriptions per 1,000 Member Months by Ethnicity

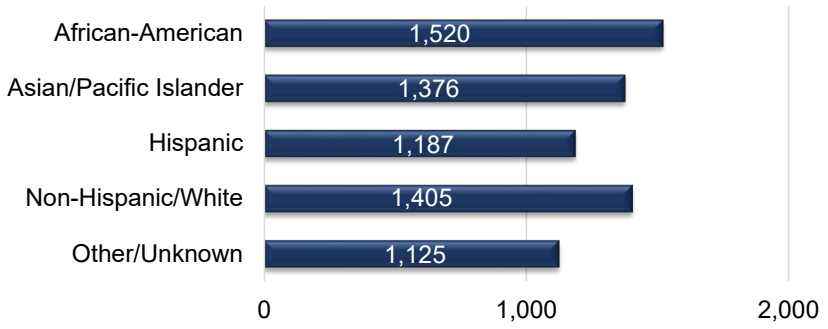
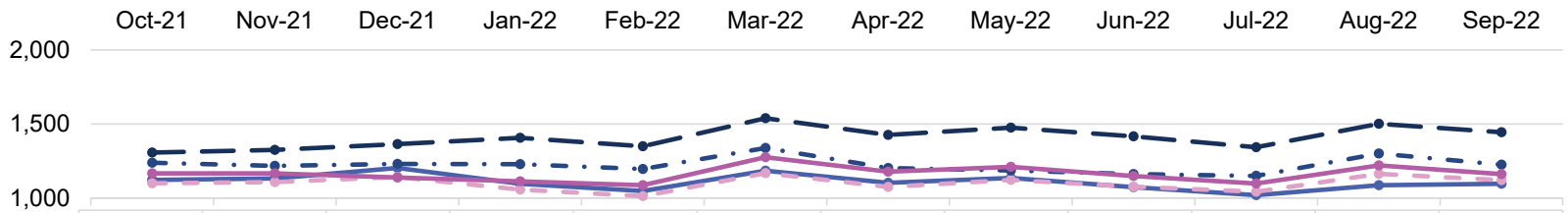


Fig 22: Prescription per 1,000 Members by Plan, by Month



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
CalOptima	1,307	1,325	1,364	1,406	1,349	1,539	1,426	1,475	1,417	1,343	1,501	1,444
CenCal	1,122	1,133	1,203	1,096	1,047	1,184	1,103	1,136	1,074	1,019	1,086	1,097
CCAH	1,100	1,108	1,142	1,058	1,013	1,168	1,076	1,122	1,076	1,042	1,163	1,121
HPSM	1,238	1,218	1,230	1,229	1,196	1,338	1,202	1,187	1,161	1,149	1,301	1,226
PHC	1,166	1,166	1,140	1,113	1,087	1,276	1,178	1,210	1,149	1,099	1,220	1,162

WCM Utilization Figure 23 - 25: Breakdowns of Non-specialty Mental Health Visits Utilization (Oct'21 - Sept'22)

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

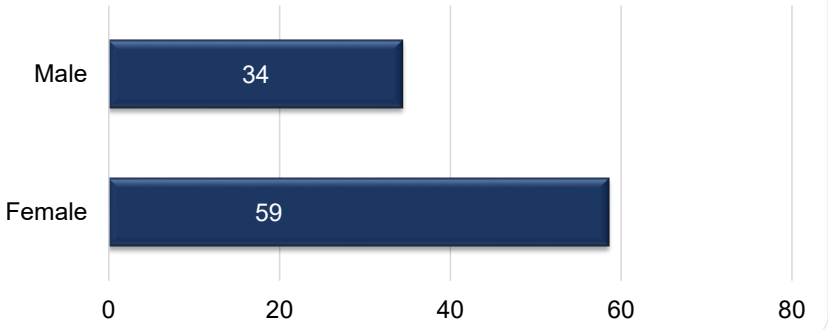


Fig 24: Non-specialty Mental Health Visits per 1,000 Member Months by Ethnicity

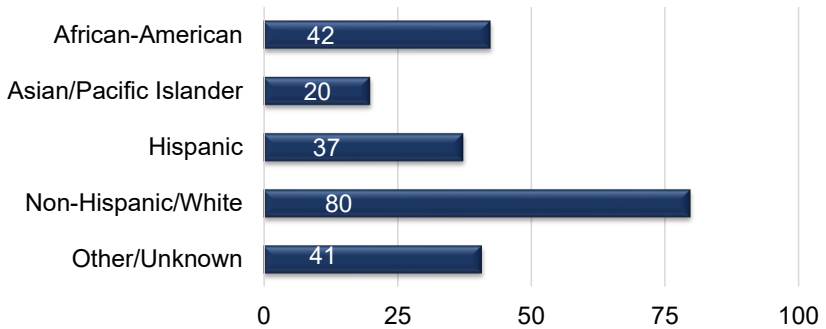
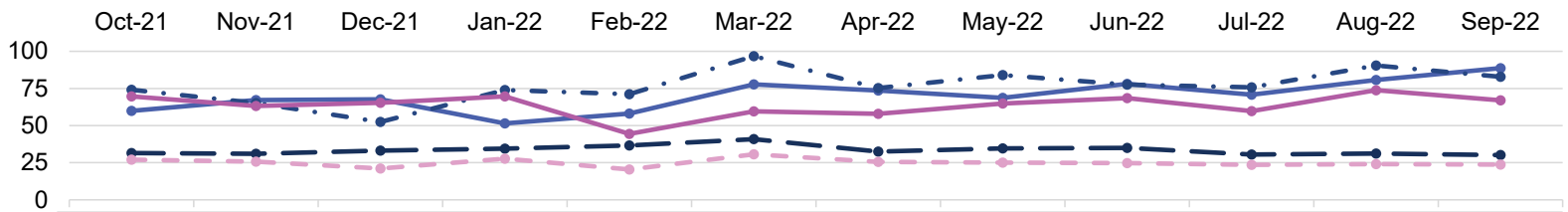


Fig 25: Non-specialty Mental Health Visits per 1,000 Members by Plan, by Month



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
CalOptima	32	31	33	34	37	41	32	35	35	31	31	30
CenCal	60	67	68	51	58	78	74	69	78	71	81	89
CCAH	27	26	21	28	20	31	26	25	25	24	24	24
HPSM	74	65	52	74	71	97	75	84	78	76	90	83
PHC	70	63	65	70	44	60	58	65	69	60	74	67

WCM Utilization Figure 26 - 28: Breakdowns of Emergency Department Visits with an Inpatient Admission Utilization (Oct'21 - Sept'22)

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

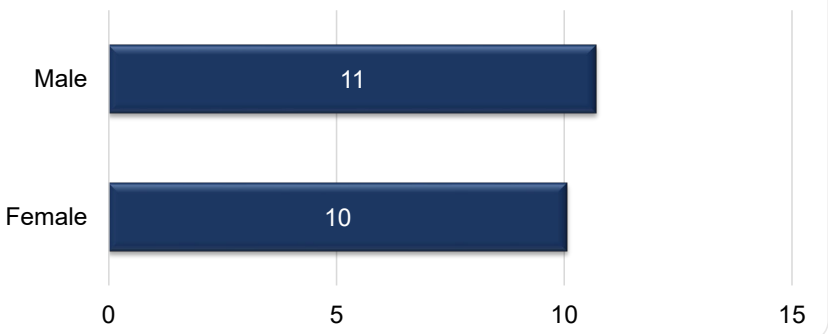


Fig 27: Emergency Department Visits with an Inpatient Admission per 1,000 Member Months by Ethnicity

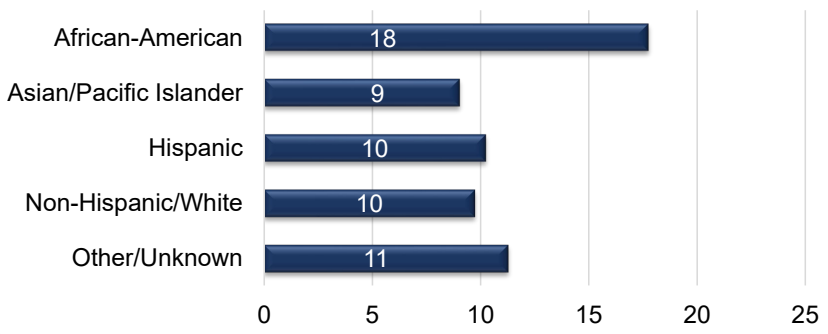
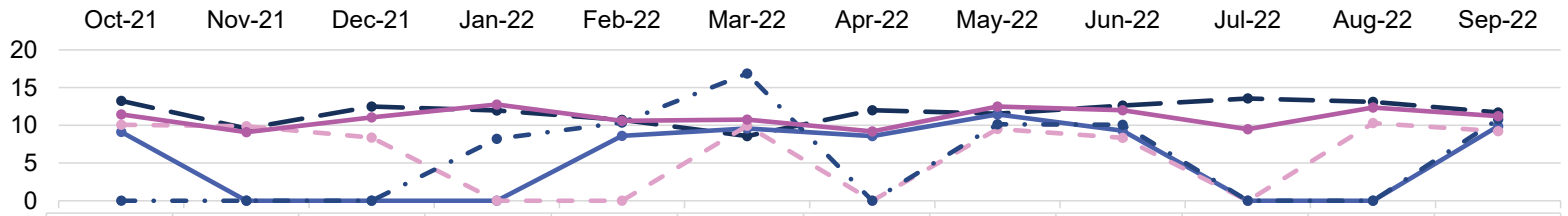


Fig 28: Emergency Department Visits with an Inpatient Admission per 1,000 Members by Plan, by Month

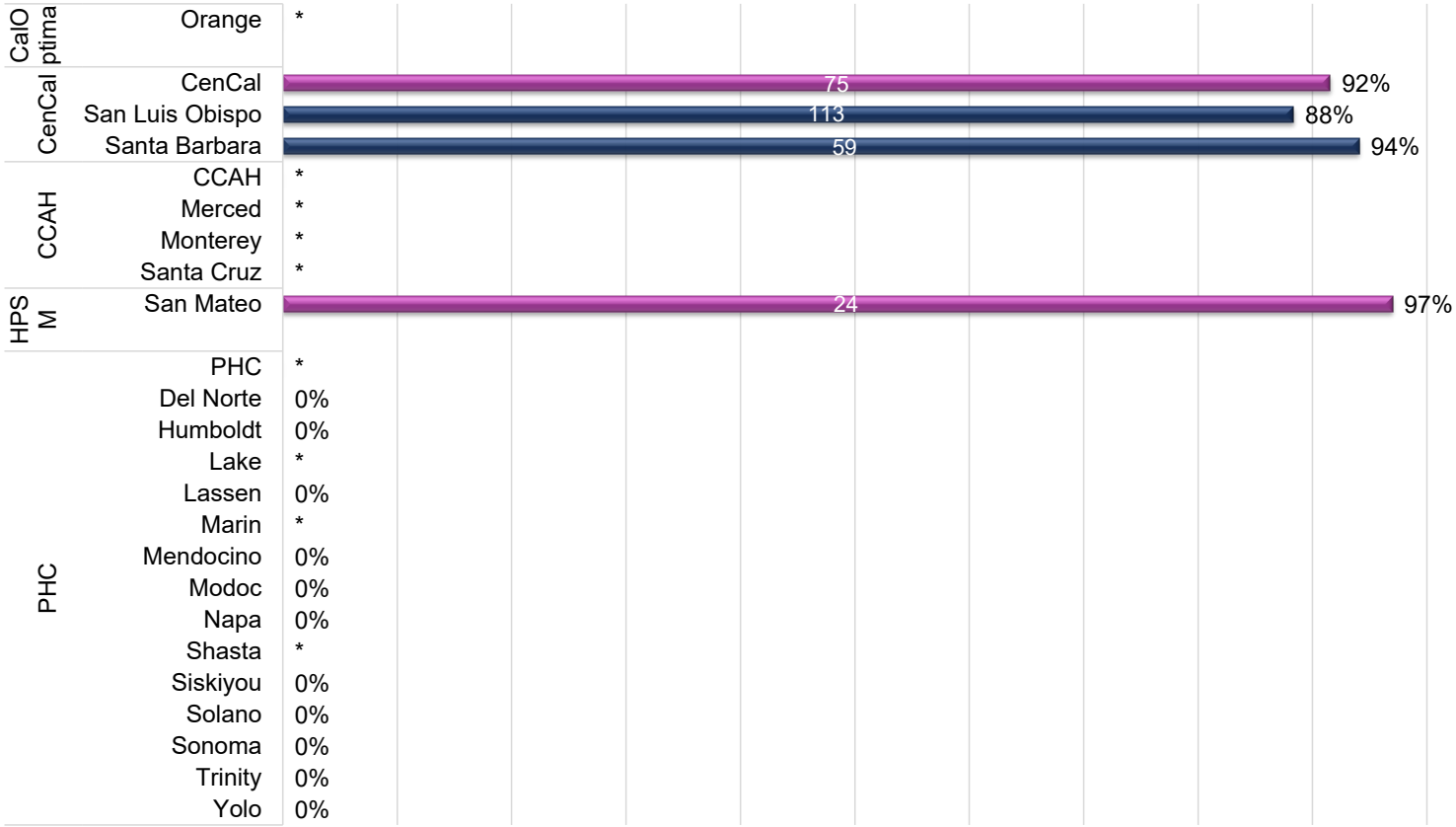


	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
CalOptima	13	10	12	12	11	9	12	12	13	14	13	12
CenCal	9	*	*	*	9	10	9	11	9	*	*	10
CCAH	10	10	8	*	*	10	*	10	8	*	10	9
HPSM	*	*	*	8	10	17	*	10	10	*	*	11
PHC	11	9	11	13	11	11	9	12	12	9	12	11

**Counts of items that are <8 are suppressed per CDO guidelines.*

WCM Figure 29: Continuity of Care (COC) Requests & Approvals per 1,000 Members (Oct'21 - Sept'22)

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



Note: This report contains data from October 2021 to September 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.
**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

WCM Figure 30: Continuity of Care (COC) Requests Upon Joining the Program, by Plan, by Month - Month 40 through Month 51

	Month 40	Month 41	Month 42	Month 43	Month 44	Month 45	Month 46	Month 47	Month 48	Month 49	Month 50	Month 51
CalOptima	*	*	*	*	*	0	*	*	0	0	*	*
CenCal	22	12	18	33	17	37	23	28	29	20	25	*
CCAH	*	*	*	*	*	*	*	*	0	0	0	0
HPSM	*	*	*	*	*	*	*	*	*	*	*	*
PHC	0	*	*	0	0	0	*	*	0	*	*	0

WCM Figure 31: Continuity of Care (COC) Requests Upon Joining the Program, by Plan, by Month - Month 52 through Month 63

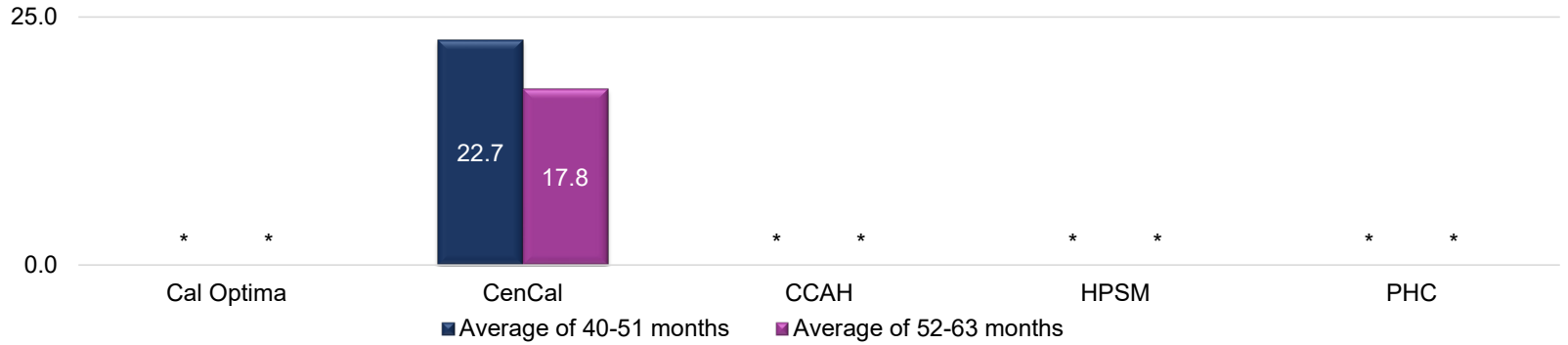
	Month 52	Month 53	Month 54	Month 55	Month 56	Month 57	Month 58	Month 59	Month 60	Month 61	Month 62	Month 63
CalOptima	*	*	0	*	0	0	0	0	0	0	0	0
CenCal	24	24	32	35	14	24	24	*	24	*	*	0
CCAH	0	0	0	0	*	*	*	*	*	0	0	0
HPSM	*	*	*	*	*	0	*	*	*	0	*	*
PHC	0	0	*	*	0	0	0	0	*	*	*	0

*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.*Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.

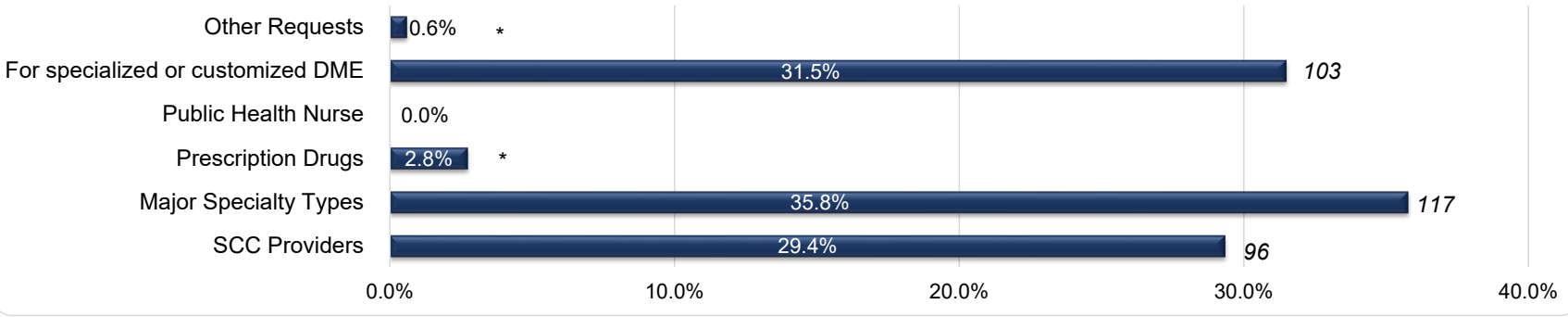
WCM Figure 32: Continuity of Care (COC) - Requests, by Plan (Oct'21 - Sept'22)

Fig 32: Plan Average COC Request Upon Joining the Program, Month 40 - Month 51 vs Month 52 - Month 63



WCM Figure 33: Continuity of Care (COC) - Requests Categories (Oct'21 - Sept'22)

Fig 33: COC Requests - Categories



**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

WCM Figures 34 & 35: Continuity of Care (COC) - Denials Reasons (Oct'21 - Sept'22)

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

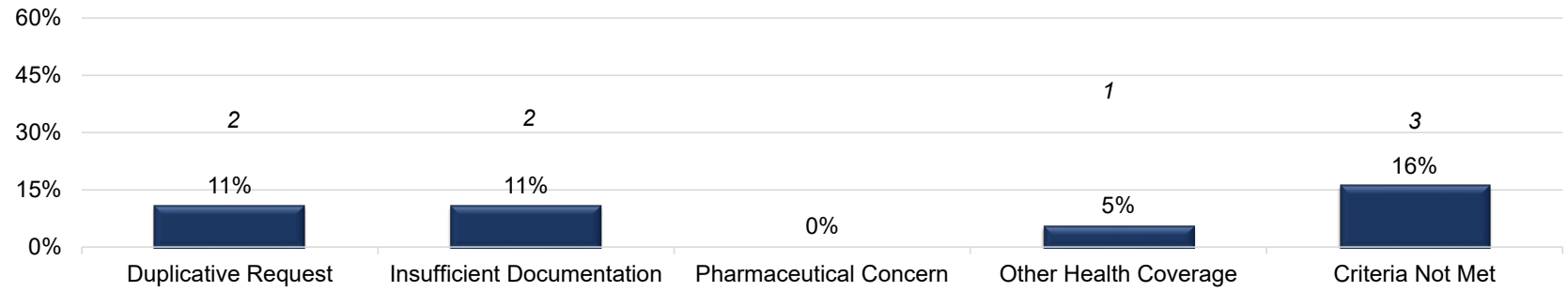
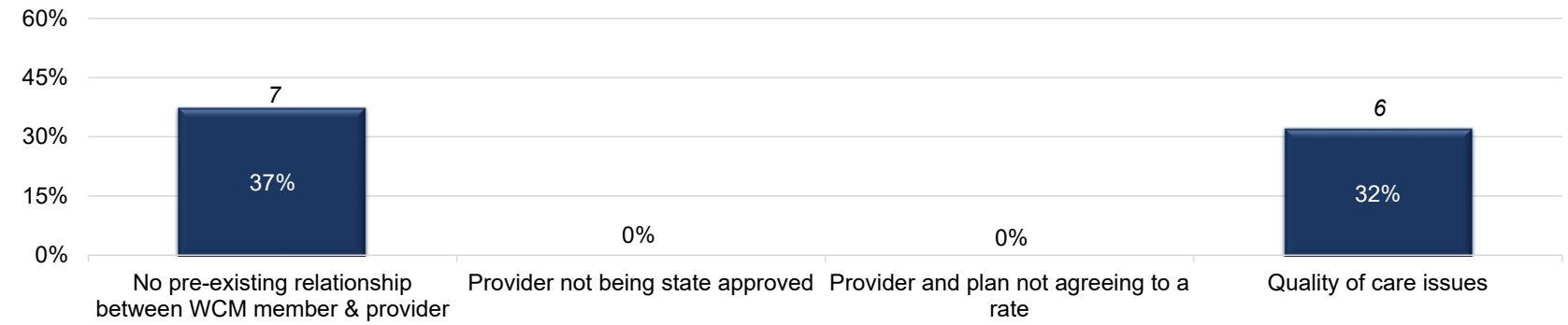


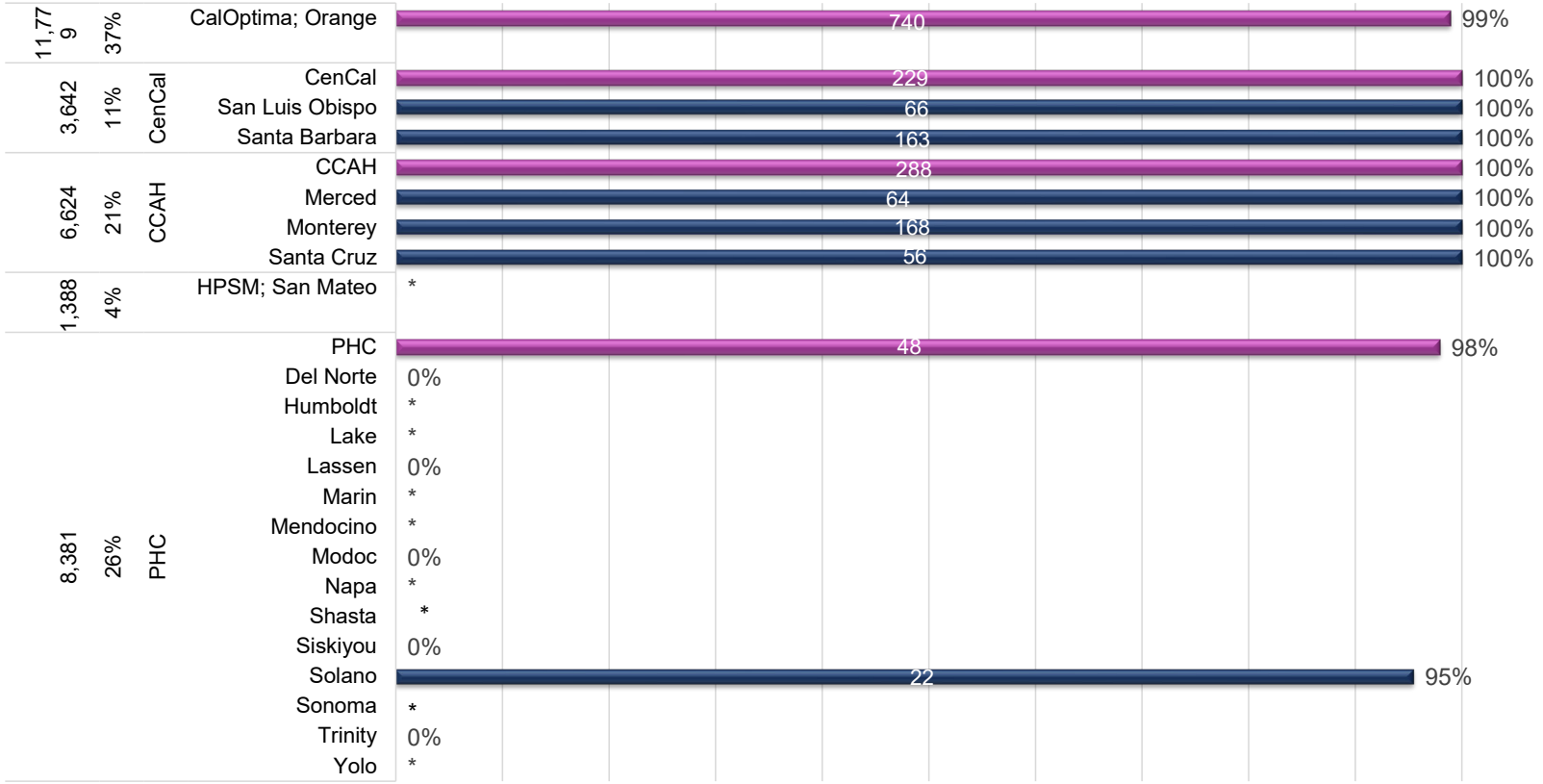
Fig 35: COC Denial Reasons (Required by APL)



Note: Please see page 8 for detailed information on why Figures 34 & 35 do not add up to 100%.

WCM Figure 36: Case Management NICU Authorization Requests & Approvals (Oct'21 - Sept'22)

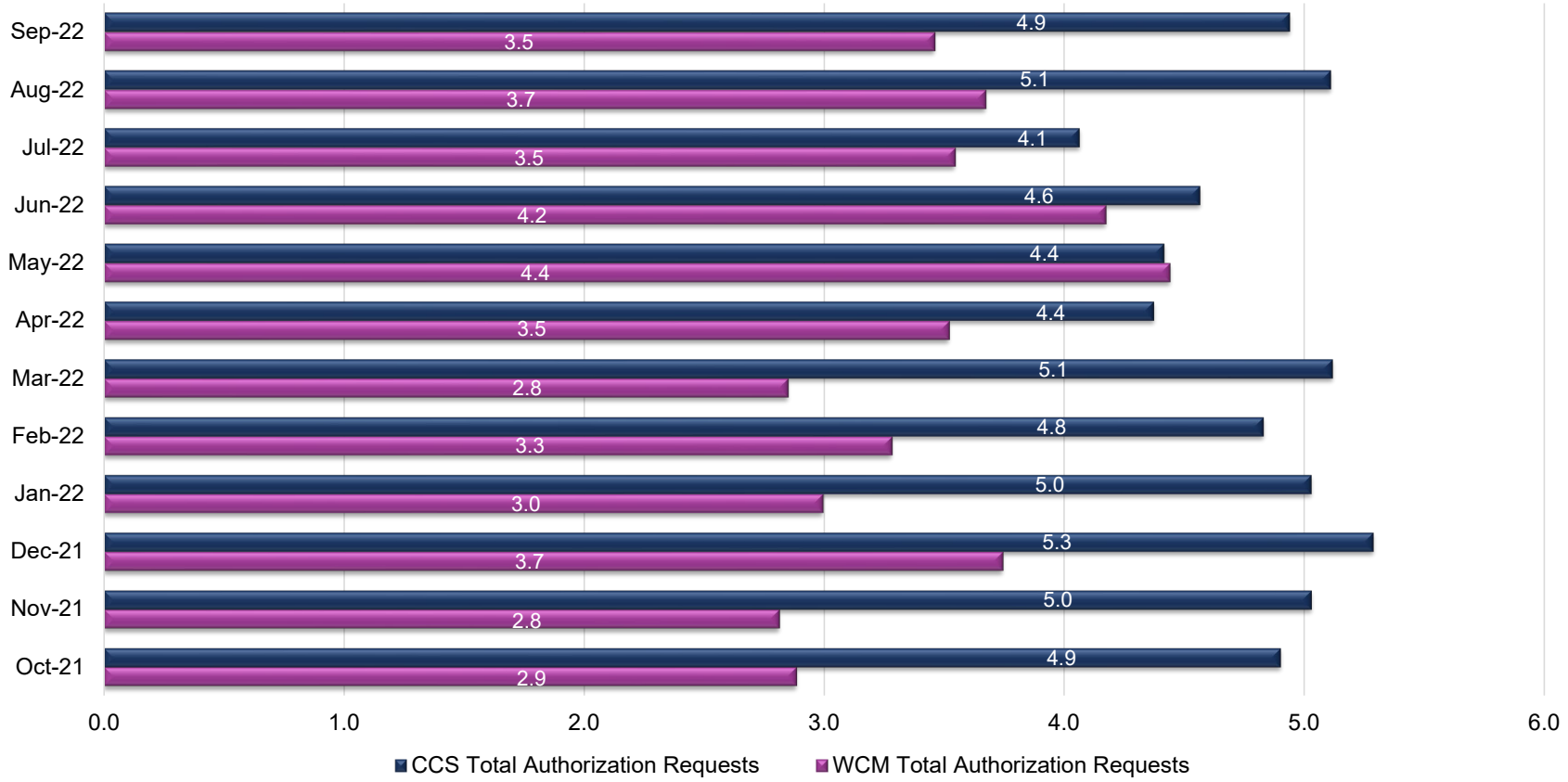
Fig 36: WCM Total NICU Authorization Requests & Percentage Approved by Plan, by County



Note: This report contains data from October 2021 to September 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.
**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

CCS and WCM Figure 37: Case Management NICU Authorization Requests (Oct'21 - Sept'22)

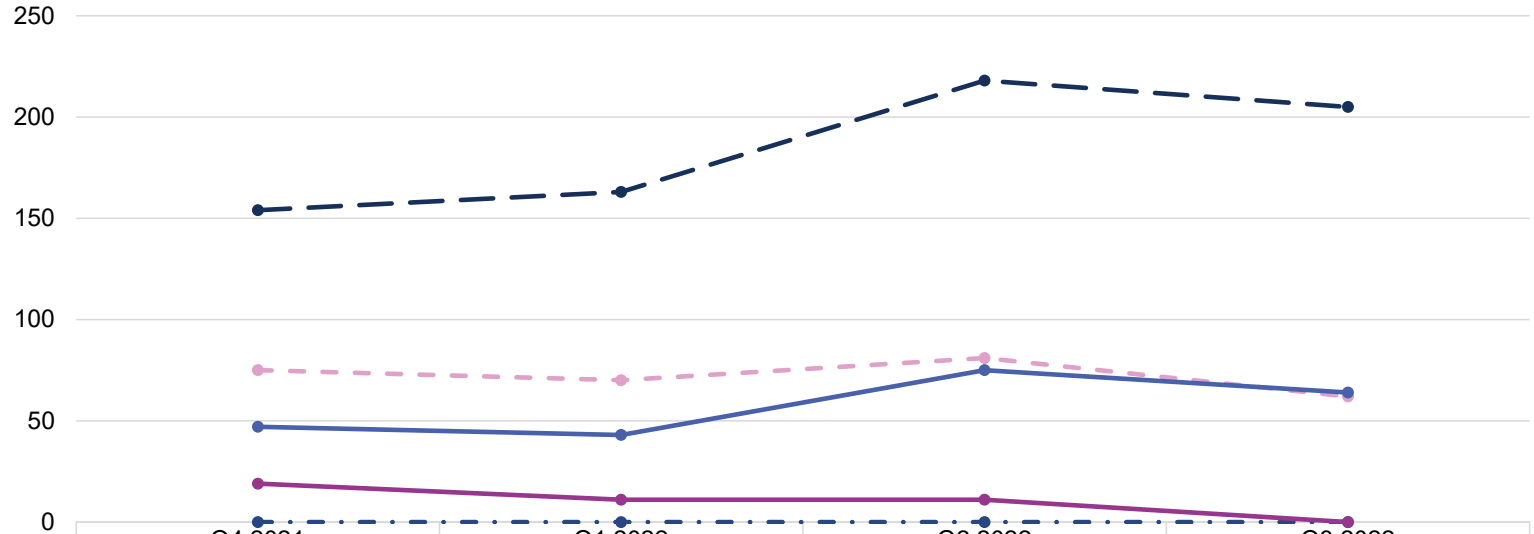
Fig 37: Statewide Total NICU Authorization Requests per 1,000 Members, by Month



Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from October 2021 to September 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 (Oct'21 - Sept'22)

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



	Q4 2021	Q1 2022	Q2 2022	Q3 2022
CalOptima	154	163	218	205
CCAH	75	70	81	62
CenCal	47	43	75	64
HPSM	*	*	*	*
PHC	19	11	11	*

Note: This report contains data from October 2021 to September 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.
**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

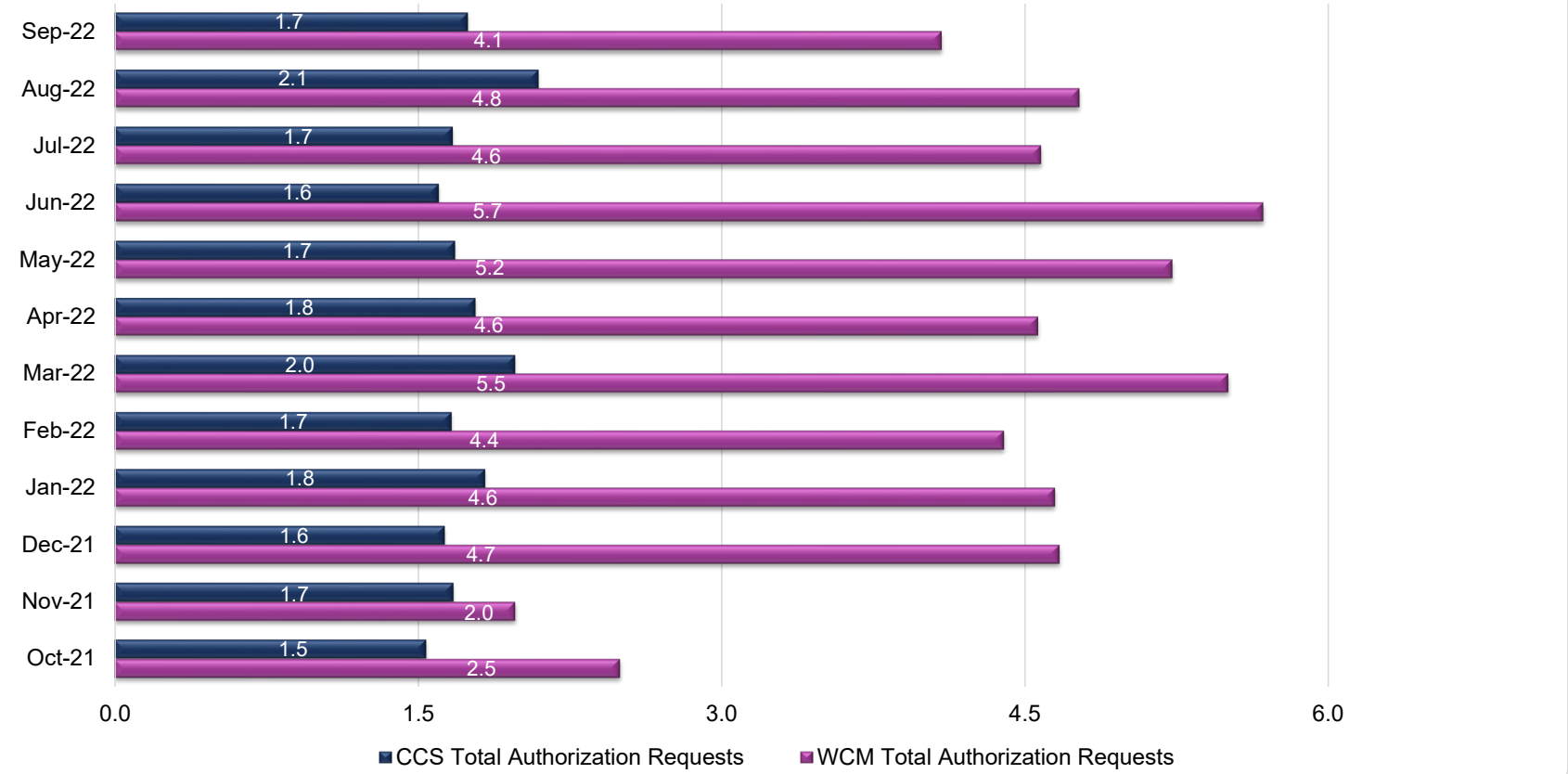
WCM Figure 39: Case Management PICU Authorization Requests & Approvals (Oct'21 - Sept'22)

Fig 39: WCM Total PICU Authorization Requests & Percentage Approved by Plan, by County

Note: This report contains data from October 2021 to September 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.
*Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.

CCS and WCM Figure 40: Case Management PICU Authorization Requests (Oct'21 - Sept'22)

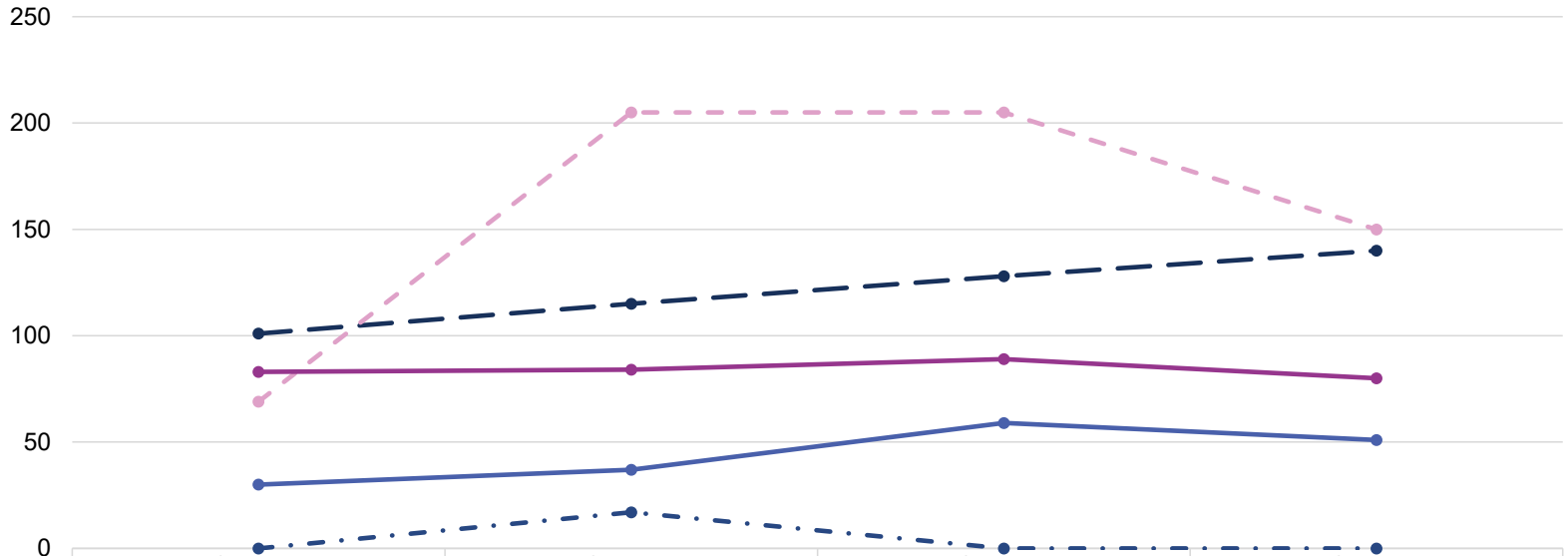
Fig 40: Statewide Total PICU Authorization Requests per 1,000 Members, by Month



Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from October 2021 to September 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 (Oct'21 - Sept'22)

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

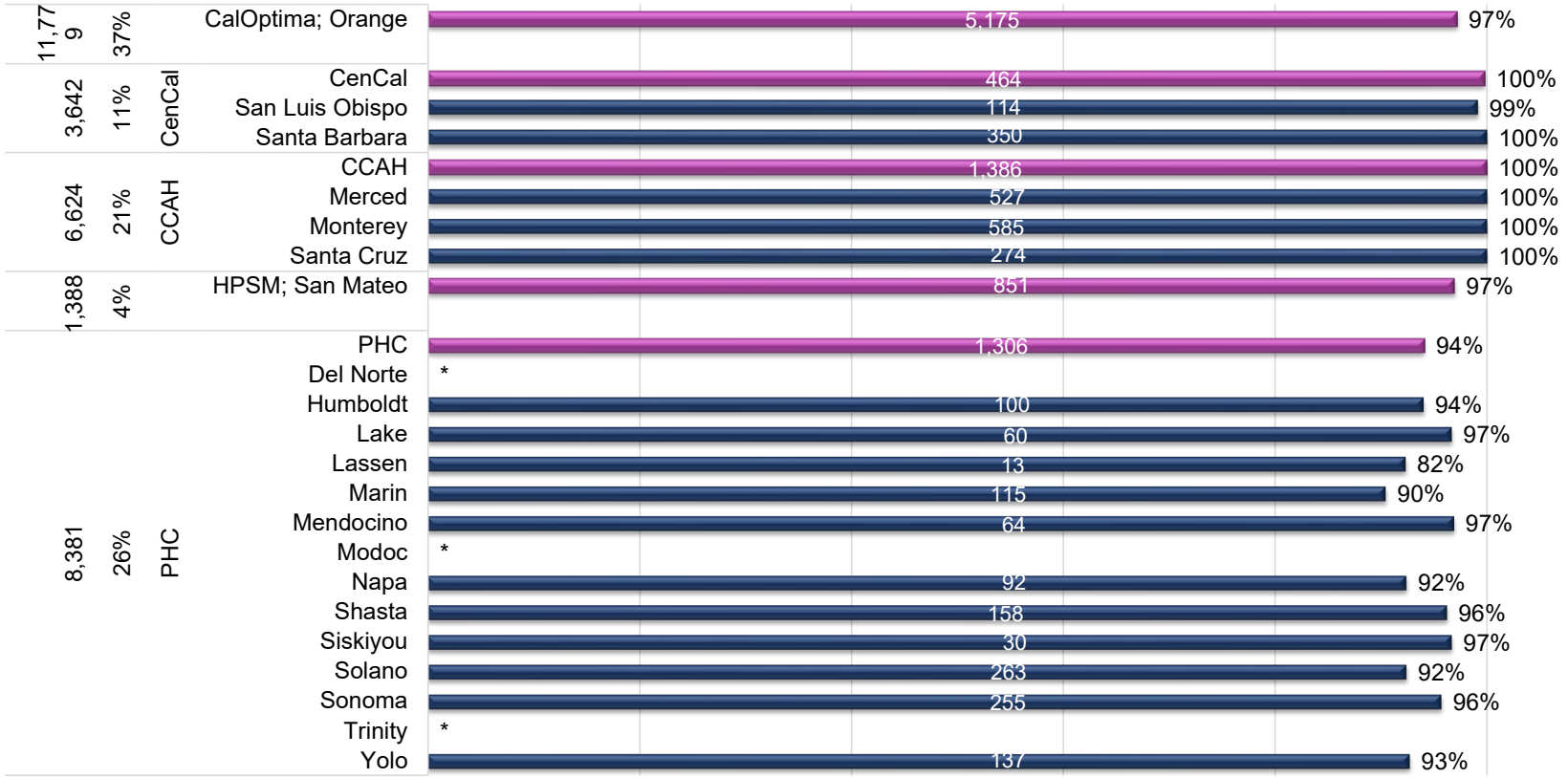


	Q4 2021	Q1 2022	Q2 2022	Q3 2022
CalOptima	101	115	128	140
CCAH	69	205	205	150
CenCal	30	37	59	51
HPSM	*	17	*	*
PHC	83	84	89	80

Note: This report contains data from October 2021 to September 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.
**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

WCM Figure 42: Case Management Inpatient Facilities and Special Care Centers (SCC) Authorization Requests & Approvals (Oct'21 - Sept'22)

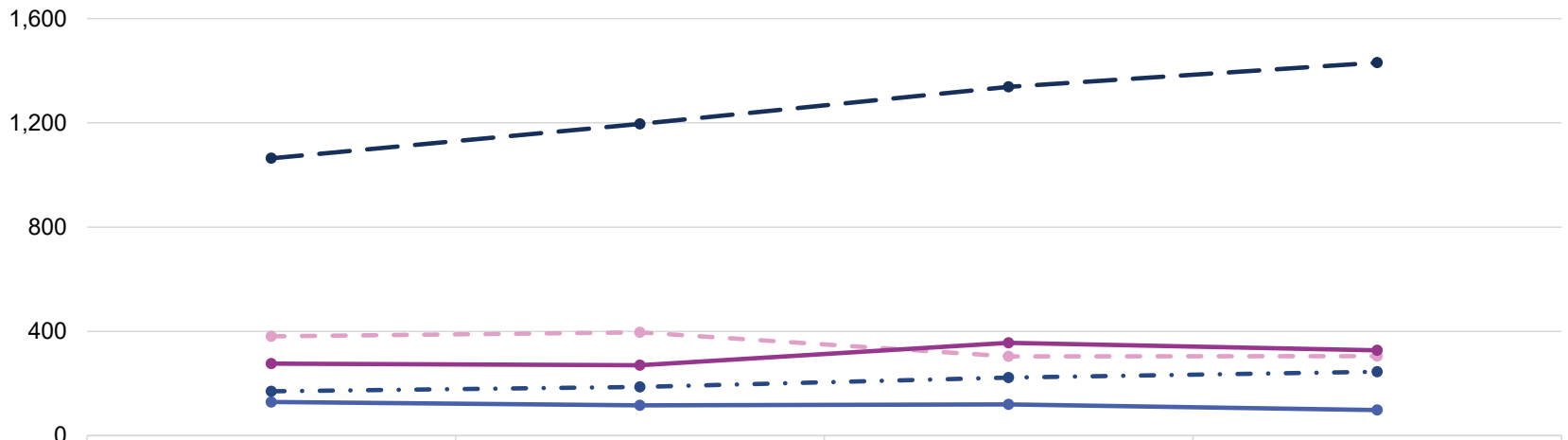
Fig 42: WCM Total Inpatient Facilities and SCC Authorization Requests & Percentage Approved by Plan, by County



Note: This report contains data from October 2021 to September 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.
**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

WCM Figure 43: Case Management Inpatient Facilities and Special Care Centers (SCC) Authorization Requests (Oct'21 - Sept'22)

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

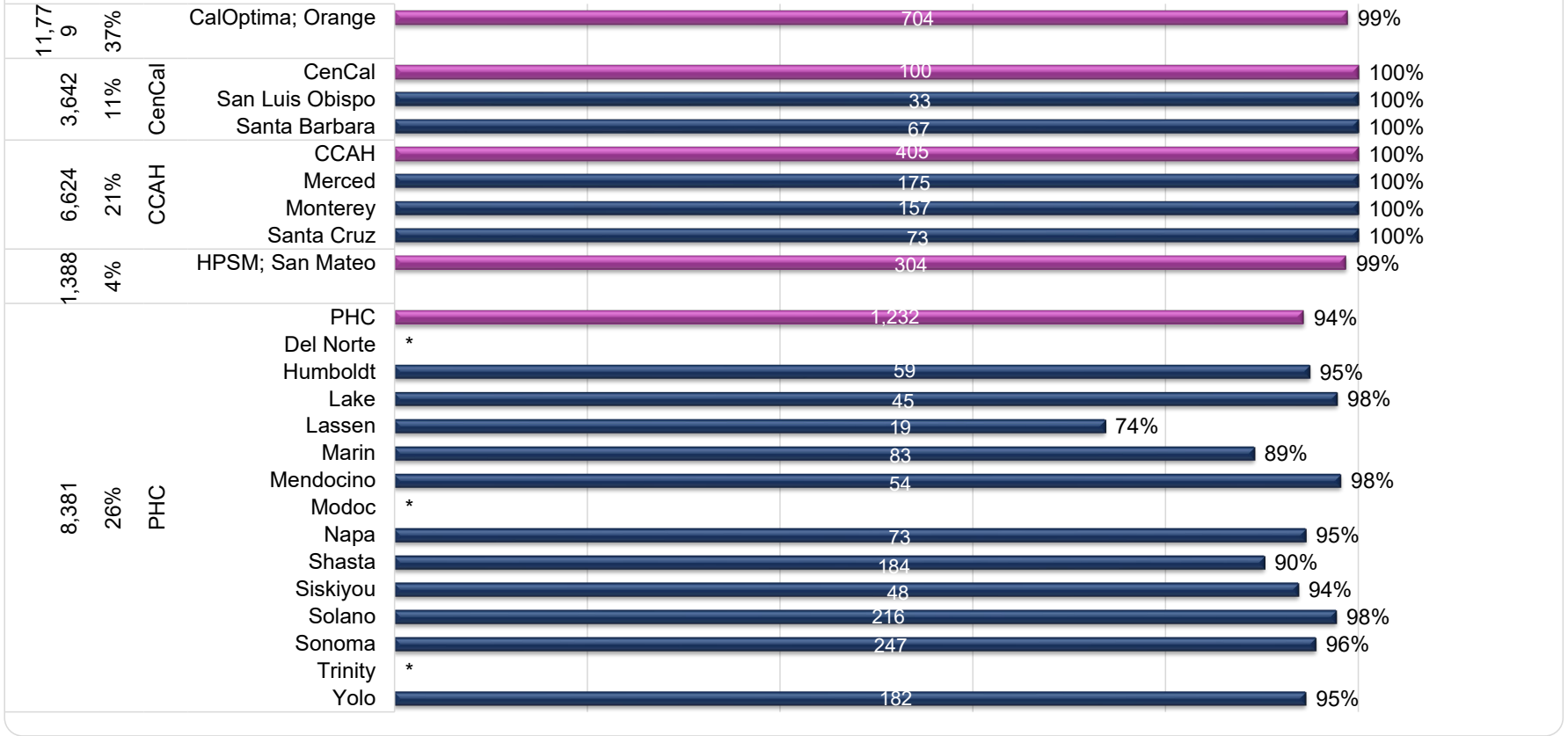


	Q4 2021	Q1 2022	Q2 2022	Q3 2022
CalOptima	1,064	1,196	1,338	1,431
CCAH	381	396	304	305
CenCal	129	116	120	98
HPSM	170	187	223	245
PHC	276	270	356	327

Note: This report contains data from October 2021 to September 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 (Oct'21 - Sept'22)

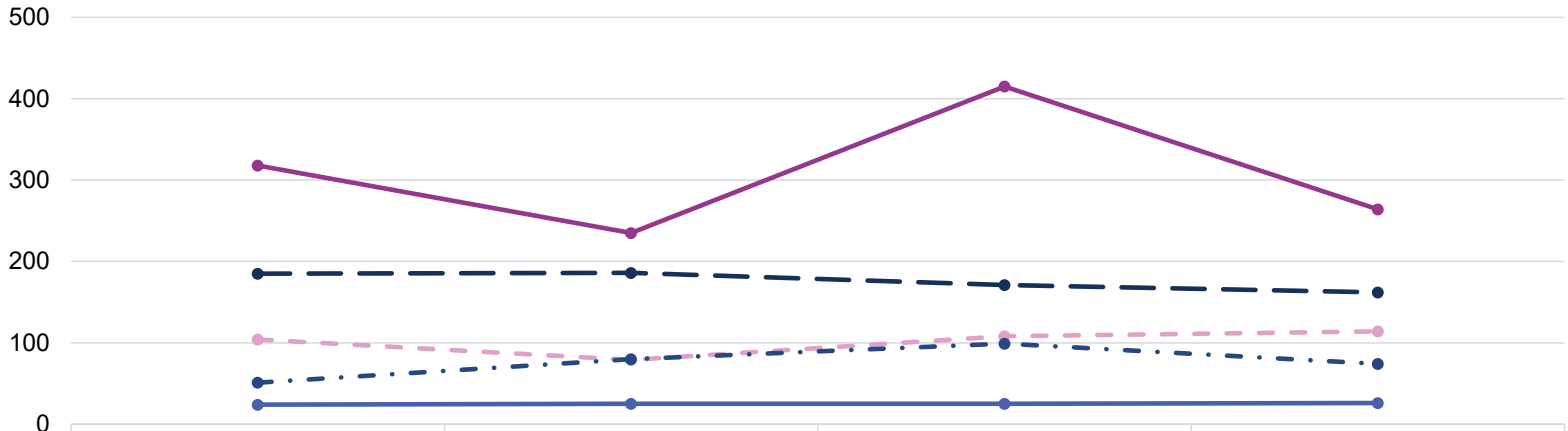
Fig 44: WCM Total Specialized or Customized DME Authorization Requests & Percentage Approved by Plan, by County



Note: This report contains data from October 2021 to September 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.
**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

WCM Figure 45: Case Management Specialized or Customized DME Authorization Requests (Oct'21 - Sept'22)

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



	Q4 2021	Q1 2022	Q2 2022	Q3 2022
CalOptima	185	186	171	162
CCAH	104	79	108	114
CenCal	24	25	25	26
HPSM	51	80	99	74
PHC	318	235	415	264

Note: This report contains data from October 2021 to September 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.
**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

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

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

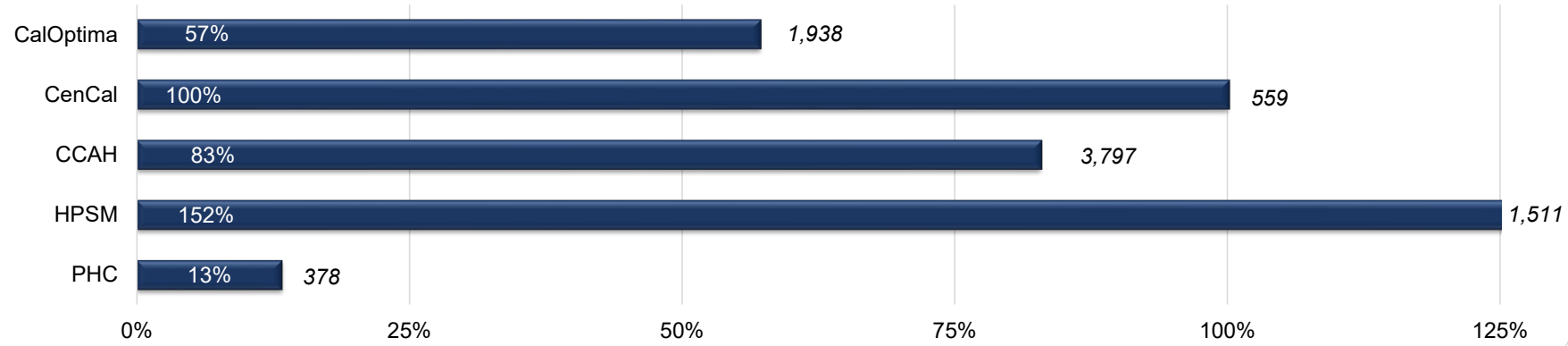
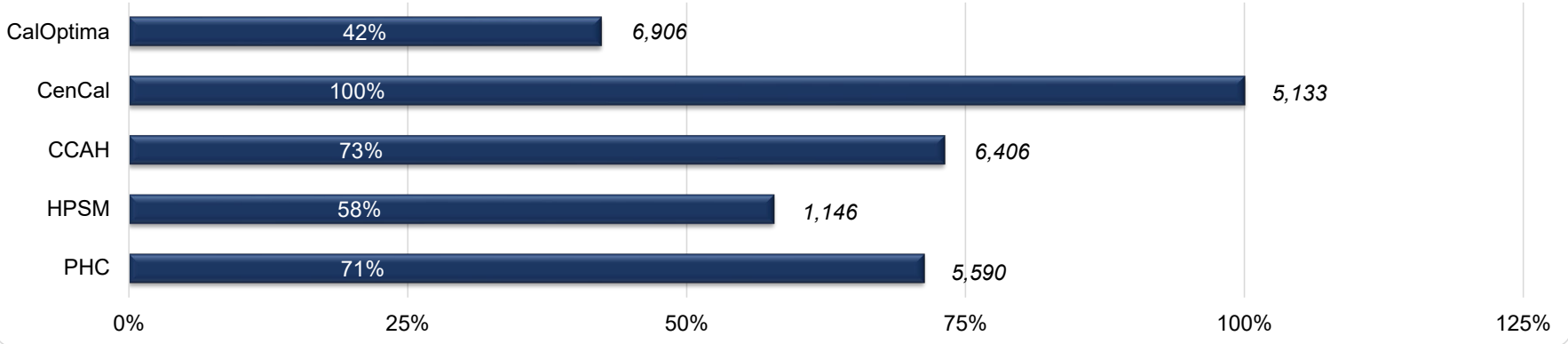


Fig 47: Percentage of Low Risk Members who Received an Assessment, by Plan



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 (Oct'21 - Sept'22)

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

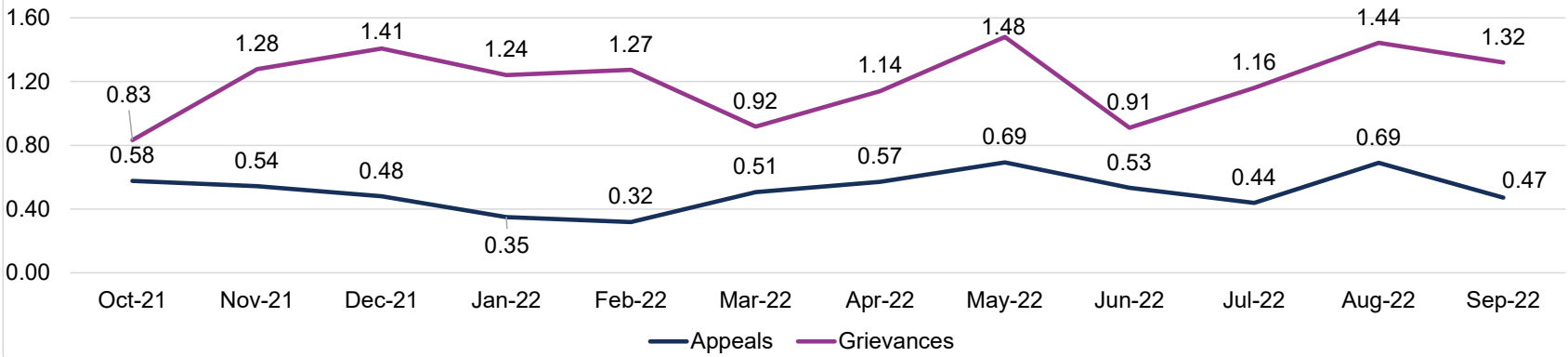
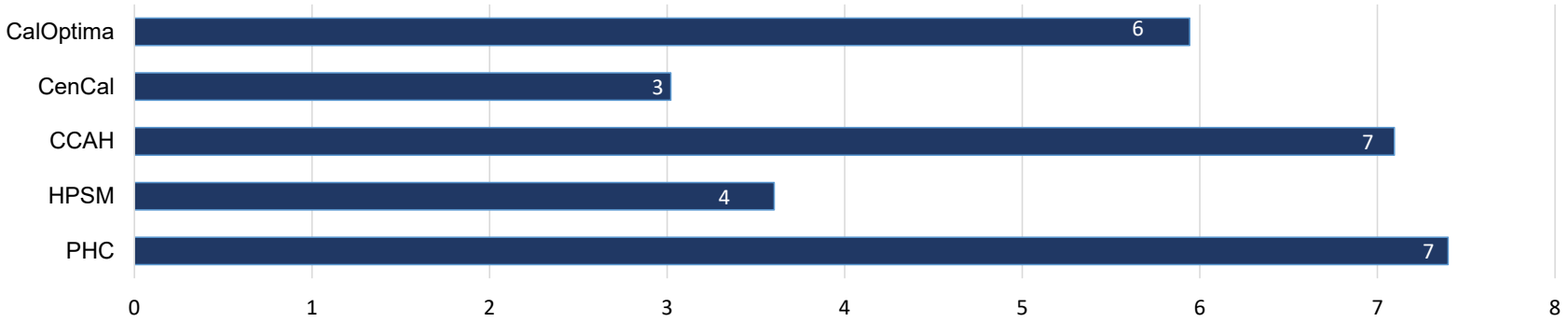
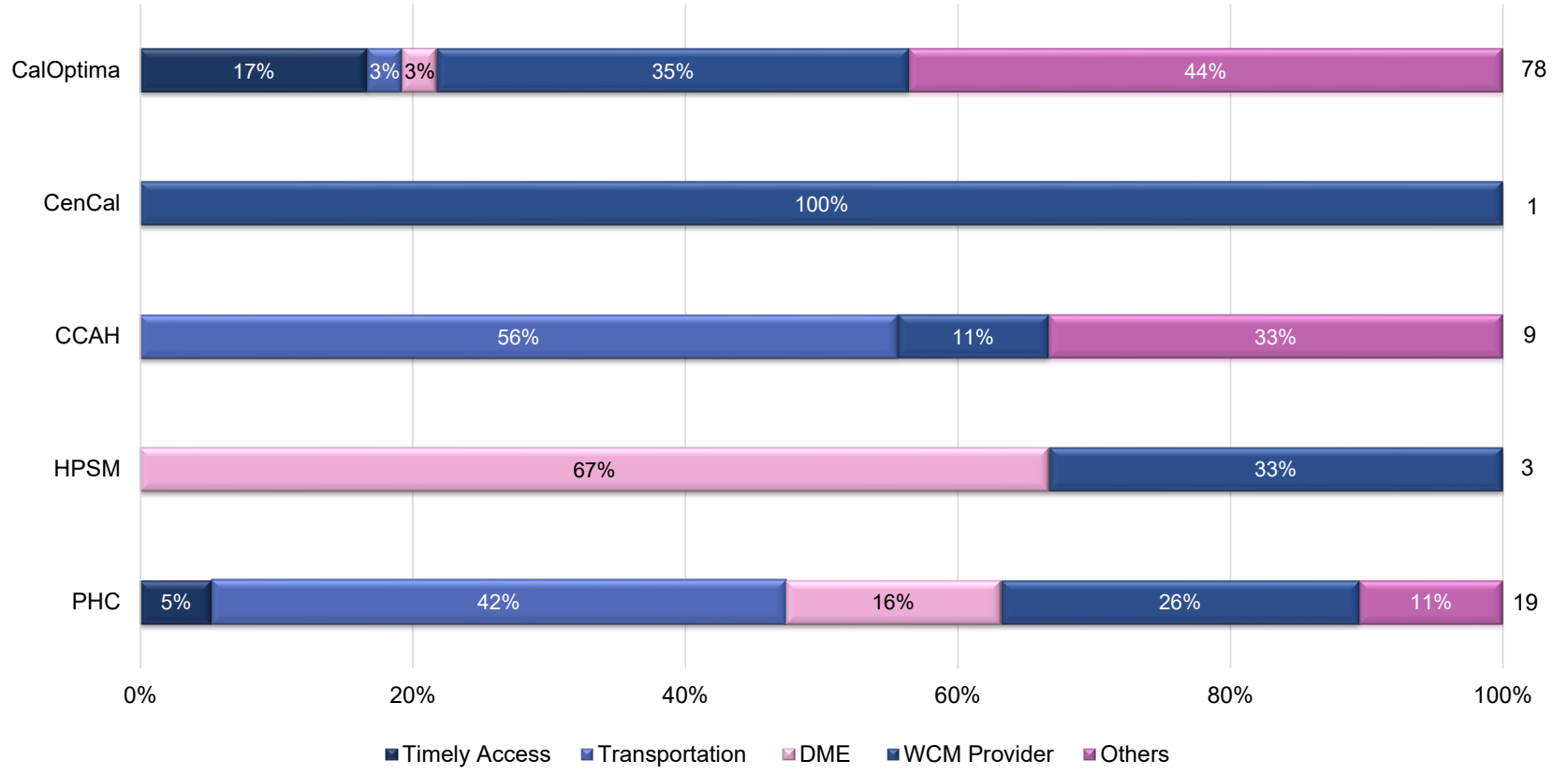


Fig 49: WCM Appeals per 1,000 Member Months, by Plan



WCM Figure 50: Grievances - Breakdown by Categories, by Plan (Oct'21 - Sept'22)

Fig 50: Grievances Categories, by Plan



WCM Figure 51: Family Advisory Committee Meetings Table (Oct'21 - Sept'22)

Plan Name	Number of Committee Members	Number of Meetings Held Oct'21 - Sept'22	Recruitment Efforts	Seats to be Filled
CalOptima	10	5	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.	1 of 11
CCAH	9	6	After the guidance was lifted from the California Department of Public Health and the California Governor's Office, regarding the COVID-19 virus, Alliance offices were reopened. Recruiting efforts began in the community, including: • Committee members created a WCM/FAC fact sheet that is routinely shared at outreach events via YHM in each of the Alliance's counties • WCM/FAC members shared the fact sheet with Community Based Organizations and Schools where their WCM kids participate • County MTU departments and Regional Centers use the fact sheet to recruit members • The Community Engagement Director who staffs the WCM/FAC presents to CBOs and other entities regarding the committee	9 of 19
CenCal	16	4	Currently recruiting for 2 positions - seeking help from family advocacy groups	2 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	16	5	• Total FAC Parent / Authorize representative membership: 13 • CCS County Staff in attendance at the August FAC meeting: 2 • Community Resource Center(s) who attended the August FAC meeting: 1 • FAC Community Member(s) who attended the August FAC meeting: 1 • The meeting in August went well. There was robust conversation about the PHC transportation benefit resulting in an extended invite to the Transportation team to present at the November FAC meeting. There was also an Enhanced Care Management (ECM) presentation. • Outreach and meetings with expansion counties are underway and FAC recruitment is discussed. • Our Care Coordination team continues to attend MTU clinics when appropriate. This has yielded WCM Family/AR interest in membership and also serves as a conduit for increased communication between PHC CC staff and MTU therapists. • Care Coordination continues to offer an incentive to staff who successfully recruits a new family member / authorized representative for the FAC. Leadership sends out quarterly emails one month prior to the FAC quarterly meeting to remind staff of this incentive opportunity.	12 of 28

CCAH explanation for member and seat discrepency: One member fills two seats on the WCM FAC Committee. This member is both a CCS Family Member and Alliance Board member, thus the number of members compared to the number of seats to be filled will have a one unit discrepancy, but the total number of seats is 19.

Appendix