Integrated California Children's Services and Whole Child Model Dashboard

Released September 2023

Table of Contents

Integrated California Children's Services and Whole Child Model Dashboard

Released September 2023

Introduction

The Integrated California Children's Services (CCS) and Whole Child Model (WCM) Dashboard contains data for April 2021 through March 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.

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 medical 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 medically 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, CCS dedicated 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 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 thelast 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

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.

A trend of total CCS and WCM enrollment over time are displayed in Figure 1. In April 2021, 134,359 members were enrolled in CCS. Enrollment increased to 145,794 members in March 2022. In April 2021, 30,580 members were enrolled in WCM. Enrollment increased slightly to 31,624 members enrolled in March 2022.

Figure 2 shows that 48% of CCS enrollees identified themselves as Hispanic. This was calculated by using member reported ethnicity for the month of March 2022 as the numerator, divided by total enrollment for March 2022 as the denominator. Figure 2 also shows that 53% of WCM enrollees identified themselves as Hispanic. This was calculated by using member reported ethnicity for the month of March 2022 as the numerator, divided by total enrollment for March 2022 as the denominator.

The CCS population consists of 46.4% female and 53.6% male as displayed in Figure 3. This was calculated by using enrollment by gender in March 2022 as the numerator, divided by the total enrollment in March 2022 as the denominator. The WCM population consists of 52.9% male and 47.1% female as displayed in Figure 3. This was calculated by using enrollment by gender in March 2022 as the numerator, divided by the total enrollment in March 2022 as the denominator.

Figure 4 displays enrollment by primary languages. In March 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 March 2022 as the numerator, divided by the total CCS enrollment in March 2022 as the denominator. In March 2022, 59.4% of WCM members spoke English and 37.6% spoke Spanish as their primary spoken language. This was calculated by using WCM enrollment for each language in March 2022 as the numerator, divided by the total WCM enrollment in March 2022 as the denominator.

Figure 5 displays enrollment by age. In March 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 March 2022 as the numerator, divided by total CCS enrollment for March 2022 as the denominator. In March 2022, 33% of WCM members were between the ages 12 and 17, and 15% of WCM members were between the ages of 18 and 20. This was calculated by using WCM enrollment for each age range for the month of March 2022 as the numerator, divided by total WCM enrollment for March 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 37,402 members. The smallest enrollment displayed is 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 enrollment by County, in alphabetical order. Orange County had the most enrollment with 11,771 members and Trinity County had the least with 39 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 plan.

Figure 9 displays that for CCS, female enrollees made 1,922 outpatient visits per 1,000 member months while males made 1,971 outpatient visits per 1,000 member months. This was calculated by using the number of CCS outpatient visits for each gender for April 2021 through March 2022 as the numerator, divided by the CCS enrollment for each gender for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000. Figure 9 also displays that for WCM, female enrollees made 2,773 outpatient visits per 1,000 member months while males made 2,873 outpatient visits per 1,000 member months. This was calculated by using the number of WCM outpatient visits for each gender for April 2021 through March 2022 as the numerator, divided by the WCM enrollment for each gender for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000.

For Figure 10, CCS members that identified as African American made the most outpatient visits at 2,810 per 1,000 member months. This was calculated by using the number of CCS outpatient visits for each ethnicity for April 2021 through March 2022 as the numerator, divided by the CCS enrollment for each ethnicity for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000. Figure 10 also shows WCM members that identified as Asian/Pacific Islander made the most outpatient visits at 3,457 per 1,000 member months. This was calculated by using the number of WCM outpatient visits for each ethnicity for April 2021 through March 2022 as the numerator, divided by the WCM enrollment for each ethnicity for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000.

Figure 11 shows the trend in the number of statewide CCS and WCM outpatient visits from April 2021 through March 2022. This was calculated by using the number of outpatient visits for each program per month for April 2021 through March 2022 as the numerator, divided by the enrollment for each program per month for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000. From April 2021 to March 2022, the CCS program has fewer outpatient visits per 1,000 on average, with a slight increase in utilization for CCS and WCM over the year.

Figure 12 shows the trend in the number of WCM outpatient visits for each participating plan from April 2021 through March 2022. This was calculated by using the number of outpatient visits for each plan per month for April 2021 through March 2022 as the numerator, divided by the enrollment for each plan per month for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000. All MCPs had an increase in outpatient visit utilization, with CalOptima having the highest utilization rate and Central California Alliance for Health (CCAH) having the lowest, on average.

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 enrollees had 30 inpatient admissions per 1,000 member months and female enrollees had 27 inpatient admissions per 1,000 member months. This was calculated by using the number of CCS inpatient visits for each gender for April 2021 through March 2022 as the numerator, divided by the CCS enrollment for each gender for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000. Figure 13 also displays that for WCM, male enrollees had 24 inpatient admissions per 1,000 member months and female enrollees had 25 inpatient admissions per 1,000 member months. This was calculated by using the number of WCM inpatient visits for each gender for April 2021 through March 2022 as the numerator, divided by the WCM enrollment for each gender for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000.

For Figure 14, in the CCS program, African American members had the most inpatient admissions at 48 per 1,000 member months. This was calculated by using the number of CCS inpatient visits for each ethnicity for April 2021 through March 2022 as the numerator, divided by the CCS enrollment for each ethnicity for April 2021 through March 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 33 per 1,000 member months. This was calculated by using the number of WCM inpatient visits for each ethnicity for April 2021 through March 2022 as the numerator, divided by the WCM enrollment for each ethnicity for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000.

Figure 15 shows the trend in the number of statewide CCS and WCM inpatient admissions from April 2021 through March 2022. This was calculated by using the number of inpatient admissions for each program per month for April 2021 through March 2022 as the numerator, divided by the enrollment for each program per month for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000. From April 2021 to March 2022, WCM plans have fewer inpatient admissions per 1,000 on average, with steady utilization for both programs over the year.

Figure 16 shows the trend in the number of WCM inpatient admissions for each participating plan from April 2021 through March 2022. This was calculated by using the number of inpatient admissions for each plan per month for April 2021 through March 2022 as the numerator, divided by the enrollment for each plan per month for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000. CalOptima had a significant decrease in inpatient admissions. CenCal and PHC had slight increases in inpatient admissions. Health Plan of San Mateo (HPSM), and CCAH had significant increases in inpatient admissions.

WCM Emergency Department (ED) Visits

This data is not reported by CCS counties at this time. 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 plan.

Figure 17 displays that male enrollees made 64 ED visits per 1,000 member months and female enrollees made 65 ED visits per 1,000 member months. This was calculated by using the number of ED visits for each gender for April 2021 through March 2022 as the numerator, divided by the enrollment for each gender for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000.

For Figure 18, African-American members made the most ED visits at 101 per 1,000 member months. This was calculated by using the number of ED visits for each ethnicity for April 2021 through March 2022 as the numerator, divided by the enrollment for each ethnicity for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000.

Figure 19 shows the trend in the number of ED visits for each participating plan from April 2021 through March 2022. This was calculated by using the number of ED visits for each plan per month for April 2021 through March 2022 as the numerator, divided by the enrollment for each plan per month for April 2021 through March 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 reported by CCS counties at this time. 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 plan.

Figure 20 displays that female enrollees had utilized 1,249 prescription medications per 1,000 member months while males had utilized 1,222 prescription medications per 1,000 member months. This was calculated by using the number of prescriptions for each gender for April 2021 through March 2022 as the numerator, divided by the enrollment for each gender for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000.

For Figure 21, African-American members utilized the most prescription medications at 1,503 per 1,000 member months. This was calculated by using the number of prescriptions for each ethnicity for April 2021 through March 2022 as the numerator, divided by the enrollment for each ethnicity for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000.

Figure 22 shows the trend in the number of prescription medications for each participating plan from April 2021 through March 2022. This was calculated by using the number of prescriptions reported by each plan per month for April 2021 through March 2022 as the numerator, divided by the enrollment for each plan per month for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000.

WCM Non-Specialty Mental Health

This data is not reported by CCS counties at this time. Non-specialty mental health 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 plan.

Figure 23 displays that female enrollees made 62 non-specialty mental health visits per 1,000 member months while males made 34 non-specialty mental health visits per 1,000 member months. This was calculated by using the number of non-specialty mental health visits for each gender for April 2021 through March 2022 as the numerator, divided by the enrollment for each gender for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000.

For Figure 24, Non-Hispanic/White members made the most visits at 82 per 1,000 member months. This was calculated by using the number of non-specialty mental health visits for each ethnicity for April 2021 through March 2022 as the numerator, divided by the enrollment for each ethnicity for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000.

Figure 25 shows the trend in the number of non-specialty mental health visits for each participating plan from April 2021 through March 2022. This was calculated by using the number of non-specialty mental health visits for each plan per month for April 2021 through March 2022 as the numerator, divided by the enrollment for each plan per month for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000.

WCM Emergency Department (ED) Visits with an Inpatient Admission

This data is not reported by CCS counties at this time. 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 plan.

Figure 26 displays that male and female enrollees both 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 April 2021 through March 2022 as the numerator, divided by the enrollment for each gender for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000.

For Figure 27, African American members made the most ED visits with an inpatient admission at 14 per 1,000 member months. This was calculated by using the number of ED visits with an inpatient admission for each ethnicity for April 2021 through March 2022 the numerator, divided by the enrollment for each ethnicity for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000.

Figure 28 shows the trend in the number of ED visits with an inpatient admission for each participating plan from April 2021 through March 2022. This was calculated by using the number of ED visits with an inpatient admission for each plan per month for April 2021 through March 2022 as the numerator, divided by the denominator is enrollment for each plan per month for April 2021 through March 2022 as the denominator. The dividend was then multiplied by 1,000. An asterisk (*) represents numbers have been suppressed for Plans 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 remained steady for CenCal and PHC. HPSM and CCAH had significant increases in ED visits with an inpatient admission from April 2021 through March 2022. CalOptima had a significant decrease in ED visits with an inpatient admission from April 2021 through March 2022.

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

This data is not reported by CCS counties at this time. Plans 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 continuity of care period. CoC data is submitted by plans. 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 that requests for CoC per 1,000 members ranged from less than 11 for CalOptima, CCAH, and PHC to 91 for CenCal. This was calculated by using the number of CoC requests for each plan for April 2021 through March 2022 as the numerator, divided by the enrollment for each plan in March 2022 as the denominator. The dividend was then multiplied by 1,000. Figure 29 also displays percentage of CoC requests approved, by Plan and by County. The approval percentage ranged from 89% for CenCal to 100% for HPSM. This was calculated by using the number of approved CoC requests for each Plan and each County for April 2021 through March 2022 as the numerator, divided by the total number of CoC requests for each Plan and each County for April 2021 through March 2022 as the denominator.

Total number of CoC requests for each Plan for the months 34 through 45 after joining the program are shown in Figure 30. In the thirty-fourth month of operation, CalOptima and CCAH reported less than 11 requests, CenCal reported 41 requests, HPSM reported 22 requests, and PHC reported 0 requests. In the forty-fifth month of operation, CenCal reported 37 CoC requests, CalOptima and PHC reported 0 requests, and CCAH, and HPSM reported less than 11 requests. An asterisk (*) represents numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable.

Months 46 through 57 upon joining the program for CoC requests are displayed in Figure 31. In the forty-sixth month of operation, CenCal reported receiving 23 CoC requests, while CCAH, HPSM, CalOptima, and PHC each reported less than 11 requests. In the fifty-seventh month of operation, CenCal Reported 24 CoC requests, PHC, HPSM, and CalOptima reported 0 CoC requests, and HPSM reported less than 11 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 32 shows the average number of CoC requests for each plan for months 34 through 45 compared to months 46 through 57. CenCal had an average of 28.4 requests for months 34 through 45 and 23.8 requests for months 46 through 57. The remaining plans reported an average of less than 11 CoC requests for both periods. An asterisk (*) represents numbersthat have been suppressed for Plans 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 21 times, or 4.4% of the time, while 130, or 29.3%, of requests were made for major specialty types. This was calculated by using the number of CoC requests for each category for April 2021 through March 2022 as the numerator, divided by the total number of CoC requests for April 2021 through March 2022 as the denominator.

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

Figure 35 shows reasons for CoC denials required by APL. No pre-existing relationship between WCM member and provider accounted for 13 or 68% of COC denial reasons while 2, or 11% were due to quality-of-care issues. This was calculated by using the number of CoC denials for each reason for April 2021 through March 2022 as the numerator, divided by the total number of CoC denials for April 2021 through March 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

Plans must provide case management and care coordination for CCS-eligible members and their families. Plans 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 Care Center (SCC) authorization requests, and Specialized or Customized DME authorization requests. Case management data is submitted by plans. 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

Figure 36 displays total requests for NICU authorizations and percent approval rate by Plan and by County. Total plan enrollment and percent distribution of program enrollment in each plan is displayed on the far-left column for reference. The approval percentage ranged from 97% for PHC to 100% for CenCal, CalOptima and CCAH. This was calculated by using the number of approved NICU authorizations for each plan and each County for April 2021 through March 2022 the numerator, divided by the number of NICU requests for authorizations for each Plan and each County for April 2021 through March 2022 as the denominator. An asterisk (*) represents numbers have been suppressed for Plans 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 5.8 CCS NICU authorization requests per 1,000 members for April 2021. There were 5.2 CCS NICU authorization requests per 1,000 members for March 2022. The figure also displays that there were 3.1 WCM NICU authorization requests per 1,000 members for April 2021. There were 2.8 WCM NICU authorization requests per 1,000 members for March 2022.

Figure 38 displays the trend of total requests seeking authorization for NICU services for each plan each quarter. For example, CCAH reported 18 requests in Q2 2021, 38 requests in Q3 2021, 75 requests in Q4 2021, and 70 requests in Q1 2022. HPSM reported 0 requests for all four quarters. An asterisk (*) represents numbers have been suppressed for Plans 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 Plan and by County. The figure displays that total requests for PICU authorizations ranged from 24 for HPSM to 441 for CalOptima. Total plan enrollment and percent distribution of program enrollment in each plan is displayed on the far-left column for reference. The approval percentage for PICU requests ranged from 98% for PHC to 100% for CenCal and CCAH. This was calculated by using the number of approved PICU requests for authorizations for each plan and each County for April 2021 through March 2022 as the numerator, divided by the number of PICU authorizations for each plan and each County for April 2021 through March 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 were 1.7 CCS PICU authorization requests per 1,000 members in April 2021 and March 2022. The figure also displays that there were 2.5 WCM PICU authorization requests per 1,000 members in April 2021 and 5.5 authorization requests per 1,000 members for March 2022.

Figure 41 displays the trend of total requests seeking authorization for PICU services for each plan each quarter. For example, CalOptima reported 94 requests in Q2 2021, 131 requests in Q3 2021, 101 requests in Q4 2021, and 115 requests in Q1 2022. HPSM and CCAH reported fewer than 11 requests for Q2 and Q3 2021. An asterisk (*) represents numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable.

WCM Inpatient Facilities and SCC Authorizations

This data is not reported by CCS counties at this time. Figure 42 displays total requests for SCC authorizations and approval rate, by plan and by County. The figure displays that Inpatient Facilities and SCC authorization requests ranged from 472 for CenCal to 4,294 for CalOptima. Total plan enrollment and percent distribution of program enrollment in each plan is displayed on the far-left column for reference. The approval percentage for Inpatient Facilities and SCCA ranged from 93% for PHC to 100% for CenCal. This was calculated by using the number of approved Inpatient Facilities and SCC authorizations for each Plan and each County for April 2021 through March 2022 as the numerator, divided by the number of Inpatient Facilities and SCC requests for authorizations for each Plan and each County for April 2021 through March 2022 as the denominator.

Figure 43 displays the total requests seeking authorization for SCC services for each plan each quarter. For example, CenCal reported 92 requests in Q2 2021,134 requests in Q3 2021, 129 requests in Q4 2021, and 117 requests in Q1 2022.

WCM Specialized or Customized DME Authorizations

This data is not reported by CCS counties at this time. Figure 44 displays total requests for DME authorizations and approval rate, by plan and by County. The figure displays that specialized or customized DME requests for authorizations ranged from 115 for CenCal to 1,241 for PHC. Total plan enrollment and percent distribution of program enrollment in each plan is displayed on the far-left column for reference. The approval percentage ranged from 94% for PHC to 100% for CenCal, CCAH, and HPSM. This was calculated by using the number of approved specialized or customized DME authorizations for each plan and each County for April 2021 through March 2022 as the numerator, divided by the number of specialized or customized DME requests for authorizations for each plan and each County for April 2021 through March 2022 as the denominator.

Figure 45 displays the total requests seeking authorization for DME services for each plan each quarter. For example, PHC reported 353 requests in Q2 2021, 335 requests in Q3 2021, 318 requests in Q4 2021, and 235 requests in Q1 2022. An asterisk (*) represents numbers have been suppressed for Plans 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 counties at this time. Plans 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. Plans 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 plan. 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 plans and the dashboard charts show the last month in the reporting period as a point of time view.

For Figure 46, the percentage of high-risk members who received an assessment ranged from 6% to 144%, which is 8,436 assessments for CCAH and 1,337 assessments for HPSM[1], respectively. This was calculated by using the number of high-risk assessments for each plan as of March 2022 as the numerator, divided by the number of high-risk members in each plan in March 2022 as the denominator. Each denominator is different because each plan has a different number

[1] 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.

of high-risk members.

For Figure 47, the percentage of low-risk members who received an assessment ranged from 41% to 100%, which is 6,335 assessments for CalOptima and 4,976 assessments for CenCal, respectively. This was calculated by using the number of low-risk assessments for each plan as of March 2022 as the numerator, divided by the number of low-risk members in each plan in March 2022 as the denominator. Each denominator is different because each plan has a different number of low-risk members.

WCM Grievances and Appeals: Figure 48-50

This data is not reported by CCS counties at this time. CCS-eligible members enrolled in managed care are provided the same grievance and appeal rights as other plan members. Plans must have timely processes for accepting and acting upon member grievances and appeals. Grievances and appeals data are submitted by plans. 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.

For Figure 48, WCM appeals and grievances per 1,000 members are trended over 12 months (April 2021 - March 2022). In April 2021, plans reported to have received 0.65 appeals per 1,000 members and 0.98 grievances per 1,000 members. In March 2022, plans received 0.51 appeals per 1,000 members and 0.92 grievances per 1,000 members.

WCM appeals per 1,000 member months are shown by plan in Figure 49. CenCal reported to have received 4 appeals per 1,000 member months while HPSM reported 11 appeals per 1,000 member months.

Figure 50 displays percent distribution of major categories of total grievances reported by plans. Total grievances for each Plan are displayed on the far-right end of the bar.[2] This was calculated by using the number of each grievance type for each plan for April 2021 through March 2022 as the numerator, divided by the total number of grievances for each plan from April 2021 through March 2022 as the denominator.

WCM Family Advisory Committee Meetings: Figure 51

This data is not reported by CCS counties at this time. Plans must establish a quarterly Family Advisory Committee (FAC) for CCS 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

[2] 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.

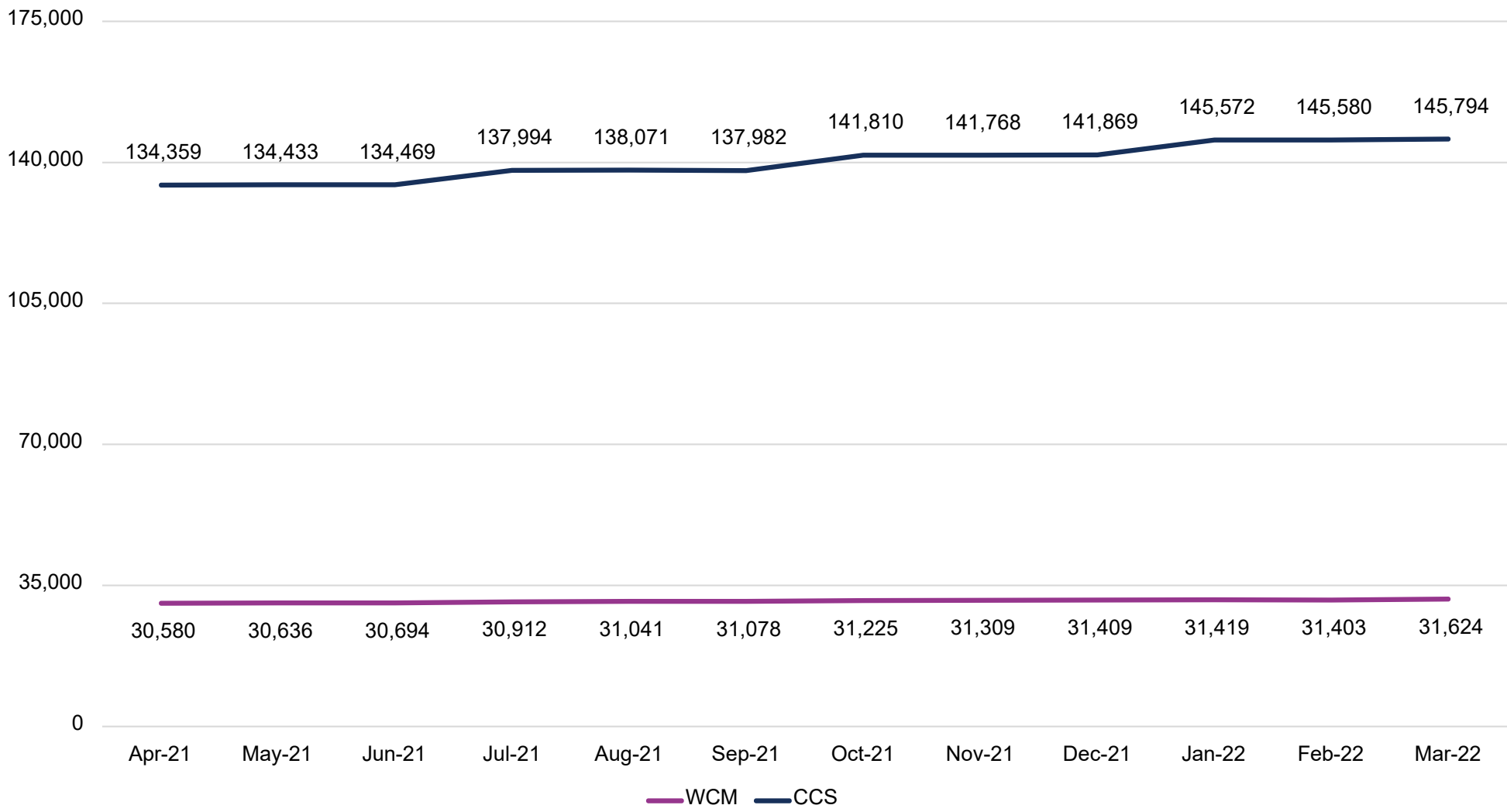
number of committee members, meetings held, recruitment efforts and seats to be filled for each plan over 12 months (April 2021 - March 2022).

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

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

Fig 1: Monthly Statewide Enrollment



Note: This report contains data from April 2021 to March 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 March 2022

Fig 2: Enrollment by Race/Ethnicity

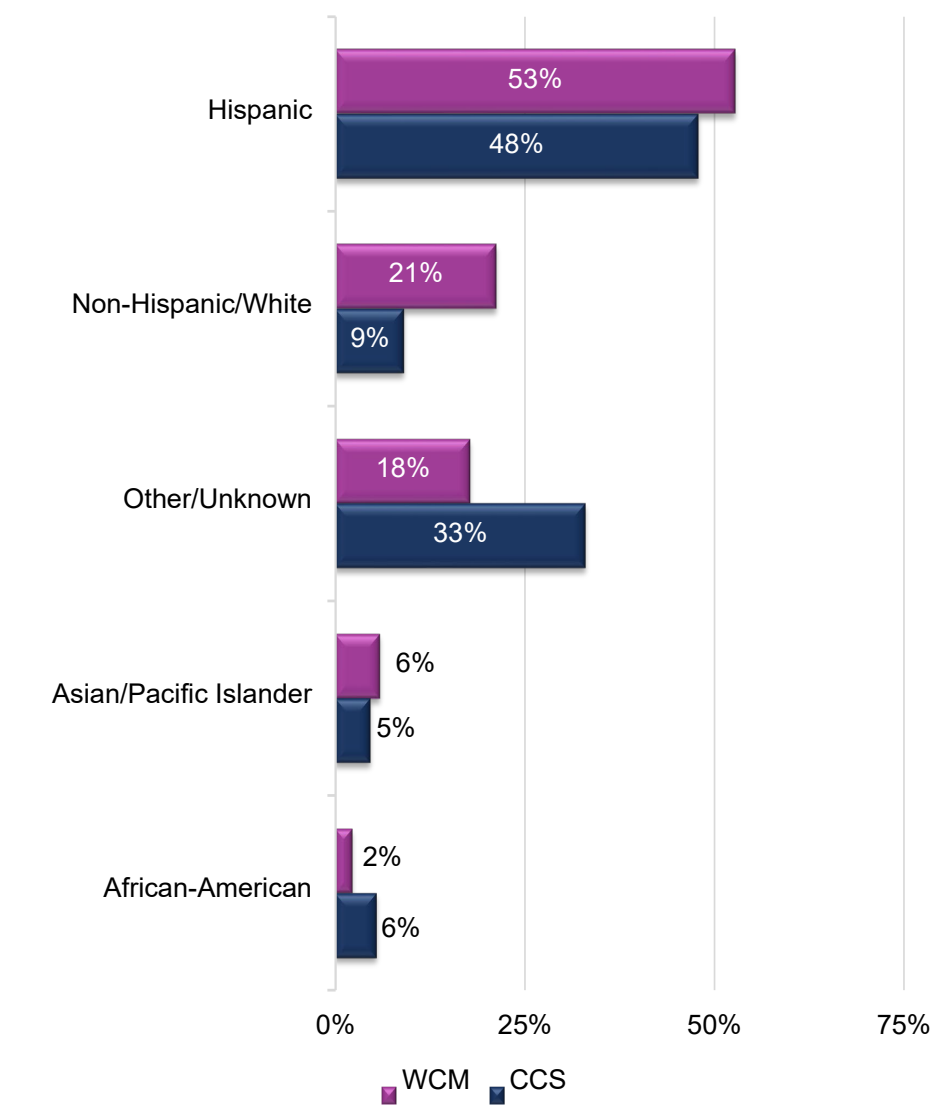
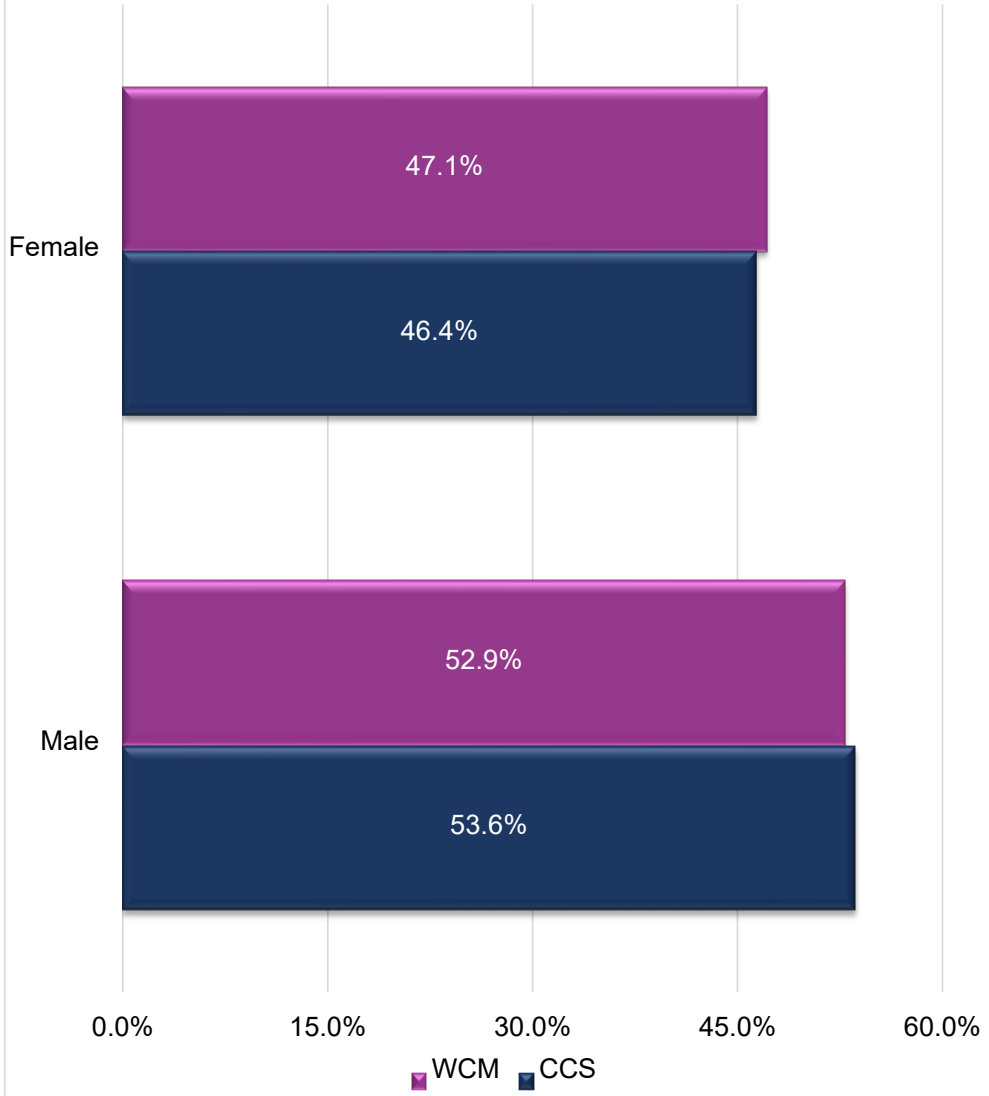


Fig 3: Enrollment by Gender



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 March 2022

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

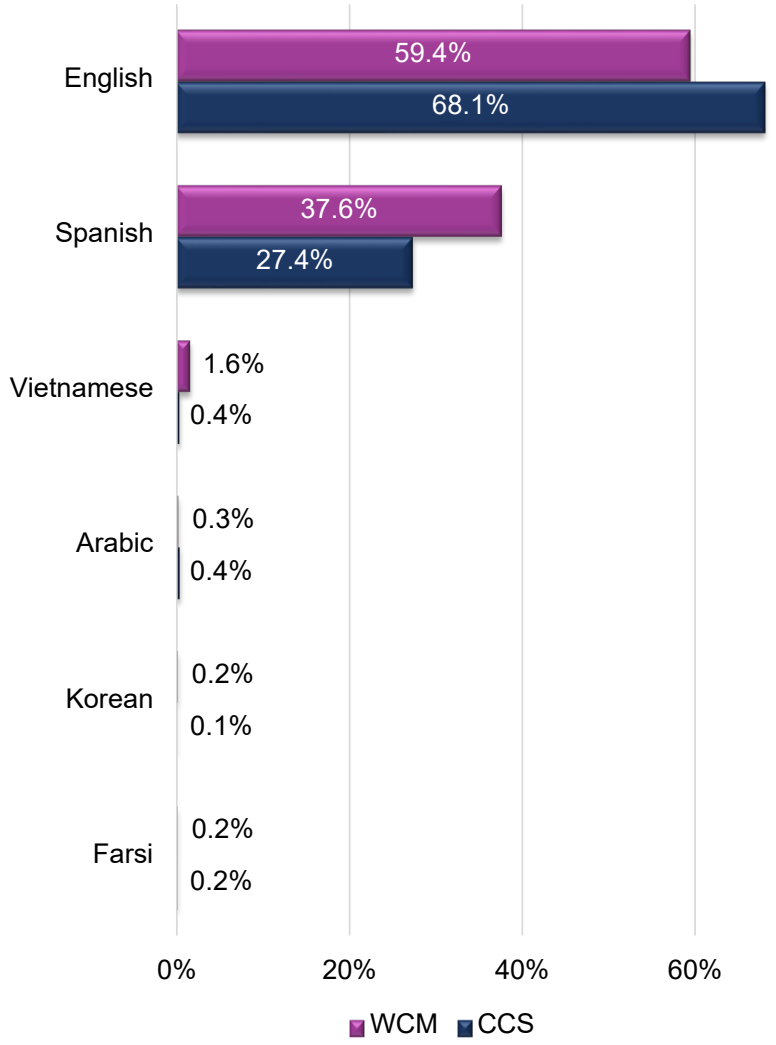
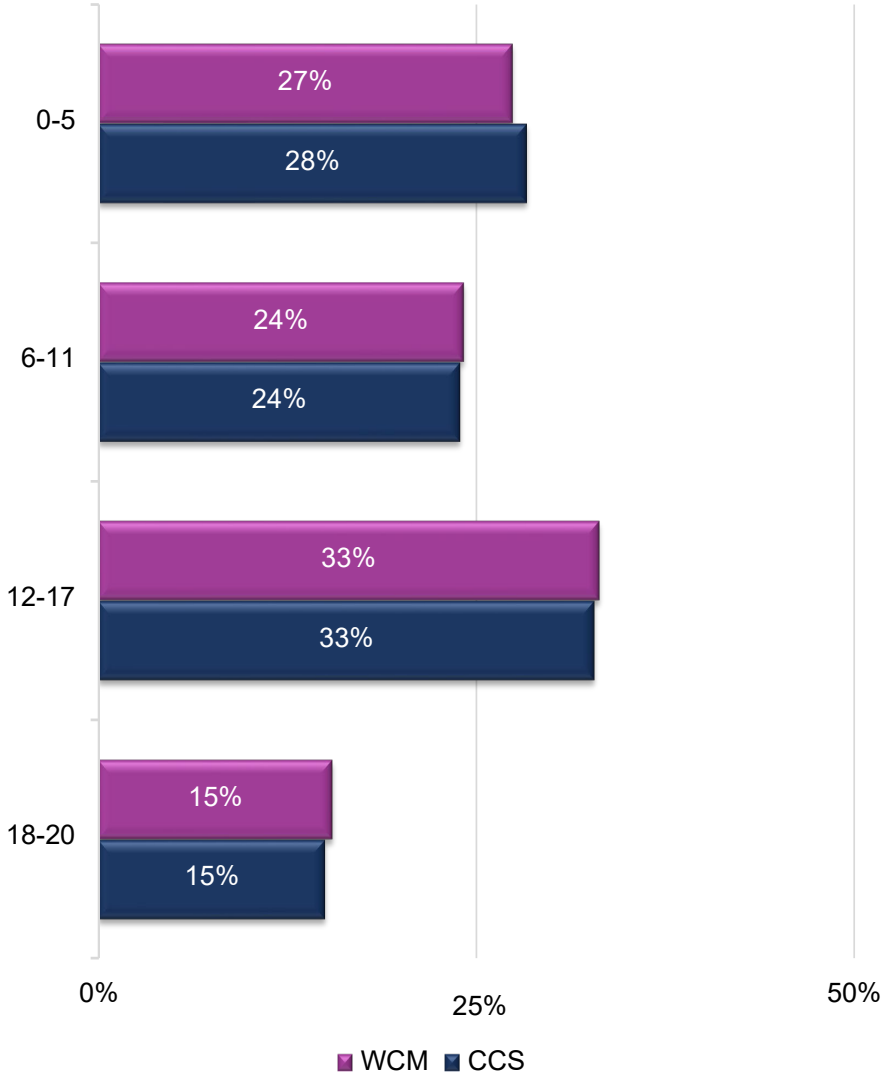


Fig 5: Enrollment by Age



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 March 2022

Fig 6: Total Classic CCS Enrollment by County

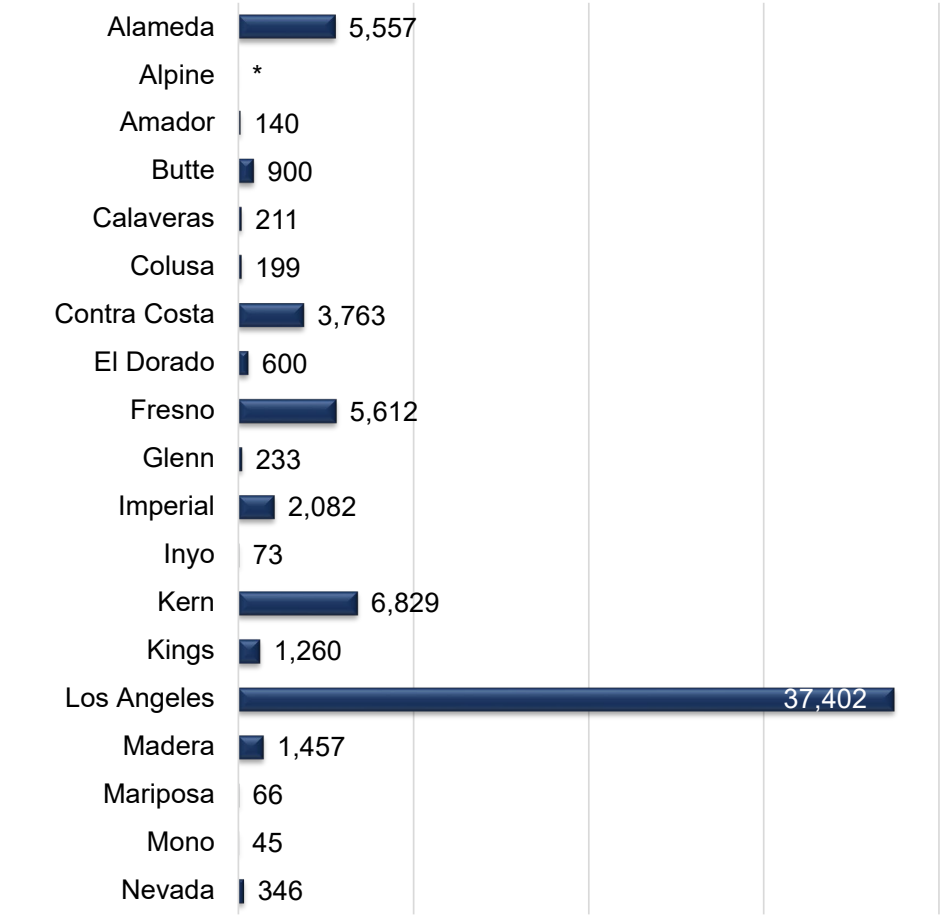
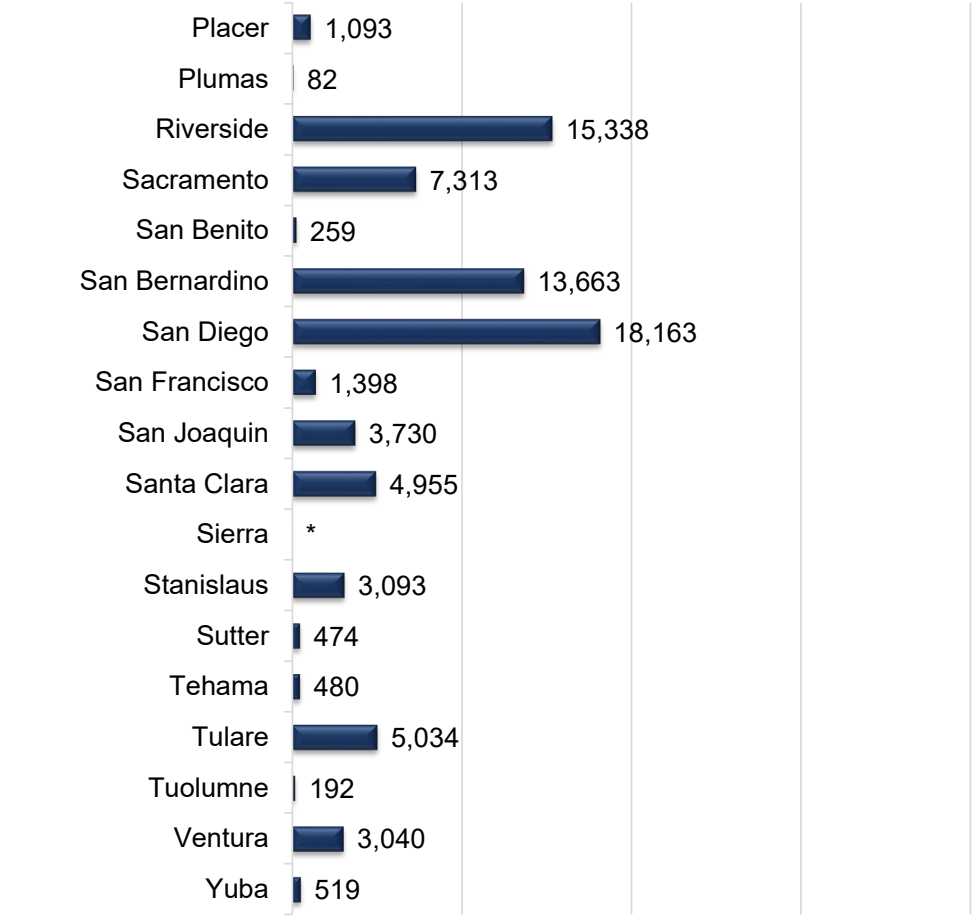


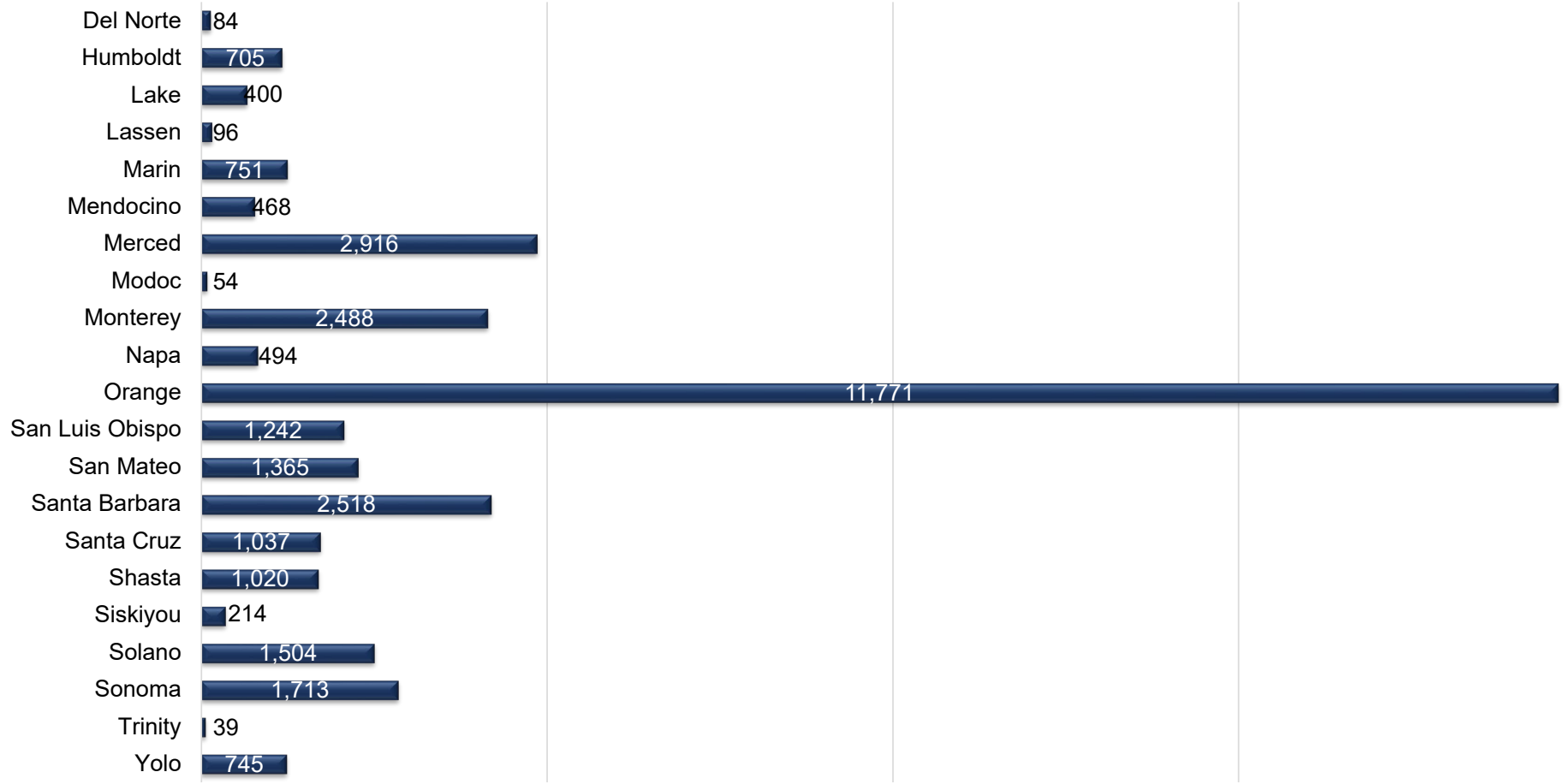
Fig 7: Total Classic CCS Enrollment by County



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 March 2022

Fig 8: WCM Enrollment by County



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

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

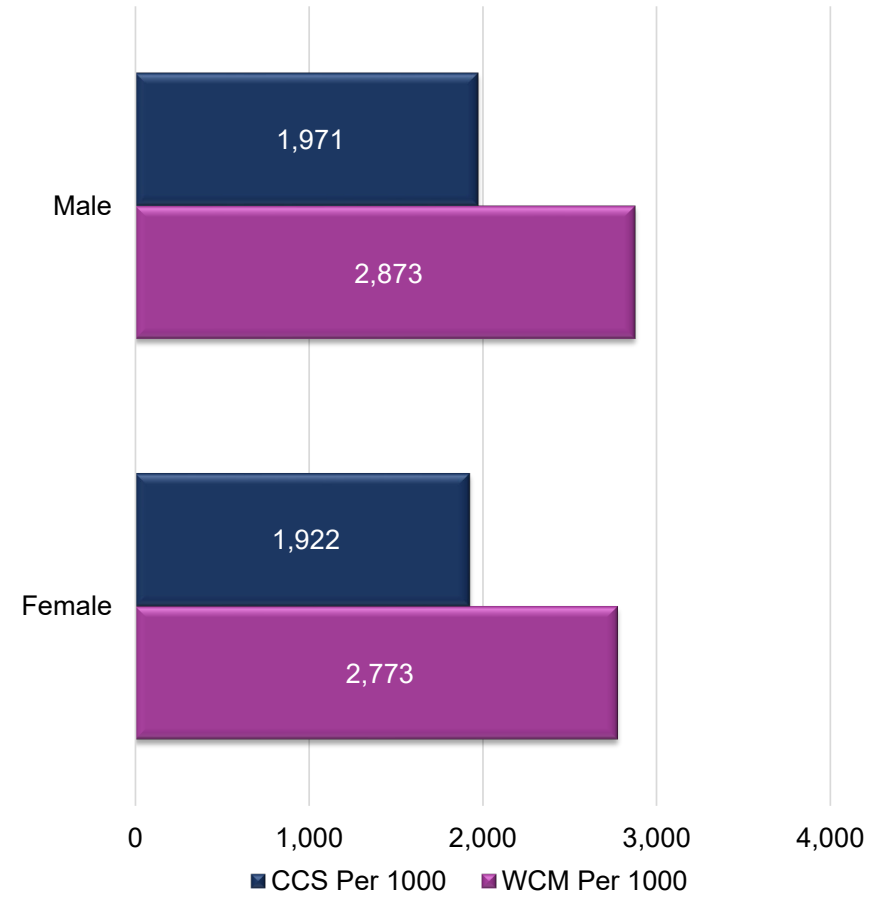
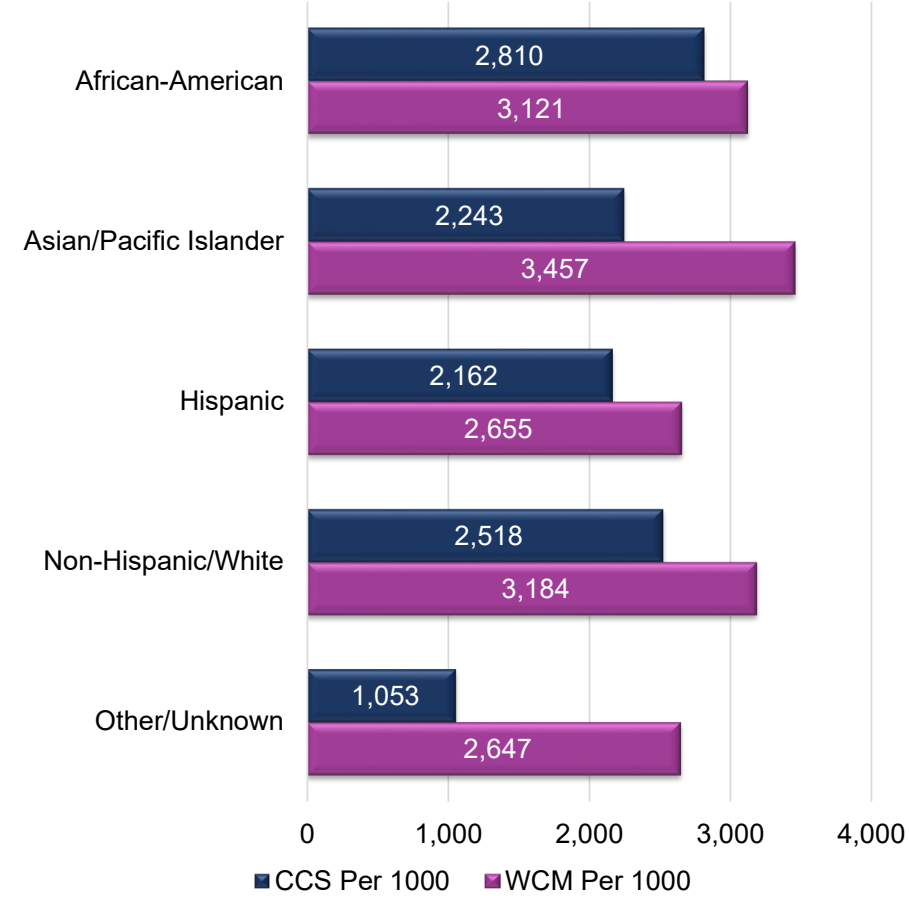


Fig 10: Outpatient Visits per 1,000 Member Months by Ethnicity



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

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

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

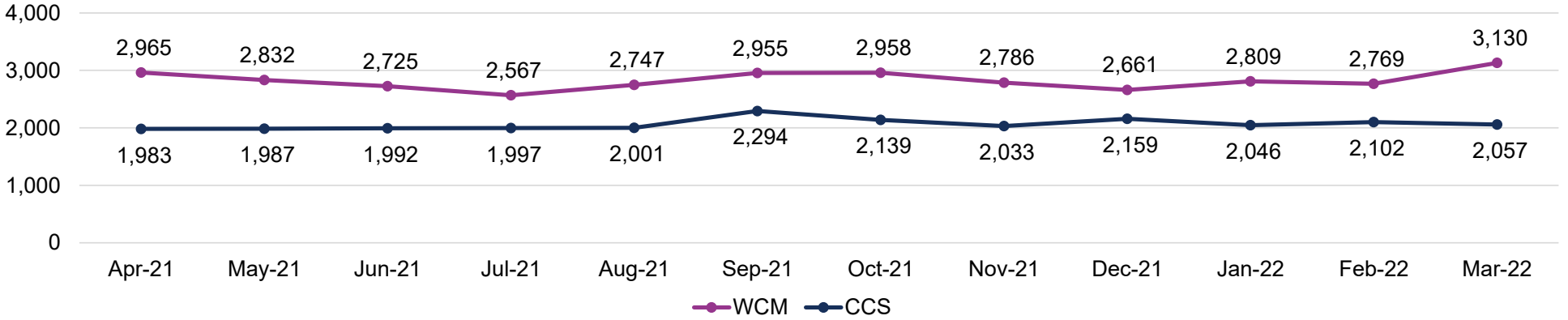
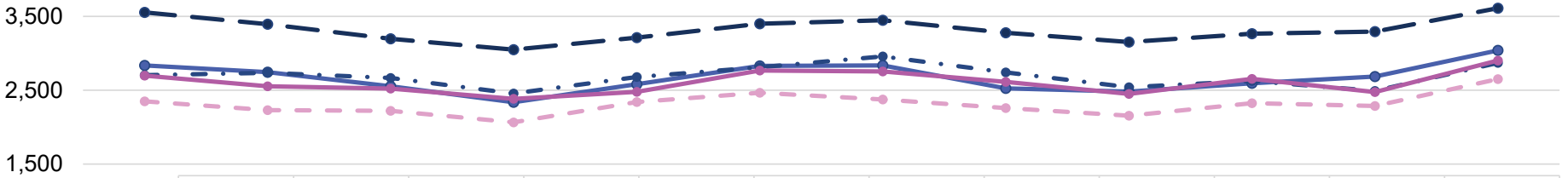


Fig 12: WCM Outpatient Visits per 1,000 Members by Plan, by Month



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
CalOptima	3,556	3,394	3,196	3,050	3,211	3,401	3,449	3,277	3,152	3,267	3,293	3,612
CenCal	2,836	2,745	2,554	2,338	2,581	2,831	2,835	2,525	2,481	2,593	2,686	3,040
CCAH	2,350	2,230	2,221	2,066	2,340	2,464	2,375	2,259	2,156	2,325	2,286	2,651
HPSM	2,705	2,734	2,666	2,456	2,680	2,811	2,958	2,741	2,542	2,626	2,492	2,872
PHC	2,699	2,554	2,522	2,383	2,477	2,765	2,755	2,614	2,451	2,653	2,477	2,903

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

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

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

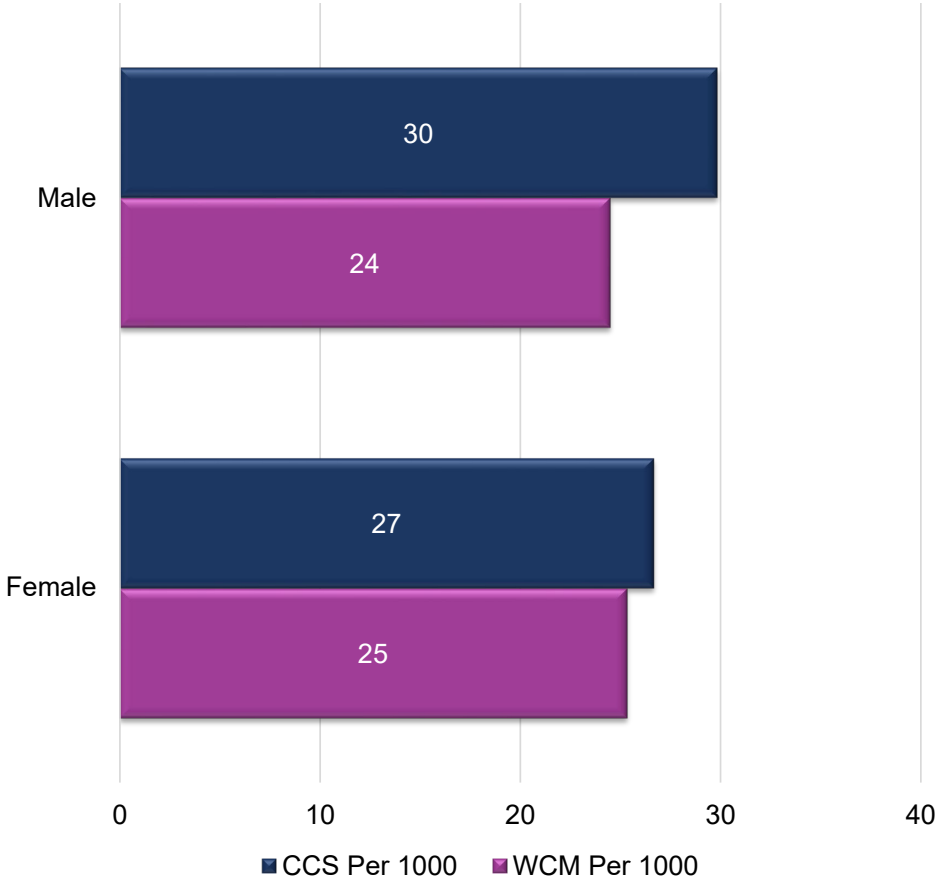
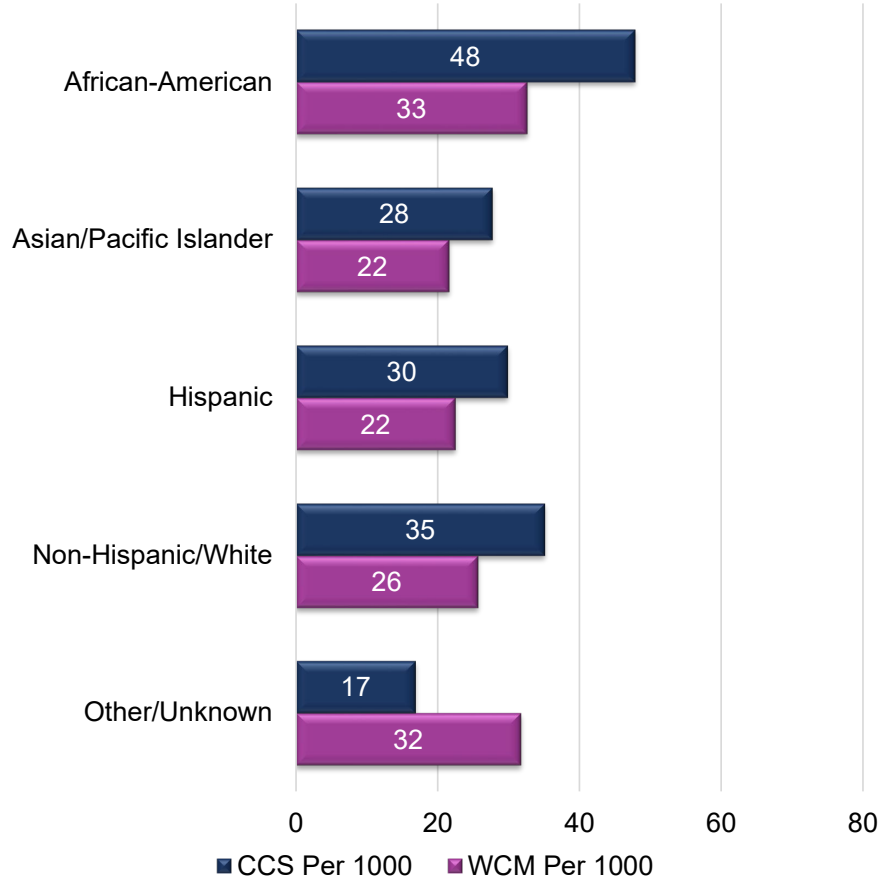


Fig 14: Inpatient Admissions per 1,000 Member Months by Ethnicity



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

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

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

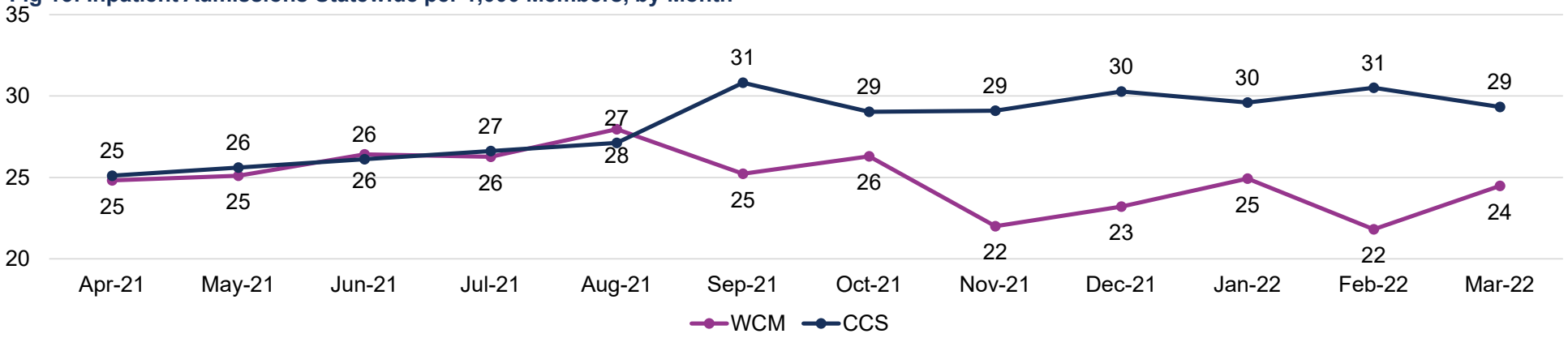
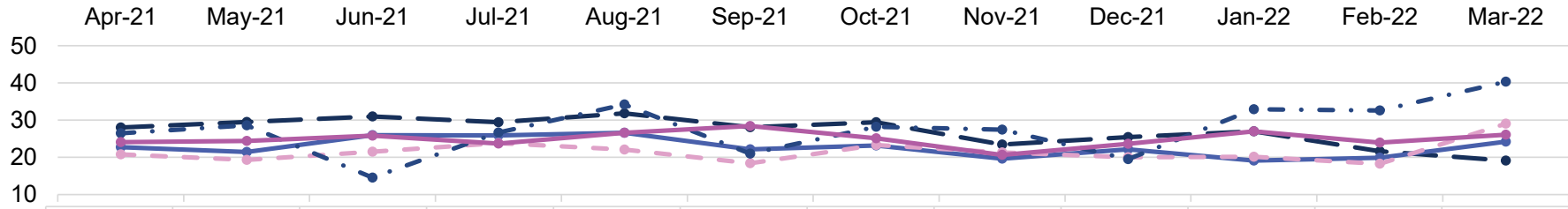


Fig 16: WCM Inpatient Admissions per 1,000 Members by Plan, by Month



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
CalOptima	28	29	31	29	32	28	29	23	25	27	22	19
CenCal	23	21	26	26	27	22	23	20	22	19	20	24
CCAH	21	19	22	24	22	18	23	21	20	20	18	29
HPSM	26	29	15	27	34	21	28	27	19	33	33	40
PHC	24	24	26	24	27	28	25	21	24	27	24	26

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

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

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

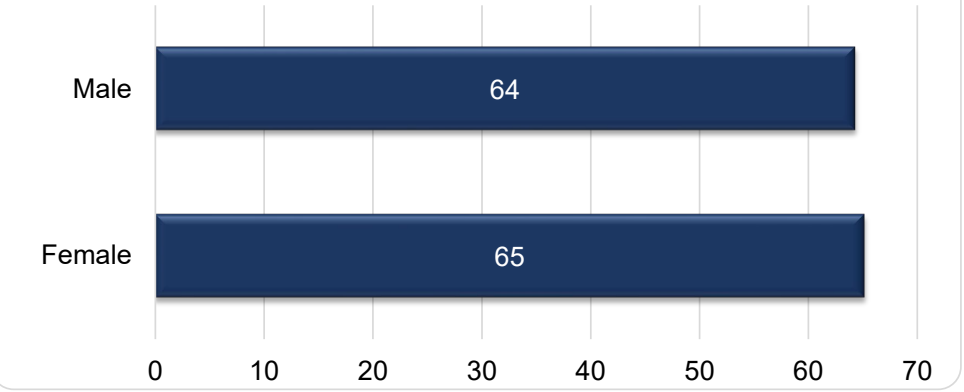


Fig 18: ED Visits per 1,000 Member Months by Ethnicity

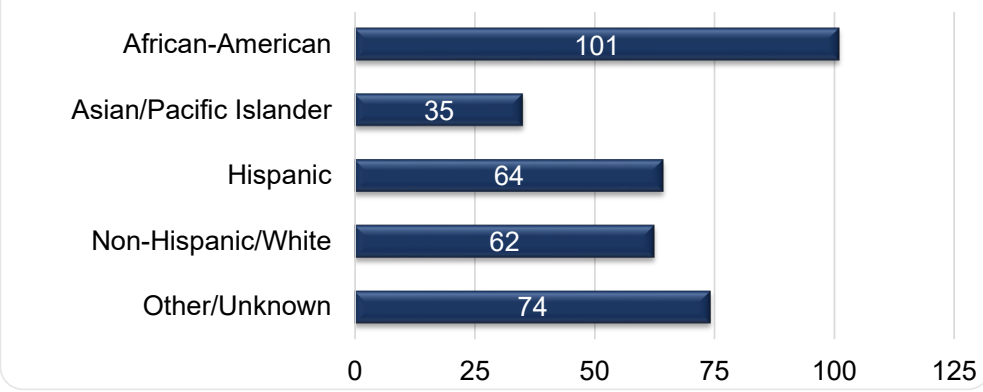
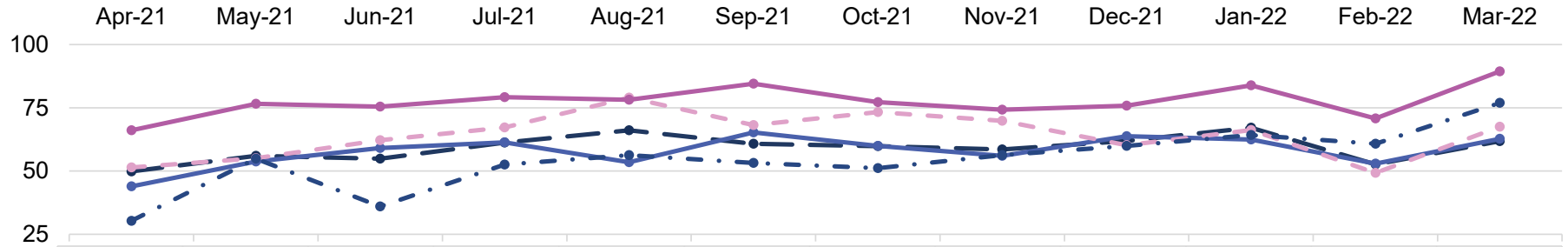


Fig 19: ED Visits per 1,000 Members by Plan, by Month



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
CalOptima	50	56	55	61	66	61	60	59	62	67	53	62
CenCal	44	54	59	61	53	65	60	56	64	63	53	63
CCAH	51	55	62	67	79	68	73	70	60	66	49	68
HPSM	30	55	36	53	56	53	51	56	60	64	61	77
PHC	66	77	75	79	78	85	77	74	76	84	71	89

WCM Utilization Figure 20 - 22: Breakdowns of Prescriptions Utilization (Apr '21 - Mar '22)

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

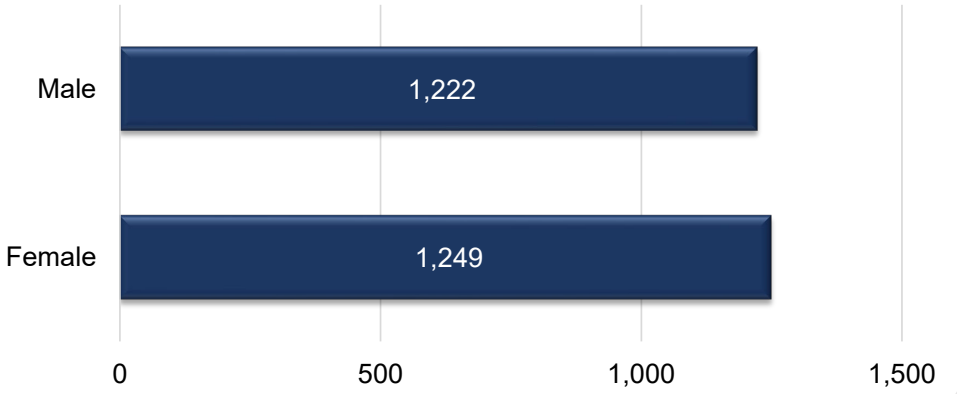


Fig 21: Prescriptions per 1,000 Member Months by Ethnicity

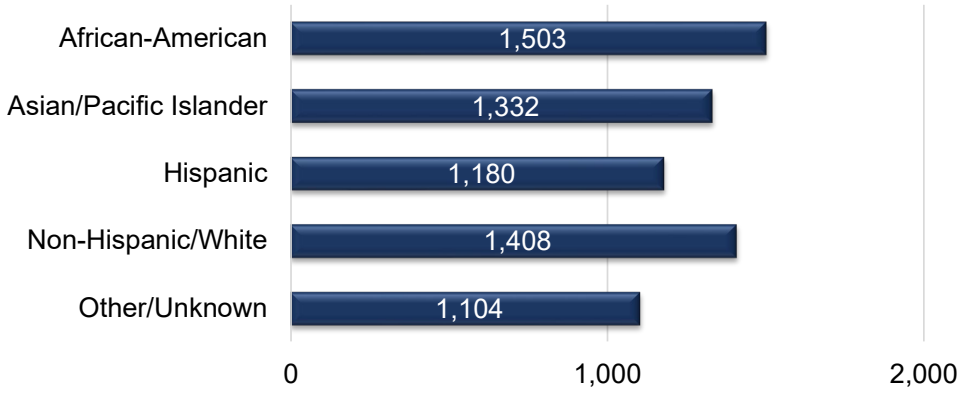
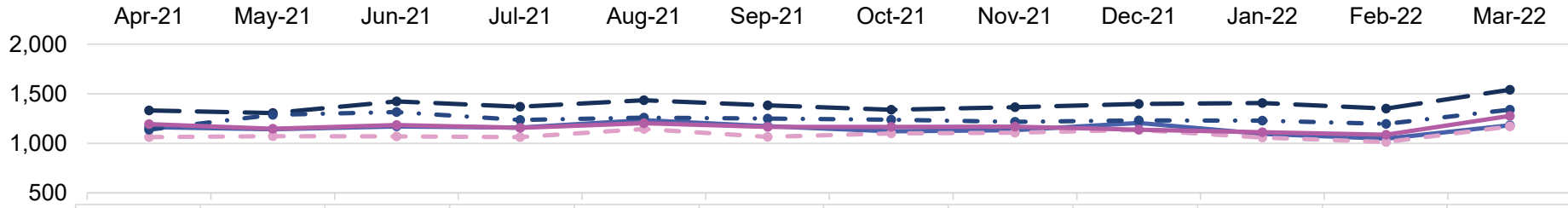


Fig 22: Prescription per 1,000 Members by Plan, by Month



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
CalOptima	1,332	1,305	1,422	1,368	1,433	1,383	1,339	1,365	1,397	1,407	1,349	1,540
CenCal	1,163	1,141	1,169	1,158	1,233	1,173	1,122	1,133	1,204	1,096	1,047	1,181
CCAH	1,063	1,072	1,070	1,062	1,146	1,064	1,100	1,108	1,136	1,058	1,013	1,170
HPSM	1,138	1,286	1,315	1,235	1,259	1,250	1,238	1,218	1,230	1,229	1,196	1,339
PHC	1,194	1,146	1,185	1,156	1,203	1,165	1,166	1,167	1,138	1,112	1,086	1,276

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

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

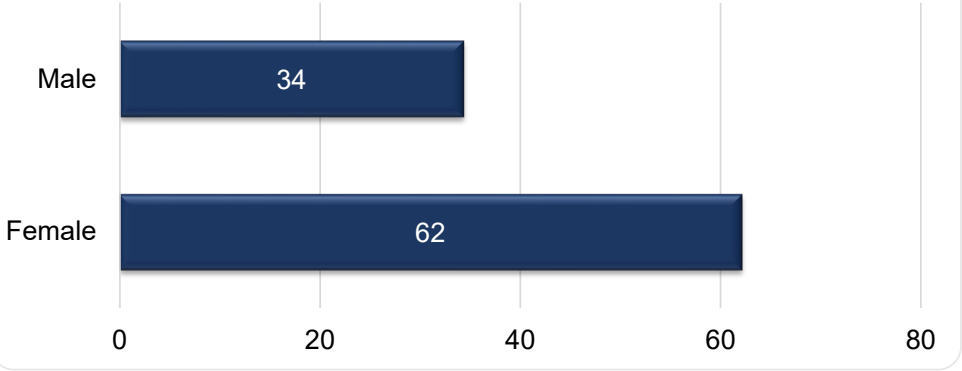


Fig 24: Non-specialty Mental Health Visits per 1,000 Member Months by Ethnicity

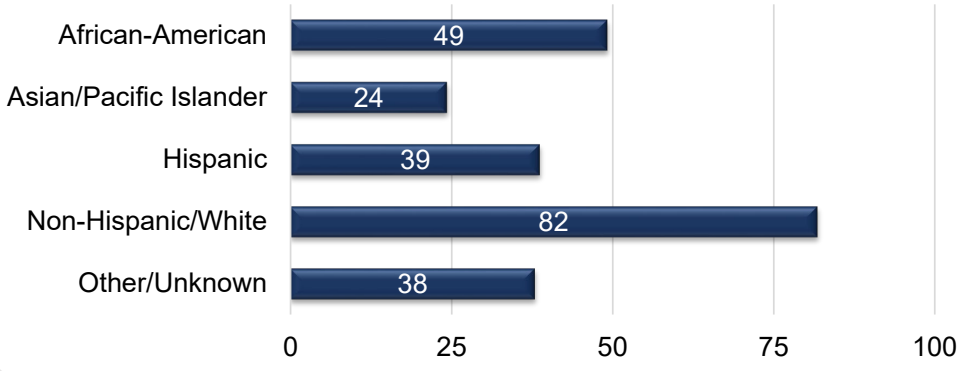
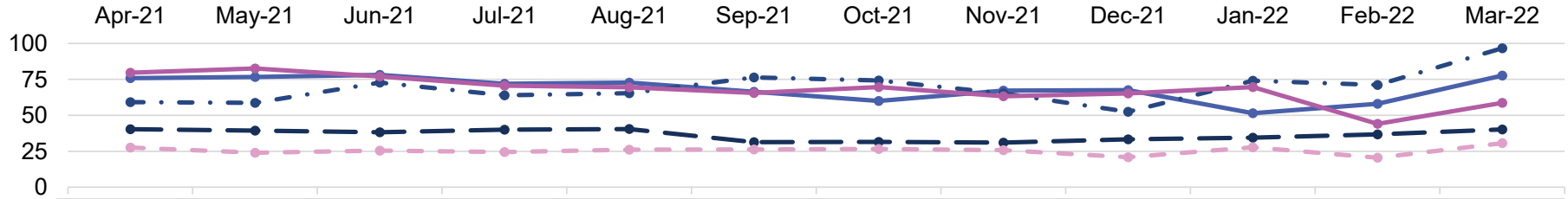


Fig 25: Non-specialty Mental Health Visits per 1,000 Members by Plan, by Month



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
CalOptima	40	39	38	40	40	31	32	31	33	34	37	40
CenCal	76	77	78	72	73	66	60	67	68	51	58	78
CCAH	28	24	25	24	26	26	27	26	21	28	20	31
HPSM	59	59	73	64	65	76	74	65	52	74	71	97
PHC	80	83	77	71	69	65	70	63	65	70	44	59

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

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

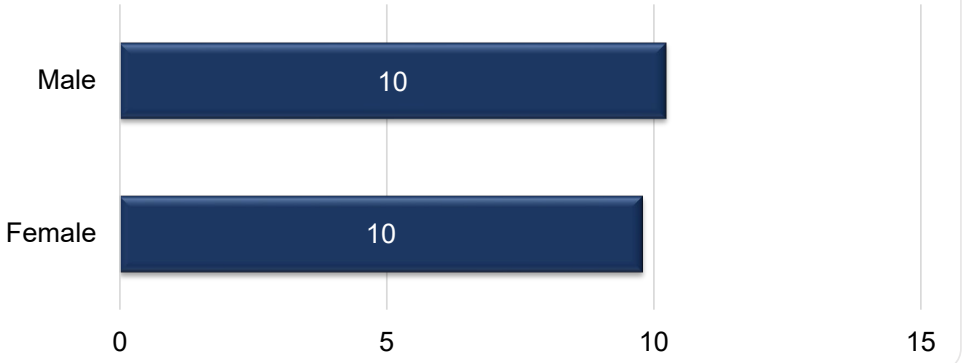


Fig 27: Emergency Department Visits with an Inpatient Admission per 1,000 Member Months by Ethnicity

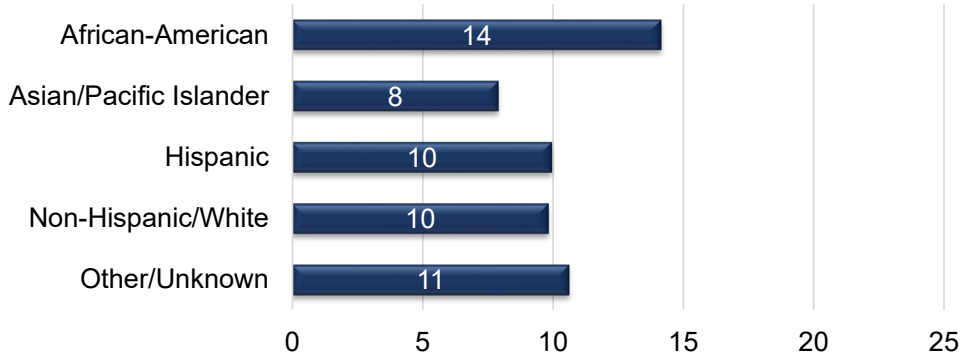
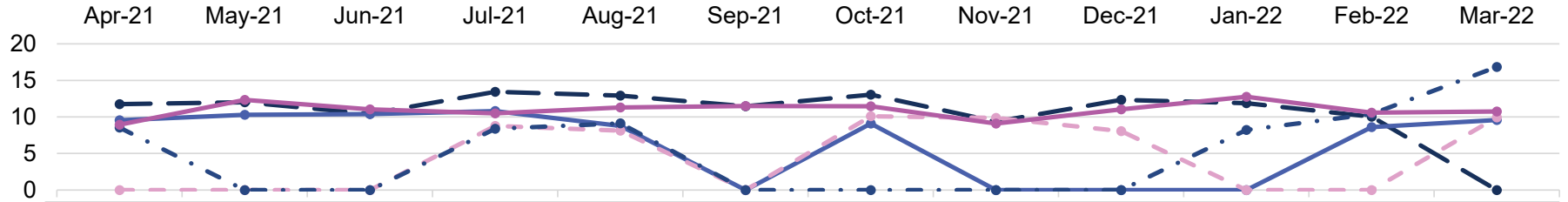


Fig 28: Emergency Department Visits with an Inpatient Admission per 1,000 Members by Plan, by Month

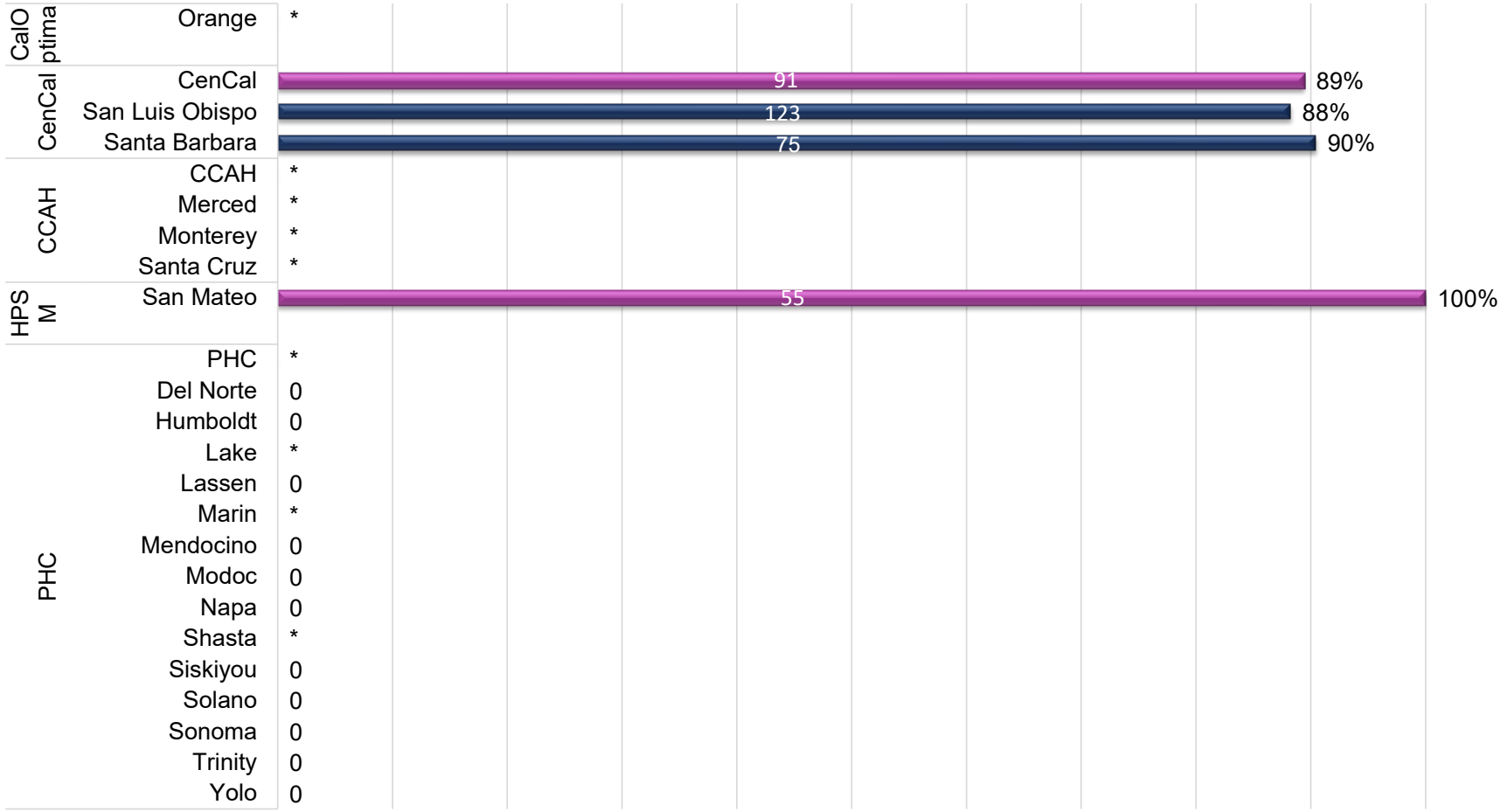


	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
CalOptima	12	12	10	13	13	11	13	9	12	12	10	*
CenCal	10	10	10	11	9	*	9	*	*	*	9	10
CCAH	*	*	*	9	8	*	10	10	8	*	*	10
HPSM	9	*	*	8	9	*	*	*	*	8	10	17
PHC	9	12	11	10	11	11	11	9	11	13	11	11

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

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

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



Note: This report contains data from April 2021 to March 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 34 through Month 45

	Month 34	Month 35	Month 36	Month 37	Month 38	Month 39	Month 40	Month 41	Month 42	Month 43	Month 44	Month 45
CalOptima	*	*	*	0	*	*	*	*	*	*	*	0
CenCal	41	28	46	34	36	17	22	12	18	33	17	37
CCAH	*	*	*	*	*	*	*	*	*	*	*	*
HPSM	22	17	21	*	*	*	*	*	*	*	*	*
PHC	0	0	0	0	*	*	0	0	0	*	*	0

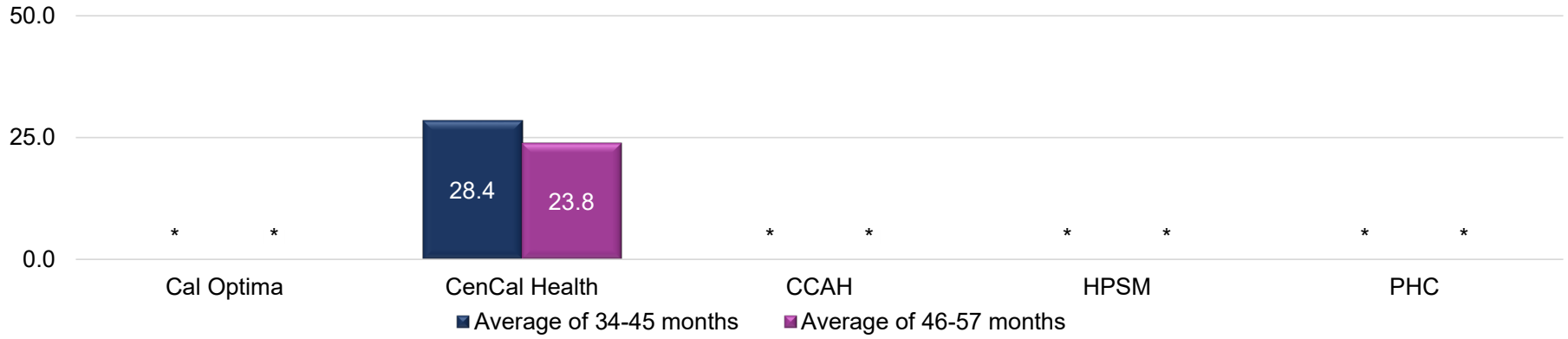
WCM Figure 31: Continuity of Care (COC) Requests Upon Joining the Program, by Plan, by Month - Month 46 through Month 57

	Month 46	Month 47	Month 48	Month 49	Month 50	Month 51	Month 52	Month 53	Month 54	Month 55	Month 56	Month 57
CalOptima	*	*	0	0	*	*	*	*	0	*	0	0
CenCal	23	28	29	20	25	*	24	24	32	35	14	24
CCAH	*	*	0	0	0	0	0	0	0	0	*	*
HPSM	*	*	*	*	*	*	*	*	*	*	*	0
PHC	*	*	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.*

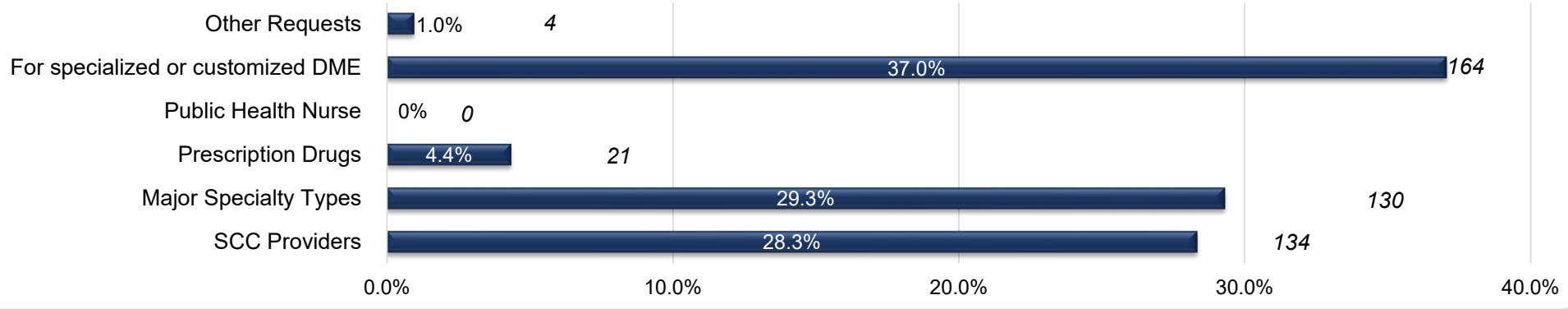
WCM Figure 32: Continuity of Care (COC) - Requests, by Plan (Apr '21 - Mar '22)

Fig 32: Plan Average COC Request Upon Joining the Program, Month 34 - Month 45 vs Month 46 - Month 57



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

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

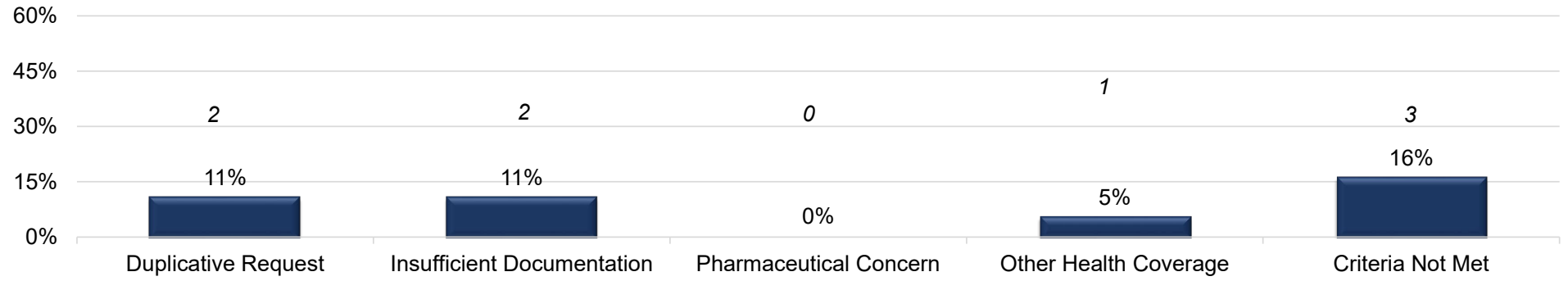
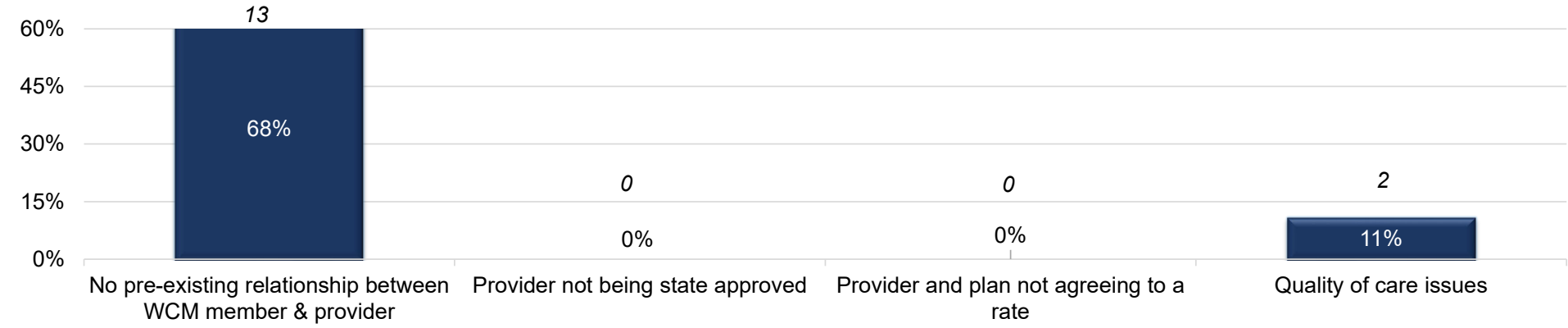


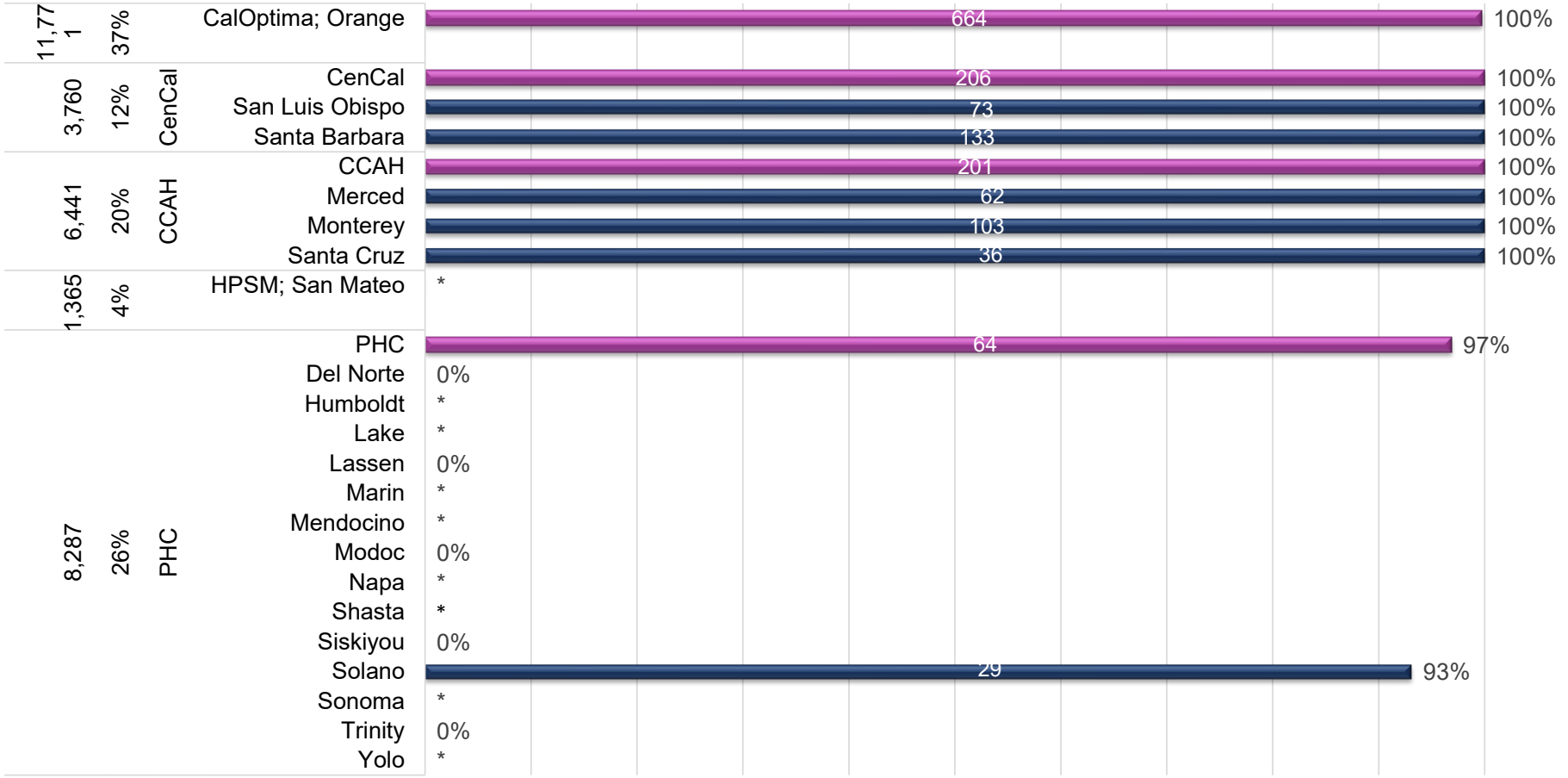
Fig 35: COC Denial Reasons (Required by APL)



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 (Apr '21 - Mar '22)

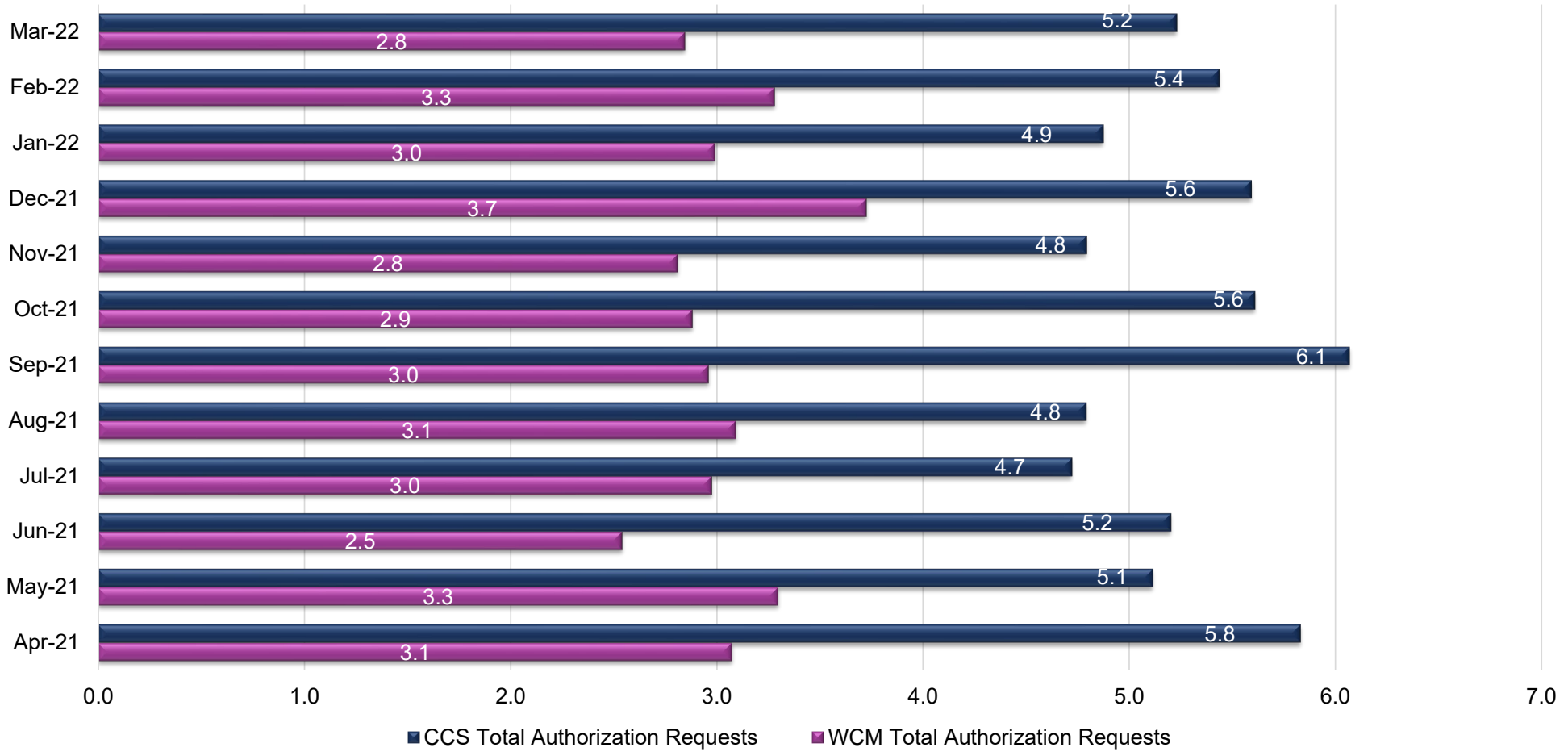
Fig 36: WCM Total NICU Authorization Requests & Percentage Approved by Plan, by County



Note: This report contains data from April 2021 to March 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 (Apr '21 - Mar '22)

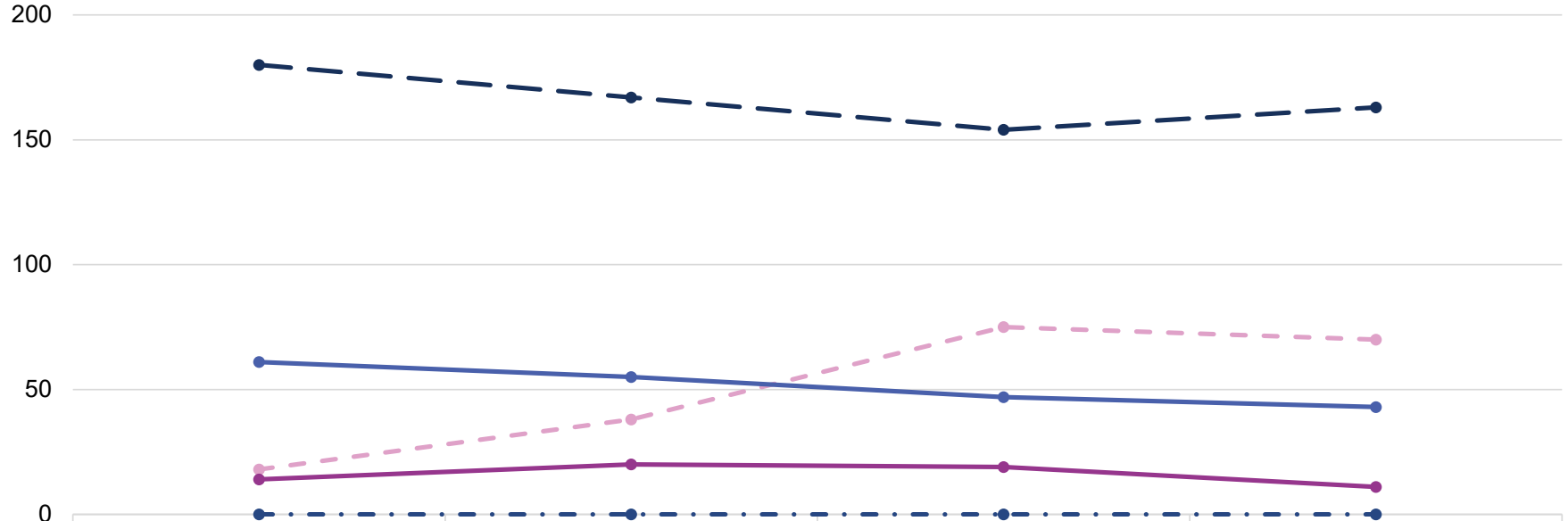
Fig 37: Statewide Total NICU Authorization Requests per 1,000 Members, by Month



Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from April 2021 to March 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 (Apr '21 - Mar '22)

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

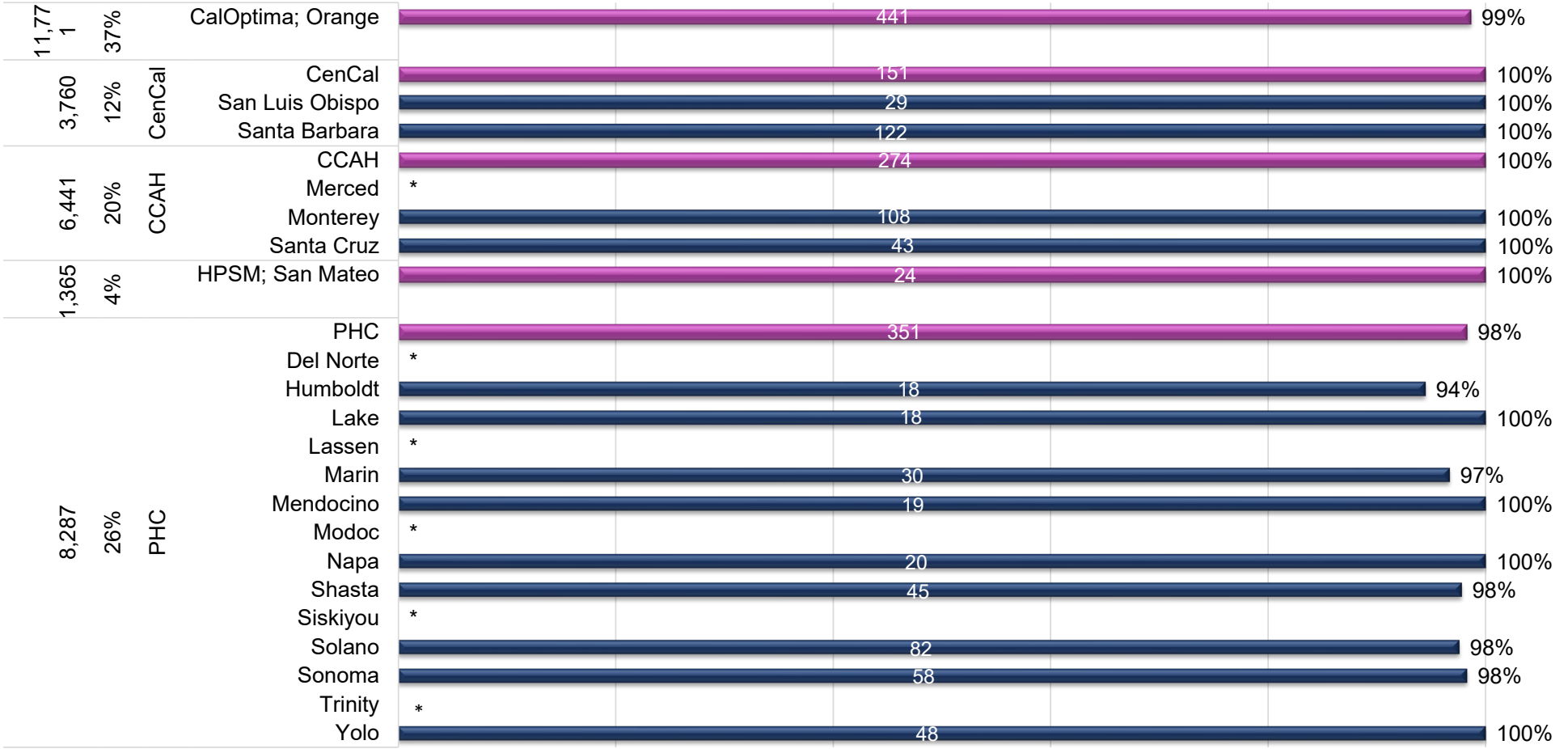


	Q2 2021	Q3 2021	Q4 2021	Q1 2022
CalOptima	180	167	154	163
CCAH	18	38	75	70
CenCal	61	55	47	43
HPSM	0	0	0	0
PHC	14	20	19	11

Note: This report contains data from April 2021 to March 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 (Apr '21 - Mar '22)

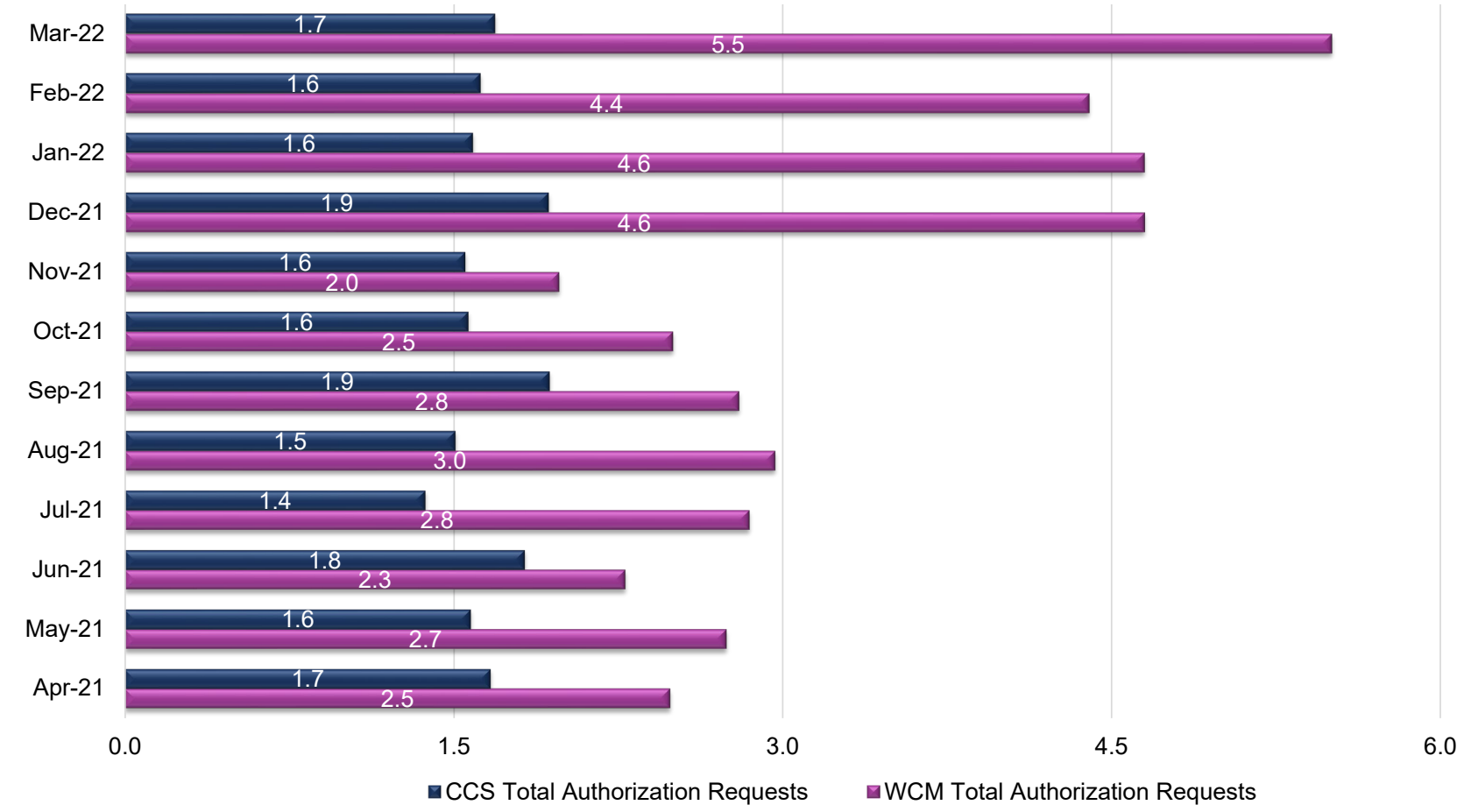
Fig 39: WCM Total PICU Authorization Requests & Percentage Approved by Plan, by County



Note: This report contains data from April 2021 to March 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 40: Case Management PICU Authorization Requests (Apr '21 - Mar '22)

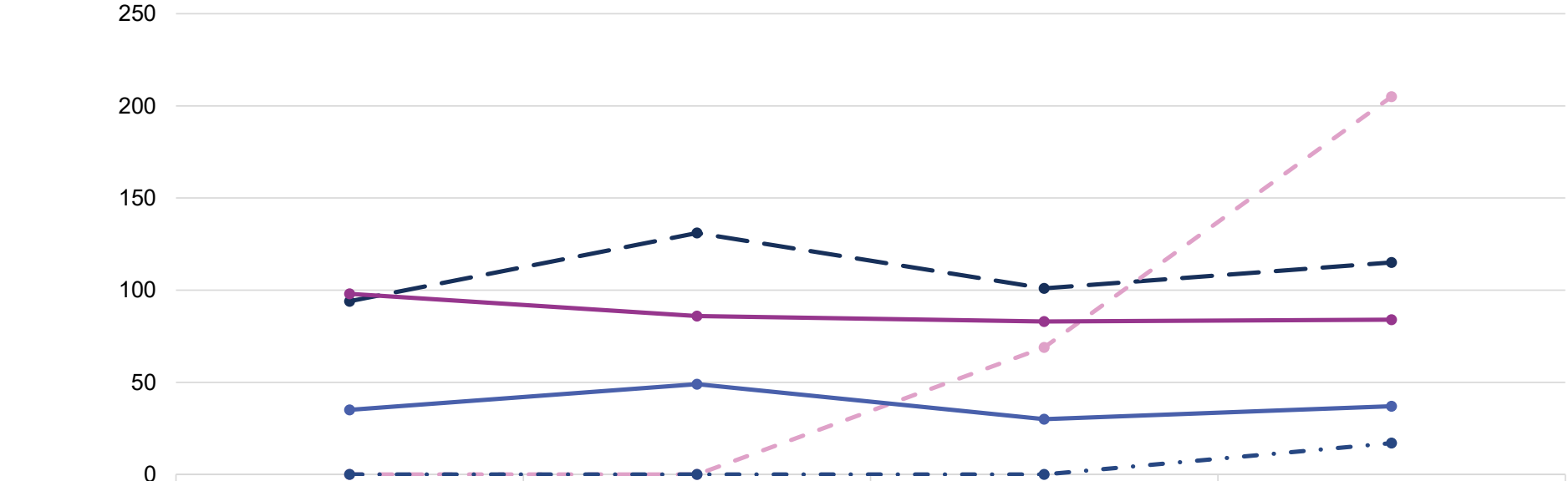
Fig 40: Statewide Total PICU Authorization Requests per 1,000 Members, by Month



Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from April 2021 to March 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 (Apr '21 - Mar '22)

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

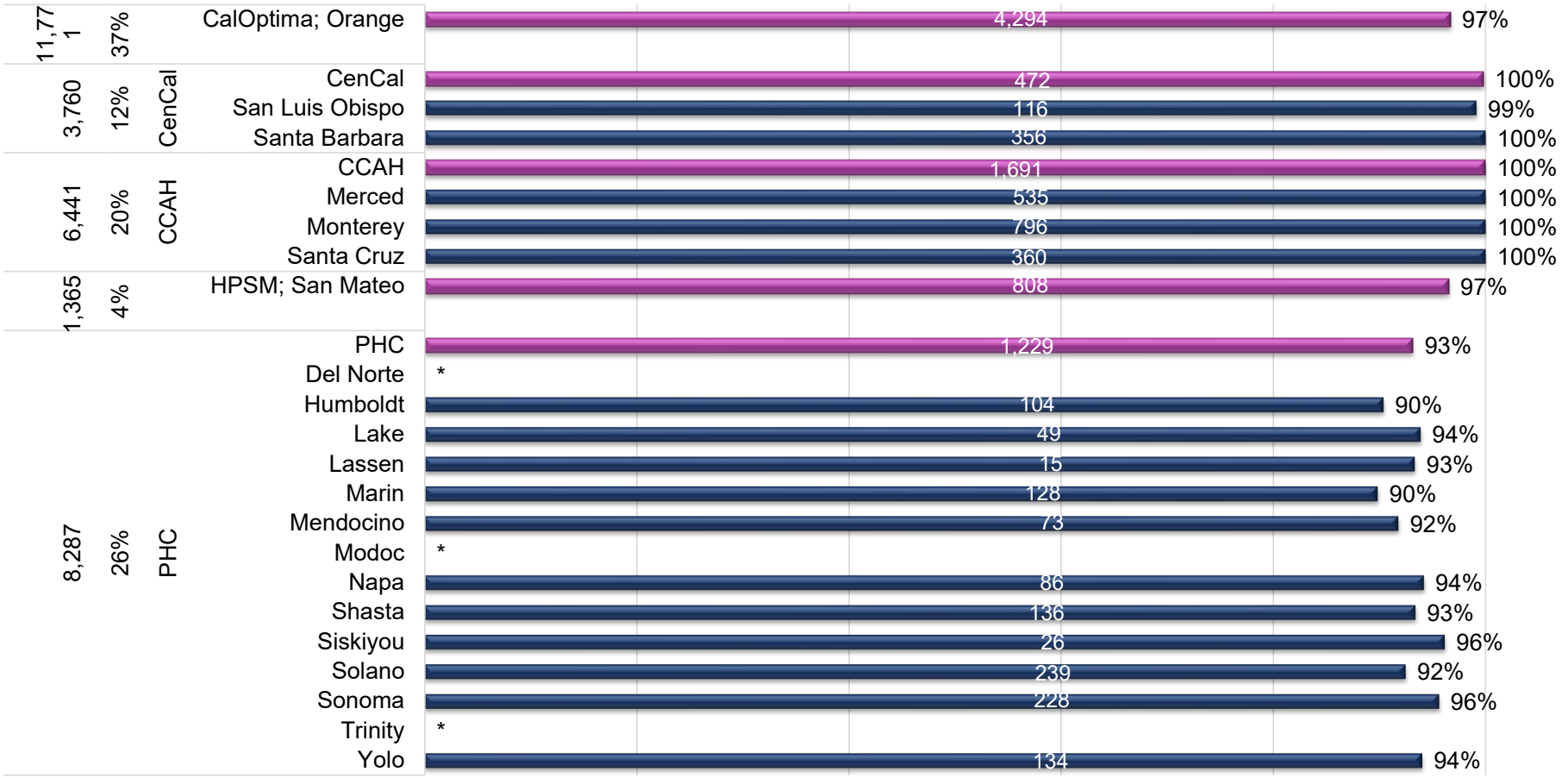


	Q2 2021	Q3 2021	Q4 2021	Q1 2022
CalOptima	94	131	101	115
CCAH	*	*	69	205
CenCal	35	49	30	37
HPSM	*	*	*	17
PHC	98	86	83	84

*Note: This report contains data from April 2021 to March 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 a 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 (Apr '21 - Mar '22)

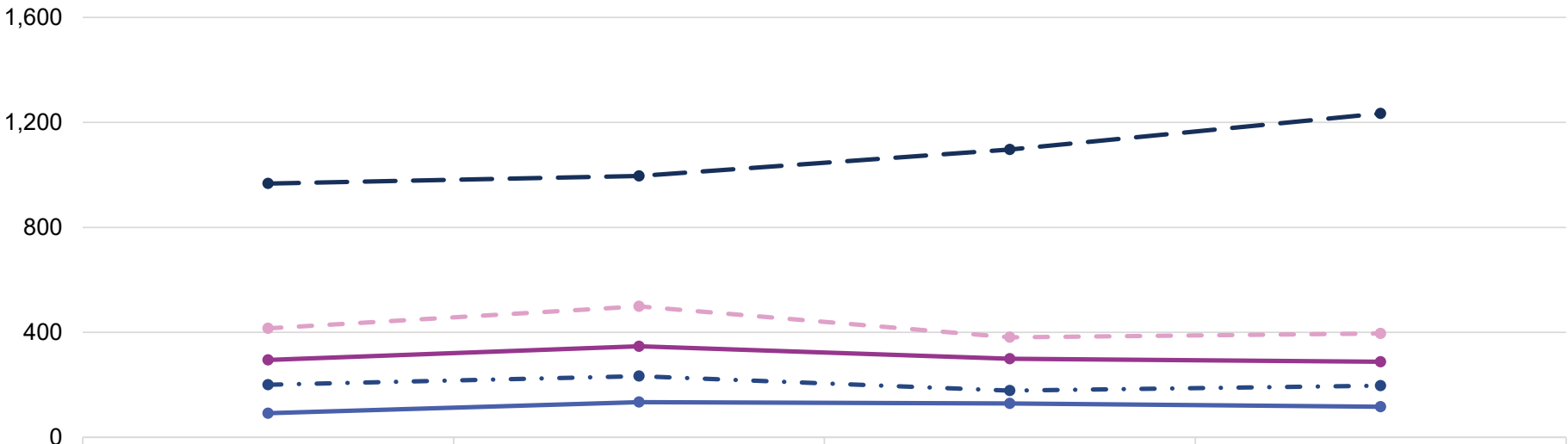
Fig 42: WCM Total Inpatient Facilities and SCC Authorization Requests & Percentage Approved by Plan, by County



Note: This report contains data from April 2021 to March 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 43: Case Management Inpatient Facilities and Special Care Centers (SCC) Authorization Requests (Apr '21 - Mar '22)

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

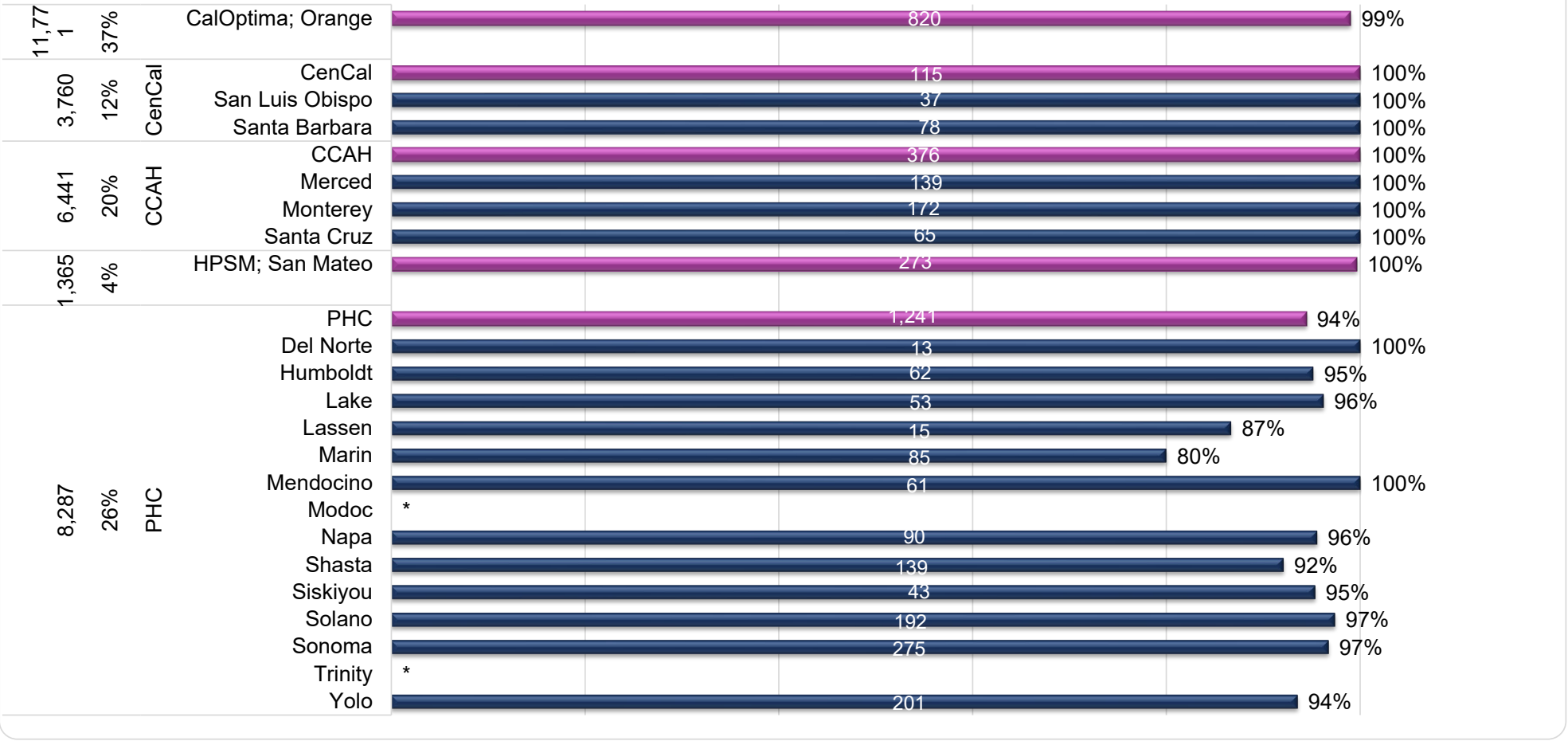


	Q2 2021	Q3 2021	Q4 2021	Q1 2022
CalOptima	967	996	1,097	1,234
CCAH	415	499	381	396
CenCal	92	134	129	117
HPSM	200	233	178	197
PHC	295	347	299	288

Note: This report contains data from April 2021 to March 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 44: Case Management Specialized or Customized DME Authorization Requests & Approvals (Apr '21 - Mar '22)

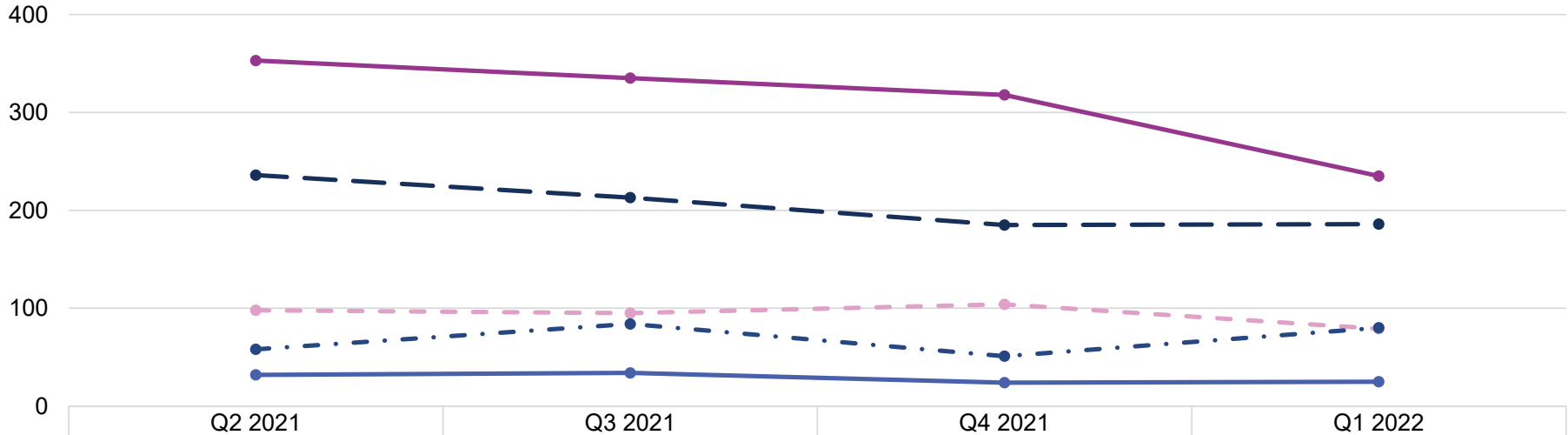
Fig 44: WCM Total Specialized or Customized DME Authorization Requests & Percentage Approved by Plan, by County



Note: This report contains data from April 2021 to March 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 45: Case Management Specialized or Customized DME Authorization Requests (Apr '21 - Mar '22)

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



	Q2 2021	Q3 2021	Q4 2021	Q1 2022
CalOptima	236	213	185	186
CCAH	98	95	104	79
CenCal	32	34	24	25
HPSM	58	84	51	80
PHC	353	335	318	235

*Note: This report contains data from April 2021 to March 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 - March 2022

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

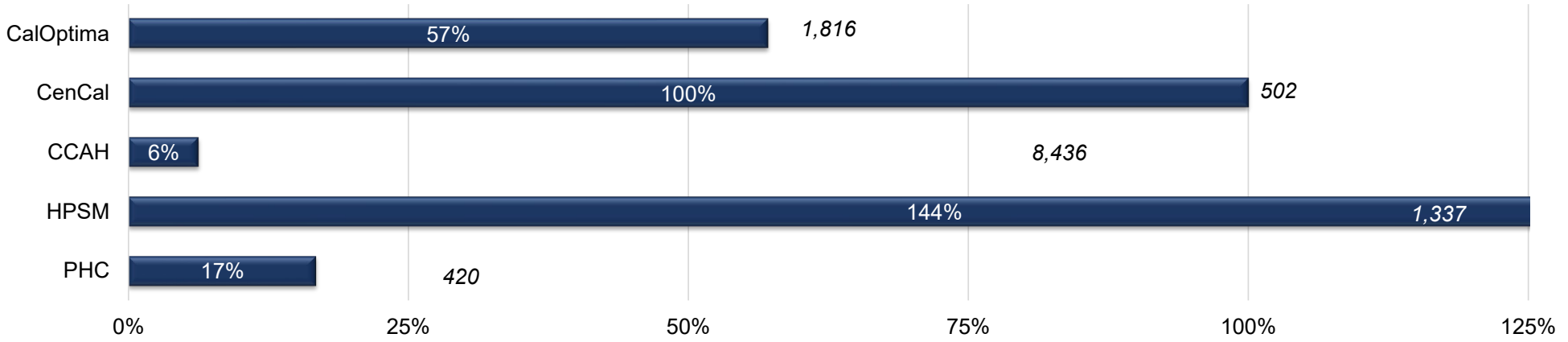
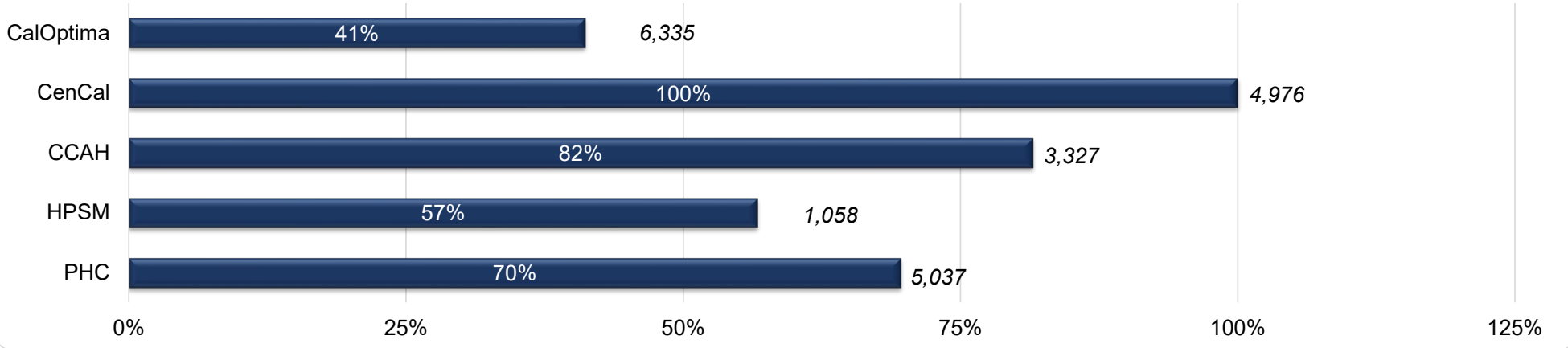


Fig 47: Percentage of Low Risk Members who Received an Assessment, by Plan



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 (Apr '21 - Mar '22)

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

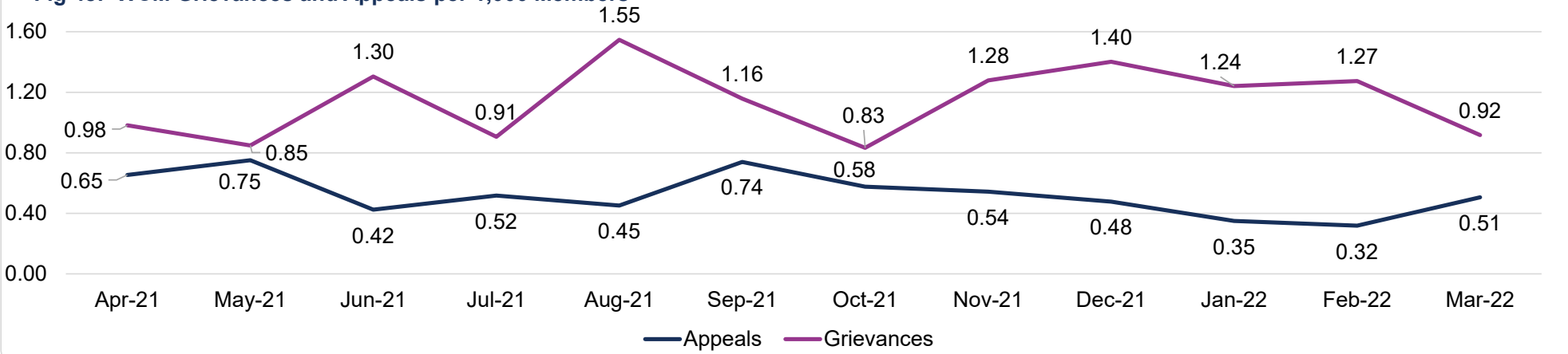
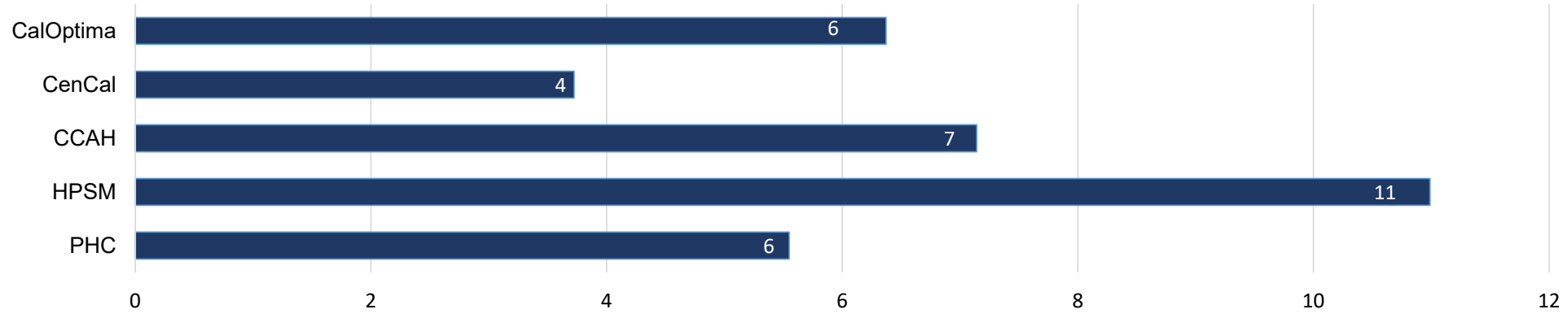
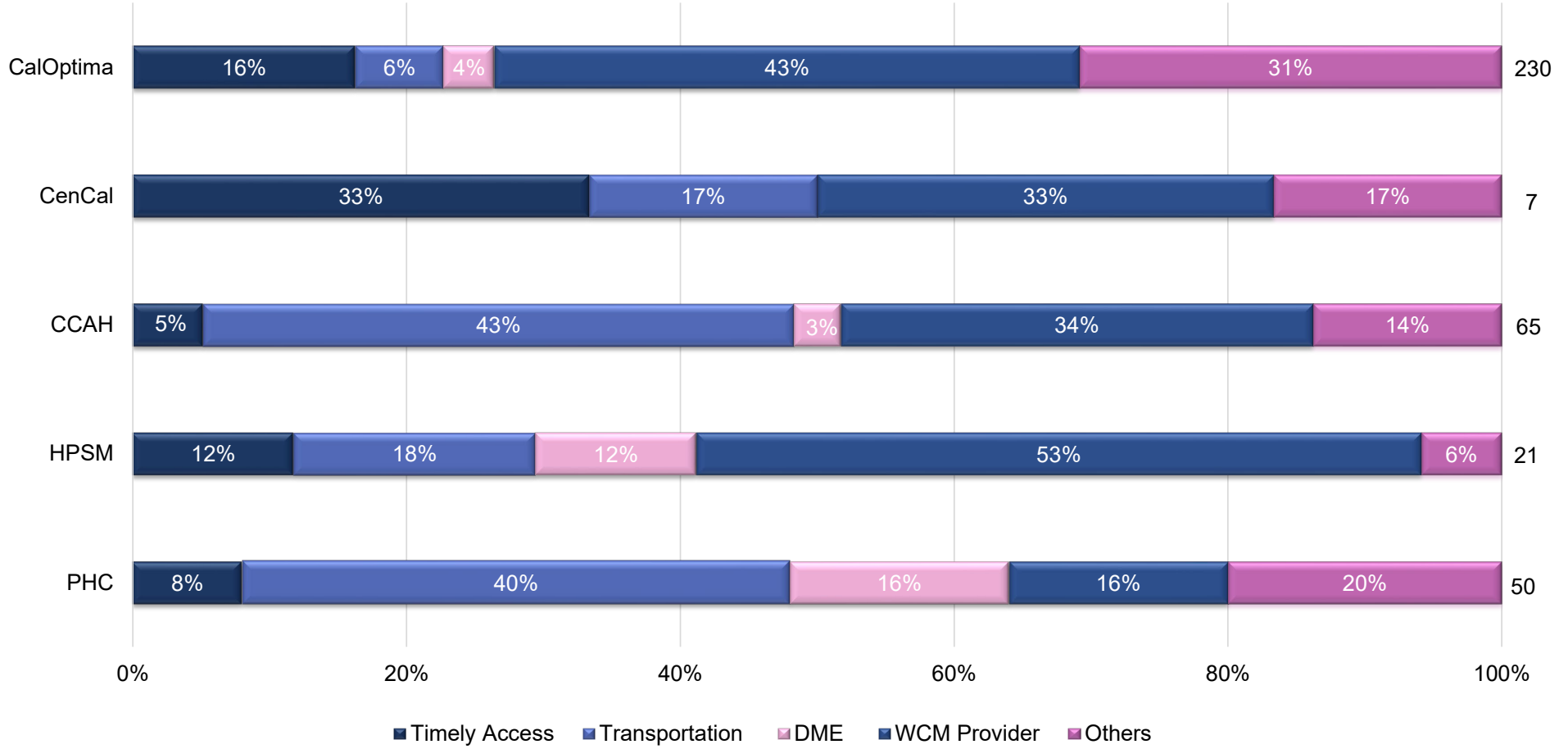


Fig 49: WCM Appeals per 1,000 Member Months, by Plan



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

Fig 50: Grievances Categories, by Plan



WCM Figure 51: Family Advisory Committee Meetings Table (Apr '21 - Mar '22)

Plan Name	Number of Committee Members	Number of Meetings Held Apr'21 - Mar'22	Recruitment Efforts	Seats to be Filled
CalOptima	7	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	4 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	16	4	Currently recruiting for 2 positions (CCS Family Member) - seeking help from family advocacy groups.	2 of 18
HPSM	22	4	Efforts are ad hoc as HPSM's Social Workers make contact with families.	N/A. No target number of seats to fill.
PHC	7	4	In regards to recruitment efforts, we have several family members attending our committee meeting on the 22nd of February who are considering joining, and we will be discussing updates to the PHC Website and other recruitment opportunities with the group at that time. Additionally, we are sharing information with the county MTUs as well as other providers' offices to encourage referral to our FAC team.	21 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