DEPARTMENT OF HEALTH CARE SERVICES

Integrated California Children's Services and Whole Child Model Dashboard

Released March 2022

The California Children's Services (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 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 Whole Child Model (WCM) program is for children and youth under 21 years of age who meet the eligibility requirements of California Children's Services (CCS) and are enrolled in a managed care plan under a county organized health system (COHS) or Regional Health Authority (RHA). 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, Diagnosis, and Treatment (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 Whole Child Model 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 are reported by Managed Care Plans (Plans) 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.

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 managed care plans 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 October 2019, 122,427 members were enrolled in CCS. Enrollment increased slightly over time to 126,331 members in September 2020. In October 2019, 29,372 members were enrolled in WCM. Enrollment decreased slightly through April, then increased to 29,471 members enrolled in September 2020.

Figure 2 shows that 49% of CCS enrollees identified themselves as Hispanic. This was calculated by using member reported ethnicity for the month of September 2020 as the numerator, divided by total enrollment for September 2020 as the denominator. Figure 2 also shows that 54% of WCM enrollees identified themselves as Hispanic. This was calculated by using member reported ethnicity for the month of September 2020 as the numerator, divided by total enrollment for September 2020 as the denominator.

The CCS population consists of 46.6% female and 53.4% male as displayed in Figure 3. This was calculated by using enrollment by gender in September 2020 as the numerator, divided by the total enrollment in September 2020 as the denominator. The WCM population consists of 52.6% male and 47.4% female as displayed in Figure 3. This was calculated by using enrollment by gender in September 2020 as the numerator, divided by the total enrollment in September 2020 as the denominator.

Figure 4 displays enrollment by primary languages. In September 2020, 66.5% of CCS members spoke English and 28.5% spoke Spanish as their primary spoken language. This was calculated by using CCS enrollment for each language in September 2020 as the numerator, divided by the total CCS enrollment in September 2020 as the denominator. In September 2020, 57.7% of WCM members spoke English and 39.1% spoke Spanish as their primary spoken language. This was calculated by using WCM enrollment for each language in September 2020 as the numerator, divided by the total WCM enrollment in September 2020 as the denominator.

Figure 5 displays enrollment by age. In September 2020, 32% of CCS members were between the ages 12 and 17 and 14% 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 2020 as the numerator, divided by total CCS enrollment for September 2020 as the denominator. In September 2020, 32% of WCM members were between the ages 12 and 17, and 14% 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 September 2020 as the numerator, divided by total WCM enrollment for September 2020 as the denominator.

Figures 6 and 7 display total CCS enrollment by county, in alphabetical order. The largest enrollment is Los Angeles County with 34,082 members. The smallest enrollment displayed is Mono County with 58 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 11,237 members and Trinity County had the least with 49 members.

CCS and WCM Outpatient Visits:

An outpatient visit is defined as a patient who is not hospitalized overnight but 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 2,099 outpatient visits per 1,000 member months while males made 2,172 outpatient visits per 1,000 member months. This was calculated by using the number of CCS outpatient visits for each gender for October 2019 through September 2020 as the numerator, divided by the CCS enrollment for each gender for October 2019 through September 2020 as the denominator. The dividend was then multiplied by 1,000. Figure 9 also displays that for WCM, female enrollees made 2,703 outpatient visits per 1,000 member months while males made 2,870 outpatient visits per 1,000 member months. This was calculated by using the number of outpatient visits for each gender for October 2019 through September 2020 as the numerator, divided by the enrollment for each gender for October 2019 through September 2020 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 3,036 per 1,000 member months. This was calculated by using the number of outpatient visits for each ethnicity for October 2019 through September 2020 as the numerator, divided by the enrollment for each ethnicity for October 2019 through September 2020 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 3,287 per 1,000 member months. This was calculated by using the number of outpatient visits for each ethnicity for October 2019 through September 2020 as the numerator, divided by the enrollment for each ethnicity for October 2019 through September 2020 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 October 2019 through September 2020. This was calculated by using the number of outpatient visits for each program per month for October 2019 through September 2020 as the numerator, divided by the enrollment for each program per month for October 2019 through September 2020 as the denominator. The dividend was then multiplied by 1,000.

Figure 12 shows the trend in the number of outpatient visits for each participating plan from October 2019 through September 2020. This was calculated by using the number of outpatient visits for each plan per month for October 2019 through September 2020 as the numerator, divided by the enrollment for each plan per month for October 2019 through September 2020 as the denominator. The dividend was then multiplied by 1,000.

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 33 inpatient admissions per 1,000 member months and female enrollees had 31 inpatient admissions per 1,000 member months. This was calculated by using the number of CCS inpatient visits for each gender for October 2019 through September 2020 as the numerator, divided by the CCS enrollment foreach gender for October 2019 through September 2020 as the denominator. The dividend was then multiplied by 1,000. Figure13 also displays that for WCM, male enrollees had 29 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 inpatient visits for each gender for October 2019 through September 2020 as the numerator, divided by the enrollment for each gender for October 2019 through September 2020 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 54 per 1,000 member months. This was calculated by using the number of CCS inpatient visits for each ethnicity for October 2019 through September 2020 as the numerator, divided by the CCS enrollment for each ethnicity for October 2019 through September 2020 as the denominator. The dividend was then multiplied by 1,000. In the WCM program, African-American members had the most inpatient admissions at 42 per 1,000 member months. This was calculated by using the number of inpatient visits for each ethnicity for October 2019 through September 2020 as the numerator, divided by the enrollment for each ethnicity for October 2019 through September 2020 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 October 2019 through September 2020. This was calculated by using the number of inpatient admissions for each program per month for October 2019 through September 2020 as the numerator, divided by the enrollment for each program per month for October 2019 through September 2020 as the denominator. The dividend was then multiplied by 1,000.

Figure 16 shows the trend in the number of inpatient admissions for each participating plan from October 2019 through September 2020. This was calculated by using the number of inpatient admissions for each plan per month for October 2019 through September 2020 as the numerator, divided by the enrollment for each plan per month for October 2019 through September 2020 as the denominator. The dividend was then multiplied by 1,000.

WCM Emergency Room (ER) Visits:

An ER visit is defined as a patient that presents at a hospital staffed for the reception and treatment of immediate medical care. The data in this section is broken down by gender, ethnicity and plan.

Figure 17 displays that male enrollees made 63 ER visits per 1,000 member months and female enrollees made 64 ER visits per 1,000 member months. This was calculated by using the number of ER visits for each gender for October 2019 through September 2020 as the numerator, divided by the enrollment for each gender for October 2019 through September 2020 as the denominator. The dividend was then multiplied by 1,000.

For Figure 18, African-American members made the most ER visits at 92 per 1,000 member months. This was calculated by using the number of ER visits for each ethnicity for October 2019 through September 2020 as the numerator, divided by the enrollment for each ethnicity for October 2019 through September 2020 as the denominator. The dividend was then multiplied by 1,000.

Figure 19 shows the trend in the number of ER visits for each participating plan from October 2019 through September 2020. This was calculated by using the number of ER visits for each plan per month for October 2019 through September 2020 as the numerator, divided by the enrollment for each plan per month for October 2019 through September 2020 as the denominator. The dividend was then multiplied by 1,000.

WCM Prescriptions:

Prescriptions 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 1,299 prescription medications per 1,000 member months while males had utilized 1,276 prescription medications per 1,000 member months. This was calculated by using the number of prescriptions for each gender for October 2019 through September 2020 as the numerator, divided by the enrollment for each gender for October 2019 through September 2020 as the denominator. The dividend was then multiplied by 1,000.

For Figure 21, African-American members utilized the most prescription medications at 1,677 per 1,000 member months. This was calculated by using the number of prescriptions for each ethnicity for October 2019 through September 2020 as the numerator, divided by the enrollment for each ethnicity for October 2019 through September 2020 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 October 2019 through September 2020. This was calculated by using the number of prescriptions reported by each plan per month for October 2019 through September 2020 as the numerator, divided by the enrollment for each plan per month for October 2019 through September 2020 as the denominator. The dividend was then multiplied by 1,000.

WCM Non-Specialty Mental Health:

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 56 non-specialty mental health visits per 1,000 member months while males made 38 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 October 2019 through September 2020 as the numerator, divided by the enrollment for each gender for October 2019 through September 2020 as the denominator. The dividend was then multiplied by 1,000.

For Figure 24, non-Hispanic/white members made the most visits at 85 per 1,000 member months. This was calculated by using the number of non-specialty mental health visits for each ethnicity for October 2019 through September 2020 as the numerator, divided by the enrollment for each ethnicity for October 2019 through September 2020 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 October 2019 through September 2020. This was calculated by using the number of non-specialty mental health visits for each plan per month for October 2019 through September 2020 as the numerator, divided by the enrollment for each plan per month for October 2019 through September 2020 as the denominator. The dividend was then multiplied by 1,000.

WCM Emergency Room (ER) Visits with an Inpatient Admission:

This data focuses on those patients who visited the ER 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 enrollees made 11 ER visits with an inpatient admission per 1,000 member months while female enrollees made 10 ER visits with an inpatient admissions per 1,000 months. This was calculated by using the number of ER visits with an inpatient admission for each gender for October 2019 through September 2020 as the numerator, divided by the enrollment for each gender for October 2019 through September 2020 as the denominator. The dividend was then multiplied by 1,000.

For Figure 27, African-American members made the most ER visits with an inpatient admission at 20 per 1,000 member months. This was calculated by using the number of ER visits with an inpatient admission for each ethnicity for October 2019 through September 2020 as the numerator, divided by the enrollment for each ethnicity for October 2019 through September 2020 as the denominator. The dividend was then multiplied by 1,000.

Figure 28 shows the trend in the number of ER visits with an inpatient admission for each participating plan from October 2019 through September 2020. This was calculated by using the number of ER visits with an inpatient admission for each plan per month for October 2019 through September 2020 as the numerator, divided by the denominator is enrollment for each plan per month for October 2019 through September 2020 as the denominator. The dividend was then multiplied by 1,000. An asterisk(*) represents numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable.

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

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), continuity of care 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 Health Plan of San Mateo (HPSM) to 125 for CenCal Health (CenCal). This was calculated by using the number of COC requests for each plan for October 2019 through September 2020 as the numerator, divided by the enrollment for each plan in September 2020 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 93% for CenCal to 100% for Central California Alliance for Health (CCAH). This was calculated by using the number of approved COC requests for each plan and each county for October 2019 through September 2020 as the numerator, divided by the total number of COC requests for each plan and each county for October 2019 through September 2020 as the denominator.

Total number of COC requests for each plan for the months 16 through 27 after joining the program are shown in Figure 30. In the sixteenth month after joining the WCM program, CalOptima reported less than 11, CenCal reported 35, and CCAH reported 50 COC requests. In the twenty-seventh month after joining the WCM program, CenCal reported 37 COC requests, while CalOptima and CCAH both reported less than 11 requests. HPSM has operated in a CCS Pilot program for a period of 5 years prior to the implementation of the WCM, resulting in its lower number of COC requests during this reporting period. An asterisk (*) represents numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable.[1]

[1] As CalOptima implemented the WCM program in July 2019, the 12 month continuity of care period passed prior to this time period for WCM transition members. CalOptima began capturing COC requests as COC extension requests. CalOptima began reporting COC requests only for newly eligible WCM members, which decreased accordingly.

Months 28 through 39 upon joining the program for COC requests are displayed in Figure 31. In the twenty-eighth month of operation, CenCal reported receiving 45 COC requests, while CalOptima and CCAH both reported less than 11 requests. In the thirty-ninth month of operation, CenCal reported 17 COC requests, while CCAH and HPSM reported less than 11 COC requests. CalOptima has not yet reported their thirtieth through thirty-ninth months of participation in the program. An asterisk (*) represents numbers have been suppressed for Plans that have low number of observations asthey are seen as statistically unreliable. A double dagger (‡) represents Plans who have not reached this month in their observation yet.

Figure 32 shows the average number of COC requests for each plan for months 16 through 27 compared to months 28 through 39. CenCal had an average of 31.7 for months 16 through 27 and 34.7 for months 28 through 39. CCAH had an average of 18.8 for months 16 through 27 and fewer than 11 for months 28 through 39. An asterisk (*) represents numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable. A double dagger (‡) represents Plans who have not reached this month in their observation yet.

Figure 33 displays major categories for the COC requests. Specialized or customized DME was requested 111 times, or 13.1% of the time, while 313, or 37.0%, of requests were made for major specialty types. This was calculated by using the number of COC requests for each category for October 2019 through September 2020 as the numerator, divided by the total number of COC requests for October 2019 through September 2020 as the denominator.

Figure 34 shows reasons for COC denials not required by APL. Four duplicative requests accounted for 18% of COC denial reasons while one denial reason or 5% each were due to insufficient documentation, pharmaceutical concerns, other health coverage, and criteria not met. This was calculated by using the number of COC denials for each reason for October 2019 through September 2020 as the numerator, divided by the total number of COC denials for October 2019 through September 2020 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 59% of COC denial reasons while 0% were due to quality of care issues and for provider not being state approved. This was calculated by using the number of COC denials for each reason for October 2019 through September 2020 as the numerator, divided by the total number of COC denials for October 2019 through September 2020 as the denominator.

Please note that for Figure 34, only the top 5 denial reasons are displayed. Figure 35 displays all denial categories as required by the APL, 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 Partnership Health Plan of California (PHC) to 100% for CalOptima, CenCal and CCAH. This was calculated by using the number of approved NICU authorizations for each plan and each county for October 2019 through September 2020 as the numerator, divided by the number of NICU requests for authorizations for each plan and each county for October 2019 through September 2020 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 6.9 CCS NICU authorization requests per 1,000 members for October 2019. There were 6.5 CCS NICU authorization requests per 1,000 members for September 2020. The figure also displays there were 3.0 WCM NICU authorization requests per 1,000 members for October 2019. There were 3.9 WCM NICU authorization requests per 1,000 members for September 2020.

Figure 38 displays the trend of total requests seeking authorization for NICU services for each plan each quarter. For example, CCAH reported 28 requests in Q4 2019, 36 requests in Q1 2020, 23 requests in Q2 2020, and 26 requests in Q3 2020. HPSM reported fewer than 11 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 78 for HPSM to 735 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 99% for PHC to 100% for the other four plans. This was calculated by using the number of approved PICU requests for authorizations for each plan and each county for October 2019 through September 2020 as the numerator, divided by the number of PICU authorizations for each plan and each county for October 2019 through September 2020 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 1.4 CCS PICU authorization requests per 1,000 members in October 2019 and 1.9 authorization requests per 1,000 members for September 2020. The figure also displays that there were 5.4 WCM PICU authorization requests per 1,000 members in October 2019 and 4.2 authorization requests per 1,000 members for September 2020.

Figure 41 displays the trend of total requests seeking authorization for PICU services for each plan each quarter. For example, CalOptima reported 160 requests in Q4 2019, 201 requests in Q1 2020, 154 requests in Q2 2020, and 220 requests in Q3 2020. HPSM reported fewer than 11 requests for Q4 2019 and Q2 2020. 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:

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 517 for CenCal to 5,435 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 Special Care Centers ranged from 96% for PHC to 100% for CCAH and CenCal. This was calculated by using the number of approved Inpatient Facilities and SCC authorizations for each plan and each county for October 2019 through September 2020 as the numerator, divided by the number of Inpatient Facilities and SCC requests for authorizations for each plan and each county for October 2019 through September 2020 as the denominator. An asterisk (*) represents numbers have been suppressed for Plans that have low number of observations asthey are seen as statistically unreliable.

Figure 43 displays the total requests seeking authorization for SCC services for each plan each quarter. For example, CenCal reported 184 requests in Q4 2019, 142 in Q1 2020, 99 in Q2 2020, and 92 requests in Q3 2020.

WCM Specialized or Customized DME Authorizations:

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 56 for CenCal to 1,483 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 October 2019 through September 2020 as the numerator, divided by the number of specialized or customized DME requests for authorizations for each plan and each county for October 2019 through September 2020 as the denominator.

Figure 45 displays the total requests seeking authorization for DME services for each plan each quarter. For example, PHC reported 313 requests in Q4 2019, 446 requests in Q1 2020, 368 requests in Q2 2020, and 356 requests in Q3 2020. CenCal reported fewer than 11 requests in Q4 2019 and Q3 2020. 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*

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 24%, which is 342 assessments for PHC to 107%, which is 861 assessments for HPSM.[2] This was calculated by using the number of high-risk assessments for each plan as of September 2020 as the numerator, divided by the number of high-risk members in each plan in September 2020 as the denominator. Each denominator is different because each plan has a different number of high-risk members.

[2] 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.

For Figure 47, the percentage of low-risk members who received an assessment ranged from 41%, which is 4,960 assessments for CalOptima to 80%, which is 2,737 assessments for CenCal. This was calculated by using the number of low-risk assessments for each plan as of September 2020 as the numerator, divided by the number of low-risk members in each plan in September 2020 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*

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 is 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 (October 2019 - September 2020). In October 2019, plans reported to have received 0.48 appeals per 1,000 members and 0.95 grievances per 1,000 members. In September 2020, plans received 0.71 appeals per 1,000 members and 0.85 grievances per 1,000 members.

WCM appeals per 1,000 member months are shown by plan in Figure 49. CCAH reported to have received 0.3 appeals per 1,000 member months while HPSM reported 2.0 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 is displayed on the far right end of the bar.[3] This was calculated by using the number of each grievance type for each plan for October 2019 through September 2020 as the numerator, divided by the total number of grievances for each plan from October 2019 through September 2020 as the denominator.

WCM Family Advisory Committee Meetings: *Figure 51*

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 number of committee members, meetings held, recruitment efforts and seats to be filled for each plan over 12 months (October 2019 - September 2020).

[3] 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

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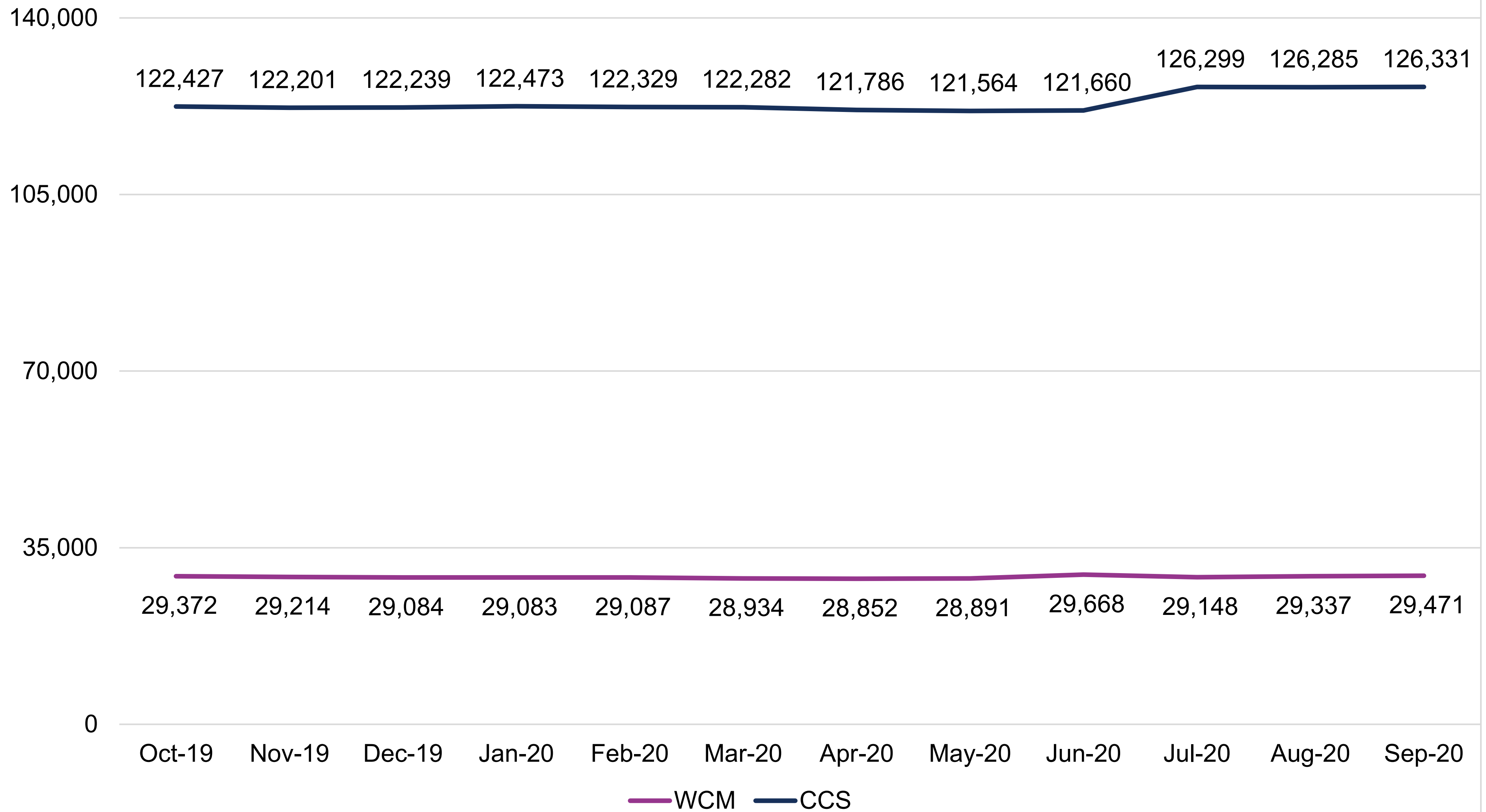
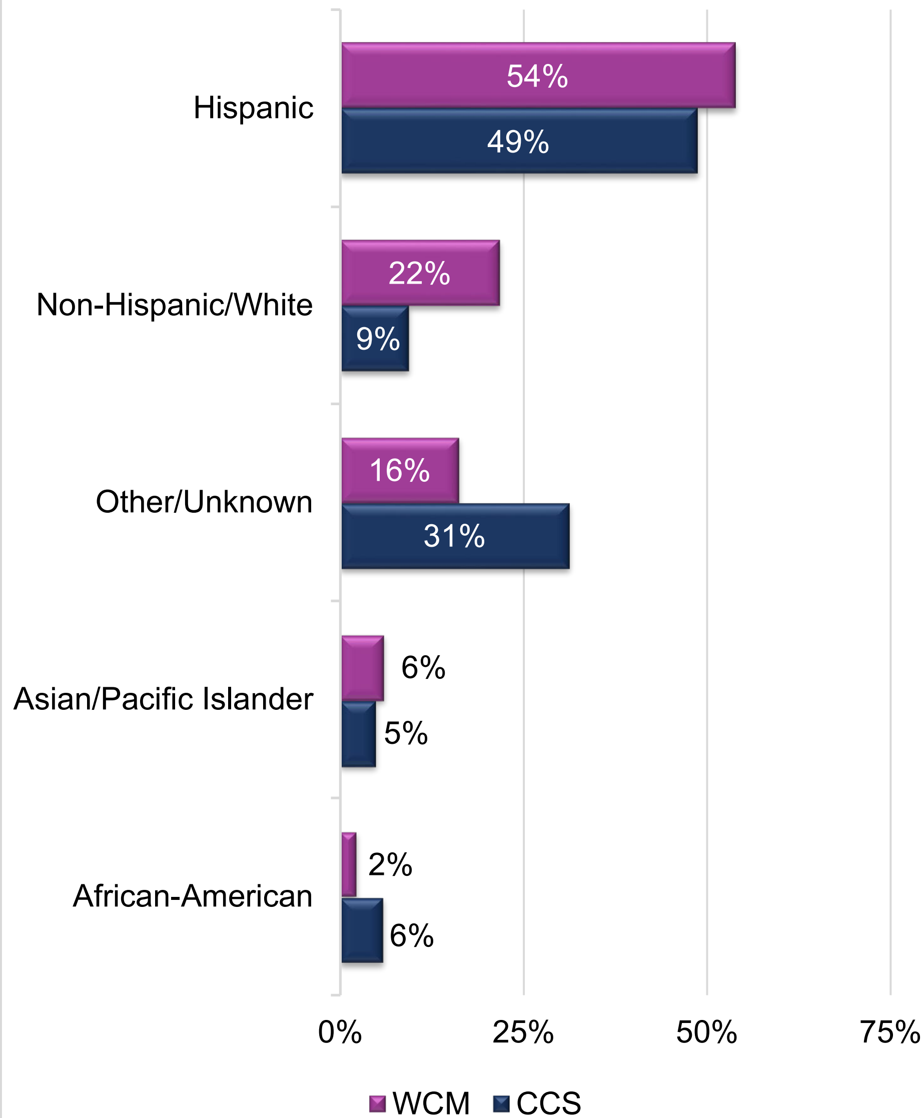
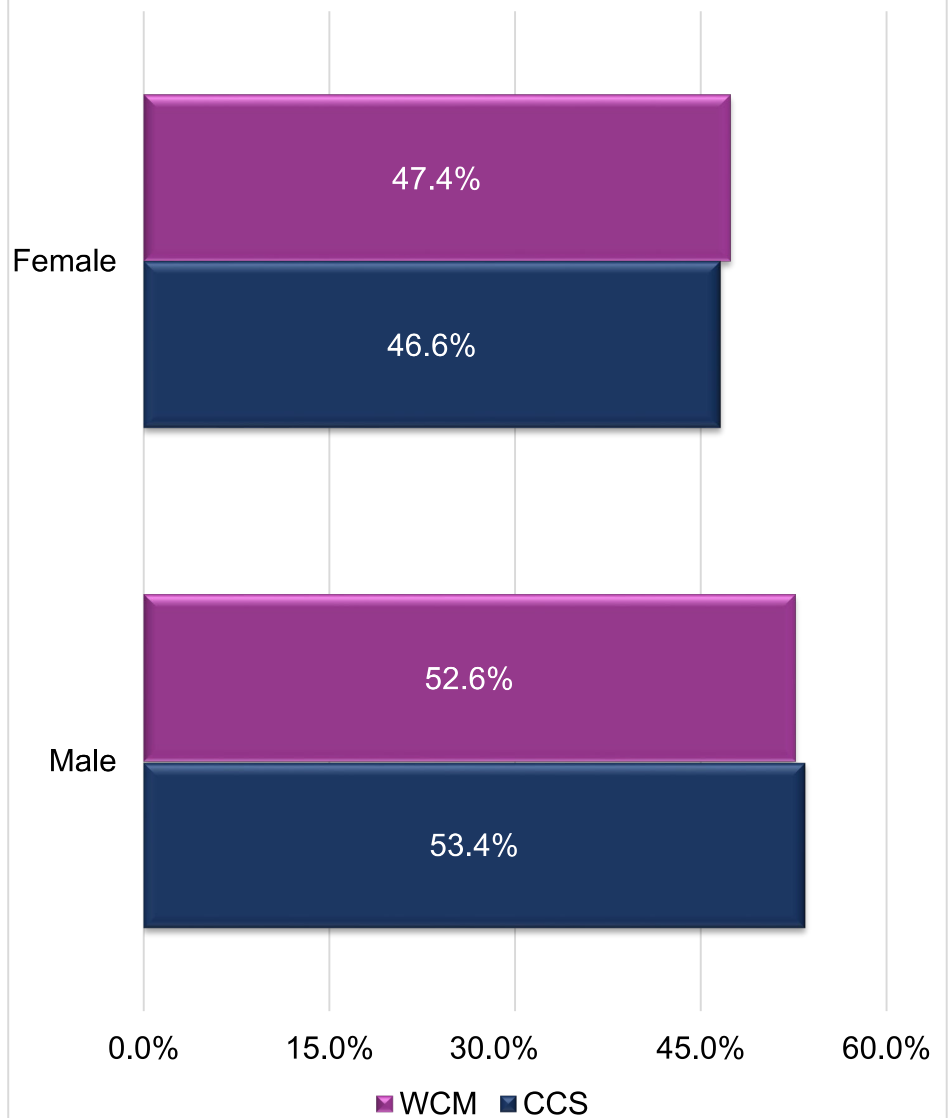
CCS and WCM Enrollment and Demographics Figure 1: Breakdown of Enrollment (Oct'19 - Sep'20)



Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from October 2019 to September 2020.

CCS and WCM Enrollment and Demographics Figures 2 & 3: Breakdowns of Population as of September 2020





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

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CCS and WCM Enrollment and Demographics Figures 4 & 5: Breakdowns of Population as of September 2020

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

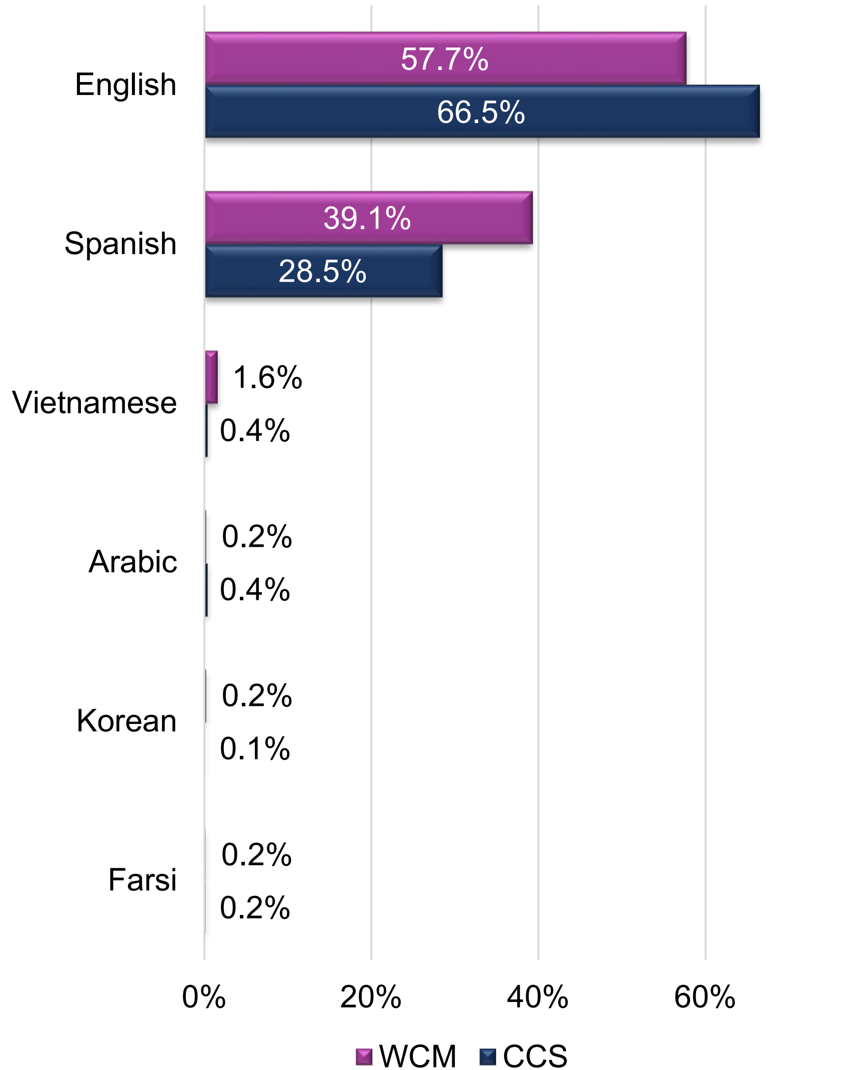
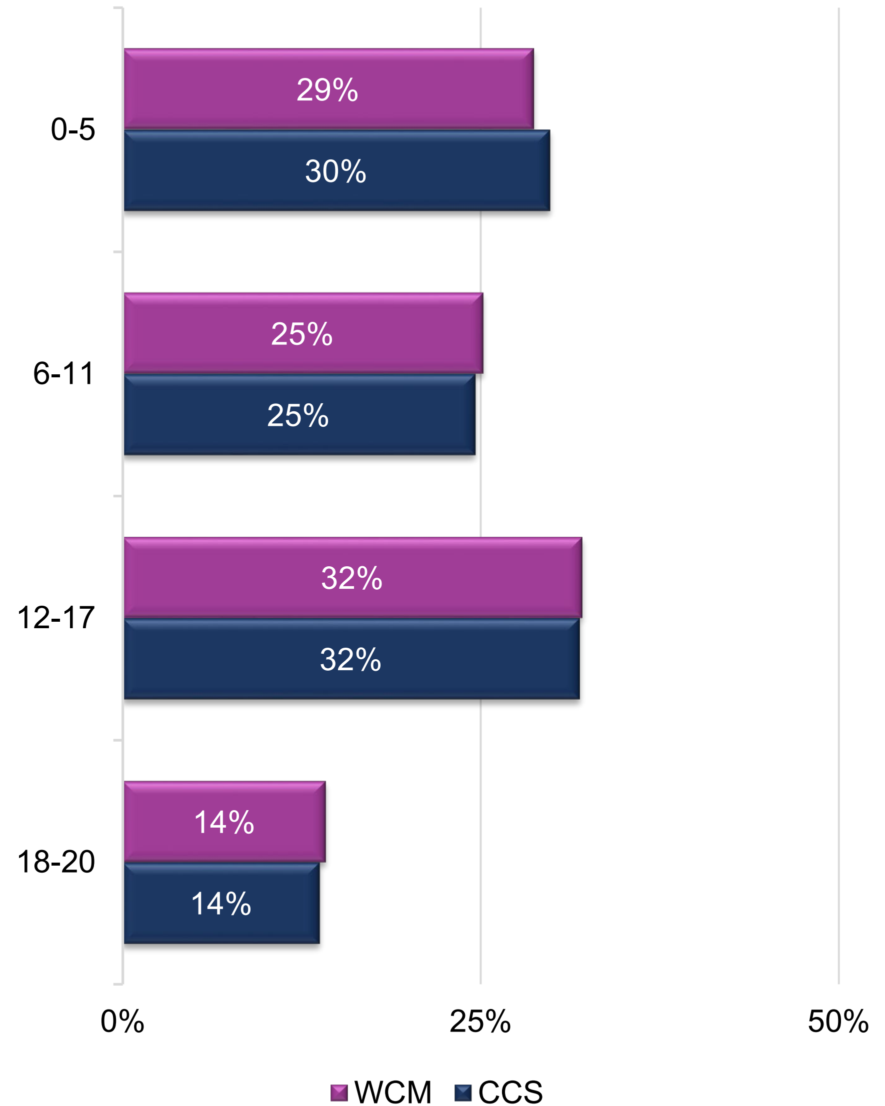


Fig 5: Enrollment by Age



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 2020

Fig 6: Total Classic CCS Enrollment by County

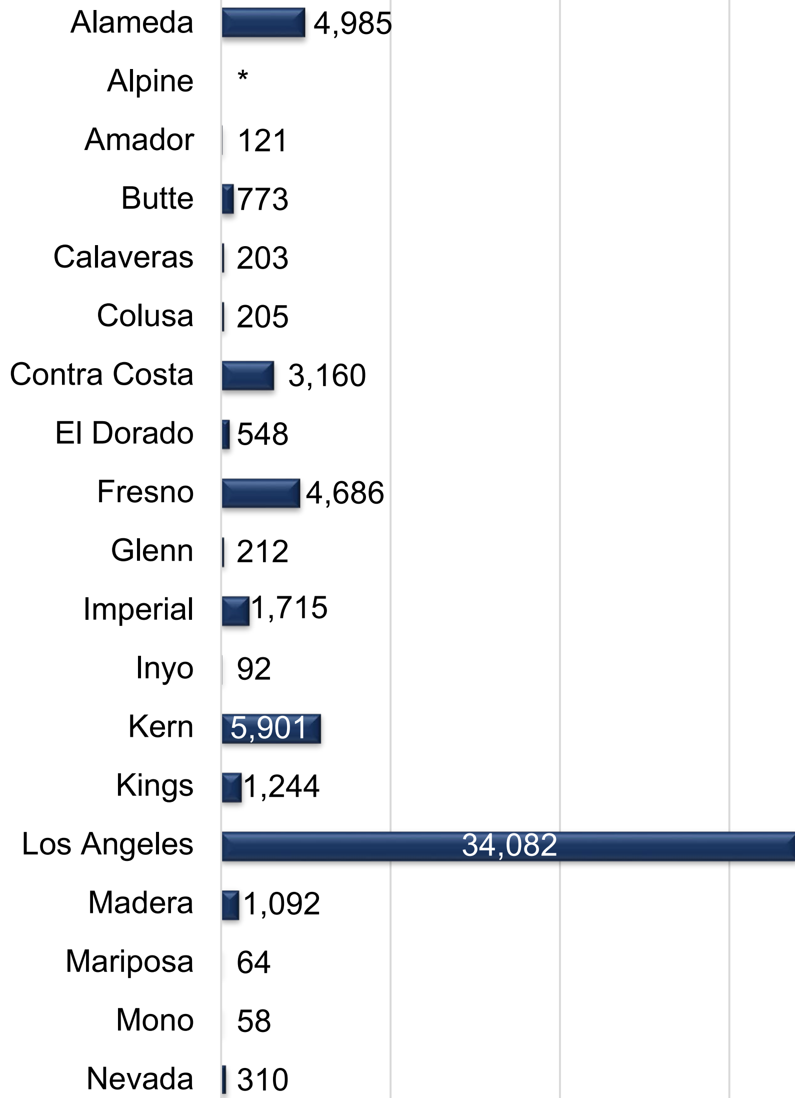
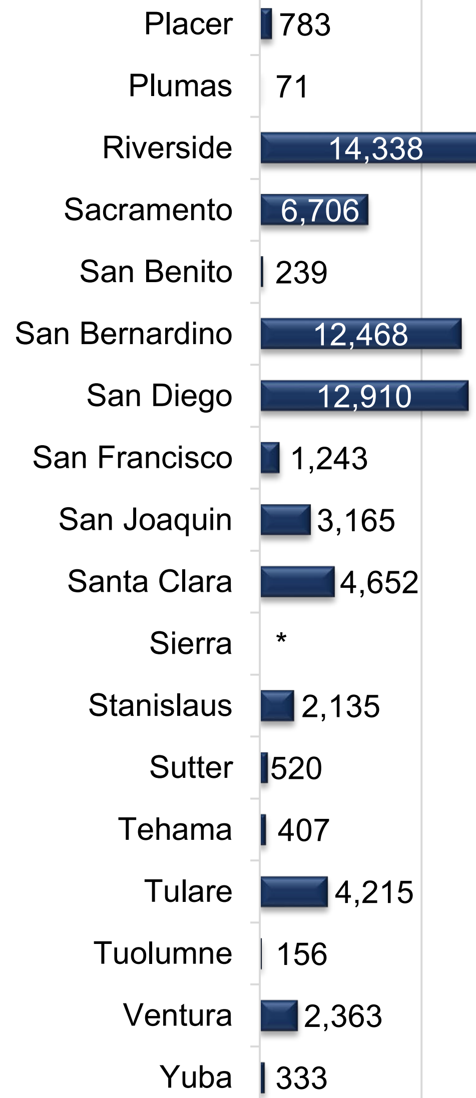
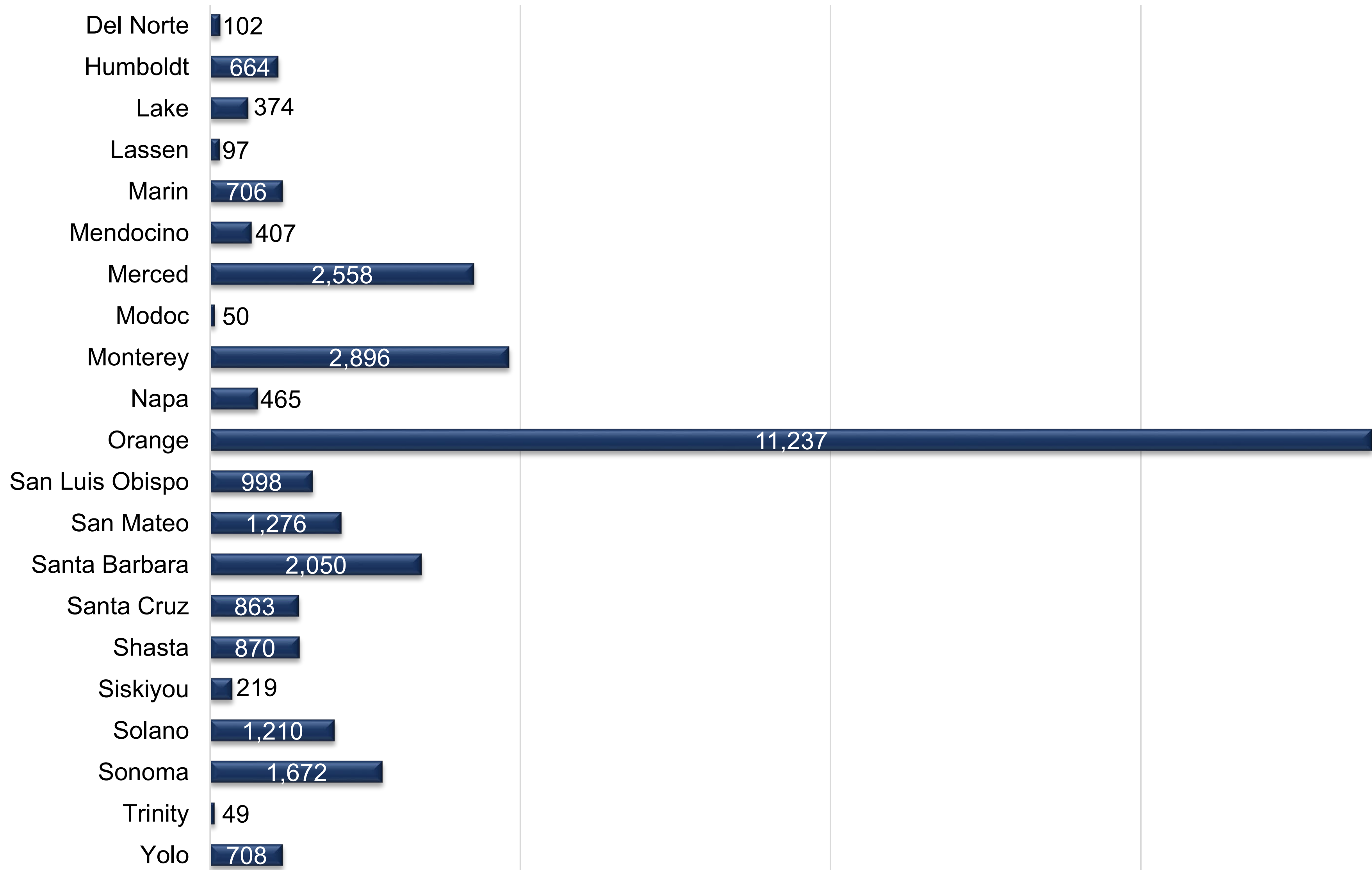


Fig 7: Total Classic CCS Enrollment by County



Note: CCS refers to counties operating outside of the Whole Child Model Program.
<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 2020



CCS and WCM Utilization Figures 9 & 10: Breakdowns of Outpatient Admissions Utilization (Oct'19 - Sep'20)

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

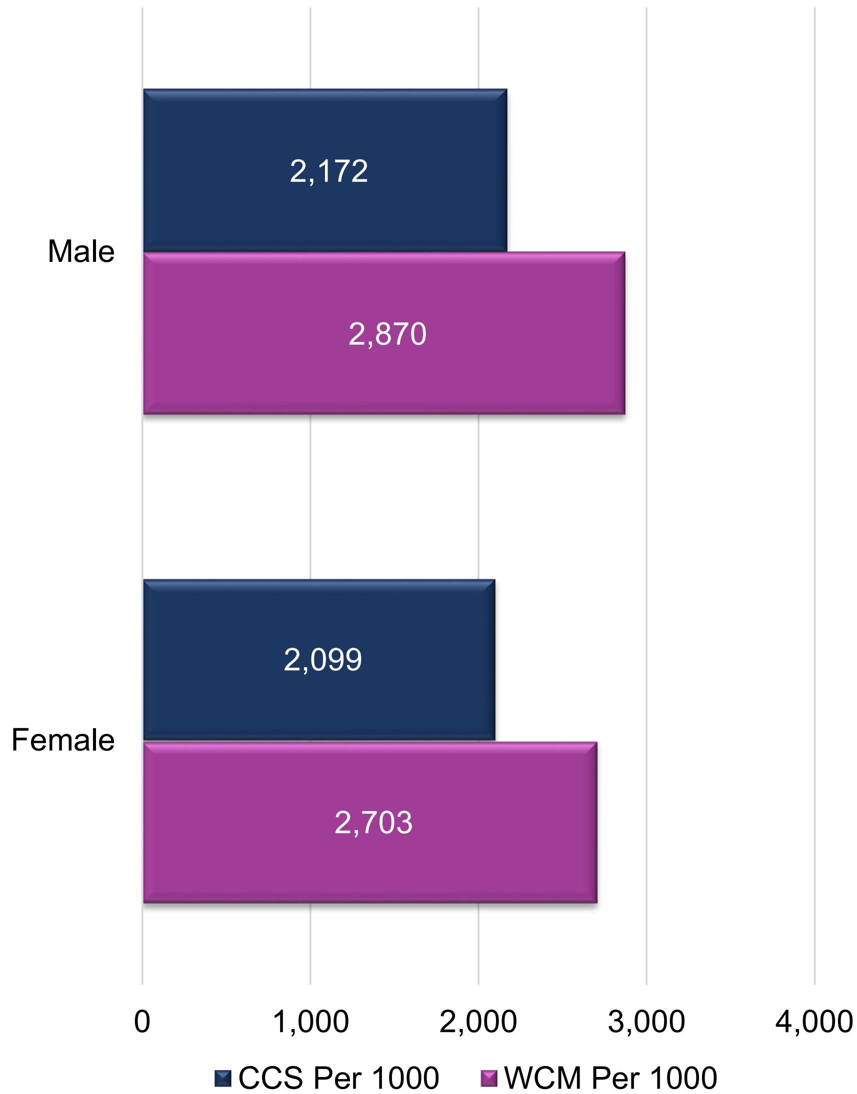
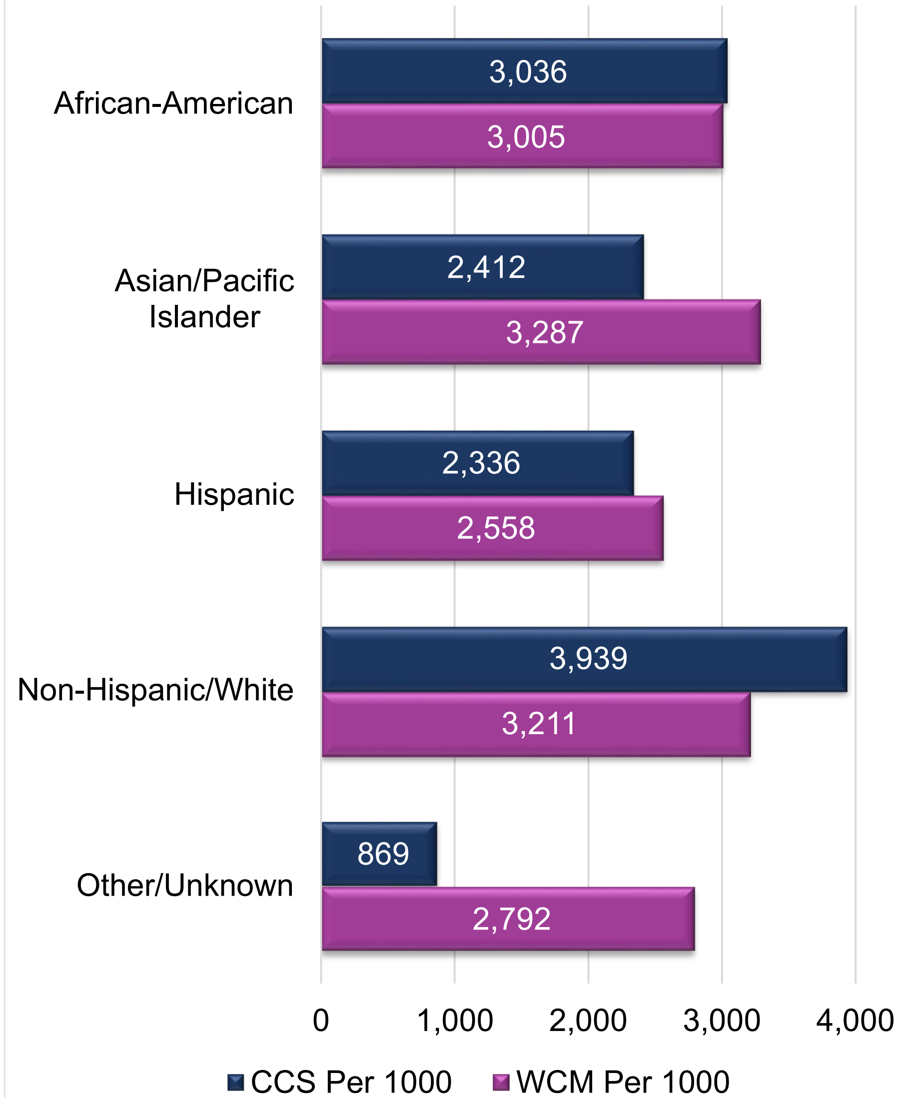


Fig 10: Outpatient Visits per 1,000 Member Months by Ethnicity



Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from October 2019 to September 2020.

CCS and WCM Utilization Figures 11 & 12: Breakdowns of Outpatient Admissions Utilization (Oct'19 - Sep'20)

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

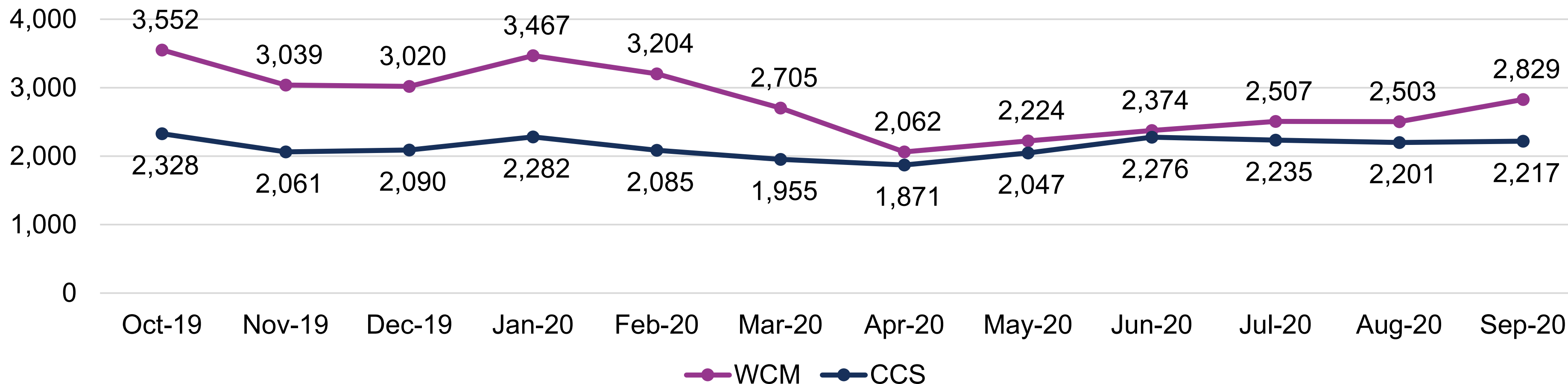
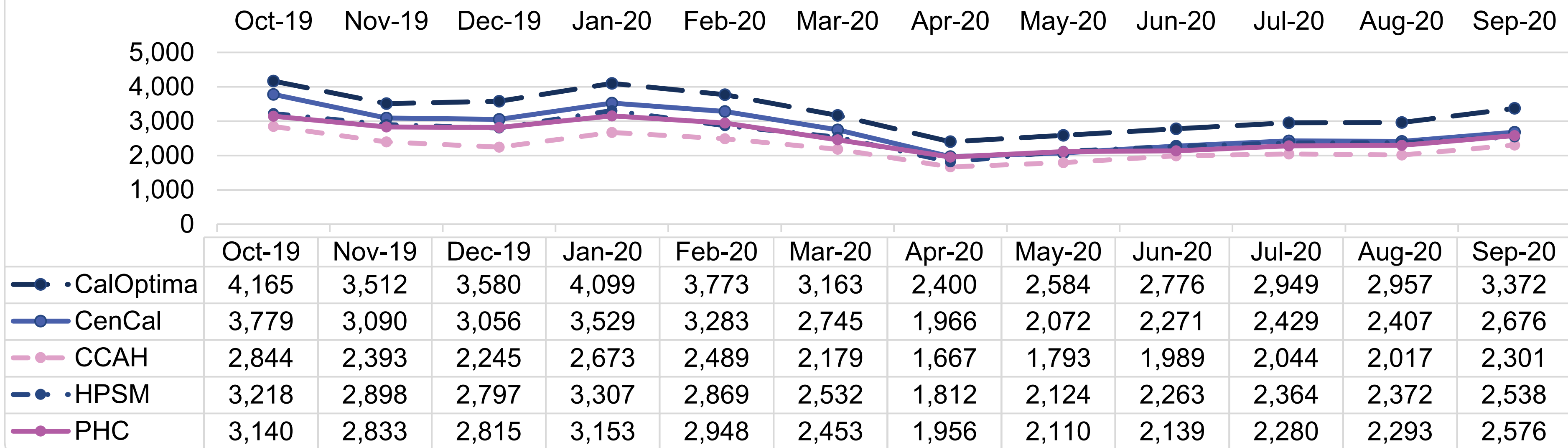


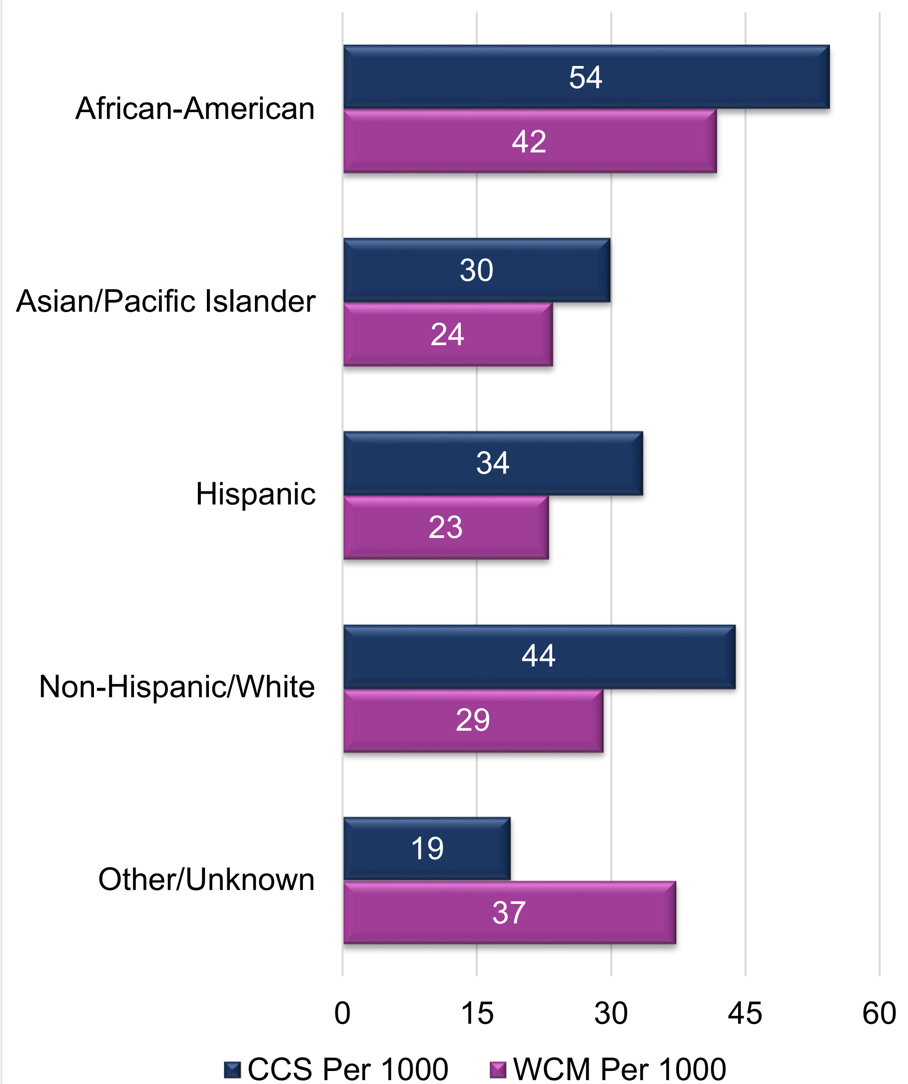
Fig 12: WCM Outpatient Visits per 1,000 Members by Plan, by Month



	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
CalOptima	4,165	3,512	3,580	4,099	3,773	3,163	2,400	2,584	2,776	2,949	2,957	3,372
CenCal	3,779	3,090	3,056	3,529	3,283	2,745	1,966	2,072	2,271	2,429	2,407	2,676
CCAH	2,844	2,393	2,245	2,673	2,489	2,179	1,667	1,793	1,989	2,044	2,017	2,301
HPSM	3,218	2,898	2,797	3,307	2,869	2,532	1,812	2,124	2,263	2,364	2,372	2,538
PHC	3,140	2,833	2,815	3,153	2,948	2,453	1,956	2,110	2,139	2,280	2,293	2,576

Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from October 2019 to September 2020.

CCS and WCM Utilization Figures 13 & 14: Breakdowns of Inpatient Visits Utilization (Oct'19 - Sep'20)



Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from October 2019 to September 2020.

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CCS and WCM Utilization Figures 15 & 16: Breakdowns of Inpatient Visits Utilization (Oct'19 - Sep'20)

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

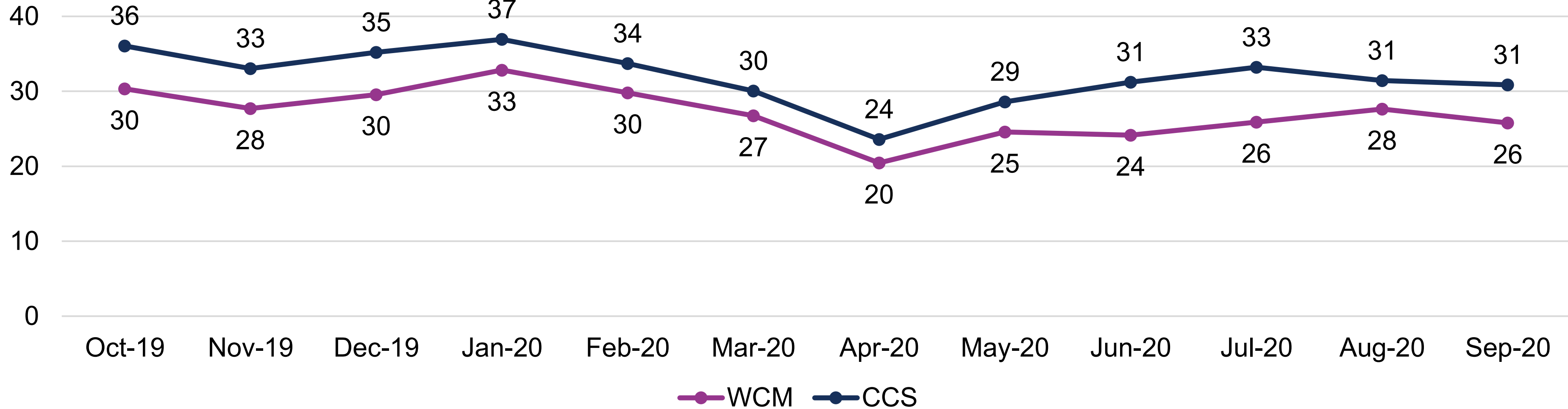
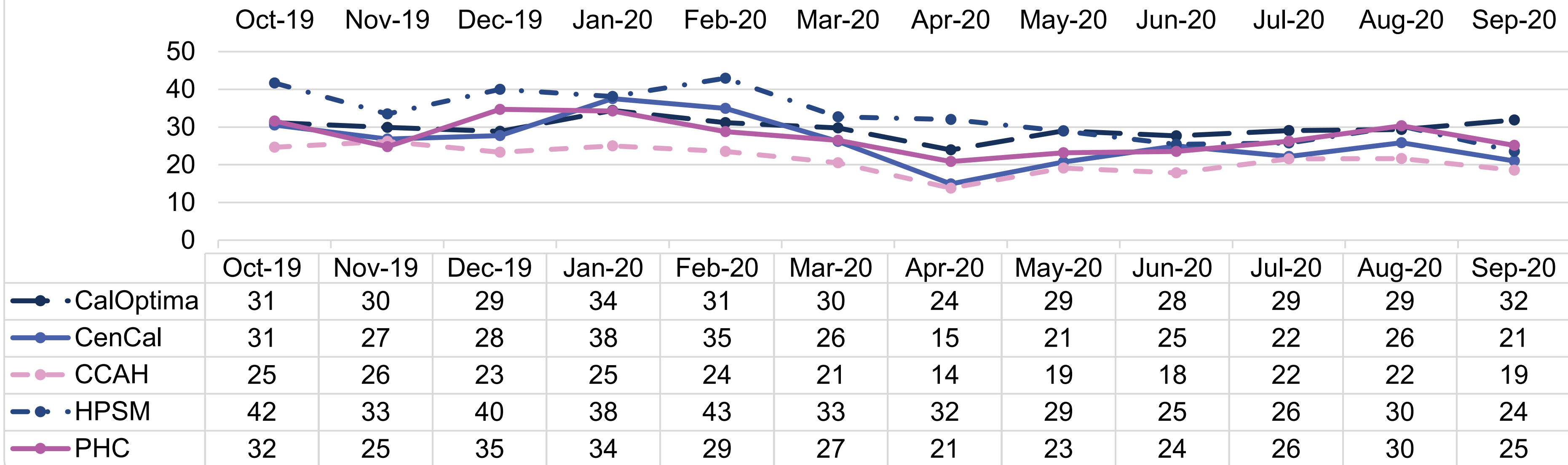


Fig 16: WCM Inpatient Admissions per 1,000 Members by Plan, by Month



	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
CalOptima	31	30	29	34	31	30	24	29	28	29	29	32
CenCal	31	27	28	38	35	26	15	21	25	22	26	21
CCAH	25	26	23	25	24	21	14	19	18	22	22	19
HPSM	42	33	40	38	43	33	32	29	25	26	30	24
PHC	32	25	35	34	29	27	21	23	24	26	30	25

Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from October 2019 to September 2020.

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WCM Utilization Figure 17 - 19: Breakdowns of Emergency Room Utilization (Oct'19 - Sep'20)

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

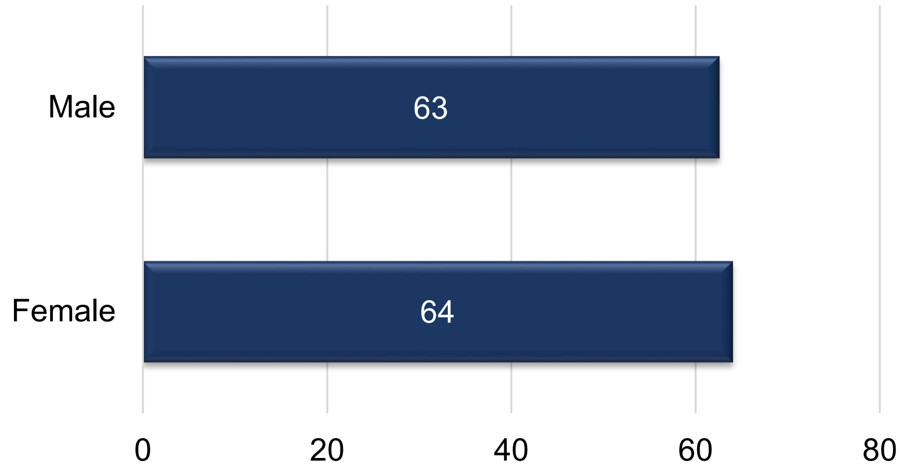


Fig 18: ER Visits per 1,000 Member Months by Ethnicity

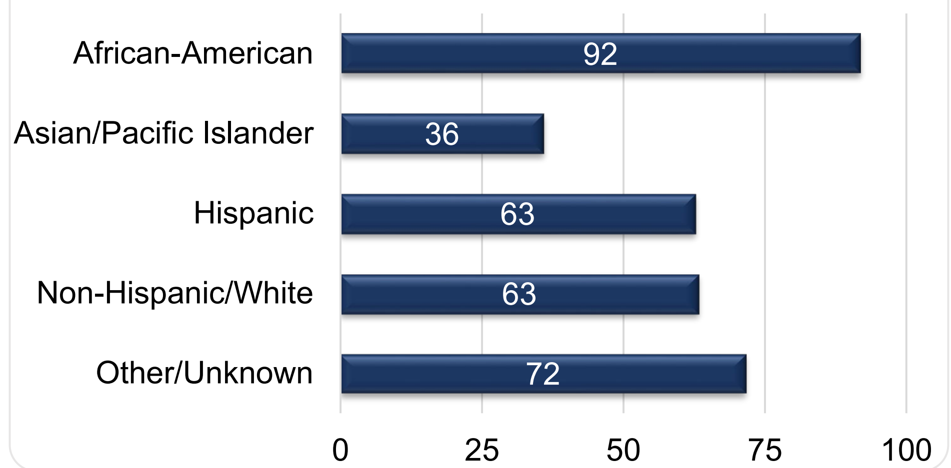
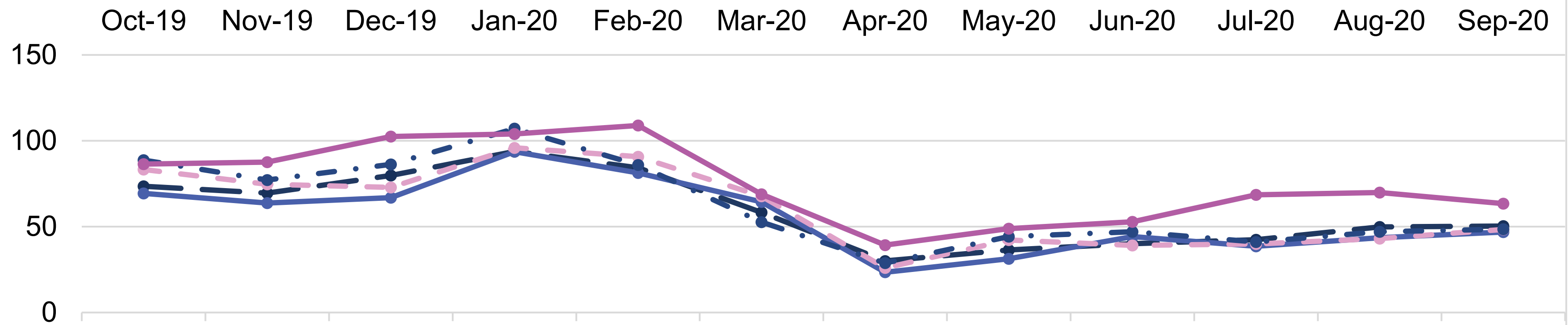


Fig 19: ER Visits per 1,000 Members by Plan, by Month



	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
CalOptima	74	70	80	94	84	58	30	36	40	42	50	50
CenCal	69	64	67	94	81	64	23	31	44	39	44	47
CCAH	83	75	73	96	91	68	26	42	39	40	43	48
HPSM	89	77	86	107	86	53	29	44	47	41	47	49
PHC	86	88	102	104	109	69	39	49	53	68	70	63

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WCM Utilization Figure 20 - 22: Breakdowns of Prescriptions Utilization (Oct'19 - Sep'20)

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

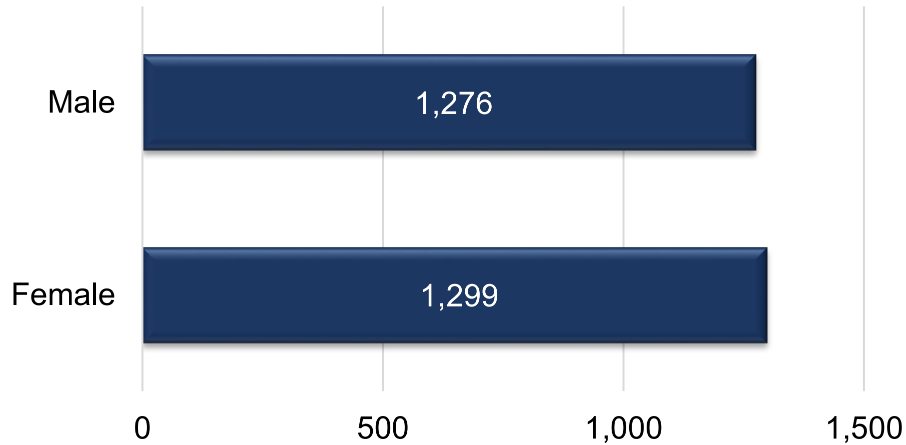


Fig 21: Prescriptions per 1,000 Member Months by Ethnicity

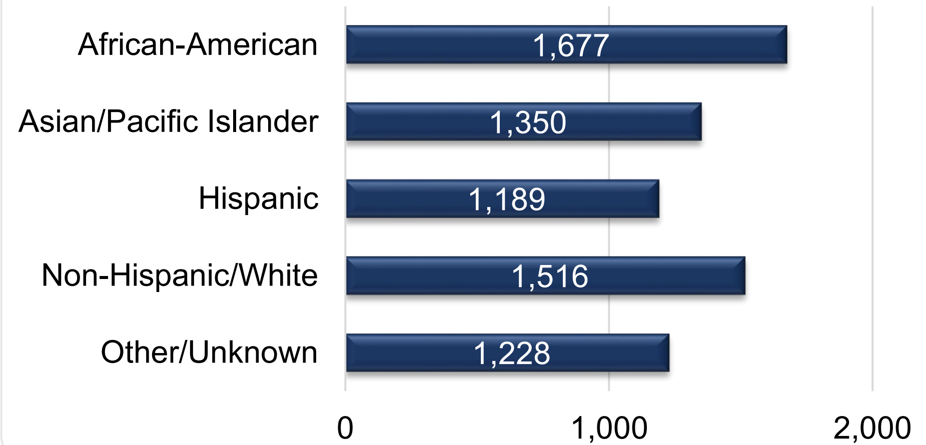
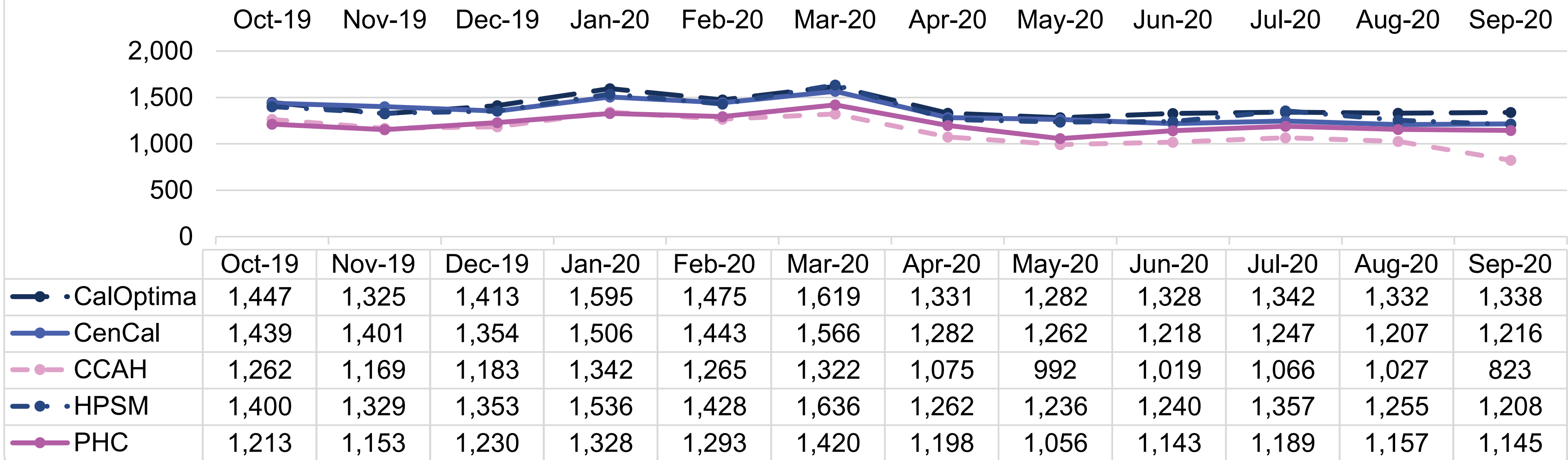


Fig 22: Prescription per 1,000 Members by Plan, by Month



	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
CalOptima	1,447	1,325	1,413	1,595	1,475	1,619	1,331	1,282	1,328	1,342	1,332	1,338
CenCal	1,439	1,401	1,354	1,506	1,443	1,566	1,282	1,262	1,218	1,247	1,207	1,216
CCAH	1,262	1,169	1,183	1,342	1,265	1,322	1,075	992	1,019	1,066	1,027	823
HPSM	1,400	1,329	1,353	1,536	1,428	1,636	1,262	1,236	1,240	1,357	1,255	1,208
PHC	1,213	1,153	1,230	1,328	1,293	1,420	1,198	1,056	1,143	1,189	1,157	1,145

WCM Utilization Figure 23 - 25: Breakdowns of Non-specialty Mental Health Visits Utilization (Oct'19 - Sep'20)

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

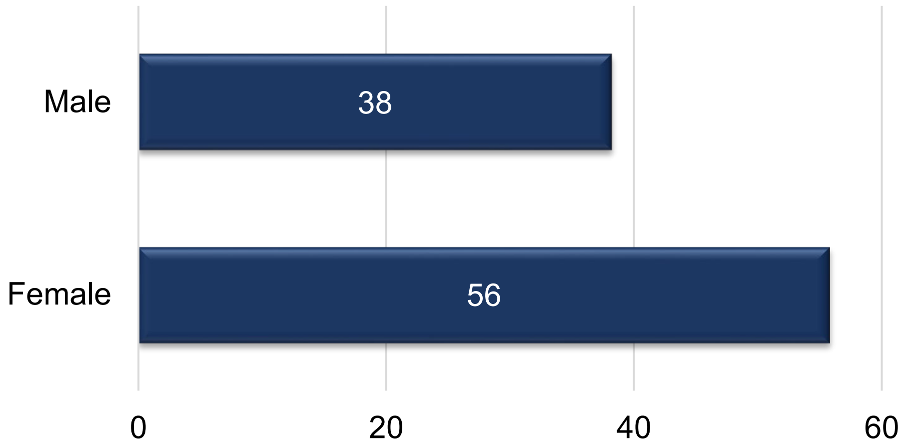


Fig 24: Non-specialty Mental Health Visits per 1,000 Member Months by Ethnicity

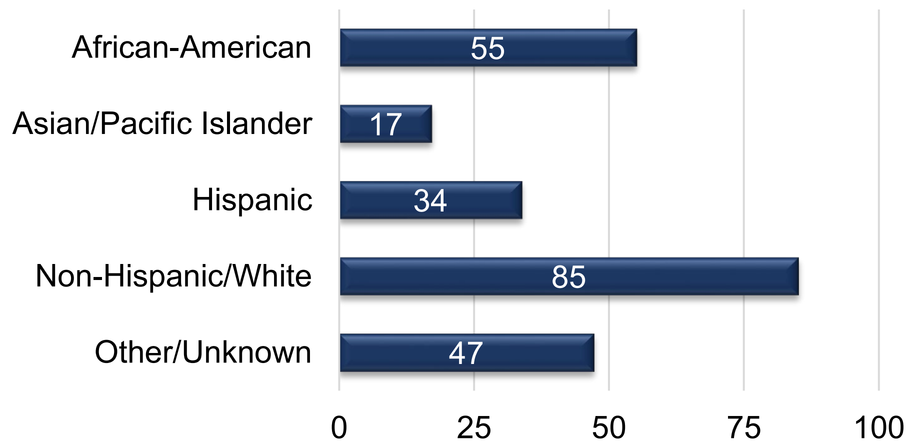
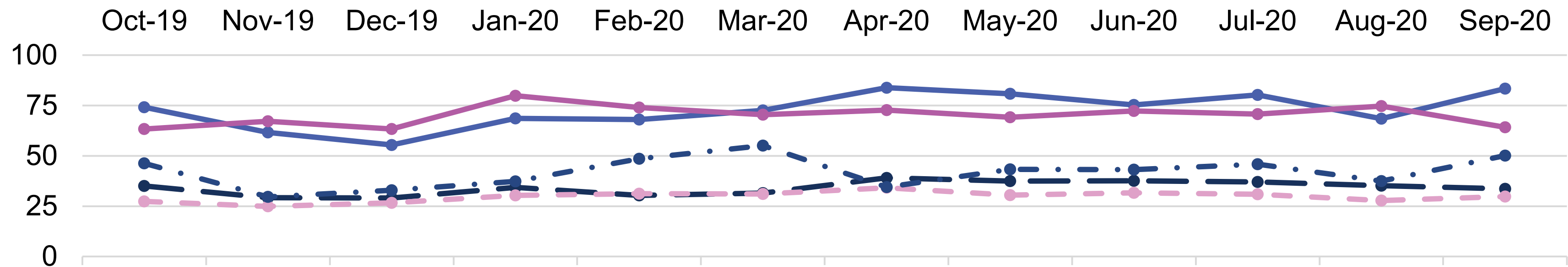


Fig 25: Non-specialty Mental Health Visits per 1,000 Members by Plan, by Month



	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
CalOptima	35	29	29	34	30	31	39	38	38	37	35	34
CenCal	74	62	55	69	68	73	84	81	75	80	68	83
CCAH	27	25	27	30	31	31	34	31	32	31	28	30
HPSM	46	30	33	37	49	55	34	43	43	46	37	50
PHC	63	67	63	80	74	70	73	69	72	71	75	64

WCM Utilization Figure 26 - 28: Breakdowns of Emergency Room Visits with an Inpatient Admission Utilization (Oct'19 - Sep'20)

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

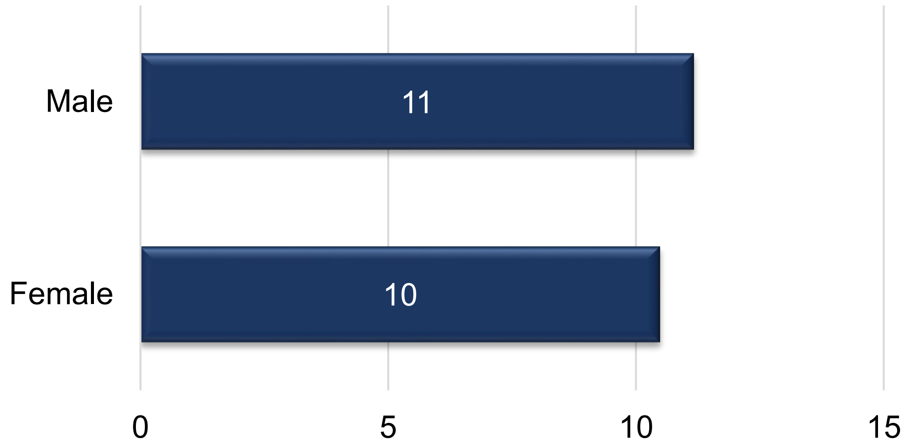


Fig 27: Emergency Room Visits with an Inpatient Admission per 1,000 Member Months by Ethnicity

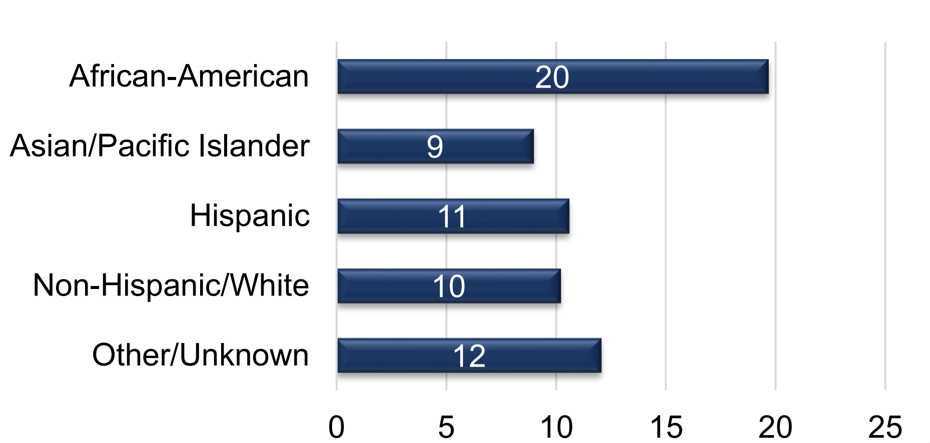
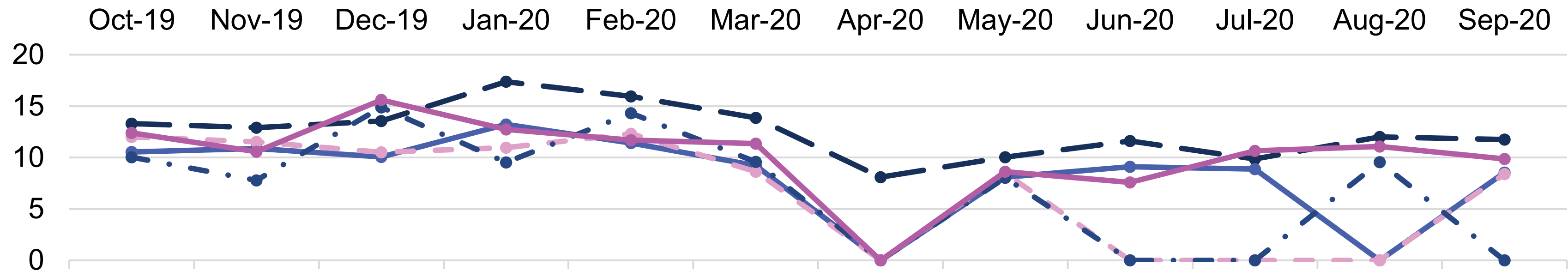


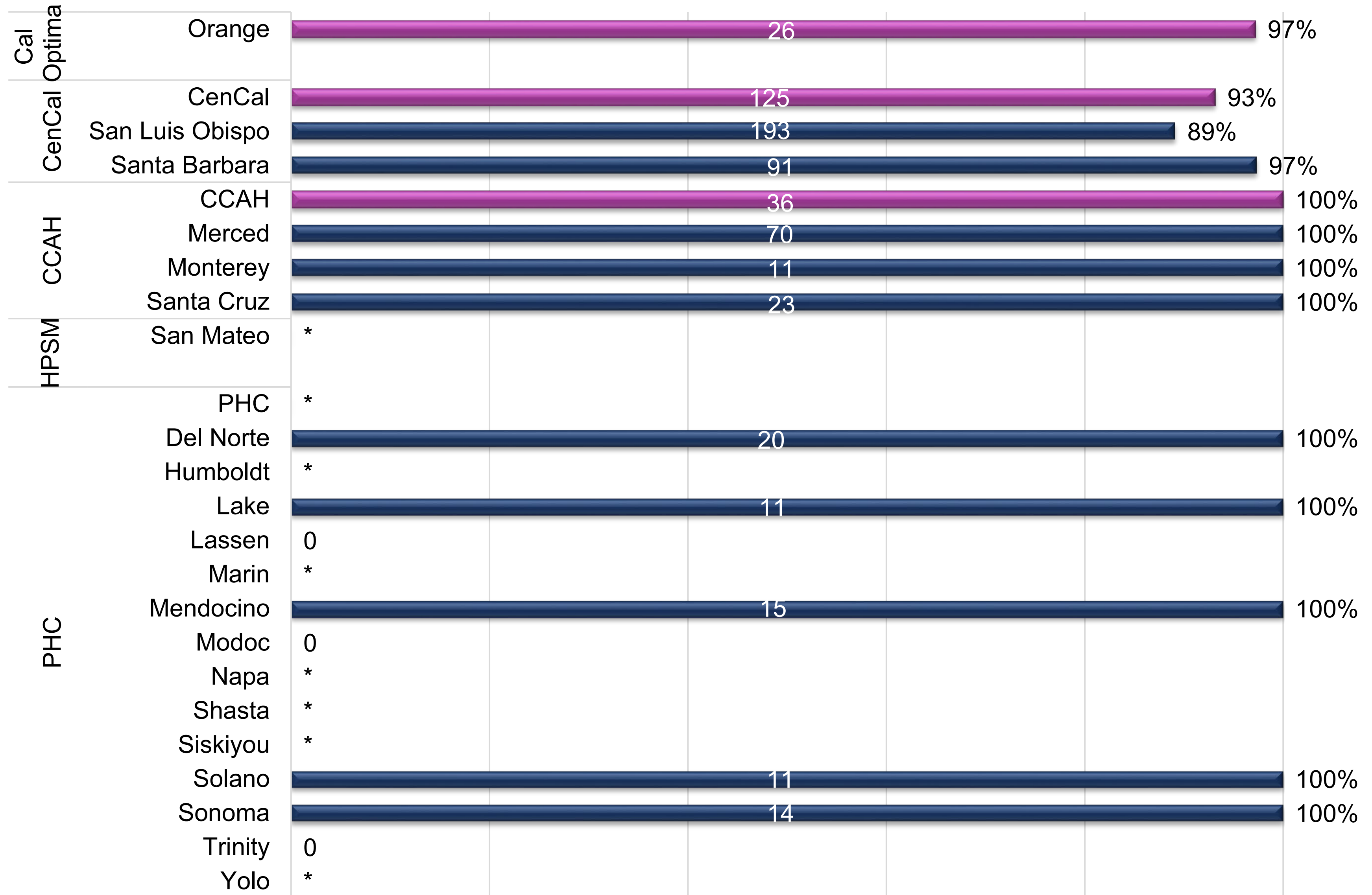
Fig 28: Emergency Room Visits with an Inpatient Admission per 1,000 Members by Plan, by Month



	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
CalOptima	13	13	14	17	16	14	8	10	12	10	12	12
CenCal	11	11	10	13	11	9	*	8	9	9	*	9
CCAH	12	12	11	11	12	9	*	8	*	*	*	8
HPSM	10	8	15	10	14	10	*	8	*	*	10	*
PHC	12	11	16	13	12	11	*	9	8	11	11	10

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'19 - Sep'20)



Note: This report contains data from October 2019 to September 2020.
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 16 through Month 27

	Month 16	Month 17	Month 18	Month 19	Month 20	Month 21	Month 22	Month 23	Month 24	Month 25	Month 26	Month 27
CalOptima	*	*	*	*	*	*	*	*	*	0	*	*
CenCal	35	47	49	0	0	35	50	31	27	29	40	37
CCAH	50	71	26	14	21	34	*	*	*	0	*	*
HPSM	0	0	*	0	0	0	0	*	*	*	0	0
PHC	0	0	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 28 through Month 39

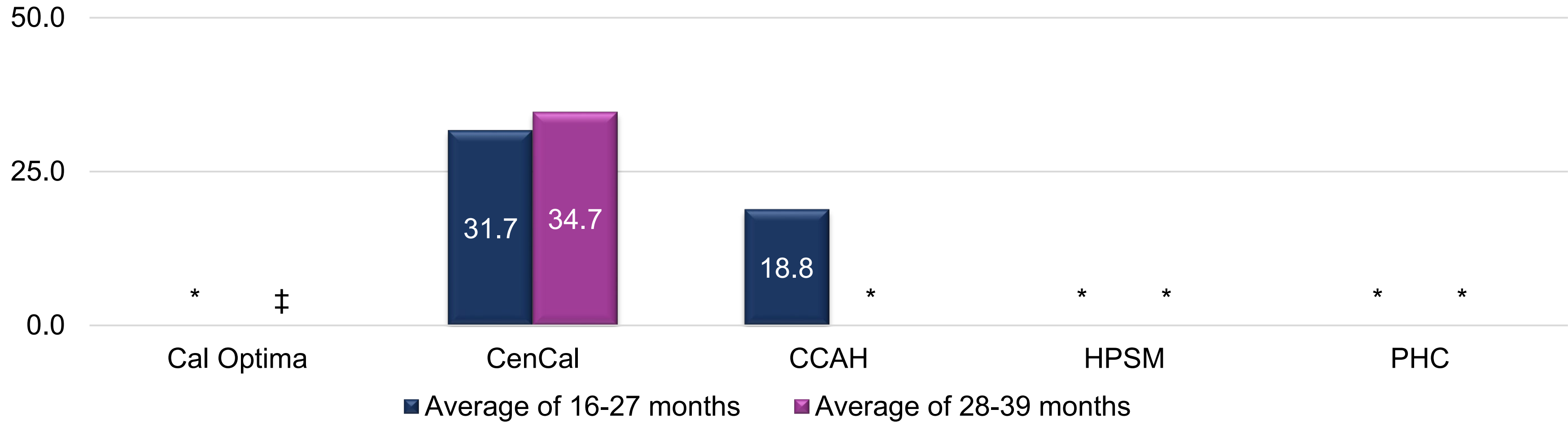
	Month 28	Month 29	Month 30	Month 31	Month 32	Month 33	Month 34	Month 35	Month 36	Month 37	Month 38	Month 39
CalOptima	*	*	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡
CenCal	45	23	32	44	31	39	41	28	46	34	36	17
CCAH	*	*	*	0	*	*	*	*	*	*	*	*
HPSM	0	*	*	*	*	0	22	17	21	*	*	*
PHC	0	0	0	0	*	*	0	0	‡	‡	‡	‡

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.

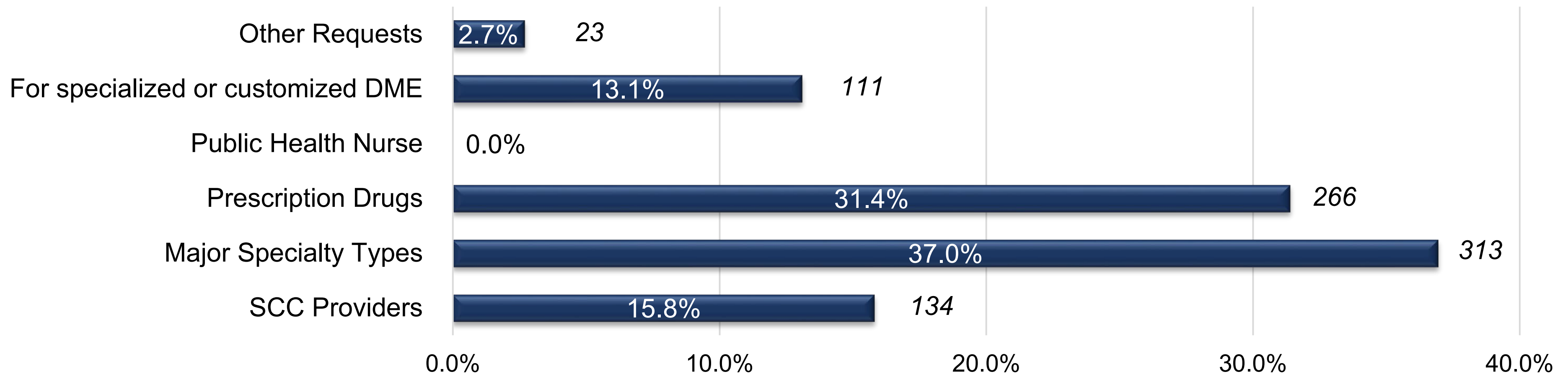
**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

‡ Plans who have not reached this month in their observation yet.

WCM Figure 32: Continuity of Care (COC) - Requests, by Plan

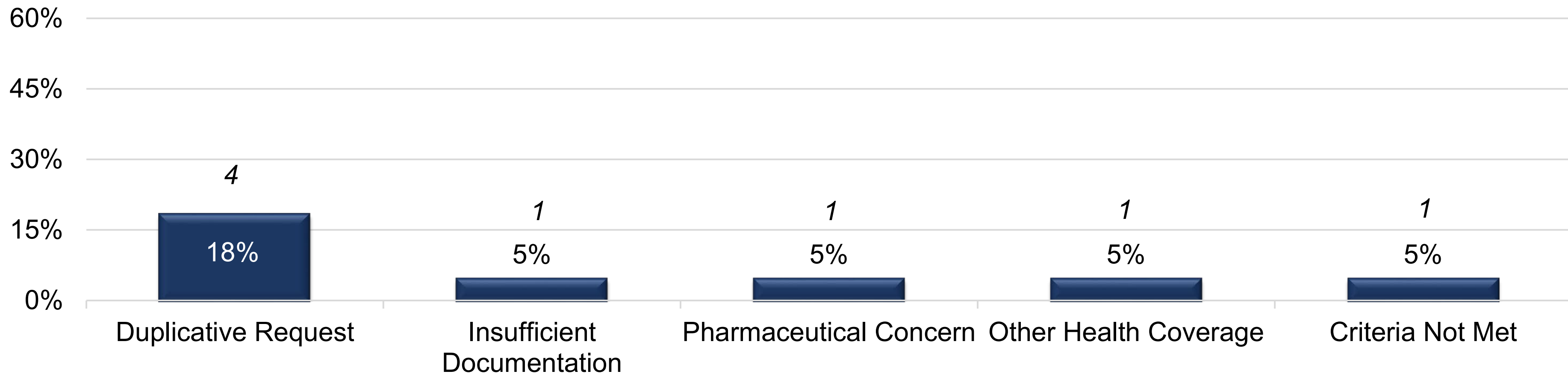


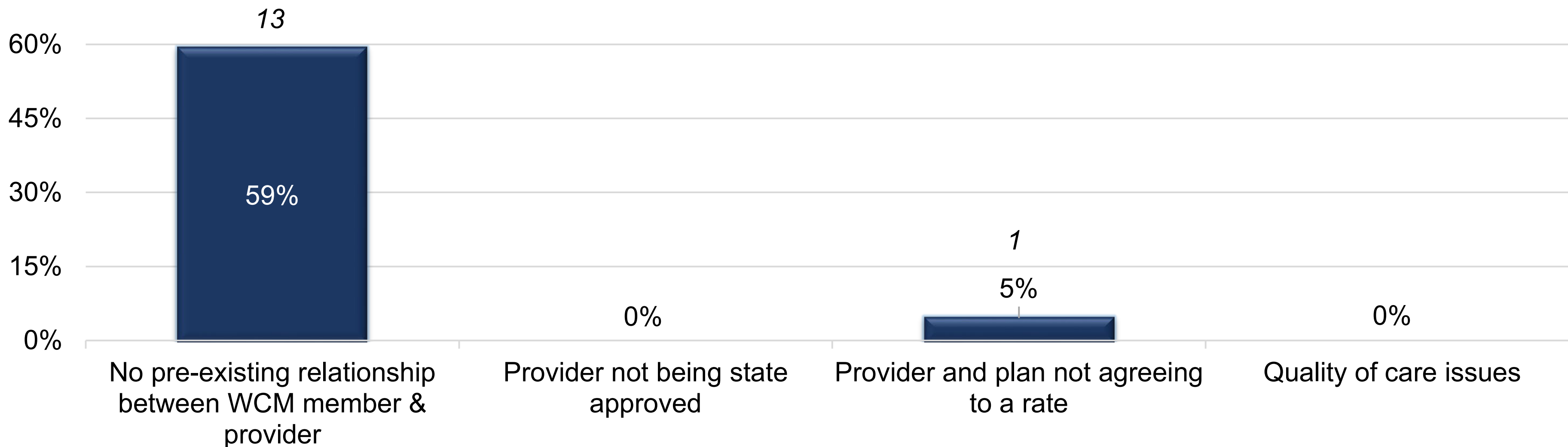
WCM Figure 33: Continuity of Care (COC) - Requests Categories (Oct'19 - Sep'20)



**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*
‡ Plans who have not reached this month in their observation yet.

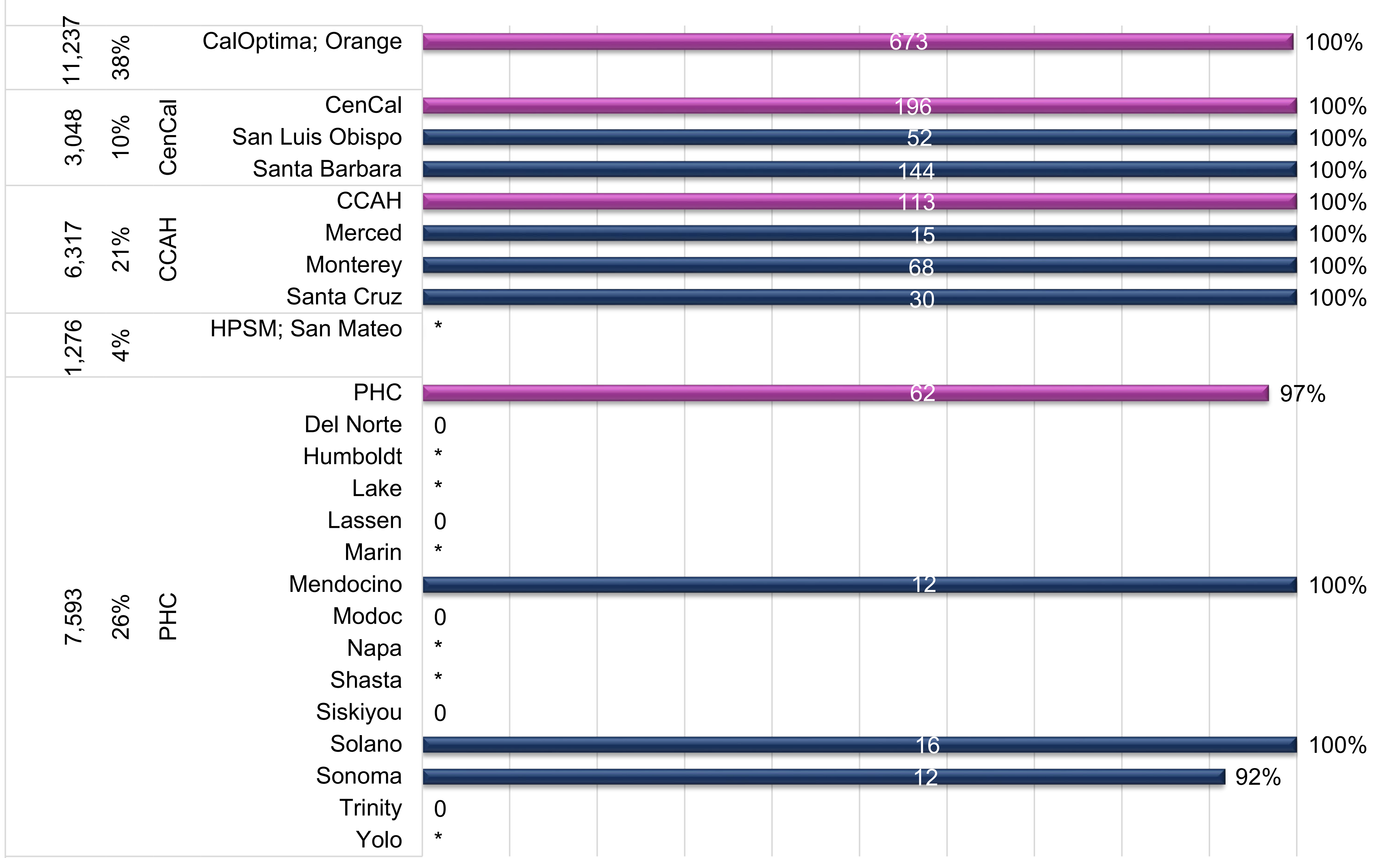
WCM Figures 34 & 35: Continuity of Care (COC) - Denials Reasons (Oct'19 - Sep'20)





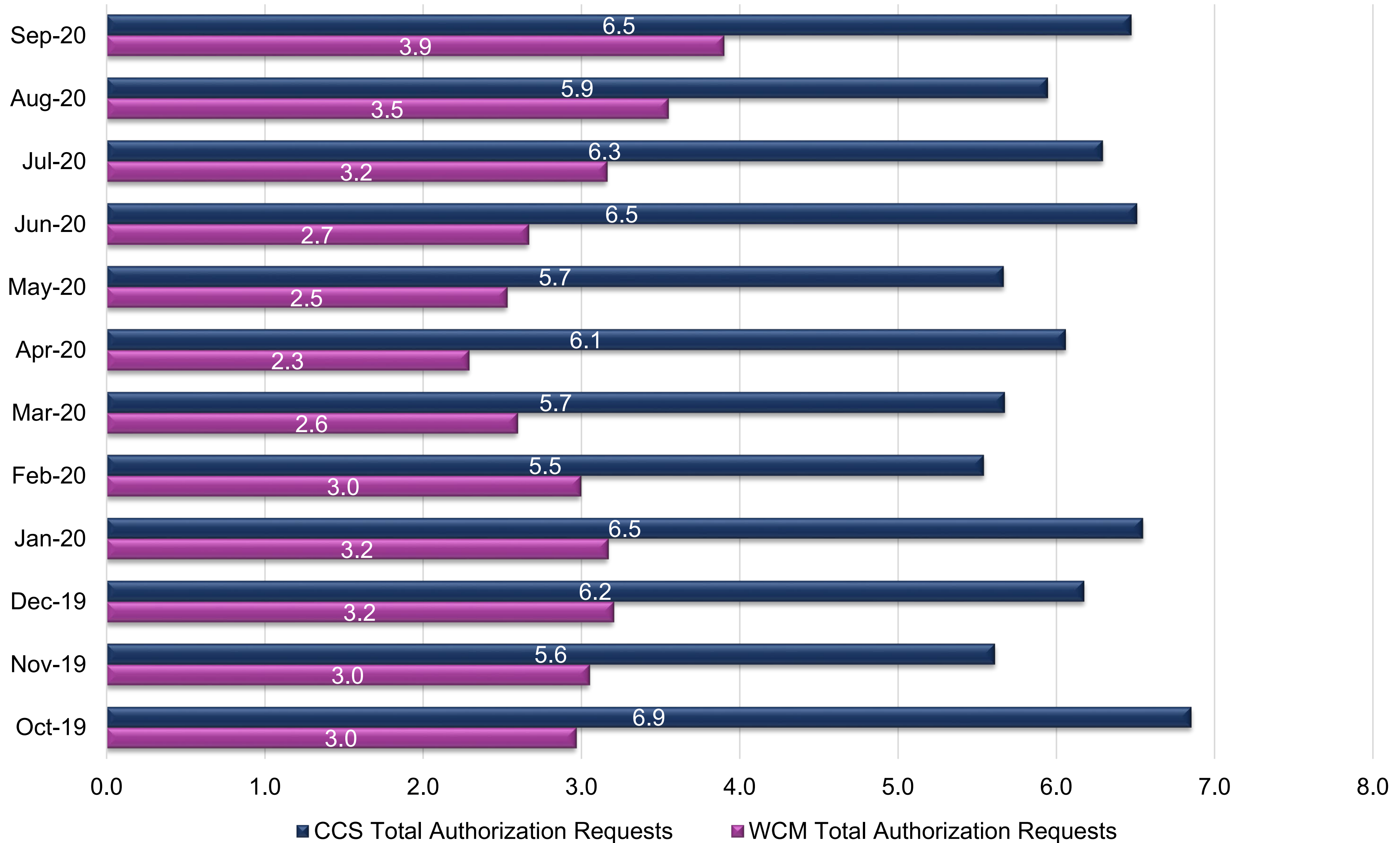
Note: Please see page 9 for detailed information on why Figures 34 & 35 do not add up to 100%.

WCM Figure 36: Case Management NICU Authorization Requests & Approvals (Oct'19 - Sep'20)



Note: This report contains data from October 2019 to September 2020.
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.

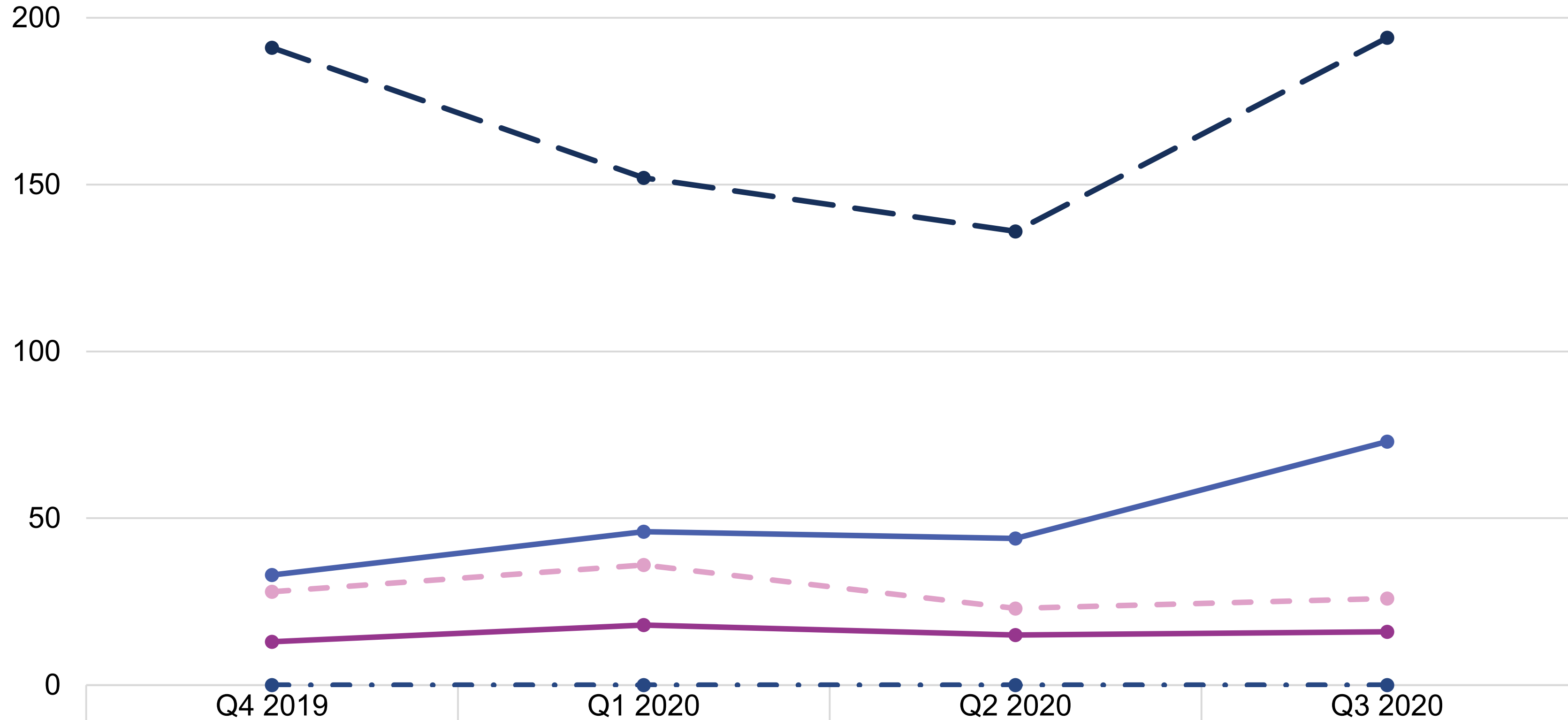
CCS and WCM Figure 37: Case Management NICU Authorization Requests (Oct'19 - Sep'20)



Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from October 2019 to September 2020. 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'19 - Sep'20)

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



	Q4 2019	Q1 2020	Q2 2020	Q3 2020
CalOptima	191	152	136	194
CCAH	28	36	23	26
CenCal	33	46	44	73
HPSM	*	*	*	*
PHC	13	18	15	16

Note: This report contains data from October 2019 to September 2020.

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

**HPSM for all four quarters had 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'19 - Sep'20)

Note: This report contains data from October 2019 to September 2020.
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.*

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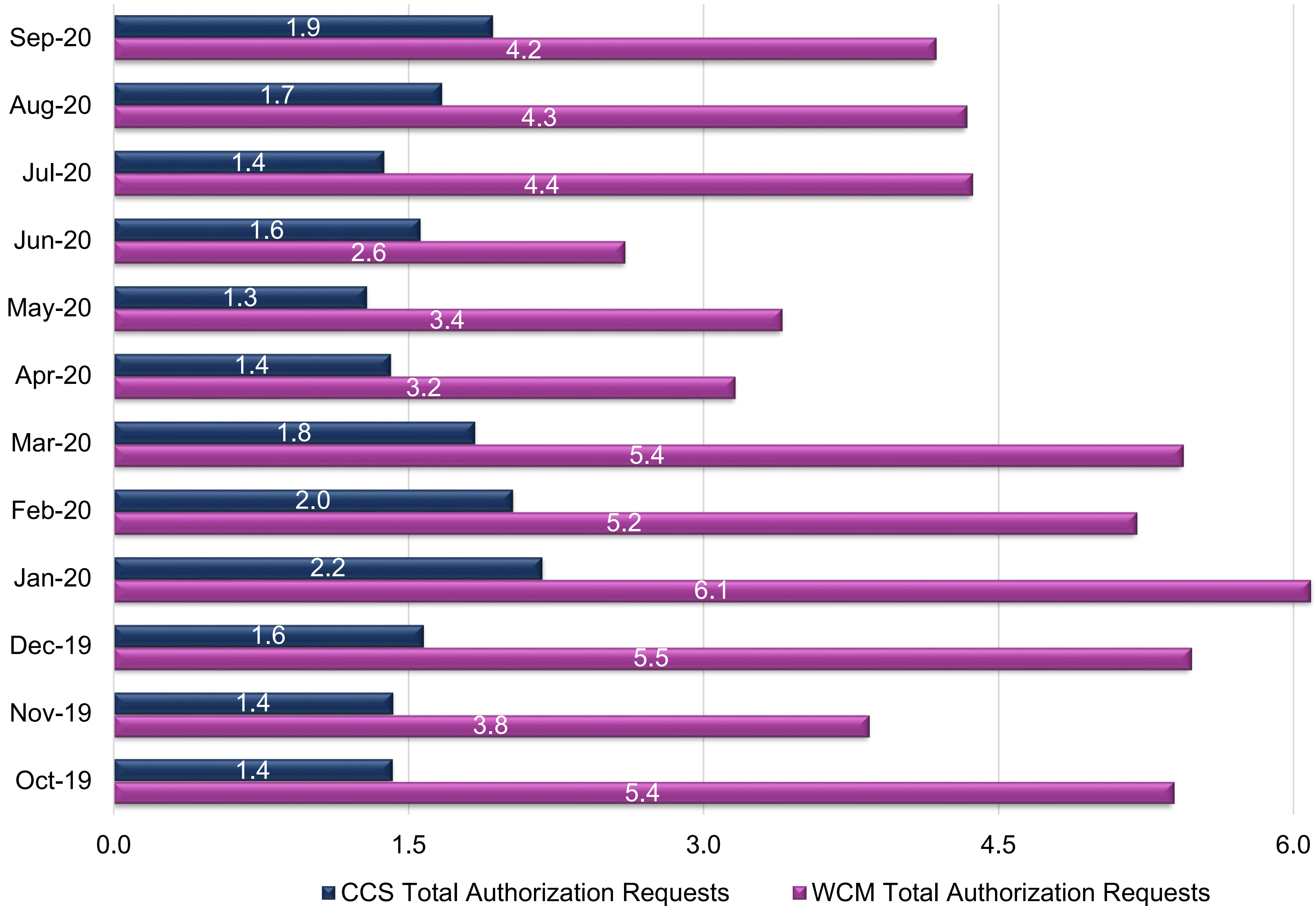
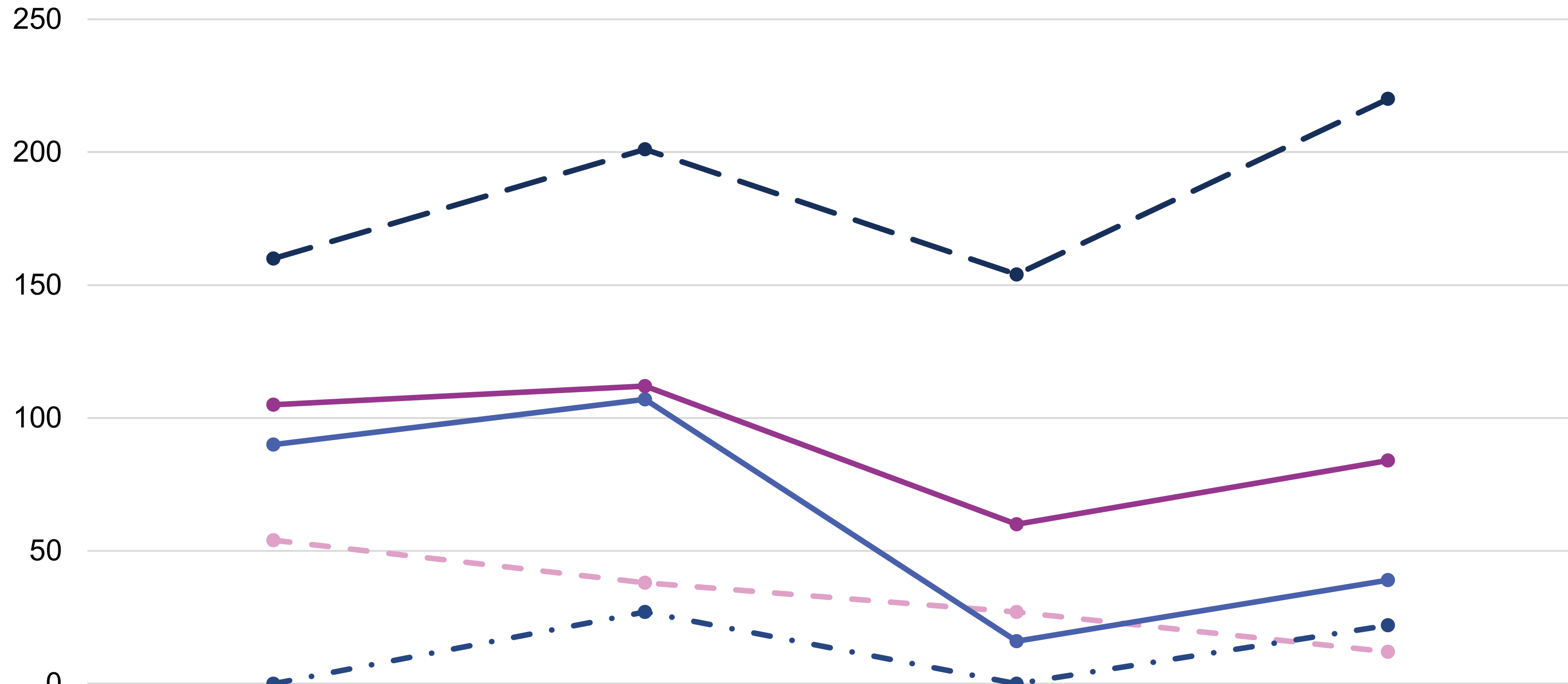
CCS and WCM Figure 40: Case Management PICU Authorization Requests (Oct'19 - Sep'20)



Note: CCS refers to counties operating outside of the Whole Child Model Program. This report contains data from October 2019 to September 2020. 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'19 - Sep'20)

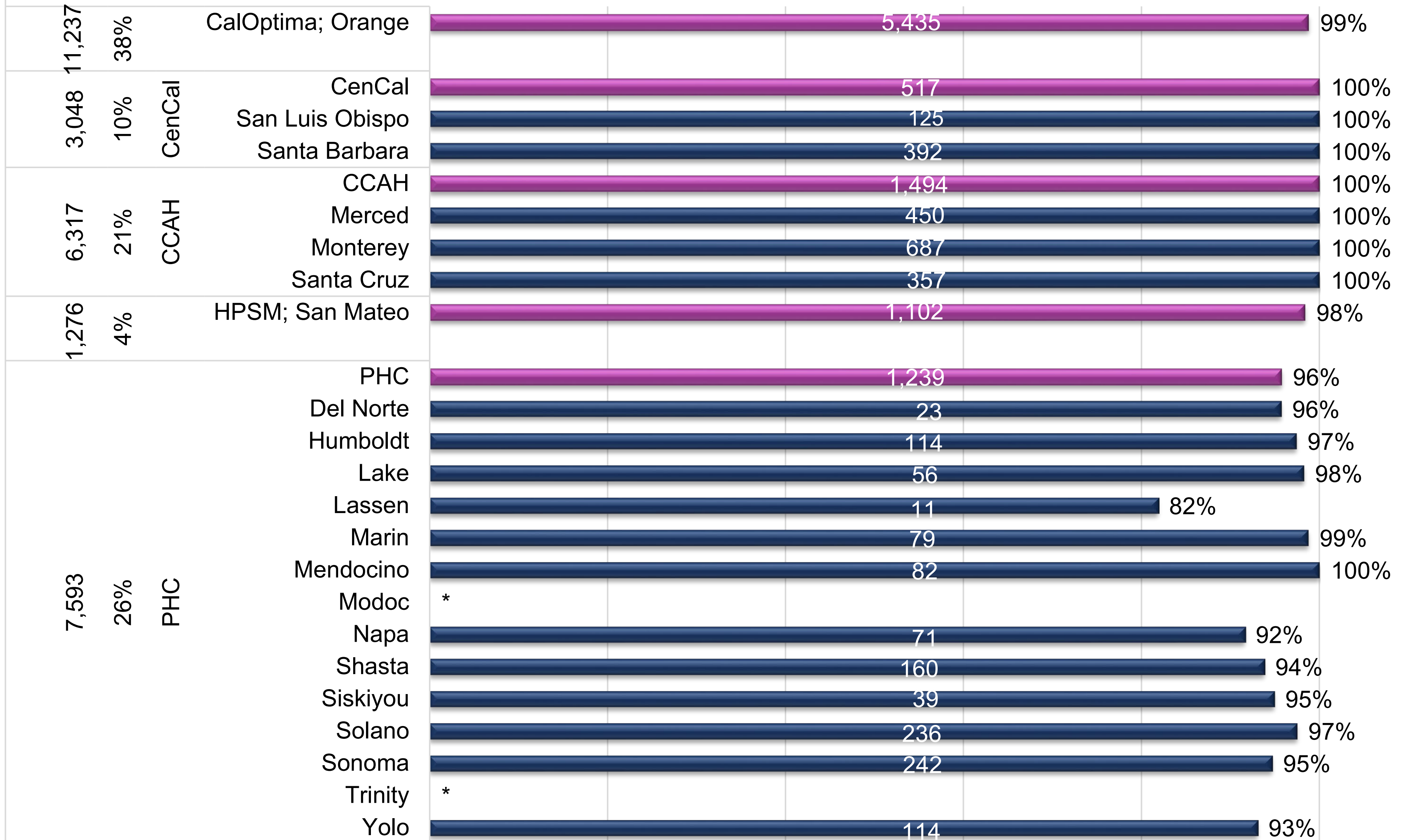
Fig 41: WCM Total PICU Authorization Requests by Plan, by Quarter



	Q4 2019	Q1 2020	Q2 2020	Q3 2020
CalOptima	160	201	154	220
CCAH	54	38	27	12
CenCal	90	107	16	39
HPSM	*	27	*	22
PHC	105	112	60	84

Note: This report contains data from October 2019 to September 2020.
CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019 and CalOptima joined in July 2019.
**HPSM for Q4 2019 and Q2 2020 had counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

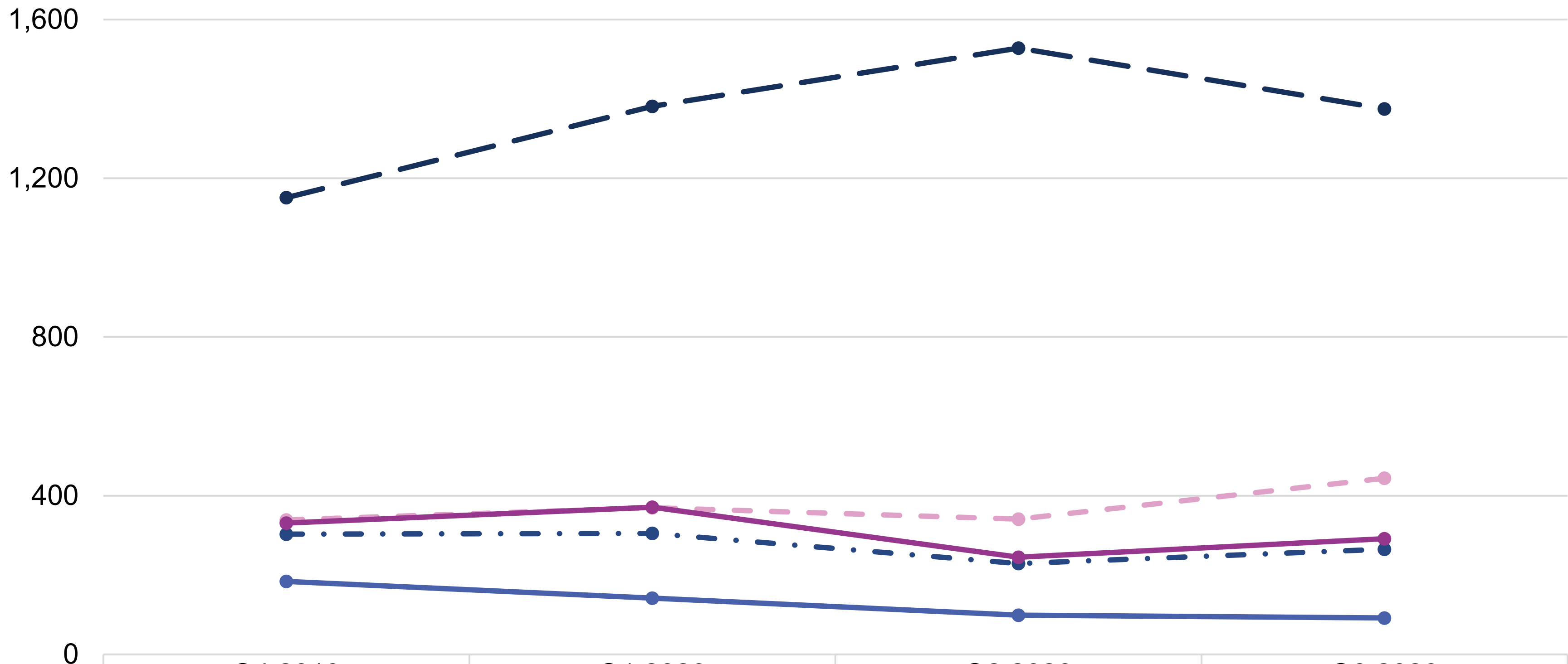
WCM Figure 42: Case Management Inpatient Facilities and Special Care Centers (SCC) Authorization Requests & Approvals (Oct'19 - Sep'20)



Note: This report contains data from October 2019 to September 2020.
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 (Oct'19 - Sep'20)

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



	Q4 2019	Q1 2020	Q2 2020	Q3 2020
CalOptima	1,151	1,381	1,528	1,375
CCAH	339	370	341	444
CenCal	184	142	99	92
HPSM	303	305	229	265
PHC	331	371	245	292

Note: This report contains data from October 2019 to September 2020.
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 (Oct'19 - Sep'20)

Note: This report contains data from October 2019 to September 2020.
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.*

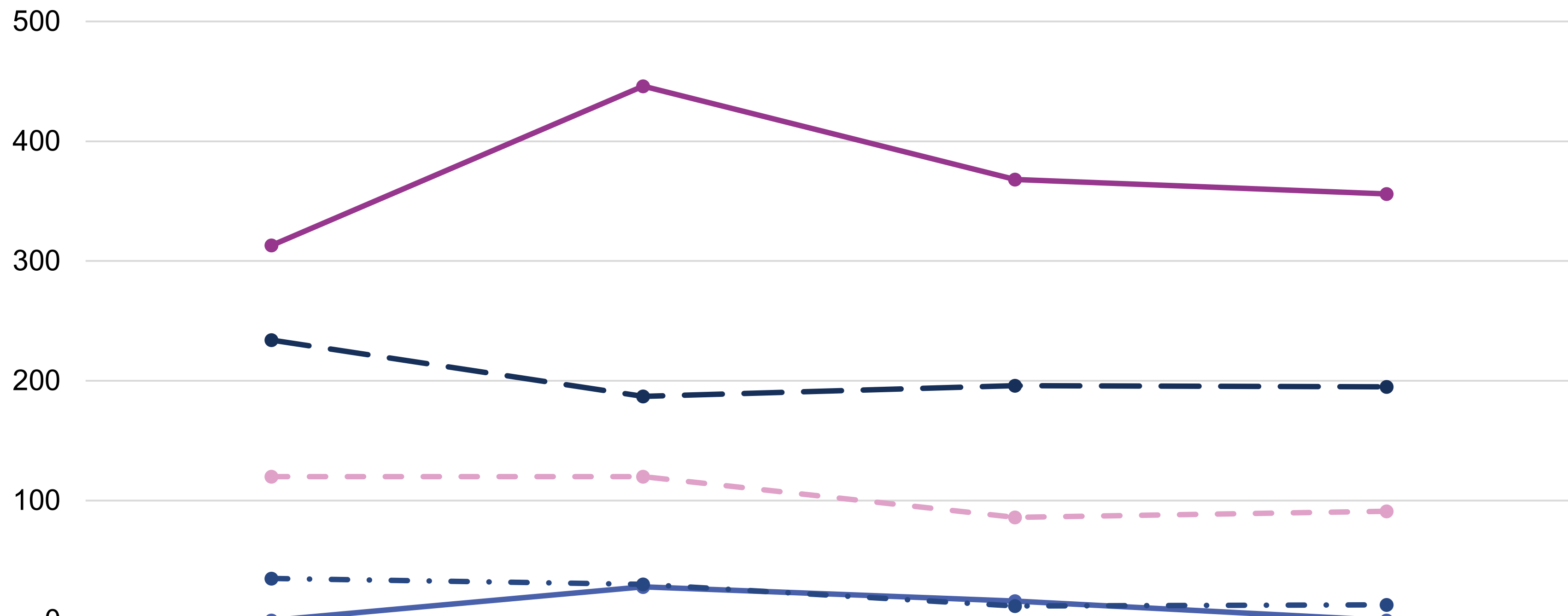
DEPARTMENT OF HEALTH CARE SERVICES

Integrated California Children's Services and Whole Child Model Dashboard

Released March 2022

WCM Figure 45: Case Management Specialized or Customized DME Authorization Requests (Oct'19 - Sep'20)

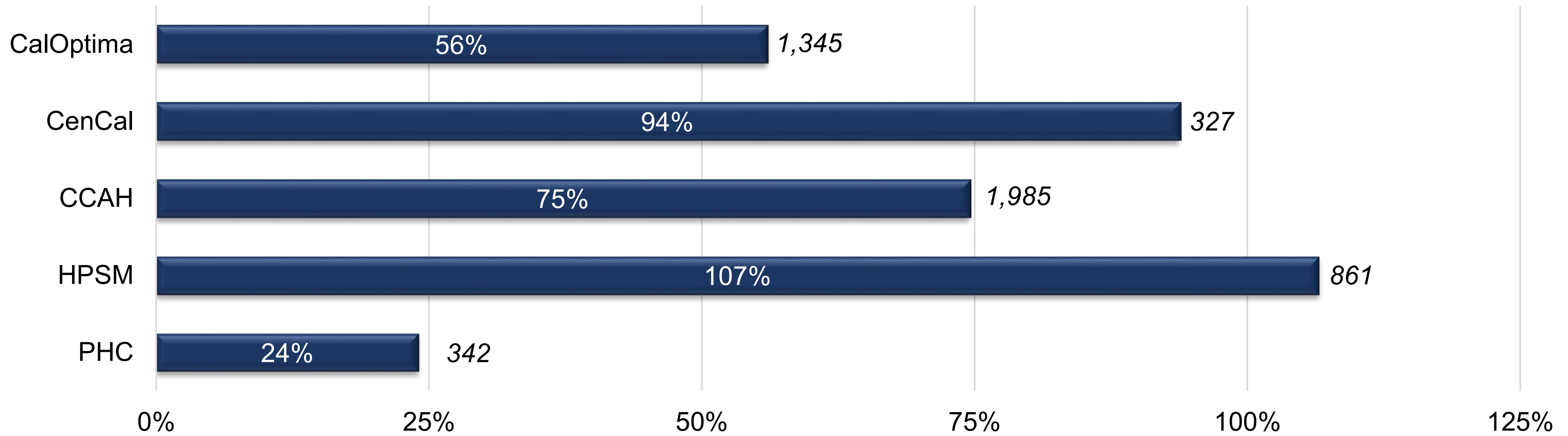
Fig 45: WCM Total Specialized or Customized DME Authorization Requests by Plan, by Quarter

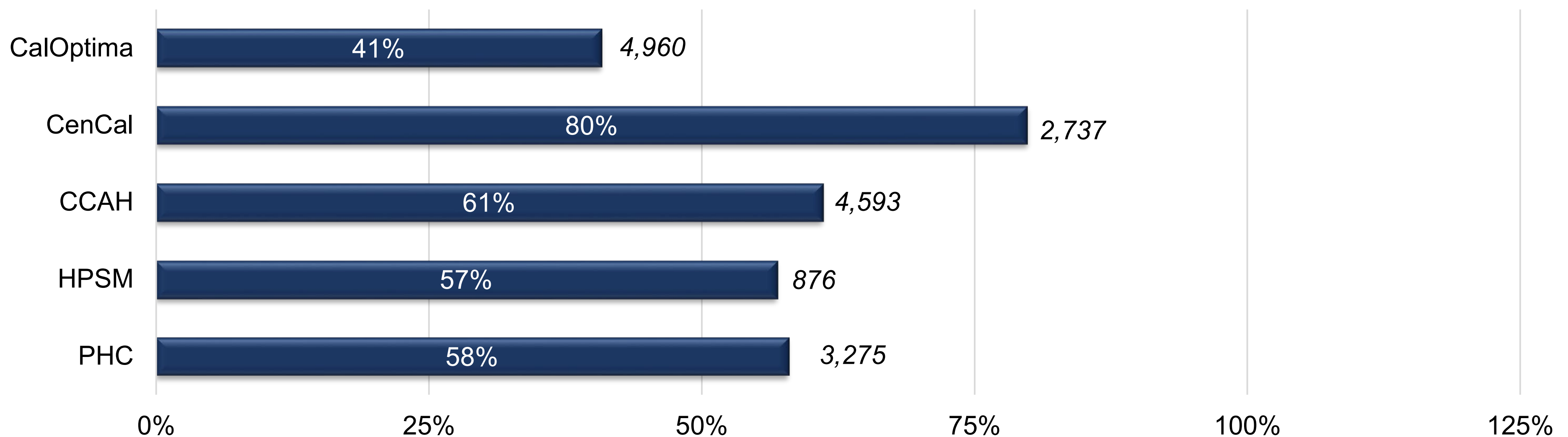


	Q4 2019	Q1 2020	Q2 2020	Q3 2020
CalOptima	234	187	196	195
CCAH	120	120	86	91
CenCal	*	28	16	*
HPSM	35	30	12	13
PHC	313	446	368	356

Note: This report contains data from October 2019 to September 2020.
CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019 and CalOptima joined in July 2019.
**CenCal for Q4 2019 and Q3 2020 had counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

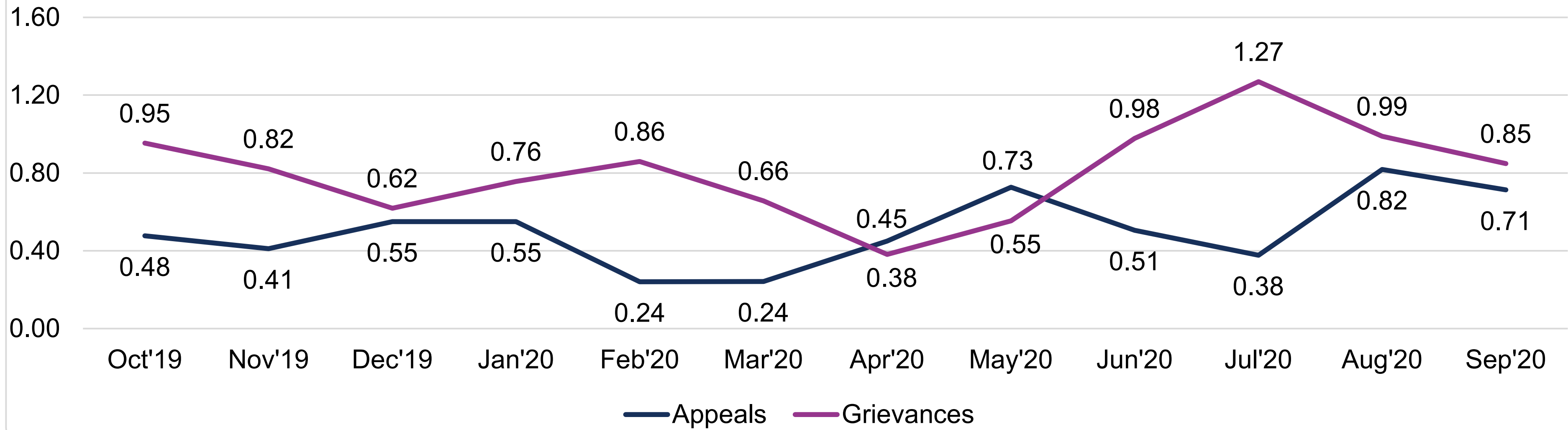
WCM Figures 46 & 47: Care Coordination High-Risk and Low-Risk Assessments - September 2020

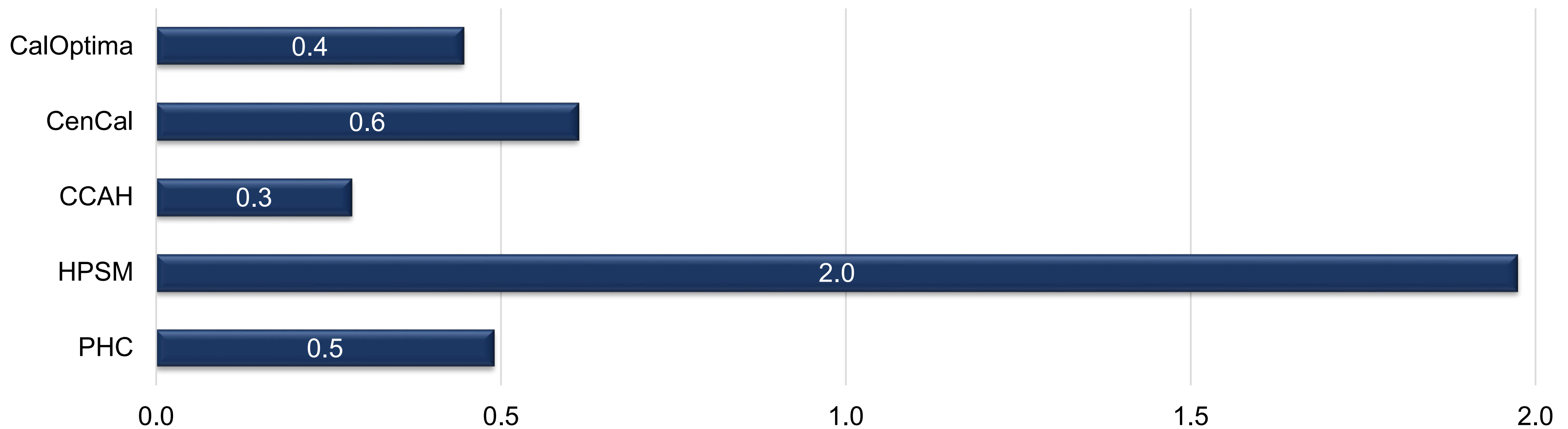




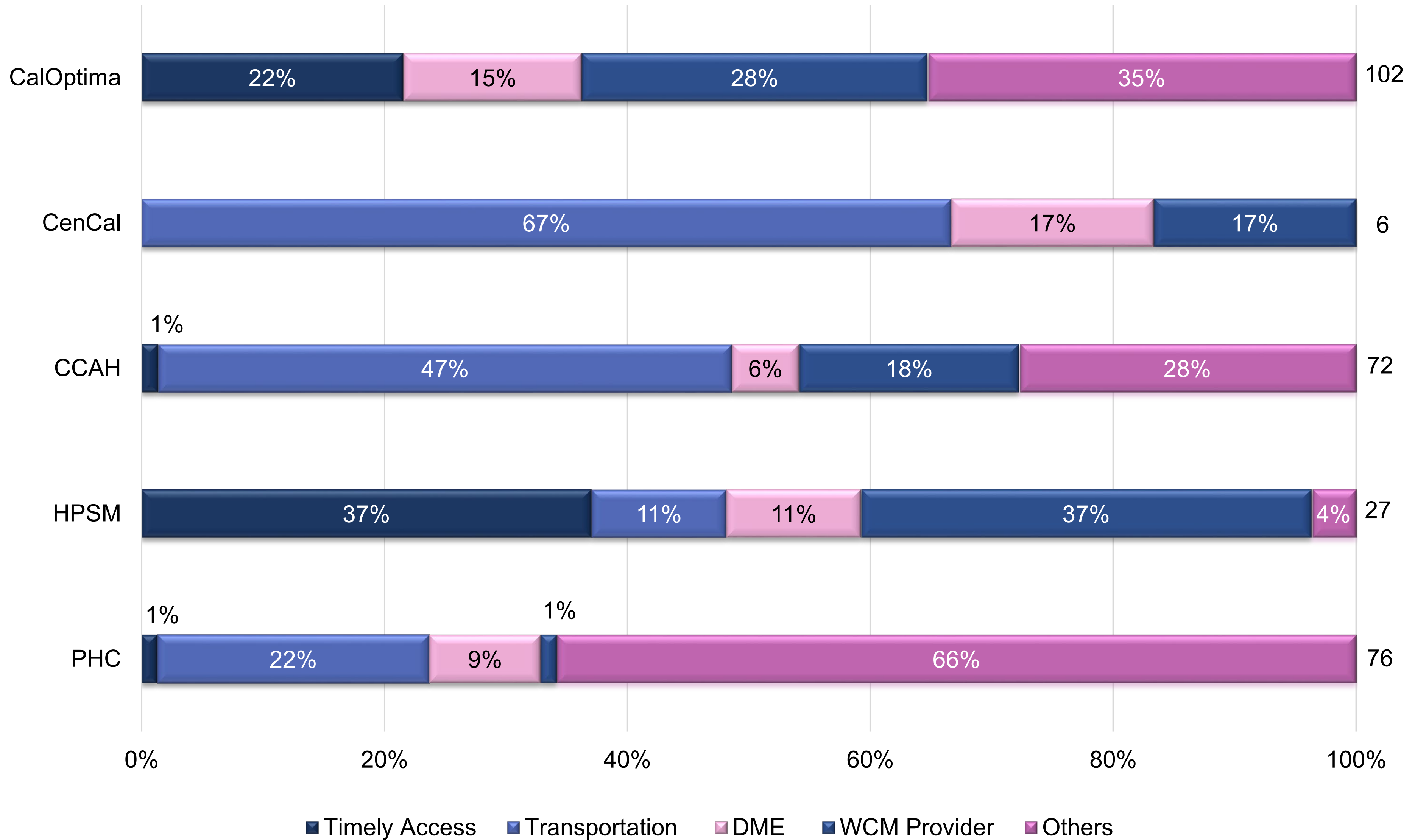
Note: DHCS is following up with WCM MCPs on assessments to clarify expectations and provide technical assistance.

WCM Figures 48 & 49: Grievances & Appeals per 1,000 Member Months (Oct'19 - Sep'20)





WCM Figure 50: Grievances - Breakdown by Categories, by Plan (Oct'19 - Sep'20)



WCM Figure 51: Family Advisory Committee Meetings Table (Oct'19 - Sep'20)

Plan Name	Number of Committee Members	Number of Meetings Held Oct'19 - Sep'20	Recruitment Efforts	Seats to be Filled
CalOptima	9	5	The WCM FAC as of September 2020 had six family members and three community representatives. Staff continued to recruit through existing members and publicizing the openings on CalOptima's website, and regular updates in newsletters to community members.	2 of 11
CCAH	16	10	2019-20 recruitment efforts included direct outreach to WCM families, including the utilization of the Alliance newsletter to announce openings on the advisory committee as well as Case/Care Management staffs and community partners to inform members they interact with of advisory committee openings. 2019 recruitments efforts proved successful with 4 new members that were officially onboarded in February 2020.	3 of 19
CenCal	16	4	Currently recruiting for 2 positions - seeking help from family advocacy groups	2 of 18
HPSM	15	4	Efforts are ad hoc as HPSM's Social Workers make contact with families.	N/A. No target number of seats.
PHC	13	4	By December 2019, committee membership was open to any interested parties. Our original goal of recruiting 2 members per county was not providing enough interest so we relaxed that approach. We were actively requesting referrals to the committee from providers via our PQC meetings, from county CCS staff via our WCM JOC meeting as well as in meetings with individual counties, and Care Coordination Staff was prompted to encourage members they were in contact with to attend as well. We did and still maintain a page on our PHC website that discusses the FAC with contact information for interested members. In every meeting, Partnership Healthplan of CA (PHC) encourages our existing members who know other parents of special needs children to encourage participation in our group. PHC will reach out to any referrals we identify. In addition, there is also information about the FAC on our website (member's section) that encourages participation.	15 of 28

Note: Number of Committee Members is connected to the Seats to be Filled. DHCS works with the Plans to maintain a consistent definition. DHCS follows up quarterly to ensure the seats are filled as quickly as possible.