Managed Care Whole Child Model Dashboard

Released October 2021

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. Dashboard data are reported by Managed Care Plans (plan) or Counties.

- **Point-in-time charts:** Figures 2-6, 40, and 41.
  Charts display data for the last month in the reporting period.
- **Trend charts:** Figures 1, 9, 12, 15, 18, 21, 24, 32, 34, 36, 38 and 42.
  Charts display each month's or quarter's data in the last 12 months of the reporting period.
- **Cumulative charts:** Figures 7, 8, 10, 11, 13, 14, 16, 17, 19, 20, 22, 23, 27-31, 33, 35, 37, 39, 43, 44 and 45.
  Charts display the sum of the last 12 months' data in the reporting period as one figure.
- **Tables:** Figures 25 and 26.
  Tables display each month's data in the last 12 months of the reporting period.

Whole Child Model Enrollment and Demographics: *Figures 1-24*

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 whole child model data for Figures 1-24. Figures 1-6 displays WCM enrollment and demographics. Figures 7-24 displays utilization data. Figures 1, 9, 12, 15, 18, 21, and 24 are trend charts displaying monthly data over the last 12 months. Figures 2-6 show data for the last month in the reporting period as a point of time view of the Whole Child Model program. Figures 7, 8, 10, 11, 13, 14, 16, 17, 19, 20, 22, and 23 are cumulative charts, showing the sum of the 12 months' data as one figure.

Enrollment and Demographics:

The data in this section examines the trend of enrollment over time as well as the breakdown of the WCM member demographics. Evaluation of Medi-Cal members enrolled in the managed care plans participating in the WCM program occurs monthly. Demographic data studies the structure of the WCM population in terms of ethnicity, gender and primary languages.

A trend of total enrollment over time is displayed in Figure 1. In April 2019, 17,761 members were enrolled in WCM. Enrollment increased over time to 28,939 members enrolled in March 2020. CenCal, CCAH, and HPSM began offering WCM services July 2018. Partnership joined WCM Program in January 2019 and CalOptima joined WCM program in July 2019. The increase of membership in July 2019 is due to CalOptima joining the program.

Figure 2 shows that 15,623, or 54%, of enrollees identified themselves as Hispanic. This was calculated by using member reported ethnicity for the month of March 2020 as the numerator, divided by total enrollment for March 2020 as the denominator.

Figure 3 displays WCM enrollment by age. In March 2020, 32% or 9,205 members were between the ages 12 and 17, and 14% or 3,919 members were between the ages of 18 and 21. This was calculated by using enrollment for each age range for the month of March 2020 as the numerator, divided by total enrollment for March 2020 as the denominator.

Figure 4 displays WCM enrollment by primary languages. In March 2020, 16,412, or 56.7%, of members spoke English and 11,570, or 40.0%, spoke Spanish as their primary spoken language. This was calculated by using enrollment for each language in March 2020 as the numerator, divided by the total enrollment in March 2020 as the denominator.

The WCM population consists of 15,248, or 53%, male and 13,691, or 47%, female as displayed in Figure 5. This was calculated by using enrollment by gender in March 2020 as the numerator, divided by the total enrollment in March 2020 as the denominator.

Figure 6 displays total WCM enrollment, by plan and by county. The raw numbers are displayed within the bar graph. As of March 2020, HPSM reported 1,253 children and CalOptima reported 11,316 children enrolled in the program. Figure 6 also displays WCM enrollment per 1,000 children enrolled in the Medi-Cal program. Partnership reported 23 enrollees in Del Norte County and 41 enrollees per 1,000 children enrolled in the Medi-Cal program in Marin County. This was calculated by using enrollment in WCM in each plan and county in March 2020 as the numerator, divided by members aged 0-21 years into the Medi-Cal program in each plan and county in March 2020 as the denominator. The dividend was then multiplied by 1,000.

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 7 displays that male enrollees made 80 ER visits per 1,000 member months and female enrollees made 79 ER visits per 1,000 member months. This was calculated by using the number of ER visits for each gender for April 2019 through March 2020 as the numerator, divided by the enrollment for each gender for April 2019 through March 2020 as the denominator. The dividend was then multiplied by 1,000.

For Figure 8, African-American members made the most ER visits at 113 per 1,000 member months. This was calculated by using the number of ER visits for each ethnicity for April 2019 through March 2020 as the numerator, divided by the enrollment for each ethnicity for April 2019 through March 2020 as the denominator. The dividend was then multiplied by 1,000.

Figure 9 shows the trend in the number of ER visits for each participating plan from April 2019 through March 2020. This was calculated by using the number of ER visits for each plan per month for April 2019 through March 2020 as the numerator, divided by the enrollment for each plan per month for April 2019 through March 2020 as the denominator. The dividend was then multiplied by 1,000. A dagger (†) represents Plans who are not in the observations yet.

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 10 displays that female enrollees made 2,947 outpatient visits per 1,000 member months while males made 3,184 outpatient visits per 1,000 member months. This was calculated by using the number of outpatient visits for each

gender for April 2019 through March 2020 as the numerator, divided by the enrollment for each gender for April 2019 through March 2020 as the denominator. The dividend was then multiplied by 1,000.

For Figure 11, members that identified as Asian/Pacific Islander made the most outpatient visits at 3,637 per 1,000 member months. This was calculated by using the number of outpatient visits for each ethnicity for April 2019 through March 2020 as the numerator, divided by the enrollment for each ethnicity for April 2019 through March 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 April 2019 through March 2020. This was calculated by using the number of outpatient visits for each plan per month for April 2019 through March 2020 as the numerator, divided by the enrollment for each plan per month for April 2019 through March 2020 as the denominator. The dividend was then multiplied by 1,000. A dagger (†) represents Plans who are not in the observations yet.

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 male enrollees had 31 inpatient admissions per 1,000 member months and female enrollees had 28 inpatient admissions per 1,000 member months. This was calculated by using the number of inpatient visits for each gender for April 2019 through March 2020 as the numerator, divided by the enrollment for each gender for April 2019 through March 2020 as the denominator. The dividend was then multiplied by 1,000.

For Figure 14, African-American members had the most inpatient admissions at 48 per 1,000 member months. This was calculated by using the number of inpatient visits for each ethnicity for April 2019 through March 2020 as the numerator, divided by the enrollment for each ethnicity for April 2019 through March 2020 as the denominator. The dividend was then multiplied by 1,000.

Figure 15 shows the trend in the number of inpatient admissions for each participating plan from April 2019 through March 2020. This was calculated by using the number of inpatient admissions for each plan per month for April 2019 through March 2020 as the numerator, divided by the enrollment for each plan per month for April 2019 through March 2020 as the denominator. The dividend was then multiplied by 1,000. A dagger (†) represents Plans who are not in the observations yet.

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 16 displays that female enrollees had utilized 1,345 prescription medications per 1,000 member months while males had utilized 1,320 prescription medications per 1,000 member months. This was calculated by using the number of prescriptions for each gender for April 2019 through March 2020 as the numerator, divided by the enrollment for each gender for April 2019 through March 2020 as the denominator. The dividend was then multiplied by 1,000.

For Figure 17, African-American members utilized the most prescription medications at 1,724 per 1,000 member months. This was calculated by using the number of prescriptions for each ethnicity for April 2019 through March 2020 as the numerator, divided by the enrollment for each ethnicity for April 2019 through March 2020 as the denominator. The dividend was then multiplied by 1,000.

Figure 18 shows the trend in the number of prescription medications for each participating plan from April 2019 through March 2020. This was calculated by using the number of prescriptions reported by each plan per month for April 2019 through March 2020 as the numerator, divided by the enrollment for each plan per month for April 2019 through March 2020 as the denominator. The dividend was then multiplied by 1,000. A dagger (†) represents Plans who are not in the observations yet.

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 19 displays that female enrollees made 52 non-specialty mental health visits per 1,000 member months while males made 37 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 2019 through March 2020 as the numerator, divided by the enrollment for each gender for April 2019 through March 2020 as the denominator. The dividend was then multiplied by 1,000.

For Figure 20, non-Hispanic/white members made the most visits at 77 per 1,000 member months. This was calculated by using the number of non-specialty mental health visits for each ethnicity for April 2019 through March 2020 as the

numerator, divided by the enrollment for each ethnicity for April 2019 through March 2020 as the denominator. The dividend was then multiplied by 1,000.

Figure 21 shows the trend in the number of non-specialty mental health visits for each participating plan from April 2019 through March 2020. This was calculated by using the number of non-specialty mental health visits for each plan per month for April 2019 through March 2020 as the numerator, divided by the enrollment for each plan per month for April 2019 through March 2020 as the denominator. The dividend was then multiplied by 1,000. A dagger (†) represents Plans who are not in the observations yet.

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 22 displays that male enrollees made 13 ER visits with an inpatient admission per 1,000 member months while female enrollees made 12 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 April 2019 through March 2020 as the numerator, divided by the enrollment for each gender for April 2019 through March 2020 as the denominator. The dividend was then multiplied by 1,000.

For Figure 23, African-American members made the most ER visits with an inpatient admission at 21 per 1,000 member months. This was calculated by using the number of ER visits with an inpatient admission for each ethnicity for April 2019 through March 2020 as the numerator, divided by the enrollment for each ethnicity for April 2019 through March 2020 as the denominator. The dividend was then multiplied by 1,000.

Figure 24 shows the trend in the number of ER visits with an inpatient admission for each participating plan from April 2019 through March 2020. This was calculated by using the number of ER visits with an inpatient admission for each plan per month for April 2019 through March 2020 as the numerator, divided by the denominator is enrollment for each plan per month for April 2019 through March 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. A dagger (†) represents Plans who are not in the observations yet.

Continuity of Care (COC): *Figures 25-31*

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 25-26 are tables displaying monthly data for 12 months. Figures 27-31 are cumulative charts, showing the sum of the 12 months' data as one figure.

Total number of COC requests for each plan for the months 10 through 21 after joining the program are shown in Figure 25. In the tenth month of operation, CalOptima reported 33, CenCal reported 55, CCAH reported 39 and Partnership reported receiving 20 COC requests. In the twenty-first month of operation, CenCal reported 35, and CCAH reported receiving 34 COC 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.

Months 22 through 33 upon joining the program for COC requests are displayed in Figure 26. In the twenty-second month of operation, CenCal reported receiving 50 COC requests. In the thirty-third month of operation, CenCal reported receiving 39 COC requests. CalOptima has not yet reported their twenty-fourth month of participation in the program. 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 27 shows the average number of COC requests for each plan for months 10 through 21 compared to months 22 through 33. CenCal had an average of 38.6 for months 10 through 21 and 35.7 for months 22 through 33. CCAH had an average of 29.3 for months 10 through 21 and fewer than 11 for months 22 through 33. An asterisk (*) represents numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable.

Figure 28 displays major categories for the COC requests. Specialized or customized DME was requested 153 times, or 10.1% of the time, while 867, or 57.1%, of requests were made for prescription drugs. The high number of prescription drug COC requests were due to Partnership joining the WCM program in July 2018 and receiving a high volume of requests from members that were in previously carved-out counties. This was calculated by using the number of COC requests for each category for April 2019 through March 2020 as the numerator, divided by the total number of COC requests for April 2019 through March 2020 as the denominator.

Figure 29 shows reasons for COC denials not required by APL. Duplicative requests accounted for 13 or 39% of COC denial reasons while 2 denial reasons or 6% were due to other health insurance coverage. This was calculated by using the number of COC denials for each reason for April 2019 through March 2020 as the numerator, divided by the total number of COC denials for April 2019 through March 2020 as the denominator.

Figure 30 shows reasons for COC denials required by APL. No pre-existing relationship between WCM member and provider accounted for 6 or 18% 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 April 2019 through March 2020 as the numerator, divided by the total number of COC denials for April 2019 through March 2020 as the denominator.

Please note that for Figure 29, only the top 5 denial reasons are displayed. Figure 30 displays all denial categories as required by the APL, besides "Others". Neither Figure 29 nor Figure 30 adds up to 100%.

Figure 31 displays that requests for COC per 1,000 members ranged from 16 for HPSM to 164 for CenCal. This was calculated by using the number of COC requests for each plan for April 2019 through March 2020 as the numerator, divided by the enrollment for each plan in March 2020 as the denominator. The dividend was then multiplied by 1,000. Figure 31 also displays percentage of COC requests approved, by plan and by county. The approval percentage ranged from 93% for Partnership to 100% for CCAH. This was calculated by using the number of approved COC requests for each plan and each county for April 2019 through March 2020 as the numerator, divided by the total number of COC requests for each plan and each county for April 2019 through March 2020 as the denominator.

Case Management: *Figures 32-39*

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) authorizations, Pediatric Intensive Care Unit (PICU) authorizations, Inpatient Facilities and Special Care Center (SCC) authorizations, and Specialized or Customized DME authorizations. Case management data is submitted by plans. Figures 32, 34, 36, and 38 are trend charts displaying quarterly data over 12 months. Figures 33, 35, 37, and 39 are cumulative charts, showing the sum of the 12 months' data as one figure.

NICU Authorizations:

Figure 32 displays the trend of total requests seeking authorization for NICU services for each plan each quarter. For example, CCAH reported 21 requests in Q2 2019, 38 requests in Q3 2019, 28 requests in Q4 2019, and 36 requests in Q1 2020. Partnership reported fewer than 11 requests in Q2 and Q3 2019, and HPSM reported fewer than 11 requests for all four quarters. CalOptima joined in July 2019 and was not in observation during Q2 2019 to report any numbers. An asterisk (*) represents numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable.

Figure 33 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 98% for Partnership to 100% for CenCal and CCAH. This was calculated by using the number of approved NICU authorizations for each plan and each county for April 2019 through March 2020 as the numerator, divided by the number of NICU requests for authorizations for each plan and each county for April 2019 through March 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.

PICU Authorizations:

Figure 34 displays the trend of total requests seeking authorization for PICU services for each plan each quarter. For example, CCAH reported 29 requests in Q2 2019, 52 requests in Q3 2019, 54 requests in Q4 2019, and 38 requests in Q1 2020. HPSM reported fewer than 11 requests for Q3 2019, so the values for Q2 and Q3 2019 have been suppressed. CalOptima joined in July 2019 and was not in observation during Q2 2019 to report any numbers. An asterisk (*) represents numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable.

Figure 35 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 74 for HPSM to 501 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 CalOptima and PHC to 100% for all the other three plans. This was calculated by using the number of approved PICU requests for authorizations for each plan and each county for April 2019 through March 2020 as the numerator, divided by the number of PICU authorizations for each plan and each county for April 2019 through March 2020 as the denominator. An asterisk (*) represents numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable.

Inpatient Facilities and SCC Authorizations:

Figure 36 displays the total requests seeking authorization for SCC services for each plan each quarter. For example, CenCal reported 108 requests in Q2 2019, 141 requests in Q3 2019, 184 requests in Q4 2019, and 142 requests for Q1 2020. CalOptima joined in July 2019 and was not in observation during Q2 2019 to report any numbers.

Figure 37 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 575 for CenCal to 3,914 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 Partnership 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 April 2019 through March 2020 as the numerator, divided by the number of Inpatient Facilities and SCC requests for authorizations for each plan and each county for April 2019 through March 2020 as the denominator. An asterisk (*) represents numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable.

Specialized or Customized DME Authorizations:

Figure 38 displays the total requests seeking authorization for DME services for each plan each quarter. For example, Partnership reported 471 requests in Q2 2019, 383 requests in Q3 2019, 313 requests in Q4 2019, and 446 requestsin Q1 2020. CenCal reported fewer than 11 requests in Q3 and Q4 2019. CalOptima joined in July 2019 and was not in observation during Q2 2019 to report any numbers. An asterisk (*) represents numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable.

Figure 39 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 82 for CenCal to 1,613 for Partnership. 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 Partnership 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 2019 through March 2020 as the numerator, divided by the number of specialized or customized DME requests for authorizations for each plan and each county for April 2019 through March 2020 as the denominator.

Care Coordination: *Figures 40-41*

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 40, the percentage of high-risk members who received an assessment ranged from 31%, which is 363 assessments for Partnership to 100%, which is 284 assessments for CenCal. This was calculated by using the number of high-risk assessments for each plan in March 2020 as the numerator, divided by the number of high-risk members in each plan in March 2020 as the denominator. Each denominator is different because each plan has a different number of high-risk members.

For Figure 41, the percentage of low-risk members who received an assessment ranged from 39%, which is 4,454 assessments for CalOptima to 74%, which is 2,009 assessments for CenCal. This was calculated by using the number of low-risk assessments for each plan in March 2020 as the numerator, divided by the number of low-risk members in each plan in March 2020 as the denominator. Each denominator is different because each plan has a different number of low-risk members.

Grievances and Appeals: *Figure 42-44*

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 42 is a trend chart displaying monthly data over 12 months. Figures 43 and 44 are cumulative charts, showing the sum of the 12 months' data as one figure.

For Figure 42, WCM appeals and grievances are trended over 12 months (April 2019 - March 2020). In April 2019, plans reported to have received 15 appeals and 38 grievances. In March 2020, plans received 7 appeals and 19 grievances.

WCM appeals are shown by plan in Figure 43. CalOptima reported to have received 18 appeals while PHC reported 59 appeals.

Figure 44 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. This was calculated by using the number of each grievance type for each plan for April 2019 through March 2020 as the numerator, divided by the total number of grievances for each plan from April 2019 through March 2020 as the denominator.

Family Advisory Committee Meetings: *Figure 45*

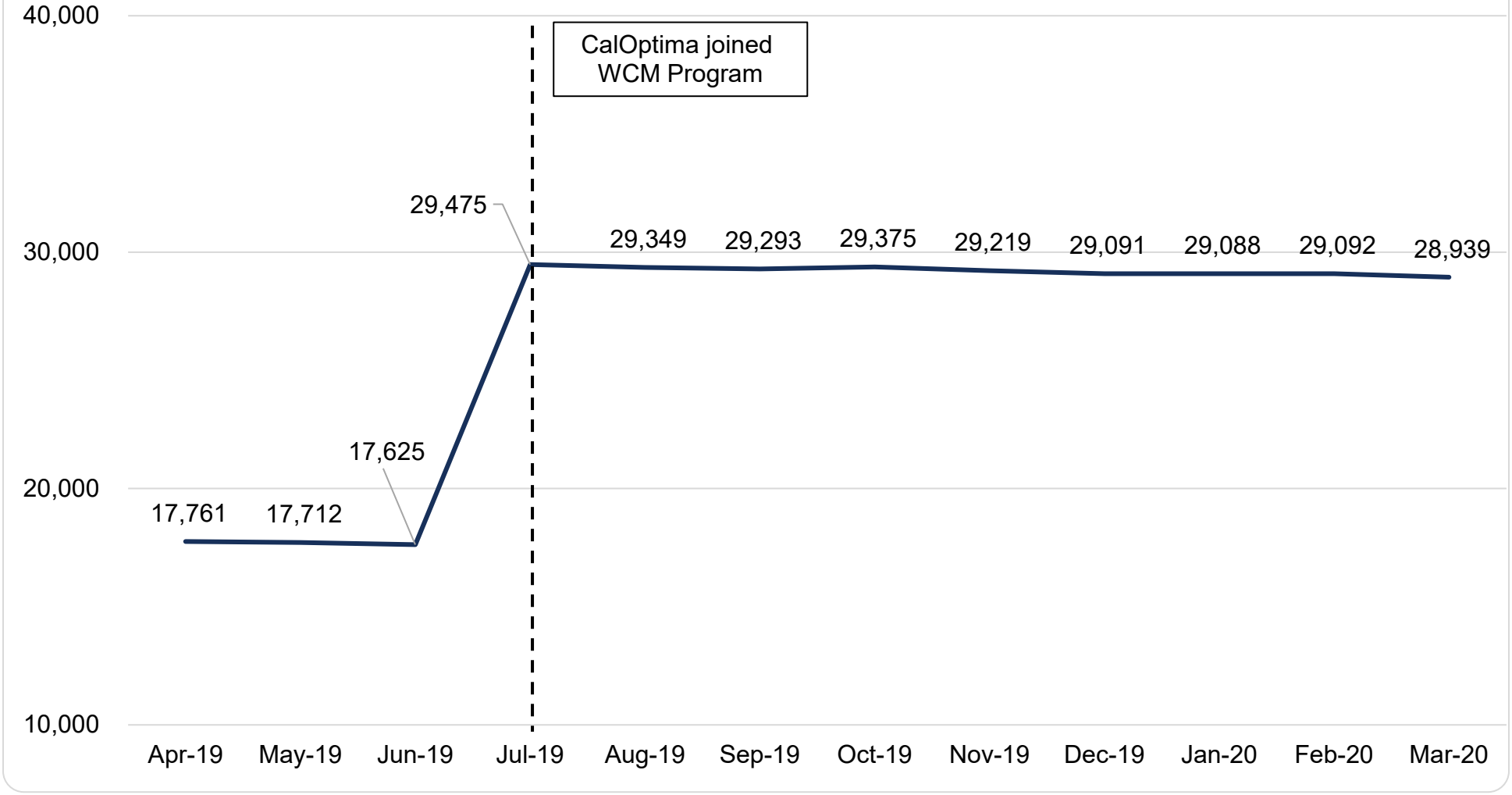
Plans must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers. Figure 45 summarizes the number of committee members, meetings held, recruitment efforts and seats to be filled for each plan over 12 months (April 2019 through March 2020).

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

Whole Child Model Enrollment and Demographics Figure 1: Breakdown of Enrollment (Apr'19 - Mar'20)

Fig 1: Whole Child Model Enrollment



Note: This report contains data from April 2019 to March 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.

Whole Child Model Enrollment and Demographics Figure 2 - 5: Breakdowns of Population as of March 2020

Fig 2: Enrollment by Race/Ethnicity

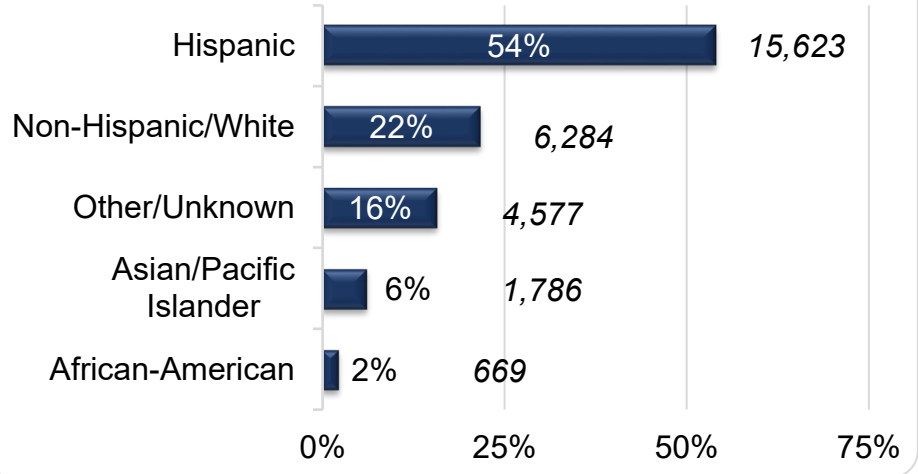


Fig 3: Enrollment by Age

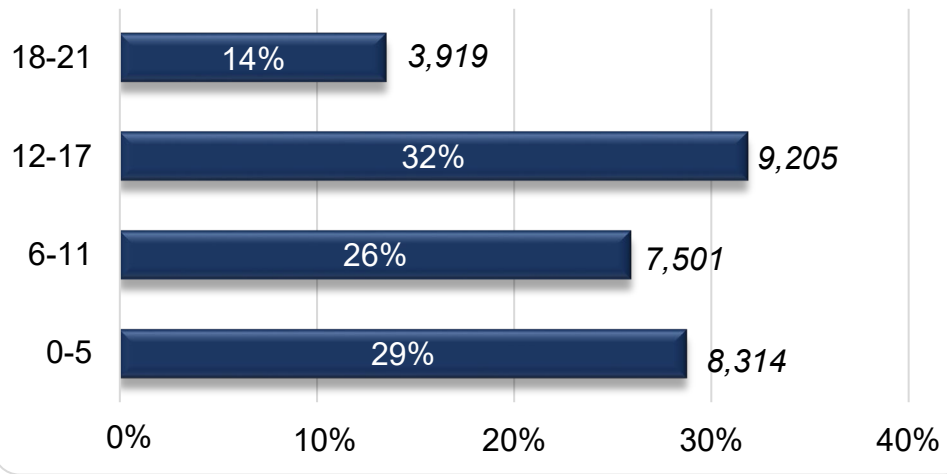


Fig 4: Enrollment by Language Spoken

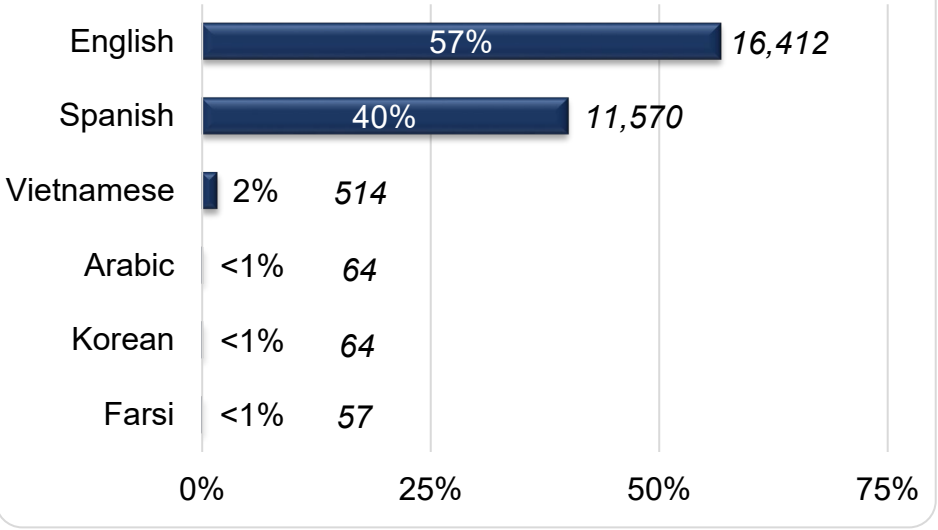
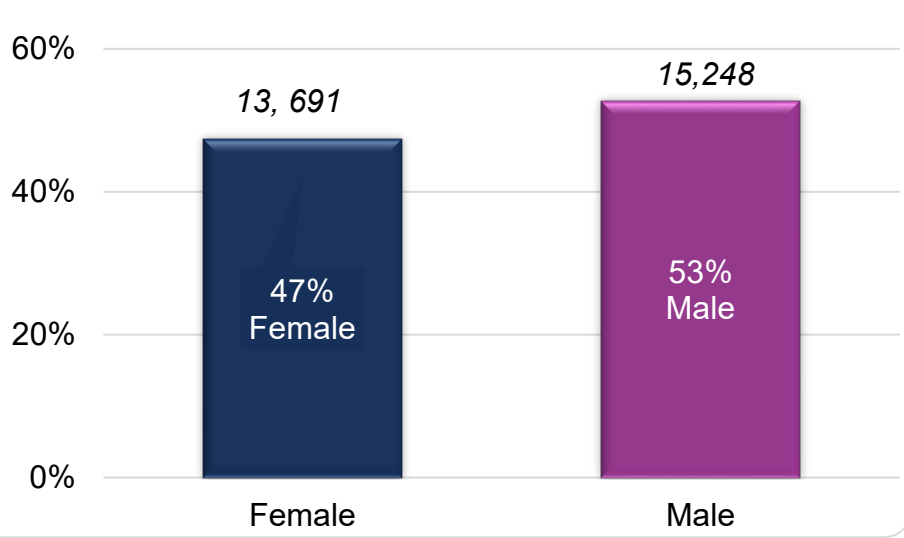
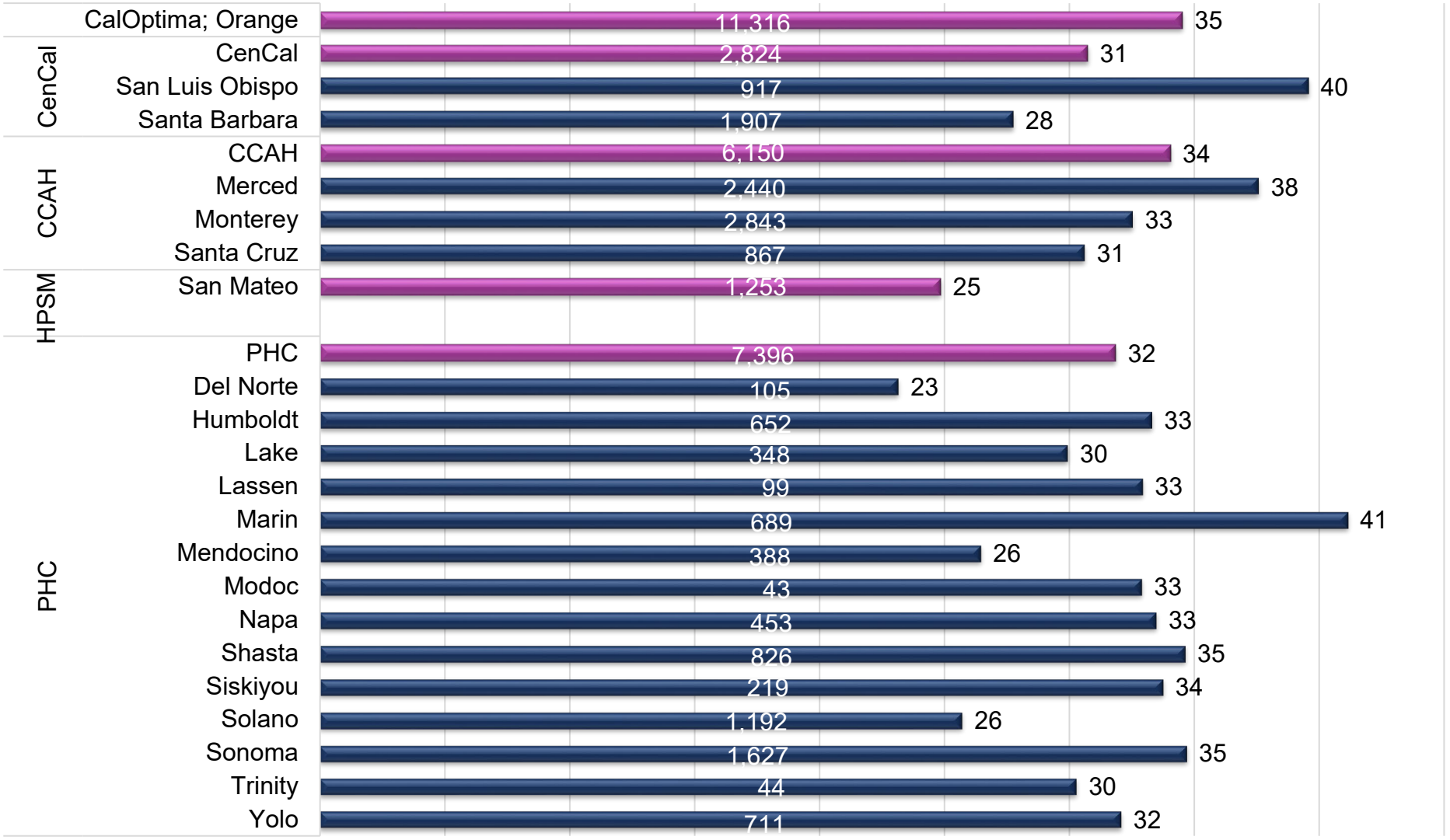


Fig 5: Enrollment by Gender



Whole Child Model Enrollment and Demographics Figure 6: Breakdowns of Population as of March 2020

Fig 6: Total WCM Program Enrollment & WCM Enrollment per 1,000 Children Enrolled in Medi-Cal, by County, by Plan



Whole Child Model Enrollment and Demographics Figure 7 - 9: Breakdowns of Emergency Room Utilization (Apr'19 - Mar'20)

Fig 7: Emergency Visits per 1,000 Member Months by Gender

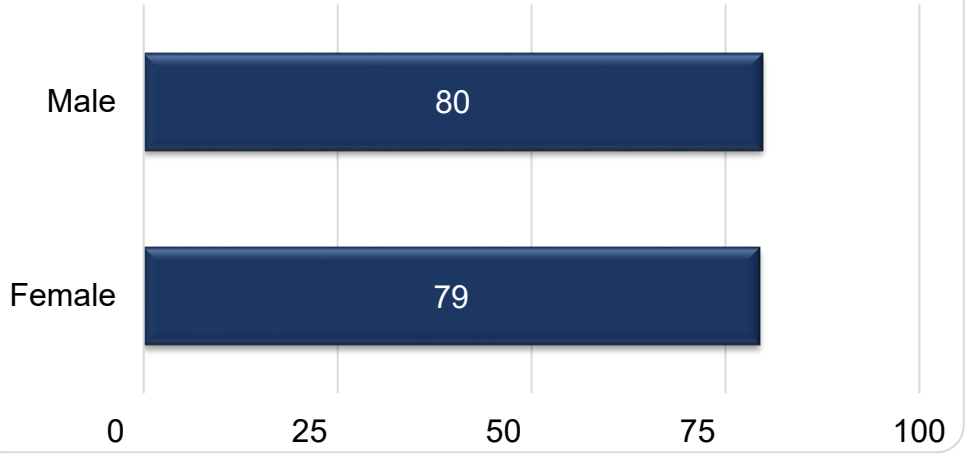


Fig 8: Emergency Visits per 1,000 Member Months by Ethnicity

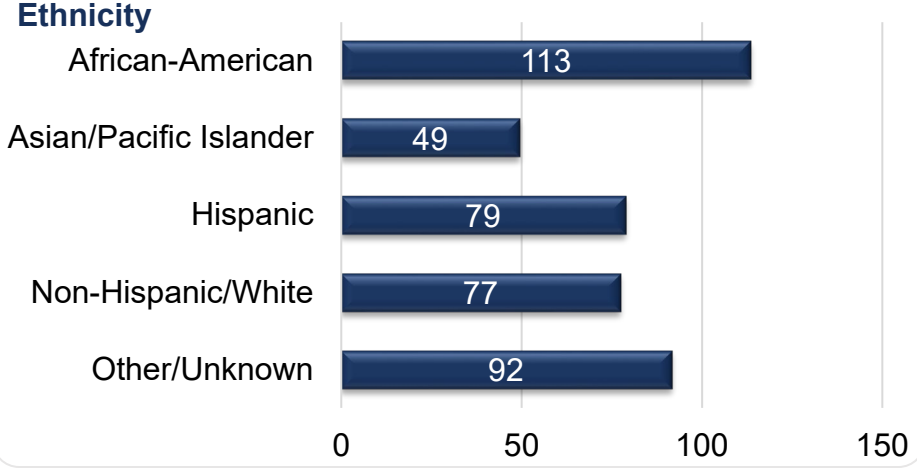
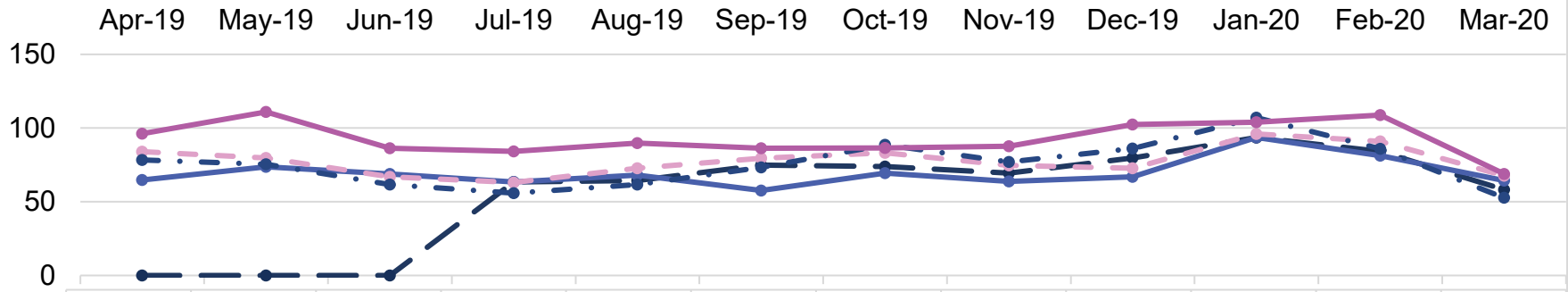


Fig 9: ER Visits per 1,000 Members by Plan, by Month



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
CalOptima	†	†	†	63	64	75	74	69	80	94	84	58
CenCal	65	74	69	63	68	58	69	64	67	94	81	64
CCAH	84	80	67	63	73	80	83	75	73	96	91	68
HPSM	78	75	62	56	62	73	89	77	86	107	86	53
PHC	96	111	86	84	90	86	86	88	102	104	109	69

† Plans who are not in the observations yet.

Whole Child Model Enrollment and Demographics Figure 10 - 12: Breakdowns of Outpatient Admissions Utilization (Apr'19 - Mar'20)

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

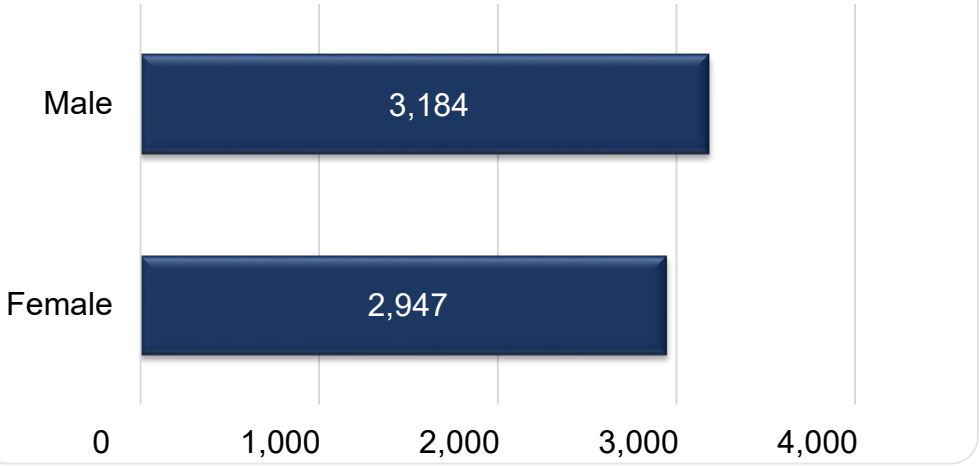


Fig 11: Outpatient Visits per 1,000 Member Months by Ethnicity

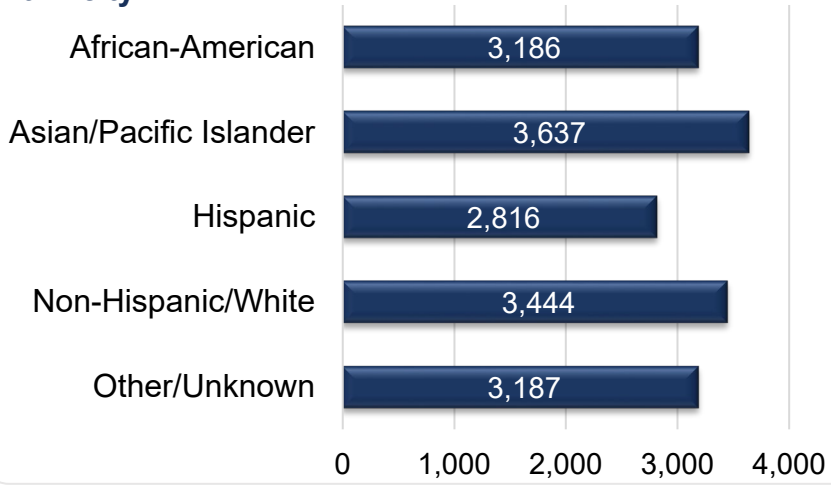
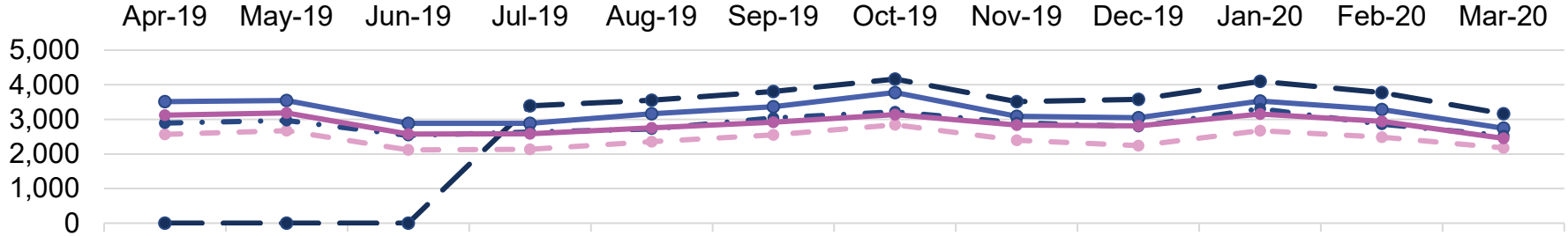


Fig 12: Outpatient Visits per 1,000 Members by Plan, by Month



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
CalOptima	†	†	†	3,386	3,552	3,807	4,164	3,511	3,579	4,097	3,770	3,159
CenCal	3,511	3,544	2,882	2,883	3,162	3,368	3,776	3,087	3,049	3,527	3,282	2,743
CCAH	2,566	2,676	2,116	2,131	2,355	2,548	2,842	2,392	2,244	2,672	2,489	2,178
HPSM	2,895	2,967	2,532	2,632	2,723	3,038	3,218	2,899	2,797	3,305	2,862	2,530
PHC	3,121	3,186	2,574	2,583	2,750	2,919	3,139	2,832	2,814	3,151	2,945	2,451

† Plans who are not in the observations yet.

Whole Child Model Enrollment and Demographics Figure 13 - 15: Breakdowns of Inpatient Visits Utilization (Apr'19 - Mar'20)

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

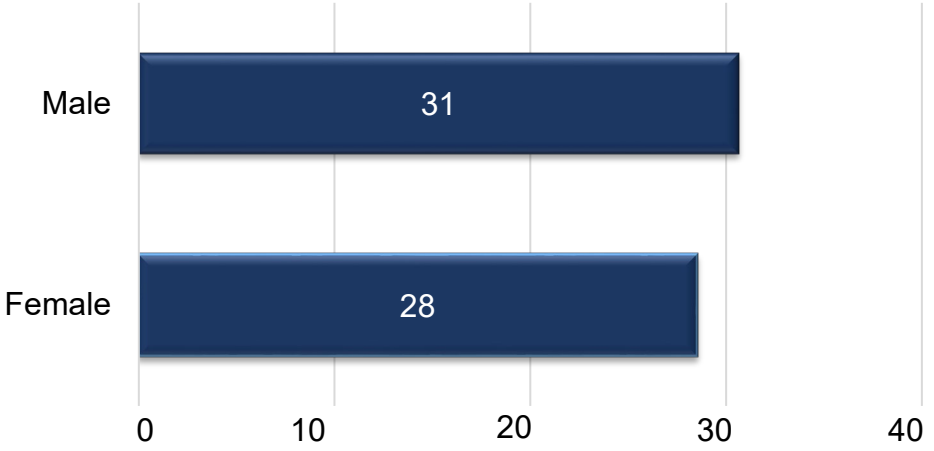


Fig 14: Inpatient Admissions per 1,000 Member Months by Ethnicity

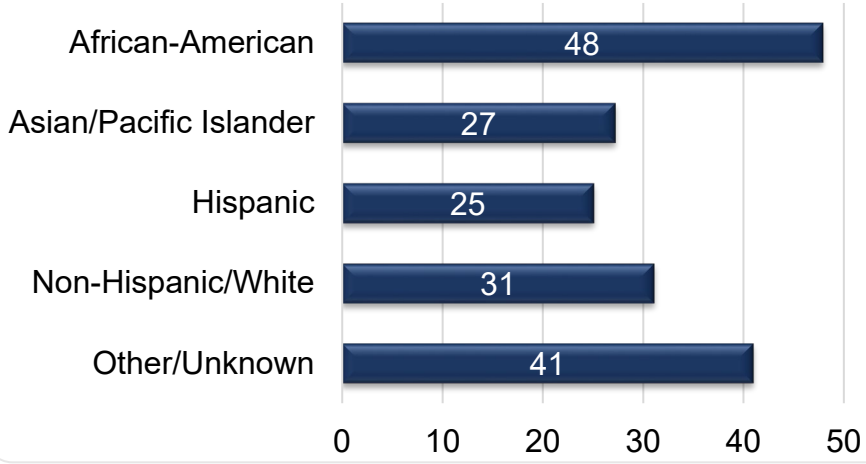
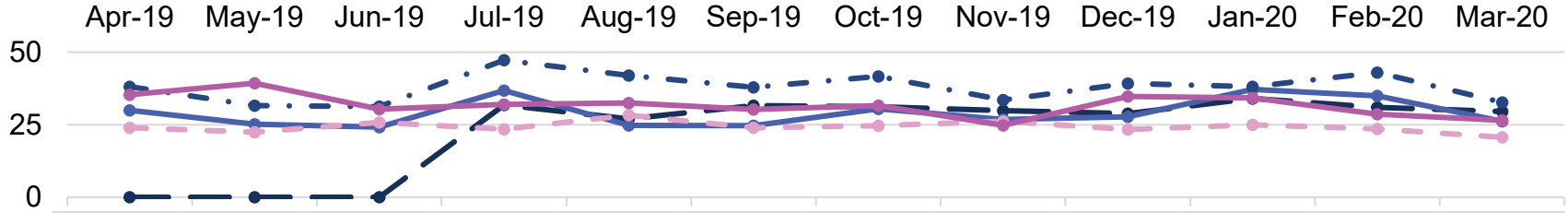


Fig 15: Inpatient Admissions per 1,000 Member Months by Plan, by Month



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
CalOptima	†	†	†	32	27	32	31	30	29	34	31	30
CenCal	30	25	24	37	25	25	31	27	28	37	35	26
CCAH	24	22	26	23	28	24	25	26	23	25	23	21
HPSM	38	32	31	47	42	38	42	33	39	38	43	33
PHC	35	39	30	32	33	30	32	25	35	34	29	27

† Plans who are not in the observations yet.

Whole Child Model Enrollment and Demographics Figure 16 - 18: Breakdowns of Prescriptions Utilization (Apr'19 - Mar'20)

Fig 16: Prescriptions per 1,000 Member Months by Gender

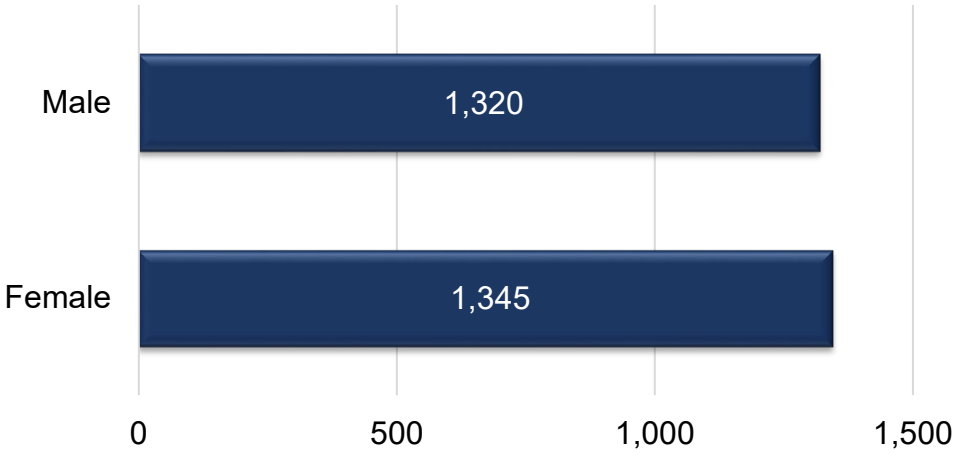


Fig 17: Prescriptions per 1,000 Member Months by Ethnicity

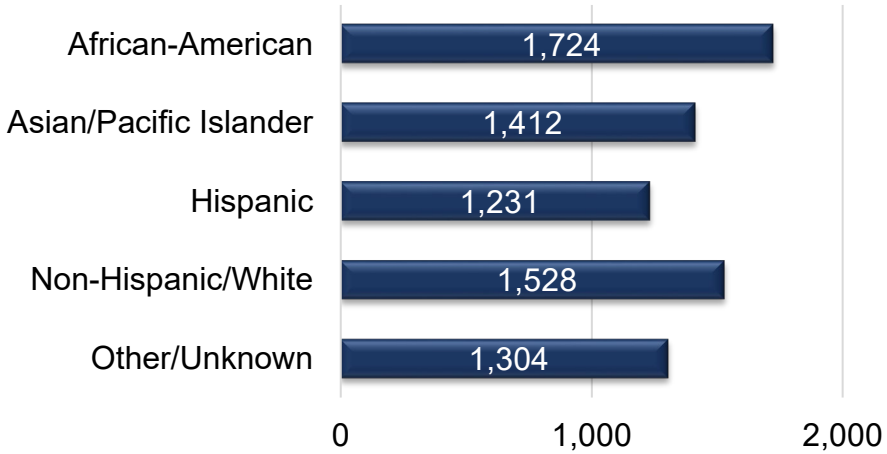
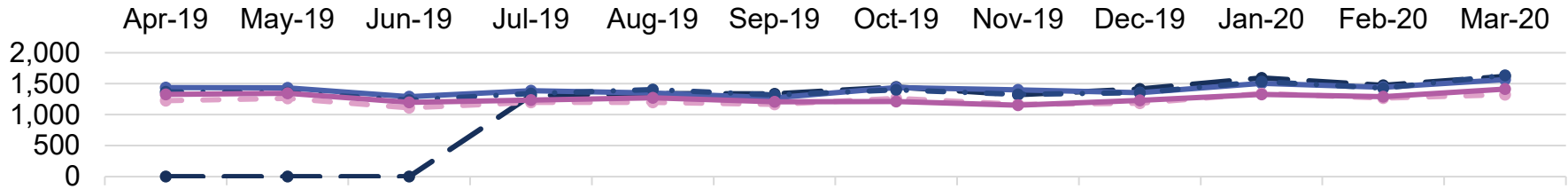


Fig 18: Prescription per 1,000 Members by Plan, by Month



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
CalOptima	†	†	†	1,308	1,342	1,336	1,447	1,325	1,413	1,595	1,475	1,619
CenCal	1,438	1,433	1,292	1,386	1,350	1,272	1,439	1,401	1,354	1,506	1,443	1,566
CCAH	1,227	1,264	1,111	1,198	1,200	1,168	1,263	1,169	1,184	1,343	1,266	1,323
HPSM	1,370	1,355	1,236	1,339	1,405	1,320	1,400	1,329	1,353	1,536	1,428	1,636
PHC	1,327	1,346	1,197	1,235	1,270	1,209	1,213	1,153	1,230	1,328	1,293	1,413

† Plans who are not in the observations yet.

Whole Child Model Enrollment and Demographics Figure 19 - 21: Breakdowns of Non-specialty Mental Health Visits Utilization (Apr'19 - Mar'20)

Fig 19: Non-specialty Mental Health Visits per 1,000 Member Months by Gender

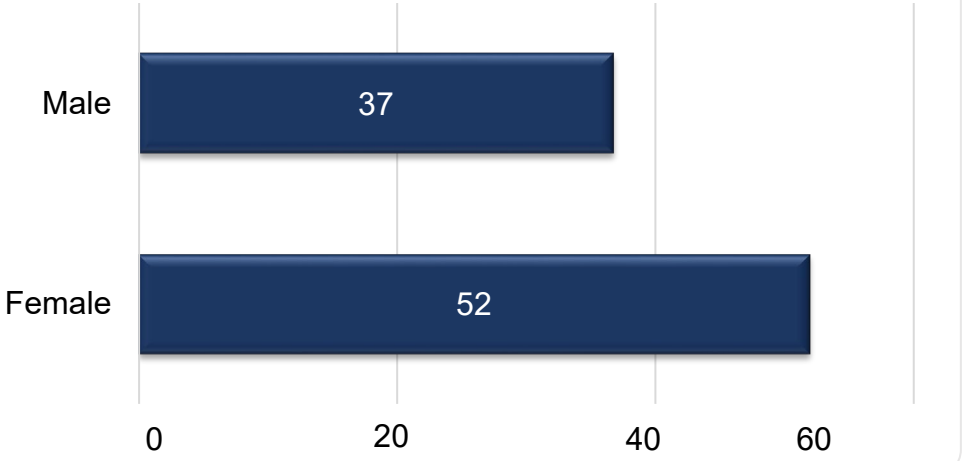


Fig 20: Non-specialty Mental Health Visits per 1,000 Member Months by Ethnicity

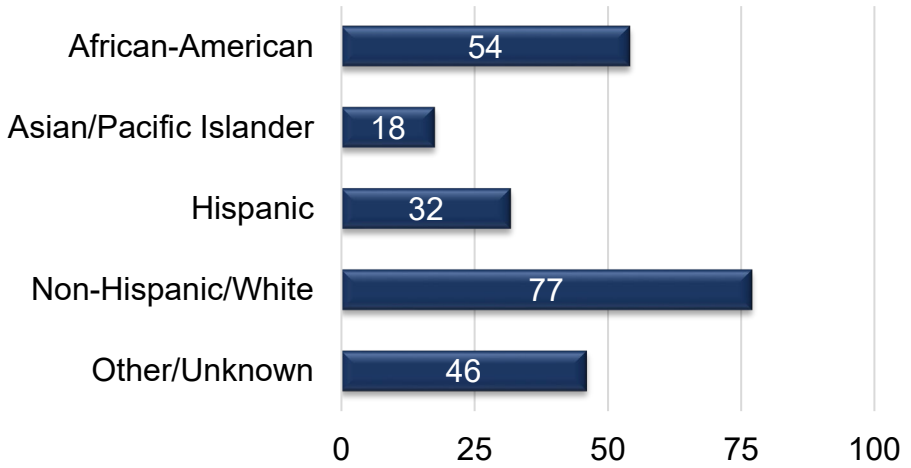
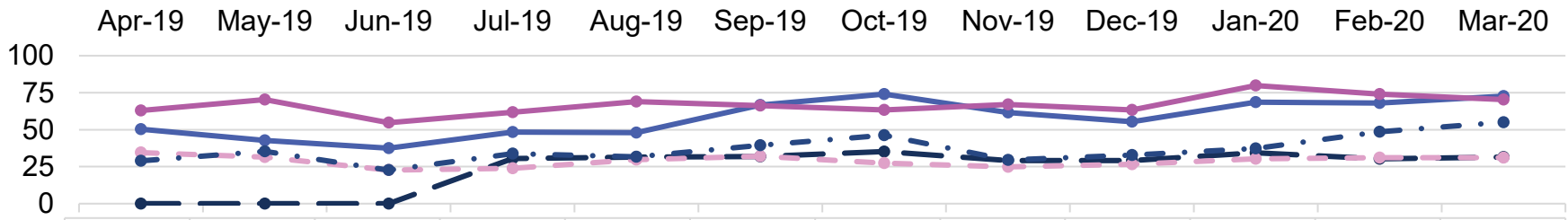


Fig 21: Non-specialty Mental Health Visits per 1,000 Member Months by Plan, by Month



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
CalOptima	†	†	†	30	31	32	35	29	29	34	30	31
CenCal	50	43	38	48	48	67	74	62	55	69	68	73
CCAH	35	32	23	24	30	32	27	25	27	30	31	31
HPSM	29	35	23	34	32	39	46	30	33	37	49	55
PHC	63	70	55	62	69	66	63	67	63	80	74	70

† Plans who are not in the observations yet.

Whole Child Model Enrollment and Demographics Figure 22 - 24: Breakdowns of Emergency Room Visits with an Inpatient Admission Utilization (Apr'19 - Mar'20)

Fig 22: Emergency Room Visits with an Inpatient Admission per 1,000 Member Months by Gender

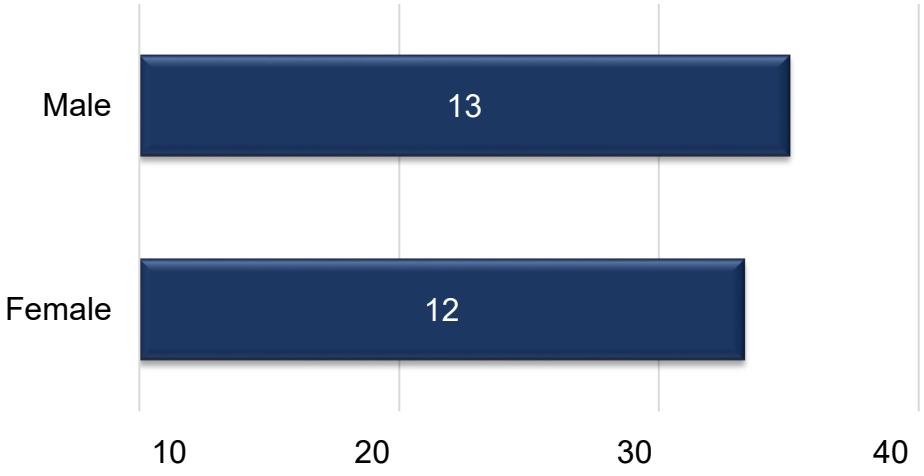


Fig 23: Emergency Room Visits with an Inpatient Admission per 1,000 Member Months by Ethnicity

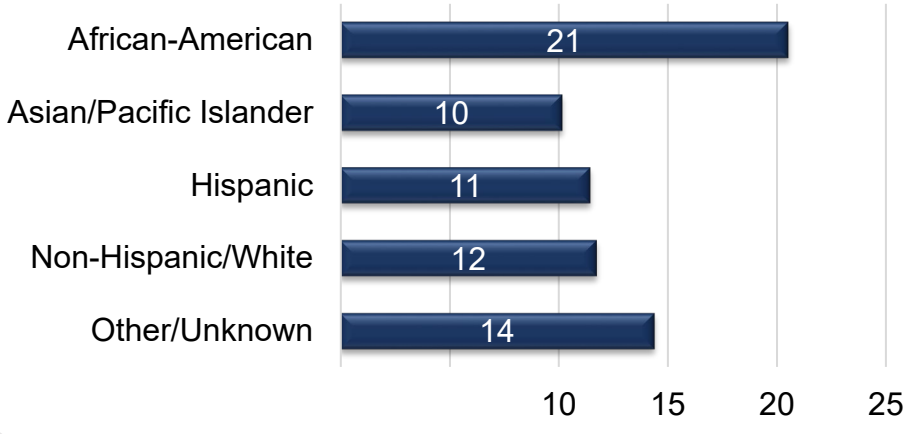
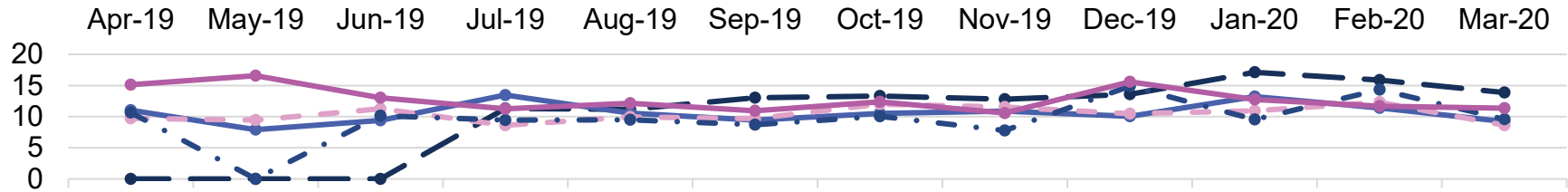


Fig 24: Emergency Room Visits with an Inpatient Admission per 1,000 Member Months by Plan, by Month



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

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

†Plans who are not in the observations yet.

Whole Child Model Figure 25: Continuity of Care (COC) Requests Upon Joining the Program, by Plan, by Month - Month 10 through Month 21

	Month 10	Month 11	Month 12	Month 13	Month 14	Month 15	Month 16	Month 17	Month 18	Month 19	Month 20	Month 21
CalOptima	33	11	16	29	14	23	*	*	*	*	*	*
CenCal	55	45	49	52	37	59	35	47	49	0	0	35
CCAH	39	20	15	22	21	18	50	72	26	14	21	34
HPSM	*	*	*	*	*	*	0	0	*	0	0	0
PHC	20	48	*	*	0	*	0	0	0	0	0	0

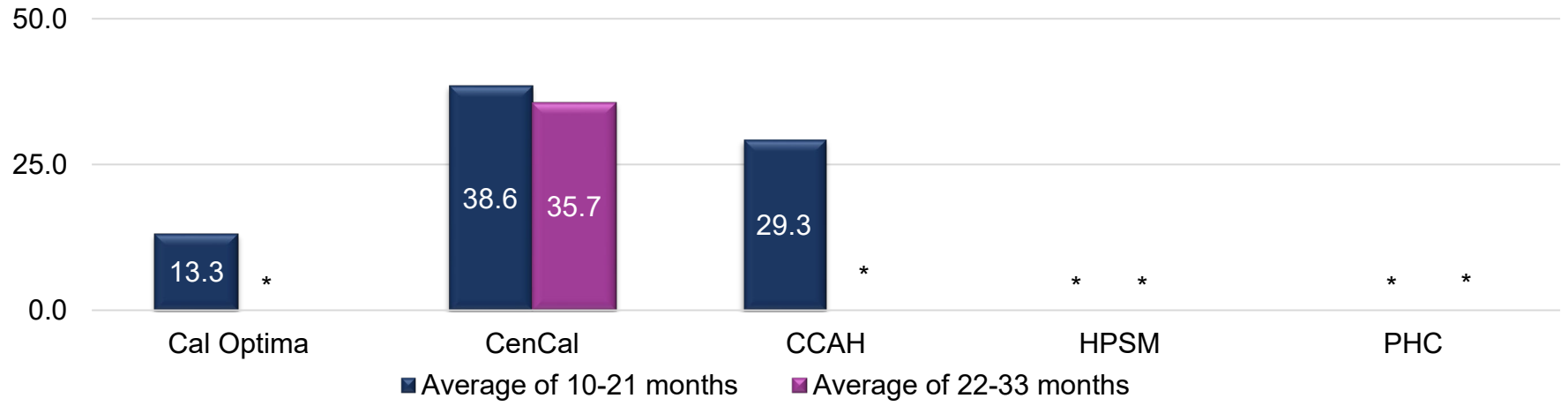
Whole Child Model Figure 26: Continuity of Care (COC) Requests Upon Joining the Program, by Plan, by Month - Month 22 through Month 33

	Month 22	Month 23	Month 24	Month 25	Month 26	Month 27	Month 28	Month 29	Month 30	Month 31	Month 32	Month 33
CalOptima	*	*	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡
CenCal	50	31	27	29	40	37	45	23	32	44	31	39
CCAH	*	*	*	0	*	*	*	*	*	0	*	*
HPSM	0	*	*	*	0	0	0	*	*	*	*	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.*
‡ Plans who have not reached this month in their observation yet.

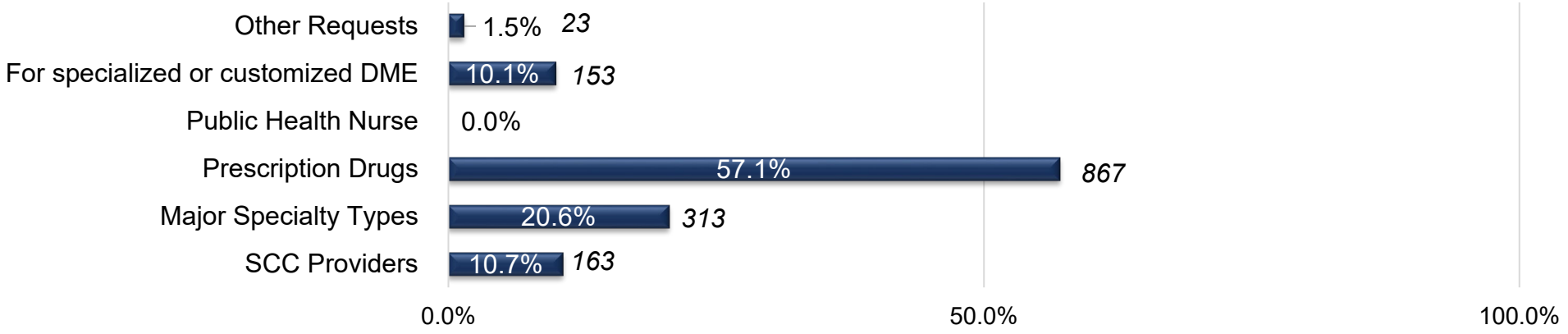
Whole Child Model Figure 27: Continuity of Care (COC) - Requests, by Plan

Fig 27: Plan Average COC Request Upon Joining the Program, Month 10 - Month 21 Vs Month 22 - Month 33



Whole Child Model Figure 28: Continuity of Care (COC) - Requests Categories (Apr'19 - Mar'20)

Fig 28: COC Requests - Categories



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

Whole Child Model Figures 29 & 30: Continuity of Care (COC) - Denials Reasons (Apr'19 - Mar'20)

Fig 29: Top 5 COC Denial Reasons (Not Required by APL)

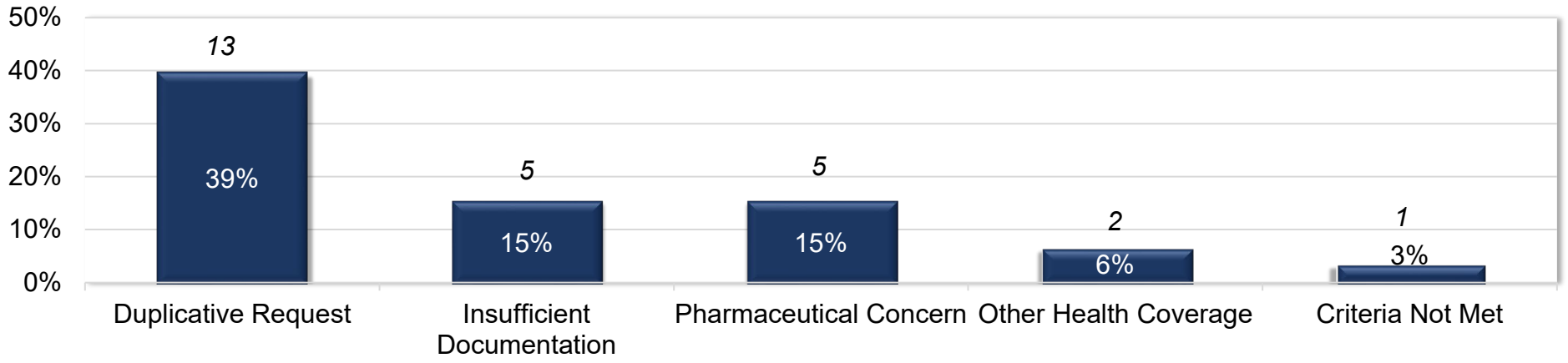
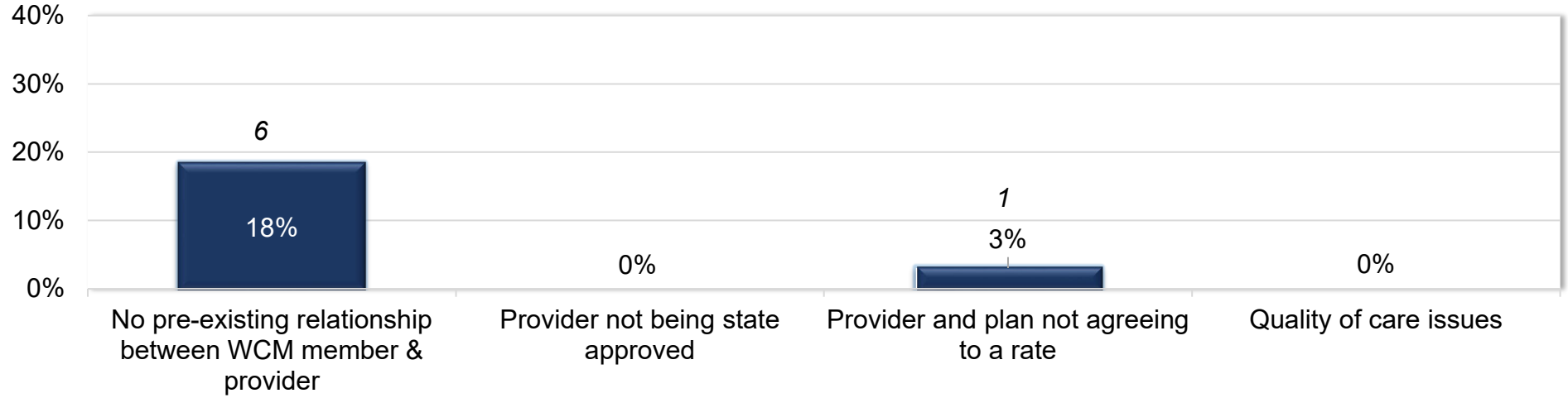


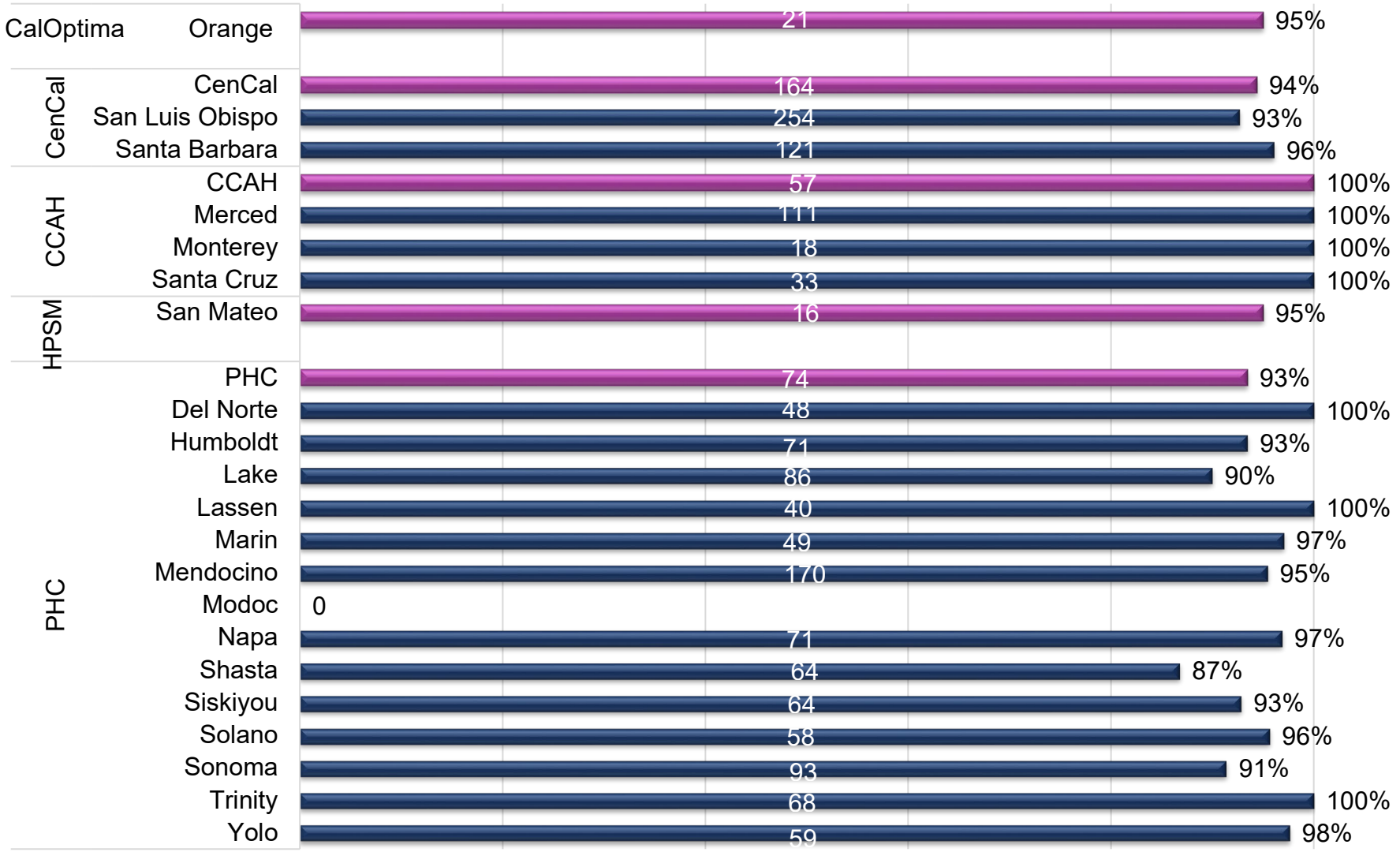
Fig 30: COC Denial Reasons (Required by APL)



Note: Please see page 8 for detailed information on why Figures 29 & 30 do not add up to 100%.

Whole Child Model Figure 31: Continuity of Care (COC) Requests & Approvals per 1,000 Members (Apr'19 - Mar'20)

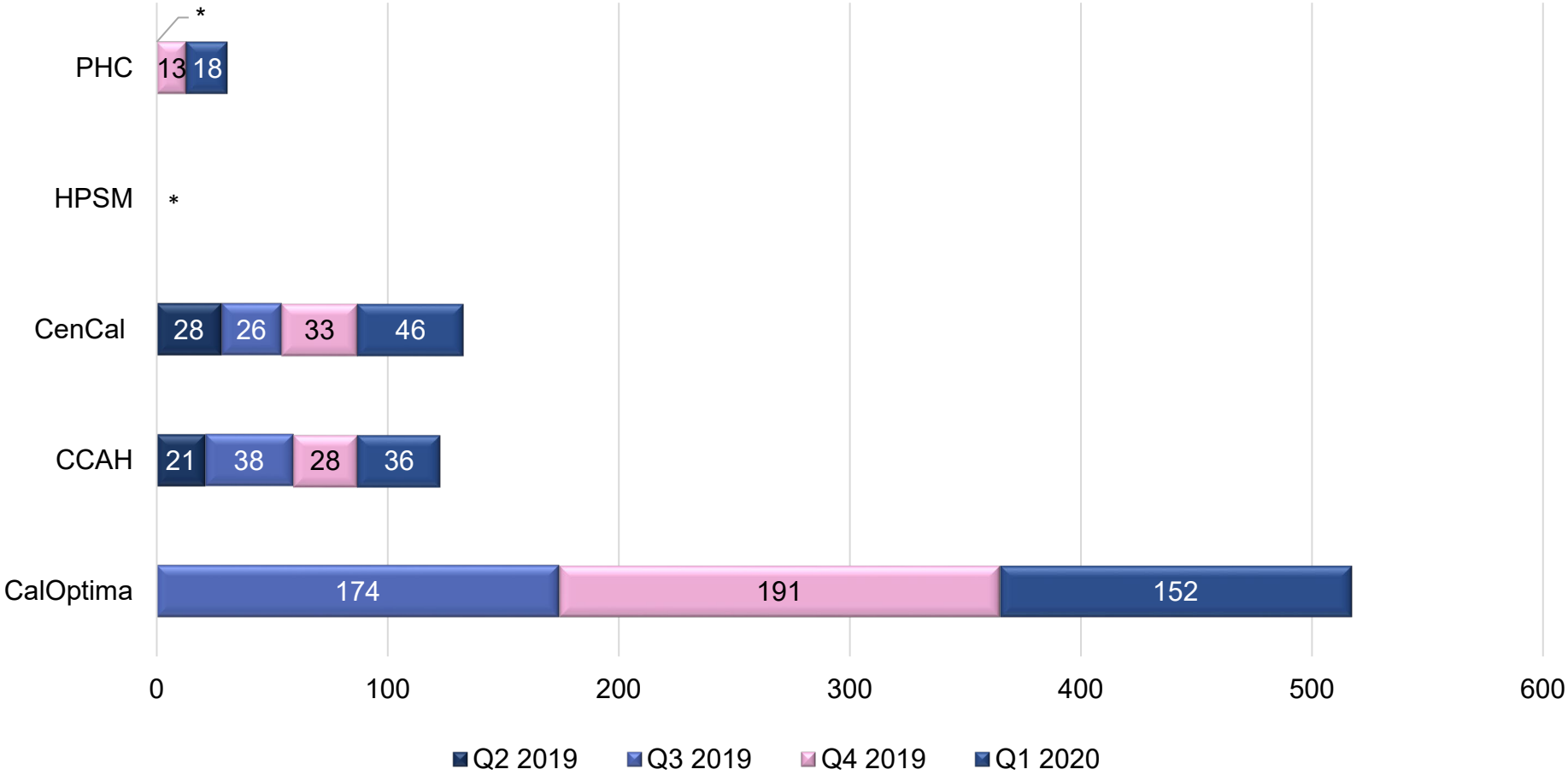
Fig 31: COC Request per 1,000 Members & Percentage Approval by Plan, by County



Note: This report contains data from April 2019 to March 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.

Whole Child Model Figure 32: Case Management NICU Authorizations & Approvals (Apr'19 - Mar'20)

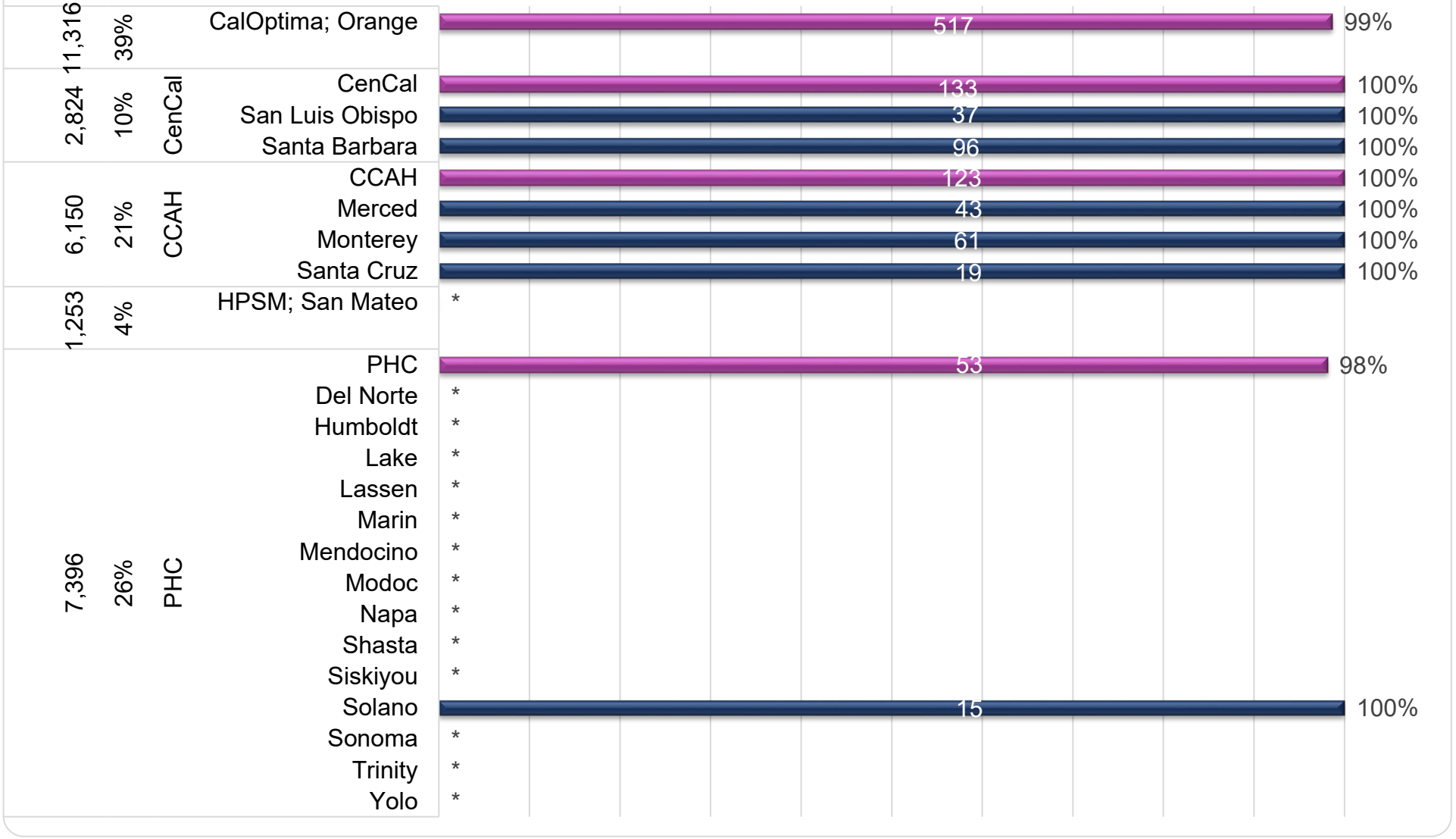
Fig 32: Total Requests for NICU Authorizations by Plan, by Quarter



Note: This report contains data from April 2019 to March 2020. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019.
CalOptima joined in July 2019 and was not in observation during Q2 2019 to report any numbers.
** PHC for Q2 and Q3 2019 and HPSM for all four quarter had counts of items <11 and are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

Whole Child Model Figure 33: Case Management NICU Authorizations & Approvals (Apr'19 - Mar'20)

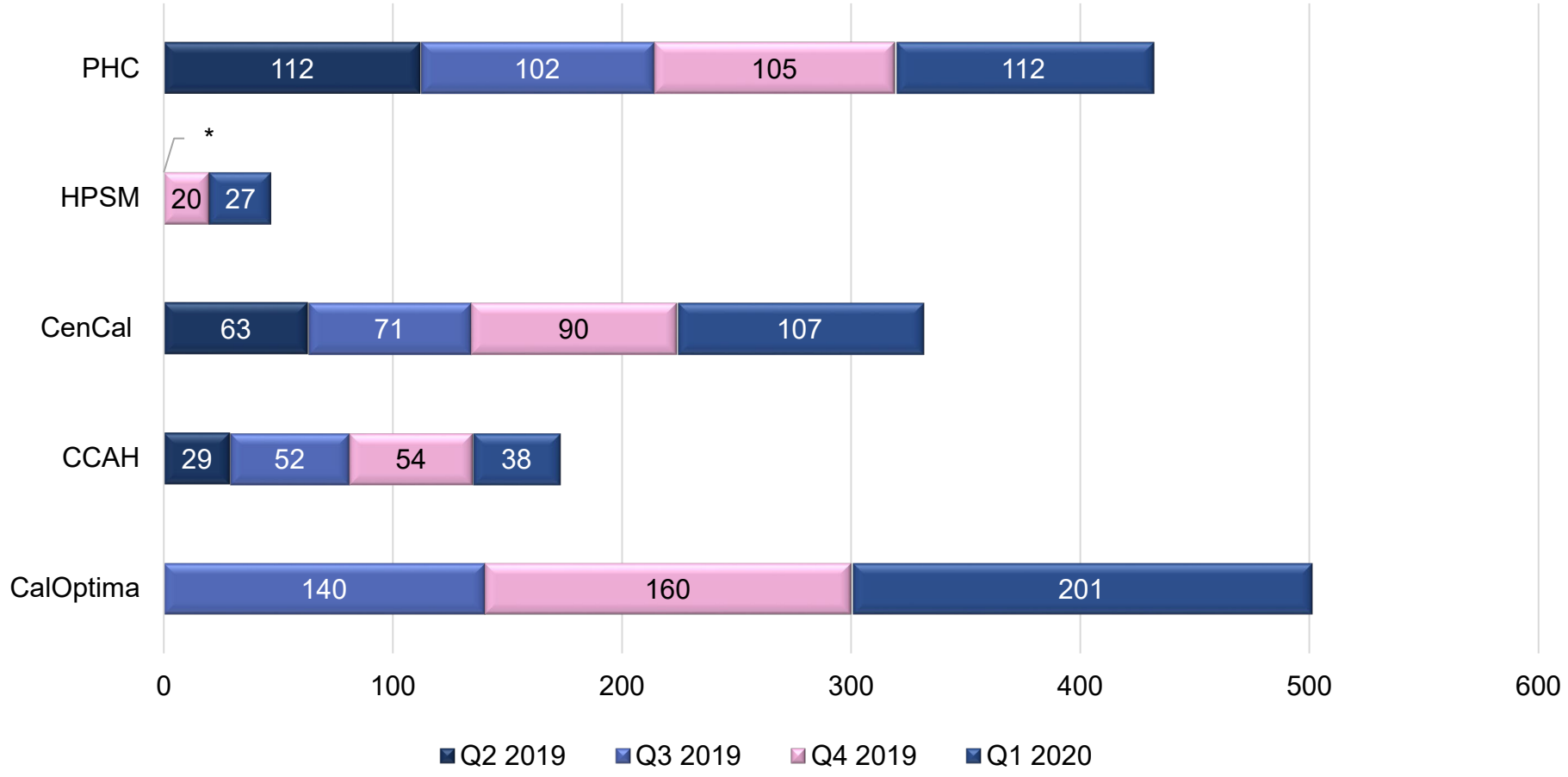
Fig 33: Total Requests for NICU Authorizations & Percentage Approved by Plan, by County



Note: This report contains data from April 2019 to March 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.*

Whole Child Model Figure 34: Case Management PICU Authorizations & Approvals (Apr'19 - Mar'20)

Fig 34: Total Requests for PICU Authorizations by Plan, by Quarter



Note: This report contains data from April 2019 to March 2020. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019.
CalOptima joined in July 2019 and was not in observation during Q2 2019 to report any numbers.
**HPSM for Q2 and Q3 2019 had counts of items <11 and are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

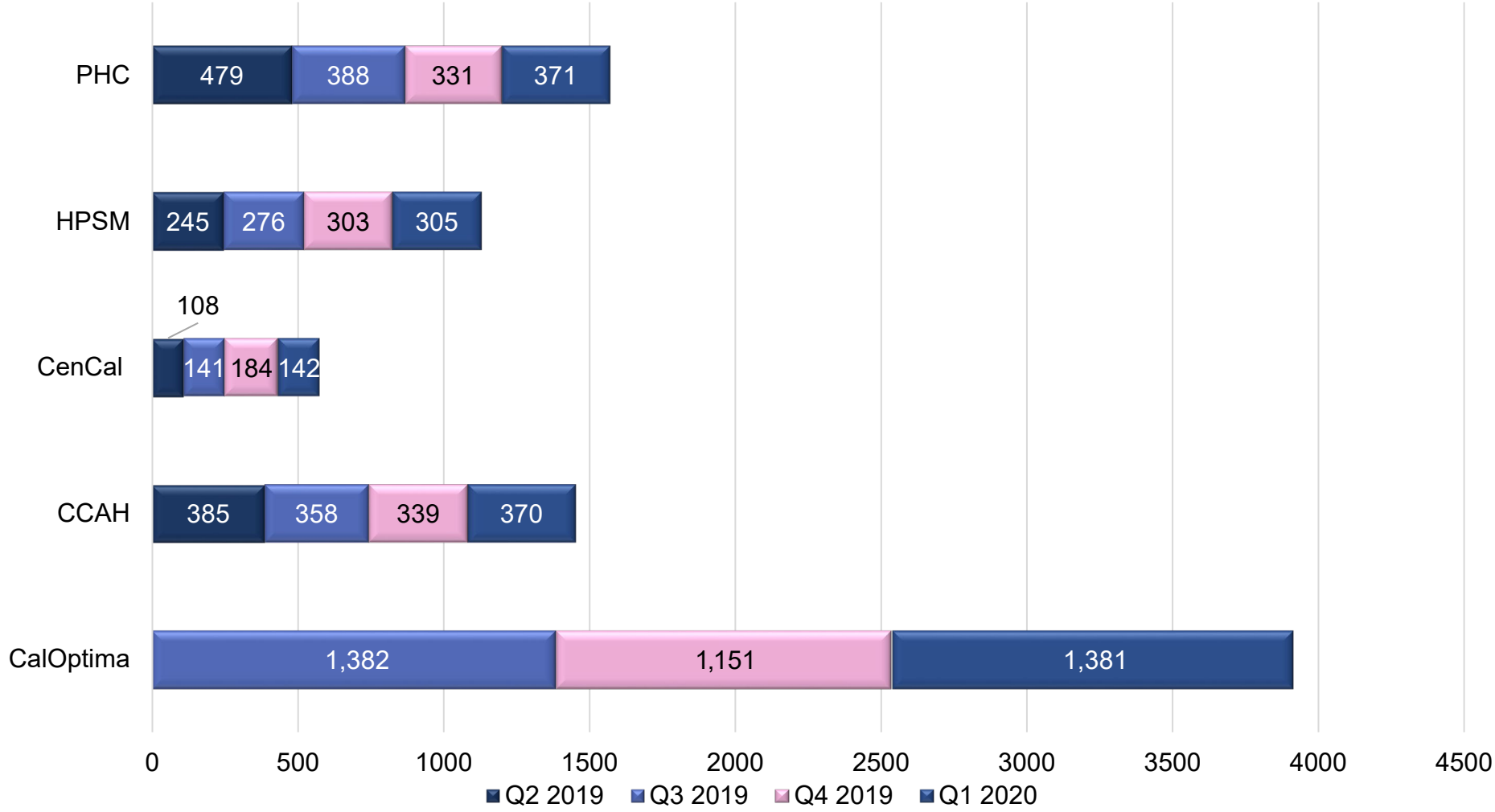
Whole Child Model Figure 35: Case Management PICU Authorizations & Approvals (Apr'19 - Mar'20)

Fig 35: Total Requests for PICU Authorizations & Percentage Approved by Plan, by County

Note: This report contains data from April 2019 to March 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.*

Whole Child Model Figure 36: Case Management Inpatient Facilities and Special Care Centers (SCC) Authorizations & Approvals (Apr'19 - Mar'20)

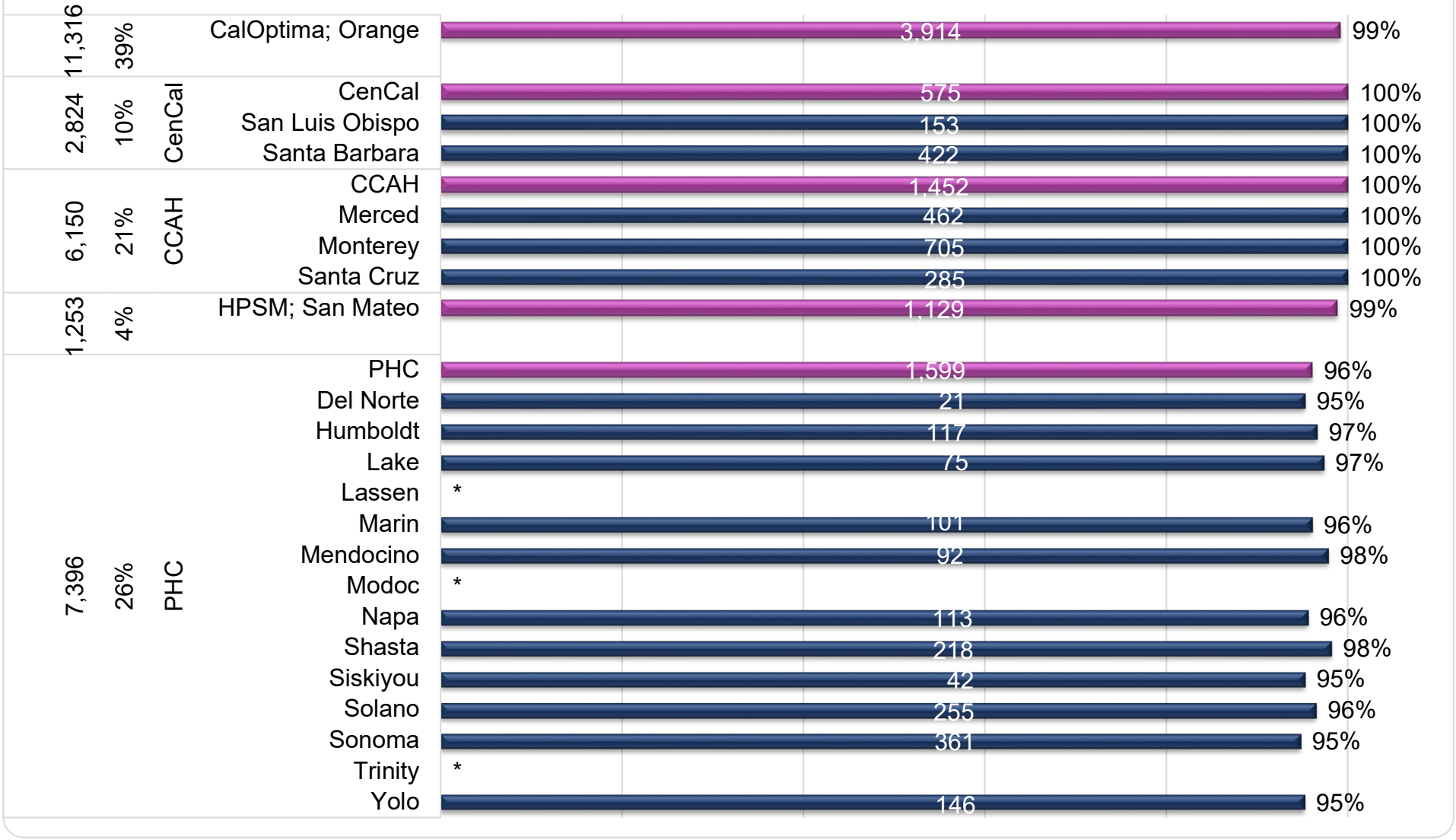
Fig 36: Total Requests for Inpatient Facilities and Special Care Centers (SCC) Authorizations by Plan, by Quarter



Note: *This report contains data from April 2019 to March 2020. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019.*
CalOptima joined in July 2019 and was not in observation during Q2 2019 to report any numbers.

Whole Child Model Figure 37: Case Management Inpatient Facilities and Special Care Centers (SCC) Authorizations & Approvals (Apr'19 - Mar'20)

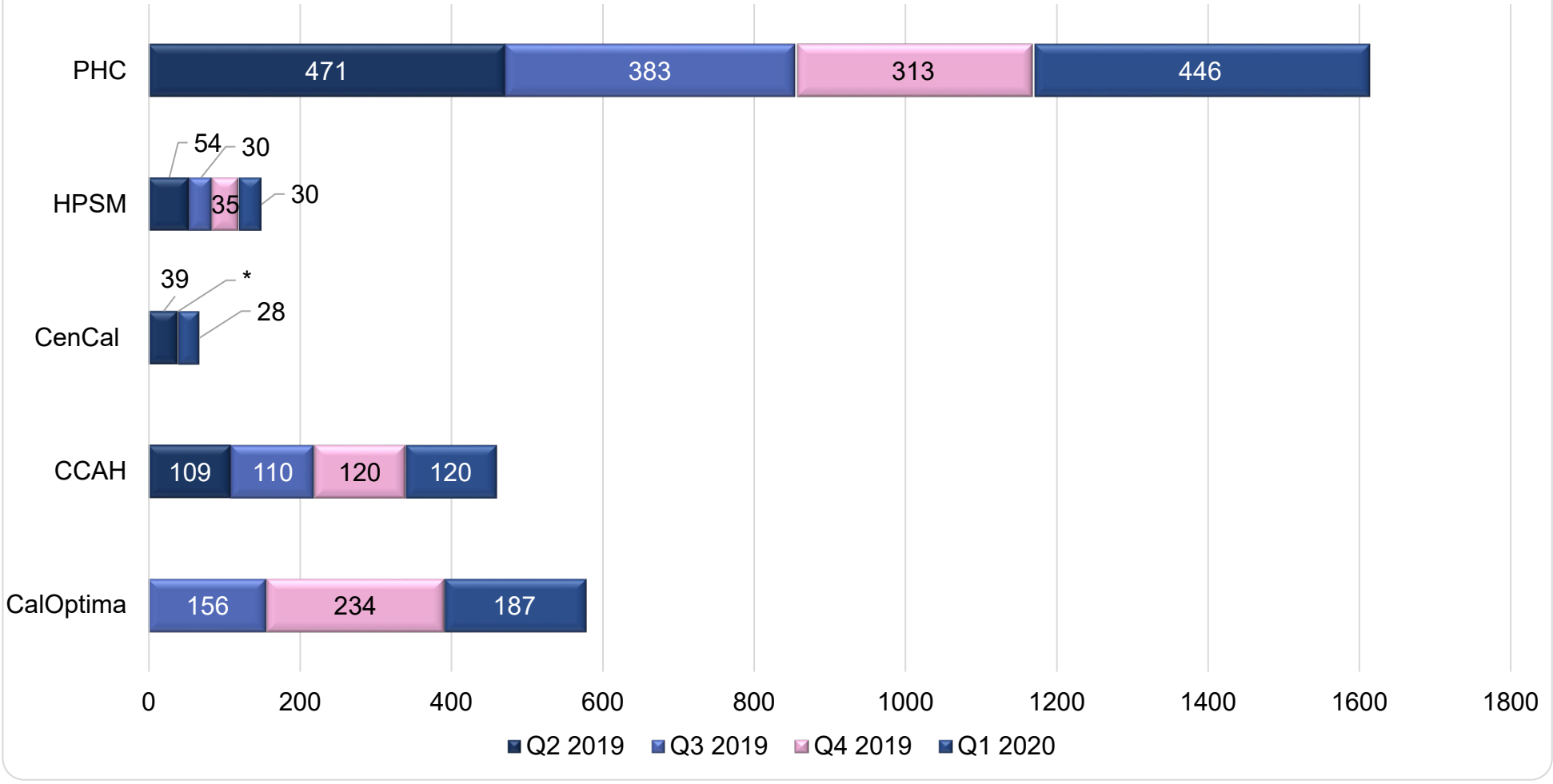
Fig 37: Total Requests for Inpatient Facilities and SCC Authorizations & Percentage Approved by Plan, by County



Note: This report contains data from April 2019 to March 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.*

Whole Child Model Figure 38: Case Management Specialized or Customized DME Authorizations & Approvals (Apr'19 - Mar'20)

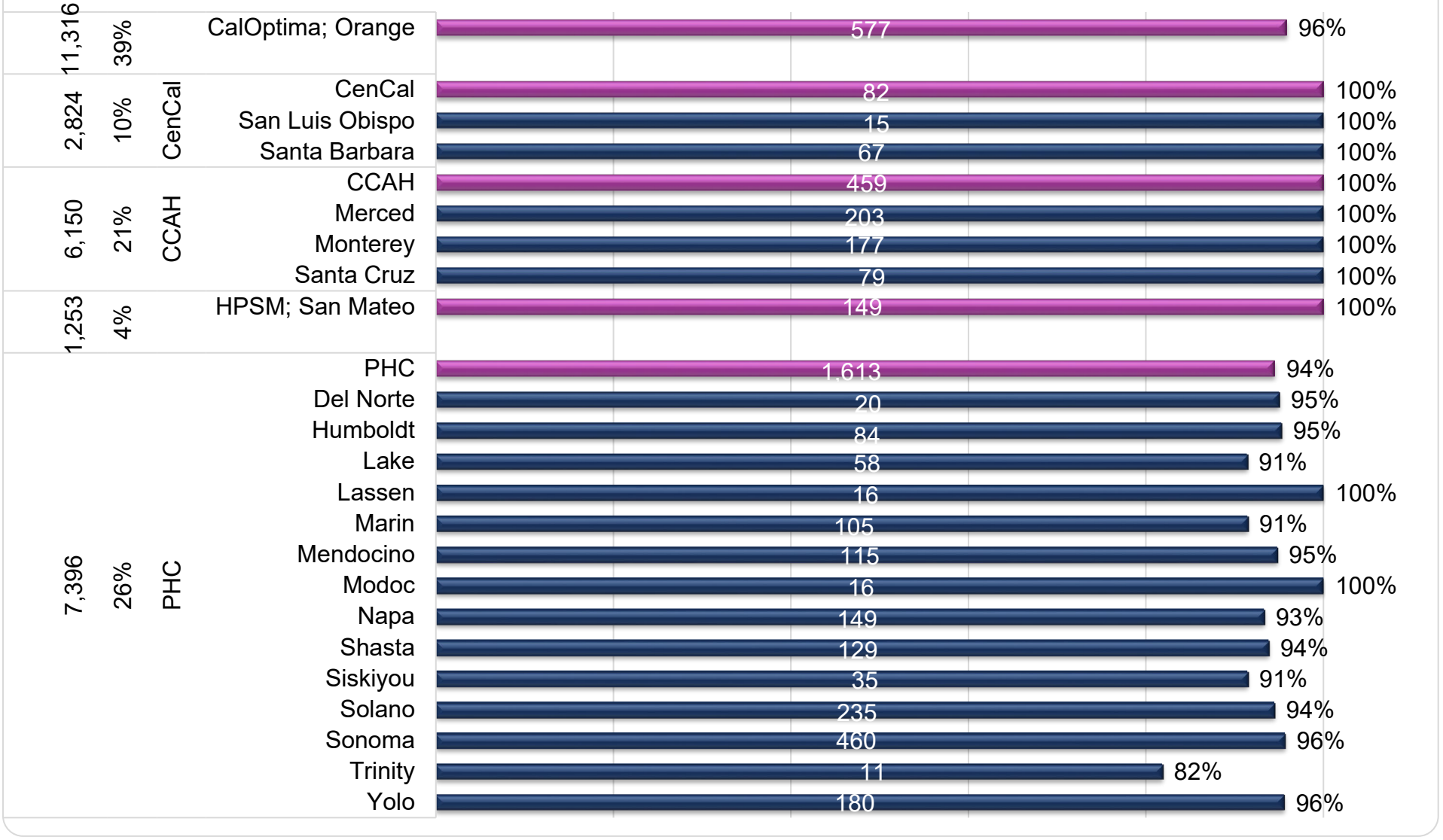
Fig 38: Total Requests for DME Authorizations by Plan, by Quarter



Note: This report contains data from April 2019 to March 2020. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019.
CalOptima joined in July 2019 and was not in observation during Q2 2019 to report any numbers.
**CenCal for Q3 and Q4 2019 had counts of items <11 and are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

Whole Child Model Figure 39: Case Management Specialized or Customized DME Authorizations & Approvals (Apr'19 - Mar'20)

Fig 39: Total Requests for Specialized or Customized DME Authorizations & Percentage Approved by Plan, by County



Note: This report contains data from April 2019 to March 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.

Whole Child Model Figures 40 & 41: Care Coordination High-Risk and Low-Risk Assessments - Mar'20

Fig 40: Percentage of High Risk Members who Received an Assessment, by Plan

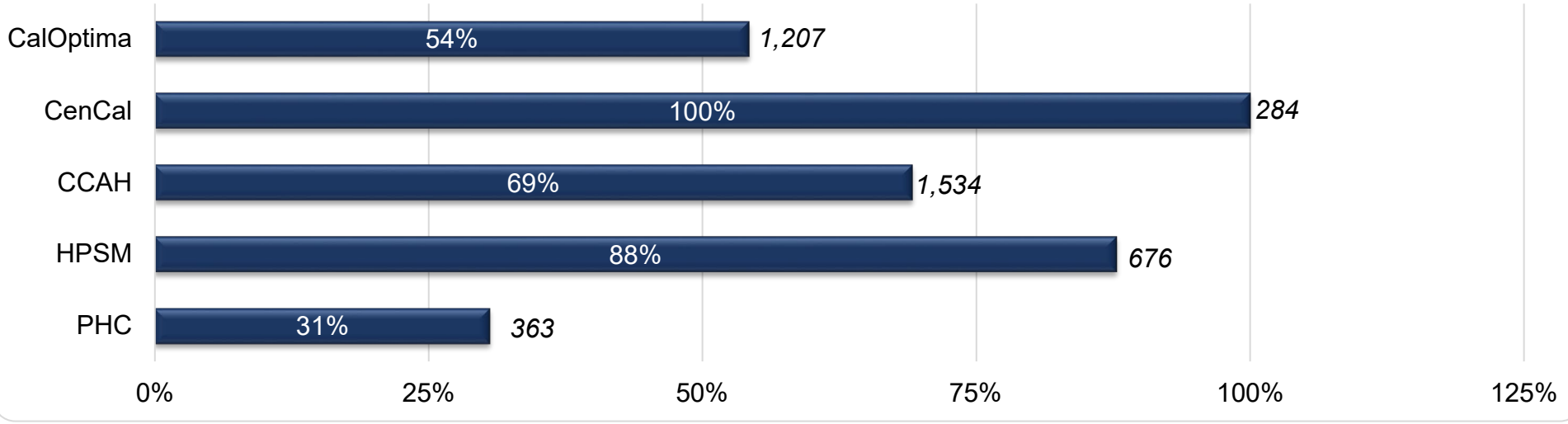
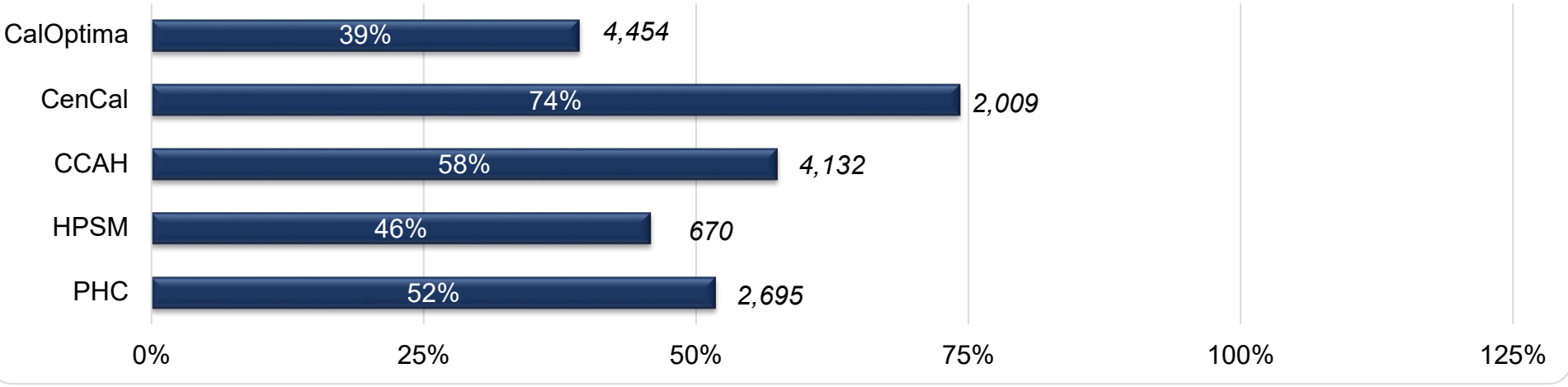


Fig 41: Percentage of Low Risk Members who Received an Assessment, by Plan



Whole Child Model Figure 42 & 43: Grievances & Appeals (Apr'19 - Mar'20)

Fig 42: WCM Grievances and Appeals

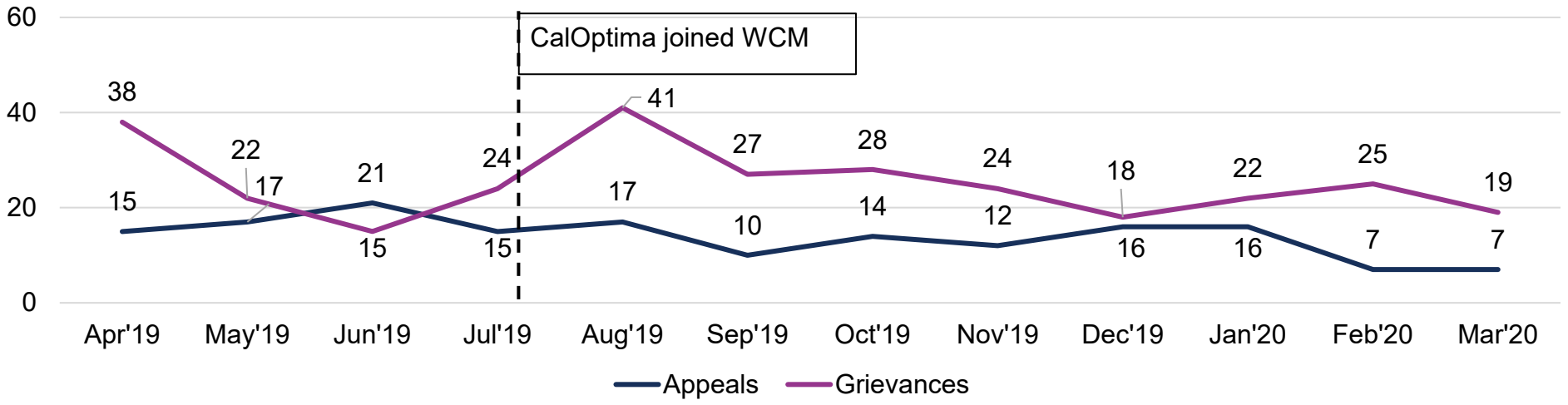
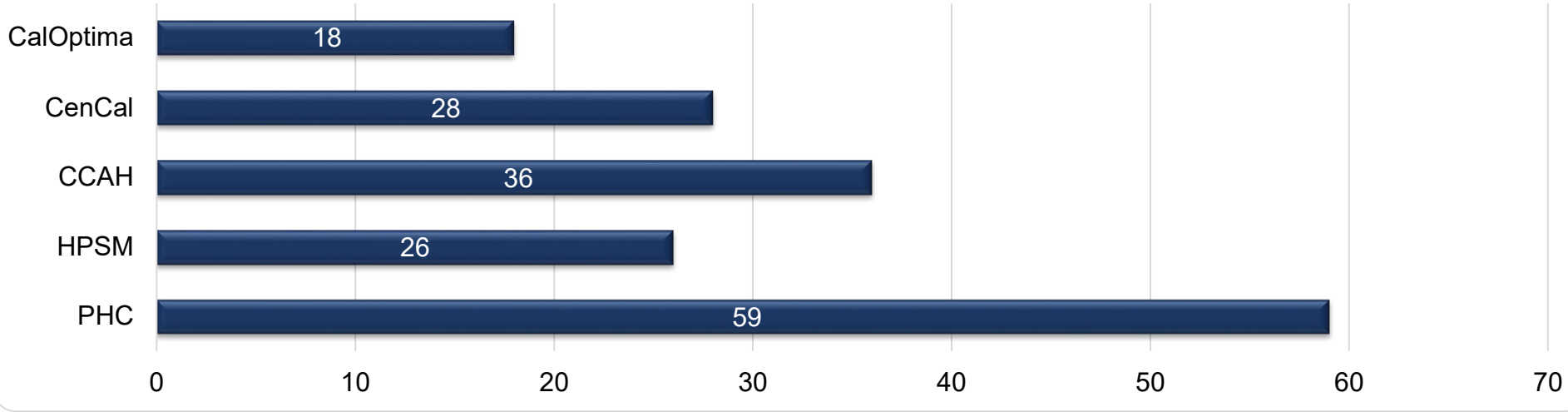
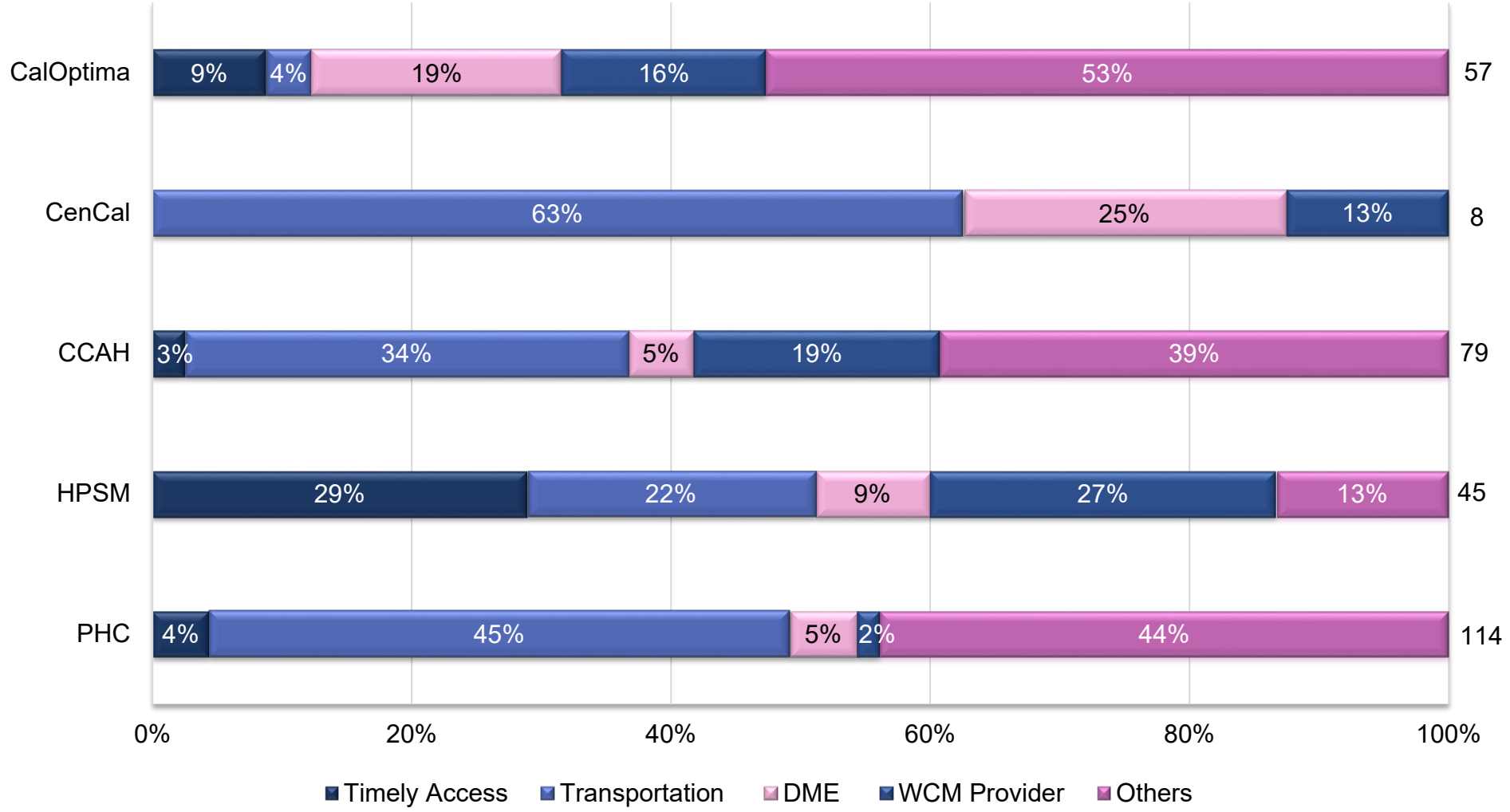


Fig 43: WCM Appeals, by Plan



Whole Child Model Figure 44: Grievances - Breakdown by Categories, by Plan (Apr'19 - Mar'20)

Fig 44: Grievances Categories, by Plan



Whole Child Model Figure 45: Family Advisory Committee Meetings Table (Apr'19 - Mar'20)

Plan Name	Number of Committee Members	Number of Meetings Held Apr'19 - Mar'20	Recruitment Efforts	Seats to be Filled
CalOptima	9	6	The WCM FAC lost a family member due to their child turning 21 in November 2019. The committee picked up an additional family member and a consumer advocate during the course of the 2019 and concluded the year with 5 family members and 2 community representatives. Staff continues 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	12	2019 recruitment efforts included direct outreach to WCM families, including 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	18	4	All positions have remained filled therefore, no additional recruitment has been done.	0 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 to
PHC	14	6	By December 2019, FAC membership was open to any interested parties. Original goal of recruiting 2 members per county did not provide enough interest and so was relaxed. Plan requested referrals from providers via PQC meetings, county CCS staff via WCM JOC meeting and meetings with individual counties. Care Coordination Staff was prompted to encourage members they were in contact with to attend. Plan maintains webpage under the member's section with information on FAC and contact information for interested members. Plan also encourages existing members who know other parents of special needs children to encourage participation in the group. PHC will reach out to any identified referrals.	14 of 28