Managed Care Whole Child Model Dashboard

Released September 2020

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 2-5, 39, and 40.
  Charts display data for the last month in the reporting period.
- **Trend charts:** Figures 1, 8, 11, 14, 17, 20, 23, 35, and 41.
  Charts display each month's data in the last 12 months of the reporting period.
- **Cumulative charts:** Figures 6, 7, 9, 10, 12, 13, 15, 16, 18, 19, 21, 22, 26-30, 32, 34, 36, 38, 42, 43, and 44.
  Charts display the sum of the last 12 months' data in the reporting period as one figure.
- **Tables:** Figures 24, 25, 31, 33 and 37.
  Tables display each month's data in the last 12 months of the reporting period.

Whole Child Model Enrollment and Demographics: *Figures 1-23*

The data in this section comes from the DHCS Medi-Cal Management Information System/Decision Support system (MIS/DSS). Figures 1-5 displays WCM enrollment and demographics. Figures 6-23 displays utilization data. Figures 1, 8, 11, 14, 17, 20, and 23 are trend charts displaying monthly data over the last 12 months. Figures 2-5 show data for the last month in the reporting period as a point of time view of the Whole Child Model program. Figures 6, 7, 9, 10, 12, 13, 15, 16, 18, 19, 21, and 22 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 July 2018, 11,058 members were enrolled in WCM. Enrollment increased over time to 17,625 members enrolled in June 2019. CenCal, CCAH, and HPSM began offering WCM services July 2018. Partnership joined WCM Program in January 2019. The large increase of membership in January 2019 is due to Partnership operating in 14 counties and serving the largest population of all the plans participating in WCM.

Figure 2 shows that 51% of enrollees identified themselves as Hispanic. This was calculated by using member reported ethnicity for the month of June 2019 as the numerator, divided by total enrollment for June 2019 as the denominator.

The WCM population consists of 53% male and 47% female as displayed in Figure 3. This was calculated by using enrollment by gender in June 2019 as the numerator, divided by the total enrollment in June 2019 as the denominator.

Figure 4 displays primary languages. 59.8% of members reported English and 38.8% reported Spanish as their primary spoken language. This was calculated by using enrollment for each language in June 2019 as the numerator, divided by the total enrollment in June 2019 as the denominator.

Figure 5 displays total WCM enrollment, by plan and by county. The raw numbers are displayed within the bar graph. As of June 2019, HPSM reported 1,288 children and Partnership reported 7,447 children enrolled in the program. Figure 5 also displays WCM enrollment per 1,000 children enrolled in the Medi-Cal program. Partnership reported 24 enrollees in

Solano County and 39 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 June 2019 as the numerator, divided by members aged 0-21 years into the Medi-Cal program in each plan and county in June 2019 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 6 displays that male enrollees made 80 ER visits per 1,000 member months and female enrollees made 81 ER visits per 1,000 member months. This was calculated by using the number of ER visits for each gender for July 2018 through June 2019 as the numerator, divided by the enrollment for each gender for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000.

For Figure 7, African-American members made the most ER visits at 116 per 1,000 member months. This was calculated by using the number of ER visits for each ethnicity for July 2018 through June 2019 as the numerator, divided by the enrollment for each ethnicity for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000.

Figure 8 shows the trend in the number of ER visits for each participating plan from July 2018 to June 2019. This was calculated by using the number of ER visits for each plan per month for July 2018 through June 2019 as the numerator, divided by the enrollment for each plan per month for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000. †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 9 displays that female enrollees made 2,542 outpatient visits per 1,000 member months while males made 2,610 outpatient visits per 1,000 member months. This was calculated by using the number of outpatient visits for each gender for July 2018 through June 2019 as the numerator, divided by the enrollment for each gender for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000.

For Figure 10, Other/Unknown members made the most outpatient visits at 2,880 per 1,000 member months. This was calculated by using the number of outpatient visits for each ethnicity for July 2018 through June 2019 as the numerator, divided by the enrollment for each ethnicity for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000.

Figure 11 shows the trend in the number of outpatient visits for each participating plan from July 2018 to June 2019. This was calculated by using the number of outpatient visits for each plan per month for July 2018 through June 2019 as the numerator, divided by the enrollment for each plan per month for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000. †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 12 displays that both male and female enrollees had 29 inpatient admissions per 1,000 member months. This was calculated by using the number of inpatient visits for each gender for July 2018 through June 2019 as the numerator, divided by the enrollment for each gender for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000.

For Figure 13, African-American members had the most inpatient admissions at 40 per 1,000 member months. This was calculated by using the number of inpatient visits for each ethnicity for July 2018 through June 2019 as the numerator, divided by the enrollment for each ethnicity for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000.

Figure 14 shows the trend in the number of inpatient admissions for each participating plan from July 2018 to June 2019. This was calculated by using the number of inpatient admissions for each plan per month for July 2018 through June 2019 as the numerator, divided by the enrollment for each plan per month for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000. †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 15 displays that female enrollees had utilized 1,270 prescription medications per 1,000 member months while males had utilized 1,193 prescription medications per 1,000 member months. This was calculated by using the number of prescriptions for each gender for July 2018 through June 2019 as the numerator, divided by the enrollment for each gender for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000.

For Figure 16, African-American members utilized the most prescription medications at 1,638 per 1,000 member months. This was calculated by using the number of prescriptions for each ethnicity for July 2018 through June 2019 as the numerator, divided by the enrollment for each ethnicity for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000.

Figure 17 shows the trend in the number of prescription medications for each participating plan from July 2018 to June 2019. This was calculated by using the number of prescriptions reported by each plan per month for July 2018 through June 2019 as the numerator, divided by the enrollment for each plan per month for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000. †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 18 displays that female enrollees made 45 non-specialty mental health visits per 1,000 member months while males made 33 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 July 2018 through June 2019 as the numerator, divided by the enrollment for each gender for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000.

For Figure 19, non-Hispanic/white members made the most visits at 64 per 1,000 member months. This was calculated by using the number of non-specialty mental health visits for each ethnicity for July 2018 through June 2019 as the numerator,

divided by the enrollment for each ethnicity for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000.

Figure 20 shows the trend in the number of non-specialty mental health visits for each participating plan from July 2018 to June 2019. This was calculated by using the number of non-specialty mental health visits for each plan per month for July 2018 through June 2019 as the numerator, divided by the enrollment for each plan per month for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000. †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 21 displays that both male and female enrollees made 11 ER visits with an inpatient admission per 1,000 member months. This was calculated by using the number of ER visits with an inpatient admission for each gender for July 2018 through June 2019 as the numerator, divided by the enrollment for each gender for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000.

For Figure 22, African-American members made the most ER visits with an inpatient admission at 22 per 1,000 member months. This was calculated by using the number of ER visits with an inpatient admission for each ethnicity for July 2018 through June 2019 as the numerator, divided by the enrollment for each ethnicity for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000.

Figure 23 shows the trend in the number of ER visits with an inpatient admission for each participating plan from July 2018 to June 2019. This was calculated by using the number of ER visits with an inpatient admission for each plan per month for July 2018 through June 2019 as the numerator, divided by the denominator is enrollment for each plan per month for July 2018 through June 2019 as the denominator. The dividend was then multiplied by 1,000.

*The numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable. †Plans who are not in the observations yet.

Continuity of Care (COC): *Figures 24-30*

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 24-25 are tables displaying monthly data for 12 months. Figures 26-30 are cumulative charts, showing the sum of the 12 months' data as one figure.

Total number of COC requests for each plan for the first twelve months after joining the program are shown in Figure 24. In the first month of operation, Cal Optima reported 30, CenCal reported 30, CCAH reported 54 and Partnership reported receiving 510 COC requests. In the twelfth month of operation, Cal Optima reported 16, CenCal reported 49, CCAH reported receiving 15 COC requests. Partnership's high COC requests for the first 5 months is due to the plan operating in 14 counties and serving the largest population among the plans participating in WCM. 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.

The post twelve months upon joining the program for COC requests are displayed in Figure 25. In the thirteenth month of operation, CenCal reported 52, CCAH reported receiving 22 COC requests. Cal Optima has not yet reported their thirteenth month of participation in the program. In the twenty-fourth month of operation, CenCal reported receiving 27 COC requests. Partnership has not yet reported their twenty-fourth month of participation in the program.

*The numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable. †Plans who are not in the observations yet.

Figure 26 shows the average number of COC requests for each plan for the first twelve months compared to the post twelve months. CenCal had an average of 41.3 for the first twelve months and 35.2 for the post twelve months. Partnership had 126.4 for the first twelve months. Of note, Cal Optima hasn't yet reached their post twelve months and Partnership has only reached half of their post twelve months. *The numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable. †Plans who are not in the observations yet.

Figure 27 displays major categories for the COC requests. Public health nurses were requested 0.3% of the time while 79.7% 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 July 2018 through June 2019 as the numerator, divided by the total number of COC requests for July 2018 through June 2019 as the denominator.

Figure 28 shows reasons for COC denials not required by APL. Absence or insufficient documentation accounted for 24% of COC denial reasons while 2% were due to other health insurance. This was calculated by using the number of COC denials for each reason for July 2018 through June 2019 as the numerator, divided by the total number of COC denials for July 2018 through June 2019 as the denominator.

Figure 29 shows reasons for COC denials required by APL. No pre-existing relationship between WCM member and provider accounted for 18% of COC denial reasons while 0% were due to quality of care issues. This was calculated by using the number of COC denials for each reason for July 2018 through June 2019 as the numerator, divided by the total number of COC denials for July 2018 through June 2019 as the denominator.

Please note that for Figure 28, only the top 6 denial reasons are displayed. Figure 29 displays all denial categories as required by the APL, besides "Others". Neither Figure 28 nor Figure 29 adds up to 100%.

Figure 30 displays that requests for COC per 1,000 members ranged from 32 for HPSM to 179 for CenCal. This was calculated by using the number of COC requests for each plan for July 2018 through June 2019 as the numerator, divided by the enrollment for each plan in June 2019 as the denominator. The dividend was then multiplied by 1,000. Figure 30 also displays percentage of COC requests approved, by plan and by county. The approval percentage ranged from 87% for CenCal to 100% for CCAH. Plans that have low percentage approvals are seen as statistically unreliable because of the low number of observations. Caution should be exercised when evaluating the results. This was calculated by using the number of approved COC requests for each plan and each county for July 2018 through June 2019 as the numerator, divided by the total number of COC requests for each plan and each county for July 2018 through June 2019 as the denominator. *The numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable.

Case Management: *Figures 31-38*

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 31, 33, 35, and 37 are trend tables/charts displaying monthly data over the last 12 months. Figures 32, 34, 36, and 38 are cumulative charts, showing the sum of the 12 months' data as one figure.

NICU Authorizations:

Figure 31 displays the trend of total requests seeking authorization for NICU services for each plan per month. The numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable. †Plans who are not in the observations yet.

Figure 32 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 96% for Partnership to 100% for CenCal and HPSM. This was calculated by using the number of approved NICU authorizations for each plan and each county for July 2018 through June 2019 as the numerator, divided by the number of NICU requests for authorizations for each plan and each county for July 2018 through June 2019 as the denominator.

*The numbers have been suppressed for counties that have low number of observations as they are seen as statistically unreliable.

PICU Authorizations:

Figure 33 displays the trend of total requests seeking authorization for PICU services for each plan per month. In July 2018, CCAH reported 22. Partnership joined the WCM program in January 2019 and reported 25 requests. In June 2019, CenCal reported 21 and Partnership reported 30 requests. *Plans that have low number of observations have been suppressed as they are seen as statistically unreliable. †Plans who are not in the observations yet.

Figure 34 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 44 for HPSM to 223 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 for PICU requests was 100% for all plans. This was calculated by using the number of approved PICU requests for authorizations for each plan and each county for July 2018 through June 2019 as the numerator, divided by the number of PICU authorizations for each plan and each county for July 2018 through June 2019 as the denominator.

*The numbers have been suppressed for counties that have low number of observations as they are seen as statistically unreliable.

Inpatient Facilities and SCC Authorizations:

Figure 35 displays the total requests seeking authorization for SCC services for each plan per month. In July 2018, CCAH reported 149, CenCal reported 44, and HPSM reported 86. Partnership joined the WCM program in January 2019

and reported 84 requests. In June 2019, CCAH reported 118, CenCal reported 41, HPSM reported 75, and Partnership reported 156 requests.

Figure 36 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 570 for CenCal to 1,431 for CCAH. 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 was 96% for Partnership and HPSM while 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 July 2018 through June 2019 as the numerator, divided by the number of Inpatient Facilities and SCC requests for authorizations for each plan and each county for July 2018 through June 2019 as the denominator.

*The numbers have been suppressed for counties that have low number of observations as they are seen as statistically unreliable.

Specialized or Customized DME Authorizations:

Figure 37 displays the total requests seeking authorization for DME services for each plan per month. In July 2018, CCAH reported 22. Partnership joined the WCM program in January 2019 and reported 111 requests.

*The numbers have been suppressed for Plans that have low number of observations as they are seen as statistically unreliable. †Plans who are not in the observations yet.

Figure 38 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 71 for HPSM to 874 for Partnership. The high number of requests reported by Partnership is reasonable due to its enrollment of 7,447 members, 54% of the WCM enrollment. Total plan enrollment and percent distribution of program enrollment in each plan is displayed on the far left column for reference. The approval percentage was 92% for Partnership and 100% for CCAH and HPSM. This was calculated by using the number of approved specialized or customized DME authorizations for each plan and each county for July 2018 through June 2019 as the numerator, divided by the number of specialized or customized DME requests for authorizations for each plan and each county for July 2018 through June 2019 as the denominator.

*The numbers have been suppressed for counties that have low number of observations as they are seen as statistically unreliable.

Care Coordination: *Figures 39-40*

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 39, the percentage of high-risk members who received an assessment ranged from 43% for Partnership to 93% for CenCal. This was calculated by using the number of high-risk assessments for each plan in June 2019 as the numerator, divided by the number of high-risk members in each plan in June 2019 as the denominator.

For Figure 40, the percentage of low-risk members who received an assessment ranged from 32% for HPSM to 53% for CenCal. This was calculated by using the number of low-risk assessments for each plan in June 2019 as the numerator, divided by the number of low-risk members in each plan in June 2019 as the denominator.

Grievances and Appeals: *Figure 41-43*

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

For Figure 41, WCM appeals and grievances are trended over the last 12 months (July 2018-June 2019). In July 2018, plans reported to have received 5 appeals and 11 grievances. In June 2019, plans received 21 appeals and 15 grievances.

WCM appeals are shown by plan in Figure 42. CenCal and Partnership reported to have received 22 appeals while CCAH reported 32 appeals.

Figure 43 displays major categories of total grievances reported by plans. This was calculated by using the number of each grievance type for each plan for July 2018 through June 2019 as the numerator, divided by the total number of grievances for each plan from July 2018 through June 2019 as the denominator.

Family Advisory Committee Meetings: *Figure 44*

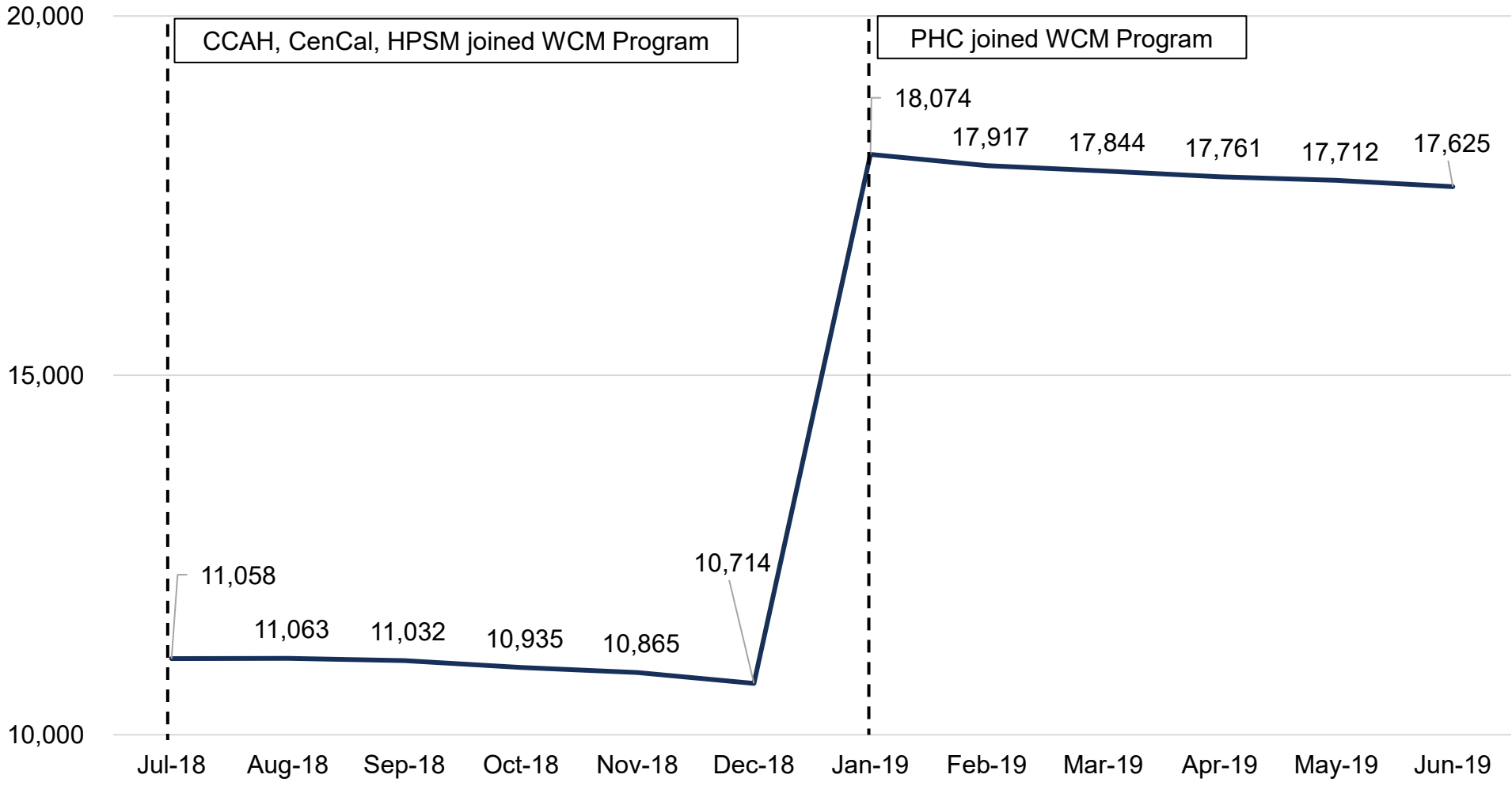
Plans must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers. Figure 44 summarizes the number of committee members, meetings held, recruitment efforts and seats to be filled for each plan for the last 12 months (July 2018-June 2019).

Plan Key:

Plan Name	Plan Abbreviation on Dashboard	WCM Implementation Date
Cal Optima	Cal Optima	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 (Jul'18 - Jun'19)

Fig 1: Whole Child Model Enrollment



Note: *This report contains data from July 2018 to June 2019. 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 - 4: Breakdowns of Population as of June 2019

Fig 2: Enrollment by Race/Ethnicity

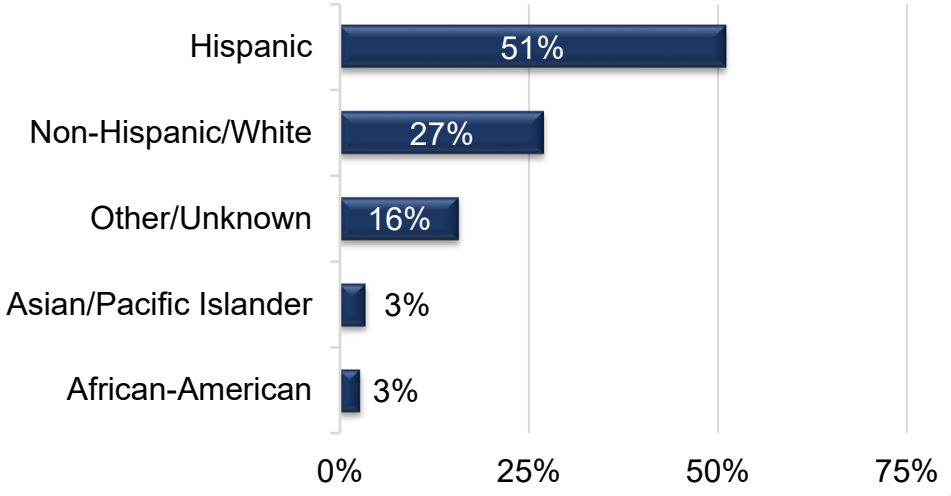


Fig 3: Enrollment by Sex

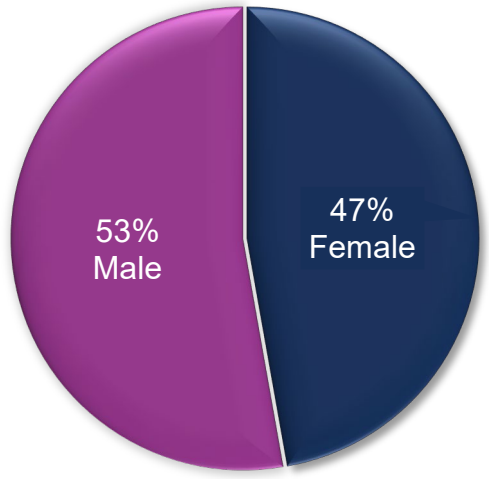
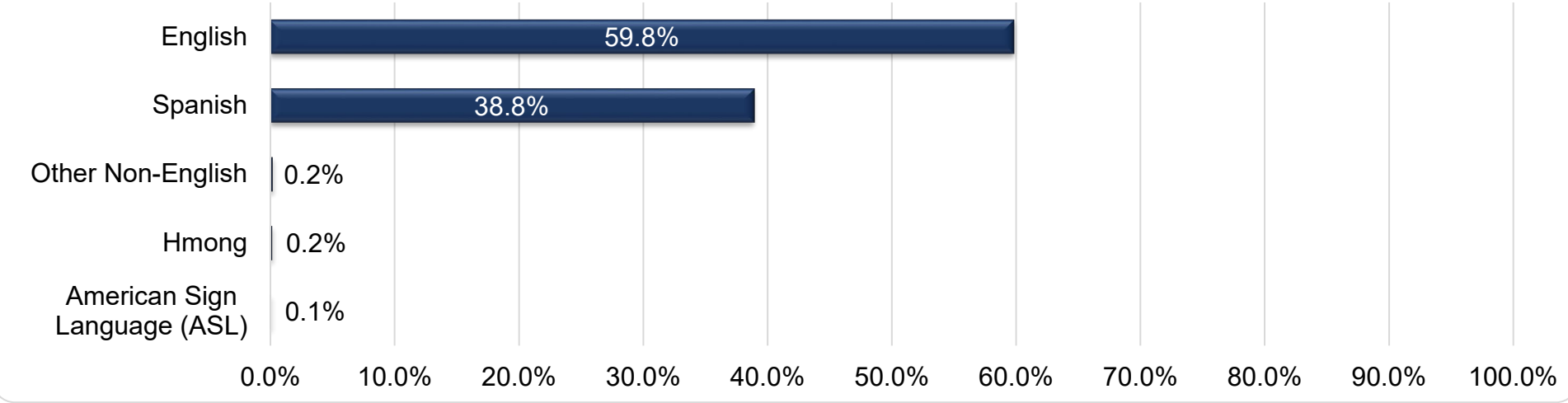
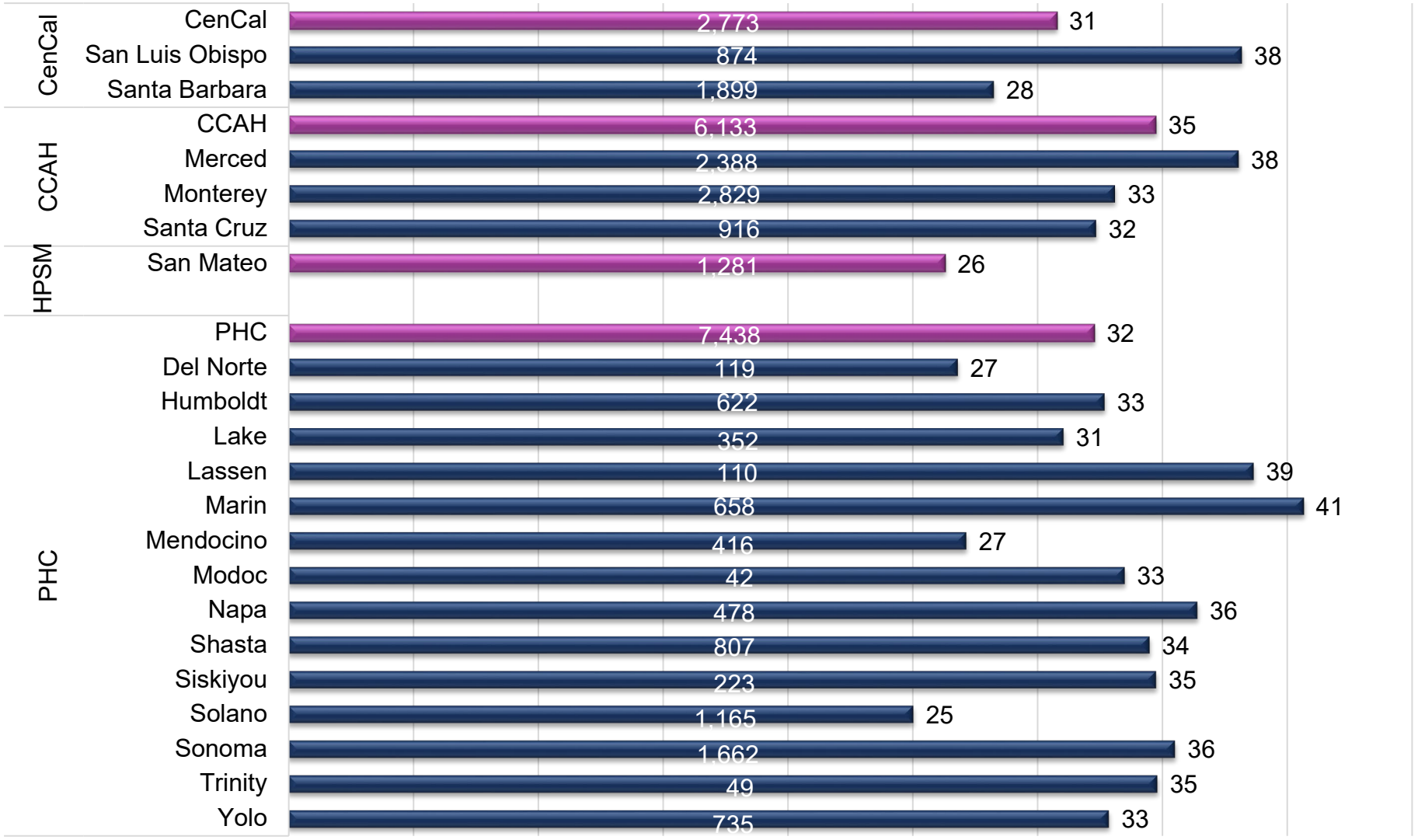


Fig 4: Enrollment by Language Spoken



Whole Child Model Enrollment and Demographics Figure 5: Breakdowns of Population as of June 2019

Fig 5: 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 6 - 8: Breakdowns of Emergency Room Utilization (Jul'18 - Jun'19)

Fig 6: Emergency Visits per 1,000 Member Months by Sex

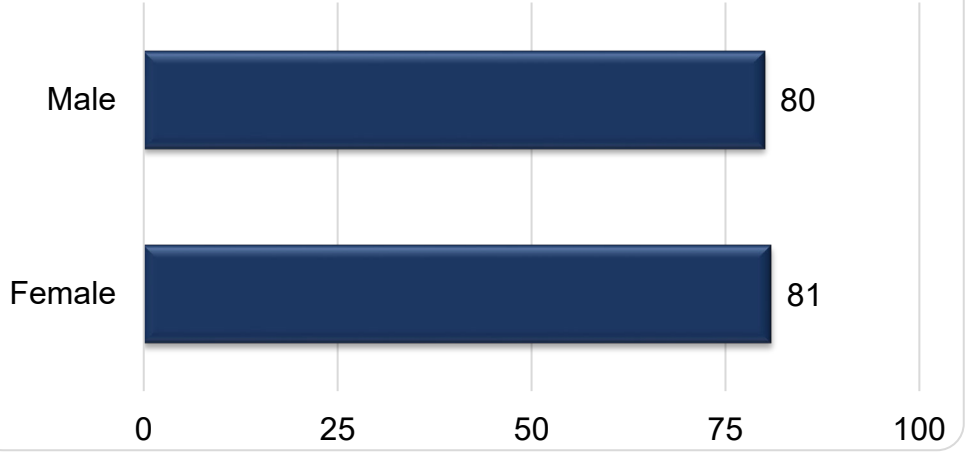


Fig 7: Emergency Visits per 1,000 Member Months by Ethnicity

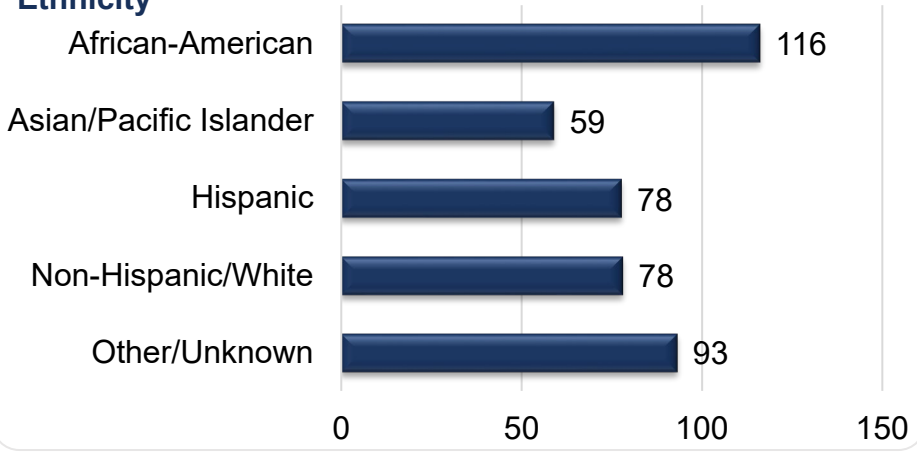
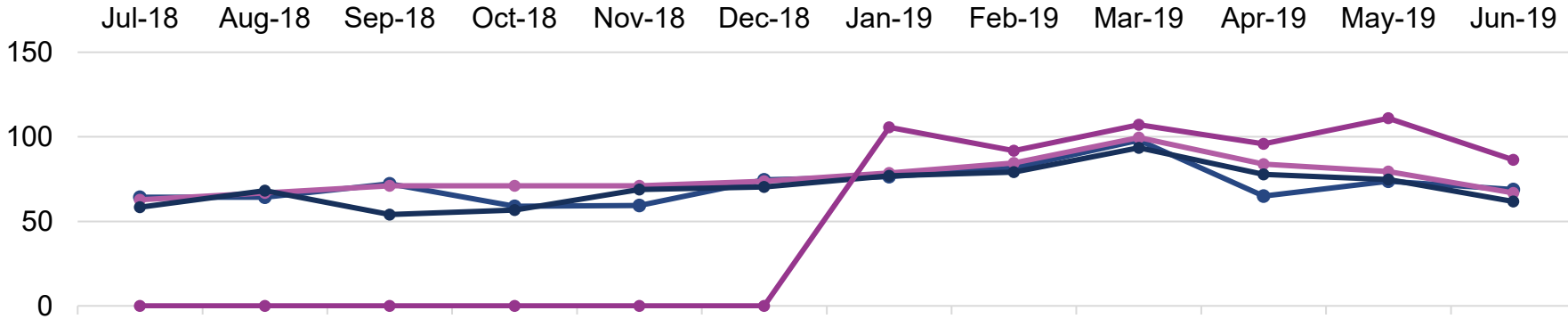


Fig 8: ER Visits per 1,000 Members by Plan, by Month



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
CenCal	64	64	72	59	59	75	76	82	98	65	74	69
CCAH	63	67	71	71	71	74	79	84	100	84	80	67
HPSM	58	68	54	57	69	70	77	79	94	78	75	62
PHC	†	†	†	†	†	†	106	92	107	96	111	86

†Plans who are not in the observations yet.

Whole Child Model Enrollment and Demographics Figure 9 - 11: Breakdowns of Outpatient Admissions Utilization (Jul'18 - Jun'19)

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

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

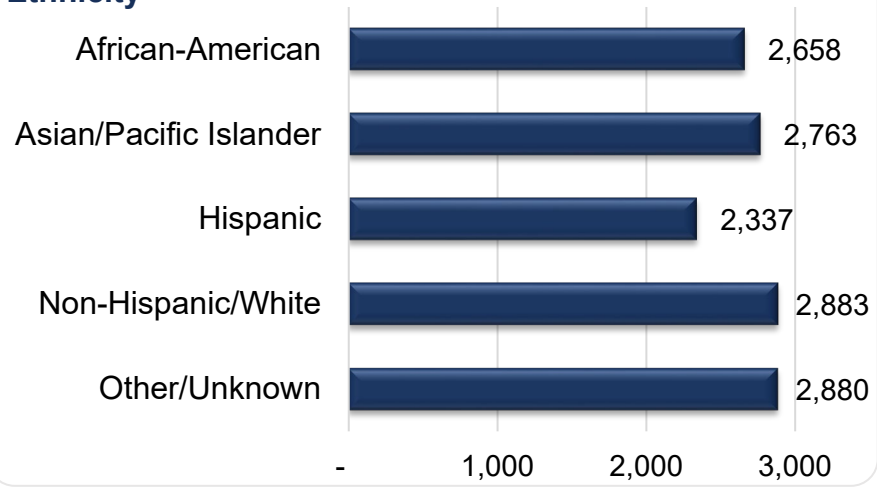
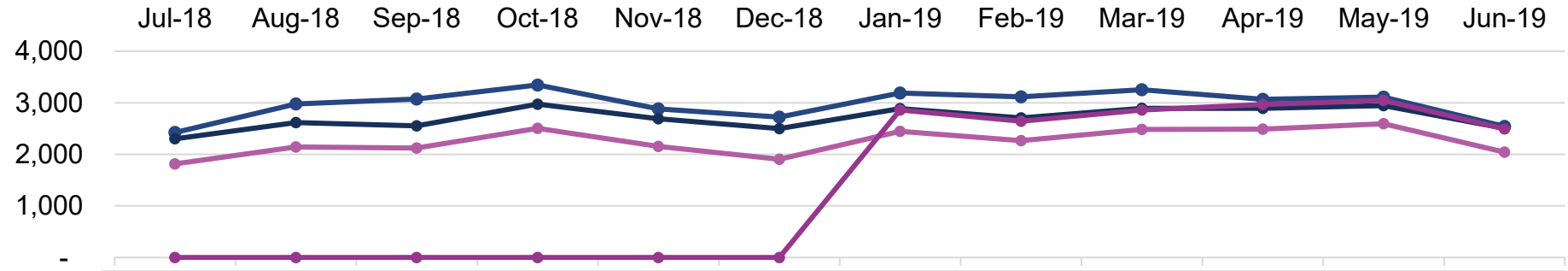


Fig 11: Outpatient Visits per 1,000 Members by Plan, by Month



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
CenCal	2,424	2,978	3,072	3,346	2,884	2,720	3,190	3,113	3,253	3,066	3,112	2,542
CCAH	1,815	2,142	2,122	2,506	2,156	1,907	2,445	2,264	2,485	2,491	2,594	2,043
HPSM	2,301	2,619	2,554	2,974	2,693	2,501	2,887	2,707	2,890	2,892	2,947	2,504
PHC	†	†	†	†	†	†	2,859	2,641	2,860	2,966	3,047	2,494

†Plans who are not in the observations yet.

Whole Child Model Enrollment and Demographics Figure 12 - 14: Breakdowns of Inpatient Visits Utilization (Jul'18 - Jun'19)

Fig 12: Inpatient Admissions per 1,000 Member Months by Sex

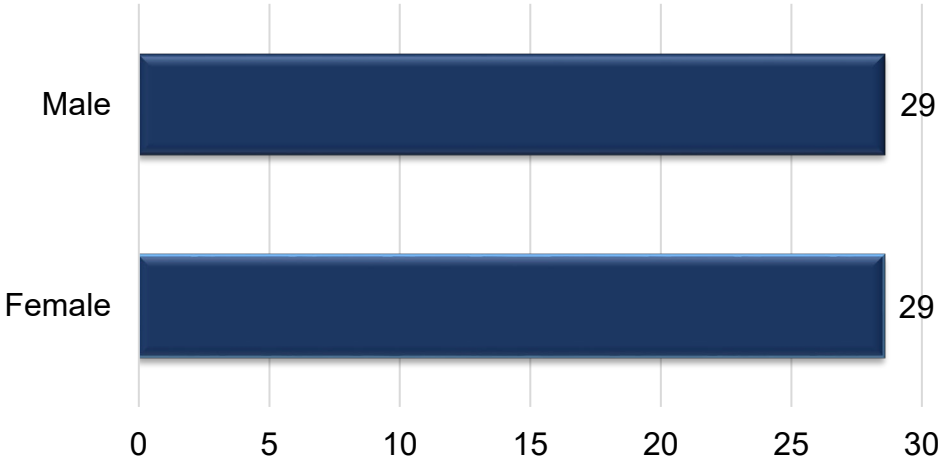


Fig 13: Inpatient Admissions per 1,000 Member Months by Ethnicity

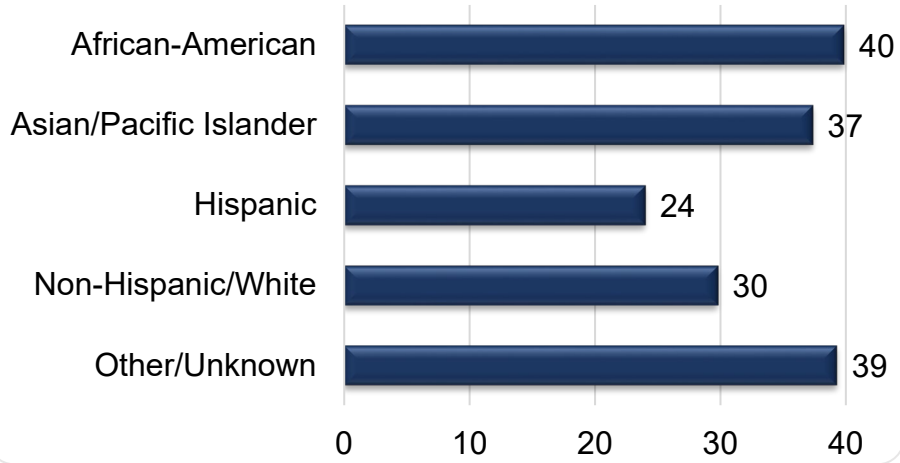
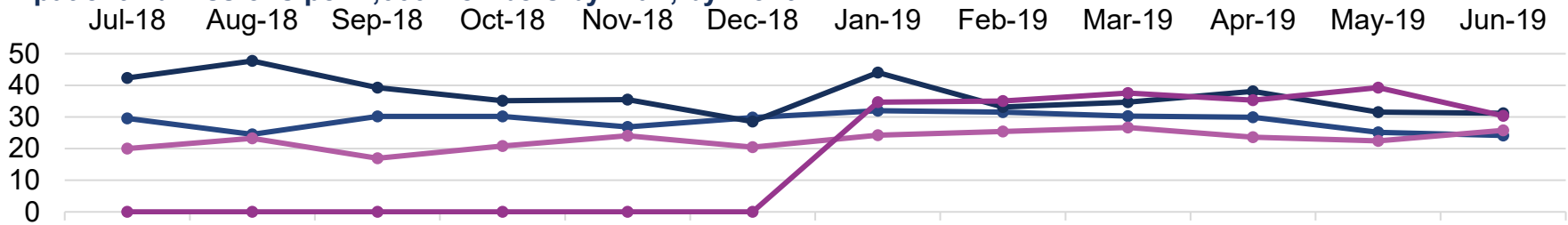


Fig 14: Inpatient Admissions per 1,000 Members by Plan, by Month



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
CenCal	30	25	30	30	27	30	32	32	30	30	25	24
CCAH	20	23	17	21	24	21	24	25	27	24	22	26
HPSM	42	48	39	35	36	29	44	33	35	38	32	31
PHC	†	†	†	†	†	†	35	35	38	35	39	30

†Plans who are not in the observations yet.

Whole Child Model Enrollment and Demographics Figure 15 - 17: Breakdowns of Prescriptions Utilization (Jul'18 - Jun'19)

Fig 15: Prescriptions per 1,000 Member Months by Sex

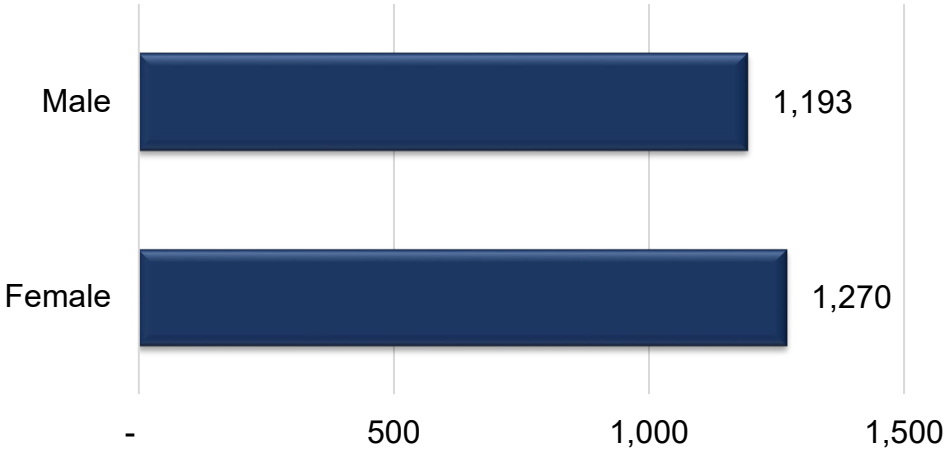


Fig 16: Prescriptions per 1,000 Member Months by Ethnicity

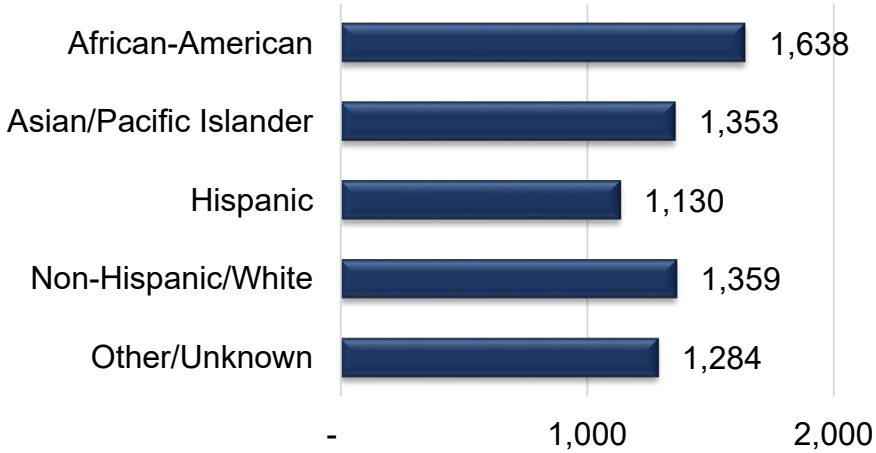
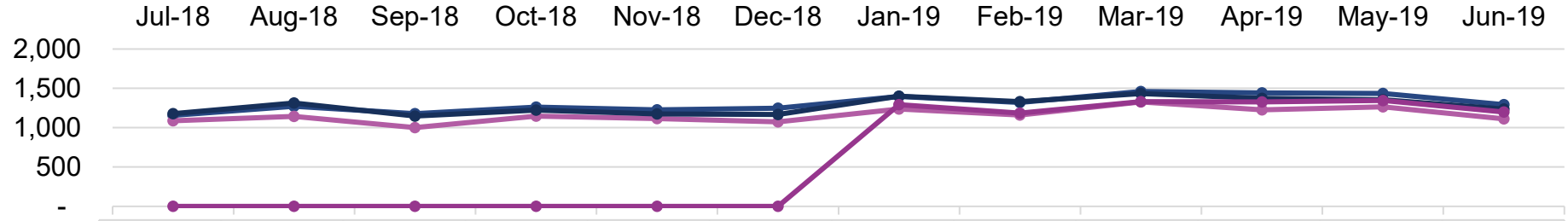


Fig 17: Prescription per 1,000 Members by Plan, by Month



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
CenCal	1,157	1,271	1,178	1,262	1,228	1,249	1,397	1,319	1,460	1,443	1,436	1,294
CCAH	1,089	1,145	1,001	1,147	1,115	1,074	1,237	1,162	1,327	1,227	1,264	1,111
HPSM	1,178	1,313	1,148	1,224	1,176	1,168	1,401	1,330	1,434	1,372	1,356	1,237
PHC	†	†	†	†	†	†	1,292	1,184	1,333	1,328	1,346	1,197

†Plans who are not in the observations yet.

Whole Child Model Enrollment and Demographics Figure 18 - 20: Breakdowns of Non-specialty Mental Health Visits Utilization (Jul'18 - Jun'19)

Fig 18: Non-specialty Mental Health Visits per 1,000 Member Months by Sex

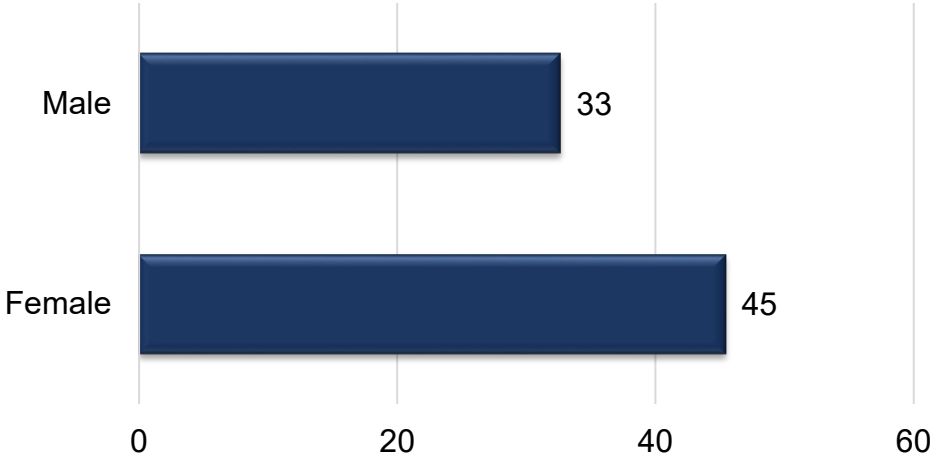


Fig 19: Non-specialty Mental Health Visits per 1,000 Member Months by Ethnicity

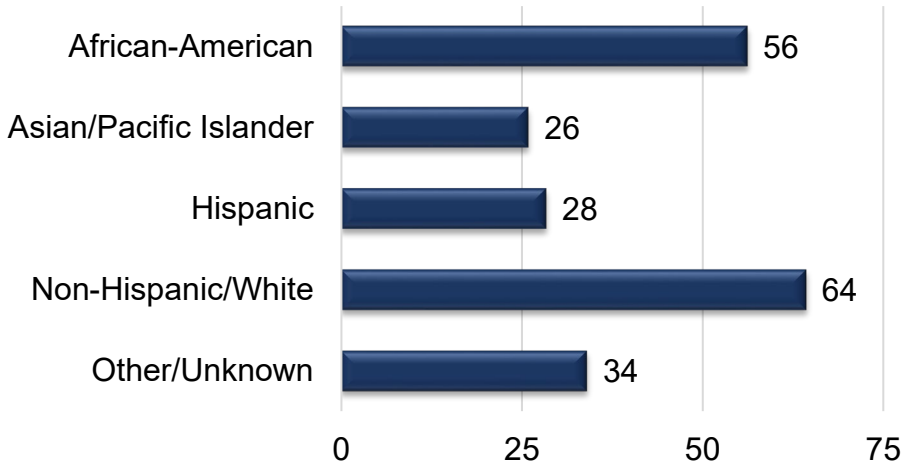
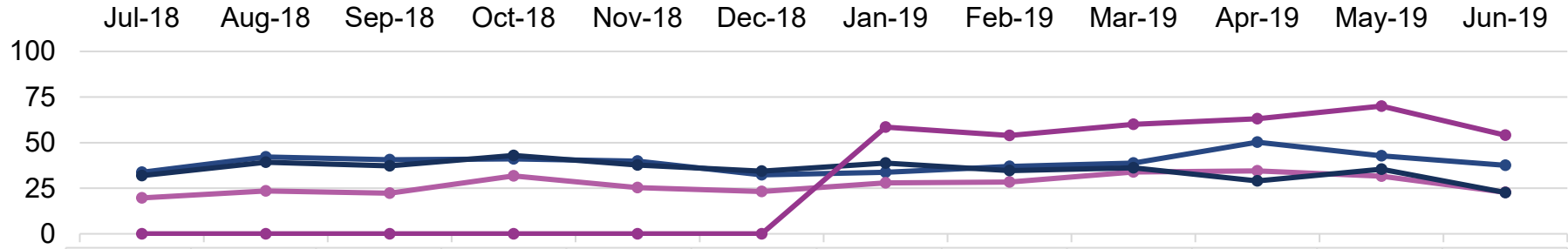


Fig 20: Non-specialty Mental Health Visits per 1,000 Members by Plan, by Month



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
CenCal	34	42	41	41	40	32	34	37	39	50	43	38
CCAH	20	24	22	32	25	23	28	28	34	35	32	23
HPSM	32	39	37	43	38	34	39	35	36	29	35	23
PHC	†	†	†	†	†	†	58	54	60	63	70	54

†Plans who are not in the observations yet.

Whole Child Model Enrollment and Demographics Figure 21 - 23: Breakdowns of Emergency Room Visits with an Inpatient Admission Utilization (Jul'18 - Jun'19)

Fig 21: Emergency Room Visits with an Inpatient Admission per 1,000 Member Months by Sex

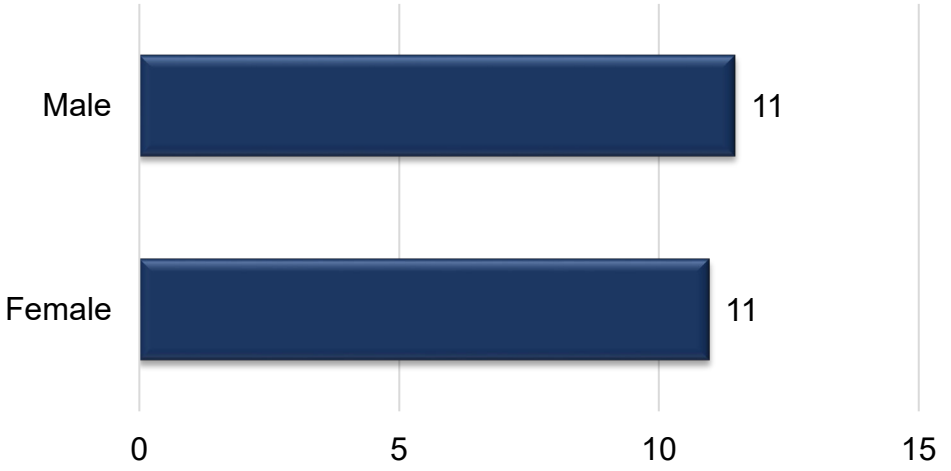


Fig 22: Emergency Room Visits with an Inpatient Admission per 1,000 Member Months by Ethnicity

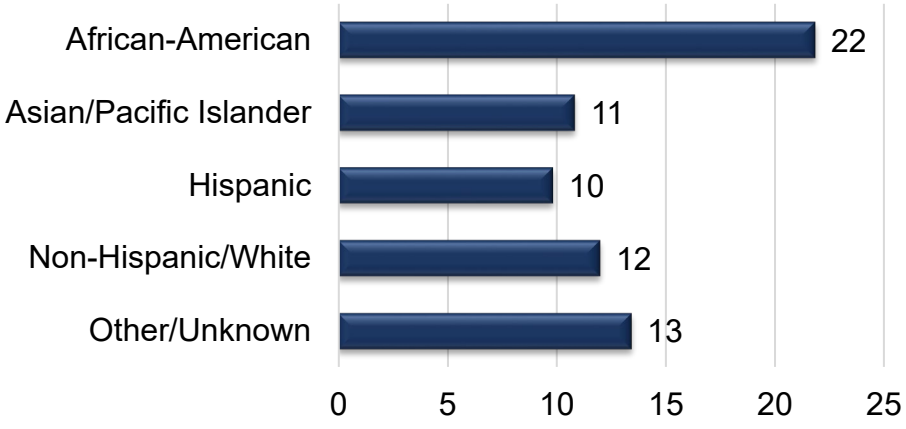
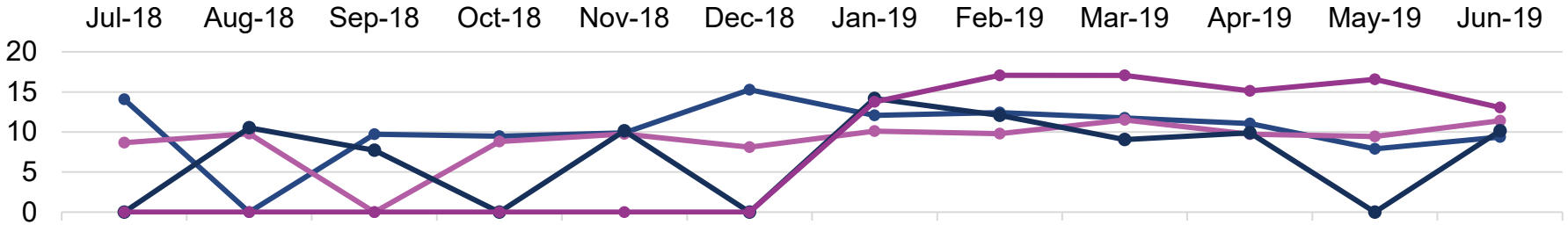


Fig 23: Emergency Room Visits with an Inpatient Admission per 1,000 Members by Plan, by Month



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
CenCal	14	*	10	9	10	15	12	12	12	11	8	9
CCAH	9	10	*	9	10	8	10	10	12	10	9	11
HPSM	*	11	8	*	10	*	14	12	9	10	*	10
PHC	†	†	†	†	†	†	14	17	17	15	17	13

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

†Plans who are not in the observations yet.

Whole Child Model Figure 24: Continuity of Care (COC) Requests by Plan, by Month for the First Twelve Months Upon Joining the Program

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
CalOptima	30	23	26	28	26	33	32	21	21	33	*	16
CenCal	30	41	21	44	59	19	44	49	40	55	45	49
CCAH	54	39	46	43	49	55	54	51	33	39	20	15
HPSM	*	*	*	*	*	*	*	14	*	*	*	*
PHC	510	254	206	141	115	56	64	62	40	20	48	*

Whole Child Model Figure 25: Continuity of Care (COC) Requests by Plan, by Month for the Post Twelve Months Upon Joining the Program

	Month 13	Month 14	Month 15	Month 16	Month 17	Month 18	Month 19	Month 20	Month 21	Month 22	Month 23	Month 24
CalOptima	†	†	†	†	†	†	†	†	†	†	†	†
CenCal	52	37	59	35	47	49	*	*	35	50	31	27
CCAH	22	21	18	50	72	26	14	21	34	*	*	*
HPSM	*	*	*	*	*	*	*	*	*	*	*	*
PHC	*	*	*	*	*	*	†	†	†	†	†	†

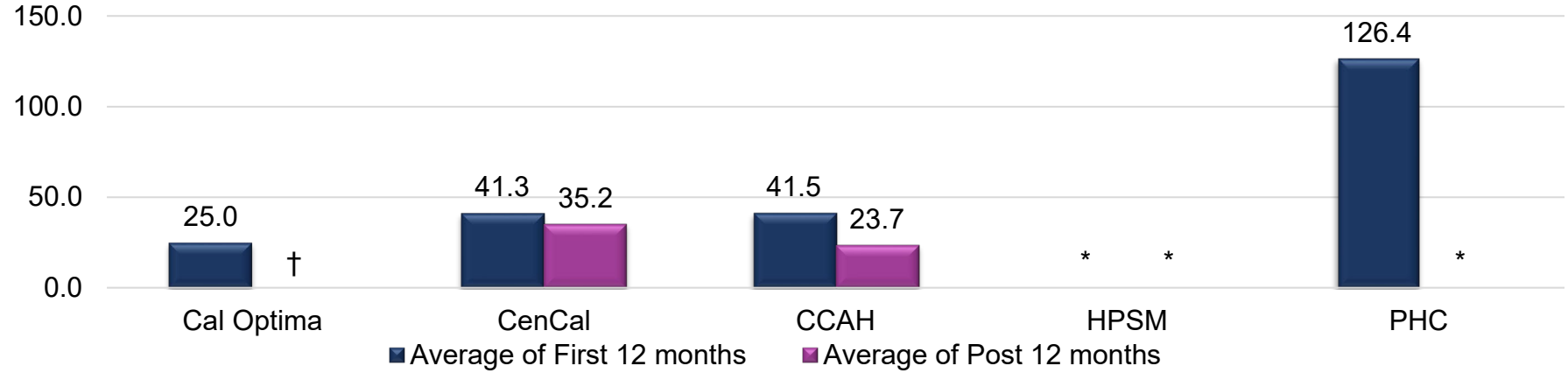
Note: CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019 and CalOptima joined in July 2019. Please see page 7 for more information on Partnership's high volume of COC requests for the first 5 months (Figure 24) and for Plans not having reached their post 12th month period of operation (Figure 25).

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

†Plans who are not in the observations yet.

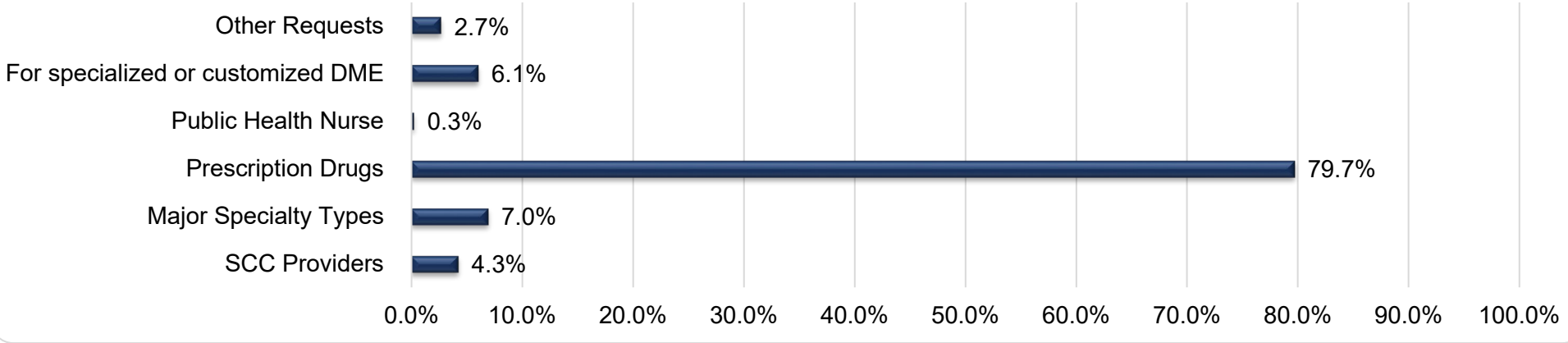
Whole Child Model Figure 26: Continuity of Care (COC) - Requests, by Plan (Jul'18 - Jun'20)

Fig 26 - Plan Average COC Request - First 12 Months Vs Post 12 Months Period



Whole Child Model Figure 27: Continuity of Care (COC) - Requests Categories (Jul'18 - Jun'19)

Fig 27: COC Requests - Categories



Note: Please see page 7 for more information on Plans not having reached their post 12th month period of operation (Figure 26). Please see page 7 for more information on Partnership's high number of prescription drug COC requests (Figure 27).
**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*
†Plans who are not in the observations yet.

Whole Child Model Figures 28 & 29: Continuity of Care (COC) - Denials Reasons (Jul'18 - Jun'19)

Fig 28 -Top 6 COC Denial Reasons (Not Required by APL)

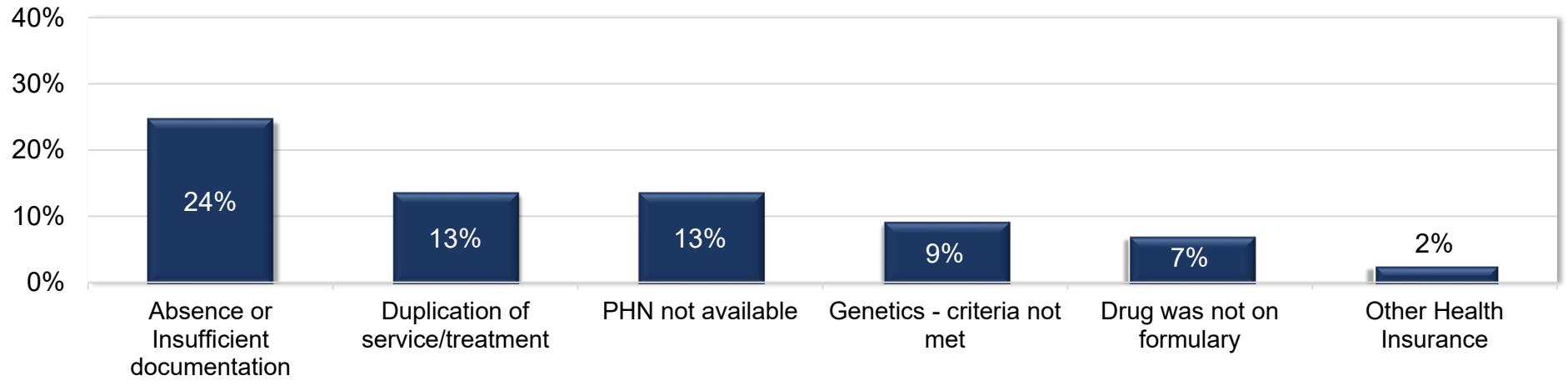
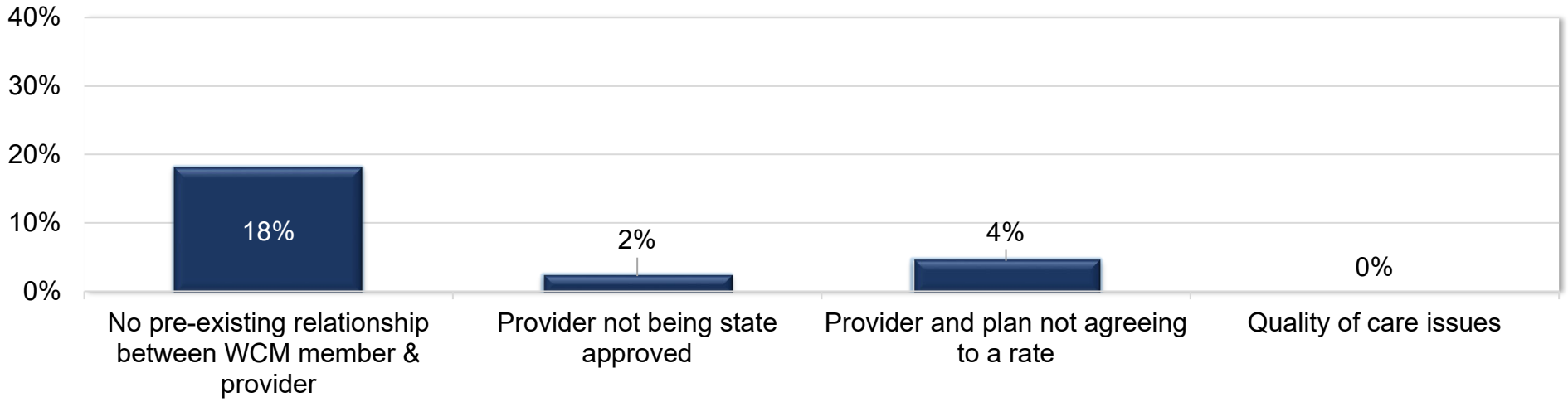


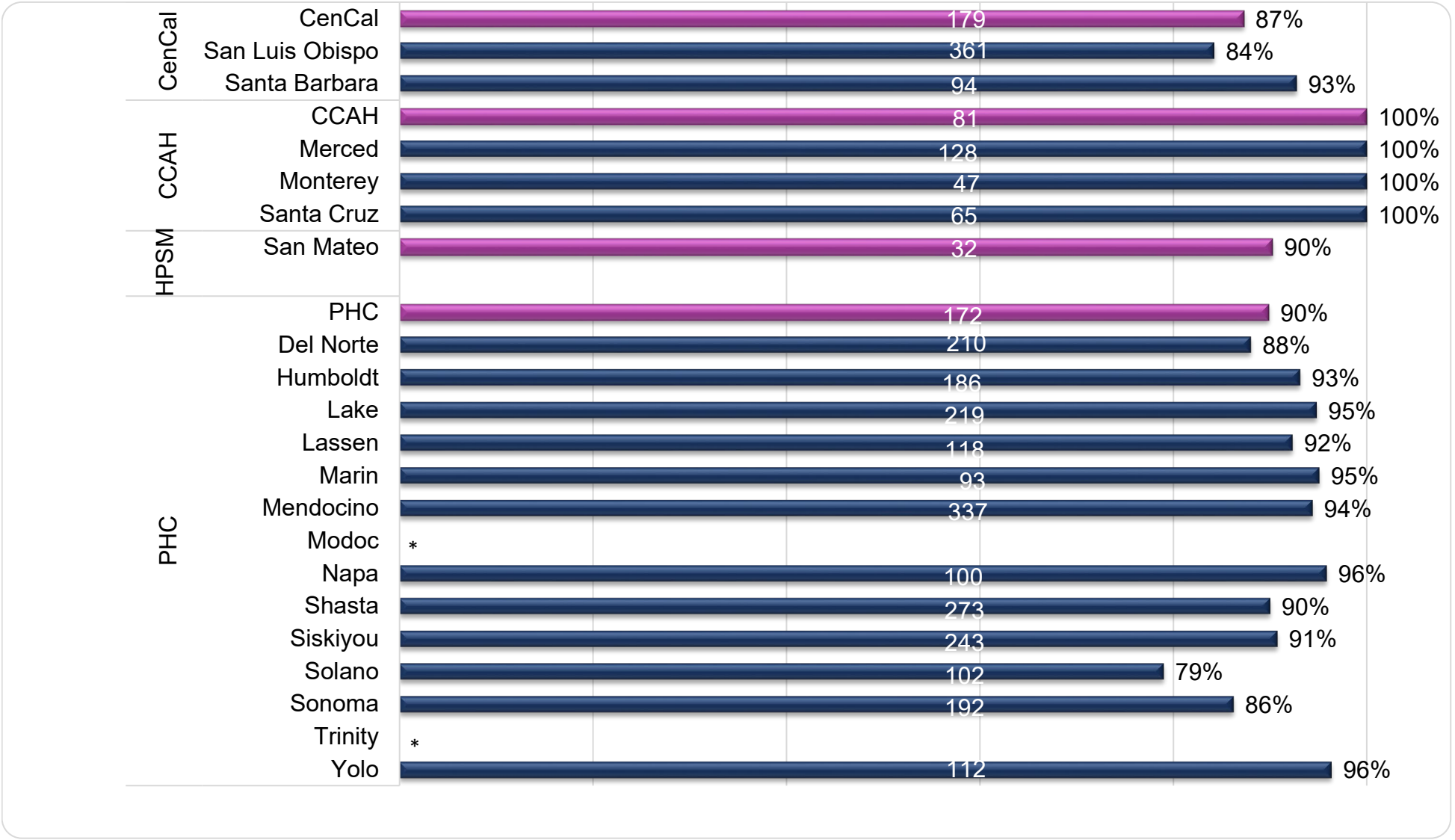
Fig 29 - COC Denial Reasons (Required by APL)



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

Whole Child Model Figure 30: Continuity of Care (COC) Requests & Approvals per 1,000 Members (Jul'18 - Jun'19)

Fig 30: COC Request per 1,000 Members & Percentage Approval by Plan, by County



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

Whole Child Model Figure 31: Case Management NICU Authorizations & Approvals (Jul'18 - Jun'19)

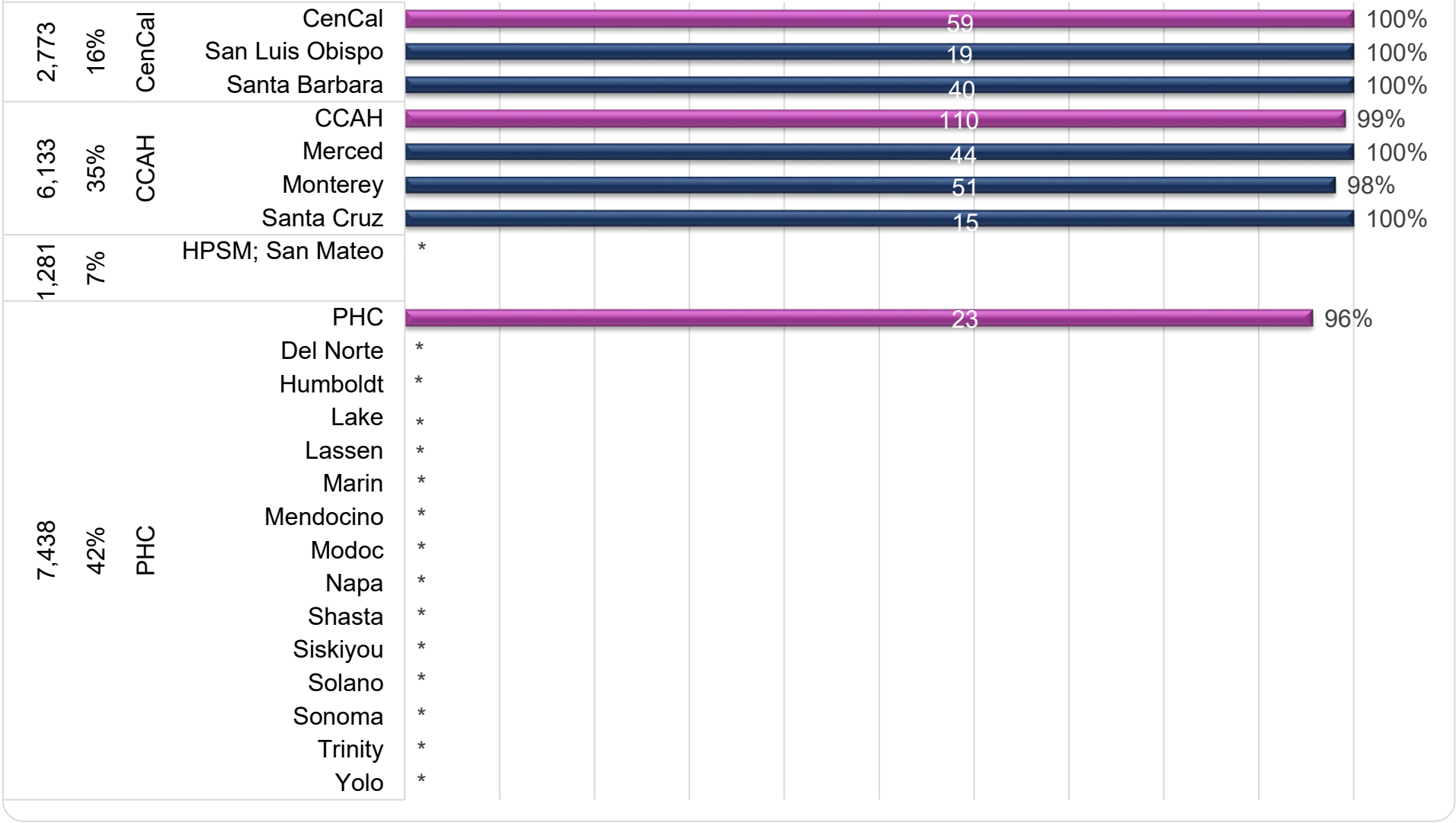
Fig 31: Total Requests for NICU Authorizations by Plan, by Month

	Jul'18	Aug'18	Sep'18	Oct'18	Nov'18	Dec'18	Jan'19	Feb'19	Mar'19	Apr'19	May'19	Jun'19
CalOptima	†	†	†	†	†	†	†	†	†	†	†	†
CenCal	*	*	*	*	*	*	*	*	*	*	*	13
CCAH	*	12	12	*	*	*	*	*	12	*	*	*
HPSM	*	*	*	*	*	*	*	*	*	*	*	*
PHC	†	†	†	†	†	†	*	*	*	*	*	*

Note: This report contains data from July 2018 to June 2019. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019.
**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*
†Plans who are not in the observations yet.

Whole Child Model Figure 32: Case Management NICU Authorizations & Approvals (Jul'18 - Jun'19)

Fig 32: Total Requests for NICU Authorizations & Percentage Approved by Plan, by County



Note: Total WCM enrollment and percentage distribution of WCM enrollment by Plan are displayed in the far left column for reference.
**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

Whole Child Model Figure 33: Case Management PICU Authorizations & Approvals (Jul'18 - Jun'19)

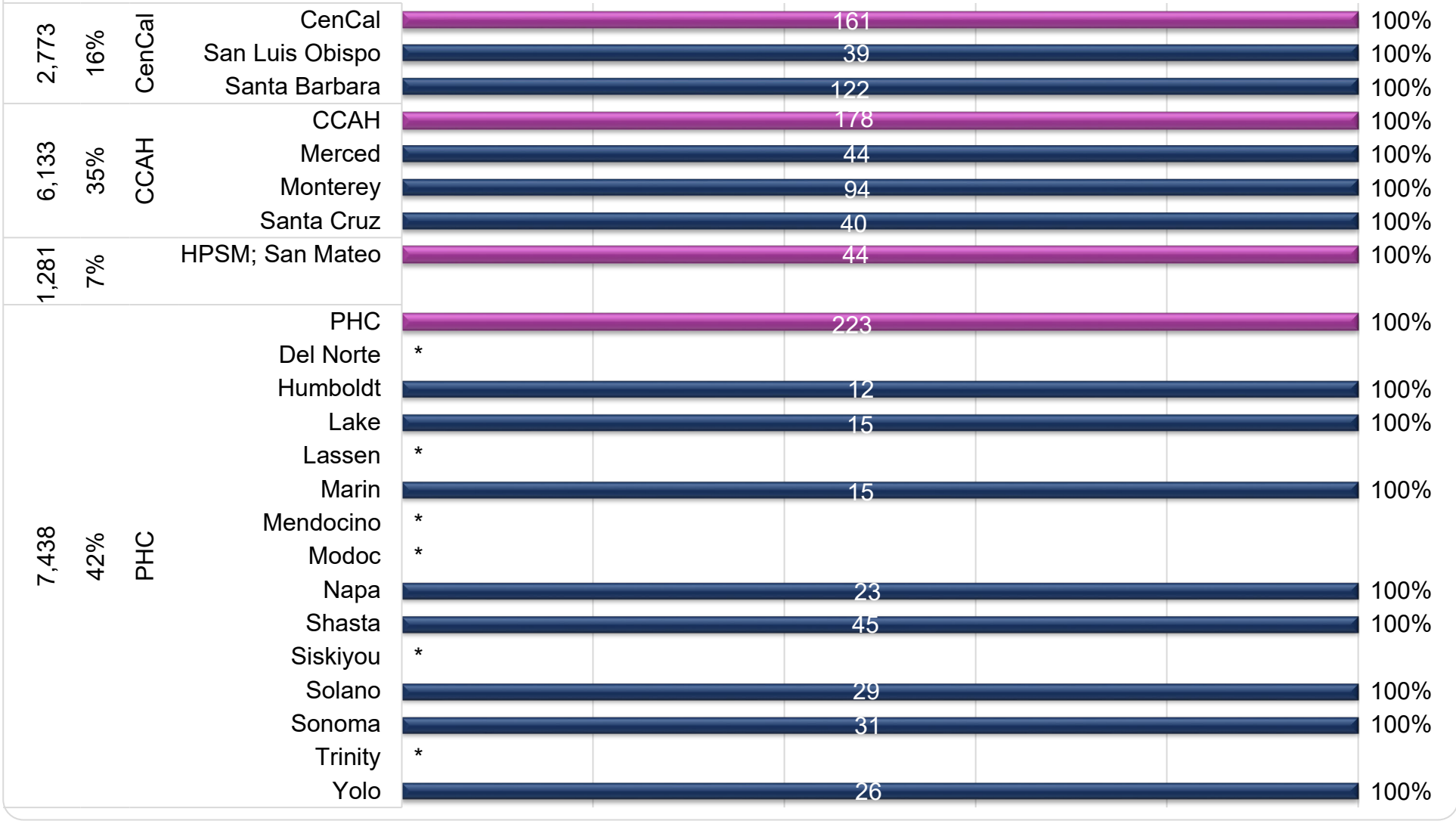
Fig 33: Total Requests for PICU Authorizations by Plan, by Month

	Jul'18	Aug'18	Sep'18	Oct'18	Nov'18	Dec'18	Jan'19	Feb'19	Mar'19	Apr'19	May'19	Jun'19
CalOptima	†	†	†	†	†	†	†	†	†	†	†	†
CenCal	*	*	*	*	*	*	13	15	18	21	21	21
CCAH	22	21	16	21	16	*	19	14	*	12	*	*
HPSM	*	*	*	*	*	*	*	*	13	*	*	*
PHC	†	†	†	†	†	†	25	37	49	37	45	30

Note: This report contains data from July 2018 to June 2019. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019.
**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*
†Plans who are not in the observations yet.

Whole Child Model Figure 34: Case Management PICU Authorizations & Approvals (Jul'18 - Jun'19)

Fig 34: Total Requests for PICU Authorizations & Percentage Approved by Plan, by County

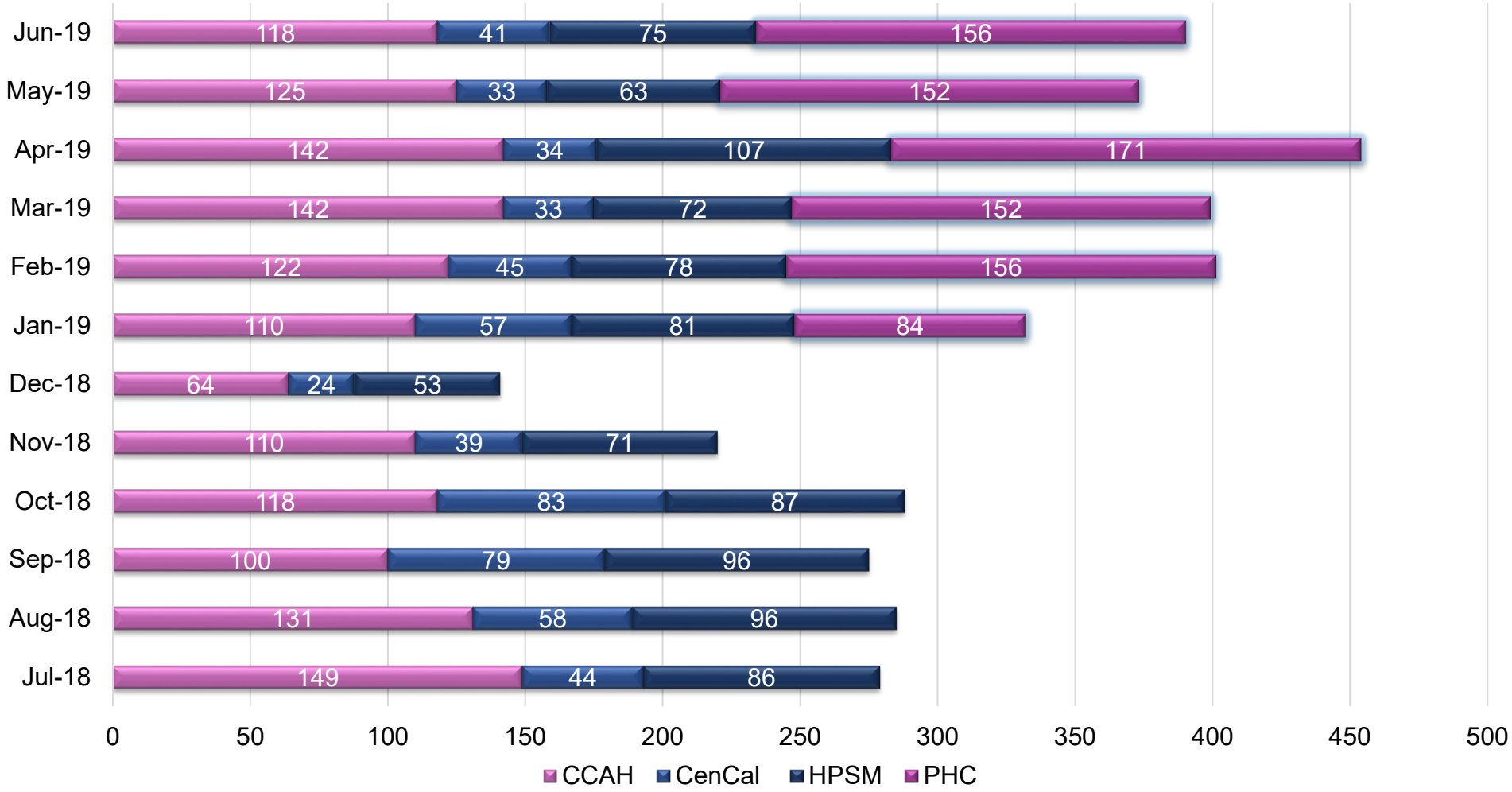


Note: This report contains data from July 2018 to June 2019. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019.

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

Whole Child Model Figure 35: Case Management Inpatient Facilities and Special Care Centers (SCC) Authorizations & Approvals (Jul'18 - Jun'19)

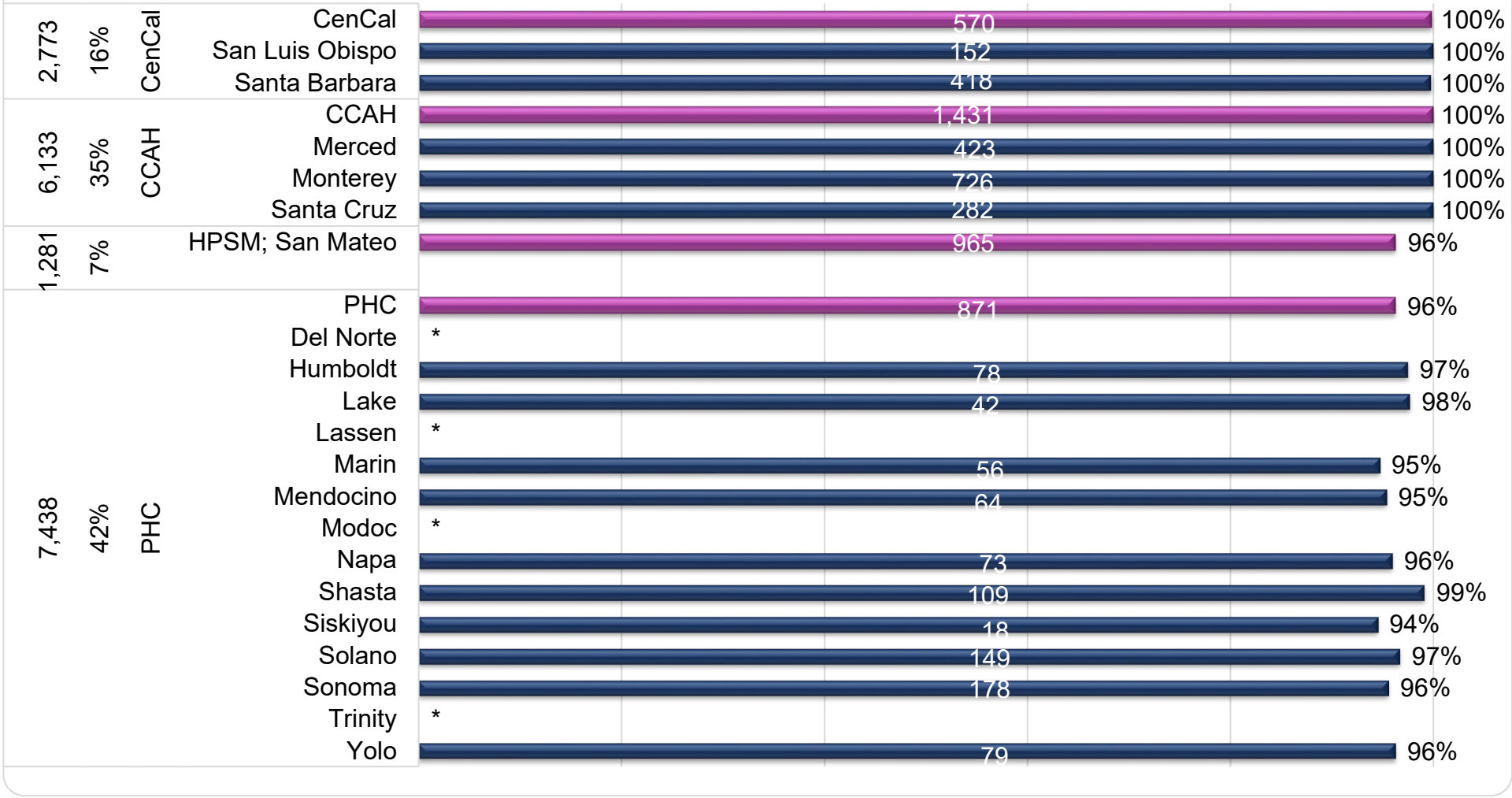
Fig 35: Total Requests for Inpatient Facilities and Special Care Centers (SCC)Authorizations by Plan, by Month



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

Whole Child Model Figure 36: Case Management Inpatient Facilities and Special Care Centers (SCC) Authorizations & Approvals (Jul'18 - Jun'19)

Fig 36: Total Requests for Inpatient Facilities and SCC Authorizations & Percentage Approved by Plan, by County



Note: Total WCM enrollment and percentage distribution of WCM enrollment by Plan are displayed in the far left column for reference.
**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

Whole Child Model Figure 37: Case Management Specialized or Customized DME Authorizations & Approvals (Jul'18 - Jun'19)

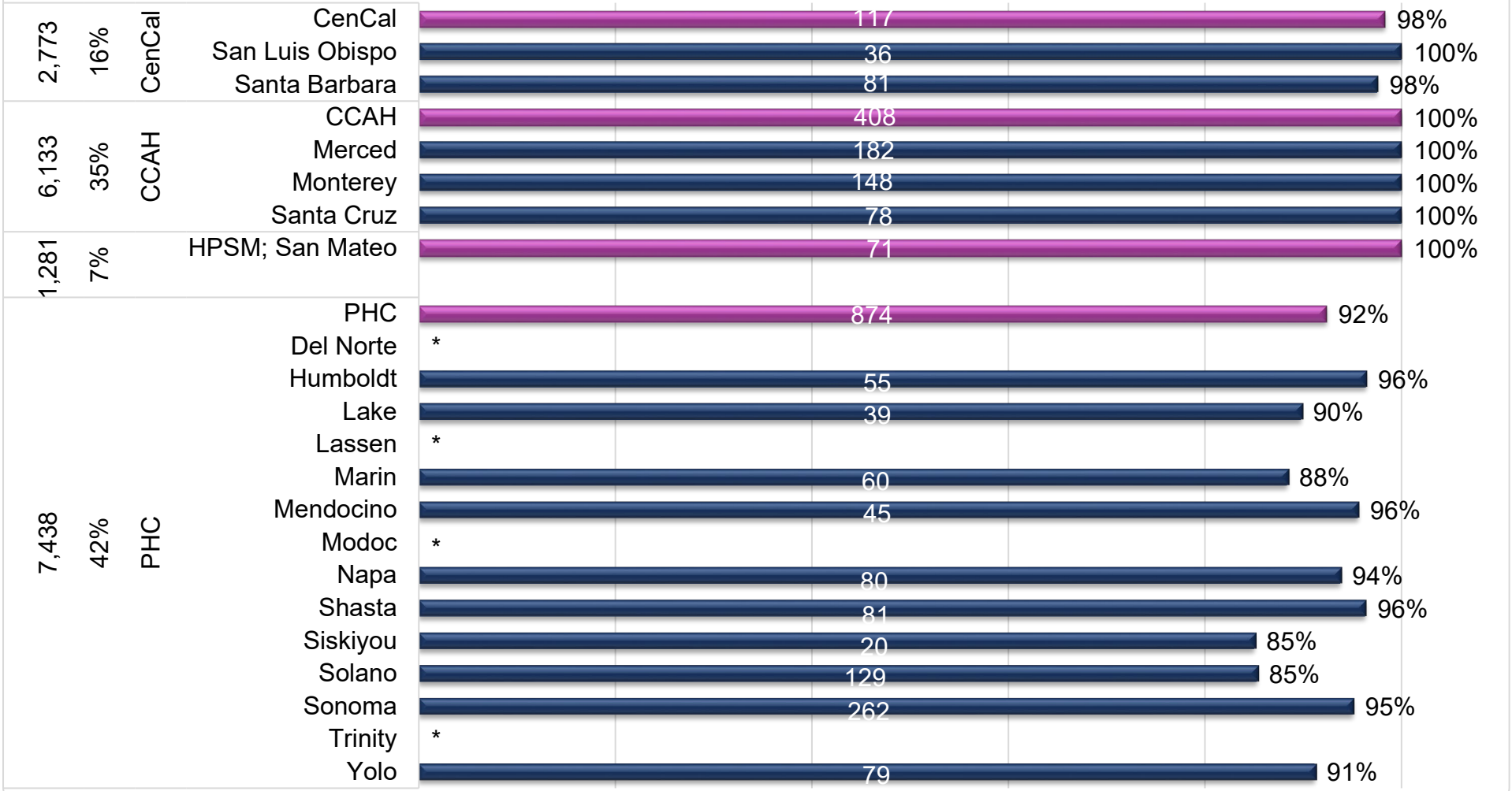
Fig 37: Total Requests for DME Authorizations by Plan, by Month

	Jul'18	Aug'18	Sep'18	Oct'18	Nov'18	Dec'18	Jan'19	Feb'19	Mar'19	Apr'19	May'19	Jun'19
CalOptima	†	†	†	†	†	†	†	†	†	†	†	†
CenCal	*	*	*	*	*	*	*	13	12	15	16	*
CCAH	22	34	31	37	49	41	23	33	29	45	39	25
HPSM	*	*	*	*	*	*	*	*	17	13	31	*
PHC	†	†	†	†	†	†	111	145	147	182	133	156

Note: This report contains data from July 2018 to June 2019. CenCal, CCAH, and HPSM began offering WCM services in July 2018. Partnership joined WCM Program in January 2019.
**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*
†Plans who are not in the observations yet.

Whole Child Model Figure 38: Case Management Specialized or Customized DME Authorizations & Approvals (Jul'18 - Jun'19)

Fig 38: Total Requests for Specialized or Customized DME Authorizations & Percentage Approved by Plan, by County



Note: Total WCM enrollment and percentage distribution of WCM enrollment by Plan are displayed in the far left column for reference.
**Counts of items that are <11 are suppressed per the DHCS De-Identification Guidelines v. 2.0, November 2016.*

Whole Child Model Figures 39 & 40: Care Coordination High-Risk and Low-Risk Assessments - Jun'19

Fig 39: Percentage of High Risk Members who Received an Assessment, by Plan

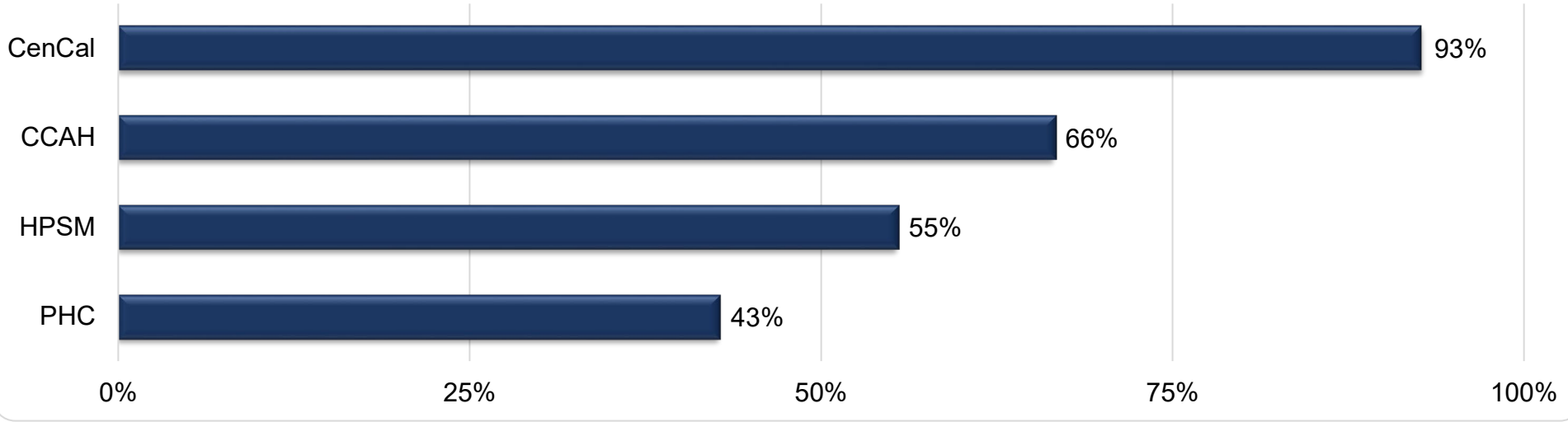
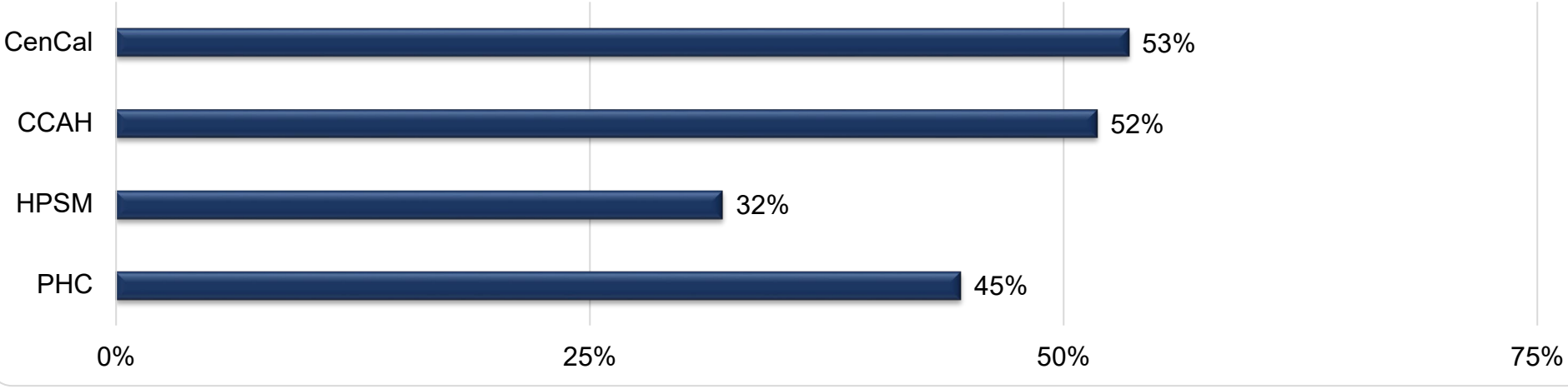


Fig 40: Percentage of Low Risk Members who Received an Assessment, by Plan



Whole Child Model Figure 41 & 42: Grievances & Appeals (Jul'18 - Jun'19)

Fig 41: WCM Grievances and Appeals

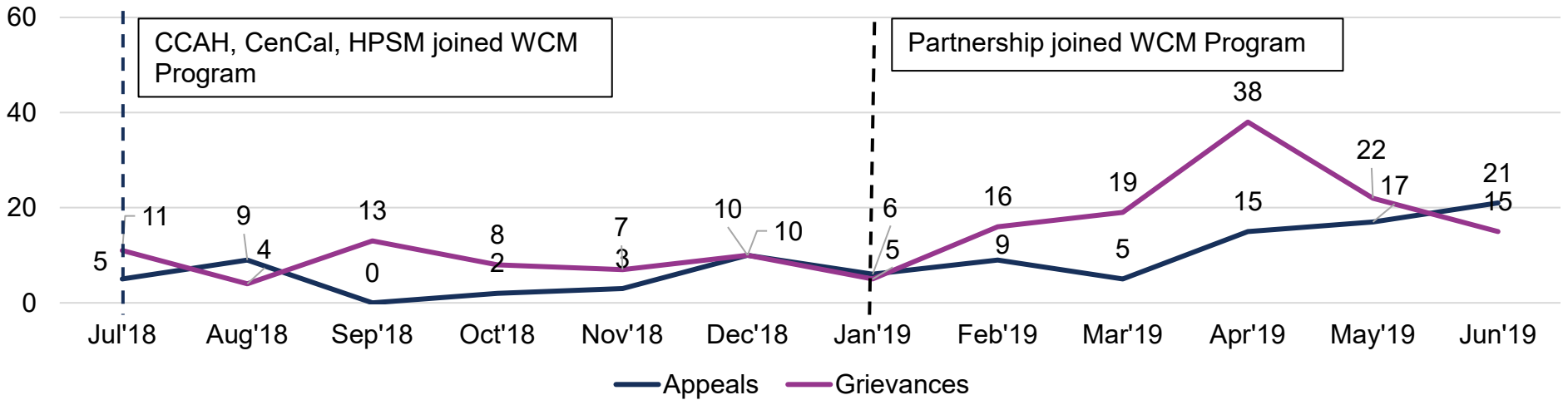
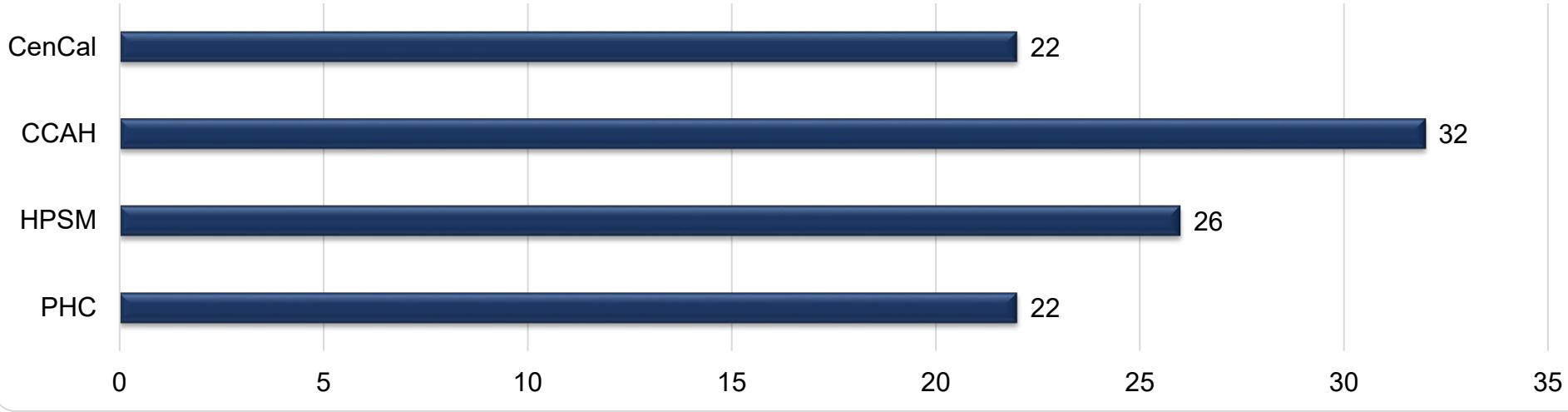
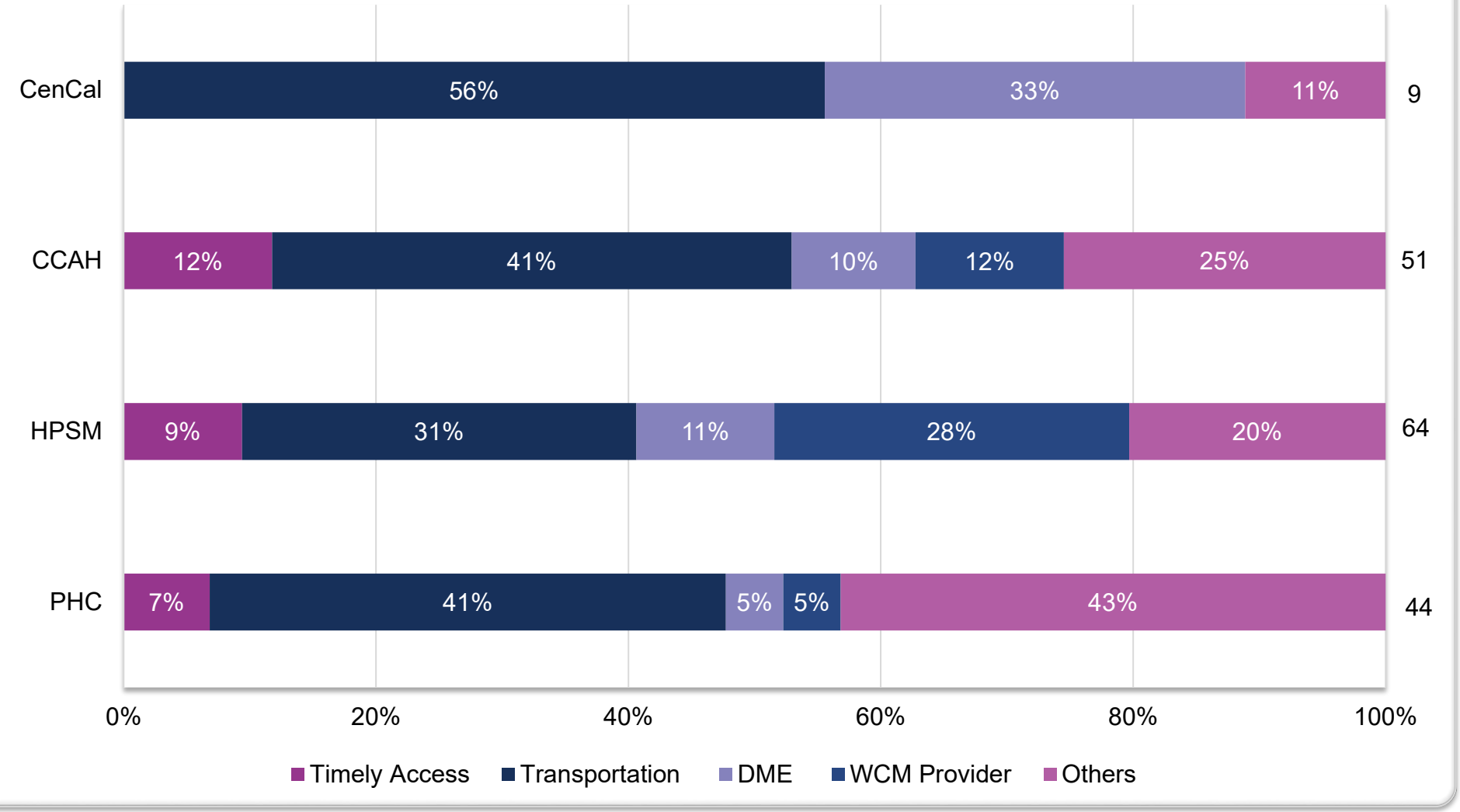


Fig 42: WCM Appeals, by Plan



Whole Child Model Figure 43: Grievances - Breakdown by Categories, by Plan (Jul'18 - Jun'19)

Fig 43: Grievances Categories, by Plan



Whole Child Model Figure 44: Family Advisory Committee Meetings Table (Jul'18 - Jun'19)

Plan Name	Number of Committee Members	Number of Meetings Held Jul'18 - Jun'19	Recruitment Efforts	Seats to be Filled
CCAH	16	13	Four new members were recently recruited and on boarded to the Alliance's WCMFAC in 2020. Ongoing recruitment efforts will continue regularly as seats remain open. Recruitment efforts of Alliance member committees include newsletter postings, mailings, and direct outreach to members identified by staff as being engaged in care or case management and interested in sharing feedback to continually improve the program.	16 of 17 filled
CenCal	19	4	Actively seeking and sustaining representation from Consumer, providers and community stakeholders across the continuum of care for membership on the FAC.	N/A because all available seats are filled.
HPSM	15	4	Efforts are ad hoc as HPSM's Social Workers make contact with families.	N/A. Did not have a target number of seats to fill.
PHC	12	5	Engaging in numerous activities to not only recruit members for the FAC, but to encourage beneficiaries, their parents/caregivers and other to participate in the bi-monthly meetings.	16 out of 28 seats to be filled.