Key Element	CCS HEALTH PLAN (CCSHP) FOR CSHCN
Target Pop	▪ All kids with CCS-eligible conditions, regardless of payer source (CCS could be tightened to include only conditions requiring complex case management and/or expected to last at least 12 months)
Enrollment	▪ Mandatory in pilot region ▪ Medical/financial eligibility determination
Geographic service area	▪ One or more contiguous counties in single region
Covered Benefits	▪ All current Medi-Cal benefits ▪ All CCS-covered services for CCS conditions with all CCS-approved providers, institutions and vendors according to state CCS standards ▪ Care coordination ▪ Whole child carve-in to CCS, with primary care and non-CCS specialty care services made the responsibility of the expanded CCS program ▪ CCSHP has flexibility to provide non-covered benefits and services within specified criteria (e.g. medical and/or support services that currently are not Medi-Cal or CCS benefits and rates for DME and vendored services that exceed typical CCS reimbursement that are believed to promote healthier outcomes for the child)
Medical home/case management	▪ Each child will be assigned medical home based on the child's medical needs and family preferences ▪ Medical home could be primary care provider, specialist, or Special Care Center, with strong linkage to the CCSHPs nurse case manager ▪ Project will seek to provide medical home based care coordination/family support through collaboration with local family support organizations, including Parent Health Liaisons via contract between local family support organization and CCSHP ▪ Medical home provider working with CCSHP's nurse case manager will be responsible for directing the child to appropriate medical services, providing family-centered care, and coordinating services across the entire continuum of care for the child ▪ Tiered approach to authorization of services based on provider paneling and level of expertise via Service Code Groupings designed by the pilot for basic primary care services and for specialists/Special Care Centers/hospitals, subject to CCSHP medical team approval of treatment plan, with some services reserved for plan-level and perhaps even state-level authorization (such as out-of-state care) ▪ CCSHP staff will decrease time spent authorizing care and increase time in treatment planning, providing care coordination and oversight, including assisting with linkages among PCPs, specialists, hospitals, vendors and out of area services ▪ Hospital Liaison Teams will be based at major tertiary/quaternary institutions, and will include CCSHP nurse case managers and social workers ▪ Project will coordinate with CHDP at county level for better linkages and integration with primary care providers ▪ Project will build on existing local medical home and pediatric support activities where possible
Financing reimbursement model	▪ Fee-for-service for at least the first year for collection of accurate and reliable cost data (with appropriate actuarial consultation regarding length of time required to collect and analyze cost data) ▪ Construction of alternate payment mechanisms once cost data is secured, to include potentially capitation, global payments, bundled payments and/or enhanced reimbursement for PCP medical homes ▪ No risk (or minimal risk) for the first year ▪ Risk assumed once alternate payment mechanisms underway, with strictly defined risk corridor to ensure that children continue to receive appropriate care ▪ CCSHP to pay claims; no use of state Fiscal Intermediary
Program administration	▪ CCSHP responsible for overall design, implementation and administration of plan ▪ Project will actively collaborate with MCH programs at county level

Contracting options	▪ Contract with ASO or existing non-profit plan for infrastructure needs including data collection, management of primary care network, quality improvement activities, and claims/billing
Evaluation Points	▪ Timely access to appropriate level and location of care ▪ Child health outcomes (including community-based outcomes such as increased school attendance) ▪ Reduction in unnecessary ER visits and other measures of changes in health care delivery ▪ Family satisfaction with care and care coordination ▪ Cost analysis including analysis of project cost savings

Soman 4/9/10; rev. Obrinsky/Schlageter/Strunin 4/10/10