

Department of Health Care Services
California Children's Services (CCS) Redesign
July 17, 2015

STAKEHOLDER COMMENTS TO THE WHOLE CHILD MODEL

Comment Period:	June 12 – July 3, 2015
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Stakeholder	Category	Comment/Question
Sunthorn Sumethasorn <i>Medical Director, Public Health Los Angeles County</i> (E1)	Provider Network Adequacy	1. Inadequate number of providers. Many providers are not CCS paneled.
	Medical Loss Ratio	2. Unclear if MD fee could keep the CCS bump with the new structure. How could we ask the doctors to do more or the same with less? If the doctors were to keep comparable incomes, and managed care has to keep some profit, how could State spend less dollars doing so?
	Other or No Health Insurance	3. How does proposed model fit the 10-20% children with no insurance/private insurance? CCS program does not only care for M/C eligible children (approximately 80-90%), but also children with no insurance/private insurance.
	NICU	4. How can excluding NICU services from the proposed delivery model save the State more dollars? A good example of CCS projects is "Partners for Children, PFC", or Pediatric Palliative Care Waiver Program.
	Knowledge and Expertise with CCS Structure	5. CCS case management staff continually learn and educate themselves about times cutting edge technologies and the benefits are passed on to patients/families to direct them to the right providers. Would similar expertise/knowledge be maintained or carried on in the proposed structure. Children with CCS conditions receive expertise/knowledge of subspecialty car that is unfamiliar in the adult world.
Sunthorn Sumethasorn <i>Medical Director, Public Health</i>	Continuity of Other State Programs	1. The stakeholder raised numerous questions in regard to "State Programs," especially balancing satisfaction rate, cost effectiveness, and etc.

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<p><i>Los Angeles County</i></p> <p>(E24)</p>	<p>Out-of-Network Providers</p>	<p>2. How does the State address patient's need to seek specialty expertise outside the local managed care network of providers, through either regional (such as whole Southern California Region), Statewide, or through contracting process with Out-of- State providers?</p>
	<p>Rate Reimbursement and Loss Ratio</p>	<p>3. What is the required minimal medical loss ratio for the managed care plan(s) to participate in the CCS carve-in?</p>
	<p>Readiness Requirements</p>	<p>4. How does the State prepare to have a robust system and personnel to evaluate managed care plan's readiness, adequacy, at the beginning and going forward?</p>
	<p>Access to Care</p>	<p>5. How does the State regulate possibly varying negotiated rates for services, and benefits with providers and vendors by competing plans to ensure equitable access and distribution?</p>
<p>Kris Calvin <i>AAP-CA Foundation</i></p> <p>(E2)</p>	<p>Data</p>	<p>1. Absence of data showing a new system would be better for enrolled children, or even able to maintain quality while being less expensive for the state in the long-run.</p>
	<p>Financial</p>	<p>2. Greatest weakness of this proposal is the elimination of a financially disinterested party to implement care coordination and to make utilization authorization decisions.</p>
	<p>Provider Network Adequacy</p>	<p>3. Ensuring the adequacy of networks is essential to strengthen the family-centered nature of the “redesigned system”.</p>
	<p>Monitoring, Oversight, and Evaluation</p>	<p>4. Proposal does not include the following:</p> <ul style="list-style-type: none"> • State-established standards that a MH of a child with complex conditions must meet. • Continuous quality improvement/self-assessment requirements for MH. • Ongoing state implemented evaluation/monitoring or incentives for MH.
	<p>Case Management / Care Coordination</p>	<p>5. Transferring responsibilities for case management and utilization review to managed care plans will increase fragmentation of subspecialty care for CCS children, when compared to the current CCS system.</p>
	<p>Extend Carve-Out</p>	<p>6. We urge that the CCS carve-out be extended for a year before any model is proclaimed “new and improved” over what we currently have. This would permit an evidence base for</p>

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		any decision, including evaluation of the one CCS pilot currently in operation.
Helen G. Thomas <i>Association of Regional Center Agencies</i> (E3)	Case Management / Care Coordination	1. Emphasizes care coordination and streamlined service authorizations for expeditious service delivery, highlights the importance of care transition of young adults aging out of the CCS program.
	Continuity of Care	2. A mechanism in place to ensure care coordination process remains seamless and disruption of services is avoided/minimized.
	Financial	3. In the current CCS delivery system, care coordination decisions are made by financially disinterested CCS staff. Assigning both full financial risk and care coordination to health plans has the potential to create a barrier to access to needed services or equipment, particularly for expensive treatments or equipment.
	CCS Eligible Conditions	4. Attention given to the needs of children and youth that cannot be met under the chosen Managed Care Plan.
	Regional Centers Workload	5. Regional Center caseloads are high. If Regional Centers take on a more active role in the CCS process, funding must be in place for increased workload.
	Implementation Timeline	6. Concerned the implementation timeline may jeopardize the health plans ability to realistically deliver stated outcomes.
Diane J. Nugent, MD <i>Centers for Inherited Blood Disorders (CIBD)</i> (E4)	Oppose Model	1. Oppose proposed model as it does not ensure access to CCS SCC or paneled providers. Removes the authority to determine medical necessity for a rare disorder care from CCS SCCs and moves to Managed Medi-Cal Health Plans. 2. Support guiding principles of whole-child however missing is specific attention to rare high risk, high cost deceases.
	Access to Care	3. Does not ensure patient access to CCS rare disorder specialty teams. Potentially increases avoidable hospitalizations and raising costs.
	Blood Factor Carve out	4. Does not ensure a “carve out” of clotting factor.
Randall Curtis <i>Hemophilia Council of</i>	Data	1. No data to support the Department’s position that these medically fragile children would be better cared for under the managed care delivery system.

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California Diane J. Nugent Western State Regional Hemophilia Network (E18)	Access to Care	2. Proposal does not ensure patient access to CCS rare disorder specialty teams—California’s network of eleven federally supported hemophilia treatment centers.
	Blood Factor Carve Out	3. Proposal does not ensure a carve out of clotting factor, which is currently the policy under Medi-Cal Managed Care for both CCS and Genetically Handicapped Persons Program.
	Provider Network Adequacy	4. Proposal does not ensure network adequacy and oversight evidenced through the California State Auditor’s Medi-Cal Audit report.
Jacqueline Johnson Children’s Medical Services Kings County Health Department (E5)	Retain Current CCS Model Process	1. The current program is standardized and Counties follow the same guide lines, processes, procedures and does work. Why is there such a push to redesign the program and take it out the hand of the counties?
Jacqueline Johnson Kings County Public Health Department (SM19)	Dental and/or Vision	1. The Whole-Child Delivery Model sounds like the best way to benefit the child and assures complete care in a timely manner. Does it include dental and vision provisions?
	County Role	2. I am sorry that this concept was not presented to the counties to implement as part of the existing CCS program.
Deanna Hansen, CO Ray Tegerstrand’s Orthopedic Appliance (E6)	More Rural Health Information	1. Seek more input from the families. Rural Health is different, how. How will this proposed model affect the health of these children? Provide more “understandable” information for this group of individuals.
Judith Reigel County Health Executives Association of California (CHEAC)	County Role	1. If case management functions are to be moved to managed care plans, counties need to assess how best to perform their remaining roles. DHCS will need to develop an accurate and fair methodology for funding counties’ residual responsibilities. County staff and facility concerns if changes are only piloted.

Stakeholder	Category	Comment/Question
(E7)	Continuity of Care	<p>2. Plan a careful and deliberative transition process to assure that children continue to have access to their providers and that families receive the required care providers, care coordination, and assistance.</p> <p>Meaningful local process to assure that children care currently overseen by county CCS staff will continue to receive quality services by appropriate providers and those families receive support after their care coordination is transitioned to health plans.</p>
	Timeline	<p>3. Timeline proposed for transition is insufficient to assure that children are safely transitioned to a new system.</p>
	MTP	<p>4. The proposed model exempts health plans from financial risk for MTP services but does not discuss the MTP authorization process or how health plans will coordinate care with the county MTP programs.</p>
Lishaun Francis <i>California Medical Association</i> (E8)	Patient Provider Adequacy	<p>1. Currently beneficiaries have the choice of either fee-for-service or managed care providers; patients receive the best care when they have a choice about how to receive that care.</p>
	Timeline	<p>2. Support phased-in approach, shows an acknowledgement of the complexities involved with changing health care delivery systems for this vulnerable population. Recommend starting with smaller counties and slowly phase-in the project after receiving confirmation the transition was indeed successful.</p>
	Provider Network Adequacy	<p>3. Concerned about the adequacy of provider networks in the Managed Medi-Cal plans that will be covering CCS eligible beneficiaries. Beneficiaries will have an insurance card without true access to care.</p>
	Monitoring, Oversight, and Evaluation	<p>4. Concerned about whether staffing levels at the Department of Managed Health Care (DMHC) and in DHCS' Medi-Cal Managed Care Division are sufficient for performing monitoring and oversight.</p>
	Rates	<p>5. Adequate rates cover physicians' costs in both fee-for-service and the managed care Medi-Cal delivery systems. Insufficient rates have a direct impact on the health plans to adequately recruit and retain physicians to treat the CCS population.</p>
Patricia Alcalá, PA <i>Founder/Director of "Making Change For Children"</i>	Family Centered Care	<p>1. Inclusion of the family from the day the child is born/diagnosed with a chronic illness should be the beginning of their education into the health care world. Family member</p>

Stakeholder	Category	Comment/Question
(E9)		should feel respected as if they are a part of the team, not left out like an outsider.
Justin Garrett <i>March of Dimes California Chapter</i> (E10)	Carve Out	1. Ends the carve out of CCS services for children in certain counties from Medi-Cal managed care and does not contain the needed protections, consider the unique needs of these children and ensure that the essential entities are involved in the important medical decisions.
	Data	2. Lack of evaluation with current pilots. Title V surveys indicate that families in CCS are more satisfied than families in Medi-Cal managed care and CCS has been effective at cost containment.
	Provider Network Adequacy	3. No enforcement mechanisms to ensure CCS providers are being appropriately contracted by the plans. The proposal does not ensure that medical decision making remains with the SCCs.
	Family Centered Care	4. Vital for families to be actively engaged in the development of care plans and provision of services provided to CCS children.
	Audits	5. Health of CCS children is too important and too fragile to risk ending the carve out of critical CCS services from the Medi-Cal system given all of the issues that the audit found.
Laurie A. Soman <i>CRISS Project</i> (E11)	Access to Care	1. Concerns about the potential impact on timely and coordinated access to appropriate care for CCS children as well as on the state's entire regionalized system of care for all CYSHCN. In addition, the proposal also would dismantle the population-based, public health functions of the CCS program.
	Data	2. What data is the Department basing this proposal? What evidence does it have to indicate that transferring responsibility for core CCS services to Medi-Cal managed care plans with full financial risk would improve care to children with CCS conditions? The Title V Needs Assessment indicated high satisfaction among families with CCS services, including access to pediatric subspecialty care and CCS case management. For example, 89% of parents reported being very satisfied or satisfied with CCS case management services, and 82% of parents rated overall CCS services as scoring between 8 and 10 on a scale of 1 to 10.
	Provider Network Adequacy	3. No assurance of access to the entire CCS statewide provider network.

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		Concerned that any proposal that may weaken the CCS statewide provider network threatens the entire regionalized pediatric system of care that serves all children in California, not just those eligible for CCS.
	Case Management / Care Coordination	4. Moving responsibilities for case management and utilization review into many disparate managed care plans will increase the fragmentation of subspecialty care for CCS-eligible children, compared to the current system that governs CCS policies benefits and access.
Laurie Soman <i>CRISS</i> (SM39)	Implementation Timeline	1. The timeline is too ambitious and risky for children and the provider network. Recommend that implementation be delayed and the CCS carve-out be retained to encompass a much slower, more thoughtful and deliberative process.
	Other or No Health Insurance	2. How will Kaiser handle CCS children? Is DHCS planning to include children who meet the 20% income test in the model? Most already have insurance, so if yes, will they be made eligible for full-scope Medi-Cal? If not, how will their CCS services be accessed?
	Access to Care	3. How will the proposal protect access to appropriate providers if case management and care planning are transferred to plans at full financial risk with little or no experience managing the needs of this population?
	Reconsider Proposal	4. Urge DHCS to reconsider the approach as it poses a potential danger to the health and well-being of CCS children and a possible threat to the existing state's regionalized pediatric system.
Erin M. Kelly, MPH <i>Children's Specialty Care Coalition</i> (E12)	County Realignment	1. Recommend the Department provide a brief presentation on the Realignment structure at the next RSAB meeting.
	Data	2. No evidence based data to support.
	Two-Plan Model	3. The proposed model is not suited for two-plan model counties and recommends further stakeholder discussions to understand the complexity of these counties.
	MCMC Plans not Ready	4. Concerned the shift in control from SCCs to the managed care plans that are assuming risk. Providers will be jeopardized if case management, treatment plans, etc. reside with plans that are at financial risk.

Stakeholder	Category	Comment/Question
Erin M. Kelly <i>Children's Specialty Care Coalition</i> (SM30)	Specialty Care Centers (SCC)	1. Concerned about the shift in locus of control away from the SCCs, to the managed care plans that are assuming risk.
	Other Models	2. Concerned that the HPSM model cannot be replicated and may not be relevant, given its small CCS population and other unique county and health care characteristics.
	Monitoring, Oversight, and Evaluation	3. There is no reference in the current proposal, to conducting an independent evaluation for the counties that will be phased-in come 2017. This must be done before consideration is given to further expanding this model in other counties.
John Mosher <i>Program Specialist Bilingual, Marin CCS</i> (E14)	Case Management / Care Coordination	1. If changes to the CCS program result in closing local offices or shifting care coordination and other CCS services outside local communities, the result may erode the quality of care of our patients.
Pip Marks <i>Family Voices of CA</i> (E15)	Provider Network Adequacy	1. Concerns about traditional managed care. Our primary concern is the well-known criticism of managed care and lack of timely access. One of the most important components to families, who have children with special needs, is timely access to specialty care.
	Monitoring, Oversight, and Evaluation	2. Concern that DHCS is not prepared to monitor Medi-Cal Managed Care system, due to a recent audit.
	Extend CCS Carve-Out	3. Extend CCS carve out, review more models, and ensure essential components of the CCS program, include state quality standards, timely access to appropriate pediatric sub-specialty care, medical case management and care coordination, are maintained for CSHCN.
Pip Marks & Juno Duenas <i>Family Voice</i> (E17)	Provider Network Adequacy	1. Concern that DHCS will not ensure health plans have adequate networks to server beneficiaries evidenced through finding from the Medi-Cal Managed Care's audit report.
Pip Marks and Juno Duenas <i>FVCA and Support for Families of Children with Disabilities</i>	Access to Care	1. Evidence exists that commercial managed care plans have denied children with serious CCS-type medical conditions access to appropriate pediatric services (i.e., pediatric sub-specialists, pediatric therapies and medical equipment, and pediatric habilitation services).

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(SM12)	DME	2. DME is not mentioned. Acquiring the DME equipment (correct and specialized) is a struggle.
	Implementation Timeline	3. DHCS is not ready to implement the Whole Child Model. DHCS has not evaluated Managed Care CCS pilots and reported to the Legislature. 4. Concerned about the state audit "Improved Monitoring of Medi-Cal Managed Care Health Plans is Necessary to Better Ensure Access to Care." DHCS did not ensure that health plans had adequate provider networks to serve beneficiaries. 5. Please extend the CCS carve-out from Medi-Cal managed care for one more year, so DHCS can collect data, do evaluations on current pilots, and ensure our children have timely access to the specialty providers.
Ben Rubin, PH.D. <i>Children Now</i> (E16)	DME	1. DME is not mentioned. Acquiring the DME equipment (correct and specialized) is a struggle.
	Implementation Timeline	2. DHCS is not ready to implement the Whole Child Model. DHCS has not evaluated Managed Care CCS pilots and reported to the Legislature. 3. Concerned about the state audit "Improved Monitoring of Medi-Cal Managed Care Health Plans is Necessary to Better Ensure Access to Care." DHCS did not ensure that health plans had adequate provider networks to serve beneficiaries. 4. Please extend the CCS carve-out from Medi-Cal managed care for one more year, so DHCS can collect data, do evaluations on current pilots, and ensure our children have timely access to the specialty providers.
	Dental and/or Vision	5. Recommend explicitly articulating how dental and vision care will be included in the model.
	Monitoring, Oversight, and Evaluation	6. Recommend the Whole-Child Model include metrics and standards that will be used to assess the care experience of the patient and family and the efficiency and effectiveness of the CCS health care delivery system.
	Provider Network Adequacy	7. Recommend provider networks will be periodically reassessed by health plans and confirmed by DHCS post-transition, and what actions will be taken if health plans are not meeting relevant network adequacy standards.

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Ann Davis <i>American Academy of Physician Assistants</i> (E19)	Provider Network Adequacy	1. American Academy of Physician Assistants propose to allow physician assistants to apply to become paneled CCS providers.
Teresa Stark <i>Kaiser Permanente(KP)</i> (E20)	Continuity of Care	1. Support the continuation of existing fully integrated models, i.e. HPSM and KP, but seek clarity on what the provision means in more specific terms, to ensure our CCS kids are not disrupted from the whole child care they are currently receiving with KP.
	Kaiser Responsibilities	2. What roles will KP play in those COHS counties that do not have contractual agreement with KP?
	Capitated Rates	3. Seek confirmation that “plans would be at full financial risk” and will receive a capitation payment for CCS carve-in services. Important for KFHP because if a COHS asks KFHP to accept delegation of CCS carve-in services, KFHP will decide on an acceptable compensation structure. If COHS delegate their CCS carve-in duties and responsibilities to KP, whether KP will have an opportunity to negotiate acceptable capitation compensation.
Ann-Louise Kuhns <i>California Children’s Hospital Association</i> (E21)	Care Quality	1. Concerned that Medi-Cal Managed Care has a bad track record in terms of care quality especially in terms of care for chronically ill patients.
	Patient Satisfaction	2. Medi-Cal Managed Care has worse patient satisfaction compared to current CCS Program according to recent survey. 3. Medi-Cal Manage Care program for seniors with serious health conditions is not popular with enrollees, and more than 50% of eligible individuals opt out of the program.
	Monitoring, Oversight, and Evaluation	4. The Department, especially the Medi-Cal Managed Care (MCMC), appears to lack the capacity to provide even minimal oversight for the current population enrolled in MCMC, and it is difficult to believe that the Department could adequately monitor a CCS transition under these circumstances.
	Cost-effectiveness	5. Current CCS program is cost-effective and we question whether changes would be as cost-effective.

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	Access to Care	6. Proposal will destroy the current statewide network of CCS providers therefore impairs access to specialty care.
	Administrative Burden	7. New model will add administrative complexity, burden, and uncompensated cost to providers.
Sherri R. Sager <i>Lucile Packard Children’s Hospital</i> (E22)	Case Management / Care Coordination	1. Concerned that Medi-Cal Managed Care lacks the expertise to manage care of CCS children, designing treatment plans, determining the locus of care, issuing service authorizations, and monitoring service delivery, especially at the financial full risk of health plan.
	Access to Care	2. Under the new proposal, children would not be ensured access to the full CCS provider network.
	Monitoring, Oversight, and Evaluation	3. Department’s track record is poor in oversight, monitoring, and enforcement and this poor track record will repeat under the new proposal.
	Monitoring, Oversight, and Evaluation	4. Proposal will be implemented without adequate planning or evaluation, and affect more than 50,000 CCS children.
Wendy Longwell <i>Rowell Family Empowerment</i> (E23)	Case Management / Care Coordination	1. Concerned the new proposal for Medi-Cal Managed Care will not be able to handle the needs of CCS children (most fragile clients).
	Eligibility	2. Concerned the existing CCS offices will still be in charge of eligibility reviews and the counties will be in charge of the MTUs, this proposal would create a fractured system.
	Provider Network Adequacy	3. Concerned proposal will lose specialists and fail to maintain an adequate provider network.
	Maintenance & Transportation	4. Current CCS system reimburses children and family’s transportation to see the child’s specialists. Concerned the proposal will not cover transportation to ensure care.
Cater O’ Connor <i>San Diego CCS</i>	Monitoring, Oversight, and Evaluation	1. Since there was no formal evaluation implemented on this Demonstration Project, what outcome measures and objective data can be shared that demonstrates the effectiveness of this model?

Stakeholder	Category	Comment/Question
(E25)	Data	<p>2. Can you show comparison before and after the Carve-In/Pilot?</p> <ul style="list-style-type: none"> • Change if any on San Mateo County’s funding obligation • Change if any on DHCS’ role • Change if any of HPSM’s role; financial risk • Staff satisfaction • Patient/Family satisfaction
Norma Williams <i>Public Health Nurse in Del Norte County</i>	County Role	<p>1. What role will county staff play in the new proposal? Concerned that the new proposal will affect current staff. Comment (to voice) frustration that line staff did not have an opportunity to voice opinions.</p>
(E26)	Case Management / Care Coordination	<p>2. Removing care coordination from local staff to health plan will take away the local knowledge and presence, which have been tremendous support for family.</p>
	MTP	<p>3. Del Norte County is currently contracting with others to provide MTU services. How would this change under the new proposal?</p>
	County Role	<p>4. Questions regarding County CCS staff’s versus Regional Offices roles and responsibilities.</p>
Paulomi Shah <i>Sonoma County</i>	Monitoring, Oversight, and Evaluation	<p>1. What structured evaluation was done in HPSM and RCHSD pilots to support that the whole child model would be best if rolled into the health plans? What collection tools will be used and what standards would be set regarding future outcomes with these health plans?</p>
(E27)	Title V	<p>2. Based on Title V needs assessment, families were satisfied with the CCS program. Why not continue to incorporate the whole child approach into CCS instead of the health plans? Or consider subcontracting.</p>
	Case Management / Care Coordination	<p>3. County staff are trained and licensed to provide care coordination and case management, why eradicate county roles? 4. Partnership Health Plan has not provided any additional care coordination to any of our clients. Who will perform the role of the licensed nurse case manager that currently exists in county CCS programs?</p>
	Family Centered Care	<p>5. Currently county CCS programs have Social Service Workers and Public Health Assistant positions that provide support and guidance to our CCS families. Such collaboration will</p>

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		disappear under the new model.
	Provider Network Adequacy	6. Concerned the program will lose providers, especially specialists, if the same level of reimbursement is not maintained.
	Continuity of Care	7. How will the health plans take over this practice to ensure there is continuity of care with adult specialists?
	MTP	8. How will there be integrated care coordination with the Health Plans? Will the new Redesign proposal allow children who are financially ineligible continue to remain medically eligible for the MTP?
	Eligibility	9. Inquire clarification on the status of the CCS-only kids during the implementation phase.
	Maintenance & Transportation	10. Will some of the critical benefits of the CCS program remain intact given the cost of traveling (i.e., gas, bridge toll, parking)?
Amy Carta <i>Santa Clara County</i> (E28)	Other or No Health Insurance	1. How will the program operate for those families with private coverage?
	State / County Relationship	2. Concerned regarding services authorization.
	Provider Network Adequacy	3. Concern that COHS do not have the CCS paneled providers necessary since there will be obstacles phasing in a new provider network.
	Monitoring, Oversight, and Evaluation	4. Lack of current quality measures and reports to measure performance and evaluate the program. DHCS should develop standards of care and quality measures for medical homes and care coordination.
	Readiness Requirement	5. More details needed in term of readiness requirements
Elizabeth Russel <i>Los Angeles County Public Health</i> (E29)	Eligibility	1. What happens with the CCS only children? 2. What happens with the children that go from one financial situation to another, e.g., Medi-Cal to CCS vice versa?
	DME	3. What happens when the DME needed cannot be provided by a contracted vendor?
	Provider Network Adequacy	4. What happens if a specialty provider cannot or will not contract with the plan?

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	Transition of Care	5. What happens when the children transfer from San Mateo to another County?
	Monitoring, Oversight, and Evaluation	6. How did the pilot start with no outcomes measures in place?
Elizabeth Russel <i>Los Angeles County - Children's Medical Services</i> (SM9)	Reconsider Proposal	1. Proposed model appears limited and based on one small County that is not representative of the State. Strengthen the whole-child model by allowing customization to suit the specifics of the Counties.
	CCS Only	2. Wording includes the CCS only population but no mechanisms to do this are addressed. There is no representation for social work, audiology, dental, and occupational therapy with very limited physical therapy, nursing and physician staffing.
	Monitoring, Oversight, and Evaluation	3. Given the lack of State medical professionals how will these plans be developed and monitored?
	Transition of Care	4. Provide regulatory safeguards to assure that youth aging out of CCS (i.e., Medi-Cal or commercial plans) have transition programs.
	MTP	5. Preserve the present Medical Therapy Program model.
	Implementation Timeline	6. Not enough time to allow the implementation and evaluation of various methods of achieving the whole-child model. Given the State's diversity, multiple whole-child models need to be implemented and evaluated.
John Sullivan <i>Redwood Coastal Regional Center</i> (E31)	Provider Network Adequacy	1. Raise a question of whether health plans will include current CCS nurses and physicians in the provider network
John Sullivan MD <i>Pediatrician</i> (SM37)	Implementation Timeline	1. Unclear how effectively DHCS will be able to implement, or what will happen when/if plans deviate from requirements, or whether DHCS will be able to improve past performance in monitoring and enforcing compliance in regulating managed care plans. Unclear how capitated full financial risk health plans will both be able to selectively contract with providers while maintaining "existing member/provider relationships" (in short or long term?)

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		Slow down process, subject pilot counties' projects to careful and meaningful scrutiny prior to full state implementation and/or dismantling of CCS infrastructure.
Farrah McDaid Ting <i>California State Association of Counties</i> (E32)	Stakeholder Engagement	1. CSAC respectfully requests the opportunity to be added as member of this Advisory Board.
	County Role	2. Counties are concerned with the potential impacts to county staffing, continuity of care, and other administrative concerns potentially created by this proposal.
	MTP	3. Additional details regarding the Department's vision for how the MTP program may be impacted by this proposal are needed.
	Implementation Timeline	4. CSAC urges DHCS to incorporate flexibility into the timeline and to use initial and ongoing assessments to inform the appropriateness of proceeding with the next phase of implementation.
Stephen R Melli <i>Assistant Medical Director, LA County CCS</i> (E33)	Family-Centered Care	1. Concern that the proposal will create a void of appropriate pediatric subspecialists to provide care.
	Other or No Health Insurance	2. There is no attention paid to the CCS eligible children who have no health coverage or those with private insurance, but still meet CCS financial eligibility criteria.
	Medical Loss Ratio	3. Note that the current Medical Loss Ratio (MLR) is about 8%, and concern that putting the program under Medi-Cal Managed care would only worsen/increase the MLR. 4. Also inquire about an estimated capitation rate to the MMCP per member that would take into account the extreme expenses of the CCS population.
Sharon Collier, RN <i>Valley Children's Hospital</i> (SM1)	Eligibility	1. CCS Medical eligibility criteria for services need revision in several disease categories; 41848 Diseases of the Respiratory System and 41811 Infectious Diseases.
Anita Richards <i>No organization</i> (SM2)	Data	1. Keep the whole child model with County CCS. Concerned with loss of services with managed care. Need more data before model change decision.
	Stakeholder Outreach	2. Letters should be sent to families for comment about the implementation.
Anonymous 1	Transparency &	1. Implement measures requiring Health Plans to provide reports on how they are doing.

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<i>No organization</i> (SM3)	Accountability	Keep reports available to DHCS staff, stakeholders and CCS families.
	CHDP	2. The Whole-Child Model also needs to absorb/integrate CHDP services.
Anonymous 2 <i>No organization</i> (SM4)	Implementation Timeline	1. Timeline does not bring on large urban areas until later. Many details will be missed with this approach. 2. Bring 1 to 2 major population centers in early on the process and carefully monitor issues.
	Monitoring, Oversight, and Evaluation	1. Key features will ensure that COHS and other Medi-Cal Managed Care plans maintain CCS required standards for care delivery.
Anonymous 3 <i>No organization</i> (SM6)	MTP	2. Give more details of how the county will maintain MTU services.
	Case Management / Care Coordination	1. As a carved in county directly impacted by this model, the Partnership Health plan of California has not demonstrated any expertise in case managing the needs of CYSHCN. 2. CCS in carved in MCMC counties will case manage the whole child.
Pat Howard <i>Napa County CCS</i> (SM7)	Lack of Model Options	1. There should be more than one option for stakeholders to compare and consider.
	County Role	2. What are you going to do with all of the seasoned case management professionals who know the CCS case management program and spent months/years learning the “ins and outs” of this complicated system?
	Provider Paneling	3. Decision makers are out of touch with the children who need services. The paneling system is a joke because it takes too long and the database is not current.
Anonymous 5 <i>No organization</i> (SM10)	Provider Network Adequacy	1. Many counties have inadequate networks of CCS paneled providers and inadequate access to current CCS specialty care.
	RSAB	2. Examination of the CCS Advisory Group to ensure it has adequate stakeholders to manage leadership and guidance.
	Continuity of Care	3. In most counties children see the same providers for specialty care regardless of who is funding the care. If the current funding structure is blocking access to care, continuing the existing funding structure will not prevent 'disruption or erosion in care' as that already occurs for many families and children.

Stakeholder	Category	Comment/Question
Kathryn Carlsen <i>Placer County CCS</i> (SM11)	MCMC Plans not Ready	1. No adequate infrastructure in place or contracts with providers in current Medi-Cal Managed Care (MCMC) plans to provide adequate care for this population. Current MCMC plans have difficulty with the current system in providing the treatment and necessary follow-up
Anonymous 6 <i>No organization</i> (SM13)	Provider Network Adequacy	1. Concerned Primary Care Physicians will be allowed to take on more of the disease management in rural counties where specialists are limited. COHS may also have smaller specialty provider networks (i.e., Partnership not currently contracted with all of the Specialty Care Centers we use).
	RSAB	2. Limited representation of rural northern California on CCS Advisory Board.
	Monitoring, Oversight, and Evaluation	3. Recent State Auditor reported on lack of Managed Care Plans oversight and quality assurance of provider networks.
Anonymous 7 <i>No organization</i> (SM14)	Reconsider Proposal	1. DHCS staff in charge of the stakeholder process has not been listening to the experts for several months. The Whole Child Model proposed has no basis in any of the discussions and will fail to serve the children.
Rose Clifford <i>SFDPH CCS</i> (SM15)	Dental and/or Vision	1. You cannot assure comprehensive services without including oral care. Please include dental with the "specialty care providers".
	County Role	2. An important necessity for these children and their families is to have partners that are their individual health care advocates. Local county CCS case managers can enhance and provide this role over managed care.
	Implementation Timeline	3. Not enough time.
R. Lee Fitzsimmons <i>Santa Cruz County CHDP</i> (SM16)	Dental and/or Vision	1. Concerned vision and oral health were not specifically mentioned. Vision and oral health is often missed. Include to the Whole Child Model "oral health" and add a dental referral schedule to the initial health assessment and annual reassessments periodicity.
Theresa Anselmo <i>Center for Oral Health</i>	Dental and/or Vision	1. No mention of oral health as a component of the model. Oral health should be added to the methodology and services covered. Dental conditions, beyond malocclusion, are already incorporated into CCS services, and are part of the EPSDT benefit.

Stakeholder	Category	Comment/Question
(SM17)	Dental and/or Vision	2. Include dental health, as a service, within the MTU. Ongoing pilot programs currently include the services of a Registered Dental Hygienist/Registered Dental Hygienist in Alternative Practice on site, or comprehensive services in a mobile/portable model.
Carol Schaefer <i>CHDP/CCS Sacramento CA</i>	Dental and/or Vision	1. No mention of dental or vision in this model. To maintain the CCS core program and infrastructure included these two benefits to the "Whole Child Model".
(SM18)	Case Management / Care Coordination	2. Who in the State will be monitoring the case management/care coordination and plans? How many case managers and auditors will the State hire to insure that plans are adhering to requirements?
Sara Copeland, MD <i>Santa Clara County Public Health Department</i>	Other or No Health Insurance	1. The proposal does not address those clients who have third party insurance. How will this model work with children who have high deductibles or high co-pays that reach >20% of out of pocket costs?
(SM20)	Implementation Timeline	2. The timeframe for the outlined requirements is short and lacks any current framework for development from the State.
	Title V Requirements	3. The Title V grant application outlines increased involvement by the State and State health departments in the care and outcomes of CYSCHN. The migration from local health departments is not in line with the community based systems and puts the Public Health Department's funding at risk.
	Medical Necessity	4. Medical necessity is not addressed in the transition and the understanding of the Numbered Letters (100s) and the multiple Regulations will be lost by this move.
	Monitoring, Oversight, and Evaluation	5. Phase 2 should be a 6 month evaluation period to test all the requirements, quality measures and readiness criteria.
Eileen Rodgers <i>CCS Shasta County</i>	Case Management / Care Coordination	1. Concerned the case management duties that are currently performed by public health nurses at county level will be lost in the transition to managed care (i.e., families will not be connected with community resources).
(SM21)	Rural Health Clients	2. M&T is important in rural areas of Northern California, without assistance families may not travel to Sacramento or Bay Areas for medical services. Managed care organizations may not provide M&T assistance to families.

Stakeholder	Category	Comment/Question
Ana Stenersen - on behalf of the 5 Carve In Counties <i>CCS Santa Barbara (also representing Yolo, Napa, Solano, Marin)</i> (SM22)	Case Management / Care Coordination	1. Workload of case managers will increase. How will this be mitigated? A formula has to be created to determine workload and necessary FTEs due to increased case management responsibilities.
	Readiness Requirements	2. How will DHCS measure Health Plan's readiness?
	Monitoring, Oversight, and Evaluation	3. Goals listed for the redesign are too broad and generalized to measure.
Margaret Fisher <i>SF Department of Public Health</i> (SM23)	Dental and/or Vision	1. Dental care is essential to the overall health of the CCS child. Dental access needs to be spelled out for Managed Care Plans to ensure access for routine preventive care and specialized restorative /surgical dental care for CCS children.
	Monitoring, Oversight, and Evaluation	2. How will monitoring be reported to community stakeholders? How will transparency be ensured?
Thakur <i>Ravenswood Family Health Center</i> (SM24)	Dental and/or Vision	1. Whole Child Model needs to include the dentist as an essential member of the care team. Early establishment of a dental home will prevent the high costs of restorative care. At a stakeholder engagement level, it is critical to have a dentist/ dental consultant on the team as revisions and policy changes are considered.
Karen Krumenacker <i>Humboldt County Public Health</i> (SM25)	Dental and/or Vision	1. No mention of dental services, vision services, or other services that the child may require.
	Case Management / Care Coordination	2. Would there be one or multiple Case Manager(s) for all identified problems, referrals, and the needs for the child (i.e., including the CCS-eligible and non-CCS eligible conditions)?
Eileen Richey <i>Association of Regional Center Agencies (ARCA)</i> (SM26)	Full Financial Risk	1. Assigning both full financial risk and care coordination to health plans has the potential to create a barrier to access needed services or equipment, particularly for expensive treatments or equipment.

Stakeholder	Category	Comment/Question
	Regional Centers	2. The proposal addresses the need to include other systems of care, such as the Regional Center (RC) system as part of the interdisciplinary care team. Suggestion that the redesign team clarify the expectations for including the RC. Regional center caseloads are high. If the expectation is for RCs to take on a more active role in the CCS process, sufficient funding must be addressed for the increased workload.
	Provider Network Adequacy	3. Concerned there may not be enough specialty and subspecialty providers for select members who are very medically fragile with very specialized needs.
Angela Dreyer, RN, MSN, PHN <i>CCS LAC</i> (SM27)	MTP	1. Retain both the NICU and MTP clients, which are currently in CCS, and will reduce fragmented care.
	Carve Out	2. CCS with the Carve Out model has an overhead cost of 7%, and is far less than any managed care plan can offer. It is more cost effective to retain the Carve Out Model.
Elizabeth Evenson <i>California Association of Health Plans</i> (SM28)	Provider Paneling	1. Access challenges exist which are a result of the CCS paneling process. A number of hospitals have the capacity and ability to serve the CCS population, but have not been CCS-certified due to the lengthy CCS paneling process (i.e., up to six months for providers and two years for facilities).
	MTP	2. Request clarification on whether MTP would be carved-out in the CCS carve-in counties. Which entity will be responsible for authorizations for MTP services and how will the coordination between the plan and the authorizing body for MTP occur?
Hanh Pham <i>Health Plan of San Mateo</i> (SM29)	OHC / Kaiser	1. Will all CCS clients be included in the Whole-Child Model? No mention of children with Other Health Coverage Primary and Medi-Cal/CCS secondary. 2. How will Kaiser Permanente (KP) interact with the health plans? Currently, with KP, CCS care is carved out of our contract with our KP patients. There is disagreement over who pays for treatment, and is the condition CCS related.
	Provider Paneling	3. Is there a way to ask CCS-paneled providers to make a good faith effort to contract with the Health Plans? Major providers, like UCSF, will not engage with us in contracting talks. When a patient needs to be seen at UCSF, we need to execute a one-time contract for the patient to get care.

Stakeholder	Category	Comment/Question
	Health Assessment and Care Plan	4. Please provide some statewide guidance on what should be on a health assessment and care plan. The State could work with CMSNet to provide a platform within E-47, so a County could record client assessments and care plans.
	Information Technology (IT)	5. I think the CCS Advisory Group should have a sub-group that only focuses on IT, and how to create an IT strategy for CCS.
	Monitoring, Oversight, and Evaluation	6. No mention of an evaluation. It is important to include an evaluation component so that there is evidence on the model's effectiveness.
Dave Kramer-Urner <i>County of Santa Cruz CCS, Medical Therapy Program</i> (SM31)	RSAB	1. There has been significant concern that the RSAB process was not effective and did not guide the development of the DHCS proposal in any meaningful way. How would a future CCS Advisory Group assure that stakeholder engagement brings different results?
	Implementation Timeline	2. Oppose any fixed implementation timeline that precedes thorough evaluation and assessment of the HPSM pilot.
	Monitoring, Oversight, and Evaluation	3. No formal evaluation. Lack of evidence to talk about implementation dates.
	Readiness Requirements	4. Support development of detailed readiness requirements, and believe these should be in place before setting a date for implementation of a Whole Child proposal.
	Electronic Health Record	5. Development and testing of an integrated electronic health records system is critical, and should precede setting a date for implementation.
Liz Duffy <i>Placer County CCS</i> (SM32)	Provider Network Adequacy	1. How do you propose that the MCP will contract with each CCS paneled provider? Who will provide oversight? MCP are a business model -based on making a profit. How does this philosophy fit into caring for the high cost, vulnerable population?
	Monitoring, Oversight, and Evaluation	2. Has the State Auditor's Report on Managed Care Plans documenting poor performance and lack of oversight been reviewed with shortcomings addressed by the Stakeholders group?
	Capitated Rates / Full Financial Risk	3. Has the capitation for the MCPs been established if they are to be at full financial risk. What about clients that have MCP + OHC? What about the undocumented client? The issue with payment is the difficulty in getting paid timely.

Stakeholder	Category	Comment/Question
Ralph Moran <i>No Organization</i> (SM33)	Data	1. Model was designed without data with respect to health outcomes and the cost saving places financial burden on tax payers. The Model fails to provide coordinated care and would fragment services since it does not include MTP/NICU services. The whole child care services are provided in current CCS model.
	Full Financial Risk	2. The Model is financially irresponsible. It did not take into account public's (both family and CCS client) or the CCS Redesign Stakeholder Advisory Board (RSAB) impute when the model was redesigned. It only benefits Manage Care's profits which is evident by the exclusion of MTP client and NICU kids.
pamro12113 <i>No Organization</i> (SM34)	Reconsider Proposal	1. Continue with recommendations from the CCS RSAB which were not included or consulted with the "Whole-child delivery Model". Use data available from 'Carve Out' counties to design a model that is based on outcomes and cost while assuring quality care coordinated services.
	Data	2. Model was designed without data with respect to health outcomes and cost saving which places financial burden on tax payers. The Model fails to provide coordinated care and would fragment services since it does not include MTP/NICU services.
Leticia Gutierrez <i>LA County Children's Medical Services</i> (SM35)	Provider Paneling	1. LA County Redesign pilot proves that having higher standards through CCS paneled providers and CCS approved hospitals improves patient outcomes.
	MTP	2. The whole child model does not include MTP and NICU clients which will create a gap in care. MTP and NICU children have very complex needs and require care coordination.
	Data	3. The whole child pilot is not based on best practices because there is no data or evaluation to support it. Medical managed care plans will create fragmented care for CCS clients as they delegate to IPAs and medical groups which dilutes care.
Patty Chan <i>No Organization</i> (SM36)	Full Financial Risk	1. Concerned with the financial risk to the COHS. Will there be funds to assure the COHS have the funds to build an enhanced reimbursement system?
	Medical Homes	2. Will there be enough medical homes to accept individuals with eligible conditions, to continue managing the person beyond the age for CCS? Devise a mechanism to enhance payments to medical homes who are FQHC (federally qualified health centers).

Stakeholder	Category	Comment/Question
Anonymous 8 <i>No Organization</i> (SM38)	Implementation Timeline	1. Phase 2 challenging based on the enormous scope of change, especially for rural counties where access to qualified care is already a challenge for our clients, and MCP is located hours away.
	Specialty Care Centers (SCC)	2. In our County, there are NO SCC's and our local MCP does not have existing contracts with many of the SCC's used by our County.
	Maintenance and Transportation	3. Out-of-county travel is frequent for our CCS clients, families need M&T. How can we ensure that the MCP plan will authorize non-contracted SCCs? How will our clients get M&T assistance?
Eileen Espejo <i>Children Now</i> (SM40)	Dental and/or Vision	1. Dental needs and access to oral health services need to be made more explicit, as part of the key features that comprise the consumer protections, plan readiness, and access monitoring of this model. Dental needs to be made more explicit as part of the key features that comprise this model.
Chris Dybdahl <i>RSAB Member; Santa Cruz County CCS Administrator</i> (SM41)	Monitoring, Oversight, and Evaluation	1. DHCS needs to prove it is capable of overseeing and ensuring that CCS standards are uniformly maintained, that business interests at any level do not impede access to care, administrative care coordination be staffed by public health nurses and licensed, culturally competent social workers.
	Case Management / Care Coordination	2. Why remove care coordination from CCS which has experts, PHNs, SWs, paraprofessionals, and the highly integrated MTP team?
	Provider Network Adequacy	3. The existing CCS network currently available is the best, is simple, and fair. Current policy, states when families wish to use services more distant than the closest equivalent provider, the family has to bear all costs of T&M.
	RSAB	4. This proposal came forth at the midpoint of RSAB in-person meetings; RSAB has not agreed to it. For Secretary Dooley it appears to be a fait accompli. Did someone misrepresent to the Secretary that RSAB was all on board?