CCS Models of Care

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Two Models of CCS at PHC

- County Organized Health System (COHS)
- Medi-Cal Managed Care in 14 Counties
  - 4,000 CCS members in PHC Counties
- 10 Counties CCS are “Carved Out”
  - Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Sonoma, and Trinity
- 4 Counties CCS are “Carved In”
  - Marin, Napa, Solano, and Yolo

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Carve-Out Model

- CCS counties may be dependent or independent
- The CCS program is responsible for eligibility and authorization of services; and works with PHC on the coordination of services related to the child.
- PHC is responsible for providing services not under CCS conditions; and working with the county on care coordination.
- All CCS services are paid by FFS Medi-Cal. The CCS provider bills the state who pays for these services.

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Carve-In Model

- County CCS is responsible for eligibility and authorization of services (all are independent counties within PHC service area)
- PHC is responsible for coordination of CCS and non-CCS services the child is authorized to received.
- The state gives PHC a capitated payment to include all CCS and non-CCS services a child receives.
- The CCS provider sends the claims to PHC who pays.

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Experience with Carve-In Model

- Allows PHC to be the primary point of contact to address concerns relating to:
  - Continuity of care;
  - Open communication among all parties including physicians providers and families;
  - All CCS and non-CCS related care and billing issues; and
  - Fragmented care

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Partnership Model to Engage Members and Families

- Determine PHC Eligibility
- High Level of Customer Service
- Continuity of Care
- Access to Care
- Fiscal Responsibility
- Coordination of care for the “whole child”

- Examples: Dedicated Members Service and available staff, member focus groups, and community training

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Partnership Model - CCS

- PHC holds quarterly meetings with CCS agencies throughout our service area using in-person, telephonic and video conferencing. This increases collaboration across county lines and allows agencies to share issues and concerns and share their innovative activities.
- Members with an active CCS case are placed in a “special member” status that allows them to receive care throughout California without referral from PCP
- PHC has access to DHCS’ PEDI system to check on authorizations
- Internal IT system flags all CCS eligible members and tracks all authorizations, and CCS Case openings and closings.

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Care Coordination - CCS

- Special Program Case Managers are assigned by County/Region to act as liaisons to CCS, GHPP, and Regional Centers, tertiary care centers, providers, and members
    - Case Managers educated and experienced with youth who have special needs
- PHC and County CCS agencies work collaboratively to ensure all the member's health care needs are met
- PHC works as a coordinator to promote continuity of care regardless of the payer source
- PHC assists members with transition to adult care as they age out from CCS

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Benefits and Cost of the Carved-In Model

Benefits

- One stop shop for coordination – Single point of contact for families
- Improved communication amongst CCS and PHC
- Good working relationship with parents and advocates
- CCS Providers have one location to send claims

Costs

- Increased PHC staff and administration costs if all counties are carved-in
- Look at increasing demands of transportation needs of CCS population
- Invest in CCS provider training on how to bill PHC

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Ongoing Work

Areas Working Well

- Effective Communication
- Efficient problem resolution
- Improved Coordination of the “whole child” regardless of condition

Continued Development

- CCS provider trainings
- Would like to see more CCS data available to the plans.
- Expand access to more CCS providers in rural areas
- Increasing access to specialty care, Telemedicine, and transportation

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