CCS/Medi-Cal Children
Aging out of CCS

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MCHAP Meeting
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Presentation Outline

1. CCS Program Overview
2. Transition Pathways from CCS
3. Perspectives on Issues/Challenges
4. Strategies and Best Practices
5. Performance Measurement
6. Open Discussion
CCS Program Overview

Program Description

• The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions.

Common Diagnoses

• CCS-eligible conditions include, but are not limited to: chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae.

Administration

• The CCS program is administered as a partnership between county health departments and DHCS.
Transition Pathways from CCS
Transition planning is the process of preparing adolescents and families to move from a pediatric to an adult model of health care. 

*Health Care Transition to Adulthood* is the deliberate, coordinated process of moving a patient from pediatric oriented health care to adult oriented health care, with the goal of optimizing the young adult’s ability to assume adult roles and functions. 

(Mennito & Clark, 2010)
Transition Pathways for Adolescents Aging out of CCS

CCS

- Developmentally Disabled (DD) Waiver / 1915(i) SPA
- Home and Community-Based (HCB) Alternatives Waiver
- Assisted Living Waiver (ALW)
- HIV/AIDS Waiver
- Genetically Handicapped Persons Program (GHPP)
- Medi-Cal Managed Care
## HCBS Waiver Services

### Developmentally Disabled (DD) Waiver / 1915(i) SPA
- Case management
- Chore services
- Homemaker
- Home health aide services
- Respite care
- Habilitation
- Environmental accessibility adaptations
- Skilled nursing
- Transportation

### Home and Community-Based (HCB) Alternatives Waiver
- Case management (e.g. transitional)
- Home health aide services
- Home modifications to enable improved access
- Personal care
- Medical equipment maintenance and recurring expenses
- PERS (Personal Emergency Response service, installation and fees)
- Respite care (both at home and in residential care on a temporary basis)
- Habilitation
- Skilled nursing services

### Assisted Living Waiver (ALW)
- 24 hour oversight
- Personal care and assistance
- Health-related services: skilled nursing
- Arrange/provide transportation
- Social services
- Habilitation

### HIV/AIDS Waiver
- Supplemental skilled nursing
- Supplemental home health aide
- Homemaker services
- Nutritional Consultations
- Durable Medical Equipment and Supplies
- Transitional Services
Genetically Handicapped Persons Program (GHPP)

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<tr>
<th>GHPP</th>
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<tbody>
<tr>
<td>• Special Care Centers (SCC)</td>
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<tr>
<td>• Hospital stay</td>
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<td>• Outpatient medical care</td>
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<td>• Pharmaceutical services</td>
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<td>• Surgeries</td>
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<td>• Nutrition products and medical foods</td>
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<td>• Durable Medical Equipment (DMEs)</td>
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<td>• Home health services, such as skilled nursing visits</td>
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<td>• Therapy services, such as physical therapy, occupational therapy, and speech therapy</td>
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<td>• Mental health services such as psychotherapy counseling</td>
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<td>• Medical supplies</td>
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Perspectives on Issues/Challenges
Patients’ Perspective on the Issues/Challenges

Availability of Information:
- Unaware of the programs available
- Unaware of the process/timelines or how to apply

Access:
- Concerns with changes to adult providers
- Concerns with perceived access to subspecialists and specific services
- Language/cultural barriers with new providers
- Continuity of services
MCPs’ Perspective on the Issues/Challenges

**Data**
- Consistent data sharing with the CCS Program
- Access to the beneficiary-specific data with enrollment and claims information
- Lack of access to pharmacy data (carved-out medications)

**Barriers to Access / Continuity of Services**
- Number of CCS paneled providers in several counties
- Helping patients and their families transition from Pediatric Care to Adult Medicine
- Non-compliant patients/families due to hesitation of changing their physician
DHCS Perspective on the Issues/Challenges

Communication Between Delivery Systems

- Data sharing between the various programs/delivery systems and MCPs
- Promoting continuity of services for beneficiaries
- Facilitating best practices between CCS, MCPs, and Waiver Programs
Strategies and Best Practices
Strategies and Best Practices

DHCS Transition Planning

- Identify individuals who are going to transition to managed care and provide data to the MCPs for continuity of services planning
- Provide plan enrollment and Client Index Number (CIN) level information with authorization dates, service codes, and referring provider
- Provide enhanced monthly data that includes the past year of CCS, Specialty Mental Health, and Encounter/FFS claims
- Ensure current MCP requirements to provide case management, care coordination, and continuity of services
- Convene CCS Transition Collaboration meetings between DHCS Quality Improvement clinical staff, MCP Care Managers, and Medical Directors to identify and resolve transition of care issues
Strategies and Best Practices

DHCS Transition Planning (continued)

- Identify and outreach to individuals who are going to transition
- Identify waiver programs for which the beneficiary may qualify
- Have continued discussions with MCPs and DHCS on working through transition issues and best practices
Strategies and Best Practices

MCP Transition Planning

• Utilize enrollment and CIN-level data supplied by DHCS for continuity of services and transition planning
• Perform risk stratification within 90 days of plan enrollment (new requirement under the Managed Care Final Rule)
• Deliver current contractual requirements to provide case management, care coordination, and continuity of services
• Hold regular meetings with county CCS staff
• Participate in collaborative meetings with CCS and DHCS to work through transition issues and identify best practices
Open Discussion