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	guided by numbered letters and regulations still leave a lot open to interpretation. Multiple numbered letters outline the discretion of the medical director. In the move to COHS, the medical director is no longer a financially disinterested party and this leaves room for loss of benefits. 4. The fact that the COHS do not have the CCS paneled provider necessary and that there will be a phased-in basis for getting clients into CCS paneled care (point 5 in Section 2), leaves room for multiple clients to lose their current providers and be moved to unqualified and unpaneled providers at the cost of their care for the ease of the managed care plans. 5. The fact that there are not current quality measures or means to report, indicates lack of readiness by the state and the counties to truly understand the impact of these major changes. The quality measures and an initial assessment must be done prior to making this major move for clients in the most vulnerable populations. 6. There is no provision or support for rigorous case finding in the community or hospitals- so many clients who could potentially benefit from CCS case management will not have access- again dis-incentive for health plans to enroll more clients.	3. For point 4 DHCS will develop standards of care and quality measures for medical homes and care coordination partnerships between providers and CCS and/or the health plans for implementation in the 33 counties where the migration of care to managed care is still in process.	
Key Features of the Whole-Child Model	Questions and concerns regarding CCS Whole Child Model from CICs (Carve In Counties): Marin, Yolo, Napa, Solano, Santa Barbara • No data to support that this model is successful • No data to show any fiscal impacts of this model to CCS and Health Plan • No data to show effectiveness of care coordination or family satisfaction • Work load of case managers will obviously increase – how will this be mitigated?	Blank	Santa Barbara County CCS (SM22)

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	• A formula has to be created to determine work load and necessary FTEs as a result of increased case management responsibilities • How will DHCS measure Health Plan's readiness? • How will CCS appeals process be integrated with the health plan's grievance process? • There should be a plan for data and authorization system integration (IT, encryption, communication) • Goals listed for the redesign are too broad and generalized to measure		
Key Features of the Whole-Child Model	Dental Care is essential to the overall health of the medically fragile CCS children. Dental Access needs to be spelled out on how the Managed Care Plans are going to ensure this access for both routine preventive care AND necessary specialized restorative or surgically necessary dental care, for CCS kids.	Existing fully integrated models will continue as part of the Whole-Child Model, such as Health Plan of San Mateo and Kaiser Permanente. A MODEL THAT INCLUDES DENTAL CARE MUST BE INCLUDED HERE.	San Francisco Department of Public Health (SM23)
Key Features of the Whole-Child Model	The whole child model needs to include dentist as an essential member of the care team. Oral health is the most common unmeet health care need and often neglected. Early establishment of a dental home will hopefully prevent the high costs of restorative care	Blank	Ravenswood Family Health Center (SM24)
Key Features of the Whole-Child Model	Specify if there would be one, or multiple Case Managers to address the diagnose, referrals & needs of the child(ren)	Blank	Humboldt County Public Health (SM25)
Key Features of the Whole-Child Model	The current CCS system oftentimes results in conflict when providers from one county recommend services to be carried out in another county. It is ARCA's hope that any changes made to the existing CCS model will enhance care coordination and break down barriers to children and youth accessing needed services. ARCA is concerned with the proposal's heavy reliance on a pilot program that served very small counties which do not represent the experiences of families living in large counties. There are layers and complexities of MCP service provision. Commercial health plans contract with independent practice management groups which then	Blank	Association of Regional Center Agencies (SM26)

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	contract with independent practice associations which then contract with providers and physicians. These result in lengthy pre and prior authorization processes and could potentially impact the availability of financial resources to managing actual care of youth with special health care needs.		
Key Features of the Whole-Child Model	By leaving out NICU and MTP cases this will lead to fragmented care for those patients.	Leave in the NICU and MTP clients. As done in CCS now. Thus reducing fragmented care.	Los Angeles County CCS (SM27)
Key Features of the Whole-Child Model	The plans request more information on which entity (the plan or the Department) would be responsible for credentialing CCS providers. The Department's proposal does not address the existing access issues that are a result of the challenges with the CCS paneling process. There are a number of hospitals that have the capacity and ability to serve the CCS population, but have not been CCS-certified due to the lengthy CCS paneling process which typically takes up to six months for providers and two years for facilities. Plans request more information regarding network adequacy and how this will be monitored. Plans believe that is appropriate to have different standards for primary care physicians and specialists and would like to work with the Department on the establishment of those standards to reflect the availability of CCS providers. Plans also have concerns about the requirement that all plans contract with CCS-paneled providers to serve enrollees that age out of the CCS program. The paneling issues described above continue to be a challenge in this environment. Additionally, CCS providers often do not want to contract with health plans or accept the health plans rates. Furthermore, many CCS providers are focused on the pediatric population and it may be more appropriate to	Blank	California Association Health Plans (CAHP) (SM28)

Section	Comments on the Model	Proposed Revisions	Organization
	transition aged-out enrollees to different providers. The flexibility to do so should be built into any requirements related to CCS transitions.		
Key Features of the Whole-Child Model	Will ALL CCS clients be included in the Whole-Child Model? I didn't see any mention of children with Other Health Coverage Primary, and Medi-Cal/CCS secondary. In our Pilot, children with OHC Primary are included, but children who are CCS State-only are not. We are also concerned about how Kaiser Permanente will interact with the health plans since we have problems with Kaiser Permanente. Our main problem revolves around the fact that CCS care is carved out of our contract with our Kaiser Permanente patients. This means that there is ongoing tension over who pays for what treatment, and whether or not the condition is CCS related or not. This defeats the idea of the whole-child model. What can we do to eliminate this problem? For the CCS provider paneling process, is there a way we can ask CCS-paneled providers to make a good faith effort to contract with the Health Plans? We find that some major providers, like UCSF, won't even engage with us in contracting talks. This means that every time a patient needs to be seen at UCSF, we need to execute a one-time contract for the patients to get care there.	Include ALL CCS children in the Whole-Child model. Either require Kaiser to carve-in the CCS condition and care for the whole child, or disenroll patients from Kaiser upon their enrollment in the CCS program. Require CCS-paneled providers to make a good faith effort to contract with the Health Plans.	Health Plan San Mateo (SM29)
Key Features of the Whole-Child Model	The Coalition is concerned about the shift in locus of control away from the specialty care centers (SCCs), to the managed care plans that are assuming risk. We have significant concerns that timely access to providers will be jeopardized if case management, treatment plans and service authorizations reside with these plans that are at financial risk. Without specific payment models to support the resources required by CCS standards, there is a risk that SCCs will no longer be able to provide the depth and breadth of services for CCS patients. The model also does not assure that acuity based (risk based) care is provided to high risk children.	Blank	Children's Specialty Care Coalition (SM30)

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	The current CCS SCC standards are based on a fee-for-service reimbursement system and are vague as to the periodicity of care. The Department needs to adapt these standards to include risk based periodicity of care, when shifting the responsibility to health plans. Plans do not have the medical expertise across the subspecialty spectrum to allocate appropriate resources across the continuum of care; certainly there will be no incentive to do so. The allocation of resources has to be determined by the SCCs, not the Plan. Additionally, plans often contract with their own laboratory, and imaging providers who are not part of the CCS certified centers, and lack the expertise in complex pediatric conditions. This could compromise quality and result in treatment delays. CCS patients will have specific needs for high cost drugs, which are often not included in plan formularies. Without the ability to include co-pays, the formularies will likely be restrictive and have the potential to delay access to essential medications.		
Key Features of the Whole-Child Model	Please be sure to include all Medical Therapy Program medically eligible children in the Whole Child model. Requiring MCMC plans to contract with all CCS paneled (or panel-eligible) providers is important. Given recent acknowledgement that DHCS has not consistently monitored health plans to assure adequacy of networks to meet current Medi-Cal beneficiaries' needs, it will be important to establish how that will be corrected before adding this far more at-risk population to the MCMC rolls. Developing comprehensive CCS quality measures should precede roll out of this model. In particular, I hope DHCS will support the work of the MTP in this area, including development of a state-supported Electronic Health Record that integrates data collection capacity for quality assessment.	Blank	Santa Cruz County CCS, MTP (SM31)
Key Features of the Whole-Child Model	1. Placer County is almost 2 yrs into Medi-Cal managed care and we still have no MOUs nor have we had a care coordination mtg. Who will oversee the MCP to ensure clients are receiving adequate care?	Blank	Placer County CCS (SM32)

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	2. MCP are not contracted with one of the major medical centers in our region providing CCS care. 3. MCP have inadequate provider panels for primary, how do you think they are going to have adequate providers for specialty care? We do not have one OB in Placer county accepting new clients on either MCP. This has led to poor outcomes which we would be glad to discuss with the state.		
Key Features of the Whole-Child Model	Model was designed without data with respect to health outcomes and cost saving which places financial burden on tax payers. The Whole-Child Delivery Model fails to provide coordinated care and would fragment services since the Whole Child Delivery Model does not include MTP/NICU services. Whole child care services is already being provided in current CCS model which includes MTP/NICU services.	Continue with recommendations from the CCS Redesign Stakeholder Advisory Board (RSAB) which were not included or consulted with the "Whole-child delivery Model". Use data that is available from "Carve Out" counties in order to design a more real model that is based on outcomes and cost while assuring quality care coordinated services.	Individual / No Organization (SM33)
Key Features of the Whole-Child Model	Model was designed without data with respect to health outcomes and cost saving which places financial burden on tax payers. The Whole-Child Delivery Model fails to provide coordinated care and would fragment services since the Whole Child Delivery Model does not include MTP/NICU services. Whole child care is already being provided in current CCS model which includes MTP/NICU services.	Continue with recommendations from the CCS Redesign Stakeholder Advisory board which were not included not included or consulted with the "Whole-child delivery Model" Use data available from 'Carve Out" counties in order to design a more real model that is based on outcomes and cost while assuring quality care coordinated services.	Individual / No Organization (SM34)
Key Features of the Whole-Child Model	The San Mateo pilot is based on a CCS population of about 2000 clients with only 7 PHNs and 1 Senior nurse. This pilot does not realistically reflect the needs and complexity of the majority of chronically ill children throughout California. Again, no data to reflect positive outcomes.	LA county Redesign pilot proves that having higher standards through CCS paneled providers and CCS-approved hospitals improves patient outcomes.	Los Angeles County, CMS (SM35)
Key Features of the Whole-Child Model	Will there be enough medical homes to accept individuals with eligible conditions as the expectation is 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).	To assure to families and clients the continuity of care with their providers to the end of the CCS eligibility for that condition. Incorporate reimbursement recommendations for medical homes beyond the CCS age to build volume of providers	Individual / No Organization (SM36)

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Key Features of the Whole-Child Model	Many good points made: however 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?)	all the features need more detail and real allocation of resources and real means to monitored and enforced in reality.----------and need to wait to incorporate lessons learned prior to imposing on entire state.	Individual / No Organization (SM37)
Key Features of the Whole-Child Model	1. How will Kaiser handle CCS children if this model is implemented? 2. 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? 3. Please specify the continuity of care requirements under the model. Will they apply to all children who would lose access to a CCS-paneled provider once enrolled in the model? How long will they be in effect? 4. What level of state CCS staffing will be maintained in order to administer the program infrastructure including CCS provider paneling?	All the items in this section need a great deal more specificity.	CRISS (SM39)
Key Features of the Whole-Child Model	Dental needs to be made more explicit as part of the key features that comprise this model.	Wherever relevant, insert dental to ensure readers know this is included. In third bullet, following health plans insert "and Denti-Cal".	Children Now (SM40)
Key Features of the Whole-Child Model	I admire how existing CCS program has made improvements at county level and statewide. For instance, the program's interest in increasing the percentage of CCS clients with a medical home, and coordinating communication of medical reports between specialty providers and the medical home resulted in --- 95% CCS kids have medical homes! That other 5% certainly comprises a lot of "one and done" orthopedic clients plus new referrals/clients that CCS and in many cases MCPs	The reader who is a member of RSAB wonders about the last bullet -- "DHCS will work in partnership with recognized experts and stakeholders to develop comprehensive CCS quality measures and ongoing public data reporting". RSAB are such experts and stakeholders, but these subjects were not broached in meetings, except I suppose by the Data Workgroup, and if that is true then please integrate that Workgroup's recommendations into this section.	RSAB Member (SM41)

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	work to get into a medical home. So my question about the fourth bullet - "DHCS will promote medical home models and care coordination partnerships..., discussion of best practices and future modernization efforts into the remaining counties" is: Is DHCS' degree of exertion in these going to be different that the effort currently applied? As I said, counties have been modernizing and streamlining and improving care coordination practices and improving relations with pharmacies and SCCs all along (at least in my 13 yr experience). Counties are looking forward to amplified contact and support from System of Care. We cannot overlook the State's leadership in vastly improving CMS Net/Web, introducing service code groupings, even its informal communication tool, This Computes! and its data webinars (yay!). Lastly here, the model needs to respect client choice to access any provider anywhere in the state. Just declare it so. No reason to require MCPs to develop their own network of CCS paneled providers, certified hospitals and SCCs. That would reduce the quality of the program. This huge state has an appropriately huge, one of a kind network.	It is unfortunate that there is a mantle of incredibility over this bullet point. After all, this proposal came forth a 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?	
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	The pilot project proved nothing and therefore why put children's needs on the line. KEEP it with the local CCS offices.	Blank	Individual / No Organization (SM2)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	Transparency and accountability should be included in the Whole-Child Delivery Model. Please implement measures to have the health plans provide reports on how they are doing and have those reports be available not just to DHCS staff, but also stakeholders, and CCS families.	Blank	Anonymous (SM3)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	I agree that this will decrease confusion mostly for the clients and clients' families.	Blank	Anonymous (SM6)

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Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	As a carved in county directly impacted by this model in the near future, I can say without hesitation that Partnership Healthplan of California has not demonstrated any expertise in case managing the needs of CYSHCN.	CCS in Carved In MCMC counties will case manage the whole child	Napa County CCS (SM7)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	Given the lack of State medical professionals how will these plans be developed and monitored? Stakeholder input alone will not be sufficient to accomplish this task. The list of requirements are comprehensive but will require work beyond the capabilities of the present State system. There is no mention of coordination of contracts across Counties. Presently standards and policies (numbered letters and information bulletins) are developed by coalitions of medical staff at the County level and then approved and published by the State.	County CCS programs will participate in readiness reviews with funding from the State to provide this additional service. Controls will be in place for those families that move from one County to another to assure continuation of services - same benefits and access to same providers. The State will continue to develop standards and policies with increased medical staffing and input from coalitions of Counties.	Los Angeles County, CMS (SM9)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	Many counties have inadequate networks of CCS paneled providers, and inadequate access to specialty care now, under CCS. It does not seem that DHCS is strong enough of an entity to ensure coordinated access prior to the transfer to the managed care provider, if the agency cannot currently motivate or enforce county agencies to meet this requirement.	Blank	Anonymous (SM10)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	Will the state provide the funding for families to serve on the Family Advisory Committees – travelling expenses, stipends for time taken etc.?	Blank	FVCA & Support for Children with Disabilities (SM12)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	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 SCCs we use).	Blank	Anonymous (SM13)
Whole-Child Model Consumer Protections, Plan	5th bullet "Detailed protocols for enhanced care coordination..." Please include dental in this model.	Blank	San Francisco Department of Public Health CCS

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Readiness, and Access Monitoring			(SM15)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	I have a concern that even though primary, specialty, inpatient, outpatient, mental health, and behavioral health services are mentioned that vision and oral health were not specifically mentioned. So often vision and oral health is missed. As this model is termed the Whole-Child model it would be good to specify oral health and add a minimum dental referral schedule to the initial health assessment and annual reassessments periodicity.	Blank	Santa Cruz County CHDP (SM16)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	Again, it is imperative to include oral health and oral health providers. Oral health is a primary care service and should not be omitted from this model.	Detailed protocols for enhanced care coordination among primary, specialty, inpatient, outpatient, oral health mental health, and behavioral health services through an organized delivery system.	Center for Oral Health (SM17)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	There is no mention of dental or vision in this model, in order to maintain the CCS core program and infrastructure these two benefits need to be included in the "Whole Child Model". How will providers be counted in your assessment, will a provider's part time status be taken into account, or will all providers be considered FTE? Will duplicate locations count as a provider, or will each name be considered only once? Who in the State will be monitoring the case management/care coordination and plans? How many case managers and auditors does the State plan to hire to insure that plans are adhering to requirements.	Blank	Sacramento CCS, CHDP (SM 18)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	1. This whole section is an unfunded mandate for health plans without any prior development of standards or templates for development; this is in the 18 months prior to enrollment of the CCS clients and prior to receiving any client payments. It leaves the COHS and programs to demonstrate success when there are no measures of success outlined. 2. No enforcement is available or mechanism in place to ensure that counties will have these requirements	Prior to the implementation of this migration from CCS program control to managed care plans, DHCS will develop model templates and protocols that the health plans will demonstrate they have in place as a measure of readiness for this change in systems of care. The DMHC will have established program monitoring and quality measures and perform pre and post implementation assessments with the COHS.	Santa Clara County Public Health Department (SM20)

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	outlined. 3. The timeframe to have these outlined requirements is incredibly short and lack any current framework for development from the state and does not provide any support to these small rural counties to meet the requirements. 4. There is no indication of how the state will assess readiness. This should be a high priority in order to ensure success of the new model.		
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	Questions and concerns regarding CCS Whole Child Model from CICs (Carve In Counties): Marin, Yolo, Napa, Solano, Santa Barbara • No data to support that this model is successful • No data to show any fiscal impacts of this model to CCS and Health Plan • No data to show effectiveness of care coordination or family satisfaction • Work load of case managers will obviously increase – how will this be mitigated? • A formula has to be created to determine work load and necessary FTEs as a result of increased case management responsibilities • How will DHCS measure Health Plan's readiness? • How will CCS appeals process be integrated with the health plan's grievance process? • There should be a plan for data and authorization system integration (IT, encryption, communication) • Goals listed for the redesign are too broad and generalized to measure	Blank	Santa Barbara County CCS (SM22)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	Dental ACCESS is not evident in this plan and needs to be more clearly looked at and planned for.	Detailed protocols for enhanced care coordination among primary, specialty, inpatient, outpatient, DENTAL HEALTH, mental health, and behavioral health services through an organized delivery system. Specific components will include: Health homes; culturally appropriate care; initial health assessment and annual reassessments; developing a care plan for	San Francisco Department of Public Health (SM23)

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		each child; establishing interdisciplinary care teams; providing health promotion; transitions of care; referrals to social support services; REFERRALS AND COORDINATION TO PREVENTIVE DENTAL CARE; referral to and coordination with behavioral health services; coordination with In-Home Supportive Services and Regional Centers; and links to other community services.	
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	Work is needed in finding dental homes for the patients within and outside of their service area that meets the needs of the populations.	Blank	Ravenswood Family Health Center (SM24)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	• Section 3, bullet 5 of the proposal addresses the need to include other systems of care, such as the regional center system as part of the interdisciplinary care team. ARCA appreciates the inclusion of this important collaboration between regional centers and MCPs. However, ARCA suggests that the redesign team clarify the expectations related to this. Regional center caseloads are already unmanageably high. If the expectation is for regional centers to take on a more active role in the CCS process, sufficient funding must be put in place to address the increased workload. • The plan as currently written does not clearly outline the dissemination of information to CCS members on the transition to a MCP. ARCA proposes that language be added to emphasize procedures within the CCS system and DHCS to improve the consistency of information dissemination on the transition plan, implementation phase, and change in care coordination roles. • Complaint and appeal processes available to families of impacted children must be robust and immediately responsive to their concerns regarding service delays	Blank	Association of Regional Center Agencies (SM26)

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	and denials. Children with significant medical complexities oftentimes cannot wait for typical appeal processes to run their course.		
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	CCS has a broad range of providers, pediatric specialists. This is far greater than any Managed Care can offer. Some Managed Care groups would have to restructure in order to have access to as many pediatric specialists as CCS. CCS also sets the standard for quality through provider paneling and facility approval.	Without the constraints of the Managed Care plan, CCS has more options for authorizing pediatric specialists.	Los Angeles County CCS (SM27)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	We support the plans' responsibility for utilization management, case management, and quality management functions, given that the plans will be at full risk. This will help to realize efficiencies of the managed care system and provide Whole-Child care.	Blank	California Association Health Plans (CAHP) (SM28)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	We think it would be helpful if the State could provide some state-wide guidance on what should be on a health assessment and care plan. At the least, it would be great if the State could work with CMS Net to provide a platform within E-47 so that each County could house their health assessments and care plans within the system. We have many concerns about the "Integrated electronic health records system" requirement. Among these are: 1. What exactly is meant by an integrated EHR? Integration between the County and Health Plan, integration between the Health Plan and all providers? This is very unclear. 2. Does the State want the CCS information to stay within CMS Net? If so, how will this system interface with the Health Plan system? If not, how can CMS Net support Health Plan functions (such as G&A)? 3. There are a lot of problems that arise because of information delays between CMS Net and MEDs. What can be done about this?	Blank	Health Plan San Mateo (SM29)

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	4. MEDs and automatic enrollment or disenrollment from the Pilot. We find that MEDs is not automatically dis-enrolling patients from the Pilot even if they no longer live in the County or have Medi-Cal. What can be done to fix this problem? 5. If CMS Net will still be used, then how will Health Plan access the data within the system? Will Health Plan have full-write access to CMS Net?		
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	The careful monitoring, oversight and enforcement of these plans will be critical. Yet, the recent state auditor report, released in June, shined a light on the Department's inability to do this effectively. The findings from this audit included that DHCS did not verify accuracy of provider networks or other data on timely access provided by the plans. Additionally, the audit revealed that the ombudsman office for Medi-Cal members to receive assistance and file complaints did not have the capacity to meet the demand, with over 12,000 calls per month going unanswered. This is unacceptable for any population, but especially for families with children with serious and complex medical conditions. Additionally, 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.	Blank	Children's Specialty Care Coalition (SM30)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	Again, I support development of detailed readiness requirements, and believe these should be in place before setting a date for implementation of a Whole Child proposal. Similarly, development and testing of an integrated electronic health records system is critical, and should precede setting a date for implementation. (In particular, state supported EHR for the MTP must be included in any such integrated system.) The discovery of thousands of unanswered calls from the current MCMC ombudsman office must be addressed and rectified before a grievance and appeals process can be considered	Blank	Santa Cruz County CCS, MTP (SM31)

Section	Comments on the Model	Proposed Revisions	Organization
	credible.		
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	1. How do you propose that the MCP will contract with each CCS paneled provider? Even the San Mateo plan is not contracted with UCSF? 2. Again, who will provide oversight? 3. MCP are a business model -based on making a profit - How does this philosophy fit into caring for the high cost, vulnerable population? 4. Do the MCP want the CCS clients? What happens if they back out of their contracts?	Blank	Placer County CCS (SM32)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	Model was designed without data with respect to health outcomes and cost saving which places financial burden on tax payers. The Whole-Child Delivery Model fails to provide coordinated care and would fragment services since the Whole Child Delivery Model does not include MTP/NICU services. Whole child care services is already being provided in current CCS model which includes MTP/NICU services.	Continue with recommendations from the CCS Redesign Stakeholder Advisory Board (RSAB) which were not included or consulted with the "Whole-child delivery Model". Use data that is available from "Carve Out" counties in order to design a more real model that is based on outcomes and cost while assuring quality care coordinated services.	Individual / No Organization (SM33)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	Model was designed without data with respect to health outcomes and cost saving which places financial burden on tax payers. The Whole-Child Delivery Model fails to provide coordinated care and would fragment services since the Whole Child Delivery Model does not include MTP/NICU services. Whole child care is already being provided in current CCS model which includes MTP/NICU services.	Continue with recommendations from the CCS Redesign Stakeholder Advisory board which were not included not included or consulted with the "Whole-child delivery Model" Use data available from 'Carve Out" counties in order to design a more real model that is based on outcomes and cost while assuring quality care coordinated services.	Individual / No Organization (SM34)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	Blank	Plans have provisions and a process to reimburse providers who are not paneled for emergency care and surgeries. Plans have protocols to seek and authorize care to out of area (state and country) care when needed County provides annual updates and technical support to the COHS on treatment plans Suggested points of measurement: timely medical eligibility. Authorizations have a % of necessary benefits consistent with Dx Utilization of authorized	Individual / No Organization (SM36)

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		benefits.	
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	Need assurance that provider networks will actually be in place in reality. Difficult to determine this for every single county. Rural small counties especially impacted and may be at a disadvantage in negotiations with large health plans.	State CCS needs to continue to be responsible for setting, revising, monitoring, and enforcing CCS standards; unrealistic for numerous health plans all to be doing this for every ccs provider. "specific policies regarding specialty care" need to include that if medically necessary and if family and child needs are realistic, that patients have access to the most appropriate provider regardless of health plan network.	Individual / No Organization (SM37)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	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. In fact, they only have a contract with one tertiary care center, located 4 hours away from our County. Out-of-county travel is frequent for our CCS clients, so lots of crucially needed M&T. How can we ensure that the MCP plan will authorize non-contracted SCCs? How will our clients get M&T assistance?	Blank	Anonymous (SM38)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	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? Who at the plan would be responsible for case management? What expertise would they be required to have with children/youth with special health care needs? How is “adequate network” defined? Will DHCS require that plans contract with many CCS-approved providers and facilities, including tertiary and quaternary facilities? How would the Department ensure that children are able to access services out-of-network or out-of-state? What expertise would the plans have in order to know when and where children need to be sent for care?	Blank	CRISS (SM39)
Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	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.	In the penultimate bullet, detail on what is meant by "integrated." Does this mean among “all providers" serving” the beneficiary enrolled in CCS?	Children Now (SM40)

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Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring	The first two bullets taken together are actually a good argument to simply keep the existing statewide network, rather than requiring the various MCPs to create their own for some reason. Please explain for what reason all those separate networks is a feature of the proposal? I suspect it has to do with money, but I have no idea about how this benefits the proposal. I imagine SCCs are going to insist on the same deal with every MCP. Why would a specialty care physician that treats children from seven counties want different deals from each county?	Obviously, I think keeping the existing network available for all is best, is simplest, and most fair. It is already policy that when families wish to use services more distant than the closest equivalent provider, the family has to bear all costs of transportation and maintenance. The fifth and sixth bullets are features and qualities that exist in current county CCS programs. "If it is not broken, why fix it?" In the first two RSAB meetings stakeholders expressed their need to see identified the problems of the current CCS program; after all, that would provide the logical basis to focus the group on areas that need improvement, and integrate those solutions in the redesign. But that was not permitted. In my estimation, concerning bullets five and six, CCS is doing a very good job. Especially with care coordination, which begins at the time of referral and happens concurrently with determination of eligibility, and of course continues as needed. "Referral to and coordination with behavioral health services" is already the role of MCP and physician, is it not? I think "developing a care plan" is the physician's and SCC team's job, that care coordinators, wherever they are, attend to "Integrated electronic health records" -- please briefly describe the pass/fail standards. What parties must be integrating records? CCS, MCP, SCC, PCP, Paneled Physician, Regional Center, MH provider, Dental, Vision, etc. Across counties, across MCPs? Include MTU Online (please take this as a recommendation that MTU Online be enhanced and supported -the good arguments are in System of Care's hands).	RSAB Member (SM41)
CCS Program Improvement and Stakeholder	Improved transitions for youth aging out of CCS is much needed. However, it is difficult to see how limiting DME providers to those contracted with a specific plan would improve access to DME. What will happen to those	Provide regulatory safeguards to assure that youth aging out of CCS whether Medi-Cal or commercial plans have transition programs. Provide funding for professional staff to coordinate these transition	Los Angeles County, CMS (SM9)

Section	Comments on the Model	Proposed Revisions	Organization
Engagement	benefits that are presently CCS only?	plans. Provide safeguards that benefits will remain for the specialized DME needed for children with severe physical disabilities.	
CCS Program Improvement and Stakeholder Engagement	Similar comment as #3; the current model severely lacks access to both DME and care coordination, therefore serious examination should take place as to whether the CCS Advisory Group has adequate stakeholders to manage leadership and guidance in these areas.	Blank	Anonymous (SM10)
CCS Program Improvement and Stakeholder Engagement	Please include oral health care providers, local coalitions, or oral health programs (CHDP, Health Promotion, etc.)	Blank	Center for Oral Health (SM17)
CCS Program Improvement and Stakeholder Engagement	What are the improvements?	Blank	Kings County Public Health Department (SM19)
CCS Program Improvement and Stakeholder Engagement	The new Title V grant application outlines increased involvement by the State and State health departments in the care and outcomes of C/YSCHN. This move to the managed care program effectively moves the care coordination and quality assurance out of the local health jurisdictions control to private entities with a financial interest in the authorization of services and access to care. The charge for the next round of grant funding is to facilitate the development of community-based systems of services for such children and their families. This migration from local health departments is not in line with the community based systems at all, which puts the Public Health Department's funding at risk.	Blank	Santa Clara County Public Health Department (SM20)
CCS Program Improvement and Stakeholder Engagement	Questions and concerns regarding CCS Whole Child Model from CICs (Carve In Counties): Marin, Yolo, Napa, Solano, Santa Barbara • No data to support that this model is successful • No data to show any fiscal impacts of this model to CCS and Health Plan • No data to show effectiveness of care coordination or	Blank	Santa Barbara County CCS (SM22)

Section	Comments on the Model	Proposed Revisions	Organization
	family satisfaction • Work load of case managers will obviously increase – how will this be mitigated? • A formula has to be created to determine work load and necessary FTEs as a result of increased case management responsibilities • How will DHCS measure Health Plan's readiness? • How will CCS appeals process be integrated with the health plan's grievance process? • There should be a plan for data and authorization system integration (IT, encryption, communication) • Goals listed for the redesign are too broad and generalized to measure		
CCS Program Improvement and Stakeholder Engagement	How will this monitoring be reported to community stakeholders? How will transparency be ensured? This needs to be made evident to the public and community stakeholders.	DHCS will continue stakeholder engagement through all phases of implementation of the Whole-Child Model, and will also host ongoing discussions of program improvements applicable to all counties and identified in the Title V Needs Assessment, such as improved transitions for youth aging out of CCS, improving access for Durable Medical Equipment, and care coordination protocols. SUMMARIES OF THESE DISCUSSIONS WILL BE POSTED ON THE DHCS WEBSITE. QUARTERLY SURVEYS WILL BE DISSEMINATED AND ANALYZED BY AN OUTSIDE ORGANIZATION SUCH AS CHILDREN NOW OR OTHER NGO TO EVALUATE AND ENSURE TRANSPARENCY AND THAT COMMUNITY INPUT IS INCLUDED IN THIS PLAN.	San Francisco Department of Public Health (SM23)
CCS Program Improvement and Stakeholder Engagement	At a stakeholder engagement level, it is critical to have a dentist/ dental consultant on the team as the revisions are made and policy changes are considered	Blank	Ravenswood Family Health Center (SM24)
CCS Program Improvement and Stakeholder Engagement	• ARCA supports the robust involvement of families of CCS children and youth in the planning and implementation phases. The families are essentially the primary care managers of their children's care. Many families have experienced significant difficulty	Blank	Association of Regional Center Agencies (SM26)

Section	Comments on the Model	Proposed Revisions	Organization
	accessing needed services through managed care plans, particularly for children with significant specialized medical needs. Their participation and input on how to lessen any barriers to access should be strongly supported and encouraged. • While ARCA recognizes the inclusion of stakeholders' input in the planning process, ARCA is concerned that the short timeline for implementation may jeopardize the ability of the health plans to realistically deliver the stated outcomes. ARCA proposes that any available data to measure readiness of health plans, acceptable outcomes of individual health plans, and realistic ability to deliver CCS services, be made available to the stakeholders during the first phase of the implementation process. ARCA also proposes that should the data fail to provide adequate information for assured readiness implementation, the department should consider delaying the implementation until such time when health plan readiness is demonstrated by additional data.		
CCS Program Improvement and Stakeholder Engagement	CCS has employed the help and advice of many advocacy groups, including a Patient Family Advisory Committee, which includes family members to improve the quality of care.	Blank	Los Angeles County CCS (SM27)
CCS Program Improvement and Stakeholder Engagement	Since under the Department's proposal health plans will be at full financial risk once the CCS services are carved-in, a discussion on rates and how health plans will be appropriately reimbursed for these services is a key component of any redesign efforts. We request the opportunity to meet with the Department to discuss the rate development process for the CCS population. It is critical that the rate development process for the CCS Whole Child pilot be thorough and transparent. CCS rates paid to plans should acknowledge and reflect that CCS providers may not agree to capitated arrangements given the wide variance of CCS conditions. Plans request	Blank	California Association Health Plans (CAHP) (SM28)

Section	Comments on the Model	Proposed Revisions	Organization
	clarification on whether rates will vary based on condition (for example, the cost of treating a bone fracture versus hemophilia). Plans also request that the Department considers risk corridors, given the wide variance of conditions and treatment needs. It will be critical that the rates that are determined are sufficient to cover the needs of this complex population and we look forward to working collaboratively with the Department on the rate development process.		
CCS Program Improvement and Stakeholder Engagement	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.	Blank	Health Plan San Mateo (SM29)
CCS Program Improvement and Stakeholder Engagement	I think 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?	Blank	Santa Cruz County CCS, MTP (SM31)
CCS Program Improvement and Stakeholder Engagement	As stated above, we don't have an MOU with one plan. Was the stakeholders input even taken into consideration?	Blank	Placer County CCS (SM32)
CCS Program Improvement and Stakeholder Engagement	Model was designed without data with respect to health outcomes and cost saving which places financial burden on tax payers. The Whole-Child Delivery Model fails to provide coordinated care and would fragment services since the Whole Child Delivery Model does not include MTP/NICU services. Whole child care services is already being provided in current CCS model which includes MTP/NICU services.	Continue with recommendations from the CCS Redesign Stakeholder Advisory Board (RSAB) which were not included or consulted with the "Whole-child delivery Model". Use data that is available from "Carve Out" counties in order to design a more real model that is based on outcomes and cost while assuring quality care coordinated services.	Individual / No Organization (SM33)
CCS Program Improvement and Stakeholder Engagement	Model was designed without data with respect to health outcomes and cost saving which places financial burden on tax payers. The Whole-Child Delivery Model fails to provide coordinated care and would fragment services since the Whole Child Delivery Model does not include MTP/NICU services. Whole child care is already being	Continue with recommendations from the CCS Redesign Stakeholder Advisory board which were not included not included or consulted with the "Whole-child delivery Model" Use data available from 'Carve Out" counties in order to design a more real model that is based on outcomes and cost while assuring	Individual / No Organization (SM34)

Section	Comments on the Model	Proposed Revisions	Organization
	provided in current CCS model which includes MTP/NICU services.	quality care coordinated services.	
CCS Program Improvement and Stakeholder Engagement	It appears some gaps for comments from the public are missing.	Blank	Individual / No Organization (SM36)
CCS Program Improvement and Stakeholder Engagement	Hope stakeholder input will continue to be heeded.	Blank	Individual / No Organization (SM37)
CCS Program Improvement and Stakeholder Engagement	Seek statewide CCS program improvements such as: • Address the whole child by extending CCS authorizations to and closely coordinating with CCS-paneled child- and family-centered medical homes; • Implement acuity assessments of enrolled children, individual care plans, and intensive care coordination; • Improve care coordination across multiple systems used by CCS children, including behavioral health, special education, and Regional Centers; • Mandate family and youth participation at every level in design, implementation, evaluation and decision-making concerning the system of care, with financial support; • Focus on system quality improvement, including use of standardized quality measures appropriate to children and youth with special health care needs and attention to family satisfaction and participation; • Collect and analyze program data regarding process and outcome measures and releasing the information in periodic public reports.	Blank	CRISS (SM39)

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CCS Program Improvement and Stakeholder Engagement	My recommendation is to provide an update on CCS redesign and promote stakeholder engagement in the Whole-Child Model by having this as a standing agenda item in other existing stakeholder processes, such as and including the LA PHP Dental Stakeholder Group, the Medi-Cal Dental Advisory Committee, and the Medi- Cal Children's Advisory Panel.		Children Now (SM40)
CCS Program Improvement and Stakeholder Engagement	Yes, case management / care coordination documentation -- protocols; maintain transferability of documentation, electronically. Enhance MTU-Online. Rapid response MEDS correction. In this and other sections I get the sense that phase one implementation will be pilots. I echo other RSAB members who asked, what is the plan for when the pilot(s) do not succeed?	Blank	RSAB Member (SM41)
County Roles, including Medical Therapy Program	County roles have been successful. Measure the outcomes to prove if County vs Managed Care is more successful. County level MTU clinics have been very successful. Many children's needs are met due to the MTU Clinics where they monitor the needs of the child at the therapy unit as well. The Local CCS office Liaison, MTU THERAPY, SCHOOL and Doctors see the child and their needs are met.	Blank	Individual / No Organization (SM2)
County Roles, including Medical Therapy Program	I wish there was more detailed description of what the state meant in saying that the county will maintain MTU services.	Blank	Anonymous (SM6)
County Roles, including Medical Therapy Program	What are you going to do with all of the seasoned case management professionals who know the CCS case management program and who have spent months, if not years learning the ins and outs of a complicated system of care?	Blank	Anonymous (SM8)
County Roles, including Medical Therapy Program	What will be covered in the MOUs to be established between Managed Care Plans and the Medical Therapy Programs (MTPs)? How will the MTPs be funded? Who will be responsible for writing the therapy prescriptions? Will the present Medical Therapy Clinics (MTCs) be maintained? Will the MTP staff be able to continue with DME and P&O clinics and providers?	Preserve the present Medical Therapy Program model with Medical Therapy Clinic physicians signing the treatment plans and coordinating with therapists, DME and orthotics vendors to continue to provide the treatment and services necessary for this chronic/complex population. Include Managed Care Plan representation in the MTCs. Consideration should be given to having the MTCs become Special	Los Angeles County, CMS (SM9)

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		Care Centers serving those populations not served by other hospital based SCCs. SCCs should be considered "specialized" medical homes for the children they serve (chronic, complex conditions). Consideration should be given to including all CCS eligible diagnoses with OT/PT need to be served at the MTP.	
County Roles, including Medical Therapy Program	The intent to continue financial, residential, and medical eligibility determinations does not follow logically with the managed care providers' new role as the partner with full financial risk, or the goal of redesign that simplifies the funding structure to improve cost effective service delivery. In most counties children are seeing 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 would not prevent 'disruption or erosion in care' as that already occurs for many families and children.	Blank	Anonymous (SM10)
County Roles, including Medical Therapy Program	Why would eligibility remain with the county if the COHS is responsible for all payments? How will this work in the dependent counties? Please clarify no changes to county realignment structure expected to be necessary when duties will be changing.	Blank	Anonymous (SM13)
County Roles, including Medical Therapy Program	I do believe that there needs to be more consistent care coordination and authorization role across all the counties. However, I don't believe that the huge health plans are the best choice to take on this role for children with special and complex needs. These children are not in a "one size fits all" situation. Each child and their families have unique challenges. One of the many important necessities for these children and their families is to have partners that can be their individual health care advocates. This is a role that local county CCS case managers can enhance and provide over managed care. Please reconsider this model and instead help to improve CCS county services.	Blank	San Francisco Department of Public Health CCS (SM15)
County Roles, including Medical Therapy Program	This would be a great opportunity to include dental health as a service within the MTU. There are pilot programs currently underway that include the services of a Registered Dental Hygienist/Registered Dental Hygienist in	Include oral health as part of the services that may be included within a MTU	Center for Oral Health (SM 17)

Section	Comments on the Model	Proposed Revisions	Organization
	Alternative Practice on site, or comprehensive services in a mobile/portable model		
County Roles, including Medical Therapy Program	What will be the expertise of the State employees overseeing this program? Will the case management/care coordination roles be filled by RNs, LVNs, or lay people? Will the plans be required to have medical personnel (physicians, RNs) oversee the case management?	Blank	Sacramento CCS, CHDP (SM18)
County Roles, including Medical Therapy Program	What will the county roles be?	Blank	Kings County Public Health Department (SM19)
County Roles, including Medical Therapy Program	1. Managed care plans do not have the medical knowledge and understanding that has been cultivated by the county CCS programs to know or understand the complex needs of these children. In San Mateo county where they have the most experience with this, the CCS nurses continue to do the authorizations and they have a CCS trained medical director for the pilot to assess medical necessity. 2. The care coordination done by the managed care plans for elderly people is very different than what will be needed by the children with special healthcare needs. There is no documentation or indication that because they can do case review and utilization review for healthy children that they can also provide care coordination and case management for very complex and sick children as well. 3. This move to managed care authorization of CCS services is a change in how services are authorized to the same model of care used for healthy children. 4. DHCS does not have a template or blueprint with which to assure that care is consistent or not lost in	Keep care coordination and service authorization with the CCS programs – add to the services allowed or authorized to include all care for the child. There will be less training needs, more continuity for the clients and less potential for conflict of interest when it comes to determining medical necessity.	Santa Clara County Public Health Department (SM20)

Section	Comments on the Model	Proposed Revisions	Organization
	this move. The eventual development does not assure quality or access of care. 5. Medical necessity is completely left out of this transition and the understanding of all the hundreds of numbered letters and the multiple regulations will be lost by this move.		
County Roles, including Medical Therapy Program	I would like to see the definition of "care coordination". Is it simply a new term for the case management duties that nurses are currently doing at the county level or will it be something less? I am concerned that case management duties that are currently performed by the public health nurses at the county level will be lost in the roll over to managed care and families won't be connected with community resources for example.	Blank	Shasta County CCS (SM21)
County Roles, including Medical Therapy Program	Questions and concerns regarding CCS Whole Child Model from CICs (Carve In Counties): Marin, Yolo, Napa, Solano, Santa Barbara • No data to support that this model is successful • No data to show any fiscal impacts of this model to CCS and Health Plan • No data to show effectiveness of care coordination or family satisfaction • Work load of case managers will obviously increase – how will this be mitigated? • A formula has to be created to determine work load and necessary FTEs as a result of increased case management responsibilities • How will DHCS measure Health Plan's readiness? • How will CCS appeals process be integrated with the health plan's grievance process? • There should be a plan for data and authorization system integration (IT, encryption, communication) • Goals listed for the redesign are too broad and generalized to measure	Blank	Santa Barbara County CCS (SM22)

Section	Comments on the Model	Proposed Revisions	Organization
County Roles, including Medical Therapy Program	How will dental care coordination by the MC Plans be monitored and quality be ensured.	Blank	San Francisco Department Public Health (SM23)
County Roles, including Medical Therapy Program	Considerations toward enhancing co-location of services and cross referencing them for a patient centered approach to health care.	Blank	Ravenswood Family Health Center (SM24)
County Roles, including Medical Therapy Program	• ARCA acknowledges that the County Organized Health Systems (COHS) do not typically allow their members to access care outside of the plan. ARCA is concerned that there may not be enough specialty and subspecialty providers for select members who are very medically fragile with very specialized needs. ARCA suggests that the redesign team ensures at the plan readiness process, that the COHS have specialty and subspecialty providers even in the absence of a critical mass of children needing such services. • ARCA is also concerned that the MCPs may not have sufficient expertise to manage the care of very medically fragile children and youth. ARCA suggests that some form of measure be in place to assess the MCPs readiness to manage the care of this select population.	Blank	Association of Regional Center Agencies (SM26)
County Roles, including Medical Therapy Program	Again by not including MTP patients, which could be an expensive group, the managed cares are exempting themselves of this responsibility, and also this could lead to fragmented care for those patients in the MTP	Leave the CCS Program Carve out Model as it includes MTP patients.	Los Angeles County CCS (SM27)
County Roles, including Medical Therapy Program	We understand that the Department would like to keep certain county functions in the CCS program, such as eligibility determinations; however there is concern around the length of time it currently takes to complete this process and we would like to work on ways to address this in both the current system and in any counties that carve-in CCS. At least one plan noted that Counties may	Blank	California Association Health Plans (CAHP) (SM28)

Section	Comments on the Model	Proposed Revisions	Organization
	and do elect to expand the benefit population; for example, to undocumented immigrant children. The plans request clarification on how the Department anticipates providing continuity of care for this population. Would some populations need to continue to be carved-out and served by the county, or will a waiver be necessary to carve them into the plan? Does the Department anticipate that any services for a CCS child will be carved-out (for example, transplants)? The plans also request clarification on whether the medical therapy program (MTP) would be carved-out in the CCS carve-in counties. It is not clear which entity will be responsible for authorizations for MTP services and how the coordination between the plan and the authorizing body for MTP will occur.		
County Roles, including Medical Therapy Program	The goal of reducing payment delays for providers is worthy, and our local MCMC group has proven superior in this (not having to access Medi-Cal through the Xerox intermediary as CCS does)--this would appropriately become their responsibility in the new model. This section is troubling in that it seems to remove the critical element of CCS case management activities from CCS, relegating them to financial and residential eligibility determination. These latter roles would be very appropriate for MCMC personnel, while leaving intact one of the fundamental successes of the CCS program: experienced, appropriately trained public health nurses and case coordinators who are expert in addressing the needs of the CYSHCN population. In order to assure continued successful outcomes in the MTP, the program must remain integrated with the CCS case management team. A model that sees the MTP as separable fundamentally misunderstands the intense coordination required to meet the needs of CYSHCN.	Blank	Santa Cruz County CCS, MTP (SM 31)
County Roles, including Medical Therapy Program	1. If we can't get an MOU for primary care, how do you propose that the counties will be able to establish an MOU for the whole child? Will the MOU be in place before the process begins. 2. Why do you need CCS staff to establish program	Blank	Placer County CCS (SM32)

Section	Comments on the Model	Proposed Revisions	Organization
	eligibility? 3. Inter-county transfers will cause delays in services. 4. How can the MTU stand alone as many clients have Medi-Cal, OHC. 5. Is there legislation being proposed to change the intent of CCS?		
County Roles, including Medical Therapy Program	Model was designed without data with respect to health outcomes and cost saving which places financial burden on tax payers. The Whole-Child Delivery Model fails to provide coordinated care and would fragment services since the Whole Child Delivery Model does not include MTP/NICU services. Whole child care services is already being provided in current CCS model which includes MTP/NICU services.	Continue with recommendations from the CCS Redesign Stakeholder Advisory Board (RSAB) which were not included or consulted with the "Whole-child delivery Model". Use data that is available from "Carve Out" counties in order to design a more real model that is based on outcomes and cost while assuring quality care coordinated services.	Individual / No Organization (SM33)
County Roles, including Medical Therapy Program	Model was designed without data with respect to health outcomes and cost saving which places financial burden on tax payers. The Whole-Child Delivery Model fails to provide coordinated care and would fragment services since the Whole Child Delivery Model does not include MTP/NICU services. Whole child care is already being provided in current CCS model which includes MTP/NICU services.	Continue with recommendations from the CCS Redesign Stakeholder Advisory board which were not included not included or consulted with the "Whole-child delivery Model" Use data available from 'Carve Out" counties in order to design a more real model that is based on outcomes and cost while assuring quality care coordinated services.	Individual / No Organization (SM34)
County Roles, including Medical Therapy Program	The whole child model does not include MTP and NICU clients which will create a gap in care as MTP and NICU children have very complex needs and require care coordination.	LA County Redesign pilot includes NICU and MTP and all children who meet CCS criteria using higher standards for inpatient and outpatient services through CCS paneled providers and CCS approved hospitals/special care centers	Los Angeles County, CMS (SM35)
County Roles, including Medical Therapy Program	The Medical Therapy Conference should be a model for whole child assessment.	Blank	Individual / No Organization (SM36)
County Roles, including Medical Therapy Program	This is a fundamental, radical shift in policy for which earlier reports have recommended close study in comparison with other models, prior to implementation. CCS (while underfunded and understaffed for years), has administered service authorization and provided some degree of care coordination with decisions independent of payers, for decades and for an extremely low-overhead	Slow down process, subject pilot counties' projects to careful and meaningful scrutiny prior to full state implementation and/or dismantling of CCS infrastructure.	Individual / No Organization (SM37)

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	and no profit . Not easy to believe a priori, and no clear evidence to support the idea that health plans (especially commercial ones) will be able to provide more administrative support (comprehensive care coordination etc.), with less overhead and possibly a profit margin, than CCS has done, or than alternative models might.		
County Roles, including Medical Therapy Program	Are Counties responsible for the whole child of MTP-Only clients?	Blank	Anonymous (SM38)
County Roles, including Medical Therapy Program	Reconciling county roles and funding with this proposal will be extremely complicated, perhaps more so than DHCS realizes. There are many complicated issues concerning coordination with the Medical Therapy Program, none of which are addressed in the proposal. E.g., who will pay for DME? How will services be coordinated between the plan and the MTP?	Blank	CRISS (SM39)
County Roles, including Medical Therapy Program	An explanation of how Denti-Cal FFS and the Medi-Cal Managed Care plans could coordinate via county roles would be helpful.	Blank	Children Now (SM40)
County Roles, including Medical Therapy Program	This section (5) quotes the introduction, but has deleted the rhetorical "children...receive services in two or more separate systems of care THAT DO NOT ALWAYS (my emphasis) coordinate effectively." "Always" and "never" had best be avoided. "A single, unified care coordination team that can ensure access across an array of services" -- The proposal does not mention MCPs taking on responsibilities that currently are the duties of Regional Centers, Denti-Cal, Mental Health, Behavioral Health (alcohol and substance use disorders) or Education. Not to mention SCCs that are pretty good about care coordination across departments. Please expound and clarify. Care coordination does not seem to be containable in a single entity, rather it "coordinates" with care coordinators wherever they may be, for instance in the family, or within the robust PCP clinic.	I recommend deleting the phrase that includes: "always". It is not "always", we agree, don't we? What is the percentage of good vs not so good coordination? The survey reported 85% of families were satisfied with CCS care coordination. That was from RSAB meeting #1, when Dr. Abramson reported the survey.	RSAB Member (SM41)

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Proposed Timeline for CCS Whole-Child Model Implementation	I propose to allow more time, to involve the local CCS offices, Nurse Case Mangers to be involved in this Implementation. But, gather more useful data to come to the censes if the WHOLE CHILD MODEL will be successful. IT has not been proven yet. Look at counties with transportation issues, providers availability within those counties before you start implementing this Whole Child Model.	Blank	Individual / No Organization (SM2)
Proposed Timeline for CCS Whole-Child Model Implementation	concerned that time line does not bring on large urban areas until much later---many details will be missed with this approach	Blank	Anonymous (SM4)
Proposed Timeline for CCS Whole-Child Model Implementation	Seems to me that the implementation is just right around the corner breathing down my neck already! My county's Managed Care Plan and CCS have not yet initiated a conversation to be ready for this inevitable change. We have not heard any thoughts from the Managed Care Plans of California or from the state DHCS on how Managed Care Plans feel about this proposal.	Blank	Anonymous (SM6)
Proposed Timeline for CCS Whole-Child Model Implementation	There is not sufficient time to allow the implementation and evaluation of various methods of achieving the whole-child model.	Implementation 2017-2018 of revised medical eligibility to eliminate diagnoses that are not chronic/complex. Implementation 2017-2018 of a uniform set of outcomes standards to evaluate the various whole-child models. Evaluation 2021 of the various whole-child models for chronic/complex children (FFS, Managed Care, and combined FFS/Managed Care) to be based on outcomes achieved.	Los Angeles County, CMS (SM9)
Proposed Timeline for CCS Whole-Child Model Implementation	We do not agree with the proposed timeline for several reasons: 1. We don't believe DHCS is ready to roll out their new Whole Child Model as it has not evaluated Managed Care CCS pilots and reported to the Legislature. Without an evaluation, there is no way to know the impact of pilots on access to care, family and provider satisfaction, and cost effectiveness.	Blank	FVCA & Support for Children with Disabilities (SM12)

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	2. We are especially concerned about the recent state audit "Improved Monitoring of Medi-Cal Managed Care Health Plans is Necessary to Better Ensure Access to Care." which says: The Department of Health Care Services did not ensure that health plans had adequate provider networks to serve beneficiaries. Thousands of calls from Medi-Cal beneficiaries to the Department's Ombudsman have gone unanswered. We ask DHCS to please extend the CCS carve-out from Medi-Cal managed care for at least one more year, so the DHCS has more time to collect data, do the proper evaluations on current pilots and use this valuable time to ensure our children have timely access to the specialty providers they desperately need. We need to make sure our children come to NO HARM.		
Proposed Timeline for CCS Whole-Child Model Implementation	Not enough time.	Blank	San Francisco Department of Public Health CCS (SM15)
Proposed Timeline for CCS Whole-Child Model Implementation	When will the pilots be reviewed and what is the timeline for input before all counties are required to move tothis model?	Blank	Sacramento CCS, CHDP (SM18)
Proposed Timeline for CCS Whole-Child Model Implementation	Blank	Phase 2 should be a 6 month evaluation period to test all the requirements, quality measures and readiness criteria Moving everything back by 6 months.	Santa Clara County Public Health Department (SM20)
Proposed Timeline for CCS Whole-Child Model Implementation	Questions and concerns regarding CCS Whole Child Model from CICs (Carve In Counties): Marin, Yolo, Napa, Solano, Santa Barbara • No data to support that this model is successful • No data to show any fiscal impacts of this model to CCS and Health Plan • No data to show effectiveness of care coordination or	Blank	Santa Barbara County CCS (SM22)

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	family satisfaction • Work load of case managers will obviously increase – how will this be mitigated? • A formula has to be created to determine work load and necessary FTEs as a result of increased case-management responsibilities • How will DHCS measure Health Plan's readiness? • How will CCS appeals process be integrated with the health plan's grievance process? • There should be a plan for data and authorization system integration (IT, encryption, communication) • Goals listed for the redesign are too broad and generalized to measure		
Proposed Timeline for CCS Whole-Child Model Implementation	AGAIN Dental needs to be included in the MOUS specifically.	Blank	San Francisco Department of Public Health (SM23)
Proposed Timeline for CCS Whole-Child Model Implementation	While ARCA understands the need for DHCS to develop a proposal in anticipation of the sunset of the existing CCS carve-out, ARCA is concerned that the Behavioral Health Treatment (BHT) services transition to MCPs is still in its implementation phase and has proved to be a very challenging endeavor, particularly in rural counties. Implementation of another programmatic change in those same counties may prove to be very difficult. ARCA suggests a re-evaluation of MCPs' ability to adjust to so many changes in such a concentrated period of time.	Blank	Association of regional center Agencies (SM26)
Proposed Timeline for CCS Whole-Child Model Implementation	Plans appreciate the timeline outlined in the proposal, and the Department's phased-in approach to implementation. We also appreciate the ongoing opportunities for stakeholder feedback and discussions of program improvements as the CCS Redesign process moves forward. However, several of the issues outlined in our previous letter (April 22, 2015) still need to be addressed by the Department and will become even more important as Redesign efforts move forward.	Blank	California Association Health Plans (CAPH) (SM28)

Section	Comments on the Model	Proposed Revisions	Organization
Proposed Timeline for CCS Whole-Child Model Implementation	As I've noted throughout, I oppose any fixed timeline for implementation that precedes: thorough evaluation and assessment of the HPSM pilot, the closest real-world approximation of many elements of this proposal; development of readiness criteria approved by the stakeholder groups; development of comprehensive CCS quality measures, including the MTP; demonstration of improved monitoring of network adequacy and response to grievances brought by MCMC beneficiaries.	Blank	Santa Cruz County CCS, MTP (SM31)
Proposed Timeline for CCS Whole-Child Model Implementation	It seems that the timeline is too short to ensure the safety of the CCS vulnerable population.	Blank	Placer County CCS (SM32)
Proposed Timeline for CCS Whole-Child Model Implementation	Model was designed without data with respect to health outcomes and cost saving which places financial burden on tax payers. The Whole-Child Delivery Model fails to provide coordinated care and would fragment services since the Whole Child Delivery Model does not include MTP/NICU services. Whole child care services is already being provided in current CCS model which includes MTP/NICU services.	Continue with recommendations from the CCS Redesign Stakeholder Advisory Board (RSAB) which were not included or consulted with the "Whole-child delivery Model". Use data that is available from "Carve Out" counties in order to design a more real model that is based on outcomes and cost while assuring quality care coordinated services.	Individual / No Organization (SM33)
Proposed Timeline for CCS Whole-Child Model Implementation	Model was designed without data with respect to health outcomes and cost saving which places financial burden on tax payers. The Whole-Child Delivery Model fails to provide coordinated care and would fragment services since the Whole Child Delivery Model does not include MTP/NICU services. Whole child care is already being provided in current CCS model which includes MTP/NICU services.	Continue with recommendations from the CCS Redesign Stakeholder Advisory board which were not included not included or consulted with the "Whole-child delivery Model" Use data available from 'Carve Out" counties in order to design a more real model that is based on outcomes and cost while assuring quality care coordinated services.	Individual / No Organization (SM34)
Proposed Timeline for CCS Whole-Child Model Implementation	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 often delegate to IPAs and medical groups which unfortunately dilutes care.	LA County CCS Redesign pilot reinforces continuity of care and specialized care.	Los Angeles County, CMS (SM35)
Proposed Timeline for CCS Whole-Child Model	Evaluation and performance expectations are clearly defined prior to implementation	This comment is planning for implementation: To include clear and consistent messages for the families and stakeholders of the changes and processes. For	Individual / No Organization

Section	Comments on the Model	Proposed Revisions	Organization
Implementation		the implementation to have all agencies give the same message. Have benefit cards which clearly document eligibility to prevent and delays for service or when obtaining medication.	(SM36)
Proposed Timeline for CCS Whole-Child Model Implementation	In my opinion, completely unrealistic. Slow down process, subject pilot counties' projects to careful and meaningful scrutiny prior to full state implementation and/or dismantling of CCS infrastructure.	Blank	Individual / No Organization (SM37)
Proposed Timeline for CCS Whole-Child Model Implementation	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.	Blank	Anonymous (SM38)
Proposed Timeline for CCS Whole-Child Model Implementation	The timeline is much too ambitious and risky for children and the provider network. CRISS recommends strongly that implementation be delayed and the CCS carve-out be retained to encompass a much slower, more thoughtful ad more deliberative process.	Blank	CRISS (SM39)
Proposed Timeline for CCS Whole-Child Model Implementation	Having reached this last section, I am reminded that a colleague wrote into the survey that much needs to be worked out, much needs to be examined, assessed and measured first before implementing a pilot (this proposal, or the final design of this proposal), else there can be no evaluation of the "after". With that in mind, and given my experience on RSAB, it appears necessary for stakeholders to spend a lot of time helping counties and MCPs to prepare. Not just time, but time together -meetings, public process, and more meetings with DHCS representatives, who need to come to meetings -not all the meetings, but as needed or as requested. Also, given the State Auditor's recent report (included in its entirety by this reference as part of my comments), DHCS had better prove itself capable of overseeing and ensuring that CCS standards are uniformly maintained, that business interests at any level do not impede access to care, that administrative care coordination be staffed by public health nurses and licensed, culturally competent social workers. Prove up	Blank	RSAB Member (SM40)

Section	Comments on the Model	Proposed Revisions	Organization
	first. These kids and their families are very vulnerable, often at risk, have low health literacy, and many are loaded with psycho-social issues. They need the best, not a redesign that is going to be a long time on the learning curve. The timeline is unrealistically ambitious. I do appreciate the phrase, "NO EARLIER than January 2017". More about the expectation that care-coordination, please. Care coordination sometimes has to begin as soon as a referral comes in; care coordination is not separable in time from eligibility determination...so this is murky. On the subject of care coordination, why bother to remove this element from CCS which has experts, PHNs, SWs, paraprofessionals, and the highly integrated MTP team doing such a knock-up job? I think this is the question you will hear from the great majority of stakeholders.		

Section	Comments	Organization
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	Medical eligibility criteria for CCS services needs to be revised in several disease categories, especially in 41848 Diseases of the Respiratory System and 41811 Infectious Diseases. There are many children with chronic lung disease, with tracheostomies, and with vent dependence that are not covered by CCS. Clearer, specific criteria should be developed (flow chart?). For Infectious Diseases, CCS needs to look at Valley Fever and what type of severity should be covered. There are many kids with lesions in organs and they are denied medical eligibility for CCS. One of the biggest issues facing hospitals are the fights between CCS and managed care over who should pay for services. Managed care should not be able to refuse payment when CCS has determined a case is not eligible. Managed care should pay the hospital and then have a route for the CCS determination to be further evaluated. If managed care can get CCS to agree to pay, then the managed care can be reimbursed by the hospital after CCS has paid the hospital. Hospitals should not have to have so many unpaid accounts due to fights between CCS and managed care.	Valley Children's Hospital (SM1)
General Comments about the Whole-Child Model and / or the CCS Program	I would like the CCS program and Stakeholders to communicate with CCS parents of children enrolled in CCS and allow them to work closely with the WHOLE CHILD Model as it will affect them directly. Letters should be sent out to each family, allowing them the opportunity to speak up and be part of this implementation.	Individual / No Organization (SM2)

Section	Comments	Organization
Improvement Stakeholder Process		
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	The Whole-Child Model also needs to absorb/integrate CHDP (Child Health and Disability Prevention Program) services.	Anonymous (SM3)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	bring 1-2 major population centers on board early in process--carefully monitor issues so that full scale roll out will benefit from earlier implementation	Anonymous (SM4)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	I am keeping an open mind which means I ought to give this a chance.	Anonymous (SM6)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	At this point, It seems like a lot of bureaucrat decision makes who can craft charts and hold meetings and pat each other on the back with "good question!" but who are sadly out of touch with the boots on the ground and the children who need services. Also, the paneling system is a joke. It takes too long and the databases are not current. Even this survey is not user friendly.	Anonymous (SM8)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	Given the diversity of the State multiple whole-child models need to be implemented and subsequently evaluated. The local County departments of public health/healthcare services have the staffing and knowledge base to best coordinate care for the children with special healthcare needs. The State should retain and improve standards of care with increased medical professional guidance.	Los Angeles County, CMS (SM9)

Section	Comments	Organization
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	Concerns regarding: • Limited representation of rural northern California on CCS Advisory Board • Case management services will be less, families will have less advocacy, families will have less follow-up and encouragement to follow medical recommendations • Recent State Auditor report on lack of Managed Care Plans oversight and quality assurance of provider networks • Will the case management of the whole child be a responsibility of the COHS or can they delegate this authority to the PCP? If there is an option to delegate, my concern would be that the PCP would be unable to properly case manage due to heavy client loads/limited PCPs in the rural areas	Anonymous (SM13)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	It is imperative that oral health be included in the restructuring of CCS. A person is not healthy without good oral health, several CCS qualifying conditions have oral health components and complications, and oral disease conditions often contribute to or exacerbate CCS qualifying conditions.	Center for Oral Health (SM17)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	CCS currently manages children with craniofacial anomalies, including cleft palate, as well as accidents/trauma to the face and mouth, and medically handicapping malocclusion. Many other CCS children are allowed dental care depending on their CCS eligible condition. Here are some: Seizure disorders, immune deficiencies, cerebral palsy, hemophilia and other blood dyscrasias, such as thalassemia, sickle cell disease, etc., malignant neoplasms, including leukemia, rheumatoid arthritis, chronic renal disease, cystic fibrosis, and others, at the determination of the county CCS medical director. To manage the health of the "Whole Child" it is imperative that dental be included in this model.	Sacramento CCS, CHDP (SM18)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	I feel that the whole child concept is great. I am sorry that this concept was not presented to the counties to implement as part of the existing CCS program.	Kings County Public Health Department (SM19)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	• None of the recommendations from other entities have been included in this proposal. The rationale has not been communicated and the research and evidence used to outline this plan has been lacking. The terminology of “Whole Child” is used over and over again, but the mechanism of care is to take the model used for well child care for health children in managed care programs and apply it to these very complex and medically fragile children. There has been a startling lack of statistics or evidence to support this model change and no evidence or data has been provided that would support the theory that moving all children to the managed care Medi-Cal programs would be an improvement.	Santa Clara County Public Health Department (SM20)

Section	Comments	Organization
	• Luis Rico and Anastasia Dodson presented on 12/2/14 the following statement: ○ Without regard to sunset of the CCS managed care "carve-out," DHCS is not predisposed to mandatorily enroll CCS eligible children into Managed Care Organizations for treatment of their CCS health condition. • However there are no components from any of the other plans evident in the process, the idea of a redesign has not been upheld and DHCS should honor their initial statements. • Fundamental goals for the whole process as presented to the RSAB at the initial meetings are listed below from DHCS, however they have not achieved- there is no process for measurement nor quality indicators for programs: 1. Improve care and outcomes for children and youth with special health care needs by ensuring that they receive coordinated care, and 2. Identify indicators that will measure quality in order to improve care for these children and their families.	
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	M&T is very important in the rural areas of Northern California. Without assistance families may not travel to the Sacramento or Bay Areas for medical services for their child. I am concerned that the managed care organizations may not be as generous as CCS in providing M&T assistance to families. I am also concerned that in order to save money the managed care organizations may be tempted to say a child is well enough to be followed by their PCP locally instead of traveling to the center for care.	Shasta County CCS (SM21)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	Questions and concerns regarding CCS Whole Child Model from CICs (Carve In Counties): Marin, Yolo, Napa, Solano, Santa Barbara • No data to support that this model is successful • No data to show any fiscal impacts of this model to CCS and Health Plan • No data to show effectiveness of care coordination or family satisfaction • Work load of case managers will obviously increase – how will this be mitigated? • A formula has to be created to determine work load and necessary FTEs as a result of increased case management responsibilities • How will DHCS measure Health Plan's readiness? • How will CCS appeals process be integrated with the health plan's grievance process? • There should be a plan for data and authorization system integration (IT, encryption, communication) • Goals listed for the redesign are too broad and generalized to measure	Santa Barbara County CCS (SM22)
General Comments about the Whole-Child Model and / or the CCS Program	Dental care is a critical ongoing health need of the CCS child. The Whole Child Model has completely left dental access and care coordination for ongoing dental care, out. This demonstrates a lack of inclusion of the oral health community both within DHCS and at the statewide level. This is extremely concerning as the planning for this transition moves forward. Your introduction statement says:	San Francisco Department of Public Health

Section	Comments	Organization
Improvement Stakeholder Process	"This approach meets the six goals for CCS Redesign (listed below); including the primary goal to provide comprehensive treatment, and focus on the whole-child and their full range of needs rather than only their CCS eligible conditions." When dental care is completely left out of this redesign plan, it makes me, and any reasonable person, skeptical that the redesign of CCS can provide "comprehensive treatment and focus on their full range of needs". Please do recruit CCS Dental professionals to help guide this re-design plan. Thank you!	(SM23)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	YES - Cost effectiveness or Medical Loss Ratio CCS with the Carve out model has an overhead cost of 7%, that is far less than any managed care plan can offer. Therefore it is more cost effective to retain the Carve out Model. Bottom Line: Leaving the Carve out Model is • more cost effective • provides better quality care • has a great network of providers I implore you to look at the facts and to consider the quality of care for this very vulnerable group of special needs children.	Los Angeles County CCS (SM27)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	I don't see any mention of an evaluation. I think it is very important to include an evaluation component so that there is evidence on the model's effectiveness.	Health Plan San Mateo (SM29)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	Thank you for developing and presenting this proposal for public consideration. The CCS Redesign Goals are laudable, and achievable, with changes made that build on the strengths of the CCS program and the Medi- Cal Managed Care plans. I support extension of the carve-out, as DHCS proposes for the 33 non-Whole-Child counties, for the entire CCS system, so that the infrastructure for a successful transition can be developed before the implementation is begun.	Santa Cruz County CCS, MTP (SM31)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	1. 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? 2. San Mateo's pilot is not applicable to most of the counties in the state. They are in a small geographic, urban area with lots of available providers. 3. Has anyone identified what is broken with CCS and directly addressing those issues. It seems to us that the issue is payment - not only how much the providers are paid, but the difficulty in getting paid in a timely way.	Placer County CCS (SM32)
General Comments about the Whole-Child Model and / or	The Whole Child Delivery 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 which are two of most costly and most import services which are accessed by CCS clients.	Individual / No Organization (SM33)

Section	Comments	Organization
the CCS Program Improvement Stakeholder Process		
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	Model was designed without data with respect to health outcomes and cost saving which places financial burden on tax payers. The Whole-Child Delivery Model fails to provide coordinated care and would fragment services since the Whole Child Delivery Model does not include MTP/NICU services. Whole child care is already being provided in current CCS model which includes MTP/NICU services.	Individual / No Organization (SM34)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	Is there a way to compel the UC medical centers to be providers?	Individual / No Organization (SM36)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	In my opinion, the fundamental contradiction in plan is that it replaces current access to CCS approved providers, and financially disinterested authorization of services by experienced CCS MD and PHNs, with financially driven decisions by health plan staff (with no requirement for any experience or expertise in care of CSHCN) working for capitated plans with full financial risk. Second, that decision to proceed with proposed model pays lip service, but notable lack of substance, in heeding the input of multiple stakeholders, including RSAB process, and very credible input from, for example, CRISS stake holders group. Third, based on DHCS past performance in monitoring quality of Medi-Cal managed care, I have minimal faith that the department is likely to effectively monitor quality, access, or readiness of health plans without robust outside checks and balances. Fourth, also on past performance, I strongly suspect the timetable for radical re-organization and privatization of CCS functions, is highly likely to result in short term and probably long term disruptions in care of children with special health care needs. Fifth decision for proposed model has been made in the startling absence of any actual data to compare it with any other model, nor with any data suggesting that "similar" models have achieved measurable positive outcomes.	Individual / No Organization (SM37)

Section	Comments	Organization
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	How will County and MCP IT interface? Who will provide necessary IT support? Our County has very limited IT support available.	Anonymous (SM38)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	CRISS cannot support the proposed model and urges the Department to reconsider its approach. Given what we already know about the medical complexity and vulnerability of CCS children, as well as the quality and cost-effectiveness of the CCS program, there is no urgency to make the radical changes proposed by the Department and every reason to make any changes in a slow and deliberative way. We urge the Department to extend the CCS carve-out and to focus on ways to improve the CCS program, building on its strengths and the recommendations from the 2014/2015 Title V Needs Assessment specific to children with special health care needs. See response to question #4 for list of potential program improvements.	CRISS (SM39)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	Thank you for the opportunity to provide comment. Overall, Children Now would like to see more explicit references and description of how dental comprises the whole-child model.	Children Now (SM40)
General Comments about the Whole-Child Model and / or the CCS Program Improvement Stakeholder Process	I expect RSAB members will be polled, not just via this survey, but in some other manner. What consensus exists about any element of this proposal? What consensus exists about anything that is not an element of his proposal? etc. It would have been good to have proceeded as Devon Dabbs suggested at the first meeting, to have an online forum to share thoughts, identify issues, problem solve - in short, to accelerate progress and allow more expression. As for myself, I was honored to have been invited to join this group of knowledgeable, thoughtful, and caring people. At this time I am disappointed by the disconnect between the stated purpose of RSAB and the publication of this proposal which has not been vetted by RSAB; RSAB did not have a hand in crafting it. The proposal was delivered at the mere mid-point of the in-person meetings (the webinar/teleconference was a poor substitute; I found it very hard to attend to the screen, the written comments showing up on the side of the screen, and the speakers. A lesson learned.). At the last CCS Executive Committee the Department heard feedback from RSAB members that the workgroups quickly discovered a wide gap in knowledge, differences in perspectives, and even differences in usage of terms - such that it would be necessary to take more time than was given to develop work group products. RSAB members also expressed at the Exec disappointment that an evaluation of current CCS was not undertaken, to identify what problems existed, and where, and what was being done about them - indeed, that was not allowed as an RSAB task. It is not too late; it is never too late as long as it happens before changes are	RSAB Member (SM41)

Section	Comments	Organization
	implemented.	