

**Department of Health Care Services  
California Children's Services (CCS) Redesign  
Whole-Child Model  
June 11, 2015**

Based on an extensive six-month stakeholder process to identify strategies to improve and integrate care for children who qualify for the California Children's Services (CCS) program, the Department of Health Care Services (DHCS) has developed a proposed "Whole-Child Model" to be implemented in *specified* counties only, no sooner than January 2017. 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. In the counties that have not been chosen for this Whole-Child approach, DHCS and stakeholders will continue to work on alternative concepts and proposals to improve the care for CCS recipients.

CCS Redesign Goals:

- **Implement Patient and Family-Centered Approach:** Provide comprehensive treatment and focus on the whole-child rather than only their CCS-eligible condition(s).
- **Improve Care Coordination through an Organized Delivery System:** Provide enhanced care coordination among primary, specialty, inpatient, outpatient, mental health, and behavioral health services through an organized delivery system that improves the care experience of the patient and family.
- **Maintain Quality:** Ensure providers and organized delivery systems meet quality standards and outcome measures specific to the CCS population.
- **Streamline Care Delivery:** Improve the efficiency and effectiveness of the CCS health care delivery system.
- **Build on Lessons Learned:** Consider lessons learned from current pilots and prior reform efforts, as well as delivery system changes for other Medi-Cal populations.
- **Cost Effective:** Ensure costs are no more than the projected cost that would otherwise occur for CCS children, including all state-funded delivery systems. Consider simplification of the funding structure and value-based payments to support a coordinated service delivery approach.

Based on stakeholder feedback to seek a better integrated and coordinated system but proceed carefully with changes to the program, the department's proposal provides a balanced, measured approach, maintaining the core CCS provider standards and network of specialty care, and implementing a gradual change in a modest portion of the state (less than one-third), with an extended phase-in and stringent readiness and monitoring requirements to ensure continuity of care and continued access to high-quality specialty care.

**Current CCS System and Need to Improve Integration and Reduce Fragmentation**

Under the current system, most children with CCS-eligible conditions are enrolled in both the CCS fee-for-service system and Med-Cal managed care, and receive services in two or more separate systems of care that do not always coordinate effectively. In addition, as the health care delivery system has evolved, multiple care coordination and authorization roles have emerged across counties, providers, and health plans, at times resulting in confusion for parents and payment delays for providers.

These silos of care are preventive services for non-CCS conditions provided by Primary Care Providers, who may be pediatricians, family practitioners, or general practitioners contracted through Medi-Cal managed care health plans, and CCS-condition specific care provided by CCS-paneled pediatric subspecialists, as well as CCS-paneled acute inpatient hospital services. Behavioral health services may also be provided through a health plan or county mental health plan. Further, Regional Center services or In-Home Supportive Services may be provided through other state or county agencies. Most, but not all, county CCS programs are responsible for medical eligibility determination, care coordination, and service authorization for CCS-eligible services.

While having children in a single integrated system of care would be ideal, the fragile nature of the CCS population requires any change to be carefully vetted and staged to prevent unnecessary disruption or erosion in care. After significant discussion and review of models discussed at the Redesign Stakeholder Advisory Board (RSAB) DHCS has developed a multi-year framework for a “whole child” approach that relies on existing successful models and delivery systems.

### **Section 1. Whole Child Delivery Model**

The department proposes a Whole-Child Model which means an organized delivery system that will assure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children’s hospitals, specialty care providers, and counties. The first phase will incorporate CCS services into the integrated care systems of most County-Organized Health Systems (COHS). COHS are county developed and operated delivery systems with strong community ties. CCS services are already integrated into three COHS in six counties, through the CCS “carve-in,” so three of these plans already have experience with key elements of this model. In addition to Health Plan of San Mateo, which has already implemented most elements of this model, the COHS will include Partnership Health Plan (four counties already carved-in), CalOptima, Central California Alliance for Health, and CenCal Health (one county already carved-in). Health plans would be at full financial risk, with a whole-child approach to provide and coordinate all primary and specialty care, similar to the Health Plan of San Mateo model. These plans will be required to demonstrate support from various stakeholders that may include the respective county CCS program, local providers and hospitals, and local families of children with CCS eligible conditions or local advocacy groups representing those families. Implementation in COHS counties without CCS already “carved-in” will start no earlier than January 2017, and is subject to a successful readiness review by DHCS.

The Whole-Child approach may also be implemented in up to four counties in the Two-Plan Medi-Cal managed care model. The Medi-Cal Two-Plan model delivery system provides consumers a choice between a commercial health plan and a county developed health plan. The determination of these counties will be based on an application of interest to DHCS from at least one managed care plan in a Two-Plan model county, with demonstrations of support from various stakeholders that may include the respective county CCS program, local providers and hospitals, and local families of children with CCS eligible conditions or local advocacy groups representing those families. Based on the application, and subject to federal approval, DHCS may propose that CCS covered services be incorporated into only one Medi-Cal managed care health plan in a Two-Plan model county. Implementation will begin no earlier than July 2017, and is subject to a successful readiness review by DHCS.

The table below lists the counties with CCS services currently “carved-in” to Medi-Cal managed care plans, and the additional counties proposed for carve-in as part of the Whole-Child Model.

<b>Counties with current CCS carve-in (6)</b>	Marin, Napa, San Mateo, Solano, Santa Barbara, Yolo
<b>Proposed Additional CCS Whole-Child Counties (19)</b>	Del Norte, Humboldt, Lake, Lassen, Mendocino, Merced, Modoc, Monterey, Orange, Santa Cruz, San Luis Obispo, Shasta, Siskiyou, Sonoma, Trinity, and up to four 2-plan model counties

Overall, DHCS is taking a measured approach that builds on current organized delivery systems, and increases coordination of primary, specialty, and behavioral health services within Medi-Cal managed care plans. Among other benefits, this model proposes to improve care transitions and access to specialty care for youth aging out of CCS, since those youth will most likely be transitioning into Medi-Cal managed care, and the proposed changes will require all Medi-Cal managed care plans to include CCS providers in the health plan’s network.

**Section 2. Key Features of the Whole-Child Model**

- Existing fully integrated models will continue as part of the Whole-Child Model, such as Health Plan of San Mateo and Kaiser Permanente.
- Children included in the Whole-Child Model in each specified county will include CCS Medi-Cal, Optional Targeted Low-Income Children’s Program (former Healthy Families), and CCS State-only populations.
- DHCS will require health plans to follow continuity of care requirements to support existing member and provider relationships.
- In the remaining 33 counties where the Whole-Child Model is not offered, DHCS proposes to extend the CCS carve-out for three years, to January 1, 2019, and consider potential implementation of the Whole-Child Model in additional counties. In the meantime, DHCS will promote medical home models and care coordination partnerships between counties, providers, and health plans in these counties, with continued discussion of best practices and future modernization efforts into the remaining counties.
- To improve continuity of care and access to specialty providers for youth aging out of CCS and transitioning to Medi-Cal managed care, the department will require all Medi-Cal managed care health plans, on a phased-in basis, to contract with CCS providers or providers who meet the CCS panel requirements.
- This model will maintain the CCS core program infrastructure including the regional provider network, through the existing DHCS credentialing process, including CCS provider paneling.
- DHCS will work in partnership with recognized experts and stakeholders to develop comprehensive CCS quality measures and ongoing public data reporting.

### **Section 3. Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring**

To provide seamless and coordinated access to a full array of primary, specialty, and behavioral health services, detailed readiness requirements will be developed in consultation with stakeholders. Health plans will be required to meet these readiness requirements prior to implementation, and DHCS and the Department of Managed Health Care (DMHC) will conduct program monitoring and oversight for access and quality measures. Key readiness requirements for health plans will include:

- Evidence of adequate network of CCS-paneled providers.
- Specific policies and procedures regarding access to specialty care outside of the designated catchment area consistent with the existing CCS regional provider network.
- Evidence of health plan policies and procedures that include CCS provider standards.
- CCS family advisory committees in each county that meet at least quarterly.
- Detailed protocols for enhanced care coordination among primary, specialty, inpatient, outpatient, 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 each child; establishing interdisciplinary care teams; providing health promotion; transitions of care; referrals to social support services; referral to and coordination with behavioral health services; coordination with In-Home Supportive Services and Regional Centers; and links to other community services.
- Evidence of culturally and linguistically appropriate resources and readiness, including physical access.
- Specific policies around transitions, both initial enrollment and aging out of CCS, to ensure continuity of care.
- Integrated electronic health records system.
- Access to a grievance and appeals process for resolution of member issues.

### **Section 4. CCS Program Improvement and Stakeholder Engagement**

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. The CCS Advisory Group will replace the Redesign Stakeholder Advisory Board, and ongoing improvement efforts will continue to be guided by the department's six Redesign goals.

### **Section 5. County Roles, including Medical Therapy Program**

Counties have served as a valued partner with providers and the state to provide CCS care coordination and service authorization for children and youth with special health care needs. However, as the health care delivery system has evolved, multiple care coordination and authorization roles have emerged across counties, providers, and health plans, at times resulting in confusion for parents and payment delays for providers.

To establish a single, unified care coordination team that can ensure access across an array of services, responsibility for CCS care coordination and service authorization activities will shift in

phases from counties to the health plans in the Whole-Child model counties. Counties and health plans, with support from DHCS, will jointly develop Memorandums of Understanding (MOUs) to document transition plans for these activities. DHCS will work collaboratively with counties on the accounting process and adjustments to support this structure; no changes to the county realignment structure are expected to be necessary. Counties (or the state, for dependent counties) will continue to perform initial and periodic financial, residential, and medical eligibility determinations.

In addition, the Whole-Child Model seeks to strengthen partnerships among local Medical Therapy Programs, health plans, and providers, to promote improved outcomes and integrated care. Counties will maintain responsibility for Medical Therapy Programs, but enhanced partnerships will be promoted by DHCS and addressed in local MOUs with health plans and counties.

## **Section 6. Proposed Timeline for CCS Whole-Child Model Implementation**

### **Phase 1: June 2015 – December 2016**

- Stakeholder discussions and development of detailed health plan requirements, quality measures, contracts, and readiness criteria.
- County-Health Plan MOUs developed.
- Evaluation of applications of interest in Two-Plan model counties.
- Program Improvement efforts continue.

### **Phase 2: January – July 2017**

- Initial phased-in implementation begins in COHS counties, pending readiness review.
- Ongoing quality monitoring and reporting.
- Assess initial implementation and feedback from families and stakeholders.

### **Phase 3: July 2017 – December 2018**

- Incorporate feedback from assessment of initial implementation.
- Initial phased-in implementation begins in Two-Plan Model counties, pending federal approval and readiness review.
- Ongoing quality monitoring and reporting.
- Stakeholder discussions around Whole-Child Model effectiveness, and potential changes for implementation in additional counties.

### **Phase 4: January 2019 - Ongoing**

- CCS carve-out sunsets in remaining counties.
- Consider potential implementation of the Whole-Child Model in additional counties.