California Children's Services Advisory Group Meeting

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

April 12, 2023

Agenda

Welcome and Housekeeping	1:00 – 1:05
Department Updates, Roll Call, and January Meeting Recap	1:05 – 1:20
Policy Initiatives	1:20 – 1:35
Whole Child Model Implementation Update	1:35 – 2:00
Transition into Adulthood	2:00 – 2:10
CCS Program Updates	2:10 – 2:25
Break	2:25 – 2:35
CalAIM Enhanced Care Management: Child & Youth Update	2:35 – 3:00
Whole Child Model Evaluation	3:00 – 3:45
Public Comment	3:45 – 3:55
Wrap-up, Next Steps and Thank you	3:55 – 4:00

Housekeeping & Webex Logistics

Do's & Don'ts of Webex

- Participants are joining by computer and phone (link/meeting info on **California Children's Services (CCS) Advisory Group website**)
- Everyone will be automatically muted upon entry
- CCS Advisory Group members: 'Raise Your Hand' or use the Q&A box to submit Questions
- Other participants: Use the Q&A box to submit comments/questions or 'Raise Your Hand' during the public comment period
- Live Closed Captioning will be available during the meeting

Note: DHCS is recording the meeting for note-taking purposes

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Department Updates

Advisory Group Members

Liz Gibboney | *Partnership Health Plan of California*
Lianna Chen | *Health Plan of San Mateo*
Michelle Gibbons | *County Health Executives Association of CA*
Jerry Cheng, MD | *Kaiser Permanente SCAL*
Allison Gray | *Lucile Packard Foundation for Children's Health*
Whitney Clark | *Sutter Health*
Kelly Hardy | *Children Now*
Michael Harris | *CenCal Health*
Dena Davis | *CenCal Health*
Domonique Hensler | *Rady Children's Hospital and Health Ctr.*
Kristen Dimou | *County of San Diego Health and Human Svcs. Agency*
Michael Hunn | *Interim CEO CalOptima*
Mary D. Giammona, MD | *Molina Healthcare California*
Carol A. Miller, MD | *CCS Medical Advisory Committee*
Jennifer Mockus | *Central California Alliance for Health*
Miriam Parsa, MD | *Cottage Children's Medical Center*
Lara Khouri | *Children's Hospital Los Angeles Medical Group*
Francesca Peterson | *San Luis Obispo County*
Kristen Rogers | *CalOptima*
Ann Kinkor | *Epilepsy California*
Susan Skotzke | *Central California Alliance for Health*
Ann Kuhns | *California Children's Hospital Association*
Laurie Soman | *Children's Reg. Integrated Service System*
Lael Lambert | *Marin County CCS Program*
Amy Westling | *Association of Reg. Center Agencies*
Erin Kelly | *Children's Specialty Care Coalition*
Stephanie Dansker | *Association of Regional Care Centers*
Anthony Magit, MD | *Children's Specialty Care Coalition*
Beth Malinowski | *SEIU California*
Jolie Onodera | *California State Association of Counties*
Linnea Koopmans | *CEO, Local Health Plans of California*

January Meeting Recap

The following topics were reviewed and discussed at the January Advisory Group meeting:

- Whole Child Model Readiness
- PATH Transition to Adulthood
- Public Health Emergency Unwinding Plan
- UCSF Whole Child Model Evaluation

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Policy Initiatives

CalAIM: CCS Monitoring and Oversight Workgroup Update

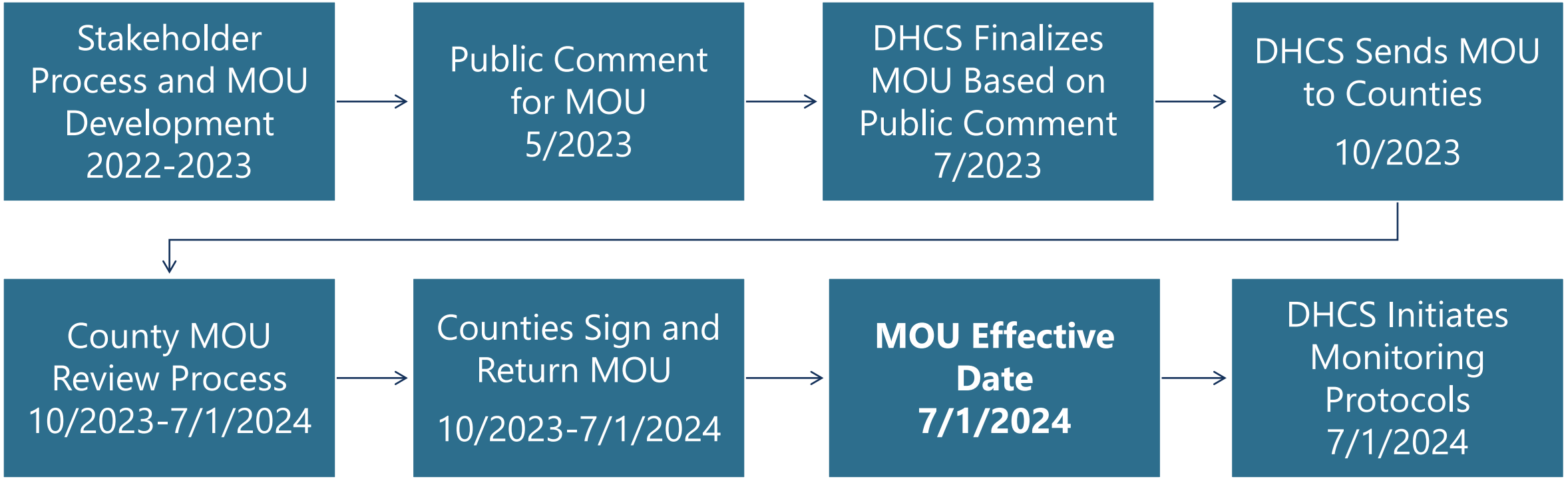
California Advancing and Innovating Medi-Cal (CalAIM)

The Department of Health Care Services (DHCS) intends to provide enhanced monitoring and oversight of all 58 counties to ensure continuous, and unwavering optimal care for children. To implement the enhanced monitoring and oversight of CCS in all counties, DHCS will develop a robust strategic compliance program. Effective compliance programs begin with ascertainable goals, performance measures, and metrics capturing all federal and State requirements.

January and March Meeting

- During the January and March meetings, the following topics were discussed:
  - CCS case management definition and core activities
  - Grievance, Training, and Survey Numbered Letters (NL)
  - CCS compliance activities
  - Enforcement and corrective action proposal
  - MOU development
  - Promoting transparency for the CCS program
  - DHCS accountability proposal

Memorandum Of Understanding (MOU) Development



CCS Monitoring and Oversight Updates

» Since the March meeting, DHCS is working on the following items:

Activity	Update	Due Date
County Compliance Activities	Revising quarterly and annual reporting requirements following workgroup comments	5/31/23
Grievance NL	Revising for DHCS to primarily intake grievances following public comments	6/30/23
Survey NL	Revising to include quarterly and annual reporting requirements following public comment	6/30/23
Enforcement and Corrective Action NL	Will be shared for public comment in April	6/30/23
Training NL	Revising following public comment	6/30/23
Appeal and State Fair Hearing NL	Will be shared for public comment in April	6/30/23
MOU	Will be shared for public comment in May	7/1/24

CCS Monitoring and Oversight Workgroup Meeting

Next CCS Monitoring and Oversight Workgroup Meeting		
Year	**Meeting Date**	**Activity**
2023	June 26 at 3-5 PM PT	***Capstone Meeting*** • Purpose of CCS Monitoring and Oversight • MOU feedback review • Closing out outstanding topics • Crosswalk of WCM MCPs/CCS program requirements

Meeting notices and materials will be posted, in advance, on the DHCS website.

Next Steps

- Following the last meeting of the CCS Monitoring and Oversight Workgroup, DHCS will:
  - Update and/or retire outdated policy guidance documents
  - Create Technical Assistance Guides to post online
  - Draft Quarterly and Annual Report Templates for counties
  - Develop Findings Report templates to post findings online
  - Update the DHCS webpages for training and compliance

Discussion

Child Health Disability Prevention (CHDP) Program Transition Workgroup Update

CHDP Transition Overview

- To reduce administrative complexities, DHCS will sunset the CHDP Program effective July 1, 2024
- Program activities will be transitioned to other delivery systems already in place
- DHCS must conduct the transition as described in HSC 124024 (a)

CHDP Transition Overview

- Senate Bill 184 requires DHCS to consult with stakeholders in the development of a transition plan. The CHDP Transition Plan will include:
  - A post-transition monitoring and oversight plan
  - A plan for how providers will be monitored
  - CHDP Childhood Lead Poisoning Prevention (CHDP-CLPP) program activities through existing Medi-Cal delivery systems
  - A plan to fund administrative and service costs for the Health Care Program for Children in Foster Care (HCPCFC)
  - An analysis and plan to retain existing local CHDP positions
  - Opportunities for alignment with Population Health Management

Current Activities of CHDP Transition

- To support the CHDP Transition to date, DHCS has:
  - Convened a workgroup composed of representatives from various governmental and non-governmental stakeholders to help inform and develop a detailed transition plan

- Stakeholders include representatives from the following:
  - County Public Health Nurses
  - Service Employees International Union
  - Parent Representative
  - County CHDP Deputy Director
  - Local Health Plans of California
  - California Department of Public Health
  - California Department of Social Services
  - Managed Care Plans
  - Children Now
  - County Health Executives Association of California
  - Medi-Cal Children's Health Advisory Panel
  - County Welfare Directors Association of California
  - California Association of Health Plans
  - Family Voices of California
  - American Academy of Pediatrics California
  - California Dental Association
  - County Health Executives Association of California
  - Medi-Cal Children's Health Advisory Panel
  - County Welfare Directors Association of California
  - California Association of Health Plans
  - Family Voices of California
  - American Academy of Pediatrics California
  - California Dental Association

Current Activities of CHDP Transition Cont.

- DHCS has developed and implemented a timeline for workgroup meetings to discuss the following:
  - Transition of CHDP Gateway to Children's Presumptive Eligibility
  - Early and Periodic, Screening, Diagnostic and Treatment (EPSDT)
  - Quality and Population Health Management (QPHM) Initiatives to Support the Transition
  - Managed Care Monitoring and Oversight
  - Budget and Resource Overview
  - Health Care Program for Children in Foster Care
- DHCS continues to update the CHDP Transition Plan based on feedback from workgroup members following workgroup meetings and is working collaboratively across DHCS divisions and sister Departments to incorporate feedback

Transition Workgroup Meetings

- During the January, February and March meetings, the following topics were discussed:
  - CHDP transition purpose and timeline
  - CHDP Transition Workgroup expectations
  - CHDP Gateway shifting to Children's Presumptive Eligibility (CPE)
  - EPSDT processes, activities, and toolkit
  - QPHM initiatives to support the CHDP transition
  - Managed care plans monitoring and oversight
  - Current budget overviews for the CHDP, HCPCFC, CHDP-CLPP, and CCS programs
  - Future budget allocation discussion
  - Transition of CHDP program staff

Future Transition Workgroup Meetings

May 3, 2023

- CHDP CLPP Roles & Responsibilities
- CHDP Newborn Hearing Screening Program activities
- CHDP Oral Health activities

June 14, 2023

- HCPCFC as a standalone Program
  - Financial
  - Administrative
  - Training & Program Manual
  - Enhanced monitoring & oversight
  - Memorandums of Understanding (MOU)

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Whole Child Model Implementation Update

Whole Child Model (WCM) Implementation - Kaiser

- Kaiser WCM Implementation
  - Kaiser will implement in the following existing WCM counties effective January 1, 2024:
    - Marin, Napa, Orange, San Mateo, Santa Cruz, Solano, Sonoma, Yolo

WCM Implementation - Proposed

- DHCS proposed Trailer Bill will newly implement WCM in the following counties:
  - Effective January 1, 2024: Colusa, Glenn, Nevada, Plumas, Sierra, Sutter, Tehama. Yuba, Mariposa, San Benito
  - Effective January 1, 2025: Placer, Butte, Alameda, Contra Costa, Imperial
- Kaiser will also implement in the following proposed new WCM counties:
  - Effective January 1, 2024: Sutter, Yuba, Mariposa
  - Effective January 1, 2025: Placer, Contra Costa, Alameda, Imperial

Key Driver for WCM Implementation – County Plan Model Changes

- 12 of the 15 proposed new WCM counties are converting to County Organized Health System (COHS) counties effective January 1, 2024, as part of the approved county plan model changes in the recent Medi-Cal Managed Care procurement process completed by DHCS
- Existing WCM managed care plan Partnership Health Plan (PHP) is expanding into 10 new counties and Central California Alliance for Health (CCAH) is expanding into 2 new counties

Key Driver for WCM Implementation – County Plan Model Changes

- As part of the approved County Plan Model Changes three counties will also be transitioning to Single Plan Model counties which share many similarities with COHS counties including primarily that there is a single Medi-Cal managed care plan (MCP) serving the county
- DHCS intent is to conform policy across counties operating with one plan
- The three new Single Plan Model counties are Alameda, Contra Costa and Imperial

Phase-In

- Implementation of WCM in new counties is purposefully split into two phases with the 10 new dependent CCS counties implementing January 1, 2024, and the 5 new independent and/or Single Plan Model counties implementing January 1, 2025
- DHCS phase-in strategy aligns with feedback received from the impacted counties and MCPs and accounts for the significant level of planning and time to ensure a seamless transition of duties and responsibilities in independent counties and new WCM MCPs
- All MCPs administering WCM will continue to be held accountable to existing requirements in Welfare and Institutions Code Section 14094.11

Readiness

- DHCS is preparing to release notification of Readiness Deliverables to the new WCM counties and existing/new WCM MCPs
- Shared County/MCP readiness deliverables will include submission of a transition plan and memorandum of understanding (MOU)
- MCP readiness review process focuses on the following areas:
  - Provider network adequacy
  - Member communications
  - Contractual and regulatory compliance
- County readiness deliverables will be applicable to county administration of CCS eligibility responsibilities and coordination of care with MCPs when beneficiaries are accessing care through both the MCP and county delivery systems
- DHCS will conduct transitional monitoring of the MCPs and Counties during and following the transition until it is determined that it is no longer needed (at least six months)

Next Steps

- DHCS has initiated or is in the process of initiating monthly meetings (commencing in April) with the counties and MCPs
  - As possible these monthly check-ins are being organized as joint county/MCP meetings
- DHCS distribution of MCP and County Readiness Deliverables notifications and checklists

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Transition to Adulthood

Transition to Adulthood

- Transition of Care from Pediatric to Adult Frequently Asked Questions (FAQ) documents are currently being drafted for the:
  - Member
  - Providers
  - Counties
- Member FAQ
  - Transition Planning
  - Providers
  - Insurance and Coverage
  - Programs, Supports and Resources
- Member FAQ will go out for comment before the next CCS AG

Transition to Adulthood (cont'd)

- What guidance surrounding DME transitions needs to be included in the member FAQ?
- What resources does the county coordinate for CCS beneficiaries that need to be considered when drafting the member FAQ to ensure continuity?
- What suggestions on language could be added to the member FAQ to ensure a fruitful discussion between the CCS case manager and the beneficiary/family?

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CCS Program Updates

Title V Needs Assessment

- Federal legislation dictates that the Title V Needs Assessment (NA) must occur every 5 years; DHCS supports this effort however the California Department of Public Health (CDPH) is the state Title V lead agency
- Substantial effort over the past 5 years to include all Child and Youth with Special Health Care Needs (CYSHCN) per federal recommendations
- This approach will be reflected in the upcoming NA, where CYSHCN will be folded into the overall NA without a separate process specific to California Children's Services (CCS)
- At the July CCS Advisory Group meeting DHCS will provide an in-depth presentation of the NA process

Guidance Documents

Posted/Distributed:

- Continuous Glucose Monitoring Systems Numbered Letter (NL)
- Low Protein Therapeutic Food (LPTF) Information Notice
- Medical Necessity Determination NL

Coming Soon for External Stakeholder Review:

- Transplants NL
- Whole Child Model NL
- Inter-County Transfer
- Medical Therapy Program Duplication of Services NL
- Rheumatology Special Care Center Standards

Continuous Coverage Unwinding

- The continuous coverage requirement ended on March 31, 2023, and Medi-Cal members may lose their coverage
- Medi-Cal redeterminations began on April 1, 2023, for individuals with a June 2023 renewal month
- Goal of DHCS: Minimize member burden and promote continuity of coverage
- How you can help:
  - Become a **DHCS Coverage Ambassador**
  - Join the DHCS Coverage Ambassador mailing list to receive updated toolkits as they become available
  - Check out the Medi-Cal COVID-19 PHE and Continuous Coverage Unwinding Plan (Updated January 13, 2023)

Continuous Coverage Unwinding

- DHCS is committed to maximizing continuity of coverage for Medi-Cal beneficiaries through the course of the Continuous Coverage Unwinding Period
- Counties and MCPs have been directed to update beneficiary's contact information upon contact
- Medi-Cal members can visit KeepMediCalCoverage.org, which includes resources for members to update their information and find their local county offices. It will also allow them to sign up to receive email or text updates from DHCS

Dashboard and Workgroup Update

- CCS Quality Metrics Workgroup
- Integrated CCS/WCM Dashboard
- CCS/WCM Quality Dashboard

The dashboards can be found here: WCM Dashboard (ca.gov)

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Break

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CalAIM Enhanced Care Management (ECM) for Children and Youth Update

Context: What is California Advancing and Innovating Medi-Cal (CalAIM)?

CalAIM is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. The goals of CalAIM include:

Implement a whole-person care approach and address social drivers of health

Improve quality outcomes, reduce health disparities, and drive delivery system transformation

Create a consistent, efficient, and seamless Medi-Cal system

Population Health Management (PHM)

- PHM is a **cornerstone of CalAIM** and **launched January 1, 2023**
- Establishes a **cohesive, statewide approach** that ensures all members have access to a comprehensive program that leads to improved outcomes and health equity
- Connect members to **timely and appropriate services**
- Provides **care management** for members at high risk of poor outcomes
- Provides **transitional care services**
- Identifies and mitigates **social needs and social determinants** to reduce disparities
- **Gathers and shares accurate data** to better understand and address individual and community preferences, needs, disparities, and effective interventions

PHM Care Management Continuum

Managed Care Plans are required to have a broad range of programs and services to meet the needs of all members organized into the following three areas, at different levels of intensity.

Enhanced Care Management (ECM) is for the **highest-need members** and provides intensive coordination of health and health-related services

Complex Care Management (CCM) is for members at **higher or medium-rising risk** and provides ongoing chronic care coordination, interventions for temporary needs, and disease-specific management interventions

Basic Population Health Management (BPHM) encompasses programs and services for **all** MCP members, including care coordination and wellness/prevention programs, all of which require a strong connection to primary care

Transitional Care Services are also available for all MCP members transferring from one setting or level of care to another

What is Enhanced Care Management (ECM)?

ECM is a new Medi-Cal benefit to support **comprehensive care management** for enrollees with complex needs who must often engage several delivery systems to access care, including primary and specialty care, dental, mental health, substance use disorder (SUD), and long-term services and supports (LTSS).

- ECM is a **whole-person approach** to address clinical and non-clinical needs
- DHCS' vision for ECM is to **coordinate all care for eligible Members**, including **across these different health delivery systems**
- Every MCP member enrolled in ECM will have **a dedicated lead care manager**
- ECM is interdisciplinary, high-touch, person-centered, and **provided primarily through in-person interactions** with Members where they live, seek care, or prefer to access services

ECM Core Services

DHCS has defined seven "ECM core services," which must be provided.

- **Outreach and Engagement**
- **Comprehensive Assessment and Care Management Plan**
- **Coordination of and Referral to Community and Social Support Services**
- **Enhanced Coordination of Care**
- **Member and Family Supports**
- **Health Promotion**
- **Comprehensive Transitional Care**

For more information on ECM Core Services, see ECM Policy Guide (December 2022) on the DHCS ECM & Community Supports Website

Who is ECM for?

ECM is available to Medi-Cal Managed Care Plan enrollees who meet a "Population of Focus" criteria

- ECM for Adult Populations of Focus went live on January 1, 2022 in some counties (those with Whole Person Care Pilots and Health Home Programs)
- ECM for Adult Populations of Focus then expanded to include all counties in July 2022
- **ECM will go live for Children and Youth Populations of Focus on July 1, 2023**

Populations of Focus for ECM

Go-Live Date	ECM Populations of Focus
Jan 1, 2022 (WPC / HHP counties) **Jul 1, 2022 (all other counties)**	» *All Members enrolled in a WPC Pilot who are identified by the WPC Lead Entity as belonging to a Population of Focus (includes children/youth served by WPC)* » Adults and Their Families Experiencing Homelessness » Adults At Risk of Avoidable Hospital or ED Utilization » Adults with Serious Mental Health and/or SUD Needs » Individuals Transitioning from Incarceration (some WPC counties)
Jan 1, 2023	» Adults Living in the Community and At Risk for Long Term Care (LTC) Institutionalization » Adult Nursing Facility Residents Transitioning to the Community
Jul 1, 2023	» Adults without Dependent Children/Youth Living with Them Experiencing Homelessness » Children & Youth Populations of Focus
Jan 1, 2024	» Birth Equity Population of Focus » Individuals Transitioning from Incarceration *(statewide, inclusive of the former WPC counties that already went live on January 1, 2022)*

ECM Populations of Focus (POF)

New in July 2023

ECM Population of Focus		Adults	Children & Youth
1	Individuals Experiencing Homelessness	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization (*formerly called "High Utilizers"*)	✓	✓
3	Individuals with Serious Mental Health and/or Substance Use Disorder Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	✓
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	✓

ECM has been available for adults with intellectual or developmental disabilities (I/DD) and pregnant and postpartum individuals from the launch of ECM if they meet the eligibility criteria for any existing Population of Focus. In July 2023, children and youth with I/DD or who are pregnant/postpartum will also be eligible for ECM if they meet the eligibility criteria for any existing Population of Focus.

ECM Population of Focus #1:
Individuals Experiencing Homelessness

Children & Youth

POF #1 launched for adults in 2022 and will launch for children & youth in July 2023 as follows:

Homeless families or Unaccompanied Children/Youth Experiencing Homelessness who:

1. Are experiencing homelessness, as defined under the modified HHS 42 CFR Section 11302 "Homeless" definition; **or**
2. Are sharing the housing of other persons (i.e., couch surfing) due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals (in hospital without a safe place to be discharged to)

Notes on the Definition:

» Children, youth, and families do **not** need to meet the additional "complex physical, behavioral, or developmental need" criteria noted for adults to qualify for ECM

» Clause 2 above is modified from the 45 CFR 11434a McKinney-Vento Homeless Assistance Act and is included in this POF to ensure ECM captures the breadth of unsafe, substandard, and insecure living conditions that Members, particularly children and youth, may experience

ECM Population of Focus #2:
Individuals At Risk for Avoidable Hospital or ED Utilization

POF #2 launched for adults in 2022 and will launch for children & youth in July 2023 as follows:

Children and youth who meet one or more of the following conditions:

1. **Three or more** emergency room visits in a **12-month** period that could have been avoided with appropriate outpatient care or improved treatment adherence
2. **Two or more** unplanned hospital and/or short-term SNF stays in a **12-month** period that could have been avoided with appropriate outpatient care or improved treatment adherence

ECM Population of Focus #3:
Individuals with Serious Mental Health and/or Substance Use Disorder Needs

Children & Youth

POF #3 launched for adults in 2022 and will launch for children & youth in July 2023 as follows:

Children and youth who:

1. Meet the eligibility criteria for participation in, or obtaining services through one or more of:
   i. Specialty Mental Health Services (SMHS) delivered by county Mental Health Plans (MHPs)
   ii. The Drug Medi-Cal Organization Delivery System (DMC-ODS) **or** the Drug Medi-Cal (DMC) program

Notes on the Definition:

» No further criteria are required to be met for children and youth to qualify for this ECM POF. Children and youth do **not** need to meet the additional criteria noted for adults to qualify for ECM.

» Children and youth are **not** required to be enrolled in or have accessed services through SMHS, DMC-ODS, or DMC to be eligible for ECM.

ECM Population of Focus #4:
Individuals Transitioning from Incarceration

Children & Youth

POF #4 was piloted in some Whole Person Care counties in 2022 and will launch statewide for both adults and children & youth in January 2024.

Children and youth who:

Are transitioning from a youth correctional facility or transitioned from being in a youth correctional facility within the past 12 months

Notes on the Definition:

» Children and youth who are transitioning from a youth correctional facility or transitioned from a youth correctional facility within the past 12 months do **not** need to meet the additional criteria noted for adults to qualify for ECM.

ECM Population of Focus #7:
Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition

Children & Youth

Children and youth who:

1. Are enrolled in California Children's Services (CCS) **or** CCS Whole Child Model (WCM)

   and

2. Are experiencing at least one complex social factor influencing their health. Examples include (but are not limited to) lack of access to food; lack of access to stable housing; difficulty accessing transportation; high measure (four or more) of ACEs screening; history of recent contacts with law enforcement; or crisis intervention services related to mental health and/or substance use symptoms

Notes on the Definition:

» Children in CCS or CCS WCM are eligible to receive ECM if they meet the criteria of any other ECM Population of Focus, even if they do not have a complex social factor that causes them to meet the criteria in Clause (2) of this Population of Focus. For example, many children in CCS have a co-occurring behavioral health need; these children would be eligible for ECM.

ECM Population of Focus #7:
Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition

Examples of Eligible Members:

- A child enrolled in CCS due to their cerebral palsy and child's family requests assistance to address food insecurity within the child's household

- A toddler enrolled in CCS while in the hospital to treat recent lead poisoning. The child is now clinically ready for discharge but cannot safely transfer home because the family cannot afford the necessary repairs to abate the environmental lead housing hazards

ECM Population of Focus #8:
Children and Youth Involved in Child Welfare

Children and youth who meet one or more of the following conditions:

1. Are under age 21 and are currently receiving foster care in California
2. Are under age 21 and previously received foster care in California or another state within the last 12 months
3. Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state
4. Are under age 18 and are eligible for and/or in California's Adoption Assistance Program
5. Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months

Notes on the Definition:

» Foster care is defined in California by WIC 11400(f).
» California's Adoption Assistance Program is defined by WIC 16120 and provides financial and medical coverage with the goal of facilitating the adoption of children who otherwise may have remained in long-term foster care.
» California's Family Maintenance program is defined by WIC 16506 and designed to support a child or youth remaining in a safe, secure, stable home.

How will families access ECM for their children?

Eligible Enrollees…

- Can be identified through their Medi-Cal Managed Care Plan (MCP), provider, family/caregiver, community-based organizations (CBOs), **or via a self-referral**
  - MCPs must regularly and proactively identify members who may benefit from ECM and meet the criteria of Populations of Focus
- Are assigned an **"ECM Provider"** who best meets their needs. The ECM Provider makes sure the enrollee has a **single "Lead Care Manager"** who coordinates their care and services across Medi-Cal delivery systems and beyond
- Can opt out of ECM at any time, as ECM is completely **voluntary**

How is ECM delivered?

MCPs contract with community-based providers to offer ECM:

Note: MCPs contract with many Provider types

Medi-Cal Managed Care Plans (MCPs)

Example: A Federally Qualified Health Center (FQHC)

What are some of the MCPs' roles & responsibilities for ECM?

- **Establish Provider networks** to deliver ECM
- **Contract** with Providers that have experience serving the Populations of Focus and expertise providing core ECM-like services (**DHCS is not setting provider rates for ECM**)
- **Identify** eligible members and **authorize** ECM
- **Assign** eligible members to ECM Providers
- **Provide training** for ECM Providers
- **Oversee and monitor** ECM service delivery

What are ECM Provider requirements?

- Providers are **community-based entities**, with experience and expertise providing culturally appropriate, intensive, in-person, timely care management services to individuals they will serve in ECM
- Assign a dedicated, individual **Lead Care Manager** to each MCP Member enrolled in ECM, who is responsible for meeting with MCP Members in-person to form a trusting relationship and coordinate care across medical, behavioral, and social service systems
- Agree to **contract with Medi-Cal MCPs** as ECM Providers and negotiate rates
- Must be able to **either submit claims to MCPs or use a DHCS invoicing template** to bill MCPs if unable to submit claims and **must have a documentation system for care management**

Who Are ECM Providers?

» Medi-Cal MCPs may choose to contract with a wide range of provider types, including but not limited to*:

- Federally Qualified Health Centers (FQHCs) / Community Health Centers (CHCs)
- Primary care providers or specialists or physician groups
- Counties
- County behavioral health plans
- Behavioral health entities
- Community mental health centers
- Local health departments
- Rural Health Clinics (RHCs)
- Indian Health Services Programs
- California Children's Services (CCS) providers (including Specialty Care Centers (SCCs)
- Hospitals or hospital-based physician groups or clinics (including public hospitals and district and/or municipal public hospitals)
- Organizations serving individuals experiencing homelessness and/or justice-involved individuals
- Community-based organizations (CBO)
- Community Based Adult Services (CBAS) providers
- In Home Supportive Services (IHSS) providers
- Skilled nursing facilities (SNF)
- Substance Use Disorder (SUD) treatment providers
- First 5 County Commissions
- School-Based Health Centers
- Other qualified providers or entities that are not listed above, as approved by DHCS

So long as the provider can meet all the core requirements to become an ECM Provider (on the prior slide)

How does ECM fit with existing programs?

Existing programs with a care coordination/care management component serve many of the same children and youth who will be served in ECM. This is not an exhaustive list.

Children & Youth Focused California Programs

- California Children's Services (CCS)
- CCS Whole Child Model (WCM)
- Specialty Mental Health Services (SMHS) Targeted Case Management (TCM)
- SMHS Intensive Care Coordination (ICC)
- California Wraparound
- Health Care Program for Children in Foster Care (HCPCFC)

Vision

- ECM will provide whole child care management **above and beyond** what is provided by the pre-existing programs
- ECM serves as the **single point of accountability** to ensure care management across multiple systems/programs – the "air traffic control" role
- ECM does **not take away funding from existing care management programs**; other programs' care managers can choose to enroll as an ECM provider and receive **additional** reimbursement for ECM from MCPs

Appendix

ECM Core Services

ECM Core Services	Description
Outreach and Engagement	• MCPs are responsible for (1) identifying (or accepting referrals for) Members who are eligible for ECM and (2) assigning every Member authorized for ECM to an ECM Provider • ECM Providers are responsible for reaching out to, and engaging, assigned Members
Comprehensive Assessment & Care Management Plan	• This process involves the ECM Members and their family/support persons as well as appropriate clinical input in developing a comprehensive, individualized, person-centered care plan • The care plan is based on the needs and desires of the Member; should be reassessed based on the Member's individual progress or changes in their needs and/or as identified in the care plan; and incorporates the Member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, social supports and SDOH • Comprehensive care management may include case conferences to ensure that the Member's care is continuous and integrated among all service Providers
Enhanced Coordination of Care	• Enhanced Coordination of Care includes the services necessary to implement the care plan including, but not limited to, organization patient care activities, communicating the Member's needs and preferences to the care team, and maintaining regular contact with the Member and their family member(s)
Health Promotion	• Health Promotion includes services to encourage and support Members receiving ECM to make lifestyle choices based on healthy behavior, with the goal of motivating Members to successfully monitor and manage their health
Comprehensive Transitional Care	• Comprehensive Transitional Care includes services intended to support ECM Members and their families and/or support networks during discharge from hospital and institutional settings and facilitating ECM Members' transitions from and among treatment facilities, including admissions and discharges • MCPs or ECM Providers should provide information to hospital discharge planners about ECM so that collaboration on behalf of the Member can occur in as timely a manner as possible
Member and Family Supports	• Member and Family Supports include activities that ensure the ECM Member and family/support are knowledgeable about the Member's conditions, with the overall goal of improving their adherence to treatment and medication management
Coordination of & Referral to Community/Social Support Services	• Coordination of and Referral to Community and Social Support Services involves determining appropriate services to meet the needs of Members receiving ECM, to ensure that any present or emerging social factors can be identified and properly addressed

Discussion

Agenda

Welcome and Housekeeping	1:00 – 1:05
Department Updates, Roll Call, and January Meeting Recap	1:05 – 1:20
Policy Initiatives	1:20 – 1:35
Whole Child Model Implementation Update	1:35 – 2:00
Transition into Adulthood	2:00 – 2:10
CCS Program Updates	2:10 – 2:25
Break	2:25 – 2:35
CalAIM Enhanced Care Management: Child & Youth Update	2:35 – 3:00
Whole Child Model Evaluation	**3:00 – 3:45**
Public Comment	3:45 – 3:55
Wrap-up, Next Steps and Thank you	3:55 – 4:00

Whole Child Model Evaluation

Introduction: WCM Overview

- In 2016, the California Legislature passed Senate Bill (SB) 586. which authorized the Department of Health Care Services (DHCS) to establish the Whole Child Model (WCM) program in 21 designated counties in a phased approach
- Phase 1 – CenCal Health (CenCal), Central California Alliance for Health (CCAH) and Health Plan San Mateo (HPSM)
- Phase 2 Partnership Health Plan (Partnership)
- Phase 3 – CalOptima
- SB 586 also required DHCS to contract with an independent entity to conduct an evaluation to assess Medi-Cal managed care plan (MCP) performance and the outcomes and the experience of CCS-eligible children and youth participating in the WCM program, including access to primary and specialty care, and youth transitions from WCM program to adult Medi-Cal coverage

Introduction: WCM Goals

The WCM aimed to improve care coordination for primary, specialty, and behavioral health services for CCS and non-CCS conditions within MCPs. In addition, the benefits were to be consistent with CCS program standards, with CCS Paneled Providers, Special Care Centers (SCCs), and pediatric acute care hospitals providing healthcare. Furthermore, the WCM was to meet the following goals for CCS redesign:

1. Implement a patient- and family-centered approach
2. Improve care coordination through an organized delivery system
3. Maintain quality
4. Streamline care delivery
5. Build on lessons learned

Introduction: WCM Evaluation Aims

- Measure the impact of the WCM on access to care, service use, quality of care, and coordination of care for patients and their families
- Assess the impact on the health system
- Assess any additional lessons learned

Evaluation Approach: Design

To evaluate whether or not the main goals of the WCM were achieved, the UCSF evaluation team approached the evaluation through five main research questions (RQ). These questions also addressed specific evaluation domains to meet the requirements of the California Welfare and Institutions Code (WIC) Section 14094.18 (2018).

- Q1. What is the impact of the WCM on children's access to CCS services?
- Q2. What is the impact of the WCM on the patient's and family's satisfaction?
- Q3. What is the impact of the WCM on providers' satisfaction with the delivery of services and reimbursement?
- Q4. What is the impact of the WCM on the quality of care received?
- Q5. What is the impact of the WCM on care coordination?

Methods: Mixed Methodology Triangulates Data to Produce Robust Findings

- Key informant (All counties and plans) and parent interviews (all WCM phases and Classic CCS)
- State level survey representing all CCS children in both WCM and Classic CCS counties
- Medi-Cal data (All claims-MIS/DSS)
- All Hospital and Emergency Room data (HCAI)
- CMS-NET data (CCS case management and referrals)
- CAIR2/RIDE (California Vaccination data)
- Referral data from plans
- Grievance and state fair hearings

Methodology: Strengths & Weaknesses

- **High-Level Strengths:**
  - Mixed methods approach, triangulating qualitative & quantitative data, linking survey and claims
  - Uses propensity score-matching & Difference in Difference analysis to compare matched Classic CCS comparison group for our outcomes
  - Includes data from many sources, such as vaccination data, encounters data, & more
- **High-Level Weaknesses:**
  - Telephone survey with CCS families is cross sectional, showing only associations over time and not causations
  - CCS covers a diverse group of children with varying condition severity and service need. Therefore, the overall evaluation may not capture all the nuances of need among the most disabled
  - COVID-19 may have impacted utilization and other data

Results and Conclusions

Research Question 1: What is the impact of the WCM on children's access to CCS services?

- KIs reported that aspects of care such as DME and referrals were streamlined
- WCM plans expanded CCS paneled providers post WCM and over 90% of visits with CCS paneled providers and pediatric specialists were seen in network.
- There were lower number of grievances for access to care in the WCM as compared to the Classic CCS comparison group.
- Based on enrollment and claims data, enrollment into CCS decreased across all study groups including Classic CCS, but WCM groups had statistically significant lower rates of CCS enrollment as compared to Classic CCS.

Research Question 1: What is the impact of the WCM on children's access to CCS services? Provider Access from Claims Analysis (DiD)

Measure	HPSM WCM	Phase I	Phase II	Phase III
Outpatient Visits				
CCS Paneled Provider Visits	↑	↓	↑	↓
Special Care Center Visits	↑	↑	↓	↓
Specialist Visits	↑	↓	ND	↓
Mental Health Care Visits (low/med, high severity)	ND	ND	ND	↑
Primary Care Visits	↑	↑	↓	ND
Well-Child Visits (0–15 months)	*	ND	ND	ND
Well-Child Visits (0–30 Months)	*	↑	ND	ND
Well-Child Visits (3–6 Years)	*	↑	ND	↑
Well-Child Visits (12–20 Years)	*	↑	↓	↑

Table Key

- ND = no statistical difference
- Outcome increased or higher as compared to Classic CCS
- Outcome Decreased or lower as compared to Classic CCS
- *Too few to perform DID
- Green indicates positive outcome, Red indicates negative, no color indicates neutral

Survey results for claims data context

- <5% of WCM clients on survey reported difficulty with getting a provider visit
- <12% of WCM clients on survey had any unmet specialty needs
- Primary care (HEDIS measure) mostly improved or was stable.

Research Question 1: What is the impact of the WCM on children's access to CCS services? Access to Ancillary Services, Health Outcomes and Travel to providers (DiD)

Measure	HPSM WCM	Phase I	Phase II	Phase III
Ancillary Services				
Durable Medical Equipment (DME)	*	ND	ND	↓
In-Home Supportive Services (IHSS)	↑	ND	↑	↑
Pharmacy	↑	↓	↓	ND
Outcomes				
ED Visits	↑	ND	↑	ND
ED with Follow-Up	ND	ND	ND	ND
Hospitalizations	↑	ND	ND	↓
Hospitalization with Follow-Up	↑	↑	↑	ND
Hospital Length of Stay	ND	ND	ND	↓
Hospital Readmissions	*	ND	ND	↓
Travel Distance**				
Travel to Overall Visits	ND	↑	ND	↑
Travel to Specialists	ND	↑	ND	↑
Travel to CCS Paneled Providers	ND	↑	ND	↑
Travel to SCC	ND	ND	↑	↑
Travel to Primary Care	ND	↑	↓	↑

Table Key

ND = no statistical difference.

↑ Outcome increased or higher as compared to Classic CCS comparison group post-WCM implementation.

↓ Outcome decreased or lower as compared to Classic CCS comparison group post-WCM implementation.

* Too few *n* to perform difference in Difference (DiD) model.

Green indicates positive outcome, Red indicates negative, no color indicates neutral

Conclusions by Research Question

Research Question 1: What is the impact of the WCM on children's access to CCS services?

- Overall access to care was maintained in the WCM with high rates of continuity with primary care and specialty care, high rates of authorization approval, and lower grievances rate as compared to Classic CCS and generally.
- While specialist visit use outcomes were mixed in this evaluation, less than 13% of families reported unmet specialist needs. While not statistically significant, a higher proportion of Classic CCS respondents have higher unmet specialist needs as compared to WCM clients.
- The increase in emergency department visits in the WCM warrant further investigation and quality improvement work.

Research Question 2

What is the impact of the WCM on the patient's and family's satisfaction?

- The majority of respondents in all WCM study groups indicated they were "satisfied" or "very satisfied" with the services they have been receiving.
  - Satisfaction with services was similar to Classic CCS respondents
- Family interviews: Following the transition to the WCM, most parents noted that it was more difficult to access case management services.
  - No direct contact, navigation of a phone tree in order to access the appropriate department, all of which took more time and multiple phone calls.
  - Families needing to call their county's CCS office when they were confused or needed help.
- Grievances: All WCM plans had an increase in total grievances, but the increase was only statistically significant for Phase II.

Conclusions by Research Question

Research Question 2: What is the impact of the WCM on the patient's and family's satisfaction?

- The WCM was successful in either keeping satisfaction unchanged or improving satisfaction for CCS related services as compared to Classic CCS after implementation.
- On most measures of satisfaction, the majority (>70%) of parent respondents in all WCM study groups indicated they were "satisfied" or "very satisfied" with the various specialty and CCS related services they have been receiving. Only 3% had any grievance reported indicating high levels of satisfaction with CCS services in the WCM.

Research Question 3

What is the impact of the WCM on providers' satisfaction with the delivery of services and reimbursement?

- DME providers reported that the WCM streamlined authorizations and subsequent access to DME and supplies
- KIs reported their dissatisfaction with both the Medi- Cal re-enrollment process and the increased CCS staff workload immediately after the WCM implementation.

Conclusions by Research Question

Research Question 3: What is the impact of the WCM on providers' satisfaction with the delivery of services and reimbursement?

- Key informants from the CCS program reported increased CCS staff workload they experienced immediately after the Specialists WCM implementation and suggested more funding support to account for this unanticipated increased workload.
- The DME vendor key informants were quite satisfied with a quicker and more efficient authorization process in the WCM, as compared to the lengthy DME authorization process in Classic CCS.
- Providers were mixed on reimbursement on the provider survey, which likely depends on what services are being rendered and billed for. The survey results mirror the findings of the key informant interviews, with satisfaction with DME, but also dissatisfaction, which may stem from difficulties with contracting providers and differences in provider networks.

Research Question 4

What is the impact of the WCM on the quality of care received?

- Clients in the HPSM WCM, Phase II, and Phase III all experienced a larger increase in grievances related to quality of care, per 100,000 member months pre-/post WCM implementation, than did their Classic CCS county counterparts.
- KIs reported that the WCM had an impact on both provider and DME quality, whereby CCS clients in the WCM had increased access to an expanded MCP network of providers and DME vendors, but some of these providers and vendors were less qualified to work with CCS clients because they were not specialized or experienced in working with children with complex chronic conditions

Research Question 4

What is the impact of the WCM on the quality of care received?

- Most families surveyed reported that quality of CCS care received was either the same or improved in the WCM across all domains measured (general healthcare quality, primary care services, specialty care services, medical therapy, pharmacy and behavioral health services).
  - The majority (60-80%) thought quality across the different CCS services were the same post-WCM implementation
  - 10% or less stated that the CCS services were worse post WCM Implementation
  - Among those who thought services were worse, the individuals tended to report poorer self-reported health, and higher numbers of specialists used.

Research Question 4

What is the impact of the WCM on the general child health quality of care received? (DiD)

Outcome	HPSM WCM	Phase I	Phase II	Phase III
Outpatient Visits				
Depression Screening	*	↑	↑	↓
Childhood Vaccinations	*	↑	ND	ND
Adolescent Vaccinations	*	ND	ND	ND

ND = no statistical difference.
↑ Outcome increased or higher as compared to Classic CCS comparison group post-WCM implementation.
↓ Outcome decreased or lower as compared to Classic CCS comparison group post-WCM implementation.
*Too few *n* to perform difference in Difference (DiD) model.

Green indicates positive outcome, Red indicates negative, no color indicates neutral

Conclusions by Research Question

Research Question 4: What is the impact of the WCM on the quality of care received?

- Overall, the quality of CCS-level care in the WCM appeared to be maintained at a similar level with that of Classic CCS clients. The majority of survey respondents in each WCM study group indicated that since the transition to WCM, the quality of services remained the same.
- HEDIS quality measures (Depression screening and vaccinations) mostly improved or stayed the same.
- For those who thought care was worse, subgroup analyses showed that those with greater specialty use and poorer self reported health status was associated with higher dissatisfaction with the WCM. Further investigation would be needed to evaluate the impact of the WCM on the more medically complex patients.

Research Question 5

What is the impact of the WCM on care coordination?

- The HPSM WCM, Phase I, and Phase III survey responses did not differ from Classic CCS respondents.
- While 67% of family respondents are “satisfied” or “very satisfied” with care coordination, a large percentage of respondents, 33%, are “neither satisfied nor dissatisfied,” “dissatisfied,” or “very dissatisfied.”
- More Phase II respondents responded they were “dissatisfied” or “very dissatisfied” with the care coordination services compared to Classic CCS (Phase II=26% vs Classic CCS=17%).
- A large percentage of respondents, 39%, indicated the care coordinator “sometimes” or “never” demonstrated knowledge of important information related to the client’s medical history. The differences between WCM study groups and Classic CCS were not statistically significant.

Research Question 5

What is the impact of the WCM on care coordination? (DiD)

Outcome	HPSM WCM	Phase I	Phase II	Phase III
Case Management	↑	ND	↑	↑
SCC Visit within 90 Days of Referral	↑	ND	↑	↓
Transition to Adult Care: Maintenance of insurance	ND	ND	ND	ND
Transition to Adult Care: Primary Care Visit	ND	ND	ND	↑
Transition to Adult Care: Specialist Visit	ND	ND	ND	ND
Transition to Adult Care: ED Visit	ND	ND	ND	ND
Hospitalizations	ND	ND	ND	ND

ND = no statistical difference.
↑ Outcome increased or higher as compared to Classic CCS comparison group post-WCM implementation.
↓ Outcome decreased or lower as compared to Classic CCS comparison group post-WCM implementation.
*Too few *n* to perform difference in Difference (DiD) model.

Conclusions by Research Question

Research Question 5: What is the impact of the WCM on care coordination?

- Care coordination as executed by high-quality case management has been identified across families and key stakeholders as a critical core of the CCS program.
- KI reports in the first year of the WCM, CCS case management was different from MCP case management. In MCPs, case managers were not as easily accessible to the CCS clients and MCP case management was neither centralized nor coordinated by one person, but instead it was fragmented, and CCS clients accessed services through a telephone triage system.
- Despite the KI reports, the majority of survey respondents in all WCM study groups (69%) were "usually" or "always" able to get as much help as they wanted with arranging or coordinating healthcare. The differences between the WCM study groups and Classic CCS comparison group were not statistically significant.
- Overall case management claims were higher as compared to and outcomes similar to that of Classic CCS.

Overall Results

- The Whole Child Model had either no difference as compared to Classic CCS or positive impact to the majority of CCS client participants across the majority of evaluation measures as compared to Classic CCS clients.
- Areas of improvement for both WCM and Classic CCS are noted in this evaluation and are discussed by research question.
- Details of the results can be found in the appendix of this PowerPoint.

Overall Conclusions

- The CCS WCM maintained services and provided CCS level quality of care for the majority of CCS clients in the WCM
- There were little differences between WCM and Classic CCS on outcomes and satisfaction on most measures

Research Team and Acknowledgements

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ADJACENT CCS PROGRAM IMPROVEMENTS

CCS Monitoring and Oversight

Assembly Bill 133, Article 5.51 established CalAIM subsection (b), requiring DHCS to consult with counties and other affected stakeholders to develop and implement all of the following initiatives to enhance oversight and monitoring of county administration of the CCS program:

- Establish statewide performance, reporting, and budgetary standards, and accompanying audit tools used to assess county compliance with federal and state requirements applicable to the CCS program.
- Conduct periodic CCS quality assurance reviews and audits to assess compliance with the established standards.
- Assess each CCS program to ensure appropriate allocation of resources necessary for compliance with standards, policies, guidelines, performance, and compliance requirements.
- Determine and implement a process to inform each CCS program of, and make available on its internet website, the latest standards, policies, guidelines, and new performance and compliance requirements imposed.
- Establish a statewide tiered enforcement framework to ensure prompt corrective action for counties that do not meet established standards.
- Require each county to enter into a Memorandum of Understanding (MOU) with DHCS to document each county's obligations in administering the CCS program.

Assembly Bill 133, Article 5.51

CCS Monitoring and Oversight Workgroup Goals

- DHCS has leveraged a comprehensive workgroup comprised of CCS stakeholders utilizing their experience, knowledge, and best practices to build a collaborative process that results in a finalized CCS Monitoring and Oversight Compliance Program Plan and metrics and standards
- Finalized documents will be used to create an MOU template, supporting attachments for the different county model types, and related guidance documents that will standardize and enhance compliance, monitoring, and oversight efforts to benefit beneficiaries, counties, providers, and DHCS.
- The workgroup has been in process since January 2022 and concludes in June 2023. County-State MOUs will be executed in advance of DHCS' initiation of monitoring protocols effective July 1, 2024.

APPENDIX:
WCM Evaluation

Evaluation Approach: Design

Research Question	Research Methods	California Welfare and Institutions Code Sections
Q1. What is the impact of the WCM on children's access to CCS services?	• Qualitative interviews with parents/guardians • Key informant interviews with stakeholders • Telephone survey with parents/guardians • Analysis of claims data • Grievances data	14094.18(b)(1), (b)(2); (b)(3), (b)(4), (b)(8), (c)(1), (c)(2), and (c)(3)
Q2. What is the impact of the WCM on the patient's and family's satisfaction?	• Qualitative interviews with parents/guardians • Telephone survey with parents/guardians	14094.18(b)(4)
Q3. What is the impact of the WCM on providers' satisfaction with the delivery of services and reimbursement?	• Key informant interviews with stakeholders • Telephone survey with parents/guardians • Online survey of CCS healthcare, DME, and pharmacy providers	NA

Evaluation Approach: Design

Research Question	Research Methods	California Welfare and Institutions Code Sections
Q4. What is the impact of the WCM on the quality of care received?	• Qualitative interviews with parents/guardians • Telephone survey with parents/guardians • Key informant interviews with stakeholders • Analysis of administrative data • Metrics of standards of care (HbA1c and depression screening) • Immunization rates • Grievances data	14094.18(b)(1), (b)(2), (b)(3), (b)(4), (b)(5), (b)(8), (c)(1), (c)(2), (c)(3), and (c)(4)
Q5. What is the impact of the WCM on care coordination?	• Qualitative interviews with parents/guardians • Telephone survey with parents/guardians • Key informant interviews with stakeholders • Analysis of administrative data	14094.18(b)(6) and (b)(7)

Evaluation Approach: Analysis and Data Sources

- Interviews with parents and guardians of children who transitioned into the WCM (35 total interviews)
  - Completed between October 2019 and January 2020
  - CalOptima (N = 9)
  - CenCal Health (N = 2)
  - Central California Alliance for Health (N = 6)
  - Health Plan of San Mateo (N = 9)
  - Partnership Health Plan (N = 6)
  - Classic CCS (N = 3)
- Key information (KI) interview with stakeholders working in or with CCS, WCM counties, or WCM with parents and guardians of children who transitioned into the WCM MCPs (83 total interviews)
  - Completed between October 2019 and May 2022
  - Represented all WCM and Counties, as well as CCS Special Care Centers and DME

Evaluation Approach: Analysis and Data Sources

- A statewide interview of parents and guardians of children in CCS, both in WCM and Classic CCS counties
  - Completed between March and June 2020

CCS Group	# of Completed Surveys
WCM HPSM	316
WCM: Phase I	790
WCM: Phase II	451
WCM: Phase III	321
Classic CCS: Dependent	283
Classic CCS: Independent	722
Total	2,883

- An online provider survey of clinical, durable medical equipment and pharmacy providers serving CCS clients in the WCM
  - Completed between March 2022 and May 2022
  - Represented all WCM and Counties, as well as CCS Special Care Centers and DME

Evaluation Approach: Analysis and Data Sources

- The administrative claims and encounter data cover two years of pre-enrollment and at least two years of post-enrollment. The cohorts had staggered start dates as follows:
- Health Plan of San Mateo (HPSM) WCM: July 1, 2016 to June 30, 2021
- Phase I: July 1, 2016 to June 30, 2021
- Phase II: January 1, 2019 to December 31, 2020
- Phase III: July 1, 2017 to June 30, 2021
- Classic CCS: Comparisons will be made using time windows and propensity score–matched counties that mirror each WCM study group (HPSM WCM, Phase I–Phase III)
- Total number of eligible clients was 737,708 in the entire study time frame
- Total number of MIS/DSS claims was 331,117,208. There were over 21.5 million HCAI encounters

Evaluation Approach: Analysis and Data Sources

- Medi-Cal Claims Data from DHCS
- Hospital and Emergency Department Visit Data from DHCS
- CMS Net from DHCS
  - Statewide eligibility, case management, and service authorization
- Vaccination Data from the California Department of Public Health's California Immunization Registry
- Referral Data (provided by the WCM managed care plans) and,
- Grievances and State Fair Hearings Data:
  - Grievances (January 2015 through December 2021). There were 8,857 unique CCS clients who filed a grievance while in CCS
  - State Fair Hearings (January 2015 to October 2020). There were 1,263 hearings for CCS clients

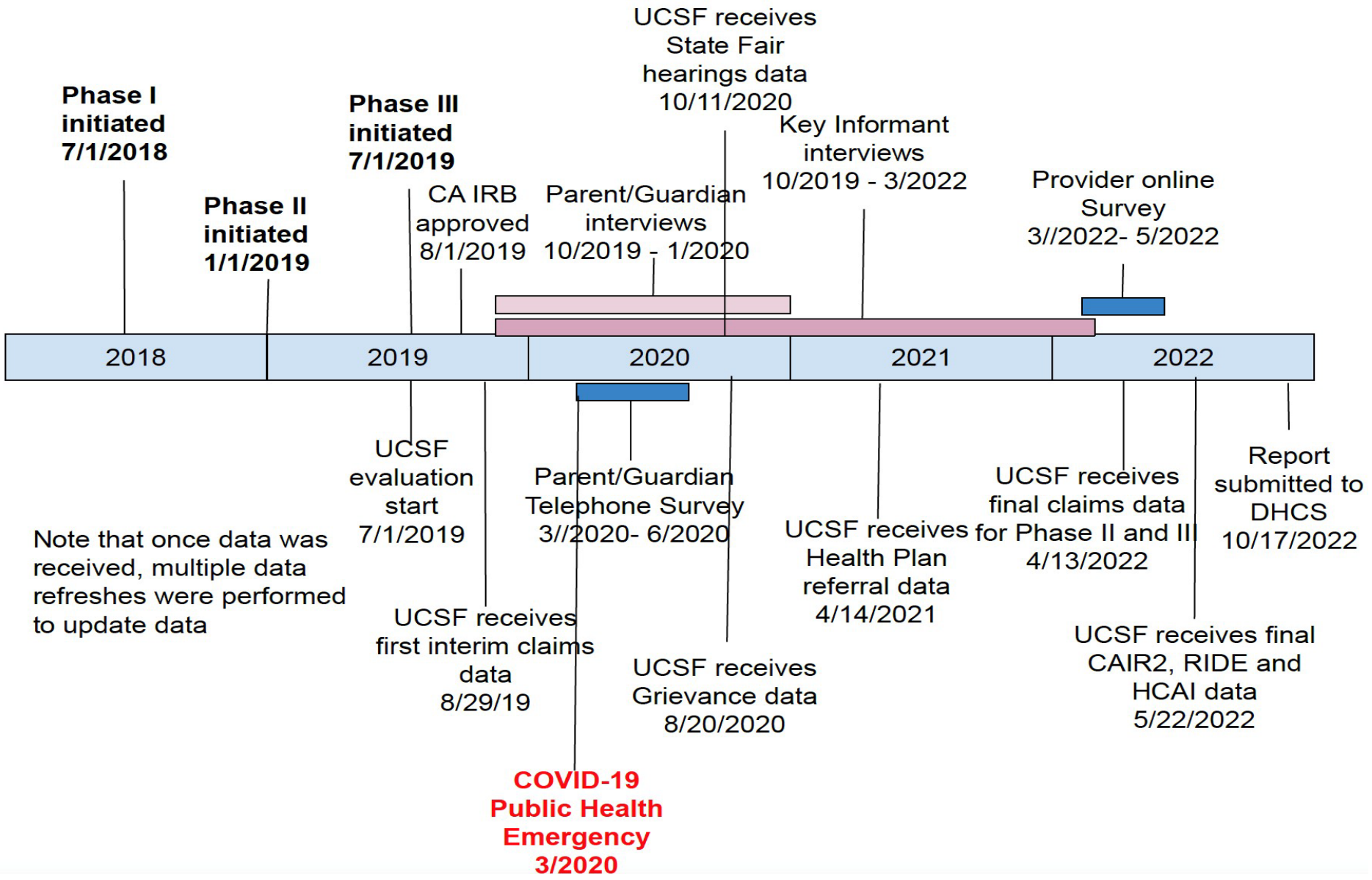
Methodology: Analysis Plan

- KIs were analyzed using qualitative methods
- Surveys were analyzes using appropriate univariate and bivariate statistics and regression analyses. The Family survey was survey weighted with population weights to provide population estimates
- Claims data were analyzed using descriptive statistics and regression analyses
- To evaluate the effect of the WCM, a difference in difference analysis (DiD) was performed on propensity score matched clients to account for temporal trends

Methodology: WCM Study Groups

Health Plan	Counties
Phase I — Implemented July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo (HPSM)*	**San Mateo**
Phase II — Implemented January 1, 2019	
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Phase III — Implemented July 1, 2019	
CalOptima	Orange
* HPSM was analyzed separate from Phase I due to the involvement of being part of the 1115 waiver, and most HPSM CCS clients were in the WCM in 2013	

Evaluation Timeline



Methodology: Propensity Score Match and Regression Analyses

= Phase I WCM Independent Counties (Santa Barbara, San Louis Obispo, Merced, Monterey, Santa Cruz, & San Mateo)

= Phase I Classic County Comparison for Independent Counties (Fresno, Ventura, Kern, Santa Clara*, & Tulare; HPSM only: San Francisco* & Santa Clara*)

= Phase II WCM Independent Counties (Humboldt, Mendocino, Sonoma, Napa, Marin, Solano, & Yolo)

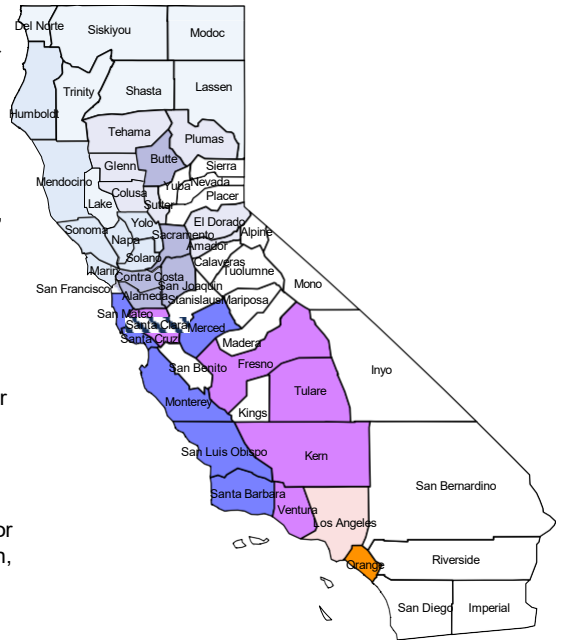
= Phase II WCM Dependent Counties (Modoc, Lassen, Trinity, Del Norte, Siskiyou, Shasta, & Lake)

= Phase II Classic County Comparison for Independent Counties (Butte, Sacramento, Contra Costa, Alameda, San Joaquin, & San Francisco*)

= Phase II Classic County Comparison for Dependent Counties (Tehama, Plumas, Glenn, Sutter, Colusa, El Dorado, & Amador)

= Phase III WCM County (Orange)

= Phase III Classic County Comparison (Los Angeles)



*San Francisco county is in Phase II for Classic CCS and also in Phase I for HPSM; Santa Clara county is in Phase I for Classic CCS and Phase I for HPSM. These two counties are indicated with stripes on the map.

Additional independent variables for propensity score matching

- Age
- Sex
- Language spoken at home
- Illness Severity: Chronic Illness and Disability Payment System (CDPS)
- Race/ethnicity
- CCS qualifying condition
- Independent/Dependent County

Additional independent variables for regression

- Disability (Children with Disabilities Algorithm)
- Season (for seasonality for outcomes)

* Initial county match by geographic region and independent/dependent CCS county status

Discussion

Agenda

Welcome and Housekeeping	1:00 – 1:05
Department Updates, Roll Call, and January Meeting Recap	1:05 – 1:20
Policy Initiatives	1:20 – 1:35
Whole Child Model Implementation Update	1:35 – 2:00
Transition into Adulthood	2:00 – 2:10
CCS Program Updates	2:10 – 2:25
Break	2:25 – 2:35
CalAIM Enhanced Care Management: Child & Youth Update	2:35 – 3:00
Whole Child Model Evaluation	3:00 – 3:45
Public Comment	3:45 – 3:55
Wrap-up, Next Steps and Thank you	3:55 – 4:00

PUBLIC COMMENT

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THANK YOU!

Next Meeting: July 12, 2023