

California Children's Services (CCS) Model Options

*Findings from the Lucile Packard Foundation for Children's Health Convening in support of the CCS 1115 Waiver Technical Workgroup**

The Lucile Packard Foundation for Children's Health hosted a convening in support of the CCS 1115 Waiver Technical Workgroup on March 1, 2010 in San Francisco. The purpose of the meeting was to provide members of the CCS Technical Workgroup, and other key stakeholders, with an in-depth overview of potential 1115 Waiver program options for CCS and the opportunity to discuss, review, and identify model options for CCS test piloting in California.

Four program options were presented and reviewed at the outset of the convening by Sally Bachman, Ph.D., Catalyst Center, Boston University. The options included: Medicaid Managed Care, Specialty Health Care Plan, Provider Based Accountable Care Organization, and Enhanced Primary Care Case Management. Each program option contains a set of key characteristics with regard to financial reimbursement, program administration, enrollment, geographic service area, target population, covered benefits, and provision of a medical home with case management, but is flexibly constructed, allowing for the integration of components from other options.

Following the overview of the four program options, attendees met throughout the day in a series of small teams, first to discuss the strengths, weaknesses, concerns, etc., of each program option, and then to identify elements of possible models for CCS test piloting. At the conclusion of the day, 16 model options were identified. Although the models were largely predicated on one of the four program options, many incorporated elements from two or more program options.

The small group discussion format and diverse team membership, including providers, family advocates, county and state staff, and other key stakeholders, enabled teams to consider and address a wide range of elements in their model option frameworks. As a result, the proposed models reflect a variety of perspectives.

The following tables present a high level summary of the key characteristics of the 16 proposed models developed by convening participants. A more detailed description of these models can be found at www.innovationlabs.com/lpfch-ccs. These models have been organized and grouped by the care delivery option that most closely aligns with the principle of the model. All of the proposed models reflect thoughtful analysis and examination of areas in which attendees felt CCS effectiveness could be maintained while program efficiencies could be realized. Because of time constraints, convening attendees were unable to fully develop the model options. It was also not within the purview of the convening to try to consolidate the models or make specific pilot recommendations. That said, these proposed models provide an important foundation for members

*Convening held at the Crowne Plaza Hotel, San Francisco.

of the CCS Technical Workgroup to further develop viable test pilot models with detailed implementation components around each of the four care delivery model options.

Proposed Model Options – California Children’s Services (CCS) Convening*

Medi-Cal Managed Care

Model/ Concept	Target Population	Enrollment	Geographic Area	Covered Services	Medical Home/ Case Mgmt/ Care Coord	Financing Structure	Payment	Administra- tion	Structure	Metrics	Standards	Provider	Patient / Family Focus
Medi-Cal Managed Care	CCS-eligible enrolled in Medi-Cal, Healthy Families, CCS-only	Mandatory	County and/or Regional	Current Medi-Cal benefits, care coord & other	✓	Capitated payment by the state for defined set of benefits & services, Plan fully at-risk	Provider Rates determined by Health Plan	Administra- tion by Health Plan under state contract					
Team 1: Model B			May not be generalizable to whole state		✓	Capitation w/risk adjustment + tiered payment	Enhance payment for PCCM/Medical Home	COHS		LOS ED Use	Enhanced CCS standards	Pediatr- icians	
Team 2: Model B <i>All-Inclusive Care</i>	All CCS Kids	Focus on chronic conditions		All inclusive Care	✓		Consolidated payment				CCS	Primary Specialist Dental Behavioral School Regional Ctr	✓
Team 5: Model A <i>Medi-Cal Managed Care In COHS</i>	All CCS Kids	Focus on chronic conditions	Regionalized		✓	Risk Adjusted Payment		COHS		Costs utilization patient/ family satisfaction		All CCS- approved hospitals, PCPs, MDs, SCCs	✓
Team 7: Model B <i>Medi-Cal Managed Care Plan</i>	Eligibility based on income and diagnosis	Voluntary			✓		Increased reimbursement to assure adequate provider participation		Regionalize specialty care access				✓

Enhanced Primary Care Case Management (EPCCM)

Model/ Concept	Target Population	Enrollment	Geographic Area	Covered Services	Medical Home/ Case Mgmt/ Care Coord	Financing Structure	Payment	Administration	Structure	Metrics	Standards	Provider	Patient / Family Focus
Enhanced Primary Care Case Management	CCS-eligible enrolled in Medi-Cal, Healthy Families, CCS-Only	Mandatory	County and/or Regional	Current Medi-Cal benefits, CCS services, care coord & other	✓	FFS or monthly care	FFS, Monthly Care Mgmt Payment, Performance- Based Incentives	By state or contract					
Team 1: Model A <i>Fee for Service Model for CCS Kids</i>			Whole State/ Rural Region		✓	Medi-Cal FFS + Coordinatin g Cap	Pay for performance	ASO – current CCS Program	Chronic care mgmt	Decrease ED use	Enhanced Standards	Pediatr- cians	✓
Team 4: Model B <i>Enhanced CCS</i>	Whole child carve out		24/7 access to warm line + after hours		✓	FFS with incentives; risk- adjusted by complexity of child			Case managers support PCP FQHC connections			PCPs Specialists with incentives	
Team 5: Model B <i>EPCCM + CCS Platform</i>	CCS kids with long- term chronic needs		Regional by provider	All medically necessary services	✓	All payer sources	Bundled payments; risk models	ASO	Single point care coordination build on CCS SCC structure			All CCS- approved	
Team 6: Model B <i>Medical Home for Complex Conditions – Whole Child</i>	All CCS, including undocu- mented				✓	FFS with Incentives		ASO	Medical Home / tiered approach to Medical Home intensity	Reduce ED visits	CCS standards	Expand role of MDs; regional hospital liaison on site	✓
Team 8: Model A <i>Aspects of Current CCS Program</i>	Subset of CCS Population		1 region or county		✓	FFS		CCS	CCS Regional Office enhanced primary care with enhanced case mgmt	Decrease ED use and hospital utilization	Enhanced Standards		✓

Specialty Health Care Plan

Model/ Concept	Target Population	Enrollment	Geographic Area	Covered Services	Medical Home/ Case Mgmt/ Care Coord	Financing Structure	Payment	Administration	Structure	Metrics	Standards	Provider	Patient / Family Focus
Specialty Health Care Plan	CCS-eligible enrolled in Medi-Cal, Healthy Families, CCS-Only	Mandatory	County and/or Regional	Current Medi-Cal benefits, CCS services, care coord & other	✓	Capitated payment by the state (PMPM) Considers Risk- Adjusted Rates, Risk Corridors, Stop-Loss Mechanisms	Provider Rates determined by Health Plan	Administration by Health Plan under state contract					
Team 4: Model A <i>Regional Specialty Carve Out</i>	Children with long term disabilities / chronic or complex conditions		County-based Regional + Rural		✓	Capitated Payment	Enhanced reimbursement for care coordination	ASO	SCC is medical home with care coordination;		CCS standards	PCP Creden- tialing	
Team 6: Model A <i>Health Plan for CSHCN (CCS)</i>			Counties/ Regions		✓	Capitated based on acuity and condition	Annual payment from CCS	CCS	Whole-child, tier-based case management		Enhanced Standards	Regional hospital liaison on site	✓
Group 7: Model A <i>Regional Specialty Health Care Plan</i>	Based on diagnosis; population stratification	Mandatory				Shared risk pools	Incentive structures shared risk pool +/- providers	Based on CCS infrastructure	Based on CCS; Credentialing for providers			Creden- tialled providers	✓
Team 8 Model B <i>Specialty Care Network - Health Plan</i>			San Diego County		✓		Bundled payment or fee for service		Enhanced primary care with enhanced case management				

Provider-Based Accountable Care Organization

Model/ Concept	Target Population	Enrollment	Geographic Area	Covered Services	Medical Home/ Case Mgmt/ Care Coord	Financing Structure	Payment	Administration	Structure	Metrics	Standards	Provider	Patient / Family Focus
Provider- Based Accountable Care Organization	Subset of CCS with specific chronic conditions only	Mandatory	Regional	Current Medi-Cal benefits, CCS covered services, care coord & other		Considers Risk- Adjusted Rates, Risk Corridors, Stop-Loss Mechanisms	Global Payment + Performance- Based Incentives	Administration by Health Plan under state contract	Physician-led multi- disciplinary teams		Provider standards Approval of Hospitals and SCCs		
Team 2: Model A <i>Family- Centered Care</i>	Subset of CCS					FFS, Capitation, Global	Consolidated payment	Contract with agency to manage care	Regional centers and hospital provide primary and specialty care (CHIPRA)	Functional & Clinical 6 MCH Measures	CCS	Primary Care/ Specialist	✓
Team 3: Model A <i>SCCs Take on Primary Care Function</i>	One CCS condition or multiple CCS conditions served by single facility					SCC takes on financial risk	Bundled Payment – Stop Loss Protection		Builds on existing capabilities of SCC; SCC coordinates care and primary care		Build on existing standards	Specialists (CCS paneled) & PCPs	
Team 3: Model B <i>Rural</i>			Focus on Rural Region SCC in coordination with PCPs			SCC does not take on financial risk	FFS		SCC is a coordination hub with a coordinator and advice nurse	LOS ED use; hospitaliza- tion	SCCs with electronic link to providers	PCP or clinic takes on care coord with SCC	

*Legend: PCCM= Primary Care Case Management; COHS= County Organized Health System; ED= Emergency Department; LOS= Length of Stay; FFS= Fee for Service; PCP= Primary Care Provider; SCC= Specialty Care Centers; MCH= Maternal Child Health; FQHCs = Federally Qualified Health Centers; ASO=Administrative Service Organization; Ctr= Center; Coord= Coordination.

** Additional domains, cited by only one or two models, include the following: *Performance-Based Incentive, Control Group, Cost Containment, Training and Electronic Health Records.*