SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER
CALIFORNIA CHILDREN'S SERVICES (CCS) TECHNICAL WORKGROUP
Meeting #4 – Monday, April 12, 2010
10:00am – 2:30pm
Sacramento Convention Center, Room 103

The meeting convened at 10 AM.

Attendance

Technical Workgroup members attending: David Alexander, Lucile Packard Foundation for Children's Health (LPFCH); Yvette Baptiste, Family Resource Center; John Barry, CCS, Shasta County; Gregory Buchert, CalOptima; Kris Calvin, American Academy of Pediatrics (AAP) (by phone); Albert Carlson, SEIU; Ricky Choi, Asian Health Services; Mary Davis, Orange County; Juno Duenas, Family Voices; Wesley Ford, Children's Medical Services, Los Angeles County; Erin Aaberg Givans, Children's Specialty Care Coalition (CSCC); Marilyn Holle, Disability Rights California; Tom Klitzner, UCLA Medical Center; Sherreta Lane, California Children's Hospital Association (CCHA); Frank Mannino, UCSD Medical Center; Janice Milligan, Health Net of California; Diana Obrinsky, Alameda County; Chris Perrone, California Healthcare Foundation (CHCF); Tara Robinson, Family Voices (by phone); Debbie Ruge, Los Angeles County; Stuart Siegel, Children's Hospital Los Angeles (CHLA) (by phone); Laurie Soman, Children's Regional Integrated Service System (CRISS).

Others attending: David Maxwell-Jolly, Director, DHCS; Gregory Franklin, Director of Medi-Cal Operations and Project Director, 1115 Demonstration Waiver Project, DHCS; Luis Rico, DHCS; Marian Dalsey, Medical Consultant, Children's Medical Services Branch, DHCS; Monique Parrish, LifeCourse Strategies.

Public in Attendance: 9 individuals attended in person, and 23 people called in on the listen-only telephone line.

Welcome and Introductions

Monique Parrish, LifeCourse Strategies welcomed the group and provided an overview of the agenda. She explained that the planning group had decided that this would be the final meeting of the CCS Workgroup - there will be no fifth meeting. She thanked members of the group for their contributions to the Workgroup and recognized that the composition of the Workgroup and the dedication of its members had been a tremendous asset to Workgroup process and to the Department.

Presentation and Discussion of CCS Health Plan (CCSHP) -- *CCS Managing the Whole Child*

Diana Obrinsky, Alameda County, introduced a fifth CCS Health Plan model (CCSHP) for discussion by the group, adding to the four models discussed at the previous two meetings. She noted the origin of the model grew out of discussions in Alameda County, which had, for some time, been considering the idea of having the county CCS program manage the care of the whole child. She further reported that Laurie Soman is one of the principal

authors of the model but clarified that while other individuals in Alameda County have reviewed and helped to develop the model, it is not a formal County proposal.

The model, as presented at the meeting, is available at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CCS_Plan_Model_04_10-REV.pdf. Diana Obrinsky walked the group through the model, and explained the following points:

- Covered benefits: The last bullet states that CCSHP would have the flexibility to provide non-covered benefits and services within specified criteria. Diana Obrinsky commented that there was a time when county CCS could authorize consultation from experts outside the program, and that this was particularly useful at times with older adolescents who needed to see adult specialists. She also indicated that this earlier practice was helpful in addressing durable medical equipment (DME) issues and vendored services.

- Medical home/case management: CCSHP would design new Service Code Groupings (SCGs), in order to minimize paper flow and administrative difficulties and allow some services to be authorized by the Primary Care Provider (PCP) and some by the specialist. This would be analogous to SCG 51, a service code grouping newly authorized by the State for some surgeries. CCSHP would also use Hospital Liaison Teams as described by the State, and work more closely with Child Health and Disability Prevention (CHDP) to leverage that program's close linkages with PCPs.

- Financing: Diana Obrinsky said that the CCSHP model proposes to maintain a Fee-for-Service (FFS) payment practice for at least the first year due to concerns that the data on specialty *and* primary care costs for CCS children are insufficient to construct reliable capitated rates. Once that data is available and actuarially sound, rates can be determined and the CCSHP would assume risk.

Debbie Ruge, *Los Angeles County,* asked about the bullet under "Financing" that states that there would be no use of the State Fiscal Intermediary. Diana Obrinsky said that claims processing with the current State Fiscal Intermediary is a huge problem, and as a result, the developers of the CCSHP model decided to take the opportunity to develop another claims payment mechanism more appropriate to the services that children need.

Greg Buchert, CalOptima, said that the CCSHP represented a fascinating twist on the approach outlined in the other four models. He said that the model should address transition issues for youth as they age out of CCS, and recommended that the CCSHP also adopt the Healthcare Effectiveness Data and Information Set (HEDIS) and other evaluation measures that are required of all other health plans. He asked whether the plan as envisioned would include the full range of Medi-Cal services, such as behavioral health, dental, etc., and, if so, how would it differ from the Specialty Health Care Plan (SHP) discussed at meeting #3. Diana Obrinsky said that there were many details remaining to be worked out, but that unlike the Specialty Health Care Plan, the proposed CCSHP would not require development of an entire new infrastructure. Local Initiatives could potentially serve as fiscal

intermediaries, for example. However, she said she would have no objection to a county CCS program seeking to become an SHP if that were the direction that California chooses.

Wesley Ford, Los Angeles County, said that part of the appeal of the CCSHP is the maintenance of existing infrastructure. He said that in Los Angeles, they have discussed carving out the whole child, with the thought that the cost of primary care would not be exorbitant. He asked how cost-sharing between the state and the county would work. Diana Obrinsky said that the plan as written does not answer that question.

Marilyn Holle, Disability Rights California, said that one attractive feature of the CCSHP is that it would bring the CCS expertise and CCS case management to *all* of a child's conditions, since CCS-eligible children often have other disabilities as well.

Erin Aaberg Givans, CSCC, said that the initial reaction of her members to the model is that it should be considered going forward, since it builds on CCS's strengths, addresses bureaucratic inefficiencies, has the option of being county- or regionally-based, and doesn't try to reinvent the wheel. As with the other models, this one does not answer the question of how to bring in CCS eligible Healthy Families and CCS-only children. She noted that while the target population bullet for this model mentions potentially tightening CCS eligibility to include only conditions requiring complex case management and/or expected to last at least 12 months, the TWG has not discussed this, and there is no consensus on that point, particularly as it relates to the issue of Neonatal Intensive Care Unit (NICU) care.

Tom Klitzner, UCLA Medical Center, said that the development of the model was a tribute to the commitment of the technical workgroup (TWG), and that it combines a lot of positive ideas. He offered several potential refinements:

- This plan would want to approach the qualifications of medical homes differently than typical Medi-Cal plans.
- An additional year of FFS experience would not permit actuarially sound rate determinations.

His overall comment was that he was not sure that the CCSHP model was truly a health plan. Everything in the model with the exception of those things described under "contracting options" could be done under the current system. As far as contracting with a non-profit plan for infrastructure needs, he was not certain that plans could handle the fiscal intermediary needs, and thought that data collection should be independent in any case. Diana Obrinsky replied that CCS panels pediatricians, but does not have experience with certain other managed care provider network functions that would be important in a model that cares for the whole child. This is one reason that the model envisions a closer collaboration with CHDP.

Laurie Soman, CRISS, said that this model is based in part on the work done in 1999 as part of an application for a four-county Bay Area pilot project. In response to Tom Klitzner's question about whether the model is really a plan, she said that neither CCS nor CHDP, even combined, have the infrastructure for all the necessary tasks. While infrastructure needs could conceivably be managed through contract with an Administrative Service Organization (ASO), they also could be accomplished through linkage with a non-profit Knox-Keene entity – and this connection would be necessary were the CCSHP to take on risk at some point. The Alameda Alliance (not-for-profit health plan) was prepared to take on

that role at the time that the 1999 four-county model was developed, and Laurie Soman said she still thought that Knox-Keene linkage was needed. She said that she agreed that a year of FFS experience probably would be insufficient to permit development of actuarially sound rates, but said that model authors had wanted to leave the door open to ideas such as taking on pieces of risk, for example through case rates or other options short of full capitation.

John Barry, CCS Shasta County, said that he appreciated that this model keeps the county infrastructure together, and that it would not be a big jump for rural counties. He also said that this model might be more supportive of the Medical Therapy Program (MTP) because of the existing relationship that program has within CCS.

Chris Perrone, CHCF, said that the difference between managed care models discussed previously and the CCSHP seemed to be in the locus of power. The concern in expanding existing Medi-Cal managed care plans is that they would move forward without the expertise of county CCS programs, whereas the CCSHP would move forward without the skills and abilities of managed care plans. He suggested that the goal is to find a model with a shared locus of power, where a plan and CCS work together. He further noted that he was concerned by the absence of a designated plan from this model. Who would pay for HEDIS, for example? The state doesn't pay for that, and it does not seem likely that CCS would come up with the resources to support that data collection and analysis.

Frank Mannino, UCSD, said that two things are required to make any model work for patients: 1) the medical home - this could be provided by a PCP or specialist, but in any case the reimbursement must be sufficient, and that has not been adequately addressed in any of these models; and 2) Nurse case management. To make CCS work, a real case manager must be available all the time, which is not currently the case. This is an issue that must be addressed regardless of the test pilot model(s) selected.

Mary Davis, Orange County, noted that current CCS case management caseloads in Orange County range from 450 to 600. She said that while she appreciated the central role of CCS in this model, she said that the current and projected shortage of funding for CCS might make it impossible for any county to take on the CCSHP model.

Albert Carlson, SEIU, asked whether it would be possible for a Local Initiative to take on the functions described in the CCSHP. Diana Obrinsky said that it was not clear how case management of the whole child would work in such a system. Tom Klitzner, UCLA, noted that he sits on the board of a Local Initiative (LI), and said that although many LIs are considering whether their infrastructure could be adapted to bring Seniors and Persons with Disabilities (SPD) into an organized system of care, the CCS population poses a very different challenge. He said that CCS is a highly specialized population with its own providers, its own community relationships, its own DME needs, and while an LI may have a strong community provider network this may not in fact be the right network for this particular population. Traditional providers have served Medi-Cal managed care well and are responsible for many of its successes, but they may not be the right providers for CCS children. The things that plans were prepared to do 12 years ago (at the time that the Bay Area pilot on which CCSHP is based was developed) they may not be able to do now, due to other developments in managed care. In Los Angeles, while LA Care may have been ready to move ahead with CCS in 1999, it would be more challenging today.

Stuart Siegel, CHLA, said that he liked the flexibility that the CCSHP model allows in dealing with a variety of different diagnoses. The model allows for the inclusion of a wide variety of ancillary services, and from that perspective the model is very positive.

Kris Calvin, AAP, said that pediatricians who discussed this model prior to the meeting were very interested and enthusiastic. From the pediatricians' perspective, it builds on what's already in existence and moves it forward.

David Alexander, LPFCH, said that he was not sure whether the CCSHP represented a fifth plan, or a recasting of some of the elements discussed previously, with more detail. In its initial incarnation (with FFS payment) it resembles the EPCCM model; however, as it accepts risk it would essentially become a SHP that uses the county CCS program to do case management and care coordination. He said that to build the infrastructure that would allow CCS to do all this would be a stretch, whereas health plans are already set up to do the financing and other infrastructure pieces. He said that the question is how to retain CCS' strengths in case management and care coordination and build them into a whole-child approach. He suggested that the model design might represent the first real pilot. Diana Obrinsky said that from the developers' perspective, they are not worried about labels, but want the concepts to be considered.

Greg Buchert, CalOptima, reminded the group that while most SPDs are not enrolled in Medi-Cal managed care in most counties, adults *and children* who fall into SPD aid categories have been mandatorily enrolled in County Organized Health Systems (COHS) for over a decade. He also requested that the group be precise in its definitions and expectations for case management and care management, which should mean more than utilization management and case processing.

Janice Milligan, Health Net, said that she did not see anything in the CCSHP model that health plans couldn't do. Diana Obrinsky said she substantially agreed, and that plans do have the infrastructure for enrollment, for example, but that among the things missing from plans generally are 1) adult practitioners who can provide care for adults with disabilities, and 2) case management. CCS nursing case management ratios are far too high, but they are similarly too high in plans. County CCS programs have dealt with the lack of case management resources by identifying those children who most need more intensive nurse case management services (and some children are not in the program long-term, so the ratios may sound higher than they are in actuality), and plans would not necessarily do better. Still, the right ratios would be more like 1:50, as in Regional Centers.

Laurie Soman, CRISS, responded to Janice Milligan's point, saying that managed care plans are designed for and do a good job with meeting the needs of the majority of members, but that CCS children are by definition at the farthest tail of the normal curve. Instead of making a plan designed for the center work better for kids at the tail, the CCSHP is designed specifically for the tail of the curve.

Tom Klitzner, UCLA, agreed, saying that CCS's place in the tail of the normal curve is what makes it hard for the program to go at risk, since the actuarial piece is so hard to get right. If these children are in a regular plan, their care must be subsidized by the rest of the curve, creating the risk that their care will be diluted as a result of a focus on the majority of

enrollees. Tom Klitzner also responded to the statement in the Health Management Associates (HMA) CCS report that 80% of CCS is strong, but 20% is broken. Half of that problem (or 10% of the total) is the whole child problem (which the CCSHP, and some of the other models, solve). 5% is neonates, which is not part of the TWG discussion. Thus, he noted, if you take out neonates and incorporate a whole-child approach, the remaining problem is only 3 – 5% of the program.

Marilyn Holle, DRC, responding to Chris Perrone's comments about the locus of power, said that that locus should be where the expertise is. The attractive thing about the CCSHP proposal is that it gives authority to those with expertise. She said that it is critical that these "outliers" have a system that is focused on them, and not be fitted into a system designed for typical kids. She noted that in the past, calls from CCS case managers to legal advocates were frequent, as they sought help for their clients with issues like housing and education. Cuts to CCS mean that nobody has time to address these non-medical concerns. She said that it is essential that case management – not necessarily by nurses – be supported in the system, and that the CCSHP is the strongest model in that regard.

Albert Carlson, SEIU, asked whether counties would be willing or able to take on such a model if it involved taking risk. *Mary Davis, Orange County,* said that she believes that, while the model is beautiful, financing issues would be prohibitive. Diana Obrinsky said that, at least in Alameda, county personnel are very interested (and have in fact been active in developing the model). The question of risk would be particular to each county or region. There is no guarantee that Alameda or any other county would actually do it, but there is enough interest to justify adding detail to the model.

David Alexander, LPFCH, said that one thing that the CCSHP model does well and more explicitly than the other models is to put the child back together, which is the biggest challenge in CCS from the patient's point of view.

Tom Klitzner, UCLA, noted that the advantage of a model that takes on risk is that if costs *do* decrease, the savings come back into the plan for its own purposes. He said he would like to see if a model, like CCSHP, could in fact save anything, and if so, then talk about how to distribute those savings. He also suggested that DHCS might be able to redistribute those savings without there being a Knox-Keene licensed entity involved. The conversation should perhaps be about savings, not risk. *Erin Aaberg Givans, CSCC,* asked whether this kind of shared savings wasn't the function of an ASO, and whether there could be a shared savings "carrot" approach without full capitation.

David Maxwell-Jolly, DHCS, said that this is a core question. The State has generally started from the point of view that delegation of risk with a pool of money to work with can put the organization taking risk in the best position to use that money effectively to meet the population's needs. In the State's experience, flexibility comes hand-in-hand with taking on risk. He noted that nothing rips off savings faster than the fee-for-service system. Budgets are primed to eat up any FFS savings in the next budget round: it would be very difficult to reinvest or redistribute FFS savings in the manner Tom Klitzner described. The best way to grab savings, at least in the short run, is in a risk-taking system, which allows for the husbanding of resources to get to the "edges" of care that Marilyn Holle described earlier. From a health care services advocate point of view, David Maxwell-Jolly said that he advocates taking risk in order to hold onto the savings in the system.

Chris Perrone, CHCF, observed that to the extent that the CCSHP model is conceived of as risk-bearing, all the concerns raised about the other models arise – plus, given the fiscal pressures on counties, there are additional concerns about viability of this model given county pressures to restrict services. He then posed a question to health plans: how could they treat the whole child in their plans, and assure families that they're not getting the case management that's just for 99% of children who do not have CCS conditions? Specifically, how could a health plan segment this population into a specialized unit that treats them appropriately? *Erin Aaberg Givans, CSCC,* raised concerns about this concept, saying that the reason they have supported the CCS carve-out all along is because they feel that CCS children would get lost in health plans.

Sherreta Lane, CCHA, said that instead of savings, she imagined there would be significant additional costs in the CCSHP model, at least in the beginning. While there might be savings in the long run, in the short term, additional services and administrative costs would be significant.

Marilyn Holle, DRC, said that one problem she experiences with health plans is hostility to hospital-based clinics and special care centers. Laws requiring hospitals to take Medi-Cal have not been consistently enforced in managed care; as such, more Hill-Burton Act enforcement is important in the CCS context.

Department Analysis of Workgroup Member Feedback of Four Pilot Models

Greg Franklin, DHCS, discussed the feedback of the TWG on the four models. A summary of the models and the feedback is available at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/TestPilotMod_KeyElemCharts_TWGFeedback-Rev.pdf.

- The initial concept paper led to the development of four concepts for CCS: Enhanced Primary Care Case Management (EPCCM), specialty health care plan (SHP), enrollment of CCS kids in Medi-Cal managed care (MCMC), and Accountable Care Organizations (ACO). The Workgroup's feedback on the four broad concepts led to some additions and changes, especially in the EPCCM and SHP models.

- There were significant consistencies in the Workgroup's feedback in some areas:
    - Enrollment (should be mandatory)
    - Geographic service areas (could be county or regional)
    - Medical homes (important part of any model)
    - Covered benefits (all Medi-Cal benefits should be included)

- There were differences in the area of financing, although the TWG generally agreed that this area should include a role for the State. Issues still to be worked out include the target population, and concerns about the risks of the MCMC model to the managed care infrastructure.

- DHCS does not want to lose ground in the CCS program. Retention of the successful pieces of the program is important, and will be built into any model that emerges. The work that the TWG has done is essential to helping the state build a path to getting to a model or models. The TWG comments have been very useful, and there is currently no decision on what the model or models should be.

- DHCS is likely to consider a Request for Information (RFI) process as they continue to develop these models, in which vendors and counties would be asked to respond to questions about topics including data collection and development of actuarially-sound capitation rates. A Request for Proposals (RFP) or application process would follow the RFI process.

Tom Klitzner, UCLA, said that one challenge across all models is the provider network. The CCS provider network is highly specialized -- subspecialists, nurses for case management, primary care pediatricians who can serve as medical homes – and must be maintained in any non-statewide network. If payment mechanisms flow through a plan that develops its own provider network, this will raise family concerns about the limitations of that network. Greg Franklin replied that DHCS recognizes this challenge, saying that provider contracting is extremely complicated for complex populations.

Juno Duenas, Family Voices, asked for clarification on "mandatory enrollment." She said that she would like all her children – receiving CCS or not – to have the same PCP. She would not want a CCS child in an entirely different system. She also said that key terms, such as case management, care coordination, and medical home, require additional definition.

Chris Perrone, CHCF, suggested that DHCS should leave plenty of time between the RFI and RFP processes, as there will be a lot of work to be done subsequent to the RFI. Even before the RFI stage, there is work to be done to define the models in question, since the more developed the definition, the better the response. DHCS should be conscious that an RFI process is a communication not only to potential vendors but to families, advocates, and providers. This would not be like past procurements, where people know what the model is and the State is going out on the market for something that already exists. Instead, this is something new, and it is possible that there is a process that can help move the relationship between plans and CCS programs along even before an RFP is issued.

Greg Franklin, DHCS, asked the Workgroup for feedback on the level of geographic variation, in access, quality, and cost in CCS. If the market is not ready to respond to an RFP as Chris Perrone said, what is the extent of the gaps? Is one part of the state more ready than another? *John Barry, CCS, Shasta County,* said that accessing care is challenging in rural areas due to travel needs and distance and the lack of local providers, but that standards of care and the option to access care statewide fortunately limit the variation in quality. A child with cystic fibrosis in Modoc County can still have access to CCS-level care.

Janice Milligan, Health Net, agreed, saying that the CCS standards network, and rates, which apply statewide, ensure high quality care regardless of location. She said she questioned whether any health care plan, no matter how big, could duplicate that kind of

delivery system statewide with that kind of access, in part because a plan might not be able to negotiate rates as successfully. She also noted that the timeliness of CCS administration does vary significantly from county to county, as do caseload sizes. *Debbie Ruge, Los Angeles County,* asked Janice whether the variation in CCS program broke down along dependent/independent county lines. Janice Milligan said it did not, but seemed to be dependent on county resources: in some independent counties, CCS nurses have to work in the county clinics as a result of budget cuts; while in others, enrollment and approval processes are quick and easy. The lack of uniform standards for timing and process is a frustration.

Laurie Soman, CRISS, supported John Barry and Janice Milligan's statements, and said that she is a fan of regionalized approaches. Statewideness could be preserved while still addressing cultural variation in more rural areas. She suggested that, given that DHCS does not have an answer as to which model would work, the state should provide assistance in terms of both time and technical support to local areas that want to think and work through whether their counties could support a test pilot model. The Alameda model has the advantage of having been thought through, at length, 12 years ago.

Greg Buchert, CalOptima, asked about state audits and reviews of county CCS activities. Diana Obrinsky commented that the state had not had the resources to audit county programs, panel hospitals or special care centers for many years.

Tom Klitzner, UCLA, said that, as geographic variation is traditionally understood (different outcomes in different hospitals) there is very little in the CCS program. Variations in outcome for cardiac disease, for example, are much greater among CCS v. non-CCS hospitals than among all CCS hospitals. However, the CCS population is socioeconomically and culturally as well as medically complex. In addition, he underscored that referral to specialized care does make a difference in care and treatment outcomes.

Discussion: Implementation Feasibility for Each of the Pilot Models

Monique Parrish asked each member of the Workgroup to discuss the feasibility of implementation for the five pilot models, and to identify their preferred models and the risks and benefits of each.

Tom Klitzner, UCLA, said that the models range in terms of degrees of integration of the core elements of managed care. At the high end is MCMC, then ACO (because it has case rate payment and thus risk), then SHP (for which the group didn't discuss payment methodology), then EPCCM (with the least degree of capitation). The CCSHP model is more difficult to rank because, as written, it starts with FFS and moves to risk. There are many risks to the CCS population in capitation. Foremost because It is very difficult to derive an actuarially accurate rate – not because the children are so expensive, but because the variability of their conditions is so high. He said that he is a strong believer in the efficacy of the medical home and in team-based care management, both for improving quality of care and for garnering savings by reducing missed appointments and duplicate care, and increasing efficiencies generally. As a result, Tom said he prefers the EPCCM and CCSHP models. He said he understood the State's philosophy that savings can only be retained through capitation, but believes that savings can be redistributed in other ways, through mechanisms such as pay for performance (P4P), for example.

Wesley Ford, UCLA, said that Greg Franklin's discussion of the RFI process sounds as though counties will have flexibility to choose the models that work for them. He stated the fifth model (CCSHP) is appealing and in fact has been discussed in Los Angeles County. He did note however that all the models have advantages and disadvantages, and a decision on which way to go would require input from all Los Angeles County stakeholders. He said he was pleased that it sounds as though there is latitude for individual counties to decide what will best serve children locally.

Yvette Baptiste, Family Resource Center, said that while her expertise is not in financing, there are things about the CCSHP model that are very attractive, though the SHP model resonated most with her. From the family perspective, it is important that any model include a process to help families establish medical homes, and keep kids out of institutions; keeping the CCS infrastructure going is also important. If CCS were not to be included as a partner in any of the models, a lot would be lost.

Sherreta Lane, CCHA, said that she came to the TWG process thinking that the group would look at a variety of models, but would also discuss limiting a model to a narrower group of children, possibly defined by diagnosis. Children's hospitals are interested in a compare- and-contrast approach in which some kids remain in the current model while others are enrolled in a SHP, for example. Given that the CCS program is grossly underfunded overall, she said she would hope to hear ideas about how to finance the upfront costs of any new model. CCS' standards, provider network, and family-centered orientation must be supported and continued.

John Barry, CCS, Shasta County, said that most of the models are problematic for far-rural counties. He stated his concern that whether implemented regionally or at the county level, CCS pilots could lead to further fragmentation of the current medical system for CSHCNs, creating additional barriers and narrowing the provider base. He acknowledged that the ACO model demonstrates potential to help certain kids, but stated it could alter efforts to care for the overall CSHCN population in smaller counties. In smaller counties in particular, the expertise in serving CSHCN is at the CCS program, so that core function should be maintained. Overall, although it would require modification for rural counties, the EPCCM model in conjunction with SHP is most interesting.

Ricky Choi, Asian Health Services, said that in discussion with other AAP members, there is consensus that priorities for CCS kids include timely access to specialists and meeting the needs of the whole child. With that in mind, the AAP is most supportive of the CCSHP. He said it was hard to rank programs, because they are not directly comparable, but did like that CCSHP builds on the existing high standards of county programs. Feasibility questions aside, he did note that the CCSHP's approach of maintaining FFS for a while in order to gather better baseline data was a clever idea which allowed the financial structure to be more fully developed later with better information. Getting away from the current fiscal intermediary is another priority. He reported that the SHP would be his second choice to the extent that it supports the goals of the CCSHP. EPCCM could be overlaid on any other model as a strategy to enhance the effectiveness of medical homes.

Laurie Soman, CRISS, said that she prefers the CCSHP. In terms of feasibility and value added, she would go next to EPCCM. There is very little data on the other models as they

affect children, and she noted she would be reluctant to make the leap to those without more information. The ACO model could arguably be more like the Children's Health Insurance Program Reauthorization Act (CHIPRA) proposal, if it were focused on specific targeted conditions; however, she said she did not see the value of a generalized ACO, or a brand new SHP. Last, she stated that traditional MCMC was not appropriate for this population.

Erin Aaberg Givans, CSCC, said that the CSCC Board of Directors would be looking at all the models the following week. In general, though, the least popular choice is full inclusion in MCMC. She echoed others' comments about the feasibility of setting up a new ACO model and the difficulties with rate-setting. She noted that it would be helpful to have an overall framework from the State regarding DHCS' plans for overseeing and evaluating pilots to ensure that quality remains high in and outside of pilot programs.

Frank Mannino, UCSD, ranked his preferences as follows:

1) SHP on a regional basis: This would probably include more than one specialty center, which could be a conflict due to competition between entities in some areas, though without it, services would not be sufficient.
2) CCSHP: The model takes advantage of the existing regional systems. However, the pilot would need significant control of finances in order to succeed.

Marilyn Holle, DRC, said that from her perspective the least attractive option is a carve-in to Medi-Cal managed care. The ACO model is interesting as a first step in bundling rates. She liked the variations of the EPCCM and the CCSHP, and said that at least one pilot should address rural linkages to specialty health care. She likes the EPCCM because it's critical that children be linked to the best care, not necessarily the closest, so it's important to have a model that does not have a confined provider network. The SHP model makes sense, but the lack of flexibility of providers is a concern. CCSHP and EPCCM best carry through the medical home concept.

She additionally commented that regardless of model, the state must step up its enforcement of standards, including the reviews of Medical Therapy Units (MTUs) that CCS used to do.

Albert Carlson, SEIU, said that public accountability is important, including a public process that includes convenings and research. He stated concerns that models tested in urban areas would not be replicable in rural areas.

Greg Buchert, CalOptima, said that incorporation of CCS into MCMC was his *second* favorite model, because of the opportunity for local accountability and incorporation of local CCS programs. He underscored that care should not be denigrated, and any plan selected should require at least CCS standards, and at least, the existing CCS network, with opportunities to go above those. From the perspective of plans that already enroll CCS kids, implementation of such a model would not be difficult. In other areas, where plans will only just be beginning enrollment of SPD, it might be more challenging.

Greg Buchert said that his favorite model overall is SHP. It supports the CCS networks, but goes beyond CCS conditions to serve all CSHCN, making it potentially more sustainable financially. A SHP would create a cadre of well-equipped pediatric specialists who could

serve *all* CSHCN, and it might be an attractive option for other insurers to buy into. The SHP model would also insure that funds for CSHCN stay with those children and would not get diluted into general plan finances.

In sum, Greg Buchert commented that the ACO was interesting, but not great for California because of the legal prohibitions on corporate practice of medicine. He noted that ACOs have traditionally been used primarily in staff model hospitals, which California mostly does not have. Finally, he stated that the EPCCM model is attractive and components of it should be included in any pilot. Finally, he reported that any pilot should include the following principles: caring for the whole child; expanding CCS oversight; establishing family advisory committees; identifying cultural competence requirements; implementing data sharing across CCS; and, standardizing evaluation and reporting.

Debbie Ruge, Los Angeles County, said that with an eye toward preserving the good parts of CCS, and promoting care of the whole child, CCSHP ranks first, and MCMC last.

Janice Milligan, Health Net, said that the point of a pilot is to learn from it. In her opinion, the ACO model would provide the most new information, especially regarding whether there are ways besides HEDIS to look at quality outcomes in facilities. She noted in particular, how could services be prepaid and would outcomes in fact be better?

Additionally, Janice Milligan said that the EPCCM and CCSHP models could be incorporated into the existing system and as such did not present as pilots per se. She acknowledged however that it would be worth seeing which elements of these models lead to better outcomes, recognizing that a whole-child program of any kind should be less frustrating and costly than the current system. Concluding her remarks, she stated that there are enough good things about CCS that enrollment in a pilot should not be mandatory, and further, any pilot must be family-centered, allowing the whole family to travel together.

Juno Duenas, Family Voices, said that she would advocate keeping CCS standards, networks, and rates, and would demand core measures of access clearly defined. She stated that enrollment in a pilot should not be mandatory.

Mary Davis, Orange County, said that she was conflicted about the models. As a nurse, she said she liked many elements of the CCSHP, but from a financing standpoint preferred the SHP model, which provides some managed care-like structure without throwing kids into the existing structure. Not all areas are the same – in Orange County, CalOptima might be able to take on a SHP, but statewide replication might be problematic.

Diana Obrinsky, Alameda County, cited the comments of others, including Laurie Soman, Erin Aaberg Givans, and Marilyn Holle. She said that any RFI or RFP should specifically ask rural counties to come forward with their own plan. She would not like to see a pilot that purports to work statewide then fail in some areas.

Chris Perrone, CHCF, said that there are strong components to each model. He raised three overarching issues:

1) Small numbers: This has been discussed in the context of rate-setting, but also is an issue in terms of developing infrastructure to support pilots just for thousands or even hundreds of children.

2) What happens if a pilot is not successful, and existing local infrastructure has been dismantled?
3) To the extent that pilots take a county (or even regional) approach, how can the statewideness of the current provider network be maintained?

Continuing, Chris Perrone commented that in terms of models, there are competencies in Medi-Cal managed care that county CCS doesn't have, and vice versa. Neither the MCMC nor the CCSHP model appear to have what it takes to be independently successful in the long term, but there might be opportunities to combine elements of each. The ACO, he noted, is a different animal altogether. He highlighted that there are ACO demonstrations ongoing in the Medicare context, but emphasized that California's delivery system and rules regarding ownership are so different that he was not sure that it was a business the state should be in, although the state might support such a relationship between capitated plans and provider groups. In addition, he remarked that the ACO is not really whole-child focused.

David Alexander said that LPFCH has spent the last year trying to define an idea system for CSHCN (not CCS specifically). The enhanced system they envision would have consistent standards and access to care, a single source of financing, and a hard-wired medical home system. All these things can be achieved under any model, and thus none is necessarily better than the rest, though some involve more risk. The one most like the LPFCH model is SHP, though the financing involved makes a pilot challenging.

Additionally, David Alexander said that EPCCM by itself doesn't make sense, since CCS children need the things that managed care brings to the table – but emphasized they need their own managed care. He stated the ACO model is interesting to look at given that there are ways to bring hospitals and providers together even in a corporate model state.

In conclusion, David Alexander said the CCS system is underfunded no matter how you slice it, and this underfunding limits access to care for *all* children. In light of this, he encouraged everyone to work together to raise and address the issue of health care financing for children generally, and for CHSCN particularly.

Kris Calvin, AAP, said that her organization's Board will be having additional discussions of the models. She said she was disappointed that the TWG will not meet further, and hopes that through calls or other avenues the group can continue to work together. She said that the Workgroup process has been helpful for AAP's understanding of the issues.

Tara Robinson, Family Voices, said that she agreed with others who that Medi-Cal Managed Care is not the best solution for families, and noted that she questions the feasibility of the ACO model. She acknowledged the importance of trying to find a way to make the current system work better, to ensure that families get improved access and quality care for the whole child, and emphasized the need to address rising costs while improving data collection and analysis. Any pilot should adhere to a set of principles and standards, including the requirement to integrate a process and role for families – a requirement that might eliminate some models outright. Finally, she commented that one way to increase the success of any pilot would be to continue working in partnership with family advocates and other key stakeholders to develop pilots that simultaneously protect and innovate.

Monique Parrish summarized the common elements of the preceding discussion as follows:

- Whole child
- Bring local groups together for planning
- Maintain CCS standards
- Maintain CCS provider network
- Define terms (mandatory, case management, etc.)
- Provide ample planning time (particularly between RFI and RFP processes)
- Build in strong evaluation (patient, family, provider, state)
- Enforcement and monitoring
- Maintain family-centered focus (including via family advisory committees)
- Cultural competence
- Public accountability with consumer input

Summary Remarks from DHCS

David Maxwell-Jolly thanked Monique Parrish for her efforts in moving the Workgroup along. He said that he is relatively new to DHCS and to the CCS program, and that he has learned a lot from the Workgroup process about the complexity of the issue and the virtues and defects of the CCS program.

He recognized the foundation support from Lucile Packard Foundation for Children's Health and the California HealthCare Foundation. He acknowledged that DHCS does not have the budget to support a process like the CCS TWG, and the foundations have made it possible. He also thanked the TWG members for their participation.

David Maxwell-Jolly noted the group has struggled in the course of the meetings to define the problem of CCS – and hence the workgroup. He stated that he has consistently said that he believes it is possible to do better in delivering services in the CCS program. He said that there is general consensus that there could be a benefit to having a single locus of care for each child, for example, and with that background, the goal of the Workgroup was to conceptualize some realistic alternative models, and be able to take the next step of embarking on some and learning from them.

Commenting that certain principles will be in place regardless of the timing, location, and shape of a pilot project, David Maxwell-Jolly reported the pilot(s) will encompass the full scope of services; maintain CCS standards and providers; and continue engagement in statewide quality improvement (QI) efforts. He further noted that DHCS had heard the message that they will need to make choices about the case management features that are included in a model.

Referencing a meta-analysis of 13 studies analyzing the care of CSHCN in managed care plans, published in the journal of Academic Pediatrics,[1] David Maxwell-Jolly underscored that the study found a "relatively weak evaluative basis for guiding policy decisions."

[1] Huffman, L.C, Brat, G.A., Chamberlain, L.J., Wise, P.H., (2010). Impact of managed care on publicly insured children with special health care needs, *Academic Pediatrics*, 10:48-55.

Explaining this, he noted that California has a great opportunity to add to the knowledge base in this area. He further added that there is not much downside to trying a new model as the article found that the risks [care and costs] of piloting a model are small.

Recognizing that California's diversity is both a strength and a challenge, with regard to improving the CCS program, David Maxwell-Jolly stressed that a new pilot model does not have to be implemented statewide. Additionally he remarked that DHCS is open to all comers, and is also open to enrolling CCS children in managed care plans, notwithstanding some of the criticism of the Medi-Cal Managed Care model discussed in the TWG.

David Maxwell-Jolly emphasized that the State will have to figure out what works, but is committed to testing some models in the CCS program. He noted that he looks forward to putting some concrete results out for national examination. In that regard, he emphasized that evaluation is key: it does not make sense to embark on a pilot without a thoughtful evaluation strategy that not only reports on what happened, but allows comparative judgments, with a control or comparison group. He added that evaluation must include *quality* of care, including both structural quality and a range of outcomes, from medical results to school attendance. He also cited access ass another critical evaluation element, both from a structural point of view and from families' point of view.

Continuing, David Maxwell-Jolly highlighted cost as an important element of any pilot and underscored that both medical service and administrative costs will be examined closely. He referenced that one element within the 20% of CCS that needs fixing is the duplicate administration efforts and costs that occur in the current CCS program. He stated that the pilots will monitor the cost of managing care, as well as the cost of care itself. In the long run, he added, the State wants to know about the impact of care organizations on the cost of care, including the costs currently borne by families.

Detailing the timeline for the State, David Maxwell-Jolly reported that development of the waiver will proceed as follows: DHCS will share its draft implementation plan, which will include a roadmap and timeline for CCS, among other issues, early in May, and expects significant discussion of that document at the Stakeholder Advisory Committee (SAC) meeting on May 13, 2010. He further noted that DHCS expects to solicit ideas for CCS pilots, and additionally looks forward to a number of localities and organizations submitting proposals. Last, he stated the number of pilots that DHCS will consider depends in large part on the budget.

Summarizing, David Maxwell-Jolly reported the CCS TWG process has been invaluable. DHCS has learned a lot about health care finance, family needs, and county commitment, among other topics. Additionally, he said that he hopes that participants and DHCS can coalesce around ideas worth testing and focus on improving CCS. Finally, he recognized that the State has made attempts before, and said that he wants this to be an effort that actually takes a step forward. He thanked Workgroup members for their time and commitment and stated that although the CCS TWG process is over, DHCS will be relying on the participants as the process moves along.

Workgroup Member Summary Comments: Next Steps Regarding CCS Pilot Models

Following David Maxwell-Jolly's remarks, each TWG member made a final statement. Many members thanked DHCS and other participants for a productive process, said that they had learned a great deal, and expressed interest in continuing to work with the group as the waiver proposal and any other CCS reforms move forward. In addition, members had the following comments and questions:

Juno Duenas, Family Voices, said that she hoped that some of the ideas from the Workgroup could be applied to disabled adults as well. Many families are caring for adult children, and that population needs attention as well.

Greg Buchert, CalOptima, asked DHCS whether the CCS pilots as discussed had to be part of a Section 1115 waiver. David Maxwell-Jolly responded that some aspects of the CCS pilots would require waivers. The State is interested in putting forward multiple models because 1) proposals to deliver better quality of care with greater efficiency would make the waiver more attractive and help justify additional resources in the context of the waiver; and, 2) it is easier to retain savings when reforms are in the context of the waiver. California has saved a lot in its Medi-Cal program in the past, but if the reforms are not part of a waiver, the state loses the ability to hold onto federal dollars and redirect them within the Medi-Cal program. Although the waiver timeline is very short, DHCS believes it will be able to put forward strong reform proposals.

Albert Carlson, SEIU, asked how DHCS envisioned the waiver functioning as a bridge to health care reform. David Maxwell-Jolly said that while that aspect is a little less relevant in the CCS context given that there will not be significant insurance expansions for children, it is a major part of the overall waiver planning and will be addressed in the implementation plan. *Laurie Soman, CRISS,* asked at what point the waiver plan is sent to the legislature. David Maxwell-Jolly said that some pieces will receive legislative review, and that the version of the implementation plan that reflects input from the SAC will be shared widely, including with the Legislature.

Debbie Ruge, Los Angeles, informed the group that Southern California CCS programs have recently formed an MTP Administrators' Group. It is in the early stages, but it represents another opportunity for discussion and coordination regarding critical CCS issues.

Albert Carlson, SEIU, said that he regretted that more data on CCS was not available. He also said that he would be interested in talking to people who had developed CCS plans in 1999.

Marilyn Holle, DRC, said that she appreciated the commitment not to harm the CCS program. She mentioned a number of additional cost-saving ideas, including addressing cases in which private health plans shift expensive cases to the public purse.

Frank Mannino, UCSD, said that regardless of the model, it will be important to get physician buy-in. The State should make an effort to explain the reasons for the changes, so that providers do not think that the only goal is cost savings.

Laurie Soman, CRISS, said she appreciated the recognition of core CCS values and that if those values are held it will be harder to go wrong in future.

John Barry, Shasta County, said he appreciated the inclusion of a rural perspective.

Yvette Baptiste, Family Resource Center, said that families don't assume that they will be at the table for discussions like this, and as a representative of families she is glad to be included.

David Alexander, LPFCH, said that the Foundation is focused not on CCS but on building better care for CSHCN. CCS can be an exemplar and bring everyone else along. He asked that participants look to LPFCH as a resource in building better systems of care for these kids.

Luis Rico, DHCS, thanked the Workgroup members again on behalf of DHCS.

Chris Perrone, CHCF, recognized David Alexander not only as a funder but as a co-lead of the Workgroup, and said he had worked hard behind the scenes to make the meetings successful.

Monique Parrish thanked the group for their efforts and commitment.

The meeting adjourned at 2:30 PM.