Background

San Mateo County is one of three counties in the State that has California Children's Services (CCS) as a "carved-in" program of our County Organized Health System, the Health Plan of San Mateo (HPSM). Through this arrangement, the CCS program and HPSM coordinate efforts around care management for approximately 1,200 CCS Medi-Cal beneficiaries of the total 1,800 CCS enrollees in our community.

In addition, HPSM and our public delivery system, San Mateo Medical Center (SMMC), have been working closely with the primary pediatric teaching and specialty care provider in our community, the Lucile Packard Children's Hospital (LPCH), as well the Ravenswood Family Health Center, to evolve our efforts aimed at creating strong pediatric primary care medical homes for all publicly covered children in San Mateo County. LPCH has also led important efforts to improve communication and coordination among primary care and specialty care physicians.

Finally, we believe that there are important lessons to be learned from the recent experience of addressing the needs of adults with developmental disabilities who were previously living at the Agnews Developmental Center. The efforts of the State Medi-Cal program, in partnership with public managed care plans in San Mateo, Alameda and Santa Clara offer a strong example of approaches to support care coordination for clients with complex medical and social needs.

As we learned about the State's intent to pursue stronger managed care and/or primary care medical home arrangements for CCS-eligible children, and HMA's role in developing recommendations to inform this direction, we synthesized our learnings to date to develop recommendations for HMA's consideration. Given the lack of a common definition for the term "medical home", these recommendations articulate roles for primary care practices and managed care organizations (MCOs), which both play distinct and important roles in furthering care coordination for populations with complex medical and social needs.

Recommendations

Based on our experiences in improving the health of complex and vulnerable populations, providing a safety net of excellent pediatric primary care, integrating primary and specialty care through care coordination and leveraging our managed care expertise to bring data, care management and financial management skills to manage the care of low-income populations, we recommend the following for the CCS program:

1. Unify accountability for CCS within a single local entity that can assume risk and responsibility for medical direction, member communication, provider contracting and payment, case management/ coordination, assuring access to necessary medical services, and ongoing review of quality and member satisfaction.
    a. Ideally, CCS would no longer operate as a discrete, categorical program for a subset of children and needs, but rather be organized as a set of supports for publicly covered children that are available to augment care coordination and management as clinically appropriate.

   b. The CCS supports would be "built" on the local Medi-Cal pediatric platform, while also offering services to other publicly covered children (such as Healthy Families, Healthy Kids/ CCS-Only).
   c. The current fragmentation of funding should be eliminated, where possible, to support approaches that are integrated and patient-centered, focused on the "whole child."
   d. In communities with developed managed care infrastructures for the Medi-Cal population, MCOs should serve as central coordinating entities. In communities in which both provider and managed care capacity are more limited (such as the CMSP communities), regional managed care approaches make sense.
2. Streamline the cumbersome, individual service-based authorization processes to align with Medi-Cal managed care practices such as delegated medical management and selected prior authorization or concurrent review approaches. The State should get out of the business of being involved in these decisions, instead transferring health care responsibility and financial risk to integrated systems, while setting and monitoring quality and service levels. In this way, processes could be simplified for providers and families, with review directed only to high cost, historically high-utilization items (e.g. hospital days, brand name drugs), and away from the current State focus on individual low-cost authorizations (e.g. office visits for cancer therapy).
3. Revamp the focus of CCS case management/ service authorization for all cases, regardless of the complexity or longevity of the patient's condition, to care coordination and client support for children with chronic conditions requiring *ongoing* specialty care. Currently, CCS rules require case management support for discrete procedures (e.g., orthodontia, orthopedic surgery) in which case management does not add significant value while higher need cases suffer from lack of case management.
4. By moving to a managed care model with strong quality and service level benchmarks and monitoring, the State would allow managed care organizations to enlist pediatric primary care providers (PCPs) as key members of CCS case management teams. This would extend the effectiveness of primary care medical homes by providing the centralized case management support described above to PCPs caring for CCS clients.
   a. Such arrangements will facilitate integration of primary care and preventive health services rendered with the specialty care services required by the child, along with other support services (social services, transportation, etc) in order to ensure optimal health outcomes.
   b. Appropriate care for the complexity of conditions included in CCS will require the involvement of specialist physicians and non-medical systems, which cannot be handled by PCPs alone or without augmented support.
5. Streamline administrative requirements for participating families to build on eligibility and verification approaches used in Medi-Cal and other public coverage programs.

6. Allow case management capacity that uses a mix of expertise (medical--i.e., nurse, non-medical, social, developmental) to complement the medical care coordination role played by PCPs.
7. Develop State/Local financial arrangements that align incentives for care and cost management and provide flexibility at the local level commensurate with the capacity to assume risk.
8. Encourage the continuation of regional coordination (such as CRISS in the Bay Area region) that standardizes approaches for families served by and providers serving multiple counties.
9. Encourage provider reimbursement approaches that aim to provide care in the most clinically appropriate and cost-effective settings while also maintaining an adequate network of pediatric subspecialists and therapists necessary to serve children with complex health care needs. We believe that the structure and scale of our locally operated Medical Therapy Unit works well.
10. Support the use of health information technology (e.g., Electronic Health Records, physician referral portals, interfaces between information systems) that support improved sharing of information among distinct providers involved in the care of CCS children (primary care, specialty care, behavioral health, case management).

Discussion

The recommendations offered above are aimed at achieving the following important outcomes for the CCS and Medi-Cal programs, and the families served through CCS:

- ***Better management of care and costs.*** The current requirements and structure of CCS have not adapted to the “best practice” evolution of medical care delivered by teams of medical and non-medical providers who work together to support patients’ improved health. Unifying CCS within broader managed care structures offers much greater potential for improved care and cost management. These systems have tools and incentives to manage the needs of the whole child and have developed important linkages to necessary community supports. Specific areas of likely improvement include:
    - Reduced delays in care, specialist arrangements, etc;
    - Improved targeting of case management to the populations most likely to benefit from such enhanced support;
    - Greater involvement of the primary care team (the most cost-effective setting) for some care management functions; and
    - Improved opportunities to manage high-cost care.

- ***Improved health care quality.*** Important gains in quality have been demonstrated by managed care plans and integrated delivery systems that use data to guide clinical care that is proven to advance healthcare quality. It is challenging for CCS to capitalize on these approaches in the current “separate” administrative structure that does not include a role for primary care and may not have links to managed care approaches nor the data that supports improved quality and outcome.

- ***Improved ease of use for families.*** Singular and centralized accountability for CCS at the local level encourages client/family services that clarify families' point(s) of contact for questions, follow-up, and case management support, rather than diffusing this responsibility across multiple, distinct arenas. The goal of having a single point of contact for families when they have questions or concerns regarding their special needs child has not yet been achieved, but with this proposed integrated model, could become a reality.

- ***Reduced administrative costs.*** The current requirements do not support integration of responsibilities for areas such as medical direction and case management/ treatment authorization that are handled by both managed care organizations and the CCS program. We have worked within these structures to coordinate as much as possible but believe greater opportunity exists for administrative integration. Achievement of increased integration requires both local flexibility and the removal of State involvement in arenas in which local MCOs can assume responsibility.

We are strongly committed to meeting the needs of children with complex health care needs and believe that our experiences and best practice approaches can inform the opportunity that California has to redesign the CCS program. Given the financial and programmatic strains on the health care safety net and the Medi-Cal program, we urge all approaches to build on local systems that have evolved to address the needs of publicly covered children, so that we can leverage the strengths within these to achieve improved health and quality outcomes for children that are scalable and cost effective.

We urge the State to be cautious about building a separate system for a particular population. Even carving out the whole child will perpetuate fragmentation, responsibility disputes between systems and organizations, and cost shifting, as arguments will persist about which conditions and which children merit carving out and those arguments ultimately will affect children and their families.

We know that one of the ideas proposed is to give all responsibility for CCS children to "medical homes." First, there is not agreement over what a medical home. Second, children with special needs require case management and support services that far exceed the capacity of medical practices standing alone, even if they are given funds for "case management." They do not have customer service systems, medical informatics services, case management or utilization management services. Nor do they operate with member input and oversight, as do managed care plans. In short, we do not believe that medical practices are the appropriate place to put responsibility for all of the care that these children with special needs require.

The experience with the Agnews closure where the needs of developmentally disabled individuals were handled very effectively by managed care organizations shows that individuals with highly specialized needs can be effectively served within existing structures with careful preparation and planning. Finally, strict State regulatory and

oversight frameworks already exist for managed care organizations, frameworks that guarantee quality and grievance protections for members.

To summarize, we recommend this approach since it:

- Recognizes and builds on California's diverse systems for service delivery and care management structures;
- Recognizes and builds on the State's variety of managed care models that have proven to be effective;
- Builds on existing local infrastructures to the greatest extent possible;
- Avoids the need for a separate carve out and the costs and risks associated with building new risk bearing systems; and
- Provides a structure that can deliver high quality integrated care with clear accountability to patients, their families, and the State through appropriate quality and service level benchmarks and monitoring.