California Children's Services (CCS) Program Delivery Models of Care- Key Components with TWG Feedback

Key Elements	Enhanced Primary Care Case Management (EPCCM)	TWG Member Feedback
Target Population	Children with CCS eligible conditions: ▪ Enrolled in Medi-Cal ▪ Enrolled in Healthy Families ▪ "CCS only" children not enrolled in Medi-Cal or Healthy Families *CCS children with time-limited qualifying conditions will be excluded from participation.*	Recommendations: 1. *CCS would determine target population.* 2. *EPCCM would work for all CCS enrollees (Medi-Cal/Healthy Families/CCS-Only/Uninsured) but focus on certain conditions or diagnoses.* 3. *Limit to children with conditions that last 12 months or longer, and perhaps also shorter-term diagnoses but more complex conditions.*
Enrollment	Mandatory	
Geographic Service Area	County and/or Regional level	Recommendation*: Rural and urban models with potential for regional coverage.*
Covered Benefits	▪ All current Medi-Cal medical benefits, including EPSDT Supplemental Services; ▪ CCS Program covered services; ▪ Care coordination by the medical home; and ▪ Other medical necessary services that do not meet current Medi-Cal adult criteria.	▪ *All current Medi-Cal medical benefits, including EPSDT Supplemental Services;* ▪ *CCS Program covered services;* ▪ *Care coordination by the medical home; and* ▪ *Other medical necessary services that do not meet current Medi-Cal adult criteria.* Recommendation*: No part of the provider network would be eliminated.*
Medical Home/Case Management	Each child will be assigned a medical home (primary care physician, a specialty physician or sub-specialty physician) with responsibility for: ▪ Ensuring access to services and providing family-centered care coordination services	Recommendation: 1. *Implement a tiered system, depending on severity of need – provide range of paraprofessional or social work support to nursing-level care management.* 2. *Medical Home Index and National Committee for Quality Assurance (NCQA) standards would guide selection of vendor.*
Financing Reimbursement Model	New payment system that supports effective chronic care management: ▪ *Fee-for-Service Payment* that continues to reimburse providers under current FFS schedule for services provided. ▪ *PMPM Monthly Care Management Payment* to support medical home and care coordination management services and processes. ▪ *Performance-based incentive Payment* for the achievement of specific clinical and quality outcomes and process metrics.	*Note: the issue of financing for this model was initially unclear; a later clarification indicated that EPCCM could be financed through a capitated rate for primary care and care management services but FFS for all other care, (a traditional funding approach used by the State for PCCM services). To the extent that hospital/specialty care usage is less than typical, savings could be shared with the EPCCM plan.* Recommendation*: Family satisfaction should be measured as part of the pilot, and could perhaps be an element of P4P.*
Program Administration and Contracting Options	Administer program using: ▪ state employees ,and/or ▪ State contract with a qualified outside vendor for all or some program administration functions Eligible EPCCM vendors could include county CCS programs, PCCM/DM vendors or provider-based organizations.	Recommendation: *The EPCCM responsibility could be given to the existing CCS system, with primary care money given to that program Administration could also be done by a group of CCS plans, an Independent Practice Association (IPA) or group of IPAs, or a managed care plan or plans.* *Monitoring: Monitoring would be the responsibility of the State (CMS/CCS), but the group noted that DHCS needs staff to make this possible*

NOTE: TWG members identified the following as necessary standards for or criteria to address in the development of pilot model options: Quality (Maintenance/Improvement); Whole Child; Cost-Curve, Evaluation (Conducive to Evaluation), and Unintended Consequences.

Key Elements	Provider-Based Accountable Care Organization (ACO)	TWG Member Feedback
Target Population	Subset of the CCS population with the following chronic medical conditions: ▪ Malignancies ▪ Sickle cell disease ▪ Cystic fibrosis ▪ Cardiac conditions ▪ Spina bifida	Recommendation: *Regarding diagnoses, long-term care and long-term diagnoses (diabetes, CF), provide a strong incentive for prevention, though not a lot of cost-savings. Tumor diagnoses might be another target, since the flexibility of ACO would allow for treatments such as outpatient chemo therapy* Concerns: *1) Since it would be a conflict for the ACO to do eligibility determination, it would fall to the county, the state, or a health plan under contract.2) Defining diagnoses for ACO is challenging - high-end diagnoses create a feasibility problem, with too many issues for a single organization to manage; with low-end diagnoses (e.g., diabetes), cost savings can disappear, presumed to be mostly in complex care.*
Enrollment	Mandatory	
Geographic Service Area	Regional level	Recommendation: 1. ACO may need to be geographically defined taking into account provider and patient needs. 2. Open network across the state.
Covered Benefits	▪ CCS Program covered services; ▪ Care coordination; and ▪ Other specified services. *ACO has flexibility to provide non-covered benefits and services.*	▪ CCS Program covered services; ▪ Care coordination; and ▪ Other specified services. *ACO has flexibility to provide non-covered benefits and services.*
Medical Home/Case Management	▪ Use of physician-led, multi-disciplinary teams with responsibility for coordination and provision of specialty and subspecialty care, primary and preventive care and services ▪ Authority and financial flexibility to develop a family-centered care plan	Recommendation*: Care management would be the responsibility of the ACO.* Concerns: *Care coordination is affected by prevalence: to have an effect, care coordination should be in high-utilization conditions/diseases.*
Financing Reimbursement Model	New payment system that includes: ▪ *Global Paymen*t for a defined set of services to give providers additional flexibility in arranging and coordinating services to meet the needs of the whole child. ▪ *Performance-based Incentive Payment* for the achievement of specific cost, clinical and quality outcomes and process metrics.	Recommendation*: Consider an annual capitation model for long-term chronic disease and a global payment for an episode of care.* Concerns: *1) Global payment may increase initial costs before model generates lower overall cost per child; and, given the system of episodic payments, what happens to the child in between episodes? Would this model promote fragmentation of the child by diagnosis or body part?* *Strengths: The ACO is a great model for shared risk once the global payment is defined, 20% is held back, and then distributed among the partners if quality measures are met. This model also has a strong governance structure (arrangements between hospitals and providers).*
Program Administration and Contracting Options	Administer program via State contract with Provider-Based ACOs for defined set of administrative functions. Eligible ACOs could include designated children's hospitals and their hospital-based Specialty Care Centers (SCCs) serving CCS children.	Recommendation*: (Note: group reported limited knowledge of ACO administration). ACO might be a large specialty group or children's hospital (must recognize need to split the rate, or meld the two) that would receive the payment.* Concern: *In a five-year pilot, who pays for development of model and other upfront costs?*

Key Elements	Specialty Health Care Plan (SHP)	TWG Member Feedback
Target Population	Children with CCS eligible conditions: ▪ Enrolled in Medi-Cal ▪ Enrolled in Healthy Families ▪ "CCS only" children not enrolled in Medi-Cal or Healthy Families *CCS children with time-limited qualifying conditions will be excluded from participation.*	Recommendation: *Consider one or more conditions (possibly for contrast and compare purposes).* Concerns*: 1) There is the risk that a smaller pilot model operating with only one or several conditions might yield limited outcome data from which to draw inferences; and 2) how would the Plan financially enroll CCS-only kids and handle premiums for families with HF?*
Enrollment	Mandatory	*Mandatory*
Geographic Service Area	County and/or Regional level	Recommendation*: Can begin with a County focus but the Plan must allow for kids to go where they can receive the appropriate care. Over time, a regional and statewide focus for the plan may be options.*
Covered Benefits	▪ All current preventive, primary services and specified medical Medi-Cal benefits ▪ Medically necessary services for CCS conditions; and ▪ Care coordination *Health plan has flexibility to provide non-covered benefits and services.*	▪ *All current preventive, primary services and specified medical Medi-Cal benefits* ▪ *Medically necessary services for CCS conditions; and* ▪ *Care coordination* • *Behavioral and dental benefits; MTP would continue as a carve-out.* Concerns: *1) will other services be included, for example, kids with eating disorders? 2) Would kids with PT/OT needs from a CCS condition, but who are not eligible for the MTP, receive services?*
Medical Home/Case Management	Each child will be assigned a medical home (primary care physician, a specialty physician or sub-specialty physician) with responsibility for: ▪ Ensuring access to services and providing family-centered care coordination services ▪ Coordinating services across the entire continuum of care, settings and funding streams *Health plan may provide services to support medical home provider.*	Recommendations: *1. Develop a more robust case coordination medical home program.* *2. Address kids with complex case management needs.* *3. SHP to contract and/or develop expertise to provide appropriate family case management.* *4. Each child to have an Individualized Care Plan (ICP).* *5. Link SCCs to Primary Care.* *6. Coordinate and ensure 24/7 access to specialty/sub-specialty care.*
Financing Reimbursement Model	Health plan will be paid a risk-adjusted *Capitated Payment* by the State for a defined set of covered benefits and services. Due to the risk of small enrollment in a Specialty Plan, the financing arrangement may include risk-corridors or stop-loss mechanisms. Capitated payment approach provides health plan flexibility in arranging and coordinating services to meet the needs of the whole child. *The health plan determines provider payment rates and requirements through contract negotiation with individual providers.*	Recommendations: *1. Begin with FFS move to capitation; maintain current CCS rates.* *2. Collect and analyze payment data to develop appropriate payment mechanisms and address the "cost-curve."* *3. Address underfunding of CCS and costs to families.* *4. Consider creative case rates – examine FFS vs. Managed Care data; examine medical-loss ratio and full-risk model rates (actuarial).* *5. Consider opening SHP to kids with CCS conditions in private plans.* *6. Develop a strong evaluation plan with family/provider satisfaction.*
Program Administration and Contracting Options	Majority of CCS Program administrative functions will become the responsibility of the health plan. The State will contract with qualified health plan (s).	Recommendations: 1. *State will contract with a qualified health plan(s) that will assume administrative responsibilities for the SHP.* 2. *CCS should consider applying to become a SHP (with an ASO).* 3. *Any willing provider that meets standards for CCS can be contracted with under the SHP.*

Key Elements	Medi-Cal Managed Care Plan (MMC)	TWG Member Feedback
Target Population	Children with CCS eligible conditions: ▪ Enrolled in Medi-Cal ▪ Enrolled in Healthy Families ▪ "CCS only" children not enrolled in Medi-Cal or Healthy Families	Value-Added: *Increased eligibility is positive.* Concerns: *Variability in acuity is a major consideration in developing the model.*
Enrollment	Mandatory	Mandatory Concern: *May eliminate CCS local infrastructure.*
Geographic Service Area	County specific	County Specific Concern: *This model can only be implemented where managed care exists.*
Covered Benefits	▪ All current preventive, primary services and specified medical Medi-Cal benefits ▪ Medically necessary services for CCS conditions; and ▪ Care coordination *Health plan has flexibility to provide non-covered benefits and services.*	Value-Added: *Addresses the "Whole Child" (but should be done carefully)* Recommendations: 1. *Protect current quality.* 2. *Conduct a review and stakeholder process to determine what standards (contract requirements) would be needed in this model to maintain quality.* 3. *Maintain MTP outside Plan but linked.* Concerns: *1) 24-Hour Advice Line must be at a specialty facility; 2) Model may reduce level of current quality because of pressure to deny.*
Medical Home/Case Management	Each child will be assigned a medical home (primary care physician, a specialty physician or sub-specialty physician) with responsibility for: ▪ Ensuring access to services and providing family-centered care coordination services ▪ Coordinating services across the entire continuum of care, settings and funding streams *Health plan may provide services to support medical home provider.*	Value-Added: *Primary Care Case Management is an asset along with a centralized medical record and the responsibility of the Plan to ensure timely access to care.* Concerns: *1) This model may sacrifice the Medical Home model with risk financing; 2) Generalists at the Plan may be unfamiliar with the complex care needs of CCS kids; 3) Case Managers are not connected to capitation risk decisions/calculations.*
Financing Reimbursement Model	Health plan will be paid a risk-adjusted *Capitated Payment* by the State for a defined set of covered benefits and services. Capitated payment approach provides health plan flexibility in arranging and coordinating services to meet the needs of the whole child. The Health Plan determines provider payment rates and requirements through contract negotiation with individual providers.	Value-Added *Flexible decisions about what might be paid for by the Plan.* Concerns: *1). Risk/capitation will drive clinical decisions/utilization; 2) Risk is an issue given the lack of data; 3) Limited data information from this model is currently available - need robust data measures to evaluate number enrolled in model, family satisfaction, and administrative burden; 4) The big cost for current CCS Program is 0-1 Year/NICU – could MMC reduce overall costs?; 5) Explore how budget pressures would impact CCS under the pilot, as well as the administrative costs for big specialty providers that will have a mix of some managed and non-managed care costs.*
Program Administration and Contracting Options	Majority of CCS Program administrative functions will become the responsibility of the health plan. The State will contract amend Medi-Cal Managed Care contracts with qualified health plan (s).	Value-Added: *Decreased administrative cost to provider.* Recommendations: *Create advisory group at the Plan level.* Concern: *Less administrative structure but this may cause increase in MD administration.*