

California Children's Services (CCS) Redesign

Overview of California-Based Models

March 20, 2015

Bay Area Stakeholder Models

The Bay Area Stakeholders' group proposes three different models that could be implemented on their own or phased in incrementally, moving the CCS program toward an Accountable Care Organization (ACO) arrangement. These three models are CCS+, CCS Collaborative, and CCS ACO. These models propose to maintain six existing strengths of the CCS program, including a robust regionalized architecture for pediatric specialty care, the establishment and enforcement of statewide standards for provider participation, rigorous case finding, fiscally disinterested decisions, professional, family-centered case management/care coordination, and lack of geographic barriers to a broad network of CCS providers. The three models would add four additional elements: a whole child focus to streamline administrative processes; administrative regionalization to promote consistency; intensive care coordination for those with complex needs; and partnering with families and youth at every level.

- **CCS+ Model:** The goal of this model is to move the CCS program toward administrative regionalization. Under this model, large counties would take over administrative oversight of dependent counties, as well as sorting CCS clients according to medical / psychosocial complexity using a standardized tool for more intensive care coordination.
- **CCS Collaborative Model:** The goal of this model is to create new regional administrative entities to manage funding, administration, diagnosis, and treatment. A variety of options for risk sharing agreements could be implemented, but would require all of the counties in a region to be willing to participate.
- **CCS ACO Model:** This model is an arrangement where CCS-approved providers anchored at children's hospitals would form ACOs and contract with the Department of Health Care Services (DHCS) to provide services to the CCS population. Capitation would gradually be implemented for certain CCS-eligible conditions, but the Fee-for-Service (FFS) carve-out would be extended indefinitely for conditions that are not included in the ACO. The ACO would coordinate, but not necessarily provide, primary care for CCS enrollees.

California Children's Hospital Association Model

Under this model, the DHCS would contract with a new delivery system entity called the Kids Integrated Delivery System (KIDS) plan. A KIDS plan would be defined as "an entity selected by the department to coordinate and manage the provision of Medi-Cal and CCS services for eligible children, on a county or regional basis, consistent with managed care principles, techniques, and practices, to ensure access to cost-effective, quality care for enrolled children." The KIDS plans would be anchored by CCS-approved providers or hospitals; however networks might include additional providers

and hospitals to ensure broad and adequate coverage. The KIDS plans would coordinate and manage the provision of Medi-Cal and CCS program services to eligible children, and ensure access to cost-effective quality care.

As part of this model, the DHCS would be required to follow specific criteria when selecting a KIDS plan such as eligibility standards, and the qualifications and exclusions required for KIDS plan contracts. The KIDS plan would be required to coordinate, integrate, and provide or arrange for the full range of Medi-Cal and CCS services. Multiple KIDS plans would be able to operate within a region.

Los Angeles County CCS Program Nurse Case Management Pilot Model

The model used in the Los Angeles County's CCS pilot involves targeted case management using nurse case managers. Care coordination services are based on the complexity of the client's needs and are established by assigning eligible clients into groups based on the complexity of their qualifying medical condition and co-morbid occurrence. A medical record review is conducted to assign the client to what is referred to as a "health status group" utilizing a value scale of 1 to 9, with 9 being the greatest level of need.

The systematic client assignment based on the "health status group" allows nurse case managers with higher-ranked cases to work with fewer clients than those who managed lower-ranked cases. This approach allows for more intense case management and more frequent contact in more complex cases. Nurse case managers coordinate with hospitals and health plans, and provide both referrals and authorizations, including authorizations to primary care providers for care related to the CCS-qualifying condition.

Another innovative component of the pilot has been the development of a new software system to track patient-specific outcomes, study effectiveness of interventions and collection of additional information" that would be useful for future planning purposes.

Children's Hospital Los Angeles (CHLA) FQHC in Partnership with an Academic Medical Center Model

The CHLA uses the medical home model for its CCS eligible population. The medical home is based out of the AltaMed clinic at CHLA, which is a primary care Federally Qualified Health Center (FQHC) with a special emphasis on care for Children and Youth with Special Health Care Needs (CYSHCN). In the medical home approach, primary care physicians and residents at CHLA identify CYSHCN based on the modified Alameda risk assessment tool, which looks at medical diagnosis along with psychosocial, behavioral, and Durable Medical Equipment needs.

After the initial patient assessment, the primary care providers create a comprehensive, family-centered care plan with elements of self-empowerment and goal setting, assign a care coordinator, and follow up with the family every 3-6 months, or as needed. As part of the process, the clinic's care coordinators (Registered Nurses and Licensed Vocational Nurses) use a case management scoring system, which allows for better coordination of care among an array of other participating providers including social, behavioral and community service providers.

To ensure adequate data collection, AltaMed uses a single Electronic Medical Record (EMR) for outpatient primary care, with access to CHLA's EMR for specialty and inpatient care. In addition, AltaMed's corporate office's medical informatics (MI) team accesses insurance claims as well as the clinic's EMR to compile utilization data. The project has conducted family and provider satisfaction surveys using the medical home index survey, and are also beginning preliminary data analysis of the medical home's impact on Emergency Department visits, IP visits, and length of stay.

Children's Hospital Association Complex Care Clinic Model

As part of the ten children's hospitals that are included in the national Children's Hospital Association's three-year Coordinating All Resources Effectively grant from Centers for Medicare and Medicaid Innovation, this complex care model creates medical homes that are based out of children's hospitals. The goal of these arrangements is to create a medical home that can serve the complex health needs of this population effectively, efficiently, and comprehensively, using the Primary Care Case Management model. In this model, children's hospitals serve as the anchor points from which patient care is provided. These children hospitals would provide a wide range of services including elements of primary and specialty care along with coordination of care, as well as behavioral, social, and other community services for CYSHCN.

Partnership Health Plan California Model

Partnership Health Care (PHC) is a managed care plan serving 14 Northern California counties and is a County Organized Health System model. CCS is a managed care benefit in 4 counties: Napa, Yolo, Solano and Marin. PHC also covers non-CCS services in 10 "carve-out" counties. PHC offers comprehensive networks in the Southern Region and regionalized care networks in the Northern Region. In addition, all CCS members have a medical home which is typically reflected in the CCS service authorizations. PHC works in collaboration with the local county CCS program to authorize the specific CCS services a child could receive.

For managed care/carve-in counties served by the PHC, the DHCS provides PHC a capitated payment that includes both CCS and non-CCS services for the child. The CCS provider bills the PHC directly for all services rendered.

In carve-out counties, PHC receives a capitated rate only for the non-CCS covered services for CCS children. All CCS services are reimbursed through FFS Medi-Cal. The CCS provider bills the DHCS directly for all CCS services rendered in the carve-out counties.

Health Plan of San Mateo CCS Demonstration Project

The Health Plan of San Mateo (HPSM) model integrates the San Mateo CCS program with the county's Medi-Cal Managed Care plan. The goal of this project has been to streamline care delivery by designating a single accountable entity to:

- 1) Authorize and pay for primary, specialty, and all other needed care and services;
- 2) Focus on all the health and social service needs of the family, rather than just the needs related to the CCS condition;
- 3) Reduce duplicative administrative processes (authorization, denials, etc.);
- 4) Streamline access to needed services (e.g., pharmacy, incontinence supplies; home health, etc.) and
- 5) Reduce conflicts between different payers about fiscal responsibility for services.

HPSM serves as the "organizing entity" and oversees care coordination and authorizations for all of the client's services, including primary, specialty, inpatient, outpatient, and behavioral health services. HPSM is responsible for all services, regardless of whether service is related to the CCS condition or not. This approach allows for a greater continuity of care with all participating health care providers. To further enhance service continuity and care coordination, local county CCS staff serves as subcontractors to HPSM and are co-located at the Plan. HPSM has full financial risk for all CCS children enrolled in the project.

Rady Children's Hospital - San Diego ACO Based Model Demonstration Project

Rady Children's Hospital - San Diego (RCHSD), called California Kids Care, will provide care for children with certain CCS-eligible conditions including: Cystic Fibrosis, Sickle Cell, Diabetes, Acute Lymphoblastic Leukemia, and Hemophilia. The RCHSD model is a pre-paid, capitated model comprised of Rady Children's Health Network and clinically and financially Integrated Delivery System partners of RCHSD: Rady Children's Specialists of San Diego (Medical Foundation), Children's Primary Care Medical Group, and Children's Physicians Medical Group. The ACO provides a medical home for enrollees. In this approach, care navigators and patient technician partners will work with the medical home and the clinical team to coordinate whole-child care and services using targeted interventions and support services across the continuum of care. The ACO takes full risk, including inpatient, outpatient, and ancillary care. The Rady Children's Hospital San Diego ACO model is expected to be operational in the spring of 2015.

Kaiser Permanente Model

Kaiser Permanente, Northern and Southern California, currently cares for over 11,000 members with CCS-eligibility (7% of California's CCS population). In 2014 they submitted over 16,000 service authorization requests to CCS to treat children in inpatient and outpatient facilities. Ninety percent of these children have some form of Medi-Cal coverage, and many of these children have a long history with the Kaiser Health Plan and naturally transition to adult care within Kaiser. The Kaiser CCS Program is anchored by four CCS-certified Tertiary Medical Facilities (Oakland, Los Angeles, Roseville, Santa Clara), and they have 13 other certified inpatient facilities—many of which serve as teaching hospitals for internal and external post-graduate medical education programs. They have CCS-certified Special Care Centers for Pediatric Specialties in 64 separate locations throughout California. Kaiser Permanente has 9,600 CCS-paneled providers encompassing nearly all specialties and sub-

specialties, and multi-disciplinary teams working together ensure services are provided to address all of the children's needs across the continuum. In addition, they have dedicated individuals focused on the identification, tracking, referral and care coordination of children taking advantage of CCS services. They are a fully integrated Health Plan which focuses on patient-centered care for the "whole child", with every patient having a primary-care provider (a "home") who coordinates the child's care via the nation's largest civilian integrated electronic medical record with all other providers in the outpatient and inpatient arenas. Their pharmacies, laboratories, and imaging sites are conveniently located in virtually every facility. They currently care for 7.4 million patients (CCS and non-CCS) in their state in a model which is consistent with the principles of accountable care.