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To: CCS Redesign Team
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From: Ann Kuhns

Re: CCHA Draft Comments on CCS Redesign Models

The RSAB process is intended to bring together stakeholders around commonly shared goals, in order to design a comprehensive and integrated model for the future of the CCS program. The CCS models presented to the RSAB board are a mixture of three options for whole system reform along with several proposals more along the lines of program improvement models. There are many valuable ideas contained in all the models presented, representing the considerable time and resources that CCS stakeholders have independently and cooperatively invested in the program over the past twenty years.

Whole System Reforms

The **Bay Area Stakeholder CCS Collaborative, CCHA, and Kaiser** models all represent potential whole-system reform options that could operate across the state.

The **CCS Collaborative Model** would improve care coordination and involvement of families, as well as efficiency in the program. Since the current eligibility and case management role resides with the counties, the CCS programs currently work together to streamline eligibility determinations, and families already have strong relationships with county CCS programs, this model has many strengths. However, the model depends on the willingness of multiple counties to form a third party administrator to adjudicate claims and function as an arm of the Medi-Cal program to pay claims and perform other administrative functions. It is uncertain how administratively and financially feasible this would be. Additionally, the model assumes that providers accept full risk for clinical services over time. This may require multiple providers to have to seek Knox-Keene licenses, which could be administratively burdensome. (3/6 RSAB Goals - #1, 2, and 5)

The **CCHA Kids Integrated Delivery System model** requires CCS providers to work collaboratively with each other and families to provide both primary and specialty care for children with CCS-eligible conditions. It places value on preserving the current CCS program and standards as well as the regionalized delivery system of care, in order to ensure CCS children continue to receive access to the highest quality health care. It is an open model that is flexible enough to allow CCS providers to anchor integrated networks, provided the networks are sufficient to address the intensive needs of CCS children. It provides a path to bend the cost curve by creating opportunities for shared savings arrangements based on outcomes. (6/6 RSAB goals)

The **Kaiser model** is a fully integrated HMO model that already provides primary care and CCS services for approximately 11,000 children with CCS conditions. Carving CCS services into Kaiser for the children that Kaiser already serves would not appear to be administratively difficult and would be consistent with ensuring existing patient-provider relationships are maintained. However, the model cannot be scaled to serve the entire statewide population without significantly disrupting other patterns of care for the bulk of CCS children who are currently seen by non-Kaiser providers. Thus, the model cannot problem serve as an alternative for the entire CCS population. The Kaiser model could run in parallel with other system reforms.

Whole System Reforms for Specific Geographic Regions

The Partnership Health Plan, Health Plan of San Mateo, and the Rady Children's Hospital Demonstration Project are options for whole-system reform that can work in specific regions.

Partnership Health Plan and Health Plan of San Mateo CCS Demonstration Project provide whole-child care in the context of Medi-Cal managed care county organized health systems. Much like the Kaiser model described above, these systems arrange for both primary and specialty care for children with CCS-eligible conditions. The difference between the two models is that in the case of Partnership Health Plan, CCS services are still authorized and approved by the CCS Program; in the case of Health Plan of San Mateo, CCS workers are part of the Health Plan of San Mateo's infrastructure. One question that could help to guide further policy in this area is the extent to which one approach – maintaining separate CCS Program utilization review and care management is preferable to the other with respect to different metrics (patient satisfaction, clinical outcomes, and/or efficiency).

Rady Children's Hospital - San Diego ACO Based Model Demonstration Project. The Rady Children's Hospital Demonstration Project is an Accountable Care Organization model that has served as the basis for CCHA's proposed integrated delivery system approach described above. The Rady Children's Hospital approach shows a great degree of promise in focusing on the whole-child needs of children with CCS-eligible conditions. It is important to note in this respect that Rady is still awaiting proposed reimbursement rates from the Department of Health Care Services. We hope and expect that this model will provide significant insights into best practices for medically fragile children, once it is operational.

Program Improvement Models

Of the remaining models, all of them could work very well within the types of whole-system reform efforts described above.

The **LA County CCS Case Management model** is testing reforms that will be very valuable to improve CCS employee satisfaction and ensure that scarce staff resources are better matched with patient/family needs, regardless of which state-wide solution is implemented. Additionally, the data collected and software developed by the program could prove very useful in developing better quality metrics, streamlining care delivery, and ensuring that children are being treated in the most appropriate setting.

One of the two other Bay Area models, **CCS+**, would provide much needed uniformity across the CCS program, decreasing variability in eligibility determination and improve access to supportive services by regionalizing administration of the program. The proposal also incorporates case management improvements similar to those proposed by LA County, thereby improving the match between staff resources and CCS child/family needs.

The **Bay Area CCS ACO model** closely resembles an earlier version of the CCHA CCS proposal. This model would require the Children's Hospitals to accept risk, obtain Knox-Keene licenses, and become, essentially, managed care plans. Based on feedback from various stakeholders, including the Bay Area CCS Collaborative, CCHA has modified this proposal to focus on integrating primary and specialty care and improving outcomes and efficiency.

Like the CCS+ and LA County models, the **CHLA FQHC in Partnership with an Academic Medical Center and Children's Hospital Complex Care Clinic Models** would be appropriate to improve patient management within a larger system reform proposal. As approaches for improving care coordination and support for children with complex health needs, we would support these efforts being part of any system wide reform approaches. It is important to note that these approaches are different for different populations; that is a complex care clinic is designed to serve the needs of children with significant medical complexity while the FQHC partnership model is designed to serve the needs of children with chronic or special needs. Both approaches have merit.

Thank you for the opportunity to comment on the models presented to the RSAB.