



Department Of Health Care Services

California Children's Services (CCS) Advisory Group (AG) Meeting

January 6, 2016

10:00am – 3:00pm

MEETING SUMMARY

Members Attending: David Alexander, MD, Lucile Packard Foundation for Children's Health; Maya Altman, Health Plan of San Mateo; Dyan Apostolos, Monterey County Health Department; Steven Barkley, MD, Santa Barbara Cottage Hospital; Edward A. Bloch, MD, Children's Medical Services, LA County; Athena Chapman, California Association of Health Plans; Richard Chinnock, MD, California Specialty Care Coalition; John Patrick Cleary, MD, California Association of Neonatologists; Arlene Cullum, Sutter Health; Yvette Baptiste for Juno Duenas, Family Voices; Michelle Gibbons, California State Association of Counties; Kelly Hardy, Children Now; Tom Klitzner, MD, California Children's Services, UCLA; Ann Kuhns, California Children's Hospital; Susan Mora, Riverside County Department of Public Health; Lee Sanders, UCLA; Katie Schlageter, Alameda County; Ed Schor, MD, Lucile Packard Foundation for Children's Health, Laurie Soman, Children's Regional Integrated Service System; David Souleles, Orange County Health Care Agency; Amy Westling, Association of Regional Center Agencies

Members attending by phone: Nick Anas, MD, CHOC Children's Hospital; Kris Calvin, American Academy of Pediatrics, CA; James Gerson, MD, HealthNet; Tony Maynard, Hemophilia Council of California; Richard Rabens, MD, The Permanente Medical Group/Kaiser Permanente Northern California; Tony Pallitto, Kern County Public Health Services Department

Members not attending: Amy Carta, Santa Clara Valley Health & Hospital System Representing: California Association of Public Hospitals and Health Systems; Stuart Cohen, MD, American Academy of Pediatrics, Devon Dabbs, Children's Hospice & Palliative Care Coalition of CA; Karen Dahl, MD, Valley Children's Hospital; Chris Dybdahl, Santa Cruz County; Domanique Hensler, Rady Children's Hospital – San Diego; Abbie Totten, Health Net, Inc.

DHCS Staff: Jennifer Kent, Anastasia Dodson, Nathan Nau, Javier Portela and Brian Kentera

Facilitator: Bobbie Wunsch, Pacific Health Consulting Group

Guests: Peggy Hoover, Partnership Health Plan; Mark Maddox, CenCal Health; Terri Stanley, Cal Optima; Kathy Neal Central CA Alliance.

Follow-Up from Previous Meeting, Key Updates, and Future Meetings' Topics/Goals

Jennifer Kent, Director, DHCS

Anastasia Dodson, Associate Director for Policy, DHCS

Director Kent provided DHCS updates, including final approval of the 1115 Medicaid waiver (Waiver) on December 30th. The Waiver brings \$6.2B into California over 5 years and is key to sustaining the safety net. CCS pilots are included in the waiver as well as the entire Medi-Cal Managed Care Program. This effort by staff delayed materials being prepared for this meeting. The Governor's budget will be released tomorrow in advance of the constitutional deadline. DHCS is engaged in a number of workgroup efforts related to the work of this group and looks forward to continuing work on the Whole-Child Model as well as statewide CCS improvements.

Questions and Comments

Ann Kuhns, California Children's Hospital: There is placeholder language in the Waiver for CCS referring to criteria for the evaluation of two pilots. Can you speak about the work to develop what goes into that element of the waiver?

Jennifer Kent, DHCS: There are many placeholders that are still to be developed. Nothing more is known at this point.

Ann Kuhns, California Children's Hospital: At some point, it would be good to have a discussion here about what DHCS is thinking related to this item and to allow the AG to offer input.

Kelly Hardy, Children Now: What intersection does the 2703 Health Homes state plan amendment (SPA) have with this CCS process?

Jennifer Kent, DHCS: In the Health Homes SPA, we cannot deny eligibility for Health Homes to any population. In addition, we view the CCS population as appropriate to benefit from the Health Homes model in terms of interdisciplinary care teams and working across different programs and providers to target the complex needs' populations. This CCS Program redesign process is separate from Health Homes. The money that flows through the Health Homes SPA to plans is for care coordination, not services. Some assume the Health Home SPA is 90-10 match on everything; it is only on care coordination efforts. The CCS population would benefit from that effort but we have not specifically included or excluded them. We have acknowledged in language that to the extent that CCS population is included in a County Organized Health System (COHS) or is appropriate for health homes, they may be included but this is not an inflexible approach DHCS.

Laurie Soman, Children's Regional Integrated Service System: If DHCS is interested in doing something specifically focused on CCS and Health Homes, would it be brought to this group?

Jennifer Kent, DHCS: Yes, this would be the group to discuss any proposal. We have targeted initial implementation geography for Health Homes to the CCI (Coordinated Care Initiative) counties.

Athena Chapman, California Association of Health Plans: On Health Homes, federal requirements indicate that if anyone is eligible, they must be offered a health home.

Medi-Cal Managed Care Health Plan and CCS Requirements **Jennifer Kent, Director of Health Care Delivery Systems, DHCS**

The document presents a comparison chart of CCS, Medi-Cal Managed Care and the Whole-Child Model for each topic listed. Ms. Kent walked through the topics and discussed the way each topic works in each model of care.

Authorization of services: Ms. Kent described the way authorization of services works under each program type.

Laurie Soman, Children's Regional Integrated Service System: It would be important to have the Whole-Child Model fleshed out more in relation to authorization. In particular, information related to the expertise of those reviewing and adjudicating the requests. We want to be assured that if counties are not handling Utilization Review, which is the assumption in this document, then the expertise of those receiving those requests becomes critical.

Jennifer Kent, DHCS: Agreed, DHCS has weekly calls with the plans to discuss how this works and there are also calls happening between the local entities to discuss this topic. Your point is well taken to the importance of the transfer of history and knowledge-base of cases and authorizations going from a county program to the plan. Some plans are contracting with CCS staff to continue this function for some period, plans may employ CCS staff to make these decisions or use other mechanisms. We are helping to facilitate these conversations because we intend that there should be that transition of knowledge. Maya, can you comment on this?

Maya Altman, Health Plan of San Mateo: Our model is that county workers are sub-contracted and located with us. There has been an extensive education and training process related to this as there are different rules and timelines for managed care compared to CCS.

David Souleles, Orange County Health Care Agency: Much of this coordination work has not started in our county as we are beginning implementation of the Whole-Child Model. We need structured guidance from the state on all the topics laid out in the document to understand roles and responsibilities through this transition.

Anastasia Dodson, DHCS: We are working on guidance that will provide high level milestones, timelines, key considerations, deliverables, and lay out options for how it might work. We will work with the County Health Executives Association (CHEAC), the California State Association of Counties (CSAC) and the plans on this.

Edward A. Bloch, MD, Children's Medical Services, LA County: There may be differences between the requirements for managed care and CCS. It would help to have clarification of what have been conflicting definitions of prior authorization. In CCS, we have notification but not prior authorization. In some forms of managed care, the services cannot be performed with reimbursement guaranteed prior to authorization.

Terri Stanley, Cal Optima: In the case of urgent or emergency service, all plans allow for services without authorization. Only ongoing treatment or scheduled services require prior authorization through the plan. Once the authorization is issued, it is approved for services over a period of time.

Edward A. Bloch, MD, Children's Medical Services, LA County: In CCS, it would be authorized retroactive to the date of service, even if it is an elective service.

Terri Stanley, Cal Optima: We have strict timelines to approve authorizations that we are held accountable for (48 hours for urgent; within 5 business days if not urgent) and we report to the state. So, even though authorization is required, you can get authorization quickly.

Mark Maddox, CenCal Health: We operate under two models. Santa Barbara is a carve-in and CCS manages the eligibility and decision making process. The plan takes it over if it is not a CCS eligible service and it is fairly seamless for providers. In San Luis Obispo, we have a carve-out and there is a bit more back and forth. Not everything requires a prior authorization, in many instances, it is an issue of eligibility that relies on the county. Kids are different than adults. Even for adults, we do not look at authorizing many conditions; the list of items that requires authorization is relatively small.

Yvette Baptiste, Family Voices: For parents, the authorization process is seamless and behind the scenes unless it is denied. CCS kids are complex and their needs are urgent. What we like about the existing system is that there is attention to getting the service and not much attention to authorization and who will pay.

Dyan Apostolos, Monterey County Health Department: I would like to see making authorization more robust. It requires a medical professional who is looking, not only at the condition, but also where they should receive services. There is a cluster of activities required and it does require a medical professional.

Katie Schlageter, Alameda County: I agree. My comment is that the CCS column is not robust and not reflective of what we do. We often expedite authorization; we have strong relationships with families and providers.

John Patrick Cleary, MD, California Association of Neonatologists: The language is, five working days from receipt of adequate information. In order to improve, we need to better define this and shorten the time required.

Maya Altman, Health Plan of San Mateo: I do not want to overstate the differences between the two systems. The staff meets timely standards 97% of the time. In addition, we are trying to be thoughtful about what needs to be authorized for kids. I see the differences as relatively minor.

Richard Chinnock, MD, California Specialty Care Coalition: I hear a concern that the deep knowledge that CCS might not be available in the plans. As to the medical professional, is there something in the proposal that sets a standard for experience and knowledge that should be in place? Not just medical professional, that could be someone just out of nursing school.

Edward A. Bloch, MD, Children's Medical Services, LA County: The current regulations require that board certified pediatrician do the certification for initial determination of medical eligibility. We have physician authored protocols for nurses to follow. Protocols result in physician review about 30% of the time so we are beyond MA nurses. But I do not know if that system will continue under managed care.

Mark Maddox, CenCal Health: In the current process, any authorization request that is denied requires an MD (medical doctor) to make that determination. Nurses approve but not to deny. Current regulations say "a physician". I think that for CCS children, it is reasonable to say "a pediatrician".

Peggy Hoover, Partnership Health Plan: We have carved-in counties also. Similarly, nurses approve services but if there is a question, it is reviewed by board certified pediatricians and/or any needed specialists we can access through an outside agency to review.

Dyan Apostolos, Monterey County Health Department: In the CCS program, there is the CCS Medical Director or consultant and for simple cases, there is a public health or registered nurse.

Ann Kuhns, California Children's Hospital: How to retain the knowledge base is a fundamental question. Will DHCS require plans to do what Health Plan of San Mateo does? Will plans be able to replace CCS workers? And if so, what would be requirements for utilization review staff?

Jennifer Kent, DHCS: The language we put out in August does not require counties to do anything specific; that is a realignment discussion. We are working with CHEAC on language changes. However, we are not dictating to plans or counties what they must do. In some cases, plans will subcontract with county and county staff sits at the plan. We have an invoicing relationship process in place based on realignment. Some counties may not do that. CCS staff could be hired, contracted, or they may organize a different method. We will set out timelines and deliverables, but are not dictating the process to be used.

Ann Kuhns, California Children's Hospital: In theory, if a county and plan did not get along, and the plan wanted to hire their own staff. Does the language allow the plan to hire other staff?

Jennifer Kent, DHCS: I do not think that case actually exists. We know who the plans are; they are here at the table.

Ann Kuhns, California Children's Hospital: Over time that could change. Now, there is a federal match for administrative work. If staff gets absorbed into plan, how does the county allocation work under that scenario?

Anastasia Dodson, DHCS: We can provide more detail on those specifics. From the state's perspective, it is cost neutral; from the county's perspective, it is cost neutral; from the plans perspective, we will work to negotiate the appropriate reimbursement. This is not a budget reduction proposal.

Ann Kuhns, California Children's Hospital: The plan is responsible for what used to be a county responsibility. It is up to them, to staff this in the way that makes sense for them. The money spent by county is reduced. Does the county allocation stay the same?

David Souleles, Orange County Health Care Agency: The devil is in the details here. There will be a reduction to counties in dollars if the staffing for this responsibility goes to the plan. There is a need to ensure counties have funding to maintain their residual responsibilities under this program. For counties now, there is economy of scale in eligibility, case management and utilization review and that could change under this proposal. At the end of the day, it will be the plans' decision to staff in a way that meets state standards. The county is not in the driver seat.

Jennifer Kent, DHCS: Plans and counties must work together and work this out.

Mark Maddox, CenCal Health: We fully appreciate that we do not want to lose the subject expertise at the county, at the medical director level and nursing level. Whether we hire or contract, we would not go in a completely different direction. At the end of this, children should get streamlined service in the same places and we make the system easier to navigate for patients and providers.

Michelle Gibbons, California State Association of Counties: Under the Whole-Child Model language, I want to reiterate the intent of collaboration and counties having a voice. However, counties do not have the authority to delegate any responsibilities. The state is delegating the authority over to plans per statute.

Bobbie Wunsch, Pacific Health Consulting Group: Jennifer and Anastasia, can you describe what will be the next steps to incorporate input?

Anastasia Dodson, DHCS: This is great feedback. We want to continue reviewing the document today and get input about red flags or missing elements. We will start revisions based on this meeting input, prior to putting out a revised version. We will discuss whether the revised document will be brought to the next quarterly meeting.

Jennifer Kent, DHCS: The document is not intended to be a proposal. It is meant to be an illustrative document of how the managed care side works and how the Whole-Child Model might work. We wanted to let you know more about the managed care and Whole-Child Model requirements. If you have comments or changes based on what is here, let us know.

Dyan Apostolos, Monterey County Health Department: I appreciate the spirit which the document was drafted. We have an opportunity to educate, if we are more robust with the CCS information.

Tony Maynard, Hemophilia Council of California: Most people I encounter want to continue case management relationships with the county.

Jennifer Kent, DHCS: You want the county to be the service authorizer on case by case basis?

Tony Maynard, Hemophilia Council of California: Although there is a desire to work it out between counties and plans, I would lean more on a required good faith negotiation. I would ask we do more to ensure it happens.

Yvette Baptiste, Family Voices: Will the discussion today be added to the document? Can we see which recommendations from the AG are reflected?

Jennifer Kent, DHCS: We will come back with the revised document. When we make changes, we will let you know what is added or changed. We will also try to let you know why something was accepted or not, as much as we can.

Nathan Nau introduced his role as managed care monitoring and performance of health plans. Javier Portela introduced his role in handling infrastructure and readiness prior to implementation. Following readiness, plans move to monitoring with Nathan and staff.

Case Management and Care Coordination: Ms. Kent described the way case management and care coordination works under each program.

Arlene Cullum, Sutter Health: I think we need a separate category here for these two topics. Care coordination is about ensuring access to care. Case management may include ongoing, intensive medical management of multiple providers and procedures. Many of the services at specialty care centers (SCC) are unclear or underrepresented in this category. Later in the document, SCC is referenced but should be listed here and throughout the document in more detail and to explain the SCC value.

Susan Mora, Riverside County Department of Public Health: I appreciate the preparation of the document, but I hope that we will provide more detail about CCS in order to educate those in managed care. This is a topic that is not fully explanatory of CCS. There is no discussion of many aspects of care coordination and case management performed by CCS medical nursing staff, such as coordinating and facilitating community resources.

Anastasia Dodson, DHCS: We agree.

Laurie Soman, Children's Regional Integrated Service System: I echo the importance of the comments because this topic is the core of CCS. It is problematic not to have it fleshed out to understand current roles. Plans may not understand what is required from this description as plans think about taking on the functions.

Yvette Baptiste, Family Voices: From a family perspective, the case management term is disliked. We look at it from a care coordination point of view. Case management is operations and should be invisible to parents. It has to do with the operation of entities serving us, but parents are involved in care coordination and we should see that.

John Patrick Cleary, MD, California Association of Neonatologists: Many of the staff employed at the SCCs are a result of the payer requirements of CCS and are not reflected on plan side of the document. Where does the expectation for specific disciplines such as social worker, nutrition, occupational therapy, and others at the SCCs get reflected in the plan requirements? Would that become the good will of the hospital?

Richard Chinnock, MD, California Specialty Care Coalition: On this same point, in order to become a designated CCS neonatal intensive care unit (NICU) center, you must provide specific services. If that NICU designation goes away, where will the services be provided? We want the CCS standards and process to remain the same, but streamline the payment to integrate the whole child. I see SCCs at risk under carved-in managed care.

Anastasia Dodson, DHCS: I think this speaks to qualifications of providers they contract with and is later in the document under the credential section.

Richard Chinnock, MD, California Specialty Care Coalition: It is different to require CCS panel providers than to use a CCS designated center. Will they use the designated center as well as the provider?

Jennifer Kent, DHCS: The plan must send child where they need to go. If they need the SCC, the plan is required to send them there. I think you are raising a contract and reimbursement issue between the hospital and the plan. What is going to happen under a plan responsibility?

Arlene Cullum, Sutter Health: The difference is that there is no reference to the hospital certification requirement to use a tertiary or regional NICU facility. You are referencing providers, not the facility, the hospital component.

Jennifer Kent, DHCS: We are not changing the CCS standards. On page 11, under Whole-Child Model, I think we reference what you are looking for.

John Patrick Cleary, MD, California Association of Neonatologists: To clarify, I am not worried about the cardiologists or physician specialty providers. It is the infrastructure that oversees it

that is not spelled out here. Ultimately, many of the provider types are employed only because of the CCS requirements and it is a great service to the family.

Jennifer Kent, DHCS: We are not changing CCS standards or SCC designations or quality standards. Who pays will change; a plan will pay, not the state. We will look to see if we can make it more clear but there is no intent to change what you reference.

Terri Stanley, Cal Optima: CCS remains responsible for provider and facility designations. The plans will credential those providers and follow state requirements on top of CCS Program requirements.

Jennifer Kent, DHCS: To clarify language, plans do not credential as a CCS provider. Plans credential for their network as “credentialed providers” and CCS credentials them for CCS-panel purposes.

Steven Barkley, MD, Santa Barbara Cottage Hospital: We have been discussing the inpatient side of the SCC. On the outpatient side, we have requirements for annual visits, etc. Is that protected in this transition?

Jennifer Kent, DHCS: That is later in document. My simple explanation is that the issue is about the benefits for new services. In the Whole-Child Model, CCS will say what the standard of care should be for a particular disorder and that is the CCS policy. The state will translate that standard of care into plan requirements. To the extent that CCS has policy guidance and letters out there today for treatment, those will be translated into standards and contracting requirements for the plans.

Dyan Apostolos, Monterey County Health Department: This discussion reflects the complexity of CCS. Three parties have significant responsibility: The CCS column includes state administration and oversight, county administration, and authorizing services. Then there is the plan responsibility. I do not see a parallel of the provider network in the managed care column here. That is causing confusion.

Susan Mora, Riverside County Department of Public Health: I want to emphasize the important function of care coordination by the medical therapy program (MTP) that is critical and should be listed.

Richard Chinnock, MD, California Specialty Care Coalition: This is a substantive conversation and I appreciate having it. I understand the document is a work in progress. This discussion is helping to increase my comfort as we review and I hear Jennifer’s comments.

Ed Schor, MD, Lucile Packard Foundation for Children’s Health: I want to reiterate the difference between care management and care coordination. Families do not want to be managed. We heard from LA’s system of tiered case management at the last meeting. Care management operates inside the health care system while care coordination crosses between clinical and community. The MTP and nurses in CCS go beyond the medical to community and school. I do not think that is reflected here.

Edward A. Bloch, MD, Children’s Medical Services, LA County: On the issue of determining specific care guidance, one of the important functions of CCS care coordination teams is to determine the need for how much service for a particular condition. We may authorize one visit per month or much less depending on what is needed.

Continuity of Care: Ms. Kent described how continuity of care requirements work in managed care. This references continuity of care when a beneficiary is new to a health plan. Notices go out to beneficiaries when continuity of care is ending to spell out exemptions. In CCS transitions, health plans will do an assessment to determine level of care and coordination. The Whole-Child Model will include what is referenced on the managed care column.

David Alexander, MD, Lucile Packard Foundation for Children's Health: This is a really important issue because of the population. Most CCS conditions will last longer than 12 months and families develop relationships with providers. The notion that one year into care, the family would have to transition care to another institution is untenable. I urge that for this population, continuity of care should be for the duration of the CCS condition. The shift of care is very disruptive to families and the care team.

Jennifer Kent, DHCS: There is a misimpression here. Plans have a service area that they cover but plans do not arrange care for every condition within the service area. The plan must send you where is most appropriate. There are not many hospitals or care centers that provide CCS conditions. Just because a provider is not in the service area, the plan still must offer services.

David Alexander, MD, Lucile Packard Foundation for Children's Health: People will try to do the right thing. Here is a scenario that is likely: The pediatrician identifies a new treatment at UCLA and the family goes there for care, but a year later, the plan decides that the care at UCLA is not that different or better and moves them to another facility. I think we should take care to consider disruption to be like a denial.

Peggy Hoover, Partnership Health Plan: At a point close to the 12-month limit for continuity of care, the plan will be looking at reauthorization for another 12 months and determine the right plan. We would not disrupt care just because the 12-month period is up.

Jennifer Kent, DHCS: The legislative and statutory language says, "There is 12 months required and plans can extend continuity of care as long as it makes sense". In the example you give, it would not be disrupted based on the date. Clinicians would be in discussion to determine the right course.

Laurie Soman, Children's Regional Integrated Service System: I strongly echo David's comment. This language is concerning. Plans have always had the ability to extend continuity of care. It needs to say that the assumption is to continue established care unless there is a good reason to change. Once a relationship is established, it should continue. The provider is chosen for a good reason and there should be a good reason to change once a relationship is established. The current language is not sufficient to achieve the assumption that continuity of care continues as long as the condition exists. Later in the document, it says the plans are given the power to say, "We cannot reach agreement with an out-of-plan provider and they can seek program approval to send CCS children to a non-paneled provider" so the language in this section is particularly important.

Ed Schor, MD, Lucile Packard Foundation for Children's Health: What about continuity of care within plan? For example, a provider in the network cancels a contract with the plan.

Javier Portela, DHCS: We work with the plan on network changes in general. We cannot force providers to work with a plan so some of this is provider-driven, not plan-driven. We then ensure appropriate notice and work with the plan on a case by case basis.

Mark Maddox, CenCal Health: I agree with the comments about how important continuity of care is. From a plan perspective, there is no reason to change an established relationship with a provider. The failure of those relationships that I have experienced has sometimes been the unwillingness of the provider to contract with the plan. Or, the provider may be willing and the business office is not.

David Alexander, MD, Lucile Packard Foundation for Children's Health: If the provider is accepting CCS with fee-for-service (FFS) rates, the protection needs to be that the provider needs to accept it from the plan.

Javier Portela, DHCS: This continuity exists because of our lessons learned from other transitions. Not all providers do transition to contract with a plan. Sometimes even when rates are higher than FFS, the provider does not want to contract. We want to ensure beneficiaries are protected.

David Alexander, MD, Lucile Packard Foundation for Children's Health: The majority of providers in this situation will continue to have both FFS and contracts.

Maya Altman, Health Plan of San Mateo: Just to emphasize this, we are talking about providers insisting on rates much higher than the CCS FFS they are getting from the state. Some hospitals have insisted on 80% of charges, huge differences than what is offered. We need to take care about how much leverage we give to providers because it would be great if they would accept FFS or slightly higher. This is a huge problem for plans.

Katie Schlageter, Alameda County: It is really helpful to hear from plans directly. This is a big piece of concern in the roll-in of the Whole-Child Model. I am worried about loss of family choice and think that continuity of care will result in better health outcomes.

Yvette Baptiste, Family Voices: The topic of continuity of care has become a conversation of money. I want to address family needs in addition to financing and focus on relationships with providers, not just about who gets paid what. I am not unsympathetic to the financing but there are two aspects to this topic. The emotional toll on the family when there is disruption is huge.

Amy Westling, Association of Regional Center Agencies: If there is a need for a provider change, the document should address how the transition is accomplished and that a warm hand-off with all the information will be done.

John Patrick Cleary, MD, California Association of Neonatologists: Money is the way we ensure continuity. Hearing that it is about a plan rate or CCS FFS whichever is higher, reassures me. When we are five years into this, how would the CCS FFS rate be determined?

Jennifer Kent, DHCS: CCS eligibility will continue to be a county responsibility so the plan will be notified of any change. We will still be setting CCS rates for the rest of the counties and providers as it is today. Children are not just served within the service area that is managed care and we do not have all CCS children in managed care. The CCS providers in managed care will have both FFS payments and plan contracts.

John Patrick Cleary, MD, California Association of Neonatologists: You are speaking to today's amalgamated situation. But if we reach the vision of Whole-Child Model, and ultimately we are fully implemented, then I am concerned that the plan could say that you must go to a contracted provider, not to the best provider.

James Gerson, HealthNet: The current definition for continuity of care is mostly about in vs out-of-network relationships. With CCS, there is no definition of in or out-of-network. We want to create an incentive to keep children with the CCS provider as long as medically necessary. The issue of rate setting should be done by the state because it will be difficult if left to a plan by plan situation.

Nick Anas, MD, CHOC Children's Hospital: Today, providers have the option to refer patients to anyone they think is best regardless of where they are in the state. This is an important concept to keep in mind as we go forward. There will be circumstances where this determination becomes difficult and may require some type of arbitration or grievance process.

Tony Maynard, Hemophilia Council of California: Similarly, looking at the language, it appears that CCS is superior to managed care or Whole-Child Model. The language should reflect that continuity of care and patient choice should be retained whenever possible. Respecting a patient's choice should be considered. The goal is to be revenue neutral, not saving money.

Covered Services: The list of managed care, CCS, and Whole-Child Model requirements was introduced.

Terri Stanley, Cal Optima: What is included here are the requirements. Many plans offer services over and above the requirements such as disease management programs. Some plans are National Committee for Quality Assurance (NCQA) accredited and follow those requirements for complex case management. Many of the comments raised are embedded in those requirements and the documents that detail it. Cal Optima is NCQA accredited and we follow those requirements.

Arlene Cullum, Sutter Health: It was curious to see that the Comprehensive Perinatal Services Program (CPSP) would be integrated into the Whole-Child Model. This is a plus because it has not been well coordinated in the past. Why is High Risk Infant Follow-up listed separately?

Edward A. Bloch, MD, Children's Medical Services, LA County: To the comment on disease management programs cited, are there CCS eligible conditions within these programs?

Terri Stanley, Cal Optima: Asthma is an example of a condition that is not a CCS eligible condition but CCS eligible children suffer from these conditions as well.

Tom Klitzner, MD, California Children's Services, UCLA: I represent the Cardiac Technical Advisory Committee (CTAC) on this group. On the inclusion of new benefits, cardiology has had a host of new covered benefits over the last few years. The process has been that the state CCS would ask for input from the CTAC, and then we would see something become a covered benefit. The process you described sounds different than that. Since we will have FFS and managed care, how will this process be integrated in the future? What is the role for the technical advisory committee?

Javier Portela, DHCS: The future situation needs to be worked out. My comments were in relation to covered services for continuity purposes that are new to the plans, but not new to the state. As we go forward, if it is a truly new benefit, we will work on policy guidance to the plans.

Jennifer Kent, DHCS: To let you know how it works in the adult world, the policy decision is made about what service should be covered, who is eligible, how the prior authorization is done, and this benefit decision is handed to managed care staff to translate into standards and

contracts. In the case of Hep C, the policy said patients meeting these standards are eligible to receive this service. The recommendation by your CTAC would be translated to managed care standards and contracts.

Tom Klitzner, MD, California Children's Services, UCLA: I was confused about how it related to continuity vs a new benefit. I hear that the policy process remains essentially the same.

Laurie Soman, Children's Regional Integrated Service System: Is it correct that the Whole-Child Model column combines CCS/managed care columns? The intent is not to drop any benefits? Cochlear implants, palliative care, orthodontia are missing; this may be just an oversight.

Jennifer Kent, DHCS: Some may be omitted because the service is carved-out of managed care altogether but I will need to check if it is an error.

Athena Chapman, California Association of Health Plans: On the list of services under FFS, can many of those be provided by a non-CCS paneled provider?

Tom Klitzner, MD, California Children's Services, UCLA: This can be difficult. For some things, like a Magnetic Resonance Imaging (MRI), it is a Medi-Cal benefit already; however, CCS has worked to protect getting these services at the facility where the patient receives care for the CCS condition. The default has been to get them at the designated centers. There are instances where we accept a test result from another facility or provider but for more sophisticated tests, we want them provided at the designated CCS facility.

David Alexander, MD, Lucile Packard Foundation for Children's Health: Yes, a plan might want to use the place that is lower cost for some services, however if a facility is able to resuscitate a child from a complication due to the MRI, it may be the right place to do the test. We should have good conversation about general services being done at the right place for a CCS child.

Tom Klitzner, MD, California Children's Services, UCLA: This is an opportunity for plans to save costs. The initial tests are often done in a facility that is not the right place and these are repeated at the CCS facility. The plans can direct patients to the place where a correct diagnosis or decision will be made at lower cost.

Nick Anas, MD, CHOC Children's Hospital: I want to reiterate that cost of care at a pediatric center may be higher than community facilities, yet there may be value that ultimately save costs and save lives.

EPSDT Services: Ms. Dodson reviewed the Early and Periodic Screening, Diagnosis, & Treatment (EPSDT) services required under each program.

Laurie Soman, Children's Regional Integrated Service System: Authorization of EPSDT above and beyond Medi-Cal needs more attention in the document, for example medications not on the formulary. There are items covered by CCS under EPSDT supplemental services. How will these be built into Whole-Child Model?

Katie Schlageter, Alameda County: Hearing aids/batteries, shift nursing care, and medical foods are all examples of EPSDT supplemental services.

Terri Stanley, Cal Optima: We have language in plan contracts requiring EPSDT. We authorize and approve services under EPSDT frequently for families who may have refused CCS although they have a CCS eligible condition and we approve services under EPSDT.

Ed Schor, MD, Lucile Packard Foundation for Children's Health: Pediatric services are really services to a family. To what extent does CCS offer services to the family to meet the health needs of the child? If a family is not covered by the health plan, how would a depressed mother, impaired in caring for her child, receive service under child's coverage? How far do we extend services beyond the child? I am thinking of this especially for Marriage and Family Therapy.

Katie Schlageter, Alameda County: On outpatient mental health services, we are authorized to provide services to siblings and parents under CCS. There is a numbered letter on CCS policy although I do not think it says anything about EPSDT.

Yvette Baptiste, Family Voices: There is a need for behavioral health services. Is it covered? How and where? There is a lack of providers with experience serving families and children with special needs in the behavioral health area.

Edward A. Bloch, MD, Children's Medical Services, LA County: There are so few pediatric psychiatrists and providers with appropriate expertise in California. It is not a matter of access to the benefit, as it is trying to obtain access to an actual provider.

Grievances and Appeals: Ms. Dodson pointed out the differences in grievances and appeals required under each program type.

Laurie Soman, Children's Regional Integrated Service System: Disability Rights California wrote the appeals process for CCS. They believe the CCS appeals is a superior process to the one used in managed care. We need a specific side-by-side of CCS and managed care to determine what appeal process should be in the Whole-Child Model.

Nathan Nau, DHCS: The current grievance process includes different levels: The beneficiary can do a grievance directly with the health plan or can choose to bypass the health plan and go to a state-administered fair hearing process with an administrative judge. A third process for non-COHS plans is to file for an independent review by a physician at the Department of Managed Health Care (DMHC). This is similar to the fair hearing process but with a physician instead of a judge.

Ann Kuhns, California Children's Hospital: The Whole-Child Model counties are COHS. Those county beneficiaries would not have an option to go to DMHC since COHSs are not Knox-Keene.

Mark Maddox, CenCal Health: Just to clarify, the appeal process is about utilization review. Grievances are varied and can be between providers, from a beneficiary about a provider, the service, how I was treated, and not necessarily on utilization issues. When we see patterns, we figure out whether it is a provider issue or a system issue so we can resolve it.

Dyan Apostolos, Monterey County Health Department: If the county determines medical eligibility, would they maintain the current appeal process? On expert opinion vs appeal for therapy decisions where there is a disagreement?

Anastasia Dodson, DHCS: The document needs to specify whether the issue is about authorization or eligibility.

Edward A. Bloch, MD, Children's Medical Services, LA County: Also, the MTP appeal process differs from the administrative law judge process. There are other appeals as well, for example a request for a non-paneled provider or an out-of-state provider when we have determined the services are appropriately available in-state. So, there are many variations on appeals over a range of eligibility and medical necessity.

Individual Care Plan: Ms. Dodson presented a high level description of the minimum requirements for each program type.

Ed Schor, MD, Lucile Packard Foundation for Children's Health: This is pretty minimal information and I would like to see more added here, including definitions, roles for the family, assessment parameters, information on when is the care plan developed and updated. There is no national standard or consensus on what a care plan consists of, but it would be good to see some progress here.

Anastasia Dodson, DHCS: Hopefully some of the documents from the previous meeting may help delineate this. Subsequent meeting discussions can also add to this topic.

Susan Mora, Riverside County Department of Public Health: One hallmark of CCS is that the care coordination is multidisciplinary; physicians, occupational therapists (OT), nurses, social workers and others. The document for the Whole-Child Model speaks to sharing the care plan information but does not require inclusion of multiple disciplines, particularly OT and physical therapist in the care planning.

Laurie Soman, Children's Regional Integrated Service System: The concept of acuity assessment should also be here.

James Gerson, MD, HealthNet: Using the term of "medically necessary services" may confuse this with the treatment plan as opposed to the care plan. It should call out psychosocial issues as well as being family-centric.

Ed Schor, MD, Lucile Packard Foundation for Children's Health: My bias is that this should be individual and family care plan, not an individual care plan. Family needs should be part of the assessment and the plan.

Informing Materials: Ms. Dodson described the informing materials and noted that many are subject to federal requirements on the managed care side.

Laurie Soman, Children's Regional Integrated Service System: Will families be informed they are CCS and are entitled to certain things above and beyond normal plan services, such as going to CCS providers?

Anastasia Dodson, DHCS: The intent is to keep that as part of eligibility and it will continue to be a county responsibility as part of the materials sent out about eligibility.

Maya Altman, Health Plan of San Mateo: We do have a special section in the Evidence of Coverage (EOC) on CCS. We do inform about special benefits. It was part of our contract.

Javier Portela, DHCS: This is part of a global requirement on informing materials. We will look at plan documents to be sure CCS information is incorporated. We want to highlight this includes threshold language requirements and alternative formats as well CCS specialized information.

Ann Kuhns, California Children's Hospital: It might be helpful to mention Family Resource Centers (FRCs) availability for families.

Katie Schlageter, Alameda County: That happens in some counties but not statewide. We have family navigators and include information on FRCs and family navigators in the packet.

Edward A. Bloch, MD, Children's Medical Services, LA County: We have Memorandums of Understanding (MOUs) with FRCs through the MTP only.

Amy Westling, Association of Regional Center Agencies: FRCs are an asset to the community. They may not serve a broad age band unless they have funding to do so. Many only serve birth to three so we need to be sure referrals are accurate.

Yvette Baptiste, Family Voices: I am the Director of East LA FRC and Co-chair of LA FRC Network. We welcome any referral and will help families get to the right place for services, regardless of our funding limitations. In addition, I want to point out that the EOC is like a bible for families with special needs children. That document and the information about access to other community services helps families advocate for their child.

Maya Altman, Health Plan of San Mateo: We spent time with our family advisory committee on informing materials. Families are vocal about not wanting too much, how to highlight important information, how to send the information. When we set state standards, we have to be mindful of this. Sending too much information is like sending nothing.

Yvette Baptiste, Family Voices: For FRCs that are not funded to serve all ages, they are an important resource and this is great need and plans should consider funding them.

Athena Chapman, California Association of Health Plans: Family needs are different and we have lots of feedback that too much information can be scary. We need to tailor information or offer links to additional resources so we don't overwhelm families.

Dyan Apostolos, Monterey County Health Department: CCS has a handbook of resources that can be an addendum. It describes the MTP and other information useful to families. CCS also sends letters that inform the family incrementally over time.

Anastasia Dodson, DHCS: We should look at San Mateo to see what they have worked out so we can avoid duplication and confusion by modifying materials for managed care.

Dyan Apostolos, Monterey County Health Department: Will a family receive the same beneficiary services even if they do not fill out the application?

Maya Altman, Health Plan of San Mateo: We have always been carved-in and there has never been a special application. No action is required by the family.

Agenda discussion

Bobbie Wunsch, Pacific Health Consulting Group: Because of time constraints on the agenda, members voted to send comments on the document to DHCS and defer review of the rest of the document to the next AG meeting (beginning on page 9). What is missing that should be added before our next discussion?

David Souleles, Orange County Health Care Agency: For the next discussion, can we add MTP and the financial/eligibility functions to round out the CCS role under the Whole-Child Model?

Tom Klitzner, MD, California Children's Services, UCLA: I am wondering if it is useful to break-out SCCs in the document to delineate the extra services and how that is handled in each program column.

Kelly Hardy, Children Now: I suggest we spend time early in the agenda on the parental involvement element.

Dyan Apostolos, Monterey County Health Department: Pediatric palliative care is missing.

Katie Schlageter, Alameda County: Can you clarify the purpose of the document? Would DHCS comment next meeting on whether they would consider moving some of what CCS does into the Whole-Child Model?

Anastasia Dodson, DHCS: This document is a summary of requirements. There are many legal documents and statutes with details behind this overview. We want the core CCS Program to be reflected in the Whole-Child Model and we want to filter it through the communication process DHCS has with managed care. The appeal process is an example; we cannot have everything from both programs.

Katie Schlageter, Alameda County: Jennifer Kent mentioned some items that will continue as they are now under the Whole-Child Model.

Anastasia Dodson, DHCS: Yes, those could be moved over.

Medi-Cal Managed Care Health Plan Readiness

Nathan Nau, Managed Care Quality and Monitoring Division Chief, DHCS

Javier Portela, Managed Care Operations Division Chief, DHCS

Presentation slides available at:

http://www.dhcs.ca.gov/services/ccs/Documents/AGMeetingPPFINAL10_19_15.pdf

Mr. Portela offered an overview of the readiness review process. At a future meeting there will be additional specifics presented as they evolve and develop. Readiness is the work that occurs prior to implementation or service delivery. DHCS coordinates with DMHC when appropriate. COHS plans are not Knox-Keene and work directly with DHCS. Plan readiness includes provider network adequacy, member communications, contractual and regulatory compliance.

Questions and Comments

Bobbie Wunsch, Pacific Health Consulting Group: Can you describe the process for readiness review? How long before go-live does readiness happen? Is there a role for CCS staff?

Javier Portela, DHCS: We set weekly calls to discuss readiness elements. In some cases, we visit the plan to review and discuss readiness. We review documents, systems, contracts and other aspects of the standards. We submit a contract to CMS 60 days prior to approval and then members have 30-60 days' notice before services begin. There is no formal role envisioned for local CCS staff for review. We are looking to CCS for understanding of what should be included and what is important. State CCS staff are part of the review process and offer expertise.

David Alexander, MD, Lucile Packard Foundation for Children's Health: DHCS has transitioned a number of populations over the years. What lessons influenced this process?

Javier Portela, DHCS: Lessons learned include: Reach out to providers early, create Frequently Asked Questions (FAQ) documents and conduct outreach to the community, and prepare crosswalk information about the changes from the beneficiary point of view.

Laurie Soman, Children's Regional Integrated Service System: This is helpful. Plan readiness picks up some of the elements from the comparison document for discussion. What is the timeline for developing the readiness for CCS? What are the criteria for the specificity of network adequacy for CCS? How will you develop adequacy for in-plan and out-of-plan, including out of state? How can we work with you on the process?

Javier Portela, DHCS: The timeline depends on internal decisions about the actual transition date for beneficiaries. It will be forthcoming. However, we are already working with plans as we go. We will be assessing network adequacy based on what we know about CCS needs, there is no specific definition or national standard on this specific network adequacy.

Laurie Soman, Children's Regional Integrated Service System: Local CCS staff have information about referral and treatment services being provided.

Javier Portela, DHCS: DHCS has data on where children receive care now. We have standards for out of network care and we will review to determine whether additional adjustments are needed. As we build the timeline and readiness plan core competencies, we will share with this group.

Laurie Soman, Children's Regional Integrated Service System: This group has expertise to offer from working, serving or having children with special needs.

Ed Schor, MD, Lucile Packard Foundation for Children's Health: Are plans expected to have quality improvement plans in place? Will the state have a monitoring plan in place at the outset?

Nathan Nau, DHCS: Once the process Javier outlined is complete, monitoring begins. We heavily monitor during the transition phase. We are monitoring plans and building our internal readiness. I will present more on this later.

Ed Schor, MD, Lucile Packard Foundation for Children's Health: The Association of Maternal and Child Health Programs convened a national advisory committee and produced standards for special needs children that is being used in 27 states and might be helpful for readiness of the systems. I will forward that to DHCS.

Tom Klitzner, MD, California Children's Services, UCLA: Each population moving into the plans is big enough and sick enough that in the first week, plans will see many urgent as well as hundreds of non-urgent requests for care. How long before the go-live date will the plan have clinical information on their panel of patients to become prepared?

Javier Portela, DHCS: The enrollment process electronic exchange begins 30-60 days ahead of implementation of coverage.

Nathan Nau, DHCS: An example of this is the current transition of behavioral health services that begins February 1. We are transferring data on patients receiving services in regional centers in a HIPPA-compliant way prior to the go-live date. Plans can begin to work on continuity of data agreements and do analysis of the data.

Maya Altman, Health Plan of San Mateo: The Seniors & Persons With Disabilities (SPD), Coordinated Care Initiative (CCI), and Cal MediConnect transitions provided lessons on this transition timeline for non-COHS plans. In those situations, having clinical information prior to go-live was a problem. There were barriers in those situations and we could not have the information because they were not yet members. In this case, they are already members so we can have the data far ahead.

Nathan Nau, DHCS: We have overcome data sharing issues and we are providing information about beneficiaries 45 days ahead.

Athena Chapman, California Association of Health Plans: In past transitions, there was emphasis on the health risk assessment (HRA) because it was being measured and monitored. This group should determine the right measure for this transition. Some of the risk assessment protocols could be better defined for this population. What do plans need to spend the most energy/attention on in this transition?

Terri Stanley, Cal Optima: CalOptima developed a pediatric HRA and process developed during the SPD transition. We piloted it with Children's Hospital Orange County (CHOC) and are rolling it out to the network. We can share that information.

Anastasia Dodson, DHCS: Please send the pediatric HRA tool to the DHCS mailbox.

Dyan Apostolos, Monterey County Health Department: On network adequacy, CCS does authorize pediatricians for primary care for children with complex medical conditions. Much of the focus here has been on sub-specialty care. There is a shortage of CCS-paneled pediatricians in our area and I wonder if there is consideration of looking at specialty pediatricians for primary care under network adequacy?

Nathan Nau, DHCS: We can share service authorizations, claims data and provider information in advance and ongoing. We analyze the data to understand the trends.

Mark Maddox, CenCal Health: I get daily notifications of new CCS eligible children.

Tom Klitzner, MD, California Children's Services, UCLA: Do you get clinical information?

Mark Maddox, CenCal Health: We have access to that information. In addition, it will be the same people interfacing with families, whether through contract or other means.

Tom Klitzner, MD, California Children's Services, UCLA: The point of taking advantage of the existing relationship with county CCS staff is of benefit both the plan and the county.

Medi-Cal Managed Care Health Plan Monitoring

Nathan Nau, Managed Care Quality and Monitoring Division Chief, DHCS Javier Portela, Managed Care Operations Division Chief, DHCS

Presentation slides available at:

http://www.dhcs.ca.gov/services/ccs/Documents/AGMeetingPPFINAL10_19_15.pdf

Nathan Nau offered a preview of the presentation on plan monitoring that can be discussed in more detail at the next AG meeting. DHCS conducts transitional monitoring monthly for a minimum of six months and then quarterly for two years. Each transition is different and part of the process is working with you and other groups to determine what data will be important for monitoring. Examples of the data to be collected will include continuity of care, network adequacy, grievances, and others.

Questions and Comments

Bobbie Wunsch, Pacific Health Consulting Group: Bobbie asked for input of what should be covered at the next meeting discussion.

Ann Kuhns, California Children's Hospital: It would be helpful to see what monitoring information you are collecting from the carve-in plans who have CCS now.

Ed Schor, MD, Lucile Packard Foundation for Children's Health: Can we have a section on quality assurance?

Yvette Baptiste, Family Voices: Are there any consumer satisfaction or other qualitative data?

Susan Mora, Riverside County Department of Public Health: Will you include rates of denial of service?

Tom Klitzner, MD, California Children's Services, UCLA: In general, these are reactive measures. Are you also monitoring proactive measures like time to appointments?

Care Coordination / Medical Home / Provider Access Technical Workgroup Update

Anastasia Dodson, Associate Director for Policy, DHCS

This agenda item was deferred to another meeting because of time constraints.

Data & Quality Measures Technical Workgroup Update

Linette Scott, MD, Information Management Deputy Director and CMIO, DHCS

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention

Brian Kentera, CMS Network IT Section Chief, DHCS

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This agenda item was deferred to another meeting because of time constraints.

Public Comment

Bobbie Wunsch, Pacific Health Consulting Group: Bobbie invited CCS parents to make public comments via the member phone line.

Michelle Cabrera, SEIU CA: We represent county workers including public health nurses, MTP staff and others doing this work. It is of grave concern that the individuals who perform this work have not been involved in the discussion. Dr. Bloch does an excellent job but I hear a lot about the value of the expertise of those providing case management and services. As we move forward, it is important to have those voices represented in the conversation. There needs to be more understanding of CCS as it exists today in the context of the whole child model. If the state wants to bring the spirit of CCS into the health plan model, then understanding what it is today is really important. Also, fleshing out the pieces that are in law vs contract vs local conversations.

Danielle Kenworthy, parent of CCS child: My child is 20 years old now and CCS has been our support. I appreciate the people around the table and the work to make this system better. I do not see parents represented and I would like to see the full diversity of parents involved. I have a relationship with CCS nurses that allows me to get information and understand what is happening right now. I am not assured that this is incorporated yet.

Aaron Starfire, Maxim Healthcare Services: We are a home health care service provider. A clarification on the document related to EPSDT in the Whole-Child Model, will it have shift nursing carved-in or out of managed care? It seems to conflict with skilled nursing.

Anastasia Dodson, DHCS: That is an area we need to follow up on to figure it out, whether it is part of a carve-in or carve-out.

Maya Altman, Health Plan of San Mateo: It is carved-in for the pilot. We assume it will be part of the program.

Aaron Starfire, Maxim Healthcare Services: This program is under water. Rates were last raised 15 years ago and this problem will be pushed onto health plans in a broken state. Eligibility exists but access to services is a problem. There are thousands of hours of service in this category and it has a huge daily impact on their lives. I want to encourage you to look at that.

Jason Lindo, Childrens Service Manager, Alta Regional: I want to bring attention to two issues about the relationship between local CCS relationships and others serving the same clients. How will those relationships move over in this transition? In Sacramento County, we have a local quarterly meeting with CCS that is beneficial to our clients. I also sit on the Medical Neglect Review Committee for Sacramento County, and CCS is an invaluable part of that effort. This county is not unique. That challenge not reflected here. My unit provides care to undocumented families and CCS serves them. Even though they will be eligible for Medi-Cal soon, this is a huge paradigm shift in access to services for them. I wanted to flag these additional issues for you as you discuss the medical issues and transition.

Next Steps and Next Meetings

Bobbie Wunsch, Pacific Health Consulting Group Wunsch: Bobbie reviewed meeting dates and calls for the agenda development.

Anastasia Dodson, DHCS: Over the summer, we discussed a balance of discussion of the Whole-Child Model and topics we want to devote time to in these meetings such as transition age youth and mental health coordination. Perhaps we can discuss how to address this in the agenda. In the meantime, there are the technical work groups (TWG) meeting and we will look into whether there are issues here that can be addressed in smaller TWGs.

Meeting Schedule

April 6, 2016

July 6, 2016

October 5, 2016

CCSRedesign@dhcs.ca.gov is the website for this committee.