



## California Children's Services (CCS) Redesign Redesign Stakeholder Advisory Board (RSAB)

### Meeting #3 Summary

Friday, March 20, 2015

Sacramento, California

#### Members

##### in Attendance:

**Families / Advocates:** Pip Marks (for Juno Duenas), Family Voices of California; Tony Maynard, Hemophilia Council of California; **County Representatives:** Chris Dybdahl, Santa Cruz County Administrator for CCS; Susan Mora, Riverside County Department of Public Health; Tony Pallitto, CCS Administrator, Kern County; Judith Reigel, County Health Executive Association; Katie Schlageter, CCS Administrator, Alameda County; **Hospital Representatives:** Amy Carta, Santa Clara Valley Health and Hospital System; Arlene Cullum, Sutter Health; Karen Dahl, MD, Vice President for Quality and Patient Safety, Valley Children's Hospital; Domonique Hensler, Rady Children's Hospital; Tom Klitzner, MD, UC Medical Centers, Ann Kuhns, California Children's Hospital Association; Richard Rabens, MD, Medical Director, Kaiser Permanente Northern California State Programs; **Provider Representatives:** Maya Altman, Health Plan of San Mateo; Nick Anas, MD, Specialty Care Coalition; Athena Chapman, California Association of Health Plans; James Gerson, MD, Medical Director, Health Net, Inc.; Abbie Totten, t; **Foundation Representatives:** David Alexander, Lucile Packard Foundation for Children's Health; Ed Schor, MD, Lucile Packard Foundation for Children's Health; **CCS Executive Committee Representatives:** Dyan Apostolos, Monterey County; Ed Bloch, MD, Medical Director, Children's Medical Services, LA County; David Souleles, Orange County Health Care Agency; **Other Stakeholders:** Laurie Soman, Packard Children's Hospital and the Children's Regional Integrated Service System (CRISS)

#### DHCS Staff

##### in Attendance:

Claudia Crist, Anastasia Dodson, Hannah Katch, Louis Rico, Bobbie Wunsch



**UCLA/Stanford Staff  
in Attendance:**

Michaela Ferrari, Neal Halfon, Nathan Moriyama, Jessica Padilla, Dylan Roby, Lee Sanders, MD, Jessica Schumer, MD

**Audience Members:**

Maricris Acon, Scott Bain, Marie Barnett, Terri Cowager-Hill, Tim Curley, Allison Gray, Kirsten Halsted, David Jacobson, Erik Kelly, Cinde Kunzman, Jacob Lam, Christine Lazott, Pip Marks, Deborah Martinez, Tedrick Miles, Jennifer Ramirez, Anthony Rose, Pamela M Sakamoto, Tim Shannon, Teresa Stark, Paula Villegaz, Tina Vora

**Meeting Summary**

**Welcome Statement**

Anastasia Dodson and Jennifer Kent (DHCS) welcomed everyone and announced that the meeting would focus on models and introduced Bobbie Wunsch (Pacific Health Consulting Group) as the facilitator for the meeting.

**Goals for the Day**

Ms. Wunsch went over the agenda for the day and asked that everyone keep the following two questions in mind to frame the discussion for the day:

1. How are the components of each model aligned with the goals for CCS Redesign that DHCS has identified?
2. How can each of these approaches be adopted to different regions of the state?

**Session I: Presentations on Care Model Proposals**

1. ***Bay Area Stakeholder Models, presented by Ms. Katie Schlageter, Alameda County Administrator, California Children's Services***
  - a. PowerPoint slides for Ms. Schlageter's presentation can be found [here](#).
  - b. Ms. Schlageter provided background information on the Bay Area Stakeholders Collaborative including its focus on the [Triple Aim goals](#), and others such as partnering with families, reducing duplication and fragmentation, and providing more intensive care coordination
  - c. Ms. Schlageter walked through each of the options that the group considered. Key points from each option presented are included below.
    - 1) **Option 1: CCS+**: would create 4-5 large regions within the State. It shifts all administrative oversight to large independent counties. It would leave in place the fee-for-service (FFS) payment system. This option has been

implemented in Alameda County, which is a good example for our reference.

- 2) Option 2: CCS Collaborative requires the creation of a CCS administrative entity and implement a comprehensive payment reform that may include: capitation, bundled payments, and Pay-for-Performance (P4P).
  - 3) Option 3: Children’s Hospital Based Accountable Care Organization (ACO): requires finance structure change and programmatic change, in which CCS would operate under ACOs anchored at children’s hospitals and would maintain direct contracts with DHCS.
  - 4) More information is available [here](#).
2. A summary of the **RSAB Questions and Discussion** session following Ms. Schlageter’s presentation is included below.
- a. Ed Schor, MD, (Lucile Packard Foundation for Children’s Health) asked what kind of active oversight and enforcement of standards are in place with CCS+.
    - 1) Ms. Schlageter explained that details are not completely worked out.
    - 2) Dr. Schor commented that it should be an objective entity.
  - b. A female RSAB member asked Ms. Schlageter to elaborate on the Alameda implementation of CCS+ with regards to the intensive care coordination and how it differs from what was in place before.
    - 1) Ms. Schlageter answered that they now have an acuity tool; family conferences are also new; documented follow up is new as well.
  - c. Dr. Schor asked how primary care would be integrated into this system.
    - 1) Ms. Schlageter mentioned that San Mateo may have a better answer to the question. She added that while there was a workload increase, there was also a dramatic change in [eliminating] duplication.
    - 2) Maya Altman (CEO, Health Plan of San Mateo) added that in San Mateo, they are a single accountable entity responsible for both primary and specialty care.
    - 3) Ed Bloch, MD (Medical Director, Children’s Medical Services, Los Angeles) explained that they already authorize primary care and case manage primary care when it is related to the CCS eligible condition.
    - 4) Laurie Soman (Director, Children’s Regional Integrated Service System (CRISS)) there is a need to distinguish between the major change in the organization of care that is envisioned under Options 2 (CCS Collaborative) and 3 (Children’s Hospital Based ACOs). Ms. Soman asked Ms. Schlageter to elaborate on better integration of primary and specialty care in CCS+ as opposed to some major organization of the system: Does it involve primary care authorization, or perhaps better integration of the medical home?
    - 5) Ms. Schlageter commented that there is a question about capacity and on workload for nurses. Currently, Nurses’ capacity to do intensive care coordination is challenging.

- d. Ms. Kent asked for elaboration on the regionalization concept in terms of what the regions would be doing. One issue is inconsistency in eligibility from county to county where authorizations might differ across counties. She asked for Ms. Schlageter's thoughts on how this could be standardized.
  - 1) Ms. Schlageter provided the example of the coastal regional meeting and the collaboration developing between the organizations within that [catchment].
  - 2) Ms. Kuhns commented that this is partly a State leadership issue.
  - 3) Ms. Soman added that it has been problematic for State staff. She also commented that differences between counties have been addressed significantly over the years.
  - 4) Ms. Altman commented that the State has a strong role in consistent interpretation.
  - 5) Ms. Schlageter summarized the idea of regionalized administrative oversight.
3. **California Children's Hospital Association Model, presented by Ms. Ann-Louise Kuhns, President and CEO of the California Children's Hospital Association (CCHA)**
  - a. PowerPoint slides for Ms. Kuhn's presentation can be found [here](#).
  - b. Ms. Kuhns began with an overview of California Children's Hospitals and presented the following suggestions for the redesign of CCS:
    - 1) Model Concept: Create new organizations known as, "Kids Integrated Delivery Systems," that are responsible for primary care but not NICU services. Reimbursement methods may include capitation.
  - c. Ms. Kuhns noted that CCHA's proposal aligns with the Department's goals and that she welcomes input in terms of next steps.
4. A summary of the **RSAB Questions and Discussion** session following Ms. Kuhn's presentation is included below.
  - a. Judith Reigel (Executive Director, County Health Executives Association of California) asked for clarification on the groupings and models associated with the NICU population, the CCS-only population and the CCS/Medi-Cal population.
    - 1) Ms. Kuhns answered that the proposal was to take all kids other than NICU and CCS-Only. From CCHA's perspective, NICU causes fragmentation. CCHA feels that NICU will not be properly served under this model.
    - 2) Dr. John Cleary (Vice President/President Elect, California Association of Neonatologists) commented CCS Redesign is an opportunity to describe the gatekeepers and if the final action is to exclude NICU, that decision shouldn't be made hastily.

- 3) Dr. Bloch commented about the gatekeeper issue stating that the majority of kids do not go through NICU to CCS and asked why not include NICU in the model?
- 4) Ms. Kuhns answered that CCHA is open to including NICU.
- b. Susan Mora (CMS Program Chief, Riverside County Department of Public Health) asked how the proposal impacts CCS' ability to send children across the State or country when needed for care.
  - 1) Ms. Kuhns answered that the relationship with CCS would not change. Utilization review would occur in care management.
- c. David Souleles (Deputy Agency Director, Orange County Health Care Agency) commented that risk still resides with the State and Counties. He then asked how case management activities parse out between a County CCS case manager and a case manager in a KIDS's Network.
  - 1) Ms. Kuhns the proposal incorporates MTP, care management, utilization review, and opportunity to figure out and align these functions accordingly.
- d. Arlene Cullum asked how to justify not including children's hospitals.
  - 1) Ms. Kuhns recognized the excellent care taking place in facilities that are not the designated children's hospital under the California law, the proposal lays out a network that is designed to treat the whole child and not a condition.
- e. Tom Klitzner commented that cost may be reduced by decreasing the utilization of expensive services. He then asked what the cost is that can be incorporated into the care coordination system.
  - 1) Ms. Kuhns answered that it is dealt with in developing what the outcome measure should be and then being held accountable for that.
- f. James Gerson (Vice President & Senior Medical Director, Health Net) asked Ms. Kuhns to expand on her vision for primary care.
  - 1) Ms. Kuhns answered that they are still looking to figure this out and that they are looking at data related to the dispersal of primary care, how many primary care providers (PCPs) are seeing kids outside of specialty care management and so on.
- g. Ms. Kent commented that there are not many pediatricians in the FFS network because the market has followed the population. She then asked for clarification of carve out on a fee-for-service basis.
  - 1) Ms. Kuhns answered dependent upon the State/County fiscal aspect, the model can accommodate fee-for-service or managed care.
- h. Domonique Hensler (Director, Care Redesign Planning for RCHSD & Network, Rady Children's Hospital – San Diego) commented that in terms of capitated risk, full capitated risk is preferred because a two-step system is less nimble.



## Presentation on Medical Therapy Program

5. **CCS Medical Therapy Program, presented by Ms. Tonya Erickson, Public Health Program Manager, Monterey County Health Department – Children’s Medical Services**
  - a. PowerPoint slides for Ms. Erickson’s presentation can be found [here](#).
  - b. MTP is a program within the CCS program that provides medically necessary physical therapy (PT), occupational therapy (OT), and medical therapy conference or clinic services (often referred to as MTC). Services are provided in school-based outpatient rehab centers called Medical Therapy Units (MTU). Many of these are certified as medical outpatient rehab centers and must maintain all standards as such.
  - c. The MTP conditions are a subset of the existing CCS eligible conditions and are generally long term, physically disabling, and due to neurological or musculoskeletal disorders such as cerebral palsy, spina bifida, Muscular Dystrophy, Rheumatoid Arthritis, Spinal Cord injuries etc.
  - d. MTP services are provided up to the age of three. Then physical findings are reviewed to determine if they will transition into CCS.
  - e. Because MTP uses two data systems: MTU Online and CMSNet, and use of these systems is not consistent across counties, it is difficult to get an accurate count of the MTP population at any given time. For May of 2014, MTP represented 13.3% of the overall CCS caseload.
  - f. MTP Funding: is split 50/50 between County and State. In 2014-2015, the MTP State Appropriation was 62.6 million which the counties matched and the amount expended was 90% of that.
  - g. MTP residential and Financial Eligibility Similar to the CCS program: MTP clients must be residents of the county of application. Documentation status does not apply.
  - h. The programs provided by MTP are:
    - 1) Medically necessary PT and OT.
    - 2) Medical therapy conferences with physician oversight.
    - 3) MTP also provides durable medical equipment (DME), orthotics, and braces.
    - 4) School consultation and attendance of Individual Education Plan (IEP) meetings
  - i. MTP is inherently linked to the overall CCS administration and care coordination services.
6. A summary of the **RSAB Questions and Discussion** session following Ms. Erickson’s presentation is included below.
  - a. Ms. Dodson asked how new models might leverage MTU locations since they may be in areas that lack a traditional set of medical providers and specialists.



- 1) Ms. Erickson responded in a rural setting, MTP plays a key role in coordinating services and conferences. One advantage of the MTP is that they are in the school, in the community where the child lives.
- b. Mary Doyle, MD, (LA County CCS) identified MTP as an untapped infrastructure and a bridge between the regional center, the school district, etc.
- c. Dr. Bloch commented why not go to the extent of creating full medical facilities at the school sites?
- d. Chris Dybdahl (Santa Cruz County Administrator for CCS) commented that the number of MTUs used is about one eighth of the total.
- e. Dr. Klitzner commented MTP is a ready source of rehab medicine. It is figuring out how we integrate the providers into the other needed services that will be required by the regionalized ACO-like organization. How would you frame approaching the issue for non-MTU clients but kids in rehab medicine?
  - 1) Ms. Erickson agreed pediatric PT and OT is mostly exclusive to the MTU and funding sources are also an issue since MTU services are generally expensive.
- f. Nick Anas, MD, (Specialty Care Coalition) suggested that the group understand the MTP better, utilize technology like telemedicine to make connections from the outside, improve communications, control cost, and improve outcomes.
- i. Ms. Wunsch announced the next section and introduced the following presenters:
  - 1) Dr. Doyle, Associate Medical Director for Los Angeles County Children's CCS Program, Dr. Mona Patel, and Dr. Matthew Keefer from Children's Hospital Los Angeles (CHLA), AltaMed Program. Dr. Patel is a Medical Director for the Pediatric Patient Centered Medical Home for CSHCN at AltaMed/CHLA and Dr. Keefer is the Associate Chair of Outpatient Pediatrics and the Director of Utilization for the AltaMed/CHLA Medical Group Independent Practice Association (IPA).
  - 2) She also introduced Ellen McBride, Case Manager for Partnership Health Plan Members linked to the CCS Program and Regional Centers.
  - 3) She then introduced Dr. David Bergman, Medical Director for the Complex Primary Care Clinic at the Lucile Packard Children's Hospital, to talk about the Center for Medicare and Medicaid Innovation (CMMI) Care Grant.

## **Session II: Presentations on Current Models**

7. ***LA County CCS Enhanced Case Management/Care Coordination Project, presented by Mary Doyle, MD, Associate Medical Director, LA County CCS.***
  - a. PowerPoint slides for Dr. Doyle's presentation on can be found [here](#).
  - b. The Project is launched 2/10/14, targeting 4,000 cases and sorted them by complexity of case management need, and then sorted again by health status

- group (1-9). With 1 being children who would not qualify for CCS because they only need primary care, and 9 representing children who are critically dependent on medical technology.
- c. Case Management Interventions
    - 1) The most striking difference between the two caseloads was that the complex cases received an introductory call, a detailed needs assessment, and a medical home. The less complex cases received a letter.
    - 2) Both groups received authorizations. The complex group received a set of referrals. In this case, referral meant something that the CCS Program could not authorize but was an identified need that the family required.
  - d. Preliminary Findings: Through 2/9/15
    - 1) Nurse satisfaction was 100%
    - 2) Data collection and entry by nurses – 60% of their work day was entering and collecting data.
    - 3) Care coordination and case management improved and was evidenced by better identification of medical homes and higher rate of completion of initial assessments.
      - i. Resources were provided
      - ii. Sibling support was provided
  - e. Emerging Conclusions
    - 1) While stratifying patients by CCS medically eligible condition does not work, stratifying patients by complexity of need works better.
  - f. The model needs:
    - 1) Stratification and accurate ICD-9/10 coding are necessary
    - 2) Database and software put in place for case management
    - 3) Overall, she was very pleased with data capture, though revisions needed to reflect the workflow of case management
  - g. The model aligns with each of DHCS' CCS Redesign goals.
8. A summary of the **RSAB Questions and Discussion** session following Dr. Doyle's presentation is included below.
- a. Ms. Kuhns asked if non-complex cases of care management could be moved away from a nurse.
    - 1) Ms. Doyle answered there is a group of cases where, given good oversight, some processes and procedures can be automated.
    - b. Dr. Schor asked two questions: 1) How were comorbidities figured out? and 2) What would you change in the model at this point after having tested it?
      - 1) Ms. Doyle answered that the target group was comprised of new and existing cases. To answer Dr. Schor's second question there is a definition that they are working on to help speed things up.
  - c. Dr. Bergman asked if Ms. Doyle could elaborate on their data collection techniques.



- 1) Ms. Doyle answered that the data came from family and staff surveys, the health status group, ICD-9, and V codes provide information. Additionally, the nursing interventions are coded and may be pulled.
  - d. Ms. Wunsch introduced Dr. Patel and Dr. Keefer to speak about the AltaMed/CHLA project.
9. **CHLA/AltaMed Medical Home Project, presented by Mona Patel, MD, Medical Director for Pediatric Patient-Centered Medical Home for Children with Special Health Care Needs, AltaMed CHLA and Matthew Keefer, MD, Associate Chair of Outpatient Pediatrics, Senior Deputy Division Head of General Pediatrics and the Director of Utilization for the AltaMed-CHLAMG IPA.**
- a. PowerPoint slides for Dr. Patel and Dr. Keefer's presentation on can be found [here](#).
  - b. Program Review
    - 1) Started with the hiring two care coordinator (now, the program has a total of four care coordinators as well as one full time equivalent medical assistant)
    - 2) 882 patients and families with special needs are currently enrolled.
    - 3) PCMH Program:
      - i. The primary care pediatrician refers families in need of care coordination with a warm meet-and-greet between the family, care coordinator, and the clinic's care coordinator.
      - ii. A one hour intake is scheduled with each family.
      - iii. Phone calls are made every 3 months and in-person meetings are held every 6 months and as needed.
      - iv. Due to inadequate access to specialty care, difficulties, and access to urgent care, they are able to produce a comprehensive medical home for the entire clinic. Some specialties include: optometry, orthopedics, neurology, gastro intestinal, cardiology, allergy immunology, child psychiatry, psychology, social work, and nutrition.
      - v. Evaluation is performed using the medical home family index.
  - c. Primarily a care-based model that coordinates all specialty services. Multidisciplinary rank is also used to help with those cases that are extremely difficult to coordinate, multiple no-shows, and multiple hospital visits. An integrated interdisciplinary round system is used bi-weekly with the entire case management team looking for out of the box ideas to help the family face their challenges.
  - d. Preliminary Data Review
    - 1) Overall within one year of enrollment in the patient centered medical home (PCMH), ER visits were decreased by 21% and inpatient hospitalization by 10%.
    - 2) ER visits decreased by 39% and inpatient visits by 59%.
    - 3) These findings allowed the AltaMed Corporation to fully fund the staff.



- 4) 5 year review is currently underway.
- 5) ER visit causes are being investigated to prevent them.
- 6) For inpatient admissions, one category that is proving difficult is surgical.
- e. Dr. Keefer addressed the model's adherence to the CCS Redesign Goals.

10. A summary of the **RSAB Questions and Discussion** session following Dr. Patel and Dr. Keefer's presentation is included below.

- a. Ms. Altman asked for clarification on treatment of both CCS and non-CCS children with equal reimbursement.
  - 1) Dr. Keefer answered service is not affected by CCS designation the issue is the ability to coordinate care.
- b. Richard Rabens, MD (Kaiser Permanente Northern California State Programs) commented on the bifurcation of payment model that has been set up and the benefits with this setup.
  - 1) Abbie Totten (Health Net, Inc.) commented, that is why the market share of the FQHCs and managed Medi-Cal is growing exponentially every year.
  - 2) Dr. Keefer commented that by putting primary and specialty care together, there is a savings to be had.
- c. Ms. Soman asked what kinds of quality measures are being followed to ensure reduced utilization is also equating to improvements in outcomes and how the savings are being invested.
  - 1) Dr. Keefer responded there are no significant savings and patient satisfaction has been "through the roof" in response to the second part of Ms. Soman's question.
  - 2) Dr. Patel added that the main thing they are looking at in the family index is patient satisfaction. Specifically, increased visits.
- d. Next, Ms. Wunsch introduced Ms. McBride to speak about Partnership HealthPlan as a model having children carved in to a managed care plan while certain Partnership counties are carved out.

11. **Partnership Health Plan Model, presented by Ellen McBride, Case Manager, Partnership HealthPlan of California**

- a. PowerPoint slides for Ms. McBride's presentation on can be found [here](#).
- b. Two Models of CCS at PHC
  - 1) 10 counties are carved out, 4 are carved in.
- c. Carve-Out Model
  - 1) CCS counties can be dependent or independent.
    - i. Dependent counties send everything to Sacramento for review and approval.
    - ii. Independent counties do all of this themselves.
  - 2) CCS works with Partnership on coordination of service, with Partnership being responsible for providing services not under CCS conditions.

- 3) All CCS conditions are paid through State Medi-Cal with the CCS provider billing the State for those services.
  - d. Carve-In Model
    - 1) The carved in model counties include: Napa, Solano, Yellow, and Marin. All of these counties are independent.
    - 2) CCS handles eligibility and authorizes services.
    - 3) Claims go to Partnership where they are reviewed in conjunction with the service authorizations that CCS has completed. Then, the provider sends the claim to Partnership for payment.
  - e. Experience with Carve-In Model
    - 1) The carved in model allows Partnership to work with CCS and be the primary contact. This increases continuity of care, opens communication with all parties, and reduces fragmentation of care.
    - 2) Partnership strives for a high level of customer service which includes: continuity of care, access to care, physical responsibility, and coordination for the whole child.
    - 3) Services include: available staff, member focus groups, community trainings, partnership care coordination regarding the CCS model, quarterly meetings with CCS agencies in other areas, and quarterly meetings with all their CCS counties together.
    - 4) Care coordination staff meets with each of the counties, CCS, and regional centers quarterly.
    - 5) Internal systems flag CCS members, track authorizations, and track when CCS opens and closes cases.
    - 6) 4 special program case managers are assigned by county.
      - i. They work on transitions.
      - ii. They also work with tertiary care centers.
  - f. Benefits and Cost of the Carved-In Model
    - 1) Benefits include the fact that it is a one-stop shop for coordination; single point of contact; improved communication between CCS and Partnership; good working relationships with parents, advocates, and CCS providers.
    - 2) Costs of the model are that the model is expanding, which results in additional cost related to additional partnership staff and administration costs.
  - g. Ongoing Work
    - 1) Areas that are working well include: effective communication, efficient problem solving, improved condition of the whole child; and continuing development
    - 2) Areas that they are continuing to develop are improvements in CCS data availability for plans and increasing CCS providers in rural areas.
12. A summary of the **RSAB Questions and Discussion** session following Ms. McBride's presentation is included below.

- a. Ms. Altman explained that they are now subcontracting with the CCS County program to solve issues and MTU and benefit eligibility determinations are outside of the pilot.
  - b. Athena Chapman (California Association of Health Plans) noted that increased data capacity improves communication so that it can be known when a child is receiving services, thus improving care coordination.
  - c. Dr. Rabens commented that Kaiser hospitals have their own pediatric residencies and participate in training residence from a variety of other medical school programs.
  - d. Dr. Schor asked, to what extent they were able to perform quality oversight and give feedback to the State for those providers who were not compliant with State standards in the carve-in pilot?
    - 1) Ms. McBride answered that the State audits Partnership. Essentially, they incorporate the evaluation of providers, internal quality improvement, quality assurance, and the State's auditing in cooperation with CCS paneling projects.
  - e. Ms. Soman asked for clarification on how Partnership sees the importance of the relationship between separations of authorization in payment and asked if Ms. McBride sees this as an issue moving forward if more carved-in arrangements were rolled out.
    - 1) Ms. McBride answered that Partnership has been proactively seeking providers and is working with some of the northern counties to expand the provider network for both CCS and Partnership.
    - 2) Ms. Altman commented that the only provider they are targeting right now is UCSF.
  - b. Ms. Kuhns asked for clarification on carved-in and carved-out counties.
    - 1) Ms. McBride clarified that of the 6, 5 have the County CCS utilization review, authorization and eligibility separate.
    - 2) Ms. Kuhns also commented on the patient/family satisfaction score.
  - c. Ms. Dodson commented that there are organized delivery systems already in existence and DHCS does not want to disrupt those.
  - d. Ms. Wunsch then introduced Dr. Bergman.
13. ***Caring for Children with Medical Complexity, CARE (Coordinating All Resources Effectively) Model, presented by David Bergman, MD, Associate Professor of Pediatrics at Stanford University School of Medicine, Stanford/CMMI CARE Grant***
- a. PowerPoint slides for Dr. Bergman's presentation on can be found [here](#).
  - b. Outlined funding for the CARE project, which is an innovation award from the Center for Medicare and Medicaid (CMS) of \$23 million over three years, focusing on payment reform and care delivery reform
  - c. An overview of the target population, which is a subset of CSHCN, children with medical complexity, what they are doing with care coordination, and how dynamic care teams improve access to care and outcomes.

- d. They proposed a three-tier system of care
    - 1) Tier 1: Community pediatrician
      - i. Hospital-based complex care program where primary care and complex care for the sickest of kids can be provided.
    - 2) Tier 2: Advanced medical home
      - i. Established, interested community practices would undergo quality improvement and transformation to be able to care for kids with medical complexity. Shared services are also provided in terms of care coordination and social work support.
    - 3) Tier 3: Hospital-based complex care clinic
      - i. The idea is to be able to move the children from the hospitals to the community based programs as their health status improves or vice versa.
  - e. Explained Dynamic Care Teams, which are patient-focused, and the Tailored Access Plan, which let families know exactly who to call and when. For some families this may be a single person, whereas for others they may want separate access to specialists etc.
  - f. Explained how they are measuring outcomes for the project by using Medicaid data, gather data the number of hospital pays, outcomes, and access to care.
14. A summary of the **RSAB Questions and Discussion** session following Dr. Bergman's presentation is included below.
- a. Dr. Klitzner commented "Who is the right person to do the job that needs to be done?"
  - b. Neal Halfon, MD, (UCLA Center for Healthier Children, Families, & Communities) commented that it is all about innovations focusing on optimizing the health of the kids and their families over time.
  - c. The question was raised whether Dr. Bergman's team worked with CCS County and State teams to gain access to some of the care coordination data from CMSNet. Also if he believed that would help things because the data is more real-time.
    - 1) Dr. Bergman responded he is confronted with having 10 different programs, adding that compromises were made and predictive algorithms were used.
  - d. Dr. Cleary asked how the State makes programs that are sustainable, duplicable, and expandable.
    - 1) Ms. Dodson commented that the outcome measures technical workgroup (TWG) will be working on these issues soon.
  - e. Ms. Wunsch thanked all the presenters and those joining the conversation. She then announced a lunch break.
  - f. Ms. Wunsch called the meeting back to order and introduced the next presentation, which would include a literature review conducted on CCS



programs similar to California and programs from other states that might be applicable in California.

## **Overview of Existing Models**

### **15. *Overview of Existing Models*, presented by Michaela Ferrari, UCLA Center for Health Policy Research, and Jessica Schumer, MD, UCLA Center for Healthier Children, Families, & Communities**

#### **a. Overall System of Care Highlights**

- 1) Partners for Kids, Pediatric ACO at Nationwide Children's Hospital in Ohio, is a hospital based organization, provides care for over 300,000 Medicaid managed care.
  - i. Improves access in rural areas by providing preferential rates in areas of low penetration.
  - ii. Includes pro-active care coordination for complex patients and high Emergency Department (ED) users as well as resources and education to parents and caregivers, particularly during discharge about how to manage care.
  - iii. The majority of doctors are salaried. However, PCPs are paid a percentage above the Medicaid fee-for-service rate as a quality-based incentive to those who are contracted.

#### **b. Medical Home Highlights**

- 1) The program is staffed by one pulmonologist and two Nurse Practitioners (NP) for primary care along with a nutritionist and social worker for specialty care. Other specialists have a monthly rotation and appointments are made as needed with those specialists when they are present.
- 2) Vermont's state-based health care reform initiative (or "Blueprint for Health") provides medical homes with community health teams for all residents. The program is staffed largely by community health teams which are paid on a population basis by private insurers.

#### **c. Regional Networks and Oversight Highlights**

- 1) The Community Care of North Carolina (CCNC) Medicaid Care Manager Program provides oversight of 14 regionalized networks across 23 counties including care for CSHCN. Two main components of this program are 1) Embedding children's specialty care managers in hospitals and specialty clinics who work coordinating providers, and 2) Patient coordinators that provide assistance to families in navigating the system. Payment is made by the State as two per member per month (PMPM) fees for each enrollee—risk-stratified care coordination.
- 2) The Florida Children's Medical Services Network is a specialty Medicaid Managed Care program for children up to the age of 21 who meet certain criteria, which is similar to California's CCS program. They have

a large system of providers across the State in a very coordinated system of managed care.

**d. Care Coordination and Patient Navigation Highlights**

- 1) Rhode Island Pediatric Practice Enhancement Project included partnership of multiple organizations including the Department of Mental Health, American Academy of Pediatrics (AAP), and Family Voices.
- 2) Illinois' program includes two-person care coordination teams—one clinician and one social worker to manage each patient and provide access not only to specialty care, but also to information on how to use insurance benefits, navigating the system, at home training for care of children outside the system, and referrals to community resources.
- 3) Florida's program places State-employed care coordinators in primary care practices to provide oversight of care coordination roles.

**e. Family and Child-Centered Care Highlights**

- 1) Several states have hired patients for their time and input via stipends or salaries. This formalizes the relationship and provides compensation.
- 2) Detroit Children's Hospital has family in executive/leadership roles
- 3) Colorado has a family Leadership Registry, which is a database of families and usage leaders for children with special needs, including their areas of expertise and competencies.
- 4) A leadership training program, based on the Connecticut Parent Leadership Training Institute, has been in place for parents for about 20 years.
- 5) Minnesota's Medical Home Learning Collaborative includes parent-to-parent skills classes
- 6) Vermont provides financial advice to families
  - i. A parent of a child with special needs, who is also affiliated with the Medicaid agency, has been hired to provide financial advice to other parents.

**f. Data Collection and Communication Systems Highlights**

- 1) Washington D.C. Medicaid program provide care coverage for children with special needs, and requires use of an additional billing code in the well-child exam to provide additional screening data.
- 2) Other States
  - i. State registries have been integrated.
  - ii. Florida and Oregon both use web-based assessments in care coordination plans so that multiple providers may communicate better about the patient's management across domains.
  - iii. Ohio's Nationwide and Cincinnati Children's Hospital have data warehousing capabilities so that providers can share and access unidentified information quickly and easily.

16. Ms. Wunsch thanked Ms. Ferrari and led the questions or comments. A summary of the **Question & Answer** session following Ms. Ferrari and Dr. Schumer's presentation is included below.
  - a. Ms. Soman commented that there are issues of scale. For instance, Rhode Island is smaller than Alameda County, Vermont is smaller than San Mateo and Orange County is roughly the size of Connecticut.
  - b. Ms. Kuhns commented that California's CCS standards are unique to California.
  - c. Ms. Dodson commented that analysis of these models gives us valuable insight in care coordination, but given the complexity of some of the County rules, we need to figure out how all the pieces can fit together.
    - 1) She added that a couple of specific take-aways would be the ideas surrounding the role of parents and the types of connections that are made with partners.
  - d. Dr. Schor expressed disagreement with Ms. Dodson's comments and the State's position. He added that the group should think creatively about the best thing they can do for children and families and he fears that expediency is not the right path to take because it might lead to inadequate change as opposed to the incremental change that is needed.

### **Small Group Activity**

1. Ms. Wunsch transitioned into the small group activity. A copy of the **Breakout Discussion Exercise** can be found [here](#).
2. Dr. Roby described that the groups would be randomly selected and explained the exercise. He also called everyone's attention to the **Overview of California-Specific Models Document** (available [here](#)) as a reference for the exercise. He summarized the exercise, stating that it is intended to get a sense of what components are the most appropriate and best for improving the health of the CCS population.

### **Debrief from Small Group Sessions**

1. Ms. Wunsch reconvened the meeting following the small group breakout session and led the discussion to debrief from the small group activity. Summary take-aways of the feedback provided by the RSAB is included below.
2. **Question 1: Care Coordination Model Components**
  - a. Need to recognize "whole child" or "whole family/family-centered" approach and integrate Primary and Secondary Services
  - b. Provide culturally and linguistically competent/sensitive care and families should be involved in decision-making
  - c. Tiering, Risk Stratification, Acuity Tool, Targeting



- d. Data – Structure, Access, and Use
  - e. Importance of Medical Homes
  - f. Staff Roles and Responsibilities
  - g. Clearly define the distinction between care coordination and case management
  - h. Determine and/or designate level at which care coordination is provided
  - i. Suggest the level at which care coordination is needed
  - j. Structured Intake and Initial Assessment Care Plan and Onboarding Process
  - k. Payment & Billing
- 3. Question 2: Model Components in Other Areas**
- a. Access to Care
  - b. Adequate Resources
  - c. Infrastructure
  - d. Eligibility
  - e. Transition to Adult Care
  - f. Other Comments/Questions/Concerns/Suggestions
4. Ms. Wunsch announced that the UCLA team would collect take worksheets and staff notes to compile for the meeting summary.
5. She then announced the final portions of the meeting as updates from the technical workgroups and public comment.

### **Updates from Technical Workgroups (TWGs)**

- 6. Data TWG**
- a. Dr. Lee Sanders, Co-Chair of the Data TWG, summarized that the workgroup has met twice and a Data Request Form has been distributed to solicit data requests from the other TWGs and asked if the RSAB could identify any other public sources of data that might be able to inform questions.
  - b. Brian Kentera (DHCS), also a Co-Chair of this workgroup, added that members should make sure that the information on the forms is as clear as possible so that the data team could contact them for any further questions or concerns regarding the submitted data request. Materials and meeting information for the Data technical workgroup can be found [here](#).
- 7. Eligibility / Health Conditions TWG**
- a. Dr. Bob Dimand, Co-Chair of the Eligibility TWG, summarized the initial meeting of the workgroup and concluded by saying that next steps include posting current eligibility guidelines, neonatal intensive care unit numbered letters, and hopefully a consensus document from all 58 counties in agreement of interpretation. These, he mentioned, should serve as fruit for



discussion for the next workgroup meeting. Materials and meeting information for the Eligibility technical workgroup can be found [here](#).

#### **8. Other Groups**

- a. Ms. Dodson echoed Dr. Dimand's comments and touched on the work that she is involved with in other stakeholder groups led by the Department and noted how they function together.
- b. Ms. Ferrari clarified that the Outcome Measures and Quality TWG Kick-Off webinar would take place on April 4 from 1-3 pm. She also asked any RSAB or TWG members who have not received the Data Request Form to let her know so that it may be distributed. Materials and meeting information for all six CCS Redesign technical workgroups can be found [here](#).

9. Ms. Wunsch closed the technical workgroup update portion of the meeting and opened the floor to members of the public.

#### **Public Comment Period for Audience Members**

10. Wendy introduced herself and expressed her desire to add to the presentation on the Medical Therapy Program.
  - a. She stated that refusal of the statewide organization to craft a new Interagency Agreement that is legally compliant has resulted in increased litigation between educational agencies and DHCS. She suggested that the work started with AB 114 be finished and the relationship be severed to allow local agreements as appropriate. She then thanked everyone for their help with his matter.
11. Ms. Kuhns asked if the litigation was a way to reduce County processes associated with some sort of realignment
  - a. Wendy clarified that the mental health services that were previously provided to students with disabilities was eliminated by County mental health
  - b. Ms. Kuhns asked about State mandated local programs.
  - c. Wendy answered that integrating MTP are counterintuitive to what occurred two years ago and described the two pieces of litigation pertinent to the issue.
12. Ms. Wunsch then closed public comment and announced the last portion of the meeting.

#### **Wrap-Up, Closing, and Next Steps**

13. Ms. Wunsch announced that the next meeting is scheduled for May 29 and that it will be held at the Sacramento Convention Center. She then asked Dr. Roby to provide closing remarks.



14. Dr. Roby thanked everyone for coming and commented on common themes in the feedback provided. He went on to remind everyone that feedback from all was encouraged and would be integrated into the decision-making process.
15. Dr. Roby announced that the next meeting would focus on two components: Reports from the technical workgroups and a design meeting where the group would think through these issues and model design components that came up as important to the group.
16. Ms. Dodson thanked everyone again and highlighted the fact that this process is very important to DHCS and that all of the feedback is appreciated. She solicited feedback from everyone and then adjourned the meeting.

**END**