

California Children's Services (CCS) Redesign Redesign Stakeholder Advisory Board (RSAB) Meeting #4

Appendix A: Post-It Note Transcript

This document includes a complete transcript of the Post-It notes collected during the Small Group Breakout Discussion Exercise for the fourth Redesign Stakeholder Advisory Board (RSAB) Meeting held on June 22, 2015, in Sacramento, CA.

Questions and comments are sorted into two categories to distinguish feedback from (1) the Advisory Board and (2) the Public. Bracketed text refers to illegible writing on the Post-It notes. Where possible, we added text in brackets to attempt to clarify feedback based on what we could decipher from the written notes.

Question 1: What do you recommend as components of readiness assessment for health plans with the new CCS Whole-Child Model?

Advisory Board

- Data on current pilots should be made available so plans can learn/adjust before implementation. Needs to happen at each phase.
- Robust CCS paneled provider network. Current experience with CCS kids/youth.
- Demonstrate that the network infrastructure and care management approach increases integration.
- History of and degree of communication, coordination, collaboration that exists prior to transition.
- Plan readiness – is there software to be used by plan case managers to not only use for complex case coordination but to guarantee acquisition of data (and analysis of data)
- Plan readiness – How will plans be assessed for having hired and educated those (necessary) case managers with experience/expertise in complex case management.
- Social service staffing
- Care navigators
- Detailed plan or how plan intends to coordinate care with plan partner(s) who may already provide whole child care.
- Have on board a trained cadre of care coordinators including SPMP [skilled professional medical personnel] social workers (refer to medicalhomeinfo.org(?) series on complex med case management)
- For out of network providers – at a distance provision for transportation
- Primary network adequacy. Pediatrics
- Care management staffing
- Specialty networks adequacy
- Readiness – Should include plans for BH [behavioral health] and transitions
- Network – adequacy E.g., special needs medical homes (AAP-defined)
- Network adequacy for all CCS conditions?
- Require all plans to use current CCS staff to produce case management
- Behavioral health support
- Network adequacy – Board certified pediatricians (& those who are CCS-paneled) who will be part of the whole child approach

- A measured (meets performance?) transition from case management from county CCS programs to MCMC [Medi-Cal Managed Care] case managers
- All plans need to demonstrate an ability to rapidly respond to appeals to denials of care.
- Pediatric medical director at each MCO
- Provider network established
- Plan readiness – Can existing software models be used (such as the LA County model with its proprietary software)?
- Require contracts [c] broad array of CCS-Approved [30/40] hospitals, special care centers, & providers [a] implementation
- Readiness Review – Disruption and displacement of care across counties out of network
- Care management readiness – Consider NCQA [National Committee for Quality Assurance] as a requirement
- Mechanism in place for families to seek 2nd opinions and/or treatment outside of plan.
- Relationships in place for SCCs that doesn't exist in health plans' current region/network
- "Readiness assessment" should extend to "continuous readiness monitoring & evaluations" and option to pull CCS from plan(s) if "readiness" drops
- Family providers advisory committee established
- Quality metrics proposed
- Have on board a trained cadre of care coordinators including SPMP [skilled professional medical personnel] social workers. (Refer to medicalhomeinfo.org? series on complex med. Case mgmt.)
- Care navigators
- Social service staffing
- Plan readiness – is there software to be used by plan care mgrs. to not only use for complex case coordination but to guarantee acquisition of data (analysis of data
- Plan readiness – How will plans be assessed for having hired and educated those (necessary) case managers with experience/expertise in complex case mgmt.
- Data on current pilots should be made available so plans can learn/adjust before implementation – needs to happen @ each phase.
- History of and degree of communication
 - Coordination, collaboration that exists prior to [...]
- All health plans should adopt EMR [Electronic Medical Records] and case management records that are transferable and readable in every other county, to allow freedom of movement, change of residence
- Health plans should not be allowed to bring up CCS whole-child unless they have contracts and all CCS providers
- DHCS should have an obligation to report to RSAB & the legislature what the evidence is for this model. What is baseline – parent satisfaction; timeliness access to care; and rate of service denials. DHCS must report this before moving forward.
- Family advisory panel in place to review cases, etc.
- Care management staffing
- Primary network advocacy. Pediatrics
- For out of network providers – at a distance – provision for transportation
- Timeline is dependent on the COHS [County Organized Health Systems]? And the providers being aligned philosophically – core guidelines, [?] for refunds, etc. are complicated.
- Want to see evidence of COHS [County Organized Health Systems] performance as part of "readiness assessment" and implementation. Where are the data to support this proposal?

- Risk adjustment tool
- Eligibility clarifications
- Health Risk Assessment Standardized
- Policies + procedures needed + in place
- Readiness – Should include clear demonstration of support from county, providers, families, plans.
- Metrics identified to monitor
- Need IT support -> suggest independent IT technical group
- Use pilot families – test families before going live
 - Discharged family [MC]
 - New diagnosis C.F., C.P.
- Real-Time data (Monthly Review)
- Health plans at full financial risk for these children cannot be “made ready” to appropriately care for these children. Nothing you tag on for plans to do to be ready will change their over-riding incentive to defer/delay care. Readiness only matters if oversight and evaluation affect incentives.
- How will health plans provide risk appropriate assessment and allocation of services based on acuity of child’s condition(s).
- Data showing and coordination issues between primary and specialty care providers. How do we ensure that coordination is timely and smooth for kids and families?
- I need a better understanding of readiness requirement process. How will stake-holders be involved in development and review of proposals will the department be verifying what.
- Are there data models that can be used by plans, such as those that may have been developed for [SVSC] persons with disabilities?
- What needs to leave county? Model cost in advance i.e. cardiac
- Why start in the most vulnerable, rural counties? Virtually every child in those counties has to travel to reach CCS care.
- Is referenced in the proposals pre-requirements. Concerns in light of recent audit.
- Where is the data?? Worry about why we don’t have data. Readiness is having data now
- DOFFR – Division of Functional + Financial Responsibility
- Evaluation of financing proposal and impacts on all partners
- Readiness is having access to all the specialty care centers now – not waiting to demonstrate sufficient access based on population – things change
- Data – meaningful & outcome [u....] determined in advance, to be measured at intervals.
- Evidence of comprehensive provider network (in/out of county)
- Primary care pediatricians need to be in oversight committees
- No one has confidence that DHCS can do this well. There is no evidence that DHCS actually knows what plans are doing well.

Public

- Identification of “adequate” provider networks. I’d like detail of this along with geographic standards for “network”. (Our kids drive 2+ hours for care)
- Access to sub-specialists
- CCS specific network adequacy requirements that require choice (i.e., more than 1 option for care)
- Health plan funding for providers to establish required infrastructure for population management
- Continued capacity requirements must be built in and monitored AND repercussions for non-compliance. [Rebond?]

- Plan to enhance networks in a timely manner in response to changes in member needs
- Appropriate deep + wide specialty geographic language provider network
- Network adequacy – Distance, # of providers, disability access, culture and linguistics
- Integrated electronic health record is imperative
- Credible pay for performance for quality w/ providers
- Delegated PCP groups must be required to have the same or larger network than the plan
- Readiness assessment team should be independent of DHCS
- How will care be authorized appropriately according to standards by at an at risk plan?
- Does the health plans cover areas of the state to cover the client's need?
- No data to rely on as far the proposal is concerned. The proposal is being drafted because the sunset is coming up. Really need data to base the recommendation on.
- Same Dr.'s for care make sense. We do not have to change specialist.
- Readiness assessment must have family/parent participants. And they should receive stipends/funding.
- Shouldn't the readiness assessment be conducted by an independent evaluation, not DHCS?
- Readiness assessment for plans should reflect the role of the plans under the new model. The role of the plans under the new model needs to be very clean to develop the readiness requirements.
- A year of stakeholder meetings - to get the department original plan – we were promised input.
- Transparency ability around re-investment of savings
- Knowledge of CCS of health plan employees specifically as it relates to its plan partner contracts.
- Provide network & contracting; payment process– how do you pay authorizations that are done by CCS, but paid by Health Plan; County & HP relationship – who does what? By need buy-in from county.
- Look @ what meds & supplies are approved by CCS in incorporate into their formularies
- Transportation readiness – and a way to ensure there is reimbursement built into rates (what does this include? National? Statewide?)
- Ensure detailed plan for transportation to appointments (currently does not exist)
- Robust CCS paneled provider network; Current experience with CCS kids/your
- Established quality measures for PCPs
- Demonstrate that the network, infrastructure, and care management approach increases integration
- Detailed plan on how plan intends to coordinate care w/ plan partner(s) who may already provide whole child care
- Availability of sufficient number of medical staff, nurses, physicians to deliver quality services – not always done well by non-professional staff who don't understand needs of CCS clients
- Provider network readiness needs to be a matter of public record. All networks need to be ready prior to plans starting

Question 2: How can health plans most effectively incorporate whole-child values into their plan? How can partnerships with providers, county CCS, county mental health, regional centers, and other organizations be enhanced?

Advisory Board

- Care plans
- Incentives for co-location and team care
- Interdisciplinary care teams
- Member centric care plan
- Implement health homes at special care centers
- C&L issues [Cultural and Linguistic]
- What about partnership with families- They are key.
- Require a county collaborative to include: Regional Centers, Mental health, Special education, Families, Providers.
- Concern that health plans accepting full financial risk will impact service authorization decisions. How will values and fiscal realities be balanced?
- Rapid response teams to respond to specific family challenges would give important transitional information.
- Strict standard for network adequacy
 - Ask pediatric [subspecialty priorities]
- I love the LA children's complex care coordination model-presented 2 meetings ago
- Wouldn't it be more effective to incorporate more primary care into the specialty clinics? Is this avoided due to cost over outcome?
- Whole child – How can LA [County's] experience with an integrated unit at Children's Court-incorporating MH medical issues, foster care, DCFS, etc. be explored!
- Have offices located convenient for client family visits. Be able to gain trust of families to allow/invite home visits by care coordinators, case managers.
- Stakeholder group county by county meeting to look at ground level challenges
- Round table with all organizations to develop care plans for CCS clients
- We need risk pools for primary care and specialist with the COHS [County Organized Health Systems]/Counties
- Health plans can incorporate whole-child values IF incentives are aligned with these values. CCS must retain oversight/care coordination on role (or other disinterested financially entity) because plans values and incentives are at odds.
- MTP clients with third party coverage need to be addressed.
- MTP only clients need to be addressed
- Incorporate whole-child, don't lose specialty expertise
- How do we not lose the CCS expertise in moving CCS to plan?
- Procedures to share records
- PHI issues
- Expect NICU [t...] specialty clinic to validate adequacy of out-patient support
- Whole child? Actual spec needs, medical home available? / Willing to participate? At what enhanced rates?
- How will dental and vision care be incorporated?
- Whole child? – Boarded pediatricians
- Plans should detail their approaches to BH [behavioral health] access and transition
- The CCS paneling process needs to be streamlined to increase access and ensure these providers can be incorporated into the networks

- Whole child- How do we guarantee that improvements and best practices that already exist in CCS not be lost or diluted?
- Proposal violates fundamental concept that there needs to be fiscally disinterested decisions about access to medically necessary services- if this proposal moves forward, plans should be required to connect with [county] CCS to handle UM

Public

- Offer a POS type model for CCS patients
- Poor care will result from formularies that don't contemplate/accommodate this complex population
- Pull in CHDP knowledge for whole child
- Health plans should seek virtually integrated networks to be preferred providers, which would streamline UM, etc.
- Speaking from regional center perspective-the partnership is more on coordination and services and care managements so that there is no duplication of rates. Regional center provides care management and coordination. Health needs to work with RC systems so that process is more streamlined.
- Fragmentation will result from limited networks for lab and imaging services
- CCS approves by child's needs not money. Medical looks at money first then other agencies have to pick up the pieces.
- Health plans do not provide care. They manage the financial aspects of care. They need to allow CCS-providers to drive.
- Lessons learned from SPD [Seniors & Persons With Disabilities] and GHBP transition
- There MUST be partnerships with families/caregivers of children in CCS
- "Whole child" needs to be clearly defined in order to effectively incorporate whole-child values into health plans.
- Consider a model similar to Lucille Packard collaborative maybe a volunteer board?
- What about addressing transportation and maintenance for families that have to travel out of county?
- We have no data as to how many kids in a county have CCS. How can you solve a problem if you have not defined it properly?
- Work groups/advisory committee with other stakeholders/providers to give input on whole child care. Work together to ensure that everyone identifies and knows of the main care coordinator. Sharing of patient info, care plans, and case notes, with all providers. Creation of a data dashboard for quality indicators.
- Have nurses and medical staff have consistent caseload to allow for consistency and continuity of care for clients. Again, appropriate numbers of appropriate staff is essential to success. MMC plans need to [s...] up for this.
- Partnership enhancement- Go to counties and meet with groups. Would be happy to organize a meeting with CCS, Behavioral Health Regional Center and other county stakeholders and sure other CCS administrators would do the same

Question 3: What roles can the CCS family advisory committee in each county play? What key issues could the family advisory committee address: feedback on health plan access and continuity of care requirements; feedback on requirements around culturally and linguistically appropriate resources and readiness, including physical access; any other issues?

Advisory Board

- Does the care plan include family/child goals?

- CCS family advisory committee needs to be separate of the health plans so families can feel they can express themselves[...] retribution
- Consult parents on access, transportation as well as the topics listed in the question
- [Regional] [Subspecialty] Eligibility issues are always a concern (Basic [M/cal]).
- This model should not be implemented until DHCS can report on what is going on in current CCS corrections: Parent satisfaction for CCS families in managed care; denial rates for CCS; how long kids have to wait for services– compare current care in carve – out counties – where is it better?
- Family advice. How not to lose current “best practices?”
- Role: Process for evaluating patient satisfaction surveys
- Transition plan for youth to medical will need family advice & input. There is a large variability in skills, language, transportation hurdles
- Feedback on how meaningful the care plans are
- Communication with families about availability of care coordination
- Serve as conduit for other families’ comments
- Identify sub-populations at greatest risk
- As we improve adult transition – can we improve initial CCS system contract – NICU to home 1st subspecialist/regional center contact.
- Pair family advisory committee with representative sub-specialists to help define “optimal care” to protect
- Amplify the voice of families with limited literacy + language skills
- Design or select family experience surveys
- Monitor access + quality
- Transition should be addressed.
- Families serving on FAC must be funded (stipends) for their time, travel etc.
- Role – review of network for adequacy
- Give families decision making authority for critical elements – not just “advisory”
- Must meet frequently to have impact – quarterly?
- I read proposal as saying families and others “may be included” in the advisory committee. So how will that be decided?
- Agree on key issues
- The family advisory committee in each county is best suited to identify the intangible aspects of CCS that worked for them and their children. Whether it be quick authorizations or thoughtful responses to complex medical situations
- There is something that made CCS unique and worth fighting for that should be preserved and integrated into any new model of care

Public

- Mechanism for train staff in family centered care/customer service
- Meet with plans locally to discuss concerns and work to prepare and pre-empt for local challenges -> local meeting b/w stakeholders.
- What resource is available for families to help with the transition? Thousands of dropped calls to the ombuds during the healthy families’ transition. Should be a lesson learned
- What will the family involvement look like?
- Care coordination – focus on family/individual strengths to care for condition
- Unfortunately it will be ignored regardless. Can’t win against profit.
- Family Adv. Care (FAC) How can we be sure the FAC’s input, recommendations, advice will be heard, acted on, respected (not just given lip service)
- The Family Advisory Committees are important to a family centered approach. However, family-centeredness also includes many other components not identified in this proposal.

- Understanding of county challenges, lack of resources, length of travel for families etc., rural counties vs. non-rural.
 - Also cultural challenges w/ counties, more agriculture to serve higher # of undocumented families.
- CCS family advisory can tell you what is important to their child's care
- ID issues that families and patients are having
 - Feedback on the kinds of communication to family, and its effectiveness.
- Family advocacy organizations should assist w/ the transition by helping families navigate
- Help identify potential access issues, serve as advocates, etc.
- Advisory committee should address outreach to members
- Families are not represented at every aspect of the DHCS Plan – How will that change

Question 4: What components should be included in the county-health plan MOUs, around CCS care coordination and service authorization, given that the transition approaches may vary by county? Any other issues?

Advisory Board

- Require BD. cert ped [board certified pediatricians]/AAP [American Academy of Pediatrics] – defined medical homes for special needs children, etc.
- Make documented quality items part of MOU
- Pair authorizations with authorities on topic (Avoid denials without explanation)
- Currently \$ for meals, lodging and transportation is in the CCS Admin Budget and claimed based on client's insurance category (Medi Cal covered 100% by MC FFP [Federal Financial Participation?], OTLICP [Optional Targeted Low Income Children (OTLIC) Program] 17.5 state/17.5 county/65% Feds) etc. How will managed care plans continue to provide this very important access?
- Need to include MTP – role of health plan in coordinat[ing with].
- MOUs:
 - Data – meaningful
 - Outcome measured for whole child (school days missed, compliance with necessary care, etc.).
- Don't be too prescriptive! A lot of room for [stretching?] authorization requirement.
- MOUs – require data & outcomes measures that are meaningful & that can be pre-determined, for review after data available
- Local flexibility needed for county & COHS [County Organized Health Systems] to develop a plan that works for a county based on need.
- County CCS should be used as the case management contractor until the health plan can effectively take over.
- When is timeline for “application of interest” + process contemplated for this?
- CC [Care Coordination] responsibilities shared among CCS, plans + practices.
- Separate County (CCS) vs. health plan roles for authorizing services.
- Risk Adjustment Tool
- Standardize discharge planning
- Can the CCS program “pre-approve” certain subspecialty services – e.g. – authorize a “plan of care” for a child with Leukemia.
- Standardized care planning and care plans.
- Designate hospital-affiliated complex care clinics as health homes

- Consolidate NICU follow-up services
- Require ICPs [Individualized Care Plans] and ICTs [Interdisciplinary Care Teams]
- Stipulated follow-up interval and content for hospitalization.
- How will COHS [County Organized Health Systems] provide risk appropriate assessment and allocation of services based on acuity of child's condition(s)?
- Delineation of who is responsible for appeals/fair hearings based on decision in question
- Quality withhold metrics
- Health Plans should adopt and recognize all CCS paneled providers and all CCS qualified facilities throughout Calif. Maintain client/family choice.
- Can CCS approve "open access" to certain subspecialty care based on qualifying condition?
- Very concerned re: cross-county issues (most complex care leaving county?)
- MOUs need to be very clear about the responsibility of the plan vs. the county. They should include requirements for coordination and data sharing.

Public

- Timeliness
- Grievances and appeals
- Eligibility and enrollment; data sharing and access to IT systems (E-47, Business Objects, and MEDs); Utilization review responsibilities; UR [utilization review] timeframes (how quickly authorization requests are responded to); UR [utilization review] requirements, especially in regards to patients w/ OHC (Other Health Coverage) [primary?]; co-location of CCS staff w/ health Plan; medical director oversight (CCS vs. health plan).
- Clear delineation of what quality case management looks like. Not sure all MMC [Medi-Cal Managed Care] plans know this. Timely and appropriate authorizations are essential.
- Need to recognize care coordination at the provider level
- If families can't access the specialty care their child needs, care coordination, etc. is moot.
- Lessons learned from SPD [Seniors & Persons With Disabilities] & GHBP transition
- MOUs in some geo areas need to be multi-county
- Define role of health plan vs county
- Is there competency in the plan to do care coordination
- It has been said the MTP will continue to receive state funding. How will MTP receive referrals, medical clinic oversight without the admin piece of CCS?
- Data - ! Data! Data!
- Currently CCs is responsible to transition a child from 1 county to another when they were. Who will do this now?
- Can there be county-specific data?
- It's imperative that indiv. Counties & their respective plan are crafting their own MOUs – what is the plan for this?
- Why are decisions on changing the CCS program based on 2 counties carve-in models? How will this one size fits all approach supposed to work?
- Option for plans to contract with County CCS programs while maintaining enhanced Federal Financial Participation (FFP).
- I am concerned that MMCP's [Medi-Cal Managed Care Plans] will not see the value of health staff expertise over the financial incentive for the plans.
- Help pay for hotel, etc. when child is in [hospital] far from home for families
- Transportation verbage needs to be same as CCS

- What happens when a child moves from a “carve in” county to a “carve out” in this process
- Medical eligibility: who determines? If the plan – how financial disinterest is insured (i.e. whether expensive specialty care is authorized or not).
- MMCP’s [Medi-Cal Managed Care Plans] will not incorporate appropriate expertise from disinterested financial expertise
- County issues: layoffs, long-term leases
- Clarification of county role
 - Financial elig. (case worker)
 - Medical elig determined (nurse)
 - Nurses also provide case mgmt. – difficulty seeing the difference between whole child and current model

Question 5: What do you recommend as key health plan requirements around care coordination, such as medical homes, initial assessment and reassessment, care plans, interdisciplinary care teams?

Advisory Board

- Provide families with psychosocial support to navigate system
- Horizontal integration across transitional silos
 - Health Plans, Clinics, CCS, MTP, Regional Centers
- Initial/Ongoing Assessment
- Care plans
- Sharing of outcome data with public and plan partners
- Families can request team meetings
- Open medical records- family access to medical notes via portals
- Care coordination needs to include education, regional centers, etc.
- Communication with IT solution to get at efficiencies
- Enhanced – [need-based] individualized care centers including Bit, ed, regional centers
- Parents, youth, doctors, experts, key decision makers, parent primary care coordination
- Treatment plan needs to include medical home, family, specialty
- Have on board a trained cadre of care coordinators including SPMP [skilled professional medical personnel] social workers
 - For indicators about “well-trained” see [Web link: medicalhomeinfo.org/?]
 - This link was provided to RSAB from DHCS
- Health plans must have staff committed to becoming experts in evidence-based care to this population. Learn and implement best and promising practices
- Intensive care coordination of those who need it
- Initial assessment and reassessment
- Standardized annual assessment and update of care plan
- Risk assessment of acuity and minimum requirements of service delivery scope based on acuity
- Care coordinators need to do joint assessment/care plan and make assignments
- Care coordination should be located at the provider level
- Acuity assessment and care plan
- Access to care:
 - Define optimal standard of referral: to -> Eligibility decision -> MCP authorizing service

- No break in care due to annual eligibility review
- Access to care, medical assigned [P.C.A] must be paneled (based on current standard) and be required to coordinate with specialist involved with CCS child
- Health plan should be required to provide real-time reporting to care team
 - Admissions/transfers/discharge
 - ED visits
 - Op specialty referral
 - Rx
- Enterprise data warehouse or similar single holder of data.
- Importance of real time data and thorough evaluation of phased in counties for 2017. Include all aspects referenced
- IT needs to be real time, include medical home, specialty, family
- How to address the questions plans will face when denying services -> saving money vs needed care
- Look at opportunities to transition kids from ICU to sub-acute or other level of care
- Health plans should not be responsible for UR, CCS should be
- Set goals up front and keep consistent to measure progress include Bit assessment
- Baseline (today) Examine outcomes fund research/prevention
- CCS expertise needs to be maintained or contracted-Don't lose it
- Measure outcomes and have that be transparent. Pay for outcome performance [mana?]
- Plan requirement- AAP defined spec. needs med. Homes
- Plan req.- care coordination that meets or exceeds current coord[ination] requirements in counties (e.g. LA) that have established improvements
- Have health plans contract with public health nurses to do home visits/referrals
- As kids age out, have warm hand off
- Plans need to have social work or nurse staff to assist with psychosocial support
- Medical home to do standardized assessment
- Medical home at medical center for the most complex care- CHLA presentation
- Family choice re: medical home i.e. Children's Hospital vs. primary peds.
- Can specialists serve as a medical home?
- All CCS children have a "certified" health home
- Be realistic about requirements for medical homes. Need funds to establish [a....] medical homes
- Medical homes meet AAP specialty care requirements
- Stratify caseload, retain complex cases with CCS, [l....] to medical home
- Medical homes

Public

- Plans need clear and sole responsibility for care coordination, Avoid duplication and overlap.
- Data and control groups
- Health plans should be required to demonstrate that their network includes medical homes specific to the population in the plan
- Make denials clear and what steps can parents take when get denial
- Referral process needs to be simplified-streamlined and quick
- Embrace CHDP [Child Health and Disability Prevention Program] for medical home standards
- Must require family advisory committee input
- Why have CCS providers and standards if the health plans bear the financial risk?

- Consider NCQA [National Committee for Quality Assurance] accreditation as a requirement and use that for care coordination
- Understanding the local resources services
- It is essential while we try to remain cost neutral that cost is not what drives the delivery of service
- Health plan staff must have expertise in care coordination and DME for special needs kids
- Assist with referrals and linkages to other entities (behavioral health, regional center, etc.)
- Care coordination requirements should align with others similar whole person/health home models. i.e the ACA 2703 health Home and Care Coordination
- Risk stratifications
-
- What should the initial reassessment entail/State-wide assessment?
- Should have consensus on what the care plans include. State-wide care plan?

Question 6: What topics should be addressed for ongoing CCS Program Improvement Efforts in the next six months, particularly in counties that will not be part of the initial transition to managed care? For example, care transitions, DME access, behavioral health collaboration, regional centers, etc. Which of the topics identified are of the highest priority?

Advisory Board

- Use non-COHS [County Organized Health Systems] counties as pilot to test “CCS+” approach to improving CCS care
- Collect data and evaluate performance and impact
- Form a task force of two plan counties to identify the potential challenges and solutions for implementation in 2019
- Medical home support to PCPs willing to take on CCS kids
- CCS provider relations
- Transition care planning
 - ID of adult-oriented PCPs and specialist
 - Start early
- Family advisory committees including financial support for family members who participate
- Whole child authorizations
 - Primary care with CCS-paneled providers
 - Specialty care
 - DME etc.
- Improved care coordination
 - Acuity assessment
 - Care plan development
 - Intensive care coordination based on need, including psychosocial needs
 - Better coordination across systems
- Care coordination
- Continue developing (and sharing amongst counties) care coordination models

- Family participation
- Transportation
- Care transitions are essential, both for kids that are aging out but also for kids that may “bounce” in and out of private insurance with fluctuations in family income/situation.
- Standards of care need to be updated to include [periodicity] of services for high acuity children above and beyond one assessment of multi-disc team/year.
- Real time dashboard and indications
- Focus on the children most vulnerable to [P...]
- Data-Evaluation. Nothing should move forward until we have an evaluation [...] carve-in counties today compare to carve-out counties on cost, patient satisfactions, timely access to specialty care and denial rates.
- How to transition DME that counties pay for to plans?
- Is it “business-as-usual” for those not yet participating?
- It is counterintuitive to move CCS to MCMC [Medi-Cal Managed Care] plans when federal Title V [s...] more county local involvement needed
- Highest priority is problem with INCENTIVE STRUCTURE of plans vs goals of “whole child” care. Priority = how to ensure network adequacy < care coordination via a fiscally disinterested entity.
- First- please reformulate after you have a better understanding of these issues
 - E.g. DME- when single when customized, etc., diff
- Increase transparency of DHCS activities including data analysis
- What is the purpose if the kids are moving into managed care?
- Why is delivery of complex [prenatal] diagnosis so fragmented? [Known] CCS conditions delivered at community [hospital].
- Right place-Right time for complex care i.e., [ELBW] infant
 - pre-term labor
 - Prenatal diagnosis CHD/CDH etc.
- Clear performance-specific to C/YE SHCN-measures to CCS+, including process, clinical outcomes, family centered-ness and satisfactions, and provider satisfaction.

Public

- DME access
- Remediation of claims payment technology issue causing low/no payment of CCS claims to current providers (causes access issues as vendors refuse to provide to CCS clients)
- Review list of eligible conditions. It needs to be modernized
- Transitions for patient aging out of system
- Grievance and appeals
- Whole-child care
- Reduce denial of service letters to families
- Family and patient input on CCS
- IT Sharing [CCS] and non-CCS data
- If 2 plan counties are encouraged to innovate-CLAIMS LEVEL DATA MUST BE AVAILABLE
- Look to the Stanford data to understand “current” conditions
- Continued, guaranteed access to specialty care for all CCS kids
- Is this the only model that is being considered?
- Care transition is problematic currently. How will it possibly be improved with redesign?

Other Comments/Suggestions

Advisory Board

- How will DHCS provide information/education to families so they can be effective
- A well know criticism of managed care org traditionally is that the clients have limited access- what processes will be put in place to ensure there will be access.
- Have the COHS [County Organized Health Systems] agreed to accepting risk in this model or does that still need to be negotiated
- Current comment period needs to be extended by 1 week!
- DHCS said plans would demonstrate they have access in sufficient areas depending on the kids they have- some plans don't seem to have that now, what will be different and children and families are not static. A child can develop a condition next week and will not survive it we are waiting on a plan to develop sufficient access?
- Any discussion of IT should include people with case management experience
- This has been a frustrating non-transparent process- perhaps the first 3 meetings could have been skipped if we had started with the current DHCS proposal

Public

- Interagency agreement with DOE and DHCS-is it still relevant?
- I feel DHCS has this proposal firmly set in their minds and I do not feel feedback is really being [heard]. Is this actually an advisory committee?
- Will the MTP will have a MOU with SELPA [Special Education Local Plan Area]?
- How are children guaranteed the best care- if out of the network or out of state
- Continuity of care means more than uninterrupted care
- Are there specific two-plan counties in mind? Why four? Pilots?
- Will there be a separate Corrective Action Plan process for underperforming plans for CCS?
- Who will be on the new CCS advisory Board? How will you decide?
- The proposal does not address/identify HOW the whole child proposal meets all six of the RSAB goals.
- DHCS presented a plan with NO DATA on why it was selected...WRONG
- MTP? Critical to look at the interaction of MTP and GP-especially MTC&DME
- The CCS legislative mandate did not involve the whole child? What's the [reason] for the managed care as a solution? Where is the data that supports this?
- The managed care plans do not currently have [funds or funding] to take care of CSHCN, providers do not want to be in network, why do we believe that this will miraculously [I...] now?
- Will there be expectations for consistent reimbursement contracts to prevent regionalization?
- Will plans pay to MTP medical claims?
- Call center data Transparency. Why are people calling during the transition? Where are the problems?
- NO representation from the far North that is going to transition first. You need parents and CCS employees from there
- Will there be more quality measures for CCS-beyond the measures used by [MOUs] now?
- Family participation is critically important- and funding must be provided to get families to sit at the table when decisions are being made.

- How will new/revised CCS eligible conditions be operationalized in a managed care model
- Daily we defer authorizations back to managed care as the service is not to address the CCS condition managed care will likely classify cost as CCS related when they are not.
- How do we know that the San Mateo pilot [worked]? Where is the data to support the undocumented [a....] that it does?
- Concern- I have heard that some manage care plans give a read out daily of how much money the employer save the manage care plan by denying services.
- What is the rate deferment process? Will it be like it is now or MCMC [Medi-Cal Managed Care] rates? Actuarial soundness?
- Consider other models- partial carve-ins based on medical complexity
- Can the advisory board be a more transparent selection process than RSAB?
- How is the MMCP involved in this discussion?
- In 2-plan counties, if only one plan is selected do all CCS kids in that county go to that plan? What about continuity of care?
- CCS has been working albeit, not perfectly. There are things that can be improved but, is such medical change as addressed a solution? That is radical surgery for minor ailments.