

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

**RSAB and Small Group Discussion "Take-Away" Messages
June 22, 2015**

This document provides key take-away messages from the fourth Redesign Stakeholder Advisory Board (RSAB) Meeting held on June 22, 2015, in Sacramento, CA. The document is organized into two sections: (1) Overall Stakeholder Input and (2) Breakout Group Input with related Post-It Note Transcript (see Appendix A, attached).

Overall Stakeholder Input

1. **Network Adequacy and Monitoring:** Discussion regarding network adequacy and the current process used by Department of Health Care Services (DHCS) to work with and/or audit plans. Members suggested that there should be a specific CCS component for network adequacy that does more than the current Medi-Cal Managed Care method. Consider using current CCS "standards" for certifying hospitals, paneling physicians, and approving special care centers in network adequacy process administered by DHCS Medi-Cal Managed Care Division (MMCD).
2. **Consensus for "Risk Appropriate" Care, Determinations, etc.:**
 - a. Risk stratification of new clients via initial assessment and data, followed by continued risk stratification over time.
 - b. Could lead to risk-adjusted payments, and also identifying care (i.e., enhanced medical home services, enhanced care coordination, etc.) that fits someone's needs for a specific time period. There was concern about plans doing the assessment and case management, versus the county CCS program. Stakeholders indicated plans lack the financial disinterest and the expertise to do it because CCS programs have been managing and processing service authorization requests (SARs), translating benefits, and doing case management for years even in the carved-in counties.
3. **Information Technology (IT) Workgroup:** Suggestion to create an Information Technology (IT) Group in addition to the 3 workgroups. Need to figure out integration of Electronic Health Record (EHR) and plan data with Children's Medical Services Network (CMSNet) and other sources of information.
4. **Transparency in the CCS Redesign Process:** Some participants expressed a request for more detail why decisions were made, especially in cases where it went against feedback from stakeholders. Consider putting out comparison table of stakeholder letters.
5. **"Pilots" Clarification:** Clarify issue of the term "pilots" used to describe the CCS models that will be deployed via managed care plans in COHS and 2-Plan settings.
6. **Medical Therapy Program (MTP):** It was suggested that DHCS add a MTP member to CCS Advisory Board, make clear that MTP will not be changed. Explain how integration between MTP and managed care plan will work.

7. **Case Management and Care Coordination:** Stakeholders want to underscore how these processes are different. It seems CCS county staff currently do case management, and that role will be taken on (or at least paid for) by the plan by contracting with, hiring, or bringing in new CCS “case manager” staff. However, care coordination is help with navigation, parent/family coordination, etc. Those coordinating tasks should reside as close to the child as possible, perhaps delivered by staff or physicians within the medical home, special care centers, etc. In creating requirements and guidelines for both, be clear about role and who is responsible.
8. **Implementation Evaluation:** It was suggested that an evaluation of models (including COHS, 2-Plan option, and remainder of transition in 2019 and beyond) should include baseline data collection and analysis, identification of core goals of the redesign, and future analysis of what worked, best practices, process, financial and clinical outcomes). Outcomes should include satisfaction with ambulatory care. Some suggestions for measures go beyond process and clinical measures. They include number of Ombudsman calls, reasons for Ombudsman calls, and appeals/grievances.
9. **Legislative Process:** There is confusion about how the legislative process fits into the roll-out of the Whole-Child Model and when and for what legislation is necessary.
10. **Changes to County CCS Programs:** Confusion was expressed about how this will affect the county CCS programs as a whole, particularly financially. Many county staff are worried about losing their jobs. There are long-term leases in place for many county offices, labor unions involved, etc. Further concern was visible when the idea of “pilots” came up, because counties worry that changes made to infrastructure in order to adapt to the Managed Care model will result in having to recreate systems if the pilot is removed.
11. **Special Populations:** There was concern that the proposal leaves out certain specific populations of CCS enrollees, for example those who are privately insured for primary care but receive specialty care for their CCS-eligible condition through CCS. How will whole child care be guaranteed for these children? What about for children who “churn” in and out of eligibility for Medi-Cal, but not for CCS? How will payment work for those “CCS only” cases?

Breakout Group Input (please see attached Appendix A: Post-It Note Transcript)

Group 1 – Components of Readiness Assessment of Health Plans

- All components of readiness assessment for health plans should be specific to the special requirements of children with medical complexity and special health care needs.
 - Each child should have access to a robust network that includes a child-specific medical home, qualified child subspecialty care (especially important in rural areas), child-health trained and certified care coordinators, and need-specific covered benefits such as child-specific formulary and Durable Medical Equipment (DME) services.
- Child-health data must be used to assess and monitor quality and support ongoing improvements. Quality metrics should be established in advance. DHCS should establish necessary data infrastructure. Health Plans should be required to share child-

health data with all providers (medical and non-medical) in order to meet the child's care needs.

- Community and family training and engagement should happen at all levels by integrating parents and community agencies in health plan activities, with school systems, and Regional Centers. Parents are typically the best care navigators, establishing a single point of contact for parents would be helpful.
- Both functional and financial responsibilities should be considered.

Group 2 – “Whole-Child” Values

- “Whole-Child care” needs to be defined as broadly as possible with particular attention to enrollees’ and families’ psychosocial circumstances. Health plans have not historically been responsible for psychosocial considerations but will need to become more adept at assessment to successfully manage the CCS population under the Whole-Child Model.
- Health plan management and mandates should reflect the unique nature of the CCS population.
 - Pediatricians must play a central role in health plan medical directorship.
 - Financial incentives must promote team-based care and enforce use of paneled pediatric specialists and subspecialists.
- Existing models, including current CCS initiatives, should inform care coordination and integration strategies.
- Stakeholder groups should include parents and providers, and should have more “teeth” to ensure transparency. One suggested strategy is to require health plans to respond publicly to comments or requests from stakeholder groups.

Group 3 – Role and Structure of the Family Advisory Committee

- The group cited fundamental disagreement with the overall concept of the DHCS proposal.
- Key areas for the Committee to tackle include: access to care, timeliness of care, and periodicity of services. The committee should also provide input on the provider network and what specialties should be included in the network.
- Use data for decision-making. Review patient satisfaction surveys, DHCS dashboards, and/or data via some other feedback mechanism from the plans to find gaps, especially in ambulatory care. Review data on denials to inform decisions.
- The structure of the Family Advisory Committee should be clearly defined in legislation: one committee per county; size limited to 10-15 members; located external to the health plan(s); convened by a not-for-profit entity or family resource center; funded by the health plan(s); membership conditional on being both a health plan member and parent of a child with an eligible condition.
- Create accountability by forging relationships between Family Advisory Committee leadership and Health Plan Advisory Boards.
 - Form a statewide connector (e.g., Children’s Regional Integrated Service System) to convene all of the advisory committees.
 - CRISS is also a useful model for an Ombudsman. Consider requiring health plans to have an Ombudsman if this is not already a requirement.

Group 4 – County-Health Plan MOUs, coordination and service authorization

- Lack of clarity was expressed regarding whether the MOUs would relate specifically to the transition period, or to ongoing program functioning once the transition is complete.
- Some participants expressed the feeling that given the responsibilities transferred to the health plans and away from the CCS programs, the MOUs should be between DHCS and the health plans, and that it would be up to DHCS to set the standards for the plans and evaluate them.
 - In regard to DHCS setting standards, specific requirements for care coordinators background and expertise, as well as for providers and tiering of care coordination, were suggested.
- Overall, the predominant topic for discussion was care coordination, both as it relates to the MOU and more broadly, concerning what is meant by care coordination and the fact that it occurs on various levels, not just at the health plan level.
- A second issue of importance, which also relates to care coordination, was clearly defining the roles of DHCS, counties, and the health plans.
- There were a number of questions raised around the transfer of care coordination to health plans; specifically regarding roles:
 - It will now be up to the health plan to decide if they want to contract with the county CCS programs to provide care coordination services. Currently the counties get money for care coordination and case management; this may serve as an incentive to the health plans to keep care coordination in house rather than contract with the county programs, so that this funding goes to them this. The financial incentives to the county program to contract with the plan will likely be minimal, with high risk. If the plan decides to keep care coordination in-house, the expertise of the CCS program could be lost. Many stakeholders emphasize that care coordination needs to be performed by someone with clinical expertise, not just “a technician on the phone” as is often the case for plans.
 - If care coordination remains a responsibility of the plans, stakeholders also expressed concern about who is responsible for coordinating with the MTPs, across counties when children move, etc.
 - A suggestion was made for regionalizing care coordination in smaller counties, or across plans that operate in multiple counties.
 - Another suggestion was made that if the health plans retain the responsibility for care coordination, the CCS program should be able to create blanket pre-authorizations for the CCS enrollee’s qualifying condition, to limit delays in accessing care.

Group 5 – Health Plan Requirements

- Medical Homes should be specific to the population with PCPs as the main coach/coordinator to facilitate communication across care teams (via a standardized assessment).
- Key Health Plan requirements should include: Family Advisory Committee; Clarify denials and define next steps for patients; psychosocial intervention/coordination by qualified staff (i.e. social workers, etc.).

- Some expressed concern about Utilization Review being done by Health Plans.
- Access to care can be improved by requiring defined standards for Medi-Cal PCP care delivery.
- Care coordination improvements can be facilitated by using acuity assessments and care planning during intake to determine service delivery and scope based on acuity. Can facilitate risk stratification to better allocate resources.
 - Real-Time Data and Reporting needed for Care Coordination
- Important to evaluate the implementation using Data and Control Group(s). Evaluating outcomes against Pay for Performance (P4P) and their overall impact on financing/payment reform is important. The process should be transparent.

Group 6 – Ongoing CCS Program Improvement

- The group disagreed with the overall model (i.e., Managed Care). Some stakeholders used the mantra: “Mend it, don’t end it!”
- Some expressed concern that access to durable medical equipment (DME) should be addressed, which is likely due to reimbursement rates.
- (Tiered) Care Coordination should occur at the county level. Create financial incentives for medical homes to provide care coordination. Define the level at which care coordination should occur.
 - Consider alternate forms of care including telemedicine for rural areas.
 - Incentivize proper care/care coordination. CCS does not use its influence to the power that it could.
- Use data to evaluate counties as pilots and compare to each other. Title V surveys should be done more frequently.
- Update CCS eligible conditions.