



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

Monday, June 22, 2015  
Sacramento, California

### Members

#### in Attendance:

**Families / Advocates:** 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, Valley Children's Hospital; Tom Klitzner, MD, UC Medical Centers; Ann Kuhns, California Children's Hospital Association; Richard Rabens, MD, Kaiser Permanente Northern California State Programs; **Provider Representatives:** Maya Altman, Health Plan of San Mateo; Nick Anas, MD, Specialty Care Coalition (CSCC); Kris Calvin, American Academy of Pediatrics, CA; Athena Chapman, California Association of Health Plans; John Patrick Cleary, MD, California Association of Neonatologists; James Gerson, MD, Medical Director, Health Net, Inc.; Erin Kelly (for Nick Anas, MD), California Specialty Care Coalition; **Foundation Representatives:** David Alexander, MD, Lucile Packard Foundation for Children's Health; Kelly Hardy, Children Now; Amy Westling, Association of Regional Center Agencies; **CCS Executive Committee Representatives:** Dyan Apostolos, Monterey County; Ed Bloch, MD, 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:**

David Banda; Sarah Brooks; Anastasia Dodson; Diana Dooley; Hannah Katch; Jennifer Kent; Louis Rico; Linette Scott; Kimberly Steele; Bobbie Wunsch

**UCLA/Stanford Staff**

**In Attendance:**

Lisa Chamberlain, MD; Michaela Ferrari; Max Hadler; Nathan Moriyama; Jessica Padilla; Dylan Roby; Lee Sanders, MD

**Meeting Summary**

**Welcome, Purpose of Today's Meeting, and Introductions**

1. Secretary Diana Dooley, California Health and Human Services Agency (CHHS) provided introductory comments and explained the purpose of the 4<sup>th</sup> Redesign Stakeholder Advisory Board (RSAB) meeting. She described her personal commitment to fixing the CCS program acknowledging the difficulty of doing so given the history of fragmented delivery systems affecting the delivery of coordinated care. The regionalized nature of specialty pediatric care needed for the program has also made it difficult to move the CCS population into this type of system of care.
2. Secretary Dooley's two core priorities include getting to whole-person care and maintaining a system of certification for providers serving these children. She noted that the tools in the Affordable Care Act can aid in the transition to "whole-person coordinated care," or a system of care that manages both costs and care delivery. The proposal from the Department of Health Care Service (Department) aims to move the program in that direction. She clarified that she does not support an open-ended carve-out extension beyond January 1, 2017, unless it is tied to reforms that will improve the program.
3. Secretary Dooley reiterated her personal investment in improving the program and added that parent involvement would continue with the help of RSAB Member Juno Duenas (Family Voices). She then took comments from parents in the audience.

4. Parent comments for Secretary Dooley:
  - a. A parent from the audience emphasized the importance of maintaining the quality of services that CCS provides and expressed her concerns about moving Durable Medical Equipment (DME) approvals to Medi-Cal Managed Care, noting that unless key requirements were put in place before the transition, adding responsibilities to overworked Medi-Cal staff left room for error.
  - b. Ms. Duenas highlighted elements of the model that parents appreciated, which included the use of a phased-in approach, the focus on whole-child care, the CCS Family Advisory Committees (FACs), and the commitment to ongoing discussions. However, she noted the distrust that has come about from receiving what she characterized as conflicting information about multiple models being considered for the redesign. She added that the children's needs go beyond provider certification, and include maintaining unencumbered access to skilled providers, a key benefit that CCS currently provides.
5. Secretary Dooley responded to Ms. Duenas's comment about the models considered by saying that the proposal sets forth a model that includes lessons learned from the Health Plan of San Mateo (HPSM), a pilot within a County Organized Health System (COHS). She added that she is confident in the team of experts that are working on the redesign to address their mutual goals and to minimize disagreement in the approach used to address these goals.
6. Bobbie Wunsch (Pacific Health Consulting Group), the meeting facilitator, went through the agenda for the day and underscored the fact that this meeting would be the first of two meetings devoted to a discussion of the proposed "Whole-Child Model." The next RSAB meeting, on July 17<sup>th</sup>, further continue the conversation.

### **"Whole-Child Model" Presentation and Discussion**

7. Ms. Wunsch introduced Department leadership for the presentation including Jennifer Kent, Director of the Department of Health Care Services (DHCS), Anastasia Dodson (DHCS, Director's Office), Sarah Brooks (DHCS, Medi-Cal Managed Care Division), and Louis Rico (DHCS, Systems of Care Division).



8. Ms. Kent added to the earlier discussion about models considered for the Whole-Child proposal by describing background activities that the Department carried out behind-the-scenes to inform the process.
  - a. The Department contemplated and drafted several models in an attempt to address the issue of realignment and the extremely complex financing structure of the CCS program. The medical therapies piece, which is a standalone and separate program, was considered, and regional concepts were also explored.
  - b. Ultimately, the realignment hurdles and difficulty in justifying the creation of a third delivery system for a very small population, proved to be insurmountable.
  - c. Ms. Kent explained that the measured approach proposed in the Department's Whole-Child Model brings to bear existing relationships with counties in COHS to address the issues of financing and administration of the program.
  - d. Ms. Kent ended with a request that the group engage in a robust discussion with the Department about issues and concerns that they have.
9. Ms. Dodson reviewed the PowerPoint presentation which included key aspects of the Whole-Child Model and highlighted important elements for board members to consider in their discussions. She reminded all attendees that the Public Comment Process for the Draft Whole-Child Model was available via a SurveyMonkey questionnaire or through letter submissions.
  - a. The proposed model includes **Ongoing Program Improvement and Stakeholder Engagement** via a CCS Advisory Group and three consolidated technical workgroups.
  - b. **Initial implementation** will take place in the five (5) County Organized Health Systems (COHS), and up to four (4) Two-Plan Model Counties. Health plans will contract with specialty care providers, develop Memos of Understanding (MOUs), coordinate all care, and will be at full financial











- f. Ms. Kelly asked if the Department was open to replicating Rady Children’s Hospital San Diego (Rady’s) Accountable Care Organization (ACO) pilot model in the remaining 38 counties with the carve-out extension.
    - i. Ms. Kent mentioned that to the extent that it shows desired outcomes, they are open to implementing ACOs in other places. The implementation details would be discussed with stakeholders before roll-out.
    - ii. Ms. Kent commented that all twenty-two (22) of the Medi-Cal managed care plans would be required to have CCS providers engaged in their network to mitigate the drop-off that happens when children age out of the CCS program.
  - g. Katie Schlageter (Alameda County) inquired about continued funding for the MTP, which Mr. Rico confirmed would continue. She also asked that the CCS Advisory Group have someone representing the MTP.
  - h. Kelly Hardy (Children Now) requested that the Department provide direct connections with lessons learned from other transitions to explain decisions made for implementation of the Whole-Child Model. She also asked for clarification on dental and vision benefits under the model.
  - i. Dr. Chamberlain noted the need to move to a real-time system of monitoring by finding a way to more robustly get real-time data.
14. Ms. Dodson reviewed the **Implementation Timeline** including the four phases of the roll-out, noting that there is ongoing quality monitoring and reporting at each phase. More information on the timeline could be found on slides 17 and 18 of the presentation.
15. Ms. Wunsch moderated questions and comments on the timeline sketched out by Ms. Dodson.
- a. Ms. Dodson clarified that the Department will consider phased-in roll-outs, as needed, based on county readiness reviews.

- b. Ms. Dodson explained that changes to the model require changes to appendices in the 1115 Waiver Renewal. Ms. Katch noted that changes to the waiver are not happening at this time and reiterated that the only place where changes to CCS would be referenced in the waiver renewal would be as changes to the appendices.
- c. Ms. Dodson reassured Ms. Duenas that the roll-out would include a step-by-step process that includes statutory changes, and preparation of readiness and other administrative documents.
- d. Ms. Duenas commented that it would be helpful to have a detailed timeline that includes the legislative process as a backdrop and the interaction with the waiver renewal overlaid with the redesign process.
- e. Nick Anas, MD (Specialty Care Coalition (CSCC)) commented on the need for an Information Technology (IT) technical workgroup for the purpose of developing a system of care where folks can work together to try to control quality and cost and share responsibilities.
- f. Tom Klitzner, MD (UC Medical Centers) strongly suggests that the timeline build in pilots for Two-Plan counties and discuss how best practices in these counties might work.
- g. Maya Altman (Health Plan of San Mateo (HPSM)) added that she strongly suggests having savings in the program reinvested into the program.
- h. Ed Bloch, MD (Children's Medical Services, LA County) commented that the Department should consider creating a control group to compare against the pilots.

### **Identification of Key Issues and Questions**

- 16. Ms. Wunsch described the breakout exercise and small group discussion questions.

17. She explained that the purpose of the Post-It note questions/comments exercise was intended to inform discussions during the breakout session by identifying key issues and questions for each group to discuss.

### **Small Group Session on Specific Topics**

18. 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 are included below.

### **19. Group 1 – Components of Readiness Assessment of Health Plans**

- a. All components of readiness assessment for health plans should be specific to the special requirements of children.
- b. 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.
- c. Child-health data must be used to assess and monitor quality and support ongoing improvements. Quality metrics should be established in advance. Department 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.
- d. 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.
- e. Both functional and financial responsibilities should be considered.

### **20. Group 2 – “Whole-Child” Values**

- a. “Whole-child care” needs to be defined as broadly as possible with particular attention to enrollees’ and families’ psychosocial circumstances. Health plans will need to become more adept at assessment to successfully manage the CCS population under the Whole-Child Model.

- b. Health plan management and mandates should reflect the unique nature of the CCS population.
- c. Pediatricians must play a central role in health plan medical directorship.
- d. Financial incentives must promote team-based care and enforce use of paneled pediatric specialists and subspecialists.
- e. Existing models, including current CCS initiatives, should inform care coordination and integration strategies.
- f. Stakeholder groups should include parents and providers, and have more “teeth” to ensure transparency.

### **21. Group 3 – Role and Structure of the Family Advisory Committee**

- a. The group cited fundamental disagreement with the overall concept of the Department’s proposal.
- b. 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.
- c. The FAC should use data for decision-making and to find gaps, especially in ambulatory care.
- d. The structure of the FAC 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.
- e. Create accountability by forging relationships between FAC leadership and Health Plan Advisory Boards.



- f. Form a statewide connector (e.g., Children’s Regional Integrated Service System) to convene all of the advisory committees.
- g. Consider requiring health plans to have an ombudsman if this is not already a requirement. CRISS is a useful model for an ombudsman.

## **22. Group 4 – County-Health Plan MOUs, coordination and service authorization**

- a. There was lack of clarity regarding whether the MOUs would relate specifically to the transition period, or to ongoing program functioning once the transition is complete.
- b. Given the responsibilities transferred to the health plans and away from the CCS programs, the MOUs should be between the State and the health plans; the State should set the standards for the plans and evaluate them including specific requirements for care coordinators background and expertise, as well as for providers and tiering of care coordination.
- c. 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.
- d. Clearly define the care coordination roles of the State, counties, and the health plans.
- e. In so far as care coordination is now a responsibility of the health plan, this raised many questions and concerns among group members regarding roles:
  - i. 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.
  - ii. If care coordination remains with the plans, stakeholders expressed concern about who would be responsible for coordinating with the MTPs across counties, when children move, etc.

- iii. Suggestions included: regionalizing care coordination in smaller counties, or across plans that operate in multiple counties; and, creating blanket pre-authorizations for the CCS enrollee's qualifying condition, to limit delays in accessing care.

### **23. Group 5 – Health Plan Requirements**

- a. Medical Homes should be specific to the population with Primary Care Providers (PCPs) as the main coach/coordinators to facilitate communication across care teams (via a standardized assessment).
- b. 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).
- c. Concern that utilization review should not be done by health plans.
- d. Access to care can be improved by requiring defined standards for Medi-Cal PCP care delivery.
- e. 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.
- f. Real-time data and reporting needed for care coordination.
- g. 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.

### **24. Group 6 – Ongoing CCS Program Improvement**

- a. The group disagreed with the overall model (i.e., Managed Care). Some stakeholders used the mantra: "Mend it, don't end it!"

- b. Address the issue of DME access, which is likely due to reimbursement rates.
- c. (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.
- d. Consider alternate forms of care including telemedicine for rural areas.
- e. Incentivize proper care/care coordination.
- f. Use data to evaluate counties as pilots and compare to each other. Title V surveys should be done more frequently.
- g. Update CCS eligible conditions.

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

**25.** Wendy commented that from the parent perspective, loss of services and access to care is of the utmost importance. CCS goes above and beyond Medi-Cal and this must be preserved. Wendy also commented that the Advisory Group lacks representation from the far north of the state where the initial redesign will be implemented. She suggested having CCS nurses directors and families from that region represented.

- a. In the group discussion, it was brought up that, if CCS is rolled into Managed Medi-Cal, they must cover all of CCS as well as all of Medi-Cal.

**26.** Wendy's next comment referenced Managed Medi-Cal formularies and cited issues are already coming to light with the transition from regular Medi-Cal to Managed Medi-Cal.

**27.** Wendy's final comment asked for independent evaluation of the programs.

**28.** Janice encouraged a plan for families that is transparent and knowable during transition. She suggested taking feedback from the Ombudsman, having a



navigator in place for families to contact, and asked about corrective action plans for plans that are underperforming.

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

29. Ms. Kent thanked everyone for their participation and reinforced the Whole-Child Model approach.
30. Ms. Wunsch thanked everyone and noted that the next meeting would take place at the California Lottery Pavilion on Friday, July 17<sup>th</sup>.

**END**