SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER
CALIFORNIA CHILDREN'S SERVICES (CCS) TECHNICAL WORKGROUP
Meeting #3 – Tuesday, March 30, 2010
10:00am – 2:30pm
Sacramento Convention Center, Room 103

The meeting convened at 10 AM.

Attendance

Technical Workgroup members attending: Bob Achermann, CA Association of Medical Product Suppliers; David Alexander, Lucile Packard Foundation for Children's Health (LPFCH); Yvette Baptiste, Family Resource Center; John Barry, Shasta County; Gregory Buchert, CalOptima; Kris Calvin, American Academy of Pediatrics (AAP); Ricky Choi, Asian Health Services; Mary Davis, Orange County; Juno Duenas, Family Voices; Wesley Ford, Los Angeles County; Erin Aaberg Givans, Children's Specialty Care Coalition (CSCC); Marilyn Holle, Disability Rights California; Tom Klitzner, UCLA Medical Center; Sherreta Lane, California Children's Hospital Association (CCHA); Frank Mannino, UCSD Medical Center; Janice Milligan, Health Net of California; Diana Obrinsky, Alameda County; Chris Perrone, California Healthcare Foundation (CHCF); Tara Robinson, Family Voices; Debbie Ruge, Los Angeles County; Stuart Siegel, Children's Hospital Los Angeles (CHLA); Laurie Soman, Children's Regional Integrated Service System (CRISS).

Others attending: Gregory Franklin, Director of Medi-Cal Operations and Project Director, 1115 Demonstration Waiver Project, DHCS; Luis Rico, DHCS; Marian Dalsey, Medical Consultant, Children's Medical Services Branch, DHCS; Monique Parrish, LifeCourse Strategies.

Public in Attendance: 5 individuals attended in person, and 30 people called in on the listen-only telephone line.

Welcome and Introductions

Monique Parrish, LifeCourse Strategies welcomed the group. She reviewed the Workgroup's progress to date:

- The purpose of the group is to identify and understand pilot models that would maintain effectiveness and improve efficiency.
- The first meeting featured a data presentation on the program and discussion of program strengths and weaknesses.
- On March 1, a meeting sponsored by Lucile Packard Foundation for Children's Health, which many Workgroup members attended, looked at a variety of models and worked in small groups to develop them.
- The second Workgroup meeting focused on two of four models: Accountable Care Organization (ACO) and Enhanced Primary Care Case Management (EPCCM)

The agenda for the day includes a focus on two additional models: Specialty Health Care Plan and Medi-Cal Managed Care Plan. In contrast to the last meeting, these two plan models are presented with key elements already defined, and participants will discuss the opportunities and challenges presented by each.

Diana Obrinsky, Alameda County, said that at the first meeting several issues were raised that have not been discussed since. One is the underfunding of CCS administration at the state level, and another is the fact that there is little savings to be recouped in terms of health care costs for children in CCS, given the increasing numbers of children eligible for the program and the rising costs of specialty health care. Nothing in the pilot projects addresses the cost of care or the program's capacity on the state level. In addition, it is not clear that the group has defined the problems that the pilots should seek to address. She said that she does not feel that the Workgroup has the underlying information and agreement necessary to move forward to developing pilot models, and that she is deeply concerned by the lack of opportunity to address the two issues mentioned above.

Laurie Soman, CRISS, said that she agreed, and that she felt that a number of Workgroup members had raised the concern that they don't know where the process is going. She had thought that the Workgroup would spend more time talking about what should be changed in CCS, so that solutions would be targeted to a problem. She expressed concern that there was an agenda to try certain models, regardless of whether the solutions fit the data set.

Monique Parrish said she appreciated the comments, and noted that there is a chicken-and-egg aspect to the process, noting it is difficult to know what it the optimal starting point – a big picture structural discussion of CCS or a more focused discussion of potential pilot models. Because the primary task of the Workgroup is to identify pilot models to test, and since so much has already been studied about CCS, the planning group thought it would be more productive to focus on development and evaluation of pilot models.

Greg Franklin, DHCS, said that the criticisms of the process were fair. DHCS is well aware of the underfunding at CCS and throughout health services. If there is an expectation that the Workgroup discuss some of the issues raised by Diana Obrinsky or others, that can be done. DHCS is looking to pilot an experiment putting populations into organized systems of care. The group was brought together in order to advise DHCS on how to go forward with development of these pilots – if the group or individual members don't feel that there is a problem that can be solved through these models, then that is valuable feedback. The goal of the Workgroup is to see if there's a chance of improving program quality (and possibly achieving cost savings) through putting people into organized systems. DHCS has not made decisions about what CCS pilots to pursue, if any.

Ricky Choi, Asian Health Services, said that he hoped the process would become clearer as the Workgroup continued. He suggested that, to the extent that the strategy is to compare the pilots, the same criteria should be applied to the existing CCS program. Assessing the level of evidence for each of the proposed model elements also would be helpful. Another criterion that should be added for consideration of all models is the level of state leadership needed. He said that a significant level of leadership would be needed in order to achieve any of the models under discussion.

Kris Calvin, AAP, said that her understanding was that there would be no attempt to make wholesale changes to the CCS program. Instead, the idea was to put some pilots forward and see which, if any, the stakeholders are interested in moving forward.

David Alexander, LPFCH, spoke as a funder of the Workgroup as well as a member and a participant on the planning group, saying that there is no intention to make wholesale changes to CCS. CCS has evolved organically over time, and while it is successful in many areas it is not ideal. DHCS wants to look at pilots in order to see what could be done better. The Workgroup is there to give feedback to DHCS on certain ideas and models that the state puts forward. What the state does with that advice remains to be seen.

Kris Calvin, AAP, clarified that she might support larger changes to CCS, but not in the short timeframe of the waiver process.

Wesley Ford, Los Angeles, thanked Greg Franklin for acknowledging the concerns that were raised, and asked to what extent the Workgroup should be thinking about budget neutrality as they consider the pilot models. Greg Franklin said that any CCS pilots would only be a small part of the waiver. He noted that budget neutrality is very complex, and that the Workgroup did not need to take the larger budget neutrality issue into consideration in its work. DHCS has not looked into the actuarial issues posed by bringing CCS into the managed care pool. A pilot program would look at that.

Tara Robinson, Family Voices, said that even a small pilot could have major implications if it were expanded down the road. She said that she would like to have certain core elements of the current CCS Program defined and know that they will be protected in any model.

Erin Aaberg Givans, CSCC, noted that the current budget situation makes it difficult to think about an ideal program. She called for strong state leadership in CCS to see any pilot through, to protect the regional care networks, and to maintain and enforce standards.

Marilyn Holle, Disability Rights California, suggested that, instead of developing a new pilot, DHCS focus on the counties in which CCS is already included in managed care, and analyze the data from those sites: How much are CCS enrollees referred to specialty care centers? What kind of outpatient care do they get? To what extent do CCS programs in those counties have the autonomy they need? In effect, there are three CCS pilots operating already, but no analysis. *Diana Obrinsky, Alameda County,* asked why no data from those three plans was available. Marian Dalsey, DHCS, said that there was limited data available because of how the claims are reported. In addition, because local CCS programs retain responsibility for care authorization, they are not pilots of the type being considered (in which the plans or some other entity would actually manage the care).

Stuart Siegel, CHLA, said that he had not seen a list of the problems that the pilots were trying to address. He understood from previous Workgroup discussions that some of the challenging issues in the program included medical homes and fragmentation of authorization –challenging issue areas - but said that having an actual list would assist the discussion.

Overview of Models

Greg Franklin, Deputy Director, DHCS provided an overview of two pilot models. His presentation is available at http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupCCS.aspx, under the

March 30 meeting, titled “CCS TWG 033010 Meeting.” The presentation described pilot models for enrolling CCS children in 1) Medi-Cal Managed Care Plans and 2) Specialty Health Care Plans.

Some Workgroup members had questions about the bullet stating that, under the Medi-Cal Managed Care Plan, CCS children would disenroll from Healthy Families plans. Marian Dalsey said that children in Healthy Families Program (HFP) get a different benefit package than children in Medi-Cal, and that this pilot would enroll HFP children in Medi-Cal. *Erin Aaberg Givans, CSCC,* asked if it would have to be a Children's Health Insurance Program Reauthorization Act (CHIPRA) pilot in order to get the higher federal match. Disenrollment from HFP could mean losing some federal funding. *Sherreta Lane, CCHA,* asked whether it would be possible to consider enrolling only a subset, and Greg Franklin responded that that was a possibility.

Laurie Soman, CRISS, asked whether the primary difference between the Medi-Cal Managed Care Plan pilot and the Specialty Health Care Plan pilot was the risk pool. Greg Franklin said that they differ in their pricing and financing. In Medi-Cal Managed Care, the plan is fully at risk. In the Specialty Plan, the plan may not be fully at risk.

Greg Franklin, DHCS, clarified the concepts of risk corridors and stop-loss insurance introduced in the Specialty Health Care Plan model. For risk corridors, he offered this example: On the profit side, the state takes the first 5%, and the plan gets the rest. On the loss side, the state takes the first 5%, and the plan takes the rest. Stop-loss insurance is also called reinsurance, and refers to a health plan purchasing insurance to guard against catastrophic loss.

Laurie Soman, CRISS, said she was confident that Health Plan of San Mateo (HPSM) carries stop-loss insurance, and assumed that the other plan insuring CCS children (Santa Barbara, Partnership Health Plan) do as well. Those plans have had huge losses, and have come back to the state a number of times for back-up. CCS children represent small numbers, but significant financial risk. *Stuart Siegel, CHLA,* said that this is some of the data that is missing and without it, it would be difficult to know if the Medi-Cal Managed Care and Specialty Health Care models would be feasible. He asked that the staff supply information on what the currently-insuring plans’ stop-loss insurance situation is, and how they’re managing it. *Greg Franklin, DHCS,* said that he understood the need for this data but reported that it is not currently available; however, he confirmed that Workgroup members request for this data was duly noted.

Marilyn Holle, DRC, said that in looking at the models, Workgroup members should be cognizant of interior adverse selection, in which clients with complex disabilities gravitate to providers who have experience with those conditions, and how rates will be adjusted to protect access and address costs. In addition, the Workgroup should think about how access is affected when risk is shifted down to IPAs, where the Medical Director may be the one approving or denying service.

Greg Buchert, CalOptima, asked whether DHCS was envisioning an entirely new entity for the Specialty Care Plan. Greg Franklin responded that there might be the possibility of a specialty health network within an existing plan, although the model is written as though it would be a new Knox-Keene plan. Greg Buchert said he had concerns about starting a new plan up for this purpose, given that development is a long process. Speaking as a plan representative, he said that a specialty network within the plan could open up new vistas for treating children who don't meet CCS definitions. Specialists who treat complex kids could aggregate, and the plan could keep funds segregated for pediatric populations, and pay higher rates to providers if funds were left over.

Chris Perrone, CHCF, noted that the model of a specialty network within an existing plan was a different focus than what was discussed at the LPFCH meeting on March 1. The specialty plan discussed at that meeting would not be county-based, but rather regional or statewide. CCS children enrolled in county-level plans would be pulled out and enrolled in the one or more specialty plans. *David Alexander, LPFCH,* agreed that the orientation seemed to have changed and that the model should be more clearly defined.

Laurie Soman, CRISS, noted that when there was work on CCS pilots in the 1990s, the Bay Area pilot was a regional one, a collaboration of family organizations and providers that used Alameda Alliance as an ASO. It was built on the CCS platform, with the plan providing infrastructure.

David Alexander, LPFCH, asked how the managed care model that the state presented differs from the existing county carve-ins. Marian Dalsey said that the plan would do all the care coordination, utilization review, and case management. One question would be what the remaining role of the local CCS program would be.

Small Group Discussion of the Models

The Workgroup divided into two smaller groups to discuss the two models in detail. The results of those discussions are presented in the handout, *California Children's Services (CCS) Program Delivery Models of Care – Key Components with TWG Feedback [available on the CCS webpage],* Following are notes on the questions and discussion about each of the two models

Specialty Health Care Plan

Greg Buchert, CalOptima, presented the group's discussion, including the following points:

- Could it be a plan for any Children with Special Health Care Needs (CSHCN), not only CCS? Could even be a buy-in.
- Could CCS remodel itself and become a specialty health plan, taking on some of the risk? Could be regional or statewide.
- Why not include more pediatric carve-out services, such as behavioral health and dental.
- For HFP eligible kids, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program supplemental services could be a wraparound, but the HFP funding stream would not be lost.
- Plan could have the flexibility to provide non-covered services, like non-emergency transport.

- Qualified case managers would be essential. Every single child should have an individualized care plan, not just for his or her CCS diagnosis, but for everything, including behavioral health.
- The group first assumed that the Medical Therapy Program (MTP) would remain as a stand-alone, but subsequently discussed having the plan contract with the MTP program to provide the service.
- There is so little financial data available that coming up with a capitation rate would be very challenging. Some Fee-for-Service (FFS) might need to remain, at least in the transition.

David Alexander said that LPFCH has been developing an enhanced plan for CSHCNs and it looks a lot like the Specialty Health Care Plan model developed by the small group. Theoretically, such a model might be appealing to individuals who aren't eligible for HFP or Medi-Cal, or an insurer such as Blue Shield might be interested in purchasing it in order to provide their pediatric specialty care patients with the care they need. A plan like this could be defined by the child's needs rather than the family's financial status.

Monique Parrish said that under the Specialty Health Care Plan case management complexity is integrated into the fabric of services. *Marilyn Holle, DRC*, pointed out that children come in for one CCS condition but often have 2 or 3.

Frank Mannino, UCSD, asked if neonatal care would be excluded from the plan.

John Barry, Shasta County, asked how the model might work in rural counties. *Chris Perrone, CHCF,* offered that it could work in rural or urban counties and that the difference would be at the contracting level. In urban managed care, there are more providers from whom to choose, and in rural settings, there may not be much provider choice, but in a regional or statewide model, it might not make too much difference.

Erin Aaberg Givans, CSCC, said that the model lends itself to creativity. If the region were defined to include both rural and urban areas, a CCS program in the urban center might be the lead with linkages from special care centers out to primary care sites in outlying areas.

Diana Obrinsky, Alameda County, noted that two of the elements to be maintained in any model were the CCS provider network and CCS standards. While a plan might be county-based, the provider network has to extend far enough to include the specialty providers that CCS children require.

Tom Klitzner, UCLA, said that one of the advantages of the commercial plan is that low utilizers balance high utilizers, and wondered if the small group had thought through how a capitation model could work with only high utilizers included. *Greg Buchert, CalOptima,* said that the group recognized that the capitation rates would have to be very high, but that a benefit of a specialty plan would be that money would stay within a pediatric care system, and could be reinvested in it to the extent that greater coordination yielded savings. Tom Klitzner said that another problem would be that the cap would have to be set artificially high to account for the very high risk of missing the actuarially sound rate by even a few percentage points.

Janice Milligan, HealthNet, asked if the group considered case rates. She cited the Access for Infants and Mothers (AIM) perinatal program, under which, since it's a given that enrollees will use services, the plans are paid a case rate. She noted that for CCS, there would have to be a number of case rates, for oncology, neonatal, etc.

Sherreta Lane, CCHA, called for data on spending. *Stuart Siegel, CHLA,* said that for parts of the CCS population there is some good risk factor data that can help identify low, medium, and high risk children and associated costs. However, some diseases are so uncommon that it is difficult to get a sufficient data set. He asked if it would be possible to take the data for a subset of CCS clients and look at clinical issues.

Marian Dalsey, DHCS, said that Stanford researchers would soon be examining FFS expenditure data for CCS authorized services, and FFS Medi-Cal and managed care encounter data. The clinical data to go with it, however, is unavailable, and as a result, the Stanford analysis won't include outcomes. *Marilyn Holle, DRC,* asked whether the data submitted to Stanford would include Regional Center and LEA Medi-Cal data, and Marian Dalsey said it would if those services were billed on FFS basis, but not Regional Center services that they provide. Marilyn Holle noted that many CCS/EPSDT services are provided through waiver, with the Department of Developmental Services (DDS) as an intermediary, and that these services will not show up in Electronic Data Systems (EDS).

David Alexander, LPFCH, said that the Workgroup needed to accept that it would not get the data it wants during this period of the Workgroup meetings. *Diana Obrinsky, Alameda County,* said that every conversation discusses evaluation, but without discussion of the investment in information systems necessary to collect and analyze data. Without funding for data collection and analysis, the models will not be useful. *Wes Ford, Los Angeles County,* agreed, saying a baseline for comparison had to be identified. *Tom Klitzner, UCLA,* said that without clinical data, there could be no outcomes measurement and no risk adjustment.

Kris Calvin, AAP, suggested that the fourth meeting look at what is realistic to fund as far as evaluation. She suggested that the Workgroup prioritize three requests for data and work on those.

Stuart Siegel, CHLA, suggested that the data was there, and that the problem was the ability to analyze it. He said that comparisons would be complicated: could patients treated at different institutions be compared? The state would need some real statistical assistance.

Medi-Cal Managed Care Plan Model

Laurie Soman, CRISS, presented the group's discussion, including the following points:

- Potential Negative consequences
    - Risk and capitation:
        - Potential for under-service – service authorization by risk-bearing organization.

        - Expanded medical home model is potentially endangered to the extent that risk drives what's available.
        - Generalists at a plan that is not designed for CSHCN are not necessarily helpful. For example, a 24/7 advice line would be useless if staffed by someone who doesn't know anything about complex cases or the CCS condition.
        - Difficult to implement in rural areas.
        - Construction of rates very difficult.
    - Variability in acuity is a major issue in developing this model.
    - Quality:
        - Risk drivers have the potential to reduce quality.
        - Strong consumer protections would be needed.
        - With most populations, moving into more organized care does improve quality, but this is not true for these children, who are already well connected to systems.
    - Evaluation
        - This model might provide only limited information.
        - The impact of a person-centered health care home (PCHCH) including family satisfaction and provider concept of administrative burden would be interesting to track.
        - A stakeholder group should create performance standards for how plans operationalize quality standards – similar to the CHCF-sponsored work for SPD. A pilot would need an advisory group at the plan level.
- It's a whole-child plan, but paying for both kinds of care is not the same as a real whole-child model.
- Cost curve
    - Impossible to know what the fiscal impact would be. There could be savings from less administrative structure, but the administrative costs for CCS are so low, that savings would be minimal.
    - NICU costs account for 26% of CCS costs, though they are only 12% of the population. Could a managed care plan do anything differently, if it enrolled both babies and their mothers?
- Mandatory enrollment could result in the elimination of the CCS program. Infrastructure would need to be maintained until it is clear that a pilot is going to be expanded and replicated.

Greg Buchert, CalOptima, noted that the Workgroup frequently cited the high quality of care in CCS, and asked how that quality is measured. Laurie Soman said that the literature is clear about the quality of pediatric tertiary care, and that CCS gets children to that care. Marian Dalsey said that the state has not had the ability for many years to collect appropriate data to evaluate services. The assumption is that CCS is sending children to appropriate providers and facilities, and that program standards are being followed – and the limited evaluation information that is available shows good outcomes. *Tom Klitzner, UCLA,* agreed, citing comparisons of children in CCS v. commercial plans. He also noted that findings from his own recently published paper addressing a pilot medical home project support sending children to appropriate care providers, underscoring that, as a program, CCS directs children to centers with better results. Greg Buchert asked whether CCS outcomes are better than those in other states, and Marian Dalsey said that we do not know.

Marilyn Holle, DRC, said that one measure is the experience of families with children in CCS versus those in commercial plans. She said she has had many clients who leave private health plans in order to have better services though CCS. She also suggested that CCS doesn't recognize its case management responsibility to CCS kids in commercial plans, who might stay in those plans if CCS wielded its power to make the plans provide appropriate services.

Yvette Baptiste, Family Resource Center, noted that it is not necessarily the structure of CCS that must be maintained, but the process that gets children to the appropriate site of care. *Diana Obrinsky, Alameda County,* agreed, saying providers recognize the higher quality of care available through CCS, citing the pressure that providers use to get children referred into MTP.

Next Meeting and Feedback on Today's Meeting

Monique Parrish asked the Workgroup for ideas for the agenda for the fourth meeting, to be held on April 12, 2010, at the Sacramento Convention Center.

Tom Klitzner, UCLA, suggested synthesizing the four models into a side-by-side across the continuum of criteria. Other members agreed that this would be useful, and suggested that the current program also be included as one model, for purposes of comparison.

Tom Klitzner also suggested that the group consider a model in which CCS children's primary care would be carved into FFS, with CCS managing all of their care. He said that this has as good a chance of achieving the criteria as any of the other models. Workgroup members asked how such a model would be different from EPCCM, Tom Klitzner said that EPCCM has a gatekeeper function, and this would not. Primary care, not case management, would be capitated. Marian Dalsey, DHCS, referred to an existing Medi-Cal benefit for Primary Care Case Management (PCCM), for which there is currently one contract. EPCCM refers to putting care coordination on top of the statutory model. She suggested looking at the PCCM statute and seeing if there are options there.

Debbie Ruge, Los Angeles County, said she would like to discuss making changes to the CCS eligibility system, focusing more on chronic conditions and less on acute conditions.

Chris Perrone, CHCF, noted the rapidly changing environment. He said that he would like to start the next meeting with some feedback from DHCS, and to hear whether probing models as the Workgroup has done is still useful for the purposes of the waiver. Several Workgroup members agreed. *Laurie Soman, CRISS,* said she would also like to hear what CMS's feedback on the CCS pilots was.

Tom Klitzner, UCLA, said that one issue that has not been fully addressed is the amount that the program spends on premature infants and NICU care. The question raised by Health Management Associates in their report was whether children who require NICU care but who do not have lasting CCS conditions should remain in the program. *Sherreta Lane,* *CCHA,* said that her understanding was that the Workgroup should not focus on NICU costs, and Marian Dalsey and David Alexander confirmed that DHCS had indicated that.

Juno Duenas, Family Voices, asked about the impact of federal health care reform. Tom Klitzner said that AAP and the National Association of Children's Hospitals and Related Institutions (NACHRI) both interpret the federal law's rate increase for primary care providers as applying to all pediatricians. If this is true, it would alter many equations for CSHCN. David Alexander, by contrast, has heard that the rate increase will apply only to primary care pediatricians. Juno Duenas asked if the Department could clarify these issues for the Workgroup, including the latest information about prohibitions on pre-existing condition exclusions for children.

Ricky Choi, Asian Health Services, said that to the extent that it's relevant, he would be interested in hearing about the work of the other TWGs.

The meeting adjourned at 2:30 PM.