SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER
CALIFORNIA CHILDREN'S SERVICES (CCS) TECHNICAL WORKGROUP
Meeting #2 – Tuesday, March 16, 2010
10:00am – 2:30pm
Sacramento Convention Center, Room 302

The meeting convened at 10 AM.

Attendance

Technical Workgroup members attending: Erin Aaberg Givans, Children's Specialty Care Coalition; Bob Achermann, CA Association of Medical Product Suppliers; David Alexander, Lucile Packard Foundation for Children's Health; Yvette Baptiste, Family Resource Center; John Barry, Shasta County; Gregory Buchert, CalOptima; Kris Calvin, American Academy of Pediatrics (AAP) (by phone); Albert Carlson, SEIU; Ronald Chapman, Solano County; Ricky Choi, Asian Health Services; Mary Davis, Orange County; Wesley Ford, Los Angeles County; Marilyn Holle, Disability Rights California; Tom Klitzner, UCLA Medical Center; Sherreta Lane, California Children's Hospital Association; Frank Mannino, UCSD Medical Center; Janice Milligan, Health Net of California; Diana Obrinsky, Alameda County; Chris Perrone, California Healthcare Foundation; Tara Robinson, Family Voices; Debbie Ruge, Los Angeles County; 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; David Maxwell-Jolly, Director, DHCS; Monique Parrish, LifeCourse Strategies.

Public in Attendance: 8 individuals attended in person, and 32 people called in on the listen-only telephone line.

Welcome and Introductions

Monique Parrish, LifeCourse Strategies welcomed the group and provided an overview of the agenda. This meeting is the first of a series of two, designed to focus in detail on several potential models for CCS pilots. This meeting will look at enhanced primary care case management (EPCCM) and provider-based accountable care organizations (ACO), with small group discussion on each of these models. Monique Parrish thanked the members of the Workgroup for speaking with her individually since the first meeting.

Meeting summaries will be posted on the waiver website, CCS Technical Workgroup page (http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupCCS.aspx) within a week of each meeting. Notes on errors or omissions in the summaries should be sent to Monique Parrish.

Wesley Ford, Los Angeles County, asked whether the Workgroup would still focus on the deliverables that are included in the Workgroup charter. Monique Parrish said that the group leaders and planning team were working to figure out the best way to get to the overall Workgroup outcomes, and still hoped to achieve all the deliverables in the charter.

Laurie Soman, CRISS, said that while she liked the idea of discussing models, she would like some additional context, including agreement on aspects of CCS that should be preserved, and the endpoints to be reached, regardless of model.

Monique Parrish replied that the February 9 meeting did identify some basics points of agreement on what aspects of CCS were important to preserve and where the challenges exist:

Strengths

- Excellent standards
- Statewide network and regional organization
- Commitment to improvement
- Care team and special care centers
- Administration – although there are challenges involved in CCS administration, CCS care management and care coordination is strong
- Medical Therapy Program
- Parental involvement/family-oriented approach
- Human capital

Challenges

- Financing
- Rapid growth of program costs
- Need for additional oversight
- Outcomes, quality metrics and expenditure metrics

Ron Chapman, Solano County, asked for clarification of what is broken in CCS and what the Department is trying to fix. He said that his experience with Quality Improvement (QI) efforts is that the first half of any QI cycle is spent on planning and analysis, further noting that without that kind of planning and a clear definition of the problem, it will not be possible to evaluate the models in the future. What outcome measures will be used to evaluate the models and what will they be compared to?

Greg Franklin, DHCS, noted that this is the second of the CCS TWG meetings on this topic and that much discussion remained. The DHCS Waiver Concept Paper discusses value-based purchasing, and the question is whether that approach, or some other theorem, would work well or improve or enhance anything in CCS. If so, under what model – ACO, hybrid extended PCCM, or something else?

Diana Obrinsky, Alameda County, asked for clarification on what value-based purchasing (VBP) means in this context. Greg Franklin replied that VBP looks at what aspects of the program can be leveraged in order to get better value. For example, in the area of specialty care, are there arrangements that can be made in order to get better outcomes in terms of either cost or quality? *Tom Klitzner, UCLA* noted that the central theory of VBP is that instead of paying for services or episodes, you pay for quality outcomes. *Chris Perrone, CHCF,* clarified that VBP is not just about Pay-for-Performance (P4P), but the broader notion of measurement and accountability in contracting. P4P is an example of VBP.

Laurie Soman, CRISS, said that she supports getting the maximum value for each dollar, but questioned whether the group had come to any conclusions on the desired outcomes. Greg Franklin agreed that this is the work of the group. He stated that DHCS wants to retain the CCS elements that are good but also take advantage of new ideas, and continue to add value. He underscored the Workgroup process was not an exercise in doing away with CCS.

Erin Aaberg Givans, Children's Specialty Care Coalition, said that she wanted to understand some of the big picture issues before getting into the details of the models:

1. How many pilots are proposed?

Greg Franklin replied that the Department does not have an exact number in mind, and is awaiting the work of this group. Nor has DHCS made decisions on where pilots should be. Depending on the model, it might or might not make sense to replicate that model in multiple locations. Erin Aaberg Givans then suggested it might be useful to have some expert input on the numbers of children or models that would be needed in order to have statistically significant results at the end.

2. Do we need universal standards for the pilots? For example, there should be standards for a provider network that apply regardless of the model.

3. Should the pilots be defined and developed by the Workgroup, or should the group focus on the efforts of people who are on the ground and interested in developing new projects?

Greg Franklin replied that any pilots would proceed through a Request for Proposal (RFP)/Request for Information (RFI) process, so there will be competition in any scenario. That said, there is no harm in identifying existing efforts and interested individuals and groups.

4. What exactly is the role of the Workgroup? Is it advisory only, with the State deciding on the exact structure of the pilots?

Greg Franklin said that the input from the group will influence what the State decides to do, but that there would be a competitive process. *Diana Obrinsky, Alameda County,* said that Medi-Cal managed care had not been competitive in terms of which counties participated, but only in the assignment of the commercial plan. Greg Franklin replied that in fact the process was competitive, with a huge RFI process for the commercial plans. Only the Local Initiatives were outside a competitive process.

Tom Klitzner, UCLA, proposed that as the RFP process goes forward, population and eligibility rules, and performance and measurement requirements be the same for all models. This would allow for comparative effectiveness research, which might in turn qualify the projects for federal funding.

<u>Overview of March 1st Convening: Presented Models/Outcomes</u>

David Alexander, Lucile Packard Foundation for Children's Health (LPFCH) reviewed the work of the March 1 convening sponsored by LPFCH and held in South San Francisco.

Eighteen members of the Workgroup participated. David Alexander's presentation is available at http://www.dhcs.ca.gov/provgovpart/Documents/March_16_Presentation.pdf.

David Alexander said that there seems to be general agreement among stakeholders that 80% of CCS works well, and 20% does not. Although there is no absolute agreement on what specifically works and what doesn't, there is some consensus that the disease-centric structure of the program, which separates care for a child's CCS diagnosis from the rest of her care, is not successful.

He recommended that the State look to established quality metrics, specifically the Title V. No state does very well in meeting these standards, but California does particularly badly on some of them, including access to specialty care, and access to medical home services.

A meta-analysis on CSHCN in managed care (www.ncbi.nlm.nih.gov/pubmed/20129481?itool=Email.EmailReport.Pubmed_ReportSelector.Pubmed_RVDocSum&ordinalpos=4) points out that there is very little information on how these children fare in managed care systems.

The March 1 meeting included a very useful presentation on care development options by Sara S. Bachman, PhD. The presentation is available at the website created for that convening (http://www.ustream.tv/channel/lucile-packard-foundation-for-childrens-health), and the models developed at the meeting are available at http://www.dhcs.ca.gov/provgovpart/Documents/Model_Options_CCS_Convening2.pdf.

Initial discussion of models resulted in a focus on the following four options, none of which are pure – they can be mixed and matched:

1. Enhanced Primary Care Case Management (EPCCM) – CCS remains Fee-for-Service (FFS), but EPCCM is added to the system, meaning that a provider is paid a monthly payment for providing care management for kids in their care. EPCCM can be part of any other model.
2. Provider Based Accountable Care Organization (ACO) – This model has not been used for CSHCN, though there is some experience with it in Medicare. ACO is usually part of an integrated delivery system, in which providers accept payment for management of a population, which is defined either by disease or, in the case of Medicare, by geography or other population metric. An example would be the Mayo Clinic accepting global payment for management of a group of patients. The California CHIPRA proposal that was not funded essentially followed this model: a group of providers (from PCPs to specialists to hospitals) would accept global payment for a group defined by set of diagnoses.
3. Specialty Health Care Plan – This model would involve the creation of a managed care plan specifically for children with certain diagnoses.
4. Managed Health Care Plan – This option would involve enrolling CCS children in managed care plans, and giving the plans full responsibility for their care, including authorization for care related to CCS-eligible conditions.

Tom Klitzner, UCLA, raised concerns about how CCS standards would be maintained in a managed care plan. *Greg Buchert, CalOptima*, said that the current CCS/Medi-Cal managed care arrangement, in which CCS is nominally "carved in," will not work going

forward: the managed care plans operate as a payment mechanism only, with no responsibility or oversight.

David Alexander said that options 3 and 4 are both variations on whole child/all-in models, and that the primary question is whether such an approach works better with a general population or a specialized population.

Erin Aaberg Givans asked how global payment under ACO differs from capitation payment. Greg Franklin replied that the difference is small: global payment covers all services, but is not driven by risk to the same extent as capitation payments. *Tom Klitzner* said that at a recent meeting of cardiologists, discussion about global payment usually defined it as referring to payment for an episode of care, i.e., for 30 days for everything related to a heart failure admission. He noted that ACOs typically use global payment in that way. Thus, global payment might not accommodate EPCCM, since it turns delivery decisions over to the group providing care. The following is a definition of global payment from the Commonwealth Fund (2009):

> *Global payments are fixed-dollar payments for the care that patients may receive during a given time period, such as a month or year. Global payments typically are paid on a per-patient basis; they do not vary with the actual amount of services the patient receives. Global payments may cover all or some costs of care—including physician, ancillary or hospital services, and prescription drugs (Kongstevdt 2001; Hurley et al. 2002; Commonwealth Fund 2009). Global payments bundle services at the patient level, versus a service or episode level. They place providers at risk for both the occurrence of medical conditions (insurance risk) and management of those conditions (clinical risk). Consequently, they transfer significant risk from the health plan to contracting providers. Global payments may be based on the expected costs of the covered services over the contract period, usually estimated from past cost experience. They may be adjusted based on various risk factors such as the enrollee's age, sex, and the expected progression of a current medical condition.*

Erin Aaberg Givans said that it would be important to look at whether some populations are more amenable to global payment/enhanced case rate. She also asked whether efficiencies or savings under this payment structure would be reinvested into the system to address areas where it's underfunded and where access is suffering.

Ricky Choi, Asian Health Services asked how decisions are made on dividing the global payment among providers. David Alexander said that to take on this model, California would have to build a new structure – it does not currently exist.

Laurie Soman said that expert support will be needed to model cost structures. In the last round of CCS/managed care pilot projects in the mid-90s, both the Bay Area and LA projects foundered due to rate issues. Even Coopers Lybrand (professional services firm), which consulted on the project, admitted they had no confidence in the accuracy of the rates. She underscored that a robust evaluation plan with clear definition of outcomes also must be in place at the outset. She reported this was not the case in the mid-90s, noting that even if the projects had succeeded, the evaluation plan was poor.

David Alexander listed the issues that needed to be developed in any model:

- Population
- Eligibility
- Administration
- County or region
- Financing Model (FFS, PMPM, P4P)
- Evaluation

Wesley Ford, Los Angeles, said that the charge for the small groups remained amorphous given the lack of clear goals. He suggested that some goals were to contain costs, not carve up the child, and improve quality. David Alexander agreed, offering the following goals:

- Bend the cost curve (per enrollee, because there are growing numbers of CSHCN)
- Whole-child approach
- Maintain/improve on quality

Monique Parrish said that the focus of this meeting and the next was to have members in the small and large group discussions further develop the outline of potential pilot models under each program option. The fourth meeting would then focus on outcomes and performance measures. She emphasized that the goal of the Workgroup was not to drive toward consensus, but to breathe some life into the models and see what develops.

Mary Davis, Orange County said that thousands of children in CCS aren't eligible for Medi-Cal, and that regardless of model, the Workgroup would still have to address the impact on counties and on the state of the remaining children. When you take Medi-Cal out of the equation, it increases costs to the counties because Medi-Cal subsidizes the other kids. Greg Franklin said that one of the Department's goals is not to do harm elsewhere.

Sheretta Lane, California Children's Hospital Association, cautioned that even if a model were agreed on, a lot of planning will be needed. Greg Franklin said that there would be a planning and implementation phase, including development of the RFP with criteria and standards.

Laurie Soman, CRISS, asked for clarification on whether the pilots were addressing all children in CCS, or only those in Medi-Cal. She said that she would oppose a plan that only served Medi-Cal children. Greg Franklin said that the entire population of CCS-eligible children would be included.

<u>Small Group Discussions</u>

The Workgroup spent several hours in small-group discussion of two models: Enhanced Primary Care Case Management (EPCCM) and Provider-Based Accountable Care Organization (ACO). This summary reflects the groups' reports out to the full Workgroup.

Summary Presentation: Enhanced Primary Care Case Management

Before the small group presented their discussion, *David Maxwell-Jolly, Director, DHCS,* who participated in the latter part of the EPCCM small group discussion, spoke to clarify his understanding of the model. He said that he had initially understood this option to be a FFS option, in which the child would not be enrolled in managed care, but in an EPCCM medical home. (The small group had been discussing EPCCM in a managed care context.) David Maxwell-Jolly said that in his understanding, EPCCM would be financed through a capitated rate for primary care and care management programs, which is the way the state has traditionally funded PCCM. To the extent that hospital/specialty care usage is less than typical, savings could be shared with the EPCCM plan.

David Maxwell-Jolly said that what to do with a CCS-only child in that model is a puzzle, since they don't have coverage for primary care through the state. It would work for CCS-only children where the entity that's taking on EPCCM is a specialty care group that says they want to take on primary care as well.

Laurie Soman, CRISS, said that the group did not presume managed care, but had been working under the assumption that EPCCM could be layered onto any system, including managed care – though it would be very different from existing managed care activities. David Maxwell-Jolly clarified that the small group's model would be to do EPCCM in FFS only where children aren't enrolled in managed care. Laurie Soman said that it could be used in a number of settings, but that without more context-setting it was difficult to figure out how best to use it. The small group was trying to differentiate between EPCCM and a specialty health care plan. She noted that the group actually preferred a model more like a specialty plan that would allow some deeper reorganization, given that most would agree that the existing system is not ideal for these kids.

David Maxwell-Jolly offered the idea that the EPCCM responsibility could be given to the existing CCS system, with primary care money given to that program. The small group did not discuss this idea, though *Erin Aaberg Givans* said that the group had discussed this model having potential as a regional model with linkages to tertiary care systems. She said that simply layering EPCCM onto the existing FFS system would make it difficult for providers to establish adequate networks (for Durable Medical Equipment (DME), specialty care, etc.) given current FFS rates. Better incentives for timely, efficient outpatient care are needed.

David Maxwell-Jolly further suggested that, in this model, the authorization function that currently resides in CCS could reside in an independent EPCCM entity or in an EPCCM that is part of CCS. *David Alexander, LPFCH,* noted that a specialist or subspecialist also could take on the primary care role/EPCCM, and create a primary care home.

Laurie Soman, CRISS presented the summary of the group's discussions.

- Eligibility: CCS would determine

- Populations:
    - Payor: EPCCM would work for all CCS enrollees (Medi-Cal/Healthy Families/ uninsured). For purposes of a pilot it might make sense to focus on certain conditions or diagnoses, but not to segment by payer, since payer changes are so frequent that children might be in and out of the pilot.
    - Diagnosis: Limit to children with conditions that last 12 months or longer, and perhaps also shorter-term but more complex conditions.

- Care management: A tiered system, depending on severity of need. Some children would need nursing-level care management, while others could be served by social workers or paraprofessionals.

- Role of Special Care Centers: This would depend on how the pilot population was defined, but no part of the provider network as it currently exists would be eliminated. The pilot would do no harm. The same would be true for CCS-approved hospitals.

- Administration: This also would depend on who is included, but could be a group of CCS plans, an Independent Practice Associaiton (IPA) or group of IPAs, or a managed care plan or plans.

- Monitoring: Monitoring would be the responsibility of the State (CMS/CCS), but the group noted that DHCS needs staff to make this possible.

- Funding and financing: The group felt they were limited by the EPCCM definition, and that EPCCM financing options don't really address the complexity of the situation. The group would have liked to make more significant changes to program financing.

- Incentive: Family satisfaction should be measured as part of the pilot, and could perhaps be an element of P4P. Since the group was conservative in their financing model, they did not suggest many evaluation points

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- Where to test: Rural and urban models.

- Standards for PCP: Applicants would need guidance from the State on who is capable of being a PCP – Medical Home Index and National Committee for Quality Assurance (NCQA) standards would be a basis for this determination.

Tom Klitzner, UCLA, noted that one issue with EPCCM for this population is that it's hard to find a PCP comfortable with dealing with this level of complexity. Laurie Soman agreed, and said that another reason the group favored more fundamental changes to the financing structure was in order to entice people into the work. Tom Klitzner suggested that because of the way general pediatric training is structured, there is an even greater tendency for general pediatricians to back away from treating children with complex needs. *Ricky Choi, Asian Health Services,* acknowledged the challenges for generalists in both comfort and

time, and said that further underscores the need for coordination between the PCP and specialist. *Greg Buchert, CalOptima* said that the group did recognize a role for the specialist in providing primary care in some cases, but suggested that the PCP still needed to be there to coordinate some care that the specialist might not be comfortable with, and to offer a local connection for families when the specialist might be located many miles away.

Wesley Ford, Los Angeles said that the group had discussed creating tiers in order to accommodate the different levels of care management that different children would need, and to set care management workloads based on intensity.

Ron Chapman, Solano County, said that the ACO group had discussed the feasibility of building that model from scratch. He asked whether the EPCCM group had a sense that something already exists, or whether they would similarly need extensive planning. *Diana Obrinsky, Alameda County,* said that EPCCM would similarly involve starting from scratch.

David Alexander, LPFCH, said that there is an opportunity to rethink how primary and specialty care coexist for this population. Adult PCPs typically have a number of patients with complex medical needs, and can develop proficiency in treating these concerns. General pediatricians have neither time nor much experience, since there are relatively few CSHCN and the incidence of disease and disability is so low. He wondered if there was an opportunity for cross-training, particularly since there are insufficient sub-specialists to serve as medical homes.

Frank Mannino, UCSD, reiterated that the group did not operate under the assumption that they could have any access to existing Medi-Cal managed care dollars, and was happy to hear that that could be a possibility. He said that his preference for children with complex needs would be to site EPCCM on the specialty side, in order to find sufficient expertise, and then to link from that specialty home to primary care, or embed primary care in the specialty clinic.

Tom Klitzner, UCLA, said that he had talked to David Bergman at Stanford about this issue, and that one lens through which to view it was to think of the general pediatrician not as someone who has to master various specialties, but someone who specializes in care coordination. This requires knowing more about complexity than about specific illnesses or conditions – and might be a good fit, since residents today are more interested in complex systems and community-based services. David Alexander agreed in part, saying that every child at Lucile Packard Children's Hospital has 14 diagnoses and 14 care coordinators, and that we need to look at family-centered care management and where that can be situated. While it might belong in general pediatrics, pediatric training is not geared toward that role – it mostly focuses on well-child care. LPFCH is looking at training issues as well.

Tom Klitzner referred the Workgroup to a paper he co-authored on the patient-centered medical home (PCMH), newly released in the *Journal of Pediatrics* and available at http://www.dhcs.ca.gov/provgovpart/Documents/Medical_Home_Paper.pdf. The UCLA model described in the paper has resulted in high parent satisfaction among both English- and Spanish-speaking families. There is enough going on that it would be possible to do a pilot even without the education and training pieces in place. Erin Aaberg Givans asked whether, within a PCMH, there would be a way to distribute savings into the network to ensure network adequacy.

Laurie Soman, CRISS, said that the ideal model may vary by location. In urban areas, with many systems to negotiate, training is key. In Alameda County, for example, the Alameda County Medical Home Project, which works very closely with Alameda County CCS and CHDP, as well as the other child-serving programs like Regional Center, Special Ed, the local family support organization, worked with the 60 highest-volume special needs practices and trained them in care coordination for CSCHN. A staff member visits monthly to help the practices with navigation and programs. (Note: This is a small program with limited staff.) In a rural area, by contrast, the primary care provider actually needs to provide more care for the child in between specialty visits, which are far away. The training needed is different.

John Barry, Shasta County, said that from his perspective the goal was to develop a partnership between rural PCP and special care center. *Janice Milligan, HealthNet,* said that with an advanced information portal, it is now possible to do in rural areas what urban areas can do. HealthNet is exploring linking rural health centers (RHCs) in the Valley to Valley Children's Hospital. Once that system is developed, the PCP has instant access to information – such as care plans – that they can't get in 15-minute visits.

Greg Buchert, CalOptima, said that this is the simplest of the 4 models for pilots, and that even if the state moves forward on a different model, establishing the expectation that primary care will take responsibility for these children – with payment for that coordination role – should be a priority for future contracting. *Debbie Ruge, Los Angeles County,* said that this sounded a lot like the role of the Medical Therapy Program conference pediatrician, who provides well-child care and manages other care.

Summary Presentation: Provider Based Accountable Care Organization (ACO)

Reporting for the group, *Tom Klitzner, UCLA,* said that the ACO group had begun by making up a scenario of an ACO, since nobody knew of a real one in California. Their model was a "Mayo-like" entity, MD-run, and encompassing outpatient, hospital, pharmacy, and home-based care. The group's discussion led to the identification of potential unintended consequences of the model – features of the current system that are working but could be disrupted in the new arrangement:

- Feasibility concerns: The small group identified a number of aspects of the model which threaten its viability in the CCS context:
    - In Prometheus, Inc., they separate rates for conditions. To build the model for heart disease, they used the experience of 173,000 patients. CCS has low numbers and low variability, and this makes it difficult to set an accurate global payment.
    - The global payment may increase the total cost initially, and it may be a long time before the model generates a lower overall cost per child.
    - Care coordination is also affected by prevalence: To have an effect, care coordination should be in high-utilization conditions/diseases.

- Eligibility determination: Since it would be a conflict for the ACO to do eligibility determination, it would fall to the county, the state, or a health plan under contract.

The county is the most feasible, since they currently do it, but the consequence could be the viability of the county program, since if they have eligibility but lose coordination, there will be no opportunity for cross-subsidization.

- Populations

    - Geographically-defined: by provider, or by patient? If geography is confined, should it be by providers or by patients? (By provider: e.g., all Stanford patients regardless of where they live? How does Stanford deal with the child in Humboldt?) (By patient: e.g., UCSF takes care of all SF-resident children. Either of these could be at odds with family-centeredness, so would probably require a hybrid model that allows choice that's geographically contained in provider network. (E.g., if a Sacramento child wants to stay with Stanford, they will have to get all their care within the Stanford provider network.)

    - Diagnosis-defined: how to define diagnoses that might be eligible for ACO? High end diagnoses create a feasibility problem, with too many issues for a single organization to manage. With low-end diagnoses like simple heart disease or diabetes, cost savings can disappear since those are presumed to be mostly in complex care. An alternative might be for an ACO to take on long-term care and long-term diagnoses (diabetes, CF), so there would be a strong incentive for prevention, though still not a lot of cost-savings. Tumor diagnoses might be another target, since the flexibility of ACO would allow for treatments such as outpatient chemo therapy.

- Care management would be the responsibility of the ACO

- Administration: The ACO would receive the money, but the feasibility problem here is that there are no ACOs. The closest entities are some large specialty groups, and some children's hospitals, but even there you would need to split the rate, or meld the two. Another question is, in a five-year pilot, who pays for development and other upfront costs?

- Financing: Both an annual capitation model for long-term chronic disease and a global payment for an episode of care were considered. Structuring a global payment is difficult for the reasons raised above under "feasibility."

- Performance incentives: The ACO is a great model for shared risk: once the global payment is defined, 20% is held back, and then distributed among the partners if quality measures are met. There is a possibility for everyone to benefit in this model that doesn't exist in FFS.

Participants raised concerns about fragmentation, given the system of episodic payments. What happens to the child in between episodes? It may be that such a system fragments the child across time, much as the current system fragments the child by diagnosis or even body part. The group came away sobered about the prospects for this model, which is so popular in the Medicare context. Overall, there appear to be potential benefits – including promoting coordination without being prescriptive, and risk

models that are robust and allow for rewarding quality -- if it were possible to make it work, but also significant feasibility issues.

Chris Perrone, CHCF, said that one strength of the ACO is in governance – the arrangements between hospitals and providers. Managed care capitation doesn't necessarily drive out coordination between inpatient and outpatient providers, but in practice, this is often a concern.

Greg Buchert, CalOptima, asked whether, if the ACO got all the funds for the care of the child, and governance included not only specialists but PCPs, with shared Electronic Health Record (EHR), it would still work to have global payments for episodes, with care outside those episodes still funded by the ACO.

Tom Klitzner, UCLA, imagined a process whereby the provider and hospital were charged with forming an ACO, and had to negotiate every point, from who accepts the money to getting the medical record up to speed to hiring and firing. The ACO would have significant start-up time and expenses.

Wesley Ford, Los Angeles County, asked for clarification on how the ACO contains costs. Tom Klitzner said you would build a model of what care costs now, and save 5% to use for the incentive. You would have to believe that the ability to provide care more efficiently is going to more than offset the 5%.

Diana Obrinsky, Alameda County, asked whether the small group's model involved the children staying in their Medi-Cal managed care plans. If so, the plan would still expect its capitation. Tom Klitzner said that this wasn't discussed in the group, but that he could see ACO living under the plan.

Laurie Soman, CRISS, said that the realities of access make the ACO hard to envision. You need a combination of hospital and specialty care, but even in San Francisco children can't get everything at UCSF. What if the closest institution isn't the right place? Sheretta Lane suggested that the ACO could contract with other providers, and their incentive to do so would come from measurement of quality outcomes.

Tom Klitzner, UCLA, said that the small group had framed the ACO such that it's an open network across the state. In reality, though, any of the models other than the EPCCM model will likely have to lose the open model structure and will have a provider network contracted to the plan. It's not clear how one could institute the advantages of managed care without limiting the provider network.

Chris Perrone, CHCF, said that because the ACO is diagnosis-driven, you could build into it the idea that there are no contracts for conditions that it can't serve. *Erin Aaberg Givans, CSHC,* asked, in that case, how it could be a model if it lost access to the CCS provider network, and could only be used in certain areas for certain conditions. Tom Klitzner additionally wondered how, without closing the network, the actuarial model for such a small and high-risk group could work.

Next Meeting and Feedback on Today's Meeting

Monique Parrish announced that the third meeting of the CCS Technical Workgroup will be held on March 30, 2010 from 10:00am – 2:30pm Sacramento Convention Center Room 103.

That meeting will focus on two other models: Medi-Cal Managed Care and Specialty Health Care Plans.

Yvette Baptiste, Family Resource Center, commented that although there was a lot of anxiety around the process, given the lack of clarity about the Workgroup's role, in the end everyone made it through.

Diana Obrinsky, Alameda County, said she appreciated the efforts of the Workgroup and planning group, but remained frustrated with the process. There is limited data on which to base decisions, and it is not clear that the Workgroup is actually making decisions. She reiterated the call for advice from someone who could speak to what would make a statistically valid pilot. Also, referring back to the morning session when Greg Franklin said there would be 4 meetings in total and not 5 as originally announced, Diana asked that the Workgroup leads clarify that question.

Monique Parrish said that some members of the planning group were thinking that if Meeting #3 focused on Medi-Cal Managed Care and Specialty Health Care Plans and Meeting #4 addressed the metrics and other issues, such as the Medical Therapy Program, then a Meeting #5 might not be necessary; however, no decision as yet had been made. *David Maxwell-Jolly* said that the Workgroup's discussion was exactly what was needed to help DHCS formulate the opportunities for restructuring, and that he personally was learning a lot about potential complications, models, and scope. There are a number of different ways to go about developing a pilot. At the first meeting, the group looked for modal points in the landscape that look like ideas worth developing. It is an open question whether any of these models has enough muscle to be worth a pilot. If the group does decide on a pilot model, the next step is finding someone to take it on. After that, DHCS must determine if they have the scale to make it testable and measureable.

Diana Obrinsky, Alameda County, said that she hopes that the Workgroup can continue as an advisory body as RFPs are developed, in the event that a CCS pilot goes forward. David Maxwell-Jolly said there will be some kind of consultation process going forward, but that no decisions have yet been made on this.

Laurie Soman, CRISS, asked whether the State was going to have the staff and funding to do a real evaluation of these pilots, since otherwise it's not worth doing the pilots. David Maxwell-Jolly said that DHCS would do everything it could to make sure that the appropriate infrastructure is in place.

The meeting was adjourned at 2:40 PM.