CCS

California Children's Services

Photo 1: John, Glankler MTU

Bay Area Stakeholders

CCS Redesign Recommendations

November 25, 2014

INTRODUCTION

Photo 2: Brayden, Glankler MTU

The renewal of the 1115 waiver has created the opportunity to examine current CCS operational and financial structures; to consider re-designing the program in order to maintain the high quality of medical outcomes while improving the experience for CCS-eligible children, their families, and their providers; and to provide assurances to the state that positive health outcomes can be achieved under a program with strong fiscal oversight of healthcare dollars.

Essential Elements of Care for Children with Complex Medical Needs

In November 2013, a small group of stakeholders convened in Oakland at the request of regional leaders in order to begin the process of developing alternative models for the CCS program. In the course of their deliberations, these stakeholders (hereafter referred to as the "Bay Area Stakeholders") recognized key elements of the existing program that must be preserved in order to ensure the safety of California's most medically vulnerable children. **The essential elements of California's current systems of care for children with medical complexity[1] include:**

- **Robust regionalized architecture for pediatric specialty care anchored by centers of excellence consisting of CCS-certified regional hospitals and Special Care Centers.**
- **Establishment and enforcement of the statewide standards for provider participation that underlie the statewide system of quality pediatric care for all children.**
- **Rigorous case finding at the hospital and community level.**
- **Fiscally disinterested decisions about access to medically necessary services.**
- **Professional, family-centered case management/care coordination.**
- **Access, when medically appropriate, to the broad CCS provider network with no artificial barriers based on geography.**

The Bay Area Stakeholders recognize that county CCS case management teams provide critical support to the overall system by enforcing appropriate use of services (e.g., by routing children to the most appropriate resource for medical care considering their health condition and circumstances); upholding policy and regulatory rules; eliminating duplicative and unnecessary services to improve outcomes and lower potential costs; and identifying service gaps, raising awareness of these gaps, and working with stakeholders to develop needed services.

In addition, CCS has a history of valuing input and involvement of parent organizations and the adult disability/independent living communities. Formal Family Health Liaisons at local Family Resource Centers and informal consultations with local disability agencies have enriched

[1] Although there is not yet a standard definition of children with medical complexity, the national Children's Hospital Association has recognized four cardinal domains which characterize these children. These four domains are (1) chronic, severe health conditions; (2) substantial health service needs; (3) major functional limitation; and (4) high healthcare resource utilization.

CCS services, connected families with community resources, and prepared CCS-enrolled youth and their families for transition to adult services and community support systems.

At the national level the Children's Hospital Association is working to describe ideal regionalized systems of care for children with medical complexity. The Bay Area Stakeholders note that in California, these regional systems already exist, formed largely as a result of sustained and creative foresight of state leaders in CCS and the Department of Health Care Services, and we do not want to undermine them. Rather, we want to strengthen and streamline the CCS program's regionalized systems and to improve the sustainability of the administrative and fiscal structures that underpin them.

Over the course of 12 months the group of Bay Area Stakeholders grew from 12 to 110 participants representing 55 organizations, including county CCS programs, managed care plans, hospitals, pediatric sub-specialists and primary care providers, the American Academy of Pediatrics, individual family members as well as family organizations and advocacy groups, and the Lucile Packard Foundation for Children's Health. **Despite this diversity, we have consensus that the six essential elements of the current system, outlined above, must be preserved, and we agree that the following four elements are indispensable in any well-considered CCS program revision:**

- **Whole child focus to streamline administrative processes and reduce system fragmentation.**
- **Administrative regionalization to ensure consistency in application of program policy and standards and to take advantage of economies of scale.**
- **Intensive care coordination for those children with high clinical and/or psychosocial need.**
- **Partnering with families and youth at every level as co-creators of the system of care that will serve them, and meaningful involvement of this community in the design, operations, structure, and oversight of the system of care.**

Traditional Medi-Cal Managed Care and Children with Complex Conditions

We are aware that the state has been considering moving the entire population of CCS-eligible children into Medi-Cal managed care plans. **The Bay Area stakeholders agree that taking this action will fail to preserve the six essential existing elements of the CCS program and will not accomplish the programmatic improvements that we consider critical.**

Medi-Cal managed care plans have historically worked well for healthy children in some communities. However, most CCS-eligible children by definition are medically complex and require highly specialized provider networks which are not typically found in sufficient numbers in mainstream managed care plans. Lack of specialty provider networks and potential geographic limitations would create artificial barriers to accessing the existing, robust regional CCS specialty networks, and this would lead to increased regional inconsistency, fragmentation of care, and health inequities for CCS-eligible children. Furthermore, because these children's medical care is typically expensive and sometimes unpredictable, their enrollment in managed

care plans may actually destabilize the Medi-Cal managed care system. Medi-Cal managed care plans also lack the authority to create or enforce the rigorous provider standards that CCS has established. In addition, Medi-Cal managed care plans have not typically engaged in meaningful collaboration with families and youth receiving specialty services or the key family organizations that represent them.

Photo 3: Monica, Glankler MTU

6 KEY ELEMENTS TO RETAIN

The Bay Area Stakeholders support positive changes to redesign the CCS program. We recognize six key elements of the existing program that must be preserved in order to ensure the safety of California's most medically vulnerable children:

- Robust regionalized architecture for pediatric specialty care anchored by centers of excellence consisting of CCS-certified regional hospitals and Special Care Centers.
- Establishment and enforcement of the statewide standards for provider participation that underlie the statewide system of quality pediatric care for all children.
- Rigorous case finding at the hospital and community level.
- Fiscally disinterested decisions about access to medically necessary services.
- Professional, family-centered case management/care coordination.
- Access, when medically appropriate, to the broad CCS provider network with no artificial barriers based on geography.

4 NEW ELEMENTS TO ADD

We believe the following four additional elements are indispensable in any well-considered CCS redesign:

- Whole child focus to streamline administrative processes and reduce system fragmentation.
- Administrative regionalization to ensure consistency in application of program policy and standards and to take advantage of economies of scale.
- Intensive care coordination for those children with high clinical and/or psychosocial need.
- Partnering with families and youth at every level as co-creators of the system of care that will serve them, and meaningful involvement of this community in the design, operations, structure, and oversight of the system of care.

Stakeholder Recommendations for Redesign

In the course of our discussions, three models for updating and revising the CCS program emerged, models which we are calling **CCS+**, **CCS Collaborative**, and **CCS ACOs**. Each of the three models is briefly described in the following pages. **CCS+** envisions operational improvements that are possible with existing funding and staffing. The **CCS Collaborative** and the **CCS ACO** models share important attributes, including opportunities to restructure risk sharing and reimbursement methodologies. Having recognized that these three models are not mutually exclusive, and may best be viewed on a continuum, **the Bay Area stakeholders recommend that the state implement CCS+, while simultaneously engaging in negotiations to move the program towards either the CCS Collaborative or the CCS ACO model**.

We all agree that the changes we are proposing should be introduced slowly and carefully, in a thoughtfully staged fashion, in order to ensure that the architecture of pediatric specialty care in California is not dismantled, and to ensure continuing access to these services for CCS-eligible children. In order to accommodate this thoughtfully staged implementation, we also recommend that CCS redesign be removed from the 1115 waiver discussions–the timetable for which would artificially accelerate this process–and that the CCS carve-out from managed care be extended. At every stage of implementation, independent evaluations should be performed to ensure that the architecture for care, quality of services and access to care remain robust. Finally, policy makers should work to ensure that the system is designed to reinvest any savings resulting from efficiencies back into the systems of care for medically complex children.

Our proposal will advance the state's articulated goal of moving the CCS population into a more "organized delivery system of care," while preserving the six essential elements of the existing CCS program and moving towards full implementation of the additional four elements recognized as critical to the future of the CCS program.

Photo 4: Mohamed, Cesar Chavez MTU

RECOMMENDATIONS TO DHCS

The Bay Area Stakeholders propose a thoughtfully staged redesign of the CCS program as follows:

1) Implement CCS+, which envisions operational improvements that are possible with existing funding and staffing

2) Simultaneously negotiate to move the program towards either the CCS Collaborative or the CCS ACO model, which includes opportunities to restructure risk sharing and reimbursement methodologies

3) Remove CCS redesign from the1115 waiver discussions

4) Extend the CCS carve-out from managed care

5) Stage transitions carefully in order to ensure that no harm is done to the regionalized pediatric system of care, and that the health and well-being of individual children is protected

6) Ensure robust evaluation of redesign efforts at each stage of implementation

7) Assure that savings from efficiencies are reinvested back into the systems of care for medically complex children

PROPOSAL FOR CCS REDESIGN

CCS+

In the first phase of CCS redesign, which we are calling CCS+, existing county CCS programs would remain intact, but regional administrative oversight would be instituted in order to support counties as they implement targeted programmatic improvements in a standardized fashion. These targeted improvements will be designed in a manner supported by evidence from both the literature and our collective experience. Targeted programmatic improvements would include at a minimum:

Photo 5: Eligio, Cesar Chavez MTU

- Administrative regionalization according to catchment areas reflecting treatment and travel patterns. Large independent counties would provide administrative oversight and issue authorizations for small dependent counties. This approach could reduce the state's burden of providing administrative support to dependent counties, improve provider satisfaction, and potentially reduce administrative costs.
- Whole-child case management for improved integration of care, including authorization of primary and specialty care services and possible additional supports for the primary care medical home. This should reduce administrative duplication with existing managed care plans serving CCS-eligible children.
- Intensive care coordination, including acuity assessments, care plans, and case conferences, delivered strategically and targeted to match the level of need; e.g., greater intensity of services to children with high medical and/or psychosocial complexity. This should increase use of preventive services and decrease unnecessary use of more costly high end services.
- Incorporation of Family Strengthening and support protocols, based on the work of the California Network of Family Strengthening Networks.[2]

Partnering with families and youth, including case conferencing, will become a core operating principle for CCS case management in all of the following activities. CCS clients would be stratified according to medical and/or psychosocial complexity, using a standardized assessment tool. The intensity of care coordination would be matched to the level of identified need. For the most complex children, CCS would take responsibility for identifying and assigning an appropriately resourced medical home, which would then be authorized by CCS to provide primary care medical home services related to the management of the CCS eligible condition. Enhanced transition planning and family navigation services, provided by skilled professionals, would ensure efficient utilization of services and smooth transition between environments (i.e., inpatient to outpatient, between counties or regions, and from pediatric to

[2] California standards for family strengthening and support have been described by the California Network of Family Strengthening Networks. These standards can be viewed at http://www.cnfsn.org/standards-of-quality.html.

adult medical care systems). Improved care coordination with a greater focus on secondary prevention is expected to control costs. Ultimately, we believe this approach will reduce family stress and improve family satisfaction with services.

Fee-for-service reimbursement would continue, at least initially, although other payment options could still be explored in partnership with the state. The program currently bundles authorizations (for example, by issuing 01 and 02 Service Code Groupings), so it is entirely reasonable to envision bundling payments as well.

Strengths of CCS+:

- CCS+ uses institutional knowledge and experience to advantage. CCS has a long history of providing care coordination for this population. CCS+ builds on the CCS program's demonstrated strengths and maintains statewide standards for pediatric care, while focusing on improving operational protocols to implement the statewide standards more consistently.
- Some counties are already prepared to implement elements of CCS+ with existing staffing.
- This approach does not disrupt the CCS provider network or the architecture of pediatric specialty care in the state.
- Administrative regionalization will reduce fragmentation and inconsistencies in medical eligibility determinations and authorizations and may result in reduced administrative costs that can be redirected to care coordination, family support, medical home support, and other approaches that promote quality care.
- CCS+ maintains full access to the broad and deep CCS network of providers.
- The Public Health focus of the program is preserved, emphasizing its mission to ensure the ongoing availability of high-quality pediatric subspecialty services for all of California's children, and to link the most medically vulnerable of these children efficiently to these services.
- Case management remains with a fiscally disinterested public health entity, ensuring that all children are directed to the appropriate health care resource regardless of location or cost and maintaining quality care for medically complex children.
- Keeping the CCS program within local Public Health facilitates opportunities to collaborate with CHDP in support of the Primary Care Medical Home. Integration of the two programs will move us toward our goal of providing efficient, high-quality case management for the whole child.
- CCS+ incorporates family and youth partnering in the provision of services to CCS-eligible children for a family centered system of care.

Issues for the future:

- The financing structure for the program remains the same. While the bulk of risk remains with the state, the risk for the intensity of any given service continues to be shared by providers who are at times inadequately reimbursed for services.
- Fee-for-service reimbursement does not provide incentives for providers to streamline clinical services.
- As a fee-for-service program, CCS+ would require continuation of the current level of resource support from State DHCS. Hence, negotiations to move toward the CCS Collaborative or CCS ACO model should be pursued as CCS+ is implemented.

Photo 6: Eligio, Cesar Chavez MTU

CCS Collaborative

The four targeted programmatic improvements identified for CCS+ would become core elements of the CCS Collaborative model. These improvements are:

- whole-child case management with support for families and the medical home,
- administrative regionalization,
- intensive care coordination matched to the level of identified need, and
- incorporation of Family Strengthening and support protocols.

This model also retains:

- fiscally disinterested case management by medical professionals in Public Health, as well as
- full access to the broad and deep CCS provider network.

The CCS Collaborative model presumes the creation of a new administrative entity which, on a regional level, would manage the funding of CCS administrative functions as well as diagnosis and treatment services. This administrative entity will also manage fiscal arrangements collaboratively with the state in order to distribute risk at multiple levels throughout the system. Savings from operational efficiencies and improved outcomes would ultimately be expected to contribute to the fiscal sustainability of the CCS Collaborative administrative entity. Risk sharing agreements will be designed to ensure the stability of the regionalized CCS provider network and will be implemented in a staged manner. In order to avoid fragmentation of the CCS program, county participation would need to be mandatory, within each participating region. Risk sharing strategies may include:

Photo 7: Perry, West Oakland MTU

- capitation
- bundled payments
- risk corridors
- reinsurance
- fee-for-service with performance incentives
- standard fee-for-service[3].

This administrative entity would likely be a public/private partnership, and may require the development of a Joint Powers Agreement. The entity will have the authority to execute contracts for certain administrative services, such as claims processing at the regional level.

[3] It should be acknowledged that even in fee-for-service arrangements, providers incur some financial risk as reimbursement rates may be inadequate to cover the services provided.

Strengths of the CCS Collaborative Model:

- The CCS Collaborative model maintains a structure similar to that of CCS+ and accomplishes the same functional goals, incorporating all 10 essential elements identified as key to successful CCS redesign.
- As with CCS+, the Public Health focus of the CCS program remains intact.
- Because the CCS Collaborative model envisions enrolling all children who are currently eligible for CCS, lapses in Medi-Cal eligibility will not result in disruption of clinical and/or administrative case management services available to these children and their families.
- Implementation of comprehensive payment reforms, inherent in this model, align with state and federal priorities and support innovation and collaboration.
- The structure of the CCS Collaborative creates opportunities for distributing risk at multiple levels across the system.
- Over time, the CCS Collaborative model significantly controls the state's share of fiscal risk for managing the medical needs of CCS-eligible children.
- The CCS Collaborative ensures that savings resulting from efficiencies would be reinvested in the systems of care for medically complex children.

Issues for the future:

- The details and identity of the regional administrative entity, which is key to the CCS Collaborative model, have not yet been fully described. The complexity of the governance structure may result in a long lead time prior to implementation.
- The costs associated with establishing this administrative entity are unknown, but may not be negligible.
- As a newly created organization, the CCS Collaborative will have to rely upon the experience of its constituent members for managing this care-intensive, heterogeneous and costly population.
- In the course of negotiating fiscal arrangements with the state, members of the CCS Collaborative may be asked to take on more fiscal responsibility than they are prepared to accept.
- It may be challenging to negotiate risk-sharing arrangements that retain fiscally disinterested case management.
- Until the details of risk-sharing arrangements with the state are fully elaborated, uncertainty will remain regarding the types and number of provider contracts the Collaborative will be required to establish. The Collaborative would need to ensure the inclusion of partners with experience in negotiating rates and service contracts.

- Fragmentation could be created if counties are not mandated to participate in the CCS Collaborative, or if the collaborative regions are small.
- DHCS may need to contract with 3-4 Collaboratives in the state.
- This model may face resistance from providers, if the additional layers of administrative oversight take financial resources away from direct patient care.
- This model increases fiscal risk to providers.
- Knox-Keene licensure issues could be a potential barrier to implementation depending upon the structure of the DHCS-Collaborative risk relationship.

Photo 8: John, Glankler MTU

CCS ACOs anchored at Children's Hospitals

Under the CCS Accountable Care Organization (ACO) model, the state would allow CCS providers to form networks that would, over time, become accountable care organizations and assume responsibility for managing all medically necessary care for children with selected CCS-eligible conditions. In order to maintain CCS standards, only CCS-approved providers would be eligible to form CCS ACOs. Each ACO would be anchored by a Children's Hospital and would include affiliated CCS providers throughout the catchment region in order to ensure an appropriate breadth and depth of clinical expertise. The CCS ACOs would contract directly with the Department of Health Care Services and would take responsibility for coordinating all medically necessary care and support services for CCS-eligible children enrolled in the ACO. Capitation would be implemented gradually and enrollment would be phased in slowly for children with selected CCS-eligible conditions. In this way, participating providers would be able to build capacity to assume financial risk for these populations in a discrete and sustainable way, and to identify care coordination approaches and best practices that are most likely to meet the specific needs of the children being served.

The CCS ACOs would assume fiscal risk for the delivery of medical services to enrolled children and would negotiate safeguards so that risk is appropriately and fairly apportioned between contracting providers and the state.

CCS ACOs will need to determine how case management and utilization activities should best be continued under this model, given the lack of experience at children's hospitals in providing community-based case management. During the staged implementation phase, the ACOs would have opportunities to learn from the state and local CCS programs, which have extensive expertise in this area. One option would be for the CCS ACOs to subcontract with county CCS programs to provide case management services.

Children with CCS-eligible conditions that are not included in the ACOs would remain in the existing fee-for-service CCS program. These children would include neonates being treated in the hospital NICUs, because the high costs of serving these children could not be reduced through preventative care or care coordination. CCS-eligible children without Medi-Cal, including the undocumented, would also remain in CCS+. This model would therefore require an indefinite extension of the existing CCS carve-out from managed care for non-ACO-enrolled children. County CCS programs would continue to determine eligibility, and would continue to provide case management services for children not enrolled in the regional CCS ACOs.

Strengths of the CCS ACO Model:

- Providers at California's Children's Hospitals have a long and successful history of treating children with CCS-eligible conditions.
- The carefully staged implementation period would minimize programmatic disruption and allow the CCS ACOs to adjust their approach as experience is gained.
- This proposal would allow for the coordination of all medical care services within one delivery system.

- CCS ACOs would eventually assume most of the fiscal risk for providing all medically necessary services to enrolled children, thus reducing the state's risk burden.
- This approach would align fiscal incentives among providers.
- CCS ACOs ensure that savings resulting from efficiencies would be reinvested in the systems of care for medically complex children.

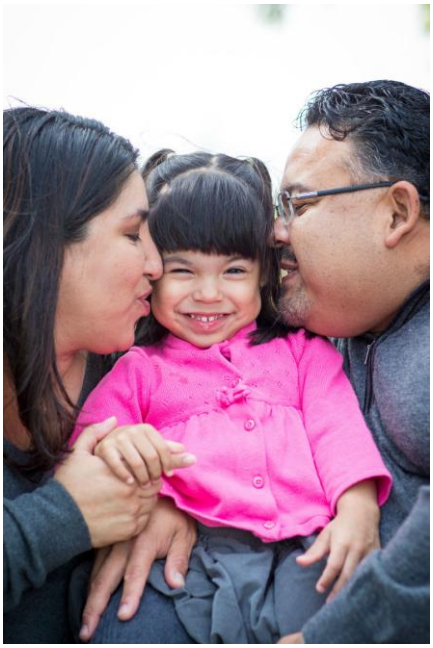

Photo 9: Monica, Glankler MTU

Issues for the future:

- The structure and reach of the ACO's service delivery network and operational capabilities have not yet been defined in sufficient detail to determine whether current Children's Hospitals have sufficient network capacity, operational resources, or financial resources to implement an ACO.
- States have typically had challenges in determining catchment areas and developing criteria for provider/facility driven initiatives such as ACOs, health neighborhoods, and specialty health homes.
- A CCS ACO would not necessarily include fiscally disinterested case management, currently a hallmark of success of the CCS program.
- Children's hospitals currently do not have as much expertise or experience in community-based case management as the county CCS programs have.
- CCS ACOs could result in narrower provider networks, depending on how the networks are designed. A CCS ACO that is financially at risk for some or all healthcare services for these children may have the financial incentive to retain those children within its own network, thus potentially limiting access to providers outside the network who may have greater expertise in specific circumstances. By the same token, the ACO will have the incentive to ensure that children receive support services to allow them to remain in their communities.
- If CCS ACOs exclude children without Medi-Cal, as described, children and their families may experience frequent disruption of clinical and/or administrative case management services as the child's Medi-Cal eligibility status changes.
- Fragmentation will be created by enrolling some CCS-eligible children into the ACOs while retaining others in the current CCS program. Additional fragmentation may result if regional ACOs are numerous and small, with narrow networks, and if they overlap geographically.
- This approach will require providers to enter into new contracting arrangements with at least one ACO and possibly with multiple ACOs within the same region.

- DHCS will need to contract with multiple ACOs throughout the state and likely multiple ACOs within the same region.
- Children's hospitals would need to acquire knowledge and experience in developing relationships with multiple local community providers, vendors, pharmacies, etc.
- This model increases fiscal risk to providers.
- Knox-Keene requirements could be a barrier to establishing ACOs.

Photo 10: Jewleus, West Oakland MTU

BAY AREA STAKEHOLDERS

Alameda County Health Care Services Agency
Alameda County Interagency Children's Policy Council
Alameda Health Consortium
California Children's Hospital Association
CARE Parent Network
CCS Alameda
CCS Contra Costa
CCS Humboldt
CCS Los Angeles
CCS Marin
CCS Mendocino
CCS Monterey
CCS Napa
CCS Placer
CCS San Francisco
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CCS Shasta
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Children Now
Children's Specialty Care Coalition
CMS San Luis Obispo
CMS Riverside
Contra Costa Health Plan
Developmental-Behavioral Pediatrics
East Los Angeles Family Resource Center
Family Support Network
Family Resource Network
Family Voices of California
Hospital Council of Northern and Central California
Insure the Uninsured Project
Kaiser Permanente
Kaiser Permanente Sacramento
Lucile Salter Packard Children's Hospital

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Miller Children's Hospital
Optumas
Pacific Health Consulting Group
Parent of a CCS child
PHD Santa Clara
Salinas Valley Memorial Healthcare System
Santa Clara Valley Medical Center
Stanford Hospital
Support for Families
Sutter Medical Center Sacramento
Through the Looking Glass
UCSF Benioff Children's Hospital Oakland
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