



Department Of Health Care Services

California Children's Services (CCS) Advisory Group (AG) Meeting

April 6, 2016

10:00am – 3:00pm

MEETING SUMMARY

Members Attending: Nick Anas, MD, CHOC Children's Hospital; Dyan Apostolos, Monterey County Health Department; Steven Barkley, MD, Santa Barbara Cottage Hospital; Edward A. Bloch, MD, Children's Medical Services, LA County; Athena Chapman, California Association of Health Plans; Richard Chinnock, MD, California Specialty Care Coalition; John Patrick Cleary, MD, California Association of Neonatologists; Arlene Cullum, Sutter Health; Yvette Baptiste for Juno Duenas, Family Voices; Michelle Gibbons, County Health Executives Association of California; Kelly Hardy, Children Now; Tom Klitzner, MD, California Children's Services, UCLA; Dave Kramer-Urner, Santa Cruz County CCS; Ann Kuhns, California Children's Hospital; Susan Mora, Riverside County Department of Public Health; Tony Maynard, Hemophilia Council of California; Tony Pallitto, Kern County Public Health Services Department; Richard Rabens, MD, The Permanente Medical Group/Kaiser Permanente Northern California; Lee Sanders, UCLA; Ed Schor, MD, Lucile Packard Foundation for Children's Health, Laurie Soman, Children's Regional Integrated Service System; David Souleles, Orange County Health Care Agency; Farrah McDaid-Ting, California State Association of Counties; Amy Westling, Association of Regional Center Agencies

Members not attending: Kris Calvin, American Academy of Pediatrics, CA; Amy Carta, Santa Clara Valley Health & Hospital System Representing: California Association of Public Hospitals and Health Systems; Stuart Cohen, MD, American Academy of Pediatrics, Devon Dabbs, Children's Hospice & Palliative Care Coalition of CA; Karen Dahl, MD, Valley Children's Hospital; Chris Dybdahl, Santa Cruz County; James Gerson, MD, HealthNet; Domonique Hensler, Rady Children's Hospital – San Diego; Katie Schlageter, Alameda County; Abbie Totten, Health Net, Inc; David Alexander, MD, Lucile Packard Foundation for Children's Health; Maya Altman, Health Plan of San Mateo

Members attending by phone: No one attended by phone.

DHCS Staff: Jennifer Kent, Anastasia Dodson, Sarah Brooks, Jill Abramson, James Delgado, and Brian Kentera

Guests: Peggy Hoover, Partnership Health Plan; Mark Maddox, CenCal Health; Terri Stanley, Cal Optima; Kathy Neal, Central CA Alliance for Health

Welcome, Introductions, and Purpose of Today's Meeting **Jennifer Kent, Director, DHCS**

Director Kent welcomed everyone, reviewed the agenda, and the timing of the meeting.

CCS Program Improvement and Medical Home Discussion

Anastasia Dodson, Associate Director for Policy, DHCS

Jill Abramson, Public Health Medical Officer, DHCS

Presentation Slides: <http://www.dhcs.ca.gov/services/ccs/Documents/PowerPointApril.pdf>

Anastasia Dodson provided an overview of the CCS program improvement that is applicable for CCS across the state. The discussion was related to county performance measures that have been published for the past 10 years. These included: Medical Home, timeliness of CCS eligibility, Special Care Center (SCC) referrals, aging out transition planning with the addition of NICU antibiotic use, and medical determination eligibility. The Medical Home was the primary discussion item. In addition, transition planning for youth aging out is an active topic of sharing and coordination. Jill Abramson added that some counties flagged the issue of not having adult providers in the SCCs.

Questions and Comments

Edward A. Bloch, MD, Children's Medical Services, LA County: One aspect of that issue is Genetically Handicapped Persons Program (GHPP) SCC would not see transitioned youths because they could not get paid.

Anastasia Dodson, DHCS: Yes, and that is a topic we can do something about.

Ann Kuhns, California Children's Hospital: DHCS did work with Stanford on post discharge rates of follow-up visits. Ann had questions about the data.

Anastasia Dodson, DHCS: We left that as a data measure topic and further analysis is needed. This discussion focuses on items that we have confirmed data and tangible next steps.

Nick Anas, MD, Children's Hospital Orange County: The issue of transitioning to adult providers is a challenge and an opportunity, regardless of CCS Redesign. Adult providers have no familiarity with the diseases we are asking them to care for.

Laurie Soman, Children's Regional Integrated Service System: There are many reasons for this difficulty in transitioning to adult providers. There is a lack of training because children live now who did not used to survive; rates are an issue; and, there is the issue of losing the support system that children receive through the SCC. This is not the topic for today, but we need to discuss it. There was substantial work done on transition and some counties are working to implement. If anything is useable from that work, let's not recreate. The Title V Needs Assessment included a recommendation to extending CCS to age 26, to allow for longer transition.

Edward A. Bloch, MD, Children's Medical Services, LA County: There are some helpful advances. There are some new boards, for example, an internal medicine cardiology sub-board for congenital heart disease.

Yvette Baptiste, Family Voices: I want to confirm the comments Laurie mentioned. What I experienced as a family during the transition was the care coordination from the SCC was not there anymore. There is a whole set of navigation required.

Anastasia Dodson, DHCS: Thank you for that input. We will now talk about the Medical Home.

Jill Abramson presented slides on the medical home and mentioned DHCS is interested in discussing the topic of transition. The input received from the February 24th Agenda planning conference call was that medical home would be the first topic to discuss, prior to the transition issue discussion. The goal is to have consensus on the definition of medical home; whether to use the medical home in CCS and what entities considered a medical home. Dr. Abramson reviewed slides listing elements of various definitions of medical home adopted by different organizations, in addition to discussing how to measure the medical homes. A number of questions were used to focus the discussion:

- Should CCS require a medical home?
- If so, what should the definition of medical home be?
- For which group(s) of children should a medical home be considered?
- How would requiring a medical home benefit CCS children?
- How would care differ under a medical home from what is provided today?

Questions and Comments

Edward A. Bloch, MD, Children's Medical Services, LA County: I do not think the issue is whether to have a medical home, it is that there are so few practices that will achieve the highest score or meet the definition. Instead, we need a project of quality improvement for the existing sites that have at least some of the core elements in place, such as a board certified pediatrician. At this point, many kids are assigned to medical homes without a board certified pediatrician.

Laurie Soman, Children's Regional Integrated Service System: DHCS did substantial work on medical homes for CCS and it brought forward some of the issues that Edward Bloch has raised. I do not think we expect that every medical home for every CCS child can meet every standard; but we can work on quality improvement to move practices along the continuum toward some type of certification. For me, it would make sense to look back at what we thought were required elements and how can we move along the continuum.

Anastasia Dodson, DHCS: Some of the current discussion is based on the previous work. It is extremely ambitious to meet these rigorous standards statewide. Looking at the questions we have listed, what do we think about the definition that will allow us to move forward to improve care and outcomes?

Tom Klitzner, MD, California Children's Services, UCLA: I sit on a number of groups, including National Center for Medical Home Implementation, Project Advisory Committee. There is growing consensus about the medical home for children with medical complexity and children with special health care needs (CSHCN) look different, and both groups are present in the CCS system. At UCLA, we have about 300 children who need many specialists. We run it like a complex care medical home. We do quality improvement and research. We take it upon ourselves to interact with all the spheres the child is in, like school. That complex medical home has lots of resources and costs a lot to run, but it saves our medical center four times what it costs. The next group services a child who has cancer (or a heart condition) and needs specialty care but not from many different specialists. The last group services children who do not need what the second level, tier two group needs. You cannot give all services to all the

children. How to do that segmentation is important. I believe the top 3% of complex kids' need a primary care provider, in many cases resides near the hospital. It would seem this creates challenges for parents, but they spend a lot of time at the hospital and linking the outpatient care to the hospital allows us to use their hospital visits efficiently. For tier two, children I see once per year, they need services from the social worker or other team members, and they need a pediatrician in the area where they live to offer what a community pediatric provider normally offers. SCCs are not that good at well services, immunizations, etc. Well children need a community-based, Medical Home. This cross-cutting framework with complexity segmented into tiers (Tier 3: complex; Tier 2: special needs but not as complex; Tier 1: well kids) allows for the design of systems to meet the needs of each group.

Anastasia Dodson, DHCS: Thanks so much for that input.

Edward A. Bloch, MD, Children's Medical Services, LA County: My comment is that several SCCs have built into their teams a general pediatrician to serve as the medical home. We already have that mechanism. For 15 years, we have authorized primary care to the most appropriate primary care doctor, who is a board certified pediatrician. The pediatrician may be on the SCC team.

Yvette Baptiste, Family Voices: On the question of requiring a medical home. Yes, from a parent perspective, both the definition and the components are important. We do not want a standard that is less for CCS. In my work on quality standards for adults, we would never think that because the standard is difficult to meet, we should not adopt it.

John Patrick Cleary, MD, California Association of Neonatologists: I endorse the comments of complex care having several ways to be delivered. On the slide of medical home definition, the care in the Neonatal Intensive Care Unit (NICU) should meet the definition. It is not possible to expect a primary pediatrician is immediately identified. Requiring this would create the expectation that the NICU is to help transition the family.

Anastasia Dodson, DHCS: Yes, the work group discussed this issue as, "upon discharge", what is the care plan, providers, etc.

John Patrick Cleary, MD, California Association of Neonatologists: Yes, rather than considering this solely at discharge, the expectation should begin prior to discharge. We should have the CCS-certified NICU provide that level of care from the first point of contact in NICU.

Ed Schor, MD, Lucile Packard Foundation for Children's Health: There is national data on CSHCNs that shows that California ranks last on a number of quality measures. Most are related to the Tier 3 group not getting preventive, standard kinds of care. We all ought to agree that every child should have a regular source of care with responsibility for that child. If we go into managed care, we need to hold managed care responsible. On the different levels of medical home, this is tied to different levels of reimbursement. Payers reimburse differently for each level of medical home. At this point, the complex kids lose money because medical home can only bill as primary care practices.

Jennifer Kent, DHCS: This is a loaded question. Yes, we would want all children to have a medical home. If we were to require CCS providers to ensure a medical home, how would we

measure and track it? That is the challenge to the group. There are many definitions and if we make this a requirement, how would you expect the medical home to be held accountable to providing those services, assuming there is a reimbursement attached. How would the state realize impact other than billing codes?

Edward A. Bloch, MD, Children's Medical Services, LA County: Your question, how do we assure this will happen properly? We have an existing model in the specialty care model that is imperfectly actualized. You can do things similar to what happens in the high volume centers. For lower volume primary care sites, you could have medical home reports submitted to CCS similar to the reports that SCCs submit. You can evaluate the services, the plan of care, just as we do with SCCs. In the current model, some centers do an excellent job of showing that in their reports – some not. There are some who may not be acting as a SCC and there must be some way to enforce standards in the medical home process.

Ed Schor, MD, Lucile Packard Foundation for Children's Health: I think that is right. To get in the door, you need to document the capability, such as certain team members in place. Then, once in the system, you need to document that certain processes are being accomplished and that you are achieving the outcomes we expect from a medical home. I think it should mean holding people accountable to each level of the system over time. This is a quality improvement process as much as a certification process.

Tom Klitzner, MD, California Children's Services, UCLA: My program saves the hospital money and saves the state money, but it does not help the provider because of the reimbursement structure. Every medical home definition has certain structural requirements. I do not think Agency for Healthcare Research and Quality (AHRQ) would understand our model, but AHRQ was able to see the relationship of our services to their requirements. That is a baseline everyone should do at their level of certification. David Bergman at Stanford did work on the performance of different tiers. Standards for Tier 1 are basic Healthcare Effectiveness Data and Information Set (HEDIS) requirements and a community practice should be doing that already. For Tier 2, it should be all of Tier 1 plus the structural requirements of the agencies. Tier 3 requirements are already in CCS standards and they are auditable. The outcomes are in those CCS reports. The reports have extensive notes and are already submitted. Tier 3 specialty care medical home should be doing all the HEDIS and Tier 1 services and standards. We have a care plan, care team, and access plan (for common emergencies) for those types of elements that could determine if the medical home is offering all kinds of care. If you use the matrix of the CCS standard mapped to the level of medical home, it might be a framework.

Laurie Soman, Children's Regional Integrated Service System: I like the idea of looking at acuity. Some County CCS programs are doing that and implementing that already. In Alameda County, we have a medical home project and have done two quality improvement projects with different sites (health centers and private pediatricians) to improve medical home index scores. Northern California seems to have many more pediatricians accepting Medi-Cal than elsewhere. The team concept works well in health centers but they are oriented toward adults. The quality improvement was to focus on pediatrics and kids with special needs. The contrast is the board certified pediatricians who are comfortable caring for special needs kids and are willing to take them. The medical index scores were flipped – health centers were high on cultural competency and not as high on caring for special needs kids. Private pediatricians scored high on knowing what to do for special needs kids but not high in other areas. We want both. We

need to be cognizant of how this plays out in the real world. The American Academy of Pediatrics (AAP) just surveyed providers about their comfort serving as a medical home and that data should be built into this conversation. We should keep an open mind that there is no single way to implement medical home in the variable sites across California.

Nick Anas, MD, CHOC Children's Hospital: Lee Sanders showed 50% of CCS money is in the hospital setting. We need to focus there – we need to keep kids out of Emergency Department (ED). When they go to the ED, they get lots of tests and/or end up in the hospital. Second, the transition from hospital to home will be easier if children have a medical home. Managing an intensive care unit (ICU) taught me that it is hard to get children home once they become an inpatient. We need to have the medical home involved to keep them from going to hospital and work to get them home quickly if they are admitted. And, we can also measure this.

Athena Chapman, California Association of Health Plans: There seems to be agreement that a medical home for CCS is a good idea. I want to understand the implications. For kids in managed care as part of redesign, is the plan the medical home? It sounds like there are challenges bringing all practices up to the standards. Are there implications for plans that have CCS carved-in now? Who the plan contracts with? How do we bring a practice up to CCS standards?

Jennifer Kent, DHCS: We were intentionally not discussing this as fee-for-service (FFS) vs Managed Care. Many children spend time in SCCs, how do we understand the care coordination they receive? How do we measure the care coordination? How do we reimburse for care coordination?

Dyan Apostolos, Monterey County Health Department: I am not certain what the implication is.

Jennifer Kent, DHCS: Athena asked, what about plans vs FFS. We are not speaking at the plan level in terms of expectation. We are dropping this discussion to the provider level, rather than the focus being on who is paid for a responsibility. If we require a medical home, it would apply across the board whether in a whole child model county, a carved in county, etc.

Terrie Stanley, CalOptima: From a plan perspective, we are advocates of health homes/medical homes – not just for CCS kids - because it is the coordination and focus on the care those members need and want. My question is about the availability and readiness of practitioners to offer the services. Given the access standards plans must meet, we would have to discuss how to accomplish this if we cannot have both. If the medical home is 70 miles away and unless there is someone local, when something happens at 10pm, it will mean a trip to the ED with a likely admission to the hospital. We would like to avoid this when it is unnecessary. We have aimed for a local presence of a practitioner who can meet basic needs, while working with SCCs on the child's complex issues. That hybrid model works well in some situations and should be considered in this conversation.

Edward A. Bloch, MD, Children's Medical Services, LA County: Athena's question has practical issues embedded. In some plans, they require time limits for visits, 10 minutes for a practitioner to see a child and accomplish everything. It would be impossible to do medical home services under these constraints. Another point, as much as plans support the concept of medical homes, CSHCNs currently are not assigned to board certified pediatricians in Los Angeles.

They are assigned randomly to primary care. There are plenty of board certified pediatricians to see them, but that has not been the priority.

Yvette Baptiste, Family Voices: Laurie brought up that there are kids in SCCs and they get more coordinated, better quality service. In LA County, lots of kids are seen by neighborhood doctors who are not even pediatricians and the quality is poor. They are not providing a medical home and not collaborating with systems. Therefore, for many kids that will be impacted by this change, we need to ensure quality, especially if we are talking tiers, for the kids in the middle.

Dyan Apostolos, Monterey County Health Department: This would not result in much of a change for kids in Monterey County. Most private physicians do not take Medi-Cal and most CCS kids are in Federally Quality Health Centers (FQHCs). For their viability, the FQHCs do limit the time for visits. There is the flexibility to reassign kids to pediatricians, especially for high needs kids. But in general, we do not have enough access and the high needs kids are most impacted.

Richard Chinnock, MD, California Specialty Care Coalition: This is a challenging conversation because of the diversity of the state. Should we require medical homes for CCS kids statewide irrespective of Whole-Child Model? This is problematic given the different ways care is organized across the state. I am big fan of the SCC designation for a primary care medical home but I think almost all require some backstop funding support from a children's hospital or other entity. In the Whole-Child Model, the advantage is there would be different ways to organize and pay for the care. One size does not fit all for the whole state, it is a challenge.

Tom Klitzner, MD, California Children's Services, UCLA: There are national models for distributing care between the center and distant sites, John Gordon has done work on this. In Medi-Cal, the traditional providers had many patients and were brought into managed care. Now we are talking about high acuity kids and the traditional providers are not the best source of care. The other thing in Medi-Cal managed care is patient choice. Patients look in a directory and pick anyone. I have wondered, should we suggest, if not require, a certain level of certification for some patients' provider?

Jennifer Kent, DHCS: Safety net is the term we use and it implies something in statutory language. We have required safety net providers to be contracted in plans, such as, FQHCs and Public Hospitals. The language has transitioned to primary care and specialty care providers. The patient always has the ability to choose a plan, unless they are in a County Organized Health System county, and to choose a provider within the plan. Beneficiaries are assigned if they do not choose, but they can always switch. You cannot force a patient to see a certain provider. You can encourage because you think it is appropriate, for example "do not use ED", but ultimately, we cannot require. In the larger system, there are fundamental choices patients are allowed. When you overlay CCS in managed care, they could choose to have their specialist designated as primary care provider. We are still trying to hone the way care is provided to CCS in managed care.

Edward A. Bloch, MD, Children's Medical Services, LA County: The freedom of choice hits a brick wall, because it is not okay for parents to endanger their child by choosing a provider that is not appropriate.

Laurie Soman, Children's Regional Integrated Service System: It looks like we are closing out this segment of the agenda so I have a process question. How do we want to proceed on this important issue? We all want to see this move forward. Will this go to a work group? How will we answer these questions and move forward?

Jennifer Kent, DHCS: We can have a smaller, focused group working on definitions, requirements, and other process topics. In addition, after lunch, we could continue to discuss the medical risk assessment question. If we agree everyone needs a medical home, what should be the frequency of medical risk assessments?

Anastasia Dodson, DHCS: The genesis of this conversation was county performance measures. We want to close that out. Should we continue to measure as we are? Is there a different way to measure? Should we look at special care requirements?

Medi-Cal Managed Care Health Plan and CCS Readiness

Sarah Brooks, Deputy Director of Health Care Delivery Systems, DHCS

Javier Portela, Managed Care Operations Division Chief, DHCS

Nathan Nau, Managed Care Quality and Monitoring Division Chief, DHCS

David Banda, Health Program Specialist, DHCS

Presentation slides <http://www.dhcs.ca.gov/services/ccs/Documents/PowerPointApril.pdf>

Jennifer Kent introduced the topic and announced that Patricia McClelland will be joining DHCS, over Systems of Care. Patricia will be the lead for CCS, Children's Health and Disability Prevention (CHDP), and Genetically Handicapped Persons Program (GHPP). She comes from Santa Clara Health Plan and is the parent of an adult son who was a CCS beneficiary.

Sarah Brooks reviewed slides summarizing feedback from the previous meeting's discussion of the comparison chart of CCS, managed care, and Whole-Child Model (Comparison Chart). Sarah mentioned that the Whole-Child Model will meet or exceed the CCS standards.

Feedback on the Comparison Chart received during the last AG meeting included:

- Authorization for Services: Clarify prior authorization definition.
- Case Management or Care Coordination: Recognize County role; separate into two categories.
- Continuity of Care: Documentation describing how transition is accomplished and how to do a "warm hand-off".
- EPSDT: Add EPSDT supplemental services covered by CCS (i.e. Hearing aids/batteries, medical foods, shift nursing care).
- Grievance and Appeals: Identify types of appeals occurring from eligibility and medical necessity. This is important to track concerns and lift up issues.
- Individual Care Plans: Add definitions, roles of the family, assessment parameters, and identify when the care plan is developed and updated.

Additional feedback was received via a comment letter. Ms. Brooks asked Laurie Soman to review the points in the comment letter submitted by Children's Regional Integrated Service System (CRISS), Family Voices of California, Children Now, Children Defense Fund and the Hemophilia Council. The purpose of the comment letter was to ensure that all elements in the CCS column be included the Whole-Child Model column.

Comment letter suggestions:

- Authorization for Services: Attention to staffing in the CCS column, in particular, professional staffing standards should be added. More attention to the authorization process, standards, and the opportunity for expedited authorizations and annual review of authorizations.
- Case Management or Care Coordination: Separate these into two categories and include more detail on the staffing standards for case management. SCCs are very important; however, we should remember there are no SCCs for many conditions. Parent health liaison positions have been lost in some places due to budget issues, but are a good model and very successful to highlight.
- Continuity of Care: One distinction that is not specific in the document is that the child should continue to receive continuity of care as long as they have the condition. Family choice for their provider should be respected and is a CCS practice.
- Early Periodic Screening, Diagnostic, and Treatment (EPSDT): Expand the list of services included under this category such as non-formulary pharmacy, vision and hearing aids, physical therapy, speech therapy, palliative care, and the ability to authorize a rural health clinic as the medical home. The medical necessity definition for EPSDT is different in CCS than for Medi-Cal managed care and plans may not be aware of that.
- Grievance and Appeals: On paper, it may look as though managed care plans have shorter timelines for action, however, Disability Rights CA believes the CCS grievance and appeals are longer than managed care and should be retained.
- Individual Care Plans Care: The language here should be “developed and implemented” with care managers, not just shared. Other care plan requirements should be included such as social work assessments, nutrition assessments, and others.

Additional items not yet included:

- Network Adequacy: This is not included on the list and should be added. Medi-Cal is about time and distance while the CCS network adequacy is about state standards for expertise, adequacy, and access. CCS requires statewide access that is medically necessary, regardless of distance.
- Parental Involvement: This is not uniform throughout CCS, but it is best practice and can be built in, such as family advisory councils, parent liaison, family navigation, and family satisfaction.
- Provider Credentialing: There are specific points in the letter that should be reflected.
- Transition Planning: Add transition items, such as, referrals to specialists after age 21, self-advocacy, dealing with conservatorship, DME requirements (currently less in Medi-Cal than in CCS).
- Transportation, Lodging, and Meals: This is clarified in the comment letter as well.
- Medical Therapy Program (MTP): This is not included in the document. It should be added and noted as a need for integration/coordination between programs.
- Quality of Care: CCS is the population-based program for CSHCNs and this is different than care for expensive children. There are CCS-specific quality programs, such as the California Perinatal Quality Care Collaborative (CPQCC). In addition, there are process and access measures tracked from Children’s Medical Services Network (CMS-Net).

Dyan Apostolos, Monterey County Health Department: On the Medical Therapy Unit (MTU), it is important that there is a liaison between the MTU and the primary care doctor to be sure future assessments are acted on and that there are records on all assessments done in the past.

Laurie Soman, Children's Regional Integrated Service System: In summary, we want everyone to have shared knowledge of what the CCS Program does and recommend that the Whole-Child Model column reflect everything that CCS does.

Sarah Brooks, DHCS: Thank you for those helpful comments. There are two worlds meeting with different languages and this is a good conversation to bring those worlds closer together. We have noted that the managed care column is probably not inclusive of everything that exists or it is presented in different language than CCS uses. I appreciate the inclusion of best practices and we look forward to hearing more about those in these redesign discussions to build on quality of care, spread those practices.

Questions and Comments

Dyan Apostolos, Monterey County Health Department: CCS is built in as a work-around to authorize what used to be In-home Operations (IHO). IHO may need to be looked at in view of managed care.

Edward A. Bloch, MD, Children's Medical Services, LA County: The IHO interface with CCS is far from optimal.

Sarah Brooks, DHCS: We are working on this topic. We are looking at policy and procedures to strengthen how we support children moving from one system to another. We will discuss at a later time.

Yvette Baptiste, Family Voices: What is the next step for the Comparison Chart? Will we get updates?

Jennifer Kent, DHCS: The original purpose of the Comparison Chart is to educate and illustrate Medi-Cal Managed Care, CCS, and Whole-Child Model. We will take the comments and consolidate the document.

Yvette Baptiste, Family Voices: That would be helpful. It is important to be able to go back to parent networks to explain what is different or has changed.

Jennifer Kent, DHCS: The Comparison Chart is meant to be illustrative not the guiding document.

Data and Quality Measures Technical Workgroup Update Stanford Data Analysis

Lee Sanders, MD, Stanford Center for Policy, Outcomes and Prevention

Presentation slides <http://www.dhcs.ca.gov/services/ccs/Documents/PowerPointApril.pdf>

Dr. Sanders provided an update from University of California Los Angeles (UCLA) on paid claims data analysis for more than 300,000 CCS children from 2007-2012 on:

- How do these children use health care services?
- What is the distribution of program spending for that care?

Dr. Sanders walked through data results displayed on a number of slides. He reviewed enrollment data findings that documented differences in enrollment periods based on primary diagnostic category, with the “neurologic” category having the longest enrollment, and “injury” having the shortest enrollment. He reported on spending by health service. Hospital costs account for 50% of the cost. Moreover, the distribution of program spending analysis indicates that a small number of children account for the largest costs. He reviewed a number of policy briefs and data reports on the web site, <https://cpopstanford.wordpress.com/reports-and-policy-briefs/>.

Questions and Comments

Ann Kuhns, California Children’s Hospital: I do not understand how to interpret the charts. Can you include standard deviation and median? It might be easiest to understand if there was a median, as well as, the specific detail.

Lee Sanders, MD, UCLA: We will include that in the revision.

Edward A. Bloch, MD, Children’s Medical Services, LA County: These data give the impression that CCS is responsible for the decisions to spend money in each of the categories you list. In fact, CCS is not responsible for determining residential placement or home health. Those are Medi-Cal decisions.

Jennifer Kent, DHCS: It does not imply CCS is responsible. However, if a child has a CCS eligible condition, the claim is part of the data analysis.

Edward A. Bloch, MD, Children’s Medical Services, LA County: Yes, and there may be opportunities to be more efficient, that CCS is not involved in. Home health expenditures, in particular, are not always health care from our point of view. I am not referring to ventilators or kids with medical needs, but there are fair number of kids that can achieve the services they need with respite care, not private duty nursing.

Jennifer Kent, DHCS: Home health is a large category and it includes sub-acute situations. It may be the way the data is characterized.

Nick Anas, MD, CHOC Children’s Hospital: Are you doing a deeper dive into the hospital costs so we can learn more about those expenditures?

Lee Sanders, MD, UCLA: Yes, however as we get deeper into administrative data, it gets tricky to ensure it is valid.

Tom Klitzner, MD, California Children’s Services, UCLA: This is fascinating data. The CCS spend by health category – when you say .03 of kids account for 80% of spending, you are referring to .03 of all enrollees, correct?

Lee Sanders, MD, UCLA: Yes.

Tom Klitzner, MD, California Children's Services, UCLA: This is an issue of priorities for our targeting. The prevalence may be low in residential care and it would be tough to move the spend lower. For hospital costs, there may be a larger number of kids, more days, and more opportunity to lower costs. For outpatient pharmacy, the cost is high but it is likely a few high cost drugs. A deeper dive will help us understand the targeting.

Yvette Baptiste, Family Voices: I want to go back to the comment about home health. Parents have difficulty providing care to very fragile children. It is really important to have the right care at home to support parents.

Edward A. Bloch, MD, Children's Medical Services, LA County: I am not suggesting they should not be at home. I do not have data at the moment, but there are cases brought to me with no real nursing care being provided for the children. I agree those children need to be at home and the parents need support.

Michelle Gibbons, County Health Executives Association of California: What is the lens that DHCS is bringing to the data?

Jennifer Kent, DHCS: Dr. Sanders has a long standing interest in this data that pre-dates this redesign group. DHCS used the data presentations throughout stakeholder meetings to ground decisions and recommendations. The data can be helpful to us and to external groups. It is not about targeting cost reductions; it is about understanding high cost populations. We see similar data in other groups, like the Dual Eligible population. For them, it was "How can we get them home with In-Home Support Services (IHSS) rather than in an institution?" I look at the data to help us understand what is useful to focus on.

Tom Klitzner, MD, California Children's Services, UCLA: I appreciate the way the data is used by DHCS. When we looked at hospital savings, the ED costs were included in the hospital stay and it was not broken out. We believed, if we prevented some of the ED visits, we would avoid the admission.

John Patrick Cleary, MD, California Association of Neonatologists: Some home health costs also impact hospital costs. The availability of a next step can also impact longer stays.

Lee Sanders, MD, UCLA: I agree. It is correct that ED cost is part of hospital. To Michelle's questions, here are some themes in our research group: Who are the vulnerable children and where are the systems vulnerable? What is the ability of systems to care for CCS kids? What are the opportunities? We do not have a universal clinical data-set but we can use the claims data to examine some items.

Jennifer Kent, DHCS: We had Jim Watkins, head of the research and analytics group, do a presentation of children in Medi-Cal. CCS children were lifted up in that data and co-existing mental health conditions was found important. He has access to data that Dr. Sanders does not have. The ED visits were most likely to be a respiratory condition regardless of their CCS condition. These highlights help focus our attention and activity.

Ann Kuhns, California Children's Hospital: It would be great to democratize the data. The reports are helpful, but when I have follow-up questions, it makes me wish I wish I could have access to the data; especially for questions where only a few of us are interested.

Lee Sanders, MD, UCLA: We do not want to monopolize the data and we have looked at how we can collaborate with others.

Ann Kuhns, California Children's Hospital: It seems the data should be similar to the California Health Interview System (CHIS). Rather than have us ask individual questions, allow us to pay for data analysis that is relevant to a specific question.

Jennifer Kent, DHCS: It is not clean data; not de-identified, so there are policies about how it can be used that involve legal agreements and prevent it from going farther afield. Dr. Linette Scott is leading the open data portal effort for DHCS. This data is quite different than CHIS.

CCS Performance Measures

Linette Scott, Information Management Deputy Director and CMIO, DHCS

Presentation slides: <http://www.dhcs.ca.gov/services/ccs/Documents/PowerPointApril.pdf>

Dr. Linette Scott offered an update from the Performance Measures work group meetings on four items: Medical Home, Determination of CCS Program Eligibility, Special Care Center Referrals, and Aging Out Transition Planning. There has been input offered from a range of stakeholders. DHCS is also looking at how to work with different kinds of available data to minimize new data collection. What measures help us understand the population? How are we doing caring for children under the various models?

Questions and Comments

Laurie Soman, Children's Regional Integrated Service System: Earlier, there was a discussion of eliminating the current medical home measure. What are your thoughts about how the current medical home data through CMSNet can be used? Are you looking to change the definition?

Linette Scott, MD, DHCS: I do not have a specific answer yet. As we move forward, some of the measures may need to change and how we define the terms. The health care environment is changing rapidly overall. The conversation has been about defining the terms and what do some of the measures mean, in one context compared to how it may be used in another context. What does the measure tell us? How do we leverage technology and the health exchange? How do we use quality and process measures, as well as administrative data? How do we drill down to compare and identify best practices?

Jennifer Kent, DHCS: Are there measures in DHCS or elsewhere that is a combination or hybrid of administrative and outcomes? In the absence of good administrative data, are there good proxies?

Linette Scott, MD, DHCS: An example might be the measure for transitions and referrals: it counts things, but the underlying question is how do we think about how children move through the system as they age that can serve as a proxy for the system overall. Sometimes we do not

have clinical data, but there is a lot we can learn from the administrative data. That challenges us to think about proxies. We are working on psychotropic medications for foster children and recently posted some results. When we think about that and HEDIS measures, they get at different steps in the process. Some measures tell us about the prescriber, others about the how the system works together. If a child has to go to three different locations for us to do well on that measure, then that measure gives us an indication of how well the system is integrating; how the system is working. That is how we need to think about the data we have, to understand the system.

Sarah Brooks, DHCS: Are clinical and administrative measures together hybrid measures?

Linette Scott, MD, DHCS: There are specific measures that are clinical in HEDIS. Sometimes, it is administrative claims data and clinical chart review combined. Where we can use administrative data, it is easier.

Care Coordination / Medical Home / Provider Access Technical Workgroup Update

Anastasia Dodson, Associate Director for Policy, DHCS

Presentation slides: <http://www.dhcs.ca.gov/services/ccs/Documents/PowerPointApril.pdf>

Anastasia Dodson reported on the work group meetings. She commented on the overlap with other discussions, such as medical home that are being discussed. At the January webinar, three counties presented different models being used. The webinars are well attended and seem useful to the work. She invited members present who participated in the webinar to comment. The next meeting is June 3, 2016.

Questions and Comments

Tony Maynard, Hemophilia Council of California: There will be a point where it will be useful to have our managed care colleagues at the table.

Laurie Soman, Children's Regional Integrated Service System: I have a different question. On the draft All County Letter concerning the Whole-Child Model, page two outlines the populations and I am concerned that it says "up to age 18". Is that a mistake?

Sarah Brooks, DHCS: Yes, we got comments and will fix it.

Laurie Soman, Children's Regional Integrated Service System: There are CCS state only children who come in under other coverage rules - I cannot imagine they will all be enrolled?

Jennifer Kent, DHCS: No, state-only means undocumented individuals, not other coverage.

Dyan Apostolos, Monterey County Health Department: Under General Questions and Timeline, it lists palliative care. I thought the palliative care waiver was carved-out of managed care?[?]

Jennifer Kent, DHCS: It would be helpful to have a comment submitted to DHCS on this topic. Managed care is responsible for palliative care under hospice benefits, so it is a distinction between palliative care waiver vs palliative care as a service.

Ed Schor, MD, Lucile Packard Foundation for Children's Health: Going back to the question of health assessments, our foundation published a report on how several states are approaching this that may be a resource. No one seems to have the answer so whatever California chooses to do is likely to be in the spectrum of what others are recommending. Important highlights from the literature to consider include co-existing mental health conditions, neurologic conditions, and social complexity. The social complexity topic brings up who is fiscally responsible, CCS or others? One method is to tier and use the Chronic Disease Screener from the National Center for Health Statistics, National Survey for Children's Health. It is an instrument with 15 or more questions. The issue is in how it is scored, but could be a good starting place. However, Florida used it, but scored it a way intended to exclude children from the program, not include them. So, as you approach health assessment, it is important to consider the assessment's intent.

Jennifer Kent, DHCS: When I asked about the health assessment as a tool, I was thinking about the fact that you may not have the full complement of information outside CCS. Is it helpful to the provider or care coordinators to have a check-in every six months or year to know about changes? How do we coordinate care if we do not know about things outside the CCS condition?

Ed Schor, MD, Lucile Packard Foundation for Children's Health: Where it gets murky is in the tiered categories. If someone is in tier 2 with a single chronic condition, but if there are other factors such as a parent with mental illness, it becomes very difficult to manage the child's care. Perhaps this should push them to Tier 3. So many other factors beyond the health condition influence the management of the conditions.

Jennifer Kent, DHCS: I am referring to a full assessment including all the surrounding factors such as homelessness, foster care setting. All the items that help providers do a care plan as well as anticipate needs due to those other factors.

Edward A. Bloch, MD, Children's Medical Services, LA County: To the extent that families communicate with us, we do address all those things in our new model, not just the CCS eligible condition. The more complex category does take account foster care or a family with difficulties.

Steven Barkley, MD, Santa Barbara Cottage Hospital: I agree that complex social needs should bump kids from Tier 2 to Tier 3, but complex medical care is not going to help get a child fed.

Tom Klitzner, MD, California Children's Services, UCLA: I agree with these comments. You suggested and I agree that assessment is a moving target. I think this argues strongly for the primary care, outpatient pediatrician to be involved. As much as I appreciate my SCC colleagues, they tend to focus on the high medical acuity issues they are dealing with and not the changes in social setting that may have occurred. The primary care medical home is the right setting to do the kind of assessment you refer to. In our project, there is a large questionnaire, of parents of CCS children and there is a very significant number we are finding with mental health issues.

Yvette Baptiste, Family Voices: It seems that the tier model is positive. However, I want to make sure that when things change or a child goes from one tier to another, a family is involved in the decision making and not just informed by a letter. I also have a question about where we

want to end up as a group. What can DHCS tell us about this process? Where are the issues going?

Jennifer Kent, DHCS: CCS Redesign has multiple tracks. First, the Whole-Child Model has a timeline. Second, DHCS acknowledged that post-ACA (Affordable Care Act), we needed to look at all of our process and programs. This is a strong program but it can be improved and this process also can address a concerted effort to improve the system. For example, if we want to focus on specific targets and specific metrics, we have to start with the process we are engaged in now. What are the right measures and how are they defined? There will be a series of process and quality items that we want to get feedback about as part of a long term effort.

Public Comment

Ken Adams, San Bernardino County CCS: Was the spend analysis a reflection of a pattern or a certain point in time? If this is to inform policy, is it useful to look at only one year?

Lee Sanders, MD, UCLA: That was a report across the claims for one year. We do want to look at trends over time.

Aaron Starfire, Maxim Home Healthcare Services: I want to echo support for the idea of a tiered structure. We are the largest provider of complex home care in California. What we see is that whether it is a premature infant discharged home from a hospital on a ventilator or a 14-year-old fully integrated in the community, it is the same reimbursement, regardless of the child's stability. A tiered reimbursement matched to complexity will help those with complexity get the care they need in a more efficient way. When the care is more complex and the fee is the same, it does not allow for the care that is needed.

Next Steps and Next Meetings

There was a change in the meeting schedule for the next meeting. It will be June 29th instead of July 6th. All materials will be posted on the website, CCSRedesign@dhcs.ca.gov.

June 29, 2016

October 5, 2016