Department of Health Care Services
California Children's Services (CCS) Advisory Group
April 12, 2017

Meeting Summary

Members that attended: Richard Chinnock, MD, California Specialty Care Coalition; John Patrick Cleary, MD, California Association of Neonatologists; Arlene Cullum, Sutter Health; Juno Duenas, Family Voices; Tonya Erickson, Monterey County Health Department; Bob Freeman, CenCal Health; Liz Gibboney, Partnership HealthPlan of California; Michelle Gibbons, County Health Executives Association of California; Kelly Hardy, Children Now; Teresa Jurado, CCS parent representative; Tom Klitzner, MD, California Children's Services, UCLA; Dave Kramer-Urner, Santa Cruz County CCS; Ann Kuhns, California Children's Hospital Association; Lael Lambert, Marin County CCS; Alan McKay, Central California Alliance for Health; Ed Schor, MD, Lucile Packard Foundation for Children's Health; Michael Schrader, CalOptima; Laurie Soman, Children's Regional Integrated Service System; David Souleles, Orange County Health Care Agency; and, Amy Westling, Association of Regional Center Agencies.

Members that attended by phone: Maya Altman, Health Plan of San Mateo; Kristen Dimou, County of San Diego Health and Human Services Agency; Lara Khouri, Children's Hospital Los Angeles Medical Group; Ann Kinkor, Epilepsy California; and Tony Pallitto, Kern County Public Health Services Department.

Members that did not attend: Nick Anas, MD, Children's Hospital – Orange County; Steven Barkley, MD, Santa Barbara Cottage Hospital; Michelle Cabrera, SEIU California; Kris Calvin, American Academy of Pediatrics, CA; Domonique Hensler, Rady Children's Hospital of San Diego; Kausha King, Care Parent Network; Tony Maynard, Hemophilia Council of California; and Farrah McDaid-Ting, California State Association of Counties.

DHCS Staff: Jennifer Kent, Director; Jacey Cooper, Assistant Deputy Director; Patricia McClelland, Division Chief; Javier Portela, Division Chief; Nathan Nau, Division Chief; and Maria Jocson, MD, Public Health Officer.

Guest Speakers: Maya Altman, Health Plan San Mateo (HPSM) and Hahn Pham, HPSM.

Agenda: http://www.dhcs.ca.gov/services/ccs/Documents/Agenda04-12-2017.pdf
Presentation slides: http://www.dhcs.ca.gov/services/ccs/Documents/Presentation04-12-2017.pdf

Welcome, Introductions, and Purpose of Today's Meeting
Jennifer Kent, Department of Health Care Services (DHCS)

Ms. Kent reviewed details for the day and invited the Advisory Group committee members to introduce themselves.

Federal and General Updates
Jennifer Kent, Department of Health Care Services (DHCS)

Federal updates were provided that included the May Revision information. It was announced the implementation of the CCS Whole-Child Model (WCM) would be delayed six (6) months for all phases. The delay will allow more time for rate development, network adequacy assessment, outreach, and communication related to the changes. DHCS shared an analysis regarding the American Healthcare Act (Federal perspective) and prioritized three key issues:

- Per Capita Cap - DHCS estimated a significant, multibillion dollar loss to the State's program,
- CHIP eligibility, and
- CHIP Reauthorization - DHCS received information this most likely not come up until fall 2017. DHCS does have changes in the budget based on the CHIP reauthorization and the Department has assumed it will be reauthorize at the lower level of funding.

Performance Measures Technical Workgroup (TWG)
Patricia McClelland, Systems of Care Division Chief, DHCS
Dr. Maria Jocson, Public Health Medical Officer, DHCS

DHCS formed a Performance Measures TWG to align and standardize performance measures for Children and Youth with Special Health Care Needs (CYSHCN) across various programs. TWG specific tasks included review and discussion of: the performance measures categories, identifying any gaps and overlaps among the programs, defining new or redefining existing performance measures, and identifying data sources for the various performance measures baselines. The various programs included the CCS Program, Title V Federal Block Grant, 1115 Waiver CCS Demonstration Project, and the WCM.

Refer to the PowerPoint Presentation, slides 4 through 10.

Questions and Comments

Question: Can DHCS help us understand what is being looking at regarding the family participation category?

Response: There are specific measures under each category in the matrix and one category is family participation. For example, Title V, is an example of an evidence based measure and is used to measure the input in transition planning. Under CCS Program Plan and Fiscal Guidelines (PFG), there is a family evidence-based survey that was used, and there are components to the survey like whether the family is involved in the plan for special care center (SCC) referrals or whether the family member is an expert on CYSHCN.

Question: Did the topic of linking data for babies transitioning from NICU come up at all? For instance, it is worthwhile to mention there is some low hanging fruit that the State is already involved with, such as California Perinatal Quality Care Collaborative (CPQCC) and developmental follow-up.

Response: Yes. In relation to the High Risk Infant Follow-Up (HRIF) Program, DHCS is analyzing how to link NICU discharged patients to follow-up care.

Question: What is the percentage of high-risk cardiac patients receiving follow-up services at the clinics? What are the subgroups of subspecialty care qualifying for diagnoses that could be expected to be in the system?

Response: DHCS, along with the CPQCC contractor, Stanford, are researching the data that both identify CCS eligible conditions and the specific conditions identified by HRIF. DHCS and Stanford are looking at the percentage of cardiac patients being seen at follow-up and how these patients are being followed by their general pediatrician or subspecialist, beyond the HRIF period. In October 2016, DHCS updated the HRIF medical eligibility criteria to include congenital heart disease.

Question: Will the AG members be able to see the feedback from the two webinars?

Response: Feedback from the first webinar was previously shared during the second TWG webinar. DHCS is currently compiling and analyzing the feedback from the second webinar and will be completed in 6 to 8 weeks.

Question: Should the AG members expect to see another draft of the Performance Measures Recommendations in 6 to 8 weeks?

Response: DHCS will provide the final Performance Measures Recommendations draft to AG members for a two-week comment period; and DHCS will consider the comments prior to finalizing the measures.

Question: What are DHCS's plans to collect baseline data both in the county organized health systems (COHS) and the 37 other counties? There are two ways to collect baseline data for the following: 1) There is the general evaluation around Senate Bill (SB) 586; and 2) Evaluating CCS Programs.

Response: DHCS is not at the stage to collect baseline data.

Durable Medical Equipment (DME) and Continuity of Care (COC)
Patricia McClelland, Systems of Care Division Chief, DHCS

DHCS hosted a series of targeted discussions with various representatives that included County CCS MTP therapists, physicians from Children's Specialty Care Coalition, family advocacy groups, and DME vendors. The purpose of the discussions was to receive feedback to identify what specialized DME items to include in the COC provision specified in SB 586, to identify best practices, and to identify the DME program transition concerns.

Refer to the PowerPoint Presentation, slides 11 through 16.

Questions and Comments

Question: What kind of concerns were the vendors voicing?

> *Response*: Vendors do not understand how they are going to be paid. Vendors are currently paid by invoice and want to know if this process will continue in the health plan environment.

Question: I recall hearing vendors were concerned about what they were being paid and that sometimes this is a barrier for finding vendors willing to serve this population. Did that come up?

> *Response*: The feedback received from the vendors related to the lack of vendors in certain areas. The rates did play into their feedback.

Question: Did either vendors discuss a limitation on items they provide?

> *Response*: One vendor specialized in custom wheelchairs and the other vendor specialized in orthotics/prosthetics. Within those specialties, no limitation on items they provided was discussed.

Question: Did this group touch on what the two vendors' relationship is going to be between the Medical Therapy Program (MTP) and the health plan around authorization and payments?

> *Response*: The discussion did not include that topic. It was specific to the DME and COC.

Question: What is the mechanism for promoting a good relationship between the MTP and the health plans? Specifically around the expertise from the MTP and its recommendation in the authorization process?

> *Response*: The Memorandum of Understanding (MOU) will address the need to develop the relationship between the health plans and the counties. DHCS will host a workshop or webinar with the health plans and counties to start the discussion around the MTP and Medical Therapy Unit (MTU) conferences.

Question: Is the Department thinking about ways or have some type of communications among the health plans? Are there any vehicles for cross plan communication?

> *Response*: Health Plan of San Mateo (HPSM) is here to talk about their lessons learned and experience under the pilot. DHCS also hosts a monthly call with the health plans. The health plans can share their concerns, information, and connect with each other.

Neonatal Intensive Care Unit (NICU) Update
Javier Portela, Managed Care Operations Division Chief, DHCS

DHCS formed a discussion group to review what is occurring today in various NICU scenarios and what those same scenarios might look like in the WCM. The group will develop a recommendation based on the outcomes from the discussion group.

Refer to the PowerPoint Presentation, slides 17 through 20.

Questions and Comments

Question: What is the issue the group is discussing?

Response: The focus is primarily on NICU acuity, authorization, and payments. The group looked at which entity will perform the NICU acuity assessment, which entity will be authorizing the care, and which entity will be responsible for payment in the WCM.

Question: Is the group also looking at the issue of who is paying during the first few months or when the baby can be on the mother's Medi-Cal?

Response: This topic was discussed and adjustments have been made to the program.

Question: Previously, an issue that came up was the acuity criteria. Is the group looking at it because it is not part of CCS eligibility?

Response: Yes. The group is looking more at the structural process of NICU acuity assessment and not at eligibility.

Health Plan San Mateo (HPSM) Best Practices and Lessons Learned
Maya Altman, Chief Executive Officer, HPSM
Hanh Pham, CCS Demonstration Project Director, HPSM

Hanh Pham shared HPSM's lessons learned and experiences from the last four (4) years as a CCS pilot program, and how they developed their model.

Refer to the PowerPoint Presentation, slides 21 through 36.

Questions and Comments

Question: Can you describe the relationship between HPSM and San Mateo County CCS Program, and the decision-making points that led to the contractual structure of HPSM retaining the CCS staff? Can you also speak to the system HPSM is using, and how you share data back and forth?

Response: Under the CCS pilot, HPSM is the entity the State contracts with for all utilization management and care coordination for patients who are both in the CCS Program and HPSM. HPSM subcontracts with the county CCS Program to provide care coordination and utilization management.

In terms of the structure of how decisions are made, they are made jointly. Initially there were monthly meetings and eventually bi-monthly meetings. The meetings included CCS administrators and medical directors, HPSM's CCS pilot medical director, and other staff. Discussions include roles and responsibilities and what changes should be made. In terms of information technology (IT), information sharing and communication; CCS staff are co-located with HPSM and this is helpful. County CCS Program also have access to all of HPSM IT system via a remote computer system. In addition, County CCS Program provides HPSM with reports we need from CMSNet.

Question: HPSM is in a pilot program. The understanding is the pilot will expire and HPSM will be transferring to the WCM. What does HPSM envision changing with the transfer?

Response: HPSM does not envision much change. WCM gives county organize health systems (COHS) the responsibility for CCS and the CCS patients. It is similar to what HPSM is doing now.

Question: Will the financial structure between HPSM and county CCS change?

Response: No. It should not.

Question: We have been talking about counties no longer receiving the enhanced match for services. Is that going to be for all WCM counties?

Response: Yes. The WCM counties will not get the enhanced match for clinical staffing on the administrative costs.

Question: How is HPSM handling inter-county transfers (ICT)?

Response: It is not much of any issue, but HPSM does recognize they will have to find a way to provide information to the county CCS Program. HPSM has been discussing with county CCS and the State on what type and how much information to share for ICT.

Question: Were there any true implementation challenges? What did HPSM do until the system worked?

Response: The biggest negotiation was county CCS and HPSM getting comfortable with the evidence-based guidelines. County CCS uses the CCS numbered letters (N.L.) and HPSM uses the Milliman Care Guidelines (MCG). DHCS requires written evidence base guidelines when making any type of clinical decision. The CCS N.L. are not always comprehensive and do not always have written clinical guidelines. HPSM worked with the county to use the MCG if there was not a N.L.

Question: Were there situations where N.L. and MCG were not specific enough? MCG tends to not deal specifically with this patient population.

Response: One of the concerns CCS staff had is that MCG were not specific enough to pediatric CCS patient. The HPSM CCS medical director was needed for those cases. If

there is no CCS N.L. and no appropriate MCG, HPSM entrusts our medical directors to make the appropriate decision.

Question: Most people would recognize the MCG is not designed for complex pediatric population. CCS medical directors often research individual circumstances. The children often have rare conditions and treatment medications. In those situations, is there a role for the CCS medical director to help negotiate when there is not a specific guideline from the N. L. and the MCG?

Response: The county CCS medical director, the HPSM CCS pilot medical director, and the HPSM chief medical officer rely on each other's experiences as much as possible. HPSM trusts the medical directors will use their physician training to make the appropriate decision.

Question: What does care coordination mean to you? Is it with the system for medical care or all the systems that are involved with the child with disability and their special health care needs?

Response: For HPSM, care coordination means to provide proactive care coordination that meets the needs of the patient, the family, and social and medical needs. HPSM understands these things have a big impact on each other, such as it is hard to take care of medical needs when the patient has psychosocial needs. Similarly, the parents are the major caregiver of the patients. HPSM wants to ensure if there were any major issues affecting the families, they could help and be an added resource for them.

Question: Can you define "all" transitional needs?

Response: HPSM has a checklist that includes medical needs. It asks the patient if they have a primary care doctor, adult primary care doctor, adult specialist, DME prescription, housing, education, and transportation. It ensures all psychosocial needs are addressed as well.

Question: In regards to patient involvement, how involved are HPSM's patients?

Response: HPSM solicits feedback from the patients and ask them to share their thoughts on how HPSM is performing on various aspects such as the care coordination and the pediatric intake evaluation. HPSM's family subcommittee reviewed the survey and provided HPSM with feedback to make sure the survey was effective and user friendly. After the family subcommittee reviewed the survey, a parent liaison, and select families completed the survey; HPSM edited the survey accordingly based on feedback.

Question: Is HPSM including schools in the patient's care coordination plan? How is HPSM explaining these coordination plans for a child, in a special education program, with very special needs where the MTUs are?

Response: For children with individualized education plans (IEPs), the CCS nurses coordinate services with the schools as appropriate, especially around physical therapy and occupational therapy, and speech. Currently, HPSM is primarily focusing on coordinating

services with many different agencies, however they would like to have the schools involved.

Question: Can you give examples of the frequency and challenges when there is not an appropriate CCS provider in the network or out-of-network versus an agreement to use a non-CCS noncontract provider?

Response: HPSM initially asks the patient to use an in network CCS-paneled provider. Sometimes that is not possible if a patient has a long-term established relationship with a non-network provider. HPSM does not want to break that relationship and will allow the patient to go out-of-network. Cases involving an out-of-network, non-CCS paneled provider is rare. It usually occurs when a patient needs long-term care. The facilities do not want to contract with the health plan nor do they want to be CCS-paneled provider. HPSM will do a letter of agreement with the facility.

Question: What are the respective roles for care coordination between the specialty care center and the health plan? With behavioral health as an example, the SCC would handle care coordination.

Response: Behavioral health is a Medi-Cal benefit. HPSM is required to provide mild to moderate behavioral health services. The county mental health department provides HPSM's behavioral health services. For CCS patients, the CCS coordinator is involved to make sure the patient is able to access services and coordinates follow-up care, if needed.

Question: What is HPSM's relationship with the Medical Therapy Program (MTP)?

Response: HPSM relies on the Medical Therapy Unit (MTU) to authorize DME and therapy for patients in the MTU. HPSM is able to use the MTU's expertise and feels there is no need to make changes to the current relationship.

Division of Responsibility and Allocation Methodology Update
Jacey Cooper, Assistant Deputy Director of Health Care Delivery Systems, DHCS

DHCS provided an update on the division of responsibility and the county allocation methodology.

Refer to the PowerPoint Presentation, slides 37 through 40.

Questions and Comments

Question: Is there an intent to update with the current caseload?

Response: Yes. DHCS will use the same time-period when caseloads are pulled for budgeting purposes.

Open Discussion

Jennifer Kent, Director, DHCS

Question: Is there a plan to hire and fill the CCS chief medical officer position?

Response: Yes. DHCS intends to fill the position. It is difficult to recruit medical experts at the State so it may be awhile.

Question: Are there any plans to update numbered letters and/or produce new numbered letters?

Response: DHCS is working on many important issues. If there is a particular numbered letter-causing confusion in the field and need to be address, DHCS is always willing to take feedback.

Public Comments

Jennifer Kent, Director, DHCS

No questions during this section.

Next Steps and Next Meetings

All materials will be posted on the DHCS website at http://www.dhcs.ca.gov/services/ccs/Pages/AdvisoryGroup.aspx

Next meetings on the following dates:

- July 11, 2017