

# California Children's Services (CCS) Redesign Data Technical Workgroup (TWG) Kick-Off Webinar Summary Notes Friday, February 20, 3-4pm PST

The complete recording of this webinar is available [here](#).

## Role of the Data TWG and potential research areas - Dylan Roby, UCLA

Dr. Dylan Roby (UCLA) welcomes everyone to the webinar, introduces the group's co-chairs, Mr. Brian Kentera (DHCS) and Dr. Lee Sanders (Stanford Center for Policy, Outcomes, and Prevention (CPOP)), and the other TWG members who are on the call. Dr. Roby explains that the role of the Data TWG will be to triage and prioritize requests for information from other TWGs, find out if the relevant information is available and the requisite analyses feasible, and consider potential for future data development to facilitate provision of any data that isn't currently accessible or in a useable format. He suggests a few potential areas of exploration for the Data TWG, based on previous suggestions from RSAB members:

1. Access and include denied and unpaid CCS claims in the aggregate claims database.
2. Assess potential for development of a "data warehouse" to allow CCS providers to share de-identified data and track outcomes over time for future monitoring and evaluation.
3. Analyze cost containment issues and make projections about potential cost impact of proposed Redesign changes to the CCS program.

## Existing Sources of CCS Data - Brian Kentera, DHCS

Mr. Kentera introduces himself and presents an overview of the existing sources of CCS data that the State has access to and that RSAB and TWG members can use in their work.

1. Claims and encounters: Claims are reported in the 35C paid fee-for-service (FFS) claims and managed care encounters data set. The data dictionary and technical specification manual for the 35C are publicly accessible [here](#). The 35C dataset includes CCS-authorized claims, Medi-Cal FFS claims, and Medi-Cal Managed Care encounters. Approximately 90% of CCS enrollees are Medi-Cal enrollees, so non-CCS authorized FFS claims in the database are generally for primary care. The database also contains claims from other sources if they are associated with Medi-

Cal, such as the Department of Social Services, Department of Mental Health, and the Department of Developmental Services. Unlike “carved-out” counties, which have CCS FFS claims, carved-in counties have managed care-like encounters, which may not have complete or accurate cost or diagnosis information. Mr. Kentera noted that currently there are some inconsistencies in the data on eligibility diagnoses across counties and between claims and encounters. To ameliorate this, the State is trying to tie the primary CCS-qualifying condition diagnosis to the diagnoses on the claims and encounters. Dr. Sanders notes that CPOP was able to do in their analytics.

2. Eligibility: CCS eligibility data is included in the Medi-Cal Eligibility Data System (MEDS), which includes the date of eligibility, one of eight qualifying codes for Medi-Cal, the health plan, some family information, and the CCS indicator. Once an enrollee is approved for CCS enrollment, their data is also accessible in the Children’s Medical Services Network (CMS Net), the county/state case management system for CCS. Within CMS Net, there is data on up to 99 CCS-eligible conditions for an enrollee, as well as the county geographic region, financials, language, and case closure information.
3. Service Authorizations: Service authorizations, which must be received prior to any CCS services can be performed, are also included in CMS Net. Within the service authorizations, there are data on the client, the service code(s), usually the CCS diagnosis, admit days for inpatient claims, and provider/facility information if the authorizations are to a specific provider.
4. Provider Information: Since CCS providers must also be Medi-Cal providers, there is a detailed data set on Medi-Cal providers, including NPI codes, name, location, provider type, and a flag to indicate if they are CCS-paneled or part of a CCS Special Care Center.

Suggestions for data queries, based on the Mr. Kentera’s overview of existing data:

- a. Data TWG member Ms. Ann Kuhns suggests that if there is any way to query the counties and see if there are any common areas where the data are particularly inconsistent, that would be useful both in helping us interpret the data and identify areas for reporting improvements. If we could then do a targeted query on specific claim types that have been identified by certain counties as consistently denied or unpaid, we could get a better sense of inconsistencies across counties. She suggests that this might be something we could collaborate with the County/State Relationships TWG on.
- b. Dr. Roby suggests we take that a step further and feel empowered to make recommendations around coding standards to improve data uniformity and quality as part of the Redesign.

## Overview of Stanford CPOP's CCS Administrative Data Analyses – Lee Sanders, CPOP

Dr. Sanders introduces himself, describes how he and the CPOP team have been working with DHCS, with support from the California Health Care Foundation (CHCF), to analyze the claims data and authorizations in CMS Net through 2012 (and soon 2014). The slides for Dr. Sanders' presentation at the first RSAB meeting in December 2014, detailing much of CPOP's work, along with their policy briefs, can be found [here](#).

Dr. Sanders' noted that CPOP's research has been motivated by three main questions:

1. How do children use health care services? CPOP has looked at patterns of care use by age, inpatient versus outpatient care, medical complexity (using the pediatric medical complexity algorithm), primary diagnostic category, etc.
2. What is the quality of care and are services used appropriately? Dr. Sanders notes that CPOP has mostly had to use proxy measures to assess quality. He suggests that one such proxy is access to care in the month after hospital discharge, including follow-up calls. In addition, CPOP is intending to look at regional variability in outcomes, and have already done so at the aggregate level.
3. How is cost of care distributed for the CCS population? The findings from the CCS data confirm national findings about cost distributions in this population, which is that 10% of CCS children account for more than 70% of cost, and 1% account for 25% of cost. The biggest drivers of cost are inpatient and residential care, along with home health care and pharmacy. Neurology and hematology are some of the most expensive condition-related costs. In addition, certain subsets of children are persistently high cost over time, which lends itself to further analysis and research into these populations.

Dr. Sanders reminds everyone that if they receive data requests that are specific to a certain region, or have a sample with a lot of exclusions, they may not be able to report sample sizes that are too small. This would be a HIPAA violation, because sample sizes that are too small may contain identifiable information.

### Research Questions, Directions and Next Steps

Dr. Roby invites the other Data TWG members on the call to chime in, now that they have had an overview of what data are available and some of the analyses that have already been done. Suggestions are as follows:

**1. Coordinating with other TWGs:**

- a. Ms. Kuhns suggests that the Data TWG should be coordinating with the Outcome Measures/Quality TWG to ensure that we're measuring the information that we really need, and establishing a baseline from which to track performance over time. Dr. Roby concurs, and notes that Dr. Sanders and Dr. Lisa Chamberlain, also from CPOP, will be on that TWG.
- b. Mr. Christopher Perrone suggests that the Data TWG should create a data request template for the other TWGs to use, both to understand the other TWGs' priorities as well as the key policy proposals on the table.

**2. CCS Redesign recommendations for future data collection and reporting:**

- a. Dr. Anand Chabra says that a lot of the analyses that can be done with existing data have already been conducted by CPOP, and that we should be focusing on recommendations for the future, and in particular, standardizing data across the State.

**3. Potential analysis of existing quality and satisfaction data:**

- a. Ms. Athena Chapman offers to look into whether there is any quality and monitoring data that individual health plans collect that we might be able to access. She also notes that we will have some challenges looking at data from "carve-in" counties, because we just have encounter data rather than claims.
- b. Ms. Kuhns says she will look at the CHCF Dashboard to see whether or not health plans currently collect Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data. Dr. Roby adds that even if CAHPS data is collected, it will not be linked to CCS cases, but that there might be some way to have a third party make such linkages between clinical quality and patient satisfaction for specific populations or conditions.

**4. Further analyses of existing data:**

- a. Ms. Kuhns asks if it would be possible to look at a broad array of diagnoses at the same time, or at procedure codes, rather than just the primary diagnosis, as a different way of exploring the potential variability in the data (the assumption being that the diagnosis data may not be consistent or accurate). The goal of this would be to figure out if the regional variability is a result of unequal access to services, or differences in authorization, or something else.
  - i. Dr. Sanders suggests that to answer that question, they should first query the data to see what the regional variability in diagnosis and enrollment looks like. They can then make hypotheses as a group about why that variability exists, and either dig deeper into the data or bring the question to another relevant TWG.

- b. Dr. Chabra suggests that we look at the demographics, utilization, and spending characteristics of the CCS enrollees who are also being served by the Medical Therapy Program (MTP), which are identifiable in CMS Net.
- c. Ms. Kuhns suggests that we should look at whether or not there are any regional variations in active care by race/ethnicity. Dr. Sanders notes that they have looked into this a little bit and there doesn't seem to be much variation, except in counties like Alameda and Los Angeles.

Dr. Roby wraps up the conversation by indicating that the Data TWG will plan to hold webinars or conference calls every couple of weeks, and correspond via email in between meetings as needed. He, Dr. Sanders, and Mr. Kentera will work to address some of the questions that came up during the webinar. The Data TWG chairs will report back on their activities at the March and May RSAB meetings. A data request template and summary notes from this webinar will be circulated for Data TWG members' feedback, and then posted online.