



California Children's Services Program

Advisory Group Meeting
April 10, 2019



Agenda

Welcome, Introductions, Purpose of Today's Meeting, and
Federal and State Update

Whole Child Model Evaluation

Telehealth in Medi-Cal

Workgroup Update: Transition to Adulthood

CalOptima Whole Child Model Implementation

Phase 3 Whole Child Model Network Certification

Advancements in Monitoring Quality in Managed Care

Open Discussion

Public Comments, Next Steps, and Upcoming Meetings



Welcome, Introductions, Purpose of Today's Meeting, and Federal and State Update

Jennifer Kent

Director

Department of Health Care Services



Whole Child Model (WCM) Evaluation

Nathan Nau, Chief

Managed Care Quality and Monitoring Division

Guoyong Wang

Research Scientist III

Department of Health Care Services



WCM Evaluation

- Senate Bill (SB) 586 requires DHCS to contract with an independent entity to conduct an evaluation of the WCM program.
- DHCS selected the University of California, San Francisco (UCSF) to conduct the evaluation.
- DHCS developed monitoring and reporting requirements to ensure managed care plans (MCPs) participating in WCM are in compliance with SB 586 requirements.
 - The data collected will be utilized by UCSF for the purposes of the evaluation.



SB 586 Evaluation Requirements

The following requirements are included in SB 586:

- Access to specialty and primary care
- Utilization of CCS-paneled providers
- Type and location of CCS services
- Utilization rates
- Patient and family satisfaction
- Appeals and grievances
- Authorization of CCS-eligible services
- Network and provider participation
- Continuity of care after aging out of the CCS program
- Compare and contrast WCM program and CCS program in counties where the services are mutually exclusive



Goals of the Evaluation

In addition to meeting the requirements of SB 586, the evaluation will fully review and assess:

- Impact of WCM patient and family-centered approach
- Impact of WCM on care coordination
- Impact of WCM on overall quality of care and access to care
- Impact of WCM on the streamlined delivery of care
- Overall cost



Evaluation Design

- Comparisons
 - Before vs after
 - Program vs no program
 - Eligible and non-eligible populations comp
- Trends from the WCM population
 - Healthcare services (utilization)
 - Patient experiences



Evaluation Instruments

- CCS authorized and non-authorized claims datasets
- Managed care encounters
- Appeals and grievances
- Qualitative interviews of families in WCM
- Telephone survey of families in WCM



WCM Evaluation Timeline

April
2019

- Receive feedback on the Evaluation Design
- Work with the Evaluators to revise the Evaluation Design and develop Scope of Work

May - June
2019

- Finalize Evaluation Design and Scope of Work
- Finalize Contracting

July 1,
2019

- Contract Executed



WCM Evaluation Timeline (*Cont.*)

Dec.
2019

- Report on progress of evaluation, instrument development and data collection

June
2020

- Report on progress of evaluation and preliminary results
- Report on progress of evaluation and data collection

January
2021

- Report to Legislature outlining preliminary results from Phase I and II counties.

June
2021

- Final report of all evaluation results from Phase I, II, and III counties.



DHCS requests your feedback on the draft Evaluation Design.

Please provide feedback or other questions on the Evaluation Design by April 24, 2019, to MCQMD@dhcs.ca.gov.



Telehealth in Medi-Cal

Cynthia Smiley, Chief
Benefits Division
Department of Health Care Services



Medi-Cal Benefits Division

- Responsible for managing and ensuring the uniform promulgation of federal and state laws and regulations regarding Medi-Cal benefits, policies and services.
- Primary liaison with the federal Centers for Medicare & Medicaid Services and coordinates with other divisions and state departments to ensure compliance with Medicaid requirements.
- A team of medical professionals (physicians and nurses), technical staff, and a research scientist work together in defining and developing complex medical policy including the scope of medical benefits under the Medi-Cal Program.



History of Medi-Cal and Telehealth

- DHCS began reimbursing for services delivered via telehealth after the Telemedicine Development Act of 1996.
- Medi-Cal currently covers:
 - Evaluation & management (E&M) codes
 - Psychiatric therapeutic procedures
 - Originating site facility fees and transmission fees
 - Teleophthalmology, teledermatology, and teledentistry
 - X-rays & EKG interpretations/reports



Medi-Cal and Telehealth

- Medi-Cal telehealth service is emerging as a critical technology to:
 - Increase access to healthcare services.
 - Significantly affect some of the most challenging problems of our current health care system: access to care, cost-effective delivery, and distribution of limited providers.
 - Change the current paradigm of care and allow for improved access and improved health outcomes in cost-effective ways.



Stakeholder Feedback

- In December 2017, DHCS released a draft update of its telehealth policy to more than 30 organizations and managed care plans, to receive their feedback on adding new codes for Medi-Cal telehealth services.
- We worked with many of the same stakeholders in 2012 when we updated our telehealth policy in response to the Telehealth Advancement Act of 2011.



Stakeholder Feedback *(cont.)*

2018 Most Popular Comments

- The home should be an originating site for telehealth
- Expand telehealth to match or exceed what Medicare currently covers
- Expand access to specific benefits
- Support for eConsults
- Support for telehealth services in emergency rooms, skilled nursing facilities, and inpatient settings
- Add additional codes for telehealth beyond Medicare's list
- Support remote patient monitoring for chronic conditions



Telehealth Moving Forward

- DHCS revised the telehealth policy to clarify that Medi-Cal providers have flexibility to use telehealth as a modality for delivering medically necessary services to their patients.
- In October 2018, DHCS shared the draft Telehealth policy documents, including Provider Manual Sections and draft All Plan Letter, to more than 1,500 stakeholders.
- DHCS received feedback from more than 30 organizations.



Telehealth Moving Forward (*cont.*)

What changed?

- Allows Medi-Cal providers flexibility to determine if a particular service or benefit is clinically appropriate for telehealth.
- Places no limitations on originating or distant sites.
- Authorizes e-consults under the auspice of store and forward.
- Does not provide a specific list of services that may be provided via telehealth.



Telehealth Moving Forward (*cont.*)

What changed?

- Defines who is responsible for maintaining documentation of consent.
- Allows provider flexibility for documentation to substantiate the appropriateness of services provided via telehealth.
- Allows written and verbal consent.



Telehealth Moving Forward (*cont.*)

What changed?

- Defines that a Medi-Cal provider rendering telehealth services must be licensed in California.
- Implements Place of Service Code 02 and modifier 95 for services delivered via telehealth.
- Does not include a policy to address remote patient monitoring.



Telehealth Moving Forward (*cont.*)

- Publish the Provider Manual sections by Spring 2019.
- Are there any questions?



California Department of Health Care Services

- **For More Information on Medi-Cal Telehealth:**
 - DHCS Medi-Cal and Telehealth website available at
<https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx>
- Cynthia Smiley, Chief, Benefits Division
Cynthia.Smiley@dhcs.ca.gov



Workgroup Update: Transition to Adulthood

Jill Abramson, MD, MPH, FAAP
Public Health Medical Officer
Department of Health Care Services



Transition to Adulthood

Key Points Discussed

Defined Transition,
population, and Age

Bridge to Adult Care

Who should be involved?

At what age should
transition begin?

Transition Activities

Got Transition Elements

Key Issues Around Transition

Access to Care

Medical Insurance

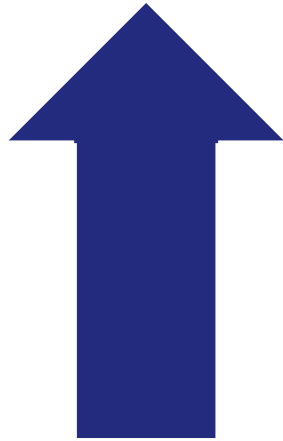
Self-Management

Psychosocial Determinates
of Health

Clients with
Developmental Challenges



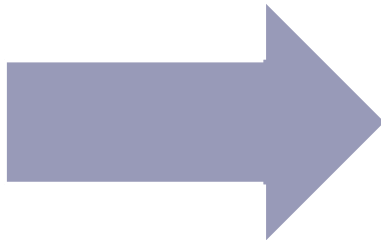
Transition to Adulthood



Element 5 Transfer of Care

- Creating a transfer of care checklist
- Prepare a transfer package for youth leaving the practice
- Communicating with the new adult provider

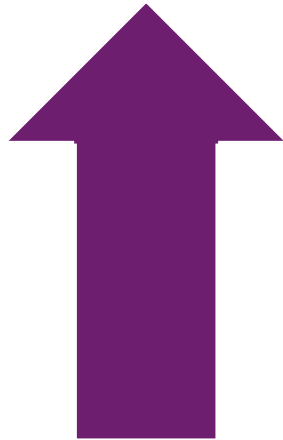
Key Points



- Does not specify receiving provider type
- Who is responsible for the transfer package?
- Not enough adult providers for kids with rare CCS conditions
- Key to transition may be access to EHR, tertiary care centers, and working closely with managed care plans



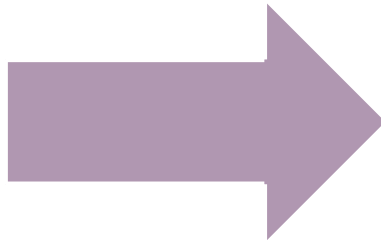
Transition to Adulthood



Element 6 Transfer of Completion

- Contact youth/family to confirm transfer of responsibilities to adult provider
- Confirm transfer with adult practice
- Build ongoing and collaborative partnership with adult primary and specialty care providers

Key Points



- Suggestion to use Integration into Adulthood Care vs. Transfer Completion
- Lack of personnel to follow-up on transition 3-6 months afterwards or after 21
- Youths with complex diseases recognize the subspecialty as their medical home



Workgroup Meetings

2019

☐ Wednesday, April 24



CalOptima Whole-Child Model (WCM) Implementation

**CCS Advisory Group Meeting
April 10, 2019**

**David Ramirez, M.D.
Chief Medical Officer**

CalOptima Delivery System Structure

- CalOptima's delivery system is a public-private partnership that enables it to meet the needs of its members
 - NCQA 4.0 plan rating in 2018
 - DHCS Quality Award in 2018
- CalOptima maintains plan responsibilities and delegates other responsibilities to contracted delegated health networks
- 14 delegated health networks
 - 4 Health Maintenance Organization (HMO) health networks
 - 3 Physician-Hospital Consortium (PHC) health networks
 - 4 Shared Risk Group (SRG) health networks
 - 2 CalOptima-managed health networks

CalOptima Key Responsibilities

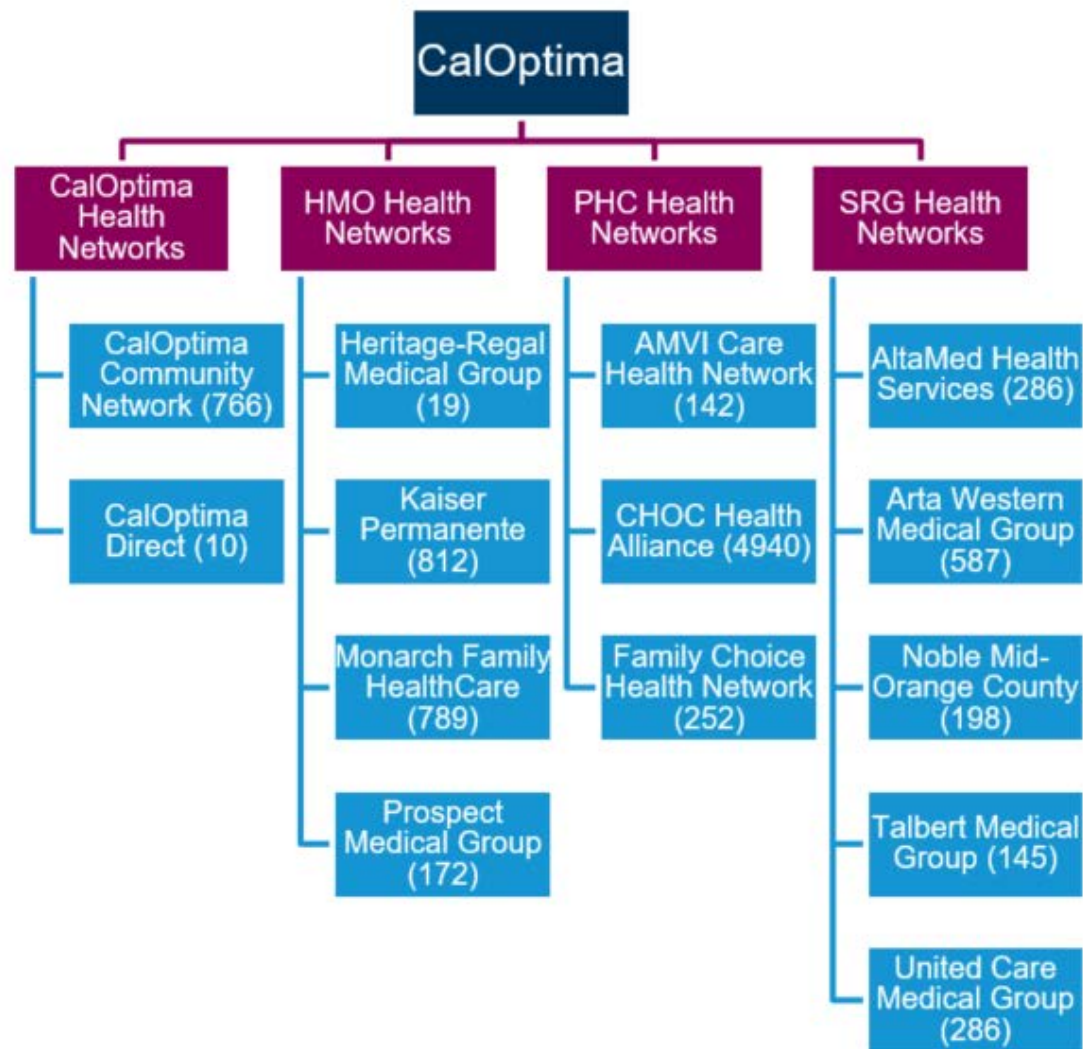
- CalOptima key responsibilities (for all members)
 - Quality improvement and quality analytics
 - Model of care
 - Member and provider communications
 - Pharmacy benefits and management
 - County CCS coordination
 - Provider data management
 - Oversight of delegated responsibilities
 - Behavioral health services (Medi-Cal only)
 - Grievances and appeals (except Kaiser)
 - Health education (except Kaiser)
 - Long-term services and supports (except Kaiser)

Delegated Health Network Responsibilities

- Delegated health networks subcontract with providers and hospitals to serve the members assigned to them
- Delegated health network responsibilities (for assigned members)
 - Case management and care coordination
 - Utilization management and authorization determinations
 - Claims processing
- CalOptima performs all health network functions for its two health networks

CalOptima Delivery Structure

Includes
number of
CCS members
by network



Health Network Assignment

- Members have up to 30 days to select a health network of their choice upon enrollment
 - During this period, members are temporarily assigned to CalOptima Direct (COD) network
- Members have the option of changing their assigned health network every month
- Members are auto-assigned if they do not select a health network
 - Auto-assignment based on location, family link, other member factors and network quality

Health Network Assignment (cont.)

- Members not eligible for health network enrollment are assigned only to the CalOptima Direct network (COD)
 - Share-of-cost
 - Residence outside of Orange County
 - Fairview Developmental Center residents
- Members with specific health conditions are assigned only to CalOptima Community Network (CCN)
 - ESRD
 - Hemophilia
 - Transplant

Out-of-Network Care

- Health networks are required to follow all applicable regulations, sub-regulatory guidance, and CalOptima policies and procedures with respect to provision of medical services
- Each health network has contracted providers
- Health networks are required to provide all medically necessary care for their assigned members
 - If one of the health network's contracted providers is not able to provide medically necessary care, the health network must authorize and coordinate care with an appropriate out-of-network provider

WCM Transition

- CalOptima and Orange County CCS are dedicated to ensuring a seamless transition for families and members
- Stakeholder events
 - Family events
 - Community-based organizations
- Standing committees
 - WCM Family Advisory Committee
 - WCM Clinical Advisory Committee
- Operational meetings
 - County CCS clinical and operational workgroups
 - Frequent meetings with delegated health networks

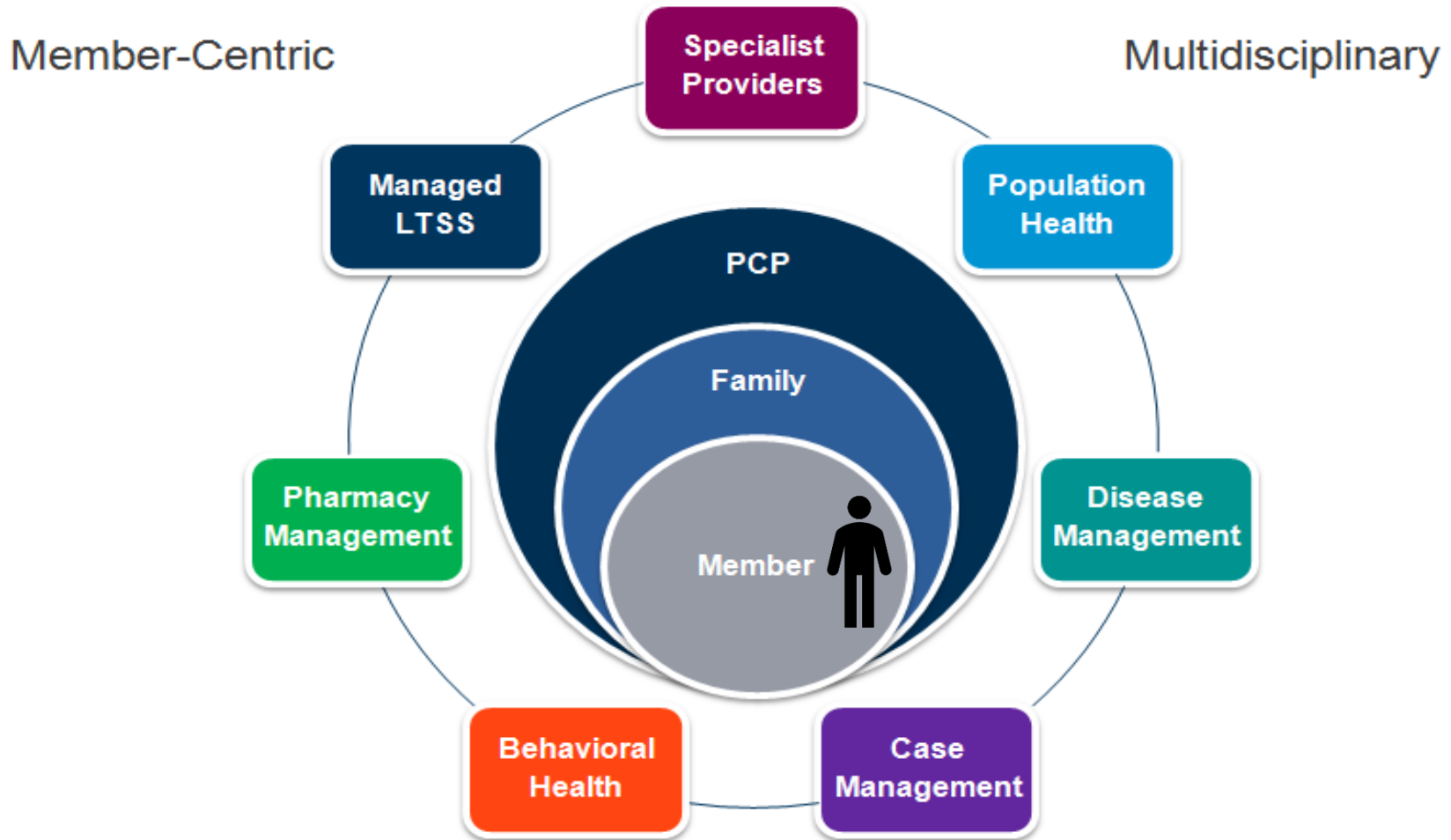
WCM Transition (cont.)

- Health network assignment
 - Existing CalOptima WCM members
 - Will stay with their assigned health network
 - New CalOptima WCM members
 - Children with a family link will be assigned to the linked health network
 - If there is no family link for a child under age 18, they will be auto-assigned to CHOC Health Alliance unless the parent chooses another health network
- WCM service authorization requests
 - Member's assigned health network will manage both CCS and non-CCS service requests
 - CalOptima will manage all pharmacy requests

WCM Transition (cont.)

- Out-of-network care
 - Health networks are required to provide all medically necessary care for their assigned WCM members
 - If one of the health network's contracted providers is not able to provide medically necessary care, the health network must authorize and coordinate care with an appropriate out-of-network provider

Our Model of Care



Care Management Oversight Detail

Interdisciplinary Care Team (ICT)

Member or representative invited/attended

PCP invited/attended

Appropriate discipline/pertinent specialist invited/attended

Individual Care Plan (ICP)

ICP developed timely from Health Needs Assessment (HNA) completion

PCP visit and evidence of care planning documented

Addressed all HNA-identified issues

Documented discussion of care goals with member/family

Signed by physician providing care

Signed by licensed care manager

Member version provided with date/mail documentation

Member version provided in preferred language/format

WCM Quality-Focused Oversight

- Quality matrix
 - Access to care/network management
 - Coordination of care
 - Utilization of services
 - Prevention and chronic diseases measures
 - Key HEDIS measures
 - Member satisfaction, complaints and grievances
- Regular review of metrics
- A key component of our overall Quality Improvement Program

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner





Phase 3 Whole Child Model Network Certification

Nathan Nau, Chief

Managed Care Quality and Monitoring Division

Bambi Cisneros, Chief

Program Monitoring and Compliance Branch

Department of Health Care Services



Phase 3 WCM Overview

- CalOptima was delayed from Phase 2 to Phase 3 and is scheduled to be implemented July 1, 2019.
- CalOptima operates in a delegated structure and was required to submit additional information to assure readiness.
- The delay allowed for additional contracts between CalOptima, its delegated entities (DEs) and CCS-paneled providers/facilities to be executed and DHCS to validate the submission and ensure all requirements were met.



Network Certification Requirements

- All WCM MCPs are required to have executed contracts with the following:
 - 24 core specialty/provider types
 - Tertiary hospital
 - Pediatric community hospital
 - NICU Special Care Center
- Each provider type had to meet the required overlap:
 - 50% in-county,
 - 25% regionally,
 - 10% statewide, or;
 - contract with at least one for specific provider type



Network Certification

Core Specialty List

Allergy and Immunology	Oral and Maxillofacial Surgery	Pediatric Psychiatry and Neurology
Emergency Medicine	Orthopedics	Pediatric Pulmonology
Family and Adolescent Medicine	Pediatric Cardiology	Pediatric Radiology
General Surgery	Pediatric Clinical and Laboratory Immunology	Pediatric Rheumatology
Hematology and Oncology	Pediatric Critical Care	Pediatric Sleep Medicine
Hepatology	Pediatric Dermatology	Pediatric Sports Medicine
Infectious Diseases	Pediatric Developmental and Behavioral Medicine	Pediatric Urology
Neonatal-perinatal Medicine	Pediatric Endocrinology	Physical Medicine and Rehabilitation
Neurology	Pediatric Nephrology	Plastic Surgery
Ophthalmology	Pediatric Pathology	Podiatry



DE Network Certification Components

- DEs are required to meet 23 of the 27 components in order to participate in WCM, which include specialists, hospitals and Special Care Centers.
- CalOptima is required to contract with the remaining four components:
 - Pediatric Dermatology
 - Oral and Maxillofacial Surgery
 - Pediatric Developmental and Behavioral Medicine
 - Transplant Hepatology



Network Certification Deliverables Submissions

- DHCS also required CalOptima to submit for review and approval:
 - Delegated Entity Attestation
 - Oversight and Readiness Activities for Implementation
 - Auto-Assignment Process and Algorithm
 - Member and Provider Notices
 - Contract Signature Pages between CalOptima, its DEs and Providers
 - Updated Policies and Procedures
 - DE Monitoring
 - Continuity of Care



Phase 3 Network Certification Results

- Effective July 1, 2019, CalOptima is approved for full implementation of WCM and will be included in the July 2019 Assurance of Compliance Network Certification submission to CMS due to meeting all readiness and certification requirements.
- The July 2019 Assurance of Compliance Network Certification report will be posted at <https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacy.aspx>



Questions?



Advancements in Monitoring Quality in Managed Care

Anna Lee Amarnath, MD, MPH, Chief
Medical Quality and Oversight Section
Department of Health Care Services



Abbreviations

- AAP: American Academy of Pediatrics
- ADHD: Attention Deficit Hyperactivity Disorder
- BMI: Body Mass Index
- CHIP: Children's Health Insurance Program
- CIS: Childhood Immunization Status
- CMS: Centers for Medicare and Medicaid Services
- COPD: Chronic Obstructive Pulmonary Disease
- DHCS: Department of Health Care Services
- EAS: External Accountability Set
- ED: Emergency Department
- EQRO: External Quality Review Organization



Abbreviations (*cont.*)

- F/U: Follow Up
- HbA1c: Hemoglobin A1c (diabetes test)
- HEDIS: Healthcare Effectiveness Data and Information Set
- HIV: Human Immunodeficiency Virus
- MCAG: Managed Care Advisory Group
- MCP: Medi-Cal managed care health plan
- MPL: Minimum Performance Level
- MY: Measurement Year
- NCQA: National Committee for Quality Assurance
- RY: Reporting Year
- USPSTF: United States Preventive Services Task Force



Governor's Focus on Medi-Cal

- Expanding Medi-Cal to cover undocumented young adults up to age 26
- Consolidate pharmaceutical purchasing under Medi-Cal
- Funds for mental health workforce training and early treatment/detection programs
- Funds for Whole Person Care Pilot Program intended for supportive housing services
- Proposition 56 funds to increase provider payments, family planning services, developmental screenings, and trauma screenings
- Value Based Payment Program to improve care for certain high-need, high-cost populations



Governor's Focus on Children

- Affordable access to quality health care
- Commitment to early childhood development
- Emphasis on populations that are at-risk or low-income (Medi-Cal)



Governor's Requests

- Partnership and collaboration as California increases our state's commitment to early childhood development
- Asked all California health plans to review their current networks, processes, outreach and metrics for pediatric screenings and services
- Directed DHCS to review its data in regards to pediatric measures and identify areas that require improvement



DHCS Quality Strategy

- Three Linked Goals
 - Improve the health of all Californians
 - Enhance quality, including the patient care experience, in all DHCS programs
 - Reduce the Department's per capita health care program costs
- Seven Priorities
 - Improve patient safety
 - Deliver effective, efficient, affordable care
 - Engage persons and families in their health
 - Enhance communication and coordination of care
 - Advance prevention
 - Foster healthy communities
 - Eliminate health disparities



Quality Measures



Measure Set

Current

External Accountability Set

- MCPs report yearly on a set of quality measures
- Most measures are from HEDIS®

Future

Managed Care Accountability Set

- MCPs and DHCS will report yearly on a set of quality measures
- Measures will be from CMS Child and Adult Core Sets as feasible



2019 CMS Child Core Set

- BMI Assessment
- Chlamydia Screening Women
- Childhood Immunization Status
- Screening for Depression and F/U Plan
- Well-Child Visits in the First 15 Months of Life
- Immunizations for Adolescents
- Developmental Screening in the First 3 Years of Life
- Well-Child Visits in the 3rd- 6th Years of Life
- Adolescent Well Visits
- Children & Adolescents' Access to Primary Care Practitioner
- Pediatric Central Line-Associated Bloodstream Infections
- Cesarean Birth
- Audiological Diagnosis No Later Than 3 Months of Age



2019 CMS Child Core Set *(cont.)*

- Live Births < 2,500g
- Timeliness of Prenatal Care
- Contraceptive Care Postpartum Women
- Contraceptive Care All Women
- Asthma Medication Ratio
- Ambulatory Care ED Visits
- F/U Care for Children Prescribed ADHD Medication
- F/U After Hospitalization for Mental Illness
- Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics
- Use of Multiple Concurrent Antipsychotics in Children & Adolescents
- Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk
- Percent who Received Preventive Dental Services
- CAHPS® Survey



2019 CMS Adult Core Set

- Cervical Cancer Screening
- Chlamydia Screening in Women
- Flu Vaccinations for Adults
- Screening for Depression and F/U Plan
- Breast Cancer Screening
- BMI Assessment
- Elective Delivery
- Postpartum Care
- Contraceptive Care Postpartum Women
- Contraceptive Care All Women
- Controlling High Blood Pressure
- Comprehensive Diabetes Care –HbA1C testing
- Comprehensive Diabetes Care –HbA1C >9%
- Diabetes Short-Term Complications Admissions
- COPD or Asthma in Older Adults Admission Rate
- Heart Failure Admissions
- Asthma in Younger Adults Admissions
- Plan All-Cause Readmissions
- Asthma Medication Ratio
- HIV Viral Load Suppression



2019 CMS Adult Core Set *(cont.)*

- Annual Monitoring for Patients on Persistent Medications
- Initiation & Engagement of Alcohol & Drug Abuse or Dependence Treatment
- Medical Assistance with Tobacco Cessation
- Antidepressant Medication Management
- F/U After Hospitalization for Mental Illness
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder on Antipsychotic Medications
- F/U After ED Visit for Alcohol & Drug Abuse or Dependence
- F/U After ED Visit for Mental Illness
- Diabetes Care for People with Serious Mental Illness: HbA1c 9.0%
- Use of Opioids at High Dosage in Persons Without Cancer
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Concurrent Use of Opioids and Benzodiazepines
- CAHPS® Survey



Core Set Resources

- 2019 CMS Adult Core Set:
<https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-adult-core-set.pdf>
- 2019 CMS Child Core Set:
<https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-child-core-set.pdf>
- Current CMS Core Sets Review Process:
<https://www.mathematica-mpr.com/features/MACCoreSetReview>
 - Form to Recommend Measure for Addition:
<https://goo.gl/forms/anrnnh7pXPDGvaRl2>
 - Form to Recommend Measure for Removal:
<https://goo.gl/forms/No00jICqwCrEZ98B3>



Benchmarks

Current

Minimum Performance Level

- DHCS contracts require the MCPs to perform at least as well as the lowest 25% of Medicaid plans in the US

Future

Minimum Performance Level

- DHCS will require MCPs to perform at least as well as 50% of Medicaid plans in the US where that information is available and services measured are delivered by MCPs
- DHCS may establish alternative benchmarks where that information is not available and services measured are delivered by MCPs



Accountability

Current

When MCPs do not meet the MPL

- Quality improvement work is required

Future

When MCPs do not meet the MPL

- Corrective Action Plans will be imposed
- Sanctions will be imposed
- Quality improvement work will be required



Timeline

- DHCS is planning to implement these changes for RY 2020 for care that is delivered during MY 2019
- DHCS is in the process of developing an implementation plan for these changes



Quality Reports



Public Reports

Current

EQRO Reports

- EQRO Technical Report
 - Plan Specific Evaluation reports
- CAHPS® Survey Report
- Health Disparities Report

Future

EQRO Reports

- EQRO Technical Report
 - Plan Specific Evaluation reports
- CAHPS® Survey Report
- Health Disparities Report
- Annual Compliance Report



Health Disparity Report

- 2016 Health Disparity Report
 - Selected metrics from the EAS
 - Stratified by age, gender, race/ethnicity, primary language
 - Available online
- 2017 Health Disparity Report
 - All metrics from the EAS
 - Stratified by age, gender, race/ethnicity, primary language
 - Expected to be available Spring 2019
- 2018 Health Disparity Report
 - All metrics from the EAS and additional information based on other available data sources
 - Stratified by age, gender, race/ethnicity, primary language
 - Expected to be available by end of 2019
- Future Reports will continue to expand with regards to metrics and stratifications based on available data sources



Annual Compliance Report

- DHCS will develop an annual compliance report
 - This may be a new report or a new section added to the Managed Care Dashboard
 - The report will include information on:
 - Preventive Services
 - Network compliance
 - Corrective Action Plans
 - Sanctions



Questions?



Open Discussion

Jennifer Kent

Director

Department of Health Care Services



Public Comments, Next Steps, and Upcoming Meetings

Jennifer Kent

Director

Department of Health Care Services



CCS AG Meeting 1700 K Street

2019

July 24 (Wednesday)

October 9 (Wednesday)



Information and Questions

- For Whole Child Model information, please visit:
 - <http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx>
- For CCS Advisory Group information, please visit:
 - <http://www.dhcs.ca.gov/services/ccs/Pages/AdvisoryGroup.aspx>
- If you would like to be added to the DHCS CCS Interested Parties email list or if you have questions, please send them to CCSRedesign@dhcs.ca.gov