California Children’s Services
Program Redesign

Redesign Stakeholder Advisory
Board Meeting #5

July 17, 2015
9:30-9:55  ▪  Registration, Gather and Networking
10:00-10:15  ▪  Welcome, Introductions, and Purpose of Today’s Meeting
10:15-11:45  ▪  Implementation Timeline, CCS Whole-Child Model Feedback, and Next Steps
11:45-12:15  ▪  CCS Advisory Group and Technical Workgroups
12:15-12:45  ▪  Lunch
12:45-2:30  ▪  Discussions with COHS Health Plans, Counties, and Family Members
2:30-3:30  ▪  Presentation and Discussion on CCS Data
3:30-3:50  ▪  Public Comment Period for Audience Members
3:50-4:00  ▪  Wrap-up and Next Steps
California Children’s Services Program Redesign

Introductions
Purpose for Today

Jennifer Kent, Director, DHCS
Bobbie Wunsch, Pacific Health Consulting Group
California Children’s Services Program Redesign

Implementation Timeline and Whole Child Model Feedback

Jennifer Kent, Anastasia Dodson, and Sarah Brooks

DHCS
Main topics from SurveyMonkey and e-Mail submitted comments:

- Provider Network Access / Adequacy / Continuity of Care
- Case Management / Care Coordination
- Monitoring / Oversight / Evaluation
- Implementation / Timeline / Readiness
- Rates / Provider Payment
- County Administration
- Dental and/or Vision
- Medical Therapy Program
- Eligibility
- Data
California Children’s Services Program Redesign

CCS Advisory Group
Technical Workgroups

Louis Rico, DHCS
CCS Advisory Group / Technical Workgroup

- CCS Advisory Group member selection
- CCS Technical Workgroup member selection
AG meeting scheduled: October 7, 2015

Ongoing discussions include:

- Readiness standards
- Consumer protections
- Quality monitoring and reporting
- DME
- Transitions of youth aging out of CCS
- Implementation
- CCS program improvement in other counties
Technical Workgroups

Health Homes / Care Coordination / Transitions + Provider Access & Network

Care Coordination, Medical Homes, and Provider Access

Data + Outcome Measures / Quality

Data and Performance Measures

Eligibility / Health Conditions

Eligible Conditions
Technical Workgroups

Care Coordination, Medical Homes, and Provider Access

Meets every other month beginning August 12, 2015, Wednesday, 9:00 am-12:00 pm

Data and Performance Measures

Meets every other month beginning September 9, 2015, Wednesday, 9:00 am-12:00 pm

Eligible Conditions

Meets quarterly beginning September 23, 2015, Wednesday, 9:00 am-12:00 pm
Advisory Group data requests, email:

CCS-AdvisoryGroupDataRequests@dhcs.ca.gov
California Children’s Services Program Redesign

Lunch
California Children’s Services Program Redesign

Discussions with COHS Health Plans, Counties, and Family Members

Bobbie Wunsch, PHCG
COHS Discussion

1. Tell us a little about your health plan first and then how you have worked with CCS in the past, either with carved in services or through an MOU with CCS?

2. What process and major challenges should be considered in developing a provider network for children with complex chronic populations? What are the challenges to securing the right types of providers for this population? In the case of the CCS population what are the criteria for identifying and including appropriate specialty and sub-specialty providers?

3. How is “care coordination” defined in the context of a health plan and what does this mean for a child with a CCS health condition? How would you ensure Care Coordination of the “whole child”?

4. The transition of any population from one health care delivery system to another may impact pharmacy benefits. How has your health plan dealt with this in the past? Or if you have not, how will the plan address this issue?

5. How have or will health plans ensure access (for continuity of care) to out-of-network CCS providers and sustain that access?

6. What measures or methods do health plans use to ensure member needs are being addressed.

7. What mechanisms are in place or can be in place to ensure that the needs and concerns of children and families are known by health plans? What do health plans do or can they do to reach out to children and families to help them understand how to access health care in a managed care system?
Findings from CCS Administrative Data

July 17, 2015

Lee M. Sanders, MD, MPH, Stanford CPOP
Brian Kentera, Chief CMS Network Branch, DHCS

CCS Redesign Stakeholder Advisory Board
Overview

1. Update on Data Requests from the CCS RSAB

2. New Comparisons across County Groups
Methods

Retrospective, population-based analysis of all paid claims for the CCS Program (FY2012)

Use of care: Total capture

Spending:
  Total capture of CCS-related care
  Partial capture of non-CCS-related care (FFS)
Data Source

All paid claims for all CCS enrollees, 7/1/2011 to 6/30/2012, abstracted from the state's Management Information System / Decision Support System.

“Total spending per child” includes all paid claims for children enrolled in fee-for-service MediCal and all condition-specific claims for children enrolled in managed-care MediCal.
Definitions


**Types of Care:** Broad categories based on claim type: Inpatient, Residential Facility, MD visit, Pharmacy, DME, Home Health, ED visit, Dental, Other Outpatient.

**Counties:** All California counties labeled by number. Data for county excluded if cell size < 25 children. Grouped as defined by DHCS.
Definition of County Groups

Carved-In Counties
Marin, Napa, San Mateo, Solano, Santa Barbara, Yolo

“Whole Child” Counties
Del Norte, Humboldt, Lake, Lassen, Mendocino, Merced, Modoc, Monterey, Orange, Santa Cruz, San Luis Obispo, Shasta, Siskiyou, Sonoma, Trinity

Other Counties
HIPAA Expert Review

Standard protocols to protect the privacy and security of PHI, following the standards and requirements of HIPAA, the HITECH Act, established agreements with California DHCS, and the DHCS Guidelines (Public Aggregate Reporting – Guidelines Development Project (PAR-GDP), August 25, 2014).

- All aggregated tables and figures were reviewed independently by two senior project leaders (Drs. Sanders and Chamberlain) by the data analyst (Olga Saynina), and by the research assistant (Gabriel Washington).

- Any cell size (numerator) reporting <= 25 individuals or <=25 events was suppressed.

- Total N for each subgroup in the ensuing figures is noted.
Data Requests from CCS RSAB

Previously Presented Analyses and Tracking Document*
1. Denied claims (not feasible)
2. Enrollment periods, by diagnostic category and county
3. Description of CCS NICU population, by region (pending this month)
4. Types of outpatient Care (pending this month)
5. Enrollees and spending by type of care.
6. Sites of hospital and outpatient care (pending this month)
7. List of CCS providers (deferred to DHCS)
8. Number of CCS enrollee hospital stays, by hospital
9. Hemophilia claims by county (not PHI feasible)
10. Spending trends over last 3 years (pending data retrieval and cleaning)
11. Use and Spending across 3 County groups

*Available at DHCS, UCLA and Stanford CPOP Websites
Comparison Across 3 County Groups

What are the differences in Care Use and Spending across the 3 County Groups, as defined by DHCS for CCS Redesign?
Proportion of Children

- 76.6%: 1. Carve-in Counties
- 19.3%: 2. Whole-child Counties
- 4.1%: 3. Other Counties
# Primary Diagnostic Category

<table>
<thead>
<tr>
<th>Category</th>
<th>Carve-in Counties</th>
<th>Whole-child Counties</th>
<th>Other Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology/Cardiothoracic Surg</td>
<td>10.5%</td>
<td>13.3%</td>
<td>12.3%</td>
</tr>
<tr>
<td>ENT</td>
<td>13.9%</td>
<td>12.7%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>8.7%</td>
<td>8.5%</td>
<td>8.9%</td>
</tr>
<tr>
<td>External/Injury</td>
<td>6.0%</td>
<td>7.7%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>2.5%</td>
<td>2.4%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Hem/Oncology</td>
<td>5.5%</td>
<td>5.6%</td>
<td>6.4%</td>
</tr>
<tr>
<td><strong>Neonatology</strong></td>
<td><strong>5.2%</strong></td>
<td><strong>3.1%</strong></td>
<td><strong>5.0%</strong></td>
</tr>
<tr>
<td><strong>Neurology/NeuroSurgery</strong></td>
<td><strong>17.0%</strong></td>
<td><strong>14.2%</strong></td>
<td><strong>14.7%</strong></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>4.6%</td>
<td>5.0%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Ortho</td>
<td>6.6%</td>
<td>6.2%</td>
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<tr>
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<td>3.3%</td>
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>2% difference between Carve-in and Whole-child counties in bold
# Primary Diagnostic Category

<table>
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<tr>
<th>Category</th>
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<th>Excluding SM</th>
<th>San Mateo</th>
<th>Whole-child</th>
<th>Other</th>
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<tr>
<td><strong>Cardiology</strong></td>
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*>2% difference between Carve-in and Whole-child counties in bold*
Medical Complexity

- 3 Complex Chronic
- 2 Non-complex Chronic
- 1 Non-Chronic
Use of Health Care Services

**Percent Hospitalized**
- Carve-in Counties: 18%
- Whole-child Counties: 16%
- Other Counties: 21%

**Percent with Home Health Services**
- Carve-in Counties: 7%
- Whole-child Counties: 11%
- Other Counties: 14%
Use of Health Care Services

### Percent Hospitalized

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### Percent with Home Health Services

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Location of Hospital Care

1. Children's Hospitals
2. UC System
4. Large HMO
5. Other

Carve-In Counties
Whole Child Counties
Other Counties
Outpatient Care After Hospitalization

MD Visit Within 28 Days Post-Hospitalization

- 1. Carve-in Counties: 56%
- 2. Whole-child Counties: 56%
- 3. Other Counties: 52%
Outpatient Care After Hospitalization

MD Visit Within 28 Days Post-Hospitalization

1. Carve-in Counties
2. Whole-child Counties
3. Other Counties

- 1. Carve-in Counties excluding San Mateo
- San Mateo
- 2. Whole-child Counties
- 3. Other Counties
Average Spending (per child per year)
Average Spending (per child per year)

1. Carve-in Counties
2. Whole-child Counties
3. Other Counties

17,065
15,740
20,665
15,663
17,683
Average Inpatient Spending (per child) among Hospitalized Children

Hospital Services

- Carve-in Counties
- Carve in Counties excluding San Mateo
- San Mateo
- Whole-child Counties
- Other Counties

$41,126 $40,996 $41,548 $41,992 $38,307
Average Outpatient Spending (Per Child)

1. Carve-in Counties
2. Whole-child Counties excluding San Mateo
3. Other Counties

$6,336
$5,235
$4,418
$3,996
$9,224
Summary - 1

Characteristics of CCS enrollees are similar across all 3 regions, except ...

• Children in Carve-In and in Other Counties are more likely to be medically complex (32% vs. 29%) than those in Whole-Child Counties.
  – San Mateo County, with higher rates of medical complexity, explains this difference.

• Children in Carve-In Counties are more likely to have a primary diagnosis in the neurology and neonatology categories than those in Other Counties.
  – San Mateo County, with higher rates in neonatology, explains most of this difference.
Summary - 2

Use of Care by CCS enrollees is similar across county groups, except ...

• Children in Carve-In and Whole-Child Counties are less likely to be hospitalized than those in Other Counties.
• Children in Carve-In and Whole-Child Counties are less likely to use Home-Health Services than those in Other Counties.
• Children in Carve-In Counties are less likely to be hospitalized in free-standing children’s hospitals.
• Children in Carve-In and Whole-Child Counties have higher rates of MD visits after hospitalization than those in Other Counties.
  – San Mateo County, with higher rates for older children, explains some of this difference.

Spend per CCS enrollee is higher for Carve-In Counties than for Whole-Child Counties.

• San Mateo County, with higher spend for non-MD outpatient care, explains most of this difference.
Thank You

Questions?

Advisory Group data requests, email: CCS-AdvisoryGroupDataRequests@dhcs.ca.gov
For CCS Redesign information, please visit:


Please contact the CCS Redesign Team with questions and/or suggestions:

- CCSRedesign@dhcs.ca.gov

If you would like to be added to the DHCS CCS Interested Parties email list, please send your request to:

- CCSRedesign@dhcs.ca.gov