
HMA

HEALTH MANAGEMENT ASSOCIATES

*Considerations for Redesign of the California
Children's Services (CCS) Program*

PRESENTED TO

STATE OF CALIFORNIA

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*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics
and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

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ABOUT THE PAPER

This paper has been developed to provide technical assistance to the State of California as it considers redesign of the California Children's Service (CCS) program and the renewal of the State's Medicaid 1115 Hospital/Uninsured Waiver. As such, it presents a range of options that could be included by the state in a waiver request to the federal government. This paper was developed with a much abbreviated time period for stakeholder comment and with the understanding that there will be continued discussions with stakeholders about the CCS program and waiver options.

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Health Management Associates

Health Management Associates is an independent national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985, in Lansing, Michigan, Health Management Associates provides leadership, experience, and technical expertise to local, state, and federal governmental agencies, regional and national foundations and advocacy groups, investors, multi-state health system organizations and single site health care providers, as well as employers and other purchasers in the public and private sectors.

The California HealthCare Foundation

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, CHCF's goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford.

INTRODUCTION

The California HealthCare Foundation engaged Health Management Associates (HMA) to provide technical assistance to the State of California as it considers redesign of the CCS program as a component of the California Medicaid 1115 Hospital/Uninsured Waiver renewal. Such support includes examining the CCS program and providing the state with options and considerations for program redesign based on stakeholder input. For this project, HMA participated in a project kick-off call with Department identified stakeholders on July 20, 2009, and provided the State with a final written paper on August 31, 2009.

Multiple stakeholders, ranging from parents of children enrolled in CCS to health care providers, health plans, and counties, expressed impassioned interest in the program during discussions with HMA. Most stakeholders wanted additional time to comment and interact, which was not possible given the timeframe for this report. The condensed timeframe was necessary in order to allow the Department of Health Care Services' (DHCS) time to include high level concepts in the state's 1115 Waiver Concept Paper to be submitted to the federal government in September 2009.

Scope of Project

This project was created to explore options to redesign the CCS program, specifically to see if a new service delivery model would improve the CCS program and meet both stakeholder and the state's needs. Before engaging HMA, the California HealthCare Foundation had already begun a stakeholder process identifying issues and challenges faced by the CCS program and the children served by CCS. The goal of this process was to engage stakeholders by discussing possible options for redesign of the CCS program and to determine the CCS design features that, in the opinion of stakeholders, should be changed (or that should be retained).

This project and paper are one step in the process of redesign. DHCS will continue developing the CCS redesign through the work it does in developing the waiver concept paper, negotiations with the federal government, the ABX4 6 (Chapter 6, Statutes of 2009) stakeholder process and the completion of the required California Children's Services Program Title V Needs Assessment, which includes assessment of services for Children with Special Health Care Needs.

HMA interviewed over 60 CCS stakeholders from varying geographic regions and with different perspectives of the program. Stakeholders included County CCS program administrators, County Health Executives, physicians, hospitals, Medi-Cal managed care plan representatives, advocates and family members and State agency representatives. In addition to stakeholder input, HMA conducted a limited amount of data analysis based on the data available and short timeframes in which to complete this paper. HMA also reviewed programs developed in other states for specialized populations. Additional data, stakeholder discussions, and analysis are necessary before any conclusions can be drawn about the proper redesign for CCS.

There were several aspects of the CCS program that were beyond the scope of this project, including the Medical Therapy Program (MTP), CCS income limits and medical eligibility requirements, the intricacies of state county financing, the legal responsibilities of the state and counties under this program, and CCS dental coverage. Please note that while this paper does not examine the specific conditions that should qualify a child for CCS, it does discuss the CCS medical conditions that are carved-out of Medi-Cal managed care and the Healthy Families program (California's Children's Health Insurance Program).¹ Additional information provided by stakeholders on CCS program medical eligibility has been included in the section of this paper entitled "Policy Issues for Further Exploration."

Challenges Facing CCS

The California Children's Services program provides vital services to children with the most serious, sometimes life-threatening, conditions and illnesses. The nature of the children's conditions and illnesses require that expert pediatric care be delivered as quickly as possible. While there is no question of the enormous value of the CCS program to children with qualifying conditions, the program's design and financing created over many decades presents significant challenges to providers, counties, the State and, most importantly, the children served by the program.

In our discussions, stakeholders emphasized the critical importance of the CCS program and noted that there is much that needs to be protected and built upon. Stakeholders commented repeatedly that CCS is a leader in establishing standards for care that not only improve the health care of children enrolled in CCS but all children in California. Stakeholders cited evidence that the CCS model has resulted in extremely positive outcomes for children enrolled in the program. Stakeholders also discussed the quality improvement work that the CCS program has undertaken with the children's hospitals to reduce hospital-acquired infections. Some stakeholders pointed to specific initiatives and program designs that have been successfully implemented in some counties, or with some "sub-populations", that should be evaluated for expansion. These include the Children's Regional Integrated Service System (CRISS) in the Bay Area and hemophilia centers. One stakeholder summarized the feedback of many by stating that "80 percent of CCS works" and that the State should focus on keeping what works while fixing the remaining 20 percent that does not work well.

While most stakeholders agreed that only certain aspects of CCS need to be improved, there was strong disagreement about the specific CCS aspects that work well and those that do not. A consistent theme from CCS providers was the lack of consistency among counties in determining which children are eligible for CCS and the services that are covered. However, the county staff who operate the program felt there was consistency between counties in most cases and that the appearance of an inconsistent process was due to the medical complexity of the children covered by the program and the complexity of medical eligibility requirements.

¹ Note: The medical conditions for CCS eligibility and the carve-out do not need to be the same.

Most stakeholders stated that the possible enrollment of CCS eligible children into existing Medi-Cal or Healthy Families managed care plans for receipt of all of their care was not a good model. They expressed concerns that the plans were not ready to manage children with these complex conditions, that the plans lack staff with pediatric and pediatric-subspecialty experience, and that the financial risk for the CCS population would have adverse consequences on the children and the plans. However, representatives from some County Organized Health Systems (COHS), that already have varying levels of risk for CCS children, expressed an interest in exploring how they could further expand their role. Most other health plans wanted to continue the carve-out.

There is general agreement among stakeholders that redesign of CCS must involve all three funding sources, Medi-Cal, Healthy Families, and CCS-only. There is considerable interest in including the medical therapy program in the redesign.

There is significant apprehension and fear among stakeholders concerning the state's plans for CCS as it prepares a concept paper and eventually a renewal (amendment) to California's 1115 Hospital/Uninsured Waiver. One stakeholder questioned the need for inclusion of CCS program changes in the 1115 waiver and asked why this would be necessary, the implication being that the state plans to fundamentally change the CCS program (most likely in the area of cost containment) and needs waiver authority to do this. CCS has undergone significant state budget cuts, both at the state and county levels. Most stakeholders believe that CCS is increasingly underfunded and that access to providers and care is at risk due to this underfunding. Stakeholders are concerned that the waiver may be used to mandate enrollment of all CCS enrolled children into capitated, managed care with accompanying reductions in eligibility, access and/or services. This is especially concerning if the waiver renewal is being crafted to, among other things, reduce the overall growth of the Medi-Cal program.

Some of the CCS program challenges raised by stakeholders in our discussions included:

- The CCS carve-out, (provision of CCS services for CCS "conditions" outside of the health plan), was originally established to allow for quick and efficient access to pediatric specialty care services. However, it is increasingly apparent that the carve-out creates challenges coordinating services to meet the range of needs of CCS eligible children. With the carve-out, health plans are required to refer every child to local CCS programs for care when there is a potential CCS condition. Some stakeholders believe that this leads to an over referral of children, causing administrative delays in the CCS program. It is clear that considerable health plan, county and state administrative time is spent determining which entity has responsibility for covering and managing the care of these children, often leaving the families and children caught in the middle.
- Access to providers, particularly certain specialty care providers and some durable medical equipment providers, is challenging. While CCS physician rates are 39 percent higher than the rest of Medi-Cal's rates, CCS rates nevertheless suffer from the overall low rate structure in Medi-Cal. In addition, the Medi-Cal rate freezes and reductions for physician and outpatient care, further distort the CCS payment structure. Access to care

is also impacted by delays in enrolling providers for participation in CCS and Medi-Cal and overall shortages in the number of specialists and primary care physicians trained to serve special needs populations.

- Inter-county and state CCS office variation in medical decision-making and the authorization process for CCS services create issues for families and providers. Further, the process is widely viewed as too lengthy and complicated, resulting in delays for children in need of timely provision of specific health care services.
- Problems with the Medi-Cal and CCS claims payment processing system currently operated by EDS were cited by stakeholders as a factor that leads to provider reluctance to participate in the CCS (and Medi-Cal) program. These stakeholders believe that the effectiveness of the CCS program is jeopardized by these issues. One stakeholder commented that in the past EDS had CCS specialists to resolve these problems but CCS problems are now sent to generalists who do not understand the complexities of the CCS program.
- Administration of the program is highly fragmented. The funding responsibilities between the state and the counties further fragment the program and make administration and redesign very difficult.
 - The state establishes policy for the program and operates substantial parts of the program including claims processing, the case management system and service authorization for the dependent counties.
 - Independent counties operate other parts of the program including determining if a child is financially eligible for CCS-only, determining if the child's health condition is a qualifying health condition, and authorizing services.
 - Medi-Cal and Healthy Families health plans have the responsibility to make referrals to CCS under the carve-out and to coordinate care provided by the plan with the CCS program.
 - While the county's responsibility is the same for all three programs, the state county financing arrangement is different depending on whether the state or county pays the non-federal share of the program and who benefits from federal Medicaid funding. Further, the obligations of the State and county for funding the CCS-only program are unclear and outdated.
- Many stakeholders commented that the CCS program lacks leadership at DHCS and that in order to redesign the program, DHCS must provide more leadership and use greater flexibility in running the program. The comments ranged from concerns about the vacancy of the position of chief physician for the CCS program as well as the lack of DHCS leadership in addressing CCS problems.

In addition, there are other challenges facing the CCS program, and initial data points to issues related to rapid growth in program expenditures; however, further data evaluation is required to completely understand the implications for redesign.

- Growth is occurring most rapidly in Healthy Families (23 percent from FY 2005 to FY 2008) and Medi-Cal (10 percent from FY 2005 to FY 2008) expenditures. However, the data needed to understand the reasons for the program growth was not available. The large growth in CCS Healthy Families of 22.82 percent is much greater than the rate of growth of the Healthy Families program which was about 12 percent for this time period. While growth would be expected due to the state and counties shifting CCS only children to Healthy Families to obtain federal matching funds, the CCS only program grew by 2.22 percent. Thus much of the growth of CCS Healthy Families is likely attributable to growth caused by the CCS carve-out.
- The distribution of CCS costs by users varies greatly. Seventy-seven percent of the CCS users are on Medi-Cal and CCS Medi-Cal accounts for almost 90 percent of CCS expenditures. Conversely, 13 percent of the users are on Healthy Families, which accounts for 8 percent of expenditures. CCS-only comprises 10 percent of the users and 3 percent of the expenditures. Much of the size of CCS Medi-Cal expenditures is likely attributable to Medi-Cal covering infants in families with incomes up to 200 percent of the federal poverty level and to Medi-Cal coverage starting at the month of application and being retroactive if there are medical expenses.
- The top five medical diagnostic categories account for 55 percent of CCS Medi-Cal expenditures. The top two relate to newborn care and make up 32 percent of CCS Medi-Cal expenditures.

While there is significant pressure to redesign the CCS program because many state and county officials believe it is not sustainable in the future due to increasing cost and insufficient state and county funding, there was also clear concern among the stakeholders that CCS is underfunded and that any changes must do no harm and be tested on a limited basis to ensure they work before extending them statewide.

STAKEHOLDER INPUT ON REDESIGN OPTIONS

Because of the challenges in caring for children with complex health care needs and the complexities of the current health care system, there are multiple issues to consider when evaluating how to redesign the CCS program. Key issues and critical functions include:

- State and county funding
- State and county administration
- Eligibility determination
- Program enrollment
- Authorization of services
- Outreach and education

- Provider network development and maintenance including provider certification, provider training and provider recruitment
- Quality improvement and program oversight
- Claims processing
- Service delivery options
- Case management/care coordination
- Medical management including review of appropriate level of care and appropriate place of service
- Special features including medical homes, specialty centers, etc.

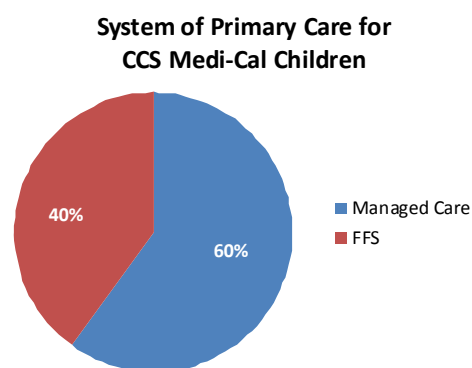
In our discussions with stakeholders, we considered a range of options for CCS redesign. From these discussions, key themes and principles emerged. In some instances, there was significant agreement among stakeholders regarding how the problems and potential solutions were viewed, while in other instances there was considerable disagreement. In this section, we highlight the key issues and options discussed with stakeholders and the stakeholders' responses.

Should the current policy of carving-out treatment for CCS conditions from the Medi-Cal and Healthy Families managed care contracts continue?

Many of the CCS children in California currently receive Medi-Cal services through Medi-Cal managed care health plans ("health plans"), in areas of the state where there is Medi-Cal managed care, but the treatment of CCS-related conditions is carved-out of the health plan's contractual responsibility. Based on data provided by the DHCS for fiscal year 2007-08, there are 128,340 Medi-Cal children receiving services from CCS. Of those children, approximately 60 percent (76,704) were enrolled in Medi-Cal managed care health plans and the remainder received care through the fee-for-service system.

An exception to this managed care carve-out are the three county organized health systems (COHS) operating in five counties that assume the fiscal role of the state, including being at risk for the cost of treatment for CCS conditions, while the counties continue to perform their role of eligibility determination and service authorization. Treatment of CCS-

related conditions is also carved-out of the health plan's responsibility in Healthy Families, where all children are in a health plan. Children in CCS-only, receive only the services required for the treatment of CCS related conditions. These children may have other health coverage that could cover some of their CCS services and/or other medically necessary services not related to



their CCS eligible condition, while others may not receive those services or obtain them from private or other government sources.

Questions have arisen as to whether the carve-out for treatment of a single condition or set of conditions from the primary coverage system can lead to problems coordinating care. Further, questions have been raised as to whether it is in the best interest of the child to carve-out treatment of the CCS condition while the managed care plan provides primary care for children who require longer-term specialized services.

According to DHCS budget estimates, in FY 2009-10, Medi-Cal will spend nearly \$1,700,000,000 on services to Medi-Cal beneficiaries that are authorized by the CCS program. About \$680 million is for payments for children enrolled in Medi-Cal managed care plans. The same arrangement occurs for Healthy Families subscribers with CCS eligible conditions, with CCS Healthy Families expenditures of over \$156 million on these services for the same time period.

In our discussions with stakeholders, issues with the carve-out were clearly delineated.

- The carve-out system creates incentives to push coverage, and therefore payment, to the “other” side. Since the coverage of conditions can be complicated in the CCS program, “teasing out” responsibility for coverage creates a natural tension between the managed care plans and the CCS program.
- Health plans are required by the state to refer children with potential CCS eligible conditions to CCS and there is every financial incentive to do so, since their rates are based on historical experience with the CCS carve-out and maximizing and expanding the children subject to the carve-out reduces plan expenditures. For example, according to the DHCS budget Medi-Cal estimates, the cost of the Medi-Cal CCS carve-out increased from \$584 million in the May 2008 Estimate to \$679 million in the May 2009 Estimate, a 16 percent increase.
- This bifurcated system creates confusion among providers who are not entirely sure who will cover the payment if the services are provided and requires additional administrative work on the part of providers to deal with denials and resubmission of claims to multiple payers. In some cases, particularly for neonates and infants in Neonatal Intensive Care Units (NICU), the carve-out can result in CCS coverage for a few days, then Medi-Cal managed care coverage for a few days followed by a return to CCS coverage for remaining days in the NICU.

Despite these problems, there was no clear agreement across the groups of stakeholders on how these problems should be resolved. There was support for ending the carve-out of “CCS conditions” by disenrolling CCS children and serving the “whole child.” In fact, stakeholders were uniform in agreeing that a CCS program principle should be to serve “the whole child.” However, in discussions with stakeholders regarding how the principle of serving the whole child would be operationalized, there was less uniformity in their views. Suggestions included that specialty clinics or centers become responsible for complex children and receive a “bundled payment” for all of their care or that a specialty managed care plan be tested that would enroll

solely CCS children. However, a specialty plan, while viewed more favorably than other options, was cautiously entertained as a possible pilot that should only be undertaken if the stakeholders in the pilot area supported such an approach. There was almost uniform agreement that enrollment of CCS children into existing managed care health plans for all of their care, including care for their CCS condition, was unacceptable.

Should time-limited or single system conditions be handled in a different model than complex, long-term CCS conditions?

Some children enrolled into the CCS program have a time limited or single system condition, such as a compound fracture, hearing loss, or congenital cataracts. Other children have conditions that are likely to continue into the future and/or that are multi-systemic (such as hemophilia or cancer). There was discussion in several stakeholder groups on whether these two “groups” of eligible conditions should be handled in the same or different ways, from an administrative perspective. In addition, there was considerable discussion on whether the qualifying medical conditions for CCS should be changed and many time-limited conditions eliminated. Medical eligibility is beyond the scope of this project, but is discussed later in the section of this paper entitled “Policy Issues for Further Exploration.” There are several options available to treat the “whole” child within a single system.

Option 1: Have CCS conditions covered by Medi-Cal managed care and Healthy Families health plans.

This option was overwhelmingly rejected by stakeholders, with the exception of some of the COHS plans, who are interested in exploring serving all CCS children for both primary and CCS related care. The primary concerns are that coverage by existing health plans would result in:

- Disruption of the networks of care already established for CCS, which have been successful in meeting the needs of CCS children and their CCS conditions;
- Delays in children accessing the specialty care that they need;
- Problems receiving adequate care because current Medi-Cal health plans do not understand what is involved in treating CCS children; and
- Problems related to managing risk for CCS children, especially because a few children can be very expensive. The county organized health systems that are responsible for CCS payments have experienced problems when a few children require care costing, in some instances, over \$1 million per year.

Option 2: Continue to include children with CCS-eligible time-limited conditions in the CCS program, but for CCS children who are Medi-Cal or Healthy Families eligible, enroll these children into Medi-Cal managed care or Healthy Families health plans and have the plans responsible for treating these conditions. The health plan becomes responsible for all the child's health care needs. (Note that this option permits continued access to CCS-only for children who are not Medi-Cal or Healthy Families eligible.)

This option received mixed stakeholder reviews. There appear to be two predominant opinions.

- The first opinion is that time-limited conditions are more appropriately treated in the Medi-Cal managed care program and are not truly appropriate for CCS case management. These conditions, although not completely defined, are not chronic, complex or disabling and are not seen as requiring intensive case management or multi-disciplinary specialized care. However, in implementing this option DHCS would need to consider development of specific health plan contractual requirements and rate changes to ensure the children's special health care needs are met. These could include requirements concerning inclusion of CCS-paneled providers in the health plan network and specific care coordination requirements, for example.
- The second opinion is that there are few truly time-limited conditions and that trying to separate these conditions has the potential to inadvertently eliminate care for children whose circumstances may require more intensive services than available outside of CCS.

There is an additional consideration with time-limited conditions that is an important policy consideration. In the CCS-only program, the children are typically uninsured and CCS may be their only source for coverage of the conditions that are considered time-limited. For this population, there would be no Medi-Cal or Healthy Families health plan to take on this responsibility unless the state created a CCS limited benefit package and temporarily enrolled them into a health plan.

Option 3: Disenroll CCS children with complex, chronic conditions from existing Medi-Cal managed care health plans and Healthy Families health plans.

The majority of stakeholders interviewed agreed that children receiving services for CCS-related conditions have complex needs that are not served well by traditional health plans and should be carved-out entirely (disenrolled) from the existing Medi-Cal or Healthy Families health plans for all services. The majority of stakeholders felt strongly that the expertise and experience of traditional health plans was not adequate for this special needs population. There was some difference of opinion on the role of traditional HMOs compared to the COHS plans, which currently serve special needs populations in California. Some COHS plans interviewed felt strongly they had the experience and interest in serving CCS children by providing both primary and CCS services.

Carving these children entirely out of existing health plans provides an opportunity to structure a specialty health plan or medical home/specialty care center for these children that cannot be achieved under a structure where only the services related to CCS conditions are carved-out of

the health plan. Requiring a complete carve-out of all children with complex chronic conditions is a necessary step in creating a new delivery system for these children.

Option 4: Disenroll (carve-out) all CCS children (including children with time-limited conditions) from existing Medi-Cal managed care and Healthy Families health plans.

There were a large number of stakeholders who believed that any child enrolled in the CCS program should be entirely carved-out of (disenrolled from) the existing Medi-Cal managed care and Healthy Families health plans regardless of the type of condition. There was concern that trying to handle different CCS children in different ways based on diagnosis would be complex and confusing.

As with Option 3, carving these children entirely out of existing health plans provides an opportunity to structure a specialty health plan or medical home/specialty care center for these children that cannot be achieved under a structure where only the services related to CCS conditions are carved-out of the health plan. Requiring a complete carve-out of all children is a necessary step in creating a new delivery system for these children.

If the carve-out of CCS “conditions” is ended, how are both primary care and CCS-related services provided to the whole child?

Most stakeholders agreed that CCS eligible children should be carved-out of existing Medi-Cal and Healthy Families health plans (be disenrolled) in order to serve “the whole child,” but many stakeholders were unclear on how to create the details of the model.

It was clear in the discussions that most stakeholders would have been more comfortable comparing details of proposed models rather than participating in a high-level discussion of models. This detailed discussion was not possible within the constraints of this project and will need to take place before specific changes to the CCS program can be decided.

All of the discussions were prefaced by participants saying the most critical message to decision-makers in regard to redesign of the CCS program is to “**do no harm.**” Protection of the children in this program was at the forefront of all discussions: many participants were cautious in examining change and concerned that a model had already been created by the State without stakeholder input. Despite these reservations, there was a considerable amount of discussion on components of possible future models.

A number of stakeholders believed that the county CCS programs played an important role in case managing these children. This was felt most strongly by the county staff who are responsible for case management, and who felt they play a vital role in understanding local issues, ensuring that children get the care they need and resolving any problems with access to care. In addition, county stakeholders discussed the benefit of claiming 75 percent federal funding for their staff time, whereas other models could potentially reduce the federal claiming level for case management to the federal matching rate of 50 percent (effective January 2011).

Regardless of the type of model selected, there were general areas of interest among the majority of stakeholders. From these areas, overall key features of the model needed for CCS redesign emerged:

- A single system of care for the whole child, including primary care and CCS services.
- A managing entity (if not the county CCS staff) must have experience and expertise in managing complex, chronically ill children.
- CCS Standards of Care and regionalization of specialized care are important components of any model, although some may need to be re-examined.
- Financial flexibility is needed to incentivize outpatient care, home health and DME.
- A claims payment system needs to be created that could appropriately deal with the intricacies of the CCS program either within or outside of EDS.
- The creation of a regional or statewide administrative structure is needed to reduce county variability.
- Simplification of the overlapping state and county responsibility and funding is needed to reduce confusion.
- Strong state leadership is needed.

We found agreement among most stakeholders that changes to the CCS program should be implemented consistently for Medi-Cal, Healthy Families, and the CCS-only children. Many stakeholders interviewed suggested one or more pilots be used to design, implement, and evaluate any type of CCS redesign. Those supporting a pilot felt the children in the program were too vulnerable and that there was too much at stake to change an entire program statewide at one time.

Of the options discussed, stakeholders expressed interest in, to varying degrees, maintaining the current CCS program but “tweaking” certain features, more fully implementing a Medical Home model, creating a specialty health plan, creating a specialty network, or using an Administrative Services Organization (ASO) in some capacity to help administer the program.

Suggested CCS Program Changes

During our discussions of CCS redesign, one of the key issues discussed was the role of the current CCS program. Some stakeholders, particularly participants actively operating CCS programs, saw a complete CCS carve-out of the whole child as the most appropriate health care model for CCS children based on their experience and expertise working with CCS children. Some of the Medi-Cal managed care plan representatives favored continuation of the current carve-out and cited the successes they had coordinating care with CCS local offices and staff. They also pointed to special care coordination models the health plan had implemented with the county CCS program to meet the needs of CCS children.

Despite the overwhelming support for the CCS program, the majority of participants stated that there are opportunities for improvement in the current system. From our discussion, several critical issues that should be addressed were raised, including:

- Financing of CCS at the local level needs to be overhauled. It threatens the viability of other critical public health functions and is insufficient to support a growing CCS population.
- The capped allocation from the state has led to significant reductions in local CCS staffing, which results in delays in processing authorizations and providing services. CCS case managers have unreasonable case loads and cannot meet the demands of their job in a timely manner. A similar or worse condition exists for state CCS offices which have had significant budget cuts and are subject to state furloughs.
- CCS is not at present a full scope program so a “whole” child approach would require the addition of primary care responsibility.
- The counties are not responsible for funding primary care for CCS-only and CCS Healthy Families-enrolled children, those programs where there is a county share for CCS. However, the counties believe that adding primary care would merge together the cost of CCS and primary care and thus increase county obligations.
- County and state CCS office variations in administration, including medical eligibility and prior authorizations, need to be addressed. Requirements for eligibility determination and prior authorization should be reviewed for opportunities to streamline, particularly if denial rates are low.
- There is a potential role for hospital-based liaison teams to improve discharge planning and smooth out regional variation.

The Role of the Medical Home

The medical home model at the national level has been created with a strong emphasis on patient-centered primary care. Although most stakeholders agreed with the concepts of a medical home, there was concern about how to operationalize this model for the CCS population. There was also skepticism by some stakeholders regarding whether a medical home model could provide effective care management for this population and would be an improvement upon the existing CCS case management and specialty care provider requirements. There was also discussion about the required and significant financial investment needed to prepare physicians to become a “medical home” for this population and questions about whether the state would or could fund this investment.

Although the majority of stakeholders questioned a generalist physician’s ability to appropriately operate a medical home model for these children, there were a few stakeholders who expressed the need to support family physicians in the management of the care of a CCS child, particularly in rural areas. There was some criticism that the CCS program removes children from the care of the family physician with no coordination or contact with the family physician.

The national Maternal and Child Health Bureau has identified six national outcomes or goals for Children with Special Health Care Needs (CSHCN) as critical indicators of success in achieving the goals outlined in the national agenda. Outcome 2 is: All children with special

health care needs will receive coordinated ongoing comprehensive care within a medical home. Ten states have been identified as leaders in developing medical homes for Medicaid and CHIP. They are summarized in the table below.

Strengthening of the medical home and its role in a redesign of the CCS program requires extensive evaluation but could begin with review of medical home models in states targeting children or persons with chronic conditions.

Characteristics of Medical Home Programs in 10 Leading States²				
State	Targeted population	Focus of Care	Definition	Recognition
Colorado	Medicaid, CHIP plans to extend to all children in state.	Children: all conditions Adult Pilot: cardiovascular disease, diabetes, low back pain, prevention, depression	Children's definition found in 2007 legislation (SB 07-130) Joint Principles (adult pilot)	Developed own standards (pediatric practices) NCQA PPC-PCMH (adult pilot) TBD
Idaho	All residents Idaho	All conditions	Joint Principles	TBD
Louisiana	Medicaid/CHIP	All Conditions	Joint Principles(modified)	NCQA PPC PCMH plus additional criteria
Minnesota	Medicaid/CHIP Plan to extend to all insured Minnesotans 2010	Complex conditions first	Defined in 2008 Minnesota statute	Developed own standards
New Hampshire	Medicaid adults	Chronic conditions	Joint Principles	NCQA PPC-PCMH
North Carolina	Medicaid/CHIP	All conditions	Defined in provider handbook	Developed own standards
Oklahoma	Medicaid/CHIP	Children, pregnant women and women in breast and cervical cancer prevention and treatment programs	Joint Principles	Developed own standards
Oregon	All residents of Oregon	All conditions	Defined in 2007 legislation, Healthy Oregon Act	Developed own standards
Rhode Island	Medicaid adults	Adults with disabilities Multi-payer pilot: adults with coronary artery disease, depression, diabetes	Joint Principles	NCQA PPC-PCMH
Washington	Medicaid/CHIP	Children and adults with disabilities	Defined in 2007 legislation. (Senate Bill 5930 Chapter 259)	Developed own standards

² Source: N. Kaye and M. Tacach, Building Medical Homes in State Medicaid and CHIP Programs, The National Academy of State Health Policy and The Commonwealth Fund, June 2009.

Any discussion of a medical home must include a discussion of the need to properly reimburse providers in order to ensure their participation and ability to provide the required services. Currently, the 39 percent rate add-on for CCS physician services is only provided for services to treat CCS conditions. If the program integrates primary care and uses a medical home, the question will be whether this enhanced rate will be provided for all services provided to the child. Further, according to the Kaiser Family Foundation, California starts with a much lower payment level than the other states that have been successful in establishing medical homes. For example, rates for primary care in California are 47 percent of Medicare while in North Carolina they are 95 percent, in Oklahoma, 100 percent and in Pennsylvania, 62 percent.³ A successful medical home model requires adequate funding to support the requirements placed on the medical home.

If a medical home model was created for the CCS program, it would need to emphasize specialty care and care management. From our discussions, several critical components were identified:

- Appropriate financing must be provided for care management functions performed by the medical home.
- Startup funding along with adequate long-term financing is needed to create the medical homes.
- State leadership would be needed to support implementation of web-based tools for physicians and medical informatics.
- Clinical guidelines and disease management protocols developed as part of the medical home initiative would need to be dispersed throughout the physician community.
- Physicians serving as the medical home must have skills, on-going education, and interest in serving children with chronic and complex conditions.
- A medical home model must be accompanied by a method to address some of the funding problems in the Medi-Cal fee-for-service program where reimbursement is low for outpatient and physician care.

Comprehensive Specialty Plan or Network Options

Stakeholders discussed the option of developing a specialty plan for children in the CCS program. The option was of interest to some stakeholders, assuming the details of the program were vetted in advanced, and based on data when possible, included a program evaluation component from program inception and was implemented by an entity with appropriate experience and expertise.

In states that use a comprehensive health plan or network, the health plan/network is the single delivery system through which the child receives all of their health care services and which

³ Kaiser Family Foundation, Kaiser State Health Facts, available at <http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4>

could include behavioral health services and even long-term care institutional and community-based services. A comprehensive health plan/network for children with special health care needs must include inpatient hospital services because that is where the bulk of expenditures are.

A comprehensive health plan/network is paid on a capitated basis (a per member per month payment) and may be fully at-risk, partially at-risk or have no risk (cost settle at the end of the year). Those that serve high-cost members require a capitation payment that is sufficient to ensure risk is not unreasonable (if the plan is at-risk). The risk-based rates can be developed in a way that serves as an incentive for certain desired outcomes that might include:

- Reduced inpatient care in favor of outpatient care;
- Improved care coordination;
- Use of disease management practices;
- Use of a comprehensive medical home model; and/or
- Implementation of electronic medical records, e-prescribing and other technologies demonstrated effective in improving outcomes and reducing costs.

The comprehensive health plan/network may perform an array of administrative functions now performed by the agency operating the children's program; most commonly service authorization, care coordination, claims payment, service utilization reporting (encounter data) and quality reporting. Part of the responsibility of a comprehensive health plan is to ensure an adequate network (numbers and types of providers, qualifications of providers) and adequate access (distance, travel times, wait times, case load). The agency operating the children's program typically retains eligibility determination, quality management oversight, and data analysis responsibilities. A comprehensive health plan/network can also be required to provide 24/7 nurse call line access, urgent care capabilities, and family supports.

Florida Children's Medical Services (CMS) operates both a primary care case management (PCCM) program, with an established provider network much like the paneled provider arrangements for the CCS program and a medical home model, as well as a specialty managed care plan. The PCCM model operates in the parts of the state where Medicaid managed care has not to-date been successfully implemented (primarily rural areas). CMS is not a licensed HMO but is instead operating as Provider Service Network or PSN. A PSN is a type of managed care arrangement authorized in Florida Statute that is comprised of a comprehensive network of providers that includes inpatient, outpatient, physician and other services. CMS is housed within the Department of Health, which is the Title V agency.

Other examples of specialty plans exist, some for children with special needs and others for adults with special needs. For example, Texas is enrolling all foster care children into a single, specialized Medicaid managed care plan. In Arizona, the state's developmental disabilities agency is the Medicaid managed care plan for all persons with a developmental disability who are Medicaid eligible (part of Arizona's Long-Term care System or ALTCS). Many examples

exist for persons who meet nursing home level of care, including specialty plans for children, adults under 65, and elders in Florida, New Mexico, New York, and Wisconsin, to name a few.

There was concern among some stakeholders that a specialty plan model could eliminate county case management functions and some stakeholders maintained there was no evidence that the replacement model would do a better job of ensuring that CCS children get the care they need. Further, there was concern that no entity could successfully take over the risk for the cost of CCS, where there are some very high cost children. Stakeholders with an interest in a specialty plan or network saw the potential for reducing county variation in program operations. Some stakeholders stated they might support a pilot specialty plan if capitation and risk arrangements were appropriate and other details could be resolved. In general, stakeholders indicated:

- A preference for a non-profit entity/entities to administer the program.
- The entity would operate the full range of administrative services with the exception of eligibility determination, which should remain with the CCS program.
- A specialty plan model should retain CCS Standards of Care and Regionalization with modifications if needed.
- A specialty plan should be designed (and should be able to achieve) a reduction in inter-county variation in medical decision making and authorizations for services, if eventually implemented across the state.
- There should be increased financial flexibility through a partial capitation payment and variable, shared risk or no-risk arrangement for the specialty plan, with concerns expressed over a fully capitated arrangement.

Administrative Service Organization Options

States vary considerably in how they administer services for children with special health care needs. Some states are now contracting out administration of their programs with *Administrative Services Organization (ASOs)* (sometimes also referred to as a Third Party Administrators or TPAs). These ASOs may administer most or some of the program.

Arizona is using the ASO model to administer their program that is comparable to CCS (Children's Rehabilitative Services or CRS) effective October 1, 2008, the Arizona Physicians IPA or APIPA. CRS contracts with providers of specialty services just as they did prior to contracting with APIPA. Providers are required to coordinate care with PCPs and health plans. APIPA is responsible for:

- CRS eligibility determination and enrollment;
- Claims and encounter processing;
- Grievances, appeals, and provider claim disputes;
- Member services, including member education and advocacy;

- Utilization management, including prior authorization, concurrent review, case management/care coordination;
- Quality management, including quality of care issues, performance improvement projects, and quality measurements; and
- Parent Action Councils.

APIPA (AmeriChoice) is under contract to the Arizona Department of Health Services. The Arizona Medicaid program reports that the decision to contract with an ASO was made based on feedback from multiple community stakeholders, including the public, acute care health plans and the subcontractors. Arizona determined the most efficient and effective means of delivering specialty care to children with special health care needs was to use an ASO to administer the program.

Some California counties and the County Medical Service Program (CMSP) have had success using ASOs to administer their indigent care programs. While the indigent care programs do not serve children with special health care needs, many indigent care program enrollees are homeless, have a mental illness, or have a major chronic illness, or all three. San Diego County is now working with its ASO to integrate medical homes into their program for some conditions.

Florida CMS is currently procuring the services of a TPA (Florida's regulatory category for ASOs). The TPA implementation will be piloted in three areas of the state before statewide roll-out. CMS is procuring a TPA to provide the following functions:

- Health care eligibility and enrollment;
- Provider administration;
- Claims processing and payment;
- Fee collection and processing;
- Service authorization;
- Fiscal operations;
- Utilization review and management; and
- Development and implementation of clinic management and care coordination software.

In general, stakeholders did not express interest in an ASO to administer all or some of the CCS program. However, this model has the potential to address a number of stakeholder identified problems including the ability to improve the case management system, obtain a CCS specific claims processing system, the ability of the ASO to restructure rates and not rely upon Medi-Cal rates, and to bring a number of reforms to CCS while maintaining a fee for service payment process.

How do you create financial flexibility?

The financing of the CCS program, including financing of any future “models,” such as a specialty plan or network, was of great interest to stakeholders. Many were interested in creating funding flexibility and using incentives to encourage the most effective and efficient care for the child and to address funding problems with the Medi-Cal and CCS programs. Feedback on appropriate financing arrangements was mixed.

- Some stakeholders stated that traditional fee-for-service is the only way to make sure the child receives all needed services and to protect the very high-cost child. Although, even in the FFS system, stakeholders were concerned that Medi-Cal and CCS rate structure that did not reimburse for the provider’s full cost of providing care and which provided relatively low rates with no rate increases for outpatient care was creating problems in providing the right care for the child and threatened to undermine that ability of the CCS program to provide needed care.
- The possible use of full capitation was met with some skepticism and in general stakeholders were concerned that such an approach would create problems in a high-cost population.
- Many of the stakeholders were interested in exploring a partial capitation approach with appropriate compensation for outliers, i.e. the highest cost children. One of the biggest interests in considering a partial capitation financing structure was a general consensus that financial incentives need to be aligned to create a program with greater access to outpatient, home health and DME services. This was seen as a way to support appropriate discharge planning; greater flexibility in payment to providers; and an appropriate claims payment system that could deal with the intricacies of the CCS program.

In addition to funding for the CCS administrative entity, there was considerable discussion about the impact of the state and county funding split that reduces financial flexibility and impacts the ability to redesign the program. The County Health Executives expressed significant concern that CCS was not a part of the county public health department’s core mission and in fact, detracts from their core mission. They are concerned that the growth of the cost of the CCS program occurring at the same time that the state is cutting county support and county revenue is dropping, will make the CCS program unsustainable. Further, the counties believe that the state has altered the traditional partnership where the state matched county expenditures. At the same time, if counties are required to finance parts of the program, the county executives felt it was important for all contributing counties to have a significant role in program administration, particularly the eligibility determination and authorization process. Some of the county medical directors felt that with the tightening of the budget, they have become more efficient and more effective.

USING DATA TO DRIVE IMPROVEMENTS FOR CCS CHILDREN

Children served by the California Children's Services Program (CCS) are an important population from health care services, economic, and policy perspectives. As the state moves forward with consideration of a range of options for a Medicaid waiver request that may include CCS program redesign, it is critical that both quantitative and qualitative data be integrated in order to make the best decision for one of the most vulnerable groups of children in the state. Data is key to determining program effectiveness, detecting problems, defining priorities, identifying innovative solutions, and allocating resources for improved health outcomes. However, data or information alone will not transform outcomes.

Data, which are simple measures of characteristics of people and things, have little inherent meaning or value. Analysis of the data enables the identification of patterns and areas of focus, thereby creating information to generate recommendations, rules for action, and effective program changes.

Using data effectively for considering changes to the CCS program is a three stage process.

- First, it is important to have an overview of the program, i.e. a general understanding of the size and scope of the program.
- Second, an iterative process involving stakeholder perspectives, political considerations, and descriptive statistics for the CCS program accomplished during this first stage, will generate additional research questions based on the specific challenges faced by the program and the specific areas of concern that need to be addressed by redesign options.
- Third, additional analyses based on these questions should ultimately drive decision making and provide detail that DHCS will need as it moves forward with more specific redesign possibilities.

Due to the abbreviated timeline of this specific project and the limited data available, HMA has initiated Stages 1 and 2 described above, however, there is still much that needs to be done to provide the necessary information that stakeholders indicated they need to make informed decisions regarding CCS reform options.

The Department made concerted and dedicated efforts to provide data on CCS children and services for this document. However, the fact that data analysis was not part of the original scope of work and that this project had an abbreviated time frame restricted the Department's ability to provide HMA with data necessary to provide greater specificity for reform options. It is very clear from our review that the critical data needed to properly understand and redesign CCS is not currently available. For example, we were not able to obtain usable data on the difference in cost for a child who was only in fee for service vs. a child enrolled in managed care and subject to the carve out. Additionally, some of the Department's public data could not be used in this report as it was found by the Department to be unreliable. Coordination within the DHCS on production of data needs to be improved so that the Department can ensure that the data it publishes is reliable.

Far more data on the major cost drivers of CCS is needed to properly develop reform. The program has a wealth of raw data, however for redesign to be successful, this data has to be better organized and analyzed so that redesign can properly target the correct areas of the program.

Stage 1: An Overview of the CCS Program

DHCS provided HMA with data that begins to support a broad overview of CCS utilization and expenditures. These data are critical to providing an aerial view of the program and are a necessary preliminary step to delving deeper into the program's operations. However, it is this latter step (i.e., that occurs in Stages 2 and 3), that is most useful since it focuses on addressing specific issues, identified by DHCS and stakeholders, that compromise the quality of the CCS program and that can potentially be improved.

In Stage 1, we relied on several data sources. These include:

- Children's Medical Services Network (CMS Net) and the LA County Automated Case Management System;
- Medi-Cal Management Information System and Decision Support System (MIS/DSS);
- Surveillance and Utilization Reporting System (SURS); and
- A report by the Institute for Public Health, Graduate School of Public Health, San Diego State University (SDSU), "Evaluation of Expenditures by CCS Beneficiaries: 2001-2005."

Each of these data sources has strengths and weaknesses; however, the MIS/DSS data has the most potential moving forward. In the past, the MIS/DSS has not included CCS data from all three programs (i.e., CCS Medi-Cal, CCS Healthy Families, and CCS only.) However, the newly implemented MIS/DSS contract now includes data from all three sources. Additionally, the MIS/DSS includes claims for services provided to CCS children from other departments including Mental Health and Developmental Services, as well as the Children Health and Disability Prevention (CHDP) program.

As a \$1.8B dollar program serving 191,000 children, a general understanding of how CCS program expenditures and utilization drive the questions posed in Stage 2 are critical to laying out the required detail in any CCS proposed redesign. For example, as discussed below, medical services for newborns and for children with hemophilia are examples of two areas which comprise a large portion of the total CCS expenditures. Consequently, questions that focus on children with these conditions and other conditions that comprise a high proportion of expenditures can help CCS better provide care and use resources more efficiently.

Stage 2: What the Data Tells us About the CCS Program

In FY 2000-01, total CCS program expenditures were approximately \$764 million with a case load of approximately 134,400 children. However, by FY 2007-08 the program had grown

significantly in both expenditures, to \$1.8B, and the number of users, to 191,000 children.⁴ The increase in the number of children contributed to some of the growth but caseload increased only 30 percent while expenditures increased nearly twice as much, 58 percent. The driving force behind the rapid inflation in health care costs is not well understood. Several changes occurred during this time period that affected CCS including the growth of the carve-out in Medi-Cal and Healthy Families, changes to the rate methodology for blood factor, and increased hospital costs. The reaction to the increased cost of the program is in large part driven by what caused the growth. For example, if a large part of the growth is due to the expansion of managed care and the carve-out, part of this growth is a natural outcome of that state policy. Before the managed care carve-out, there was no reason for a hospital to seek CCS coverage for a Medi-Cal child in a NICU as Medi-Cal fee for service paid that claim. Now with the carve-out, health plans must refer many of these children in CCS, creating a cost shift to CCS rather than a new cost.

The question, therefore, is how to address program costs while maintaining and improving the quality of the program. The first step to answering this question is getting a handle on CCS program expenditures and utilization. (Appendix 1 includes a series of questions and bullets that summarize information on CCS expenditures and utilization). The second step to answering this question must begin with an exploration of what factors are driving CCS program costs.

The expenditures for Medi-Cal CCS clients drive most of the CCS program costs, approximately nine of every ten dollars. Medi-Cal children ages 0-1 are major cost drivers of the program accounting for 37 percent of expenditures. Based on FY 2007-08 expenditures for Medi-Cal CCS of \$1.6B, this is \$592 million. While data specific to aggregate NICU and perinatal related services for each CCS child were not available, information on expenditures by age combined with the fact that 62 percent of CCS program expenditures in FY 2007-08 were for inpatient hospital care suggest that additional data analysis on inpatient care for children ages 0-1 may be necessary to understand how to control these costs. Reform options must address the sources of the problem, e.g. are a large portion of the mothers of these children not receiving proper prenatal care and is a targeted intervention necessary; should all of these NICU children be covered by CCS rather than their health plan, or are there specific programs or interventions that can be developed to address NICU cost and lengths of stay?

Another major cost driver of the program are costs for children with hemophilia, a condition that is a subset of the MDC, diseases of the blood and blood forming organs. While these costs account for just under \$100M for all CCS programs or just under 6 percent of total program expenditures, the cost per child was more than 6 times the average cost for a CCS child at \$59 thousand, in FY 2007-08. The Department has worked to initiate better ways to obtain Factor products for treating hemophilia, such as through use of rebate contracts for the CCS-HFP and CCS-only, use of supplemental rebates for CCS Medi-Cal and CCS-only and through contracts

⁴ Data for FY00-01 are from data provided to SDSU by DHCS for their report "Evaluation of Expenditures by CA Children's Services Beneficiaries: 2001-2005."

with specialty pharmacies. However, there still remain potential ways to reduce program expenditures in this area by finalizing the use of specialty pharmacies in a manner that ensures better use of these medications with less waste and that potentially reduces the 20 percent mark-up on product cost, for the cost of dispensing. Additional analyses exploring expenditures by various providers and provider types or variations in expenditures for children of similar age and condition severity may provide insights into controlling costs. In an 1115 federal waiver, there may also be opportunities to reduce program expenditures through making better use of the federal 340B program.

While the above information begins to explore the cost drivers of CCS, a more thorough analysis is necessary. Additionally, reform options that incorporate care for the CCS child rather than the CCS condition must take into account the aggregate costs and cost drivers for the CCS child, not just the CCS condition. To date, most work has focused on CCS program costs rather than CCS children's costs. While we have not yet obtained aggregate data for many CCS children, the 40 percent of Medi-Cal CCS children enrolled in Medi-Cal FFS will have claims data for their entire scope of care.⁵

Stage 3: Additional Research Questions to Drive Future Decision Making

In the course of the stakeholder interviews, stakeholders raised issues about various limitations of the program or areas for consideration that may potentially improve the program. Many of them noted that without additional data it would be difficult to address some of these issues and limitations. A preliminary list of questions driven by stakeholder comments is provided in Appendix 2.

⁵ On the advice of the Department, this report does not use any data in this report from a June 2009 Department PowerPoint presentation on Medi-Cal cost drivers, <http://www.sor.govoffice3.com/vertical/Sites/%7B3BDD1595-792B-4D20-8D44-626EF05648C7%7D/uploads/%7BB6F5D9DA-0284-44D5-B43D-FB840D2C50BD%7D.PDF>

CONSIDERATIONS FOR THE STATE

Based on our discussions with stakeholders, we found the following principles and considerations are crucial for the redesigned CCS program.

- First, do no harm.
- The whole child should be served in one system for both primary and CCS-related care.
- Traditional health plans do not have the experience, expertise, or desire to meet the unique needs of CCS children.
- Overlapping state and county responsibilities and county variation should be minimized. Financial flexibility is a key to redesign.

Given these principles as a starting point, there are multiple options to be further explored by the state in redesigning the current CCS program. Program components can be designed to address the principles desired by stakeholders and to account for the unique circumstances in California. HMA offers the following discussion on some additional items for consideration.

Consider the Implications of Geography in Redesign

California is not a simple system of care. There are great divisions between the north, south, and the valley, and between urban and rural areas. These geographic issues must be considered in any redesign of the CCS program. Although changes should be consistent statewide, there may be requirements for regional variation based on provider availability and distance/time for travel. A solution that may work in an urban area may not work in a rural area due to limits on provider availability and travel times and distances. Any solutions identified for the CCS program will require attention to local concerns, including geography.

Ensure Financial Flexibility

There are two major barriers to flexibility in the current program:

- The financial structure of the CCS program could be a major barrier to redesign of the program. The funding is based on a history of statutory compromises that established the state and county share of the CCS program and has little logic today. Medi-Cal pays the entire cost of the services for children on Medi-Cal. For CCS Healthy Families, the state and counties share the cost of the non-federal share. For CCS-only, the state and counties split the cost of the services. The federal funding from the 1115 hospital financing waiver goes entirely to the state for use in hospital financing.
- Financing is further complicated by how state law defines the funding responsibility for the CCS program. Counties are only required to provide a maintenance-of-effort based on expenditures for health care services in FY 1990-91. The counties are now funding

program services at a level approximately twice the amount than is legally required. Further, CCS is not an entitlement program, although from a practical standpoint it operates as one. As the CCS-only program is bound by the availability of funds, when either the state or a county lacks funds, provider payments are held until there is more money available.

There are several options the State could consider to begin to deal with the barriers to financial flexibility, including, but not limited to:

“Buy-Out” the CCS-Only Program

The CCS program was included in “realignment,” which significantly complicates redesign with both the counties and state funding the program. It is our understanding that there was not a programmatic reason at the time for including CCS and the unintended consequence has been to increase the complexity of the program. The County Executives expressed significant concern that CCS, while not a part of the county public health department’s core mission, was jeopardizing the counties responsibility to meet its core public health mission. Providers also believe that the fragmented nature of CCS funding has to be resolved to effectively redesign CCS.

It is not practical for the CCS-only program to be treated differently than Medi-Cal. Medi-Cal, accounting for 77 percent of CCS children and 90 percent of program expenditures, provides the size and related resources that allows the CCS-only program to be able to operate. To be effective, the three programs need to operate together within a single system. However, counties have concerns about delegating responsibility for eligibility and service authorization when they have a financial stake in the game.

By buying out the county for the CCS-only program, the state gains greater flexibility to restructure the program. This buy-out could be done in a budget neutral way by either swapping the program in realignment with another social services or health services program that could be used to meet the funding threshold necessary for the realignment or by addressing funding responsibility for other programs such as CCS medical therapies. If the state were to buy-out the CCS-only program, this would make a program redesign much easier.

Today, much of the cost of the CCS Medi-Cal program is controlled by the counties who have no financial stake in the outcome of the Medi-Cal component. There may be concerns about the state assuming more financial responsibility for the CCS program, while the counties retain the ability to significantly control state expenditures with no risk involved, however this is already the case for 90 percent of the program expenditures.

Change the Fee-For-Service Payment Structure

The CCS program currently uses the fee-for-service (FFS) payment structure. While FFS as a payment system should ensure that services can be provided, there are several problems with the Medi-Cal and CCS payment system. There is no flexibility available in the existing FFS system to pay more than FFS rates for outpatient, DME or home health services, all areas where increased funding could potentially decrease inpatient stays. There is also no way to use

financing to create incentives for hospitals to provide more care in an outpatient setting, when appropriate for the child. While the State routinely increases inpatient rates, it has rarely increased rates for these other lower cost services, and on occasion, has decreased rates. Thus, the lower cost services become less available potentially ending up with care being provided in higher cost settings.

In addition, the current FFS structure does not work well for initiatives like telemedicine and does not provide for increased payments for tertiary care physicians or nurses to spend time in non-face-to-face activities such as telephone consultations with PCPs and families, discussions with specialists or community resources or written detailed clinical summaries. While some of these services are reimbursable, low Medi-Cal rates hinder a provider's ability to use these services. Other services are not reimbursable as they do not meet the criteria for payment.

There are alternative financing strategies for the state to consider in redesign of CCS. In determining the preferred model, it is important to consider that CCS children are not the typical, healthy children most often served in Medi-Cal or the Healthy Families programs. The nature of CCS conditions requires a financing mechanism that ensures appropriate payment in order to diminish incentives to limit care.

The financing options include use of a global payment or capitation payment to support a provider-based model to serve the whole child that would include an enhanced medical home. This payment would provide greater flexibility for the CCS program by permitting the provider "group" to manage services and dollars, potentially freeing up funds to support more outpatient or home-based care when appropriate or to support telemedicine, etc. Implementation of a capitated specialty plan is another option⁶ or a combination of ASO and specialty plan capitation as a third option.

Administration

Just as the FFS payment system and the county responsibility for the CCS-only program are problematic from a financial perspective, they are equally problematic from an administrative perspective. Because there is a strong preference among stakeholders to end the carve-out and meet the needs of the whole child, and because of the previously discussed financial challenges, a redesign should address options to improve program administration.

The development of one or more specialty plans was not widely endorsed and clearly is of concern to many stakeholders who have grave concerns about the application of "capitated managed care" as a vehicle for program change. There was some interest in exploring this possibility further to fully understand the options for design of this type of plan, especially in

⁶ The Institute for Child Health Policy (ICHP) at the University of Florida has done a considerable amount of work on financing and reimbursement strategies for Children with Special Health Care Needs (CSHCN) in managed care settings. In a capitated model, ICHP suggests a combination of health-based risk adjustment with reinsurance at a low attachment point more closely align payments and expenditures on the average for CHSCN.

the areas of eligibility determination, capitation rate development and accompanying risk arrangements.

While there was little interest expressed in the ASO model, we believe the possibilities in this area should be discussed in detail with stakeholders. The lack of interest was at least in part the result of the short timeframe and limited information available for review with stakeholders during the timeframe for this project. An ASO could operate some, many or all CCS program administrative functions. While it is likely most cost-efficient to contract for the broadest set of administrative services, efficiencies could be achieved with a limited set of contracted responsibilities. Improvements could be obtained in the case management and claims processing systems and there could be increased rate flexibility. This more narrow approach might be viewed favorably by the various CCS stakeholders. Strong preference was expressed, for example, for continued CCS program/county operation of eligibility determination.

Network Requirements

Any redesign of the CCS program must include stringent requirements for provider networks that include CCS paneled providers and regionalization of services. A consistent comment from stakeholders was that strengths of the CCS program are its standards and credentialing and they should be continued and expanded as part of any redesign effort.

It is critical to provide education and training to network providers, including family practice physicians and pediatricians, in order to support care of these children in a provider setting close to home. In this manner, there would be an increase in expertise among willing providers and this is particularly important in rural areas of the state.

Policy Issues for Further Exploration

In our discussions with stakeholders, several policy areas emerged that were beyond the scope of our project but are important areas for further policy discussion and decisions, and have significant implications for CCS Redesign.

NICU

While we do not have discrete data on how much CCS spends on NICU services, the inpatient expenditures for children ages 0-1 are high and likely to be attributable to NICU costs. A CCS redesign must pay particular attention to these costs. In addition to examining how services are reimbursed, the review should include whether there are ways for the Medi-Cal program to work with pregnant women during their pregnancy to improve birth outcomes and avoid NICU days. With Medi-Cal paying for approximately 46 percent of all births in the state and Medi-Cal and CCS covering a significant portion of the NICU days in the state, taking action to improve birth outcomes could be one of the most cost-effective changes to the CCS program.

In addition to the expense to the CCS program for infants in the NICU, there is also considerable administrative complexity in how the medical eligibility criteria are designed for the CCS program. A neonate or infant who requires care in a NICU does not necessarily have a CCS qualifying condition. An infant in a NICU is eligible for the CCS program when they have

the conditions specified conditions under Policy Letter NL 05-0502 (May 15, 2002), which allows an NICU infant to qualify for CCS based on NICU services rather than a CCS condition. For example, NICU infants receiving supplemental inspired oxygen and tube feedings meet medical eligibility for CCS.

CCS providers and staff from the counties expressed concern that children who need complex NICU services are often transferred to specialty hospitals and referred to the CCS program too late and at a point where earlier intervention would have prevented medical complications.

The complexity of NICU services can result in an infant moving in and out of the CCS program and creates financial incentives for providers and managed care plans to provide treatment in such a way that an infant moves into CCS.

There was discussion of several key NICU issues that should be further explored:

- It may not be appropriate for certain NICU conditions to qualify for the CCS program in the absence of other CCS conditions.
- In a program redesign, serious consideration should be given to disenrolling NICU infants from managed care if eligibility is due to CCS conditions.
- CCS standards for NICU care are necessary and important to address quality issues.
- NICU is an expensive component of the CCS program and there are not enough detailed data available to understand the full impact of this population on the program.

This is an area where further analysis is needed and discussions with CCS and hospital and health plan medical leadership are critical to determine the most appropriate way to manage NICU care.

CCS-Eligible Conditions

There was significant discussion on whether or not the current CCS-eligible conditions should be re-examined to determine if all CCS-eligible conditions are appropriate for the level of intensive case management or multi-disciplinary specialized care provided through the CCS program. Some stakeholders, particularly CCS Medical Directors, felt strongly that as the program has developed over time there has not been a critical analysis of medical eligibility criteria. This appears to be an area where physicians serving CCS children are critical to the discussion, along with policy makers.

Implications of CCS Redesign for MTP

Although the Medical Therapy Program was beyond the scope of our project, several stakeholders discussed an important relationship between CCS and MTP. We received feedback from stakeholders that CCS redesign should include the implications for the MTP program.

CCS CHIP Waiver

The creation of a waiting list for children eligible for Healthy Families and the potential disenrollment of over 600,000 children from this program by June 1, 2010, will place additional

financial pressure on the CCS program and both DHCS and county funding. Given current rules, many CCS Healthy Families children may be disenrolled from Healthy Families but still remain eligible for CCS. This will shift 65 percent of the CCS cost of these children to the state and counties.

Since the current Managed Risk Medical Insurance Board (MRMIB) regulations do not exempt many CCS eligible children from either the waiting list or disenrollment, other alternatives to obtaining federal funding for these children should be explored. If the Healthy Families budget problems are not resolved, one opportunity is for the state to seek federal approval, including possibly of a federal 1115 waiver that allows the state to provide CCS-only services under CHIP for children who are on the waiting list or may have to be disenrolled. This will not materially affect MRMIB's budget but could significantly reduce increased cost to the State and county budgets.

HMA Recommendations

The California HealthCare Foundation requested HMA provide recommendations to the state through this project. Although we do not have specific models to recommend, we do have recommendations for continuing the process of redesign.

1. In addition to workgroup under ABX4 6 (Chapter 6, Statutes of 2009), create a smaller group of stakeholders, representing each constituency group, to work through differences in perception and reality of areas for redesign. We would suggest this group be no more than 15 individuals and meet for no more than four (4) meetings. The goal is to quickly generate a set of workgroup recommendations on areas for CCS program redesign. These recommendations could be taken to the Title V Needs Assessment Workgroup for comment.
2. Consider completely "carving-out" children with complex needs entirely from their health plan and create a comprehensive care model for these children. The current carve-out creates additional administrative expense, appears to shift costs from managed care to the CCS program, and often puts providers and families in the middle. The options for a comprehensive model, such as those described in this paper, should be vetted with stakeholders to develop a system capable of meeting the needs of the whole child. Consider changes to the CCS carve-out for children in NICUs to limit the carve-out to newborns with other CCS qualifying conditions. Further, review whether care for children with time-limited or single system conditions can best be addressed within existing Medi-Cal or Healthy Families health plans (ending the carve-out for these children) or by including completely carving-out these children into a new CCS system. Final recommendations on the structure of the carve-out cannot be completed without more thorough data analysis on cost, conditions, utilization, and quality indicators.
3. Any redesign effort should consider all three funding sources, CCS Medi-Cal, CCS Healthy Families, and CCS-only, together as they cannot be addressed separately.

4. Develop better CCS program data to understand the cost drivers and savings opportunities in the program. Much more data are needed to understand the program and create a comprehensive strategy for redesign. During this review, we were only able to obtain limited and insufficient data and were unable to fully analyze the program.
5. Evaluate the cost drivers behind the CCS program expenditures of \$1 billion of its \$1.7 billion on about 17,000 children or 13 percent of the children in the program, generating 60 percent of the program cost. Any effort to reform the program must better understand the dynamics of the cost drivers in the program. A thorough understanding of this group will enable the state to identify what can be done to address their health care needs and the cost of this care.
6. Closely analyze the cost of NICU care in the CCS program with the assistance of stakeholders with expertise in this area. Can NICU care be prevented through better prenatal care? Should the carve-out for NICU be changed to only carve-out children with other CCS conditions?
7. Ensure that CCS is effectively purchasing and managing the cost of blood factors at the pharmacy and supplier level, a large cost in the CCS program.
8. Explore how to change the funding structure or mechanism for the Medi-Cal and CCS FFS program so that the program better compensates for care and enables the provision of care in alternative, lower cost settings. There is the potential for program savings if the program is able to reduce unnecessary hospital days.
9. Explore how to realign the county and state share of the program.
10. Explore models that can improve CCS program administrative efficiency and care (including the use of an ASO) and determine if any components of case management can be performed at the provider level or need to be maintained at the county level.
11. Assess how well the Medi-Cal claims processing system pays CCS claims and whether improvements can be made. This review should include exploring the option of creating CCS specialists to address CCS provider concerns at the Medi-Cal fiscal intermediary.
12. Address complaints about DHCS leadership.
13. Fully inform stakeholders and provide opportunities to participate in CCS program redesign.
14. Implement substantive CCS changes resulting from redesign on a phased-in basis to ensure that the changes work prior to statewide rollout. Ensure that an evaluation is incorporated into any pilot project to adequately assess the pilot's effectiveness.
15. Maintain a principle of "Doing no harm" in any changes made to the CCS program.

APPENDICES

Appendix 1: Questions Related to CCS Program Costs, Utilization and Caseload

Brief Summary

- **What is the total number of CCS children receiving services and what are their expenditures?**
 - Total CCS expenditures in FY 2007-08 were \$1.8 billion with a total of 191,272 children using CCS services.
- **How does total utilization and expenditures vary by funding source?**
 - Medi-Cal accounts for more than three quarters of users, 77%, approximately 146 thousand, and almost nine of every ten CCS program dollars, \$1.6 billion in FY07-08 (Exhibits 1 and 2).
 - Healthy Families (HF) accounts for 13 percent of users, 25 thousand children, but only 8 percent of expenditures, \$144 million in FY07-08. There may be multiple explanations for a disproportionately lower percent of expenditures but certainly one of them relates to reimbursement. While there is retroactive eligibility for CCS in Medi-Cal there is no retroactive eligibility for HF. Therefore, the HF plans may absorb more of the initial costs for CCS children than under a system of retroactive eligibility (Exhibits 1 and 2).
 - CCS-only children, those who don't qualify for Healthy Families or Medi-Cal, comprise just 10 percent of those using services, (20,000), and three percent of total expenditures or \$59 million in FY07-08 (Tables 1 and 2).⁶
- **How does utilization and expenditures vary by county?**
 - Los Angeles accounts for 29 percent of expenditures.
 - The ten counties with the highest expenditures account for 75 percent of total program expenditures.
- **What are the average expenditures per CCS child who uses CCS services?**
 - Average expenditures in FY 2007-08 per person (PP) varied considerably by program. Medi-Cal is highest at \$11,000 pp, followed by HF \$5,700, and CCS-only at approximately \$3,000 pp. However, average pp expenditures are of limited use without knowing the distribution of expenditures. A few high-cost cases (high-cost outliers), can easily drive up the arithmetic average. Data based on for example, quartiles would be more informative. (Data on the distribution of expenditures were not available at the time of the writing of this document.)

- **What are the expenditures for hospitalizations?**
 - Hospitalization expenditures comprised 62 percent of all expenditures for all programs.
 - Hospitalizations were a significant proportion of expenditures for CCS Medi-Cal and CCS Healthy Families children, 62 percent and 60 percent, respectively, but less than half of CCS expenditures (43 percent) for CCS-only children.
- **What is the caseload and expenditures by condition?**
 - The top five medical diagnostic categories (MDCs) for FY07-08 for Medi-Cal CCS children were 1) Vcodes (e.g. live births); 2) Certain Conditions Originating In The Perinatal Period; 3) Congenital Anomalies; 4) Diseases Of The Blood And Blood-Forming Organs (Hemophilia); and 5) Diseases Of The Respiratory System (Exhibit 5).
 - In aggregate, they accounted for more than half of Medi-Cal CCS program expenditures, 55 percent.
- **What is the expenditure growth by program, i.e. CCS Medi-Cal, CCS Healthy Families, and CCS Only?**
 - All three CCS programs experienced increased growth in expenditures between FY 2005-06 and FY 2007-08 (Exhibit 3). Medi-Cal, with the largest number of CCS children increased, on average, approximately 10 percent each year, while Health Families increased annually at a rate more than twice that of Medi-Cal with a compound annual growth rate of 23 percent.
- **What is the CCS caseload for MC vs. FFS?**
 - Among CCS Medi-Cal children, approximately 60 percent of the caseload was enrolled in a Medi-Cal managed care plan based on caseload numbers as of March 2009.
 - CCS Healthy Families children are all enrolled in a managed care plan.
 - There is no public information on the type of plan or insurance available to CCS-only children.
- **How large is the CCS provider panel?**
 - In July of 2009, there were a total of 20,980 CCS paneled providers in a variety of specialties with 43 percent of them practicing in pediatrics or internal medicine. However, we do not know how many patients they saw or how the number of specialists compares to the number of children with conditions treated by the specialist.

Exhibit 1. CCS Clients Using CCS Service By Program, FY 2007-08

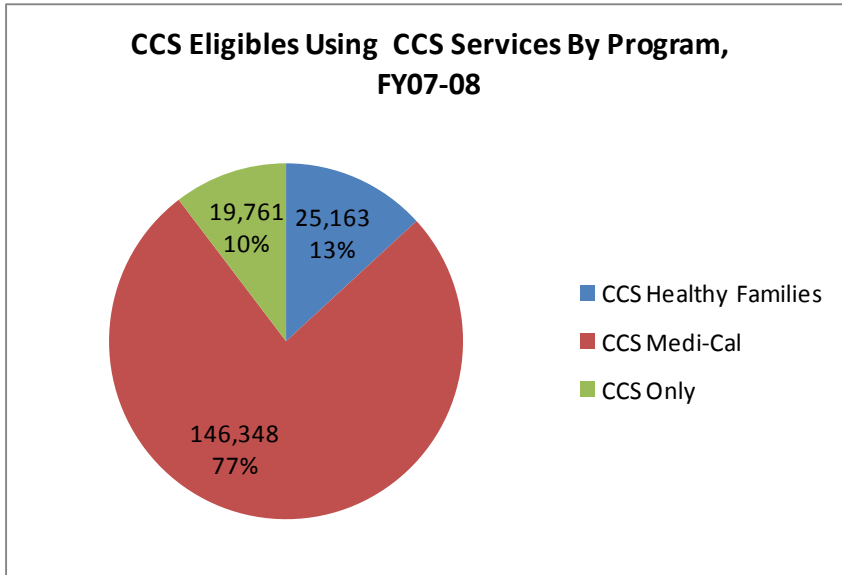


Exhibit 2. CCS Expenditures for CCS Service By Program, FY 2007-08

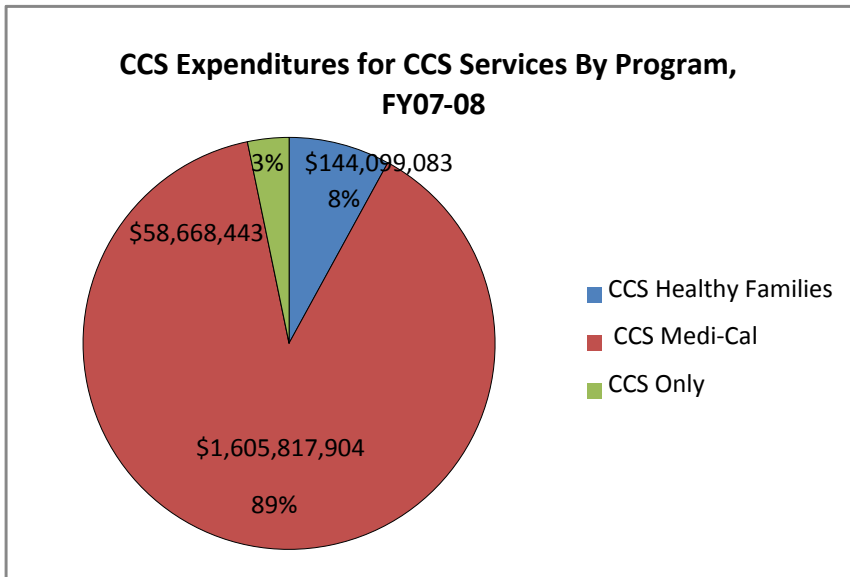


Exhibit 3. Expenditure Growth By CCS Program FY 2005-2006 Through FY 2007-2008

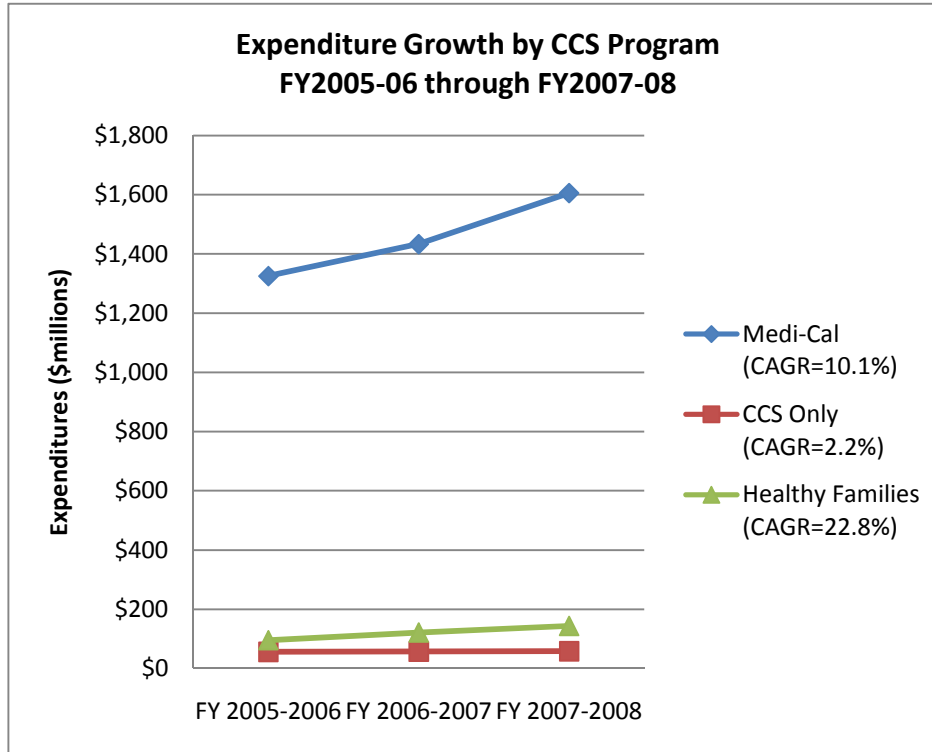


Exhibit 4. Counties With The Highest CCS Expenditures (All Programs) FY 2007-08

Rank	County	CCS Service Users	Percent of CCS Users	Total Expenditures (\$)	Percent of Total Expenditures
1	Los Angeles	41,063	21%	525,170,623	29%
2	Orange	11,536	6%	135,995,943	8%
3	San Bernardino	11,178	6%	132,496,626	7%
4	San Diego	16,397	9%	131,365,938	7%
5	Riverside	9,772	5%	111,541,652	6%
6	Fresno	8,591	4%	84,529,002	5%
7	INVALID	18,216	10%	66,694,311	4%
8	Kern	6,587	3%	61,928,852	3%
9	Alameda	4,706	2%	57,930,164	3%
10	Sacramento	5,654	3%	55,514,026	3%
	Total	133,700	70%	1363167136	75%

Exhibit 5. Top Five Medi-Cal CCS Medical Diagnostic Groups by Expenditures, FY2007-2008

MDC	Total Expenditures	% of Total Expenditures
Vcodes (e.g. Live births)	299,552,775	19%
Certain Conditions Originating In The Perinatal Period	211,298,011	13%
Congenital Anomalies	177,466,616	11%
Diseases Of The Blood And Blood-Forming Organs	105,117,186	7%
Diseases Of The Respiratory System	93,217,052	6%
Diseases Of The Nervous System	92,467,530	6%

Appendix 2: Questions Related to Stage 2 of Data Analysis

Below is a preliminary list of questions driven by stakeholder comments. While there were many important questions raised, those listed below are limited to the questions where an analysis of data can provide more information. Each question includes a discussion of:

1. The issue: This defines what it is we want to understand better e.g. the high costs associated with care for children under 1 year of age.
2. The questions that arise from the issue.
3. The relevance: This addresses why answering the question could be helpful as the Department considers redesign options.

The questions below are by no means a definitive list and would benefit from further stakeholder discussion to confirm that these are the most relevant questions and to identify other critical questions. In considering whether to pursue further investigation into each of these questions there are three questions the Department and stakeholders should consider: 1) what is the cost of answering this questions, e.g. labor and computer resources? 2) how long will it take to answer the question, e.g. a month, a year? 3) and, ultimately, what is the value of answering the questions, i.e. how much closer does it bring us to effectively implementing meaningful change relative to the time and money spent?

Issue #1: Continuity in Eligibility: Some of the stakeholders expressed concern that some CCS children are moving in and out of the CCS program which can result in a lack of continuity of care. Important questions related to this are: how often does this occur, for how many children and how does it affect care?

Questions:

1. What is the continuity for CCS children? How many months of eligibility have CCS children had over a given multi-year period, e.g. 3-5 years and during each year?
2. What characteristics, e.g. conditions, are associated with children who frequently lose and regain eligibility for the CCS program?
3. How many children regain eligibility because of a catastrophic event, e.g. a hospitalization or emergency department visit? Are there children with certain conditions, in certain locations, or in certain age groups for whom this happens more frequently?

Issue #2: Eligible Conditions: Many of the stakeholders thought that the conditions that make a child eligible for CCS should be revisited, however, no one know how many children fell into each of the eligible condition categories or what the costs associated with those conditions were?

Question: How many children and what are the costs associated with each eligible condition.

Relevance: Before making changes to eligibility requirements, it may be helpful to better understand the current status on eligibility by condition.

Issue #3: The CCS child vs. the CCS condition: A consensus of the stakeholder group was that any reform option should encompass care for the entire CCS child not just the CCS eligible condition. However, to date, to the best of our knowledge, little analysis has been done to examine total expenditures and utilization for CCS children.

As shown above, Medi-Cal beneficiaries with CCS eligible medical conditions comprise approximately 75 percent of all CCS enrollees and 90 percent of CCS program costs with approximately 40 percent of Medi-Cal CCS children in FFS. The FFS MIS/DSS claims data can provide complete information on the total costs associated with treating a CCS child including those related to the CHDP program, DDS and mental health services.⁷ Additionally, by looking at episodes of care through the Episode Treatment Group (ETGs), we can better understand the costs associated with the complete continuum of care for a child not just expenditures by claim type, e.g. by ICD-9s, by procedure codes, etc.

Questions:

- What other non-CCS eligible conditions are CCS children treated for? How do they compare in frequency to other children in the program?
- What are the total costs, i.e. the non CCS and CCS costs associated with CCS children?
- How does the total cost of CCS children compare to other Medi-Cal children?
- How does the cost of care for a CCS child in FFS Medi-Cal compare to a child in managed care Medi-Cal?

Relevance: Most data analysis has been restricted to the CCS program which encompasses just a portion of the child's care. If we are to consider options for providing care for the whole child we need to better understand the costs and analysis for the child.⁸

Exploring differences between care where CCS services are carved into a managed care plan versus carved-out may also provide insight into controlling costs. While it is difficult to compare different regions of the state, CenCal has a plan in San Luis Obispo (SLO) where CCS children are carved-out and a plan in Santa Barbara (SB) where CCS children are carved in. Looking at total Medi-Cal claim expenditures (CCS Medi-Cal plus Medi-Cal) for CCS children in SLO and CCS expenditures plus capitation for CCS children in SB under a single plan may provide more insight into the total cost of CCS children and differences between FFS and MC.

Issue #4: Reimbursement and Financial Incentives: Stakeholders repeatedly spoke of the necessity of financial incentives and appropriate reimbursement to be included in any reform

⁷ Healthy Families CCS children are in managed care and complete claims data are not available for this group of CCS children. CCS only children do not have publicly available data on other health services they receive.

⁸ Since it is not uncommon to code a newborn's claims with the mother's Social Security Number, a critical component of this or any analysis would be to screen out the mothers claims.

options. Some stakeholders noted that some providers did not submit claims or “gave up” submitting claims because the process was too onerous, e.g. if a claim has multiple errors, it has to be resubmitted multiple times since only one error at a time, rather than all the errors in batch, are returned to the provider for review.

Questions:

- Do some CCS providers have greater rates of denied claims?
- Are there certain types of claims that are flagged for review or delayed? (This may result from the fact that EDS may have edits to detect outliers as indicators of fraud and these edits may be inappropriate for CCS claims, since they are unusual by definition. Changes in the processing of CCS claims may be necessary.)

Relevance: Only through understanding where when and why reimbursement is inadequate can we move toward an improved program with appropriate financial incentives. The MIS/DSS has data on denied claims and the reason why these claims were denied.

Issue #5: Hospital Inpatient Utilization: Some stakeholders indicated that they did not have enough information to comment on whether “inpatient use was excessive.”⁹ Previous recommendations, e.g. those from the LAO, related to reforming CCS, have noted the importance of shifting incentives away from inpatient hospital care. And, hospital care, as shown above, at 62 percent of CCS expenditures is clearly a big cost driver. However, many stakeholders indicated that, for most physicians, their goal is to get the patient out of the hospital and it is not clear whether inpatient use is “excessive.” Qualifying use as excessive implies a standard or benchmark for “normal” or “not excessive” that does not currently exist. While HMA has not done an exhaustive search it is unlikely that there are comparable, condition stratified risk adjusted national data that could serve as a benchmark. However, the CPQCC data may provide some insight for NICU babies and the OSHPD data may provide some insight for other conditions.

Questions:

- How do length of stay and expenditures for hospitalizations vary across hospitals for specific conditions for all CCS children?
- How do length of stay and expenditures for hospitalizations vary across hospitals for specific conditions for CCS children who are primary costs drivers, e.g. those who are under 1 year of age? (By understanding which hospitals have lower LOS and lower inpatient costs without readmissions, or ED visits for all CCS children and those who are less than 1 year of age, there may be important lessons to be learned for other hospitals. The Medi-Cal MIS/DSS includes data on hospitalizations for all CCS patients with fields indicating why they have been hospitalized. A retrospective risk score associated with each patient could be used to adjust for difference in risk within condition across

⁹ One of the Discussion Guide questions was whether inpatient use was excessive.

hospital as lengths of stay (LOS) and expenditures were analyzed by condition and by hospital.)

- Are there some hospitals that have risk adjusted NICU stays that are lower than other hospitals? If so, what can we learn from them, e.g. can this be attributed to transfer protocols, better access to DME vendors, better access to outpatient specialty care? (The CPQCC data submitted to CCS is a rich source of data that has been underutilized to date due to lack of resources, but includes information on risk adjusted length of stay for NICU CCS babies.)¹⁰
- How do length of stay and expenditures for hospitalizations for specific conditions differ for CCS children compared to children with private payers? (By linking CCS children to OSHPD data, either through SSN or a probabilistic linkage, one could look length of stay and total charges (adjusted to reflect costs) for CCS children with certain conditions. Adjusting for risk may be possible by looking at diagnoses two through twenty-four in the discharge record.)

Relevance: Stakeholders repeatedly indicated a need for more information about inpatient care. Comparisons across hospitals may provide insightful solutions, e.g. one stakeholder cited a model in Fresno where the children's hospital owns a home health agency and it is based in the children's hospital. The stakeholder commented that it has had great success since it has built community connections with DME vendors and it effectively acts as the DME provider.¹¹

A letter from the County of Los Angeles Children's Medical Service to HMA stated "The question of more efficient use of inpatient services is certainly worthy of scrutiny. The assumption or conclusion or unfounded belief that the current number of inpatient days authorized by CCS program is excessive is not supported by the evidence I have had a chance to review. We would welcome a more thorough analysis of all relevant data..."¹²

Issue # 6: NICU costs: If healthier babies are born, most importantly quality of life is improved for the child and their family, but secondarily, expensive NICU costs are saved. A large portion of hospital expenditures are attributable to babies requiring neonatal intensive care and other high cost services associated with congenital anomalies.

¹⁰ As noted by Dr. Gould of CPQCC, the risk adjusted value is derived from CCS NICUs but is based on all infants cared for in the NICUs. The stratified data is based on both CCS and non-CCS hospitals. In addition to LOS it may be important to account for re-admission rates as a balancing measure. Although the rates are risk adjusted, one might want to consider looking at (and also risk adjusting) specific types of patients whose post discharge needs could be quite different. Another issue is whether to risk adjust for in hospital morbidity (as well as those factors present 5 min after birth) as this could be highly influenced by quality of care.

¹¹ The Home Health Agency is Children's Home Care in Fresno and the stakeholder noted that the administrator has been tracking results and had evidence to show that they had good results in getting kids home and staying home. An analysis of home health agency data in conjunction with hospitals data may provide insights into effective collaborations between hospitals and home health agencies.

¹² Correspondence from County of LA Children's Medical Services to Ca Dept of Health Services and HMA dated August 11, 2009.

While we want to best understand how to most cost effectively provide this care, ideally we want to have healthy babies.

Question:

- Are mothers getting appropriate prenatal care? Are there certain groups of mothers who are not getting prenatal care or appropriate prenatal testing? Are there barriers to getting care?

Relevance: If the data suggest that certain groups are not getting appropriate prenatal care a targeted intervention may be possible. Early intervention that results in just a small increase in the number of healthy babies could potentially save the state millions.

The MIS/DSS can determine how many and what claims were submitted for mothers of NICU children to determine whether they received prenatal care and what prenatal care they received, Additionally analysis can be done by aid code, including those for undocumented residents, etc, and age.

Issue #7: Provider Access: Stakeholders repeatedly discussed the need for better provider access noting the shortage of PCP providers skilled in seeing CCS kids and specialty providers. However, this problem is difficult to address without having any data on the size and scope of limited provider access.

Questions:

- How many CCS paneled providers are there in each county and how many patients do they see by physician specialty, including PCPS? (Access is determined not simply by the number of paneled physicians but by the volume of patients paneled physicians are willing to see.). How does the number of providers by specialty compare to the number of CCS children with the related condition who are within a specified radius (or within the county) of the provider's office?

Relevance: Concerns over provider access were repeated throughout discussions. Understanding the extent of provider access will help target a solution. One option may be to consider an online Health Passport that would address multiple issues. First, a secured online CCS health record could potentially provide CCS children greater access to the expertise of a wider range and number of specialists who could provide medical consultations to CCS children. This would not be a substitution for direct access to a specialist but could potentially be a valuable complement to specialist visits and serve as support for the PCP. Second, as with many Medi-Cal families and like foster children, when CCS children move from place to place care is disrupted and an electronic record could mitigate this problem.

Issue#8 Controlling Costs of Treating Children with Hemophilia: Disease of the blood and blood forming organs which includes hemophiliacs is one of the top five MDCs by expenditures, account for 7% of Medi-Cal CCS expenditures.

Question: How can costs for caring for children with hemophilia be reduced and what savings can be obtained for expensive drugs, e.g. Factor IX, that are prescribed for hemophiliacs.

Question: To what extent have and can 340B pricing reduce costs? (Federal 340B outpatient drug program prices are available to the 11 CA Hemophilia Treatment Centers that receive HRSA grants. Most of the HTCs have pharmacies that purchase blood disorder treatment drugs (hemophilia main treatment is called "factor") at 340B prices. DHCS has initiated action to obtain 340B pricing in other drug categories. Is blood factor another area to consider this approach?

Many of the questions above focus on costs, and, without question, controlling costs issues are critical. However, equally, if not more critical, is the issue of maintaining CCS standards and setting performance benchmarks. Many stakeholders also discussed the possibility of tying performance or quality standards to reimbursement. While a detailed consideration of this topic is beyond the scope of this document, incorporating outcomes and performance measures for CCS children will be an essential component of any reform options.

Appendix 3: Stakeholder Groups

The Department of Health Care Services identified representatives from the following stakeholder organizations to participate in discussion groups for this project.

We received written comments to the stakeholder discussion guide from additional organizations and individuals. We also received letters from parents with children in the CCS program.

CCS Executive Committee
County Health Executives Association of California
California Children's Hospital Association
UC Medical Centers
Public Hospitals
Sutter Hospitals
CCS NICU TAC
American Academy of Pediatrics
Children's Specialty Care Coalition
CCS PICU TAC
CCS Cardiac TAC
American Academy of Family Physicians
Neonatal Quality Improvement Initiative
California Perinatal Quality Care Collaborative
High Risk Infant Follow-Up Program
Family Voices
Individual Families
The Children's Partnership
California Protection and Advocacy Inc.
Hemophilia Council
Children's Hospice and Palliative Care Coalition
Family Resource Centers
HealthNet
Blue Cross
CalOptima
Blue Shield
Health Plan of San Mateo
Managed Risk Medical Insurance Board
California Department of Public Health
California Department of Mental Health
California Department of Developmental Services
Association of Regional Center Agencies