Whole Child Model Health Plans Focus Group Summary CCS Title V Needs Assessment 2018-2020

Contents

Biggest Barriers to Whole Child Model Implementation & Maintenance of CCS Goals

- **Higher costs, which changes partnerships with other organizations that are valuable to the care of CYSHCN:**
  - "We hired a lot of county staff that I had worked with so we felt like we started on a great level because we took knowledgeable CCS Staff. But the biggest thing that we had to deal with are the **rising expenses, we did cost comparative analysis—our in-patient rates have gone up about 35%.** UCSF has refused to contract with us and Lucille Packard refused as well—they want to do 90% charges, which puts strains on us financially.
  - "We've always contracted with Lucile Packard, it was an existing contract it didn't have CCS rates—we pay higher rates to Lucile Packard than DHCS was (we had this fight years ago). UCSF has never agreed to contract with us until CCS Whole Child Model—but they won't take any adults, we'd have to pay 50% more. Oakland children's UCSF won't contract with us either—**that is challenging because there are things that exist there that don't anywhere else**."
- **Lack of access to CMS Net and other electronic records systems**:
  - "Not having access to the systems that we would have wanted to when we went live, I.E. CMS net. We have it now. It is being spread across the counties."

- **Eligibility issues come up often, and can result in delays to care:**
    - "We are one of the few that has "dependent" counties and that makes it hard, we meet monthly with all of the counties together and the difference between dependent and independent we always have to stop and think about how to determine how eligibility or how things work. **Delays for enrollment and eligibility as a result**. Many of these counties may have only had a small amount dedicated to small counties FTE, so taking from county staff was tough. Timeliness and accuracy of information for approval for enrollment. We've had to come up with safety nets like how long will they have to wait to be eligible in our system based on what the state is saying in their system. We tend to disagree with the state on eligibility or we think that they are [eligible], and the state doesn't, and they think they are and we don't. Access is always a huge issue for us, particularly our CCS kids because we don't have a lot of pediatric specialists in our remote counties, which creates a lot of transportation issues."
- **Data/Evaluation: It is problematic that there was no baseline evaluation to determine how WCM implementation is progessing**:
    - "The lack in evaluation before this began, which means that we can't really tell what the current state of things are. We have a lot of concerns about the nature of the data that is being asked for and that it isn't really accurately reflecting what is going on. **We also have concerns about the accuracy of that data that the state is sending us**. We are told that there are children that are Whole Child Model and we don't feel like they should be. We pointed out the issues in June [of 2018] and they haven't fixed anything—there is no mechanism to back date the data, **the data that they delivered that is inaccurate will be inaccurate permanently**. Before Whole Child Model we didn't have this problem with the data—the data says that the person is in the system without a date, just that they are active this month."
    - "We told DHCS that we should be getting together now to demonstrate the data elements they needed to be successful in the very beginning and the state didn't. And the state staff did not. **Now our staff is really not sure about why they are collecting the data**."
    - "One of the challenges is the evaluation of the implementation; the providers all have different relationships with the patients and different relationships with each other. **Parent's expectations are driven by the county previously or their relationships with providers and orgs.** Which level of satisfaction is the standard? Had we had that to begin with, we would have known what to do. In [redacted] county there was no CCS staffing, they were really struggling. We would have all known what we were aiming for."

Transition from CCS Medi-Cal to Medi-Cal Managed Care

- **This transition has been hard on both CCS County Administrators and MCMC Health Plans, especially because the logistics were not planned out:**
    - "Our teams have always worked very closely with the counties, we had CCS liaisons, we had MOUs with the programs. We had a really good partnership. It is the expectation of how it's going to go—with three different counties, it is really hard. There was a grieving period

during that transition because the county had to let go and they were losing something. The level of investment that they need to maintain the kids that have remained is higher than the state anticipated."

- **The clarity around the role of MTUs has created friction and logistical issues:**
  - "We also found that in some of the dependent counties because the MTUs stayed and everything was embedded and intertwined, then we had to untangle it—sometimes a half an FTE total. They were still holding on to care coordination."
- **Some county CCS staff were hired by the Health Plans, integration of staff has been difficult:**
  - "We hired a few of the county staff, I wouldn't say that it was the majority."
  - "We did a 'contract back' with all of our counties. One outright rejected it, one tried but couldn't."
  - "We did with one county, but it didn't last very long. **But what we and CCS didn't realize is that the approach is so different, we all just thought that they could just come over and do the same work, but it was really a different job and I don't know how well that the county prepared those staff for it, but they weren't and they left**."
  - We started in [year] to be a pilot program and we partnered with the county, the county staff were brought over and co-located, but the county staff were really difficult. Some of the county staff believed that Medi-Cal Managed Care is evil and they were very against Whole Child Model, and they undermined it, and it is still taking a long time to integrate. Now we say, 'you are our contractor and this is what the state expects.' And you can't have county staff report to Health Plan staff, so there are a lot of complications."
  - "We were telling them, 'here's how you have to do the work,' and they would say that it was outside of their labor contracts and that they would have to renegotiate their labor contracts and we'd have to consult with each county. In order to let us have those staff we would have had to limit their responsibilities."
- **DHCS lacked communication or facilitation of communication that might have helped this transition to be easier:**
  - "We were aligned at the policy level with the county, and the county had open positions for CCS, and then that made it less challenging. The counties had conversations with DHCS separately, at least in our case, we would immediately talk about those conference calls. They did that instead of having the two parties get together. DHCS talked with the counties under a code of silence and then with the Health Plans under a code of silence. We have a great relationship with our counties, we work really well together, I think there is an idea in Sacramento that we don't, so they keep us separate—but that isn't true."
  - "I agree, they do work well with us on some aspects, but we could have had larger conversations. Given that Health Plans operate in very different ways, it would be good to be on the same page, even when solving locally at the county level simultaneously."

Case Management

- **Moving out of County CCS, CYSHCN and their families are not used to the way that Health Plans implement case management:**

- **"**Everything the [Health Plan] says is under the fact that the county is working with us. I think the words behind the definition here, 'case management,' means probably that you have a smaller group of kids, and managing a targeted care for those kids. When we tried to implement this way, the case managers were getting 500 kids, and [they're] only able to deal with a few at a time. As a result, there were people in the program that had no idea that in the program there were no 'touch points.' "

- **Health Plans feel that the new model of case management allows more CSYCHN to have case management than before:**
  - "In theory what everyone here is saying is that case managers had large caseloads in the hundreds and they were only working with about 30 of them that were very complex. And they feel like now under this new model they are able to get access and to reach the other hundreds and that the case managers never even go into contact with them."
- **Risk tiering is being utilized by some Health Plans to support case management, but there are still issues:**
  - "We used a risk scoring system, but we took the approach of everyone has to have the option to interface with someone. Granted it has been really difficult to get that going. We have very clear guidelines and expectations, but we have staff that is doing things in a meandering way. I think it is useful to think about whether you want care coordination, service coordination, or case management. If these people are going to self- assess and see what is going on, we can see what they need and evaluate if they can get things done. Right now all we can do is get that risk assessment done slowly and painfully. Case managers were involved in all aspects of their patient's care, and when we moved them from that to our model, it was hard for them to let go of this and [they] feel like their work is less meaningful."
  - "We designed the risk assessment specifically to look at social issues too, or mostly. We also do a psychosocial risk score and a medical risk score. The idea behind capturing that data was to assess what the needs are."
- **Some Health Plans also feel that 'case management' would better serve CYSHCN as 'care coordination' instead:**
  - "We are finding now that what the large need is is 'coordination' not really case management. It makes sense that we would be providing complex case management to these kids, but really the need is to connect them into the system and getting them connected to the providers and then they don't need as much of a 'touch point' especially for parents that are fierce advocates."
- **Social workers can be utilized in the transition to provide this care in a way that makes more sense from a Health Plan perspective:**
  - "We found out that the Public Health nurses that used to be CCS county-level, they did a lot of paperwork, and they never went out into the field. There was a really cultural difference there because the paperwork was really convoluted."
  - "Our program management makes it clear that the paperwork is for social workers and the high clinical management is for PHNs."
  - "We've increased out number of social workers on our staff significantly and we have found that to be much more productive or valuable then having our nurses do this."

- "We think there is really room for social workers to do more work, I don't see as high of value coming out of the nursing work. The social workers are the most valued members of our team; we want to hire more social workers."

- **Health Plans are making efforts to ensure that families get to have familiarity with the people that 'case manage' their CYSHCN:**
  - "One of the things that we heard from the counties is that they wanted to get to know the people they were calling. So we made sure that there would be at least three people per county that could take that on."
  - "We have really made it clear, either they can call our main number or the assigned case manager. We have the nurses assigned based on the PCP offices. We did this by county in order for them to become resource experts."
- **Health plans feel that through the changes to case management under WCM, they are able to provide quality services to *all* CYSHCN (and even their families), not just the extremely complex CYSHCN**:
  - "Thirty kids that were getting [a lot of attention] and then the thousands who are not, and I feel like the conversation is so focused on what is going not well for the [complex] kids and not what is improving for the majority of the members. Especially because the counties are really proud of the work that has been done. **We want all of the kids that have been identified that have received [complex care] to be satisfied, and we *also* want the others to be too. I think there is a high gain there that isn't being recognized**."
  - "When they are getting into the 'Whole Child' child part, there are other children, siblings."
  - "We can provide one team for the whole family. That is a big benefit of Whole Child Model."

Medical Home

- **Some Health Plans are Medical Homes or provide the capacity for Medical Home:**
  - **"**They do at [Health Plan], they have a Medical Home, but they can also seek specialty care without requiring permission or referral authorization from their Medical Home. We definitely want and encourage Medical Home, but not necessarily in their capitated agreement without PCPs. We have one clinic that has been certified."
  - **"**Medical Home is a philosophy of Medi-Cal Managed Care, most that transitioned were linked to a Medical Home through their PCP and that was maintained. We promote that model of making sure that it is going to the PCP. PCPs are not paneled, but all of the specialists are paneled."
  - "In terms of having a Medical Home, we feel better about people having 'one stop shopping.' We had patients in CCS that didn't know that they had appeal rights. Now they know, and I don't think we've had any grievances filed. We help them predominately to navigate the system."
- **Primary care physicians (PCPs) from Health Plans are still learning how to work with CYSHCN:**
  - "Not every PCP is as comfortable with a complex kid—sometimes specialists like Lucile Packard are used to that, they have PCPs that are used to it there."

- "I have talked to a few PCPs, and prior to Whole Child Model I was told that sometimes they were left out."

- **Partnering with PCPs or healthcare organizations has been a challenge and a benefit:**
  - "We could all benefit from a relationship with Kaiser so we are trying to partner with them. Very few PCPs in general that want to partner with us. When we have partnered with the Medical Home side of things, it has been extremely successful when they see smaller groups of kids...there are a lot of different programs out there that are trying to figure out how to partner with PCPs."

Service Authorization Requests vs. Treatment Authorization Requests (SARs vs. TARs)

- **Health plans find that utilizing TARs means more specificity in care**:
  - "Because a SAR is very broad, the CCS nurses could just initiate a SAR, but with the health plans a TAR is more specific—we adjudicate but we don't drive the care and so there has to be a PCP that has to initiate that care and they end up more involved as a result. Nurses can't do it anymore under Whole Child Model. We're looking at medical appropriateness by doing it this way, versus having a SAR authorize them for a year. A SAR would allow almost anything, a lot of those things within the SAR don't require a TAR—so you have to put it into perspective because an MRI requires a TAR, but the things around it don't (i.e. blood draw, medical apt). This way now we have a total knowledge around things, what we read was there were really tedious and detailed codes via SARs."
  - "We actually measured the amount of authorizations that the staff were doing prior and after the transition, there were less authorizations with the transition to the TAR. So I don't think it would be burdening the providers. The SAR is the outlier; the TAR is what other health insurance plans do."
  - Our TAR process has been pretty consistent. The big difficulty w/ figuring out where we are is that **we didn't have any baseline data**. We implement at the HPs a lot of diff complex programs.
- **The role of the MTU is unclear and sometimes that creates issues:**
  - "With some of those smaller counties they will sometimes have larger medical clinics and one of the things that we found is that the CCS staff would go to the MTUs and write requests for the TARs. Logistically we have had to work around this."

Medical & Financial Eligibility

Health Plans on Medical Eligibility:

- **Medical eligibility is arbitrary, and could benefit from inclusion of mental and behavioral issues:**
  - "I find it to be very arbitrary; also there is no inclusion of behavioral and mental issues. They could really benefit. The problem is that it differs across counties such as asthma, but then they end up in ERs in counties where they don't qualify…"

- "But I do think that the Whole Child Model is a huge opportunity, because CCS leaves out developmental delays, and behavioral health issues and you can't really say that they cover children with special health care needs, because these kids fall under that branch. We want to be able to get that child to services whether they have CCS eligibility or they don't."

Health Plans on Financial Eligibility:

- **Financial eligibility criteria is inadequate:**
  - "…You can also have someone fall off of financial eligibility and that doesn't mean that they don't still need it. So there is an inequity building because they have less funding support outside of CCS eligibility. I would love to have a pediatric team that doesn't operate within this arbitrary line; I don't think it benefits the children."

On Eligibility in General:

- **Many Health Plans see Whole Child Model as a way to get around the restrictions put in place by eligibility criteria (financial or medical), which they feel is necessary:**
  - **"**We have to think about it from the patient or family perspective, **if a kid is having a negative experience, we want our team to be able to get involved regardless of eligibility. This is what the Whole Child Model allows us to act on**. My son had very acute and time related issues and was on CCS and it was terrible, and so I called the [the Health Plan] and they helped. And I would want to still be on [Health Plan] if I were still in need. I kept wondering 'I work in this industry, how can other families that don't have this knowledge navigate this?'"
  - **Also in the case of paneled providers, health plans have viewed this as a type of eligibility that can be a barrier, but also a benefit under WCM:**
    - "One of the things that we have heard loud and clear from the providers is a sigh of relief because they don't have to wait months to determine if they get approved for eligibility. This is one area that may be a benefit and maybe even entice providers to get paneled with us."
    - "We had one hearing aid vendor that was CCS paneled and they refused to provide to CCS kids because they didn't want to bill through the state they only wanted to bill through [Health Plan]—now under Whole Child Model they don't have to do that."
- **Neonatal ICUs present issues for Health Plans because eligibility fluctuations quickly:**
  - "If I could be an advocate for any particular issue, it would be the NICU, we are literally afraid to touch it—there is a policy that is functioning well enough, but anything can change and cause a lot of confusion. Our CCS team receives all of the NICU requests to cover the expense or authorization request. The NICU complexity is all tied up in Medi-Cal eligibility and that changes, and trying to keep up with that on a day to day basis is difficult and these are some of the most expensive cases and they shift over time. There is no way to tell what the baby's insurance will be after the first two months on the mom's [insurance]."
- **There are issues with Medi-Cal as secondary insurance:**
  - **"**This brings up a problem, how to coordinate care when Medi-Cal operates as secondary insurance and there is a primary insurer? The system is only set up at the claims level and then we are held to requirements with an insurer that isn't held to the numbered letters. Most all of them agree that this creates a lot of complications."

- **Please note: Eligibility is also mentioned as a barrier of care in the first section of this summary.**

Durable Medical Equipment (DME)

- **Health plans have had mostly positive relationships with vendors:**
    - "We have a number of partnerships with vendors and we haven't amended it, but we haven't had significant issues in providing the services."
- **The role of MTU/MTPs continues to be uncertain, but health plans are trying to work through it on DME issue:**
    - **"**The coordination with the MTPs has been a change and what we were able to do is to give them access to our provider portal and that helped because then they were able to have insight into where they were in the process. They were wanting us to follow-up, because those were some of the conversations that they used to have, and now the MTP knows that they need to be coordinating follow-up with the vendors themselves, which they were in the past using CCS staff to do."
- **Health plans have different experiences and ideas about DME delay—but they agree that specialized DME causes delays:**
    - When asked if there are many DME delays: **"**No, due to the Whole Child Model, if there were delays in the past, there are delays now."
    - "We had a DME person come and set expectations on what a normal delay would be based on the nature of something needing to be custom built. We are trying to monitor for system delay versus building delay."
    - "We agree there are delays on highly specialized DME."

Transportation

- **Funding and administration of the transportation benefit is/was disorganized**:
    - "Counties have capped funding and it was all over the map for how they were administering that benefit. We are working on it because it was complicated, and we had a recent situation when we had to fly parents out and I asked about what happened in the past and they were not applying it in accordance with the letter. Some counties used to pay for both parents, but they are only supposed to pay for one."
- **…As a result, changes during the implementation of WCM are causing confusion:**
    - "You get a lot of backlash for how they are used to handling transportation. The CCS program historically was more adaptable to county specific needs, and when you transition that to the expectation that the health plans are going to follow the numbered letters to the letter of the law it feels like there is a disruption of the benefit. But in reality that rule always had to be followed and we have to figure out how to make it a cohesive program. It was well intentioned because they were trying to do what was best for the families. We're stuck in

the position a lot to pay people from other counties to drive in remote counties. We do gas reimbursement when possible, but we have to be creative."

Mental & Behavioral Health

- **Health plans experience struggles with getting this care for CYSHCN that others have expressed, but they sometimes utilize partnership with the county to address these issues:**
    - "We partner with county behavioral health, usually. And once someone gets into treatment we are less worried, but getting them into treatment for mental and behavioral health is harder, and I'm sure that varies plan by plan."
- **…Some even suggest that these issues are hard in general for all of the populations they serve, not just for CYSHCN**:
    - "Our challenges with behavioral health and mental health are not unique to children and youth with special health care needs and their families."
    - "I would say that across all populations the lack of mental health providers is a huge issue in general. We're trying to support our clinics and hire in more behavioral health into the clinical setting. The networks are adequate, and all of the areas are underserved."
- **Some made suggestions or provided examples of the work that they are doing to ensure that mental and behavioral health care is a component of health plans:**
    - "I do think that the proactive assessment should include identifying that need and linkage to MH and BH for mom and child. I don't think that intentional linking existed before. I think that identifying the need for those services is a positive thing."
    - At [Health Plan], we really pushed telehealth, and the number one specialty that we are providing through telehealth is behavioral health, and we have contracted with Beacon to do it. In the [city] office, we have a behavioral health team from Beacon sitting 20 feet from our care coordination team."
    - "We've put a lot of efforts into expanding these services."

Family Participation & Family Engagement

- **Health plans encourage family participation through family advisory committees, stakeholder meetings, and community forums**:
    - "Family advisory committees, we also had stakeholder meetings in the beginning. Until it actually comes down to the time, we didn't get a lot of participation. We asked out of county CCS partners for families to be on our advisory committees and we gave them incentives. We also partnered with Family Voices. Some of these families and kids were only seen once a year, we had to send some of our staff to the clinics so they could know our face and voice, which is what they asked for."

- "We hosted community forums starting in 2015 and going forward. Worked with CRISS and Family Voices. We sponsored families to go to the Family Voices conferences. Once we got the advisory up and running, we are meeting monthly and letting the committee drive that. They have coalesced and formed and they are more engaged now. We do it by phone and we aren't formally doing it as a Brown Act advisory board because you can't do it by phone, so we aren't calling it an 'advisory group' it is called a 'committee.' We made that shift two or three months ago. We also have televideo. Some of it is earning people's trust and making sure that they know that their participation can make a difference."

Suggestions for Next 5 Years

- "Improve the info coming back and forth, the communication between who is and isn't CCS."
- "The system needs to recognize the social determinants of health and provide funding to address those in addition to the funding to address the health need.