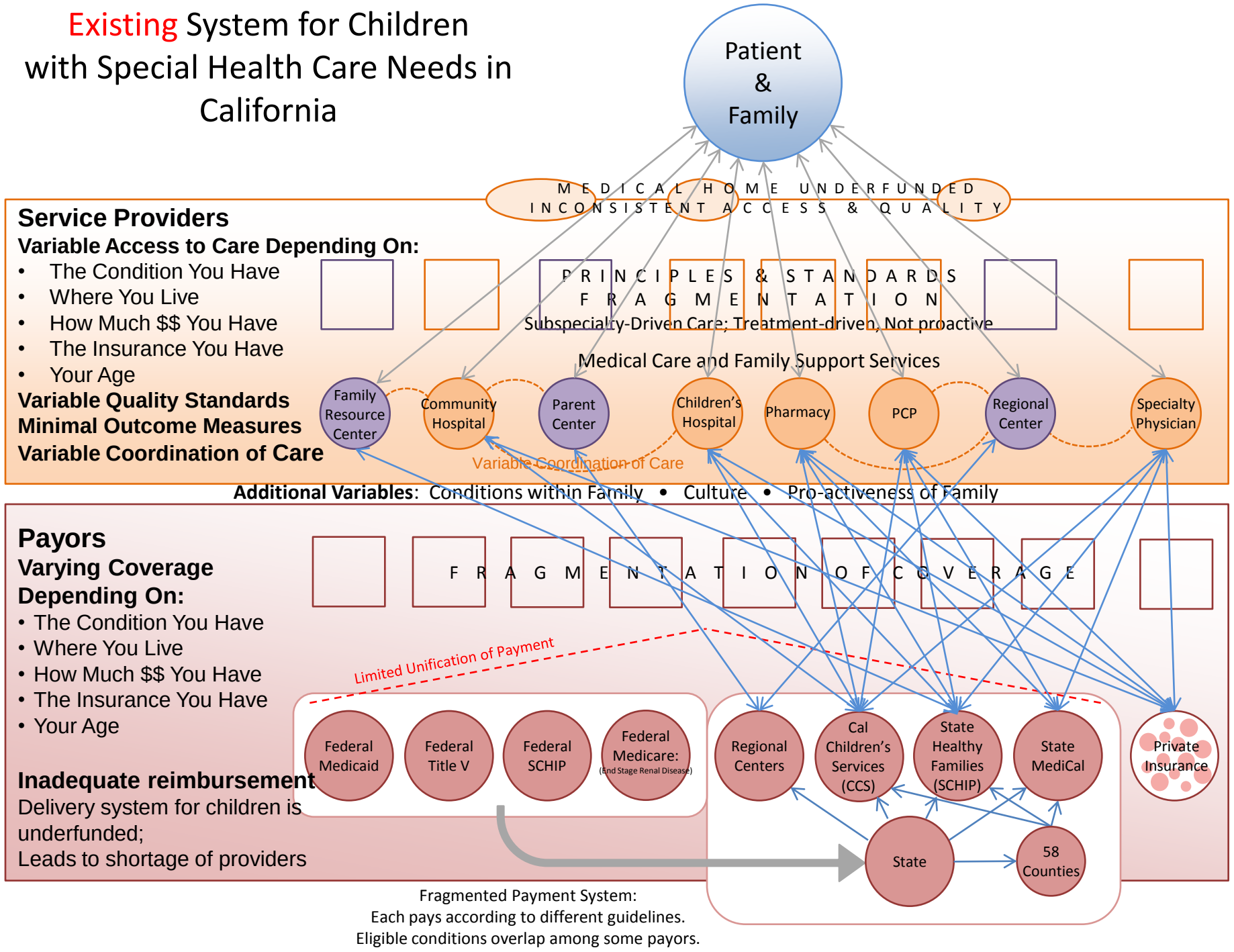
Lucile Packard Foundation for Children's Health

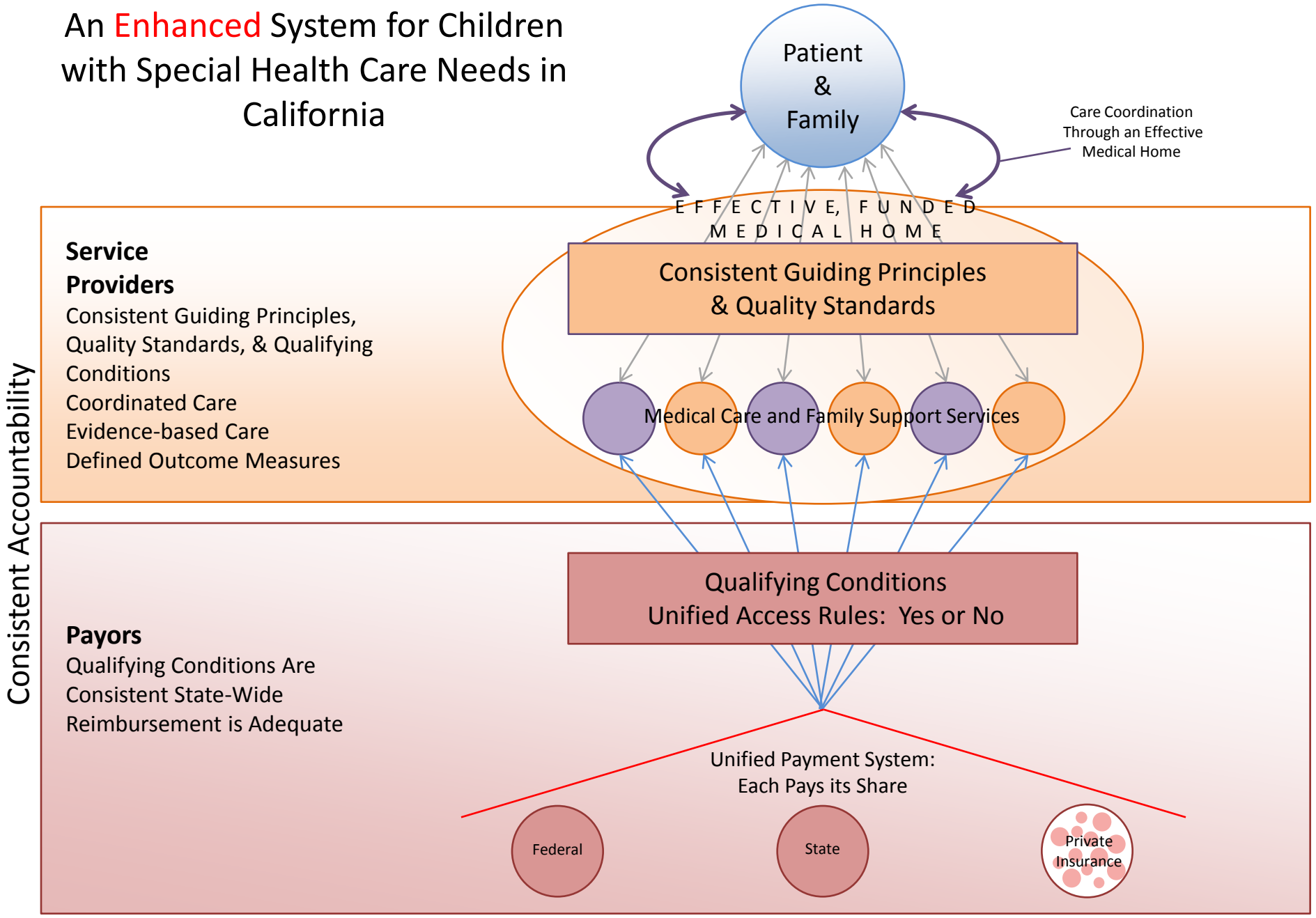
Children with Special Health Care Needs in California: Legislative Briefing April 18, 2013

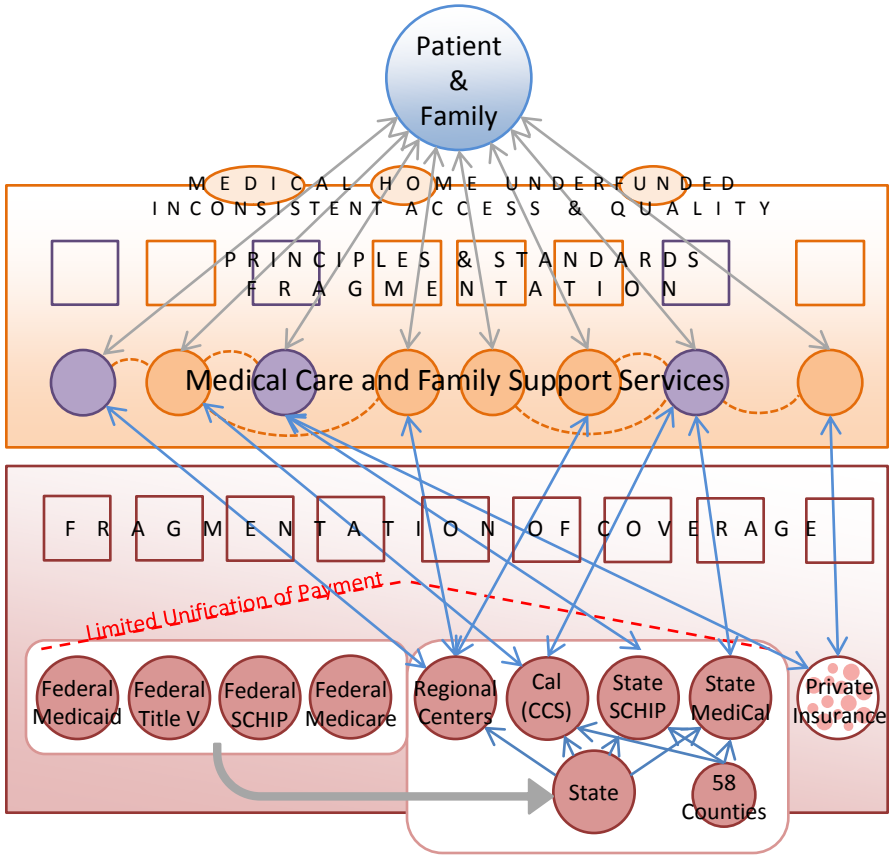
David Alexander, MD
President and CEO
Lucile Packard Foundation for Children's Health
www.lpfch-cshcn.org

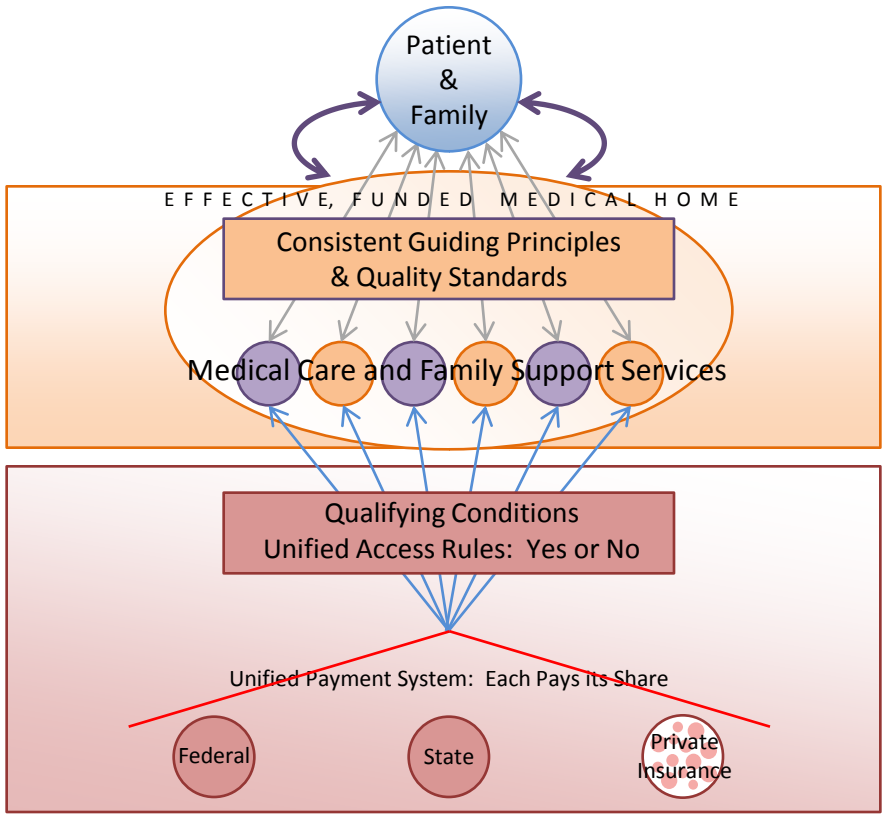
Existing System for Children with Special Health Care Needs in California



An Enhanced System for Children with Special Health Care Needs in California




Existing System
Patient & Family
MEDICAL HOME UNDERFUNDED
INCONSISTENT ACCESS & QUALITY
PRINCIPLES & STANDARDS
FRAGMENTATION
Medical Care and Family Support Services
FRAGMENTATION OF COVERAGE
Limited Unification of Payment
Federal Medicaid
Federal Title V
Federal SCHIP
Federal Medicare
Regional Centers
Cal (CCS)
State SCHIP
State MediCal
Private Insurance
State
58 Counties


Enhanced System
Patient & Family
EFFECTIVE, FUNDED MEDICAL HOME
Consistent Guiding Principles & Quality Standards
Medical Care and Family Support Services
Qualifying Conditions
Unified Access Rules: Yes or No
Unified Payment System: Each Pays its Share
Federal
State
Private Insurance

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California State Assembly
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CAHMI
The Child & Adolescent Health Measurement Initiative

Prevalence, Characteristics and Experiences of California's Children with Special Health Needs

California Legislative Briefing
April 18, 2013

Christina Bethell, PhD, MPH, MBA
Professor, OHSU School of Medicine
Director, The Child & Adolescent Health Measurement Initiative

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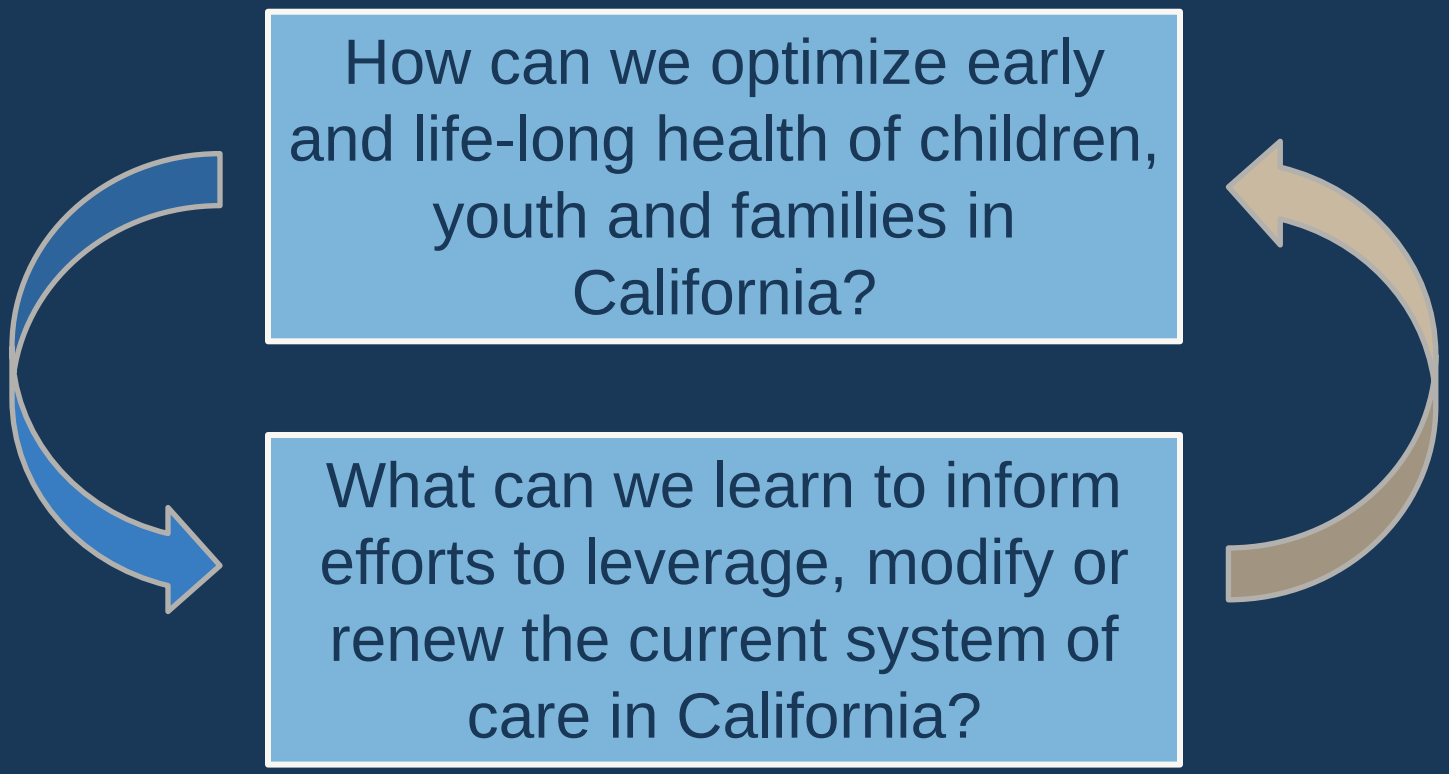
Why?

- **Optimize health and wellbeing of California's children**



Who Are Children With Special Health Care Needs (CSHCN)

"CSHCN are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally"

- Curren… …eed or type
- At risk …
  - diag…
  - unc…
  - mee…
  - bor…
  - psy… …erse Chi…

Why Not Define by Diagnoses?

- Common **DX errors**, misses and miscoding
- Significant **within DX variation** in needs
- Significant **across DX similarities**
- **Multiple conditions** is the norm
- Needs **naturally vary** across time within any DX
- Supposedly **"non-serious" DX** can be very serious depending on co-morbidities and psychosocial context

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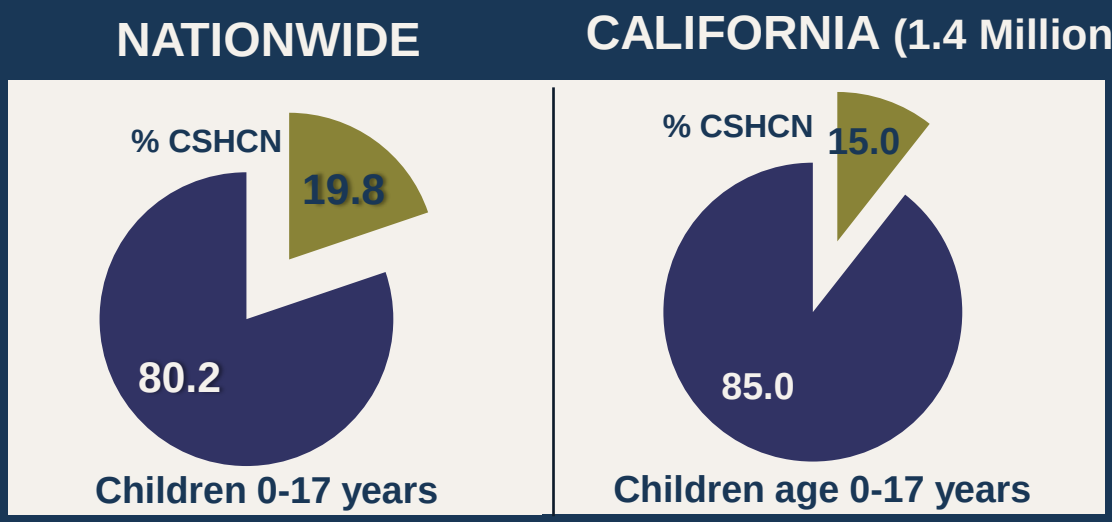
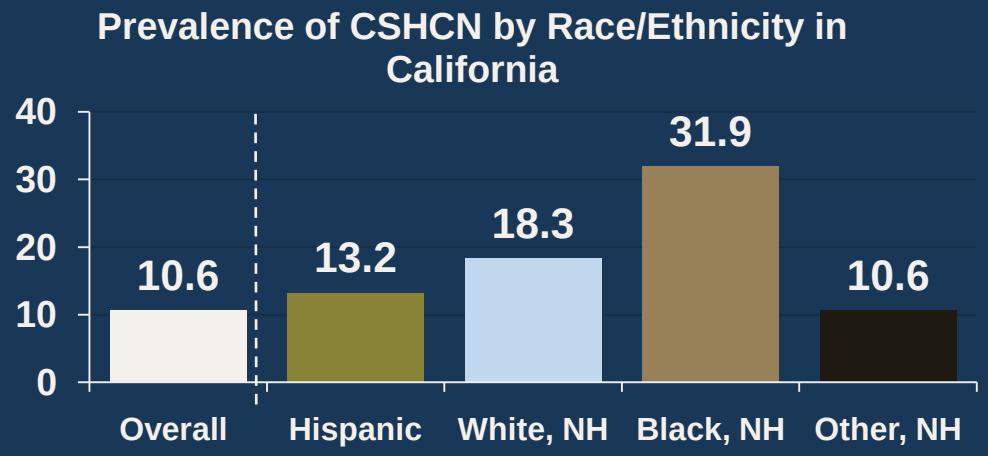
Overall Prevalence and Variation by Race/Ethnicity



Data Source: 2011/12 National Survey of Children's Health



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Demographic Characteristics of California's CSHCN

		Non-CSHCN	CSHCN	CSHCN with Complex Health Needs
Age	0-5 years	36.2%	18.8%	18.1%
	6-11 years	32.0%	38.0%	38.8%
	12-17 years	31.8%	43.2%	43.1%
Sex	Male	49.4%	58.1%	60.4%
	Female	50.6%	41.9%	39.6%
Race/Ethnicity	Hispanic	25.2%	17.4%	18.9%
	White, NH	51.5%	56.8%	55.9%
	Black, NH	12.8%	16.4%	16.0%
	Other, NH	10.5%	9.3%	9.2%
Household Income Level	0-99% FPL	22.2%	23.6%	27.5%
	100-199% FPL	21.5%	21.6%	22.4%
	200-399% FPL	28.3%	27.9%	26.7%
	400% or more	28.0%	26.9%	23.4%

DATA SOURCE: 2011/12 National Survey of Children's Health

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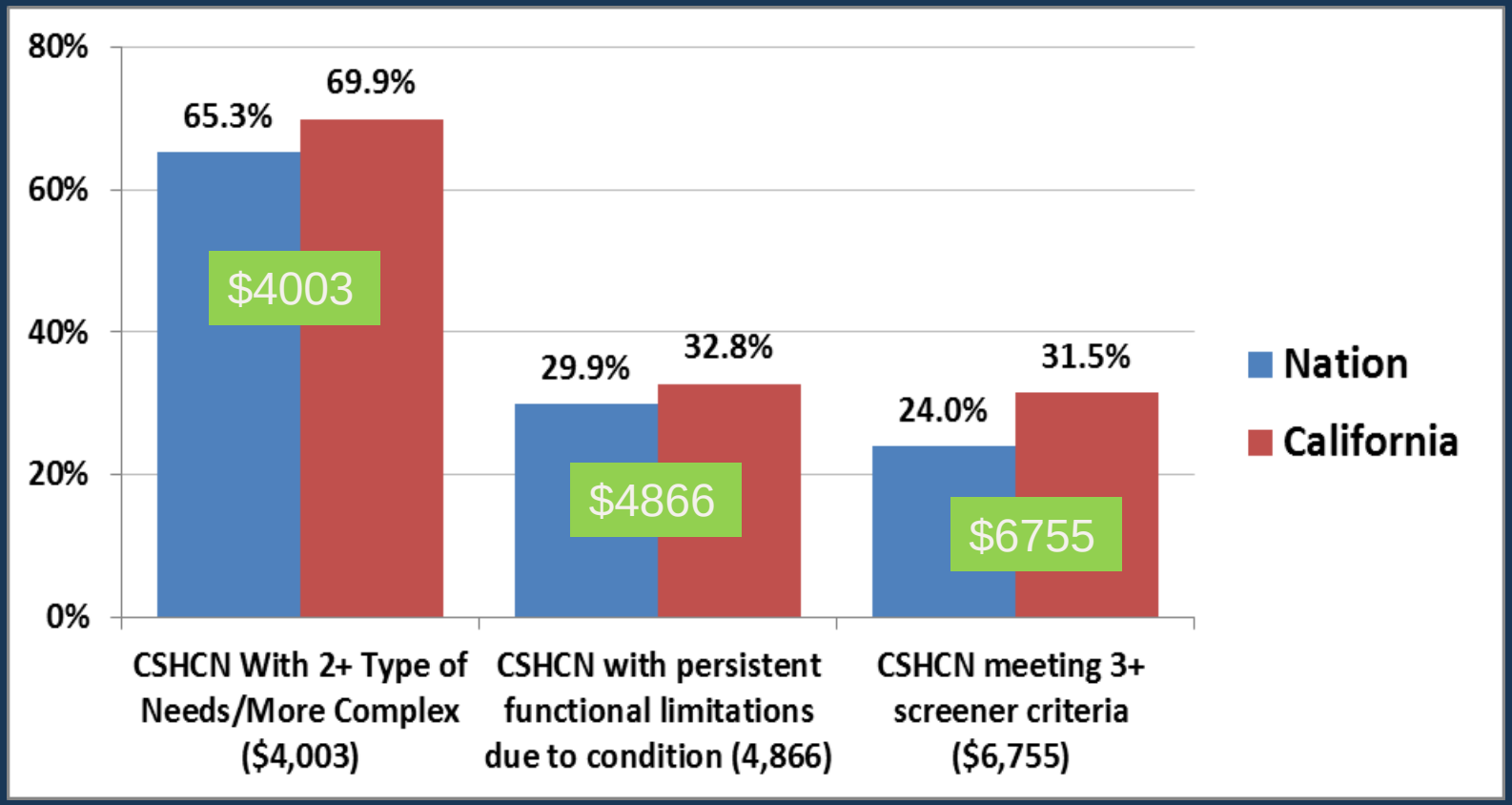
Prevalence and Medical Expenditures for CSHCN: By Complexity



(For reference: Non-CSHCN average expenditures: $856).

Prevalence Data: 2011/12 National Survey of Children's Health; Expenditures Data: 2008 MEPS

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Expanding Our Reach: Importance of a Broad View

	Nation	California
Children with Current Chronic Conditions and Special Health Care Needs (CSHC)	19.8%	15.0%
Non-CSHCN Who May Be At Risk for Special Health Care Needs		
Chronic Conditions (1+ of 18 conditions assessed) -but not CSHCN	8.1%	8.1%
Met 1+ CSHCN Consequences (but not condition/duration CSHC criteria)	10.3%	10.3%
Risk of Developmental Delay: Moderate or Severe (PEDS) (< age 6)	20.2%	20.2%
Adverse Child and Family Experiences (2+ of 9 assessed)	15.5%	15.5%
Born Premature	8.1%	8.1%
Overweight/Obese: (age 10-17)	22.3%	23.3%
Non-CSHCN: 1+ risk factors	39.0%	39.7%
CSHCN + Non-CSHCN With 1+ Risk Factors	**58.8%**	**54.7%**

DATA SOURCE: 2011/12 National Survey of Children's Health (2011/12 NSCH).
*Number of conditions is based upon the list of 18 conditions included in the 2011/12 National Survey of Children's Health, including ADD/ADHD, anxiety problems, asthma, autism/ASD, behavioral problems, brain injury or concussion, depression, developmental delay, diabetes, hearing problems, intellectual disability, bone/joint/muscle problems, learning disability, epilepsy or seizure disorder, Tourette Syndrome, vision problems.
**Almost half of children (47.9%) nationally have 1 or more Adverse Child/Family Experiences, with 44.3% of children in California.
Nine Adverse Child/Family Experiences were included in the survey: (1) socioeconomic hardship, (2) divorce/separation of parent, (3) death of parent, (4) parent served time in jail, (5) witness to domestic violence, (6) victim of neighborhood violence, (7) lived with someone who was mentally ill or suicidal, (8) lived with someone with alcohol/drug problem, (9) treated or judged unfairly due to race/ethnicity.

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Positive and Protective Health Indicators: By CSHCN Status

	California Non-CSHCN	California CSHCN
Protective Home Environment (no smoking in home; share meals; limit TV…)	28.7%	19.5%
Neighborhood Safety & Support	56.8%	53.9%
Factors that Promote School Success	63.3%	53.0%
Resilience: Age 10 months-5 years	81.5%	63.0%
Resilience: Age 6-17 years	68.0%	62.7%
Met All Flourishing Components: (6-17)	51.7%	43.2%
11+ Missed School Days (6-17)	3.0%	20.8%
High Levels of Parenting Aggravation w/Child	12.0%	27.8%

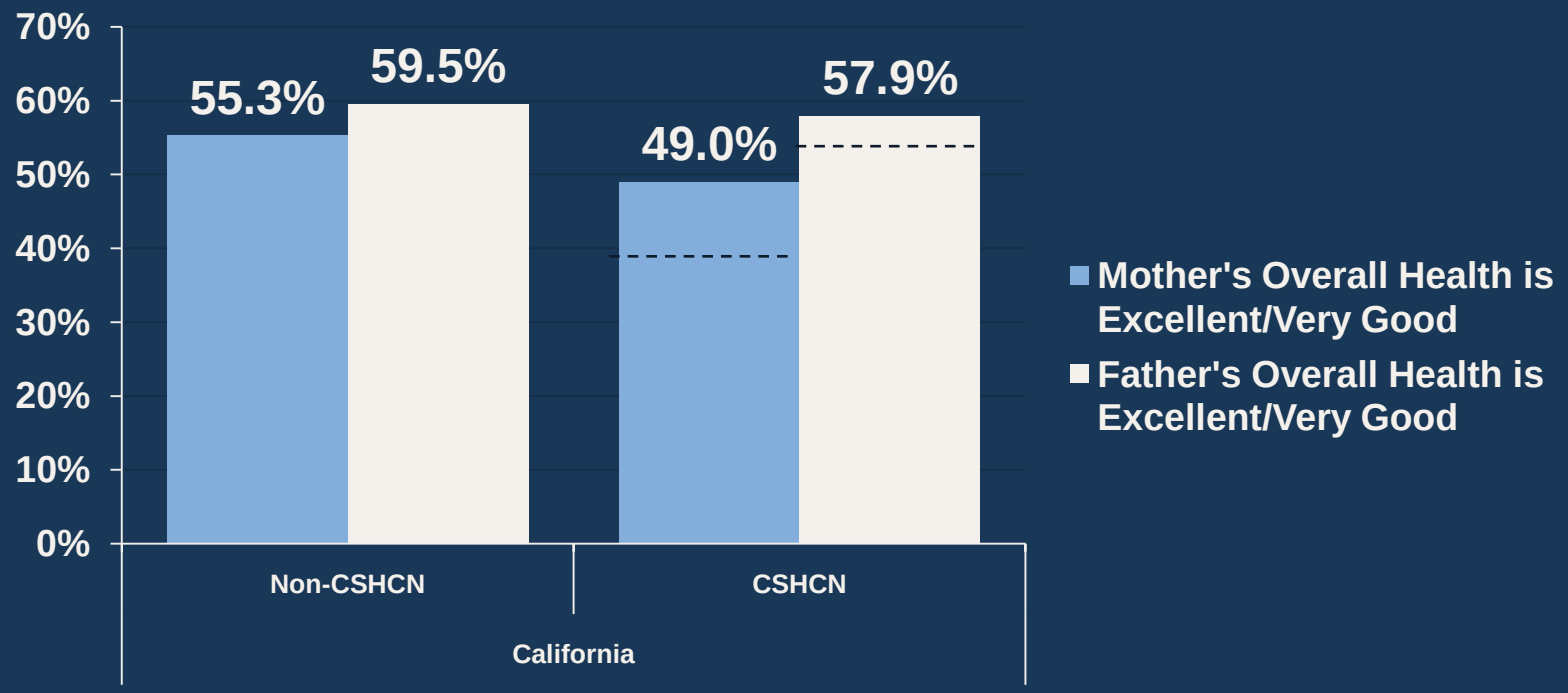
DATA SOURCE: 2011/12 National Survey of Children's Health

Health of the Family: Parental Health

Parental Overall Health Status (Physical & Mental/Emotional) by CSHCN Status

CSHCN with More Complex Needs are noted with dark blue dotted line.

DATA SOURCE: 2011/12 National Survey of Children's Health



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Health Care Quality Summary Measure (All Children)

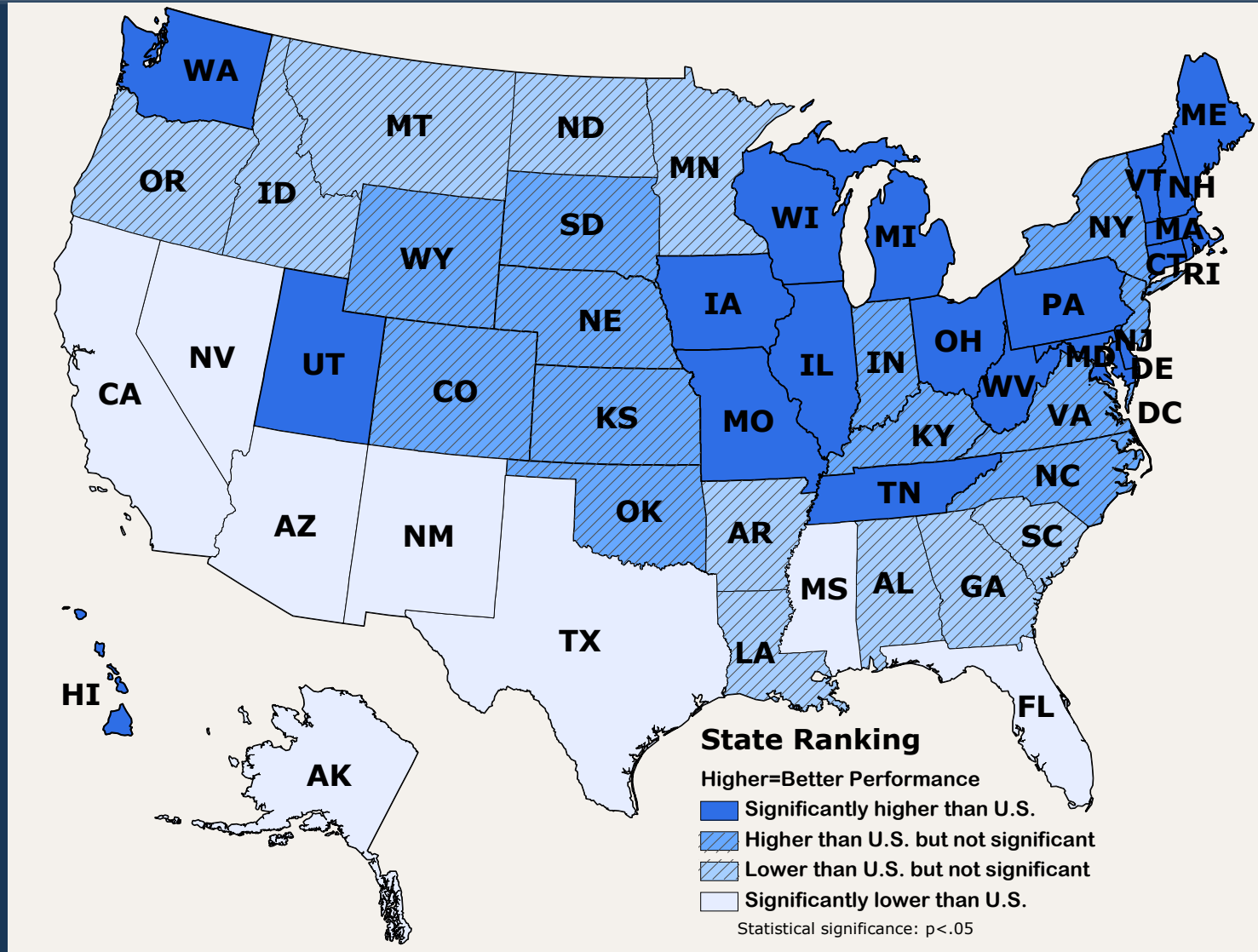
DATA SOURCE: 2011/12 National Survey of Children's Health

Nationwide:
39.0%

California:
31.7%
(Ranks Lower 5)

Health Care Quality:

- Adequate Health Insurance
- Preventive Medical Visit in Past Year
- Has a Medical Home



Health Care Quality Summary Measure (CSHCN)

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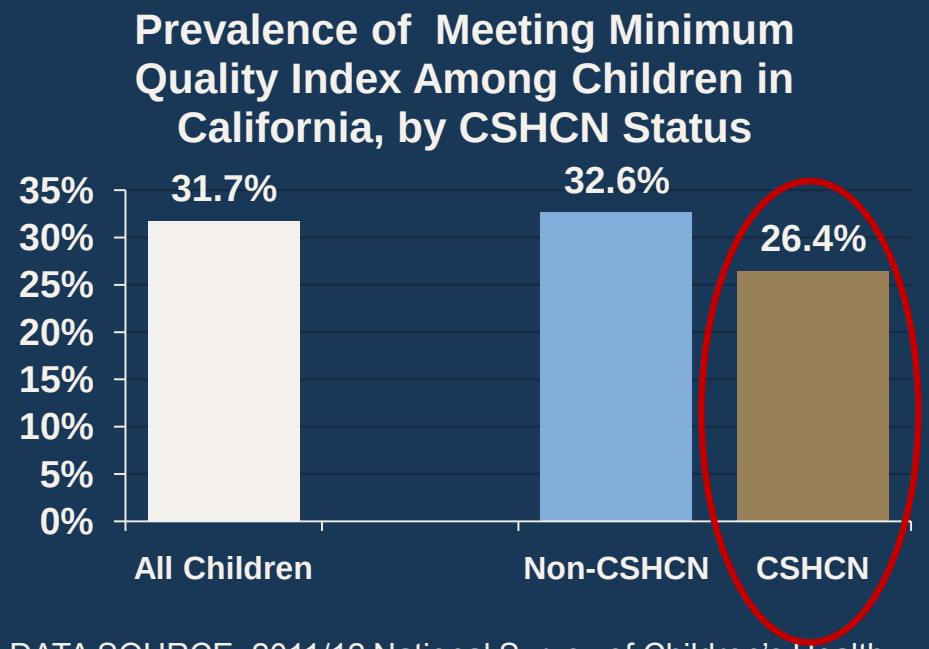
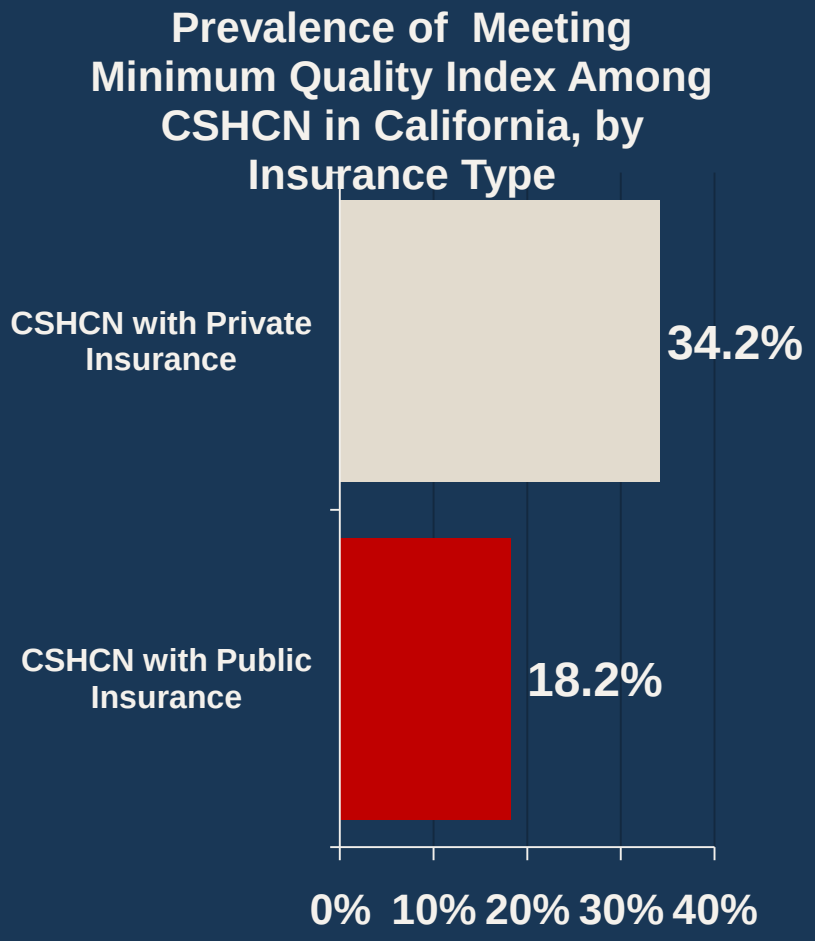


DATA SOURCE: 2011/12 National Survey of Children's Health



DATA SOURCE: 2011/12 National Survey of Children's Health

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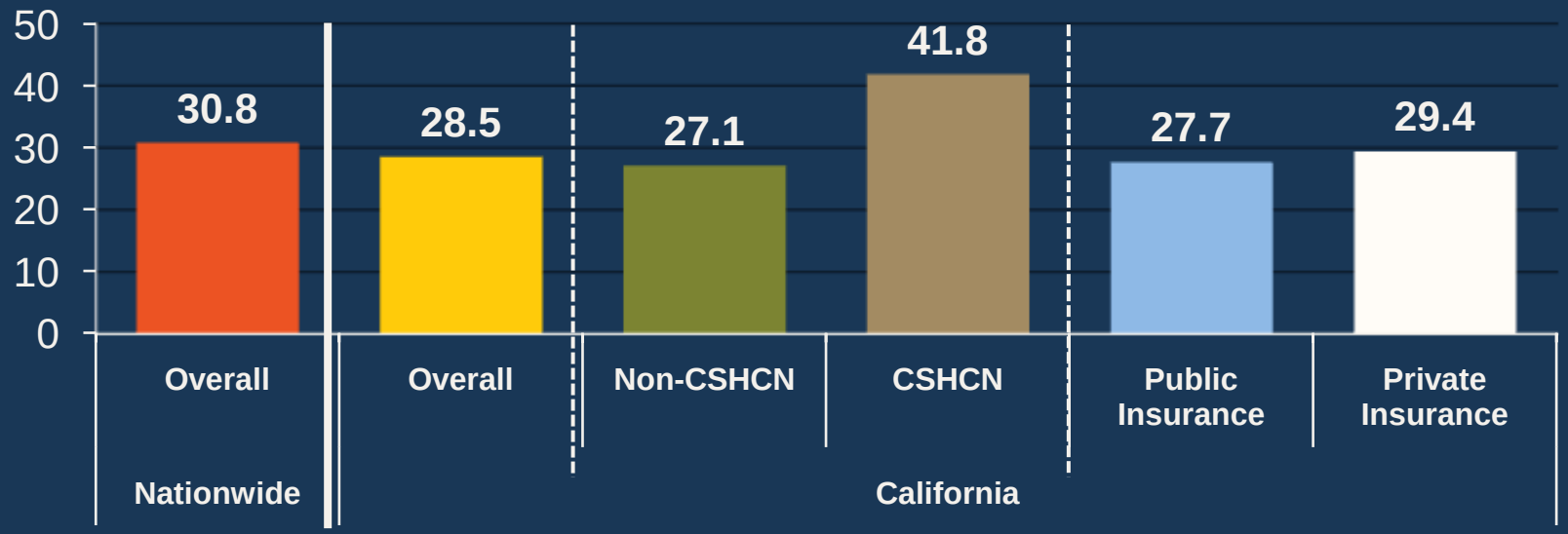
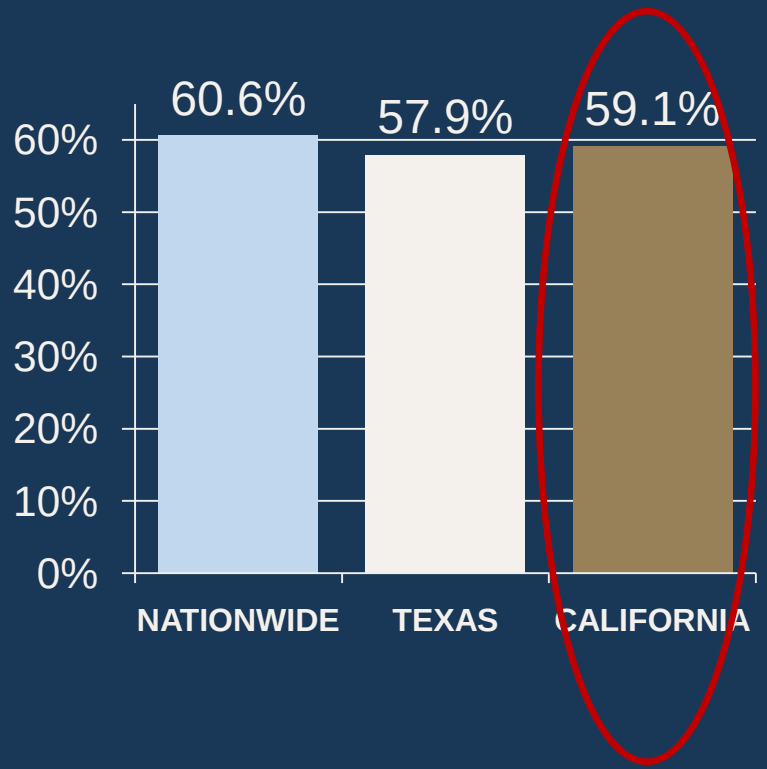
Key Opportunity
Developmental Screening

Developmental screening refers to a child (age 10 months-5 years) being screened for being at risk for developmental, behavioral and social delays using a parent-reported standardized screening tool during a health care visit.



DATA SOURCE: 2011/12 National Survey of Children's Health

Consistent and Adequate Health Insurance

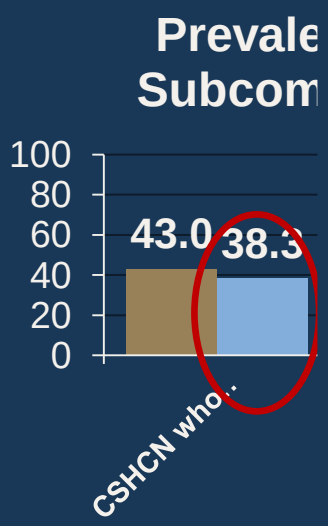


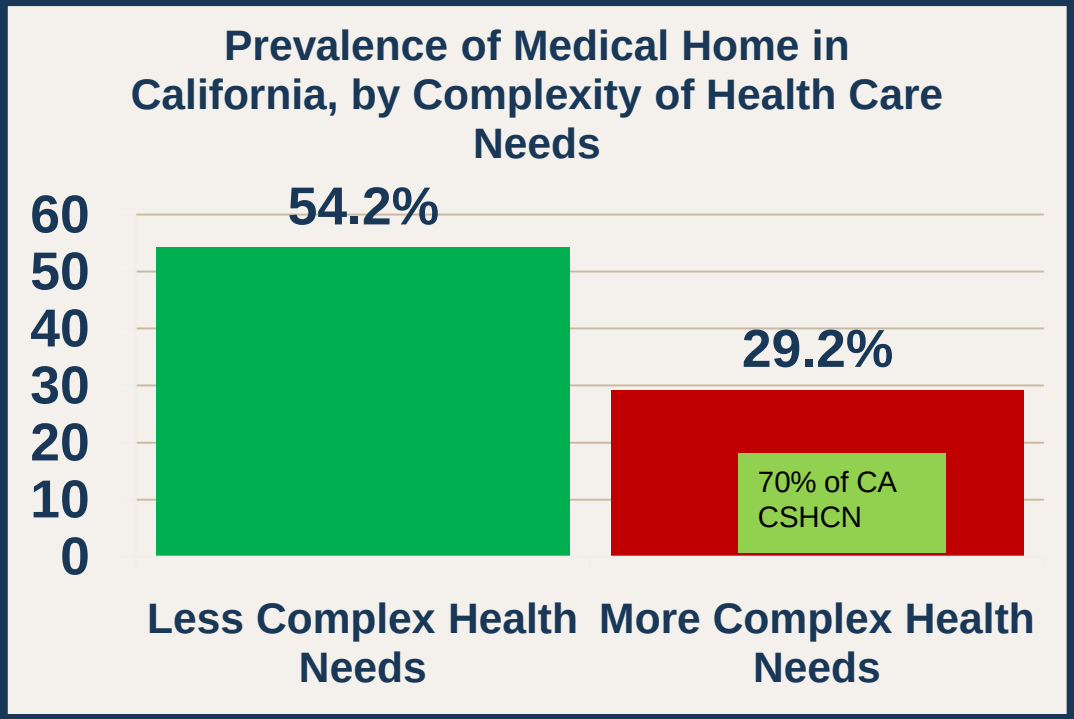
COMPONENTS OF CONSISTENT AND ADEQUATE HEALTH INSURANCE	
1. CSHCN who are currently insured	96.5%
2. CSHCN who have consistently had insurance for past year	91.7%
3. CSHCN with adequate health insurance	62.8%
3a. CSHCN's health insurance offer benefits or cover services that meet his/her needs	83.0%
3b. CSHCN's health insurance allow him/her to see the health care providers he/she needs	86.4%
3c. CSHCN's health insurance premiums or costs reasonable	71.2%

DATA SOURCE: 2009/10 National Survey of Children with Special Health Care Needs

Medical Home

- The American Academy of Pediatrics' (AAP) description of a "medical home" lists seven defining components: accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective.





alifornia State Ranking on edical Home Overall and Subcomponents	
erall Medical Home	44th
re Coordination	46th
mily-Centered Care	44th
oblems Accessing eeded Referrals	50th

DATA SOURCE: 2009/10 National Survey of Children with Special Health Care Needs

Medical Home: Care Coordination (CC)

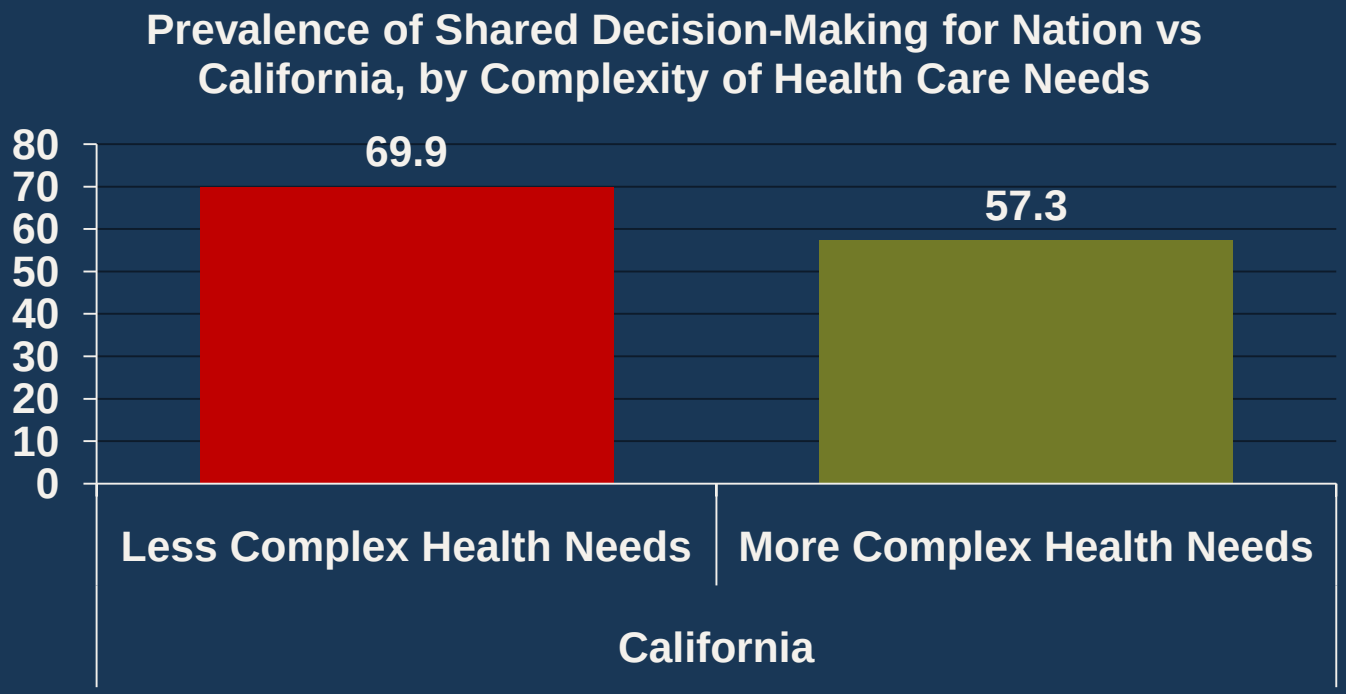
Receipt of Effective Care Coordination when Needed, California and Nation, by Complexity of Health Needs and Insurance Type

CSHCN Receiving Care Coordination	More Complex CSHCN	Less Complex CSHCN
% CSHCN 2+ services (qualify for CC items)	83.7%	59.5%
% 2+ getting any CC help	22.2%	19.5%
% very satisfied with doctor-doctor communication	44.8%	33.1%
% very satisfied with doctor-school communication	52.8%	21.8%
Summary Measure: % who received effective care coordination, when needed	45.8%	70.1%

DATA SOURCE: 2009/10 National Survey of Children with Special Health Care Needs

Shared Decision-Making

CSHCN whose families are partners in shared decision-making: California ranks last (51st) in the nation

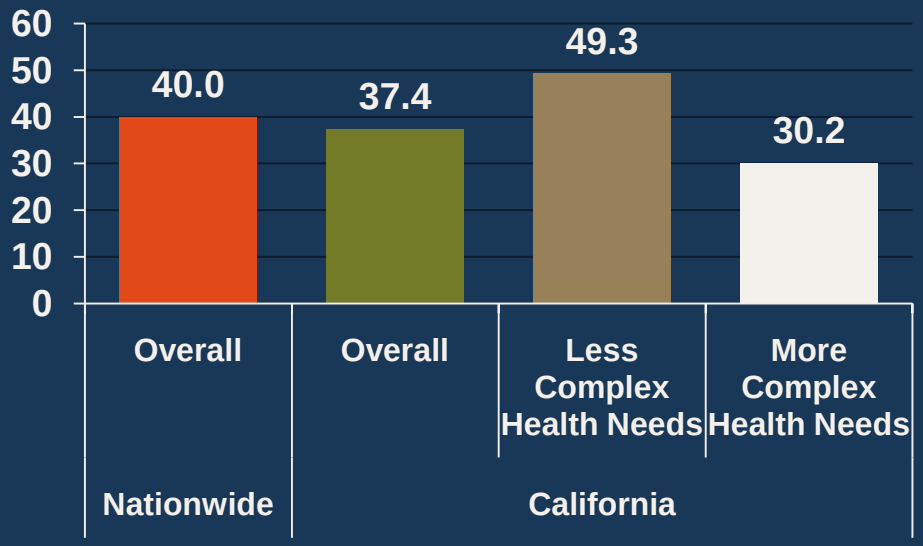


DATA SOURCE: 2009/10 National Survey of Children with Special Health Care Needs

Transition to Adulthood

Youth with special health care needs who receive the services necessary to make appropriate transitions to adult health care, work and independence -- CSHCN age 12-17 years only

Prevalence of Youth Transition to Adulthood, California vs Nation, by Complexity of Health Care Needs



Components of Youth Transition in California:

Anticipatory Guidance: Over half of adolescents (58.4%) did not get all needed anticipatory guidance

- Discuss shift to adult health care providers
- Discuss changing health needs as youth becomes an adult
- Discuss health insurance as youth becomes an adult

Self-Management Skills: Almost ¾ of adolescents have doctors who encourage self management skills (73.7%)

- Older youth are more likely to be encouraged (12-14: 65.4%; 15-17: 81.2%)

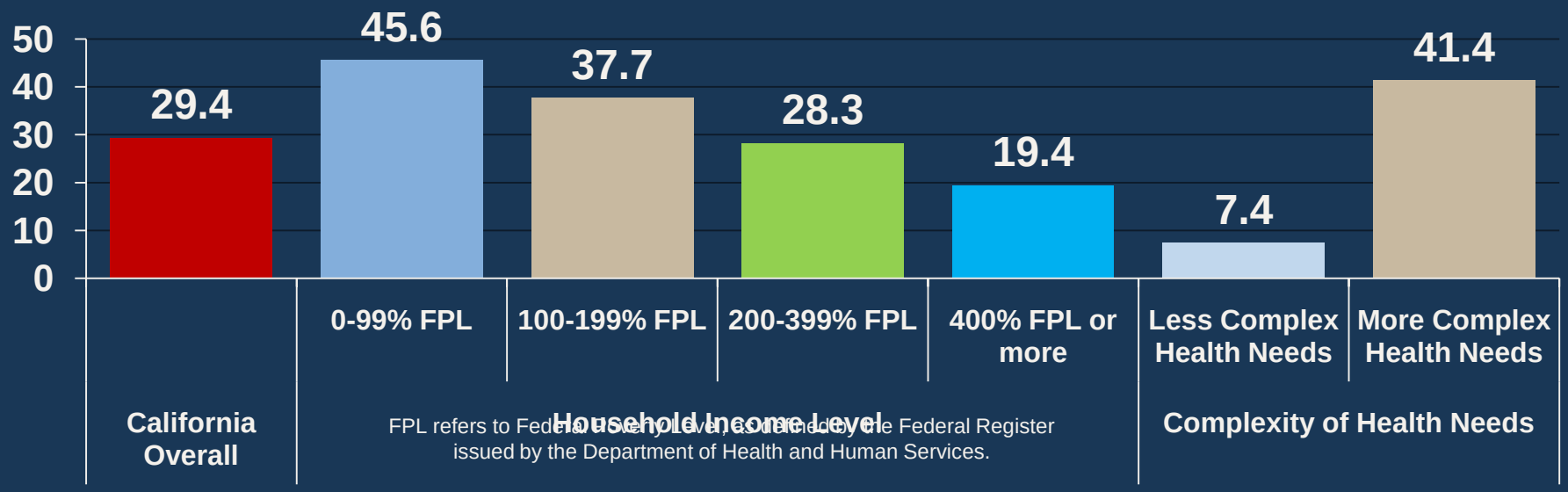
DATA SOURCE: 2009/10 National Survey of Children with Special Health Care Needs

Impact on the Family

CSHCN whose conditions cause family members to cut back or stop working

- California ranks last (51st) in the nation

Prevalence of CSHCN whose conditions cause family members to cut back and/or stop working in CALIFORNIA, by Household Income and Complexity of Health Needs



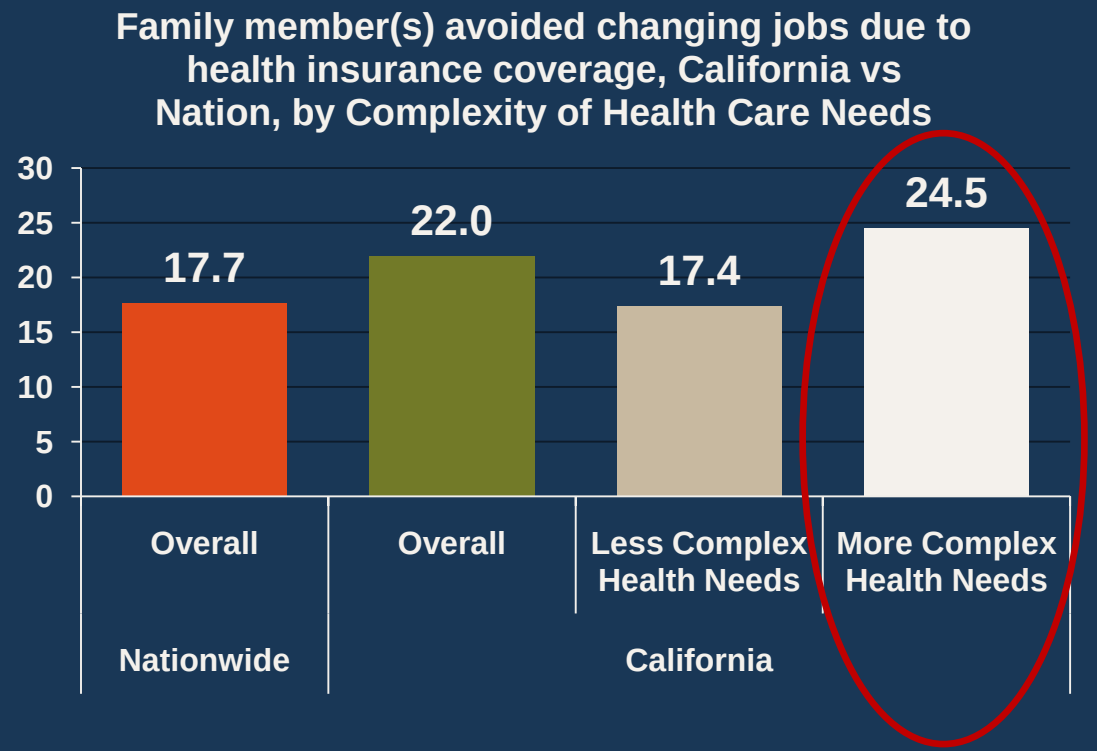
FPL refers to Federal Poverty Level, as defined by the Federal Register issued by the Department of Health and Human Services.

DATA SOURCE: 2009/10 National Survey of Children with Special Health Care Needs

Health Insurance and Work

CSHCN whose family member(s) avoided changing jobs in order to maintain health insurance for child

California ranks 46th in the nation on this measure

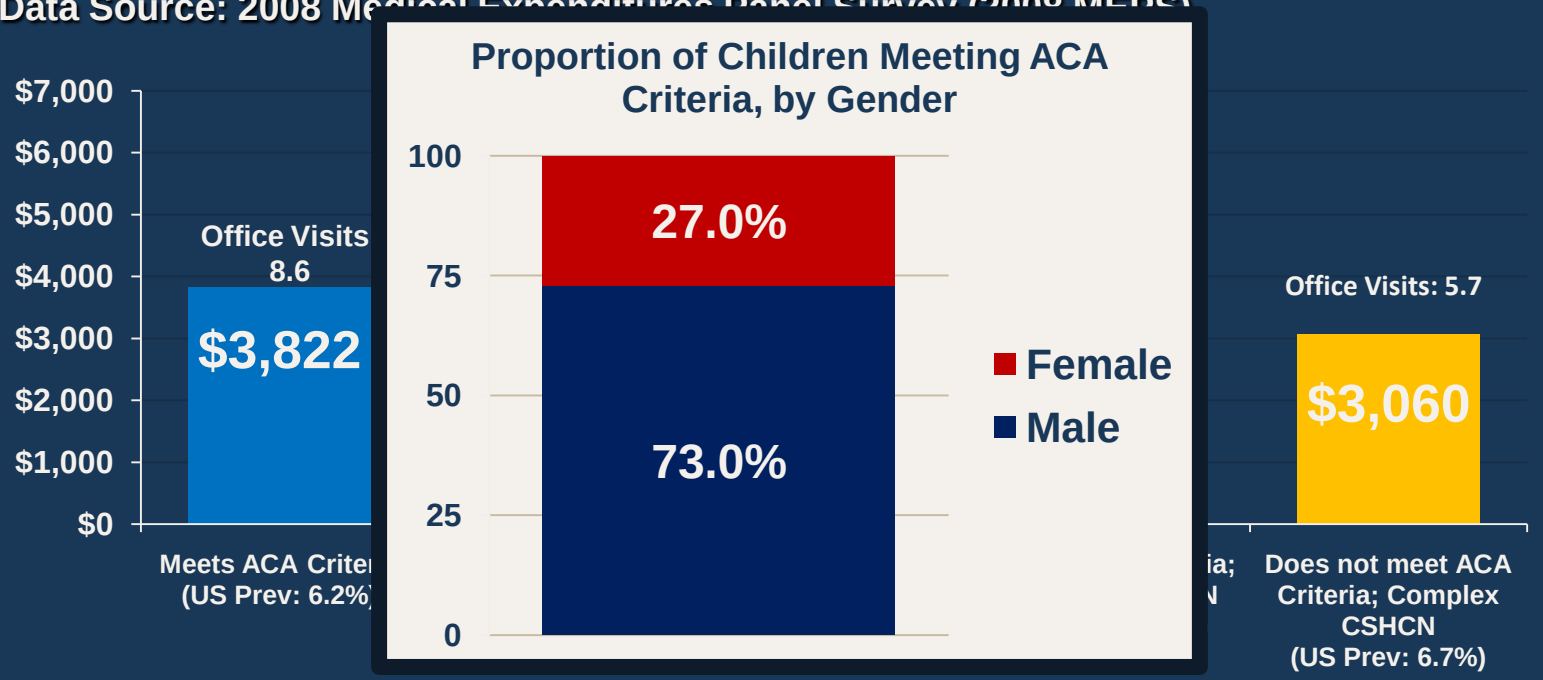


DATA SOURCE: 2009/10 National Survey of Children with Special Health Care Needs

The Importance of Selecting Incentives Carefully: Medical Home

Comparing Prevalence and Utilization of Children who Qualify on CSHCN Screener, compared to Affordable Care Act (ACA) Medical Home Section 2703 Condition List*. Average total healthcare expenditures and average number of office-based healthcare visits in past year.

Data Source: 2008 Medical Expenditures Panel Survey (2008 MEPS)



*ACA Medical Home Section 2703 outlined diagnosis-based criteria for eligibility. This included having (1) One serious mental illness, and/or (2) Two conditions on the list (asthma, diabetes, heart disease, and being overweight). HIV/AIDS is optional upon CMS approval at state-level. (Public Law 111-148, Section 2703. March 23, 2010. Available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf)

Questions or Further Information

If you have any questions, feel free to contact us:

The Child and Adolescent Health Measurement Initiative

www.cahmi.org

Email: cahmi@ohsu.edu

For more data on Children with Special Health Care Needs, visit:

National Data Resource Center (DRC) for Child and Adolescent Health

www.childhealthdata.org

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CCS Medical Eligibility

- California Children's Services offers assistance to children who have a health problem covered by CCS (and meet additional criteria related to household income):
  - Infectious Diseases
  - Neoplasms
  - Endocrine, Nutritional, and Metabolic Diseases, and Immune Disorders
  - Diseases of Blood and Blood-Forming Organs
  - Mental Disorders and Mental Retardation
  - Diseases of the Nervous System
  - Diseases of the Eye
  - Diseases of the Ear and Mastoid
  - Diseases of the Circulatory System
  - Diseases of the Respiratory System
  - Diseases of the Digestive System
  - Diseases of the Genitourinary System
  - Diseases of the Skin and Subcutaneous Tissues
  - Diseases of the Musculoskeletal System and Connective Tissue
  - Congenital Anomalies
  - Perinatal Morbidity and Mortality
  - Accidents, Poisonings, Violence, and Immunization Reactions

It is important to consider whether the diagnostic-based approach is capturing the children that could benefit most from services.

- Capturing children with less complex health care needs
- Missing children with more complex health needs without the specific diagnoses

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STATE PROGRAMS FOR MEDICALLY COMPLEX CHILDREN:

WHO IS COVERED? WHO ISN'T?

Bernardette Arellano
Director of Government Relations
California Children's Hospital Association

California Children's Hospital Association

CCHA has been providing leadership and advocacy on behalf of the eight independent children's hospitals in California for more than 20 years. We are driven by the ideal that every child requires access to the high quality, cost-effective primary, preventive and specialty health care services available at children's hospitals.

Topics

- Children's Insurance Coverage
- Insurance by California State Program
- Covering Children with Special Healthcare Needs (CSHCN)
  - Private Health Insurance
  - California Children's Services Program (CCS)
- CSHCN

The Basics

9 Million Children in California

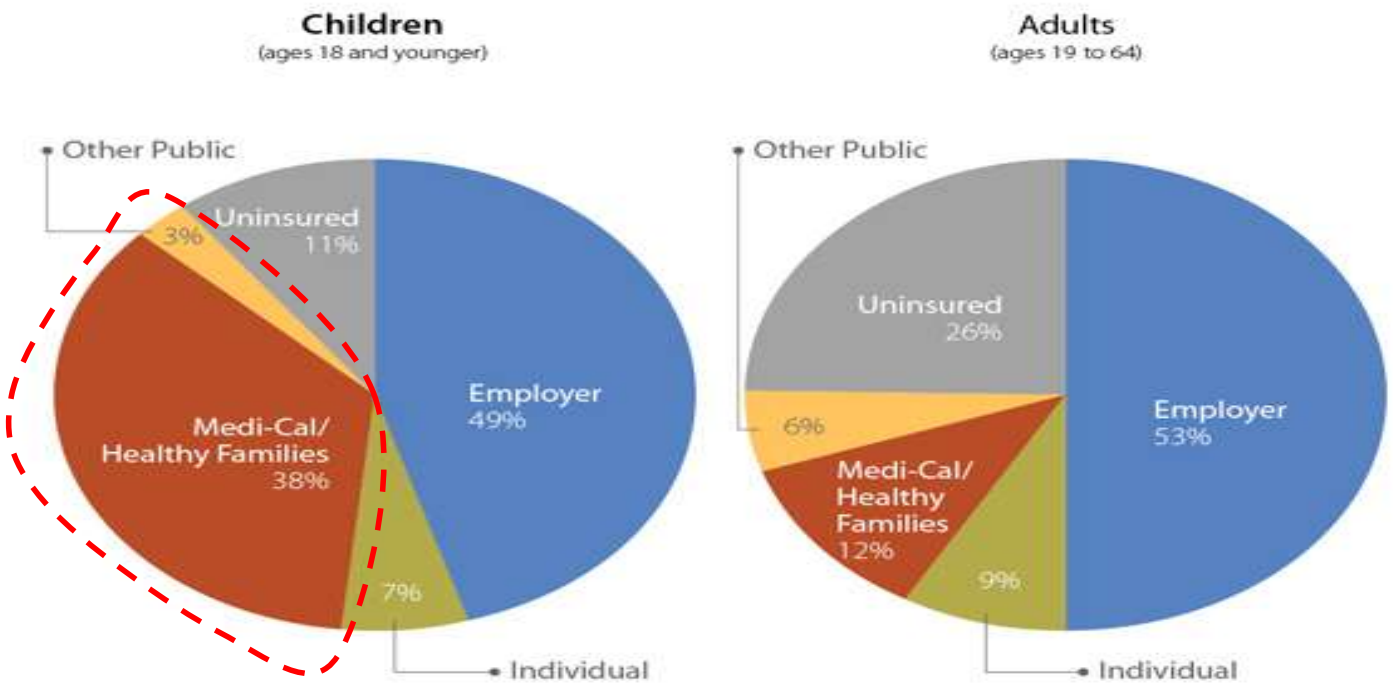
- Private Insurance: 3.05 million children
- Public Insurance: 4.85 million children
- Uninsured: 1.1 million children

1.4 Million Children in California have special health care needs

Sources of Coverage (California)

CALIFORNIA CHILDREN'S HOSPITAL ASSOCIATION

Sources of Insurance Coverage for Children and Adults
California, 2011



Notes: Percentages may not add up to 100 because individuals may receive coverage from more than one source. Other Public includes Medicare, Military, Tricare/CHAMPVA, and Veterans Administration.

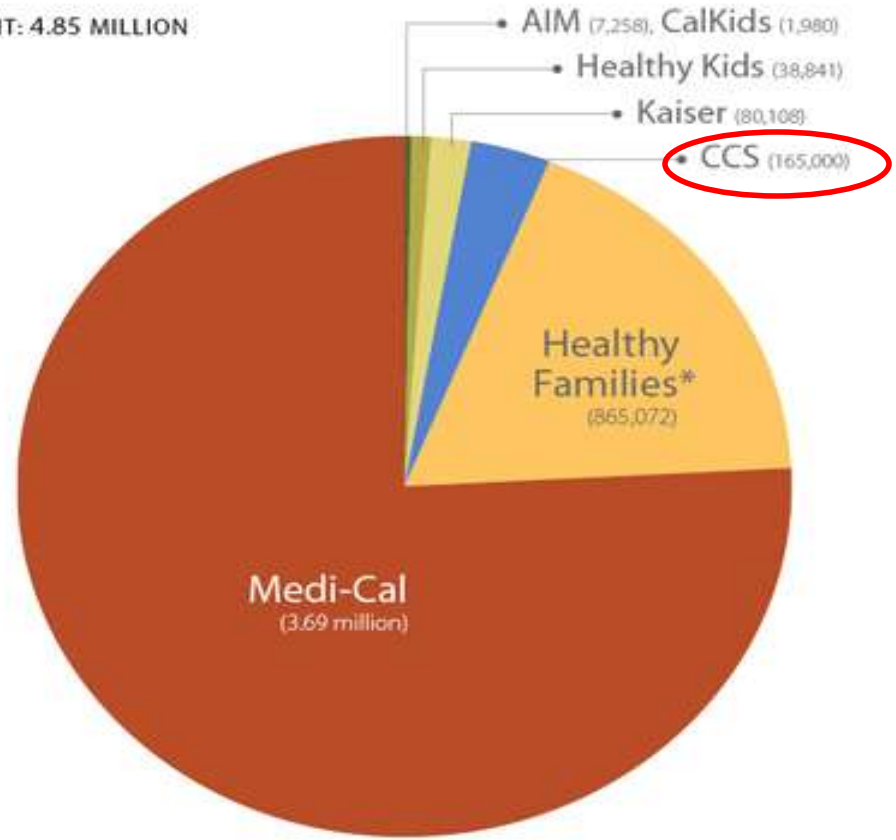
Source: United States Census Bureau, Current Population Survey (CPS), March 2011 Supplement, accessed September 2012, www.census.gov.

Enrollment in Children's Insurance Programs

California, January 2011

CALIFORNIA CHILDREN'S HOSPITAL ASSOCIATION

TOTAL ENROLLMENT: 4.85 MILLION

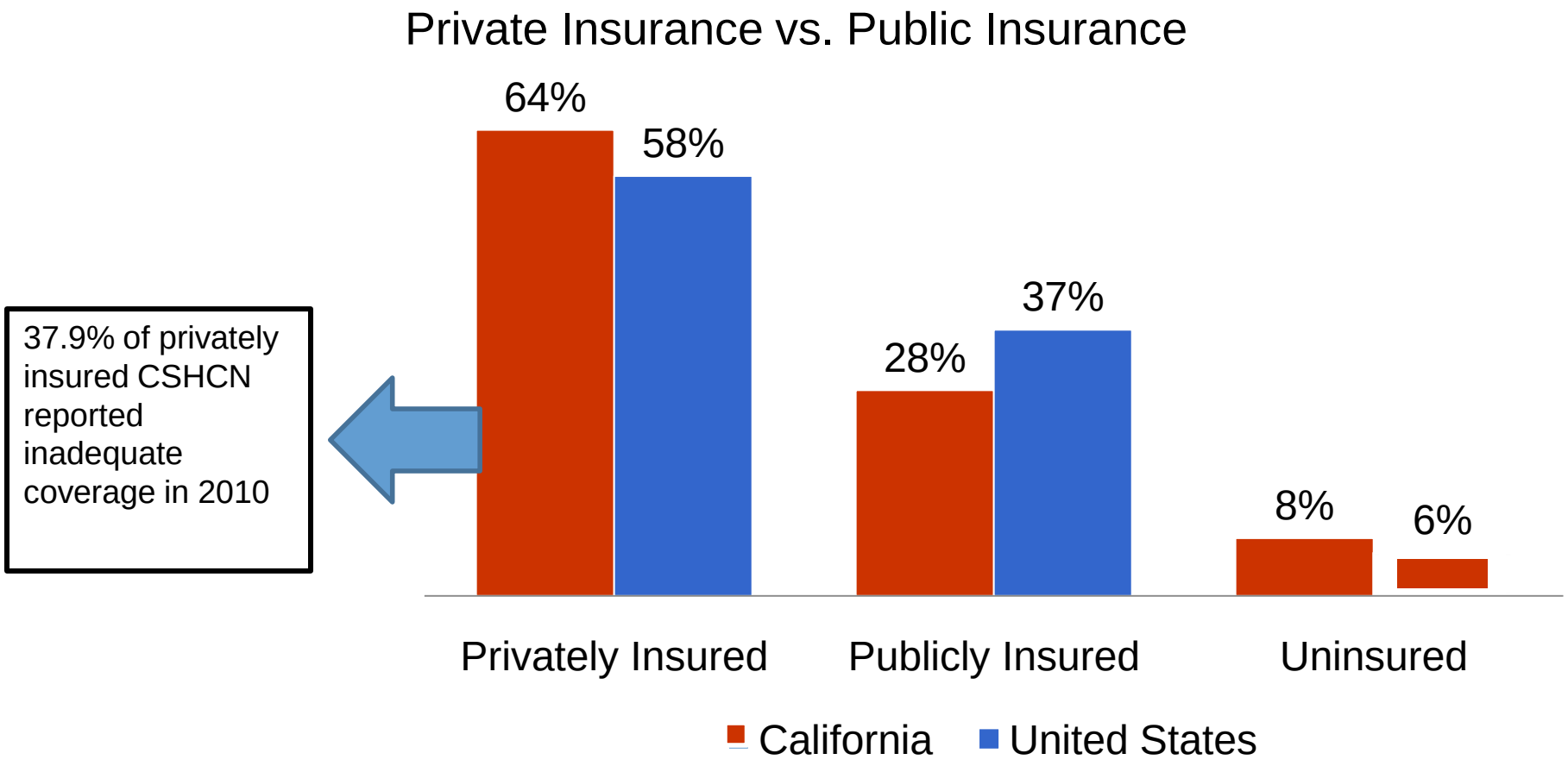


*Children enrolled in Healthy Families will be transferred to Medi-Cal in phases beginning January 2013.

Note: Child Health and Disability Prevention (CHDP) is not a standalone program, so it is not included.

Sources: AIM: Access for Infants and Mothers, www.mrmib.ca.gov. CalKids, www.californiakids.org. CCS: California HealthCare Foundation, *Assessing the California Children's Services Program*, www.chcf.org. Healthy Families: Managed Risk Medical Insurance Board, www.mrmib.ca.gov (2001–2012). Healthy Kids: California Coverage and Health Initiatives. Kaiser Child Health Plan: Kaiser Health Plan. Medi-Cal: California Department of Health Care Services, Beneficiary Files (2001–2012), www.dhcs.ca.gov.

Covering Children with Special Health Care Needs (CSHCN)



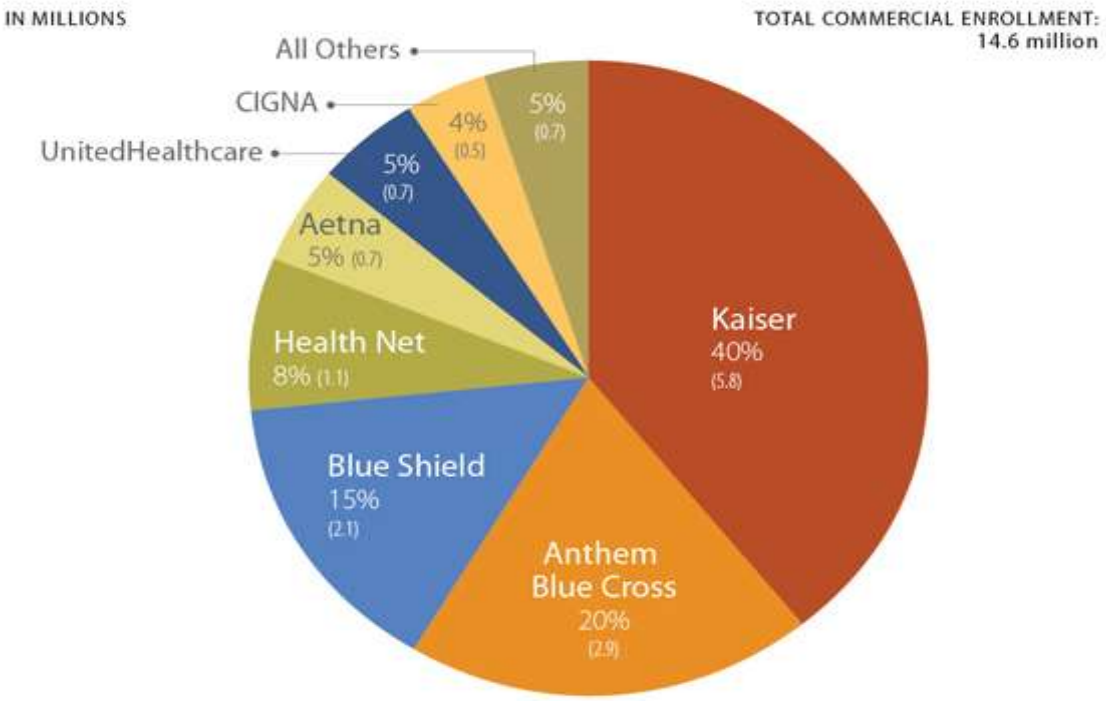
*Lucile Packard Foundation for Children's Health, "Children with Special Health Care Needs: A Profile of Key Issues in California (2010)"

Sources of Private Health Insurance

CALIFORNIA CHILDREN'S HOSPITAL ASSOCIATION

Commercial Enrollment

DMHC and CDI Combined, 2011



Notes: "Commercial" refers to health insurance individually purchased or obtained through an employer group. It excludes Administrative Services Only and self-insured enrollment, which the California Health Benefits Review Program estimates at 3.1 million. Enrollment figures are as of December. See Appendix B for additional enrollment details. All Others includes carriers that had fewer than 500,000 combined enrollees and reported group or individual enrollment. These plans include Chinese Community Health Plan, Heritage, Sharp, United Agricultural Employee Welfare Benefit Plan and Trust, and Western Health Advantage. Figures for UnitedHealthcare include PacifiCare enrollment.

Sources: Department of Managed Health Care (DMHC), Health Plan Financial Summary Data; California Department of Insurance (CDI), Statistical Analysis Division, Group & Individual Covered Lives for Comprehensive Major Medical, 2011.

Private Health Insurance

Why is coverage sometimes inadequate?

- Network and benefit variations between providers
- Health insurance products tend to primarily focus on adults.
- Information about the coverage may not be available when the parent(s) select a plan.
- Parent(s) may select a health plan before they have/adopt a child, opting for a more restrictive but less expensive plan.
- Employer sponsored health plan might not cover dependents.

Public Health Insurance Programs

- Medi-Cal
- Healthy Families
- California Children's Services
- Kaiser Permanente Child Health Plan
- Child Health and Disability Prevention (CHDP)
- CalKids (County only)
- Healthy Kids (County only)
- Access for Infants and Mothers (AIM)

What are the options for families?

- There are 8 public health insurance programs for children in California, all with different eligibility requirements.
- Less medically complex children can access services through standard government insurance products and with support from other programs available to treat their conditions.
- The sickest, most medically complex children are covered by the California Children's Services program.

CCS Program Overview

- **More than insurance:** Diagnostic and treatment services, medical case management and physical and occupational therapy services for eligible children under age 21.
- Administered as a partnership between the state and county health departments but shaped by the counties.
- Funded through a combination of county, state, and federal dollars
- Children access CCS in three ways:
  - CCS only (“Straight CCS”)
  - CCS/Medi-Cal
  - CCS/Healthy Families
- Care for CCS conditions is “carved out” of managed care plans in most CA counties until 2015

*Source: DHCS CCS website

CCS Eligibility

	Family Income Requirements	Age and Citizenship status	Reimbursement Model
CCS Only	Under $40,000 or out of pocket costs for eligible condition > 20% of family's gross annual income OR Medical Therapy Program only	Under 21 years of age - Undocumented - Uninsured - Other insurance with qualifying out of pocket cost	Fee for Service County and state dollars only
CCS/ Medi-Cal	Has full scope Medi-Cal and a CCS eligible condition.	Under 21 yrs of age US Citizen or Permanent Resident	Medi-Cal managed care covers preventative and non-CCS related diagnoses FFS rates for eligible conditions
CCS/ Healthy Families	Healthy Families Eligible and a CCS eligible	Under 21 yrs of age California Resident	Transitioning to Medi-Cal Managed care but retaining HF funding ratio for non-CCS related diagnoses. FFS rates for eligible conditions

*Source: DHCS CCS website

CCS Eligible Conditions

**Problems that are physically disabling, or need to be treated with medicine, surgery, rehabilitation.

- Congenital heart disease
- Cancers
- Hemophilia and sickle cell
- Serious chronic kidney problems
- Spina Bifeda
- AIDS
- Cystic Fibrosis
- Severe head, brain, or spinal cord injuries

- Most children in CCS have more than one eligible condition
- Some children are eligible for a short amount of time, some will be CCS kids until they turn 21.

What makes CCS so special?

CALIFORNIA CHILDREN'S HOSPITAL ASSOCIATION

- High quality, specialized providers and care centers that tailor care to the child's unique health care needs.
- Providers that meet rigorous standards across the range of healthcare settings.
- Case management, referral and connection to providers, treatment centers, other state/county agencies.
- Provides care that families would otherwise not be able to afford.

Insuring CSHCN - looking ahead

- Even with CCS available, almost one quarter (24.2%) of California CSHCN have conditions that cause financial hardship for their families.*
- 28% of California CSHCN have families that pay $1,000 or more in out-of-pocket medical expenses annually.*
- Persistent shortages in pediatric subspecialists, low reimbursement, and lack of access to care in rural areas remain problematic.
- Need to protect and improve medically fragile children's access to specialty healthcare services in the new ACA environment.
  - Hospitals transitioning to risk based payment models – implications for high-risk patients
  - Considering the needs of the medically fragile when designing integrated care models.
  - The California HBX and children with special healthcare needs
- Section 1115 Waiver CCS Pilots and the future of the CCS program

*LPFCH, "Children with Special Health Care Needs in California: A profile of key issues"

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CATALYST CENTER

IMPROVING FINANCING OF CARE for Children & Youth WITH SPECIAL HEALTH CARE NEEDS

Children with Special Health Care Needs in Medi-Cal and the California Health Benefits Exchange

Meg Comeau, MHA
Director, The Catalyst Center
Boston University School of Public Health

April 18, 2013

Medicaid Matters to ALL Children...

But it's **especially important** to children with disabilities and special health care needs.

Why? Because it offers **comprehensive** and **affordable** health care coverage to low income children who:

- do not have access to private insurance;
- cannot afford the premiums or the out-of-pocket costs associated with private insurance;
- need services not covered by private insurance

Children with special health care needs (CSHCN) by insurance category

Type of insurance	% of California CSHCN	% of CSHCN in the US
Private insurance only	60.0%	52.4%
Public insurance only (Medicaid/CHIP)	28.1%	35.9%
Both public and private coverage	8.3%	8.2%
Uninsured	3.6%	3.6%

SOURCE: National Survey of Children with Special Health Care Needs, 2009/10. Child and Adolescent Health Measurement Initiative, Data Resource Center on Child and Adolescent Health website. Retrieved 4/13/13 from http://www.childhealthdata.org/browse/survey/results?q=1810&r=6&r2=1

Medi-Cal: An Overview

- State/Federal Partnership
  - Jointly funded (50/50 split in CA)
  - State administered program with flexibility under federal guidelines
- Eligibility for Children
  - Financial Need (family income <250% of FPL)
  - Medical Need (SSI enrollment)
  - Institutional Need (ex. Home and Community-based Service waivers)
  - Out-of-Home Placement (ex. children in foster care)

Covered Services

Mandatory Services

- Inpatient and outpatient hospital
- Physician services
- Family planning services
- Nursing facilities
- Nurse practitioners
- Laboratory and Dx imaging
- Transportation
- Home health services
- Early Periodic Screening, Diagnosis and Treatment (EPSDT) for children under 21

Optional Services

- Prescription drugs
- Occupational, speech and physical therapies
- Targeted case management
- Rehabilitative services
- Personal care services
- Dental services
- Hospice services

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

- Applies to all Medicaid-enrolled children under age 21
- Screening, diagnosis and subsequent treatment of identified needs must be provided *even if the service is not included in the state's Medicaid plan*
- Thus, any medically necessary service for children is actually mandatory

State Health Exchanges aka "the Marketplace"

- Opening January 1, 2014 in each state
- Choice of different individual and small group (<100 employees) "Qualified Health Plans" (QHPs)
- Includes Essential Health Benefits (EHBs)
- Help for consumers in choosing a plan
- Help with affordability:
  - Subsidies between 100% and 250% FPL
  - Tax credits between 100% and 400% FPL

California Health Benefit Exchange: *Covered California*

- State-based Exchange (one of 18)
- Independent public entity within state government with a five-member board appointed by the Governor and the Legislature
- CA was the first state to authorize an Exchange after the ACA was signed

Medi-Cal, Covered California and CSHCN

- Approximately 500,000 children are expected to be eligible for coverage under Covered California
- ACA calls for integration of Medicaid, CHIP and the Exchanges – even though there are differences in eligibility
  - Single application
  - Plan for seamless movement between them when eligibility changes is necessary
- Essential that they work together to ensure kids stay covered!

For more information,
please contact us at:

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CATALYST CENTER

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PRIVATE COVERAGE UNDER CALIFORNIA'S ACA:
BENEFITS AND COST-SHARING REQUIREMENTS AFFECTING CHILDREN AND ADOLESCENTS WITH SPECIAL NEEDS

Peggy McManus
The National Alliance to Advance Adolescent Health
Washington, DC
April 18, 2013

THE NATIONAL ALLIANCE
TO ADVANCE ADOLESCENT HEALTH

Key Questions for Presentation

1. How well does Kaiser's benchmark plan meet the needs of children and adolescents with special health care needs?
2. Are there particular services important to children and adolescents that are limited or excluded from the benchmark plan?
3. What differences in out-of-pocket payments (deductibles, copays, coinsurance) will families face in platinum, gold, silver, bronze, and catastrophic plans?
4. To what extent will families who qualify for cost-sharing subsidies be protected from high out-of-pocket costs?
5. What pediatric-specific requirements were part of CA's qualified health plan solicitation?
6. What critical issues should policymakers, families, and health care providers focus on with the new private coverage options that California's ACA will be implementing?

Funding and Approach

- Funding: Packard Foundation for Children's Health
- Information Sources
  - Benefits: Kaiser's benchmark plan and KP interview, CA's ACA legislation, CA mandated benefits, and CCS interview
  - Cost-sharing: Covered California final standard benefit plan designs
  - Qualified health plan requirements: CA's solicitation/RFP
- Child/Adolescent Services
  - 48 services important to children and adolescents with special needs under 10 essential health benefit categories
- Final Policy Brief
  - Preliminary findings today (minus dental and vision services) and policy brief submitted to Foundation in next 2 weeks

Important Background

- Kaiser's small group HMO plan was selected as CA's benchmark plan
- CA prohibits insurers from making benefit substitutions, except for prescription drugs
- CA also prohibits insurers from imposing treatment limits that exceed Kaiser's benchmark plan
- The Kaiser plan is the "reference" plan for most private individual and small group products sold inside and outside of CA's exchange starting next October

More Important Background

- Kaiser's benchmark plan did not cover habilitative services or pediatric dental and vision services – two of 10 required essential health benefits. CA supplemented Kaiser's coverage to include:
  - Habilitative covered under the same terms as rehabilitative
  - Pediatric dental care covered as Healthy Families
  - Pediatric vision care covered as FEDVIP Blue Vision
- State-mandated benefits important to children will be covered, including:
  - Asthma and diabetes treatment and equipment/supplies, FDA-approved contraceptives, PKU testing and treatment, mental health parity, and behavioral treatment for PDD and autism

How well does Kaiser's benchmark plan meet the needs of children and adolescents with special needs?

- Very well! Kaiser offers a broad set of covered benefits for children and adolescents, mostly without visit limits

- Certain services are especially expansive: preventive care (beyond ACA requirements), mental health and substance abuse services (continuum of care), rehabilitative services, home health care, and skilled nursing facility care (more than most small groups cover)

- Small group plans typically set very restrictive visit limits on services such as ancillary therapies and home health, and fail to cover intensive outpatient care or residential treatment for mental health and substance use disorders

Are there particular services important to children with special needs that are limited or excluded from the benchmark plan?

- Benefit exclusions: family therapy, hearing aids, and cochlear implants, and inpatient treatment beyond detoxification for chemical dependency

- Benefit limitations:
  - Intensive outpatient/partial hospitalization and residential treatment for mental health and substance use disorders covered on short-term basis
  - Home care is covered up to 2 hours per visit and up to 3 visits per day for 100 visits/year
  - Skilled nursing facility care is covered up to 100 days per benefit period

What differences in out-of-pocket payments will families in platinum, gold, silver, bronze, and catastrophic plans face?

- Huge differences for families who do not qualify for cost-sharing subsidies!

- Actuarial values
  - Platinum: 88% (on average, family will pay 12% out of pocket)
  - Gold: 78%
  - Silver: 68.3%
  - Bronze: 60.4%
  - Catastrophic: 60.4%

More cost-sharing differences

- Deductible differences (per family)
  - Platinum and gold: NONE
  - Silver: $4,000 for certain medical services and $500 for brand-name drugs
  - Bronze: $10,000
  - Catastrophic: $12,800

- Out-of-pocket limit on expenses (per family)
  - Platinum: $8,000
  - Gold, silver, bronze, & catastrophic: $12,800

More differences

- Copay or Coinsurance Amounts in Platinum versus Bronze Plans
  - Ambulatory care (deductible in bronze applies after 1st 3 visits)
    - PCP visit: $20 vs $60
    - Specialist visit: $40 vs $70
  - Emergency care (deductible applies in bronze)
    - ER services: $150 vs $300
  - Hospitalization (deductible applies in bronze)
    - Inpatient hospital room: $250/day up to 5 days vs. 30%
    - Outpatient hospital fees: $250 vs 30%

More differences

- Lab services (deductible applies in bronze)
  - Lab tests: $20 vs 30%
  - CT/PET scan/MRI: $150 vs 30%
- Rehabilitative/Habilitative Services and Devices (deductible applies in bronze)
  - Therapy services: $20 vs. 30%
- Prescription Drugs (deductible applies in bronze)
  - Generic: $5 vs $25
  - Preferred brand name drugs: $15 vs $50

To what extent will families who qualify for cost-sharing subsidies be protected from high out-of-pocket costs?

- Quite a bit of protection for families at income levels from 100% FPL up to 400% FPL, as required by ACA
- Premium tax credit varies by income, ranging from the premium limit being 2% of family income for families between 100-133%% FPL to 9.5% of income for those with incomes at 350-400% FPL.
- Premium subsidies are only for the silver plan in the exchange.
- Cost-sharing assistance subsidies available for those at 100-250% FPL
- Out-of-pocket spending protections also vary by income, based on maximum limits for Health Savings Accounts

More on subsidized cost-sharing in CA's Silver Plan

Deductibles (family)

100% - 150% FPL:	None
150% - 200% FPL:	$1,000 for medical, $100 for drugs
200% - 250% FPL:	$3,000 for medical, $500 for drugs

Out-of-Pocket Limit (family) for Covered Expenses

100% - 200% FPL:	$4,500
200% - 250% FPL:	$10,400

Copays/Coinsurance for Selected Services

PCP:	$3 (100-150% FPL), $15 (150-200% FPL), $40 (200-250% FPL)
Specialist:	$5 vs $20 vs $50
ER:	$25 vs $75 (deductible applies) vs $250 (deductible applies)
Hospitalization:	10% vs 15% (deductible applies) vs 20% (deductible applies)
Generic drugs:	$3 vs $5 vs $20
Brand name drugs:	$5 vs $15 (deductible applies) vs $30 (deductible applies

What pediatric-specific requirements were part of CA's qualified health plan solicitation?

- Introduction recognized CA's history of multi-specialty and organized medical groups
- RFP emphasized contracting with providers and networks that have historically served low income and insured populations
  - Essential community health providers (eg, FQHCs, county hospitals and consider SBHCs)
- RFP emphasized provider network adequacy
  - Yet, no requirement for identifying the PCP and specialists with pediatric certification
  - QHPs allowed to have 2-tiered in-network benefit levels with higher cost-share for more expensive in-network choice
- RFP emphasized quality improvement
  - QHPs must report on pediatric and adult performance measurement (HEDIS)
- RPF emphasized innovation
  - QHPs encouraged to describe medical home, QI, patient engagement, and community prevention efforts

What critical pediatric issues should policymakers consider with implementation of new private coverage under CA's ACA?

- Work with CCS and state AAP and AACP chapters to establish a clear definition of "medically frail" children exempt from private benchmark coverage. (Others exempt: children on SSI, in foster care or receiving adoption assistance, dual eligibles, the medically needy, and pregnant adolescents)
- Review qualified health plans' (QHPs') adherence to Kaiser's benchmark benefits
- Examine QHPs' prior authorization and medical necessity standards for children's care
- Review QHPs' pediatric provider in-network services, including CCS providers and child and adolescent mental health providers, and also formulary
- Ensure QHPs have mechanism to coordinate CCS benefits and inform families
- Ensure family information and education about cost-sharing differences by plan type
- Monitor access to care and experience among families whose children and adolescents have special needs at different income levels in different plans
- Form a children's ACA advisory group to assist in reviewing formularies, prior authorization criteria, provider adequacy, QI, and access to care.

Critical Issues for Families and Health Care Providers

- Inform families who may qualify as disabled or medically frail or as a “special group” of their exemption from mandatory enrollment in benchmark benefits
- Encourage families, if able, to purchase the platinum or gold plans
- Inform families about the cost-sharing liabilities in silver and especially in bronze plans
- Inform older adolescents and young adults and their families about the cost-sharing liabilities in catastrophic plans
- Encourage families to find out about participating provider networks, noting the differences between the different “tiers” of participating providers and the implications for out-of-pocket payment liabilities and protections

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FAMILY VOICES *of California*

Juno Duenas

April 18 , 2013

What Works Well

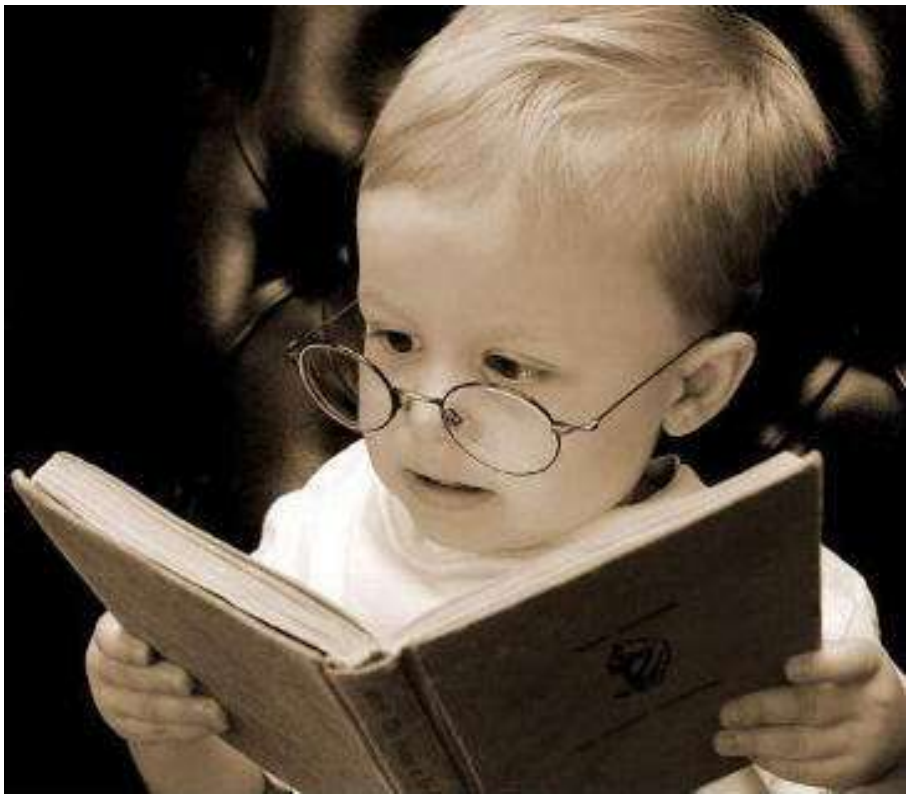
MCHB Core Performance Measures

- Families partner in decision making at all levels and are satisfied with the services they receive
- coordinated comprehensive care in a medical home
- adequate private and/or public insurance to pay for the services they need
- Children are screened early and continuously
- Community-based services for children and youth are organized so families can use them easily
- Youth with special health care needs receive the services necessary to make transitions

What Works Well?

Communities that recognize the parent as the customer and the central care coordinator

Families Partner In Decision Making At All Levels And Are Satisfied



- Information And Education
- At Risk Families
- Planning Implementation Evaluation
- Copies of Reports
- Peer Parent Services

Coordinated Ongoing Comprehensive Care Medical Home

- Define Care Coordination
- Access To Primary And Specialists
- Autonomy To Work Directly With Their Providers
- Continuity And Time
- Training

Families Have Adequate Private And/Or Public Insurance

- Clear Payment Policies
- Payer Of First Resort
- Clear Information What How and Who
- Multiple Methods
- Linguistic And Cultural Responsiveness

Children Are Screened Early And Continuously

Screen

Screen

Screen

Community-based services are organized

Systems Issues Across At State And Local Level

- Community Based Information

Youth receive the services to make transitions

- Infrastructure to develop and implement transition plans
- Build capacity of adult care providers

Accountability

Assessment

Evaluation

Table

THANK YOU!!!

THE TRANSFORMATION OF CHILD HEALTH IN CALIFORNIA

Why The CCS Program Has Become Crucial To All Children In California

Paul H Wise, MD, MPH

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CHILD HEALTH IN THE UNITED STATES HAS BEEN TRANSFORMED

- **Sharp reduction in serious, acute diseases**

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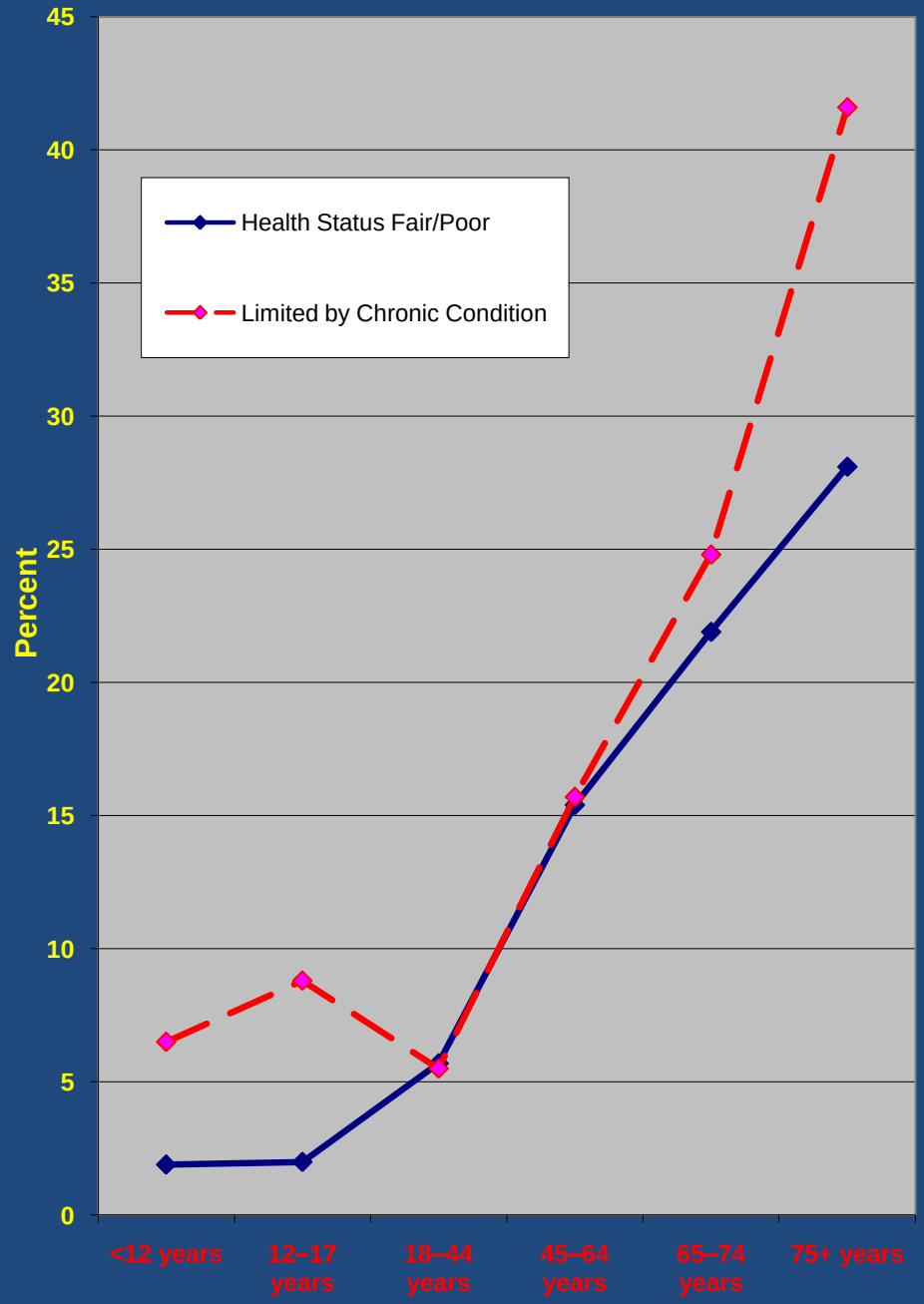
- **Concentration of illness, mortality and expenditures in chronic diseases**

CHILD HEALTH IN THE UNITED STATES HAS BEEN TRANSFORMED

- **Sharp reduction in serious, acute diseases**
- **Concentration of illness, mortality and expenditures in chronic diseases**
- **However, chronic illness in children remains relatively rare compared with chronic illness in adults**

SERIOUS CHRONIC CONDITIONS ARE RARE IN CHILDREN

- WHILE ALMOST HALF OF THE ELDERLY ARE LIMITED BY THEIR CHRONIC CONDITIONS, LESS THAN 8 PERCENT OF CHILDREN ARE LIMITED BY CHRONIC ILLNESS



HEALTH STATUS AND LIMITATIONS BY AGE, US 2005

CHILD HEALTH CARE SYSTEM MUST BE DIFFERENT THAN THAT FOR ADULTS

- IN GENERAL, HIGH QUALITY SERVICES ASSOCIATED WITH EXTENSIVE EXPERIENCE AND HIGH VOLUME

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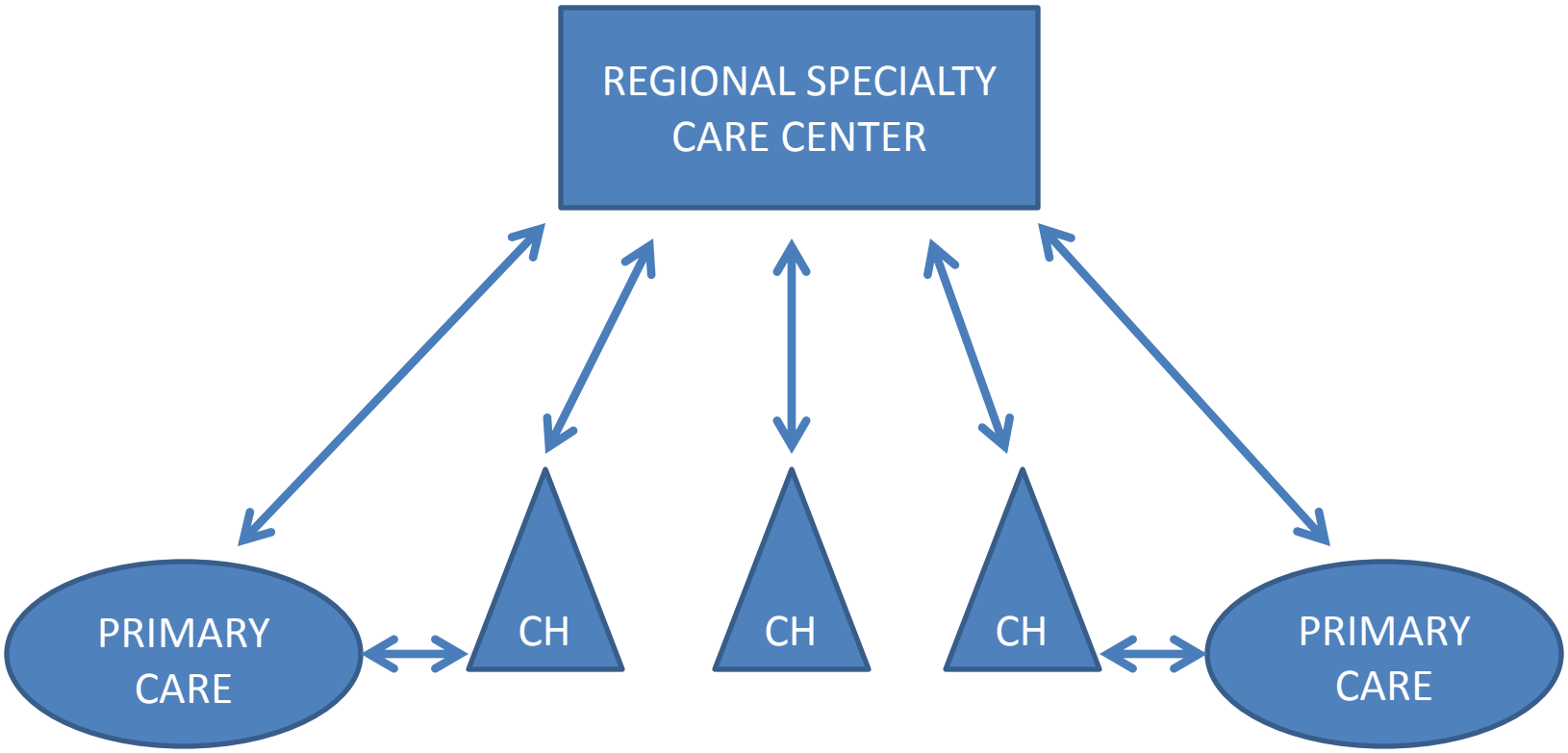
CHILD HEALTH CARE SYSTEM MUST BE DIFFERENT THAN THAT FOR ADULTS

- IN GENERAL, HIGH QUALITY SERVICES ASSOCIATED WITH EXTENSIVE EXPERIENCE AND HIGH VOLUME
- BECAUSE SERIOUS CONDITIONS ARE RARE IN CHILDREN, REGIONAL REFERRAL CENTERS WITH SPECIAL EXPERTISE WERE CREATED
- REGIONALIZED SPECIALTY CARE SYSTEMS SHOWN TO BE AMONG THE MOST IMPORTANT ADVANCES IN MODERN PEDIATRICS



TO ENSURE HIGH QUALITY SERVICES FOR SERIOUSLY ILL CHILDREN, RARE CONDITIONS MUST BE REFERRED FROM COMMUNITY HOSPITALS (CH) TO REGIONAL SPECIALTY CARE FACILITIES

THE IMPORTANCE OF THE CALIFORNIA CHILDREN'S SERVICES PROGRAM

- ARCHITECTURE FOR ***REGIONALIZED*** SPECIALTY CARE SERVICES IN CALIFORNIA

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- ARCHITECTURE FOR ***REGIONALIZED*** SPECIALTY CARE SERVICES IN CALIFORNIA

- PROVIDES REGIONALIZED STRUCTURE FOR ***ALL CHILDREN*** IN CALIFORNIA, NOT ONLY POOR CHILDREN

CCS HAS BECOME MORE THAN SAFETY NET PROGRAM

- BECAUSE SERIOUS CONDITIONS ARE RARE IN CHILDREN, ***PRIVATELY INSURED CHILDREN DEPEND UPON THE SAME REGIONALIZED CENTERS*** AS CCS PATIENTS

CCS HAS BECOME MORE THAN SAFETY NET PROGRAM

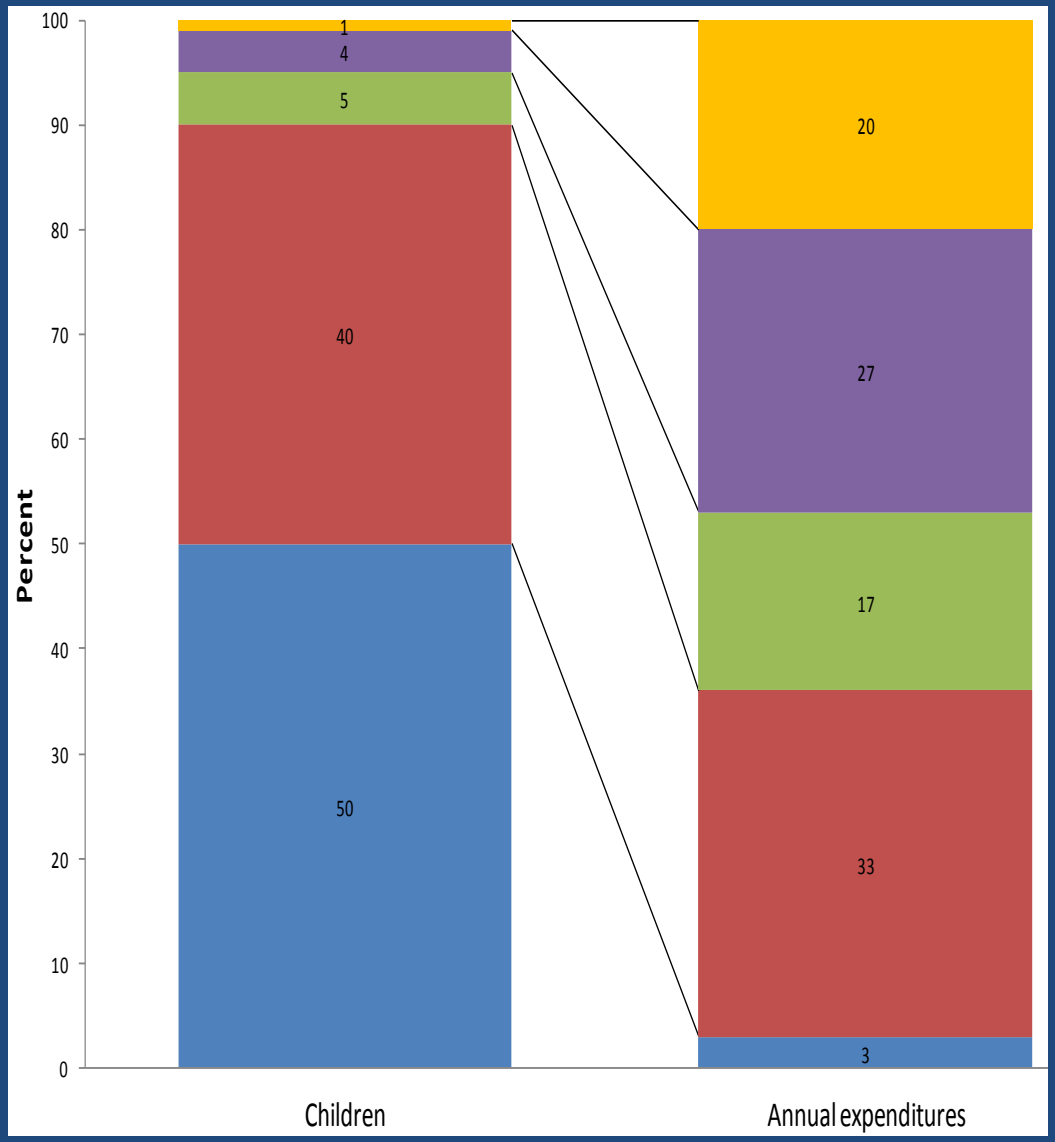
- BECAUSE SERIOUS CONDITIONS ARE RARE IN CHILDREN, ***PRIVATELY INSURED CHILDREN DEPEND UPON THE SAME REGIONALIZED CENTERS*** AS CCS PATIENTS

- ANY UNRAVELLING OF CCS REGIONALIZATION WILL AFFECT THE CARE OF ***ALL*** SERIOUSLY ILL CHILDREN IN CALIFORNIA

A SMALL GROUP OF CHILDREN ACCOUNT FOR THE MAJORITY OF CCS EXPENDITURES

- ONLY 10% OF CHILDREN ACCOUNT FOR APPROXIMATELY TWO-THIRDS OF CCS EXPENDITURES
- PROVIDES ***REMARKABLE OPPORTUNITY*** TO REDUCE EXPENDITURES BY IMPROVING EFFICIENCY AND QUALITY FOR A RELATIVELY SMALL GROUP OF CHILDREN

EXPENDITURES IN CCS



CRITICAL CHALLENGES

- PROTECT WHAT IS WORKING IN THE CCS PROGRAM – REGIONALIZED SPECIALTY CARE

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- EROSION OF CCS PROGRAM WILL AFFECT THE QUALITY OF CARE FOR ALL SERIOUSLY ILL CHILDREN IN CALIFORNIA

CRITICAL CHALLENGES

- PROTECT WHAT IS WORKING IN THE CCS PROGRAM – REGIONALIZED SPECIALTY CARE
- EROSION OF CCS PROGRAM WILL AFFECT THE QUALITY OF CARE FOR ALL SERIOUSLY ILL CHILDREN IN CALIFORNIA
- WE KNOW WHERE THERE ARE MAJOR OPPORTUNITIES TO IMPROVE CARE AND REDUCE EXPENDITURES