

Children's Regional Integrated Service System (CRISS)

Principles of Health Care Delivery to Children and Youth with Special Health Care Needs (C/YSHCN)

The Children's Regional Integrated Service System (CRISS) supports the concept of redesign of the CCS program. As currently configured, CCS has many critically important components that have driven excellent health outcomes for medically complex and fragile children, including low-income children and children without legal documentation, and have supported the regionalized pediatric system of care that serves all California children. These components must be preserved in any redesign proposal. At the same time, this almost 90-year-old program and its system of care for children and families will benefit from new attention and new approaches.

Critical Components of a Redesigned CCS System of Care

CRISS believes that the following components must be retained in any redesign of CCS:

1. Strong regionalized system of pediatric specialty care, anchored by centers of excellence consisting of CCS-certified regional hospitals and Special Care Centers with CCS-paneled pediatric physicians and other providers, and driven by statewide pediatric quality standards and oversight.
2. Enforcement and regular updating of clearly established statewide standards for credentialing that reflect pediatric training and experience and quality and volume standards.
3. Rigorous case-finding at the hospital and community level.
4. Fiscally disinterested decisions about access to medically necessary services that are driven by children's medical conditions and child and family needs.
5. Professional, family-centered case management/care coordination.
6. Access when medically appropriate to the broad CCS provider network with no artificial barriers based on geography.

CRISS believes that inclusion of the following new elements would strengthen and support CCS redesign:

1. Implementation of a whole child focus to better integrate primary, specialty and other care for CCS children in patient- and family-centered medical homes.
2. Intensive care coordination for children with high medical and/or psychosocial needs and family-centered support.
3. Regional collaboration to ensure consistency in application of program policy and standards and take advantage of economies of scale, e.g. through multi-county collaborations that allow for effective, efficient implementation of state policy and standards.¹
4. Family and youth participation, from rural and urban areas, at every level in design, implementation, evaluation and decision-making concerning the system of care that serves them, with financial support to enable and enhance effective participation.
5. Enhanced attention to quality improvement of the system, including use of standardized quality measures appropriate to C/YSHCN and public reporting of results.

¹ Examples include the (unsuccessful) CRISS proposal several years ago to State CMS that it be permitted to pilot a "hub" strategy, in which larger counties would assume some functions of surrounding dependent counties such as eligibility determination and authorizations; regional collaborations that can negotiate with durable medical equipment and other vendors; and collaborations to identify access problems, collect regional data on the problems, and design solutions.

CRISS Principles for Consideration of Redesign of the CCS System of Care

CRISS urges the use of the following principles as members and policy-makers consider potential approaches for redesign of the CCS program:

1. The delivery and flow of health care for children with special health needs should be highly coordinated to ensure efficient access to high-quality care, should be based on the whole child's medical and related needs, should reflect sound pediatric principles, and should address health, developmental, social and behavioral needs of C/YSHCN.
2. Redesign must ensure access to California's current regionalized pediatric health care systems for neonatal, pediatric intensive, and other pediatric care under statewide CCS provider credentialing and quality standards. Children should have access to medically and developmentally appropriate care regardless of the geographic region in which they reside.
3. C/YSHCN should have clearly identified medical homes, including primary care providers and pediatric sub-specialists when appropriate. Families should have the ability to exercise choice in selecting providers, contingent on providers' meeting credentialing standards.
4. Credentialed provider networks should include all pediatric sub-specialties, pediatric hospitals, child-appropriate DME and other supply vendors, and other pediatric-appropriate services. Providers should meet clearly established state standards for credentialing that reflect pediatric training and experience and meet quality and volume standards.
5. The benefit package for children should be broad and representative of children's needs, including appropriate medical, dental, developmental, behavioral, and rehabilitative services; pharmaceuticals; DME and medical supplies; and ancillary services. Care coordination should be a recognized and reimbursed component of service delivery to C/YSHCN and should include attention to appropriate transition of youth from the pediatric system of care. The system should seek to build capacity for local service delivery, particularly in rural areas, whenever possible.
6. Quality indicators specific to children and youth with special health care needs and linked to national benchmarks should be identified and a system for reporting and analyzing each system of care's outcomes developed. Any redesigned CCS system of care should include the capacity to implement practice changes and enhance access to services (e.g., telemedicine, home health) that are linked to on-going outcome analysis. Quality assurance and evaluation activities should include measures of family satisfaction.
7. Financing of health care delivery to C/YSHCN should recognize their special needs and the extra costs inherent in caring for a medically complex population:
 - a. Fee-for-service systems should reimburse at rates that reflect actual costs of care. Fee-for-service reimbursement should include the capacity to cover important pediatric services beyond typical medical care (e.g. office visits and procedures) such as care coordination.

- b. An incremental approach to funding care for C/YSHCN should include funding for assuring the continuum of care approach, including pediatric home health, telehealth, and other strategies.
 - c. Capitated systems should have capitation rates that are risk-adjusted to reflect actual costs of care. Rates should include additional services such as care coordination. Capitated systems should be extremely cautious in considering assigning risk to providers (i.e. there should be no financial disincentives to the provision of necessary care) and should avoid full risk to plans through strategies such as reinsurance or risk-sharing with the state.
 - d. All savings achieved through redesign should be reinvested in the system of care for children and youth with special health care needs.
8. There should be a permanent, financially supported stakeholder group or groups for long-term oversight of implementation of any new systems of care for C/YSHCN. The stakeholder group(s), with diverse and comprehensive representation, would be charged with ensuring that the systems represent a true improvement over the current CCS program, that they deliver quality outcomes at least equal to those under CCS, and that they remain effective, efficient, family-centered, and responsive to the needs of the children and families served. CRISS and Family Voices of California are examples of groups that provide this kind of oversight function.

Conclusion

Application of these principles leads us to four important conclusions:

1. A system of care for CCS children and youth must be designed and implemented specifically to meet their needs.
2. Traditional Medi-Cal managed care plans and county-based or other narrow networks that limit access to pediatric providers are not acceptable for C/YSHCN.
3. Proposals for CCS redesign must include a thorough stakeholder process to develop viable alternatives to the current system and avoid hasty transitions that could endanger the lives of children and youth, as well as permanent stakeholder oversight of new systems of care to ensure appropriate long-term implementation.
4. Any models for significant redesign of the CCS program should be thoroughly evaluated before major system-wide changes are implemented.

CRISS is ready to work with the State, providers and organizations concerned with redesign of the CCS program to better meet the needs of children with complex medical conditions and their families.

*Approved by CRISS Council
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This document draws on the work of many organizations concerned with the care of C/YSHCN and reflects earlier documents produced by CRISS, Family Voices of CA, Lucile Packard Foundation for Children's Health, California Children's Hospital Association, and the Bay Area Regional Stakeholders Group.