

July 2, 2015

Department of Health Care Services
Systems of Care Division
P.O. Box 997413, MS 8100
Sacramento, CA 95899

Sent by email: CCSRedesign@dhcs.ca.gov

Re: CCS Whole-Child Model

Dear CCS Redesign Team:

The California Children's Health Coverage Coalition is pleased to have the opportunity to provide input on the Whole-Child Model proposed on June 11, 2015 for redesigning the California Children's Services (CCS) Program. Our coalition is dedicated to ensuring that all of California's children have timely access to high-quality health care services. We recognize the key role of the CCS Program in providing health care services for children with special health care needs whose families are unable to pay for these services, as well as ensuring high-quality care is available to all children in case of a critical accident or illness. While the CCS Program has been very effective at fulfilling its mission, to the point of serving as a model program for other state and federal efforts to develop open access to children's hospitals, we commend the effort to improve the program by providing comprehensive treatment for the "whole child" rather than for CCS-eligible conditions only. We also appreciate the potential to streamline what are currently complex financing and administrative arrangements between the counties and the state. However, we have serious concerns with the Whole-Child Model as currently formulated, and are limited in our ability to assess the proposal by details that have not yet been specified and a lack of CCS enrollment data for each of the proposed counties. We look forward to working with the Department of Health Care Services (DHCS) in this important effort, and understand that DHCS is quickly developing legislation that would implement the Whole-Child Model. We offer the following thoughts and would be pleased to review bill language to ensure that it addresses these concerns:

Utilization Review and Out-of-County Care

In the Whole-Child Model proposal, Medi-Cal Managed Care health plans (health plans) are responsible for service authorization, while counties maintain responsibility for initial and ongoing financial, residential, and medical eligibility determinations. The proposal appears to be at odds with what was discussed by CCS Redesign Stakeholder Advisory Board (RSAB) members. Stakeholders have consistently identified that it is critical for financially disinterested parties with sufficient expertise (currently the counties) to maintain the ability to authorize services. Furthermore, the proposal is silent on the question of whether CCS enrollees would be able to access services outside of their counties, including outside the state – and if so, how transportation costs will be covered. Currently, children are referred out-of-county when warranted by the limited availability of appropriate specialty providers and services to treat a child's condition, which can be very rare. The model also contains no guarantees or protections that children will not end up seeing adult specialists if a health plan cannot find an in-network pediatric specialist. We strongly urge that counties, not health plans, explicitly maintain responsibility for both eligibility determinations and utilization review, including the ability to authorize out-of-county and out-of-state pediatric services. Without this change, we cannot support the proposal.

Pilot Evaluation

While the CCS Whole-Child Model proposal does not make this explicit, at the RSAB meeting on June 19 Director Kent indicated that the model would be implemented as a pilot program. If these are indeed pilots, whose future expansion would be contingent upon their success, why should counties dismantle existing CCS infrastructure, and how will the pilots be evaluated in a cost-effective but sufficiently robust way to judge their success? Given the strengths of the CCS program, we urge that the state err on the side of caution in implementing changes by limiting any pilots to a smaller number of counties than currently proposed without dismantling existing CCS infrastructure. We also suggest that the state avoid starting with the rural counties, which have particularly challenging health care access issues for the CCS-eligible population given the geographic distribution of children's hospitals in the state.

Treating the Whole Child and Other CCS Redesign Goals

We fully support the primary goal of the Whole-Child Model proposal: to provide comprehensive treatment, and focus on the whole-child and their full range of needs. To this end, we recommend explicitly articulating how dental and vision care will be included in the model. We similarly support the six CCS Redesign Goals, but are not clear about how the Whole-Child Model as proposed would accomplish these goals. While we recognize that the proposal is a starting point, details that have yet to be specified are critical for evaluating whether the model would be sufficient to achieve the stated goals. We therefore recommend that the Whole-Child Model include metrics and standards that will be used to assess the care experience of the patient and family and the efficiency and effectiveness of the CCS health care delivery system. Metrics should be sufficient to detect disparities in care quality across geographic regions and CCS-eligible subpopulations.

We understand from the June 19 meeting that the state will continue to partly fund the Medical Therapy Program, but it would be helpful to make that more explicit. In addition, it would be helpful to have details about how the proposal is expected to impact children who have CCS "wrap" and third-party private coverage.

Network Adequacy and Health Plan Readiness

Network adequacy and health plan readiness are critical factors that will determine the success of a transition of care coordination responsibilities from counties to health plans. The recent report from the California State Auditor on the monitoring of Medi-Cal Managed Care Health Plans (Report 2014-134: Improved Monitoring of Medi-Cal Managed Care Health Plans Is Necessary to Better Ensure Access to Care, June 2015), concludes that DHCS did not verify that the provider network data it received from health plans were accurate. At a minimum, a transition of responsibilities from counties to health plans should be undertaken only after the recommendations suggested in the State Auditor's report are fully implemented and oversight mechanisms are in place to ensure that provider networks are adequate, properly used, and publically disclosed. DHCS should also describe how provider networks will be periodically reassessed by health plans and confirmed by DHCS post-transition, and what actions will be taken if health plans are not meeting relevant network adequacy standards.

Lessons Learned

One of the CCS Redesign Goals is to build on lessons learned from current pilots, prior reform efforts, and delivery system changes for other Medi-Cal populations. We agree that a consideration of what did and did not work well with prior efforts is critical, particularly for the CCS-eligible population since any lapses in care could be life threatening. However, it is unclear in the Whole-Child Model proposal what lessons were learned and how they have been

incorporated into the model design. We recommend that DHCS articulate what lessons have been learned and how these lessons will be incorporated into any care transitions impacting the CCS-eligible population.

At a minimum, this effort should include lessons learned from the CCS pilot projects (particularly since the majority of the pilots were not implemented), the transition of Healthy Families enrollees into Medi-Cal, the Coordinated Care Initiative, and the Behavioral Health Treatment benefit expansion into managed care. We know the failure to fully enact the pilot programs under the previous waiver were due, at least in part, to an inability to negotiate risk between DHCS and the counties. The proposal states that health plans will be at risk for CCS care but is silent about how those arrangements will be made and sustained. Stakeholders need more details about the financing aspects of this proposal. Going forward, stakeholders should hear from health plan leaders about this risk and how they anticipate controlling costs without harming children.

Family Support and Stakeholder Involvement

We appreciate the work of DHCS to include families in the stakeholder process. The family advisory councils within health plans are necessary but not sufficient, and existing call lines are inadequate. For example, a recent state auditor's report found that more than 45,000 calls per month to the DHCS Medi-Cal Managed Care Office of the Ombudsman were dropped from February 2014 to January 2015. Families need CCS dedicated call lines at the county, health plan, and state levels. Additionally, Family Resource Centers and family-to-family navigators should be trained to help with the transition. As the experience of patients and families is central to the success of any future instantiation of the CCS program, feedback from families regarding every aspect of system design and implementation should be considered mandatory. We urge DHCS to make explicit additional opportunities for family advocates to provide their perspective, especially flexible opportunities such as online surveys that are sensitive to parents' limited time. We further believe that effective communication would be aided if participants in the newly proposed workgroups, including families, provide DHCS written recommendations and DHCS, if choosing a divergent course, provide written rationales. The involvement of directly impacted parties, including County-Organized Health Systems (COHS) representatives is critical and should be mandatory.

Thank you for your consideration of these comments. We would welcome any opportunity to discuss our comments and work with DHCS to help strengthen the CCS Program.

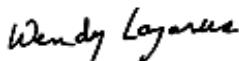
Sincerely,



Ted Lempert
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The Children's Partnership



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