



CCHA Testimony
Senate Health Committee
Informational Hearing: The Future of the California Children's Services (CCS) Program
November 18, 2015

I'm Ann-Louise Kuhns, President and CEO of the California Children's Hospital Association. We represent the eight, free-standing, not-for-profit children's hospitals in California. On behalf of our members, thank you for the opportunity to talk with you today about the CCS Program. You have asked us to address several specific questions related to the Program and the Department of Health Care Services' proposal to carve CCS into Medi-Cal managed care. Before I address those questions, however, I would like briefly to give you some context about children's hospitals and the CCS Program.

California's children's hospitals provide the backbone of pediatric specialty care in California and are major providers of care to the CCS population. Children's hospitals provide 68 percent of all CCS inpatient care and operate a preponderance of CCS approved "special care centers" -- which are the outpatient and inpatient centers that are designed to treat holistically the complex social, emotional, medical and support needs of CCS children with medical conditions like Cystic Fibrosis, hemophilia, sickle cell, cerebral palsy, and cancer. Children's hospitals tend to treat children with the most complex medical needs, including children who are transferred to us from community hospitals. We are deeply committed to caring for all children with complex health care needs, including those children eligible for the CCS Program.

California's children's hospitals are also in the vanguard of developing new and innovative approaches to caring for children with medically complex health care needs. For example, Lucile Packard Children's Hospital at Stanford and UCLA Mattel Children's Hospital are two of just ten hospitals across the nation that received a three-year Health Care Innovation Award (HCIA) from the Center for Medicare and Medicaid Innovation (CMMI) to test a care coordination model for children with medical complexity. Last month two other children's hospitals in California, Children's Hospital Orange County and Rady Children's Hospital-San Diego, were awarded a four-year grant from the same federal agency to facilitate the transformation of pediatric medical practices by creating practice guidelines that will focus on prevention, clinical quality, enhancing the patient experience, and reducing the total cost of care. And finally, Rady Children's Hospital is developing a full risk, capitated demonstration pilot to coordinate health care services across the continuum of care for children with eligible chronic medical conditions currently enrolled in the CCS Program.

All of these pilots have the potential to improve the efficient delivery of services to our pediatric patients and we are hopeful that the Department will embrace each of these efforts as it seeks to improve the CCS Program.

Now, I'd like to answer the questions you had posed regarding the Department's proposal to carve CCS into Medi-Cal managed care.

One of the questions you asked is what works well about the CCS Program. From our perspective, there are two aspects of CCS that work particularly well for children with special health care needs. First, the program has developed rigorous clinical standards that providers must meet in order to treat children with CCS coverage. The standards ensure that these children obtain care from experienced providers with appropriate pediatric-specific expertise. For example, the program requires that cardiac surgery on neonates can only be performed by an appropriately credentialed, board certified pediatric cardiac surgeon. Similarly, the program requires that a pulmonary special care center must include a social worker and a dietician, to help address the psycho-social and dietary needs of patients with cystic fibrosis.

The standards put in place by the CCS Program benefit not only those children who receive services through CCS. These same providers that see CCS patients also treat privately insured patients. Thus, the high quality of care that is fostered and maintained by the CCS program benefits all California children with special health care needs.

Moreover, research indicates that the types of standards adopted by the CCS program can have real world implications for improving health outcomes. For example, this year the American Journal of Cardiology published a longitudinal study of regionalized pediatric specialty care and pediatric cardiac heart disease in California. The study concludes that over three decades, the use of the regionalized pediatric network of specialty providers – the same providers who are approved by the CCS program – increased while pediatric mortality from cardiac heart disease decreased. Research like this supports our view that CCS's credentialing and program standards must be maintained under any transition to managed care.

The second aspect of the CCS Program that we believe works well is the use of CCS-specific utilization review and care management procedures and staff to ensure that children get the right care at the right time. Children are not little adults, and children with CCS conditions have particularly unique health and support needs that are unlike the needs of other children. County and state CCS staff have a tremendous amount of experience with the particular needs of the CCS population as well as knowledge about the appropriate medical expertise that is best suited to a particular child's needs – whether that expertise is available locally, regionally or elsewhere in the state. It's important to point out in this respect that surveys indicate that parents of children in the CCS Program are very satisfied with this aspect of the Program. It's also important to note that the expertise provided by state and county CCS staff would be difficult if not impossible to recreate on a health plan-by-health plan basis. For this reason, we would recommend that county and state CCS staff continue to perform the care management and utilization review functions under any transition to managed care.

You had also asked whether Medi-Cal managed care plans should receive a separate rate for CCS children or whether the funds for CCS children should be blended into a single rate that the plan would receive for all children it covers, both CCS and non-CCS. We believe very strongly that plans must receive a separate, special CCS rate for the CCS children they cover. Without this rate, plans would have a disincentive to identify children as CCS eligible. Providing a special CCS rate ensures that plans will seek to appropriately serve CCS-eligible children in order to obtain the enhanced rate. That rate can also be tied directly to the use of specific standards and requirements.

In addition to the recommendations I've just provided, we would recommend that the legislature consider the following five improvements to the Department's proposal.

1. Phase-in implementation of the CCS carve-in, starting with COHS counties and moving to two-plan model and Geographic Managed Care (GMC) counties after an evaluation has been completed. We believe that carving CCS into two-plan and GMC plan counties poses considerably more risk to the pediatric specialty care network than will be the case in COHS counties. For example, in Los Angeles, the Medi-Cal managed care health plans delegate risk to subcontracted plans who frequently further delegate risk to large medical groups. This complex arrangement reduces the funding available for providing actual medical care, and would make contracting arrangements very burdensome for a large pediatric specialty care provider, like Children's Hospital Los Angeles.
2. Require stringent reporting requirements specific to the CCS population so that policy makers will be able to determine whether the promise of improvement is being realized. For example, one of the goals of the whole child model is to maintain quality and access to care. Thus, it seems reasonable that plans should be required to report annually on access to special care centers as well as primary care and be held accountable when access standards are not met.
3. Require access to Independent Medical Review. Currently, almost all enrollees in managed care plans in California have access to appeal a denial of service to Independent Medical Review. The only exception is the county organized health plans. Given the medical complexity of CCS children, it seems reasonable to ensure that they have access to this important consumer protection.
4. Require continuity of care for the length of the CCS condition, not just twelve months. Many children in the CCS Program have complex, life-long conditions like sickle cell or cystic fibrosis. We believe that it would be reasonable to require continuity of care protections that extend for the life of the CCS condition, rather than arbitrarily limiting this protection to twelve months.
5. Require improved opportunities for family and provider engagement. The CCS population risks getting lost in the larger demands of the Medi-Cal managed care program. We believe that plans should be required to establish specific advisory committees for parents and CCS providers that can report to the plan's governing body.

At a minimum, these are the consumer protections that we recommend the Legislature adopt as part of any legislation to implement a CCS carve-in.

We do agree, however, that the Department's proposal has the potential to address one particular shortcoming of the current CCS Program. That is the lack of coordination between a child's primary care, which is frequently the domain of the child's Medi-Cal managed care plan, and that child's specialty care, which is arranged and paid for by the CCS program. This gives rise to disputes between Medi-Cal managed care plans and the CCS program over which program is responsible for services. This can leave the family and the medical provider stuck in the middle. A CCS carve-in could resolve these sorts of problems.

In closing, I would like to express our appreciation to you, Senator Pan, Assemblyman Bonta and the many other legislative champions who, throughout the years, have helped to protect this important program. It was only with your support that we were able to obtain passage of AB 187, which extended the CCS carve-out for another year. I would also like to take this opportunity to express our appreciation to the Governor for signing the bill. The Governor stated that he did so as an expression of good faith towards all of those who must work together to thoughtfully, responsibly, and appropriately transform this important health care program. We are here in that spirit and we appreciate the ability to provide our input today.