

## **Senate Health Committee CCS Hearing**

Wednesday, November 18, 2015

Location: California Endowment

Time: 11:00am-2:30pm

Provider, Hospital and Plan Panel Session: 1:05-1:45pm

### **Testimony of the Children's Specialty Care Coalition (CSCC)**

***By Richard Chinnock, MD, President***

I am Richard Chinnock, President of the Children's Specialty Care Coalition, also known as CSCC. I am also the Chief Medical Officer and Department Chair for Loma Linda University Children's Hospital. I am a board certified pediatrician and organ transplant specialist.

The Children's Specialty Care Coalition was founded in 1998 to address the growing crisis in availability of pediatric sub-specialty physicians. Today, the Coalition represents nearly 2,000 pediatric sub-specialty physicians statewide. These physicians are at the forefront of providing care to CCS children and families, and work as part of the multi-disciplinary care teams at the inpatient and outpatient special care centers (SCCs).

The Coalition is dedicated to ensuring access to high quality medical care for CYSHCN through strong leadership, education and advocacy.

We have been sponsors of the CCS carve-out legislation since 1999.

I would like to thank the Senate Health Committee for holding this important hearing on the California Children's Services Program (CCS) and I would like to acknowledge the Department of Health Care Services (DHCS) for working with stakeholders to improve CCS care delivery and outcomes.

The Coalition has been an active participant in the stakeholder process, and we share in the same goals as the Department, which is the development of an enhanced system of care that decreases fragmentation and better meets the needs of the "whole child".

**As the stakeholder process continues, it is important to underscore what works well in the current CCS program model.**

One of the most integral parts of the current CCS program is the existing set of clinical standards for providers and special care centers. These standards ensure children obtain care from providers with appropriate pediatric specific expertise and require special care centers to have a multi-disciplinary team and approach to care. These standards have provided quality care for all children, not just those in CCS.

**There are elements of the current CCS program that do not work well. These include:**

- mental health coordination and access, in particularly funding for special care centers to be able to adequately coordinate and/or provide mental health services for CCS children;
- communication and coordination between specialty care providers and primary care providers;
- tiering of children based on complexity and need for enhanced case management;
- the lack of resources available to support creating and developing standards for medical homes;
- the lack of substantive and intelligible data regarding quality and outcomes to demonstrate program effectiveness or ineffectiveness; and
- durable medical equipment (DME) access significantly varies depending on county region.

The Coalition looks forward to working with the Legislature and Department to address these concerns, and improve the care delivery and health outcomes for this population.

## **Now I would like to address the Whole Child Model, proposed by DHCS.**

First and foremost, the Coalition appreciates the additional time that the signature of AB 187 provided for stakeholders, legislature and Department to continue these discussions and ensure the appropriate safeguards are in place for children and families.

The Coalition is glad that the Whole Child Model includes a phased-in approach, and that the model maintains the standards of care, which has made CCS at the forefront of the delivery of quality care for children with special health care needs. Another strength of this proposal is improving the transition of care for CCS children who age-out of eligibility for the program.

However, while the ‘whole child’ proposal is well intentioned, there is currently no evidence to substantiate that this model of care will provide care “on par” or better than the current CCS program. The Coalition continues to support data-driven solutions. The Health Plan of San Mateo Pilot program, on which the Whole Child Model was designed, has not yet been evaluated. We believe that it is of utmost importance that the 2017 transition to the County Organized Health Systems (COHS) must have an independent evaluation before other counties are transitioned into managed care.

## **What alternatives to/changes would you recommend be made to the DHCS CCS proposal?**

The Coalition’s priority is to ensure CCS eligible children have uninterrupted access to quality pediatric specialists and the special care teams. The proposal is unclear about how plans will be monitored in terms of adherence to CCS standards and adequacy of networks.

Additionally, rates must remain sufficient to be able to recruit and retain specialty providers. We encourage the Department to work closely with providers and health plans to develop adequate rates, and careful consideration needs to be given to any significant changes to the program that could destabilize provider networks and diminish the quality of care.

Moving forward, the Coalition would also like to see consideration be given on testing new models of care in the remaining counties before 2019.

## **What is your perspective on the shift of utilization review/case management from the county to the Medi-Cal managed care plan?**

Regarding the shift of utilization review and case management from the county to the plans, the Coalition has significant concerns in shift of locus of control for these functions.

CCS providers have existing working relationships with the county CCS offices, and the county staff have years of experience and expertise of working with this pediatric population.

We are aware that the health plans will want to do utilization review, if they are assuming risk. If health plans, assume this role, the Coalition recommends that plans be required to consult with an advisory panel comprised of providers and include this panel in expedited approval and/or appeal processes. Additionally, consideration should be given to distinguishing benefits design for CCS designated patients that provides clear and specific guidelines to the plans. Specifically, patients, plans, and providers will need flexibility to go beyond traditional limits to services such as PT, OT, and Rx.

## **Should there be a separate Medi-Cal rate for “carved in” CCS children?**

We believe that CCS kids need to remain “unique”, which should be reflected in the way health plans are paid. Without this rate, plans would have a disincentive to identify children as CCS eligible. Therefore, a separate CCS rate will ensure CCS kids remain unique and that there is continued adherence to quality and standards.

**In closing**, I would like to thank the Senate Health Committee for the opportunity for the Coalition to share our perspective, and for convening this hearing.

We look forward to continued participation in the DHCS stakeholder advisory process, and appreciate the shared commitment of stakeholders, the legislature, and the Department to provide a “quality” system of care that meets the needs of the most medically fragile children.