California Legislature

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Senate Health Committee Oversight Hearing
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11:00 a.m. – 2:15 p.m.
The Future of the California Children's Services Program
The California Endowment
1000 N. Alameda Street
Los Angeles, CA 90012

The California Children's Services Program (CCS) provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under 21 years of age with CCS-eligible conditions (e.g., severe genetic diseases, chronic and severe medical conditions, and traumatic injuries) from families unable to afford catastrophic health care costs. Established in 1927 to help children obtain treatment for services that were amenable to surgery, the CCS program currently serves approximately 180,000 children, 90% of whom are also eligible for Medi-Cal. Most Medi-Cal beneficiaries, including children, are required to enroll in Medi-Cal managed care plans. However, for children who are enrolled in both Medi-Cal and CCS, CCS services are "carved-out" of Medi-Cal managed care in most counties until January 1, 2017.

In mid-2015, the Department of Health Care Services (DHCS) released its proposal for the CCS program based on a "whole-child model" under which a CCS-eligible child would receive all of their care through the Medi-Cal managed care plan, rather than continuing to receive care for their CCS-eligible conditions outside the plan. The whole child model would be implemented no sooner than July 2017 in 25 of 58 counties in California. For counties outside the "whole-child model" DHCS proposed a three-year carve-out extension (until at least January 2019).

The purpose of this oversight hearing is to provide an opportunity for DHCS to publicly explain to the members of the Senate Health Committee its proposal for the CCS program redesign, how DHCS plans to ensure high quality care for CCS children, and to develop a set of legislative priorities for the future of the program. The members of the committee will hear from the parents of children enrolled in the CCS program, county CCS physicians and nurses and other CCS health care providers on what works well and what does not work well in the CCS program.

Stakeholders will also provide their perspectives on the DHCS proposal and may offer recommendations, alternatives or potential changes to the DHCS proposal.

Background on CCS

Medical and Financial Eligibility for CCS

The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy health care services to children who are under 21 years of age with CCS-eligible conditions and who are in families unable to afford catastrophic health care costs. CCS-eligible conditions are defined in part in statute but primarily in regulations. CCS covers children with problems such as:

- Congenital heart disease;
- Cancers, tumors;
- Hemophilia, sickle cell anemia;
- Thyroid problems, diabetes;
- Serious chronic kidney problems;
- Liver or intestine diseases;
- Cleft lip/palate, spina bifida;
- Hearing loss, cataracts;
- Cerebral palsy, uncontrolled seizures;
- Rheumatoid arthritis, muscular dystrophy;
- AIDS;
- Severe head, brain, or spinal cord injuries;
- Severe burns;
- Problems caused by premature birth;
- Severely crooked teeth; and,
- Broken bones

In addition, the Medical Therapy Program (MTP) is a program within CCS that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have handicapping conditions, generally due to neurological or musculoskeletal disorders. PT and OT services are provided at Medical Therapy Units (MTUs), which are outpatient clinics located in designated public schools.

A child eligible for CCS must be a resident of California, have a CCS-eligible condition, and be in a family with an adjusted gross income (AGI) of $40,000 or less in the most recent tax year. Children in families with higher incomes may still be eligible for CCS if the estimated cost of care to the family in one year is expected to exceed 20% of the family's adjusted gross income.

CCS Program Administration

The CCS program is administered as a partnership between county health departments and DHCS. In counties with populations greater than 200,000 (independent counties), county staff perform all case management activities for eligible children residing within their county. This includes determining all phases of program eligibility, evaluating needs for specific services, determining the appropriate providers, and authorizing medically necessary care.

For counties with populations under 200,000 (dependent counties), the Children's Medical Services Branch of DHCS provides medical case management and eligibility and benefits determination through its regional offices. CCS authorizes and pays for specific medical services and equipment provided by CCS-approved specialists.

Funding for CCS

The CCS program is funded by several different fund sources depending upon the enrollment status of the child (for example, Medi-Cal versus state-only CCS) and the types of services received (for example, diagnosis and treatment versus medical therapy), as shown below:

Diagnosis/Treatment and Therapy:

Medi-Cal/CCS: 50% federal Medicaid funds and 50% General Fund for diagnosis/treatment; counties pay 50% of non-federal share for medical therapy services.

Medi-Cal Targeted Low-Income Children Program (TLICP is Medi-Cal for children who were previously eligible for the Healthy Families Program)/CCS: For family incomes under $40,000 AGI: 65% federal Childrens Health Insurance (CHIP) funds, 17.5% General Fund and 17.5% county funds.

For family incomes over $40,000 AGI: 65% federal CHIP funds and 35% General Fund.

State-only: 50% General Fund and 50% county funds.

Special Education Students: Billed to Medi-Cal when child has been identified as Medi-Cal eligible; otherwise 50% General Fund and 50% county funds.

County Administration/case management:

Medi-Cal/CCS: 50% federal Medicaid funds and 50% General Fund.

State-only CCS: 50% General Fund and 50% county funds.

Medi-Cal TLICP/CCS: 65% federal CHIP funds, 17.5% General Fund and 17.5% county funds.

Provider rates in CCS

In most areas of the state, CCS is reimbursed through fee-for-service delivery model. Existing law requires provider rates of payment for services rendered in certain state health programs (including CCS) to be identical to the rates of payment for the same service performed by the same provider type under the Medi-Cal program, except these rates can be greater than the Medi-Cal rate that would otherwise be applicable if those rates are adopted by the DHCS director in regulations. DHCS has adopted a regulation that reimburses for physician and podiatry services provided under CCS at rates which are 39.7% greater than applicable Medi-Cal rate. CCS inpatient hospital rates are the same as those in Medi-Cal.

Medi-Cal Managed Care and the CCS "Carve Out"
Most Medi-Cal beneficiaries, including children, are required to enroll in Medi-Cal managed care plans. However, for children who are enrolled in both Medi-Cal and CCS, CCS services were carved out of Medi-Cal managed care pursuant to SB 1371 (Bergeson, Chapter 917, Statutes of 1994). Under the carve out, CCS-covered services for CCS-eligible children are not incorporated into Medi-Cal managed care, and are instead provided and paid for on a fee-for-service basis through the CCS Program. The initial carve out under SB 1371 was for three years. The CCS carve out has been extended repeatedly since then, usually for three or four year periods.

Exceptions to the managed care carve-out are three County-Organized Health Systems (COHS) which have six counties which are at risk for the cost of treatment for CCS-eligible conditions of children enrolled in both Medi-Cal and CCS. Two of these COHS (Partnership Health Plan and CenCal Health) serve more than one county and have counties that are carved in and counties that are carved out for CCS services. The county CCS program continues to perform its role of eligibility determination and service authorization in these two COHS plans, while HPSM has a different service authorization arrangement described below. This year, AB 187 (Bonta), Chapter 738, Statutes of 2015 extended the carve out one additional year, until January 1, 2017.

2010 Medi-Cal Waiver and CCS pilots
SB 208 (Steinberg, Chapter 714, Statutes of 2010), was one of two bills in 2010 implementing the 2010 Medi-Cal waiver renewal. One provision of SB 208 was a requirement that DHCS establish, by January 1, 2012, organized health care delivery models for CCS-eligible children, from four specified models:

- An enhanced primary care case management program.
- A provider-based accountable care organization.
- A specialty health care plan.
- A Medi-Cal managed care plan that includes payment and coverage for CCS-eligible conditions.

Five demonstration applicants (San Mateo Health Plan, Alameda County, L.A. Care, Children's Hospital Orange County, and Rady Children's Hospital in San Diego) were approved in 2011, but only the San Mateo Health Plan pilot (described below) has been implemented. The Rady Children's Hospital in San Diego is for a subset of CCS-eligible children with specified conditions but it has not been implemented.

Existing law requires DHCS to conduct an evaluation to assess the effectiveness of each model in improving the delivery of health care services for children who are eligible for CCS. The evaluation must include all of the following:

- The types of services and expenditures for services;
- Improvement in the coordination of care for children;
- Improvement in the quality of care;
- Improvement in the value of care provided;
- The rate of growth of expenditures; and,
- Parent satisfaction.

Health Plan of San Mateo pilot
The Health Plan of San Mateo (HPSM) CCS Demonstration Project/Pilot serves approximately 1,500 patients in San Mateo County (CCS state-only patients are excluded). The pilot began in April 2013. Through the pilot, whole-child care coordination and utilization review is provided by one person (for CCS and non-CCS services). HPSM assumes financial risk for the whole child (both the CCS and non-CCS conditions). HPSM and San Mateo County defined each entity's roles and responsibilities for the pilot through a Memorandum of Understanding (MOU). Program oversight and operational leadership is provided by a leadership team from HPSM and San Mateo County, and all county CCS staff are co-located at HPSM. Program successes from the pilot identified by HPSM are as follows:

- One public health nurse care coordinator that provides care management for the whole child (both CCS and non-CCS eligible conditions);
- Co-location of county CCS within HPSM;
- Created a culture of continuous improvement and ongoing learning;
- 34% reduction in Notices of Action (a reduction in denials because services are authorized by one person instead of separate service requests going to both Medi-Cal and CCS);
- Increased access to mental health services;
- New pharmacy formulary eliminated nearly all needless delays and denials;
- Network improvement for incontinence supplies;
- Reduced SAR/TAR Pilot to minimize paperwork and maximize patient care;
- Comprehensive assessment tool developed and being used;
- Enhanced family engagement and outreach (Family Sub-Committee, Youth Advisory
- Committee, and Parent Liaison);
- Greater IT system integration between HPSM and County;
- Reduced barriers to filing grievances and appeals; and,
- Budget neutral to date.

The May 2015 Medi-Cal estimate assumed a capitation rate of $1,417.28 per month per child for CCS enrollees in the HPSM pilot. DHCS assumed 70% of the $3,477,000 in CCS Medi-Cal administrative costs would be transferred to HPSM, and that the pilot program would be budget neutral. The May 2015 Estimate indicates DHCS has a contract with UCLA for an evaluation of the CCS program pilot, funded at a total funds amount of slightly more than $34,000 annually for fiscal year 2013-14 and 2014-15.

DHCS CCS proposal
DHCS has implemented a stakeholder process to investigate potential improvements or changes to the CCS program. A CCS Redesign Stakeholder Advisory Board (RSAB), composed of individuals from various organizations and backgrounds with expertise in both the CCS program and care for children and youth with special health care needs, was assembled in September of 2014 to lead this process. The goals of the CCS redesign process were as follows:

1) **Implement Patient and Family Centered Approach:** Provide comprehensive treatment, and focus on the whole child rather than only their CCS eligible conditions.

2) **Improve Care Coordination through an Organized Delivery System:** Provide enhanced care coordination among primary, specialty, inpatient, outpatient, mental health, and

behavioral health services through an organized delivery system that improves the care experience of the patient and family.

3) **Maintain Quality:** Ensure providers and organized delivery systems meet quality standards and outcome measures specific to the CCS population.

4) **Streamline Care Delivery:** Improve the efficiency and effectiveness of the CCS health care delivery system.

5) **Build on Lessons Learned:** Consider lessons learned from current pilots and prior reform efforts, as well as delivery system changes for other Medi-Cal populations.

6) **Cost-Effective:** Ensure costs are no more than the projected cost that would otherwise occur for CCS children, including all state-funded delivery systems. Consider simplification of the funding structure and value-based payments, to support a coordinated service delivery approach.

At the June 2015 meeting of CCS Redesign Stakeholder Advisory Board (RSAB), California Health and Human Services Secretary Diana Dooley described her personal commitment to fixing the CCS program. Secretary Dooley acknowledged the difficulty of doing so given the history of fragmented delivery systems affecting the delivery of coordinated care, and stated that the regionalized nature of specialty pediatric care needed for the program made it difficult to move the CCS population into this type of system of care.

Secretary Dooley indicated her two core priorities include getting to whole-person care and maintaining a system of certification for providers serving these children, and the proposal from DHCS aimed to move the program in that direction. Secretary Dooley indicated she did not support an open-ended carve-out extension beyond January 1, 2017, unless it is tied to reforms that will improve the program.

The DHCS June 2015 proposal for the CCS program is based on a "whole-child model." DHCS released its proposed CCS legislative language on July 16, 2015, and released revised legislative language on August 27, 2015. To date, the DHCS language has not been amended into a bill.

Under DHCS' proposed language, DHCS would have the authority to implement the CCS carve-in in additional counties no sooner than January 2017 (except for Orange County, which would begin no sooner than July 2017). The first phase would allow DHCS to incorporate CCS services into Medi-Cal managed care plans in three COHS plans in 14 additional counties upon DHCS review and certification of the COHS meeting readiness criteria.

Under the whole-child model, health plans would be at full financial risk for CCS. In addition, DHCS proposes to repeal the requirement that there be a separate actuarially sound rate for CCS-eligible children. Medi-Cal managed care plans would be required to demonstrate support from stakeholders and be subject to a readiness review by DHCS prior to implementation. The readiness review would include evidence of an adequate network of CCS-paneled providers, evidence of policies and procedures regarding access to specialty care outside of designated catchment areas, a CCS family advisory committee in each county, and an integrated electronic

health records system. Under the "whole-child model," care coordination and service authorization will shift from counties to health plans. Counties and health plans will jointly develop MOUs to document transition plans for these activities. Counties (or the state, for dependent counties) will continue to perform initial and periodic financial, residential, and medical eligibility determinations.

Counties will maintain responsibility for medical therapy programs, and MOUs will be required with health plans and counties. To improve continuity of care and access to specialty providers for youth aging out of CCS and transitioning to Medi-Cal managed care, DHCS is requiring all Medi-Cal managed care plans, on a phased-in basis, to contract with CCS providers or providers who meet the CCS panel requirements.

In addition to the COHS counties, the whole-child model could also be implemented in up to four non-COHS counties. The determination of these counties will be based on an application of interest to DHCS from at least one plan in the county, a demonstration of support from stakeholders, and a readiness review by DHCS. Based on the application and subject to federal approval, DHCS may propose that CCS be incorporated into only one Medi-Cal managed care plan in a two plan model county. In the remaining 33 counties where the whole-child model is not offered, DHCS is proposing to extend the carve-out for three additional years, until January 1, 2019, or until completion and submission of a newly required evaluation of the CCS carve-in that is implemented in COHS counties. The chart below shows the counties and plans in the DHCS proposal:

Counties with current CCS carve-in (6 counties): Health Plans: Partnership Health Plan, Health Plan of San Mateo, CenCal Health CCS care coordination/service authorization done by county (HPSM has county staff co-located in plan).	Marin, Napa, San Mateo, Solano, Santa Barbara, and Yolo.
DHCS Proposed Additional CCS Whole-Child Counties (14 counties) for no sooner than January 1, 2017: Health Plans: Partnership Health Plan, Health Plan of San Mateo, CenCal Health, Central California Alliance for Health CCS care coordination/services authorization done by Medi-Cal managed care plan.	Del Norte, Humboldt, Lake, Lassen, Mendocino, Merced, Modoc, Monterey, Santa Cruz, San Luis Obispo, Shasta, Siskiyou, Sonoma, and Trinity.

DHCS Proposed Additional CCS Whole-Child Counties (5 counties) for no sooner than July 1, 2017: Health Plans: CalOptima and up to four additional counties. CCS care coordination/services authorization done by Medi-Cal managed care plan.	Orange, and up to four additional counties that are not a COHS county or a Regional Health Authority.

Policy issues with the CCS Program and the DHCS CCS Proposal

1) **Should the CCS carve out end and the DHCS "whole child" model be implemented in certain counties?** The CCS carve out was originally enacted when children were mandatorily required to enroll in Medi-Cal managed care plans due to concerns regarding disruption to specialty care for children and youth with special health care needs, that care would be delayed or avoided, and because the special needs of the CCS population would be lost within the context of a much larger Medi-Cal managed care population. DHCS indicates the division of care and payment between CCS and the primary Medi-Cal managed care plan has posed challenges such as delays in care for children, fragmentation and a lack of coordination, and increased cost to the state.

   Access to high-quality care for children with serious chronic illness depends upon regionalized systems of care. The CCS program has developed quality standards for pediatric specialty care and standards for approval of individual providers and facilities for participation in the program so that children who have complex, chronic and often disabling medical conditions can receive high quality care. Since the 1960s, the CCS program has supported the concept of Special Care Centers (SCC), multi-specialty, multi-disciplinary teams providing care to children with a defined set of medical conditions. These centers, located at tertiary medical centers, provide staffing and services according to CCS program standards. Because serious conditions are rare in children as compared to adults, privately insured children depend upon the same regional care network as CCS patients.

   Through the RSAB process and in comments about the DHCS proposal, advocates and stakeholders have stressed the importance of the CCS standards and have raised several concerns with the proposed "whole child" model and the role of Medi-Cal managed care plans. Major concerns expressed include:

   a. The importance of regional and statewide care networks in CCS, the need for specialized care outside the county, and the lack of availability of specialist care for children within existing Medi-Cal managed care plan networks;

   b. Lack of DHCS oversight of Medi-Cal managed care plans, as evidenced in a recent audit by the Bureau of State Audits;

c. The lack of data or evaluation from the existing CCS pilots and carve-in arrangements and the effect of managed care on access and quality of care and that would show the whole child model has been successful.

2) **Limited implementation of current CCS pilot authority, with an evaluation pending.** SB 208, the 2010 waiver legislation, established a requirement that the DHCS director establish organized health care delivery models for CCS-eligible children, from four specified models. As part of SB 208, DHCS was provided the authority to require CCS eligible individuals to enroll in these models. However, only one of the current organized delivery system models has been implemented (in San Mateo County), and an evaluation of that model has not yet been released. When the carve out was continued via AB 301 (Pan), Chapter 460, Statutes of 2011 from January 1, 2012 to January 1, 2016 , language in that measure stated legislative intent to continue the prohibition of services covered by the CCS program from being incorporated solely into Medi-Cal managed care until DHCS is able to consider the pilot evaluations, along with stakeholder input, and demonstrate the most appropriate organized health care delivery models for children eligible for CCS program services, which could include continuation of the current system of care.

3) **Shift of case management and care coordination functions from the county to the Medi-Cal managed care plan.** One of the significant changes in the DHCS proposed CCS language is the requirement that counties delegate the CCS case management, care coordination, provider referral, and service functions to the Medi-Cal managed care health plan. This delegation must be in accordance with a transition plan and a written agreement approved by the county public health department and the Medi-Cal managed care health plan.

   One of the criticisms of this proposed move is that it would shift these duties from experienced and trained county public health nurses and case coordinators who are experts in addressing the needs of the CCS population to health plans who may not have the in-house pediatric expertise, and the DHCS proposal does not have a requirement that the managed care plan staff have expertise about pediatric care and the CCS program. In addition, some stakeholders argue the current CCS care coordination systems are made by financially disinterested CCS staff, and assigning both full financial risk and care coordination to health plans has the potential to create a barrier to access to needed services or equipment, particularly high cost services.

4) **Single Medi-Cal managed care rate for Medi-Cal and CCS eligible children.** Under existing law, if a Medi-Cal managed care plan is paid according to a capitated or risk-based payment methodology, a separate actuarially sound rate for CCS eligible children is required. Alternatively, a Medi-Cal managed care pilot project may, if approval is obtained from the state CCS program director, utilize an alternative rate structure for CCS eligible children.

   One of the changes in the DHCS proposal is the deletion of the requirement that there be a separate actuarially sound CCS rate, in effect authorizing a blended rate for CCS and Medi-Cal-enrolled children which would include in the current plan rate the cost of the additional CCS services. The rate for the CCS pilot program in HPSM is significantly higher than for

non-CCS children (from January 1, 2015 to June 30, 2015, the CCS pilot program rate was $1,706.58 per child per month vs. $105.01 per month for the child-only non-CCS rate). In other COHS where CCS services are carved in and outside of the plan depending upon the county, there is a higher CCS rate in carve-in counties, although the overall CCS carve-in rate is much lower and the differential is less than in San Mateo. A separate rate for CCS children provides a financial incentive for identifying children as CCS eligible, ensures the cost of care is appropriately funded, and mirrors the existing Medi-Cal rate setting process, which has rate categories based on population differences (for example, a separate Medi-Cal rate for seniors and persons with disabilities as compared to parents).

5) **CCS Eligible Conditions.** In testimony and written comments, advocates have expressed concern that CCS omits certain diagnoses that should be CCS-eligible conditions and in some case may cover conditions for which the specialized care provided by CCS is no longer necessary. DHCS indicates the list of CCS qualifying health conditions were last promulgated through regulation in 1999, and have not been amended or changed as of that date. Under existing statutory authority, changes to the CCS eligible conditions must be pursued through the regulatory process, there is no provision to amend the health conditions through provider bulletin or policy letter. DHCS has established a CCS Eligibility and Health Conditions Technical Work Group to review existing CCS eligibility and health conditions and validated assessment and eligibility determination tools, and to discuss areas for clarification and potential changes. The DHCS timeline for these changes is a report with recommendations to the Legislature at the end of 2016.

6) **Role of counties in carve-in counties.** County CCS staff currently perform medical, financial and residential eligibility determination functions, as well as their case management responsibilities. Counties have expressed concern that these functions are inter-linked and in many counties, the funding received through DHCS is "bundled" for all these administrative functions and the methodology for determining the current county allocations is problematic. Counties indicate that, if case management functions are to be moved to Medi-Cal managed care plans, counties will need to assess how best to perform their remaining roles and DHCS will need to develop an accurate and fair methodology for funding counties' residual responsibilities. In addition, counties are concerned if these new models are to be considered "pilots" as counties will need to significantly reduce staff as well as facility needs. With a change of this magnitude, it would be very difficult for counties to rebuild this infrastructure if the "pilots" were to be discontinued.

   In addition, counties express concern about the MTP within CCS that provides PT and OT services for children in outpatient clinics located in designated public schools, as under the DHCS proposal, MTP is not proposed for inclusion within the Medi-Cal managed care plan, and claims for services will remain (as they are now), outside of the plan. Under the DHCS proposal, counties indicate it is unclear how MTP services and MTP service authorization will work in the event of a disagreement between the health plan and county MTP staff.

7) **Knox-Keene licensure of COHS.**
   Initial implementation of the DHCS proposal for CCS begins with COHS counties. COHS are exempt from the requirement applicable to most other Medi-Cal managed care plans to obtain a Knox-Keene Act license from the Department of Managed Health Care. DMHC

licenses and regulates health maintenance organizations (HMOs) and some preferred provider organizations. The mission of DMHC is to regulate and provide quality of care and fiscal oversight of plans. It achieves this mission, in part, by administering and enforcing the Knox-Keene Act. Medi-Cal managed care plans, with the exception of COHS, plans for individuals at risk for nursing home care, and county specialty mental health plans, are required to obtain a Knox-Keene Act license for their Medi-Cal lines of business. One COHS, the Health Plan of San Mateo, voluntarily obtained a Knox-Keene Act license, and all other COHS (except for Gold Coast Health Plan in Ventura County) have obtained a Knox-Keene Act license for other, non-Medi-Cal lines of business.

Two of the major consumer benefits Medi-Cal beneficiaries enrolled in Knox-Keene plans have are access to the DMHC's HMO Help Center, and independent medical review (IMR). Medi-Cal beneficiaries who are not in a Knox-Keene plan do not have access to these consumer assistance tools. IMR provides an assessment of clinical issues by physicians independent of the health plan for denials based on a treatment being experimental or investigational and denials based on medical necessity. In addition, Knox-Keene enrollees have access to the DMHC's HMO Help Center, which assists health plan enrollees with a variety of plan issues. Medi-Cal beneficiaries can use the state fair hearing process for disputes involving all types of Medi-Cal issues, but the decisions are made by an administrative law judge (ALJ), the process for a review to occur can be longer than IMR, and the ALJ decision can be overturned by the director of DHCS. In addition, Medi-Cal beneficiaries can call DHCS' ombudsman line, but that line is short-staffed with inadequate phone line capacity, and was the subject of a critical audit by the Bureau of State Audits.

Legislation (SB 260/Monning) to require COHS to be subject to licensure and regulation under the Knox-Keene Act for the purpose of carrying out those Medi-Cal contracts on a phased in basis failed passage on the Assembly Floor in 2015. Should COHS be subject to DMHC licensure if CCS services are "carved in" to the plan?