

## **Senate Health Committee Questions about the DHCS CCS Proposal**

- 1) What is the policy rationale for the Department of Health Care Services' (DHCS') proposed changes to CCS?

### **DHCS Response**

The existing health care delivery system of the CCS program is bifurcated, meaning families and children seeking health care must get it from at least two different delivery systems and more if the child has a mental health condition or is eligible for services through the Department of Developmental Services. Care for CCS-eligible conditions is provided by the fee-for-service delivery system, while primary preventive health care is delivered through a Medi-Cal managed care health plan (MCP). These two systems do not always coordinate the delivery of care effectively. In addition, this bifurcated system is continuously changing, and multiple care coordination and authorization roles have emerged across counties, providers, and MCPs.

DHCS' "Whole Child Model" provides an organized delivery system that would simplify this bifurcated model, maintain CCS provider standards and the network of specialty care, improve the provision and coordination of care for children, and provide comprehensive coordinated care across a range of providers. Due to the fragile nature of the CCS population, the Whole Child Model would be carefully implemented in a limited number of initial counties to prevent any unnecessary disruption or erosion in care. In addition, DHCS is hosting discussions around CCS program improvements and modernizations, particularly in counties where the Whole Child Model will not be initially implemented. For more about the Whole Child Model, please see:

<http://www.dhcs.ca.gov/services/ccs/Documents/WholeChildModel.pdf>

- 2) How will the proposed changes to the CCS program improve the health care of children enrolled in the CCS program?

### **DHCS Response**

Children and their families will be able to receive health care under the umbrella of a MCP that will be responsible for providing comprehensive health care including primary preventive and pediatric specialty health care, as well as coordination of mental health services, regional center services (if necessary) and other ancillary services such as durable medical equipment, occupational, speech and physical therapy. Receiving health care through a single entity will simplify the process of accessing health care by eliminating the complexity that currently exists when families must try and determine if the need to see a doctor is for the qualifying CCS health condition or for services related to primary preventive care. Families can access care through a single entity and work with a care coordinator who is familiar with the child's medical history and can facilitate access to the full range of primary and specialty care. Finally, this organized delivery system will permit the DHCS to

hold a single entity responsible for providing comprehensive, high-quality health care to CCS eligible children.

- 3) How will DHCS ensure high quality of care and access to existing CCS providers under its proposal?

**DHCS Response**

Under the Whole Child Model, CCS eligible children will continue to maintain access to CCS approved providers including CCS paneled providers, CCS approved special care centers, and CCS approved hospitals. CCS paneled (approved) providers are subject to CCS provider standards. These standards also require that CCS eligible children receive health care through pediatric specialists, pediatric sub-specialty providers, and for inpatient services through hospitals approved by the CCS program. The existing network of CCS approved providers will not be adversely impacted under the Whole Child Model, but rather this Model is expected to improve access to care. The MCPs will be responsible for ensuring that CCS eligible children have access and coordination for both primary care and the CCS provider network, including pediatric specialists, subspecialty providers, Special Care Centers, and inpatient facilities. As a result of improving access to care and coordination, the quality of care provided to CCS eligible children will improve over time.

- 4) What data will be collected to ensure quality is maintained in carved in plans? For example, will a baseline of current utilization patterns be used to determine if patterns of care change as a result of carving in CCS services? Will care outcomes be tracked?

**DHCS Response**

Similar to all other MCPs, the Whole Child Model contracted County Organized Health System MCPs will be required to submit monthly encounter data, patient satisfaction survey data, applicable data from the Children’s Medical Services Network (the CCS program’s automated case management and service authorization system), quarterly grievances and appeals data, and transitional monitoring data that will be collected monthly during the initial transition phase.

With respect to collection of data to measure quality of care delivered by MCPs, DHCS has implemented a stakeholder process consisting of CCS providers, parents, counties, children’s advocates, MCPs, and other interested parties to consult with regarding improvements to the program. Stakeholder discussions will include MCP performance including data sets and evaluation methodologies to monitor performance and impact on quality of care.

- 5) What oversight and enforcement mechanisms will be in place to ensure that CCS standards are maintained and that CCS providers are being appropriately contracted and utilized by the plans?

### **DHCS Response**

As a baseline, DHCS will certify the MCP network and approve applicable policy and procedure submissions to validate readiness. Once the transition has begun, DHCS will verify that standards are maintained through a multi layered approach. First, all MCPs will be required to submit a robust set of data on a monthly basis to track pertinent performance metrics, such as continuity of care and grievances and appeals, that would allow DHCS to address emerging issues. Secondly, all MCPs would be subject to DHCS' ongoing monitoring processes. These ongoing monitoring processes include, but are not limited to:

- Monitoring appeal data sets
  - ✓ Grievance and appeals data by demographics
  - ✓ State Fair Hearings
  - ✓ Independent Medical Reviews (for non-COHS plans)
  - ✓ Quality indicators
  - ✓ Consumer Assessment of Health Plans Survey
- Data mining of encounter data
- Network Metrics
  - ✓ Quarterly network reviews conducted in collaboration with DMHC
  - ✓ Annual timely access studies

6) Will DHCS be requesting additional staff to provide oversight and enforcement of provider access and other contracting requirements for CCS?

### **DHCS Response**

No, DHCS does not intend to request additional resources.

7) How will the DHCS proposal change the county role and county staff in the CCS program?

### **DHCS Response**

Local county CCS programs will continue to be responsible for program eligibility determination; however, MCPs will be responsible for care coordination and utilization management, through a transition plan developed with local county programs.

Local CCS county programs are currently responsible for determining CCS eligibility for the residents of their county which includes determining income, residency, and qualifying medical health condition. Small counties, also referred to as Dependent counties (counties with populations of less than 200,000) are only responsible for determining income and residency eligibility, and the medical component and care coordination services are completed by state CCS staff.

Large counties (referred to as Independent Counties) with populations in excess of 200,000, are responsible for determining all three components of CCS eligibility and are also responsible for providing care coordination and utilization management for CCS eligible children within their county.

Under the Whole Child Model, Dependent Counties will continue to determine CCS eligibility. However, the care coordination and utilization management functions for these small counties will transition from the state to MCPs. State resources and functions will shift to plan readiness and monitoring and oversight functions.

Independent Counties will continue to be responsible for CCS eligibility determination; however, the care coordination and utilization management functions will become the responsibility of the MCP. The affected counties will each develop a transition plan with the MCP to determine who will perform care coordination and utilization management functions. As noted in response to question 5, all MCPs will be subject to ongoing monitoring from DHCS.

- 8) How will the DHCS proposal change or affect the medical therapy program?

**DHCS Response**

Under DHCS' proposal the Medical Therapy Program (MTP) will continue to be administered through the local county CCS program. Local county CCS programs will continue to provide physical and occupational therapy services.

In talking with the County CCS MTP staff, we agree that we need to form a specific workgroup around MTP coordination so that the transition from CCS-to-plan responsibility incorporates the expertise and knowledge of the county in the MTP environment.

- 9) What will be the process for utilization review in "carve in" counties, and what is the patient recourse to appeal decisions? Will these be tracked and reported?

**DHCS Response**

As previously described, utilization management will be the responsibility of each MCP. Each MCP will be required to have in place, prior to taking on responsibility for authorization of CCS services, a grievance and appeal process. Beneficiaries and families will be advised of this process prior to enrollment which will be described in the MCP member books. Beneficiaries will also have access to the MCP call center should they have questions or require additional information about the process and will also have the right to request a fair hearing at any time in the process. All grievances and appeals are tracked by the MCP and made available to the state for review on a quarterly basis.

To the extent that the MCP does not satisfy the member's grievance through their established appeals process, a beneficiary may file a complaint through the state fair

hearings process administered by the Department of Social Services (as currently offered to all Medi-Cal beneficiaries).

- 10) What will happen to the existing CCS fee-for-service outpatient rate augmentation that reimburses CCS outpatient providers at rates above Medi-Cal rates?

**DHCS Response:**

The existing CCS physician services supplemental rate increase will be included in the health plan capitation rate, similar to the current structure for the Health Plan of San Mateo.

- 11) How is DHCS proposal different versus the same as the current Health Plan of San Mateo CCS pilot program?

**DHCS Response:**

DHCS' Whole Child Model is similar to the current demonstration in San Mateo County. DHCS is working with stakeholders in the CCS Advisory Group to implement the Whole Child Model, and may develop additional changes based on lessons learned from the San Mateo demonstration.

- 12) What has DHCS seen regarding access and quality in its audits of health plans where CCS is "carved in" to Medi-Cal managed care plans?

**DHCS Response:**

DHCS conducted medical audits of Partnership Health Plan of California, CenCal Health Plan, and Health Plan of San Mateo in the last year. For all three MCPs, no major audit findings were discovered and none were related to CCS.

DHCS has a formal corrective action plan process to ameliorate audit findings. For the three MCPs listed above, their corrective action plan (CAP) has either been closed or is scheduled to be closed in the near future. Once closed, the audit and any CAP issued are published on the DHCS website. As such, these MCPs are in good standing. DHCS audits health plans on an annual basis, which makes the audit and corrective action plan process fluid.

- 13) What provisions of the DHCS proposal require a change in state law (for example, the shift of care management from counties to plan, blended children's rate) versus what can DHCS implement administratively?

**DHCS Response:**

DHCS has concluded that there is sufficient legal authority under existing statute to permit development and implementation of the Whole Child Model. The piece that has budget implications and is central to the relationship between the state and counties involves the county financial and contracting for CCS services. However, DHCS' continued expressed intent is to pursue clarifying legislation that makes clear the CCS county roles and responsibilities vis-à-vis the state's roles and

responsibilities. Additionally, in July and August DHCS advanced draft legislative language that contained consumer protections, health plan requirements, implementation timelines, and CCS requirements with regard to use of CCS approved providers.

- 14) Please provide a status update on currently authorized CCS pilot programs including how long they have been operational and the reasons for any delays in implementation. Are there outcome measures and objective data that can be shared that demonstrate the effectiveness of the pilot projects? What was the reason DHCS decided not to implement the other authorized pilot approaches?

**DHCS Response:**

There are two CCS demonstration pilots that are either operational or projected to be operational in the near future; these include the CCS demonstration through the Health Plan of San Mateo, an existing managed care health plan and Rady Children's Hospital, an Accountable Care Organization model. The Health Plan of San Mateo demonstration began operations in April 2013. The second CCS demonstration through Rady Children's Hospital is projected to begin operations in mid-summer 2016.

The Rady Children's Hospital model, while much smaller in terms of projected participants is significantly more complex than the Health Plan of San Mateo model because of the design of the model. That is, the Rady Children's Hospital model is specifically designed around five CCS chronic complex health conditions including Cystic Fibrosis, Hemophilia, Sickle Cell Disease, Leukemia, and Diabetes in children less than 10 years of age. A part of the requirements for this demonstration include reporting based on specific health condition clinical performance measures.

With respect to the Health Plan of San Mateo demonstration, a member/family satisfaction survey was performed in 2014, which reflected positive feedback from members relative to access to care, and a provider satisfaction survey that is planned to be administered in the near future. Recent data has also been provided by the Health Plan of San Mateo demonstration relative to follow up with member physician within 30 days of inpatient discharge. In a policy brief released by Stanford University on this measure indicated that carve in counties such as San Mateo have higher rates of physician visits after hospitalization than those in other counties. Early physician visits after hospitalization can reveal potential problems before they become detrimental and potentially avoid readmissions.

- 15) What were CCS expenditures in 2013-14, 2014-15, and projected for 2015-16? Please format using the following charts.

**DHCS Response:** The requested information is provided on the following pages.

**Fiscal Year 2013-14**

<b>Diagnosis/Treatment</b>	<b>FF</b>	<b>GF</b>	<b>County</b>	<b>Total</b>
CCS-Medi-Cal	\$1,202,837,918	\$1,202,837,918	-	\$2,405,675,836
CCS-state only	-	\$19,716,294	\$19,716,294	\$39,432,588
CCS-HFP/ OTLICP	\$113,167,744	\$30,737,470	\$30,737,470	\$174,642,684
<b>Medical Therapy</b>	<b>FF</b>	<b>GF</b>	<b>County</b>	<b>Total</b>
CCS-Medi-Cal	-	-	-	-
CCS-state only	-	\$59,248,321	\$56,953,800	\$116,202,121
CCS-HFP/ OTLICP	-	-	-	-
<b>County Admin</b>	<b>FF</b>	<b>GF</b>	<b>County</b>	<b>Total</b>
CCS-Medi-Cal	\$76,242,406	\$50,808,250	-	\$127,050,656
CCS-state only	\$5,262,000	\$2,773,175	\$8,035,175	\$16,070,350
CCS-HFP/ OTLICP	\$14,073,685	\$3,788,325	\$3,788,325	\$21,650,335

**Projected Fiscal Year 2014-15**

<b>Diagnosis/Treatment</b>	<b>FF</b>	<b>GF</b>	<b>County</b>	<b>Total</b>
CCS-Medi-Cal	\$1,312,931,719	\$1,312,931,719	-	\$2,625,863,438
CCS-state only	-	\$8,540,203	\$8,540,203	\$17,080,406
CCS-HFP/ OTLICP	\$114,994,468	\$30,959,819	\$30,959,819	\$176,914,106
<b>Medical Therapy</b>	<b>FF</b>	<b>GF</b>	<b>County</b>	<b>Total</b>
CCS-Medi-Cal	-	-	-	-
CCS-state only	\$	\$46,944,279	\$45,354,351	\$92,298,630
CCS-HFP/ OTLICP	-	-	-	-
<b>County Admin</b>	<b>FF</b>	<b>GF</b>	<b>County</b>	<b>Total</b>
CCS-Medi-Cal	\$63,330,384	\$40,352,680	-	\$103,683,064
CCS-state only	\$5,694,499	-	\$5,694,505	\$11,389,004
CCS-HFP/ OTLICP	\$10,276,056	\$2,766,647	\$2,766,611	\$15,809,314

Note: The information provided are approximations based on paid claims data which require eighteen months of lag time to ensure a full fiscal year of expenditures.

**Fiscal Year 2015-16**  
**(Actual expenditures through first quarter of fiscal year)**

<b>Diagnosis/Treatment</b>	<b>FF</b>	<b>GF</b>	<b>County</b>	<b>Total</b>
CCS-Medi-Cal**				
CCS-state only	-	\$17,887,000	16,826,000	34,713,000
CCS-HFP/OTLICP**				
<b>Medical Therapy</b>	<b>FF</b>	<b>GF</b>	<b>County</b>	<b>Total</b>
CCS-Medi-Cal	-	-	-	-
CCS-state only	-	57,195,000	58,621,000	115,816,000
CCS-HFP/ OTLICP	-	-	-	-
<b>County Admin</b>	<b>FF</b>	<b>GF</b>	<b>County</b>	<b>Total</b>
CCS-Medi-Cal	94,730,000	57,239,000	-	151,969,000
CCS-state only	5,992,000	5,746,000	11,737,000	23,475,000
CCS-HFP/ OTLICP	21,884,000	6,521,000	3,251,000	31,656,000

\*\*Note: The information provided reflect the approximate expenditures through October 2015, as the fiscal year has not yet ended.