



July 1, 2015

California Association
of Neonatologists

ChildNet Medical Associates
Specialty Medical Group
Children's Hospital
Central California

The Children's Center at
Sutter Medical Center, Sacramento

Children First Medical
Group Children's Hospital and
Research Center at Oakland

Rady Children's Specialists of
San Diego, A Medical Foundation
Rady Children's Hospital - San Diego

Department of Pediatrics
California Pacific Medical Center
San Francisco

Department of Pediatrics
Mattel Children's Hospital
David Geffen School
of Medicine at UCLA

Department of Pediatrics
Stanford University School
of Medicine

Department of Pediatrics
University of California Davis
Children's Hospital

Department of Pediatrics
University of California
San Francisco Medical Center

Department of Pediatrics
University of California Irvine
Medical Center

Loma Linda University Children's
Hospital Medical Group

Miller Children's Subspecialty Group

Pediatric Subspecialty Faculty
Children's Hospital Orange County

Children's Hospital Los Angeles
Medical Group

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

Re: Comments on DHCS' Whole-Child Model Proposal

Dear California Children's Services Program Redesign Team,

The Children's Specialty Care Coalition (CSCC) appreciates the opportunity to provide feedback on the Department of Health Care Services (DHCS) California Children's Services (CCS) Whole-Child Model proposal.

CSCC represents nearly 2,000 pediatric subspecialty physicians, and is dedicated to ensuring children with special health care needs have access to high quality medical care through strong leadership, education and advocacy. Pediatric subspecialists are at the cornerstone of providing care for children enrolled in the CCS Program.

We appreciate the Department's efforts to work with CCS stakeholders to enhance care for this population, and are supportive of the Department's six CCS Redesign Goals. CSCC shares in the belief of families and other advocates, that any reform to the program should be carefully measured, with the primary aim to do no harm to these kids and their respective families. This is particularly true, given that, families are relatively satisfied with their care in the current CCS program. The recent Title V Needs Assessment found that over 90 percent of survey respondents reported being able to see a pediatric subspecialist when needed, and CCS families and patients had an overall 86 percent satisfaction rate with the program.

First and foremost, it is the Coalition's position that any major change to CCS be thoroughly vetted by families and stakeholders, so that the proper safeguards are in place before these kids are transitioned into a new system of care. The perceived rush to pass the proposed framework during this legislative session could have unintended consequences to the health and well-being of these children. We encourage the Department to consider the many lessons learned and unintended impacts of the transition of SPD and GHDP populations into managed care. We strongly urge DHCS to take an additional year to work with the Coalition and other stakeholder groups to create the strongest possible foundation for any CCS reform. These children deserve the best possible care, and fulfilling the promise of a carefully vetted and collaborative process, is essential for achieving this aim.



The Coalition appreciates that the Whole Child Model has a phased-in approach and applauds the Department's recognition of the importance to maintain CCS standards in any reforms that take place. For youth aging out of CCS, the Coalition is pleased to see that Medi-Cal managed care plans will be required to include CCS providers in their network.

Section 1. Whole-Child Delivery Model

While the Children's Specialty Care Coalition acknowledges that the CCS program can be improved, we have several observations on the decision making process, in which the Whole Child Model was conceived. Since the beginning of the RSAB stakeholder process, organizations and families have expressed serious concerns about the ability of managed care plans to effectively care for this population and maintain the quality and access that is currently being provided. This proposal seems counter to the advisement of the Redesign Stakeholder Advisory Board (RSAB).

At the last RSAB meeting, Department leadership referenced the county realignment structure as one of the chief reasons that other models could not be considered. Currently, the Coalition and the larger stakeholder community do not have a thorough understanding of the Department's realignment structure and feel this is important to fully understand, given that this proposal was predicated on it. The Coalition recommends that the Department provide a brief presentation on the topic at the next RSAB meeting, as well as further explain the reason this impeded the Department's ability to move forward with other models of care.

There has been no evidence based data that the children will be better cared for under the COHS or other managed care plans. To date, the Department has failed to complete an independent evaluation of the pilots as required in AB 301, passed in 2011. Therefore, no evidence has been presented that the HPSM pilot is providing better care, or care on par, with the current CCS program. Additionally, the Coalition has serious concerns that the HPSM model cannot be replicated and may not be relevant, given its small CCS population and other unique county and health care characteristics.

Lastly, the Coalition strongly feels that the proposed model is not suited for two-plan model counties and recommends further stakeholder discussions to understand the complexity of these counties. The Department must be open to consideration of other models of care in these counties. Based on the Department's rationale provided for the Whole-Child Model, in regards to not wanting to create a third delivery system and undoing the county realignment structure, we are very concerned that come 2019, other counties will be folded into managed care.



Section 2. Key Features of the Whole-Child Model

The Coalition is concerned about the shift in locus of control away from the specialty care centers (SCCs), to the managed care plans that are assuming risk. We have significant concerns that timely access to providers will be jeopardized if case management, treatment plans and service authorizations reside with these plans that are at financial risk. Without specific payment models to support the resources required by CCS standards, there is a risk that SCCs will no longer be able to provide the depth and breadth of services for CCS patients. The model also does not assure that acuity based (risk based) care is provided to high risk children. The current CCS SCC standards are based on a fee-for-service that timely access to providers will be jeopardized if case management, treatment plans and service authorizations reside with these plans that are at financial risk. Without specific payment models to support the resources required by CCS standards, there is a risk that SCCs will no longer be able to provide the depth and breadth of services for CCS patients. The model also does not assure that acuity based (risk based) care is provided to high risk children. The current CCS SCC standards are based on a fee-for-service reimbursement system and are vague as to the periodicity of care. The Department needs to adapt these standards to include risk based periodicity of care, when shifting the responsibility to health plans. Plans do not have the medical expertise across the subspecialty spectrum to allocate appropriate resources across the continuum of care; certainly there will be no incentive to do so. The allocation of resources has to be determined by the SCCs, not the Plan.

Additionally, plans often contract with their own laboratory, and imaging providers who are not part of the CCS certified centers, and lack the expertise in complex pediatric conditions. This could compromise quality and result in treatment delays. CCS patients will have specific needs for high cost drugs, which are often not included in plan formularies. Without the ability to include co-pays, the formularies will likely be restrictive and have the potential to delay access to essential medications.

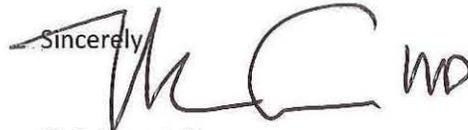
Section 3. Whole Child Model Consumer Protections, Plan Readiness, and Access Monitoring

The careful monitoring, oversight and enforcement of these plans will be critical. Yet, the recent state auditor report, released in June, shined a light on the Department's inability to do this effectively. The findings from this audit included that DHCS did not verify accuracy of provider networks or other data on timely access provided by the plans. Additionally, the audit revealed that the ombudsman office for Medi-Cal members to receive assistance and file complaints did not have the capacity to meet the demand, with over 12,000 calls per month going unanswered. This is unacceptable for any population, but especially for families with children with serious and complex medical conditions.

Additionally, there is no reference in the current proposal, to conducting an independent evaluation for the counties that will be phased-in come 2017. This must be done before consideration is given to further expanding this model in other counties.



Thank you for the opportunity to provide comment on the Department's Whole Child Model proposal. We look forward to engaging in further discussions with the Department and other stakeholders, to assure that CCS children continue have quality and timely access to the health care they need and deserve.

Sincerely,


Nick Anas, MD
President
Children's Specialty Care Coalition

Cc:
Secretary Diana S. Dooley
Director Jennifer Kent
Anastasia Dodson
The Honorable Rob Bonta
The Honorable Ed Hernandez
Speaker Toni Atkin
President pro Tempore Kevin de León