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Jennifer Kent
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Systems of Care Division
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VIA ELECTRONIC MAIL:
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Re: California Children's Services Redesign Whole-Child Model

Dear Director Kent:

The California Association of Health Plans ("CAHP") represents 46 public and private health care service plans that collectively provide coverage to over 28 million Californians. We write today to provide comments on the Department of Health Care Services' (the Department) California Children's Services (CCS) Whole-Child Model Proposal.

In general, CAHP's member plans are supportive of the whole-child approach outlined in the proposal. We appreciate the Department's thoughtful approach based on stakeholder feedback and evaluation of the lessons learned from the CCS pilot programs.

Plans appreciate the timeline outlined in the proposal, and the Department's phased-in approach to implementation. We also appreciate the ongoing opportunities for stakeholder feedback and discussions of program improvements as the CCS Redesign process moves forward. However, several of the issues outlined in our previous letter (April 22, 2015) still need to be addressed by the Department and will become even more important as Redesign efforts move forward.

Counties' Role in CCS

Plans are supportive of beginning program implementation with the County Organized Health System (COHS) plans. However, the second phase of implementation in the Two-Plan counties creates some different challenges than a CCS carve-in in the COHS counties. We look forward to working with the Department and other stakeholders to identify the unique challenges and alternative ways to approach CCS Redesign in the Two-Plan counties.

We understand that the Department would like to keep certain county functions in the CCS program, such as eligibility determinations; however there is concern around the length of time it currently takes to complete this process and we would like to work on ways to address this in both the current system and in any counties that carve-in CCS.

We support the plans' responsibility for utilization management, case management, and quality management functions, given that the plans will be at full risk. This will help to realize efficiencies of the managed care system and provide Whole-Child care..

At least one plan noted that Counties may and do elect to expand the benefit population; for example, to undocumented immigrant children. The plans request clarification on how the Department anticipates providing continuity of care for this population. Would some populations need to continue to be carved-out and served by the county, or will a waiver be necessary to carve them into the plan? Does the Department anticipate that any services for a CCS child will be carved-out (for example, transplants)?

The plans also request clarification on whether the medical therapy program (MTP) would be carved-out in the CCS carve-in counties. It is not clear which entity will be responsible for authorizations for MTP services and how the coordination between the plan and the authorizing body for MTP will occur.

Provider Paneling and Contracting

The plans request more information on which entity (the plan or the Department) would be responsible for credentialing CCS providers. The Department's proposal does not address the existing access issues that are a result of the challenges with the CCS paneling process. There are a number of hospitals that have the capacity and ability to serve the CCS population, but have not been CCS-certified due to the lengthy CCS paneling process which typically takes up to six months for providers and two years for facilities.

Plans request more information regarding network adequacy and how this will be monitored. Plans believe that is appropriate to have different standards for primary care physicians and specialists and would like to work with the Department on the establishment of those standards to reflect the availability of CCS providers.

Plans also have concerns about the requirement that all plans contract with CCS-paneled providers to serve enrollees that age out of the CCS program. The paneling issues described above continue to be a challenge in this environment. Additionally, CCS providers often do not want to contract with health plans or accept the health plans rates.

Furthermore, many CCS providers are focused on the pediatric population and it may be more appropriate to transition aged-out enrollees to different providers. The flexibility to do so should be built into any requirements related to CCS transitions.

Rates and Risk

Since under the Department's proposal health plans will be at full financial risk once the CCS services are carved-in, a discussion on rates and how health plans will be appropriately reimbursed for these services is a key component of any redesign efforts. We request the opportunity to meet with the Department to discuss the rate development process for the CCS population. It is critical that the rate development process for the CCS Whole Child pilot be thorough and transparent.

CCS rates paid to plans should acknowledge and reflect that CCS providers may not agree to capitated arrangements given the wide variance of CCS conditions. Plans request clarification on

whether rates will vary based on condition (for example, the cost of treating a bone fracture versus hemophilia). Plans also request that the Department considers risk corridors, given the wide variance of conditions and treatment needs. It will be critical that the rates that are determined are sufficient to cover the needs of this complex population and we look forward to working collaboratively with the Department on the rate development process.

We thank you for taking the time to review these comments. CAHP and its member plans are available at your convenience if you would like further discussion of any of the elements of this letter.

Sincerely,

Elizabeth Evenson
State Programs Analyst

cc (via email): Anastasia Dodson, DHCS
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