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July 2, 2015

Via Email

Jennifer Kent, Director  
California Department of Health Care Services  
1501 Capitol Ave., Suite 6001, MS: 0000  
Sacramento 95814, P.O. Box 997413

**RE: Department's "CCS Redesign Whole Child Model" Proposal**

Dear Ms. Kent:

On behalf of the California Children's Hospital Association, I am writing to respond to the Department's proposal for redesigning the California Children's Services Program as it is described in the June 11, 2015 document, "California Children's Services (CCS) Redesign Whole Child Model." In this document, the Department proposes to eliminate the current CCS carve-out over a period of four years. The Department also proposes to move programmatic authority for approving CCS treatment plans from the CCS Program to Medi-Cal managed care plans. In plain English this means that providing CCS services will become the responsibility of some of the Medi-Cal managed care plans that contract with the Department. These plans will authorize and oversee the CCS services that are provided to children with CCS-eligible conditions.

CCHA does not support the Department's proposal. It is not justified by available data, it is inconsistent with some of the Department's own principles for CCS reform, and it is not reflective of the discussions that occurred in the Department's Redesign Stakeholder Advisory Board (RSAB).

**Available Data Do Not Justify Department's Approach**

The Department lacks data to justify the desirability of eliminating the CCS carve-out. Indeed most available data would appear *not* to support the Department's proposal. For example:

- *Medi-Cal managed care quality scores are not impressive.* Aggregate quality scores for Medi-Cal managed care hover around 60 percent.<sup>1</sup> And scores for indicators related to care for chronically ill patients are even worse. For example, the Department's most recent dashboard indicates

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<sup>1</sup> <http://www.dhcs.ca.gov/services/Documents/MMCD/20150615MMCPDashboard.pdf>.

that plans on average provide annual eye exams for diabetics only half of the time.

- *Families in CCS express higher degrees of satisfaction with the CCS program than, on average, families in Medi-Cal managed care.* The 2014 Title V family survey indicate that families are overwhelmingly satisfied with the services they receive from the CCS program. Over 85 percent of families who responded rated their overall satisfaction with the Program as at least an 8 out of 10 – and over half of respondents gave the program a perfect score.<sup>2</sup> This reflects a higher degree of satisfaction than is typically reported by families enrolled in Medi-Cal managed care plans.<sup>3</sup>
- *Data from Cal Medi-Connect indicate that Medi-Cal managed care is an unpopular option for seniors with serious health conditions.* Cal Medi-Connect is the Department’s effort to enroll seniors into Medi-Cal managed care plans. These seniors are in some ways analogous to CCS-eligible children, in that many have serious health conditions and all receive services through two government programs (Medi-Cal and Medicare). Recent data indicate that the program is not popular with enrollees. Given the option, upwards of 50 percent of the individuals who are eligible to opt out of the program elect to disenroll from it. This high opt-out rate appears to be driven by a concern on the part of affected seniors that they will lose access to specialized services.<sup>4</sup>
- *The Department has a poor track record of health plan oversight.* Just last month the State Auditor found that the Department does not verify the accuracy of plan provider networks, does not validate plans’ self-reported data on access to care, and rejects thousands of telephone calls to its health plan ombudsman telephone line.<sup>5</sup> From this audit, the Department would appear to lack the capacity to provide even minimal oversight for the current population enrolled in Medi-Cal managed care. It is difficult to believe that the Department could adequately monitor a CCS transition under these circumstances.

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<sup>2</sup> <http://www.dhcs.ca.gov/services/ccs/Documents/TitleV/CCSFamilySurveyResults.pdf>.

<sup>3</sup> For example, the Department’s Medi-Cal managed care plan dashboard results related to satisfaction with whether a child received needed care; only 12 of 43 plans rated higher than 80 percent. Results here: [http://www.dhcs.ca.gov/services/Documents/MMCD/MMCD\\_Dashboard\\_Q2\\_2014.pdf](http://www.dhcs.ca.gov/services/Documents/MMCD/MMCD_Dashboard_Q2_2014.pdf).

<sup>4</sup> <http://www.californiahealthline.org/insight/2015/if-calif-ends-coordinated-care-initiative-what-happens-to-frail-senior-duals>

<sup>5</sup> <https://www.auditor.ca.gov/pdfs/reports/2014-134.pdf>

- *The Department has avoided evaluating the few models where CCS is carved in to managed care.* CCS services are now “carved in” to Medi-Cal managed care plans in six relatively small counties (Marin, Yolo, Napa, San Mateo, Santa Barbara and Solano). Although at one time state law required the Department to evaluate the carve-in, the Department sought and was granted an amendment to remove that requirement. As a result, it is impossible to assess whether the carve-in is an improvement over fee-for-service in any domain – family satisfaction, health outcomes, timely access to care, or denials of needed service.
- *The CCS program has become more efficient over time.* A recent report from the California Budget and Policy Center indicates that overall CCS costs have declined since 2007-08, despite a modestly growing caseload.<sup>6</sup> It would appear that the program, as it currently operates, is already efficient.

At the outset, the Department identified six goals for its CCS redesign process. One of these is to incorporate previous lessons learned from other care coordination efforts. On this basis alone, there would be little to recommend the Department’s proposed “Whole Child Model.”

#### **Proposal Undermines CCS Standards, Weakens Regionalized System of Pediatric Specialty Care, Could Increase Mortality Rates**

The Department is proposing to allow health plans to establish their own discrete networks of CCS providers, subject to Department approval. This approach is a misapplication of the tools used to assure provider access for a large population of predominantly healthy individuals. The very nature of many CCS conditions – which are rare and difficult to treat – necessitates a *statewide* network of diverse experts. Children with CCS conditions frequently must seek care outside of their home counties, because their treatment needs are unique. Trying to shoehorn the unique needs of CCS-eligible children into the Department’s predominantly county-based Medi-Cal managed care structure could:

- *Destroy the single statewide network of CCS providers.* Under the Department’s proposal, health plans will be capitated for CCS specialty services. Thus they will face strong financial incentives to discourage families from seeking treatment from pediatric specialty providers when

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<sup>6</sup> <http://calbudgetcenter.org/wp-content/uploads/Childrens-Health-Programs-in-CA-Report-05.11.2015.pdf>

possible. In addition, they will be able to cherry pick which CCS specialty providers they want to include in their networks and place potentially onerous barriers on families trying to access expertise elsewhere. This will place additional stress on families. It will also erode the stability of the statewide network and impede access to pediatric specialists not only for CCS-eligible children, but for privately insured children who rely on the same network of providers.

- *Add administrative complexity, burden, and uncompensated cost to providers.* Under the Department's proposal, by 2019 providers will be burdened with the cost and administrative workload of negotiating and maintaining over a dozen contracts with different health plans in different counties – for specialty services that the CCS Program has heretofore determined are necessary to serve the needs of the population. This seems duplicative and wasteful.

It's important to note in this respect that there is a substantial body of research to support the notion that mortality rates go down as volume goes up. In other words – as one might intuitively think – specialists who treat a lot of patients in many cases tend to have better outcomes than generalists who don't treat as many of these types of patients. Along those lines, this week the American Journal of Cardiology published a longitudinal study of regionalized pediatric specialty care and pediatric cardiac heart disease in California. The study concludes that over three decades, the use of the regionalized pediatric network of specialty providers increased while pediatric mortality from cardiac heart disease decreased.<sup>7</sup> We should try to never lose sight of the fact that pediatric specialty care has evolved into a regional network because it is better for children's health.

The CCS program was established in 1927. Over the decades, the program has existed as a social compact between the State and families of children with special health care needs. Under the terms of that compact, the State implied its commitment to ensuring access to appropriate specialty care for low-income children with rare and potentially fatal illnesses. The regionalized network of specialty providers assures that access. By contracting out this work to independent health plan vendors, the State is, in effect, abrogating the terms of this longstanding commitment.

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<sup>7</sup> [Variation in Use of Pediatric Cardiology Subspecialty Care: A Total Population Study in California, 1983 to 2011.](#)

### **Department Comments Leave Impression that Administrative Simplicity Trumps Other Considerations**

In explaining why the Department was unwilling to consider the other alternative approaches to CCS reform suggested by members of the RSAB, you recently said that other alternatives were “too complex” and that the small size of the CCS population could not justify the staffing resources for more regionalized approaches. While administrative complexity may be a consideration for the Department, it should not be the *only* consideration. After all, this is a program that is designed to provide services to children who are by definition “complex,” and whose families sacrifice a great deal – careers, financial stability, sleep – to meet their children’s needs with more grace and stamina than most of us will ever be asked to muster. A redesign of CCS should work to simplify the lives of these families, whether or not it simplifies work for the Department of Health Care Services.

### **Department Misstates Stakeholder Input into Its Proposal**

The Department on several occasions throughout its June 11<sup>th</sup> document implies that its stakeholder process informed and shaped the “Whole Child Model” proposal. This is misleading. In fact, the Department’s CCS Redesign Stakeholder Advisory Board was left with the distinct impression that the Department was seeking input to evaluate multiple alternative models and that the RSAB itself would have the opportunity to discuss and compare alternatives before the Department settled on an approach. For example, in December, the Department stated that the fundamental goals of the Redesign Process were to (1) improve care and outcomes for children with CCS-eligible conditions and (2) identify indicators of quality against which programmatic improvements can be made.<sup>8</sup> Until June 11<sup>th</sup>, RSAB members were left with the impression that we were working towards those goals. The RSAB as a group did not at any time suggest to the Department that folding CCS services into Medi-Cal managed care plans would constitute an acceptable redesign model.

### **Department’s *Volte-Face* Necessitates More Time for Review**

The RSAB was told by Department staff on December 2<sup>nd</sup>, 2014 that “DHCS is not predisposed to mandatorily enroll CCS eligible children into Managed Care Organizations for treatment of their CCS health condition.”<sup>9</sup> Given the Department’s change in approach, the lack of data to support this approach, and the absence of any urgency for making a change of this magnitude, we

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<sup>8</sup> <http://www.dhcs.ca.gov/services/ccs/Documents/DHSCCSRedesignVision.pdf>, page 2.

<sup>9</sup> <http://www.dhcs.ca.gov/services/ccs/Documents/DHSCCSRedesignVision.pdf>, page 2.

recommend that the Department continue the existing CCS carve-out without prejudice while the RSAB and other interested parties have the opportunity to address the concerns we and others have raised.

Sincerely,



Ann-Louise Kuhns  
President and CEO

cc: Senator Ed Hernandez  
Senator Kevin De Leon  
Senator Richard Pan  
Senator Holly Mitchell  
Speaker Toni Atkins  
Assemblyman Rob Bonta  
Assemblyman Tony Thurmond