
HMA

HEALTH MANAGEMENT ASSOCIATES

*Transitioning the California Children's Services
Program to a New System of Care:
Stakeholder Issues and Considerations*

PRESENTED TO

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INTRODUCTION

Established in 1927, the California Children’s Services (CCS) program provides diagnosis and treatment, medical case management, and physical and occupational therapy services for children under the age of 21 with CCS-eligible medical conditions (known as the CCS “qualifying conditions”). In addition to having a CCS qualifying condition, children must be financially eligible for the program.¹ Typically, CCS serves children with complex and chronic health conditions in families with low incomes.

A 2009 report from the Stanford Center for Policy, Outcomes and Prevention found that there were approximately 160,000 children receiving services from CCS². The majority of CCS enrollees also are eligible for Medi-Cal and are enrolled in a Medi-Cal managed care plan. The CCS program also operates a “CCS-only” program for children who do not qualify for Medi-Cal and provides medical therapy services in schools.

The CCS program is administered as a partnership between the California Department of Health Care Services (DHCS) and county health departments.³ The state sets the overall administrative policy and direction for CCS and conducts activities such as provider enrollment and provider payment. County CCS staff determines eligibility, authorize services and provide case management.

While most CCS-eligible children are enrolled in a Medi-Cal health plan, CCS services are not included in most of the Medi-Cal managed care plan contracts under current law.⁴ Under this arrangement, which is known as the “CCS carve-out,” the health plans identify and refer CCS-eligible children to the local CCS program. The Medi-Cal program spent approximately \$1.2 billion in state fiscal year 2012-13 on services covered under the CCS carve-out.⁵

The statutory provision that mandates the carve-out expires in December 2015. While the CCS carve-out mandate historically has been extended in statute, no decision has yet been made by the Legislature or the Governor regarding another extension. If the statutory requirement for the carve-out ends, DHCS

¹ To be financially eligible for CCS, a child must be: enrolled in Medi-Cal; uninsured with family income below \$40,000 per year; or have out-of-pocket medical expenses expected to exceed 20 percent of family income.

² California Children’s Services Program Analysis, Final Report, Stanford Center for Policy, Outcomes and Prevention, http://www.dhcs.ca.gov/services/ccs/Documents/CCSFinalReport06_30_11.pdf

³ The smaller counties share administrative responsibilities with three state regional offices.

⁴ California Welfare and Institutions Code, Section 14094.3.

⁵ California Department of Health Care Services, Medi-Cal Estimate, Policy Change 138, http://www.dhcs.ca.gov/dataandstats/reports/mceestimates/Documents/2013_Nov_Estimate/Nov13MCEst-07_Reg_PC.pdf

will have the authority to decide whether and how to cover CCS conditions under managed care.

Scope of Project

The Lucile Packard Foundation for Children’s Health, in order to ensure the best interests of the children and families involved, asked Health Management Associates (HMA) to interview key CCS stakeholders to identify the major issues and actions that would need to be addressed in the event the Legislature and the Governor ultimately decide to end or modify the current carve-out.

HMA interviewed more than 50 stakeholders with a variety of perspectives on the program, including families, consumer advocates, DHCS staff, the Medi-Cal managed care plans, providers, county executives, and CCS medical directors.⁶ The stakeholders raised a wide range of issues for consideration. There was some agreement about the issues that would need to be addressed, but many divergent views on how they should be addressed. Some stakeholders expressed concern that discussing whether and how to end the carve-out was premature given that neither pilots for testing new models nor a comprehensive evaluation of the implications of ending the carve-out have been undertaken.

This report presents the stakeholders’ views on the decision process for making potential changes to CCS, a design framework for alternative options, and key issues and considerations for redesigning care for CCS-eligible children with chronic conditions and special health care needs. Development of recommendations to address the issues and concerns were beyond the scope of the project.

DECISION-MAKING PROCESS FOR CCS REDESIGN

Most stakeholders expressed that the current CCS structure needs improvement, but they strongly opposed ending the CCS carve-out in the short term. They emphasized that the state should undertake an extensive effort to evaluate whether the CCS carve-out should be changed, to identify potential alternative systems of care, and to pilot these alternatives before statewide implementation.

Decisions Should be Data-Driven

The majority of stakeholders expressed significant concern that DHCS would move to end the CCS carve-out without a careful, deliberate, and analytical process to determine the best way to assure and improve care for CCS-eligible

⁶ As we are not attributing comments to specific individuals or organizations, the reference to stakeholders also includes DHCS.

children. They felt strongly that any change in the CCS program should be data-driven and evidence-based. They raised concerns that DHCS will end the carve-out based upon opinions and assumptions, without facts or data about how best to redesign the CCS system of care, or about the ability of Medi-Cal managed care organizations to care for children with special health care needs.

Importance of Pilots

California's current Medi-Cal Section 1115 waiver includes authority for the creation of four pilots to test different models of care⁷ for CCS with the goal of understanding how CCS could best be reformed. Consequent to approval of that waiver, in October 2011, DHCS sought to test several models of care by selecting five pilot sites to test the four different models, but only one pilot, with the Health Plan of San Mateo, has moved forward. Most stakeholders believe that the first step in deciding whether to end the carve-out, and if so, how is for the state to conduct the pilots and they were disappointed that all four models and all five pilots selected by DHCS were not implemented. Without the pilots, many stakeholders believe that data on the impact of various models is lacking. Further, it is not clear that the results from the San Mateo pilot, which utilizes county CCS staff for care management and service authorization, is transferable to changes in the program statewide which are likely to rely on a more traditional Medi-Cal managed care model if the carve-out were ended.

There are a number of reasons that the four pilots did not proceed, including state decisions as well as issues raised by the entities that were awarded pilots that could not be resolved with the state. Further, it is not clear whether the pilots would have provided adequate guidance to make decisions on how to restructure CCS as they may have been too small and not replicable statewide.

Analysis of Existing CSS Claims and Health Plan Data

DHCS has a wealth of fee-for-service CCS claims data that could be analyzed to understand CCS program costs, utilization and other factors. Stakeholders noted that CCS data should be analyzed to determine whether all CCS-qualifying conditions and/or services should be managed by the health plans or whether a subset should remain outside of the health plans' scope of service (discussed further below). It is unclear how easily this data can be accessed to complete a detailed analysis. However, an analysis of this CCS information, as well as health plan data on the services they are now covering for CCS-eligible children, are critical before any major changes are made to the CCS program.

⁷ The four pilot models include: Medi-Cal managed care; enhanced primary care case management; specialty health care plan; and provider-based accountable care organization.

Decisions Should be Based on Improving Care, Not Lowering Costs

Many stakeholders stressed that the key objective when considering any changes to CCS should be maintaining standards and improving care, rather than reducing costs.

Maintaining High Standards

Most stakeholders indicated CCS has served eligible children well and created standards of care that benefit all chronically ill children in California, not only those enrolled in CCS. Many view it as a national model that results in better outcomes. They are concerned that CCS standards would erode if the carve-out ends, and that shifting CCS services into the health plans without knowing the impact – despite state oversight – would weaken the system of care currently available to children across the state. Standards of care are discussed further later in this report.

Avoiding Cost as Decision Driver

Stakeholders also noted that program costs should not be the primary focus of any discussion about a new CCS system of care. Many stakeholders do not trust the state and are concerned that the state may end the CCS carve-out for the purpose, formally stated or otherwise, of reducing CCS program expenditures. They were concerned that the state would dismantle CCS for relatively small cost savings, while having lasting negative impacts both on children served by CCS and other chronically ill children who benefit from the current delivery system.

They pointed out that some CCS-eligible children have conditions that are costly to treat regardless of how services are delivered. Stakeholders cautioned that, while it may be possible to design a system of care that would result in better outcomes for CCS enrollees, it may not necessarily result in lower costs.

Decision Process Must Involve Stakeholders

The interviewees strongly expressed that stakeholders should be involved in discussions regarding any changes to the CCS program's current structure including an extensive process to obtain stakeholder input. In particular, consumers should be involved in all aspects of planning, implementing, and operating any change. The stakeholders almost universally commented that state policymakers (i.e., DHCS, the Governor's office, and the Legislature) need to better understand the CCS program, its benefits, and its complexities as they consider developing and implementing a new system of care for the program. Further, policymakers need to understand the risks inherent in any change to the program for both CCS enrollees as well as all children in California who benefit from the CCS standards of care. Stakeholders indicated that they must be given the opportunity to participate in and inform this discussion.

FRAMEWORK FOR REDESIGN OF CCS SYSTEM OF CARE

In our discussions with various stakeholders and DHCS, we found little consensus about how the system of care for CCS-eligible children should be redesigned or the main issues that need to be addressed. Significantly, issues that were viewed as non-controversial by one group were viewed as highly controversial by other stakeholders.

While there are multiple options for CCS redesign, this paper discusses four potential major design frameworks:

1. The current structure (whereby services are divided between counties and health plans) is maintained, with the addition of enhanced care coordination among the counties, health plans, and other service providers/programs.
2. Responsibility for providing all CCS services are shifted to the Medi-Cal health plans, while counties retain some administrative, service authorization, and/or care coordination roles.
3. Responsibility for a subset of CCS services or covered conditions is shifted to the Medi-Cal health plans.
4. CCS responsibilities are gradually transitioned to the Medi-Cal health plans (this may be coupled with any of the above options as well).

Each of the framework options is discussed in more detail below.

Option 1: Maintain current county-health plan structure with addition of enhanced care coordination between the counties and the health plans.

Under this option, the basic CCS program structure would remain intact, and the state would work to improve state and county CCS operations including care coordination between the counties and the Medi-Cal health plans. Since some CCS-eligible children also receive services and care coordination from the Regional Centers, schools, and the county mental health program, the state could work toward including the newly released national consensus standards for children with special health care needs, and improving care coordination among all entities to better meet the comprehensive needs of the children.

Option 2: Shift responsibility for CCS services to Medi-Cal health plans, while counties retain some administrative/service authorization/care coordination role.

Moving CCS services to the Medi-Cal health plans does not necessarily mean that all of the county CCS responsibilities would shift to the plans. Instead, the

counties could retain some CCS roles such as service authorization and care coordination. Further, the state and counties could continue to establish CCS quality standards and perform oversight over quality. Stakeholders pointed out that there is precedence for this “shared” model in California. For example, unlike most of the Medi-Cal health plans, some County Organized Health Systems (COHS) and counties are exempt from the carve-out. The COHS plans hold the financial responsibility for CCS services, adjudicate claims and pay providers, but the counties retain responsibility for service authorization and care management. Similarly, under the state’s Coordinated Care Initiative, the In-Home Supportive Services (IHSS) are included in the health plans’ scope of services, but the counties conduct care management and the service authorization process. However, some stakeholders expressed strong concerns about requiring the health plans to take financial responsibility for CCS services without the ability for the plan to manage the authorization process.

Option 3: Shift responsibility for a subset of CCS services or conditions to Medi-Cal health plans.

It was clear from our interviews that any discussion of changing the carve-out should include an extensive, condition-by-condition and benefit by benefit review and analysis. Some CCS-eligible children have time-limited or single system conditions while others have long-term or multi-system conditions. Long-term CCS conditions, as well as services provided to babies in the Neonatal Intensive Care Unit (NICU), often require extensive and expensive care. While some stakeholders could envision shifting responsibility for some low-cost, episodic CCS conditions to health plans, the concept of shifting high-cost services or conditions to managed care, especially with the plans being responsible for what services get provided by which provider, would be extremely controversial and would involve major changes without knowing their impact.

Many stakeholders indicated that some of the highest-cost CCS-covered conditions did not lend themselves to being shifted to health plan responsibility, for both quality-related and financial reasons. Medi-Cal health plans do not have the experience and therefore may not be prepared to meet the unique needs of children with certain complex chronic conditions. Further, some stakeholders believed that even if some conditions were shifted to health plan responsibility, specific high cost services to treat these conditions should remain carved out. Otherwise these health plans could be exposed to severe financial risk, threatening their viability. For example, if hemophilia became a condition covered under the Medi-Cal managed care contracts, some stakeholders believed that expensive pharmacy services such as clotting factor replacement therapy should remain carved-out of the health plans’ responsibilities.

There was no stakeholder consensus on whether NICU services, which represent a large cost-driver for CCS, should remain carved-out from the health plans.

Several stakeholders urged that NICU services should be assessed independently from other CCS services.

Most stakeholders viewed the CCS palliative care waiver as being highly successful and as such should remain carved out of managed care; people were very concerned that this waiver could not function well under health plan responsibility. There was considerable concern about how CCS home-and community-based services would be covered if the carve-out ends. Stakeholders consider these services to be vital for enabling children to be discharged from the hospital and return home. Stakeholders identified the need to conduct an analysis specific to the treatment of home-and community-based services if the absence of the carve-out.⁸

Finally, many stakeholders expressed concern about the impact of any change in the carve-out on the Medical Therapy Program (MTP). The county CCS programs are currently responsible for the provision of MTP services to all children needing those services in the schools, whether or not they qualify financially for CCS. Many stakeholders believe MTP services are an integral part of the CCS program. Stakeholders noted that any discussion of ending the carve-out would need to address how MTP will operate going forward and how MTP services, if they remain with the counties, will interact and coordinate with CCS responsibilities transferred to the health plans.

Option 4: Gradually transition CCS responsibilities to managed care plans.

If a full evaluation determined that the some or all of CCS carve-out should end, most stakeholders favored a long, carefully planned and monitored transition. Each step should proceed only if the previous step had been completed successfully. As most CCS-eligible children are undergoing extensive and sometimes lifesaving treatment, stakeholders underscored that the state “do no harm” and not disrupt treatment or treatment plans. Many stakeholders viewed moving responsibility for a child’s care in mid-treatment as highly risky and cited the need for multiple protections and assurances of continuity of care.

Stakeholders cited lessons from the state’s experience with transitioning the Healthy Families Program and the Medi-Cal Seniors and Persons with Disabilities (SPD) population into managed care, though they did not agree about the success of these transitions. Several stakeholders cited problems for some people and were concerned that the transition process would have to significantly improve for any change to the CCS carve-out.

Some stakeholders expressed concern that any CCS transition would be far more complex than the Healthy Families transition, pointing out that Healthy Families enrollees tend to be healthy and therefore a very different population from CCS

⁸ This review and analysis could also include certain home and community based services covered under EPSDT.

children. They noted that the children who experience the most problems with the Healthy Families transition were those with chronic conditions. Stakeholders commented that since some CCS-eligible children will be in the middle of lifesaving procedures at any given time, any failures or mistakes during a CCS transition could have a significant negative impact on these children.

The Healthy Families and SPD transitions were viewed by many stakeholders as having been very disruptive, and the state needs to better plan for a CCS transition up-front and minimize the number of changes that occur as the transition progresses. Most stakeholders felt the Healthy Families and SPD transitions were rushed, which caused confusion among those enrollees, their families, and caregivers. They stressed that the families should have been better informed about any transition and its potential impact. Educational materials and methods used to communicate with enrollees and families about a transition to managed care could be greatly improved (both in terms of content as well as overall clarity, language, and reading level). There was a strong belief that the state needs to do a better job of educating both current and future providers and families about any transition before it begins. This was particularly an issue noted by stakeholders regarding the SPD transition. There was a general consensus that any CCS transition requires a strong and effective process of involving and educating stakeholders.

THE MEDI-CAL CCS CARVE-OUT: KEY ISSUES AND CONSIDERATIONS

In summary, the decision-making process and framework options described above highlighted the following key issues that should be considered regarding the future of care coordination in California:

- Use of existing CCS and health plan data for assessing options.
- Primary focus on improving care.
- Consumer and stakeholder participation in decision-making.
- Level of experience in serving complex pediatric cases.
- Potential financial impact of shifting responsibility for CSS conditions.

In addition, stakeholders identified the following concerns and considerations that would need to be addressed if the CSS carve-out is eliminated or modified; these are discussed further below.

- Financing considerations for county CCS programs and Medi-Cal Health Plans.
- Standards of care, provider network requirements, and appropriate rates.
- Assurance of DHCS and health plan readiness.

- Enrollee protections and continuity of care.
- Care coordination role for counties and health plans.
- Impact on uninsured “CCS-only” children.
- Data analysis, reporting requirements and evaluation metrics.

Finally, some issues not raised in our stakeholder discussions, but nonetheless important for consideration include:

- Primary care/medical home and subspecialty access.
- Transparency of data.
- Equity across counties.
- Quality improvement and assurance, and the state’s role in this process, and assistance to providers to meet program expectations.

Financing Considerations for County CCS Programs and Medi-Cal Health Plans

Some stakeholders stressed that county financing issues and county capabilities must be addressed if the carve-out is to be ended. Given recent experiences with realignment⁹, there was no interest among the stakeholders to revise the existing realignment structure or create another specific realignment related to CCS.

The CCS program is financed by a combination of state, county and federal funding. While the state pays the entire non-federal share of CCS Medi-Cal, the counties pay half of the non-federal share of the CCS-Targeted Low Income Children’s Program (the former Healthy Families Program) and half of the cost of the CCS only program. Under state law counties have a capped financial responsibility for CCS. Today the county share of CCS for services is determined based on payments made for adjudicated claims.

If the carve-out were to end and CCS payments were shifted to managed care capitation payments, it is unclear whether the county share will continue and, if so, how it would work. We were unable to get a clear understanding of how the county share for the CCS-Targeted Low Income Children’s Program is now being addressed for the County Organized Health Systems that cover CCS services. The financial impact of ending the carve-out on the county share of CCS is unknown.

⁹ In 2011 the state realigned Public Safety and in 2013 the state did a realignment to address funding for the 2014 Medi-Cal expansion. Realignment is a process where the state restructures how work and fiscal responsibilities are divided between the state and counties. In the case of the 2014 health realignment, the state took over responsibility under Medi-Cal for covering low income people who were formerly covered under county indigent care programs and the counties provided funding to the state by shifting county indigent health care dollars to fund activities previously funded by the state.

Further, as mentioned earlier, stakeholders are concerned about the ability of both the state and the counties to maintain the resources and infrastructure to provide the remaining CCS services, such as CCS only children and MTP, if the carve-out is ended and much of the CCS program budget and staffing is eliminated. Given the size of CCS-Medi-Cal, it provides the ability to fund county CCS infrastructure. In addition to concerns about county financial issues, many stakeholders raised concerns regarding managed care capitated rates to the Medi-Cal health plans. They expressed concern that Medi-Cal health plan rates would be set, as they have for other populations moving into managed care, to save money for the state. This could put pressure on the health plans to reduce services, provider networks, and provider payment rates, which could, in turn, reduce quality of and access to care. Stakeholders stressed that the health plan rates must be adequate and reflect the financial risk associated with covering high-cost CCS conditions. Some stakeholders believed that the health plans would need the flexibility to manage the care and the cost of care, including the ability to establish drug formularies, require generic drugs when appropriate, and negotiate reasonable rates with providers.

Finally, as noted above, stakeholders commented that some CCS-eligible children require high-cost care that is often not predictable within a rate-setting methodology, creating significant financial risk for the health plans. If the carve-out proceeds, it will be important to carefully review the options for limiting health plan financial risk, such as using risk corridors or continuing the carve-out for certain conditions or treatments.

Standards of Care, Provider Network Requirements, and Appropriate Rates

Decisions around changing the CCS carve-out must address what standard setting responsibilities remain at the state and counties, how health plans can effectively operate in this environment, and what responsibilities and resources the CCS program will have in provider and plan oversight.

The vast majority of stakeholders considered the CCS provider network and the CCS standards of care to be major strengths of the program that should not be sacrificed if the carve-out ends. Most stakeholders indicated the state would need to continue to establish provider standards and enforce them and retain its unified approach to this process, rather than delegate this role to numerous, independent health plans. Some stakeholders also believed there is a role for the counties to play in standard-setting and enforcement as many of the issues are local in nature. They expressed concern that if the CCS role was reduced, the state would not adequately fund and staff any remaining CCS staff to work on standard setting and provider and plan oversight. One stakeholder suggested

that the recently released national standards for systems of care for CSHCN should be adopted by the state as it consider any redesign of CCS¹⁰.

Several stakeholders stressed the importance of establishing provider network requirements that ensure an adequate number, distribution, and quality of appropriate clinicians. Several stakeholders were critical of managed care because they believe few plans contract with pediatricians for primary care, but rather rely on family practice physicians to provide pediatric care. They were concerned that if the CCS carve-out ended, children would be shifted to lower-cost providers or that they would not be able to receive treatment at the CCS specialty care centers. Some stakeholders believe it would be important to mandate health plans to maintain contracts with all CCS specialty centers and/or continue to pay the current enhanced CCS physician rates.

Conversely, there was some concern that such requirements would put severe financial strain on the plans unless those providers were required to accept Medi-Cal/CCS fee-for-service rates for these services. They felt that it was not necessary to contract with all specialty centers, just a sufficient number to provide needed access. Some stakeholders also believed that if the plans had financial responsibility for paying for CCS services, the plans should also be able establish its provider network and conduct all provider credentialing. That is, if health plans take on financial responsibility, they need the authority to operate in a way that allows them to manage the population and control their risk.

Assurance of DHCS and Health Plan Readiness

Most stakeholders indicated that in addition to the need for strong standards for health plans assuming responsibility for CCS services, there is a need for thorough assessments of whether the plans meet those standards before any shift is implemented.

Several stakeholders stressed that any change to the carve-out should include an independent readiness assessment of DHCS' and the health plans' ability to implement the change. This would determine whether DHCS have resolved all critical issues including having established and ensured compliance with standards and had in advance effectively communicated with affected families and providers. The managed care plans would need to demonstrate the ability to manage the care of CCS-eligible children; assessments must ensure that the health plans meet provider network, care coordination, and quality standards; that consumer protections are in place; and that providers and families have been adequately educated about the changes using informational materials in appropriate reading ability and languages. Stakeholders stressed that such steps are necessary to avoid confusion that they believe occurred during the Healthy Families and SPD transitions to managed care.

¹⁰ http://www.lpfch.org/sites/default/files/field/publications/developing_structure_and_process_-_white_paper_and_standards.pdf

Enrollee Protections and Continuity of Care

Stakeholders urged that any transition of CCS services to managed care must not disrupt the care that a child is currently receiving, and that they should be able to complete their treatment with their current providers. A number of stakeholders commented that the child's current providers would need to receive an "adequate" rate from the health plan during the "continuity of care" period.

Several stakeholders noted that the process for obtaining either a medical exemption or an emergency disenrollment from one's health plan must improve, to ensure that families are aware of these options and that these requests are processed quickly. They suggested that these processes replicate the carve-out design whereby the child can receive CCS services through CCS providers but retain their plan primary care provider. Stakeholders again pointed out that these children may be under-going life-saving procedures and administrative delays must not prevent them from accessing the care they need in a timely manner.

Care Coordination Role for Counties and Health Plans

Stakeholders disagreed about who should conduct care coordination if the carve-out ends. They had a mixed assessment about how well the CCS program currently performs care coordination, with some very satisfied while others asserted that CCS is more of a service authorizing program than a care coordination program.

Several stakeholders expressed concern that managed care plans currently do not conduct care coordination at all, or they use staff with insufficient medical skill sets to manage the complex needs of CCS-eligible children.

Stakeholders pointed out that currently there is no model of care in California either in place or being piloted where Medi-Cal health plans and plan staff are responsible for care coordination. All care coordination is being conducted by county staff. None of the county organized health systems that do not have the carve-out and are responsible for CCS services currently provide case management for CCS-eligibles; instead, all case management is provided by county CCS staff. Even under the San Mateo CCS pilot, case management services are provided by county staff co-located at the health plan. Some stakeholders pointed out that if the carve-out ended, care coordination and service authorization could continue to be conducted by county staff, while other stakeholders expressed strong concerns about this model. Many stakeholders stressed the need to test or pilot any shift in care management responsibility, and to obtain data before making statewide changes. They also call for strong care coordination standards and requirements under managed care.

Impact on Uninsured “CCS-Only” Children

Stakeholders were concerned about how “CCS-only” children – those without Medi-Cal coverage – would obtain needed care if the carve-out is eliminated. The majority of CCS-only children are uninsured and have no source of coverage for their non-CCS related medical needs, including primary care, and the counties may not be able to provide sufficient infrastructure and resources to support their care. The state would need to consider the feasibility and costs/benefits of alternative approaches such as:

- The children enroll in the managed care plans and are provided the full Medi-Cal benefit package including CCS services;
- The counties continue to manage the CCS-only population;
- The state creates a regional CCS program for these children; or
- The state assumes responsibility for the CCS-only program.

Data Analysis, Reporting Requirements and Evaluation Metrics

As most stakeholders believe that the current CCS system has demonstrated high quality with excellent outcomes, they believe that any movement of services to managed care must have similar standards, the means to quickly measure whether those standards are being met and make changes if they are not. The current managed care standards in California and nationally do not focus on severely ill children and are not good measures for providing services for CCS conditions. New standards with the means to measure them would have to be established. The health plans and state would have to provide staff to obtain data and assess whether these standards are being met and these assessments would have to be timely so as to allow a quick identification and resolution of issue or problems.

CONCLUSION

The statutory provision that mandates the CCS carve-out from Medi-Cal managed care expires in December 2015. Legislative action on whether to extend this carve-out date will likely be considered in the 2015 Legislative session. At this time there are no statutory requirements or standards on how CCS-eligible children would be served if the carve-out were ended.

Stakeholders agree that there must be a comprehensive process involving stakeholders to evaluate the current CCS system, and to develop and assess the risks and opportunities, costs and benefits of alternative models. They are apprehensive about the potential of ending the carve-out, particularly regarding the ability of health plans, without experience serving CCS-eligible children with

complex and chronic health care needs, to provide high quality care without disruption.

The Administration and the Legislature will have to address whether multiple CCS pilots of the nature provided in the 1115 waiver are needed to decide whether to end the CCS carve-out and what a new structure would look like.

A data-driven assessment is needed that reviews the CCS program by CCS condition and CCS benefits/treatment. The analysis may show that some CCS conditions or benefits are best provided by the health plans and some (such as certain high cost treatments or conditions) are best continued through a mechanism akin to the current CCS program. How NICU services are provided needs to be specially addressed.

Further, if the carve-out is ended, there needs to be analysis and decisions made on the optimal service delivery model for providing CCS services under managed care. Issues include which entity establishes and monitors provider standards and provider network requirements, who conducts care coordination and service authorization, and how services would be provided for “CCS-only” uninsured children.

Decisions will need to be made on how to address the role of the state and counties and various state-county CCS financing issues if the carve-out is ended or modified. Most stakeholders believe that the state and counties must have a strong oversight role over CCS if the carve-out is ended or modified, and that they should be provided the resources to perform this role. DHCS must be able to conduct effective oversight of managed care and be able to quickly resolve issues and problems that arise during a transition and on an ongoing basis.

There is a strong opinion among most stakeholders that the purpose of ending or modifying the carve-out cannot be to save the state money. Further, there was significant concern about the adequacy of the rates paid to plans to ensure quality and access, whether the rates cover the risk, and whether these should be risk mitigation methods used.

Lastly, there are many implementation steps that must be taken if the carve-out is ended. Stakeholders strongly believe that DHCS must establish a detailed plan before it starts any transition process and greatly improve communications with providers and families who would be affected by any change. All stakeholders agree that there must be strong and effective stakeholder engagement throughout this process.