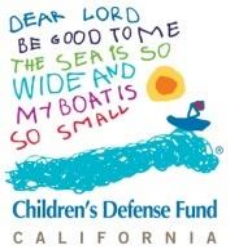
FAMILY VOICES of California

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July 13, 2016

California Children's Services Redesign Team
California State Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95852

RE: Comments on Whole Child Model Documents

Dear CCS Redesign Team:

Below are our comments on the six CCS redesign-related documents released by DHCS for comment. Please note that many aspects of these documents are premature and are pending the outcome of SB 586. It should be made clear that finalization of these documents and implementation of DHCS's approach to the Whole Child Model (WCM) is still in discussion with the CCS Advisory Group, the legislature, and with other stakeholders.

We would also note one overarching observation on the documents-- most of these documents do not provide the specifics we need in order to determine how the Department intends to plan for, measure and monitor standards for access to appropriate care, quality

of care, plan and county readiness, monitoring during the transition and post-implementation, and enforcement of standards, including clear consequences when standards are not met. We urge the Department to provide those specifics so that we can work with DHCS in ensuring that any transition to the WCM goes smoothly in ways that offer the most protections to CCS children and their families.

We also would like to reiterate our grave concerns about the Department's limit of continuity of care to 12 months. As families and advocates have stated over and over again, most of these children do not have conditions that neatly resolve within 12 months, and continued access to their usual CCS providers, who have expertise in their conditions and know them, their families, and their medical history, is crucial to their health and well-being.

**1. Implementation Timeline**

We are concerned that the timeline doesn't reflect the significant work still required to prepare for implementation of many aspects of the WCM, particularly in the areas of plan readiness, implementation monitoring, and network review. We believe that the timeline should allow more time for this work and recommend that the Department be open to greater flexibility in approaching implementation.

We would like to know what the Department thinks the role of the CCS Advisory Group will be during the coming year. As we discussed at the June 29 meeting, we think it is important for the Advisory Group, with its broad representation and expertise, to assist the Department in fleshing out the criteria for plan and county readiness and monitoring, for assessment of network adequacy, and for enforcement of standards, among other important tasks.

**2. Health Plan Readiness**

<u>Data Sharing</u>
We would like to remind the Department of our conversation at the June 29 Advisory Group meeting regarding the need for readiness criteria specific to CCS children and youth. For example, on what basis will the provider network be evaluated? What is an "adequate number of providers based on anticipated utilization"? We would like to see data on the current patterns of referral and treatment for CCS enrollees and map that to the plans' current provider networks.

We recommend that the health plans be given beneficiary-specific data earlier than 90 days before implementation. In our view six months would be optimal, in the event that data reveals that plans will have to negotiate contracts or develop other relationships with additional CCS-approved providers in order to ensure continuity of care for the CCS children already enrolled in the plans.

<u>Plan Readiness</u>
Again, we would like to see clearly defined CCS-specific readiness criteria. The draft document does not provide any detail on what readiness criteria would be applied and how they would be applied with these vulnerable children. We recommend that the Department

work with the CCS Advisory Group to develop criteria appropriate to the needs of these children and we request that the Department alert us as soon as possible to the timeline for developing the criteria.

The document calls for the plan readiness review to be completed within 30 days of implementation. Why so short a time? What happens if the plan fails review, in one or more counties? Will readiness be assessed county-by-county for multiple county plans or for each plan as a whole? We believe this matters in multi-county plans where readiness, network and other circumstances could differ by county. Therefore we recommend that the readiness review be completed at least 90 days before implementation and that readiness be assessed for each individual affected county as well as for each plan as a whole.

Network Certification

As with other aspects of readiness, we urge the Department to work with the Advisory Group to develop CCS-specific criteria for assessing network adequacy for CCS children and youth. Traditional Medi-Cal managed care standards do not address the particular needs of these children and their conditions. In addition, since demonstrating network adequacy is more than producing a list of paneled providers, we urge that adequacy criteria include such items as assessing CCS provider capacity to accept new patients and demonstrating the breadth of CCS providers in the network, including individual specialists, special care centers, and pediatric tertiary care hospitals. We also recommend, as stressed earlier, that the Department invest in the data comparisons necessary to assess network adequacy for CCS children.

Transitional Monitoring

As with the other categories, we urge the Department to work with the Advisory Group to develop monitoring guidelines specific to CCS children. We recommend that the monitoring plan include family surveys and/or interviews and analysis of any changes in pre- and post-transition referral and treatment patterns. We also recommend that the monitoring should continue on a monthly basis for 12 months before moving to a quarterly basis. Enforcement of the monitoring standards also should be addressed in the final plan. How does the Department intend to address serious problems that are identified during or after the transition?

**3. County Readiness Activities**

County Activities

It is concerning that this document doesn't include any specifics regarding the role of counties. We would like to see specifics regarding how the Department conceptualizes the role of the counties in which the WCM is to be implemented and what items will be on the checklist. We recommend that the Department work with the Advisory Group and the local CCS programs in the 21 affected counties to flesh out the role of the counties as well as the checklist and deliverables. We also recommend that the Department commit to requiring completion of the readiness review at least 90 days of implementation; completion within 30 days of implementation is far too short a time in the event that there are problems with readiness.

Memorandum of Understanding
We recommend that the MOU section detail the components of the relationship between the county and the plan, including such items as clarifying the options of the plan contracting back with county CCS staff for utilization management or hiring those expert staff to perform those functions; case-finding of CCS-eligible children; processes for notifying plans of children with CCS-eligible conditions; processes for coordination and communication between county and plan for children who may disenroll from plans or move on/off Medi-Cal; coordination between the plan and the county CCS Medical Therapy Program, with clear delineation of responsibilities of each; as well as other important components.

Transitional Monitoring
As with other sections of these documents, we recommend that the Department work in concert with the Advisory Group and local CCS programs to develop specific criteria for monitoring county readiness. We also strongly recommend that there be monthly monitoring for a minimum of 12 months post-transition before moving to quarterly monitoring.

**4. Phase-In Methodology**

Implementation Phase Dates
We are concerned that the timeline for the phase-in is unrealistic for all 21 counties and four managed care plans. We were surprised at the June 29 CCS Advisory Group meeting to learn that the proposal to implement "no sooner than" a specific date means "will be implemented on this date". We believe that implementing these radical changes for 28,000 CCS children in 21 different counties in four separate plans requires time and flexibility and recognition of the individual circumstances and progress toward readiness in each county. For example, there could be different arrangements with county CCS programs, in terms of contracting back with the program for utilization management or hiring CCS public health nurses, in each of the 21 counties.

Therefore, we strongly recommend that each phase's date be contingent on individual plans and individual counties meeting all readiness and monitoring criteria. We think this individual county flexibility should be observed even in the case of the eight Partnership Health Plan counties that came into the plan as part of the same contract. Implementation of the Whole Child Model should be dependent on satisfaction of all readiness criteria, not on artificial timelines.

CCS Provider/Plan Network Overlap Data
We believe we need more data on the overlap of plan and CCS networks in order to determine whether plans and counties are ready to proceed with implementation. We learned at the June Advisory Group meeting that the percentage of overlap on the phase-in chart refers to the percentage of CCS providers located in that county that are in the plan network, not to the overlap of CCS providers serving children in those counties and plan networks. This kind of mapping doesn't provide us much useful information on the degree to which plan networks include necessary CCS-paneled providers, programs and hospitals. In rural counties, e.g., there is usually a very small group of CCS-paneled providers, all of whom may be in the plan network, but these providers typically are not

pediatric specialists. They may not even be pediatricians, but family physicians. We strongly urge the Department to first map CCS children's referral and treatment patterns in the 21 counties and then compare those providers to plan networks, with special attention to pediatric tertiary care hospitals, special care centers, and pediatric subspecialists. Once this work is done, plans must have an adequate amount of time to address contracting with CCS providers who are not in their networks. This recommendation also supports the employment of flexible implementation start times dependent on achievement of readiness criteria, including presence of provider networks appropriate to the needs of CCS children in those regions.

Delegation of Risk

We understand that some plans engage in significant delegation of responsibility and risk for their members to large physician groups and potentially other entities. This situation will need to be addressed in those counties included in the WCM in which this delegation occurs (Orange County, e.g.). We would like to see specifics from the Department regarding how it will assess readiness and maintain appropriate monitoring regarding access, quality, and other factors when responsibility and risk are being delegated below the plan level.

**5. Frequently Asked Questions**

The introduction should explain that this is DHCS's approach to CCS redesign and that elements of the Whole-Child plan are pending, based on the outcome of legislation and the collaborative process with stakeholders. We recommend that DHCS put this introductory section into an FAQ format, as the overall explanation of managed care does not completely address some of the questions stakeholders and families have about this new plan.

Question 1: Include an explanation of "bifurcated" or change to read, "primary care and specialty care in separate systems." Also, an additional question to include in this section, "Within the managed care plan, who will be responsible for case management? Will those persons be responsible for any clinical decision-making or authorization of care? Who within the health plan will be available to help families navigate the system of care?"

Question 3: Please include a detailed explanation of how CCS children moving to a Whole-Child county from a carved-out county will be handled. How will CCS eligibility be determined and maintained? How will continuity of care determinations be made?

Question 4: Please explain further what is meant by "phased-in over time." What can families and providers in Whole-Child counties expect to be different immediately following the start of implementation?

Question 5: Please explain further how the experience of families and providers will change. Will families continue to work with CCS case management and other staff? Will families have a new case manager through the plan? How will CCS and the plan work together to serve children and families?

Question 6: Please clarify time and distance standards to receive care in the health plan. Please clarify in the FAQ that CCS children and youth who need access to out-of-state providers because of their rare conditions will continue to have that access.

Question 7: Please clarify in this question how families and providers will handle disputes regarding authorization of care. For example, will DHCS provide oversight or support for families experiencing denials? We recommend that the question include information regarding the process for families to request and obtain assistance during the transition.

We also request that this question include a clear statement regarding the continued access of CCS children and their families to Maintenance and Transportation (M&T) services. This benefit exceeds the typical transportation to medical appointments available through Medi-Cal managed care plans and is essential for CCS children and their families, particularly (but not exclusively) those in rural counties. Because of the nature of their conditions and the regionalized pediatric care system that serves them, many CCS children, even those in urban areas, have to travel distances to reach their appropriate CCS-approved provider, special care center, or pediatric tertiary care hospital. Transportation support can range from bus or taxi vouchers to mileage and tolls reimbursement to air travel for the family across the country. We are aware of at least one rural county proposed for inclusion in this WCM that arranges for county employees to drive CCS families who don't have cars out of county to appointments. The maintenance benefit (covering such things as motel stays and food) also is vital for these families. Families who have to travel eight hours for an appointment for their child should be assumed to need an overnight stay before heading back home. Similarly, CCS often covers families' overnight stays so that they can remain bedside with a hospitalized child or stay at the hospital long enough to be taught how to care safely for a medically complex child. The continuation of M&T benefits is of vital concern to CCS families and should be clearly stated in the FAQ.

Question 8: This question is confusing and needs extensive clarification regarding what responsibilities the CCS program will continue to perform for children and families. The question clearly cites the case manager as a part of the local CCS program, but the answer refers only to eligibility services. As you know from the Title V needs assessment family survey, families typically have a strong and positive relationship with their children's CCS case managers and they will want to know what relationship they will have with the case managers under the WCM.

We also strongly recommend that the Department clarify the relationship between the health plan and the Medical Therapy Program (MTP). We assume there will be no change in current MTP practice and that children will continue to see their CCS- employed MTP therapist. If this is the case, it should be stated in the FAQ, preferably as its own separate question. The question also should address coordination between the MTP and the plan, since most children in the MTP also are receiving services through the CCS treatment side of the program.

Question 10: What additional continuity of care arrangements will be allowed? As noted earlier in our comments, these children's CCS-eligible conditions typically do not resolve in

12 months, and we continue to request that DHCS require continuity of care to be at least 12 months or duration of the condition, *whichever is greater.*

Additional Questions

We recommend the addition of several questions, listed below, to the FAQ. Some of this information is covered in the managed care section, but, as that section is not written in a manner that will be very accessible to families, we suggest that it be added to the first section of the FAQ as well.

- Who can families contact within the health plan, the community or DHCS in cases of denials or difficulty navigating the health plan?
- How will DHCS monitor the quality of care children receive in the Whole-Child Model plan? What evaluation of the transition will be done? Will families be surveyed regarding their experience with the transition?
- Have other health programs transitioned into health plans? What lessons has the Department learned from these earlier transitions? How will those lessons impact this transition?

**6. County CCS-Guidance for CCS Whole Child Model Implementation**

We believe that date-certain transition preparation is premature at this point, given the ongoing nature of legislation and discussion among stakeholders, county CCS programs, family advocates, and DHCS, and we underscore our recommendations above for flexibility in approaching implementation timelines. As previously stated, we urge DHCS to clearly address outstanding issues so that counties and health plans can fully prepare and families and children are protected from costly administrative delays in treatment and services.

We recommend that this document, along with others distributed by the Department for comment, provide enough detail to equip counties to begin planning for the transition and to identify outstanding concerns that need additional state guidance. This memo should begin to provide counties with background information on:

- DHCS expectations regarding roles and responsibilities that will remain with county CCS and those that may transition to plans;
- DHCS expectations for the administration of the Medical Therapy Program and coordination of its services with plan services;
- guidelines for maintaining current CCS staff and expertise and the current CCS standards of care;
- county roles in identifying patterns of care to ensure continuity of care for CCS children;
- DHCS plans for developing systems and resources to support families during the transition;
- DHCS plans for incorporating current CCS Maintenance and Transportation, durable medical equipment, pharmacy, and other expanded CCS benefits into managed care plans;
- DHCS plans for robust plan readiness guidelines; and

- DHCS plans for monitoring implementation of the Whole Child Model, including collecting baseline data and other activities related to evaluating the impact of the transition.

We urge DHCS to incorporate these comments into future versions of these documents. We look forward to future opportunities to work together to develop safeguards and structures that ensure the healthiest future for children enrolled in CCS and their families.

Sincerely,

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