Response to DHCS CCS Redesign – Talking Points

- There is no urgency for this change to CCS none of the department’s data indicates that there is an urgent access issue to fix or any danger to CCS children that needs to be ameliorated. In fact,
  - There is no data to support that carve-in counties operate successfully and are an improvement over fee-for-service.
  - Surveys conducted by DHCS demonstrate that CCS families are overwhelmingly satisfied with the services they receive, with satisfaction higher than what is typically found for managed care plans.
  - CCS physicians, administrators, and medical consultants report anecdotally that working with managed care plans creates considerable barriers to care. Medi-Cal managed care plans have been widely criticized for system failures that CCS-eligible children cannot endure, including doctor shortages, long waits for services, and mismanaged cases.
  - The CCS program has become more efficient over time, despite a growing caseload.

- The redesign process run by the Department has not been transparent. The problems with the process have been exacerbated by this last-minute legislative proposal advanced by the Department, which limits opportunities for thoughtful dialogue and stakeholder input.

- The Department continues to drive an artificially rushed deadline, causing unnecessary stress and worry for families. Any change to the CCS program raises the prospect that families will need to overcome additional administrative hurdles in order to maintain access to clinically necessary specialty care. Data clearly indicates that access to such care improves health outcomes for children with special health care needs. Without a compelling justification for making changes to the program, it is unfair to impose such a burden on families – a burden that will impose hardships on CCS families and may negatively affect health outcomes on children.

- In currently carved-in counties, the CCS program continues to operate independently, protecting children’s access to appropriate services through its specialized case management and expertise in the care and needs of children and families in CCS. The DHCS legislative proposal is radically different because it would take the core responsibilities of the CCS program (service authorizations, case management, etc.) from the counties and give them entirely to health plans.

- The Department’s proposal misunderstands the needs of the children in the CCS program. The Department’s proposed list of readiness criteria and network adequacy requirements for plans do not adequately reflect the complexity of the conditions treated through the CCS program. For example, the 12 month continuity of care provision is clearly insufficient for a population with life-long health conditions. Similarly, The Department’s proposal directs health plans to develop “adequate” provider networks when a state-wide network already exists in the current program.

- The Department’s proposal misapprehends the fundamental purpose of CCS, will damage the state-wide network of specialty providers, and is duplicative.
  - CCS was formed precisely because the children covered by the program are costly outliers with rare conditions whose treatment can be very costly and whose providers are limited. It is in place to ensure children receive treatment that is appropriate for their health care needs, without any financial conflicts of interest.
During the July 17th RSAB meeting, the Department made continual references to allowing “market forces” to guide where children go. Their legislative language reflects this very troubling philosophy by:

- Eliminating the separate actuarially sound rate for CCS children and placing plans at full financial risk for their care, thereby providing incentive for plans to avoid using CCS providers whenever possible.
- Allowing plans to cherry pick CCS providers, and providing no oversight mechanism to ensure that plans are using CCS providers.
- Putting the onus on providers to accept health plan terms, no matter how onerous. This would undermine the regional network of care, as plans would face a financial incentive to discourage CCS providers from contracting, and then requesting exemptions from DHCS to allow them to use non-CCS providers to serve CCS children. Ultimately, it is children who will suffer for these perverse incentives, as access to CCS providers becomes more difficult.

- The CCS program needs improvement and opportunities to work through problems and find solutions that do not include a transition to Medi-Cal managed care. We are looking at the right problems but have come up with the wrong solution.