



Children's Regional Integrated Service System



Putting California's Children First



Hemophilia Council of California



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PRINCIPLES FOR THE FUTURE OF THE CALIFORNIA CHILDREN'S SERVICES PROGRAM

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These principles lay out critical components that we believe should be included in any proposals to redesign the California Children's Services (CCS) system of care.

- 1. Legislative process should be followed.** The CCS program serves California's most medically vulnerable children; as such, it is essential that any redesign proposals are thoroughly vetted by the appropriate legislative policy committees. Attempting to redesign the CCS Program in budget trailer bill language, or by simply allowing the existing carve-out to expire, does not allow adequate time for scrutiny of all of the implications of the proposal.
- 2. Any carve-in of CCS to managed care should proceed in a limited number of statutorily designated counties, and only if such counties have met robust readiness requirements.** Among the readiness requirements, the Department should require a joint proposal from the county and the health plan, which includes endorsements for a carve-in from a significant number of local and regional CCS providers, local family resource center(s), local bargaining units, and other local stakeholders.

3. **An independent evaluation of the Whole Child Model carve-in must be completed.** An independent, impartial evaluation of the Whole Child Model carve-in which considers strengths, weaknesses, lessons learned, and issues for consideration in non-COHS counties should be completed before expansion in any other counties may be authorized. The evaluation should be done after sufficient time has elapsed to be able to determine how a carve-in is working. Such an evaluation should measure: (1) whether the carve-in maintained, decreased, or improved access to CCS specialty care; (2) whether the carve-in maintained, decreased or improved access to primary care; (3) whether the carve-in improved patient and family satisfaction with the CCS program; (4) whether the carve-in increased or decreased costs; and, (5) what impact, if any, the carve-in had on youth who transition to the plan's adult system of care. A set of baseline metrics should be agreed to, and baseline data should be collected prior to implementation of the carve-in, so that the impact of the carve-in can be accurately assessed. The legislature should extend the CCS carve-out in all other counties until such an evaluation has been completed.
4. **CCS standards should be maintained in all counties, whether CCS is carved in or out of managed care.** CCS program standards and provider participation standards should remain the responsibility of the State CCS Program and be enforced and applied equally, regardless of whether CCS is carved in to managed care or remains carved out of managed care. Existing CCS credentialing and utilization standards should not be weakened in any way. Treatment decisions should be based on CCS guidelines, and if such guidelines do not exist, should be based on the clinical practice guidelines or protocols of the relevant pediatric specialty society.
5. **In counties where CCS is carved in to managed care, plans should be required to use staff who have appropriate medical credentials, training, and experience with CCS to do utilization review and care management.** The CCS Program has created an infrastructure that includes a tremendous amount of expertise in the best care of children with complex health care conditions, including the use of public health nurses, clinical social workers, and other trained staff who focus exclusively on working with CCS conditions. Knowledgeable staff has the judgement to know what a child needs and who can best provide that care. Plans should be required to use staff with the same level of expertise, wherever CCS is carved in, and honor the continuity of case management for children with complex conditions.
6. **Any managed care plans that are responsible for CCS should be required to meet access/quality benchmarks.** Plans should be held accountable for meeting CCS-appropriate access and quality standards to ensure, for example, appropriate referrals, team-based care coordination, appropriate provider referrals, and family access and supports consistent with current CCS program requirements and practice. For example, plans should be required to ensure that a child with a condition requiring a special care center referral is seen by a special care center at least annually.
7. **Timely and meaningful access and quality data should be publicly available.** Plans that are responsible for managing CCS should report quarterly on access, grievance and other quality measures that are specific to the CCS population. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) supplemental module regarding children with special health care needs should be used. These measures should be posted publicly. These measures should be developed in concert with advocates and should be tested for validity and accuracy. Without such data, it is impossible for stakeholders to understand if any plan is succeeding in delivering care to CCS children.

8. **The Department of Health Care Services (DHCS) should provide strong oversight of all plans where CCS is carved in.** DHCS oversight should ensure adequate oversight of plan performance. For example, DHCS audits should sample an adequate number of CCS cases. In addition, External Quality Review Organizations should be required to oversample CCS cases. All plans should also be required to implement a population-based quality initiative for the CCS population with public reporting requirements.
9. **Plans must be paid a distinct, separate CCS rate.** Separate, distinct CCS capitated rates for CCS children in any managed care plan should be established, not a blended capitation rate for all children that is the average of CCS and non-CCS children. Plans should have an incentive to have CCS children identified expeditiously. Moreover, funding should remain separately identified and tracked for the duration of any redesign carve-in.
10. **Payment rates must be adequate to recruit and retain qualified providers with appropriate expertise.** In 2000, the State increased CCS reimbursement rates to physicians in order to address an acute shortage of pediatric specialists in the CCS Program. The enhanced rate has been essential to efforts by medical groups and hospitals to recruit and retain pediatric specialty care providers and ensure quality and timely access to care for CCS patients and families. In order to ensure that access is not impeded in counties where CCS is carve-in, managed care plans must be required to pay physicians a rate that is equal to or greater than the current CCS enhanced rate.
11. **Robust youth/family representation should be required.** The State should engage family members, caregivers, and children and youth with special health care needs to partner in meaningful decision-making at all levels. A State-level family advisory board on the CCS Whole Child Model should be established, with families and youth representing a range of conditions, disabilities, and demographics. Each managed care plan should also have a family advisory group for CCS families, whether participating in Whole Child Model or not, to deal with issues of primary and preventive care coordination and transition-age youth. Family representatives and youth must receive training, travel reimbursements, and child care and other financial assistance to enable their participation in advisory groups. Plans should be required to establish relationships with Family Resource Centers/Family Empowerment Centers/Parent Training and Information Centers so they can provide ongoing information, education, and support that families and youth need to participate as true partners.
12. **Continuity of care should be for the length of the child's CCS condition or 12 months, whichever is greater.** Many CCS conditions are life-long. Children may be dependent on drugs or medical devices to function and thrive. These children should not be required to switch treatments arbitrarily at the end of twelve months. This standard is consistent within the current CCS program when children move from one county to another.