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October 13, 2014

Mari Cantwell, Chief Deputy Director  
Department of Health Care Services  
1501 L Street, Suite 6086  
P.O. Box 997413 MS 4000  
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

On behalf of the California Children's Hospital Association, I am writing to offer (1) our feedback on the state's 1115 Waiver and CCS Redesign Proposal and (2) our assistance as the state moves forward with these efforts. As leaders in pediatric health care we welcome the opportunity to provide you with the perspective we have gained through our extensive experience in providing high quality health care to the state's most medically fragile children.

CCHA's eight hospitals provide a significant amount of care to California's most medically fragile children. Over half of the children treated at children's hospitals are Medi-Cal eligible. Of the 1.75 million outpatient visits provided by children's hospitals each year, over 1 million are for children who are Medi-Cal eligible. In addition to providing a substantial amount of care to the pediatric Medi-Cal population, we are the state's most significant providers of specialized pediatric care for medically fragile children across the socio-economic spectrum. Children's hospitals provide the most intensive levels of pediatric care in the State. Over 60 percent of the Pediatric Intensive Care Unit (PICU) beds in California are located in a children's hospital. The children we treat are also significantly more medically complex than those treated at other facilities. The case mix (which measures resource intensity) of children treated in California's children's hospitals is nearly double that of other hospitals that treat children.

We value our long-standing partnership with the Department and look forward to working with you and your staff to ensure that children with special health care needs obtain access to medically appropriate, cost-effective, high-quality care. With that in mind, we offer the following suggestions and comments regarding the Department's 1115 concept paper and the CCS Redesign Proposal:

**Recommend Removal of CCS Redesign from 1115 Waiver.** CCHA recommends that the Department consider removing the CCS Redesign Proposal from the 1115 waiver. Neither the timing nor the potential fiscal impacts align well with the goal of improving care coordination for children with CCS-eligible conditions. The CCS Redesign Process will not be completed until the end of 2015, after the waiver will need to be submitted and approved by CMS. It is unclear whether or not an 1115 waiver will even be needed to implement the redesigns being considered. Moreover, because CCS services have been carved out of Medi-Cal managed care since 1991, including CCS in the 1115 waiver does not create additional budget neutrality "room." Thus, there is no financial benefit to the state from including CCS in the waiver. We recommend that the Department proceed carefully in evaluating options for the

future of the CCS Program. This effort will be complicated enough without attempting to align these efforts with the incredibly abbreviated timeline necessitated by the waiver – which is itself a complicated programmatic endeavor that must be completed by a date certain in order to ensure funding for California’s public hospitals.

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- *CCS Redesign Stakeholder Advisory Board.* As you may be aware, our eight children’s hospitals provide the bulk – well over half – of the inpatient care to CCS-eligible children. Any efforts to redesign the CCS program will have significant impacts on our facilities as well as the children we treat – both CCS and non-CCS eligible children. For this reason, we request that CCHA and our member hospitals have representation on the Department’s proposed CCS Redesign Stakeholder Advisory Board.
- *Workforce Development Stakeholder Group.* We are very concerned about the ability of the state’s healthcare workforce to meet the growing demand for high quality pediatric care. Our eight hospitals are the largest providers of

pediatric graduate medical education in the state. Historically CCHA-member hospitals have trained more than half the total pediatric residents trained in California each year. Unfortunately, federal support for pediatric graduate medical education has stagnated over the past several years. Despite the best efforts of our members, it has remained incredibly challenging to attract and retain pediatric subspecialists, particularly in medically underserved and rural areas. Given our substantial commitment to training the pediatricians and pediatric subspecialists of tomorrow, we would request that CCHA participate in the Workforce Development Stakeholder Group that the Department is establishing as part of the 1115 waiver process.

Thank you very much for the opportunity to comment on both the 1115 waiver and the CCS Redesign processes. We look forward to a constructive dialogue that will address the needs of medically fragile children.

Sincerely,

A handwritten signature in black ink, appearing to read 'Ann-Louise Kuhns', written over a horizontal line.

Ann-Louise Kuhns  
President and CEO

Encl.

cc: Diana Dooley, Secretary, CHHS  
Diana Hendel, Chair, CCHA  
Toby Douglas, Director, DHCS  
Pilar Williams, Deputy Director, DHCS  
Louis Rico, Division Chief, DHCS  
Wendy Soe, Policy Analyst, DHCS



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## Creating Accountable Care Organizations for CCS: A Framework for the Future

### Summary

The California Children's Services (CCS) Program is currently carved-out of Medi-Cal managed care. Under current law, that carve-out will sunset on December 31, 2015. The California Children's Hospital Association (CCHA) recommends the adoption of legislation that would allow CCS providers to form regional networks that would, over time, become accountable care organizations and assume responsibility for managing all medically necessary care for children with CCS-eligible conditions.

### Background

The California Children's Services (CCS) Program was originally created in 1927 to provide services for children who had contracted polio. Over the years, the program has grown to provide diagnosis, treatment, and medical case management services to approximately 165,000 children under the age of 21 with special health care needs who are enrolled in Medi-Cal, who are low income, or who have catastrophic medical care costs. The program serves the state's most medically fragile pediatric population, including children with serious, chronic and disabling conditions like cancer, diabetes, congenital heart defects, and cerebral palsy.

The program plays an essential role in the delivery of health care to the state's sickest children. CCS children present with a wide variety of complex conditions, some of which are rare, and many of which are unique to pediatric medicine. In order to protect the needs of this vulnerable population and ensure that the medical care delivered is effective for the children being served, the CCS program has developed rigorous program standards that providers must meet in order to treat CCS-eligible children. These standards ensure CCS-eligible children obtain care from experienced providers with appropriate pediatric-specific expertise. These standards benefit not only those children who receive services through CCS. These same providers form the regional backbone for *all* pediatric specialty care in California – for children who are privately insured as well as those receiving government-subsidized care. Thus, the high quality of care that is fostered and maintained by the CCS program benefits all California children with special health care needs.

Historically, the CCS program has operated as a public health program for the benefit of medically fragile children. Services have been paid for by a combination of state, federal and county funds, and provided on a fee-for-service basis rather than through capitated financial arrangements. In 2015, however, the law that requires that CCS services be provided on a fee-for-service basis, outside of managed care, will sunset.

As a result, policy-makers need to determine whether this carve-out should be extended or not, and if not, how these services should be managed and reimbursed.

### CCS and Medi-Cal Managed Care: A Risky Proposition

The CCS Program predates the advent of Medi-Cal managed care. When the State of California began a widespread effort to contract with managed care plans to serve the Medi-Cal population in the 1990's, CCS was mostly carved out of this effort.<sup>i</sup> This is why CCS services provided to eligible children have continued to be authorized by the CCS Program and paid for on a fee-for-service basis. If a child receiving CCS services is also eligible for Medi-Cal, her routine medical care, for things like vaccinations and annual check-ups, is the responsibility of the Medi-Cal managed care plan while her specialty care services are paid for and coordinated by the CCS Program. This approach has enabled families with very sick children to continue to access the high quality expertise of trained pediatric subspecialists.

Over the past two decades, the CCS “carve-out” from Medi-Cal managed care has been extended a number of times, even as other low-income populations have been mandatorily enrolled in these managed care plans. The reluctance to force medically fragile children into capitated arrangements overseen by traditional managed care plans reflects several concerns:

1. Most traditional managed care plans serve predominantly healthy pediatric and adult populations. Publicly available performance measures for these plans focus on well-child care metrics, such as immunization rates and check-ups. While there is ample evidence to suggest that managed care plans can provide high quality, cost effective care to predominantly healthy pediatric populations, a recent literature review concluded that there was little or no data to support the theory that enrolling children with special health care needs in Medicaid managed care plans improved quality or reduced costs.<sup>ii</sup> This suggests that traditional Medicaid managed care models may not be ideal for pediatric populations with special needs, particularly those currently enrolled in CCS.
2. The small size of the CCS population relative to the total population enrolled in Medi-Cal managed care plans may make it difficult to maintain a focus on the needs of these children. In December 2013, there were 5.8 million individuals enrolled in Medi-Cal managed care plans, and these plans are currently working to incorporate a number of new service mandates and populations – such as dual eligibles. There are a total of 165,000 children in CCS statewide. Given the number of competing demands on Medicaid managed care plans, questions have been raised about the extent to which plans would have the bandwidth to ensure that a small population of medically complex children with heterogeneous medical needs would receive the attention they deserve.

3. Contracting with existing managed care plans for CCS services would jeopardize the regionalized system of care that has evolved in California, putting at risk the quality and access to pediatric specialty care for *all* children with special health care needs. A managed care plan that is financially at-risk for the health care needs of these children has the financial incentive to seek and maintain contracts with its own preferred providers, who may lack pediatric expertise, rather than the regional providers that have historically treated this population. The high quality regional network of care that has historically served the CCS population cannot be sustained if managed care plans steer pediatric patients with special needs elsewhere.
4. Any efficiencies gained by implementation of managed care will not be reinvested to improve care for children with special health care needs. Proponents of managed care have argued that managed care may reduce the cost of care for this population. There is no data to indicate that capitating services for this population will produce savings; yet even if this were the case, there is no guarantee that such savings would be reinvested in services to improve care for these medically fragile children. Rather, these savings would accrue to the managed care plan and would be reinvested elsewhere or retained as profits.

Recognizing that any transition to managed care for the CCS population would be fraught with risk, policy makers have in the past made several attempts to implement pilot approaches to determine whether there are better models of care for children receiving services through the CCS Program. Only one proposed pilot, to implement consolidation of services within a Medi-Cal managed care County Organized Health System in San Mateo, has been implemented. This pilot has not yet been evaluated. Moreover, County Organized Health Systems are a unique breed of managed care plan – operating more like a single-payer system of care for the Medi-Cal population than a traditional managed care plan. Thus, it is not clear that the results of this pilot would be relevant to other areas of the state. As a result, there is little data upon which to assess the impacts of possible alternatives.

#### CCS and Fee-for-Service: A Potential Anachronism

While managed care presents significant risks, retaining the fee-for-service carve-out for CCS also has downsides. First, families have raised concerns about a lack of coordination between the CCS program and the Medi-Cal managed care plans that provide routine services. Second, state officials have expressed a desire to move all reimbursement for health care services from fee-for-service arrangements to capitated approaches. Third, the program risks becoming an anachronism that may be starved for resources and expertise in a state where the vast majority of health care programs are provided through managed care contracts.

### CCS Accountable Care Organizations: A Third Way

In the past, it has seemed as if there were only two alternatives for CCS: either maintain it as a fee-for-service program or incorporate it into the traditional models of Medi-Cal managed care that serve the remainder of the state's low-income population. However, implementation of health care reform has begun to transform relationships among providers and become the catalyst for new ideas that point to an alternative approach. In fact, children's hospitals in California and across the nation have begun experimenting with ways to coordinate care that may establish the foundation for a different model. This approach would incorporate managed care principles by improving care coordination for children with special health care needs and aligning fiscal incentives among providers. It would also ensure that any savings that result from efficiencies are reinvested in the system of care for these children. Specifically, CCHA recommends that the state allow CCS providers to form Accountable Care Organizations (ACOs) that would contract directly with DHCS for the provision of medically necessary services to treat the whole child, not just the CCS-eligible condition.

This approach is based in part upon work that is being done in San Diego by Rady Children's Hospital and by a model being developed by the national Children's Hospital Association (CHA). Rady has developed an ACO that takes full risk for whole-child care, including inpatient, outpatient, and ancillary medical care services, based on CCS medical condition. The program is designed to provide a medical home for children with special health care needs that targets interventions and support services to allow children to remain out of the hospital as much as possible. Rady currently accepts risk from private payers and is in negotiations with the state Department of Health Care Services to begin a pilot for select populations of CCS-eligible children. CHA is developing a national model, called the Medicaid Children's Care Coordination (MCCC) Program, which would allow the Secretary of Health and Human Services to designate children's hospitals as the medical homes for certain Medicaid-eligible children with medical complexity. Under this proposal, which is included in recently introduced federal legislation, H.R. 4930, state Medicaid agencies could elect to contract with these designated hospitals for whole child care for these medically fragile children. CHA was recently awarded a CMMI grant to lay the groundwork for this proposal and develop care coordination models in collaboration with ten hospitals nationwide, including Lucile Packard Children's Hospital at Stanford and Mattel Children's Hospital at UCLA.

CCHA recommends that state law be amended to allow for the adoption of these types of approaches for CCS throughout California. Under the CCS ACO model, whole-child care would be coordinated through regional Accountable Care Organizations (ACOs) that are comprised of approved CCS providers and anchored by children's hospitals.<sup>iii</sup> These ACOs would contract with the Department and, over time, coordinate all necessary medical and support services for CCS-eligible children statewide. Capitation would be implemented gradually and enrollment would be phased in on a CCS-condition

specific basis. In this way, participating providers would be able to build the capacity to assume financial risk for these populations in a discrete and sustainable way and identify care coordination approaches and best practices that are most likely to meet the specific needs of the children being served. This in turn will improve care delivery, efficiency and outcomes – the “triple aim” of health reform.

#### Prerequisites for Success

In order for this approach to be successful and sustainable, the following conditions must be present:

- CCS Providers Should Form the Backbone of ACOs. In order to support the pediatric expertise in the program, and the existing CCS regional delivery system, only CCS-approved providers should be eligible to form CCS ACOs. Each ACO should be anchored by a children’s hospital and include affiliated CCS providers, in order to ensure an appropriate breadth and depth of expertise is available for the population being served. However networks will need to include additional hospitals and providers to assure appropriate geographic reach, clinical expertise and network adequacy. The state should permit multiple CCS ACOs to operate in a region, provided that each ACO can meet the needs of the population being targeted.
- Implementation Phase-In for Capitation. In many areas of the state, CCS providers will need time to establish or amend contractual relationships in order to lay the groundwork for regional ACOs. These contractual arrangements may at first only enable providers to take modified forms of capitated payments, such as bundled payments, for discrete episodes of care. Over time, however, these arrangements would grow to full-risk global capitated payments, as providers develop more experience.
- Gradual Enrollment into ACO. Similarly, because the CCS population is comprised of a heterogeneous and high cost population, it will be necessary to phase-in the enrollment of children into CCS ACOs gradually. This will allow providers time to identify specific strategies to better align care and improve efficiency. CCHA recommends that the Department work with providers and families to identify a targeted number of CCS-eligible conditions in order to start incrementally and build upon successful implementation of the model over time. The conditions selected for ACO participation may vary regionally, if the Department and stakeholders deem this appropriate. Children with targeted conditions should be passively enrolled into the ACO with which their treating provider is affiliated, once the ACO is approved to coordinate care and assume risk for that condition.
- Carve-Out Extension for Remaining Population. CCHA recommends that the CCS-eligible children with conditions that are not selected for ACO



implementation remain in fee-for-service, including infants and neonates being treated in hospital NICUs. With respect to NICUs in particular, CCHA recommends retention of fee-for-service reimbursement, due to the inherent complexities of enrolling this population into any capitated arrangement.

- Treating the Whole Child. Over time, the CCS ACO must be responsible for coordinating care for the whole child. This does not mean, however, that a CCS ACO would assume financial risk for *all* services. Some services, such as behavioral health, will continue to be reimbursed through other funding streams, like county mental health. Assumption of risk for other services, such as pharmacy, will need to be determined through negotiations with DHCS.
- Risk-Mitigation Strategies Should be Available for ACOs That Need It. The CCS population is high cost and high risk. In order to ensure success, this model must include the opportunity to negotiate safeguards, as appropriate, to ensure that risk is appropriately and fairly apportioned between contracting providers and the state, depending upon the capacity of the providers to assume risk. Such an approach should include opportunities for risk corridors and reinsurance that is provided by the state.
- Maintenance of CCS-Standards. CCS Program standards must be maintained and enforced in order to ensure the continued viability and quality of these regional networks of care. Degradation of these standards or lax enforcement of them would threaten the viability of these networks and the quality of care provided by them.
- Waiver of Knox-Keene Requirements until Critical Mass is Achieved. Current state law requires ACOs to meet Knox-Keene requirements, including requirements to maintain financial reserves, or “tangible net equity” (TNE). CCHA recommends that CCS ACOs be permitted a limited-term waiver from Knox-Keene requirements until such time as total enrollment in the ACO exceeds a minimum threshold. This will allow CCS providers to devote scarce resources to program start-up and implementation.
- Adaptation to Local Models. Across the state accommodations should be made for local circumstances, such as County Organized Health Systems. In these areas, CCHA proposes that a CCS ACO cover such a county only in coordination and collaboration with the local COHS.
- Delineation of CCS Case Management Responsibilities. Currently, the state or county CCS program provides case management and utilization review services to the CCS population. CCHA recommends that state and county CCS programs work with CCS ACOs to determine how case management and utilization activities should best be provided under the model proposed here, based on local conditions. In general, CCHA believes that an ACO that is at risk for services should also be responsible for case management and utilization review

activities. However, CCHA also recognizes the extraordinary expertise that has developed at the state and local level around CCS care management.

- Adequate Reimbursement. The CCS ACO model is designed to be cost-neutral to the state. At the same time, capitated reimbursement from the state to the CCS ACO must be reasonable and must accurately incorporate all of the costs incurred for the population being served by the ACO. Any efficiencies that are gained as a result of this model must be retained by the CCS ACO system and reinvested in (1) appropriate services that enhance quality care and (2) the maintenance and enforcement of CCS standards.

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<sup>i</sup> By law, CCS is not carved-out of County Organized Health Systems in San Mateo, Santa Barbara, Solano, Yolo, Marin and Napa counties.

<sup>ii</sup> Huffman, Lynne C. M.D., Gabriel A. Brat, M.D., M.Sc., M.P.H., Lisa J. Chamberlain, M.D., M.P.H., Paul H. Wise, M.D., M.P.H. "Impact of Managed Care on Publicly Insured Children with Special Health Care Needs." *Academic Pediatrics*; Vol 10, No. 1 ( Jan-Feb 2010): 48-55.

<sup>iii</sup> This would include all children's hospitals as defined in Welfare and Institutions Code Sections 10727 and all University of California children's hospitals as defined in Welfare and Institutions Code Section 10728.