Testimony by Dr. Edward Bloch, Medical Director of Los Angeles County Children's Medical Services, before the California Senate Health Committee Oversight Hearing on the Future of the California Children's Services Program, Wednesday, November 18, 2015

Good afternoon Committee Members, thank you for the opportunity to address you today. My name is Dr. Edward Bloch. I am the Medical Director of Los Angeles County Children's Medical Services and CCS medical director since 2000. I have been a physician at CCS for the past 18 years and a member of the California CCS Executive Committee for 17 years.

While the Los Angeles County Board of Supervisors does not have a position on the State's proposed Whole Child Model and CCS redesign proposal, I am basing my testimony today on my experience with CCS in Los Angeles County and our interaction with other counties and with DHCS. The goals of CCS redesign are important and achievable even without many of the changes the model proposes. Today, I'd like to focus my remarks on our concerns in achieving these goals.

1. **What works well?** The several decades of experience counties have administering the CCS program has resulted in a constantly evolving program serving children and youth with a diverse set of serious, often life-threatening, complex medical conditions. What has worked well includes:
   - **CCS Standards:** CCS standards provide a high level of quality of care which benefits all children and youth statewide, such as the adoption of CCS standards in neonatal intensive care units. All children receiving care in CCS approved facilities benefit from CCS standards, including those who are fully (commercially or privately) insured and not in CCS.
   - **Medical Case Management:** Service authorization, case management and care coordination are provided by public health nurses under the supervision of Board-certified pediatricians (required by 1999 State Staffing Standards) in a public health setting that facilitates child/family-centered care coordination focusing on the health and well-being of the child.
   - **Robust Provider Networks:** Regional and local robust provider networks of CCS paneled physicians, and CCS-approved special care centers and tertiary hospitals and facilities form a statewide system of care for children and youth with CCS eligible conditions.
   - **Continuity and Consistency of Case Management**: Approximately 20% of the County's caseload has congenital disorders or other CCS eligible conditions requiring care from birth and extending several years. CCS provides consistency in care coordination and case management to assist parents and families in navigating their child's care.
   - **Linkage with the Medical Therapy Program:** In Los Angeles County, close coordination and collaboration with our Medical Therapy Program and its 25 medical therapy units allow for seamless occupational and physical therapy and medical case conferences for children and youth.

   This rich experience provides a foundation for counties to continue to implement program enhancements and efficiencies.

2. **What does not work well**? There is room for improvement in some areas:
   - **Coordinating care with non-CCS primary care providers.** Children and youth with very complex or multiple CCS conditions often receive the majority of their care from their CCS service providers. Currently our nurse case managers coordinate all services related to CCS eligible conditions, including primary care. Increased care coordination with these patients' non-CCS primary care providers would enhance CCS case management.

- **Establishing true medical homes for children and youth with CCS-eligible conditions.** The majority of Medi-Cal managed care primary care physicians are not Board certified pediatricians and cannot function as special needs medical homes. As a result, we authorize primary care related to CCS eligible conditions to Board certified physicians for complex conditions. In Los Angeles, we have established criteria for medical homes that families can weigh in on during the initial assessment call to assess the quality of the designated medical home.
- **Transitioning to adult providers:** Broader networks of adult subspecialists are needed to provide care for CCS youth as they transition to adult care. In Los Angeles we have partnered with a number of major medical center providers to build on our network of transition providers.
- **One-size fits all case management.** Case management based on the complexity of the child's/youth's condition or set of conditions is needed and would improve efficiency. In Los Angeles we are in the process of implementing program wide changes based on our Nurse Case Management Redesign pilot project that varied case management protocols and interventions based on the medical complexity of the child's conditions.

3. Perspective on the DHCS CCS proposal?

The CCS redesign proposal requires careful considerations that must be factored into the final proposal.

These include:

- **Potential loss of expertise in the care coordination for children and youth with special health care needs**: Currently County nurses, in consultation with our physicians, provide care coordination, case management and service authorization for children and youth in the CCS program. The medical complexity of the majority of Los Angeles County's caseload requires medical oversight for case management. Administrative case management, delegating care coordination to administrative staff rather than specialized pediatric physicians, would not provide the necessary medical expertise to determine the appropriateness of the requested services.
- **Disruption in existing services:** Managed care plans will need to establish new networks of services, potentially disrupting the long-established networks of CCS paneled providers already in place; providers who the children and families trust.
- **Reduced patient choice and access to services:** Because managed care plans must establish contracts with providers, it is probable that the resulting networks would have fewer providers, thereby limiting patient choice and access.
- **Possible reduction in service quality:** Currently, County CCS programs conduct case reviews in performing their care coordination and service authorization duties. This helps to reduce deviations from CCS standards. When deviations are identified, medical staff works with providers to resolve those issues. The proposed Whole Child Model should require managed care contracts to clearly identify how current CCS standards will be monitored and enforced to mitigate any reduction in service quality.
- **Erosion of CCS standards:** In Los Angeles we work closely with our two managed care plans – LA Care and Health Net The delegation of risk and responsibility by plans/plan partners to independent physician associations (IPAs) and medical groups could further narrow the networks of approved providers and dilute knowledge and compliance with CCS requirements. Strictly applied and rigorously monitored quality and performance standards assessed at the IPA and group level, in collaboration with the plan, and State and local CCS administrators would facilitate maintenance of CCS standards.

We recognize the need for improvements in CCS and believe that many of the redesign goals, such as patient and family-centered and whole child care can improve efficiency and cost effectiveness. In fact, Los Angeles and other counties are implementing innovations to address those goals.

4. **How will CCS staff be affected by DHCS CCS proposal?**
   - The Whole Child Model would require DHCS to contract with a managed care plan for the coordination and integration of Medi-Cal and CCS services for CCS eligible children with Medi-Cal. Consequently the case management and care coordination services currently provided by LA County CCS would be eliminated for approximately 90 percent of our current caseload. We would anticipate a similar reduction in our case management staff and related support staff.

5. **Role of county registered nurses (RNs) and medical directors in determining medical eligibility for CCS (size of programs locally, duties)**
   - All determinations for medical eligibility and for medical benefits are the legal responsibility of our physicians. Our CCS physicians have delegated to our nursing staff, within certain protocols, a great deal of routine decision-making in medical/clinical areas, and certain types of requests or referrals always require final review by a CCS MD. Similarly, even rather routine appearing requests/referrals often reveal a grey area or new technology, etc., which requires further physician review. Also, all denials that meet criteria for Due Process are appealable by families. Services deferred to a primary responsible payor, such as commercial HMOs, for example, are not appealable to CCS.

6. **How CCS care coordination is done in San Mateo vs. other counties**
   - It is my understanding that San Mateo is currently partnering with the Health Plan of San Mateo (HPSM) in a demonstration project. The pilot serves 1,500 patients with HPSM assuming financial risk for all care (CCS/non-CCS conditions). Roles for the health plan and county were jointly established. San Mateo County staff is co-located at HPSM and the health plan subcontracts with the County for financial, residential and medical eligibility determination, utilization review, case management, and care coordination and San Mateo County provides oversight of all County staff.
   - In LA County, CCS determines all eligibility and provides case management, and service authorization for over 50,000 children and youth.

7. **County financing in CCS/realignment funding**
   - I do not have the expertise to comment on financing issues

8. **In counties where CCS is "carved in" vs. not "carved in," what are the roles and interaction of the COHS and the county CCS staff for CCS services?**
   - Currently our interaction with other counties occurs when patients re-locate to other counties or receive services in another county. A small proportion of clients transfer into or out of Los Angeles County each year and a small number receive services in other counties. Because all CCS services are through CCS paneled providers, patients essentially have a statewide system of care. However, sometimes patients are not allowed to continue care with their longstanding Los Angeles-based physicians who are not in the new County's Plan network.

9. **What issues arise for counties if non-Medi-Cal CCS children remain separate from the Medi-Cal managed care plan?**

   In Los Angeles County, about 10% of our clients do not receive Medi-Cal, so current CCS county functions would need to be continued for these children and youth. Maintenance of two CCS systems of care is likely to result in:

   - Confusion for families if they move back and forth between systems if Medi-Cal coverage is lost.

- Confusion for current CCS service providers as those who are included in the managed care networks will receive a capitated rate for some children and fee for services for others.
- Disparate service provision – It is likely that non-Medi-Cal CCS clients will have access to a broader network of providers and receive a higher level of medical care coordination than children and youth receiving their CCS-related care through managed care organizations.

10. What would happen in two plan model counties (LA for example) if CCS is carved in?

- We would anticipate that shifting care of CCS eligible conditions to managed care in Los Angeles would result in significant disruption for all participants.
- First a decision would be required regarding the participation of one or both plans. Following this the plan(s) would need to contract with DHCS. MOU(s) would need to be developed between the County and one or both plans that would assume the care of children and youth with Medi-Cal and CCS eligible conditions. If only one plan participated, children with CCS eligible conditions would need to transfer to that plan. If both plans participated it is unlikely that the MOUs would be identical resulting in potentially different roles for the County with each plan.
- Plans would need to contract with CCS paneled physicians and CCS approved facilities. It is unknown the degree to which current CCS providers would become a part of the managed care network. The proposed statutory changes indicate that medically necessary care not available through the plans network would remain the "responsibility of the state and county". Theoretically at any point in a child's or youth's care, depending on the services covered by the plan, the County would need to assume coordination of, and some costs related to, services not covered by managed care.
- Los Angeles County CCS would need to identify those children and youth with Medi-Cal and cease all case management services. CCS would still provide residential, financial and medical eligibility determination, annual case review and medical therapy services for these children. Because up to 10 percent of CCS participants do not have Medi-Cal, CCS would still be required to maintain a smaller cadre of public health nurses and support staff to provide case management and care coordination services. Significant staff reductions would be anticipated.
- Patients currently enrolled in managed care plans for care unrelated to their CCS condition would need to receive their CCS care as well from those providers in the plan's network. It is unclear if their managed care plans would establish contracts with their current CCS providers. Parents would no longer be in contact with a CCS nurse case manager once their eligibility was established. All questions regarding services related to the child's CCS condition would need to be addressed to their managed care plan. Once it was determined that a plan did not cover a medically necessary service, CCS would need to review the request and authorize the service. This will result in service delays and confusion among parents navigating these authorization processes.

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