February 28, 2023

The Honorable Nancy Skinner
Chair, Senate Budget Committee
1020 N Street, Room 502
Sacramento, CA 95814

The Honorable Phil Ting
Chair, Assembly Budget Committee
1021 O Street, Suite 8230
Sacramento, CA 95814

The Honorable Roger Niello
Vice Chair, Senate Budget Committee
1021 O Street, Suite 7110
Sacramento, CA 95814

The Honorable Vince Fong
Vice Chair, Assembly Budget Committee
1021 O Street, Suite 4630
Sacramento, CA 95814

The Honorable Caroline Menjivar
Chair, Senate Budget Subcommittee on HHS
1021 O Street, Suite 6720
Sacramento, CA 95814

The Honorable Joaquin Arambula
Chair, Asm. Budget Subcommittee on HHS
1021 O Street, Suite 8130
Sacramento, CA 95814

RE: DHCS CCS Whole Child Model Expansion Budget Trailer Bill Language – OPPOSE

Dear Budget Leaders:

The California Children's Hospital Association (CCHA) and Children's Specialty Care Coalition (CSCC) are writing to express our strong opposition the Department of Health Care Services' proposed budget trailer bill language that would expand the California Children's Services (CCS) Whole Child Model into additional County Organized Health System counties in 2024 and into "Single Plan Model" counties in 2025.

An expansion of the Whole Child Model was not part of the Department's CalAIM proposal, and is inconsistent with the language of SB 586 (Hernandez), the law that created the Whole Child Model in 2016. The experience of Whole Child Model implementation over the past four years indicates that the model can deprive CCS children of access to both specialized medical care and expert case management services. Finally, the proposed transition to Whole Child Model will result in even deeper Medi-Cal cuts to CCS outpatient providers. Coming after decades of stagnant reimbursement, these cuts are unsustainable and would worsen already limited access to care for the state's medically fragile children.

<u>Department's Proposal Not Part of CalAIM and Inconsistent with the Process Included in SB 586</u>

The Department's fact sheet suggests that the Whole Child Model expansion is part of CalAIM, but when it was released in 2019, the Department's CalAIM proposal never included any mention of a

potential expansion of the Whole Child Model. In addition, the Department's proposal would expand the Whole Child Model in a manner that is inconsistent with SB 586. SB 586 allowed the Department to implement the Whole Child Model in twenty-one counties. In exchange, the Department was required by statute to undertake an independent evaluation of the Whole Child Model and was required to submit that evaluation to the legislature no later than December of 2022. This evaluation has yet to be released to the legislature or the public, nor would there be adequate time in the legislative calendar to review and digest its findings thoughtfully before budget negotiations are finalized.

Expansion of the Whole Child Model Imperils the Sustainability of the CCS Program and Reduces Access to Care

The CCS program was developed specifically to provide a package of vital health care services, rehabilitation, intensive case management, and support services to children with medically complex and/or life-threatening conditions. The Whole Child Model imperils the sustainability of the program.

Whole Child Model Threatens Viability of CCS Regionalized System of Care. CCS's success is due in no small part to the specialized care management guidelines developed by the program to ensure that children with rare, life-threatening conditions obtain services appropriate to their needs. They also ensure that children with CCS-eligible medical conditions obtain care from providers with appropriate specialty training. These experts treat life-threatening conditions, such as sickle cell disease, cystic fibrosis, and congenital heart abnormalities – conditions that are too uncommon to sustain a medical practice in a local community. CCS Special Care Centers centralize this expertise and receive referrals and serve children across county boundaries.

Efforts to capitate CCS services within local Medi-Cal managed care plans can undermine the viability of these centers, because California's Medi-Cal managed care plans are county-based. Their focus on primary care and prevention means that their networks are also largely established within county lines. Some plans discourage referring patients outside of the county, limiting patients' access to the care that they need.

Whole Child Model Results in Loss of Expert CCS Nurse Case Management. While Whole Child Model was meant to improve coordination of primary and specialty care for CCS patients, it has reduced access to expert CCS case management services. One of the most critical benefits of the CCS Program for children and families is access to knowledgeable case management services that are tailored to a particular CCS-related diagnosis. This has provided children in the program and their families with access to specially trained public health nurses who can coordinate beneficiaries' specialty care needs on an ongoing basis, potentially from their birth to age 21. Implementation of the Whole Child Model has resulted in the loss of this expertise. Under the Whole Child Model, case management for CCS conditions is no longer handled by these trained county CCS nurse case managers. Instead, CCS services are coordinated by the Medi-Cal managed

care plan. There have even been instances of case management being delegated to the patient's primary care provider when the Medi-Cal managed care plan lacks the time and resources to do it effectively, even though a local primary care provider is likely to have even less familiarity with CCS special care center programs and services than the health plan. Case management services are not interchangeable and children – particularly children with life-threatening illnesses – are not just small adults.

Whole Child Model has had Problems. County CCS staff and providers have raised issues to the Department over the last several years about problems with the Whole Child Model. For example, the Children's Regional Integrated Service System (CRISS), which works to improve care for CCS children, has identified a number of cases where Whole Child Model plans have failed to ensure CCS care is provided to children with eligible conditions, including instances where plans failed to identify children with CCS eligible conditions and instances where plans failed to ensure that children enrolled in the CCS program received the annual CCS special care center visit vital for their health. Several other issues relating to things like transportation benefits for families, the provision of medical documentation to County CCS staff, which they need in order to execute their core functions, and problems with NICU babies not being referred for CCS services and high risk infant follow-up services have also been identified by CRISS and presented to the Department through detailed issue papers[1], as well as briefings. We are still awaiting action by the Department to correct these deficiencies in the model as it is currently implemented. Until we feel secure that WCM can be made to work successfully for medically vulnerable children, it is inappropriate to consider expanding it to additional counties.

Implementation of Whole Child Model Results in Cuts in Payments to CCS Outpatient Services Provided by Hospitals

We are also opposed to the Department's proposal because it will result in cuts to supplemental payments for CCS outpatient services, jeopardizing access to this care. California's hospital quality assurance fee ("provider fee") program supplements Medi-Cal's extremely low reimbursement rates for hospital inpatient and outpatient services. The program provides less support for outpatient CCS services that are provided to children enrolled in Whole Child Model plans than to children who reside in "classic" CCS counties, where CCS services are carved out of managed care. This is because provider fee supplemental payments are adjusted for acuity when services are provided in fee-for-service but are not adjusted for acuity when they are incorporated into Medi-Cal managed care. For some hospitals, these cuts represent losses approaching $30 million annually.

Expansion of Whole Child Model Will Make an Already Precarious Situation Untenable

[1] CRISS WCM Paper- Case Management; CRISS WCM Paper- Medical Documentation; CRISS WCM Paper- Maintenance-Transportation; CRISS WCM Paper- NICU; CRISS WCM Paper- HRIF

California just endured a brutal and unprecedented surge in pediatric respiratory viruses, one that outpaced the health care delivery system's capacity to respond. Families were sometimes stuck in emergency departments for 24 hours or longer and pediatric patients who needed to be transported to higher acuity care could not be, due to a lack of available beds. Children died. For decades, the State of California has shortchanged the needs of its most medically vulnerable children. This lack of investment had real-world consequences this winter. By expanding the Whole Child Model, the Department will contribute further to the potential collapse of this extremely under-resourced and endangered pediatric delivery system. The real-world consequences will be felt by the children who depend upon these services for their health and wellbeing.

CCS Can Coordinate Well With Medi-Cal Managed Care Without Being Carved into It

A program does not need to be carved into Medi-Cal managed care to coordinate with it. Many important programs are not carved into Medi-Cal managed care, including Medi-Cal Rx, county behavioral health services, and services for children with developmental disabilities. For children who are enrolled in both CCS and Medi-Cal, the programs have always worked together to coordinate care in "classic" CCS counties (i.e., where CCS services are carved out of managed care), and families have always reported high satisfaction with this arrangement. Expansion of the Whole Child Model is unnecessary, would result in the loss of important case management expertise, may result in fewer eligible children being identified and offered services, and would be devastating to the pediatric specialty care delivery system if implemented after many decades of low reimbursement and more recent cuts.

Given the significant problems identified above, CCHA and CSCC strongly oppose this proposal. There is no justification for trying to force this expansion through a budget trailer bill and we respectfully request that the Department of Health Care Services withdraw the budget trailer bill. If the Department decides to continue forward with this proposal, we request that the proposed Whole Child Model policy changes are considered in policy committee through the normal legislative process.

Thank you in advance for your consideration. If you have any questions or would like more information, please contact Amy Blumberg with CCHA at ablumberg@ccha.org or 916-849-7349, or Katie Layton with CSCC at klayton@childrens-coalition.org or 916-443-7086.

Sincerely,

Ann-Louise Kuhns
President & CEO
California Children's Hospital Association

Erin M. Kelly
Executive Director
Children's Specialty Care Coalition

Cc: Honorable Members of the Senate Budget Subcommittee 3 on Health and Human Services
Honorable Members of the Assembly Budget Subcommittee 1 on Health and Human Services
The Honorable Susan Talamantes Eggman, Chair, Senate Health Committee
The Honorable Janet Nguyen, Vice Chair, Senate Health Committee
The Honorable Jim Wood, Chair, Assembly Health Committee
The Honorable Marie Waldron, Vice Chair, Assembly Health Committee
Scott Ogus, Deputy Staff Director, Senate Budget Committee
Andrea Margolis, Consultant, Assembly Budget Committee
Marjorie Swartz, Pro Tem's Office
Mary Ader, Speaker's Office
Anthony Archie, Senate Republican Fiscal Committee
Eric Dietz, Assembly Republican Fiscal Committee
Joe Parra, Senate Republican Caucus
Tim Conaghan, Senate Republican Caucus
Jen Flory, Senate Health Committee
Rosielyn Pulmano, Assembly Health Committee
Lara Flynn, Assembly Health Committee