CHAPTER 3—BACKGROUND TO THE POLICY EVALUATION

This study examines the impact of a payment policy that was adopted by California's Medicaid program to reimburse Title V services within a managed care delivery system. This chapter describes the evolution of Medicaid and Title V payment policies in California. It describes the Title V program, Medi-Cal payment policies, key elements of California's transition to Medicaid managed care, and the origins and implementation of the Title V carve-out.

Introduction to Medicaid and CCS

In 1927, California enacted the Crippled Children's Services Act in response to the perceived unmet needs of children whose physical disabilities could be surgically repaired (CMS, 1996). Federal legislation several years later created a federal funding mechanism for such programs in all states. Title V (Part 2) of the Social Security Act was adopted in 1935 to provide medical care to children with physically disabling medical diagnoses. The resulting Services for Crippled Children program, re-named as the Program for Children with Special Health Care Needs in the 1980's (Ireys & Eichler, 1988), thus preceded the Medicaid program by 30 years. The purpose of Title V, Part 2 was to ensure access to medical care for children with disabling diagnoses who might otherwise not receive adequate treatment, and thereby prevent or ameliorate handicapping conditions. Title V called for a comprehensive service system to include case-finding, treatment, and follow-up services (Shonkoff & Meisels, 1990). States were given the authority to define the diagnoses that would confer medical eligibility. Most states initially focused on orthopedic problems but extended eligibility for medical illnesses (Ireys & Eichler, 1988) as the program and medical technology evolved.

Until 1965, state programs established under Title V, Part 2 directly provided services or reimbursed these services, or served as both a provider and a payer of specialty services. The Social Security Act was further amended in 1965 to include Title XIX, which established Medicaid as an optional, state-administered medical assistance program that received federal matching funds. Medicaid provided a new source of medical care funding for children in low-income families. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program was adopted several years later to mandate early identification and treatment of health conditions for children 0-21 years of age who were Medicaid beneficiaries. State Title V programs have continued to directly fund

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2 Title V programs of Maternal and Child Health Services (Part 1), Services for Crippled Children (Part 2), and Child Welfare Services (Part 3) were incorporated in 1981 into the Maternal and Child Health Block Grant to states. As clarified in this chapter, the block grant funding mechanism does not affect the funding stream for most services to children who are dually Medicaid and Title V eligible, because their medical care is paid by Medicaid (an entitlement program). The block grant funding does affect funds available to the states for Title V eligible children who are not Medicaid eligible, and it also affects funds available for the administrative and case management functions of Title V programs that are not direct medical services.

3 The EPSDT program created an entitlement for child Medicaid beneficiaries age 0-21 years to "any service which the state is permitted to cover under Medicaid that is necessary to treat or ameliorate a
medical services for medically eligible children who do not meet Medicaid financial eligibility requirements.

In California, the evolution of Medicaid ("Medi-Cal") and Title V required a working relationship between these two important health programs for low-income children. These means-tested, publicly funded health programs have overlapping income eligibility criteria. The Medi-Cal program targets low-income children, and the Title V program also serves low-income children but extends its services to higher income families whose child incurs substantial medical expenditures. As detailed in the following sections, California children who are eligible for both Medi-Cal and Title V programs have their medical services paid by Medi-Cal but authorized by Title V. California administers the Title V, Part 2 provisions within the State Department of Health Services in a program called California Children Services (CCS).

3.1 Description of California's Title V Program for Children with Special Health Care Needs

Annually approximately 140,000 children participate in the CCS program (CMS 1996). Child Medi-Cal beneficiaries (age 0 to 21 years) who receive services from CCS comprise a small percentage of children in Medi-Cal. The number of child Medi-Cal beneficiaries receiving CCS-authorized services during the calendar years of 1994 through 1997 were as follows: 66,497 (1994); 69,807 (1995); 73,167 (1996); and 77,602 (1997). These children comprise an even smaller proportion of Medi-Cal beneficiaries of all ages, which averaged 5.1 million individuals monthly in 1997 (SDHS MCSS 1997). Despite the relatively small number of children, total annual expenditures for children with CCS diagnoses are significant. In calendar year 1997, approximately $564.9 million in Medi-Cal funds were expended on CCS specialty services for child Medi-Cal beneficiaries. These expenditures are part of a total of $10 billion that was expended on fee-for-service Medi-Cal in calendar year 1997; an additional $2 billion was expended on prepaid county-organized systems (COHS) and prepaid health plan payments in 1997 (SDHS MCSS 1997).

Enabling Legislation and Program Regulations

Title V, Part 2, of the Social Security Act contains a provision for the appropriation and allocation of federal funds to states, to serve children with physically disabling medical conditions. The Social Security Act requires state health departments to directly administer the Title V program for children or to supervise a locally administered program; specific regulations are contained in the Code of Federal Regulations, Volume 42. California’s Title V Children with Special Health Care Needs program (California Children Services, or CCS) is administered by the California State Department of Health Services (SDHS), and within the Maternal and Child Health Branch of SDHS. Title 22 of California's Administrative Code (Section 51013) "provides that any patient under age 21 certified as eligible for Medi-Cal who has a condition eligible under CCS shall be referred to the defect of physician and mental illness, or a condition identified by an EPSDT screening exam....even if the State does not normally include that service as a benefit of the State's Medicaid plan" (HCFA 1993). At least on paper, the EPSDT program thereby extends broad medical benefits to children.
CCS agency for case management services and prior authorization" (SDHS 1979). California's Code states that it will "establish and administer a program of services for physically defective or handicapped persons under the age of 21 years...for the purpose of developing, extending and improving such services" (SDHS 1979).

CCS is a medical program that includes financial as well as medical qualifying components. Children who are Medi-Cal beneficiaries are automatically financially eligible. California's program uses a combination of state and county funds to fund medical care for (1) low-income, uninsured children; (2) children who are insured but have gaps in service coverage (e.g., limitations to the type or volume of benefits available under their health insurance plan); and (3) children whose annual medical expenses exceed a threshold percentage of household income. CCS income eligibility is associated with an established annual income level rather than with a multiple of the federal poverty level (FPL) adjusted for family size, as used by the Medicaid program.

Identification of CCS eligible children is a continuing mission of the county CCS programs, as outlined in Medi-Cal and CCS manuals and in California code. With respect to case finding and reporting, California code states that counties "shall conduct an active and continuous program of case finding of all persons under 21 years of age who are suffering from handicapping conditions. This function may be carried out by physicians and health and welfare agencies, public and voluntary. All cases in need of CCS services shall be referred to the local agency within the county which is administratively responsible for the program" (Section 2900, Title 17, Administrative Code; State Department of Health Services, 1979). The Medi-Cal Provider Manual (2000) specifies that CCS referral is required by law. According to the manual, all Medicaid beneficiaries "under 21 years of age who are residentially, financially and medically eligible for CCS diagnostic, treatment and therapy services are required by law to be referred to the CCS program for case management."

**CCS Program Functions**

The Title V program mission extends beyond payment functions to system development and assurance objectives. Pursuant to this mission, the CCS program credentials ("panels") physicians and hospitals as providers of CCS services; supports a system of facilities that are held to certain structural standards (e.g., staffing requirements, multidisciplinary team participation in treatment plans); provides administrative case management services to children and their families; provides a

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4 Children who are not Medicaid beneficiaries are income-eligible if they are from families with annual incomes below $40,000 (unadjusted for family composition and size) or have annual medical expenditures that exceed 20 percent of their family's total income (CMS, 1996). Children who are full scope Medicaid beneficiaries receive all CCS services free of charge. On September 1, 1991, an enrollment fee was put in place as an annual CCS program fee for other participants. This fee is based on a sliding scale relative to the federal poverty level (FPL) and is waived for families if (1) their income is below 200 percent of the FPL; (2) the child is eligible for full scope (i.e., non-restricted) Medi-Cal benefits without a share of cost; (3) the only service requested is a diagnostic service to determine medical eligibility for CCS; or (4) the only service requested is for school-based Medical Treatment Unit (MTU) services.
payment authorization function for Medicaid-eligible children; and directly pays for services for medically and income eligible children who do not qualify for Medicaid.

According to CCS regulations, services authorized by CCS are to be delivered by recognized providers who meet specific requirements. For physician paneling, CMS requires written certification of medical licensing and board certification. Non-paneled physicians can provide services to CCS eligible children in some cases if the provider is in a category that is not covered by CCS standards for participation and/or when it is determined that they meet agency standards (SDHS 1978; 1991). Specifically, regulations permit authorization to be issued to a non-paneled family physician or general practitioner "for services delegated or shared by the authorized panel physician" (SDHS 1979).

For hospital facility paneling, CMS requires that most facilities meet a set of structural standards including medical staffing, physical plant, nursing service, and social work requirements, among others. CCS approval of hospitals includes four types of approvals: (1) limited approval for a hospital in a rural area that can provide specific services for a certain age group, not to exceed five days; (2) standard approval for a community hospital capable of providing intermediate care for a period not to exceed 21 days; (3) long term approval for a referral hospital that provides tertiary level care that can exceed 21 days (covering teaching hospitals and their major affiliates with approved residency programs); and (4) special approval for hospitals providing services to adolescents that do not have a pediatric service (SDHS, 1978). Because of the variability in health system capacity across the counties, there is some variation in the level of structural standards that paneled facilities may meet. Thus a specialty center in Los Angeles may have staffing levels of social workers and other support staff that a smaller, rural county might not have. Finally, hospitals may be paneled for certain diagnoses but not for others, based on their staffing and physical capacity.

Medically Qualifying Diagnoses and Determination of Eligibility

The scope of eligible conditions in California is generous relative to counterpart programs in other states, covering illnesses such as cancer in additional to the physically disabling conditions that all states cover (Maternal and Child Health Bureau 1997; Ireys, Hauck, Perrin 1985). Not all chronic or high cost medical conditions that a child may have are CCS-eligible; for example, most children with diabetes or asthma are not eligible, and services for injuries or diseases that may not produce long-term disability are generally not CCS-eligible. A summary of medical eligibility for CCS is provided in Table 3.1, Overview of California Children Services (CCS) medical eligibility. The classifications of qualifying medical diagnoses are illustrated in Table 3.1. The most common CCS medically eligible diagnoses statewide among those receiving CCS services, as identified by Children's Medical Services (using SDHS claims data) for the calendar year 1995, are identified in Table 3.2, Most common medically eligible diagnoses among Medi-Cal enrollees receiving CCS services (1995).
### Table 3.1 – Overview of California Children Services (CCS) medical eligibility

<table>
<thead>
<tr>
<th>Category</th>
<th>Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infectious and Parasitic Diseases (ICD-9 000-139)</td>
<td>Generally eligible when they involve the CNS and produce disabilities requiring surgical and/or rehabilitation services; involve bone; involve eyes, may lead to blindness and are a medically treatable condition; are congenitally acquired which may result in physical disability, and for which postnatal treatment is available and appropriate</td>
</tr>
<tr>
<td>Neoplasms (ICD-9 140-239)</td>
<td>All malignant neoplasms; benign neoplasms when they constitute a significant disability or significantly interfere with function</td>
</tr>
<tr>
<td>Endocrine, Nutritional, and Metabolic Diseases (ICD-9 240-279)</td>
<td>Generally eligible, including cystic fibrosis, inborn errors of metabolism; includes diabetes mellitus when it is uncontrolled (per CCS criteria) and/or complications are present</td>
</tr>
<tr>
<td>Diseases of Blood and Blood-Forming Organs (ICD-9 280-289)</td>
<td>Generally eligible, including sickle cell anemia, hemophilia and aplastic anemia, iron or vitamin deficiencies when life-threatening complications</td>
</tr>
<tr>
<td>Mental Disorders (ICD-9 290-319)</td>
<td>Only eligible when associated with or complicates an existing CCS-eligible condition (limited diagnosis and treatment under these conditions)</td>
</tr>
<tr>
<td>Diseases of the Nervous System and Sense Organs (ICD-9 320-359)</td>
<td>Generally eligible when they produce physical disability that significantly impair daily function; idiopathic epilepsy when seizures are uncontrolled (per CCS criteria); treatment of seizures due to underlying organic disease is based on eligibility of the underlying disease</td>
</tr>
<tr>
<td>Sense Organs (ICD-9 360-389)</td>
<td>Strabismus when surgery required; chronic infections or disease of the eye when may produce visual impairment or require complex management or surgery; hearing loss (per CCS criteria), perforation of the tympanic membrane requiring tympanoplasty, mastoiditis, cholesteatoma</td>
</tr>
<tr>
<td>Diseases of the Circulatory System (ICD-9 390-459)</td>
<td>Generally eligible, including conditions involving the heart, blood vessels, lymphatic system</td>
</tr>
<tr>
<td>Diseases of the Respiratory System (ICD-9 460-519)</td>
<td>Upper respiratory tract conditions if they are chronic, cause significant disability and obstruction, or complicate the management of a CCS-eligible condition; chronic pulmonary disease (per CCS criteria)</td>
</tr>
<tr>
<td>Diseases of the Digestive System (ICD-9 520-579)</td>
<td>Diseases of the liver, chronic inflammatory disease and congenital abnormalities of the GI system, gastroesophageal reflux (per CCS criteria), malocclusion when severe impairment of occlusal function (per CCS criteria)</td>
</tr>
<tr>
<td>Diseases of the Genitourinary System (ICD-9 580-629)</td>
<td>Chronic genitourinary conditions and renal failure; acute conditions when complications are present</td>
</tr>
<tr>
<td>Complications of Pregnancy, Childbirth, and Puerperium (ICD-9 630-678)</td>
<td>Prenatal care and delivery if the pregnancy complicates the management of the CCS-eligible condition (e.g., cystic fibrosis, diabetes, chronic renal or cardiac disease)</td>
</tr>
<tr>
<td>Disease of the Skin and Subcutaneous Tissue (ICD-9 680-709)</td>
<td>Eligible if disfiguring, disabling and require plastic or reconstructive surgery or prolonged and frequent hospitalization</td>
</tr>
<tr>
<td>Disease of the Musculoskeletal System and Connective Tissue (ICD-9 710-739)</td>
<td>Eligible if disabling</td>
</tr>
<tr>
<td>Congenital Anomalies (ICD-9 740-759)</td>
<td>Eligible if disabling or disfiguring, amenable to correction and requires surgery</td>
</tr>
</tbody>
</table>
Certain Causes of Perinatal Morbidity and Mortality (ICD-9 760-779)
Eligible if neonate with a CCS eligible condition; neonate 0-28 days if no CCS eligible condition but develops condition that requires specific NICU services and meets acuity care criteria

Accidents, Poisonings, Violence, and Immunization Reactions (ICD-9 800-999)
Eligible if serious, leads to significant disability, and/or requires surgery

Source: Children’s Medical Services, Overview of California Children Services (CCS) Medical Eligibility and General Medical Therapy Unit (MTU) Eligibility; California Children Services Manual of Procedures, Chapter 2 Medical Eligibility; International Classification of Diseases, 9th Revision, 1999.

Note: ICD-9 codes in the table refer to coding ranges for disease classification rather than to eligibility for CCS, which is based on clinical guidelines rather than on ICD-9 coding.

Table 3.2 – Most common medically eligible diagnoses among Medi-Cal enrollees receiving CCS services (1995)

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>ICD-9 Coding</th>
<th>Total Number of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number</td>
</tr>
<tr>
<td>Congenital anomalies</td>
<td>740-759</td>
<td>13,953</td>
</tr>
<tr>
<td>Cerebral palsy</td>
<td>333.7, 343, 344.0-.5,767.7</td>
<td>8,075</td>
</tr>
<tr>
<td>Congenital heart disease</td>
<td>745, 746, 747.1,.4</td>
<td>3,478</td>
</tr>
<tr>
<td>Neoplasms/malignancies</td>
<td>140-239</td>
<td>3,327</td>
</tr>
<tr>
<td>Respiratory distress syndrome</td>
<td>769, 770.8</td>
<td>2,245</td>
</tr>
<tr>
<td>Prematurity</td>
<td>765.0, 765.1</td>
<td>2,056</td>
</tr>
<tr>
<td>Seizure disorder</td>
<td>345, 780.8</td>
<td>1,976</td>
</tr>
<tr>
<td>Strabismus</td>
<td>378.0-.7</td>
<td>1,777</td>
</tr>
<tr>
<td>Cleft palate/lip</td>
<td>749</td>
<td>1,739</td>
</tr>
<tr>
<td>Spina bifida</td>
<td>741</td>
<td>1,228</td>
</tr>
<tr>
<td>Hydrocephalus</td>
<td>741.0, 742.3</td>
<td>1,077</td>
</tr>
<tr>
<td>Leukemia</td>
<td>204-208</td>
<td>999</td>
</tr>
<tr>
<td>Asthma</td>
<td>493.0, 493.1, 493.2, 493.9</td>
<td>813</td>
</tr>
<tr>
<td>Sickle cell disease</td>
<td>282.4, 282.6</td>
<td>779</td>
</tr>
<tr>
<td>Bronchopulmonary dysplasia</td>
<td>770.7</td>
<td>713</td>
</tr>
<tr>
<td>Head trauma/brain injury</td>
<td>851-854</td>
<td>708</td>
</tr>
<tr>
<td>Chronic renal disease</td>
<td>581, 582, 583, 585, 753.1</td>
<td>665</td>
</tr>
<tr>
<td>Congenital hip dysplasia</td>
<td>754.3, 755.6</td>
<td>657</td>
</tr>
<tr>
<td>Scoliosis</td>
<td>737.3, 737.4, 737.9</td>
<td>611</td>
</tr>
<tr>
<td>Arrythmia</td>
<td>427.0-427.9, 997.1</td>
<td>444</td>
</tr>
<tr>
<td>Muscular dystrophy</td>
<td>359.1, 359.2, 359.8</td>
<td>398</td>
</tr>
<tr>
<td>Arthritis</td>
<td>711.0, 714, 716.9, 720</td>
<td>392</td>
</tr>
<tr>
<td>Cystic fibrosis</td>
<td>277.0</td>
<td>388</td>
</tr>
<tr>
<td>Diabetes</td>
<td>250.1-250.9</td>
<td>365</td>
</tr>
<tr>
<td>Renal insufficiency</td>
<td>584, 586, 588, 593.9, 997.6</td>
<td>307</td>
</tr>
<tr>
<td>Hemophilia</td>
<td>286.0-286.2</td>
<td>285</td>
</tr>
<tr>
<td>HIV disease</td>
<td>042-044</td>
<td>220</td>
</tr>
<tr>
<td>Pyloric stenosis</td>
<td>750.6</td>
<td>198</td>
</tr>
<tr>
<td>Burns</td>
<td>940-946 - if .3,.4,.5</td>
<td>191</td>
</tr>
<tr>
<td>Biliary artresia</td>
<td>751.6</td>
<td>117</td>
</tr>
<tr>
<td>Growth hormone deficiency</td>
<td>258.8</td>
<td>97</td>
</tr>
</tbody>
</table>

Source: California Children’s Medical Services (May 1996).
As a medical program, CCS can authorize services that include diagnosis, treatment, surgery, physical and occupational therapy, equipment and its maintenance, transportation, and other special treatment (such as home health, and speech therapy) (SDHS 1979). In terms of coverage of diagnostic services, the CCS manual indicates that "Diagnostic services shall be provided upon evidence or suspicion that the eligible condition exists" and that "services necessary to establish a working diagnosis may be authorized" (SDHS 1979). Treatment services can extend to a non-CCS eligible medical diagnosis if the non-eligible condition develops during a hospital stay that is related to the CCS diagnosis, or if the non-eligible condition "interferes with, modifies, or complicates the treatment of an eligible condition" (SDHS 1979).

For the medical eligibility determination process, children who are thought to have a CCS eligible condition are referred by their physicians (or other provider or even family members) to CCS. After both financial and medical need screening, a determination of CCS eligibility is made. The screening of medical eligibility may involve diagnostic services that can be authorized by CCS. Financial screening requirements involve a certification of family income and resources. For children who are enrolled in Medi-Cal, CCS is designated as the agency that authorizes Medi-Cal benefits relating to CCS diagnoses. The interagency agreement between Medi-Cal and CCS delegates this authorization role to CCS whether or not the family completes the CCS certification process.

**Agency Structure and Organization**

Responsibility for the CCS program is divided between state and local offices. CMS in the California State Department of Health Services performs the provider credentialing function and maintains the statewide database of paneled providers. The largest counties in California operate CCS programs that are administered locally but that are bound by program policies and procedures set by State DHS. California's Administrative Code states that either the county health department or health and welfare department in a county with over 200,000 residents must administer an independent program, and that counties with fewer than 200,000 residents may choose to operate an independent program or operate a program jointly with SDHS. There are also three regional CCS offices (in San Francisco, Sacramento, and Southern California) with medical consultative staff who provide a consulting function to local programs with respect to medical eligibility. The regional offices also provide consulting and other expanded support to counties that have dependent CCS programs. The regional offices also have medical consulting staff who review appeals and questions that may arise in the independent counties that are covered by the specific regional office.

Thus while it is a statewide program, some characteristics of the CCS program vary across California's 58 counties. As previously described, one of these characteristics is the administrative status of the county CCS program. Independent counties operate their own case management system. In contrast, the dependent counties administer financial eligibility aspects of the program but rely on the regional office for case management functions. The assigned regional office (San Francisco, Sacramento, or Southern California) varies by county based on the county's geographic location. Finally, some county CCS programs reside in the health department while others are located within the welfare department.
3.2 Payment Mechanisms in Fee-for-Service Medi-Cal

This section describes how services traditionally have been billed for child Medi-Cal beneficiaries who may be eligible for CCS. This includes a description of the providers and agencies involved, as well as a description of the relevant policies and procedures for authorization requests and claims submittal.

Authorization Sources for Child Health Services

As illustrated in Figure 3.1, Medi-Cal payment and authorization under fee-for-service, there are a number of mechanisms that have been established in Medi-Cal by which providers can seek payment for child health services. Under fee-for-service, most basic ambulatory services such as well and sick child office visits are billed directly to Medi-Cal with no authorization required. Claims for these services are sent directly to the fiscal intermediary after the service is rendered, for claims processing.

When a request for authorization is received, any of these entities (the local Medi-Cal field office, CCS, or State Medi-Cal) may authorize a Medi-Cal service, decline to authorize the service, or defer the request to another entity for review and consideration. Claims for authorized services are identified in Medi-Cal data by the presence of a Treatment Authorization Request (TAR) indicator with a code that is unique to each authorizing entity.

Medi-Cal Field Office authorization Some Medi-Cal services such as specialty care and certain products or equipment require pre-authorization. For these services, the provider submits a request to the assigned Medi-Cal field office for review prior to providing the service. There are seven regional Medi-Cal field offices that review authorization requests for Medi-Cal benefits. This authorization process exists for all Medi-Cal beneficiaries. The location of these offices and their assigned counties are illustrated in Figure 3.2, Authorization sources: Assigned Medi-Cal field

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5 The categories of services that require TAR approval from a local field office include the following: adult day health care, dental hospitalizations, elective hospital admissions, elective hospital surgeries, extensions of acute hospitalizations, hemodialysis, home health agency services, hospice care, intermediate care facility (ICF-DD, ICF-DD/N, ICF-DD/H), kidney transplants, office visits, outpatient, outpatient "other", outpatient services, surgeries, psychiatry, transitional care, and mental health (for excluded services, which are those not covered under the Medi-Cal mental health carve-out) (Medi-Cal Provider Manual, 2000).

6 This figure does not illustrate an additional billing mechanism for child health screening services. When provided to child Medi-Cal beneficiaries, these services generally are billed directly to the SDHS through the Child Health and Disability Prevention (CHDP) program. This program operates an administrative and claims system that is separate from Medi-Cal. These CHDP screening services are part of the EPSDT Medicaid benefit for children. In some cases, screening services may be billed to Medi-Cal as ambulatory visits rather than to CHDP.
office by county, and regional CCS office (for "dependent" counties). The administrative agreement between Medi-Cal and CCS specifically states that the need for services for CCS-eligible diagnoses is to be determined by the local CCS program. The Medi-Cal field office can defer a request for authorization to CCS, for a service that is a Medi-Cal benefit but is potentially related to a CCS eligible medical diagnosis. A treatment authorization request (TAR) can be approved, approved as modified, deferred for more information, or denied (Medi-Cal Provider Manual 2000).

Figure 3.1 – Medi-Cal payment and authorization under fee-for-service

7 Figure 3.2 shows the seven regional Medi-Cal field offices and their assigned counties. Another field office was operating during the study period in Alameda County, but that field office was subsequently closed with authorizations now handled by the San Jose field office. As discussed in this section, these field offices evaluate authorization requests for any fee-for-service beneficiary. However, authorization requests for pharmaceuticals are handled by two separate Medi-Cal offices; one office serves the 48 Northern California counties, and another office serves the ten Southern California counties (Medi-Cal Provider Manual 2000). In addition, each of the seven regional Medi-Cal field offices also has special responsibility for a subset of services. For these services, the specific field office is responsible for those services statewide, irrespective of the source county. These field offices (and services) are as follows: Fresno (hearing aids, oxygen and respiratory equipment, orthotics and prosthetics, respiratory care services); Los Angeles (detoxification); Sacramento (non-emergency medical transportation for 48 Northern California counties); San Bernardino (nursing facilities); San Diego (medical transportation for 10 Southern California counties); San Francisco (organ transplants, EPSDT nutritional services, durable medical equipment (DME), occupational therapy, physical therapy, podiatry (including orthotics and prosthetics dispensed by a podiatrist), speech therapy, subacute); and San Jose (incontinence supplies, intravenous equipment, medical supplies, suction pumps). Thus the carve-out effect in each county could conceivably be influenced by behavior/policy and procedure changes in more than one Medi-Cal field office. (CCS program offices handle nearly all authorization requests related to the eligible diagnosis for a CCS participant, irrespective of the type of service.)
**CCS authorization**  The CCS program shares an authorization function with the Medi-Cal field office but has a specific target population and provides additional services. For children enrolled in Medi-Cal who have CCS qualifying medical diagnoses, services provided for the CCS eligible diagnosis are paid on a fee-for-service basis by Medi-Cal (through its fiscal intermediary) once authorized by CCS. This is based on the long-standing interagency agreement between Medi-Cal and Children's Medical Services (Title V) codified in California's Administrative Code. According to the CCS manual, "Any child certified as eligible for Medi-Cal, who has a CCS eligible condition, shall be referred to CCS for authorization and case management services" (SDHS 1979). Counties with independent CCS programs are illustrated along with dependent counties and their assignment to regional offices in Figure 3.2.

**Figure 3.2 – Authorization sources by county: Assigned CCS regional office and Medi-Cal field office**

![Diagram showing the assignment of counties to CCS regional offices and Medi-Cal field offices.](image)

Counties are assigned to a northern or southern office for pharmacy authorization. Each field office handles certain regionalized authorizations.

For child Medi-Cal beneficiaries who are identified as having CCS eligible medical diagnoses, CCS provides an administrative case management role, and authorizes medical services based on the child's treatment plan. CCS uses medical information provided by the child's treating physician(s) to determine the scope of services that can be provided within an authorization, along with the provider(s) that is/are authorized to provide the care, and the time period within which the care will
be provided. Once authorization is made, the CCS agency will approve and submit claims directly to the Medi-Cal fiscal intermediary for payment.8 Thus for the most part, CCS pre-authorizes services. Services can be reimbursed if not pre-authorized under certain circumstances, such as emergencies and pre-approved standing authorizations, but this is the exception rather than the rule.

**Regional Medi-Cal Office authorization** Finally, regional Medi-Cal offices also are characterized in Figure 3.1 as distinct potential payers for children because these offices authorize certain services that the local field offices do not. These services include pharmaceuticals (with a Northern Office in Stockton and a Southern Office in Los Angeles) and In-Home Services through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) child health benefit in Medi-Cal (handled by an office in Sacramento or an office in Los Angeles, depending on the county of residence). In-Home services are a specific Medicaid benefit that can be authorized by In Home Operations in the Medi-Cal Operations Division. Once submitted to In Home Operations, the office consults with the local CCS office to determine that the child has a CCS eligible condition and that the service is needed because of the CCS eligible condition. As described in a consumer manual on EPSDT authorizations in Medi-Cal, "In Home Operations, pursuant to an agreement with CCS, will make the TAR determination on nursing; however, the formal authorization will come from CCS" (Protection and Advocacy, Inc. 1996).

### 3.3 California’s Medicaid Managed Care Expansion

This section provides a descriptive analysis of California’s managed care expansion with particular focus on how it affects children with CCS eligible medical diagnoses.

**History of Medi-Cal prepayment**

Prepayment of health services in California’s Medicaid program began in the 1970’s with prepaid arrangements that placed the contractor at limited financial risk for Medi-Cal services. The contracted organizations generally exclusively served Medi-Cal beneficiaries, providing primary care and management of some specialty services. The primary care case management (PCCM) prepaid arrangements were permitted under a series of waivers of Medicaid provisions that were granted by the Health Care Financing Administration (HCFA) in the early 1980's. In two counties—San Mateo and Santa Barbara—California's Department of Health Services established mandatory managed care systems, based on a waiver (initially a 1115 Research and Demonstration waiver and then as a 1915(b) waiver) that extended to a limited number of counties. In other counties in the late 1980’s, Medi-Cal expanded its contracting from the limited risk PCCM organizations that had predominated to federally licensed prepaid health plans (PHPs) that served commercial beneficiaries in the State. The PHP contracts issued by Medi-Cal covered a more comprehensive scope of services. In contrast to the COHS counties, enrollment in the PHPs continued to be voluntary. By

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8 Specifically, the CCS Manual states "Claims must contain the number '8' in the last space of the TAR Control Number block which gives special numeric identity to CCS-authorized services" and that claims must contain the CCS identification stamp.
the 1990's, California's Medi-Cal Managed Care Division (MMCD) had contracts with multiple federally licensed prepaid health plans, such as Kaiser, Blue Cross, and others.

**CCS services within managed care contracts**  Many of the Medi-Cal contracts with commercial health plans in the 1990's placed the prepaid health plan at financial risk for medical care that included medical services related to CCS diagnoses. Several laws passed in 1992 and 1993 referred to the specific standards of care to which managed care contractors must adhere, concerning children with CCS conditions, and also to the need for actuarially sound rates relating to CCS services. A bill that preceded and that promoted the Medi-Cal managed care expansion outlined in California's *Strategic Plan*—Senate Bill 485 (Chapter 722, Statutes of 1992)—stated that "any managed care contractor serving children with conditions eligible under the CCS program shall report expenditures and savings separately for CCS covered services and CCS eligible children." Assembly Bill 616 (Chapter 938, Statutes of 1993), which was signed into law by the Governor on October 8, 1993, stated that any managed care contractor that served Medi-Cal/CCS children must maintain and follow CCS program standards of care including the use of CCS-paneled providers and CCS-approved special care centers. The bill further stated that "if the managed care contractor is paid according to a capitated or risk-based payment methodology, there shall be separate actuarially sound rates for CCS eligible children."

**CCS role for child Medi-Cal beneficiaries enrolled in prepaid health plans** While CCS services were included within some PHP contracts, specific roles were identified for the State and county CCS programs. Assembly Bill 616 also stated that "any managed care contract which will affect the delivery of care to CCS eligible children shall be approved by the state CCS program director prior to execution." SDHS issued instructions to managed care contractors in 1996 that also highlighted the role of CCS with respect to children with CCS qualifying conditions who might be enrolled in prepaid health plans. A policy letter issued by the SDHS Medi-Cal Managed Care Division in July 1996 affirmed the specific responsibilities of such PHPs and three operational COHS counties (Santa Barbara, San Mateo, and Solano) with respect to referral of children with possible CCS-eligible conditions to the CCS program (SDHS 1996). For Medi-Cal managed care contracts in which the PHP was at risk for all medical care related to the CCS diagnosis, the policy letter instructed the managed care contractor to identify children with CCS eligible conditions and track services provided to these children. The letter further instructed the plans to "develop and implement procedures to provide timely information on the county CCS program regarding these children." The rationale offered in the policy letter was that even though the PHP was at financial risk for medical services relating to the CCS qualifying medical diagnosis, referral to CCS was needed for purposes of continuity of medical care (should the child later lose Medi-Cal eligibility and thereby disenroll from the PHP, but still potentially meeting non-Medi-Cal CCS resource standards) and for purposes of the child receiving other "wrap-around" services that CCS provides. Examples

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9 AB 616 reiterates the existing law that managed care contractors "shall maintain and follow standards of care established by the program, including use of paneled providers and CCS-approved special care centers and shall follow treatment plans approved by the program, including specified services and providers of services."
of services that are not covered by Medi-Cal but are covered by the CCS program include care coordination from special care centers, and lodging, food, and transportation to assist the family in accessing authorized medical services.

This policy letter referred to managed care contractors that were enrolling Medi-Cal beneficiaries on a voluntary basis. During the period to which the policy letter applied, enrollment in PHPs and PCCMs was voluntary for Medi-Cal beneficiaries living in the counties where these contracts were in place.\(^{10}\)

### Expansion of Medi-Cal Managed Care

California’s 1993 *Strategic Plan for the Expansion of Medicaid Managed Care* outlined the State Department of Health Services (SDHS) intent to implement a managed care expansion that would take place in California’s largest counties. This plan was issued after 1992 legislation (Senate Bill 485) that permitted expansion of Medi-Cal managed care including elimination of a cap on Geographic Managed Care enrollment. Under the *Strategic Plan*, the majority of children enrolling in Medi-Cal were to be enrolled in full risk prepaid health plans that would administer and have financial risk for most of enrollees' medical care needs. This plan called for a rapid implementation of mandatory managed care for beneficiaries in most Medicaid eligibility aid categories. Figure 3.3, *Managed care enrollment requirements, by model, for major Medi-Cal aid categories*, illustrates the Medi-Cal eligibility aid groupings that correspond to mandatory, voluntary, or excluded status in the new managed care systems.

In designating counties for the expansion of managed care, SDHS developed specific selection criteria and identified three categories of counties. The first category of counties included those that had the following: (1) significant concentrations of Medi-Cal beneficiaries within the affected aid codes; (2) managed care plan capacity to accommodate 110 percent of the Medi-Cal beneficiaries within the affected aid categories; and (3) most of the elements of a health care delivery system for Medi-Cal beneficiaries (SDHS 1993a). Counties in the first category were those with managed care capacity considered sufficient to cover the targeted Medi-Cal beneficiaries and to permit the fee-for-service system to be "closed" by December 1993. Counties designated in the second category were those with Medi-Cal managed care plan capacity considered adequate to permit a complete transition to managed care by June 1994. All other counties were classified in the third category. The *Strategic Plan* identified 11 counties as priority counties for expansion (i.e., in the first category) based on the size of their Medi-Cal beneficiary populations.

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\(^{10}\) Of the state and local agencies involved with Medi-Cal/CCS population—including the California Department of Health Services Medicaid Managed Care Division, Children’s Medical Services, and county CCS agencies—none has monitored the number of children with CCS conditions who enrolled in PHPs during this period. Original analysis of the prepaid health plan's/managed care contractor's encounter and/or administrative data for this period would be required to generate an estimate of the number of children with CCS qualifying medical diagnoses who were enrolled in such PHPs.
The State of California was limited under its HCFA waiver to a total of five COHS systems. Thus no additional COHS systems were allowed after Orange and Santa Cruz counties (and later Solano with Napa) were added to California's waiver in 1995. Consequently a different type of managed care system was required for further expansion of Medi-Cal managed care. SDHS developed a "Two Plan Model" (described below) for implementation in the new expansion counties. In January 1996, California received formal permission from HCFA under section 1915(b) of the Social Security Act to waive section 1902(a) (which requires program availability throughout a state) to permit implementation in selected counties only; section 1902(a)(10)(B) (which requires comparability of services) to permit additional benefits not available to beneficiaries not enrolled in the Two Plan Model; and section 1902(a)(23) (freedom of choice) to permit the State to require certain beneficiaries to enroll and to restrict beneficiary choice of providers (HCFA 1996; GAO 1997).

HCFA initially approved California's request for waiver authority for January 1996 through 1998. The Balanced Budget Act in August 1997 changed federal regulations for the Medicaid program to eliminate the need for States to obtain waivers of federal law to expand their use of Medicaid managed care. However, these provisions were in place during California's development of its managed care expansion concepts and the implementation. Because these waiver requirements were
effective during California's expansion, significant oversight and approval activities were required by HCFA during the expansion. HCFA granted California's 1996 waivers contingent on several oversight provisions. HCFA's approval emphasized the importance of readiness within each county as well as readiness at the State level in terms of information system capabilities. First, HCFA required that full implementation of the Two Plan Model would not commence in a given county until HCFA had completed an on-site "readiness review" in the county that would focus on beneficiary enrollment, access, quality, and financial solvency issues (HCFA 1996). Another provision of the waiver was that the State had to respond to the needs of individuals with complex medical conditions (HIV/AIDS was offered as the example) by implementing a medical exemption process. This provision addressed concerns about individuals with special health needs being able to access medically necessary services. Specifically, this provision stated that a beneficiary who received Medi-Cal benefits through a mandatory aid category and who was under treatment with a provider who was not participating in the Two Plan Model would be eligible for a medical exemption from enrollment in the Two Plan Model.11 If the provider was a member of the Two Plan Model network or if the beneficiary was not undergoing treatment, then this provision would not apply.

**Medi-Cal Eligibility Groups Affected by the Expansion**

Managed care requirements for the different Medi-Cal eligibility aid categories ("aid codes") varied by system design. **Figure 3.3** illustrates the status of some of the largest Medi-Cal eligibility groups with respect to the managed care requirement. The requirements are shown for Two Plan Model and for GMC and COHS models.12 Most Medi-Cal beneficiaries who are eligible for Medicaid through receipt of public cash assistance are included in the mandatory group. In general, Medi-Cal eligibility aid categories that encompass beneficiaries qualifying due to disability or due to cash assistance related to disability (e.g., Supplemental Security Income, or SSI), children in foster care, and aid categories that see significant month-to-month eligibility changes due to share-of-cost status, are excluded from mandatory participation in Two Plan Model counties but are included in COHS and GMC counties.

The aid categories that comprise the mandatory and non-mandatory groups are further described in **Appendix A.1, Descriptive information for Medi-Cal eligibility aid categories**. This table summarizes managed care participation requirements and several other characteristics of Medi-Cal aid categories. One characteristic that is illustrated in the table is whether at least one beneficiary in the specific Medi-Cal aid category had at least one claim appear in the CCS authorized claims file.

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11 HCFA's approval of the waiver stated that SDHS must submit reports to HCFA on the first six months of Two Plan Model implementation in a county that included the number of beneficiaries applying for medical exemption during the reporting period; the diagnosis of the beneficiaries' condition (e.g., HIV/AIDS); whether the medical exemption was approved or denied; and any grievances or complaints that had been filed related to the medical exemption process during the reporting period (HCFA 1996).

12 Small differences are present across the different COHS and GMC models.
for the study period of 1994 through 1997. Tabulations of Medi-Cal claims show that approximately 76 eligibility aid categories contributed at least one CCS claimant between 1994 and 1997. Most aid categories contributed few claimants with about 87.8 percent of the CCS claimants coming from 10 aid categories.13

Other characteristics include whether the aid category bestows full scope or restricted14 Medi-Cal benefits to the beneficiary; whether the aid category requires share-of-cost15 for any or all beneficiaries; whether the aid category confers a mandatory managed care participation requirement in all versus some of the managed care expansion counties, and whether the aid category indicates that managed care participation is voluntary in some or all of the managed care expansion counties. The aid category are generally grouped in Table A.1 by the SDHS classification system.

In most counties, the proportion of beneficiaries in mandatory participation aid codes who in fact enrolled in the new managed care system was expected to increase sharply once the COHS plan or the Two Plan Model plans became operational. This was expected because the fee-for-service option was largely eliminated for new Medi-Cal applicants and for current beneficiaries in the mandatory aid categories. This was particularly true in the COHS counties because the aid categories conferring non-mandatory status in the COHS models mostly consisted of those eligible for Medi-Cal due to refugee status and those who became eligible for Medi-Cal retrospectively (e.g., those conferred with one or months of Medi-Cal eligibility based on expenditures incurred and thus

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13 Total CCS claimants from the aid categories with the largest claimant volume were as follows: 22.8 percent in aid code 30 (cash assistance); 20.4 percent in aid code 60 (Supplemental Security Income, or SSI); 10.6 percent in aid code 34 (low income, non-cash assistance); 9.2 percent in aid code 82 (medically indigent child); 7.7 percent in aid code 35 (cash assistance); 6.1 percent in aid code 58 (OBRA aliens with restricted Medi-Cal benefits); 3.5 percent in aid code 38 (transitional Medi-Cal); 2.6 percent in aid code 72 (133 percent of FPL for children); 2.5 percent in aid code 47 (185 percent FPL for infants); and 2.5 percent in aid code 42 (cash assistance foster care).

14 Some beneficiaries who qualify for Medi-Cal based on medical need without meeting public assistance income and resource limits receive a "restricted" Medi-Cal benefit rather than the standard, "full scope" benefit package. Restricted Medi-Cal covers emergency services and for pregnant women covers medically necessary pregnancy services including prenatal care and labor and delivery.

15 Share-of-cost (SOC) applies to some individuals who qualify for Medi-Cal through medically needy (MN) or medically indigent (MI) coverage provisions. Medically needy individuals are those who do not meet income and resource requirements for cash assistance. Medically indigent individuals are those who do not qualify for cash aid or for medically needy eligibility because they do not meet a disability standard or parental work status provision. SOC functions like a monthly deductible. An individual with SOC Medi-Cal becomes eligible for Medi-Cal once a certain amount has been expended on medical care. This "liability" amount will vary by family based on the difference between their income and a federally regulated "maintenance of need" amount. Once the "deductible" is met, Medi-Cal pays all additional costs. If SOC is not met, the individual is not "enrolled" in Medi-Cal for that month. The SOC amount that an individual must meet does not accumulate from one month to another. However, it is possible to carry over a medical bill that exceeds share-of-cost into the next month. Medically necessary services and products that are not part of the Medi-Cal benefit can be applied to share-of-cost (Protection & Advocacy 1994).
could not be assigned "retrospectively" to a health plan). These eligibility groups represent a relatively small proportion of total Medi-Cal beneficiaries.

Managed Care Models

The models of Medi-Cal managed care that were designed for implementation in the expansion counties included the following: County Organized Health Systems (COHS), Two Plan Models, and Geographic Managed Care (GMC).

The 1993 Strategic Plan identified the counties slated for COHS systems and also identified the Two Plan Model expansion counties. Counties were selected for participation in implementation of the Two Plan model based on several characteristics. According to a GAO report, two criteria that SDHS used for selection were (1) that the county had a minimum of 45,000 Medicaid beneficiaries who were eligible to participate in managed care (e.g., AFDC and like categories), and (2) that the county had an interest in participating or had a significant managed care presence in the county (GAO 1997).

County Organized Health Systems (COHS) The COHS is a county-administered, managed health care system for Medi-Cal beneficiaries. The COHS contracts with SDHS (under capitation) to provide health care to nearly all Medi-Cal beneficiaries residing in the county. Two counties in California have operated Medi-Cal managed care systems since the early 1980's. For these counties—Santa Barbara and San Mateo—CCS services are provided within a managed care system. This is in contrast to all other counties in which CCS services were paid on a fee-for-service basis by State DHS. The 1993 Strategic Plan included plans for additional COHS models in Orange and Santa Cruz counties with Solano and Napa counties added later.

Two Plan Model The 1993 Strategic Plan outlined a new type of Medi-Cal managed care system that would establish two competing plans within a county. This model was designed to promote competition by providing beneficiaries with a choice. In the Two Plan Model, a Commercial Plan selected by State DHS as part of a competitive bidding process would compete for beneficiaries along with a Local Initiative Health Plan. The Commercial Plan would be a federally licensed prepaid health plan, similar to the PHPs that contracted with Medi-Cal prior to the expansion. In contrast, the Local Initiative would be a locally designed, quasi-public managed care plan for which statutory governance rules and specific safety-net provider contracting provisions would apply.

The local initiative model was developed by SDHS to accommodate and support the viability of "safety-net" providers to Medi-Cal beneficiaries. Such providers included public county facilities (hospitals and clinics) as well as community clinics and federally qualified health centers (FQHCs) that had served the health care needs of medically indigent persons. The Local Initiative was a unique entity with some flexibility granted by statute for its network design and operations. While all Local Initiatives operate within state regulations, there is some variation in the administration and in the organization of the provider networks across counties. For example, Contra Costa County
built its Local Initiative around a pre-existing, county-organized health plan (Contra Costa Family Health Plan), while Alameda County created a county-operated plan with independent practice association (IPA) subcontractors. A different organizational strategy was adopted in Los Angeles County, where the Local Initiative operates as a quasi-public entity that is publicly accountable but not county administered, and contracts with seven "plan partners" (commercial prepaid health plans) to provide the medical care.

Counties that were selected for Two Plan Model implementation were Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Diego, San Francisco, Santa Clara, Stanislaus, and San Bernardino. Subsequently Tulare became a Two Plan Model County, while San Diego was switched to a Geographic Managed Care county. According to the SDHS Strategic Plan, counties in which public and private providers did not express interest in forming a local "consortium" for Medi-Cal managed care would be slated for development of a Geographic Managed Care system (described below).

**Geographic Managed Care (GMC)** In the Geographic Managed Care (GMC) model, SDHS planned to award a series of contracts to providers (prepaid health plans) at a sufficient number to cover the county's Medi-Cal beneficiary population. The GMC model began as a pilot in Sacramento County and subsequently became an expansion model. In these counties, State DHS contracts directly with multiple commercial plans in the particular county. In contrast to the COHS and Two Plan Model counties, the types of prepaid contracting arrangements that were in place changed relatively little in the GMC counties after the expansion. Counties that were designated as GMC counties included Sacramento and San Diego counties.

**Managed Care Network/Fee-for-Service (FFS/MCN)** The managed care network (MCN) was designed by SDHS for implementation in some of California's rural counties. In this model, primary care physicians contract with the county and provide case management to Medi-Cal beneficiaries. Reimbursement is on a fee-for-service basis with a case-management rate. Contracts for this system were offered to approximately 27 rural counties (CMA 1995). Several of these counties developed contracts with SDHS, including Sonoma and Placer counties.

### 3.4 Descriptive Analysis of California’s Title V Carve-Out Policy and Implementation

This section describes the design and implementation of California’s CCS specialty services carve-out.

**Development of the CCS Carve-out Policy**

California's Strategic Plan was ambitious in its scope and its timeframe for full implementation. It called for mandatory managed care enrollment of all beneficiaries in certain Medi-Cal eligibility aid categories, regardless of health status. In the 1993 Strategic Plan, SDHS stated that its "vision for managed care is an integrated system where the basic Medi-Cal benefit package is coordinated with the array of services that are currently only available through categorical or special waiver programs"
(SDHS 1993a). The plan also indicated that SDHS would solicit Children's Medical Services to "assist in the development of quality assurance criteria and procedures for the review of the care provided to this population by managed care contractors...." On the specific topic of inclusion of CCS services in the prepaid contracts, SDHS stated that "Some models may continue to reimburse CCS level services outside while others may incorporate full risk for all services."

Following the issuance of the Strategic Plan, concerns were voiced primarily by providers and by child health advocates that there was not adequate analysis of prepayment to protect Title V-eligible children in a fully capitated, prepaid environment. Advocates voiced concerns that prepaid health plans did not have adequate experience with these children and might subject children with CCS-eligible diagnoses to utilization review and other procedures that could be inconsistent with CCS standards. Legislation passed in 1993 specifically addressed the handling of CCS services within capitated managed care contracts. Assembly Bill 616 noted that the Medi-Cal program had the authority to "amend existing Medi-Cal managed care contracts to include the provision of medical benefits to persons who are eligible to receive medical benefits under publicly supported programs" and that as such, any managed care contractor serving children with CCS conditions must maintain and follow standards of care established by the CCS program. Continuing concerns by advocates culminated in legislation that was passed in 1994 and signed into law on September 28, 1994. The bill was sponsored by an advocacy organization (The Children's Lobby) and by a trade organization (the California Children's Hospital Association). The legislative bill originally proposed to exclude CHDP services (including prevention and treatment services) as well as CCS services from prepaid health plan contracts. However, the legislation that was passed had been modified to address only CCS services.

The Bergeson bill (SB 1371) authorized a “carve-out” of services provided for CCS eligible diagnoses from future Medi-Cal managed care contracts entered into by State DHS. It also included a provision for existing managed care contracts that placed the plan at financial risk for CCS services. The law prohibited renewal of the "CCS-include" contract provision when the contract

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16 A 1993 review of Medi-Cal managed care by HCFA's Regional Office noted the lack of financial incentives for EPSDT screening services in Medi-Cal managed care contracts. This review stated that "HMOs must absorb all EPSDT costs within capitation rates which are palpably low, and which have not been increased for the past two years (even though additional EPSDT service requirements have been added). Borrowing from the example of its PCCMs, the State should consider paying HMOs under FFS for CHDP/EPSDT health assessment services" (HCFA Region IX 1993).

17 Specifically, the bill language stated that "CCS covered services shall not be incorporated into any Medi-Cal managed care contract entered into after August 1, 1994...until three years after the effective date of the contract" and further that "providers serving children under the CCS program who are enrolled with a Medi-Cal managed care contractor but who are not enrolled in a pilot project pursuant to subdivision (c) shall continue to submit billing for CCS covered services on a fee-for-service basis until CCS covered services are incorporated into the Medi-Cal managed care contracts" (Senate Bill No. 1371). The bill also provided that "during the three-year time period described in subdivision (a), the department may approve, implement, and evaluate limited pilot projects under the CCS program to test alternative managed care models tailored to the special health care needs of children under the CCS program."
A final provision enacted by the Bergeson bill was to instruct SDHS to develop and implement a set of pilot projects to test various elements of managed care for the CCS population. Initially the bill enacted a three-year ban on managed care contracting for CCS services. However, the carve-out provision did not sunset in August 1997 due to legislation in August 1997 (SB 391) that extended the period of the carve-out to the year 2000, and to legislation in July 1999 (AB 1107) that extended the carve-out to 2005.

An important feature of the 1994 carve-out law is that it excludes from prepayment only those services specifically related to a child’s CCS-eligible diagnosis. All other medical services, which include preventive, primary care, specialty care, and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) supplemental services unrelated to the CCS-eligible diagnosis, are to be provided through the managed care plan as outlined in the Strategic Plan. The managed care participation requirement for a child does not change based on identification of a CCS eligible medical diagnosis. Like the managed care expansion provisions, upon start-up of the new managed care systems in the expansion counties, the CCS carve-out policy would immediately apply to all child Medi-Cal beneficiaries who participated in managed care. Because the policy defines the benefits and circumstances for which the plans are responsible, the policy applies to all child beneficiaries enrolled in a post-expansion managed care plan, whether the child enrolls voluntarily in a managed care plan (as a member of a voluntary participation group, such as SSI in a Two Plan Model County) or whether the child enrolls in a managed care plan due to membership in a mandated participation group.

**How the CCS Carve-Out Operates**

Coupled with the managed care expansion, the carve-out divides financial responsibility for health care between managed care organizations and the CCS program. Figure 3.4, Medi-Cal payer and authorization sources for services to potentially CCS-eligible children—With operating carve-out, illustrates the mechanisms by which medical services are paid once the carve-out is operational. This figure includes the possible payment arrangements within most counties, although as described below, not all of these payment arrangements can be exercised for all Medi-Cal child beneficiaries in the counties. As discussed below, some of the sources are unique to children enrolled in managed care, and others apply only to children in fee-for-service (i.e., non-mandatory

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18 COHS counties that were operational by 1994 (San Mateo and Santa Barbara) were unaffected by the carve-out legislation provisions, and the legislation exempted the Solano County COHS that was under development from its provisions. Napa County subsequently joined the Solano County COHS and thus was added to this group of counties exempt from the Bergeson carve-out.

19 As provided by the Strategic Plan and by subsequent policy decisions, other Medi-Cal services are excluded from the managed care contracts, including mental health, pharmaceuticals for HIV/AIDS, and certain medical services for beneficiaries with HIV/AIDS.

20 Children with SSI-related or foster care-related Medicaid eligibility and those children with share-of-cost Medicaid eligibility are not mandated to enroll in prepaid health plans, and unless they voluntarily enroll would continue to receive all Medi-Cal services on a fee-for-service basis.
eligibles). Like Figure 3.1, this figure shows that some Medi-Cal services can be submitted directly to Medi-Cal, while other services require authorization from CCS or from a local Medi-Cal field office. This figure shows the multiple potential authorization and payment sources with the CCS carve-out and managed care system in place.

Figure 3.4 – Medi-Cal payer and authorization sources for services to potentially CCS-eligible children—With operating carve-out

An important point illustrated in Figure 3.4 is that there are not only multiple authorization sources but also new organizations involved in the authorization and payment processes. The figure also illustrates the prepaid health plan mechanisms for payment, which can include per member per month payments to providers, and potentially fee-for-service (FFS) payments for some services under pre-authorization. It is important to note that those services for which a sub-contracting hospital or IPA/provider is at risk may vary by prepaid health plan. Some services may be paid FFS by a health plan and others covered within the capitation rate, depending on the county and the specific contract within the county. (A discussion earlier in this section addressed the presence of managed care contractors and their relationship to CCS prior to the expansion).
Implementation of the CCS Carve-out

The payment arrangements that operated prior to and following the managed care expansion are illustrated in Figure 3.5, Pre and post carve-out Medi-Cal payment arrangements—Managed care expansion counties, Figure 3.6, and Figure 3.7. To distinguish pre carve-out managed care plans ("PHPs") from post carve-out managed care plans—some of which are commercial prepaid health plans and some of which are Local Initiatives or County Organized Health System plans—all managed care plans operating under the carve-out provision are referred to as "MCPs" in the text and figures that follow.

For the managed care expansion counties, the implementation of the CCS carve-out occurs simultaneously with the mandate of participation in prepaid health plans. The exact start-up dates for the expansion and carve-out varied on a county-by-county basis. In the managed care expansion counties, the carve-out policy applies to any child Medi-Cal beneficiary who enrolls in a managed care plan operating under the Two Plan Model, GMC, or COHS system (with the exception of several counties). For children in voluntary or excluded aid categories who remain in the fee-for-service system in these counties, the carve-out policy does not apply unless they voluntarily enroll in managed care. The Two Plan counties continue to operate a fee-for-service Medi-Cal system for these children (as well as for the adult beneficiaries in these aid categories).

The implementation process for counties that implemented the CCS carve-out and mandatory managed care is illustrated in Figure 3.5. The figure shows how the possible payment arrangements in a county are telescoped into two possible arrangements in the post carve-out period: (1) fee-for-service Medi-Cal with fee-for-service CCS services, and (2) managed care Medi-Cal with fee-for-service CCS services. All PHP "CCS-include" contracts were phased out as the managed care expansion plans that would operate under the carve-out policy were phased in. Some Medi-Cal contracts with such PHPs expired prior to or at the expansion implementation date. Other such contracts were rolled over into the new "carve-out" contract arrangement if the PHP was part of the expansion system. In three (3) expansion counties, at least one PHP had a roll-over contract into a Commercial Plan or GMC contract. The expansion counties that had participation in "CCS include" prepaid health plans shortly before the expansion dates are identified in Table A.2, Commercial health plans operating in managed care expansion counties, pre and post carve-out. As indicated in the table, approximately eight (8) of the expansion counties had such plans in operation. This table also identifies the Commercial Plans that are participating in the Two Plan or GMC models.

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21 San Mateo and Santa Barbara counties have different arrangements that are not illustrated in this figure (these counties were fully implemented prior to the 1993 Strategic Plan and are not technically expansion counties). Also, Sacramento County continued to have one PHP (Kaiser) operate with a "CCS include" Medi-Cal contract following the expansion, and Solano and Napa counties were specifically identified in legislation as exceptions to the carve-out policy.
Figure 3.5 – Pre and post carve-out Medi-Cal payment arrangements—Non-managed care expansion counties that have no managed care

Shaded areas represent services that are capitated and prepaid to plans (per member per month)

Note: Prepaid health plans are referred to as PHPs in pre-carve-out period, and MCPs after carve-out

Figure 3.6 – Pre and post carve-out Medi-Cal payment arrangements—Non-managed care expansion counties that have voluntary managed care

Shaded areas represent services that are capitated and prepaid to plans (per member per month)

Note: Prepaid health plans are referred to as PHPs in pre-carve-out period, and MCPs after carve-out
Managed care participation for individuals in the mandated eligibility aid categories operated in the following way. Once a child enrolled in the managed care plan under the new system, the carve-out arrangement was in effect for that child. However, the expansions did not occur within the timeframe described in the Strategic Plan (1993 and 1994), nor did the Local Initiative and Commercial Plan in each county necessarily begin enrollment at the same time. For most of the Two Plan model counties, the Commercial Plan and the Local Initiative did not begin operations simultaneously, due to start-up delays for one plan or the other usually imposed by HCFA based on HCFA's readiness review. During this phase-in period, all Medi-Cal beneficiaries were given the opportunity to remain in fee-for-service, or to voluntarily enroll in the new (carve-out) managed care plan that was operational.

In the Two Plan Model Counties, when both the Local Initiative and the Commercial Plans became operational (or when both Commercial Plans were operational in a county that did not form a Local Initiative, such as Fresno County), those beneficiaries who were enrolled in health plans that had expiring Medi-Cal managed care contracts were either "rolled over" to one of the new contracting health plans or selected one of the operating health plans. A "default assignment" was applied to all beneficiaries in mandatory managed care groups who did not return managed care enrollment materials to SDHS or who did not specify a choice of managed care plans in the materials. The default assignment process generally followed a formula created by SDHS that was designed to achieve a certain flow of beneficiaries to the participating health plans within the county and to achieve a certain, pre-specified enrollment balance across the plans. (For example, the Local Initiative plan in each county was to maintain at least 60 percent of mandatory managed care eligibles, according to state law).

Experiences with "Roll-Out" in the Expansion Counties While managed care participation continued on a voluntary basis until all plans in the Two Plan Model counties were fully operational, in practice this voluntary basis was not identical to the voluntary participation...
provision that existed in the pre-expansion period with the commercial prepaid health plans. Specifically, as of July 1996 the SDHS policies and procedures in the Two Plan model counties were modified such that new Medi-Cal beneficiaries and also those undergoing their periodic eligibility redetermination were assigned to the sole operational plan by "default", unless the beneficiary stated a preference in the application materials for remaining in fee-for-service. This default assignment policy thus placed a greater responsibility on the beneficiary to exercise the fee-for-service choice than had existed prior to the policy.

The initial implementation schedule called for simultaneous operation start-up in March 1995 for all expansion counties (GAO 1997). However, the expansion counties not only implemented their managed care systems at different times but also experienced transition periods (e.g., the period of time between initial implementation of one plan through full implementation of both plans with default assignment) of different lengths due to factors that are inexorably linked to county characteristics. In some counties, default assignment was not implemented until several months after both plans were operational. These delays not only delayed the initial implementation date but also caused a staggered implementation by county.

Table 3.3, Implementation characteristics of counties with Medi-Cal managed care, presents Medi-Cal policy characteristics related to the managed care expansion and CCS carve-out by county. Specific characteristics include the total number of Medi-Cal aid categories affected by the expansion (and carve-out) in the Medi-Cal managed care expansion counties, the managed care model type and implementation date(s), the presence of PHPs and/or PCCMs in the pre-expansion period, the presence of PHP contracting with a CCS "carve-in" in the pre-expansion period, the presence of a CCS carve-out, and start dates by quarter and month of the study period (1994-1997). The start date refers to the first month in which any expansion managed care plan was operating under the carve-out policy. As this table illustrates, the date that both health plans were operational in Two Plan counties ranged from July 1996 to January 2000. These dates correspond to the date at which assignment to a health plan is required for all mandatory managed care beneficiaries. This is the "default assignment" start-up date described earlier. The dates that the two COHS expansion counties were fully operational came somewhat earlier, in January 1996 (Santa Cruz) and April 1996 (Orange).

The initial delays in system development and start-up occurred due to the lengthy planning and strategic development processes that had to take place at the county level, while delays imposed closer to the implementation dates most frequently were imposed by HCFA. Several delays unique to the Two Plan model counties included delay in developing a Request for Applications for the commercial plan selection, and in developing a Detailed Design Application for the local initiative applicant. Local initiatives also required statutory authority for operation, and thus legislation had to be written and adopted. Local initiatives had to develop an operational health plan from the ground up (and had to involve local stakeholders in their planning process) while commercial plans had to develop new provider networks to serve Medi-Cal beneficiaries in counties where they had not previously operated.
Table 3.3 – Implementation characteristics of counties with Medi-Cal managed care

<table>
<thead>
<tr>
<th>Managed care model</th>
<th>County (#)</th>
<th>County (analytical)</th>
<th>Total mandated aidcodes</th>
<th>Pre-MC expansion</th>
<th>Post-MC expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Any PHP/ PCCMs</td>
<td>CCS carve-out</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Any PHP &quot;carve-in&quot;</td>
<td>Plan type(s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Start date</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td>Study qtr (1-16)</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Study mo. (1-48)</td>
</tr>
</tbody>
</table>

**MC expansion counties—Early implementing counties (4)**

<table>
<thead>
<tr>
<th>Managed care model</th>
<th>County (#)</th>
<th>Total mandated aidcodes</th>
<th>Pre-MC expansion</th>
<th>Post-MC expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Any PHP/ PCCMs</td>
<td>CCS carve-out</td>
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<td>Any PHP &quot;carve-in&quot;</td>
<td>Plan type(s)</td>
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<td>Start date</td>
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<td></td>
<td></td>
<td>Study mo. (1-48)</td>
</tr>
</tbody>
</table>

2-plan Alameda (01) 26 Yes No Yes LI 1/1/96 9 25
2-plan Kern (15) 26 No No Yes LI 7/1/96 11 31
COHS Orange (30) 60 Yes No Yes --- 10/1/95 f 5 22
COHS Santa Cruz (44) 61 No No Yes --- 1/1/96 9 25

**Other MC expansion counties (10)**

2-plan Contra Costa (07) 26 Yes Yes (2) Yes LI 2/1/97 13 38
2-plan Fresno (10) 26 Yes No Yes CP-1 1/1/97 13 37
2-plan Los Angeles (19) 26 Yes Yes (10) Yes LI 4/1/97 14 40
2-plan Riverside (33) 26 Yes Yes (2) Yes CP 7/1/96 15 43
2-plan San Bernardino (36) 26 Yes Yes (3) Yes CP 9/1/96 11 33
2-plan San Francisco (38) 26 Yes Yes (3) Yes CP 1/1/97 13 37
2-plan San Joaquin (39) 26 Yes Yes (1) Yes LI 2/1/96 9 26
2-plan Santa Clara (43) 26 Yes Yes (1) Yes LI 2/1/97 13 38
2-plan Stanislaus (50) 26 No No Yes LI 10/1/97 16 46
2-plan Tulare (54) 26 No No Yes CP-1 2/1/99 --- ---

**Other MC expansion counties—Unique MC models (3)**

FFS/MCN Placer (31) 21 No No Yes --- 10/1/97 16 46
GMC San Diego (37) 22 Yes Yes (3) Yes --- 4/1/97 14 40
FFS/MCN Sonoma (49) 21 Yes Yes (1) Yes --- 3/1/97 13 39

**Other MC expansion counties—Not implementing CCS carve-out (5)**

COHS Napa (28) 65 No No No --- --- --- ---
GMC Sacramento (34) 22 Yes Yes (1) No' --- 4/1/94 2 4
COHS San Mateo (41) 66 --- --- No --- 1987 --- ---
COHS Santa Barbara (42) 61 --- --- No --- 1983 --- ---
COHS Solano (48) 66 --- --- No --- 5/1/94 2 5

**Non-MC expansion counties—With voluntary MC (3)**

--- Madera (20) --- Yes No No --- --- --- ---
--- Marin (21) --- Yes Yes (1) No --- --- --- ---
--- Yolo (57) --- Yes Yes (1) No --- --- --- ---
Sources: Highlights of the 1995 Program Changes (MCSS); Managed Care Annual Statistical Report for 1996; 1997; 1998 (MCSS); Eligible Counts by Managed Care Status and County, April 1998 (MCSS); CMS Information Notice No. 96-6 (May 6, 1996), Readme Documentation for Eligibility Extract File, MCSS, January 1998. Effective dates for CalOptima's phase-in of aidcodes come from California's Medical Assistance Program, Annual Statistical Report Calendar Year 1996 (MCSS). Effective dates for the carve-outs in managed care expansion counties come from MMCD, December 1999. Information on pre-MC expansion CCS "carve-in" (PHPs with CCS-include contract) from source dated January 1997

Marin and Yolo counties have voluntary enrollment PHPs (Madera in PCCMs); however, these counties are not part of the Medi-Cal managed care expansion

Napa was added to the Solano County COHS

Sacramento had one PHP with a CCS "carve-in" (Kaiser) (until the carve-out became effective for Kaiser in June 1998) and a CCS "carve-out" in effect for all other PHPs

Beginning late CY 1996 had PCCM contract with Tower

LI=Local Initiative, CP=Commercial plan

This is the effective date for CalOptima's phase-in of mandatory managed care for the following aidcodes (AFDC and AFDC-related aid groupings): 01, 02, 08, 3A, 3C, 3P, 3R, 30, 32, 33, 34, 35, 38, 39, 54, 59, 81, 82, 86.

This is the effective date for CalOptima's phase-in of mandatory managed care for the following aidcodes: 10, 14, 16, 18, 20, 24, 26, 28, 36, 6A, 6C, 60, 64, 65, 66, 68.

This is the effective date for CalOptima's phase-in of mandatory managed care for the following aidcodes: 03, 04, 13, 17, 23, 27, 37, 4C, 4K, 40, 42, 45, 5K, 63, 67, 83, 87.

---- Indicates start date in 1998 or 1999 (late implementers), or prior to 1994 (early implementers)

The delays that occurred later largely resulted from the "readiness reviews" that HCFA conducted prior to full implementation (mandatory participation) in each county. Most of the difficulties occurring in the counties that were identified by HCFA as necessitating a postponement had to do with the enrollment contractor or with deficiencies identified in the materials that beneficiaries were receiving about their managed care options. For example, the need to test enrollment broker capacity and functions delayed implementation in Fresno, Contra Costa, San Joaquin, and Santa Clara counties. HCFA postponed automatic assignment of beneficiaries in Santa Clara, San Joaquin, and Los Angeles who did not choose a plan, permitting only voluntary participation and thus slowing the implementation process (GAO 1997). The size of the affected population (over one million expected mandatory enrollees) in Los Angeles County caused a 1997 delay of several months due to HCFA concerns that enrollment problems would have an impact of substantial magnitude in such a large county. **Figure 3.8. Carve-out timing and duration of implementation transition**, illustrates the roll-out of the managed care expansion.
Other delays that were unique to the Commercial Plans or to other unique features of the Two Plan Model County continued to occur for the small number of the Two Plan Model counties that did not implement the managed care expansion by the end of the study period (December 1997). Implementation was postponed in Tulare County due to difficulties in organizing provider networks, while the commercial plan operating in San Bernardino and Riverside counties did not meet the federal Medicaid "25/75" requirement (GAO 1997). The Local Initiative in these counties began operations and continued to operate under voluntary participation.

Additional legislation pertaining to the relationship between CCS services and the scope of Medi-Cal managed care contractor's responsibilities for medical care was passed in 1996. Assembly Bill 3199 permitted SDHS to "approve, implement, and evaluate a pilot project in Tulare County" that would incorporate CCS services into the Local Initiative in that county. The bill stated that SDHS would be required to approve and develop such a pilot project "if requested by Tulare County." The bill provisions stated that children eligible for Medi-Cal and for CCS would be required to enroll as members of the Local Initiative and that the County of Tulare was authorized to negotiate with SDHS in developing this pilot project. Section (c) (1) provided that SDHS and a special advisory commission would need to agree on an appropriate capitation rate for services covered under CCS that would be "in compliance with federal and state laws and regulations" and "cost neutral to the
General Fund." Section (c) (2) (h) stated that such permission would be granted to SDHS until July 1, 1999 and that the bill would remain in effect until January 1, 2000 at which point the provision would be repealed unless additional legislation was passed before January 1, 2000 to extend the dates.22

**Impact of the Carve-out on Non-Expansion Counties**

While the carve-out provisions that related to CCS services under mandatory managed care did not apply to those counties that were not managed care expansion counties, the carve-out law did have some impact on non-expansion counties that had some Medi-Cal managed care contracting. For a small number of California counties that were not designated as Medi-Cal managed care expansion counties—including Marin and Yolo counties—State DHS had ongoing managed care contracts with prepaid health plans when the Bergeson legislation was passed. The pre and post-carve-out payment arrangements in these counties that had voluntary Medi-Cal managed care but were not expansion counties (and thus had no mandatory enrollment) are illustrated in Figure 3.7. As the figure shows, these counties had two options for Medi-Cal services at the time that the carve-out law was passed. These options were (1) participation in fee-for-service Medi-Cal, and (2) participation in a commercial prepaid health plan with a "CCS include" contract.

Initially the State DHS interpreted the Bergeson carve-out as applying only to (1) future managed care contracts in expansion counties; and to (2) existing managed care contracts in the expansion counties that might come up for renewal prior to the start up dates for the Two Plan Model plans or the COHS system. SDHS did not interpret the carve-out as applying to the managed care contracts that were operating in several non-managed care expansion counties. At the time, these counties included Madera, Marin, and Yolo counties. Following efforts by a state advocacy group for children, the State DHS reviewed its existing managed care contracts for compliance with the provisions of the Bergeson bill. In effect, SDHS thereby broadened the scope of its interpretation of the law so that the Bergeson provision on new contracts and contract renewals would apply to counties outside of the expansion counties (personal communication with CMS, July 1999). In late 1996 and early 1997, SDHS set a process in motion to exclude CCS services from the managed care contracts in the non-expansion counties that had operating Medi-Cal managed care contracts (personal communication with CMS, July 1999). Thus while SDHS eventually applied the carve-out provision to all PHP contracts, the date of the CCS services carve-out was the same date as the start-up date for mandatory PHP enrollment only in the expansion counties. More specifically, the dates were the same only in the expansion counties that implemented mandatory managed care prior to the end of 1997.

Finally, a large number (33) of California counties have not had any Medi-Cal managed care contracting. Figure 3.6 shows the payment arrangements in counties with no managed care over the course of the managed care expansion and CCS carve-out taking place in other counties. All of the

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22 Tulare had not developed a pilot that incorporated CCS services by the end of the study period (December 1997).
counties are rural and/or have small populations of Medi-Cal beneficiaries. Another two (2) counties—Sonoma and Placer counties—have FFS/MCN systems under development that provide physicians with a case management fee for providing case management in referral to and use of services outside of primary care. As indicated in Figure 3.6, all of these counties are basically maintaining fully fee-for-service Medi-Cal with CCS services continuing to be authorized on a fee-for-service basis by the CCS program. Most of these counties are listed in Table 3.3 as non-managed care counties and are referred to as "non-expansion" counties. Although they are essentially operating in a fee-for-service Medi-Cal system, Sonoma and Placer counties are identified in Table 3.3 as managed care expansion counties with unique systems because technically they are implementing a small feature of managed care.

Rate-Setting Methodologies and Impact of Carve-out on Capitation Rates

Because CCS services were excluded from prepaid contracts under the carve-out, SDHS developed capitation rates based on historical claims data that excluded those claims authorized by CCS. The approaches taken by SDHS for developing capitation rates prior to and following the carve-out are briefly described below.

In the pre-expansion managed care contracts, SDHS negotiated directly with prepaid health plans to establish per member per month (PMPM) capitated rates. A different rate setting methodology that was experienced-based was adopted for the expansion. The State of California used a complex methodology to develop payment rates for the new managed care systems. This methodology was based on the following: (1) historical claims (initially for FFS claims with dates of service of January 1993 through December 1993 and paid through July 1994, excluding COHS counties of San Mateo, Santa Barbara, and Solano); (2) experience with Medi-Cal managed care utilization in a COHS county (Santa Barbara); (3) projections for new benefits and utilization expectations; and (4) a lag factor for incurred but unpaid claims. The rate methodology included specific county adjustment factors and stratification by several eligibility group factors. Data from the Santa Barbara Health Authority were used to identify the expected units of service per vendor group and per eligibles for capitation rates for the base years of the Two Plan Model counties. The rationale for using utilization data from this COHS county was that Santa Barbara "is a well-managed managed care plan, and provides the best data available at this time" (SDHS 1995).

Because the Bergeson legislation excluded services for CCS eligible conditions from future (and any renewed) managed care contracts, State DHS produced capitation rates for managed care plans that excluded expected CCS service costs. These capitation rates were based on historical Medi-Cal claims and excluded all Medi-Cal claims that were known to be services provided for a CCS-eligible

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23 The per member per month capitation rates for Local Initiative and Commercial Plan contractors are issued annually by SDHS and published publicly. The capitation rates announced by SDHS have been contested in some instances by one or more Local Initiatives or Commercial Plans. In some instances these contested rates were subsequently augmented by SDHS. Rates for the COHS counties are negotiated and are not made publicly available.
diagnosis. More specifically, all claims that could be identified as having been authorized by CCS (i.e., those claims with a code indicating that the Treatment Authorization Request (TAR) was approved by CCS) were excluded from the rate-setting database (SDHS 1995). Consequently any paid Medi-Cal claims for services that were related to CCS diagnoses, but not authorized by CCS, would be included in the claims base used to create capitation rates. If CCS referral rates and service authorization requests increase as hypothesized, then total fee-for-service CCS authorized Medi-Cal payments could increase as such claims are increasingly picked up by CCS.

3.5 Summary

California developed a set of new delivery systems for Medicaid beneficiaries in the 1990's. The carve-out policy that was adopted in 1994 preserved the traditional Title V role of the CCS program. This chapter's review of Medi-Cal and Title V policy in California shows that the financial implications of referral changed with the carve-out, but that the requirement to refer potentially eligible children to CCS was not new. The policy created new financial incentives by preserving the fee-for-service reimbursement option only for those services that CCS programs would authorize. The difficulty in determining whether specific services are required exclusively for a particular diagnosis suggests that this mixed reimbursement policy could motivate cost-shifting from capitated care to the carved-out services. One result of such cost-shifting practices may be an increased rate of referral to CCS. A possible secondary effect may be compositional change within the CCS caseload in terms of medical diagnosis and expected expenditures per child.

Total services that children receive may not be affected by the carve-out policy, at least relative to what services would have been under a traditional, fully fee-for-service system. However, it is possible that their newly incentivized referral to the CCS program may (1) increase adherence to statutory CCS standards regarding provider paneling, and (2) increase children's access to the administrative case management functions of the CCS program. To the extent that these potential outcomes represent aspects of quality, any carve-out impact could be interpreted as indirectly promoting quality. While study limitations do not permit direct evaluation of this question, the imposed CCS carve-out may increase the proportion of child Medi-Cal beneficiaries with CCS eligible medical diagnoses who receive early and continuing care from CCS-approved physicians and ancillary providers.

24 Claims with procedure codes for organ transplant also were excluded. The Rate Development Branch in the Medi-Cal Policy Division used adjustments rather than claim exclusions to adjust for other services eliminated from managed care contracts. Those services included mental health services, long-term care facility charges (other than the month of admission and subsequent month), and ophthalmic lenses. A number of legislative adjustments also are made to the capitation rates as they become effective. Examples of the numerous legislative adjustments made in the base year capitation rates included an adjustment for a drug prescription limit (effective November 1994, prescriptions were limited to six per month resulting in a 6.8 percent reduction in the Pharmacy component), and an adjustment in the Pharmacy component (a reduction of 3 percent to Pharmacy because of a reduction in all pharmacy claims by 50 cents pursuant to Assembly Bill 2377 effective January 1995).