



California Children's Services Report 2009-2010

California Managed Risk Medical Insurance Board
Benefits and Quality Monitoring Division



July 2011



Healthy Families Program (HFP)

MRMIB provides and promotes access to affordable coverage for comprehensive, high quality, and cost effective health care services to improve the health of Californians.

Prepared by:

Marcia Schiller
Research Program Specialist I
Benefits and Quality Monitoring Division

Contributors:

Ruth Jacobs
Staff Services Manager II
Benefits and Quality Monitoring Division

Sarah Swaney
Staff Services Manager I
Benefits and Quality Monitoring Division

Juanita Vaca
Research Analyst II
Benefits and Quality Monitoring Division

Table of Contents

Program Summary		
I.	Introduction	1
II.	Background	1
III.	The CCS “Carve Out”	1
IV.	Summary of Findings	2
V.	Coordination Between CCS and HFP Plans	2
VI.	Data Sources	3
VII.	Data Anomalies	4
VIII.	Data Limitations and Future Data Plans	4
IX.	CCS Projects	4
X.	Charts	
	A. Plan Data	
	Chart 1 Health Plan Referrals as a Percentage of HFP/CCS Enrollment.....	6
	Chart 2 Health Plans HFP/CCS Referral Status.....	7
	Chart 3 Percentage of Total HFP/CCS Health Referrals by Age.....	8
	B. HFP/CCS Enrollment	
	Chart 4 Comparison of HFP and CCS Enrollment by Ethnicity.....	9
	Chart 5 HFP/CCS Cases as a Percentage of Health Plan Enrollment.....	10
	Chart 6 HFP/CCS Active Cases as a Percentage of HFP Enrollment.....	11
	C. CCS Cases and Expenditures	
	Chart 7 Percentage of Total CCS Cases by Program.....	12
	Chart 8 Percentage of Total CCS Expenditures by Program.....	12
	Chart 9 CCS Expenditures (in millions) for HFP Subscribers by Year.....	13
	Chart 10 Average Cost per HFP/CCS Case.....	13
	D. HFP/CCS Expenditures	
	Chart 11 The Most Frequent HFP/CCS Medical Conditions.....	14
	Chart 12 HFP Expenditures by CCS Medical Service.....	15

Table of Contents

Appendices

Appendix A	CCS Program Summary.....	17
Appendix B	Age and Status of HFP Children Referred to CCS and Total HFP/CCS Cases	19
Appendix C	Active HFP/CCS Cases as a Percentage of HFP Enrollment by Plan.....	20
Appendix D	Healthy Families/CCS Expenditures by Medical Condition.....	21
Appendix E	Healthy Families/CCS Expenditures by Service Type	22
Appendix F	Percentage of CCS Expenditures by Program.....	23
Appendix G	Total HFP/CCS Expenditures by County	24
Appendix H	HFP/CCS Average Cost per Child by County.....	26
Appendix I	CCS Referral Instructions and Response Template.....	27
Appendix J	MOU Template.....	29
Appendix K	Additional Resources.....	32

Program Summary

Program Summary

I. Introduction

The California Children's Services (CCS) Report for the Healthy Families Program (HFP) presents information on health, dental, and vision services that were provided to HFP children by the CCS Program from July 1, 2009 to June 30, 2010 (Fiscal Year 2009-2010). Each benefit year, 33 HFP contracted plans are required to report information regarding the number of children the plan referred to CCS for assessment and possible treatment of serious and/or chronic conditions. This report contains information on 30 health and dental plans. Vision plans reported no referrals or active CCS cases and, therefore, are not included in this report.

In addition to plan data, the Managed Risk Medical Insurance Board (MRMIB) obtains CCS enrollment and expenditure data from the Department of Health Care Services (DHCS), Children's Medical Services Branch (CMS).

This report summarizes the number of referrals plans made to county CCS programs in Fiscal Year 2009-2010, the number of active HFP/CCS cases by plan, the predominant conditions of HFP children served by CCS, and the CCS cost to provide care to HFP children. Further, the information from prior years tracks trends of costs and services provided to HFP children with CCS-eligible conditions. Monitoring the types and cost of services provided through CCS is important for MRMIB to ensure that children enrolled in HFP plans are receiving all covered medically necessary services.

II. Background

California Health and Safety Code Section 123800, et seq., authorizes the CCS Program. The legislative intent of the CCS Program is "to provide necessary medical services for children with CCS medically eligible conditions whose parents are unable to pay for those services either wholly or in part." The CCS Program provides services under Title V of the Social Security Act, which mandates the provision of care to children

with special health care needs. This includes children with certain health conditions such as diabetes, nerve and heart diseases, and congenital birth defects. CCS arranges, directs, and pays for medical services, equipment, and rehabilitation services provided by CCS-approved specialists for the treatment of CCS conditions.

CCS is a statewide program operated by each county under the oversight of the DHCS. CCS is supported by county, state, and federal funds.

County CCS programs:

- Assist children and families in navigating the CCS system;
- Expedite authorizations, claims approval, and processing;
- Provide information on client eligibility status to the counties; and
- Assist providers to obtain CCS-approved status.

Children who are eligible for CCS must have a CCS-eligible condition and are either:

- HFP enrolled;
- Medi-Cal enrolled; or
- California residents under age 21 with an annual household income of \$40,000 or less.

III. The CCS "Carve-Out"

Section 12693.62 of the California Insurance Code states that a participating plan "shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. Participating plans shall refer a child who they reasonably suspect of having a medical condition that is eligible for services under the California Children's Services Program... ."

Program Summary

HFP plans are required to refer a child to the CCS county program if the plan suspects the child could be eligible for CCS services. CCS then determines whether a child has a CCS-eligible condition (Section 123805 of the Health and Safety Code). Once a child is determined eligible for CCS, all services and care associated with the child's CCS condition and authorized by CCS are delivered by CCS-approved providers outside of the child's HFP health or dental plan and its network. This is known as the CCS "carve-out."

The child's HFP plan continues to be responsible for covering all other necessary health, dental, and vision care not covered or provided by CCS.

IV. Summary of Findings

- CCS provided services to 28,562 HFP children in FY 2009-2010. This represents 2.6% of all children enrolled in HFP.
- From FY 2008-2009 to FY 2009-2010, active CCS cases as a percentage of HFP enrollment have decreased from 3.1% to 2.6%. (Chart 6)
- Although the overall caseload (active HFP/CCS cases) has substantially decreased from FY 2008-2009 to FY 2009-2010, CCS referrals from all health and dental HFP plans have increased by 12.1% from the prior year (16,478 in FY 2008-2009 to 18,480 in FY 2009-2010).
- Health plan referrals increased by 11.6% and dental plan referrals increased by 17.1%.
- Total plan referrals for FY 2009-2010 is equal to almost two-thirds (65%) of the total number of active CCS/HFP cases at the end of the fiscal year.
- Consistent with HFP enrollment, Latinos represent the largest percentage of HFP/CCS children.

- Over the past 5 years the most common HFP/CCS medical conditions have remained constant. These are: coagulation disorders, malignancies (cancer), prematurity/live birth, cardiac, infectious diseases, and other congenital anomalies. A full listing of HFP/CCS conditions can be found in Appendix D.
- HFP/CCS children tend to be older than HFP children who are not in CCS.
 - More than half of HFP children referred to CCS by health plans are age 10 and older (59%).
 - Most of the HFP children referred to CCS by dental plans are age 10 and older (95%).
 - Only a small proportion of HFP children age 2 and under are referred to CCS (11%).
- Annual expenditures for HFP/CCS children decreased 19.4% from \$170 million in 2008-2009 to \$137 million in 2009-2010.
- Compared to FY 2008-2009, the average cost per HFP/CCS child decreased 22.6%, from \$6,630 to \$5,130 in 2009-2010.
- HFP children represent 7.7% of the overall CCS population, and they account for 6.8% of total CCS expenditures.
- The percentage of expenditures for all HFP/CCS medical categories has remained relatively constant from FY 2008-2009 to FY 2009-2010.

V. Coordination Between CCS and HFP Plans

Memorandum of Understanding (MOU)

HFP health, dental, and vision plans enter into a Memorandum of Understanding (MOU) with each county's CCS program in which the plan serves HFP subscribers.

Program Summary

The MOU describes the plan and county CCS program responsibilities in such areas as:

- Designation of plan and county liaisons
- Communication processes of liaisons
- Process for making referrals to CCS
- Case management
- Problem resolution.

Mediation of Issues

Issues arising between CCS and HFP participating plans usually involve either systemic or individual client concerns. To facilitate clear communication and address systemic issues, MRMIB hosts workgroup meetings with county CCS programs, the state CCS Program, and HFP plans. The meetings ensure that HFP children get the services and treatment they need for their CCS conditions.

In addition, MRMIB staff work to resolve individual problems reported by HFP subscribers, counties, and plans. Many of the issues reported by individual clients relate to payment for services. When these issues occur, MRMIB staff work with the parties to ensure that medically necessary services are properly provided. If the service was authorized by CCS, the provider is reimbursed by CCS. If a service was not authorized by CCS, MRMIB staff works with the family and the plan to resolve any payment or service issues.

VI. Data Sources

Each health and dental plan participating in HFP submitted data to MRMIB about the number of HFP children the plan referred to CCS during FY 2009-2010. Plans also reported the total number of children in the plan who were receiving services from CCS as of June 30, 2010. The state Department of Health Care Services (DHCS) CCS Program submitted annual cost and medical condition data to MRMIB

relating to the conditions and cost associated with HFP/CCS cases. Monthly enrollment of HFP subscribers in CCS is reported by DHCS. The MRMIB's website reports enrollment data for HFP subscribers.

Data Provided by the Plans:

- Number of FY 2009-2010 CCS Referrals that become:
 - Active cases*
 - Denied cases*
 - Pending cases*
- Ages of HFP children referred to CCS*
- Total number of active HFP/CCS cases**

Data Provided by CCS:

- Caseload
 - By Program**
 - HFP/CCS
 - Medi-Cal
 - CCS Only
 - By County**
 - By Ethnicity**
- Expenditures*
 - CCS expenditures by type of medical service
 - HFP/CCS expenditures by medical condition
 - HFP/CCS active caseload

Data Provided by MRMIB:

- Number of HFP enrollees by plan**
- Age of HFP enrollees by plan**
- Ethnicity of HFP enrollees**

* Information covers July 1, 2009 to June 30, 2010

** Information as of June 30, 2010

Program Summary

VII. Data Anomalies

Once a HFP child begins receiving CCS services, tracking the services he or she receives becomes difficult. Since a HFP child may be enrolled in a HFP health, dental, and vision plan, one child could be counted as an active CCS case under each plan in which they are enrolled.

VIII. Data Limitations and Future Data Plans

While there are some complications that can be addressed with further work between MRMIB staff, the HFP plans, and CCS, there are also some limitations that are difficult to overcome. First, some children are covered by accelerated enrollment in HFP. These procedures provide for seamless coverage during the process to determine whether the child is eligible for HFP or Medi-Cal. However, it is difficult to accurately track the expenditures for these children as they move between the two programs.

Second, when a child switches HFP health plans, the child becomes a unique user for the new health plan. With several plans leaving a number of counties during the 2009-2010 fiscal year, it is possible that two different plans counted the same child as a unique individual. However, point-in-time counts made on the last day of the fiscal year should capture each child at only one place at the end of the fiscal year, thus providing unduplicated counts of HFP children.

Third, payment of claims, which is the basis for expenditure information, can lag behind the timeframe for recording a referral or active/current case, sometimes falling into a more recent fiscal year. Therefore, some case data may fall into an earlier fiscal year than expenditure data.

Currently MRMIB does not receive claims data from CCS. Obtaining claims data would enable MRMIB to understand more fully the services HFP children receive from CCS.

In the future, MRMIB intends to seek additional information that will assist MRMIB in understanding the nuances of HFP/CCS clients and their needs such as the gender distributions and ethnicity of HFP/CCS clients.

IX. CCS Projects

Every five years, CCS is required to conduct an assessment of Children With Special Health Care Needs under Title V of the Social Security Act. CCS works with the Family Health Outcomes Project (FHOP) at the University of California, San Francisco to assess how well the needs of the CCS population are being met relative to the following six performance measures:

- 1) Families will partner in decision making.
- 2) Children and youth will have a medical home.
- 3) Families will have adequate health insurance.
- 4) Children are screened early and continuously for special health care needs.
- 5) Services are organized so families can use them easily.
- 6) Youth will receive transition services.

The 2010 report can be found at <http://fhop.ucsf.edu/fhop/>.

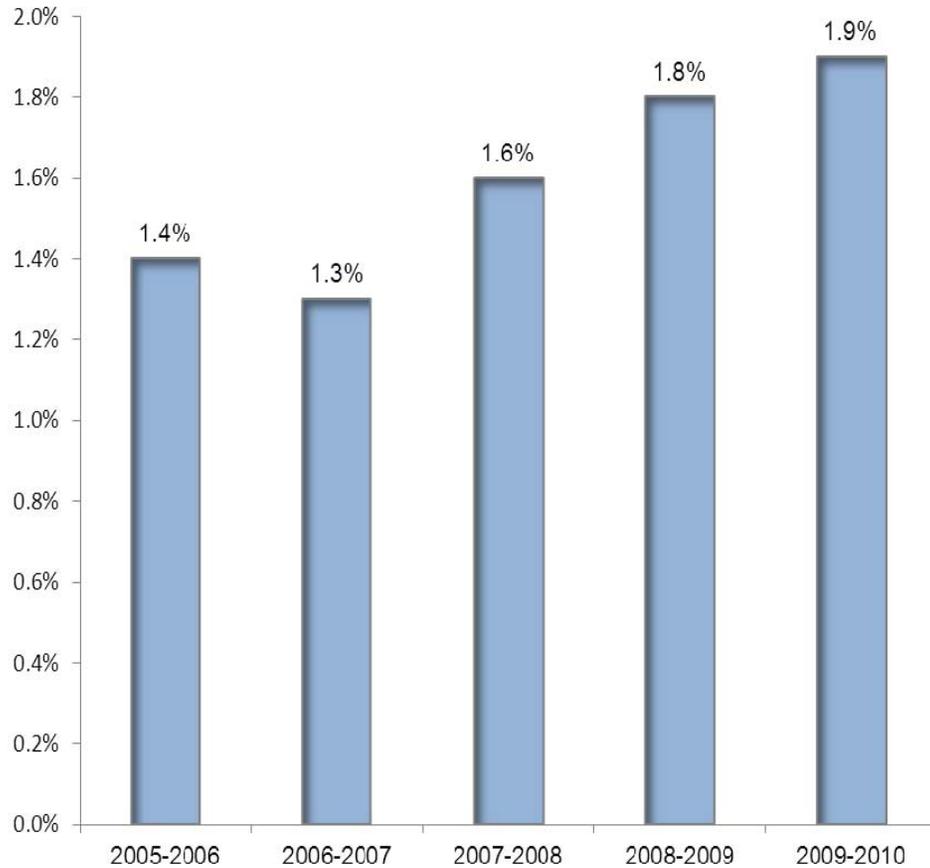
California's Section 1115 Medi-Cal waiver was approved by the Federal Centers for Medicare and Medicaid Services (CMS) on November 2, 2010. The waiver restructures the organization and delivery of health care for the most medically vulnerable populations, including children in the CCS Program. The 1115 Medi-Cal waiver is available at <http://www.dhcs.ca.gov/Documents/1115%20Waiver%20Fact%20Sheet%2011.2.10.pdf>.

INTENTIONALLY BLANK

Plan Data

Chart 1

Health Plan Referrals as a Percentage of HFP/CCS Enrollment



Data Sources:

Plan Data Referrals FY 2009-2010 and prior year data
MRMIB, HFP Current Enrollment as of 6/30/10 and prior year data

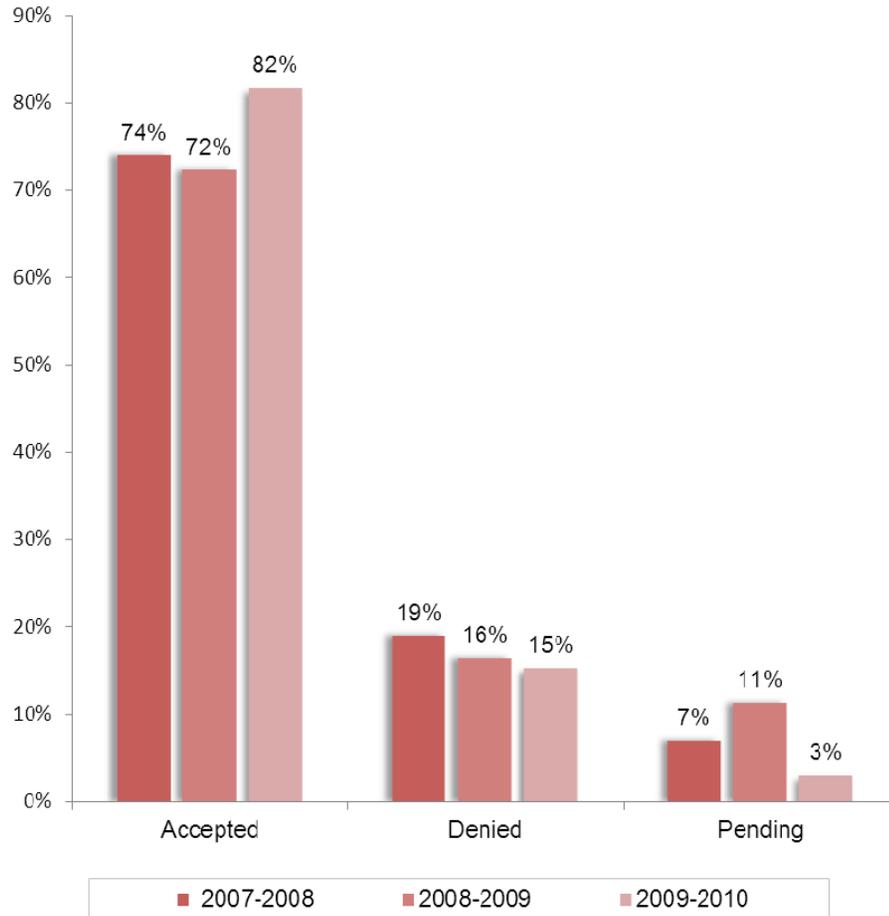
Findings

- For FY 2009-2010 health and dental plans referred 18,480 HFP children to CCS. This is an increase of 1,994 HFP cases over FY 2008-2009.
 - Health plans referred 16,740 (or 1.9%) of their HFP-enrolled children to CCS services.
 - Dental plans referred less than one percent (0.2%) of their HFP-enrolled children to CCS services.
- The increase in health plan referrals is a trend over the last four years.
- Appendix B details the number of referrals health and dental plans made to CCS in FY 2009-2010.

Plan Data

Chart 2

Health Plans HFP/CCS Referral Status



Data Source:

Plan Referrals for FY 2009-2010

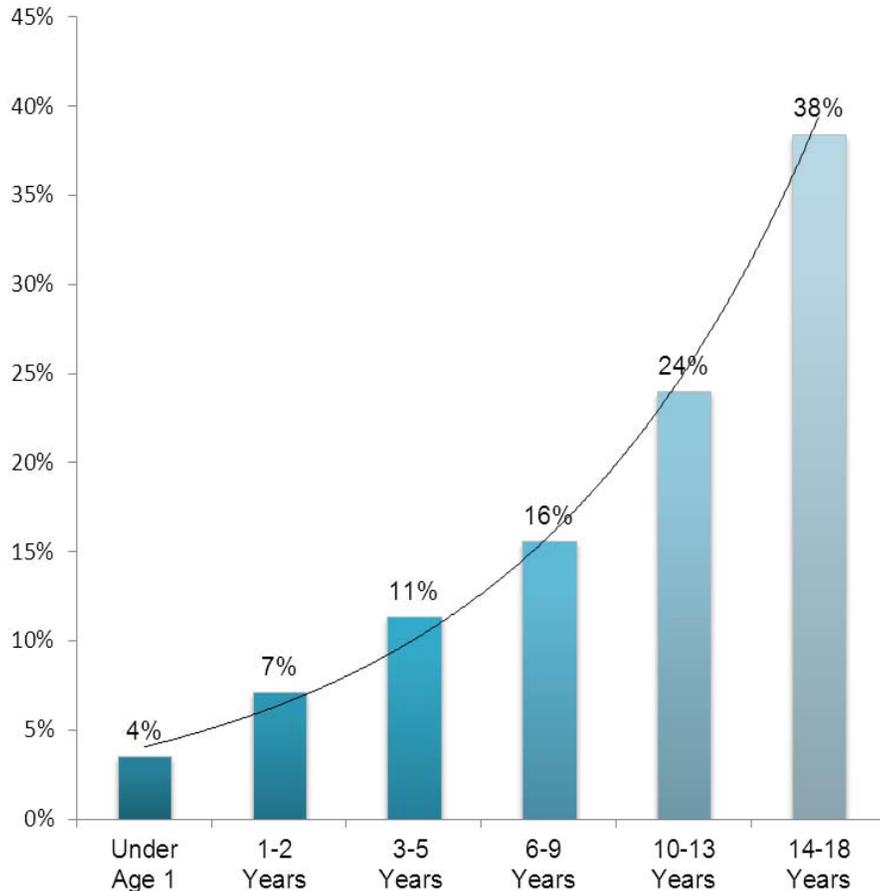
Findings

- Most referrals (82%) to CCS in FY 2009-2010 become active CCS cases.
- The following changes occurred between FY 2008-2009 and FY 2009-2010:
 - Accepted plan referrals increased by 10%
 - Denied plan referrals decreased by 1%
 - Pending plan referrals decreased by 8%
- There was a significant decline in the number of pending cases compared to FY 2008-2009. However, according to the plan, 78% of Delta Dental's referrals to CCS were pending as of June 30, 2010. (See Appendix B.)
- Most referrals to CCS by dental plans in FY 2009-2010 were accepted by CCS rather than being denied or pending.

Plan Data

Chart 3

Percentage of Total HFP/CCS Health Plan Referrals by Age



Data Source:
Plan Referrals for FY 2009-2010

Findings

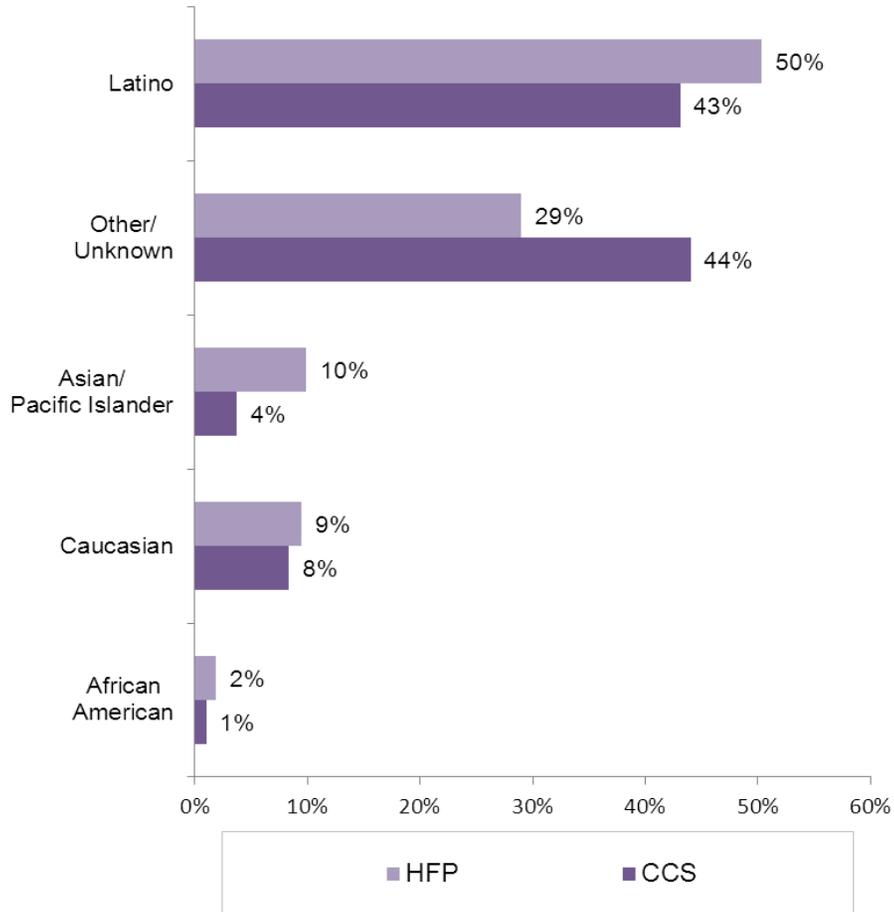
- HFP health plans referred 16,740 children in 2009-2010 (1.9% of HFP enrolled children).
- The rate of health plan referrals to CCS quickly increases with HFP child age.
- Health plan referrals:
 - More than one third (38%) of HFP plan referrals were for children ages 14 to 18.
 - Twenty-four percent (24%) of health plan referrals to CCS were for children age 10 to 13.
 - Thirty-eight percent (38%) of health plan referrals were for children under 10 years old.
- Dental plan referrals:
 - Dental plan referrals account for just under 10% of all referrals.
 - Ninety five percent (95%) of dental referrals are for children 10 and over.
- See Appendix B for specific data on plan referrals by age.

HFP/CCS Enrollment

Findings

- Latinos make up the highest percentage of HFP enrollment and of CCS cases (50% and 43% respectively).
- While Asian/Pacific Islander children make up 10% of HFP enrollment, they represent only 4% of HFP/CCS children.
- The Other/Unknown category represents cases for which the ethnicity is not known. The CCS Program uses the term "Other" and HFP uses the term "Unknown." CCS is able to classify more cases by specific ethnicity than HFP.

Chart 4
Comparison of HFP and CCS Enrollment by Ethnicity



Data Sources:

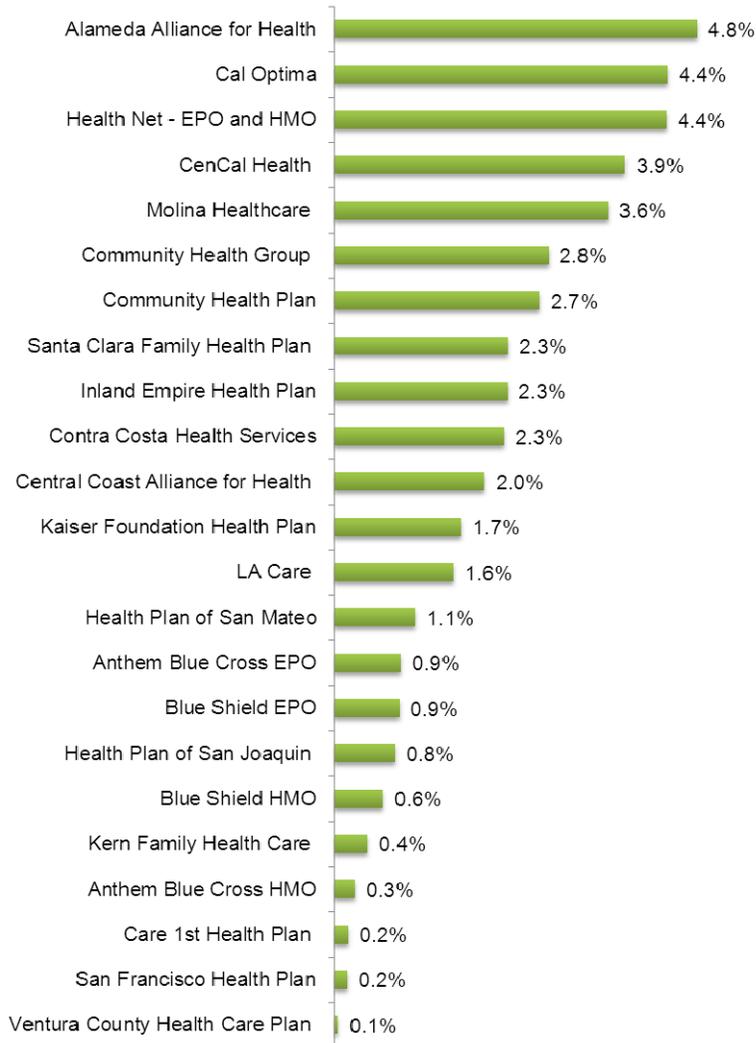
MRMIB, HFP Current Enrollment as of June 30, 2010

DHCS, CCS Participant Count as of June 30, 2010

HFP/CCS Enrollment

Chart 5

HFP/CCS Cases as a Percentage of Health Plan Enrollment



*Health Net data for EPO and HMO are combined.

Data Sources:

DHCS, CCS Participant count as of June 30, 2010

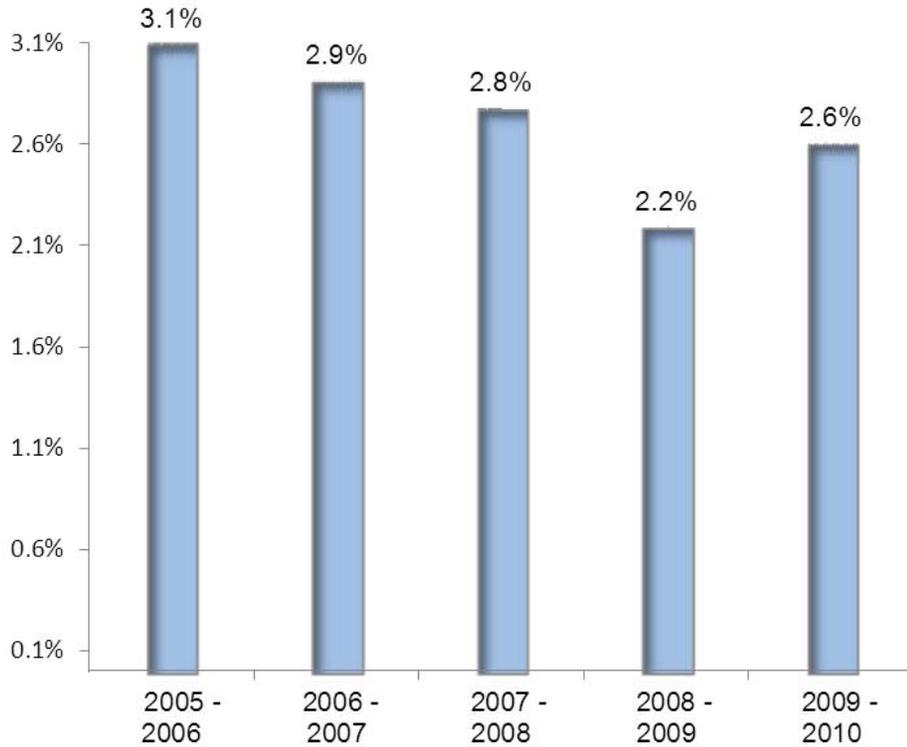
MRMIB, HFP Current Enrollment as of June 30, 2010

Findings

- The total number of active HFP/CCS cases for health plans ranges from 2 cases for Ventura County Health Care Plan (0.1% of the plan's HFP enrollment) to 415 cases for Alameda Alliance for Health (4.8% of the plan's HFP enrollment).
- Larger plans have a greater number of cases but a lesser percentage of the total plan enrollment.
- See Appendix C for specific data on the number of active HFP/CCS cases.

HFP/CCS Enrollment

Chart 6
HFP/CCS Active Cases
as a Percentage of HFP Enrollment



Findings

- Almost three percent (2.6%) of HFP members received CCS services in FY 2009-2010.
- The percentage of HFP/CCS cases has been declining over the past 5 years, from 3.1% in FY 2005-2006 to 2.6% in FY 2009-2010.

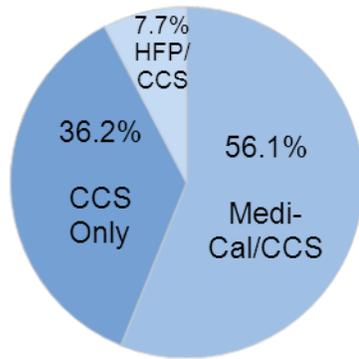
Data Sources:

Health Plan Active HFP/CCS Cases as of June 30, 2010
DHCS, CCS Participant Count as of June 30, 2010

CCS Cases and Expenditures

Findings

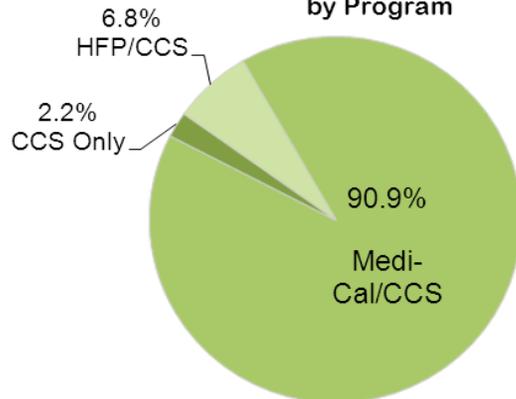
Chart 7
Percentage of Total CCS Cases
by Program



- 7.7% of children served by CCS in FY 2009-2010 were HFP subscribers, and they accounted for 6.8% of total CCS expenditures.
- More than one-third (36.2%) of children served by CCS in FY 2009-2010 were CCS-only (children with annual family income of \$40,000 or less), but they accounted for only 2.2% of the total CCS expenditures.
- More than half (56.1%) of children served by CCS were Medi-Cal subscribers, but they accounted for 90.9% of the total CCS expenditures.

Data Source: DHCS, CCS Participant Count as of 6/30/10

Chart 8
Percentage of Total CCS Expenditures
by Program

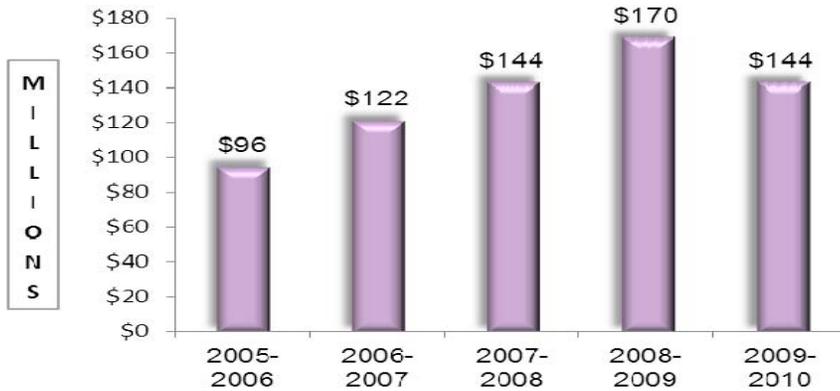


Data Source: DHCS, CCS Participant Count as of 6/30/10

CCS Cases and Expenditures

Chart 9

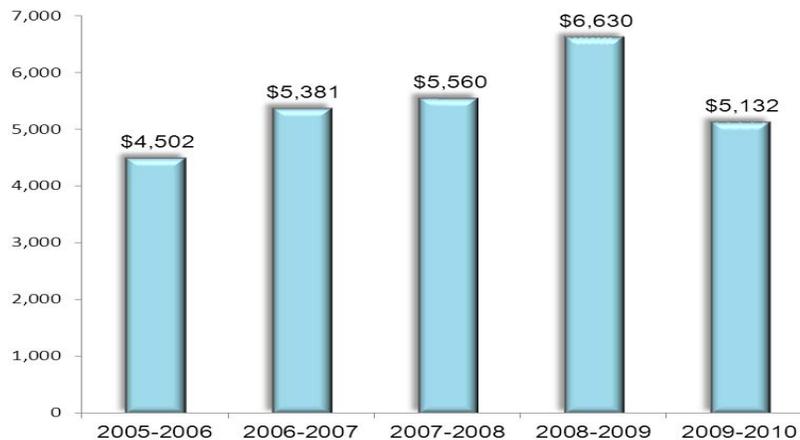
CCS Expenditures for HFP Subscribers by Year



Data Source: DHCS, CCS Paid Claims for FY 2009-2010

Chart 10

Average Cost per HFP/CCS Case



Data Sources:

DHCS, CCS Paid Claims FY 2009-2010 and prior year reports

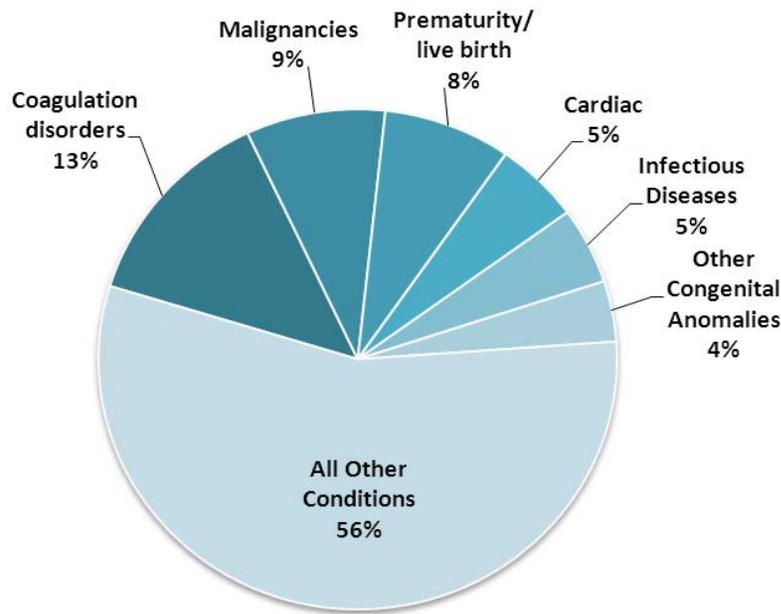
DHCS, CCS Participant Count end of FY 2009-2010 and prior year reports

Findings

- Expenditures dropped from \$169.5 million in FY 2008-2009 to \$144.1 million in FY 2009-2010, a decrease of \$25.4 million or fifteen percent (15%). This reverses a trend of increases in expenditures over the previous four years.
- CCS has spent over \$919 million on services for HFP members since 2000. These are costs that would have been incurred by HFP plans if not for the CCS carve out.
- In FY 2009-2010, the average cost per active HFP/CCS case was \$5,132 per year, which is a 22.6% decrease from FY 2008-2009.
 - It is not clear why the average cost per case declined so dramatically.
 - This decline requires further research and discussion with CCS.

HFP/CCS Expenditures

Chart 11
Expenditures for the
Most Frequent Medical Conditions



Data Source:

DHCS, CCS paid claims for FY 2009-2010

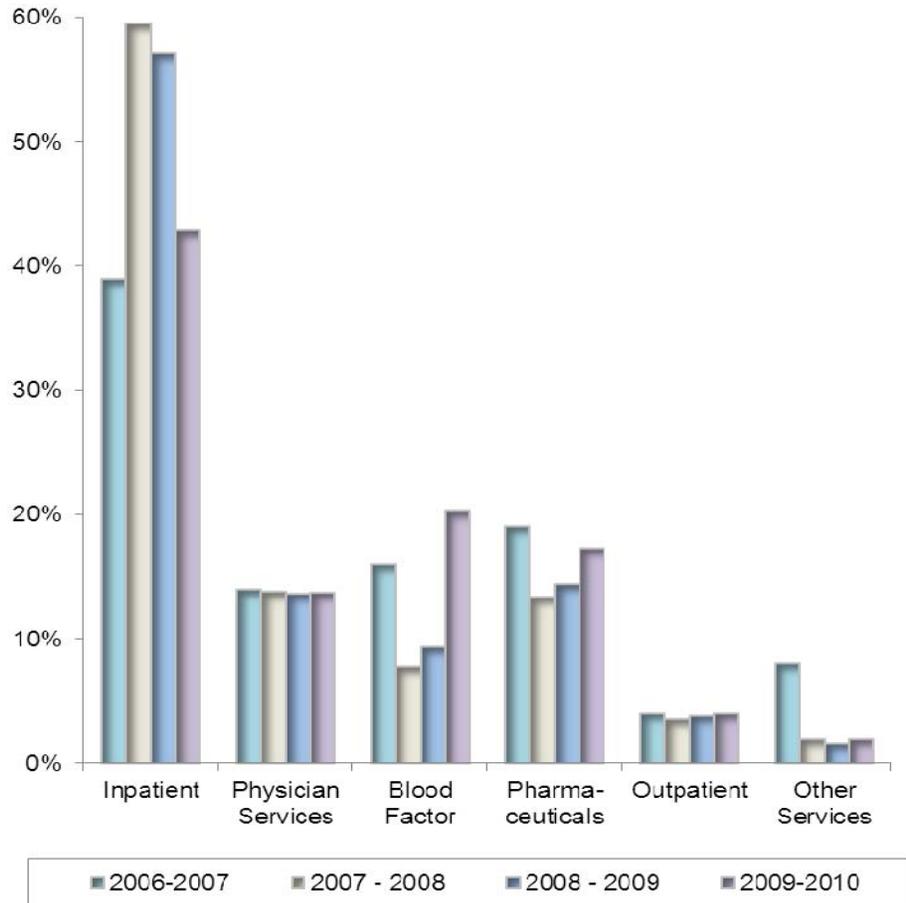
Findings

- The CCS condition categories with the highest percentage of expenditures have remained the same over the past several years.
- For FY 2009-2010, the top six expenditures for CCS conditions total 44.3% of expenditures for all medical conditions: These top expenditures are:
 - Coagulation disorders – Includes conditions such as hemophilia. About thirteen percent (13.3%) of HFP/CCS expenditures were for blood conditions.
 - Malignancies - Includes cancers of various types. This accounts for over eight percent (8.7%) of HFP/CCS expenditures.
 - Prematurity/live birth - Prematurity/live birth accounted for 8.0% of HFP/CCS expenditures and eight percent (8.0%) of HFP/CCS expenditures in FY 2009-2010.
 - Cardiac - Includes a range of congenital heart problems and diseases of the heart, representing 5.3% of HFP/CCS expenditures.
 - Infectious Diseases - Infections that involve the central nervous system, bone, or eye and lead to physical disabilities or blindness. Five percent (5%) of CCS/HFP expenditures were for treatment of these infectious diseases.
 - Other Congenital Anomalies - Includes health problems present at birth such as spina bifida, cleft palate, and cardiac conditions. Other Congenital Anomalies represented 3.9% of HFP/CCS expenditures.
 - The main trend over the last 3 years is that malignancies have decreased and coagulation disorders have increased.

Appendix D details the actual dollars spent by condition for HFP/CCS children for the past four years.

HFP/CCS Expenditures

Chart 12
HFP/CCS Expenditures
by CCS Medical Service



Findings

Changes by Medical Service:

- Inpatient care remains the highest category of HFP/CCS costs over the last four years. Compared to FY 2008-2009, the percentage of medical costs devoted to inpatient services in FY 2009-2010 has decreased from 57% to 43%.
- The cost of both Physician Services* and Outpatient Services has remained very stable for the 4 year period, at about 14% and 4% respectively of HFP/CCS expenditures.
- Blood Factor has increased over the last three years, accounting for 20% of HFP/CCS expenditures in FY 2009-2010.
- Pharmaceutical costs have varied from 13% to 19% over the past four years.

Appendix E contains the details of expenditures by service type.

Data Source:
DHCS, CCS Paid Claims FY 2009-2010 and prior year reports

*For the purpose of this chart, Blood Factor in Chart E was moved from the general Medical/Physician category and made into its own category.

Appendices

Appendix A – CCS Program Summary

Who qualifies for CCS services?

- Any HFP enrollee with a medical condition covered by CCS (7.7% of all CCS cases).
- Any Medi-Cal enrollee with a medical condition covered by CCS (56.1% of all CCS cases).
- Other California children who meet the medical, residential, and financial eligibility requirements of CCS ("CCS-Only" 36.2% of all CCS cases):
 - Medical conditions that are covered by CCS
 - Under 21 years of age
 - Family income of \$40,000 or less
 - Out of pocket medical expenses expected to be more than 20% of family income
 - California resident.

Funding for Services

Funding for CCS provided to HFP members comes from a combination of federal (65%), state (17.5%), and county (17.5%) funds. A county's financial responsibility is waived for HFP members whose annual family income is determined to be greater than \$40,000. In those cases, the state pays 35% of CCS costs.

For "CCS only" children, funding is 50% state and 50% county. For Medi-Cal children needing CCS, funding is 50% federal and 50% state.

CCS Program Financing				
	CCS/ Medi-Cal	CCS/HFP under \$40k	CCS/HFP > \$40k	CCS Only
State	50%	17.5%	35%	50%
County		17.5%		50%
Federal Match	50%	65%	65%	

CCS Services

CCS covers all medically necessary services and treatment for the child's CCS condition, including:

- Physician services
- Emergency services
- Inpatient and outpatient hospital services
- Home health care
- Prescription medications
- Diagnostic services such as laboratory tests and x-rays
- High-risk infant follow-up
- Orthopedic appliances and durable medical equipment.

CCS provides medical case management, including:

- Assistance obtaining specialty care
- Referral to other agencies including public health nurses and regional centers
- Coordination of specialty care center services for complex medical conditions that require many specialists working together
- Arranging for physical therapy and/or occupational therapy in public schools
- Other services to help parents and children such as counseling, transportation to medical appointments, lodging and meals, where appropriate
- Other medical services when determined by the CCS Program to be medically necessary.

Appendix A – CCS Program Summary

CCS-eligible medical conditions include the following:

- Conditions involving the heart (e.g., congenital heart diseases, rheumatic heart disease)
- Neoplasms (e.g., cancer, tumors)
- Disorders of the blood/coagulation disorders (e.g., hemophilia A [Factor VIII deficiency], Hemophilia B [Factor IX deficiency], sickle cell anemia)
- Disorders of the respiratory system (e.g., cystic fibrosis, chronic lung disease)
- Disorders of the genito-urinary system (e.g., serious kidney problems)
- Endocrine, nutritional, and metabolic disorders (e.g., thyroid problems, PKU, diabetes)
- Disorders of the gastrointestinal system (e.g., chronic inflammatory disease, diseases of the liver such as biliary atresia)
- Serious birth defects (e.g., cleft lip/palate, spina bifida)
- Disorders of the sense organs (e.g., hearing loss, glaucoma and cataract)
- Disorders of the nervous system (e.g., cerebral palsy, uncontrolled seizures)
- Disorders of the musculoskeletal system and connective tissues (e.g., rheumatoid arthritis, muscular dystrophy)
- Severe disorders of the immune system (e.g., HIV infection)
- Disabling conditions or poisonings requiring intensive care or rehabilitation (e.g., severe head, brain, or spinal cord injuries, severe burns)
- Complications of premature birth requiring an intensive level of care
- Disorders of the skin and subcutaneous tissue (e.g., severe hemangioma)
- Medically handicapping malocclusion (e.g., severely crooked teeth)

Appendix B – Age and Status of HFP Children Referred to CCS and Total HFP/CCS Cases

Benefit Year 2009 - 2010 PLANS	Referrals by Age							Referrals by Status							Family Refused Referral	Active CCS/ HFP Cases
	Under age 1	1-2 years	3-5 years	6-9 years	10-13 years	14-18 years	Total	Accepted		Denied		Pending		Total		
								#	%	#	%	#	%			
Alameda Alliance for Health	2	9	16	19	25	24	95	53	56%	42	44%	0	0%	95	0	415
Anthem Blue Cross EPO	126	127	167	210	254	479	1,363	1,029	75%	176	13%	158	12%	1,363	0	857
Anthem Blue Cross HMO	142	22	45	45	95	150	499	367	74%	92	18%	40	8%	499	0	318
Blue Shield EPO	0	33	72	65	69	89	328	184	56%	96	29%	48	15%	328	0	98
Blue Shield HMO	1	89	189	219	235	296	1,029	636	62%	304	30%	89	9%	1,029	0	309
Cal Optima	5	59	196	303	457	859	1,879	1,814	97%	63	3%	2	0%	1,879	0	1,724
Care 1st Health Plan	0	3	2	4	6	8	23	17	74%	6	26%	0	0%	23	0	23
CenCal Health	1	5	0	5	15	24	50	42	84%	8	16%	0	0%	50	0	302
Central Coast Alliance for Health	19	22	19	28	28	45	161	158	98%	3	2%	0	0%	161	0	394
Community Health Group	10	49	107	94	229	293	782	714	91%	68	9%	0	0%	782	1	714
Community Health Plan	0	4	16	24	68	186	298	272	91%	26	9%	0	0%	298	0	413
Contra Costa Health Services	0	1	4	5	11	5	26	21	81%	5	19%	0	0%	26	0	87
Health Net EPO and HMO	65	254	360	432	585	979	2,675	2,283	85%	334	12%	58	2%	2,675	0	6,096
Health Plan of San Joaquin	6	25	49	48	74	127	329	210	64%	119	36%	0	0%	329	0	142
Health Plan of San Mateo	0	1	0	0	2	3	6	0	0%	6	100%	0	0%	6	0	65
Inland Empire Health Plan	60	295	428	627	829	1,103	3,342	2,890	86%	384	11%	68	2%	3,342	1	1,333
Kaiser Foundation Health Plan	115	226	278	457	626	927	2,629	1,921	73%	694	26%	14	1%	2,629	0	2,708
Kern Family Health Care	11	31	34	49	62	117	304	272	89%	24	8%	8	3%	304	0	51
LA Care	0	7	6	9	10	30	62	37	60%	22	35%	3	5%	62	0	129
Molina Healthcare	69	30	39	66	68	150	422	400	95%	21	5%	1	0%	422	0	1,439
San Francisco Health Plan	7	6	4	4	10	6	37	14	38%	10	27%	13	35%	37	0	14
Santa Clara Family Health Plan	0	7	32	40	39	55	173	168	97%	5	3%	0	0%	173	0	379
Ventura County Health Care Plan	12	11	26	45	55	79	228	167	73%	61	27%	0	0%	228	0	2
Health Plan Totals	651	1,316	2,089	2,798	3,852	6,034	16,740	13,669	81.7%	2,569	15.3%	502	3.0%	16,740	2	18,012
Access Dental	0	0	0	0	5	36	41	29	71%	2	5%	10	24%	41	0	63
Delta Dental	0	0	0	0	34	21	55	10	18%	2	4%	43	78%	55	0	272
Health Net Dental	0	0	0	68	123	320	511	478	94%	33	6%	0	0%	511	3	9,154
Premier Access Dental	0	0	0	0	1	10	11	11	100%	0	0%	0	0%	11	0	27
Safeguard Dental	0	0	2	8	255	412	677	577	85%	100	15%	0	0%	677	0	577
Western Dental Services	0	0	0	1	158	286	445	400	90%	44	10%	1	0%	445	2	457
Dental Plan Totals	0	0	2	77	576	1,085	1,740	1,505	86.5%	181	10.4%	54	3.1%	1,740	5	10,550
Health and Dental Plans	651	1,316	2,091	2,875	4,428	7,119	18,480	15,174		2,750		556		18,480	7	28,562

Data Source: Plan data FY 2009-2010

Appendix C – Active HFP/CCS Cases as a Percentage of HFP Enrollment by Plan

Plan Name	Plan's Active HFP/CCS Cases	Plan Enrollment	Percentage of Plan Enrollment
Alameda Alliance for Health	415	8,648	4.8%
Anthem Blue Cross EPO	857	97,333	0.9%
Anthem Blue Cross HMO	318	114,452	0.3%
Blue Shield EPO	98	11,370	0.9%
Blue Shield HMO	309	47,739	0.6%
Cal Optima	1,724	39,053	4.4%
Care 1st Health Plan	23	11,889	0.2%
CenCal Health	302	7,842	3.9%
Central Coast Alliance for Health	394	19,749	2.0%
Community Health Group	714	25,162	2.8%
Community Health Plan	413	15,200	2.7%
Contra Costa Health Services	87	3,862	2.3%
Health Net EPO and HMO	6,096	139,363	4.4%
Health Plan of San Joaquin	142	17,486	0.8%
Health Plan of San Mateo	65	6,034	1.1%
Inland Empire Health Plan	1,333	58,025	2.3%
Kaiser Foundation Health Plan	2,708	161,015	1.7%
Kern Family Health Care	51	11,442	0.4%
LA Care	129	8,180	1.6%
Molina Healthcare	1,439	39,702	3.6%
San Francisco Health Plan	14	7,807	0.2%
Santa Clara Family Health Plan	379	16,482	2.3%
Ventura County Health Care Plan	2	3,628	0.1%
Health Plan Totals	18,012	871,463	2.1%
Access Dental	63	149,409	0.0%
Delta Dental	272	328,561	0.1%
Health Net Dental	9,154	109,801	8.3%
Premier Access Dental	27	31,242	0.1%
Safeguard Dental	577	141,962	0.4%
Western Dental Services	457	110,488	0.4%
Dental Plan Totals	10,550	871,463	1.2%

Data Sources:

Plan Active HFP/CCS Cases as of June 30, 2010
MRMIB, HFP Current Enrollment as of June 30, 2010

Appendix D - HFP/CCS Expenditures by Medical Condition

Medical Condition	Expenditures by Year				% of Total Expenditures 2009-2010
	2006-2007	2007-2008	2008-2009	2009-2010	
Other conditions*	\$58,837,163	\$43,842,456	\$52,683,902	\$43,475,681	31.7%
Coagulation disorders	\$14,052,257	\$10,891,813	\$16,518,683	\$18,294,343	13.3%
Malignancies	\$9,937,615	\$20,401,639	\$20,399,461	\$11,981,341	8.7%
Prematurity/live birth	\$0	\$12,094,804	\$11,419,394	\$10,972,037	8.0%
Cardiac	\$8,119,454	\$9,367,535	\$11,008,198	\$7,330,141	5.3%
Infectious Diseases	\$1,728,519	\$3,360,880	\$9,505,340	\$6,822,030	5.0%
Other Congenital Anomalies	\$0	\$6,680,100	\$7,555,559	\$5,400,424	3.9%
Intestinal	\$1,204,847	\$5,052,174	\$6,277,896	\$5,233,476	3.8%
Joint disorders	\$1,154,267	\$4,233,376	\$3,668,384	\$4,883,420	3.6%
Other trauma	\$4,211,982	\$4,270,020	\$5,079,997	\$4,790,448	3.5%
Diabetes	\$1,942,458	\$2,528,148	\$3,019,443	\$2,980,355	2.2%
ENT (ear, nose, throat)	\$1,870,558	\$1,558,097	\$2,713,711	\$2,208,870	1.6%
Renal	\$3,272,178	\$2,603,817	\$1,266,580	\$2,174,157	1.6%
Head injury	\$849,004	\$3,453,864	\$4,472,318	\$1,478,770	1.1%
Metabolic disorders	\$1,713,883	\$684,450	\$974,616	\$1,407,709	1.0%
Cystic fibrosis	\$766,782	\$1,283,547	\$1,751,802	\$1,261,426	0.9%
Ophthalmology	\$1,114,217	\$1,389,460	\$1,470,014	\$1,163,174	0.8%
Immune disorders	\$245,949	\$651,284	\$524,366	\$848,858	0.6%
Pituitary disorders	\$826,254	\$53,415	\$509,261	\$842,229	0.6%
Cleft palate/lip	\$781,553	\$793,955	\$947,131	\$668,105	0.5%
Anemias	\$759,996	\$837,584	\$989,593	\$545,277	0.4%
Spina bifida	\$507,008	\$538,680	\$456,765	\$490,816	0.4%
Cerebral palsy	\$415,951	\$764,627	\$590,473	\$450,661	0.3%
Other fractures	\$4,446,488	\$4,016,327	\$4,486,952	\$393,788	0.3%
Hemoglobinopathies	\$567,072	\$424,818	\$508,504	\$382,754	0.3%
Thyroid disorders	\$209,525	\$254,217	\$251,805	\$357,910	0.3%
Myopathies	\$51,855	\$470,044	\$258,503	\$266,819	0.2%
Asthma	\$123,519	\$228,404	\$159,423	\$243,564	0.2%
TOTAL:	\$119,710,354	\$142,729,535	\$169,468,074	\$137,348,583	100.0%

*Other Conditions includes all ICD-9CM medical conditions with smaller expenditures and which are not listed individually, in the above chart.
Data Source: DHCS, CCS paid claims FY 2009-2010 and prior year reports.

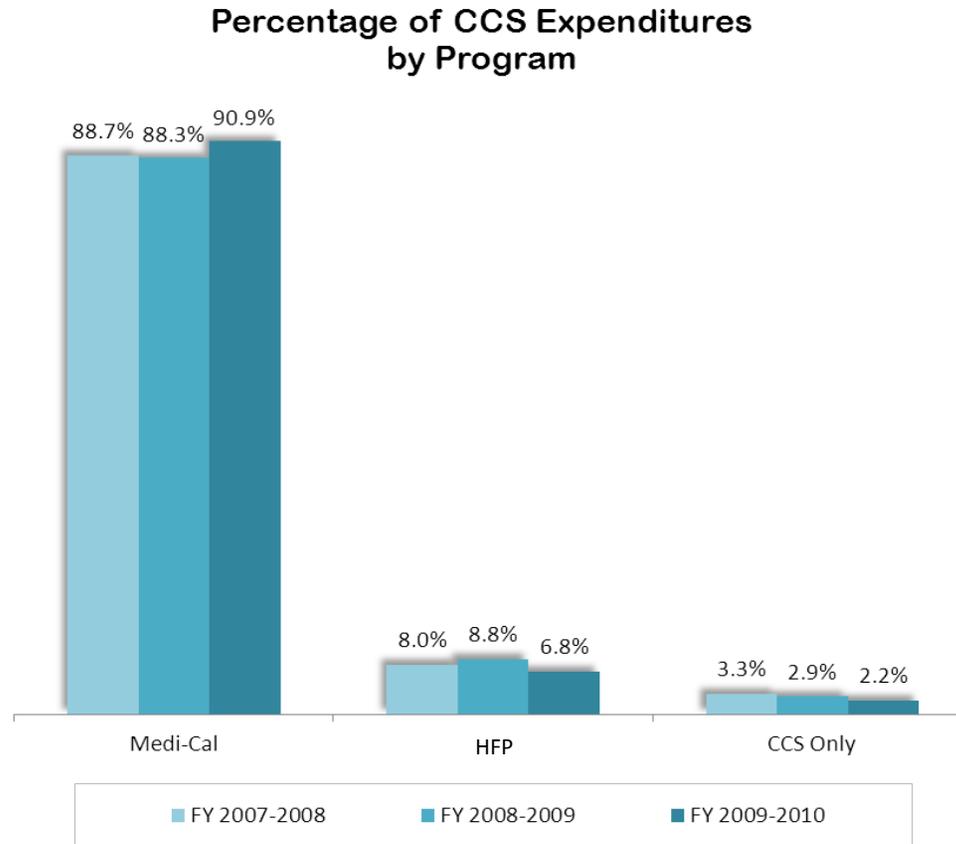
Appendix E - 2009–2010 HFP/CCS Expenditures by Service Type

CCS Service Type	Expenditures	Percent of Total
Pharmaceuticals	\$ 23,753,700	17.3%
NDC billing	\$ 21,896,153	15.9%
MD injections	\$ 1,857,547	1.4%
Inpatient	\$ 58,985,008	42.9%
Outpatient	\$ 5,463,469	4.0%
Medical Supplies	\$ 962,646	0.7%
DME	\$ 1,467,676	1.1%
Prosthetics & Orthotics	\$ 812,489	0.6%
SCC services	\$ 1,138,528	0.8%
Hospital OP room charges	\$ 1,082,130	0.8%
Medical/Physician	\$ 46,615,223	33.9%
Physician services	\$16,881,960	12.3%
Blood factor	\$27,814,126	20.3%
Audiology	\$ 1,734,223	1.3%
Hearing Aids	\$766,904	0.6%
Cochlear Implant	\$511,826	0.4%
Audiology & Speech services	\$455,493	0.3%
Therapies (OT & PT)	\$ 184,914	0.1%
Other Services	\$ 2,531,183	1.8%
Total	\$137,348,583	100%

NDC = National Drug Code
 MD Injections = Physician Administered Injections
 DME = Durable Medical Equipment
 SCC = Special Care Center

Data Source: DHCS/CCS paid claims FY 2009-2010

Appendix F – Total HFP/CCS Expenditures by Program



CCS Expenditures by Program			
Program	FY 2007-2008	FY 2008-2009	FY 2009-2010
Medi-Cal	\$1,605,478,858	\$1,690,544,065	\$1,823,227,451
Healthy Families	\$144,105,213	\$169,468,074	\$137,348,583
CCS	\$59,634,855	\$55,062,572	\$45,105,506
TOTAL	\$1,809,218,926	\$1,915,074,711	\$2,005,681,540

Data Source: DHCS, CCS paid claims FY 2009-2010 and prior year reports

Appendix G – Total HFP/CCS Expenditures by County

Total HFP/CCS Expenditures* by County

County	2006 - 2007		2007 - 2008		2008 - 2009		2009 - 2010	
	# of HFP Cases	Expenditures						
Alameda	394	\$2,935,953	429	\$2,630,356	526	\$4,652,350	560	\$2,728,021
Alpine	0	\$0	0	\$0	0	\$0	0	\$0
Amador	0	\$18,148	9	\$43,209	6	\$56,450	7	\$66,086
Butte	71	\$525,820	97	\$414,550	79	\$784,894	82	\$534,607
Calaveras	19	\$88,300	21	\$68,769	21	\$280,397	23	\$54,241
Colusa	66	\$98,598	54	\$42,445	54	\$485,438	62	\$130,377
Contra Costa	235	\$1,211,160	266	\$2,849,846	281	\$2,491,540	357	\$1,927,908
Del Norte	12	\$66,484	10	\$43,175	15	\$41,350	15	\$14,340
El Dorado	75	\$804,990	84	\$652,589	81	\$362,258	93	\$119,130
Fresno	638	\$2,822,680	690	\$3,692,727	767	\$5,002,728	778	\$4,127,115
Glenn	43	\$95,082	37	\$228,290	32	\$132,008	31	\$167,251
Humboldt	71	\$228,247	80	\$811,760	107	\$1,064,037	110	\$430,924
Imperial	175	\$1,510,828	186	\$987,087	197	\$800,726	231	\$799,944
Inyo	9	\$86,453	9	\$15,567	8	\$28,834	5	\$20,656
Kern	522	\$2,033,960	614	\$4,026,512	689	\$6,446,410	887	\$3,399,129
Kings	65	\$554,708	82	\$615,877	94	\$678,966	133	\$204,287
Lake	31	\$74,005	37	\$291,806	41	\$273,758	36	\$523,746
Lassen	5	\$15,140	6	\$7,200	4	\$16,242	7	\$54,192
Los Angeles	6,750	\$61,116,528	7,338	\$49,868,420	7,885	\$52,655,742	5,215	\$45,214,517
Madera	69	\$1,961,854	96	\$1,155,270	106	\$850,125	158	\$519,332
Marin	44	\$121,375	62	\$159,373	65	\$369,689	78	\$247,153
Mariposa	12	\$18,264	13	\$74,717	10	\$53,580	5	\$25,192
Mendocino	66	\$191,596	75	\$511,370	58	\$275,194	86	\$485,889
Merced	276	\$1,206,634	280	\$1,346,663	304	\$1,877,266	404	\$1,856,212
Modoc	9	\$25,893	7	\$6,545	6	\$2,518	6	\$762
Mono	16	\$96,396	18	\$111,987	17	\$136,525	18	\$33,436
Monterey	409	\$1,875,484	429	\$5,185,784	436	\$5,165,484	589	\$2,647,515
Napa	29	\$144,490	45	\$89,495	46	\$397,390	84	\$384,322
Nevada	64	\$179,761	78	\$294,608	52	\$317,280	65	\$628,029
Orange	2,971	\$1,169,781	2,950	\$11,093,606	2,742	\$11,408,981	3,319	\$7,997,142

Appendix G – Total HFP/CCS Expenditures by County (cont)

Total HFP/CCS Expenditures* by County

County	2006 - 2007		2007 - 2008		2008 - 2009		2009 - 2010	
	# of HFP Cases	Expenditures						
Placer	80	\$490,804	93	\$1,197,417	101	\$748,220	158	\$602,212
Plumas	11	\$28,887	10	\$2,179	3	\$27,334	5	\$35,378
Riverside	1,705	\$6,079,869	1,801	\$8,334,094	1,964	\$10,292,279	2,246	\$5,898,372
Sacramento	380	\$27,800	438	\$196,858	427	\$3,150,755	613	\$3,233,591
San Benito	50	\$209,433	62	\$804,548	65	\$645,853	68	\$765,169
San Bernardino	1,169	\$5,191,608	1,342	\$6,876,105	1,528	\$7,961,643	1,951	\$8,791,795
San Diego	2,160	\$12,252,706	2,357	\$18,104,077	2,513	\$19,719,742	3,022	\$18,455,139
San Francisco	252	\$1,096,890	260	\$1,923,012	240	\$2,153,618	240	\$1,787,465
San Joaquin	506	\$1,412,932	506	\$1,380,587	516	\$3,470,480	556	\$2,831,817
San Luis Obispo	127	\$430,068	130	\$492,734	148	\$549,233	188	\$698,142
San Mateo	209	\$549,225	218	\$1,680,389	196	\$1,942,217	246	\$1,231,973
Santa Barbara	200	\$394,256	230	\$965,712	236	\$1,712,532	334	\$1,373,116
Santa Clara	577	\$2,828,283	671	\$3,468,688	743	\$4,156,370	805	\$4,312,107
Santa Cruz	154	\$645,087	148	\$844,709	168	\$1,198,758	240	\$1,235,073
Shasta	103	\$495,071	127	\$967,473	128	\$1,326,082	109	\$760,942
Sierra	0	\$0	0	\$1,444	0	\$0	0	\$21,968
Siskiyou	20	\$74,737	21	\$44,646	20	\$161,373	18	\$39,270
Solano	54	\$137,709	67	\$660,129	65	\$717,667	76	\$366,926
Sonoma	276	\$1,281,981	248	\$925,712	306	\$1,248,397	358	\$854,443
Stanislaus	338	\$1,629,535	358	\$1,915,656	343	\$1,936,996	498	\$1,729,663
Sutter	165	\$475,745	137	\$608,448	102	\$1,439,785	155	\$278,095
Tehama	33	\$261,107	34	\$286,212	33	\$242,009	36	\$104,212
Trinity	8	\$50,999	4	\$27,903	5	\$29,863	7	\$353,040
Tulare	288	\$2,167,624	295	\$1,936,211	297	\$4,213,435	466	\$2,441,913
Tuolumne	26	\$130,115	26	\$61,318	26	\$140,317	26	\$46,357
Ventura	492	\$1,271,572	505	\$2,262,060	522	\$2,733,110	752	\$2,762,584
Yolo	59	\$285,865	70	\$484,725	72	\$144,513	101	\$508,631
Yuba	58	\$690,722	73	\$332,564	63	\$297,300	55	\$487,736
TOTAL	22,646	\$121,869,239	24,333	\$144,105,213	25,559	\$169,468,040	26,773	\$137,348,583

*Payments may have been made for services delivered in prior fiscal years and may not actually be for the cases enrolled in that same fiscal year.

Data Sources:

DHCS, CCS paid claims and HFP/CCS caseload FY 2009-2010 and prior year reports

Appendix H – HFP/CCS Average Cost per Child by County

County	2009 - 2010		
	# of HFP Cases	Expenditures	Average Cost per Case
Trinity	7	\$353,040	\$50,434
Lake	36	\$523,746	\$14,548
San Benito	68	\$765,169	\$11,252
Nevada	65	\$628,029	\$9,662
Amador	7	\$66,086	\$9,441
Yuba	55	\$487,736	\$8,868
Los Angeles	5,215	\$45,214,517	\$8,670
Lassen	7	\$54,192	\$7,742
San Francisco	240	\$1,787,465	\$7,448
Plumas	5	\$35,378	\$7,076
Shasta	109	\$760,942	\$6,981
Butte	82	\$534,607	\$6,512
San Diego	3,022	\$18,455,139	\$6,107
Mendocino	86	\$485,889	\$5,650
Contra Costa	357	\$1,927,908	\$5,400
Glenn	31	\$167,251	\$5,395
Santa Clara	805	\$4,312,107	\$5,357
Fresno	778	\$4,127,115	\$5,305
Sacramento	613	\$3,233,591	\$5,275
Tulare	466	\$2,441,913	\$5,240
Santa Cruz	240	\$1,235,073	\$5,146
San Joaquin	556	\$2,831,817	\$5,093
Mariposa	5	\$25,192	\$5,038
Yolo	101	\$508,631	\$5,036
San Mateo	246	\$1,231,973	\$5,008
Alameda	560	\$2,728,021	\$4,871
Solano	76	\$366,926	\$4,828
Merced	404	\$1,856,212	\$4,595
Napa	84	\$384,322	\$4,575
San Bernardino	1,951	\$8,791,795	\$4,506

County	2009 - 2010		
	# of HFP Cases	Expenditures	Average Cost per Case
Monterey	589	\$2,647,515	\$4,495
Inyo	5	\$20,656	\$4,131
Santa Barbara	334	\$1,373,116	\$4,111
Humboldt	110	\$430,924	\$3,917
Kern	887	\$3,399,129	\$3,832
Placer	158	\$602,212	\$3,811
San Luis Obispo	188	\$698,142	\$3,714
Ventura	752	\$2,762,584	\$3,674
Stanislaus	498	\$1,729,663	\$3,473
Imperial	231	\$799,944	\$3,463
Madera	158	\$519,332	\$3,287
Marin	78	\$247,153	\$3,169
Tehama	36	\$104,212	\$2,895
Riverside	2,246	\$5,898,372	\$2,626
Orange	3,319	\$7,997,142	\$2,410
Sonoma	358	\$854,443	\$2,387
Calaveras	23	\$54,241	\$2,358
Siskiyou	18	\$39,270	\$2,182
Colusa	62	\$130,377	\$2,103
Mono	18	\$33,436	\$1,858
Sutter	155	\$278,095	\$1,794
Tuolumne	26	\$46,357	\$1,783
Kings	133	\$204,287	\$1,536
El Dorado	93	\$119,130	\$1,281
Del Norte	15	\$14,340	\$956
Modoc	6	\$762	\$127
Alpine	0	\$0	\$0
Sierra*	0	\$21,968	\$0
All Counties	26,773	\$137,348,583	\$5,130

*Payments may have been made for services delivered in prior fiscal years and may not actually be for the cases enrolled in that same fiscal year.

Data Sources: DHCS, CCS paid claims and HFP/CCS caseload FY 2009-2010 and prior year reports

Appendix I – CSS Instructions and Response Template

**MANAGED RISK MEDICAL INSURANCE BOARD
HEALTHY FAMILIES PROGRAM**

**Instructions for Completing the
California Children’s Services (CCS) Referral Report for
HFP Benefit Year 2009-10**

This document provides guidance to HFP participating plans on completing the CCS Referral Report for Benefit Year 2009-10. **Although the 09/10 benefit year was extended 3 months, plans will be reporting data for the normal 12 month period of 07/01/09 – 06/30/10.**

County/Statewide: Please indicate whether your report is for a specific county or statewide.

For those plans that have both an EPO and HMO product, please provide separate reports for your EPO and HMO.

Health Plan Referrals: In each box, please indicate the number of children, by age, your plan referred to CCS in each quarter and then supply the total number of children referred in the box indicated.

Status of CCS Referrals: Please indicate the number of CCS referrals that were accepted and denied in each quarter. If referrals are pending as of June 30, 2010, please indicate how many referrals are pending in the box provided.

Refusals: Please indicate the number of children whose families refused the CCS evaluation.

In the box provided, please indicate the number of children enrolled in your health plan that received services from CCS as of June 30, 2010.

Please save the report using the following naming convention:

[Health Plan Name] CCS Referral Report 2009-10.xls

Please return the completed report via e-mail no later than close of business on Monday, November 1, 2010.

Send the completed report to **Sarah Swaney** at:
sswaney@mrmib.ca.gov.

If you have any questions about the report, please contact **Sarah Swaney** at (916) 323-0514.

Appendix I – CSS Instructions and Response Template

Healthy Families Program CCS Referral Report for Benefit Year 2009-2010 (12 months only 07/01/09 - 06/30/10)

Please enter data into the unshaded areas below. Gray shaded areas contain formulas.

County/ Statewide:											
Plan Name:											
Contact Name:											
Telephone:											
FAX:											
E-mail:											
Health/Dental/Vision Plan Referrals								Status of CCS Referrals			Refusals
Total number of CCS referrals made within each quarter:	Children under age 1	Children ages 1-2	Children ages 3-5	Children ages 6-9	Children ages 10-13	Children ages 14-18	Total Referrals	Accepted	Denied	Pending as of 6/30/10	Children/ Family Refused CCS Evaluation
7/01/09-9/30/10							0				
10/01/09-12/31/09							0				
1/01/10-3/31/10							0				
4/01/10-6/30/10							0				
Totals	0	0	0	0	0	0	0	0	0	0	0

Total number of active HFP/CCS children:

Active HFP/CCS children data should include all HFP children enrolled in the plan as of June 30, 2010 who were receiving services through CCS.

Please submit report by November 1, 2010 to Juanita Vaca at JVaca@mrmib.ca.gov

Appendix J – MOU Template

Memorandum of Understanding California Children’s Services Program/Healthy Families Program

Service	Health Plan Responsibilities	CCS Program Responsibilities
Liaison	Designate a liaison to CCS and/or require plan networks to designate a liaison to coordinate and track referrals.	Designate a liaison to the plan who will be the program's point of contact for the health plan and its networks to coordinate all related activities.
	Meet, at a minimum, quarterly to ensure ongoing communication; resolve operational and administrative problems; and identify policy issues needing resolution at the management level.	Meet, at a minimum, quarterly, to ensure ongoing communication; resolve operational and administrative problems; and identify policy issues needing resolution at the management level.
Provider Training	Develop policies and procedures that will ensure that providers are informed of CCS eligibility requirements and the need to identify potentially eligible children and refer to the CCS program.	Collaborate with plan to assist with the development of CCS related policies and procedures, as needed by health plan and CCS.
	Provide multiple initial training opportunities, in conjunction with the local CCS program, for primary care providers, including organized provider groups and support staff, in order to ensure awareness and understanding of the CCS program and eligibility requirements.	Collaborate with health plan to provide multiple initial training opportunities that will give providers an understanding of the CCS program and eligibility requirements.
	Collaborate with CCS to develop training materials that will assure that primary care providers, specialty providers, and hospitals understand the respective responsibilities of the health plan and the CCS program in authorizing services for subscribers with CCS eligible conditions.	Provide availability of local program medical consultant or designee to consult with primary care providers and/or specialty providers on a case-by-case basis.
	Maintain training opportunities on, at least, an annual basis.	Support ongoing training opportunities as needed.
CCS Provider Network	Develop a process to review plan providers for qualifications for CCS provider panel participation and encourage those qualified to become paneled.	Provide plans with CCS provider applications to expedite the paneling or approval of specialty and primary care network providers.
	Identify in training to providers and in the provider manual those facilities that are CCS approved, including hospitals and Special Care Centers.	Coordinate with the CMS Branch to assure identification of local CCS provider network to health plan.
	Ensure access for diagnostic services to appropriate specialty care within the network or medical group. When appropriate specialist not available within network or medical group, ensure access to appropriate plan specialist.	Coordinate with plan to refer to an appropriate CCS paneled specialty provider to complete diagnostic services and treatment as needed.

County: _____ Effective Dates: _____

Appendix J – MOU Template (cont) p2

Service	Health Plan Responsibilities	CCS Program Responsibilities
Case Identification and Referral	Develop procedures, in conjunction with the local CCS program, for plan or provider to submit the necessary documentation to determine medical eligibility at the time of referral.	Provide technical assistance to plans for the development of plan policies, procedures, and protocols for making referrals to the program, including necessary medical documentation:
	Develop procedures to specify that providers are to refer a subscriber to the CCS program within two days of a suspicion of the presence of a CCS eligible condition. (Referral date will identify the earliest possible date from which medically necessary services may be approved.)	Determine medical eligibility within five working days of receiving adequate medical documentation of the suspicion of a CCS eligible condition.
	Inform families of subscribers of referral to the CCS program and the need to have care under the direction of an appropriate CCS-paneled physician once program eligibility has been determined.	Ensure that provider, designated plan personnel, and subscriber family are informed of either program eligibility or denial upon eligibility determination. Provide medical consultation as appropriate during the time period from referral to medical eligibility determination.
	Arrange for medically necessary care during the period after referral and prior to the CCS eligibility determination. (Medically necessary services provided by a CCS-paneled provider during the interim may be authorized by the CCS program for a condition determined to be CCS eligible.)	Authorize from referral date medically necessary CCS benefits required to treat a subscriber's CCS eligible condition and be responsible for the reimbursement of care to authorized providers when CCS eligibility is established.
	Develop with network designees, where applicable, a monthly tracking list to include: name of referred subscriber; address and telephone number; birth date; social security number (if known); plan eligibility status; primary care provider name, address, and telephone number; and plan number and enrollment /disenrollment dates to be used for coordination and follow-up with the local CCS program.	Coordinate with plan liaison and network designees to share a tracking list of CCS eligibles who are known to the plans. The list will include name, CCS case number, birth date, social security number (if known), CCS eligible diagnoses, date of eligibility and status; in case of denial or closure, reason for ineligibility and date closed; referral source and primary care provider on file, if known.
Case Management/ Tracking and Follow-Up	Utilize tracking system to coordinate health care services for members receiving services authorized by the CCS program.	Assist plan in assessing, and alleviating barriers to accessing primary and specialty care related to the CCS eligible condition. Assist subscriber/subscriber family to complete enrollment into the CCS program.
	Develop policies and procedures that specify providers' responsibility for coordination of specialty and primary care services and ensure that CCS eligible children receive all medically necessary pediatric preventive services, including immunizations.	Provide case management services in order to coordinate the delivery of health care services to subscribers with CCS eligible conditions, including services provided by other agencies and programs, such as Local Education Agencies and Regional Centers.

County: _____

Effective Dates: _____

Appendix J – MOU Template (cont) p3

Services	Health Plan Responsibilities	CCS Program Responsibilities
Case Management (continued)	Develop policies and procedures that specify coordination activities among primary care providers, specialty providers, and hospitals and communication with CCS program case managers.	Develop systems that result in transmission of medical reports of services provided by CCS authorized providers to the appropriate plan primary care providers.
Quality Assurance and Monitoring	Conduct jointly with the CCS program, regular reviews of policies and procedures related to this agreement.	Conduct jointly with the plans, regular reviews of policies and procedures related to this agreement.
	Participate, at a minimum, in quarterly meetings with the CCS program to update policies and procedures as appropriate.	Participate, at a minimum, in quarterly meetings with the plan to update policies and procedures as appropriate.
	Review and update protocols annually in conjunction with the CCS program.	Review and update protocol on an annual basis in conjunction with the health plan.
Problem Resolution	Develop work plan, in conjunction with CCS, that will monitor the effectiveness of the MOU and the plan/CCS interface.	Develop work plan, in conjunction with the plan, to monitor the effectiveness of the MOU and the plan/CCS interface.
	Assign appropriate health plan management/liaison staff to participate in, at a minimum, quarterly meetings to identify and resolve operational and administrative issues, including coordination, communication, referral, training, billing, provision of appropriate services, and authorization of services.	Assign appropriate CCS program management and professional/liaison staff to participate with health plan management staff in the resolution of individual subscriber issues as they are identified.
	Assign appropriate health plan management/liaison staff to participate in, at a minimum, quarterly meetings to identify and resolve operational and administrative issues, including coordination, communication, referral, training, billing, provision of appropriate services, and authorization of services.	Assign appropriate CCS program/liaison staff to participate in, at a minimum, quarterly meetings with health plan management/liaison staff to identify and resolve operational and administrative issues; including coordination; communication, referral, training, billing, provision of appropriate services, and authorization of services.
	Refer issue to the appropriate CMS Regional Office if problem cannot be resolved locally.	Refer issue to CMS Regional Office if problem cannot be resolved locally.

Signatures of the undersigned indicate intent to develop policies and procedures that will successfully develop the local CCS and Healthy Families Program interface.

Administrator of CCS Program

Date

Plan Designee

Date

County: _____

Effective Dates: _____

Maridee A. Gregory, M.D. Children's Medical Services Branch Chief

Appendix K – Additional Resources

California Children's Services Report 2006-2008, presented to the MRMIB Board by MRMIB staff April 2009.

The National Survey of Children with Special Health Care Needs: 2005-2006: (<http://mchb.hrsa.gov/cshcn05/>).

Child Health USA 2008-2009. (<http://mchb.hrsa.gov/chusa08/>).

Families in Program and Policy FiPPs CSHCN Report: Interviews on Family Participation with State Title V Children with Special Health Care Needs Programs: By Nora Wells and Betsy Anderson of Family Voices.

The CCS Program: An Assessment of Policy Research Needs: Preliminary Findings, January 23, 2009 by Valerie Lewis for the California HealthCare Foundation.

Considerations for Redesign of the California Children's Services (CCS) Program by Health Management Associates for the California HealthCare Foundation.

Assessing the California Children's Services Program, Issue Brief August 2009 by the California HealthCare Foundation.

California Children's Services Program Statutes: Health and Safety Code Sections 123800-123995:

Evaluation of Expenditures by California Children's Services (CCS) Beneficiaries: 2001-2005 prepared by Seidman, Robert L and Wolf, Janet C for the Institute for Public Health Graduate School of Public Health: San Diego State University, Final Report June 2007.

The Role of Medicaid and SCHIP Coverage in Serving Children with "Special Health Care Needs" by Dubay, Lisa and Ruiz, Sonia for John Hopkins School of Public Health.

Understanding CCS Through the Data, Presented by Health Management Associates on July 20, 2009.

The ongoing work of the Family Health Outcomes Project can be found at http://nfhop.ucsf.edu/fhop/htm/ca_ricah/title_v/cshcn_t5_new.htm#ev.