



Date: September 26, 2016

To: CHEAC Members

From: CHEAC Staff

RE: **Summary of SB 586 - CCS Whole Child Model**

WHOLE CHILD MODEL

Counties to be Transitioned - Section 14094.5

No sooner than July 1, 2017, to implement a Whole Child Model (WCM) in the 21 County Organized Health System counties:

Del Norte	Mendocino	Orange	Shasta
Humboldt	Merced	San Luis Obispo	Siskiyou
Lake	Modoc	San Mateo	Solano
Lassen	Monterey	Santa Barbara	Sonoma
Marin	Napa	Santa Cruz	Trinity
			Yolo

Carve-out Extension – Section 14094.3

Extends the CCS carve out to January 1, 2022 for the remaining 37 counties and until an evaluation of the WCM program has been completed.

Responsibilities Shifting to the Health Plan – Section 123850

Health plans will assume the following roles from the counties (or state for dependent counties) for CCS beneficiaries enrolled in a managed care plan:

- Case management
- Care coordination
- Provider referral
- Service authorization
(including DME authorizations)

Responsibilities Remaining with the County – Section 123850

Counties will remain responsible for these functions for those not enrolled in managed care, which include:

- Children with a CCS-eligible condition in a family with an adjusted gross income of \$40,000 or less in the most recent tax year;



- Children with a CCS-eligible condition in families with an AGI greater than \$40,000, with an estimated cost of care to exceed 20 percent of the family's AGI;
- Undocumented CCS beneficiaries between the ages of 19-21 year (as they do not qualify for Medi-Cal coverage); and
- Foster children not enrolled in a managed care plan.

Counties will also remain responsible for:

- Initial and ongoing eligibility determinations; and
- Physical and occupational therapy through the Medical Therapy Program.

KEY CONSIDERATIONS PRIOR TO TRANSITION

Readiness – Section 14094.7. DHCS must determine and certify the health plan and the county has met the readiness requirements. Readiness includes:

- Plans must demonstrate the availability of an appropriate provider network;
- Plans have entered into the necessary agreements with the county.

Plans must also meet a number of other requirements when participating in the WCM including:

- Ensuring coordination with the MTP to ensure access to MTP services.
- Ensuring families are supported and have access to vital information to assist in navigating the health plan and transition.

MOUs – Section 14094.9. WCM counties and health plans, must enter into MOUs relating to the local administration and services to be provided by either the county or the health plan. DHCS must consult with counties and health plans in developing a MOU template to guide plans and counties.

CCS Administrative Allocations – Section 14094.9. DHCS must consult with WCM counties in determining the calculation for determining the administrative allocation. DHCS must provide written notice to the county of the calculation for determining the administrative allocation.

Monitoring and Oversight – Section 14094.7. DHCS must develop specific CCS program monitoring and oversight standards for the plans participating in the WCM.

Stakeholder input - Section 14094.7. DHCS is required to establish and convene a WCM stakeholder advisory group (SAG), or modify an existing WCM program stakeholder advisory group, comprised of the following representatives until December 31, 2021:

- CCS providers
- CCS Administrators
- Health plans
- Regional Centers
- Labor
- CCS Case managers



- Family Resource Centers
- Health plan family advisory groups
- CCS MTU representatives

CONTINUITY OF CARE – Section 14094.13. CCS beneficiaries are provided the following continuity of care provisions:

Providers

Health plans must allow the CCS child or youth to maintain their current CCS provider for up to 12 months. Families can appeal the continuity of care limitation to the director of the Department of Health Care Services.

Public Health Nurse Case Management

Within 90 days of the transition of CCS services into the health plan, the CCS beneficiary, parent or guardian may elect to keep their particular public health nurse for their case management and care coordination.

- Counties and health plans must enter into a MOU (see MOU section above) for the case management and care coordination of the child OR case management, care coordination, provider referral and service authorization for all or some of the WCM participants.
- In the event the PHN leaves the CCS program or is *no longer available*, the health plan can transition these roles to an employee or contractor of the plan.
- DHCS can waive the PHN case management continuity of care requirement if the health plan demonstrates that the cost exceeds the existing CCS program allocation. In this event, DHCS is required to facilitate a meeting with the county, affected labor organizations, and the health plan *in an attempt* to reach a mutually agreeable contracting arrangement.

Durable Medical Equipment (DME)

Health plans are required to ensure that the CCS child or youth maintains access to specialized or customized durable medical equipment providers for up to 12 months under the following conditions:

- The CCS eligible child or youth has an ongoing relationship with the DME provider.
- The DME provider accepts the higher of the health plan rate or the FFS rate OR enters into an agreement on an alternative payment methodology.
- The DME provider provides requested information to the plan.

Specialized or Customizable DME is defined as:

- Uniquely constructed from raw materials or substantially modified from base material for full-time use based on physician's description and orders.
- Is made to order or adapted to meet the specific needs of the beneficiary.

Extending the Continuity of Care Period

- The department can extend the duration period for DME under warranty.



- The plan may extend the duration upon its discretion.

Prescription Drugs

Health Plans must permit a CCS beneficiary to continue use of any prescription drug that is part of a currently prescribed therapy for the enrollee's CCS-eligible condition or conditions immediately prior to the date of enrollment to the WCM program. Plans must allow this until the plan and provider has completed an assessment of the child or youth, created a treatment plan and agrees that that particular drug is no longer necessary.

EVALUATION – Section 14094.18

DHCS is required to contract with an independent entity to conduct an evaluation of the WCM and is required to provide a report on the results of this evaluation to the Legislature by no later than January 1, 2021. The evaluation will:

- Compare the performance of the plans participating in the WCM compared to the performance of the CCS programs prior to implementation.
- Evaluate the inclusion of the CCS services in managed care to see if it improves access, the quality of care and/or patient experiences.
- Evaluate WCM compared to CCS in non-WCM counties.
- Analyze various data elements including:
 - Grievances and appeals
 - CCS enrollment, referrals and utilization
 - Network and provider participation
 - Patient and family satisfaction
 - Post-discharge follow-ups

REGULATIONS – Section 123850

- DHCS can implement the WCM program requirements without taking regulatory action by means of all-county letters, plan letters, CCS numbered letters, plan or provider bulletins, or similar instructions until regulations are adopted.
- DHCS is required to adopt regulations by July 1, 2020.