



Whole-Child Model
DHCS Feedback to Advocates' Version of SB 586
April 19, 2016



Requirement Requested – April 11, 2016	DHCS Position	Explanation
1. Minimum professional qualifications for CCS care coordinators/case managers to which all health plans must adhere; care coordination/case management teams should include licensed RNs or PHNs and medical social workers.	Agree	<ul style="list-style-type: none"> All health plans use nurses to case manage including reviewing and approving service authorizations. Health plans also employ social workers for purposes of care coordination. The Department of Health Care Services (DHCS or Department) is generally fine with this recommendation.
2. Ensure that access standards for pediatric specialty care are enforced.	Agree	<ul style="list-style-type: none"> The recently issued federal Medicaid Managed Care Rule requires time and distance for pediatric specialty care. DHCS will implement and monitor this requirement.
3. Include coordination with community services providers and programs outside of medical care providers as part of care coordination system.	Agree	<ul style="list-style-type: none"> Health plans engage with community service providers, when appropriate, today.
4. Develop or adopt quality of care measurements specific to the needs of CSHCN and their families with input from advocates and family agencies.	Agree	<ul style="list-style-type: none"> DHCS will develop a CCS monitoring tool with CCS specific measures. DHCS will seek public input in its development.
5. CCS practice standards and clinical policies and procedures that govern utilization decisions (i.e., CCS Program regulations, CCS Program Numbered Letters, CCS Program Information Notices, the CCS Program's <i>This Computes!</i> announcements, and any legislative policy changes as applicable) would guide health plan authorization decisions. Health plans shall use CCS Guidelines where they exist. These Guidelines shall take precedence even when they are more general and permissive than the evidence-based clinical guidelines used by health plans. In the absence of relevant CCS guidelines, protocols and clinical policies from national pediatric and pediatric subspecialty organizations and other evidence-based clinical guidelines shall be used to guide care coordination and utilization management policies. Federal Medicaid definitions of medical necessity shall apply.	Agree with modification	<ul style="list-style-type: none"> DHCS is not supportive of this suggestion as written. The Department thinks it would circumvent a health plan's ability to make authorization decisions. DHCS will support a suggestion to coordinate CCS policy letters with health plan policies.

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6. Assure that CCS enrollees and their families are aware of their rights of appeal in terms of eligibility and denials of service when they are informed of their transition to health plans, and they are informed a minimum of 6 months in advance of transition.	Agree with modification	<ul style="list-style-type: none"> • Rights of appeal are included in the health plan Evidence of Coverage which is mailed to beneficiaries upon enrollment and annually thereafter. They are also mailed when a change in coverage occurs. Notices to beneficiaries informing them of the transition will be mailed prior to transition. Rights to appeal are also included in every Notice of Action sent to a beneficiary which occurs with each denial of service.
7. Support and train families to do care coordination for their child, as evidence shows that self-management supports for chronic health conditions are likely to be cost saving.	Agree with modification	<ul style="list-style-type: none"> • DHCS believes that this should be at the health plan discretion.
8. There should be a “system” of family input. This includes families getting information, education and support at the local level to assist them in working with professionals in the care of their child, as well as building their capacity to partner at the local level and state level, (such as being on a local health plan advisory group). CA is a big state and the state should support a network of informed, educated and supported families to give input at local and state level.	Agree	<ul style="list-style-type: none"> • DHCS supports the establishment of local health plan advisory groups which should include beneficiaries and/or their family representatives.
9. Develop a new CCS monitoring tool to assess health plan compliance with CCS standards, including Special Care Center Access, network adequacy, medical home access and participation, completion of a CCS care plan for all children and transition plans for children older than 14, convening family advisory committees, selected clinical outcomes and appeal rates.	Agree with modification	<ul style="list-style-type: none"> • DHCS will develop a CCS dashboard to report on health plan performance specific to CCS. It will be shared publicly including being posted on the DHCS website.
10. Health plans shall develop and share Whole-Child Model beneficiary communications with local health plan advisory groups for review and comment.	Agree with modification	<ul style="list-style-type: none"> • DHCS will develop and share Whole-Child Model beneficiary communications and share them publicly for comment including with the CCS Advisory Group, health plans, and Whole-Child Model counties.
11. In addition to or in place of the current CCS Advisory Group, create a new statewide advisory committee consisting of health plan family advisory committee members, advocates and family member agencies to interface with DHCS staff who have authority to address state issues.	Agree with modification	<ul style="list-style-type: none"> • DHCS will continue to use the current CCS Advisory Group as its main stakeholder body. Representatives from local health plan advisory groups will be included on the CCS Advisory Group.

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12. Maintain a separate actuarially-sound health plan rate for CCS children, rather than employing a blended health plan rate.	Agree with modification	<ul style="list-style-type: none"> DHCS may or may not have a separate rate based on the appropriateness of doing so. DHCS is in discussions with its actuaries to determine what is appropriate.
13. Contract with county/state CCS staff to perform utilization review and care management functions during the initial phase of the whole child model.	Oppose, but structure may be utilized	<ul style="list-style-type: none"> COHS will conduct all utilization review and care coordination for CCS children in the Whole-Child Model counties. In some counties, COHS may contract with county CCS staff to perform this function, either as a transition or permanent service.
14. Develop an application process for COHS to request to participate in the Whole-Child Model.	Oppose	<ul style="list-style-type: none"> DHCS will provide notice to the Legislature, CMS, counties, CCS providers, and CCS families when each health plan has been reviewed and certified and determined ready to implement the Whole-Child Model.
15. Require health plans to provide CCS members with provider and medication continuity for the duration of the CCS condition. A CCS provider who does not contract with the health plan but who is treating a CCS child pursuant to continuity of care will be paid at a minimum the existing CCS provider payment rate.	Oppose	<ul style="list-style-type: none"> Children transitioned under Whole-Child Model will have an automatic provider continuity of care request which means they will not have to request continuity of care. The continuity of care period will be up to 12 months for CCS providers, however, health plans may extend the continuity of care period at their discretion. A minimum of the Medi-Cal FFS or CCS rate, whichever is higher, is required – though health plans and providers may negotiate payments under an alternate payment methodology.