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**DATE:** June 7, 2018

ALL PLAN LETTER 18-011

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN  
THE WHOLE CHILD MODEL PROGRAM

**SUBJECT:** CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL  
PROGRAM

**PURPOSE:**

The purpose of this All Plan Letter (APL) is to provide direction to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 04-0618,<sup>1</sup> which provides direction and guidance to county CCS programs on requirements pertaining to the implementation of the WCM program.

**BACKGROUND:**

Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties.<sup>2</sup> The purpose of the WCM program is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. MCPs operating in WCM counties will integrate Medi-Cal managed care and county CCS Program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.<sup>3, 4</sup>

MCPs will authorize care that is consistent with CCS Program standards and provided by CCS-paneled providers, approved special care centers, and approved pediatric acute care hospitals. The WCM program will support active participation by parents and families of CCS-eligible members and ensure that members receive protections such as

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<sup>1</sup> The CCS Numbered Letter index is available at: <http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx>

<sup>2</sup> SB 586 is available at: [https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201520160SB586](https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586)

<sup>3</sup> See Health and Safety Code (HSC) Section 123850(b)(1), which is available at: [https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?lawCode=HSC&sectionNum=123850](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=123850).

<sup>4</sup> See Welfare and Institutions Code (WIC) Section 14094.11, which is available at: [https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC)

continuity of care (COC), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning no sooner than July 1, 2018. Upon determination by DHCS of the MCPs' readiness to address the needs of the CCS-eligible members, MCPs must transition CCS-eligible members into their MCP network of providers by their scheduled implementation date as follows:

MCP	COHS Counties
<b>Phase 1 – No sooner than July 1, 2018</b>	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
<b>Phase 2 – No sooner than January 1, 2019</b>	
CalOptima	Orange
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo

**POLICY:**

Starting no sooner than July 1, 2018, MCPs in designated counties shall assume full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services, including service authorization activities, claims processing and payment, case management, and quality oversight.

Under the WCM, the MCP, county CCS program, and DHCS will each bear responsibility for various administrative functions to support the CCS Program. Responsibilities for the CCS Program's eligibility functions under the WCM are determined by whether the county CCS program operates as an independent or dependent county.<sup>5</sup> Independent CCS counties will maintain responsibility for CCS Program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS Program medical eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS will continue to maintain responsibility for CCS Program medical eligibility determinations and redeterminations, while the county CCS programs will maintain responsibility for financial and residential eligibility determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical

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<sup>5</sup> A link to the Division of Responsibility chart can be found on the CCS WCM website at: <http://www.dhcs.ca.gov/services/ccs/Pages/CCSWwholeChildModel.aspx>

redetermination and other medical determinations, as needed, for the CCS-eligible member.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS Program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage (OHC), with full scope Medi-Cal as payor of last resort.

The implementation of WCM does not impact the activities and functions of the Medical Therapy Program (MTP) and Pediatric Palliative Care Waiver (PPCW). WCM counties participating with the MTP and PPCW will continue to receive a separate allocation for these programs. The MCP is responsible for care coordination of services that remain carved-out of the MCP's contractual responsibilities.

MCPs are required to use all current and applicable CCS Program guidelines, including CCS Program regulations, additional forthcoming regulations related to the WCM program, CCS Numbered Letters (N.L.s),<sup>6</sup> and county CCS program information notices, in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations and contractual requirements.

## **I. MCP AND COUNTY COORDINATION**

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members. A quarterly meeting between the MCP and the county CCS program must be established to assist with overall coordination by updating policies, procedures, and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding (MOU) and other WCM related matters.

### **A. Memorandum of Understanding**

MCPs and county CCS programs must execute a MOU outlining their respective responsibilities and obligations under the WCM using the MOU template posted on the CCS WCM page of the DHCS website.<sup>7</sup> The purpose of the MOU is to explain how the MCPs and county CCS programs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP will serve as the primary vehicle for ensuring

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<sup>6</sup> The CCS Numbered Letter index is available at: <http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx>

<sup>7</sup> A link to the MOU template can be found on the CCS WCM website at: <http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx>

collaboration between the MCP and county CCS program. The MOU can be customized based on the needs of the individual county CCS program and the MCP, consistent with the requirements of SB 586 and dependent upon DHCS approval. The MOU must include, at a minimum, all of the provisions specified in the MOU template. Phase 1 MCPs must have submitted an executed MOU, or proved intent and/or progress made towards an executed MOU, by March 31, 2018. Phase 2 MCPs must submit an executed MOU, or prove intent and/or progress made toward an executed MOU, by September 28, 2018. All WCM MOUs are subject to DHCS approval.

### **B. Transition Plan**

Each MCP must develop a comprehensive plan detailing the transition of existing CCS beneficiaries into managed care for treatment of their CCS-eligible conditions. The transition plan must describe collaboration between the MCP and the county CCS program on the transfer of case management, care coordination, provider referrals, and service authorization administrative functions from the county CCS program to the MCPs.<sup>8</sup> The transition plan must also include communication with beneficiaries regarding, but not limited to, authorizations, provider network, case management, and ensuring continuity of care and services for beneficiaries in the process of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

### **C. Inter-County Transfer**

County CCS programs use CMSNet to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. Through their respective MOUs, the MCPs and county CCS programs will develop protocols for the exchange of ICT data, as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of the CCS member and allow for COC of already approved service authorization requests, as required by this APL and applicable state and federal laws.

When a CCS-eligible member moves from a WCM county to a non-WCM county, the county CCS program and MCP, through their respective MOUs, will exchange ICT data. County CCS programs will continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS eligible member moves out of a WCM county, the county CCS program will notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data

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<sup>8</sup> See WIC Section 14094.7(d)(4)(C), which is available at: [https://leginfo.ca.gov/faces/codes\\_displaySection.xhtml?lawCode=WIC&sectionNum=14094.7](https://leginfo.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.7).

for members to the county CCS program office. The county CCS program will then coordinate the sharing of CCS-eligible member data to the new county of residence. Similarly, when a member moves into a WCM county, the county CCS program will provide transfer data to the MCP as applicable.

#### **D. Dispute Resolution and Provider Grievances**

Disagreements between the MCP and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS.<sup>9</sup> The county CCS program shall communicate all resolved disputes in writing to the MCP within a timely manner. Disputes between the MCP and the county CCS program that are unable to be resolved will be referred by either entity to DHCS, via email to [CCSWCM@dhcs.ca.gov](mailto:CCSWCM@dhcs.ca.gov), for review and final determination.<sup>10</sup>

MCPs must have a formal process to accept, acknowledge, and resolve provider disputes and grievances.<sup>11</sup> A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the MCP directly to the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

## **II. MCP RESPONSIBILITIES TO CCS-ELIGIBLE MEMBERS**

### **A. Risk Level and Needs Assessment Process**

The MCP will assess each CCS child's or youth's risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data, or by other means. MCPs are required to develop and complete the risk assessment process for WCM transition members, newly CCS-eligible members, or new CCS members enrolling in the MCP. The risk assessment process must include the development of a pediatric risk stratification process (PRSP) and an Individual Care Plan (ICP) for high risk members. All requirements are dependent on the member's risk level that is determined through the PRSP. Furthermore, nothing in this APL shall remove or limit existing survey or assessment requirements that the MCPs are responsible for outside WCM.

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<sup>9</sup> See WIC Section 14093.06(b), which is available at: [http://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?lawCode=WIC&sectionNum=14093.06](http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14093.06).

<sup>10</sup> Unresolved disputes must be referred to: [CCSWCM@dhcs.ca.gov](mailto:CCSWCM@dhcs.ca.gov)

<sup>11</sup> See WIC Section 14094.15(d), which is available at: [http://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?lawCode=WIC&sectionNum=14094.15](http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.15).

### **1. Pediatric Risk Stratification Process**

MCPs must develop a pediatric risk stratification mechanism, or algorithm, to assess the CCS-eligible member's risk level that will be used to classify members into high and low risk categories, allowing the MCP to identify members who have more complex health care needs.

MCPs are required to complete a risk stratification within 45 days of enrollment for all members including new members, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level by:

- Review of medical utilization and claims processing data, including data received from the county and DHCS;
- Utilization of existing member assessment or survey data; and
- Telephonic or in-person communications, if available at time of PRSP.

Members that do not have any medical utilization data, claims processing data history, or other assessments and/or survey information available will automatically be categorized as high risk until further assessment data is gathered to make an additional risk determination. The PRSP must be submitted to DHCS for review and approval.

### **2. Risk Assessment and Individual Care Plan Process**

MCPs must develop a process to assess a member's current health, including the CCS condition, to ensure that each CCS-eligible member receives case management, care coordination, provider referral, and/or service authorization from a CCS paneled provider; this will be dependent upon the member's designation as high or low risk.

#### *New Members and Newly CCS-eligible Members Determined High Risk*

Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of the member's ICP. Any risk assessment survey created by the MCP for the purposes of WCM is subject to review and approval by DHCS.

#### *Risk Assessment*

The risk assessment process must address:

- a) General Health Status and Recent Health Care Utilization. This may include, but is not limited to, caretaker self-report of child's health;

outpatient, emergency room, or inpatient visits; and school days missed due to illness, over a specified duration of time.

- b) Health History. This includes both CCS and non-CCS diagnoses and past surgeries.
- c) Specialty Provider Referral Needs.
- d) Prescription Medication Utilization.
- e) Specialized or Customized Durable Medical Equipment (DME) Needs (if applicable).
- f) Need for Specialized Therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies (PT/OT /ST), mental or behavioral health services, and educational or developmental services.
- g) Limitations of Activities of Daily Living or Daily Functioning (if applicable).
- h) Demographics and Social History. This may include, but is not limited to, member demographics, assessment of home and school environments, and cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to assess the need for or impact of future health care services. These may include, but are not limited to, questions related to childhood developmental milestones; pediatric depression, anxiety or attention deficit screening; adolescent substance use; or adolescent sexual behaviors.

#### *Individual Care Plan*

MCPs are required to establish an ICP for all members determined high risk based on the results of the risk assessment process, with particular focus on specialty care, within 90 days of a completed risk assessment survey or other assessment by telephonic and/or in-person communication.<sup>12</sup> The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);
- County substance use disorder (SUD) or Drug Medi-Cal services;

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<sup>12</sup> See WIC Section 14094.11(b)(4), which is available at:  
[http://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC](http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC)

- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

The ICP will be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or their designated caregiver. The ICP should indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP should also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:<sup>13</sup>

- a) Access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an interdisciplinary team is, and what the community resources are.
- b) A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions.
- c) Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams.
- d) Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

Further, the MCP must reassess the member's risk level and needs annually at their CCS eligibility redetermination or upon significant change to the member's condition.

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<sup>13</sup> See WIC Section 14094.11(c), which is available at: [https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC)



*New Members and Newly CCS-eligible Members Determined Low Risk*

For new members and newly CCS-eligible members identified as lower risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of their enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

The MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination or upon significant change to the member's condition.

*WCM Transitioning Members*

For WCM transition members, the MCP must complete the PRSP within 45 days of transition, to determine each member's risk level, and complete all required telephonic and/or in-person communication and ICPs for high risk members and all required telephonic and/or in-person communication for low risk members within one year. Additionally, the MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination, or upon significant change to the member's condition.

MCPs must submit to DHCS for review and approval a phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year for WCM transition members.

Regardless of the risk level of a member, all communications, whether by phone or mail, must inform the member and/or his or her designated caregiver that the assessment will be provided in a linguistically and culturally appropriate manner and identify the method by which the provider will arrange for an in-person assessment.<sup>14</sup>

MCPs must refer all members, including new members, newly CCS-eligible members and WCM transition members who may have developed a new CCS-eligible condition, immediately to the county for CCS eligibility determination and not wait until the annual CCS medical eligibility redetermination period.

**B. Case Management and Care Coordination**

MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs must ensure that information, education and support is continuously provided to the CCS-eligible member and their family to

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<sup>14</sup> See APL 99-005, which is available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL1999/MMCDAPL99005.pdf>

assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:<sup>15</sup>

- Primary and preventive care services with specialty care services
- Medical therapy units (MTU)
- EPSDT<sup>16</sup>
- Regional center services
- Home and community-based services

### **1. High Risk Infant Follow-Up Program**

High Risk Infant Follow-Up (HRIF) is a program that helps identify infants who might develop CCS-eligible conditions after they are discharged from a Neonatal Intensive Care Unit (NICU). The MCP is responsible for coordinating and authorizing HRIF services for members and ensuring HRIF case management services. MCPs must notify the counties in writing, within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide COC information to the members.

### **2. Age-Out Planning Responsibility**

MCPs must establish and maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the members' CCS qualifying condition(s).

MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.<sup>17</sup>

### **3. Pediatric Provider Phase-Out Plan**

A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment to the child or youth. The MCPs must provide care coordination to

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<sup>15</sup> See WIC Section 14094.11(b)(1)-(6), which is available at:

[http://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?lawCode=WIC&sectionNum=14094.11](http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.11).

<sup>16</sup> If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See APL 18-007, which is available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-007.pdf>

<sup>17</sup> See WIC Section 14094.12(j), which is available at:

[http://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?lawCode=WIC&sectionNum=14094.12](http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.12).

CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the service of a pediatric provider. The timing of the transition should be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

### **C. Continuity of Care**

MCPs must establish and maintain a process to allow for members to receive COC with existing CCS provider(s) for up to 12 months, in accordance with WIC Section 14094.13.<sup>18</sup> This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all other applicable APLs regarding COC. The sections below include additional COC requirements that only pertain to the WCM program.

#### **1. Specialized or Customized Durable Medical Equipment**

If the MCP member has an established relationship with a specialized or customized durable medical equipment (DME) provider, MCPs must provide access to that provider for up to 12 months.<sup>19</sup> MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service rates, unless the DME provider and the MCP enter into an agreement on an alternative payment methodology that is mutually agreed upon. The MCP may extend the COC period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.<sup>20</sup>

Specialized or Customized DME must meet all of the following criteria:

- Is uniquely constructed or substantially modified solely for the use of the member.
- Is made to order or adapted to meet the specific needs of the member.
- Is uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

#### **2. COC Case Management<sup>21</sup>**

MCPs must ensure CCS-eligible members receive expert case management,

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<sup>18</sup> See WIC Section 14094.13, which is available at:

[http://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?lawCode=WIC&sectionNum=14094.13](http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.13).

<sup>19</sup> See WIC Section 14094.12(f), which is available at:

[https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=14094.12.&lawCode=WIC](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.12.&lawCode=WIC)

<sup>20</sup> See WIC Section 14094.13(b)(3) is available at:

[https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC)

<sup>21</sup> See WIC Section 14094.13(e), (f) and (g), which are available at:

[https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC)

care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing the CCS-eligible member, member's family, or designated caregiver to request COC case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with a MCP case manager who has received adequate training on the county CCS Program and who has clinical experience with the CCS population or pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services. The MCP must send a follow-up notice 30 days prior to the start of the transition.

### **3. Authorized Prescription Drugs**

CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed prescription drug that is part of their prescribed therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.<sup>22</sup>

### **4. Appealing COC Limitations**

MCPs must provide CCS-eligible members with information regarding the WCM appeal process for COC limitations, in writing, 60 days prior to the end of their authorized COC period. The notice must explain the member's right to petition the MCP for an extension of the COC period, the criteria used to evaluate the petition, and the appeals process if the MCP denies the petition.<sup>23</sup> The appeals process notice must include the following information:

- The CCS-eligible member must first appeal a COC decision with the MCP.
- A CCS-eligible member, member's family or designated caregiver of the CCS-eligible member may appeal the COC limitation to the DHCS director or his or her designee after exhausting the MCP's appeal process.

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<sup>22</sup> See WIC Section 14094.13(d)(2), which is available at:

[https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC)

<sup>23</sup> See WIC Section 14094.13(k), which is available at:

[https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC)

- The DHCS director or designee will have five (5) days from the date of appeal to inform the family or caregiver of receipt of the request and must provide a decision on the appeal within 30 calendar days from the date of the request. If the member's health is at risk, the DHCS director or designee will inform the member of the decision within 72 hours.<sup>24</sup>

In addition to the protections set forth above, MCP members also have COC rights under current state law.

#### **D. Grievance, Appeal, and State Fair Hearing Process**

MCPs must ensure members are provided information on grievances, appeals and state fair hearing processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal and state fair hearing rights as provided under state and federal law.<sup>25</sup> MCPs must provide timely processes for accepting and acting upon member complaints and grievances. Members appealing a CCS eligibility determination must appeal to the county CCS program.

#### **E. Transportation**

MCPs must provide the CCS Maintenance and Transportation (M&T) benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary costs (i.e. parking, tolls, etc.), in addition to transportation expenses, and must comply with all requirements listed in N.L. 03-0810.<sup>26</sup> These services include, but are not limited to, M&T for out of county and out of state services.

MCPs must also comply with all requirements listed in APL 17-010<sup>27</sup> for CCS-eligible members to obtain non-emergency medical transportation (NEMT) and non-medical transportation (NMT) for all other services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.

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<sup>24</sup> See APL 17-006, which is available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf>

<sup>25</sup> See APL 17-006

<sup>26</sup> See CCS N.L. 03-0810, which is available at:

<http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl030810.pdf>

<sup>27</sup> APL 17-010 is available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-010.pdf>

#### **F. Out-of-Network Access**

MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the MCP's provider network or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services.

#### **G. Advisory Committees**

MCPs must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers.<sup>28</sup> Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.<sup>29</sup> A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also establish a quarterly Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.<sup>30</sup>

### **III. WCM Payment Structure**

#### **A. Payment and Fee Rate**

MCPs are required to pay providers at rates that are at least equal to the applicable CCS fee-for-service rates, unless the provider and the MCP enter into

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<sup>28</sup> See WIC Section 14094.7(d)(3), which is available at:

[https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=14094.7.&lawCode=WIC](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.7.&lawCode=WIC)

<sup>29</sup> See WIC Section 14094.17(b)(2), which is available at:

[https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC)

<sup>30</sup> See WIC Section 14094.17(a), which is available at:

[https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC)

an agreement on an alternative payment methodology that is mutually agreed upon.<sup>31</sup>

The payor for NICU services is as follows: an MCP shall pay for NICU services in counties where NICU is carved into the MCP’s rate, and DHCS shall pay in counties where NICU is carved out of the MCP’s rate.<sup>32</sup>

For WCM counties, all NICU authorizations will be sent to the MCP in which the child is enrolled. The MCP will review authorizations and determine whether or not the services meet CCS NICU requirements. However, claims may be processed and paid by either DHCS or the MCP.

In counties where CCS NICU is carved into the MCP’s rate, the MCP will pay all NICU and CCS NICU claims. For counties where CCS is currently carved-out, the MCP will process and pay non-CCS NICU claims, and the State’s Fiscal Intermediary will pay CCS NICU claims. Payments made by State’s Fiscal Intermediary will be based on the MCP’s approval of meeting CCS NICU requirements.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities for WCM:

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
<p><b>Carved-In Counties:</b> Marin, Merced, Monterey, Napa, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, and Yolo</p>	MCP	MCP	MCP

<sup>31</sup> See WIC Section 14094.16(b), which is available at: [https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?lawCode=WIC&sectionNum=14094.16](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.16).

<sup>32</sup> See the Division of Responsibility chart

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/Physician)
<b>Carved-Out:</b> Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Orange, Shasta, Siskiyou, Sonoma, and Trinity	MCP	MCP	DHCS

**IV. MCP Responsibilities to DHCS**

**A. Network Certification**

MCPs are required to have an adequate network of providers to serve the CCS-eligible population including physicians, specialists, allied professionals, Special Care Centers, hospitals, home health agencies, and specialized and customizable DME providers. Each network of providers will be reviewed by DHCS and certified annually.

The certification requires the MCP and their delegated entities to submit updated policies and procedures and an updated provider network template to ensure the MCP’s network of providers meets network adequacy requirements as described in the Network Certification APL Attachments.<sup>33</sup>

MCPs must demonstrate that the provider network contains an adequate provider overlap with CCS-paneled providers. MCPs must submit provider network documentation to DHCS, as described in APL 18-005. Members cannot be limited to a single delegated entity’s provider network. The MCP must ensure members have access to all medically necessary CCS-paneled providers within the MCP’s entire provider network. MCPs must submit policies and procedures to DHCS no later than 105 days before the start of the contract year.

**B. CCS Paneling and Provider Credentialing Requirements**

Physicians and other provider types must be CCS-paneled with full or provisional

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<sup>33</sup> APL 18-005 and its attachments are available at:  
<http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>



approval status.<sup>34</sup> MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.<sup>35</sup> The MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.<sup>36</sup>

MCPs are required to verify the credentials of all contracted CCS-paneled providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. The MCP's written policies and procedures must follow the credentialing and recredentialing guidelines of APL 17-019.<sup>37</sup> MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

### **C. Utilization Management**

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:<sup>38</sup>

- Procedures for pre-authorization, concurrent review, and retrospective review.
- A list of services requiring prior authorization and the utilization review criteria.
- Procedures for the utilization review appeals process for providers and members.
- Procedures that specify timeframes for medical authorization.
- Procedures to detect both under- and over-utilization of health care services.

In addition to the UM processes above, MCPs are responsible for conducting NICU acuity assessments and authorizations in all WCM counties.<sup>39</sup>

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<sup>34</sup> See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: [https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel\\_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc](https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc)

<sup>35</sup> Children's Medical Services CCS Provider Paneling is available at: <https://cmsprovider.cahwnet.gov/PANEL/index.jsp>

<sup>36</sup> The CCS Paneled Providers List is available at: <https://cmsprovider.cahwnet.gov/prv/pnp.pdf>

<sup>37</sup> APL 17-019 is available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-019.pdf>

<sup>38</sup> See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at:

<http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>

<sup>39</sup> See WIC 14094.65, which is available at:

[https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=14094.65.&lawCode=WIC](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.65.&lawCode=WIC)

## **D. MCP Reporting Requirements**

### **1. Quality Performance Measures**

DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a form and manner specified by DHCS.

### **2. Reporting and Monitoring**

DHCS will develop specific monitoring and oversight standards for MCPs. MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companions guides can be attained by emailing the Encounter Data mailbox at [MMCDEncounterData@dhcs.ca.gov](mailto:MMCDEncounterData@dhcs.ca.gov). MCPs must submit additionally required data in a form and manner specified by DHCS and must comply with all contractual requirements.

## **E. Delegation of Authority**

In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in APL 17-004.<sup>40</sup> If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief  
Managed Care Quality and Monitoring Division

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<sup>40</sup> APL 17-004 is available at:  
<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-004.pdf>