



**California Children's Services (CCS) Program
Whole Child Model
Frequently Asked Questions**

Updated July 2019

The below frequently asked questions (FAQs) provide information about the Department of Health Care Services' (DHCS) "Whole Child Model." The Whole Child Model is an organized delivery system that will provide comprehensive, coordinated services for children and youth with special health care needs through enhanced partnerships with Medi-Cal managed care health plans (health plans). The Whole Child Model will be implemented no sooner than July 2018. Please note that the Medical Therapy Program (MTP) will continue to be administered by the counties under the Whole Child Model.

A. General Whole Child Model Questions

1. What is the Whole Child Model? Why is DHCS implementing it?

Answer: Children with CCS-eligible conditions today are enrolled in both the CCS fee-for-service (FFS) and managed care delivery systems. As such, they receive their services in two (or more) separate systems that do not always coordinate and communicate effectively. This can result in additional complexity for families to navigate access to care among other care coordination issues. Under the Whole Child Model, DHCS intends to eliminate this bifurcated system, strengthening overall care coordination for the beneficiary and their family resulting in better overall health outcomes and better access to care. Health plans will coordinate the beneficiary's full scope of health care needs, inclusive of primary preventive care, specialty health, mental health, education, and training rather than multiple entities coordinating these efforts separately. Beneficiaries and their families will benefit from a single point of care coordination.

2. Which health plans and counties will be in the Whole Child Model?

Answer: The Whole Child Model is proposed to be implemented in the health plans/counties shown below.

Health Plan	Counties
Phase 1 – Implemented July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
Phase 2 – Implemented January 1, 2019	
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Phase 3 – Implemented July 1, 2019	
CalOptima	Orange

3. What will happen in counties where the Whole Child Model is not implemented?

Answer: There are no further counties contemplated for the Whole Child Model at this time. Thus, there will be no change to the services that a CCS-eligible child gets in counties that do not have the Whole Child Model.

4. Who can get Whole Child Model services?

Answer: CCS-eligible beneficiaries who are on full scope Medi-Cal and live in Whole Child Model counties (See A.2 above) will receive coordinated services. The services in these counties and health plans will be phased in over time.

5. Is the CCS Program going away? Who will be responsible for the CCS Program in Whole Child Model counties?

Answer: No. The CCS Program is not going away. However, the way children and families get services and how their care is managed will change. As we put program improvements in place, CCS children and their families will not have to change their current services. Beneficiaries will become eligible in the same way as always, through the local and state CCS Programs. Health plans will manage the care overall in the Whole Child Model counties. They will also take care of approving the services.

6. Who will provide CCS services in the Whole Child Model?

Answer: Health plans will coordinate and approve all care for beneficiaries. Beneficiaries will be able to get their health care through providers who are part of the plan's network. These providers must be CCS providers with special skills (paneled providers). If a child needs to see a specialist that is not in the plan's network or is located in a different part of the state, the plan will coordinate and approve those services as well.

7. Will beneficiaries in the Whole Child Model keep the same benefits?

Answer: Yes. Children will have the same covered benefits, including primary, specialty, pharmacy, ancillary, and other services, as long as the services are still medically necessary and prescribed by the child's treating physician. The arrangement and coordination of the care will be strengthened under the Whole Child Model. Instead of arranging for care through multiple systems for authorization of services and appealing denials between systems, the model will now allow CCS children to get care through one system. This model will make it easier for CCS children to get the care they need and will result in better health outcomes.

8. Will the local county CCS Program case manager go away if my child is part of the CCS Whole Child Model?

Answer: No. Local county CCS Programs will not go away under the Whole Child Model. They will still conduct eligibility services for beneficiaries. They will also continue to be responsible for MTP and a few other services. The main change will be that the health plans will make sure that care is arranged and services are approved so beneficiaries get the care they need. Within 90 days of implementation of the Whole Child Model program, you may ask if your child's CCS case manager can keep working with you and your child. If your child's CCS case manager is not available after implementation, the health plans will assign your child a new case manager.

9. Will beneficiaries get a notice about the transition to the Whole Child Model?

Answer: Yes. Each child will receive at least two notices before the change to the Whole Child Model takes place. Health plans will also be required to call each beneficiary up to five times or until they are reached. All notices are shared for public comment.

10. Can beneficiaries still see their primary care and specialist providers?

Answer: Yes. Medi-Cal beneficiaries transitioning to the Whole Child Model have the right to request and receive continuity of care (COC). Health plans are required to establish and maintain a process to allow beneficiaries to continue to access their existing provider(s) for up to 12 months.

DHCS will monitor health plans closely to ensure they are providing continuity of care. DHCS will review COC policies and procedures prior to the transition occurring and collect monthly data until no longer needed to determine health plan compliance. It is important to note that health plans can agree to extend continuity of care beyond the 12-month period; however, if this is not possible, a warm handoff to a new CCS provider will occur ensuring no gaps in care occur.

11. Will CCS providers still need to be paneled by the DHCS CCS Program?

Answer: Yes. Providers still need to be paneled by the CCS Program. DHCS has no plans to change the way in which a pediatric provider becomes a CCS Program paneled provider.

12. Will the CCS Program standards for providers that are in place now be in the Whole Child Model?

Answer: Yes. The CCS Program provider standards that are in place now will still be a requirement. CCS Program standards are available at <http://www.dhcs.ca.gov/services/ccs/Pages/ProviderStandards.aspx>.

13. How will the CCS State-only children (which include children with other health coverage or undocumented children) who are not Medi-Cal beneficiaries get CCS services under the CCS Whole Child Model?

Answer: The CCS State-only children with other health coverage will continue to receive services the way they do today. The CCS services for children who do not have Medi-Cal will still be on a FFS basis.

Effective May 2016, children under 19 years of age without satisfactory immigration status became eligible for full scope Medi-Cal benefits. To the extent that these undocumented children also have a CCS-eligible condition, they will be enrolled in the Whole Child Model counties so that all their coverage will be coordinated as described above.

14. Will there be any changes to the Partners for Children Pediatric Palliative Care Waiver (PPCW)?

Answer: The PPCW is being terminated effective January 1, 2019. DHCS will transition the provision of pediatric palliative care services from the PPCW to the managed care or FFS delivery systems under the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). Participant transitions into managed care and FFS delivery systems will be coordinated through a warm hand off to ensure participant needs are met.

EPSDT services are an existing State Plan Benefit that provide comprehensive, preventive, diagnostic, and treatment services to eligible participants under the age of 21, as specified in Section 1905(r) of the Social Security Act. The goal of this benefit is to ensure that eligible participants under the age of 21 receive age-appropriate screening, preventive services, and treatment services that are medically necessary to correct or improve any identified conditions.

15. Will there be any changes to palliative care services for CCS Eligible Children?

Answer: Yes. A transition process is underway and scheduled to conclude by January 1, 2019. DHCS will facilitate the transfer of children currently receiving services under the PPCW to the managed care or FFS delivery system through a streamlined process and warm hand-off. DHCS will closely monitor the concerted efforts of health plans during and after the transition process.

16. Will there be any changes to the neonatal intensive care unit (NICU)?
[UPDATED July 2019]

Answer: Yes. Whole Child Model health plans will be responsible for CCS-NICU acuity assessment, authorization, and payment for all NICU services (both CCS and non-CCS) in the Whole Child Model counties. Acuity assessments will be conducted in accordance with CCS Program guidelines. Independent and dependent County CCS programs are responsible to enter the medical eligibility information into CMS Net, and conduct the residential and financial eligibility for the CCS Program. The MCPs shall inform the county CCS program if a CCS-eligible condition is later identified. Independent CCS counties will determine CCS medical eligibility and the State will determine CCS medical eligibility for the dependent counties.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities in the Whole Child Model.

Whole Child Model County	NICU Acuity Assessment	Authorization	Payor (Facility/Physician)
Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo	Health Plan	Health Plan	Health Plan

17. Will there be changes to the High Risk Infant Follow-up (HRIF) Program in Whole Child Model counties?

Answer: The HRIF Program benefits under the Whole Child Model will not change. DHCS will continue to require that each CCS-approved NICU ensure the follow-up of neonates and infants discharged from the NICU who have high risk for neurodevelopmental delay or disability. However, in Whole Child Model counties, the health plans will be responsible for determining HRIF program eligibility and ensuring the required follow-up services are provided, authorized, and reimbursed.

18. How should Whole Child Model counties proceed with transitioning HRIF cases that opened prior to Whole Child Model implementation?

Answer: The health plans and the Whole Child Model counties should collaborate on the transitioning of HRIF cases between the two entities and on the transfer of case management, care coordination, follow-up, provider referral and service authorization administrative functions to the health plans.

19. What is the process for newborn hearing screening coordination?

Answer: Babies born in California have the option to have their hearing screened. All babies should receive a hearing screening by 1 month of age, be diagnosed by 3 months of age, and be enrolled into early intervention services by 6 months of age (i.e. 1-3-6). If the baby is referred to a Hearing Coordination Center (HCC) and a diagnostic evaluation is needed, the hospital/provider will submit a service authorization request to the health plan for review and authorization.

In the case of newborn hearing screening coordination, HCCs are responsible for providing, monitoring, and tracking infant hearing screening, rescreening, diagnostic, and intervention services; assessing services needed by the infant

and family; performing data collection, processing, and analysis; and performing quality assurance activities. HCCs will contact the health plan to follow-up on the status of the service authorization request.

20. Are cochlear implants and major organ transplants carved-in or carved-out of Whole Child Model?

Answer: Cochlear implants are a carved-in benefit in Whole Child Model counties. The health plans will review and authorize the service authorization request.

Please refer to Exhibit E, Attachment 1 of the [COHS Boilerplate](#) Contract for information on covered services.

21. Will there be changes to the Medical Therapy Program (MTP) in Whole Child Model counties?

Answer: Counties will continue to receive and process referrals to the MTP and will provide physical therapy (PT) and occupational therapy (OT) services at Medical Therapy Units (MTUs). The MTUs are outpatient clinics located in designated public schools.

The counties will also continue to provide Medical Therapy Conference (MTC) services. The MTC is a multidisciplinary team meeting where a child's treatment plan for the MTP eligible condition is developed. This includes PT, OT, and recommendations for specialized equipment, such as orthotics/braces, wheelchairs, and other assistive devices.

Upon implementation of the Whole Child Model, MTP benefits and services will continue to be offered to children eligible under the current framework and this program will continue to be administered by the counties and reimbursed through FFS.

However, in Whole Child Model counties, authorization for durable medical equipment (DME) and related supplies will be submitted to the health plan for review and authorization. MTUs in non-Whole Child Model counties will continue to receive authorization of DME and related supplies from the county CCS program.

22. How will the Health Homes Program (HHP) interact with the CCS Program and the CCS Whole Child Model program?

Answer: Some children who meet HHP eligibility criteria will also be in the CCS Program. HHP services are always optional for all beneficiaries who are eligible for the program. If a CCS-eligible child chooses to utilize HHP services, HHP will only complement their CCS services by providing additional coordination of their health care and social services. A beneficiary's acceptance of HHP services will not change their health coverage or their providers. HHP is solely an optional set of care coordination services.

In Whole Child Model counties, CCS beneficiaries who are enrolled in health plans will also have access to the HHP service if they meet HHP eligibility requirements. HHP care coordination services will be organized and administered by the health plan, in the same way that most other health plan benefits are provided. HHP service will be delivered primarily by local community providers that contract with the health plan to deliver HHP services.

For more information about the HHP, including the implementation schedule link and the Final Concept Paper, which describes available services, the service delivery model, eligibility criteria, and other program elements, please visit <http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx>.

23. During an inter-county transfer process between a Whole Child Model and a non-Whole Child Model county, who is responsible to provide, organize, and authorize care for the CCS beneficiary?

[NEW July 2019]

Answer: If the CCS beneficiary is showing eligible on the Whole Child Model health plan list, it is the Whole Child Model plans' responsibility to provide, organize, and authorize care until the child is no longer shown as eligible on the health plan's list. The local county CCS program will take over the responsibility of providing, organizing, and authorizing care once the beneficiary is no longer on the health plan's eligibility list.

B. Managed Care Questions

1. What are the benefits of being in managed care?

Answer: There are many benefits of being in managed care. Here are a few examples:

- Primary Care Physician (PCP) assignment. Health plans need to make sure beneficiaries always have a PCP. Beneficiaries and their families may either choose a PCP or have one chosen for them by the health plan. Beneficiaries and their families can change their doctor to another in-network doctor at any time.
- Timely access to appointments. PCPs and specialists must offer appointments within certain time requirements.
- Out of network access. Health plans must make sure beneficiaries have access to all medically necessary services. This means that beneficiaries can get services out of the network if they cannot find them in the health plan's network.

Health plans must give beneficiaries and their families' resources for their care. This includes:

- Provider lists. Health plans must have a list of providers in print and electronic forms. These lists will help beneficiaries and their families see the types of providers that are in the health plan's network and where their offices/clinics are.
- Member services. Health plans must have a Member Services Center. This will help beneficiaries and their families when they have questions including how to find a doctor and access care.
- Interpreter services. Translators are available 24 hours a day, seven days a week.
- Care coordination. Health plans must have a care coordination team available to ensure access across an array of services and coordinate referrals and authorizations.

2. How will DHCS make sure that health plans provide access to CCS providers in their network?

Answer: DHCS will require health plans to contract with CCS paneled providers and make them available to beneficiaries in their networks ensuring timely access to care. DHCS reviews health plan networks prior to implementation to ensure they are adequate and will continue to monitor network adequacy following implementation based upon population size and service needs. For specialty types that are not available in the Whole Child Model county, the plan will be required to provide out-of-network access for beneficiaries needing those provider types to treat their CCS condition.

3. How will DHCS make sure health plans are following the requirements of the Whole Child Model?

Answer: DHCS utilizes multiple approaches when monitoring health plans. Initially DHCS monitors transitions during the implementation period and up to two years after a transition starts. DHCS collects and analyzes data for the transitioning population to ensure appropriate access to services is being provided in a timely manner. DHCS also utilized the below monitoring tools in addition to others:

- Encounter data
- Provider networks
 - Network certification
 - Require plan contracts with as many CCS paneled providers needed in-county, regionally and statewide
 - Timely access
- Grievances and appeals and State Fair Hearings
- Annual audits
- Continuity of care
- Utilization data
- Health plan call center data
- DHCS Ombudsman call center data

DHCS has a formal process for monitoring and providing health plans with technical assistance, imposing corrective action plans, and applying penalties, as appropriate. DHCS will develop a specialized monitoring tool for the Whole Child Model requiring each Whole Child Model plan to report to DHCS during the transition.

4. Will the health plans provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) in the Whole Child Model?

Answer: Yes. The health plans are required to cover and ensure the provisions of screening, preventive, and medically necessary diagnostic and treatment services for beneficiaries under the age of 21, including private duty nursing.

5. Will the Whole Child Model health plans provide Maintenance and Transportation (M&T)?

Answer: Yes. The health plans must provide the M&T benefit for a beneficiary or a beneficiary's family seeking transportation to a medical service related to the beneficiary's CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. These services include but are not limited

to, meals, lodging, and other necessary costs (i.e. parking, tolls, etc.) in addition to transportation expenses for out of county and out of state services. A beneficiary can also contact their health plan if they have additional questions about transportation benefits.

The local county CCS programs are responsible for M&T for non-Whole Child Model CCS Program beneficiaries that remain the full responsibility of the county and refer beneficiaries to the health plans for transportation services that local county CCS program do not provide.

6. Who will be responsible for Out of State services in the Whole Child Model?

Answer: The Whole Child Model health plans are responsible for providing Out of State services for beneficiaries who need to get services outside the state. A beneficiary may need to see a provider out of state if there are no specialists able to treat the CCS condition or if the plan approves out of state access to a specific provider.

C. Beneficiary Protections

1. What happens if a beneficiary is not happy with a provider or does not like the services they get from the health plan?

Answer: If a beneficiary is not happy with their services, they should first ask the health plan to help them resolve their concern. Beneficiaries and their families can contact the health plan's member services department. These member services departments are specifically designed to help beneficiaries with all kinds of issues ranging from answering questions to finding a provider for assistance. Beneficiaries can also file a complaint directly with the health plan, which is a more formal process to express a concern. They may also request a State Fair Hearing. A State Fair Hearing is a process where beneficiaries can complain directly to the State of California and an Administrative Law Judge will review the complaint.

2. What are the continuity of care (COC) protections with the Whole Child Model?

Answer: There are COC protections with the Whole Child Model program. The health plans must establish and maintain a process to allow beneficiaries to request and receive COC with existing CCS provider(s) for up to 12 months. Additional COC requirements for the Whole Child Model include:

Specialized or Customized DME

If a beneficiary has an established relationship with a specialized or customized DME provider, the beneficiary's health plan must provide access to that provider for up to 12 months. A health plan may extend the COC period beyond 12-month for a specialized or customized DME still under warranty and deemed medically necessary by the treating provider.

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

- Is uniquely constructed or substantially modified solely for the use of the beneficiary.
- Is made to order or adapted to meet the specific needs of the beneficiary.
- 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.

Authorized Prescription Drugs

Beneficiaries are allowed continued use of any currently prescribed prescription drug that is part of their prescribed therapy for their CCS-eligible condition. Beneficiaries must be allowed to use the prescribed drug until the health plan 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.

D. Medical Therapy Program (MTP)

- 1. Will MTP change because of the CCS Whole Child Model? If counties continue to run the MTP, how will health plans be involved?**

Answer: Counties will continue to administer MTP. Health plans and counties will be required to work together and coordinate services for beneficiaries receiving services from both MTP and the health plan.

E. Stakeholder Engagement

- 1. How will DHCS seek input from stakeholders on the Whole Child Model?**

Answer: DHCS will send out various documents for comment throughout and following the Whole Child Model implementation period. DHCS will carefully consider all input received as the Department works to finalize decisions regarding implementation. In addition, DHCS established the CCS Advisory Group as an entity that can provide input into CCS overall which includes the Whole Child Model. The Advisory Group members include beneficiaries and/or their family members, providers, government entities, health plans, and others. Advisory Group meetings are held quarterly and are open to the public.

F. Where to Find More Information

- 1. Where can CCS beneficiaries and their families go if they have questions about the Whole Child Model?**

Answer: Go to the DHCS CCS Advisory Group webpage at <http://www.dhcs.ca.gov/services/ccs/Pages/AdvisoryGroup.aspx>

For questions or comments, please send an email to CCSRedesign@dhcs.ca.gov

CCS beneficiaries and their families can also call the CCS Program at **1-833-388-4551**, Monday through Friday, from 8:00 a.m. to 5:00 p.m. The call is free.