CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: December 2, 2024

ALL PLAN LETTER 24-015
SUPERSEDES ALL PLAN LETTER 23-034

TO: ALL MEDI-CAL MANAGED CARE 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 and guidance to Medi-Cal managed care plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) Program. This APL conforms with CCS Numbered Letter (N.L.) 10-1224 or any superseding version of this N.L., which provides direction and guidance to County CCS Programs on requirements pertaining to the WCM Program.[1] This APL supersedes APL 23-034.[2]

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 MCPs that are in designated County Organized Health System (COHS) or Regional Health Authority counties, and to incorporate CCS covered services for Medi-Cal eligible CCS children and youth into MCP Contracts.[3] Assembly Bill (AB) 2724 (Arambula, Chapter 73, Statutes of 2022) defined an Alternate Health Care Service Plan (AHCSP) and authorized DHCS to enter into one or more comprehensive risk contracts with an AHCSP as a primary MCP in specified geographic areas effective January 1, 2024. For the purposes of this APL, the AHCSP is Kaiser Foundation Health Plan, Inc. AB 118 (Committee on Budget, Chapter 42, Statutes of 2023) authorizes the expansion of the WCM Program no sooner than January 1, 2025. The purpose of the WCM Program is to

[1] CCS-Eligible Conditions are outlined and authorized in Title XXII, sections 41401 - 41518.9, for beneficiaries, including Medi-Cal members, who have these covered conditions. These regulations are further clarified by CCS N.L.s. N.L.s can be found at: https://www.dhcs.ca.gov/services/ccs/pages/ccsnl.aspx.
[2] APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[3] State law is searchable at the following link: http://leginfo.legislature.ca.gov/faces/home.xhtml. The MCP boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.

incorporate CCS covered services into Medi-Cal managed care for WCM Members.[4] MCPs operating in WCM counties integrate Medi-Cal managed care and County CCS Program administrative functions to provide comprehensive diagnostic and treatment services of the whole child and Care Coordination in the areas of primary, specialty, and behavioral health for CCS-Eligible and non-CCS-Eligible Conditions.[5, 6, 7]

MCPs authorize care consistent with CCS Program standards and provided by CCS-paneled Providers, CCS-approved Special Care Centers (SCCs), and approved pediatric acute care hospitals. The WCM Program supports active participation from parents and families of WCM Members and ensures that Members receive protections such as continuity of care, oversight of Network adequacy standards, quality performance of Providers, and routine Grievance and Appeal processes.

The WCM Program has been implemented in the following counties and will expand effective January 1, 2025 (see the following chart for more details).

MCP	Counties
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
Implemented January 1, 2019	
Partnership HealthPlan of California	Del Norte*, Humboldt, Lake*, Lassen*, Marin, Mendocino, Modoc*, Napa, Shasta*, Siskiyou, Solano, Sonoma, Trinity*, Yolo

[4] WCM Members means Members determined eligible for the CCS WCM Program. Transitioning Members means Members transitioning from Classic CCS Programs into the WCM Program as part of a WCM Implementation listed above.
[5] See Health and Safety Code (H&S) section 123850(b)(1).
[6] See Welfare and Institutions Code (W&I) section 14094.11.
[7] For the WCM Program, Care Coordination has the same meaning ascribed by MCP's Medi-Cal Managed Care Contract with DHCS. Care Coordination means MCP's coordination of care delivery and services for Members, either within or- across delivery systems including:
A. Services the Member receives from the MCP;
B. Services the Member receives from any other MCP;
C. Services the Member receives in Fee-For-Service (FFS);
D. Services the Member receives from out-of-Network Providers;
E. Services that the Member receives through carve-out programs, such as pharmacy, substance use disorder, mental health and dental services; and
F. Services the Member receives from community and social support Providers.

Implemented July 1, 2019	
CalOptima	Orange
Implemented January 1, 2024	
Kaiser Foundation Health Plan, Inc.	Marin, Napa, Orange, San Mateo, Santa Cruz, Solano, Sonoma, Yolo
Effective January 1, 2025	
Central California Alliance for Health	Mariposa*, San Benito*
Partnership HealthPlan of California	Butte, Colusa*, Glenn*, Nevada*, Placer, Plumas*, Sierra*, Sutter*, Tehama*, Yuba*
Kaiser Foundation Health Plan, Inc.	Mariposa*, Placer, Sutter*, Yuba*

POLICY:
Participating MCPs assume full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services including, but not limited to, referrals, service authorization activities, claims processing and payment, case management, and quality oversight. Service authorization activities include Pediatric Intensive Care Unit (PICU), Neonatal Intensive Care Unit (NICU) and referrals arising from the Medical Therapy Conference (MTC), Medical Therapy Program (MTP), and Medical Therapy services that are not otherwise the responsibility of the county's Medical Therapy Unit (MTU).[8]

Under the WCM Program, the MCP, County CCS Program, and DHCS each bear responsibility for various administrative functions to support the CCS Program. Responsibility for the CCS Program's eligibility functions under the WCM Program is determined by whether the County CCS Program operates as an independent or dependent county.[9] Independent CCS counties are responsible for CCS Program eligibility including medical, financial, residential, and initial determinations for referred Members and potential Members, including responding to and tracking appeals relating to CCS Program medical eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS is responsible for CCS Program medical eligibility determinations and redeterminations including responding to and tracking appeals relating to CCS Program medical eligibility determinations and annual medical eligibility redeterminations, while the County CCS Programs are responsible for financial and residential eligibility determinations and re-determinations. MCPs must

[8] The MTP provides Medically Necessary outpatient physical therapy and/or occupational therapy and may include physician consultation in MTC for children with specific eligible medical conditions.
[9] Dependent counties have a population under 200,000 and administer the CCS Program jointly with DHCS. Independent counties have a population in excess of 200,000 and administer the CCS Program independently.

provide necessary documentation, including but not limited to Medical Records, case notes, discharge summaries (if applicable), and reports pertaining to the CCS-Eligible Condition to the County CCS Program to assist with initial and annual medical eligibility determinations.[10] For more information on determinations and redeterminations please see the Referrals to the County CCS Programs section of this APL.

MCPs must refer a Member to the county for a CCS Program eligibility determination if the Member demonstrates a potential CCS-Eligible Condition(s) as outlined in the CCS Medical Eligibility Guide.[11] MCPs are also required to provide services to WCM Members with other health coverage, with full scope Medi-Cal as the payor of last resort.

MCPs are required to use all current and applicable CCS Program guidelines in the development of criteria for use by the MCP's chief medical officer or equivalent and other case management staff. CCS Program guidelines include CCS Program statutes, regulations, additional forthcoming regulations related to the WCM Program, CCS N.L.s, and County CCS Program Information Notices.[12,13]

The WCM MCP must assume the role of the county or state CCS Program as described in the N.Ls. In addition to the requirements included in this APL, MCPs must comply with all other applicable APLs, Policy Letters, state and federal laws and regulations, as well as all contractual requirements. Transition Date is defined herein as the date which a CCS Member is transitioned from a County CCS Program into a WCM MCP.

I. MCP AND COUNTY CCS PROGRAM COORDINATION

MCPs and County CCS Programs must coordinate the delivery of CCS services to WCM Members according to the parameters outlined in the WCM Memorandum of Understanding (MOU). MCPs must prevent duplication of services by reviewing offered services.

To continuously evaluate the effectiveness of the MOU processes, MCPs must review their MOUs annually to determine if any modifications, amendments, updates, or renewals of responsibilities and obligations are needed, including incorporating any applicable contractual requirements and policy guidance into their MOUs. MCPs must also continually update policies, procedures, and protocols, as

[10] H&S section 123850.
[11] The CCS Medical Eligibility Guide can be found at: https://www.dhcs.ca.gov/services/ccs/Documents/CCSMedicalEligibility.pdf
[12] More information on the CCS Program can be found at: https://www.dhcs.ca.gov/services/ccs/Pages/ProgramOverview.aspx
[13] CCS Program publications can be found at: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/CCSPubs.aspx

appropriate, and discuss activities related to the MOU and other WCM related matters as prescribed in the MOU.

A. Memorandum of Understanding Between MCPs and County CCS Programs
In WCM Counties, the County CCS Program and the MCP must execute an MOU, utilizing DHCS' WCM MOU Template, outlining their respective responsibilities and obligations under the WCM Program. The purpose of the WCM MOU is to explain how the MCP and County CCS Program coordinate care, conduct program management activities, and engage in information exchange activities required for the effective and seamless delivery of services to WCM Members. The MOU must ensure collaboration between the County CCS Program and the MCP. If the MCP or County CCS Program modifies any of the provisions of the WCM MOU Template, the MCP must submit a redlined version of the MOU to DHCS attested to by both parties for review and approval, prior to execution. However, the MCP and the County CCS Programs may agree to include additional provisions that do not remove existing required minimum MOU provisions or reduce either parties' obligations as file and use. WCM MCPs and County CCS Programs must review the MOU annually thereafter to determine whether any modifications, amendments, updates, or renewals of responsibilities and obligations outlined within are required. The MCP must post the executed MOU on its website.[14]

B. CCS Liaison
MCPs must designate at least one individual as the point of contact for the MOU and coordination of services between the MCP and County CCS Programs who has knowledge of or adequate training on the CCS Program and clinical experience with either the CCS population or pediatric patients with complex medical conditions. CCS Liaisons must receive training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical eligibility redetermination processes with County CCS Programs, and care management and authorization processes for CCS children. The liaison must ensure the case management assignment is communicated to the county, as needed.

[14] The WCM MOU Template can be found at: https://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx. See also W&I section 14094.9.

C. Transition Plans from Classic County CCS Programs into WCM Programs[15]
To be approved to participate in the WCM Program, MCPs must develop a comprehensive transition plan detailing their collaboration with the County CCS Program on the transition of existing Classic CCS members into the MCP that is mutually agreeable by both the MCP and County CCS Program. The transition plan must describe the transfer of case management; Care Coordination; Provider referrals; and service authorization, including administrative functions, from the County CCS Program to the MCP.[16] The transition plan must describe how MCPs will work with County CCS Programs to identify transitioning Members who have acute needs or high needs prior to the transition. The transition plan must also include communication with Members regarding, but not limited to, authorizations, Provider Network, case management, and ensure continuity of care and services for Members who are 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.

D. Data and Information Sharing and Inter-County Transfer (ICT)[17]
The County CCS Program and the WCM MCP's must collaborate to facilitate the exchange of ICT data to ensure that CCS WCM Members who relocate to another county can effectively transfer their CCS benefits without interruption, including the provision of continuation of services and the transfer of current service authorization requests.[18] Refer to W&I section 10003(c) and NL 10-1123 or any superseding version of the NL.

E. Referrals to the County CCS Program
Referrals to County CCS Programs may come from any source including MCPs, Network Providers, Subcontractors, Downstream Providers, families, specialty and primary care medical Providers, community organizations, and others. The County CCS Program must communicate with the MCP when a referral is submitted directly to the CCS Program.

MCPs must refer all Members who demonstrate a potential CCS-Eligible Condition(s) and supply the necessary clinical documentation to the County CCS Program for a CCS eligibility determination if the Member:

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[15] Classic County CCS Programs means CCS Programs operating outside of the WCM Program.
[16] W&I section 14094.7(d)(4)(C).
[17] For more information on ICT, including County CCS Program responsibilities see N.L. 10-1123: CCS Intercounty Transfer Policy, or any superseding N.L.
[18] See W&I section 10003(c) and N.L. 10-1123, or any superseding N.L.

- Demonstrates a potential CCS-Eligible Condition(s) as outlined in the CCS Eligibility Manual, including results from diagnostic services or who is undergoing diagnostics for CCS;[19]
- Presents at the Emergency Department, Provider, or facility for other primary conditions, and demonstrates a potential CCS-Eligible Condition(s); or
- Demonstrates a potential MTP eligible condition.

MCPs must refer all Members with potential CCS-Eligible Condition(s) as soon as possible, to the County CCS Program for an eligibility determination.

If a WCM Member develops a new potential CCS-Eligible Condition the referral must be made as soon as possible to the County CCS Program for an eligibility determination and the MCP must not wait until the annual CCS medical eligibility redetermination period.

Following the initial referral, MCPs must promptly submit comprehensive medical documentation sufficient to allow for CCS eligibility determination by the County CCS Program. This includes the Member's most current Medical Records that document the Member's medical history, results of a physical examination by a physician, physician's assistant, or nurse practitioner acting within the scope of their licensing authority, laboratory test results, radiologic findings, or other tests or examinations that support the diagnosis of the eligible condition(s), including any MTP diagnosis.[20, 21] If applicable, NICU discharge summaries or High Risk Infant Follow-Up (HRIF) reports and final report which may confer the potential CCS-Eligible Condition(s) must also be included. All documentation must be, to the extent possible, produced within the last six months but no later than twelve months. If the County CCS Program notifies the MCP of a referral that is missing documentation or requires additional documentation to make an eligibility determination, the MCP must attempt to obtain and provide to the County any additional information the County requires, such as the above listed medical documentation. The MCP must have procedures in place regarding outreach attempts to the Provider and Member to obtain the Medical Records as well as appropriate actions if Medical Record recovery is unsuccessful.

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[19] See the CCS Medical Eligibility Guide at: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/CCSPubs.aspx
[20] See Title 22 California Code of Regulations (CCR) section 41515.1. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[21] See CCS N.L. 08-1023 and CCS N.L. 07-1023.

If the required documentation for the annual medical redetermination is not available to the County CCS Program, the MCP must provide the documentation, including efforts made to receive the documentation, no later than 60 calendar days before the Member's program eligibility end date, unless the County CCS Program verifies that all needed medical information is already available to them.

MCPs must notify and engage in a collaborative process with the County CCS Programs to remedy any issues or challenges related to the timeliness and/or completeness of records provided by the MCP that are needed for the initial determination and Annual Medical Redetermination. This can be done via monthly collaborative meetings with MCPs or other venues that are deemed appropriate by both entities. The MCP and County CCS Program must document the follow up collaboration processes in their MOU.

If a Member is no longer eligible for the Medi-Cal Program, the MCP must notify the County CCS Program as soon as the MCP is made aware, but no later than 15 calendar days of being made aware.

MCPs must refer to the County CCS Program, all Members identified as meeting the criteria for the NICU eligibility assessment as described below. CCS NICU eligibility may involve identification of a potential CCS-Eligible Condition which may confer CCS Program eligibility beyond the NICU stay. The MCP must inform the County CCS Program if a Member is at any point subsequently identified as having a potential CCS-Eligible Condition so that the County CCS Program can conduct the CCS eligibility determination process for the Member. MCPs must review authorizations and determine if services meet CCS NICU referral requirements in accordance with CCS Program guidelines found in CCS NICU Standards and CCS N.L. 02-0413, or any superseding N.L.[22]

MCPs must refer all Members with a potential MTP eligible condition to the County CCS Program and must include all supporting documentation with the referral. As a part of the CCS eligibility review, the County CCS Program will review and determine MTP eligibility. County MTPs must submit referrals to MCPs for Medically Necessary specialty services and follow-up treatment, as prescribed by the MTC physician or CCS-paneled physician who is providing the MTP medical direction for occupational and physical therapy services.[23]

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[22] For more information on NICU authorizations and program guidelines see N.L. 02-0413: NICU Authorizations, or any superseding N.L. For more information of CCS NICU referral requirements and standards please see https://www.dhcs.ca.gov/services/ccs/Pages/ProviderStandards.aspx.

[23] Ibid.

Data Analytics to Assess Referrals

MCPs must conduct, at least quarterly, a review of their inpatient utilization data to assess whether all potential WCM Members have been appropriately referred to the County CCS Program. If the MCP identifies any Members that have a potential CCS Eligible-Condition and a referral has not been made to the County CCS Program, the MCP must promptly refer the Member, providing their most recent medical records as outlined above.

F. Dispute Resolution

Medical eligibility determinations disputes between the MCP and the County CCS Program must be resolved by the County CCS Program. The County CCS Program, in consultation with DHCS in dependent counties, must make a medical eligibility determination. [24] The County CCS Program must communicate all resolved disputes in writing to the MCP.

If other disputes arise between the MCP and the County CCS Program, all parties must fulfill their responsibilities in alignment with DHCS policies, including the APL, NL, MCP Contract and WCM MOU, without delay. This includes ensuring that Members have timely access to services as specified under the WCM MOU. DHCS encourages both MCPs and County CCS Programs to attempt to resolve all disputes collegially, effectively, and at the local level before submitting the dispute to DHCS for resolution.

If disputes between the MCP and the County CCS Program cannot be resolved, the dispute must be submitted to DHCS by either entity, via email with subject "Request for Resolution" to CCSProgram@dhcs.ca.gov, for review and final determination. The Request for Resolution must include:

1. A summary of the disputed issue(s) and a statement of the desired remedies;
2. A history of the attempts to resolve the issue(s);
3. Justification for the desired remedy; and
4. Any additional documentation that are relevant to resolve the dispute, if applicable.

G. Provider Grievances

MCPs must have a formal process to accept, acknowledge, and resolve Provider disputes and grievances.[25] A CCS Provider may submit directly to the MCP a dispute or grievance concerning the processing of a payment or non-payment of

[24] W&I section 14093.06(b).
[25] W&I section 14094.15(d).

a claim by the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS Providers.

II. MCP RESPONSIBILITIES TO WCM MEMBERS

MCPs must allow Members to access CCS-Paneled Providers within all of the MCP's subcontracted Provider Network for CCS services. MCPs must ensure that information, education, and support is continuously provided to WCM Members and their families to assist in their understanding of the WCM Member's health, other available services, and overall collaboration on the WCM Member's Individual Care Plan (ICP).

A. Case Management and Care Coordination[26]

CCS Case Management is a Member and family centered care approach to ensure needed clinical and non-clinical services for the CCS-Eligible Condition, are made available to each WCM Member through comprehensive, interdisciplinary, and person-centered care management and Care Coordination to provide case finding, authorizations for services and Care Coordination to ensure that WCM Members have access to CCS paneled Providers, equipment, and services necessary for treatment of the CCS-Eligible Condition. Additional information on CCS Case Management can be found in WCM N.L. 10-1224 Attachment A: CCS Case Management Core Activities.

MCPs must designate a CCS Case Manager as an individual identified as a primary point-of-contact responsible for the provision of case management services and facilitation of Care Coordination for a Member receiving services through the WCM Program who has knowledge of or adequate training on the CCS Program and clinical experience with either the CCS population or pediatric patients with complex medical conditions for each Member.[27] MCPs must provide Case Management and Care Coordination, including referrals to subspecialists, if not previously referred by the Primary Care Provider (PCP), and service authorizations for WCM Members and their families. MCPs that delegate the provision of CCS services to Subcontractors and Network Providers must ensure that all Subcontractors and Network Providers provide Case Management and Care Coordination for Members. Members may decline Case Management services without impact to their enrollment and/or participation in the WCM Program.

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[26] W&I section 14094.11(b)(1)-(6)

[27] WCM Programs previously used the term "CCS Liaison" to mean the primary point of contact responsible for the provision of case management services and facilitation of Care Coordination pursuant to AB 118. WCM Programs have since shifted to using "CCS Case Manager" in order to align with the CCS Case Manager and CCS Liaison definition in the MCP Contract.

The CCS Case Manager can also be a point of contact for other care managers and service Providers that serve WCM Members, including Enhanced Care Management (ECM) and Community Supports Providers. ECM can be provided in addition to the WCM Program. When WCM Members are eligible for and choose to receive both CCS Case Management and ECM services, the MCP may assign some or all CCS Case Manager functions to be delivered by qualified ECM Providers, as outlined in DHCS's ECM Policy Guide.[28] To be qualified for assignment of CCS Case Management functions, ECM Providers must meet all existing CCS and WCM requirements to provide Case Management services. In addition, these qualified ECM Providers must have previous experience directly providing CCS Case Management and/or CCS clinical services. This only applies when MCPs assign some or all CCS Case Manager functions to an ECM Provider. If these functions are not being assigned, an ECM provider does not need to meet these additional requirements.

MCPs are expected to ensure that Members receiving ECM services do not receive duplicative CCS WCM services. Specifically, MCPs are required to demonstrate how they will prevent duplication in their respective Models of Care. Where it is appropriate and feasible, DHCS encourages MCPs to ensure children and youth receive comprehensive, non-duplicated care across ECM and the WCM Program.[29]

For WCM Members receiving CCS Case Management and either Complex Care Management (CCM) or ECM, MCP must ensure the appropriate coordination of care across all settings, including, but not limited to, between the Members' PCP, CCS specialty services, and, if applicable, Non-Specialty Mental Health Services and Regional Center services.

1. **Age-Out Planning Responsibility[30]**
   MCPs must maintain a process for preparing Members approaching WCM Program age limitations, including identification of primary care, specialty care Providers appropriate to the Member's CCS-Eligible Condition(s). The Care Coordination plan must be developed at least 12 calendar months before the WCM Member ages out.

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[28] The ECM Policy Guide is available at: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf.
[29] Additional information on coordination of services for Members eligible for and receiving both CCS Case Management and ECM services can be found in the CalAIM ECM Policy Guide.
[30] MCPs are Contractually required to provide or arrange for all Medically Necessary Covered Services for Members.

MCPs must identify and track WCM Members for the duration of their participation in the WCM Program and, for those who continue to be enrolled in the same MCP, for at least 36 calendar months after they age-out of the WCM Program, to the extent feasible.[31]

2. **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 of the WCM Member. The MCPs must provide Care Coordination to WCM Members in need of an adult Provider when the WCM Member no longer requires the services of a pediatric Provider. The timing of the transition must be individualized to take into consideration the WCM Member's medical condition and the established need for care with adult Providers.

B. Eligibility Assessments

MCPs must provide screening, diagnostic, and treatment services in accordance with APL 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services for Medi-Cal Members Under the Age of 21, or any superseding APL, to identify potential WCM Members.

MCPs must conduct NICU eligibility assessments in accordance with CCS Program guidelines for medical eligibility for care in a CCS-approved NICU, as found in CCS N.L. 05-0502, or any superseding N.L. All Members identified as meeting the criteria for the NICU eligibility assessment must be referred to the County CCS Program as described above.

MCPs must conduct HRIF program eligibility assessments and authorize any HRIF services for Members in accordance with the HRIF Eligibility Criteria. MCPs must ensure access or arrange for the provision of HRIF case management services.

C. Risk Level and Needs Assessment Process

Once CCS County Programs determine eligibility, MCPs must assess each WCM Member'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. This Risk Level and Needs Assessment requirements for WCM are concurrent and independent from MCP requirements to implement Risk Stratification, Segmentation, and Tiering requirements in Population Health

[31] W&I section 14094.12(j)

Management.[32] MCPs are required to develop and complete the risk assessment process for WCM Members, new eligible WCM Members, or newly transferred WCM Members.[33] The risk assessment process must include a pediatric risk stratification process (PRSP) and ICPs for Members determined to be high risk through this process.[34]

All requirements are dependent on the Member's risk level, as determined through the PRSP. Furthermore, nothing in this APL removes or limits the MCPs' existing survey or assessment requirements that they are responsible for outside of WCM.

1. **Pediatric Risk Stratification Process**
   MCPs must have a pediatric risk stratification mechanism, or algorithm, to identify the WCM Member's risk level that will be used to classify Members into high and low risk categories, allowing MCPs to identify Members who have more complex health care needs.

   MCPs are required to complete a risk stratification within 45 calendar days of the County CCS Program eligibility determination for newly eligible WCM Members and Newly transferred WCM Members. The risk stratification will assess the Member's risk level through:
   - 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 the time of PRSP.

   Members who do not have any medical utilization data, claims processing data history, or other assessments and/or survey information available must be automatically 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.

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[32] Details on Risk Stratification, Segmentation, and Tiering requirements for MCPs' Population Health Management programs are found in the DHCS Population Health Management Policy Guide, available at: https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf.
[33] Newly eligible WCM Members means Members recently determined to be eligible for the WCM Program with no history of participation in the WCM or CCS Programs. Newly transferred WCM Member means any Member who is new to the MCP but already a part of the CCS/WCM Program, as in the case of ICT.
[34] The ECM Policy Guide discusses ICPs for high-risk Members. The ECM Policy Guide is available on the ECM and In Lieu of Services webpage that can be found at: https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Home.aspx.

2. Risk Assessment and Individual Care Plan Process

MCPs must have a process to assess a Member's current health, including CCS-Eligible Condition(s), to ensure that each WCM Member receives case management, Care Coordination, provider referral, and/or service authorization from a CCS-paneled Provider, as described below:

WCM 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 completed PRSP to assist in the development of the Member's ICP.[35] Any risk assessment survey created by MCPs for the purposes of WCM is subject to review and approval by DHCS.

WCM Members Determined Low Risk

For WCM Members identified as low risk, the Member must be assessed by telephonic and/or in-person communication within 120 calendar days of completed PRSP to identify the Member's health care needs.

Risk Assessment

The risk assessment process must address:

- General health status and recent health care utilization which 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;
- Health history which may include, but is not limited to, both CCS and non-CCS diagnoses and past surgeries;
- Specialty provider referral needs;
- Prescription medication utilization;
- Specialized or customized durable medical equipment (DME) needs (if applicable);
- Need for specialized therapies (if applicable) which may include, but is not limited to, physical, occupational, or speech therapies, mental or behavioral health services, and educational or developmental services;
- Limitations of activities of daily living or daily functioning (if applicable); and

[35] For Members transitioning into the WCM Program from Classic CCS Program, the MCPs must complete ICPs for high-risk Members within 12 calendar months of the transition.

- Demographics and social history which may include, but is not limited to, Member demographics, assessment of home and school environments, and a cultural and linguistic assessment.

The risk assessment process must be tailored to each WCM Member's age group. At the MCP's discretion, additional assessment questions may be added to identify 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.

Annual Redeterminations and Reassessments
MCPs must also conduct risk assessments to reassess Member's risks and needs during the annual medical eligibility redetermination period, or upon the report of a significant change to a Member's condition as appropriate.

Individual Care Plan
MCPs must establish an ICP for all Members determined to be high risk based on results the of risk assessment process, with particular focus on coordinated specialty care. ICPs for Members determined to be high risk based on the results of the risk assessment process must be established within 90 calendar days of a completed risk assessment survey or other assessment, by telephonic and/or in-person communication.[36] If a Member's family declines having an ICP developed, the MCP must notate the denial in the Member's medical record as evidence of MCP compliance.

The ICP must, at a minimum, incorporate the WCM Member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Primary and specialty care by a CCS-Paneled Provider;
- Preventive care services with specialty care services;
- Mild to moderate or county specialty mental health services;
- EPSDT services including but not limited to palliative care[37];
- MTP services;
- County substance use disorder or Drug Medi-Cal services;
- Home and community-based services;

[36] W&I section 14094.11(b)(4)
[37] 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.

- Regional center services; and
- Other Medically Necessary services provided within the MCP Network, or, when necessary, by an OON Provider.

The ICP must be developed by the MCP case management team and must be completed in collaboration with the WCM Member, Member's family, and/or the Member's designated caregiver, as applicable. The ICP must indicate the level of care the Member requires (e.g., case management and Care Coordination, CCM, or ECM).[38] The ICP must also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[39] If the WCM Member is also enrolled in ECM through Medi-Cal, the ICP must also be referenced in ECM-related care management activities.[40]

- Access instructions for families so that families know where to go for ongoing information, education, and support in order that they may understand the goals, treatment plan, and course of care for the WCM Member and the family's role in the process; what it means to have primary or specialty care for the WCM Member; when it is time to call a specialist, primary, urgent care, or emergency room; what an interdisciplinary team is; and what community resources exist;

- A primary or specialty care physician who is the primary clinician for the WCM Member and who provides core clinical management functions;

- Case management and Care Coordination for the WCM Member across the health care system, including transitions among levels of care and interdisciplinary care teams, as well as coordination of care plans across specialties including mechanisms to track completion of follow up visits, if applicable. For example, it is expected that MCPs will confirm whether Members receive referred treatments and document when, where, and any next steps following treatment. If a Member does not receive referred

[38] For the WCM Program, CCM has the same meaning ascribed by MCP's Medi-Cal Managed Care Contract with DHCS. CCM means an approach to comprehensive care management that meets differing needs of high and medium rising-risk Members, through both ongoing chronic Care Coordination and interventions for episodic, temporary needs. Contractors must provide CCM in accordance with all National Committee for Quality Assurance CCM requirements.
[39] W&I section 14094.11(c)
[40] The DHCS Enhanced Care Management Policy Guide details ECM eligibility criteria for Medi-Cal members enrolled in CCS or WCM, as well as how ECM lead care managers must consider available information from the ICP. The ECM Policy Guide is available at: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf.

treatments, the MCP must follow up with the Member to assist in planning next steps in Care Coordination, understand barriers, and make adjustments to the referrals if warranted. MCPs must also attempt to connect with the Provider to whom the Member was referred to and facilitate a warm hand off to necessary treatment; and

- Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

WCM Transitioning Members

For Members transitioning into the WCM Program from Classic CCS Programs, the MCP must complete the PRSP within 45 calendar days of transition to determine each Member's risk level. The MCP must also 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 of the transition. Additionally, the MCP must reassess a Member's risk level and needs at the annual medical eligibility redetermination, or upon a significant change to a Member's condition.

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

Regardless of a Member's risk level, all communications, whether by phone, mail, or other forms of communication, must inform the Member and/or the Member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and must identify the method by which providers will arrange for in-person assessments.[41,42]

D. Continuity of Care for WCM Implementation[43]

MCPs must be able to initiate, accept, and process continuity of care requests from Transitioning Members, providers, and authorized representatives

[41] For more information on Diversity, Equity, and Inclusion Training Program Requirements, including the definition and requirements applicable, see APL 23-025, or any superseding APL on this topic.
[42] See APL 22-002: Alternative Format Selection for Members with Visual Impairments or any superseding APL.
[43] WCM Implementations generally occur as a result of changes in legislative guidance, including but not limited to the expansion of the WCM program to additional counties.

beginning 60 calendar days prior to the Transition Date. MCPs must begin to process all continuity of care requests within five business days of receipt. Additionally, each continuity of care request must be completed within the following timelines from the date the MCP received the request:

- 30 calendar days for non-urgent requests;
- 15 calendar days if the Member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
- As soon as possible, but no longer than three calendar days for urgent requests (i.e., there is identified risk of harm to the Member).[44]

1. **Continuity of Care for Providers**
   Upon receipt of detailed transition data from DHCS for each Transitioning Member, or at least 30 calendar days prior to the transition date, whichever occurs sooner, the MCP must conduct outreach to OON continuity of care eligible providers[45] with whom Members have pre-existing relationships to initiate a Network Provider Agreement or a continuity of care for Providers agreement. MCPs must review all available data within 30 calendar days of receiving data for the Member, including but not limited to the Member level detailed transition data from DHCS to identify the OON continuity of care eligible providers that provided services to Members during the 12 months preceding the Transition Date. MCPs must complete outreach to all eligible OON providers within 60 calendar days of the Transition Date. Outreach is defined as at least three separate attempts made to the eligible OON provider to make contact. These outreach attempts must include at least two different modes of communication such as, phone calls, emails, mailers, etc. DHCS reserves the right to request materials from the MCP documenting its outreach attempts. After making contact with the OON provider(s), MCPs must engage in good faith negotiations to achieve agreement.

   The MCP must notify the Member and the Member's CCS Case Manager within seven calendar days after processing the continuity of care for

[44] For the purposes of this APL, "risk of harm" is defined as an imminent and serious threat to the health of the Member.
[45] Provider types eligible for Continuity of Care for Providers are: PCPs, specialists, ECM Providers, Community Support providers, Skilled Nursing Facilities, and Intermediate Care Facilities for individuals with Developmental Disabilities. This also includes select ancillary Providers: dialysis centers, physical therapists, occupational therapists, respiratory therapists, mental health Providers, behavioral health treatment Providers, speech therapy Providers, and community health workers.

Providers, when applicable, if the Member's Provider is in Network, or is brought in Network as a result of the MCP's outreach, and the MCP must send notification that the Member may continue with their Provider. If the MCP and the OON Provider are unable to reach an agreement because they cannot agree to a rate, or the MCP has documented quality of care issues with the Provider, the MCP must offer the Member an alternative Network Provider.

2. **Continuity of Care for Covered Services - Prior Authorization and Active Course of Treatment**
   MCPs must honor active Prior Authorizations[46] identified in any data available to the MCP and/or when requested by a Transitioning member, provider, or authorized representative, and the MCP obtains documentation of the Prior Authorization before or within the six-month period following the Transition Date. DHCS and MCP authorization protocols may differ, therefore MCPs must allow Members to continue an Active Course of Treatment without Prior Authorization for the six-month period following the Transition Date. Upon receipt of Member level detailed transition data from DHCS and continually during the six-month period following the Transition Date, the MCP must examine all available data to identify any Active Course of Treatment that requires authorization. If an Active Course of Treatment is identified, the MCP must contact the prescribing and/or ordering Providers within 30 calendar days of discovery to establish any necessary Prior Authorizations. MCPs must continue to honor any Prior Authorization and Active Course of Treatment for the full six-month period following the Transition Date and until reassessment for medically necessary services. If the MCP does not reassess for medical necessity during the six-month period, the MCP must continue to honor Prior Authorizations and Active Courses of Treatment beyond the six-month period and until the MCP reassess medical necessity for ongoing services. If the Provider serving the Member is OON and does not enter into a continuity of care for Providers Agreement with the MCP, the MCP must engage the Member to continue the Member's Active Course of Treatment with a Network Provider.

[46] For the purposes of this APL, Prior Authorization means a formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.

3. **Durable Medical Equipment Providers and Medical Supplies**
   MCPs must allow members to keep their existing Durable Medical Equipment (DME) rentals and medical supplies from their existing DME Providers without further authorization for the full 12-month period following the Transition Date and until a reassessment has been completed and the new equipment or supplies are in the possession of the Member and ready for use. If the MCP does not complete a reassessment during the 12-month period, the MCP must allow Members to continue to keep their existing DME rentals or medical supplies beyond the 12-month period and until the MCP completes the reassessment. After 12 months from the Transition Date, the MCP may reassess the Member's authorization at any time and may require the Member to switch to a Network Provider of DME or medical supplies. If the MCP does not complete a new assessment, the authorization remains in effect for the duration of the original treatment authorization.

4. **Continuing Services with County CCS Program Public Health Nurse**
   MCPs must allow a WCM Member or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives to request continuing case management and Care Coordination from their CCS County public health nurse (PHN) within 90 calendar days of transitioning to the WCM program.[47] MCPs must begin to process non-urgent requests for continuing PHN services within:
   - Five working days of receipt of the request and complete the request within 30 calendar days of receipt.
   - 15 calendar days of receipt of the request if the Member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs.
   - As soon as possible but no longer than three calendar days for urgent requests (i.e., there is identified risk of harm to the Member).

   MCPs must make good faith efforts to reach a mutually agreeable financial arrangement for reimbursing the County CCS Program for continuing PHN services. If the MCP is unable to enter into such an arrangement, it must submit a waiver request to DHCS on the basis that reimbursement at the County CCS Program's proposed rate would result in increased program costs. If DHCS denies the waiver, the MCP must enter into an agreement with the County CCS Program to reimburse at the County CCS Program's proposed rate.

[47] W&I section 14094.13(g)

If the requested County CCS Program PHN is no longer available to provide case management and Care Coordination, the MCP must transition those services to one of its CCS Case Managers who has received adequate training on the CCS Program, and has clinical experience with the CCS population or pediatric patients with complex medical conditions.

5. **Member and Provider Outreach and Education**
   MCPs must follow the Member notification guidelines for continuity of care requests outlined in APL 23-022 or any superseding APL.[48] MCPs must inform Members of their continuity of care protections and include information about these protections in Member information packets, handbooks, and on the MCP's website.[49] This information must include how a Member, Provider, and an Authorized Representative may initiate a continuity of care request with the MCP. In accordance with APL 21-004 or any superseding APL, the MCP must translate these documents into threshold languages and make them available in alternative formats, upon request. MCPs must provide training to call center and other staff who come into regular contact with Members about continuity of care protections.

E. General Continuity of Care

This APL does not in any way limit the MCP's obligation to fully comply with the requirements of H&S section 1373.96 and all applicable APLs regarding continuity of care.[50] Sections 1 through 3 below include additional continuity of care requirements that only pertain to the WCM Program.

1. **Specialized or Customized Durable Medical Equipment**
   If a Member has a pre-existing relationship with a specialized or customized DME Provider, the MCP must provide access to that Provider for up to 12 months.[51, 52] The MCP is required to pay the Provider at rates that are at least equal to the applicable CCS FFS rates, unless the DME Provider and the

[48] Per APL 23-022, Member noticing must include a statement of the MCP's decision, the duration of the continuity of care arrangement, the process that will occur to transition the Member's care at the end of the continuity of care period, and the Member's right to choose a different Network Provider.
[49] H&S sections 1363(a)(15) and 1373.96.
[50] See APL 23-018: Managed Care Health Plan Transition Policy Guide, or any superseding APL.
[51] W&I section 14094.13(b)(2)(A)
[52] A pre-existing relationship means the Member has seen a CCS Provider for a nonemergency visit, at least once during the 12 months prior to the date of transition to the WCM Program.

MCP mutually enter into an agreement on an alternative payment methodology. The MCP may extend the continuity of care period beyond 12 months for specialized or customized DME still under warranty and deemed Medically Necessary by the treating Provider.[53]

Specialized or customized DME must be:

- Uniquely constructed or substantially modified solely for the use of the Member;
- Made to order or adapted to meet the specific needs of the Member; and
- 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. **Authorized Prescription Drugs**
   WCM Members transitioning into MCPs must be allowed continued use of any currently prescribed drug that is part of their prescribed therapy for the CCS-Eligible Condition(s) immediately prior to the date of enrollment, whether or not the prescription drug is covered by Medi-Cal Rx.[54] Physician Administered Drugs will be provided by the MCP and must also be continued. The WCM Member must be allowed to use the prescribed drug until the MCP and the prescribing physician have completed an assessment, created a treatment plan, and agree that the particular drug is no longer Medically Necessary, or the prescription drug is no longer prescribed by the County CCS Program Provider.[55] In such cases, the MCP must send a Notice of Action (NOA) to the WCM Member informing them of the service change, as well as their appeal rights.[56]

3. **Extension of the Continuity of Care Period**[57,58]
   MCPs, at their discretion, may extend the continuity of care period beyond the initial 12-month period. MCPs must provide WCM Members with a written notification 60 calendar days prior to the end of the continuity of care period informing Members of their right to request a continuity of care extension and

[53] W&I section 14094.13(b)(3)
[54] See APL 22-012: Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal RX, or any superseding APL.
[55] W&I section 14094.13(d)(2).
[56] See APL 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates, or any superseding APL.
[57] H&S section 1373.96.
[58] W&I section 14094.13(k).

the WCM appeal process for continuity of care limitations. The notification must be submitted to DHCS for approval and must include:

- The Member's right to request that the MCP extend of the continuity of care period;
- The criteria that the MCP will use to evaluate the request; and
- The appeal process should the MCP deny the request (see section F below).

In addition to the WCM continuity of care protections set forth above, MCP Members also have continuity of care rights under current state law as described in APL 23-022*,* Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023, or any superseding APL.

F. Grievance, Appeal, and State Hearing Process

MCPs must ensure that all Members are provided information on Grievances, Appeals, and State Hearing rights and processes. All WCM Members must be provided the same Grievance, Appeal, and State Hearing rights as other MCP Members. This includes the right of the WCM Member to Appeal or request a State Hearing regarding an MCP denial of the extension of a continuity of care period.[59]

MCPs must have timely processes for accepting and acting upon Member Grievances and Appeals.[60] Members appealing a CCS eligibility determination must appeal to the County CCS Program. MCPs must also comply with the requirements pursuant to APL 21-004*:* Standards for Determining Threshold Languages, Nondiscrimination Requirements and Language Assistance Services, or any superseding APL.

As stated above, WCM Members and their families/designated caregivers may request extended continuity of care with the MCP beyond the initial 12-month period. MCPs must process these requests like other standard or expedited Prior Authorization requests according to the timeframes contained in APL 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates, or any superseding APL.

If an MCP denies a request for extended continuity of care, it must provide the Member with a written NOA informing them of their right to further Appeal the

[59] W&I Section 14094.13(j).
[60] See APL 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates, or any superseding APL.

denials by the MCP and of the Member's State Hearing rights following the appeal process. This also includes cases of Deemed Exhaustion or when Members exhaust the plan's internal Appeal process. MCPs must follow all noticing and timing requirements contained in APL 21-011, or any superseding APL, when denying extended continuity of care requests and when processing Appeals. As required in APL 21-011, if MCPs make changes to any of the noticing templates, they must submit the revised notices to DHCS for review and approval prior to use.

G. Blood, Tissue, and Solid Organ Transplants

MCPs are required to cover all Medically Necessary blood, tissue, and solid organ transplants for WCM Members as outlined in the Medi-Cal Provider Manual, including all updates and amendments to the manual.[61] The MCP must refer WCM Members to a CCS-approved SCC, that has current CCS approval to transplant the specified blood, tissue, or solid organ transplants in the Member's age group (i.e., pediatric vs. adult), for an evaluation within 72 hours of the Member's PCP or specialist identifying the WCM Member as a potential candidate for a blood, tissue, and solid organ transplants. MCPs must authorize the request for the blood, tissue, and solid organ transplants after the SCC confirms that the Member is a suitable candidate for the blood, tissue, and solid organ transplants.[62]

H. Transportation

MCPs are responsible for authorizing CCS Maintenance and Transportation (M&T), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).[63]

Reimbursements for M&T expenses are available to the WCM Member/family in accordance with CCS N.L. 03-0810, or any superseding N.L.[64] MCPs must provide and authorize the CCS M&T benefit for WCM Members or the Member's family seeking transportation to a medical service related to their CCS-Eligible Condition(s) when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary costs (e.g. parking, tolls, etc.), in addition to transportation expenses, and must comply with the requirements listed in CCS N.L. 03-0810, or any superseding version of

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[61] The Medi-Cal Provider Manual can be found at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual.
[62] H&S section 1367.01
[63] See APL 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses, or any superseding APL.
[64] W&I section 14094.15

that N.L. These services include, but are not limited to, M&T for out-of-county and out-of-state services, and reimbursement for private car conveyance at the Internal Revenue Service standard mileage rate for medical transportation in effect on the date the travel occurred.

If the WCM Member or the Member's family paid for M&T expenses up front, the MCP must approve and reimburse the Member or the Member's family no later than 60 calendar days following confirmation that all required receipts and documentation have been received. MCPs are required to submit updated P&Ps outlining required documentation.

MCPs must also comply with all requirements listed in the MCP Contract and APL 22-008, or any superseding APL, for WCM Members to obtain NEMT and NMT exceeding the CCS M&T benefit as set forth in CCS N.L. 03-0810, or for services not related to a Member's CCS-Eligible Condition(s).

I. OON Access

MCPs must provide all Medically Necessary services by CCS paneled providers, which may require the Member to be seen OON. MCPs must allow WCM Members access to OON providers in order to obtain Medically Necessary services if the MCP has no specialists that treat the CCS-Eligible Condition(s) within the MCP's Provider Network, or if in-Network Providers are unable to meet timely access standards.[65] WCM Members and providers are required to follow the MCP's authorization to obtain appropriate approvals before accessing an OON provider. MCPs must ensure that WCM Members requesting services from OON providers are provided accurate information on how to request and seek approval for OON services. MCPs cannot deny OON services based on cost or location. Transportation must be provided for Members obtaining OON services. These OON access requirements also apply to the MCP's Subcontracted Provider Networks.

The MCP and their Subcontracted Provider Networks must ensure Members have access to all Medically Necessary services related to their CCS condition(s). If WCM Members require services or treatments for their CCS condition(s) that are not available in the MCP's or their Subcontracted Provider Networks, the MCP must identify, coordinate, and provide access to an OON CCS-paneled specialist.

[65] See Title 42 Code of Federal Regulations (CFR) section 438.206(c). The CFR is searchable at: https://www.ecfr.gov/.

J. Advisory Committees

MCPs must meet quarterly with a Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics.[66] The FAC must also include, but not be limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers.[67] Members serving on this advisory committee may receive a reasonable per diem payment to enable participation in the advisory committee.[68] A representative of this committee will be invited to serve as a Member of the statewide DHCS CCS stakeholder advisory group.

MCP representatives must meet quarterly with the CCS stakeholder advisory group composed of representatives of CCS providers, County CCS Program administrators, health plans, family resource centers, regional centers, recognized exclusive representatives of County CCS providers, CCS Case Managers, CCS MTUs, and representatives from Family Advisory Committees.

MCPs must also meet quarterly with a Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the County CCS administrator, medical director or designee, and at least four CCS-paneled Providers to advise on clinical issues relating to CCS-Eligible Conditions, including treatment authorization guidelines, and serve as clinical advisers on other clinical issues relating to CCS-Eligible Conditions.[69]

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 FFS rates, unless the Provider and the MCP mutually enter into an agreement on an alternative payment methodology.[70] MCPs are responsible for authorization and payment of all NICU and CCS NICU claims and for conducting NICU eligibility criteria assessments and authorizations in all WCM counties. The MCP must review authorizations and determine whether or not

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[66] MCPs are encouraged to use the recruitment recommendations listed in the Medi-Cal Member Advisory Committee: Design Recommendations for the California Department of Health Care Services. The recommendations can be found at: https://www.chcf.org/wp-content/uploads/2023/06/Medi-CalMemberAdvisoryCommittee.pdf.
[67] W&I section 14094.7(d)(3)
[68] W&I section 14094.17(b)(2)
[69] W&I section 14094.17(a)
[70] W&I section 14094.16(b)

services meet CCS NICU requirements. MCPs are also required to assume responsibility of coverage for PICU/NICU eligible newborns through their second month of life when the newborn's mother is Medi-Cal eligible and enrolled in the MCP.

IV. MCP RESPONSIBILITIES TO DHCS

A. Network Certification[71]

MCPs and their Subcontracted Provider Networks are required to meet specific Network certification requirements while participating in the WCM Program, which includes having an adequate Network of CCS-paneled Providers and approved facilities to serve WCM Members including physicians, specialists, allied professionals, SCCs, hospitals, home health agencies, and specialized and customizable DME providers.[72]

The WCM Network certification requires MCPs to submit updated P&Ps and their CCS-paneled Provider Networks via a WCM Provider Network Reporting Template.[73]

Subcontracted Provider Networks that do not meet WCM Network certification requirements will be excluded from participating in WCM until DHCS determines that all certification requirements have been met. MCPs are required to provide oversight and monitoring of all Subcontracted Provider Networks to ensure Network certification requirements for WCM are met.

In accordance with APL 23-001: Network Certification Requirements, or any superseding APL, WCM MCPs must request to add Subcontracted Provider Networks to their WCM Network no later than the Annual Network Certification submission date provided in APL 23-001, or any superseding APL.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other Provider types must be CCS-paneled with full or provisional approval status.[74] MCPs cannot panel CCS Providers; however, they must ensure that CCS Providers in their Provider Network have an active panel status. MCPs

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[71] These requirements are further outlined in the APL 23-001: Network Certification Requirements, or any superseding APL.
[72] The CCS Provider List can be found at: https://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx.
[73] The WCM Provider Network Reporting Template will be provided to MCPs upon request by emailing DHCSMCQMDWCM@dhcs.ca.gov.
[74] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements.

must direct Providers who need to be paneled to the CCS Provider Paneling website.[75] MCPs can view the DHCS CCS-paneled Provider list online to ensure Providers are credentialed and continue contracting with additional CCS-paneled Providers.[76]

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 WCM Members. MCPs' written P&Ps must follow the credentialing and re-credentialing guidelines contained in APL 22-013: Provider Credentialing/Re-credentialing and Screening/Enrollment, or any superseding APL. MCPs must develop and maintain written P&Ps that pertain to the initial credentialing, re-credentialing, 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:[77]

- 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; and,
- Procedures to detect both under- and over-utilization of health care services.

D. MCP Reporting to DHCS

1. CCS Redesign Quality Performance Measures

DHCS convened the CCS Redesign Quality Performance Measure Subcommittee to identify and recommend measures to create a standardized set of performance measures by which CCS Classic and WCM will be

[75] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[76] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf
[77] See the MCP Contract, Exhibit A, Attachment III, Utilization Management Program.

compared. In accordance with AB 118, MCPs may be required to report on additional WCM related measures effective January 1, 2025.[78, 79]

2. **Reporting and Monitoring**
   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 on a monthly basis. 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 companion guides can be attained by emailing the Encounter Data mailbox at 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. The data collected will be used to determine areas of deficiency and emerging trends.

MCPs must review their contractually required P&Ps to determine if amendments are needed to comply with this APL. If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required P&Ps and MOUs, the MCP must submit its updated P&Ps or MOUs to its Managed Care Operations Division (MCOD)-MCP Submission Portal[80] within 60 calendar days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an attestation to the Portal within 60 calendar days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The attestation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all Subcontractors and Network Providers. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. MCPs should review their Network Provider and/or Subcontractor Agreements, including Division of Financial Responsibility provisions as appropriate, to ensure compliance with this APL. For additional information regarding administrative and monetary sanctions, see APL 23-

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[78] W&I section 14094.7(b)(1), H&S section 1367.03, and 28 CCR section 1300.67.2.2(c).
[79] See the California Children's Services Redesign Performance Measure Quality Subcommittee, available at: https://www.dhcs.ca.gov/services/ccs/Pages/RedesignSubcommittee.aspx
[80] The MCOD-MCP Submission Portal is located at: https://cadhcs.sharepoint.com/sites/MCOD-MCPSubmissionPortal/SitePages/Home.aspx.

012, and any subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Bambi Cisneros

Bambi Cisneros
Acting Chief, Managed Care Quality and Monitoring Division
Assistant Deputy Director, Health Care Delivery Systems